NHS Borders

Chair & Chief Executive's Office

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Your Ref
Our Ref KH/IB/

Lewis Macdonald
Convener
Health & Sport Committee
T3.60
The Scottish Parliament
Edinburgh EH99 1SP

Dear Lewis

Thank you for your letter dated 23rd December following NHS Borders appearance before the Committee on 15th December 2020. Can I once again apologise for the difficulties with our sound and video during the session and we are therefore particularly pleased to be able to provide you with further information on the areas you have highlighted. We have answered each question in turn below:

Financial Position

In particular costs incurred as result of COVID including support provided by SG. Details of any savings as a consequence of cessation of services, and some detail as to the tasks carried out by those staff who would normally have been working in areas closed or substantially reduced.

The board approved its financial plan for 2020/21 in April 2020. The plan outlined a projected deficit of £7.9m after expected savings delivery of £10.2m. Brokerage support of £7.9m (a reduction from the 2019/20 requirement of £8.3m) was requested from Scottish Government in order to meet the board's requirement to deliver a breakeven position. This plan was prepared in advance of the COVID-19 global pandemic and in line with Scottish Government in year financial planning the financial impact of COVID-19 is assessed through the preparation of the board's Local Mobilisation plan (LMP).

The most recent iteration of the board's Local Mobilisation plan identifies additional expenditure associated with COVID-19 of £18.2m, of which £14.6m is in relation to NHS Borders expenditure (the balance being social care costs incurred by the Scottish Borders health and social care partnership). A summary of COVID-19 expenditure is presented below:

	£m
Infection Prevention & Control measures	1.4
Local testing	0.6
Contact Tracing	0.8
Immunisation Programmes	1.1
Winter resilience	1.5
Hospital Bed Capacity	3.1
Primary Care and community services	1.2
Workforce resilience	2.6
Remobilising services	1.4
Infrastructure & Equipment	0.9
	14.6

The LMP highlights a further £8.1m shortfall against savings targets; this includes duplication of figures already highlighted in the board's financial plan (i.e. brokerage requirement).

Allocations totalling £12.3m have been received to date in relation to COVID-19 expenditure, with a balance of c.£6m (inclusive of social care) not yet allocated. Scottish Government have advised health boards that all costs related to COVID-19 will be fully funded and it is anticipated that a final allocation will be received in January against the balance not yet received.

The finance report presented to NHS Borders board in December 2020 reported on the financial performance to end October (7 months). This report outlined a year to date position of £4.73m deficit, inclusive of non-delivery of savings (£4.68m). This position is inclusive of COVID-19 expenditure and funding received to date. The year to date deficit is in line with the projected deficit highlighted in the board's financial plan.

Within this forecast we identified slippage of £1.6m against recurring savings planned to be delivered in year. This is however offset by a level of non-recurring benefits arising from the impact of COVID-19 on the delivery of core NHS services, estimated to be up to £6m by the end of March 2020.

A revised outturn forecast has been prepared following recent discussions in relation to brokerage and additional COVID-19 allocations and the board is now expecting to be able to deliver a breakeven position in 2020/21, subject to confirmation of our final anticipated allocations.

Workforce

Keen to understand the flexibility shown by the workforce and how this was managed through the initial lockdown and going forward

At the outset of the COVID-19 pandemic rapid arrangements to help sustain essential services were implemented through an internal deployment hub. Where risks to the continuity of patient facing/ essential services were identified, managers, in a staff partnership process, sought volunteers from within our own workforce to assist and support core

services. It was also recognised that whilst some services were essential, with prioritisation some services were stood down in the initial phase of the pandemic and this allowed staff to prepare for deployment to different roles, locations or services of greatest need, on a temporary basis. As our COVID-19 response has evolved, we have taken steps to ensure that staff views are fully taken into account when considering deploying staff to other areas or if staff express a preference to return to their substantive post or indeed to remain within their deployed post.

As an example, in April 2020, 21 members of administrative staff volunteered and undertook a rapid training and orientation training programme as ward based Health Care Support Workers. On a daily basis staffing levels were reviewed through the daily management huddle meetings and staff reassigned for their shift to support and sustain essential services.

I would acknowledge that NHS Borders staff have been highly flexible in challenging times and we are grateful for that support while recognising that staff also have understandable concerns about being moved from their normal work area. It was vital that staff were given the opportunity to discuss any anxieties they may have and guidance on supported conversations with managers and partnership leads was issued leading to the introduction of a Deployment Agreement Form so that staff who are asked to move role have an opportunity to fully discuss the alternative role they are being considered for and have a confidential opportunity (with their staff side representative if they wish) to discuss concerns such as an underlying health condition, risk assessment/COVID-19 age, PPE and training requirements.

The general principles in relation to deployment of non-clinical staff to Health Care Support Worker roles included:

- Managers will discuss proposed re-assignment and any restrictions identified in risk assessment using the agreed Staff Deployment process
- The staff voice will be heard and listened to at each stage in the process
- An occupational health clearance was undertaken for all staff deployed to a different work area
- The request to move to an alternate area must be within the scope of competence and capability of the staff member. Managers will provide reassurance in relation to use of risk assessment and Personal Protective Equipment and uniform
- Timescales of the re-assignment will be discussed in advance however it is unlikely that managers were able to confirm the specific duration due to the evolving nature of the pandemic
- There will be no financial detriment to staff who undertake reassigned duties i.e. continue to receive, as a minimum, your standard rate of pay and allowances
- Training and where possible orientation shifts provided to equip staff for the role and local induction to the department to establish where facilities and equipment are located
- Observance of social distancing measures.

In summer 2020, NHS Borders ran a programme of staff feedback and engagement called "Collecting Your Voices" – within this both clinical and non-clinical staff were interviewed to give us an insight into their experiences of working during the COVID-19 pandemic and all staff were encouraged to provide their views using any approach that they were comfortable

with. This included interviews, emails, letters, poems, art etc. As a result of the feedback received, further attention was given to the internal deployment process particularly emphasising that moves to a new area of work or occupation were by consent. As mentioned above, in partnership with staff side representatives, a Staff Deployment protocol for internal deployment was introduced to support both managers and staff members through the deployment process and a Deployment Agreement form was developed, including a section which provided details where it was deemed not appropriate to deploy a staff member following a detailed discussion with their manager.

The Collecting Your Voices output will also be used to help shape the organisation and our staff engagement approach post COVID-19. We are now in the process of planning phase two of this programme which will continue to use staff stories to build on our staff engagement. We have also done some initial triangulation between the outcome of Collecting Your Voices and our iMatter and Pulse surveys results. This will be used to influence our Staff Governance Action Plan and Organisational Development Strategy going forward

COVID-19 Outbreak within NHS Borders

How did this happen? What precautions taken to protect individual patients while in hospital? We have all seen pictures and footage of wards across the country and while staff are protected by PPE those in general beds do not appear to have any such provisions in place.

The precautions taken to protect individual patients in hospital include the testing of all admissions for SARS-CoV-2 and early isolation of patients with possible COVID-19 symptoms. Within shared bays patients are encouraged to wear fluid resistant surgical masks (FRSM) when not at their bedside. Alcohol based hand rub is available for patient use in bays and single rooms on a risk assessed basis. Staff wear PPE and FRSM in all areas of our service in line with the national infection control guidelines. As set out in these guidelines while the type of PPE required will vary across our services depending on the type of patient and procedure being carried out it is important to emphasise that all staff have access to and wear the appropriate PPE in line with these guidelines.

As your committee members will understand we know that the virus is extremely transmissible and this has led to outbreaks across the country and unfortunately, at the moment, the precise entry route of the virus into the wards where we have had outbreaks is not known. It is also important to emphasise that with the level of patient and staff movement and the inevitable human interaction that takes place in a hospital to provide appropriate levels of care, unfortunately even with the most effective Infection control mechanisms in place, it is possible for spread to occur. In relation to our recent outbreak this may have been a result of the admission of an asymptomatic patient, asymptomatic visitors or indeed staff to patient transmission and this may only become clearer once more information is available from viral sequencing. It is also possible, of course, that the introduction and spread of the virus was as a result of infection and transmission from more than one source.

I can also confirm that the outbreak preceded the introduction of regular lateral flow testing for patient facing staff and the recommendations on extended PCR testing of inpatients (repeat testing at day five of admission and post day five testing on ward moves). Both of these

should help to reduce the risk of similar outbreaks in the future and have now been implemented in NHS Borders in line with National guidance.

Other contributory factors may also include:

- At the time of the recent outbreaks we had seen increased levels of COVID-19 in the community and this clearly increases the risk of transmission to patients and staff outside our hospitals with a resultant increase in the chance of this then being transferred into our facilities.
- NHS Borders acute hospital (the BGH) and our Community Hospitals have a higher proportion of multi-occupancy bays than newer hospitals. This makes the control of any outbreak more difficult with less access to single rooms and cubicles.
- The overall level of occupancy in our hospitals and the resultant need to move patients around the site to ensure patients are in the best possible location for their required care.
- The need to move staff around the hospital and the use of bank staff to cover any staff absences. While we have worked to minimise staff movement, this has been a requirement to maintain safe staffing levels.

Service Change

There were exchanges (column 38) around the speed of change that occurred and the greater use of technology now being deployed with mention of virtual technology which you were planning to introduce as part of a transformation programme now accelerated. We note this was to be part of financial restructuring and a general shift of care into the community and wonder what level of savings to the board this is now producing or forecast to produce?

While NHS Borders is not yet in a position to quantify the savings produced by the greater use of digital technology this will be considered as we continue to develop our Financial and Remobilisation plans and as and when we are able to refocus our attention to future financial sustainability. In addition to the benefit of the wider introduction of this technology from a financial perspective it is also important to emphasise that we see this as a key part of our overall service strategy, and when used appropriately, that this will help to improve access and modernise our services. We have also mobilised technologic changes at a significant pace to support our workforce to work differently and for example 1,081 NHS Borders Staff accessed work remotely in December 2020.

Overall Capacity during Lockdown

We recognise initial decisions were to cease all non Covid and emergency services within secondary care. At what level of overall capacity were you operating at during the lockdown period and what consideration was given to an earlier restoration of services when the potential level of Covid patients was not being reached, particularly as numbers started to decline?

NHS Borders was able to continue to deliver emergency, urgent and cancer services throughout the initial response to COVID-19. We were also able to maintain a level of urgent outpatient services and whilst a decision was made to stop routine face to face outpatient

appointments we were able to continue to provide a degree of routine appointments virtually or by telephone, where this was clinically appropriate. This was in line with the initial lockdown recommendations put in place across the UK.

As the prevalence of COVID-19 in the Borders reduced in early summer we were able to begin remobilisation planning in May 2020, on the basis that rates were lower but that we were continuing to live with COVID-19 for the foreseeable future. Services were redesigned to ensure safe pathways and processes for both patients and staff where this could not be provided virtually. A robust governance system was established to ensure routine services were 'covid-safe' before restarting. Services were restored as early as they could be redesigned and the organisation assured they were employing appropriate processes to reduce the ongoing risk of COVID-19 infection.

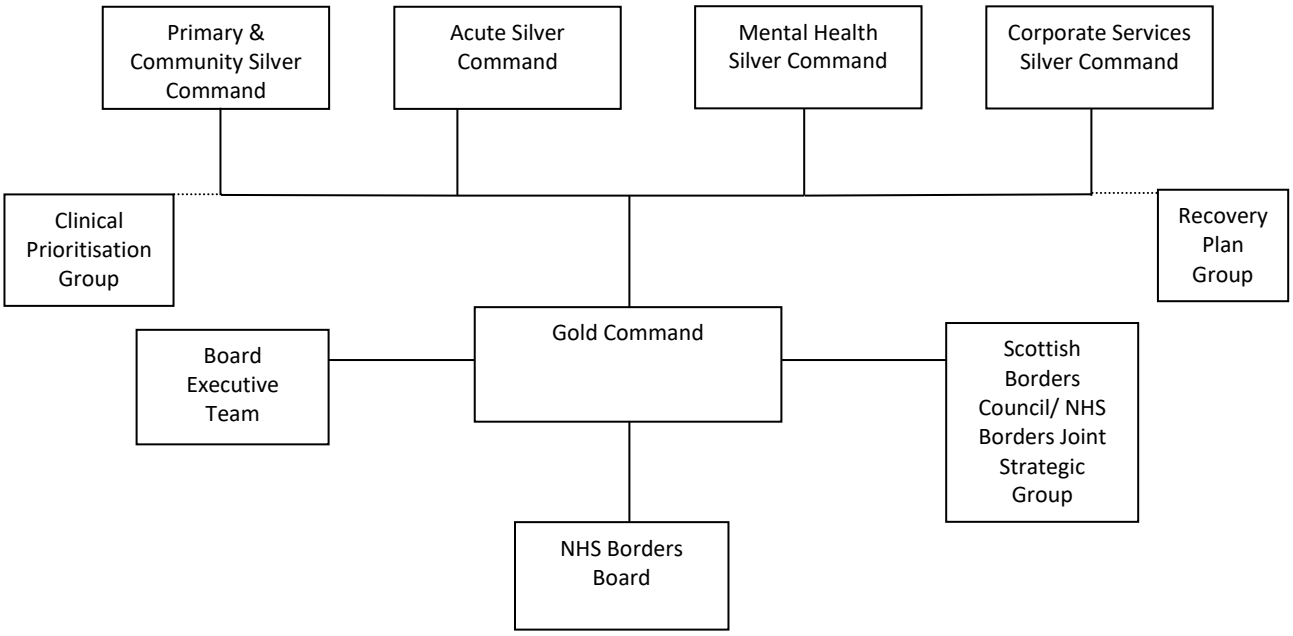
Command Structures

The Committee are also interested in the command structures that were employed. While recognising you are "a small board" and your "board's area is not huge", which might have made communications easier, we wonder how many tiers of command were operating throughout lockdown? We note your approach was "clinically led and driven" and are interested in how the interactions that took place between those clinicians leading the response and general management sat within the structures.

In response to the pandemic NHS Borders established a COVID-19 Pandemic Committee (Gold Command) which is chaired by the Chief Executive. Membership includes all of the Board Executive Team, the IJB Chief Officer and has representatives from across the system including a Consultant Microbiologist and Infection Control Manager. Our Social Care partners from Scottish Borders Council and Scottish Ambulance Service are also key members of the committee. Military staff who have been allocated to the Board also attend.

The purpose of the committee is to operationally oversee and manage the response of NHS Borders to the COVID-19 Pandemic. At the outset of the Pandemic the committee met on a daily basis and as we moved through the first wave into remobilisation this was reduced to weekly with members on standby should there be a need to increase the frequency of the meetings. As we have moved into Wave 3 we are currently meeting twice a week.

Each of our Business Units also has a Silver Operational Command Committee; these are a forum for managing the pandemic response within their own clinical area and to agree issues to be escalated to Gold Command as required. The chart below demonstrates NHS Borders Command & Control Structure:



As well as the Pandemic Committee we also established a Recovery Planning Group, the remit of which has been to bring together each Business Units individual plans into a shared whole system Remobilisation Plan and subsequent Resurgence Plan. This group has membership from across NHS Borders and our key partners. The group meets on a weekly basis and makes recommendations to the Borders Executive Team and the COVID-19 Pandemic Committee in relation to our continued response to COVID-19.

NHS Borders also participates in a weekly joint meeting with the Scottish Borders Council Management Team and the IJB to ensure our COVID-19 response is appropriately coordinated and managed, the frequency of this meeting can be flexed as and when it is needed.

Remobilisation

In relation to remobilisation could you provide further detail on the timings you are currently working towards to clear the backlog of cases. We also note Ralph Roberts indicated (column 42) the referral rate from primary care was moving back towards the normal expected rate and we wonder if you have any comment on what has happened to the numbers that were not referred during the period of cessation of services. We would have anticipated the rate now to be higher to include any "backlog" that had arisen? Can you also indicate how these new patients are being prioritised to be seen, is it simply based on date of referral?

NHS Borders is currently in the process of developing our Remobilisation Plan 2021/22 in line with Scottish Government guidelines. The deadline for submission for the actual plan is the end of February 2021, with the need to submit an additional document by the 16th April 2021

which will contain detail of our waiting times trajectory for quarter 2-4 of 2021/22. Based on the current resurgence of COVID-19 in the Borders and the associated reduction in routine capacity to ensure capacity for COVID-19 activity, we are unable at present to set out to the committee the timings we are working towards in relation to clearing of the backlog of cases. Once there is clear evidence that the current wave of COVID-19 activity is reducing and therefore an indication of when routine services can be remobilised, accurate trajectories can be determined. Prior to the current reduction in routine services, there were 896 patients waiting over 12 weeks for an operation (TTG) (30th November 2020) and 2,833 patients waiting for a new outpatient appointment (30th November 2020).

I think it is important to emphasise to the Committee that recovery of our waiting times back to the good position we were in prior to the Pandemic will take a considerable time. This will need to take into account the ongoing limits to capacity because of possible continued restrictions around social distancing and PPE. It will also need to recognise the significant build up of staff annual leave over the course of the Pandemic and the importance, if we are to retain staff in the long term to allow staff to rest and recuperate as we come out of the Pandemic.

You have also asked what has happened to those patients not referred during the first pandemic wave, in recognition that there was not an overall increase in Primary Care referrals at the point at which routine services remobilised. There are likely to be several factors here. A number of patients' conditions will have reached the point at which they require urgent or emergency care, and will have entered the Health Service through this route. Patient behaviour is another factor here; self care is likely to have increased during this period due to perceived risk of COVID-19 when accessing service. Reduced social mobility will have also reduced demand for certain aspects of healthcare, for example reductions in organised sports reducing orthopaedic injuries associated with sport.

In regards to how patients are being prioritised for routine elective surgery, patients are currently being prioritised in line with Scottish Government Clinical Prioritisation Framework. Those patients assessed as having greater clinical need for treatment are operated on first.

CAMHS

There were questions around CAMHS which were affected by our technological difficulties (column 44 in particular) and we would welcome any further detail you can provide including detail about the service being offered at present and how the increasing numbers affected will be addressed. When do you expect to be hitting the standard?

Our Child and Adolescent Mental Health Service (CAMHS) continues to provide assessment and treatment to children and young people within the Scottish Borders, including responding to emergency and urgent assessments. There has been an increase in the number of patients in the Intensive Treatment Service with a sharp rise over the last year. Neurodevelopmental assessments were progressed as far as possible with specific parts of the assessment unable to be completed due to inability to access to schools with referrals to the service showing 60:40 ratio Neurodevelopmental to mood disorder.

Challenges have also included long term sickness, unrelated to the Pandemic, that has now resolved, and while vacancies within nursing and psychology continues to be difficult to recruit to we are projecting we will have recruited to all vacant posts by April 2021. Some clinicians were also deployed during the first phase of COVID-19 to inpatient mental health units however they have all now returned to the CAMHS service.

CAMHS have plans in place to address the long waits and a review of Borders CAMHS service is underway with support from Scottish Government. A nurse has been deployed to the CAMHS service from another area of mental health to assist with waiting times for 6 months. A senior doctor has also temporarily increased their hours by two sessions for one year to support the high risk complex patients. Opt in assessment clinics delivered by senior nurses commenced in December 2020 and over the recent weeks the waiting list has stabilised. CAMHS focus is currently on the trajectory to meet the Referral To Treatment (RTT) HEAT standard and this will be ready for inclusion in the NHS Borders Remobilisation Plan to the Scottish Government in line with the deadline set out above.

Ongoing challenges include the second phase of COVID-19 and further risks of staffing compromising meeting the target and inability to access further assessments at school.

Recruitment Challenges

Nicky Berry offered to update us on recruitment issues and we look forward to details on that matter (column 45).

Some of our recruitment challenges predate the pandemic; when professionals with particular specialist skills are in short supply innovative service redesign may be required. One example of this is in our Ophthalmology service. This gave us significant concern as there were two long standing consultant vacancies and no interest in permanent posts despite repeated advertising. As a result, the service was maintained by a series of temporary locum consultants. The service leads in NHS Lothian (at the time had 21 consultant ophthalmologists) and NHS Borders (which has 3 consultant ophthalmologists posts, two of which were vacant) introduced a regional service model successfully appointing consultants to a joint NHS Lothian / NHS Borders service. This allied with skill mix in the recruitment of non-medical roles such as Orthoptists and Hospital Optometrist and the extension of training of Advanced Nurse Practitioner roles has maintained a locally delivered service for the people of the Borders.

Specifically with regards to the pandemic response, there has been additional recruitment for new services which continues alongside recruitment for established vacancies.

New / enhanced services introduced as a result of the pandemic include:

- Care Home Task Force (mutual aid from NHS to Social care)
- Test and Protect Team
- Flu and COVID-19 Vaccination Teams
- COVID-19 Assessment Hub
- Rapid Response Home Treatment Team (mental health for older adults)
- Enhanced Health Protection and Infection Control Services

In our acute services (Borders General Hospital) we are recruiting to additional healthcare support workers on a 6 month temporary contract to support revised skill mix across the wards which will allow for staffing our Winter COVID-19 escalation plan. This includes further COVID-19 specific wards to be established in line with our modelling.

Outlined below are the occupations / services with particular recruitment challenges:

1. Registered General Nurses – there has been a recurring level of existing vacancies across our health system. As a guide we have reported 44.20 WTE vacancies in September 2020 and this has increased due to newly created posts.

2. Registered Mental health Nurses - at present we are recruiting to 10.20 WTE for existing vacancies and new services identified above. With an increasing acuity of in-patients resulting from COVID-19, there has been a significant pressure on the service.

3. Care Home Support (mutual aid). At present we have seconded NHS Staff (by agreement and with consent) to SB Cares / Scottish Borders Council to support Care Homes.

GP Services

In relation to GP services we recognise financial support was provided to sustain practices and also to provide bank holiday cover. Can you advise what other financial support was provided to practices and specify what additional payments were made to GPs for running the hubs. Was a corresponding reduction made to other payments to GPs in relation to the services not provided while they were running hubs?

NHS Borders has not reduced any payments to GP practices and has directed £433k of Scottish Government funding allocation directly to GPs in order to enable them to meet the impact of COVID-19 and to allow them to open on the Easter and May 2020 public holidays.

Beyond this as part of our Remobilisation Plans we have invested in a range of areas aimed at remobilising GP practices and making health centres safe and functional, in the context of enhanced infection prevention and control measures needed to contain the spread of COVID-19.

COVID-19 Vaccination Programme

We note you delivered 45,000 flu vaccinations which seems to be around 75% of those eligible (column 50), can you give us a feel for numbers of people to be Covid vaccinated in your area?

Based on the Joint Committee on Vaccination and Immunisation priority list grouping 1-9 there are approximately 76,687 people living in the Scottish Borders who are eligible for vaccination, at this stage we anticipate an uptake of around 65,000 which equates to 85% of the eligible population being vaccinated.

Work continues at pace with the programme and the latest statistical report from Public Health Scotland ranks NHS Borders as the second highest performing mainland health board for vaccinating those eligible as at 18th January 2021.

I trust that the additional information we have provided above provided is helpful to you and your colleagues and meets your request for further information. Please do not hesitate to contact me if you require anything further.

Yours sincerely

Karen Hamilton
Chair