NHS Borders

Chair & Chief Executive's Office

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Date 13 April 2023
Your Ref
Our Ref RR/LS/ResponseHSCSApril2023

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Via Email to the Clerk of the Committee
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Dear Clerk,

Further to my attendance at the Committee on the 21st March 2023 and your subsequent letter asking for further information, please find attached the following documents.

1. An updated evidence pack
2. A response document to the additional questions listed in your follow up letter.
3. Our Financial recovery plan as requested in your initial evidence request
4. Our Planned care plan as requested in your initial evidence request
5. A scorecard setting out our assessment of our Performance, as requested in your follow up letter

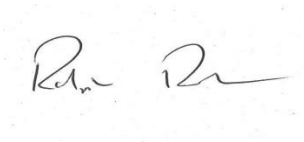
I trust this is helpful and meets the needs of the committee. We have attempted to do this in a way that is consistent with your requirements, while ensuring the Committee have as full and open responses as possible.

As ever, should you require any further information or clarity on any of the information submitted, please do not hesitate to contact me

Many thanks

Kind Regards

Yours sincerely



Ralph Roberts
Chief Executive

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SCOTTISH PARLIAMENT HEALTH, SOCIAL CARE AND SPORT COMMITTEE MEETING
21 March 2023
NHS Borders Updated Evidence Pack

1. FINANCIAL SUSTAINABILITY

Narrative below is based on the Board's Financial Recovery plan, agreed at our Board meeting on 31st March 2023. The full Recovery plan is attached as requested.

NHS Borders was placed at Stage 4 of the Scottish Government's Performance Escalation Framework in November 2018. During 2019 the Board worked closely with external support (BOLD Revolutions) to develop its financial turnaround programme. This programme was suspended at the onset of the Covid-19 global pandemic and – in common with other NHS Boards – the focus of the board shifted to its pandemic response. Despite this, in April 2021 the Board was moved down to Stage 3 of the Performance Escalation Framework in relation to its financial sustainability in recognition of the progress the Board had made in 2019/20.

The board submitted its medium-term financial plan to Scottish Government on 20th March. This plan describes a significant financial deficit of between £20-25m p.a. over the three years of the plan, net of expected savings delivery and other non-recurring actions. This describes the programme of work the Board will implement to evaluate options for delivering financial improvement, firstly to secure the level of savings assumed in the financial plan and secondly to begin to address the further steps required to achieve a sustainable financial position over the medium to long term.

At this stage there are significant risks to the delivery of the planned level of savings and urgent work is underway to ensure that implementation plans are in place as quickly as possible.

In 2022/23 we expect to have delivered between £2.0 - £2.5m recurring savings, around 1% of our Core budget. We recognise the need to urgently increase the level of savings and have set expectations accordingly. Our internal targets are set at 3% p.a. (2% against Business units and a further 1% via a workstream approach). We have also set an expectation that our longer-term transformation strategy delivers a 10% reduction in our cost base over a 3–5-year period.

We have outlined in our financial plan an expectation that we will deliver £5m recurring savings in the first two years of our plan and £7.5m in year 3. This represents 2% rising to 3% (a cumulative 7% over three years). However, delivery of this level of savings will not be sufficient to address the deficit, particularly considering further growth forecast within years 2 & 3 of the plan. This level of savings is based on a rapid assessment of the potential scale of opportunities not yet fully quantified and will continue to be refined as we develop our financial plan and recovery plan.

2. MENTAL HEALTH SERVICES

CAMHS
The service has been undertaking a waiting times initiative since June 2022. This was to see an extra 12 new patient appointments (NPAs) from the longest waits on the list. The target for this was to see 51 NPA`s per month over a 12-month period. Since commencement of the initiative (9 months) the number of patients seen has totalled 441 (Feb-23 inclusive) showing an average of 49 New Patients seen per month. The actual number on the waiting list at the end of December 2022 was 336, 44 under the projection of 380. As part of the NPA initiative the plan was to review its progress in early 2023. This review has been carried out, and following this it has been agreed to increase the new patient

appointments from 12 to 16 per week. This commenced week beginning 20th March 2023. The current longest wait for a patient is currently 39 weeks and has reduced by 55% from 71 weeks.

Psychological Therapies (PT)
In general, performance of the Psychological Therapy target (90% starting treatment within 18 weeks of referral) ranges between 80 and 90%. We do have a treatment backlog, especially in adult mental health services, which is due to very high demand. We are anticipating reporting our performance came close to meeting the 90% target in both February and March 2023.

Our Renew/Primary Care Psychological Service was established in October 2020 in partnership with our Primary Care Improvement Plan (PCIP). This provides more treatment opportunities for people presenting in primary care with low mood, anxiety and depression. This has significantly increased our PT referrals but has also met a local need and increased the range of psychological therapies available. Prior to this psychological therapy was only available in secondary care settings. We anticipate the total number of people waiting for psychological therapies to increase as has been the recent trend due to high levels of demand but are working hard to manage this.

Current service challenges:

- It is almost impossible to recruit to fixed term posts, and being a small service, maternity leave posts or fixed term posts that are not possible to fill do have a negative impact on capacity, for example within our older adult psychology service at the current time.
- We are working hard to improve pathways to increase access to psychological therapy as well as maximise the resilience of our workforce.
- We do have some gaps in our services, most notably in inpatient adult and older adult wards, early intervention to psychosis, rehabilitation, neuropsychology/neurology related, and clinical health psychology services.

Borders Addiction Service (BAS) Drugs and Alcohol Treatment Waits
In Q3 2022/23, no patients waited longer than 3 weeks for a first treatment appointment. The data is currently updated quarterly.

3. ELECTIVE WAITING TIMES

NHS Borders continues to work towards meeting the relevant TTG targets which include:

- No patient waiting over 104 weeks by September 2022
- No Patient waiting over 78wks by September 2023

We have not met the 104 weeks target and forecast that we will still have 140 patients beyond 104 weeks at the end of the current financial year. Over the past 12 months the overall shape of our TTG waiting list has changed and trajectories show that we are making steady progress in reducing the number of long waiting patients. We have seen a 43% reduction in patient reported as waiting over 104 weeks.

Continued pressures within Unscheduled Care have contributed towards limited Elective Capacity, alongside staff turnover and pressures within the nursing workforce. We have seen an increase in the proportion of patients now classified as clinically urgent; this is likely to be a consequence of delays and deterioration in condition for patients while waiting. We expect to see the numbers on the TTG waiting list increase during 2023/24 as we work through the backlog of patients waiting for Cataract Surgery. We have increased cataract capacity to mitigate this risk.

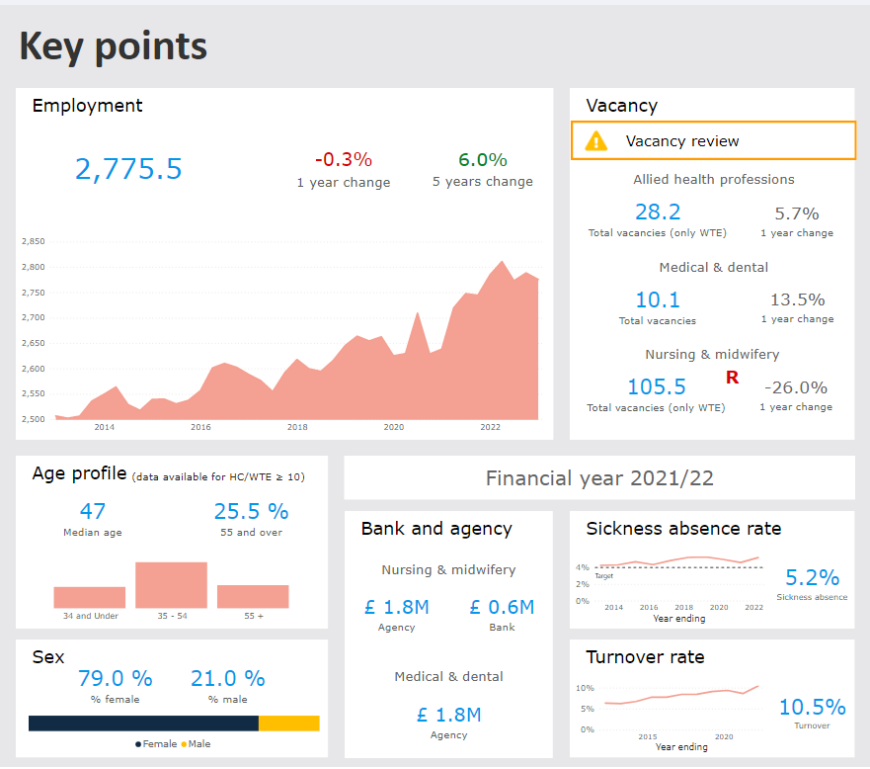
We are working towards removing 104 weeks waits during 2023/24 and reducing the overall number of patients waiting above 78 weeks in most surgical specialties. It is unlikely we will fully recover Orthopaedic waits in this timescale, given the size of the waiting list in this speciality.

We will continue to monitor progress on the above through our Planned Care Recovery Programme Board, Access Board and our Quarterly Performance Reviews. A more detailed Planed Care recovery plan has also been submitted, as requested.

4. WORKFORCE

Trends relating to Staff Turnover and Vacancies

The dashboard below presents the changes in Whole Time Equivalent (wte), demonstrating a trend of an increasing workforce (6%) in the last 5 years. Turnover of staff is higher in NHS Borders than the Scottish average, which we believe reflects the demographics of an ageing population in Scottish Borders and the falling numbers in the working age population. Overall turnover rate is 10.50%, but as high as 16% for registered nurses. The peak of leavers in March 2022 was largely due to retirements. Vacancies are highlighted below for priority groups, and outline those being actively recruited to on 31st December 2022. We recorded 105.5 vacancies for Nursing and Midwifery on 31 December 2022, with 72.6 wte having been vacant for less than 3 months, 23.5wte vacant between 3–6 months and 9.4wte more than 6 months.



Dashboard 1 – Source – Turas Data Intelligence, Data for NHS Borders at 31 December 2022

Workforce Planning

The focal point of workforce planning in the past year has been the approval of the 3-year workforce plans in October 2022 co-produced by Health & Social Care (H&SC) partners. We have identified/continue to identify how NHS Borders will respond to recovery plans post Pandemic, highlighting existing and predicted future workforce challenges, and actions to support service sustainability and transformation over the next 3 years.

The recruitment of Registered General Nurses remains our principal concern given the level of existing vacancies. Interventions include domestic UK recruitment, overseas recruitment, retire/return scheme and initiatives aimed at the recruitment of newly qualified practitioners (NQP). Generally, the Mental Health Service and Primary and Community Services nursing vacancy levels are manageable, although there are some challenges for specialist roles. However, in the acute sector to stabilise nurse staffing levels and reduce the levels of risk to patient care and the impact on staff wellbeing, there have been concerted efforts to increase the nursing workforce. We appointed 20 wte health care support workers to newly established permanent roles. New role design as an augmentation to the nursing workforce includes Pharmacy Technicians and Housekeepers. We are working with Community Planning partners to consider how we can support the creation of affordable housing for essential workers moving into the area.

We have also supported return to employment of retired practitioners and a return to practice scheme for former registrants, in partnership with Robert Gordon University. A local process for retire and return has been in place for 4 years and the interim NHS Scotland Retire and Return guideline was adopted on 30 August 2022.

5. KEY ISSUES

Emergency Access – long waits at front door/ impact on staffing and out of hours resilience - our Emergency Department (ED) continues to experience significant pressures due to capacity challenges across the whole Health & Care system. A review of the workforce model is being progressed which will include options to address the resilience and sustainability of the ED moving forward. It is anticipated the review will be complete by the end of the financial year. We are continuing work on the GP Out of Hours (BECS) Option Appraisal. The final Options Appraisal was moved to the 2nd March 2023 to ensure sufficient time to scope all options fully. It is expected that delivery and implementation of this work will continue into 2023/24. The pressure the ED is experiencing reflects the wider pressure across the whole Health & care system. Along with all other systems in Scotland, over the last few years we have seen Increased length of stay for patients in hospital and an increase in the number of patients waiting for discharge home with a package of care or to Care Homes.

Nursing Workforce Sustainability - workforce sustainability is and will continue to be an ongoing issue and in the foreseeable future we will implement the Health & Care Staffing legislation in line with national timescales. Our current challenges have been compounded in the Acute hospital due to the need to open and safely staff additional beds to minimise the pressure on our Emergency Department, Inpatient wards and elective programme. Increased levels of short notice sickness within both nursing and medical staff have caused additional pressures due to there being little resilience within in our current staffing levels.

Medical Workforce – out of hours resilience, key specialty gaps - medical staffing across services in the Borders is challenging. This is compounded by the small scale of our services, meaning that our services can be particularly susceptible to absence or vacancies. This has become harder with the ongoing sub specialisation of the medical workforce and the requirement to sustain 24/7 Out of hours services.

Primary care – practice sustainability issues - work continues to support GP Practices with the ongoing service and workforce pressures they are experiencing. Assessment of activity within Primary care suggests this is very significantly above pre-pandemic levels. In 2022/23 NHS Borders took over responsibility for running 1 GP Practice. This was the first time this has been required in the Scottish

Borders. A key priority for our Primary Care team is working with local GPs to improve Practice sustainability. NHS Borders, in conjunction with our local GPs have fully committed all of the Primary care improvement funding, allocated to the Borders, to support the implementation of the new GP contract.

FINANCIAL RECOVERY PLAN

2023 - 2026

Version 2.1

16th March 2023

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Purpose of the Report

This report is prepared in response to the Scottish Government's requirement that Health Boards requiring brokerage[1] support in 2022/23 submit a Financial Recovery Plan which describes how they will meet the requirements of the Medium Term Financial Framework (MTFF) over the three year planning cycle.

The MTFF requires that Health Boards achieve financial balance over a three year term, with flexibility of 1% available in any given year. Financial Recovery Plans are expected to demonstrate how this will be achieved, including plans for repayment of brokerage.

The report provides background and context to the financial challenges faced by NHS Borders and describes actions currently in place - and those in development - which are expected to contribute to addressing these challenges.

[1] 'Brokerage' support is borrowing financed by Scottish Government to achieve a breakeven position during a single financial year. This borrowing is repayable by the Health Board.

Status of the Recovery Plan

Version 2.1 / 16th March 2023

The Board is required to submit a final version of its Financial Recovery Plan alongside its financial plan by 16th March 2023. This iteration of the report (version 2.1) is designated as the 'final' version for purposes of submission to Scottish Government.

Additional content is provided to complete sections remaining work in progress in version 1.0 (submitted 9th February 2023).

Content has been updated to reflect changes in the Board's financial plan, including assumed level of savings, and progress towards development of financial recovery actions.

It remains the case that the Financial Recovery Plan does not yet describe actions which are sufficient to meet the requirements of the MTFF.

As such, it is intended that this will remain a 'live' document and further updates will be prepared in advance of the Quarter One forecast and submission of the Board's Annual Delivery Plan.

Version 1.0 / 9th February 2023

This document remains work in progress. A final version of the plan is expected to be prepared for submission in March 2023.

The Financial Recovery Plan presented here does not describe actions which meet the requirements of the MTFF.

The Board's financial plan describes a worsening financial position over the three year cycle and actions currently identified are sufficient only to arrest the level of increase.

Tradition cost improvement measures and productivity gain will not be sufficient to achieve this objective.

The actions likely to be required to sustainably reduce costs are expected to require whole system transformation and reform to Health & Social Care delivery within the Scottish Borders.

Whether these actions will deliver the scale of change necessary to achieve financial balance remains unclear.

The scoping and development of a transformation strategy is likely to take some time. We will be clear about the timescales for this work in the final version of this plan.

Context

Financial Context

Following publication of the Scottish Government's budget for 2023/24[2] the Director of Health Finance and Governance wrote to Health Boards to set out the details of the budget, and the framework under which financial plans were to be prepared. This letter confirmed the reintroduction of the Medium Term Financial Framework as previously advised during 2022/23, stating:

> "… where Boards are indicating that financial support is required in 2022-23, we have asked Boards to submit financial recovery plans in the new year, setting out a return to financial balance in the next three years."[3]

NHS Borders was placed at Stage 4 of the Scottish Government's Performance Escalation Framework in November 2018[4]. During the course of 2019 the Board worked closely with external support (BOLD Revolutions) to develop its financial turnaround programme. This programme was suspended at the onset of the COVID19 global pandemic and – in common with other NHS Boards – the focus of the board shifted to its pandemic response. Despite this, at April 2021 the Board was moved to Stage 3 of the Performance Escalation Framework in relation to its financial sustainability in recognition of progress achieved to date[5].

Stage 3 of the Performance Escalation Framework is described as 'significant variation from plan; risks materialising; tailored support required'. The response to this level of escalation requires the agreement of a formal recovery plan with clear milestones and accountability, supported by external expert advisors.

NHS Borders submitted its one year financial plan for 2022/23 in March 2022. This plan described a recurring deficit before savings of £19.7m. This deficit was expected to reduce to £15.7m at March 2023, predicated on delivery of £5m recurring savings. Performance at March 2023 was forecast at £12.2m deficit, inclusive of additional non-recurring actions.

At Quarter One review the Board amended its in year forecast to a projected outturn deficit of £13.7m.

Recognising the significant financial challenges faced within Health and Social Care in Scotland, NHS Boards were advised at Q1 review[6] of a need to urgently improve in year performance during 2022/23. As a *minimum*, Boards were required to develop actions to recover financial performance to the level outlined in their financial plan (i.e. £12.2m deficit).

NHS Borders submitted a Financial Recovery Plan (FRP) in November 2022 which described a potential increase to its forecast in year deficit of £15.7m, together with actions identified to recover outturn performance to £12.2m in line with financial plan.

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[2] Scottish Budget 2023-24 published on 15th December 2022.
[3] Richard McCallum Letter to Chief Executives, 15th December 2022.
[4] Paul Gray Letter to NHS Borders Chief Executive, 23rd November 2018.
[5] John Connaghan Letter to NHS Borders Chief Executive, 2nd April 2021.
[6] Richard McCallum Letter to Chief Executives and Directors of Finance, 11th November 2022.

Since this time the actions outlined in the plan have continued to be adapted in response to other emerging pressures and – where necessary – to mitigate actions which are no longer expected to deliver.

As at Month 10 (January) the Board had amended its outturn forecast to a projected deficit of £13.5m as a result of a recent increase to primary care prescribing resulting in a projected increase of £1.7m expenditure on previous plan.

Additional New Medicines funding (NRAC share of increase from £100m to £200m) was not included in the January forecast of £13.5m deficit. This provides an estimated £1.1m improvement to the forecast.

Early indication of February position and further actions currently being identified suggests that some improvement on the £12.2m forecast may yet be possible, however this is unlikely to represent the full impact of the additional New Medicines fund.

A further update to forecast will be confirmed at M11 (February).

The increasing reliance on non-recurrent solutions highlights the impact that pressures emerging within the current year forecast will have on the baseline pressures described in the financial plan.

Operational Context

Emerging from the pandemic we have continued to face a number of significant operational challenges which require both leadership and management focus:

Pressures on both primary and secondary care are exhibited through lack of whole system flow and our access performance; assessment of activity within Primary Care suggests this is very significantly above pre-pandemic levels.

Our workforce remain under significant pressure due to staff turnover and high levels of vacancy, which in turn manifests in both absence and increased risk to patient safety;

Our built environment presents increasing risks in relation to health & safety and infection control due to increasing unmet backlog maintenance and poor functional suitability affected by the design of older buildings.

These issues impact on our ability to fully remobilise services to pre-pandemic levels and affect productivity, performance and capacity to support our financial improvement programme.

A&E performance is regularly below 65% against the four hour emergency access standard. Our Emergency department regularly operates with overnight stays and long waits for admission to inpatient beds results in further disruption to flow on a daily basis.

While both cancer and diagnostics performance are strong when benchmarking to other Health Boards, TTG and Outpatients remain challenging; TTG long waits are in line with Scottish averages however theatre productivity measures benchmark poorly and the Board struggles to protect elective inpatient beds. Outpatient activity levels and proportion of long waits are below national averages.

As at end January we continued to have a small number of patients waiting in excess of two years for their first outpatient appointment and over 1500 waiting in excess of 52 weeks (against a planned national trajectory of zero by end March). This position reflects both recruitment challenges in high volume specialties (ophthalmology, dermatology) and imbalance across a broad range of other specialties where we are unable to source sufficient capacity to achieve performance in line with plan.

Over 130 patients had waits of greater than 2 years for inpatient or day case treatment as at end January against a planned trajectory of zero by end March 2023. In January alone we cancelled 52 elective surgeries due to bed pressures. We remain unable to regularly maintain ring-fenced capacity for elective surgery as a result of boarding from medical specialties.

Increased length of stay in inpatient settings has contributed to a chronic lack of hospital flow which is further impacted by delays to discharge and shortfalls in capacity in social care settings. Where additional resources have been deployed to increase care home capacity this has often been challenging to access, and in some cases has offset loss of capacity across the sector.

Between February 2022 and February 2023 there was little movement in the overall number of delays in our system and an increase in the occupied bed days associated with these delays. Weekly census data (all settings) shows an increase in number of delays from 57 to

63 over that period, with complex patients increasing from 15 to 17. The cumulative length of stay of active delays (i.e. not yet discharged) increased from 36 days per patient to 59 days, with a small number of individual patients accounting for a significant element of this increase.

The level of workforce required to provide additional inpatient capacity and manage emergency waits remains difficult to achieve. Staff turnover (16%) is higher than Scottish average with particular pressures on registered nursing posts. Daily safety briefs regularly report staffing levels which are unsafe at start of day and for which agency staffing is often deployed at short notice and premium cost. Although we have been successful in recruitment of international nurses the impact of introducing new workforce into a busy hospital setting puts further pressure on supervisory staff (i.e. charge nurses) and we have had to implement additional staffing resources to support transition of newly recruited staff.

Our use of agency staffing in senior medical (consultant) workforce is predominantly in relation to hard to fill long term vacancies where sustainability of service is an immediate priority. This includes Acute Medicine and Mental Health, as well as small number of other specialties. Recruitment to medical workforce in both acute and primary care is presenting an increasing risk to NHS Borders as we compete with urban centres for workforce.

Actions to sustain training grade rotas have largely been successful in eliminating agency in this area but present further cost pressure to historic staffing levels. Demands on this staff group have increased as training capacity has been ring-fenced and the challenges of increasing acuity in patients groups has required additional medical support to inpatient wards.

In 2022/23 NHS Borders took over responsibility for running one GP Practice under S2C arrangements. This was the first time this has been required in the Scottish Borders. We have recently agreed the closure of a branch surgery in order to sustain services in another practice. A key priority for our Primary Care team is working with local GPs to improve Practice sustainability with several other practices considered vulnerable in the short to medium term.

Our Annual Delivery Plan will describe actions in place to address the issues described above. There is further detail on our approach to efficiency & productivity elsewhere in this report.

Financial Outlook

Background

A draft three year financial plan was prepared in summer 2022 aligned to the Q1 review forecast. This outlined a position in which the Board's recurring deficit was expected to remain largely stable over a three year period, from £16.4m at March 2023 to £15.1m at March 2025. This position was predicated on 2% annual savings (recurring). A number of pressures not yet fully evaluated were highlighted as non-recurring such that the actual performance forecast for each year was as follows:

	2022/23 £m	2023/24 £m	2024/25 £m
Outturn Forecast *prepared July 2022*	(13.7)	(19.4)	(20.1)

This forecast did not fully reflect factors impacting on the wider economy, notably increasing inflation and energy costs. The publication of the Scottish Government's Resource Spending Review (May 2022) and subsequent UK treasury forecasts has highlighted an enduring volatility to economic forces which impact both directly and indirectly on NHS expenditure. Together with operational issues faced by NHS Boards, there are a number of additional challenges which increase cost pressures beyond the level described in the financial modelling undertaken in summer 2022.

Financial Plan 2023-2026

The Financial Recovery Plan is intended to outline actions to support delivery of financial performance outlined within the Financial Plan.

A draft version of the financial plan was submitted on 9th February 2023. A final version of the Board's financial plan will be shared with Scottish Government alongside this document.

The plan describes the forecast financial performance for the three year period from 1st April 2023 to 31st March 2026. The following table summarises the revenue forecast as presented within the updated plan[7].

	2023-24			2024-25			2025-26		
	R £m	NR £m	Total £m	R £m	NR £m	Total £m	R £m	NR £m	Total £m
Financial Gap before Savings	(30.4)	(2.2)	(32.5)	(28.7)	(3.2)	(31.9)	(25.3)	(6.4)	(31.7)
Savings Target	5.0	2.5	7.5	7.5	2.5	10.0	7.5	2.5	10.0
Non-Recurrent Measures	0.0	2.5	2.5	0.0	0.0	0.0	0.0	0.0	0.0
Total Savings & Non-Recurrent Measures	**5.0**	**5.0**	**10.0**	**7.5**	**2.5**	**10.0**	**7.5**	**2.5**	**10.0**
Forecast Variance against Core RRL	**(25.4)**	**2.8**	**(22.5)**	**(21.2)**	**(0.7)**	**(21.9)**	**(17.8)**	**(3.9)**	**(21.7)**

The plan describes a projected outturn position of £22.5m at March 2024 which remains broadly stable over the medium term, with a final outturn position at March 2026 of £21.7m.

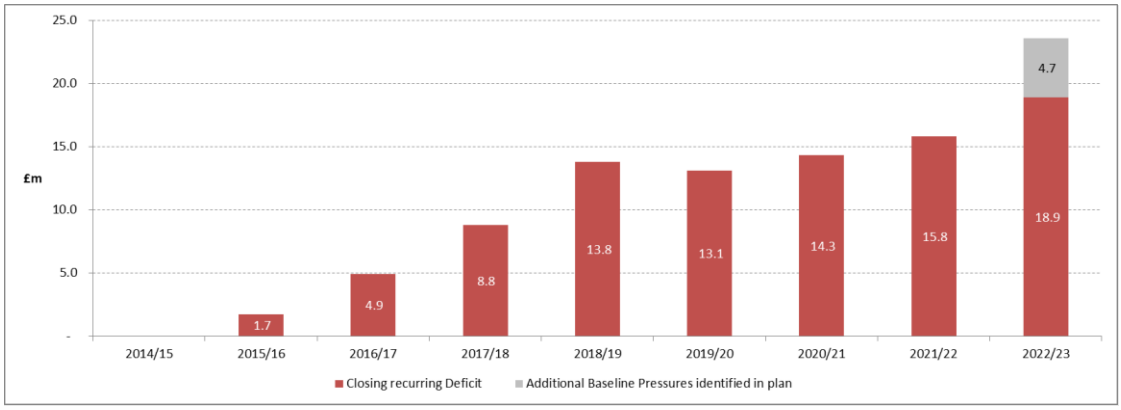
The underlying deficit is expected to reduce from £25.4m (March 2023) to £17.8m (March 2026). This position is predicated on delivery of £20.0m recurring savings over three years.

[7] As per financial plan due for submission 16th March 2023.

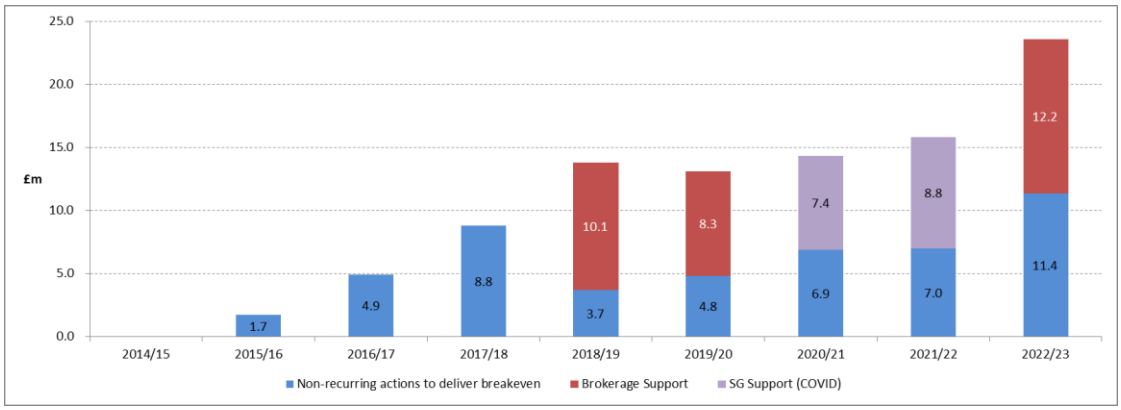
Underlying Deficit

Recurring Deficit (trend)

The following chart illustrates the growth in the underlying recurring deficit from 2015/16 onwards.



Non-recurring actions supported delivery of breakeven until March 2018, with brokerage required in 2018/19[8] (£10.1m) and 2019/20 (£8.3m). For both 2020/21 and 2021/22 additional support was received to offset non-delivery of savings as part of the COVID allocations. The actions required to deliver a breakeven position in each year are summarised below (2022/23 indicative based on current forecast).



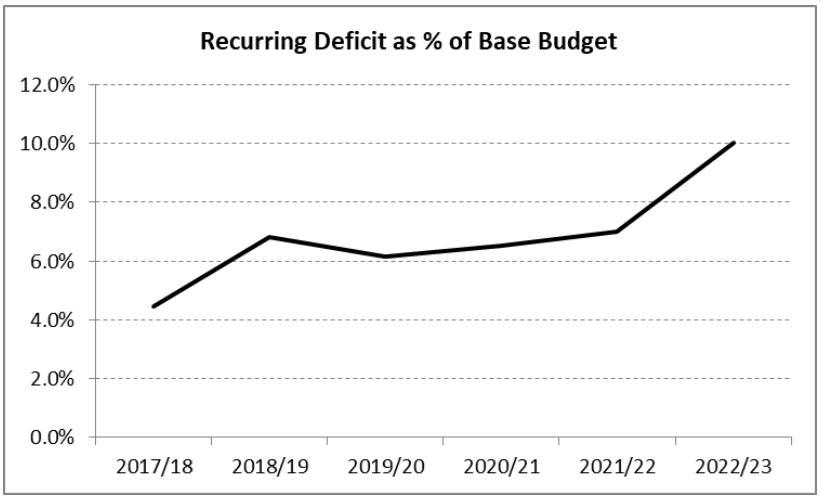
As demonstrated in the chart above, the level of non-recurring actions available within the Board reduced significantly from 2018/19 onwards, reflecting increased recurring delivery in that year. There was an increase in non-recurrent benefits across 2020/21 to 2022/23 which is attributable to reduced activity during the COVID pandemic.

The drivers for increase to deficit in 2022/23 are described in greater detail below.

[8] Brokerage support of £10.1m in 2018/19 was subsequently confirmed as non-repayable following introduction of the Scottish Government's Medium Term Financial Framework effective from 1st April 2019.

Recurring Deficit as % of RRL

Over the past five years the recurring deficit has grown from 4.5% of the Board's recurring base RRL to 10.0%.

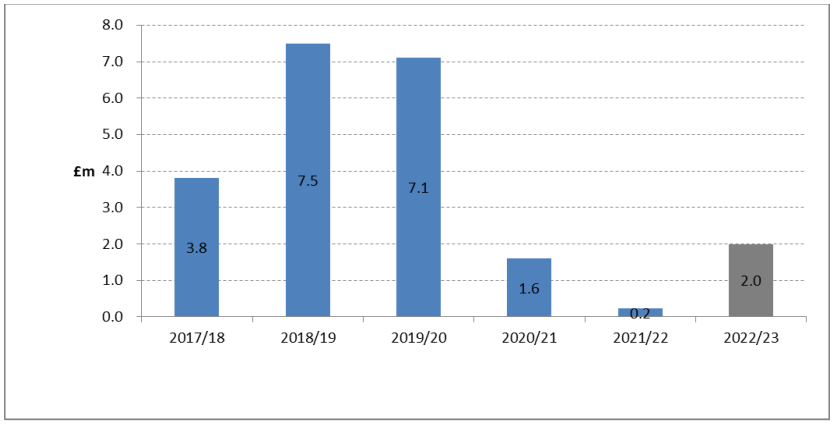


The increase in 2022/23 reflects the recurring impact of changes impacting from the beginning of the pandemic and which had been treated as non-recurring in the preceding two years.

Recurring Savings Delivery (trend)

As illustrated above, there was a slight reduction between 2018/19 and 2019/20 which reflects the significant focus given to the Board's financial turnaround programme. This achieved recurring savings of £7.5m (2018/19[9]) and £7.1m (2019/20), a high watermark for the level of savings achieved within NHS Borders in both the preceding and subsequent years.

The chart below presents the level of recurring savings delivery achieved/forecast by year:



The low level of savings delivery in 2021/22 is indicative of the impact of the pandemic on management capacity. Several attempts were made to reintroduce the Board's Financial Improvement Programme during this year to limited effect as a result of increased pressure on operational capacity and staff turnover within key services (PMO, finance).

[9] Savings delivery in 2018/19 & 2019/20 include elements initiated in each year which were fully delivered over the following year.

Key Drivers

The Board first identified a recurring financial deficit in 2015/16 and by March 2020 at the onset of the COVID pandemic this deficit had grown to an estimated £13.1m. From this point forward the deficit has increased by a further £10.5m, resulting in an opening baseline pressure in 2023/24 of £23.6m.

Narrative to be added

Inflation & Growth

Narrative to be added

Other Pressures

Narrative to be added

Scale of the Challenge

The recurring financial deficit identified in 2023/24 before savings is £30.4m. This equates to c.10% of the Board's overall expenditure, and 12% of our expected RRL baseline at April 2023. There is a further £2.2m of non-recurring pressure identified in year.

By March 2026 the savings required to achieve recurring balance are estimated at £37.8m. The current plan identifies a projected delivery of £20.0m savings, resulting in a recurring deficit of £17.8m after three years.

During the period of the plan there are additional non-recurring pressures of £11.7m.

In 2022/23 we expect to deliver between £2.0 - £2.5m recurring savings, around 1%. We recognise the need to urgently increase the level of savings and have set expectations accordingly. For 2023/24, our internal targets are set at 3% p.a. (2% recurring and a further 1% expected to be non-recurring). We have also set an expectation that our longer term transformation strategy delivers a 10% reduction in our cost base over a 3-5 year period.

We have outlined in our financial plan an expectation that we will deliver £5m recurring savings in the first year of the plan increasing to £7.5m p.a. in years 2 & 3, a total of £20.0m over three years.

This represents 2% in year 1 rising to 3% thereafter (a cumulative 8% over three years). As noted, year 1 assumes a further 1% saving to be delivered on a non-recurring basis.

Delivery of this level of savings will not be sufficient to address the deficit, particularly in light of further growth forecast within years 2 & 3 of the plan.

The level of savings outlined in the plan is broadly consistent with national planning assumptions and aligns with the level of savings delivered in 2017/18 and 2018/19 (the 'high watermark' for savings delivery achieved by the Board in previous years).

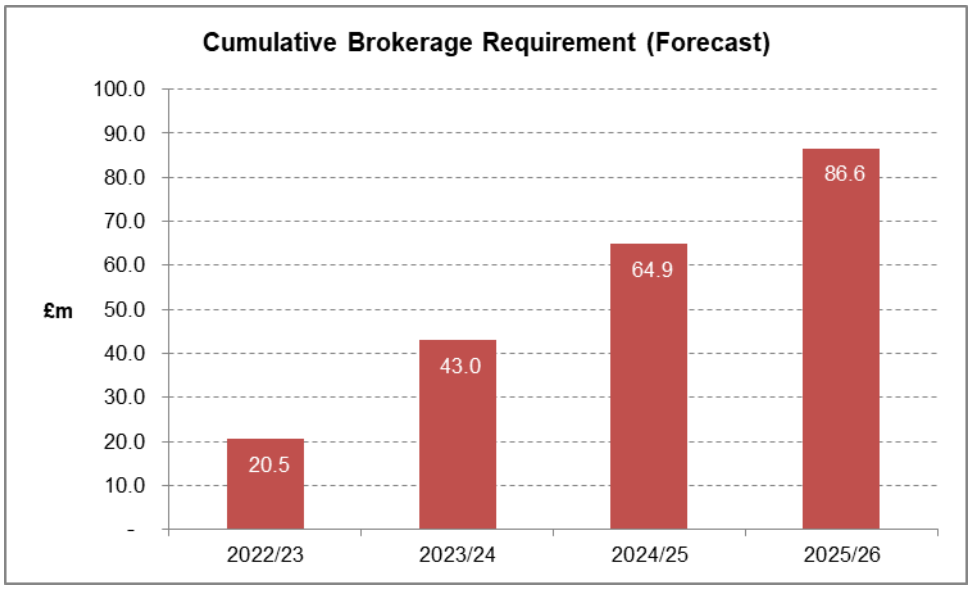
These targets will continue to be reviewed as opportunities are identified and progress to implementation. At this stage there is significant work required to secure savings in the next twelve months, and then to address the detail of savings plans in years 2 & 3 in line with existing target.

Brokerage

NHS Borders is expected to require £12.2m brokerage in order to achieve a balanced financial position in 2022/23. This will increase the accumulated brokerage repayable to Scottish Government to £20.5m, inclusive of £8.3m borrowing required at March 2020.

Although the Board reported a deficit at March 2021 and March 2022, this was supported by additional non-recurring allocations in line with the interim financial framework implemented during the COVID19 pandemic and there is no requirement for repayment attached to these allocations.

Should the financial plan forecast remain unchanged the cumulative brokerage liable for repayment at March 2026 would be £86.6m.

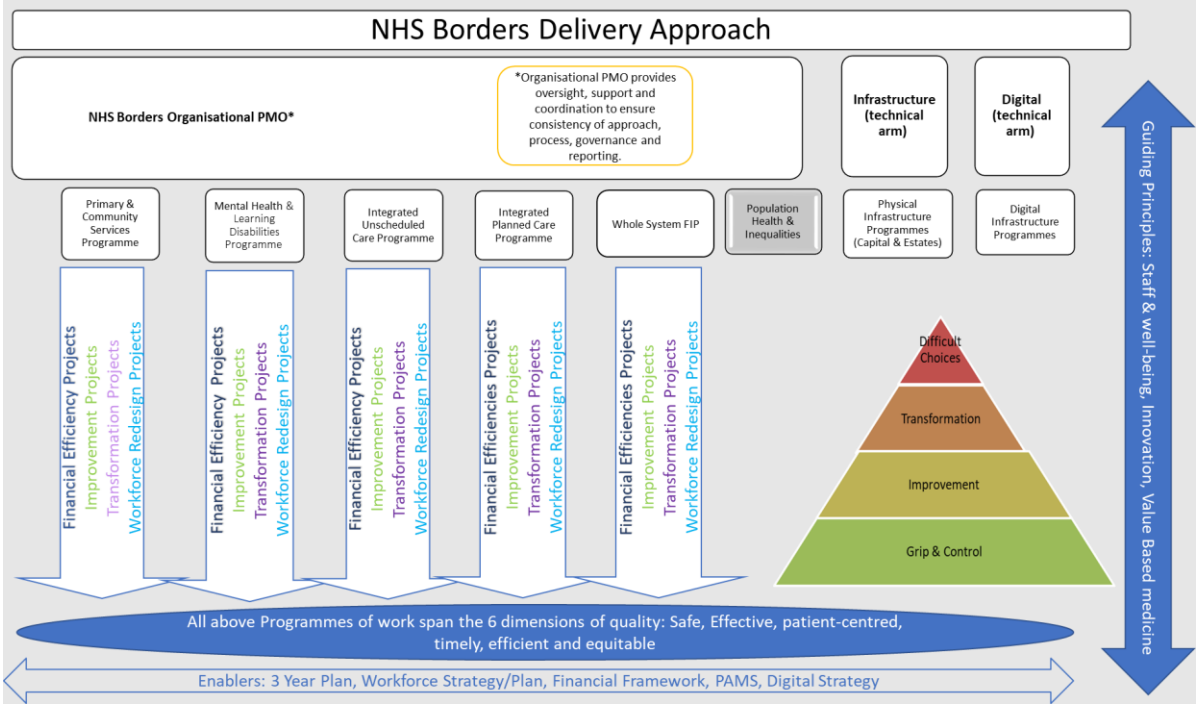


Strategic Framework[10]

NHS Borders aims to align its local planning approach to the national Sustainability & Value framework and three planning horizons.

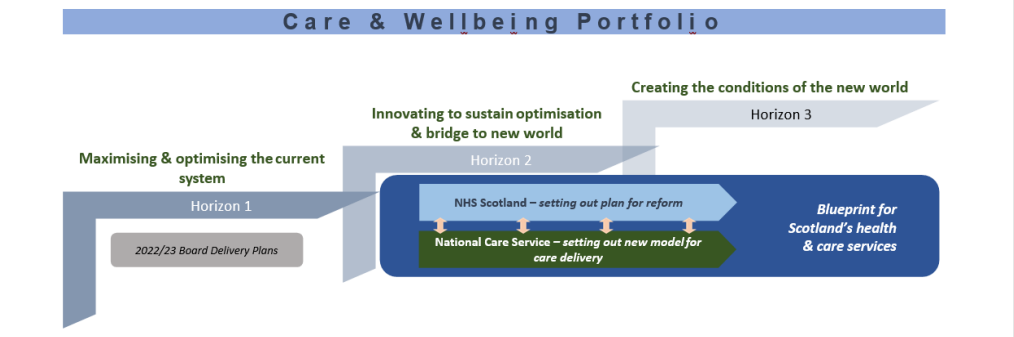
Our governance framework is established to ensure that performance, finance and workforce planning are aligned as closely as possible and that financial recovery is an integral part of both operational service planning and the board's strategic framework.

Our approach to strategic change is described below. This is intended to demonstrate how a Quality Management System (QMS) approach will be applied across all change programmes, and that financial sustainability will be embedded as a core element of all transformation programmes.



Planning Horizons

NHS Borders is developing its operational plans in line with the three horizons approach adopted by NHS Scotland, as follows:



[10] The Strategic Framework chart represents position at September 2022. This chart is currently being update to incorporate revisions to programme architecture from this date.

Operational Planning Framework

Key Principles

The Board has agreed an outline framework to support prioritisation and delivery within its operational planning. This framework has been tested with Business Units during quarter three and is being used to shape the three year operational plan to be submitted in June 2023.

- A minimum requirement for Business Units to release a 2% cash efficiency during 2023/24
- Savings targets not delivered in 2022/23 are expected to be carried forward
- Long term plans should focus on a 10% reduction in costs over future years, inclusive of any cost avoidance or productivity gain
- Staffing levels will need to remain within current overall workforce or reduced / redesigned – any growth will be an exception
- We will remobilise services to pre COVID levels
- Deliver improved productivity & performance
- Seek to reduce risks (particularly ones 'out with tolerance')
- Plans will be developed in line with our Quality Management System and aligned to the six aims of *Efficient, Safe, Effective, Patient Centred, Timely, Equitable, Sustainable*

Sustainability & Value

Arrangements in place to address Sustainability & Value are summarised below.

National Programme	NHS Borders Governance	Chaired by:	Frequency
Sustainability & Value Board	Quality & Sustainability Board	Chief Executive	Monthly
Operational Performance & Delivery Group	Integrated Planned Care Board	Director of Acute Services	Monthly
	Unscheduled Care Programme Board	Co Chair: Medical Director (NHSB) / Director of Social Care (Scottish Borders Council)	Monthly
Climate Emergency & Sustainability Board	Climate Emergency & Sustainability Group	Director of Finance (Executive lead)	Monthly
Value Based Health and Care Group	Currently being established	Medical Director (tbc)	tbc
Financial Improvement Group	Financial Improvement Programme (FIP) Board	Chair: Chief Executive	Monthly
	Financial Improvement Programme (FIP) Oversight Group	Co Chair: Director of Finance / Director of Planning & Performance	Weekly

Developing the Annual Delivery Plan

Workshops held from late 2022 onwards have identified areas for development within the Board's long term strategic framework and Annual Delivery Plan. As described within this report, the approach to financial sustainability is embedded within the principles outlined for operational planning and the development of our transformation programmes.

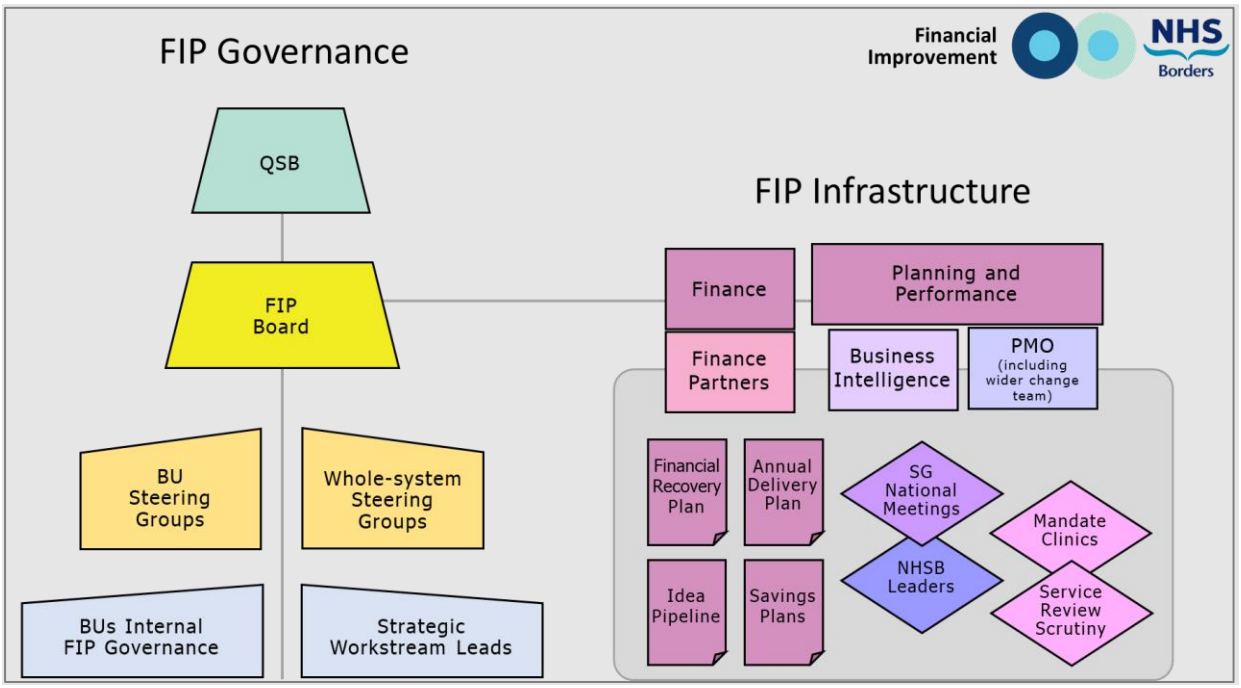
Actions emerging from these workshops have subsequently been collated and grouped to assess those most likely to support financial improvement. A further workshop was held on 27th February 2023 with leadership and senior management in order to refine these proposals and develop the Board's outline work stream programme. The outputs of this workshop are incorporated within the financial recovery actions outlined within this document.

Financial Improvement Programme (FIP)

FIP Governance

A Quality & Sustainability Board (QSB) was established in 2021 to provide oversight to the board's developing Quality Management System (QMS), including long term transformation programmes and the FIP. The QSB is chaired by the Chief Executive and reports to the health board's Resources & Performance Committee (RPC). The QSB meets on a monthly basis and is attended by the executive management team and senior management and clinical leadership from each business unit.

The following graphic describes the FIP architecture and how the FIP is aligned to the Quality and Sustainability Board.



FIP is established as a separate programme reporting in to the Quality & Sustainability Board. A FIP oversight group (previously 'Financial Turnaround Oversight Group') is co-chaired by the Director of Finance and Director of Planning & Performance. This group reviews progress on implementation of the governance and monitoring arrangements for the FIP.

Each business unit attends individual monthly meetings to review progress against the identification and delivery of planned savings. These meetings are chaired by the Chief Executive or Director of Finance, and are attended by Exec. Directors and the senior leadership team of each business unit, supported by PMO and Finance business partners.

The Project Management Office (PMO) established under the previous Turnaround programme has been retained and adapted to support the QMS and FIP programme. Business units report progress on overall development of schemes, including ideas generation, through the monthly FIP meetings with template submission to PMO in advance of each cycle.

Comms & Engagement

We have continued to employ the 'think different' branding agreed through our previous financial turnaround programme (example below).

The FIP was launched with business unit senior leadership on 21st July 2022. A clinical engagement session with primary and secondary care medical leadership was held on 7th September 2022 and a management engagement session for all managers was held on 12th September 2022. Following these sessions we have continued to develop our engagement through a series of on-going workshops with key service staff, including Partnership colleagues.

There remains significant concern about the potential dissonance caused by introducing a high visibility of financial recovery within the organisation at a time when workforce and operational pressures continue to present significant challenges to business as usual and when we are continuing to exhibit high levels of sickness absence attributable to mental health and stress related causes.

A wider 'all staff' engagement plan is now being developed for wider organisational engagement however the implementation of this plan will be considered in the context of the wider operational environment.

PMO Resources

Infrastructure to support delivery of the FIP and the wider QMS is outlined in summary below.

Resources (QMS & FIP)

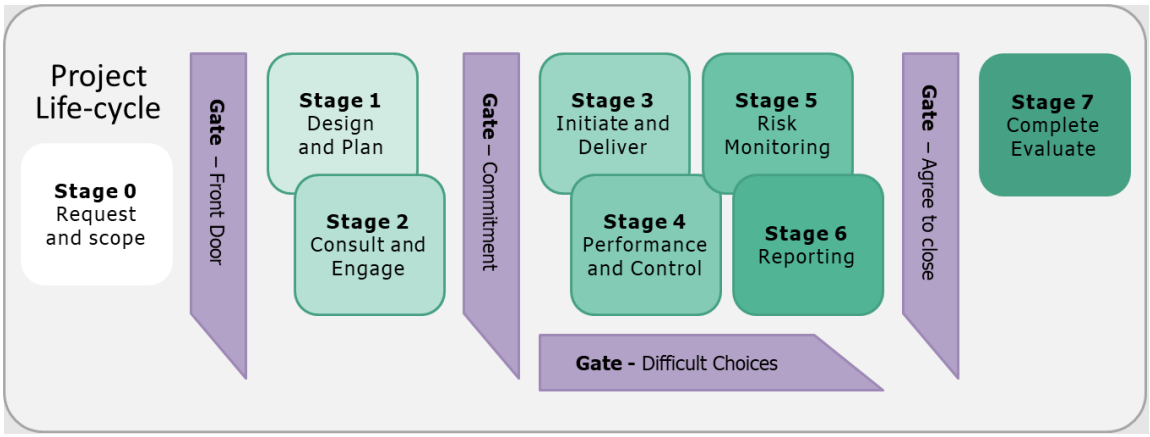
Function	Recurring WTE	Non-Recurring WTE	Total WTE
Project Management Office	7.0	4.0	11.0
Quality Improvement Team	4.4	-	4.4
Finance & Analytics	-	4.0	4.0
OD Support	-	1.0	1.0
Comms & Engagement	-	1.0	1.0
Total Workforce	**11.4**	**10.0**	**21.4**

The majority of the posts described in this structure were recruited towards the end of 2022, with significant turnover and disruption to programme during the earlier part of that year.

Project Implementation Life Cycle

The PMO has adopted a gateway approach to the development, implementation and monitoring of savings opportunities in line with the practice introduced during the Board's earlier financial turnaround programme.

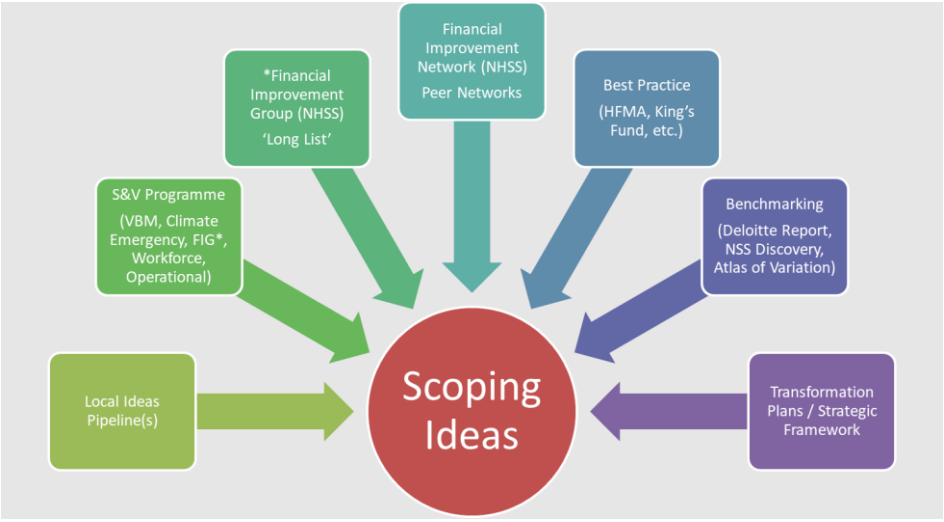
This approach is summarised below:



Identifying Opportunities

We have identified seven key routes by which we will identify potential opportunities. Our PMO has established a 'clearing house' approach to assess each potential opportunity prior to inclusion within our Financial Improvement Programme (FIP).

The graphic below summarises this approach.



Where opportunities are not expected to deliver cash release but may impact on financial planning (i.e. cost avoidance and productivity gain) we will assess whether these require to be tracked by the programme based on an evaluation of the materiality of any potential impact.

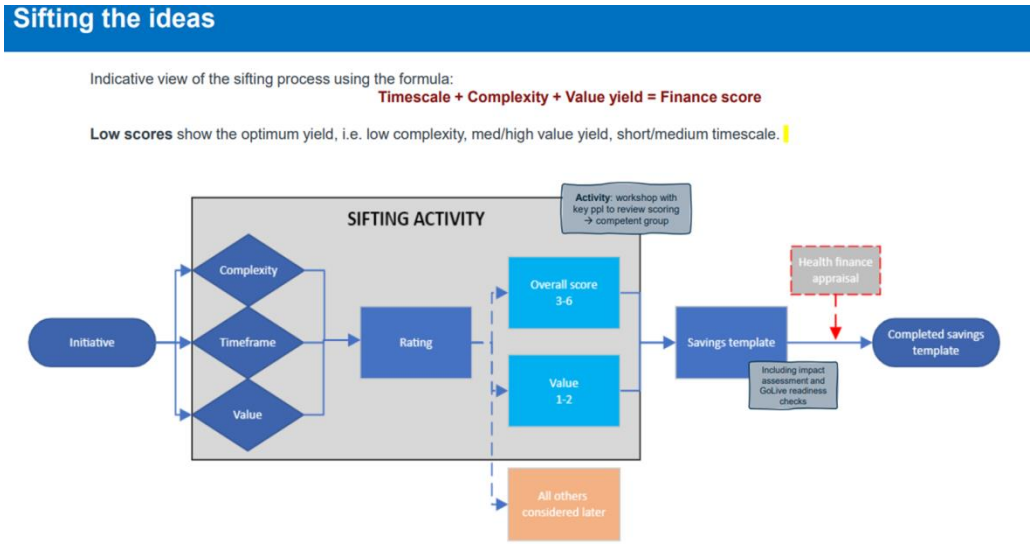
Opportunities 'Pipeline'

All potential opportunities identified through the PMO pipeline approach are logged on a central register pending initial scoping. Once high level scoping and viability is assessed proposed schemes are validated through the mandate process described above.

We are currently establishing revised reporting on pipeline opportunities and intend that progress will continue to be monitored on an ongoing basis through our FIP Board.

Prioritisation of Savings Opportunities

We are implementing a revised approach to support prioritisation of PMO resources. This approach is intended to align to the mechanisms established through the national Financial Improvement Group (FIG) as described below.



Savings Targets

As described under 'Scale of the Challenge', by end of March 2026 we anticipate that in order to deliver a balanced financial position there will be a requirement to achieve a total of £37.8m recurring savings over the three years of the plan. This excludes the additional actions to manage non-recurring pressures estimated at £12.6m over the three year period.

The recurring gap outlined above would require savings of almost 15% to be delivered over the medium term (to March 2026). This level of savings is not considered achievable by NHS Borders Health Board within the time frame of the medium term plan.

Target savings within the financial plan

It is assumed that savings of £20.0m (recurring) will be delivered over the duration of the plan, resulting in an estimated recurrent gap of £17.8m at March 2026. This position is predicated on delivery of 2.0% (recurring) savings in 2023/24[11] and 3.0% p.a. for the following two years.

Savings delivery described in the financial plan is based on high level assessment by the Director of Finance and endorsed by the Board at its financial planning workshop in February 2023. It is intended that this position will continue to be reviewed as opportunities are scoped and implementation plans are fully developed.

Internal savings targets

We have set internal targets of 3.0% with 2.0% assigned to Business Units and a further 1.0% assigned to a work stream approach. Business unit targets are delegated to individual service level aligned to budget managers within the board's scheme of delegation and reflected in financial management reporting.

This approach is intended to provide clarity of expectation to operational and senior management however it is recognised that the FIP will continue to evolve based on assessment of actual opportunities and that this will lead to adjustment in expected level of savings across both business units and work streams.

We expect that an element of this saving will be achieved through non-recurring means, or by cost avoidance schemes. As such, the financial plan has been developed on the basis of 2.0% recurring delivery in year 1 rising to 3.0% in years 2 & 3. As we increase confidence in the identification and planning of schemes we will revisit this assumption.

[11] A further 1% to be delivered non-recurrently in 2023/24.

Scoping Opportunities

SG Framework

The Financial Improvement Group (FIG) has undertaken high level assessment of potential savings opportunities across NHS Scotland. NHS Borders has developed an internal version of this assessment with intention of mapping internal FIP savings plans against this framework in order to understand where there may be further opportunity to be explored. Mapping of local schemes will be undertaken at end Quarter One when it is expected that savings opportunities will have been fully scoped.

Potential Savings Opportunities (NHS Borders)

	Area of expenditure		High Level Estimated Spend 2023/24	High Level Assessment - Savings Potential		NRAC Share of NHS Scotland Estimate
				2%	3%	
1	Prescribing	NHSB FP estimated HCH Drugs + PC Prescribing	43.0	0.9	1.3	1.6
2	Nurse Agency	Agency (forecast spend 2022/23)	2.1	0.0	0.1	0.6
3	Medical Locums	Agency (forecast spend 2022/23)	2.5	0.1	0.1	0.5
4	Non Medical agency	Agency (forecast spend 2022/23)	0.4	0.0	0.0	0.2
5	Digital	NRAC share of national estimate		0.9	0.9	0.9
6	Income generation	NRAC share of national estimate		0.3	0.3	0.3
7	Estates	NHSB Estates non-pays (maintenance, rates, etc. excluding energy/waste)	3.5	0.1	0.1	0.5
8	Energy Management / clinical waste	NHSB Energy (all fuels); waste (including domestic waste)	4.1	0.1	0.1	0.5
9	Procurement	NHSB Non-Pays excluding FHS (includes commissioned healthcare)	36.7	0.7	1.1	1.1
10	Permanent staff	NHSB (recurring) Pay Budgets less Agency costs noted above (excludes 2023/24 uplift)	149.3	3.0	4.5	1.3
			241.6	6.0	8.5	7.6

The potential savings opportunities outlined above have been mapped against the Board's own FIP savings programme for internal monitoring purposes. As further information is made available through the national FIG programme it will be routed through the internal FIP pipeline process to identify whether opportunities are additional to existing programme.

Current Savings Plans

Summary of Current Plans

Savings schemes identified to date are summarised in the following table.

Savings in-Year	2023-24 Recurring £000	2023-24 Non-Rec £000s	2023-24 Total	Risk Rating High £000s	Risk Rating Med £000s	Risk Rating Low £000s
Workforce						
Medical Supplementary Staffing		300	300		300	0
Nursing Supplementary Staffing		200	200	200	0	0
Public Dental Services Workforce Review	130		130		130	0
AHP Leadership Review	100		100		100	0
Service Reviews	290		290		290	0
Other Workforce Schemes	42		42		42	0
Total Workforce	562	500	**1,062**	200	862	0
Procurement						
Internal Audit Fees	10		10		10	0
Shredding contract	14		14		14	0
Total Procurement	24	0	**24**	0	24	0
Prescribing						
Lenolidomide	323		323			323
Product Switches	200		200		200	0
NP Contracts	192		192			192
Off Patent/Generics	250		250		250	0
PAS/PC Rebates (above baseline)	100		100		100	0
Total Prescribing	1,065	0	**1,065**	0	550	515
Estates & Infrastructure						
Boiler House Review	60		60		60	0
Phone Line Rationalisation	40		40		40	0
Waste Management	110		110		110	0
Energy Efficiency	140	250	390	60	330	0
Total Estates & Infrastructure	350	250	**600**	60	540	0
Non-Pay (Other)						
Community Dressings	18		18		18	0
Repatriation of Out of Area MH Patients	231		231	194	37	0
Gala Resource Centre	61		61	61		0
Total Non-Pay (Other)	310	0	**310**	255	55	0
Total Planned Savings Schemes	2,311	750	**3,061**	515	2,031	515
Pipeline - In-Development Stage			0	0		
Pipeline - Identified Opportunity Stage	800		800	800		
Total Pipeline Savings Schemes	800	0	**800**	**800**		
Savings Schemes (Planned and Pipeline)	3,111	750	**3,861**	**1,315**	**2,031**	**515**
Unidentified Savings	1,889	1,750	3,639	3,639		
Savings Target	**5,000**	**2,500**	**7,500**	**4,954**	**2,031**	**515**

Grip & Control

Under the previous financial turnaround programme established in 2019 the board introduced a range of measures in relation to Grip & Control, including vacancy control. These measures have remained in place during the pandemic, however operational pressures have necessitated reprioritisation of management capacity which has led to reduced monitoring and relaxation of workforce controls where significant patient safety or staff wellbeing concerns have been identified.

Measures in place are summarised in the following table.

Domain	Controls in place
Emerging Cost Pressures	All emerging cost pressures are required to be presented to the board's Operational Planning Group in SBAR format with supporting risk assessment. The board holds a contingency reserve for emerging risks which is applied where immediate investment is required in order to mitigate operational issues which are out-with the board's risk tolerance. Investment is on a short term, non-recurring basis with expectation that services develop a sustainable action plan to address on a cost neutral basis (or make separate case via the board's financial planning process). All pressures are peer reviewed and recommendations presented to the Board Executive team for final approval.
Vacancy Management	Vacancy management panels in place to review all vacancies; prioritisation of clinical posts; enhanced scrutiny of long standing vacancies and opportunities for redesign. All non-clinical posts are reviewed and decisions based on service need and workforce risk. The board has set a priority for recruitment to clinical posts. Non-clinical posts remain under consideration for recruitment on a post by post basis following vacancy panel scrutiny. An updated policy for vacancy management was implemented in January 2023.
Medical Agency & Locums	A Medical Oversight Group is chaired by the Medical Director, supported by finance and relevant corporate functions. This group undertakes review of Medical workforce issues and undertakes regular review of medical locum agency usage. Long term locums are appointed based on risk assessment of vacancies and consideration of service business continuity. Increased CDF recruitment from August 2022 was agreed with the intention of reducing reliance on agency to cover short notice shift gaps and longer term vacancies, and to support rota compliance. A review of medical agency locum usage has been commissioned to report by March 2023. Rates in place for agency use will be reviewed as part of this report.
Waiting List Initiatives	The board has an established policy for WLI rates which caps payments at 2 x consultant rate. Opportunities for EPA are considered prior to any WLI use. Waiting list payments are only applicable where there is specific funding (i.e. Access support funds). Monitoring of clinical productivity and actions to ensure delivery of core job planned activity is being reviewed through the Planned Care workstream.
eRostering	We have recently signed the MOU and agreed our implementation timelines with initiation due to begin in March 2023 and deployment by deployment by September 2023. Project governance is currently being established. It is not currently considered viable to accelerate this implementation due to pressures on senior nurses within ward areas.

Domain	Controls in place
Nurse Rostering	Nursing grip & control actions are monitored by the Director of Nursing. As a result of workforce pressures there has been a requirement for supervisory charge nurses to support registered nursing shifts, thereby reducing management capacity to undertake regular monitoring and review of KPIs. In advance of eRostering implementation the board is establishing a 'back to basics' approach to nurse rostering which is intended to ensure readiness for the transition to electronic rosters. Weekly nurse rostering reviews have been established by the Director of Nursing. Associate Nurse Directors review rota sustainability, use of bank & agency staffing, sickness absence, planned leave, etc. through these reviews.
Nurse Agency	Director of Nursing is working to implement the national action plan for Agency nursing. Reporting of Agency use is being reviewed and additional monitoring reports prepared in order to ensure this information is widely available to all relevant managers.
Sickness Absence	HR systems report absence levels to all departments on regular basis. The board has an absence management policy in place in line with national policy. Sickness absence is managed through routine performance reporting, including business unit quarterly review meetings.
Procurement	The board has a high level of adherence to national contracts and use of national distribution centre as its main supplies requisition route. Local contract awards are undertaken in line with relevant legislation. The board's procurement strategy was recently refreshed and is published on its website.
Purchase Order Compliance	Arrangements are in place to maximise Purchase Order compliance through PECOS. Following recent implementation of PECOS in Estates, all areas are now using PECOS either through direct requisitioning or via the board's procurement function. Areas of non-PO spend are in relation to service contracts and other non-goods ordering. A programme of continuous review is in place to ensure that non-PO spend is minimised and exceptions are by approval of the Chief Executive or Director of Finance.
Non-Contract Spend	Non-contract spend is reviewed on an on-going basis by the Head of Procurement. Further work is being developed through the creation of a Procurement work stream within the FIP.
Discretionary Spend	Differential controls are in place for discretionary expenditure, including purchase of stationary, staff training, etc. These controls are monitored at local level and through procurement systems, where applicable. A Discretionary spend policy is currently being developed to further strengthen this approach.
Commissioning	Policies are in place for the management of cross boundary flow activity, including referral criteria. Commissioning of out of area placements are reviewed by a multi-disciplinary ECR panel. A review is currently being undertaken to consider revised management arrangements for high cost placements within Learning Disabilities services. This review is expected to report by end March 2023.
Income Recovery	Income recovery targets are in place for trading account activities such as non-patient catering, laundry, etc. An income review is currently underway and is expected to report in April 2023.

Local Schemes

Leadership workshop

A leadership workshop was held on 27th February 2023 at which senior management and executive directors reviewed local schemes identified to date and highlighted priority areas for further assessment. This work remains in progress. Outputs of this workshop are summarised below.

Scheme Size	Savings Range		Delivery Timeframe		
			2023/24 In Year	2024/25 Medium-Term	2025/26 and Beyond Longer-Term
Small	**£1-£50,000**	**Acute Services**	• N20 Contract • Neurology service review • Pre assessment phase 2 • Specialist nurse teams • Non routine ortho		
Small	**£1-£50,000**	**Primary & Community Services**	• Orthotic Service procurement review	• Review of PDS Admin	
Small	**£1-£50,000**	**Mental Health & Learning Disabilities**	• Admin Review (MH&LD) • Medical Workforce Review • MHOAS (Mental Health Older Adults Services) Service Review • Review Borders Addiction Service and Pathways		• CMHT (Mental Health Older Adults Service (MHOAS) - Trial Dementia screening within a small GP practice within the Borders to assist with Early Diagnosis
Medium	**£50,001-£200,000**	**Acute Services**		• Woman and children's service review	
Medium	**£50,001-£200,000**	**Primary & Community Services**	• AHP Service Review - Structure & Admin	• Dentistry Workforce and vacancies review	
Medium	**£50,001-£200,000**	**Mental Health & Learning Disabilities**	• Psychological Therapy Service, Provision & Pathways - Service Review	• Repatriating provision for LD complex cases	

A number of other potential opportunities were identified aligned to work streams expected to extend across business units. These are described within the *Work streams* section of this report.

Work streams

As at 16th March 2023, scoping work continues to progress with the intention of establishing a broader programme of work streams as outlined below.

Work streams are intended to focus on opportunities for savings which extend across multiple business units. Each of these work streams is expected to have an Executive sponsor who will lead the development and implementation of actions arising within the work stream.

Work streams for Drugs & Prescribing, Procurement and Estates & Facilities have previously been established and it was initially intended that this programme would be extended to cover further work streams in relation to:

- Environmental Sustainability
- Digital Transformation
- Estates Rationalisation
- Corporate Services Review

Existing work streams included within current savings plans are outlined below.

Drugs & Prescribing

Schemes/Activities	Grand Total
	£000s
NP Contract Prices - 2022/23	92
NP Contract Prices - 2023/24	100
Off Patent/Generics	250
PC/PAS Rebates above Base	100
Polypharmacy Reviews (Invest to Save)	
Product Switching	100
Script Switch (Primary Care)	50
Biosimilars/Homecare	
Grand Total	**692**

Procurement

Schemes/Activities	Grand Total
	£000s
Income Generation - Review Trading Accounts	
National Procurement Workplan (Prices)	
Review Contract Register	
Service Contract Review	
Review 3rd Party & Voluntary Org Contracts	
Review Non-Contract Spend	
Product Standardisation (cost/quality)	
Review External Consultancy	
Review Discretionary Spend Controls	
Review Physical Media (Licenses & Subscriptions)	
Stock Management Guidance & Training	
Review Car Leasing	
Price Awareness Campaign	
Grand Total	**0**

Estates & Facilities

Schemes/Activities	Grand Total
	£000s
Clinical Waste Uplift	60
Laundry Energy Efficiency	60
Waste Segmentation (1)	50
Water Condenser Efficiency	80
Energy Rebates [Non-recurring]	250
Income Generation - Advertising	
Income Generation - Review Trading Accounts	
Grand Total	**500**

Initial scoping work towards the development of additional work streams is summarised below.

Workstream	Scope
Corporate Services Review	▪ Review of management structure and admin services, including opportunities for consolidation of admin support teams (e.g. internal help desk services). ▪ Assessment of a 'target' level overheads approach to corporate overheads.
Environmental Sustainability	Further opportunities in relation to: ▪ Waste Management ▪ Energy Efficiency ▪ Green Theatres ▪ Medical gases/propellants ▪ Single use items
Digital Transformation	▪ Near Me & Remote Working ▪ Leveraging benefits of national IT solutions, including O365 and Allocate contracts
Estates Rationalisation	▪ Review of opportunities for joint public sector estate within community settings and corporate functions ▪ Buy/Lease assessment against non-core estate ▪ Review of space utilisation and options for site disposals

During February 2023 further discussion with the Board Executive Team and Quality & Sustainability Board has begun to scope a number of additional work streams which are aligned to the Board's Annual Delivery Plan and expected to impact on both financial improvement and productivity gain. High level scoping documents have been prepared for each work stream and are summarised below.

	Workstreams	Minimum Expectation	Stretch Goal	Baseline £m	1% £m	2% £m	3% £m	10% £m
1	Workforce	No increase in overall workforce costs (except pay award); 20% reduction in Agency spend	2% Cash Release across total workforce (including aligned workstreams)	154.3	1.5	3.1	4.6	15.4
2	Bed Capacity	Reduce bed base to core funded levels	10% reduction in the cost of Inpatient Beds over 3 years	Cash release expected to be predicated on change in overall workforce costs associated with programme baselines. Scoping of detailed schemes is currently being progressed. Delivery will be against the Workforce costs profile reported above.				
3	Pathways & Community Integration	Not expected to deliver change in year 1 of plan. Minimum expectation - cost neutral.	10% reduction in whole system pathway costs					
4	Discharge & Assessment & Re-ablement teams redesign	Reduce costs to match funded base budget.	10% capacity increase at no additional cost					
5	Shared Services – Clinical	Any changes to service model will be cost neutral and will strengthen sustainability of services	Changes will support future service sustainability by maximising productivity gain and/or cash release					
6	Shared Services – Corporate	Focus on cash releasing opportunities (3% minimum saving on baseline spend)	10% Cash release (to NHSB)					
7	External SLAs	Growth in cost limited to national average (all HBs)	Restrict growth to 2%	24.4	0.2	0.5	0.7	2.4
7a	Out of Area Placements	2% Cash release	10% Cost Avoidance	3.0	0.0	0.1	0.1	0.3
8	Site Rationalisation	50% savings from any site closures	80% savings from any site closures	3.5	0.0	0.1	0.1	0.4
9	Prescribing & Polypharmacy	3% Cash release	Restrict growth to 2%	43.0	0.4	0.9	1.3	4.3
10	Service Reviews	2% Cash release	10% reduction in cost base over 3 years	See comments on Workstreams 2-6				
11	Outpatients / Theatres	1% productivity gain annually; aligned to CFSD and National operational effectiveness workstream	NHSS Upper Quartile KPIs	Non-financial benefits to be quantified as 'cost avoidance' and monitored through workstreams.				
12	Climate Sustainability / Energy & Waste	3% Cash release	10% Cash release	3.8	0.0	0.1	0.1	0.4

A full work stream programme is expected to be in place by end Quarter One (30th June 2023).

Potential Productive Opportunities

Benchmarking Review

In summer 2022 the Board commissioned an initial desktop exercise to review available benchmarking information and identify areas of potential productive opportunity. Deloitte LLP were engaged to undertake this review and a final report was provided to the Board in September 2022.

All data prepared to support the report has been provided to the Board, including dashboard analysis prepared in MS365 Power BI tool, enabling the Board to undertake further interrogation of the datasets.

The review considered information available through nationally available datasets including NSS Discovery, Scottish Health Service Cost Book, Atlas of Variation, etc. as well as population estimates and other demographic information from National Registers of Scotland.

The findings of this review are summarised in Appendix 1.

A Benchmarking Group has been established to review the full findings of the report and to undertake additional analysis where required. A full assessment and action plan remains at draft stage and is expected to be finalised by end Quarter One.

Initial areas of focus arising from the review have been identified and are being progressed through strategic programmes, including the Planned Care and Urgent and Unscheduled Care Boards.

Summary of progress to date

The following provides brief summary of key activities from the Board's Planned Care and Urgent & Unscheduled Care Programme Boards following their most recent meetings.

Planned Care Programme Board

The NHS Borders Integrated Planned Care Programme is leading work to develop sustainable elective services in the Scottish Borders and taking forward the development and delivery of a Backlog Recovery Plan. The Programme Board held its latest meeting on 23rd February. The following is an overview of the programme progress.

Key Achievements

- Revised Theatre Schedule that was implemented on the 6th February has been running smoothly, reducing the number of half-day sessions per month by 22 and releasing 11 hours of additional capacity per month.
- The Theatre productivity project has completed the Appreciative Enquiry approach as part of project start up. 60% of Theatre Staff have been engaged in this process. Thematic analysis of the improvement opportunities and staff feedback has also been completed to enable a prioritisation of these to now be developed.
- The proposed Ophthalmology QI project BOSCARD was discussed and supported by the group. The project aims to triple the number of Cataract patient operations over the next 12 months.
- Significant progress on Active Clinical Referral Triage (ACRT), Opt In process and Patient initiated review continues to be made. The opportunity to replicate ACRT process (Opt-In pathway) for PIR has been agreed to be adopted and therefore streamlining this and reducing variation for Central Booking Staff.
- The Deloitte report was considered at this month's Programme Board and further analysis at

workstream level agreed.

Urgent & Unscheduled Care Programme Board

The Scottish Borders Urgent and Unscheduled Care Programme aims to deliver transformational change, system improvement and better patient pathways for the Scottish Borders.
The latest monthly Programme Board took place on the 2nd February '23. The next board is planned for 18th April 23.

Key achievements:

- DWD (Discharge without Delay) project closure report was submitted to board. This workstream has developed supporting documentation and posters for DwD, increased Home First through process review in late 2022 and delivered a number of education workshops across the community. Recently education workshops took place in Hay Lodge CH and Hawick CH. The rollout of DwD will be delivered through a Kaizen programme at a ward level moving forward.
- Project and operational resource was moved to support the MADE (Multi Agency Discharge Event) which has now completed. Learning from the event is being considered by operational leads and will feed into the upcoming Urgent and Unscheduled Care Programme Annual Planning workshop.
- Respiratory Virtual ward - The DPIA has been completed and fully signed off. Software providers Current Health have provided training dates starting 5th April to deliver to the BGH Respiratory team. The pathways are being worked on by Dr MacKay and there will be a session week commencing 27th Feb to document the changes. The warranted environment specification has been provided and are now with IM&T.
- The Surgical HOT clinic trial started week beginning 27th March delivering clinics on Monday, Wednesday, and Friday. Initial feedback from the trial has been favourable as patients are moved out with ED for assessment.
- Hospital at Home - The notes of interest have closed and interviews for the nurse posts will be held on 3rd March 2023. The On boarding process is being worked through. The patient representative has joined the steering group and is providing useful input. The Finance sub group meetings have commenced and they have given direction on data that needs to be gathered to support the future business case.
- The first Urgent and Unscheduled Care Annual Planning workshop is in diary. This event will review progress of the programme so far and set priorities for '23/24 with a focus on sustainability and moving towards to 2023 urgent and unscheduled care vision.

Working with Partners

Background

Over the past eighteen months the Scottish Borders Integrated Joint Board has appointed a new Chair, Chief Officer and Chief Finance Officer. Prior to the appointment of the Chief Finance Officer in September 2022 the post had been vacant for two years, with the Scottish Borders Council Director of Finance performing the functions of Section 95 Officer.

Since this time, the IJB has begun to develop its new strategic framework and both NHS and Local Authority partners are working closely to support the implementation of this framework.

IJB Budget Setting

Due to the timing of the CFO appointment the financial planning for 2023/24 has continued to be led by the partner organisations with the IJBs financial plan being a consolidation of the outputs from each partner. The IJB has confirmed its intention to set an Initial Budget by 31st March 2023 with the expectation that this budget will be finalised by end June 2023. Accompanying this budget will be the relevant directions to partners which set out the strategic objectives relating to delegated functions, including Set Aside for large hospital functions, together with the financial resources within which these objectives are expected to be delivered.

Financial Risk Share Arrangements

The IJB faces the same financial challenges in relation to health-delegated functions as those within the Health Board. HSCP partnership functions continue to be managed as Business Units within NHS Borders management structure, with the exception of Learning Disabilities where a joint service is fully established.

Prior to the pandemic the IJB was already facing significant pressures on health delegated budgets and savings delivery has been limited during that period. In establishing the budget for 2023/24 the Health Board has set out its expectation that the IJB will need to contribute not only to addressing the gap on its own budget, but also to a further share of unallocated savings not previously distributed as targets to individual business units. In addition, the HB has also highlighted the conditions set out in the Scheme of Integration within Scottish Borders, by which support provided by the partners is repayable by the IJB. This is most relevant in relation to the brokerage support provided to NHS Borders, of which an element has been used to support the IJB.

The relationship with the IJB continues to be constructive and all parties remain committed to retaining a collaborative approach to forward planning. As such we anticipate that the final resolution of these aspects of the budget will be best achieved through constructive dialogue and a shared commitment to addressing the underlying problems which drive the financial deficit faced by both parties.

Financial Recovery

The IJB CFO has outlined her approach to financial recovery through a number of key actions which the IJB is looking to implement during 2023/24, including:

- Increased grip & control through enhanced decision making governance
- Establishing the IJBs financial planning approach aligned to the revised strategic framework

- Introduction of a whole system programme budgeting model to be applied across both Health & Social Care
- Review of Set Aside arrangements and governance
- Introduction of a budget review to evaluate options to deliver 'Best Value for every Pound'

We will work with the IJB to support the further development of this approach and will consider how benefits of this approach might be extended into non-delegated functions where relevant.

NHS Borders intends that the approach to savings undertaken operationally should be aligned across both delegated and non-delegated functions in order to ensure consistency of message to operational management teams.

The IJB CFO has been invited to join the Board's Financial Improvement Programme Board and in advance of the quarter one review we expect to work with the IJB to develop the NHS Borders FIP to align the board's savings programme as closely as possible with the IJBs expected approach.

Next Steps

We recognise that further work is required urgently to ensure that the level of savings described in the plan is fully identified.

We will scope savings expected to impact in both the immediate and long term, and seek to embed the actions to improve grip & control and to deliver local and work stream savings.

We will continue to focus on the immediate priority of ensuring that savings plans for 2023/24 are fully assessed and implementation is in place as soon as possible.

This will include ensuring that the work stream approach described in the paper is fully scoped and additional work streams are established within the first quarter of 2023/24.

We also aim to outline the scope of potential opportunities to address the additional savings assumed in the plan over the three years to March 2026.

Our benchmarking work will continue to evolve and we will embed this approach across our Financial Improvement and Transformation programmes to maximise opportunities for both financial improvement and productive gain. We aim to develop an action plan in relation to our Benchmarking Report referenced above by end of quarter one.

We will ensure that the Board's transformation programme continues to focus on the development of the changes required to address long term sustainability across our services.

We will work with the Scottish Borders IJB and other public sector partners to seek opportunities to drive improvement through collaboration. This will include assessment of how we expect to align our programme with the Scottish Borders IJB strategic framework.

We also aim to outline areas where we believe there are opportunities for us to work with regional partners, including Scottish Borders Council and East Region NHS Boards, to achieve greater economies of scale through joint working.

Beyond this, we believe that there will be further savings required which will only be possible through reform of services at a regional or national level, and by identification of policy changes which will fundamentally alter the demand for services which currently drives expenditure.

Appendices to the Report

Appendix 1 – Benchmarking Analysis Report: Summary of Key Findings

BENCHMARKING ANALYSIS REPORT SEPTEMBER 2022

Summary of Key Findings

Report prepared by Deloitte LLP

Workforce		Next Steps
W1	Age structure of the workforce slightly older than Scotland with sickness absence in line with national average	*Workforce is a large area of cost and a number of findings have been identified. We would recommend further investigation and / or the establishment a specific workforce workstream in the FI programme to review in more detail*
W2	Admin and support service WTE are high per 100,000 population and take up a high proportion of overall workforce WTEs (31% of all roles vs 26% for Scotland)	
W3	Admin and support services using fewer B2 and junior grades compared to D&G and Scotland	
W4	Relatively low share of WTE in nursing roles (42% vs 45% in Scotland), with more senior grades B6+ and less use of B2s compared to D&G	
W5	Slow vacancy fill rates with 36% of vacancies over 3 months, compared to 25% in Scotland and 17% in D&G within Nursing and Midwifery, largely driven by roles in the acute (adult) sector.	
W6	Agency expenditure has increased recently, however, data on bank is hard to interpret given change in system (transfer to Lothian bank), however based on informal discussions we understand it has increased too	

Site and Beds		Next Steps
S1	Number of sites per capita is higher than elsewhere in Scotland (Acute Hospital, Community and GP practices) however in line with other rural Boards	*A more detailed review of community and geriatric bed provision maybe required. This should take into account other community based service available to support the elderly population.*
S2	Acute staffed beds per 100,000 have been falling steadily over the past ten years and are broadly in line with peers although reported occupancy at 78% is lower (pre-covid)	
S3	Community staffed beds have remained unchanged over the past ten years and provision is now slightly higher than peers, on a per site basis and per 100,000 population basis. Despite this occupancy remains high.	
S4	Acute medical and surgical beds are lower per capita than peers but this probably reflects high cross boundary flow	
S5	Geriatric medicine beds per capita are very high compared to peers but this may be due to variance in reporting by specialty or reflective of the population makeup of Borders	

Primary Care and Prescribing		Next Steps
PC1	The number of GP practices per capita is slightly higher than Scotland and practices have a smaller list size. This in part reflects the rural geography and is in line with other rural Boards	*Opportunities in relation to General Practice appear limited, however, there remain areas of opportunity in prescribing expenditure in both primary care and the acute sector that are worth pursuing and quantifying further. It is understood that the pharmacy team has the ability to run in depth reports to support this.*
PC2	Average GP list sizes have increased slightly over time, but at a slower pace than the rest of Scotland	
PC3	GP headcount has remained broadly constant, within this there has been a drop in male headcount and an increase in female salaried GPs	
PC4	Overall prescribing expenditure is in line with the Scotland average (cost per 100,000 population). This finding relates to primary care with acute prescribing slightly below average	
PC5	Growth in cardiovascular prescribing spend continues (in line with the rest of Scotland) and will remain a significant cost pressure going forward	
PC6	In four BNF Chapter areas, prescribing costs are outliers compared to the rest of Scotland: Endocrine (hospital spend), Eyes, ENT and Nutrition & Blood (we understand the prescribing team are looking to review Nutrition following a recent hire)	

Mental Health		Next Steps
MH1	Adult Acute Mental Health bed numbers per 100,000 are slightly above average, with admission rates much higher, whilst occupancy rates remain low (significantly below the Royal College of Psychiatrists recommended maximum occupancy)	*Bed benchmarking was undertaken pre Covid and further interpretation is required.* *CAMHS and PT workloads should be reviewed– for example the introduction of CAPA type demand and capacity workload tool* *Further analysis is required for the data behind the high volumes of new outpatient referrals leading to booked appointments, as when coupled with a high rate of return appointments and low uptake of virtual appointment methods could be a significant opportunity area.*
MH2	Older Adult mental health bed numbers per 100,000 registered population are below the Scottish average as are admission rates and occupancy rates.	
MH3	Accepted referrals to Psychological Therapy (PT) and CAMHS per 100,000 registered population are higher than average	
MH4	CAMHS and PT waiting lists are under pressure and now above average in Scotland	
MH5	Borders has a high rate of booked outpatient referrals across all Mental Health specialties	
MH6	Better Quality Better Value (BQBV) indicators highlight a high new to return ratio with an opportunity to reduce 2,500 return appointments	
MH7	There is a relatively low uptake of virtual outpatient appointments across mental health specialties (Child & Adolescent Psychiatry, General Psychiatry [new appointments] and Psychiatry of Old Age)	

Unit Costs		Next Steps
C1	Cost Book analysis (19/20) illustrates the inpatient hospital costs are broadly in line with the Scottish average albeit with General Medicine and Gynaecology unit costs outliers (+38% and +42% respectively)	*We would recommend updating cost apportionment methods to ensure the information is sufficiently robust for opportunity identification.* *The size of the current variations would indicate that some services do have higher than expected unit costs*
C2	Day case unit costs across almost all specialties are significantly higher than the Scottish average (+34%)	
C3	Consultant led outpatient and ED unit costs are significantly higher than the Scottish average (+31%). Nurse led appointment unit costs are lower whilst AHP attendance unit costs are high	
C4	Community service unit costs are broadly in line with the Scottish average, although appear high for both the community psychiatric team and district nursing team (+32% and +45% respectively)	
C5	Theatre unit costs are between 11-19% higher depending on the comparator. Hospital administration and cleaning costs are also higher than average.	

Non-Elective Pathways		Next Steps
NE1	BQBV indicators suggest there are some modest improvements possible in the management of Ambulatory Sensitive Conditions within ED (mainly abdominal conditions)	*Non elective lengths of stay have diverged significantly from Scotland and require urgent review working with HSCP colleagues*
NE2	NSS Discovery indicators illustrate that Borders has a high admission rate from ED (31% vs 26% for Scotland)	
NE3	Length of stay (los) in the acute sector has been increasing particularly across non elective pathways. Average LoS is now over 9 days compared to 5 across Scotland. The increase is driven primarily by General Medicine and Trauma and Orthopaedics	
NE4	Delayed Discharges have steadily increased since an initial fall after Covid special measures were introduced in 2020. Average daily delayed bed days and median length of delay are now above pre-pandemic levels.	

Elective Care		Next Steps
EC1	Opportunities for improvement across elective care LoS appear modest, although average LoS have increased marginally over the Covid period	*Opportunities across the elective pathway are modest but further investigation into hip replacement and Day Case rates should be undertaken. However, it is unclear what impact Covid may have had over the past year*
EC2	BQBV indicators illustrate few opportunities from DNAs or pre operative lengths of stay	
EC3	BQBV procedures of limited value indicate potential savings almost all linked to undertaking more Primary Hips than required for the age standardised population	
EC4	Day case rates are broadly in line with BADS targets, albeit there are opportunities to improve in hip surgery, mastectomy and bladder resection. Comparisons to D&G illustrate they are doing far more day surgery and that there is opportunity above matching the BADS targets.	

Theatre Performance		Next Steps
T1	Session cancellations are very low, despite this Borders has a very high rate of cancelled operations for non clinical/ capacity reasons across all main surgical specialties	*NHS Borders appears a substantial outlier in relation to theatre efficiency. Further understanding of how these metrics are collated and measured should be sought to validate these findings.*
T2	Borders is an outlier in terms of late starts, over runs and under runs. Difficulties are apparent across all main surgical specialties (General Surgery, Urology, Ophthalmology, Orthopaedics, Gynaecology)	
T3	Borders has the slowest average procedure time (95 mins) in Scotland. Only 35 mins relates to operative time giving a Knife to Skin ratio of only 37%	*A programme of scheduling optimisation and improvement will be required*
T4	Theatre utilisation rates are line with the Scottish average but given the above, this metric is clearly masking issues elsewhere	

Outpatients		Next Steps
OP1	Outpatient DNA rates for new patients are slightly below the Scottish average (7.6% vs 8.7%) and slightly higher for returns (12.2% vs 9.8%). New to follow up ratios are mainly better the Scottish average with the exception of mental health specialties (see above)	*Continue to push the modernisation of outpatients including the use of ACRT, with greater use of virtual appointments where clinically appropriate given the rural geography*
OP2	The number of virtual outpatient appointments (video and telephone) is in line with the Scottish average but lower relative to other rural Boards such as Highland and Grampian. For new patients it is currently 14% and 22% for returns	
OP3	A number of specialties are undertaking fewer virtual appointments compared to the Scottish average (respiratory medicine, endocrine, rheumatology and general surgery)	
OP4	Borders has a slightly higher than average age / sex standardised outpatient referral ratio indicating there maybe opportunities for improvements in Active Clinical Referral Triage (ACRT)	

Cross Boundary Flow		Next Steps
CB1	13% of residents who require treatment (by HRG) and 11% of residents requiring outpatient attendances are seen outside of NHS Borders run locations, with the majority being seen in Lothian	*There is limited scope for bringing additional specialties within Borders without significant investment in services. General specialties with a high proportion of cases seen elsewhere are potential targets for repatriation.* *The cases sent to non-NHS Providers should be assessed to ascertain whether they could have been sent to NHS providers and the subsequent cost of this.*
CB2	A number of specialties have no outpatient seen at Borders locations, including Plastics (1,377 patients), Medical Oncology (773 patients) and Neurosurgery (633 patients)	
CB3	No patients required Assisted Reproductive procedures, non-admitted consultations for Immunology and Radiotherapy were seen in Borders	
CB4	Psychiatry of Old Age, Urology and Skin Surgery have all seen patients sent to non-NHS providers	
CB5	Several high volume specialties have a high proportion of cases seen in non-Borders providers such as: Respiratory Medicine outpatients (2,119 outpatients, 54% in Borders), General Surgery outpatients (5,634 outpatients, 70% in Borders) and Eyes and Periorbita admissions (838 inpatients, 63% in Borders).	

Community Services		Next Steps
CS1	With relatively few nationally available datasets looking at community service benchmarks we have little analysis to present	*Conduct local activity and cost benchmarking within community teams to understand potential productive opportunities*

Planned Care Plan Template – 2023/24

NHS Board: NHS Borders
Completed by:

Introduction

This template is guides to help inform your plan in a consistent manner however, it is not limited to the sections below therefore please extend this template to add additional information to ensure all elements of the priorities set out in the plan are captured.

Funding

1. In summary, how will you target your NRAC allocation of the £103 million?	Waiting times funding will be targeted towards the following prioritises : - **Cancer Waiting Times** – Cancer performance remains our top priority and waiting time funding will be used to ensure our good performance is maintained. As a priority this will include the recovery and maintenance of diagnostic waiting times at or below the required standard of 6 week assuming funding requested is provided. This will include bridging capacity within Endoscopy pending the development of a local and more financially sustainable solution. We have also requested additional CT and MRI mobile capacity to support recovery of Key radiology waits; this is yet to be confirmed although trajectories assume funding will be provided and will need to be adjusted based on funding allocated if not supported in full. - **Ring Fenced Elective Capacity** - Supporting the establishment of a standalone ring fenced elective surgical ward to ensure NHS Borders is able to support the maximum elective surgical capacity available, and sustain higher levels of elective surgical activity over the autumn and winter periods. Bed availability continues to represent the single largest barrier to recovering elective capacity and without consistent and sustainable access to beds, improving and sustaining higher levels of theatre productivity will become increasingly difficult. -

	- **Outpatient Waiting Times** - Targeted support for high volume outpatient specialties to accelerate recovery against national improvement trajectories, particularly where recovery has proved problematic due to workforce constraints or recruitment challenges. This alongside other performance and productivity based solutions will ensure reduced waits are sustainable. - **Ophthalmology Waiting Times** – We have focused on the development of additional operating capacity in our ophthalmology service given the significant backlog recovery required in Cataract surgery waits. This will also support work underway to improve theatre productivity in our main theatre.

Maximising Planned Care capacity locally, regionally and nationally

1. How will your Board maximise all available local capacity to deliver planned care (core and additional Waiting List activity) in 2023/24?	There are a number of activities we are undertaking : - **Capacity Planning** - We are developing clear capacity/activity performance plans at a service and specialty level. These are based on obtaining maximum value from existing resource, and importantly understanding where this is not happening, to allow for corrective action to support improvement. This includes a focus on the productive use of both specialist time and skills. Initially a targeted approach will be taken and we are focusing on the most challenged services in the first instance. - **Capacity Management** – We are implementing tools to support better and more effective use of clinical space. We have noted a reduction in activity in some services associated with clinic availability, or capacity lost to unscheduled service activity. We will implement better space management and room booking facilities for teams during 2023-24 to support better capacity management and room utilisation and ensure this is not a significant factor in reported performance moving forward.

	- **Theatre Productivity** - We are undertaking a wide ranging review and programme of improvement in our Theatre Department. This is focused on structural and behavioural barriers to increasing theatre productivity. This is being supported by a detailed training and skills needs assessment aimed at accelerating the recovery of capacity lost as experienced staff have left over the past 2-3 years, and recognising the struggle we had had in recruiting trained and experienced theatre staff. This includes changing our work force profile with the development of Scrub and Theatre Assistants at B4 and B2 respectively. We are also working with other regional Boards to support staff training by allowing access to high volume theatre environments. - **Cataract Surgery** - We are developing a hybrid Ophthalmology Theatre model with Ophthalmology nurses working across both outpatients and theatres activities. This will allow us to recovery and increase Cataract operating faster, and protect main theatre capacity for other surgical specialties. We are working towards increase operating capacity by 200% by July 2023. We are also using the specialisation this model allows to push forward improvements in productivity with the aim of establishing a standard of 8 cataracts per theatre list by September 2023/24. - **Protected Capacity** – As noted above ensuring access to beds will support effective use of elective resource, including improved theatre productivity.
2. How will your Board work across the region in 2023/24 to maximise all opportunities for regional working to deliver planned care?	A senior regional planning group has been established to review comparative waiting times within the SEAT group, share learning across the region, and ensure that available capacity is used to best effective and based on relative need. We are also working with regional partners to support training needs most specifically in Ophthalmology and Theatres in general. Access to high volume specialty specific theatres will support the accelerated development of our Ophthalmology nursing teams, and our theatre staff.

3. How will your Board work nationally, with support from the Centre of Sustainable Delivery, to maximise all opportunities to deliver planned care?	We are linked to the various Specialty Delivery Groups that have been established with a focus on identifying and delivering high impact changes on a "once for Scotland" basis. These include assessing and implementing into clinical pathways the following : - An **Active Clinical Referral Triage (ACRT)** approach to triaging and signposting referral to the optimal pathways, and as a consequence reducing unnecessarily face to face clinical consultations. - Discharging to **Patient Initiative Reviews (PIR)** and follow up, and allowing patients to determine when a review assessment is useful. - A focus on post operative length of stay for major inpatient surgery and **Enhanced Recovery after Surgery (ERAS)** evidenced based approaches given the rate limiting factor inpatient beds represent for our elective programme. - **Opt-In** - We are working to establish an opt-in approach to key elective procedures where information on likely treatment and associated risks is provided at referral, and patients asked to consider and confirm an further appointment is required and not automatically provided. This has been developed to good effect in Orthopaedics and we are considering it wider application. We are also engaged in a number of specialty specific pathway reviews being taken forward nationally and will ensure we maintain good clinical engagement, particularly in Breast Surgery and Urology were we have a significant volume of inpatient or 23 hours surgery being undertaken, and where there is opportunity for optimisation/improvement for NHS Borders in terms of length of stay reductions.
4. What specific action is your Board taking to prioritise delivery of the Waiting Times Targets for Outpatients and TTG in the most challenged specialities?	**Outpatient :** NHS Borders is committed to the standardisation across specialty areas linked to potential improvements in productivity, reliability and robust governance in booking process. This will ensure that clinics are organised and booked effectively and we maximise the capacity potential within services. We are working with our Business

	Intelligence team to ensure management reports are provided weekly to support proactive capacity management within Service Management teams, and this includes process measures that will demonstrate that planned capacity available and being used. **Administrative and Clinical Validation**: We are working with the National Elective Capacity Unit to establish a systematic process for the administrative validation of long waiting patients' across all specialty groups. This will utilise the Netcall functionally developed to support this process, and an initial assessment is expected to be completed in April. Specific actions in high risk areas include : **Dermatology :** - We are developing nurse led and GP with specialist interest (GPSI) options in dermatology in order to ensure we are maximising value from all available staff groups recognising the challenges nationally we are facing at a consultant level, and the risk to sustainability of services that this this represents. - We are working with colleagues in Primary Care to develop referral pathways supported by images for dermatology. It is hope that this will improve clinical triage and ensure appropriate risk assessment and management. - We are exploring alternative delivery models to ensure we can access sufficient service capacity over the next 12 months; this includes reviewing systems and process employed in other NHS Boards. - We are discussing the potential for in-reach capacity for Plastic Surgery to support preservation of specialist dermatology capacity for general dermatology referrals given wider issues, but also to support wider surgical training for Nurse/Consultant staff in the service.

	Ophthalmology - We working with our Ophthalmology team to reshape clinical pathways in order to ensure we are maximising service productivity. This includes "straight to surgery" pathways for cataract patients, additional optometrist capacity to manage patients with a diagnosis, and nurse led clinics/treatment where this is appropriate. All of these initiatives are aimed at maximising the support available to ophthalmology patients generally, and ensuring maximum value from or consultant level workforce.
	TTG **Elective Capacity –** Predictable capacity is an essential component of an effective recovery plan for TTG waits. We have included a case for investment in a ring fenced elective facility that will ensure we utilise available theatre capacity to best effect. Our longest waiting patients often require an inpatient stay post operatively, and are in direct competition with patients on urgent or cancer pathways when beds are limited or in short supply. Sufficient beds will ensure that patients are booking in turn and in accordance with their clinical priority. **Theatre Productivity - We** care continuing to work to recover funded theatre capacity lost over that past two years to attrition in our skilled theatre workforce. We currently have 10 members of staff at various points in their training programme and we are anticipating a step up in available capacity in our main theatre from August, with full capacity being recovered by January 2024. **Atlas of Variation –** With the support of our Value Based Medicine lead we are reviewing the output from the latest version of the Atlas of Variation. Work is underway in respect of variation noted in Cholecystectomy, hernia and hip surgery rates in NHS Borders. In addition we will be reviewing same day surgery rates to ensure opportunities

	for improvement are identified and pathways reviews are required. This is particularly relevant to Breast and Urology length of stay/day case rates. **Orthopaedics** – As our bed capacity allows we will move towards ensuring we establish a standard of 3 major procedures per full day operating. It is unlikely that NHS Borders will achieve a standard of 4 major joint operations on a full day list given the current levels of experience in theatre and the lack of specialist theatre teams. We will continue to accept our allocation of capacity at the NGJH for orthopaedics and we are anticipating an allocation of upwards of 94 patients will be sent over the course of the year. **Ophthalmology** - Hybrid staffing to accelerate an increase in capacity. We are aiming to move from x1 full day list to x3 full day lists by August 2023. We are working with the Edinburgh Service in order to access a high volume unit to support the development of skills within our Ophthalmology Nursing teams. Moving toward a realistic objective of 7 to 8 cataracts on each half days list (minimum 1 patient per 30min slot). From current performance of 6 per list. Again we are continuing to work with NGJH as part of the NTC network and will be sending 200 patients to Glasgow for their cataract procedure during 2023/24.

Protecting Diagnostic capacity locally, regionally and nationally

5. How will your Board maximise all local capacity available to deliver diagnostics in 2023/24?	We are continuing to develop workforce plans to support the maximisation of potential capacity in both Endoscopy and Radiology. While we have made progress recovery core staffing levels in Radiology, we do not yet have staffing in place to support any increase above core funded activity levels. We are continuing to push staffing levels with the aim of maximising all potential capacity on a planned and scheduled basis. This would include 7 day elective lists on CT and MRI equipment.

	Endoscopy - A significant rate limiting factor for capacity in Endoscopy remains trained endoscopists. This limits the number of scheduled endoscopy list we are able to support, and we are underutilising lists. While we have given primacy to Surgeons picking up additional Colonoscopy lists as capacity allows, this will becoming harder during 2023/24 as theatre access improves, and we renew our focus on recovering outpatient capacity. While we have attempted to recruit nurse endoscopists during 2022/23 to date this has not been successful. We are continuing to explore all options aimed at increasing endoscopist capacity locally. In the interim we will bridge utilising independent sector support. Our primary aim will be to ensure urgent waiting times are maintained at acceptable levels given their impact on wider cancer pathway performance. **Radiology** – We have managed to maintain CT and MRI capacity during 2022/23 and are well now placed from a workforce perspective moving into 2023/24. This has involved the recruitment of x4 international radiographers who have integrated well and now essential members of the wider team. However as demand for both CT and MRI increases we are now dependant on mobile technology to maintain current performance and meet this immediate capacity shortfall. We have requested an additional 14 weeks of both CT and MRI mobile access to meet projected demand above local capacity during 2023/24, in addition to a further 7 weeks and 5 weeks of CT and MRI capacity respectively to achieve a maximum diagnostic wait of 6 weeks by the end of the year. This funding does not form part of our recurring waiting times allocation and our forecast will be subject to adjustment should this funding not be forth coming. This may mean a re-evaluation of other prioritises given the interdependence of diagnostic and cancer performance.
6. How will your Board work across the region in 2023/24 to maximise all opportunities for regional working to deliver diagnostics?	We are continuing to work closely with the NECU and NTC networks to ensure that NHS Border is taking advance of any additional CT and MRI capacity that may be available at the NGJH or other units to support our waiting times position. While we have been successful in sending patient to Glasgow for MRI, we have understandably found CT

	patients less enthusiastic. However, we will continue to access support where this is available.
7. How will your Board work nationally, with support from the Centre of Sustainable Delivery, to maximise all opportunities to deliver diagnostics?	We are working with national team to maximise potential benefits offered through the implementation of initiatives like cytosponge and colon capsule. We have reviewed referral pathways and are ensuring that we are maximising the potential opportunity for ACRT offered by qfit testing, although his has proved of limited additional value with current pathways supporting directed access to qfit to primary care in NHS Borders. A majority of patients negative at initial qfit are not being referred, or are not accepted at referral screening. We are actively clinically validating all long waiting endoscopy patients and directing to an alternative pathway where this is appropriate.
8. Please set out timeline for adopting high impact changes for Endoscopy set out in Annex A.	We are developing a detailed response to the High Impact Changes noted in Annex A and this will be proved separately, however as noted a number have been implemented by the Board or form part of sustainability plans we are progressing in our Endoscopy s Service.

Productive Opportunities

9. Please set out a timeline for adopting the productive opportunities outlined in Annex B.	We will provide a separate plan for implementation timescales associated with the deliverables outlined in Annex B. However, a number have been reference in the body of the wider response noted above.

Waiting List Validation

10. Please provide assurance that administrative and clinical Waiting List Validation will be fully embedded locally and engagement with NECU has taken place to support this as appropriate.	We are working with NECU to fully implement the required 3 stage validation process for all specialty lists utilising the algorithms developed nationally, and utilising the Netcall technology to support effective communication with patients. This will include the opportunity for patient to request a follow clinical assessment should they feel this condition merits a re-assessment. We are in the process of providing the NECU team with relevant information across all long waiting patient groups, and are anticipating an initial validation exercise in April. Additionally we are working with our local BI team to further validate patient on waiting lists to eliminate duplicate entries, request a review where administrative information suggests this is merited (following admission to hospital for instance for a simalr condition). This will require additional investment in administrative support and this is included with the waiting times bid.

Cancer Waiting Times (CWT)

11. How will you Board work collaboratively with continual focus on cancer performance to fully embed and implement the Framework for Effective Cancer Management to support cancer waiting times recovery.	We have maintained strong performance in respect of cancer pathways during 2022/23, and have moved to ensure that this position is maintained during 2023/24. We will continue to focus those patients on urgent or Cancer specific pathways as a priority. This is reflected in the suggested application of additional waiting times funding aimed at ensuring diagnostic pathways for urgent patients are maintained at or below the national standard in key diagnostic tests. This reflects their importance in support prompt diagnosis and early treatment of cancer. We have made good progress in meeting the actions outlined in the Framework for Effective Cancer Management, and will continue to work towards implement any action outstanding as part of the revised action plan submitted earlier in the year.

	We have sought additional capacity support to develop local EBUS capacity to ensure NHS Borders is well placed to meet the national Optimal Lung Cancer Pathway. Utilising the Cancer Waiting Times funding support received we are looking to invest in additional clinical pathway navigation support in Prostate/Urology and Skin Cancer pathways. This reflects some the current performance and quality challenges we face, particular for prostate cancers where we have consistently failed to meet the required standard of 95%. These investments will support improvements in diagnostic and care co-ordination for these patients ensuring they navigate pathways faster than they are currently, and improving access times in general.

PERFORMANCE SCORECARD

As at 28 February 2023

Month 11

Contents Page

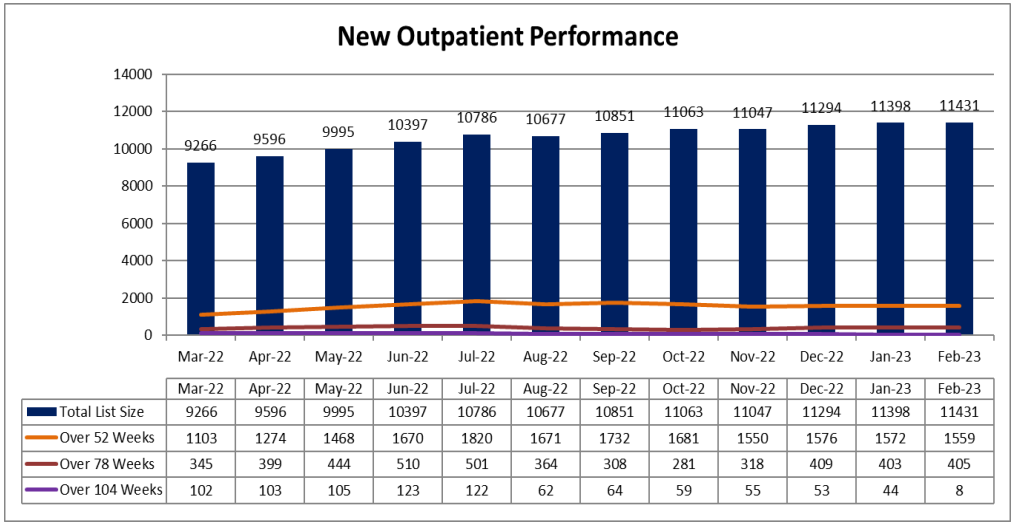
Introduction

As a result of the COVID-19 Pandemic the 2021/22 Annual Operational Plan (AOP) was replaced for all Health Boards by their Remobilisation Plan and associated trajectories agreed with Scottish Government, the latest iteration being RMP4. In 2022/23 Scottish Government moved away from further remobilisation plans and instead commissioned a one-year Annual Delivery Plan aimed at stabilising the system. To supplement this all Boards were required to submit waiting times trajectories but no other formal performance measures were agreed.

This report contains the 2022/23 waiting times performance and hot topic measures and an appendix which demonstrates AOP and Local Delivery Plan (LDP) measures (LDPs were in place as performance agreements between Boards and Scottish Government prior to AOPs and we retain some of the performance standards from those plans). In the current report performance is noted against waiting times trajectories in place as at November 2022. NHS Borders was notified in late 2022 that the amount of waiting times funding allocated to the Board is lower than anticipated; as a result some trajectories have been revised, with performance against these reported in the Board's monthly performance scorecard. A revised Delayed Discharge trajectory has also been developed and similarly, performance against this is reported in the monthly scorecard report to the Board.

Performance is measured against a set trajectory or standard. To enable current performance to be judged, colour coding is being used to show whether the trajectory is being achieved. A tolerance of 10% is applied to the standards to enable them to be given a RAG status. For standards where the trajectory is 0, the tolerance level is 1, anything higher the RAG status is red (for example waiting times and delayed discharges).

Waiting Time Performance – Outpatient Performance Total List Size by Weeks Waiting



	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23
Total List Size	9266	9596	9995	10397	10786	10677	10851	11063	11047	11294	11398	11431
Over 52 Weeks	1103	1274	1468	1670	1820	1671	1732	1681	1550	1576	1572	1559
Over 78 Weeks	345	399	444	510	501	364	308	281	318	409	403	405
Over 104 Weeks	102	103	105	123	122	62	64	59	55	53	44	8

Fig. 1

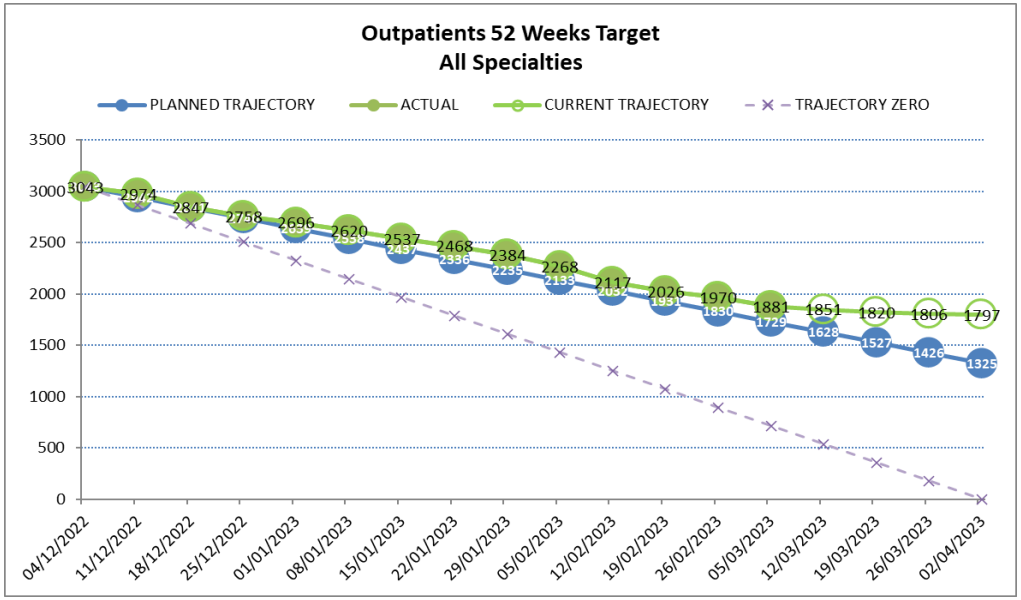


Fig. 2

New Waiting Times Targets ***Updated 07.04.2023***

The overall OPD list size marginally increased by 33 patients during February. As previously reported, overall trend is still heading in the wrong direction – demand has not increased but activity has failed to remobilise beyond 75%. The Clinical Management Teams are working to further remobilise outpatient activity and look at different ways of working to address the challenge.

Performance against 0 patient waiting over 78 weeks - NHS Borders continues to have patients waiting over 78 weeks (405 patients at the end of February). The specialties with patients over 78 weeks are specialties where there have been medical gaps in core capacity, i.e., dermatology, cardiology, orthodontics and respiratory. An exception to this is Ophthalmology where the issue has been around core nursing capacity to support flow through clinics.

The service continues to have challenges with core medical gaps in Dermatology and the service is actively exploring locum and other independent support. Cardiology, Orthodontics and Respiratory medicine have all secured core capacity from locum posts – all in post as from February.

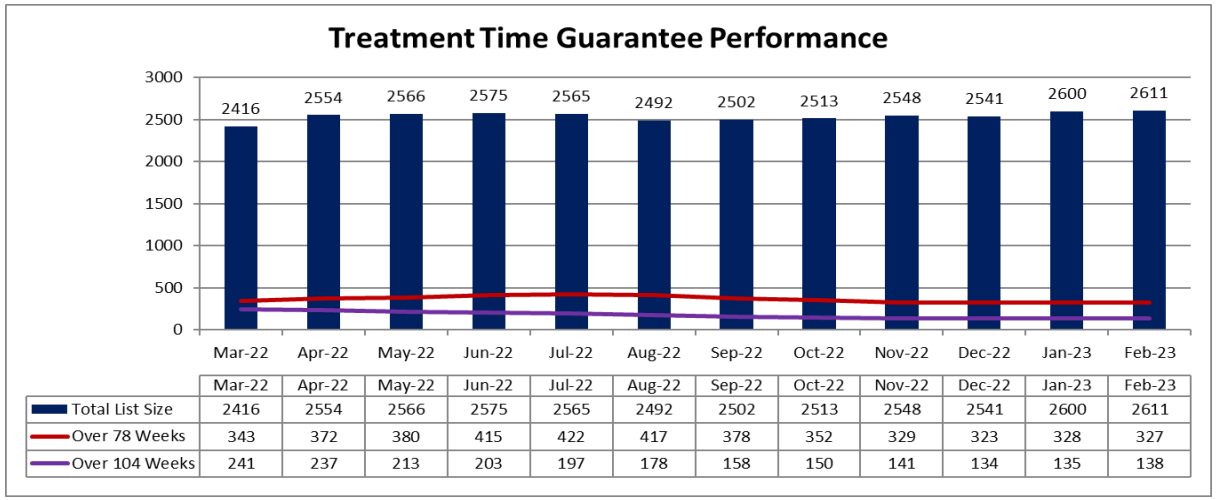
The new staffing model is underway in Ophthalmology where the service has employed 3 registered nurses who will be trained in OPD and Cataract theatre. Interviews are planned for the newly developed technician posts for OPD. Although there will be a lag time for training nurses and technicians, these posts will allow the service to increase activity through consultant clinics. Waiting Times funding has also secured an additional optometry post that will see review patients and release consultants to see more new patients contributing to reducing the waiting time.

Patients waiting over 52 weeks - 1559 patients were waiting over 52 weeks at the end of February. Meeting 52 weeks for all patients will not be achievable in NHS Borders by end of March. Nearing 80% of these patients waiting over 52 weeks are Dermatology and Ophthalmology patients.

As noted above, the service is trying to secure core and additional capacity for Dermatology. The majority of the Ophthalmology patients are patients awaiting cataract surgery. The Ophthalmology Team launched their Cataract Improvement Project on 20th February, with a view to increasing the number of cataracts completed on a weekly basis, by increasing lists and increasing the numbers of patients on lists. The cataract patients on the outpatient list will be having cataract surgery and on discussion Scottish Government it was agreed appropriate to transfer the patients straight to the IP/DC waiting list where they will be pre-assessed before surgery. No patient will be disadvantaged by this but it will give a truer picture of out waiting lists by treatment.

The majority of other specialties (24% of the total of those waiting over 52 weeks) have secured core/additional capacity to see long waiting patients.

TTG Performance Against Trajectory- All Specialties



	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23
Total List Size	2416	2554	2566	2575	2565	2492	2502	2513	2548	2541	2600	2611
Over 78 Weeks	343	372	380	415	422	417	378	352	329	323	328	327
Over 104 Weeks	241	237	213	203	197	178	158	150	141	134	135	138

Fig. 3

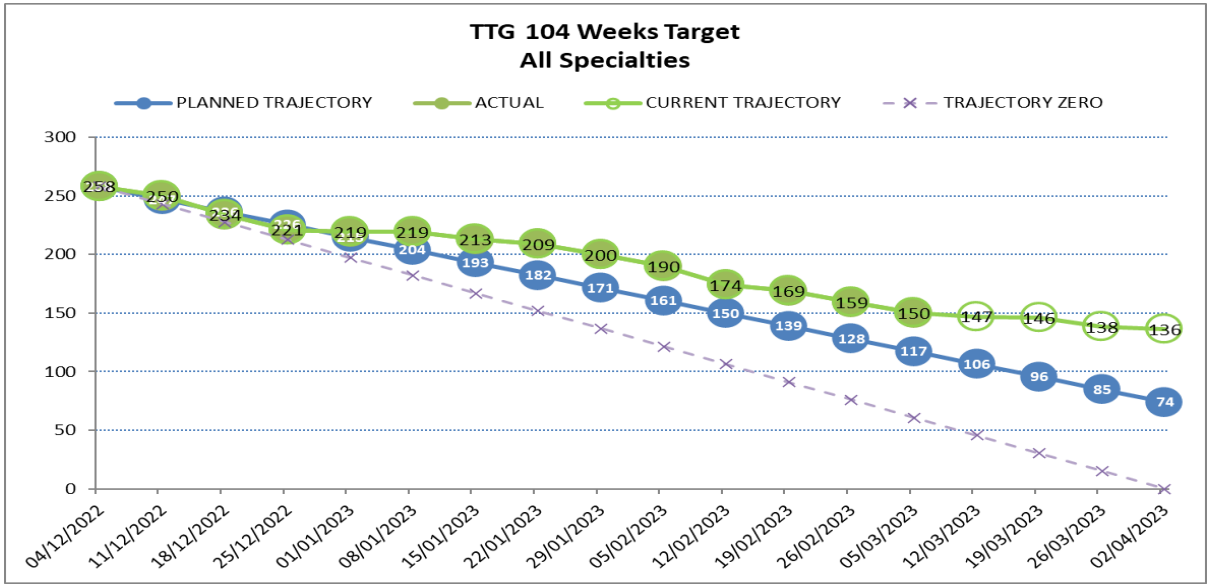


Fig. 4

What is the data telling us? ***Updated 07.04.2023***

The waiting list size remains roughly the same as last month with 2611 patients on the waiting list, with 138 patients waiting over 104 weeks being treated.

It should be noted that the new Scottish Government inpatient/day case surgery TTG targets are:

- **No patient waiting more than 2 years by end September 2022**
- **No patient waiting more than 18 months by September 2023**
- **No patient waiting more than 1 year by September 2024**

Why is this the case & what is being done?

Continued lack of IP bed capacity. The continued closure of Ward 17 throughout February as a result of ongoing Ward Staff and Bed Pressures has resulted in listing fewer IP procedures. This affects the ability of BGH to conduct elective operations on a sizeable number of our patients; this is particularly evident in the case of long-waiting patients who require Athroplasty.

104 week TTG Trajectory

The effect of the reduction in Elective operating in January can be seen clearly in the 'TTG 104 weeks' chart as the actual trajectory drifted above the planned trajectory. We continue to focus effort to reduce the number of patients that are still waiting over 104 weeks for an operation. It is acknowledged that this will be more of a challenge for Trauma and Orthopaedics compared to other specialties.

TTG Project

A new Theatre Schedule was introduced in February. The aim of this was to ensure that theatre time was allocated to surgical specialities appropriately, but also to reduce the number of half day sessions. It is estimated that each half day session results in approximately 1 hour of lost time. The main changes in the new schedule are an increase in the number of sessions allocated to General Surgery by 4 sessions a month and the reduction in the number of half day sessions by 11.

Mental Health Waiting Times CAMHS

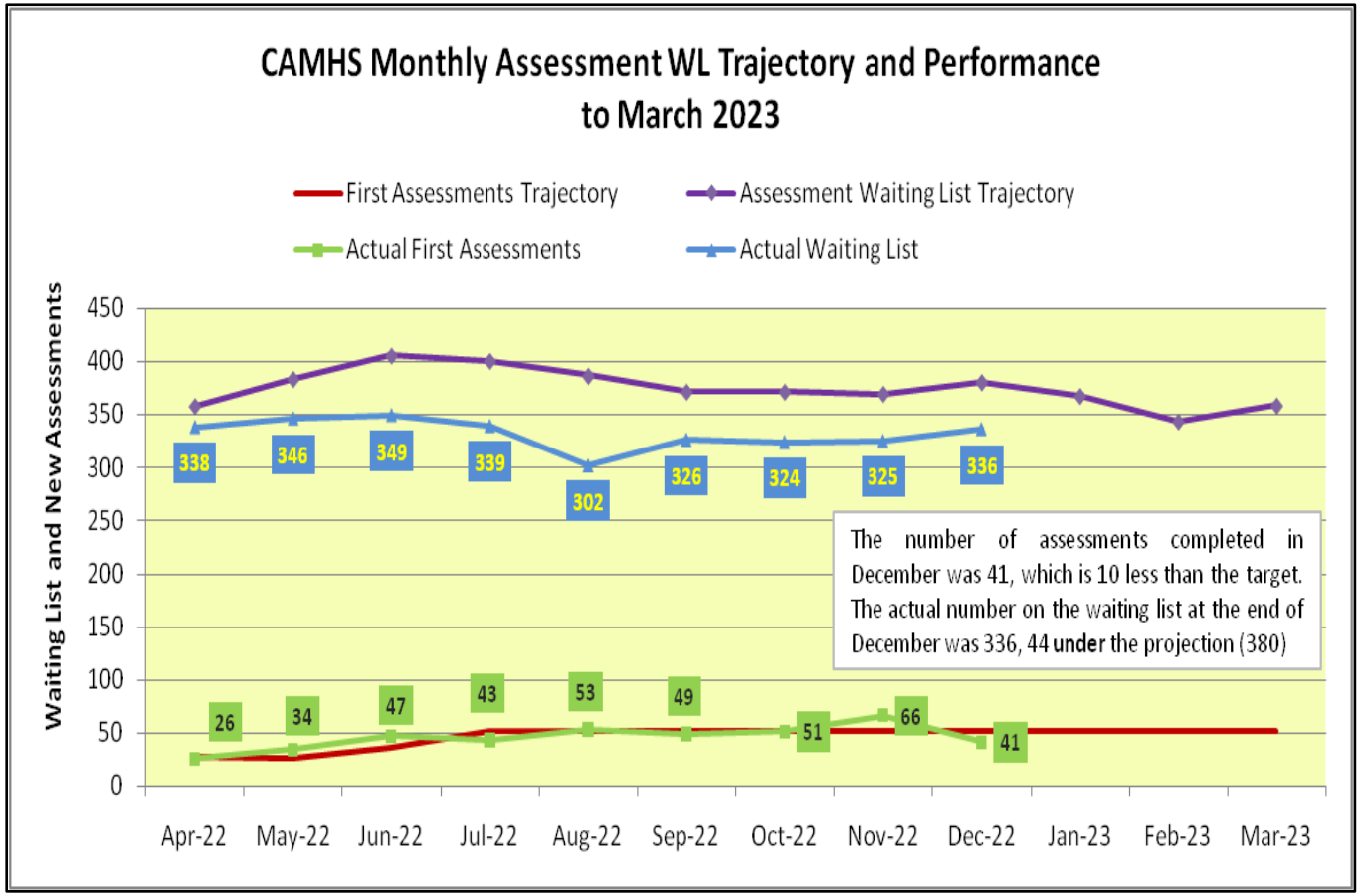


Fig. 5

Note: This is the latest data available as at 31 December 2022. There is a lag time for reporting information due to national submission deadlines.

What is the data telling us? ***Updated 07.04.2023***

The number of new assessments to be achieved in December was agreed at 51 but actual achievement was 41. The waiting list increased in December and was sitting at 336 cases waiting to be assessed but this is still below the WL projection for December of 380.

Why is this the case?

Recruitment initiatives are ongoing, currently we have only two registered nurse vacancies of which we are pleased that we have four applicants for the two posts, short listing and interview processes are currently taking place. The two health care support workers are now in temporary posts for one year as a new initiative to support the registered nurses and are supporting the service really well. Long term sickness absence within nursing continues to present the service with additional challenges. Psychology recruitment to vacant posts is also ongoing with the new starts due to commence in their roles over the next few months. Administration continues to be recruited at 100%. Within Medical staffing there is currently one consultant vacancy. We continue to see high level of accepted referrals into service which impacts on trajectories.

What is being done?

The New Patient Appointments (NPA's) plan which commenced on 13th June continues, and the service targets have been seeing 12 new patients per week (included in the 12 appointments, 2 are urgent/unscheduled care appointments) this plan will be in place in order to see a minimum of 12 new patients per week 52 weeks of the year, this will be across all disciplines. A review of the NPA has taken place and an agreement to re-evaluate in 3 months' time has been established with view to increase the number of NPA`s (numbers will be determined at that time). The tagging process continues to allow the team to review patients waiting to access the service, with a view to determining appropriate sign-posting or establishing any possible interventions prior to a first appointment. The tagging process supports the reduction of the number of patients actually requiring access to the CAMHS service and potentially reducing the numbers of those waiting on the list. A new referral template is being currently piloted, again to support if any interventions can be established prior to the first appointment. Access to specialist young person beds continues to be challenging placing demands on the adult acute inpatient service.

Mental Health Waiting Times- Psychological Therapies

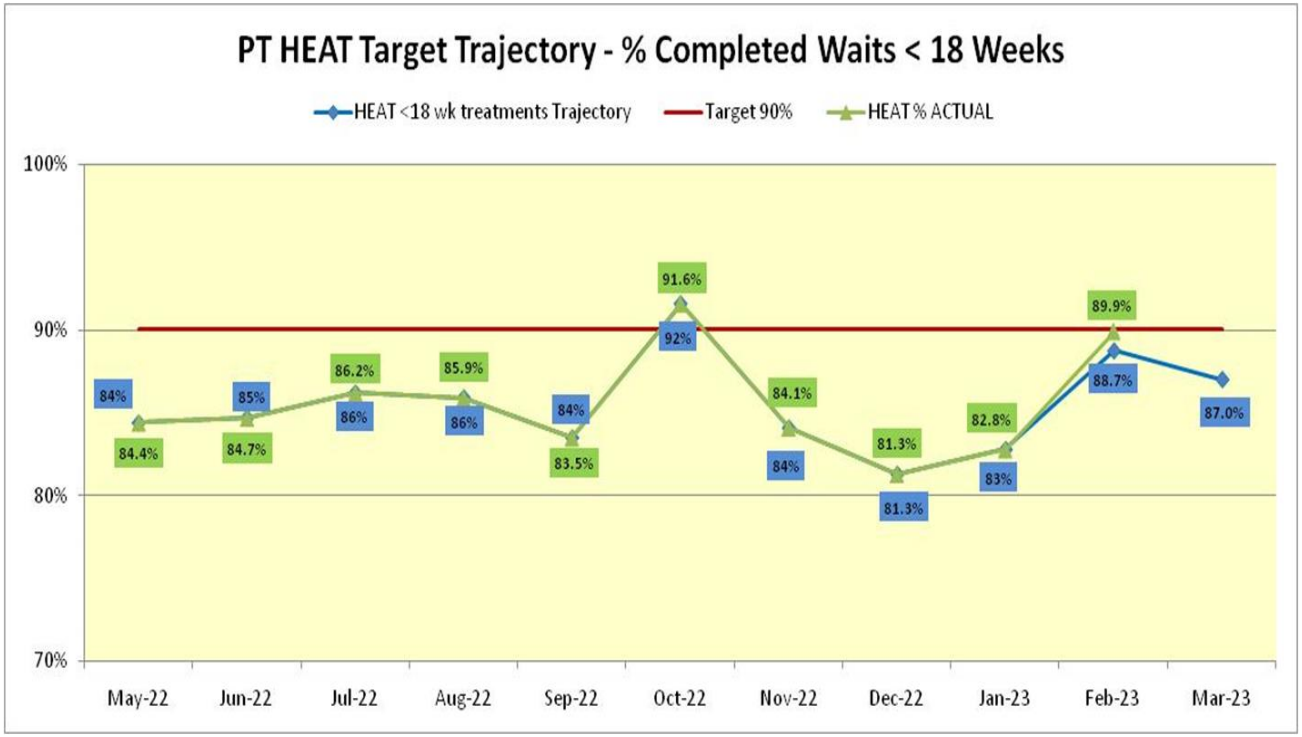


Fig. 6

What is the data telling us? ***Updated 23.03.2023***

This illustrates the HEAT target performance from May 2022 – February 2023 against the trajectory, which was 82.8% for January 2023 (December 2022 81.3%) based on actual performance. This has increased to 89.9% in February 2023.

Why is this the case?

Changes we have made to courses and the festive period have impacted on our performance and trajectory in December. Performance improved in January and February due to new staff coming into posts and utilising some locums. We anticipate performance may be negatively affected by financial constraints and the impact of especially high referral patterns, most notably in adult psychology.

What is being done?

We will be reviewing our annual data for the 2022/23 financial year in April and May, and completing projections for the 2023/24 financial year which will be presented to Access Board in May/June.

It is important for us to review our data for 2022/23 as we made a series of assumptions given the previous 2 years' data was affected by Covid and hence not necessarily representative of normal patterns. As a result of this when we estimated proposed activity, capacity and non-attendances; we put in estimated averages to show a regular pattern.

For 2023/24 financial year we will be repeating DCAQ for all services to reflect changes in referral patterns and ensure our resource is most appropriately focused and utilised.

Unscheduled Care Performance - 4 Hour Emergency Access Standard Performance

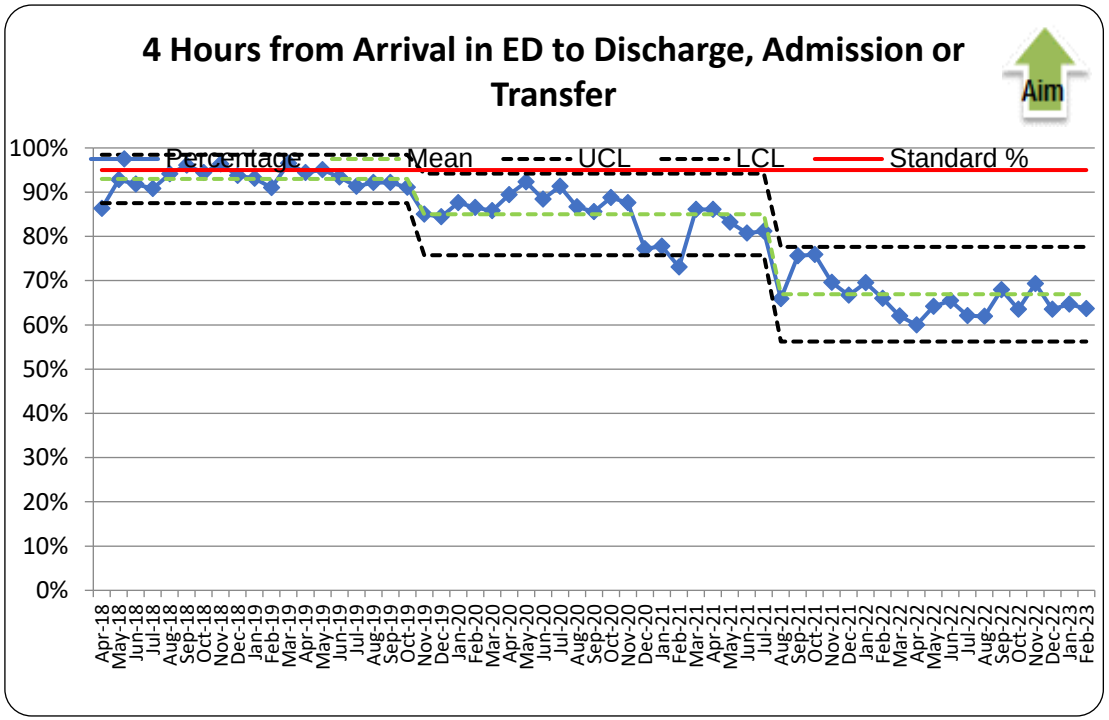


Fig. 7

What is the data telling us?

Performance in the Emergency Department for February 2023 was 60.3% vs 63.2% in January 2023.

We had 2001 attendances with 794 breaches of our emergency access standard in February 2023.

Why is this the case?

The 4-hour emergency access standard ("the standard") is a whole system measure; to either admit or provide definitive treatment and discharge for 95% of unscheduled care patients within 4-hours requires a collaborative approach from all parts of the health and social care system to provide patient flow.

ED patients who require admission experience long waits for a bed greater than 4 hours, 8 hours and 12 hours with 184 patients waiting over 12 hours, and 29 patients waiting over 24 hours. This increase has resulted in Blue ED regularly being opened and red status being declared. The Full Capacity Protocol was also enacted and multiple occasions throughout February given prolonged pressures, high levels of acuity and significant bed waits.

The 4EAS is influenced by a range of factors including, but not limited to:

- the volume of Emergency Department (ED) attendances
- the pattern of arrival of ED attendances i.e. high volumes within a short period causing crowding
- patient acuity
- bed pressures

What is being done?

The Scottish Borders Urgent and Unscheduled Care Programme Board has been established and has commenced a weekly reporting cycle. Other key improvement activities underway include:

- ED Workforce Review -. The review will ensure that the department offers as safe a model as possible to manage the current pressures while considering wider questions such as overnight senior medical leadership and recruitment and retention. The review is due to be presented at Acute Q by April 2023.
- Discharge Hub Kaizen - This kaizen will build on learning and approach from previous successful kaizens and work in a fully formed and seamless multi-disciplinary manner to effectively unblock, problem solve and effectively discharge patients to their next place of care. This work is being progressed by the General manager of PACS and is being supported by the General Manager of Unscheduled Care (Acute).
- Virtual Respiratory Capacity Test of Change - this includes the use of wearable devices for patients with Respiratory infections, enabling early supported discharge. It is planned that the first phase test of change will commence in April 2023. It is expected that this programme will drive down length of stay and support early supported discharge.

Delayed Discharge

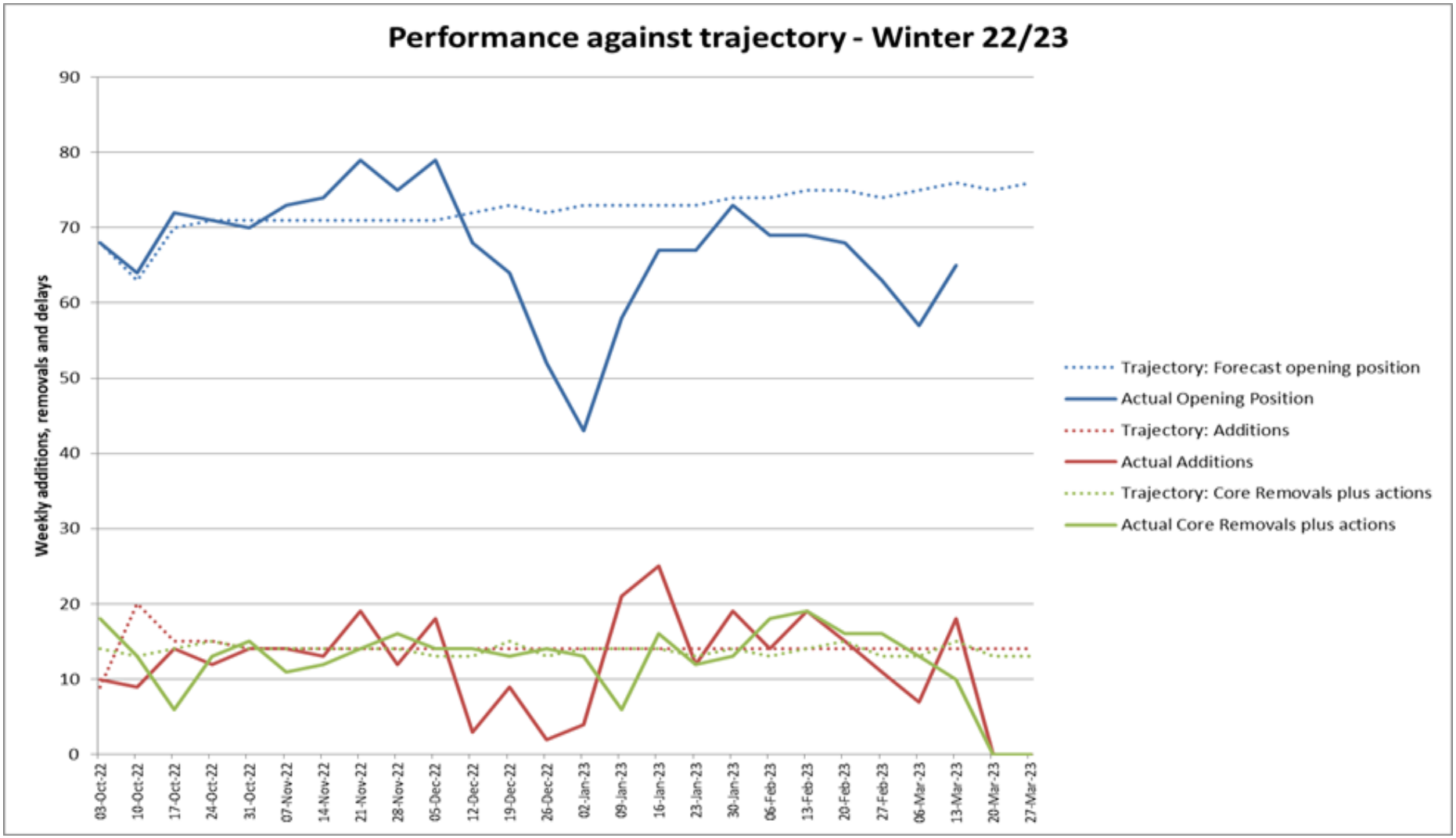


Fig. 8

What is the data telling us?

Current performance is below trajectory. As noted in the previous update, the referral/ addition rate and number of people delayed waiting for care reduced temporarily due to high levels of inpatients with covid and flu in the hospital system between mid December 2022 and early January 2023. As expected, we then experienced a subsequent high rate of referrals once people became fit for discharge.

Why is this the case?

The trajectory set was a pessimistic forecast based on ongoing increasing demand for care from the hospital system, and the potential for a reduction in removals as interim care capacity opened earlier in 2022 was fully occupied. Referrals to care from the hospital system have increased since the beginning of the pandemic from 11.4 / week. The table below summarises performance against trajectory over the 24 week period from 3 October 2022 to 13 March 2023:

24 weeks	Referrals	Removals
Total forecast	339	332
Total actual	314	325
Variance	-25	-7
Forecast - weekly	14.1	13.8
Actual - weekly	13.1	13.5
Variance - weekly	-1.0	-0.3

Referrals have been slightly lower than forecast which has resulted in improved performance. There were a number of demand reduction actions including the 'Supporting the Right Direction worker' promoting SDS Option 1 in the BGH, sustaining improvements from the MAU Kaizen and implementing better delayed discharge process across clinical boards. We are unclear on whether these have over-delivered or whether demand has reduced slightly.

Removals are slightly below our trajectory forecast. Of the 325 removals, 60.6% have been transferred to care, and 39.4% have become unfit. It must be noted that a number of the patients who have been recorded as becoming unfit were unfit for discharge at the point of referral/addition to the waiting list, or who needed to be transferred to a community hospital, and as such were inappropriately referred to the waiting list and subsequently removed.

What is being done?

There has been a comprehensive Multi-Agency Discharge Event undertaken in the BGH, Mental Health Wards, Community Hospitals, Home First and Interim Care. There is now a weekly report outlining all patients who are in hospital for over 21 days and a focus from all Clinical Boards on those who are in hospital the longest. It is expected that this will

improve outcomes and reduce demand for care. There are also plans to undertake a Kaizen in the Complex Discharge Function within the BGH (START and Discharge and Pathways team and their interface with Home First and the Rapid Assessment and Discharge service).

The two tranches of interim care non-recurrent funding from the Scottish Government are ending at the end of this financial year, and as a result the HSCP Joint Executive Team is exploring appropriate mitigations to the loss of this funding from April 2023. The Scottish Borders Health and Social Care Integration Joint Board will also consider options to further expand care capacity, building on the additional capacity brought into place last year. This will be presented for approval within the budget for 2023-24 to the Integration Joint Board, once the offer from NHS Borders has been confirmed.

In addition to the plans noted above, over the coming year, there is significant work on the development of a reablement service within the Scottish Borders Council Adult Social Care service, the integration of Home First with this service, the transformation of overnight care for homecare, additional Extra Care Housing capacity opening in summer in Poynderview Gardens (Kelso), a refocus on Community Led Support – expanding the What Matters Hub function and reducing social work assessment waits, the Social Work digital pathfinder, and the implementation of further unpaid carer supports. All of these initiatives are expected to yield significant productivity and capacity gains in social care and social work assessment, which will in turn improve the position relating to delayed discharge.

A new trajectory is currently being developed for the summer 2023 period.

Appendix to Main Performance Scorecard – Performance Against Previous Agreed Standards

Contents Page

Key Metrics Report – AOP Performance

Current Performance Key

R	Under performing	Current performance is significantly outwith the trajectory/ standard set	Outwith the standard/ trajectory by 11% or greater
A	Slightly Below Trajectory/ Standard	Current performance is moderately outwith the trajectory/standard set	Outwith the standard/ trajectory by up to 10%
G	Meeting Trajectory	Current performance matches or exceeds the trajectory/standard set	Overachieves, meets or exceeds the standard/trajectory, or rounds up to standard/trajectory

Symbols

Better performance than previous month	↑
No change in performance from previous month	↔
Worse performance than previous month	↓
Data not available or no comparable data	-

Key Metrics Report Annual Operational Standards

	Measure	Target/ Standard	Period	Position	Period	Position	RAG
Annual Operational Plan Measures	Cancer waiting Times - 62 Day target	95% patients treated following urgent referral with suspicion of cancer within 62 days	Nov-22	84.2%	Dec-22	93.1%	↑
	Cancer waiting Times - 31 Day target	95% of patients treated within 31 days of diagnosis	Nov-22	100.0%	Dec-22	94.1%	↓
	New Outpatients- Number waiting >12 Weeks	Zero patients waiting longer than 12 weeks (maximum)	Dec-22	7200	Jan-23	7400	↓
	New Inpatients- Number waiting >12 Weeks	Zero patients waiting longer than 12 weeks (maximum)	Dec-22	1850	Jan-23	1931	↓
	Treatment Time Guarantee - Number not treated within 84 days from decision to treat	Zero patients having waiting longer than 84 days.	Dec-22	111	Jan-23	64	↓
	Referral to Treatment (RTT) - % treated within 18 weeks of referral	90% patient to be seen and treated within 18 weeks of referral.	Dec-22	67.9%	Jan-23	88.4%	↑
	Diagnostics (8 key tests) - Number waiting >6 weeks	Zero patients waiting longer than 6 weeks for 8 key diagnostic tests	Dec-22	1202	Jan-23	1073	↑
	CAMHS- % treated within 18 weeks of referral	90% patients seen and treated within 18 weeks of referral	Nov-22	31.3%	Dec-22	30.8%	↓
	A&E 4 Hour Standard - Patients discharged or transferred within 4 hours	95% of patients seen, discharged or transferred within 4 hours	Dec-22	63.5%	Jan-23	64.7%	↑
	Delayed Discharges - Patients delayed over 72 hours	Zero patients delayed in hospital for more than 72 hours	Dec-22	33	Jan-23	45	↑
	Psychological Therapies - % treated within 18 weeks of referral	90% patient treated within 18 weeks of referral	Nov-22	84.1%	Dec-22	81.3%	↓
	Drug & Alcohol - Treated within 3 weeks of referral	90% patient treated within 3 weeks of referral	Nov-22	100%	Dec-22	100%	↔
	Sickness Absence Rates	Maintain overall sickness absence rates below 4%	Dec-22	6.41%	Jan-23	6.91%	↑

Cancer Waiting Times *(please note there is a 1-month lag time for data)*

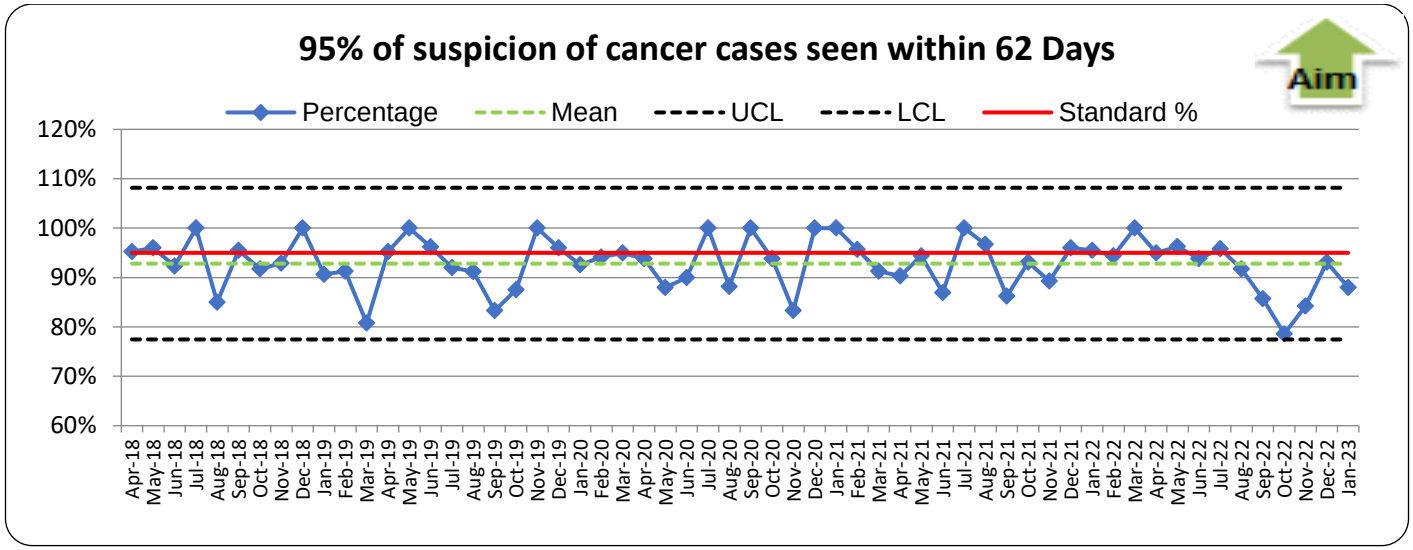


Fig. 9

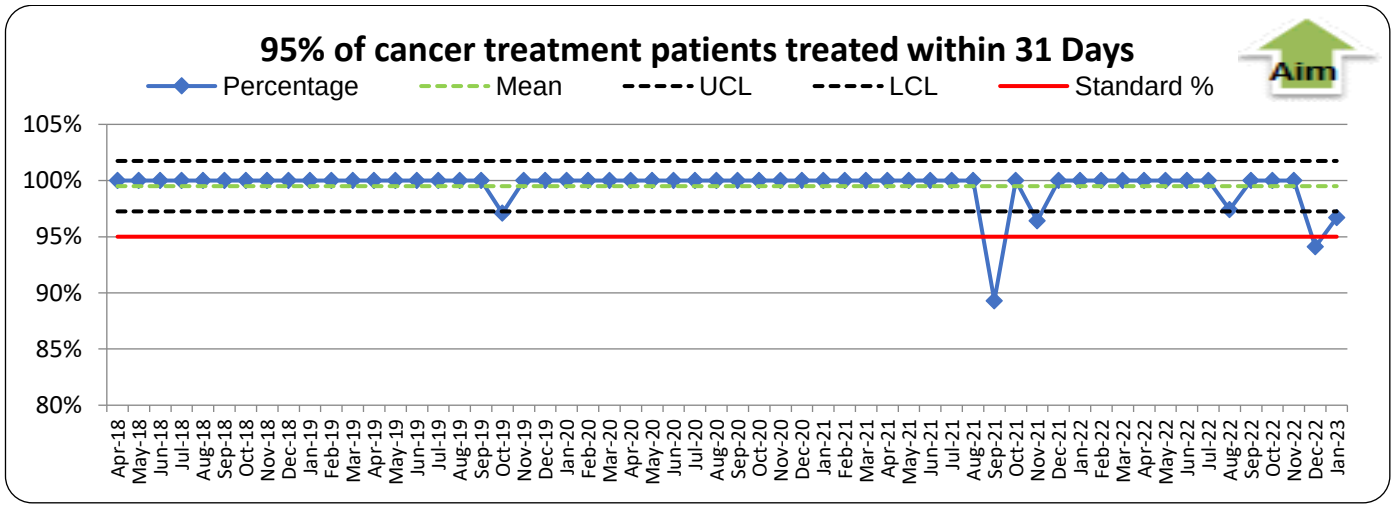


Fig. 10

Stage of Treatment- Outpatients Waiting Over 12 Weeks

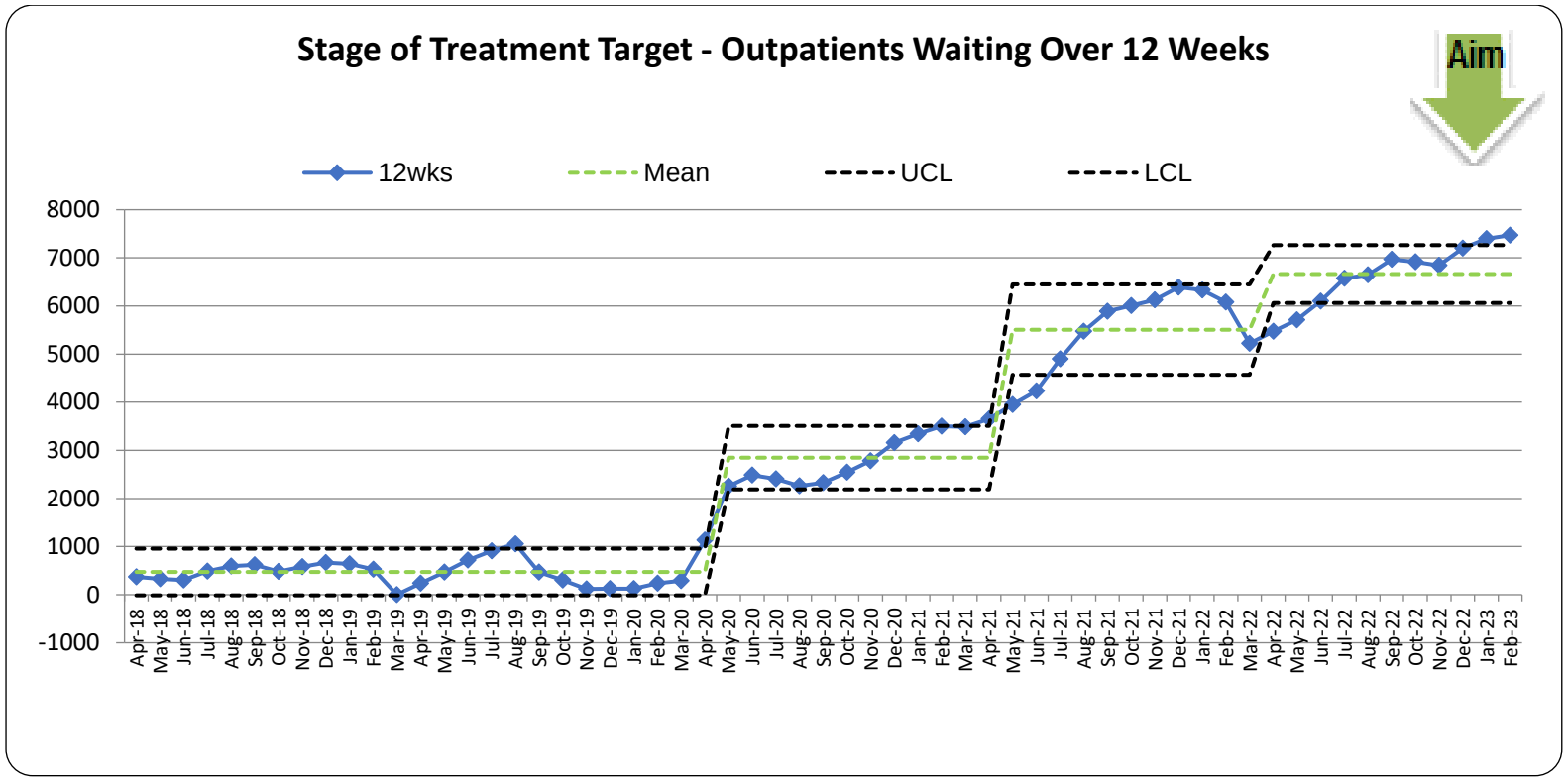


Fig. 11

Stage of Treatment- Inpatients Waiting Over 12 Weeks

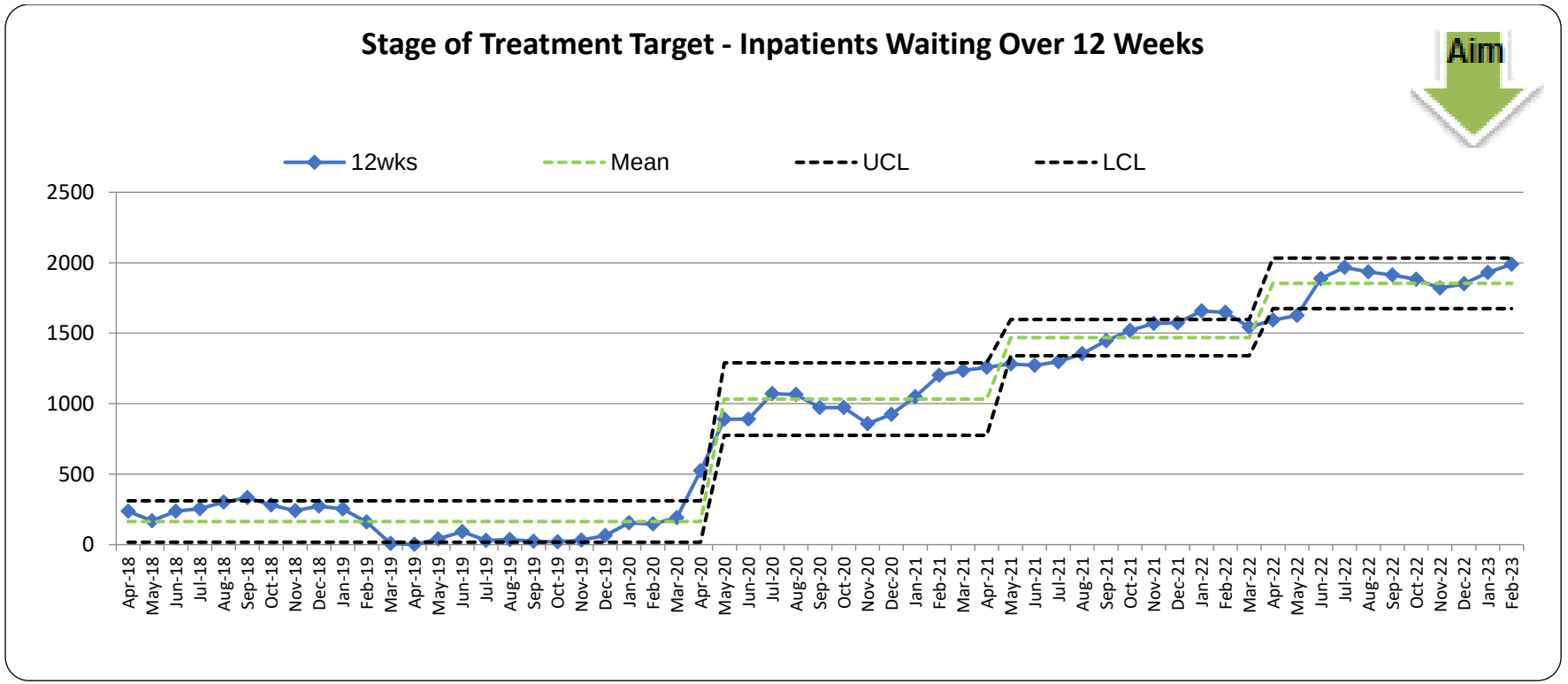


Fig. 12

Patients Treated within the 12 weeks Treatment Time Guarantee

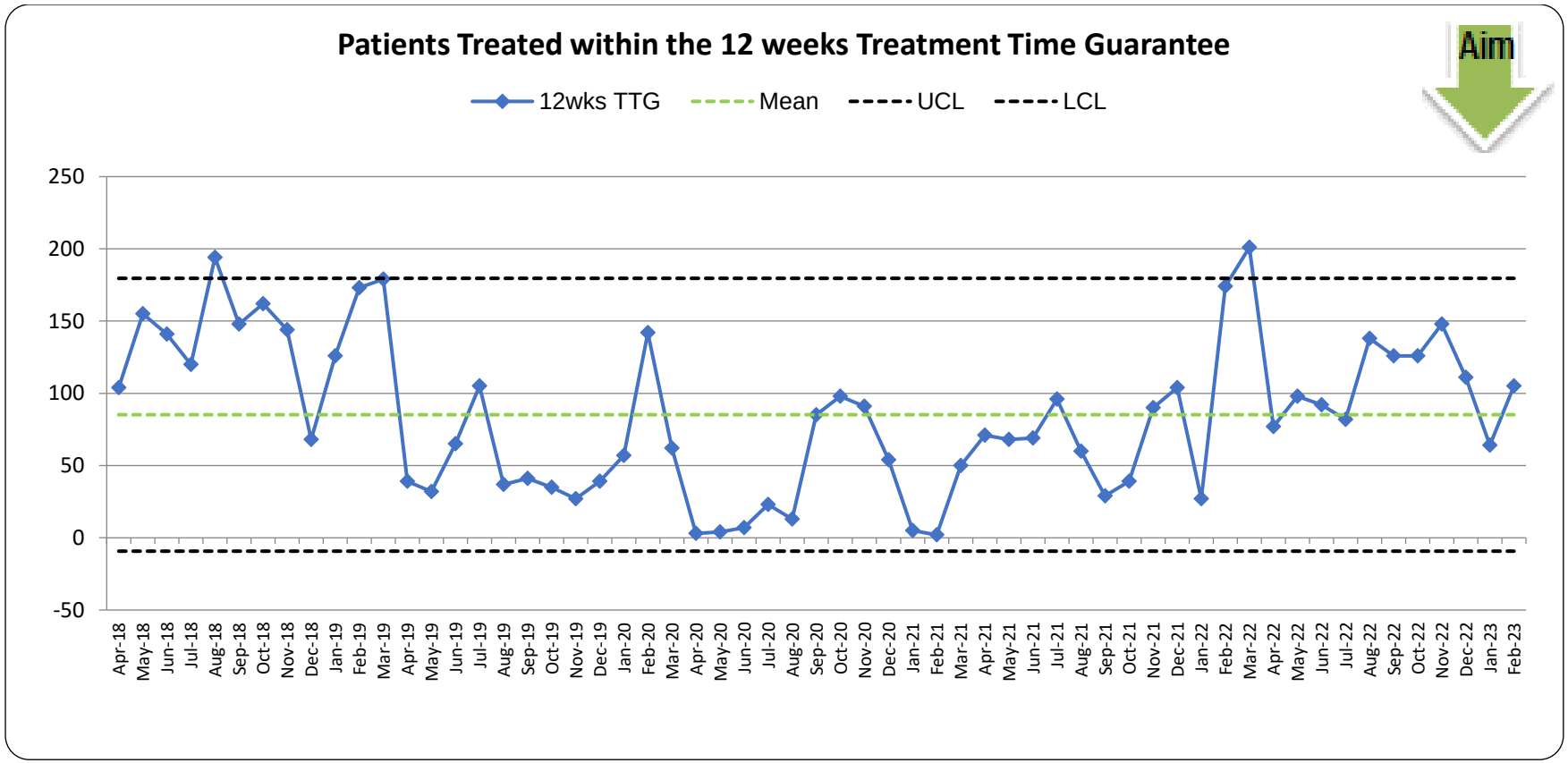


Fig. 13

18 Weeks Referral to Treatment Combined Pathway Performance

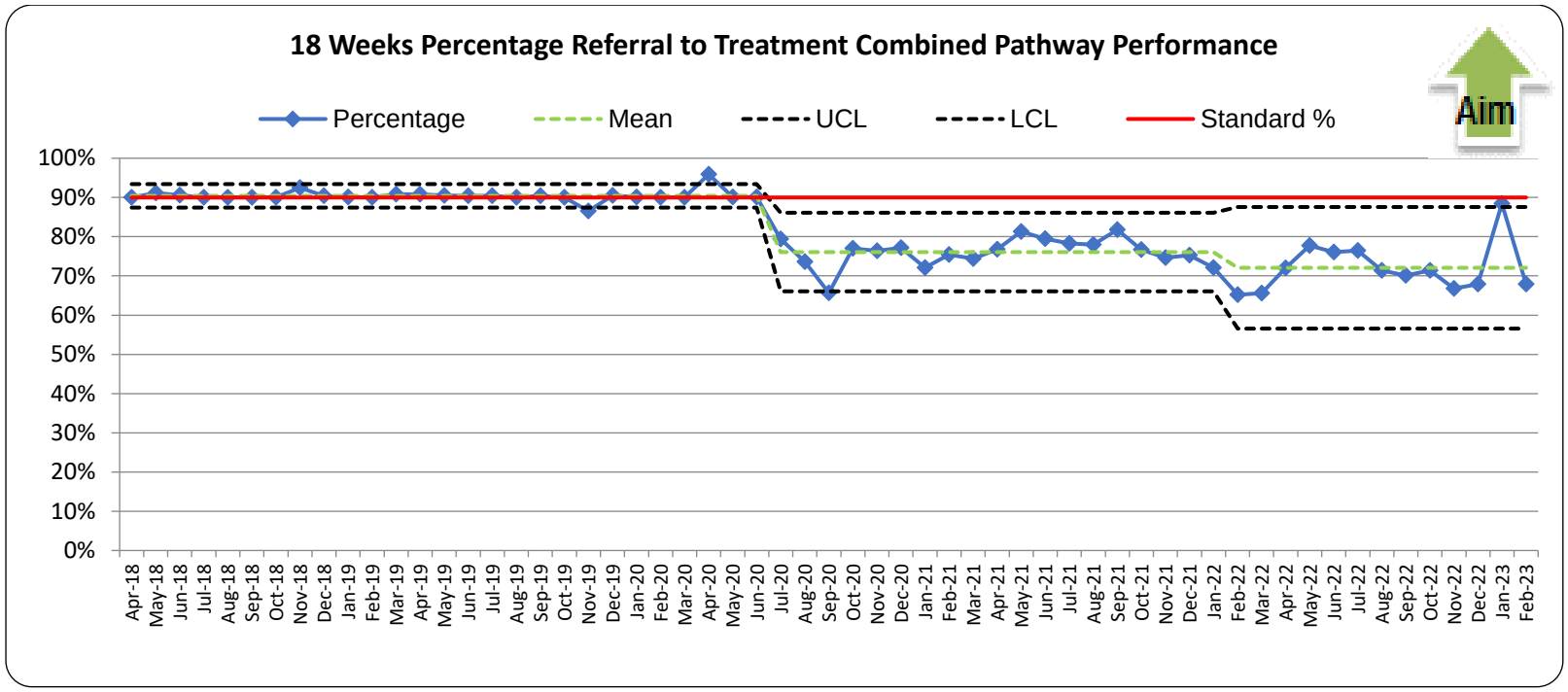


Fig. 14

Diagnostic Waits

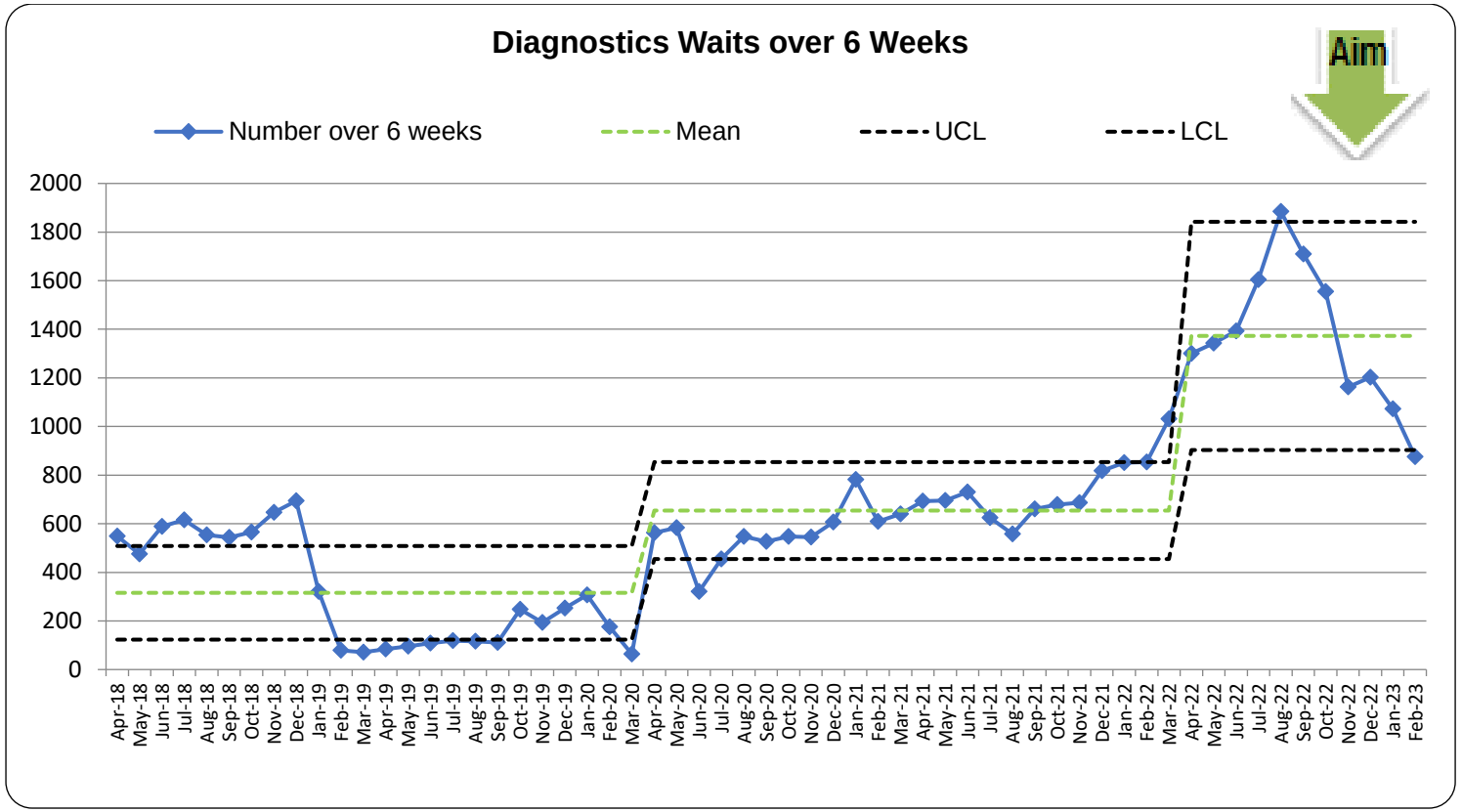


Fig. 15

CAMHS Waiting Times- 18 Week Referral to Treatment

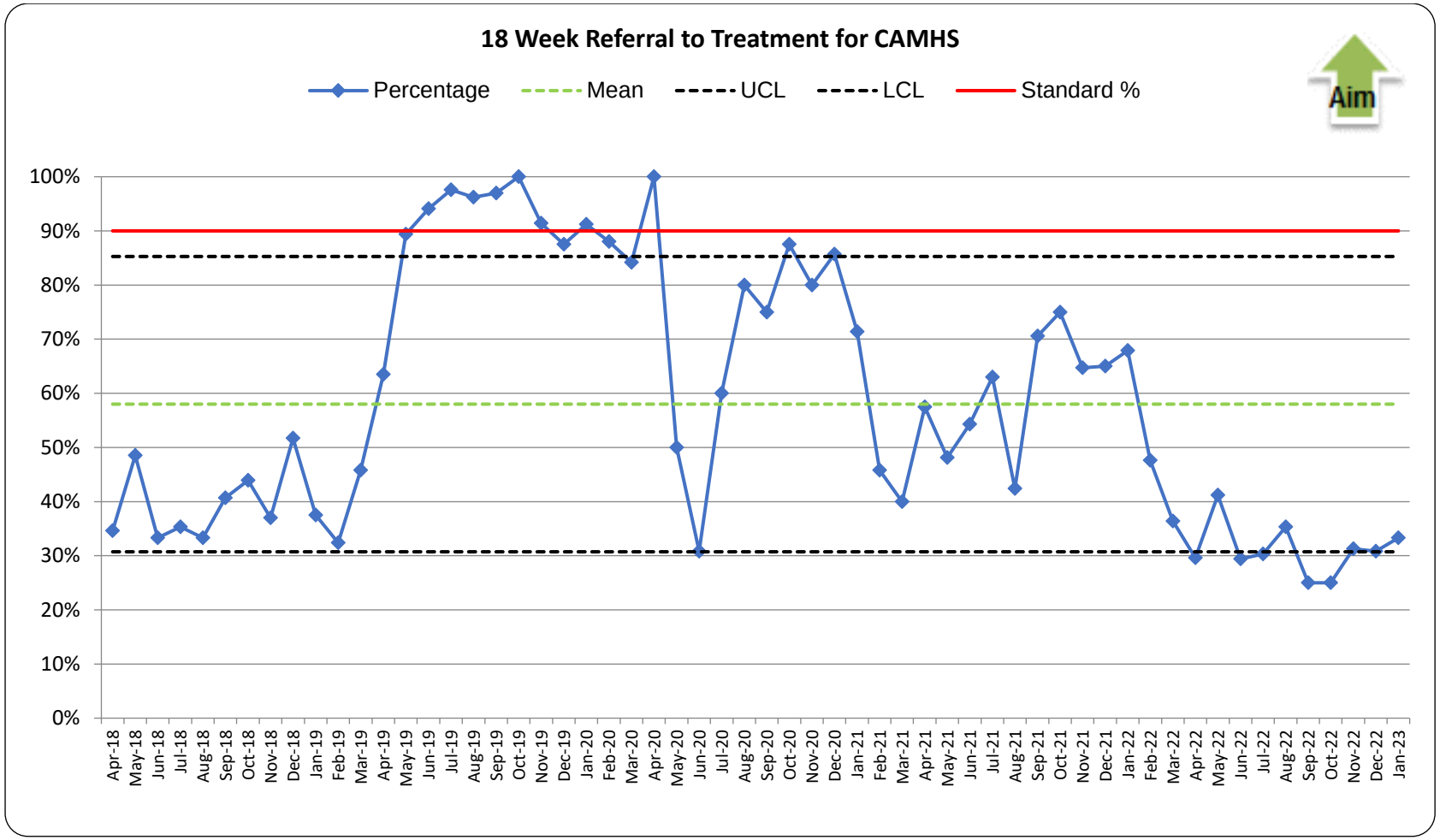


Fig. 16

Psychological Therapies Waiting Times- 18 Week Referral to Treatment

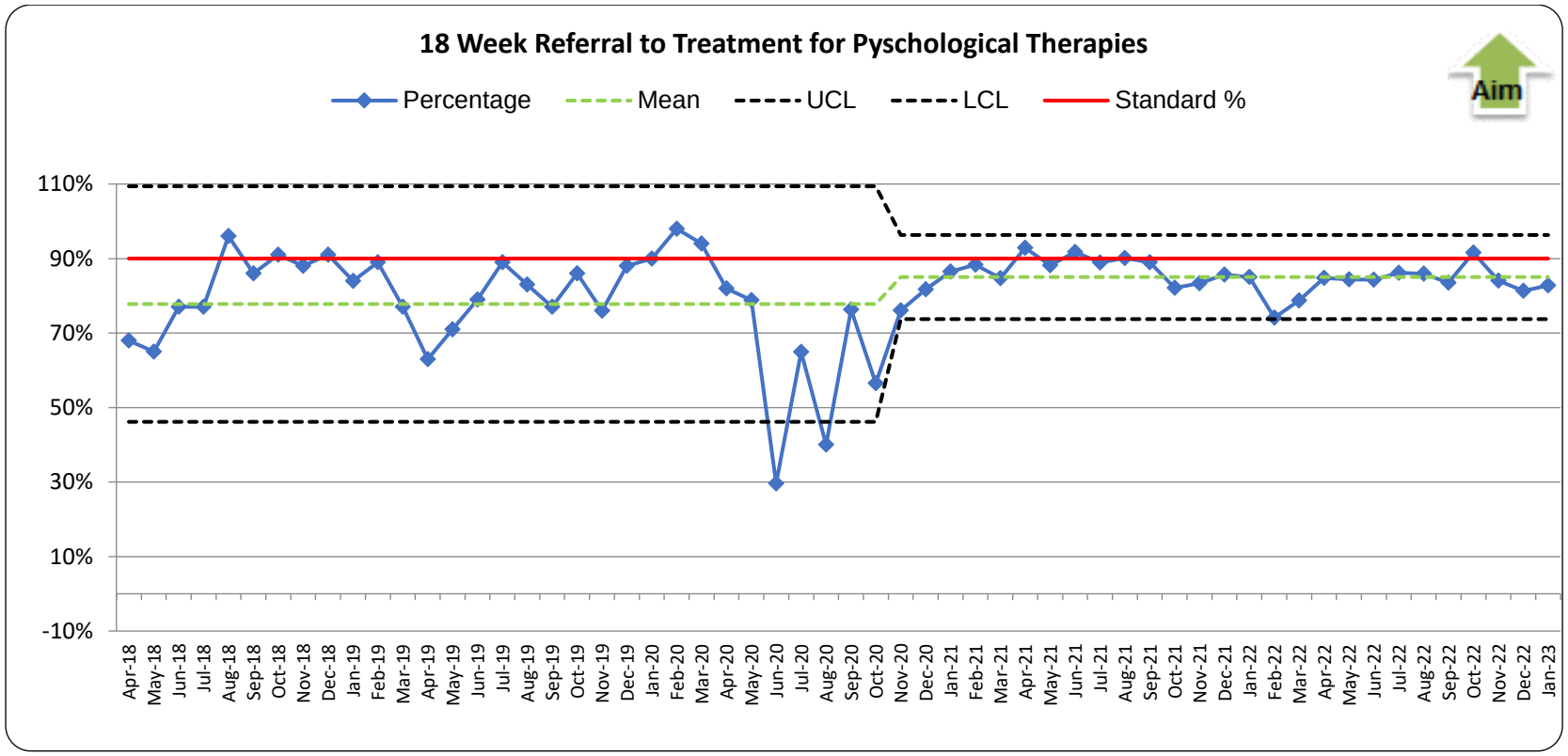


Fig. 17

Delayed Discharges

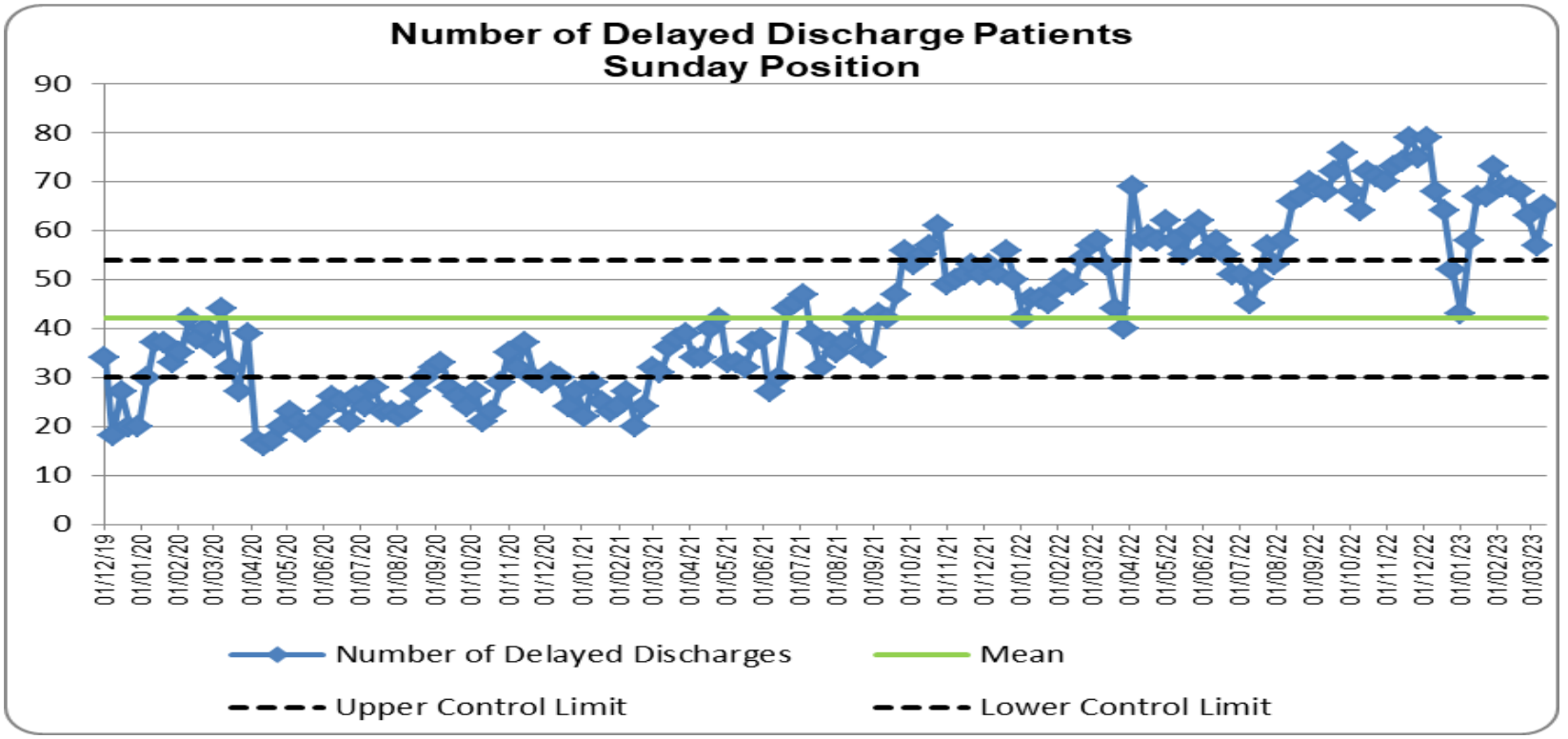


Fig. 18

Fig. 19

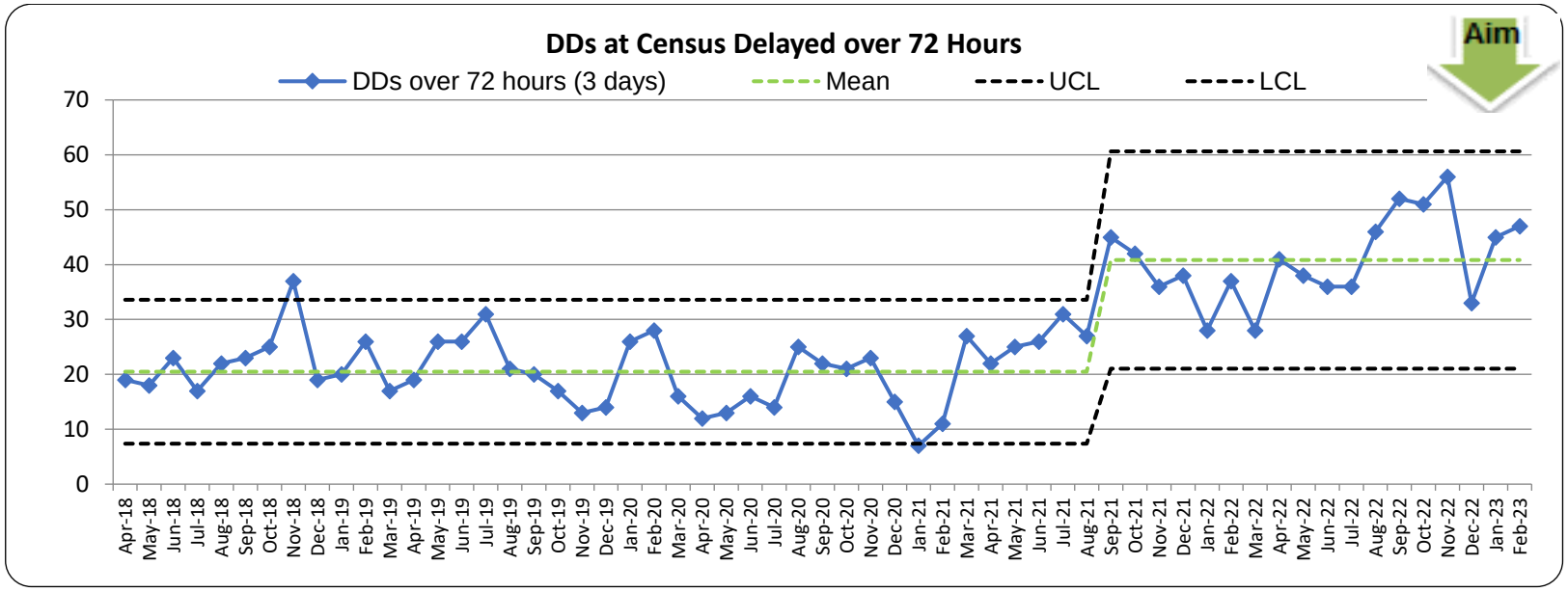
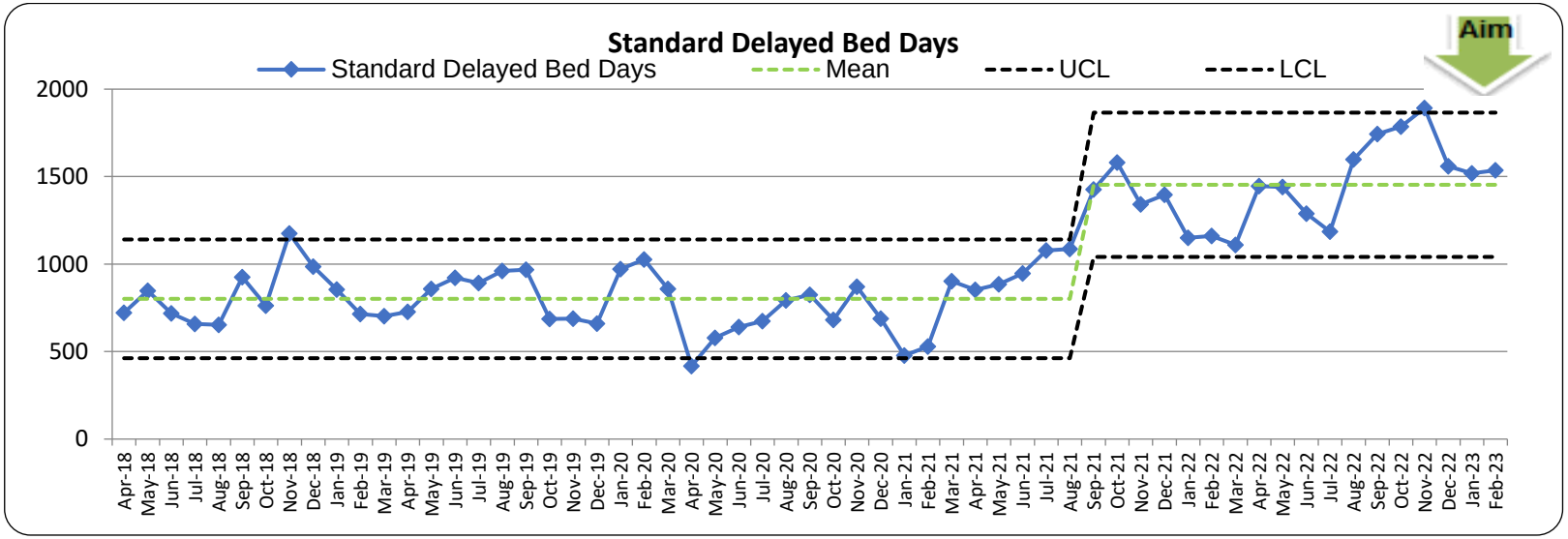

DDs at Census Delayed over 72 Hours
DDs over 72 hours (3 days)
Mean
UCL
LCL
Aim
70
60
50
40
30
20
10
0
Apr-18 May-18 Jun-18 Jul-18 Aug-18 Sep-18 Oct-18 Nov-18 Dec-18 Jan-19 Feb-19 Mar-19 Apr-19 May-19 Jun-19 Jul-19 Aug-19 Sep-19 Oct-19 Nov-19 Dec-19 Jan-20 Feb-20 Mar-20 Apr-20 May-20 Jun-20 Jul-20 Aug-20 Sep-20 Oct-20 Nov-20 Dec-20 Jan-21 Feb-21 Mar-21 Apr-21 May-21 Jun-21 Jul-21 Aug-21 Sep-21 Oct-21 Nov-21 Dec-21 Jan-22 Feb-22 Mar-22 Apr-22 May-22 Jun-22 Jul-22 Aug-22 Sep-22 Oct-22 Nov-22 Dec-22 Jan-23 Feb-23

Fig. 20


Standard Delayed Bed Days
Standard Delayed Bed Days
Mean
UCL
LCL
Aim
2000
1500
1000
500
0
Apr-18 May-18 Jun-18 Jul-18 Aug-18 Sep-18 Oct-18 Nov-18 Dec-18 Jan-19 Feb-19 Mar-19 Apr-19 May-19 Jun-19 Jul-19 Aug-19 Sep-19 Oct-19 Nov-19 Dec-19 Jan-20 Feb-20 Mar-20 Apr-20 May-20 Jun-20 Jul-20 Aug-20 Sep-20 Oct-20 Nov-20 Dec-20 Jan-21 Feb-21 Mar-21 Apr-21 May-21 Jun-21 Jul-21 Aug-21 Sep-21 Oct-21 Nov-21 Dec-21 Jan-22 Feb-22 Mar-22 Apr-22 May-22 Jun-22 Jul-22 Aug-22 Sep-22 Oct-22 Nov-22 Dec-22 Jan-23 Feb-23

Drugs & Alcohol

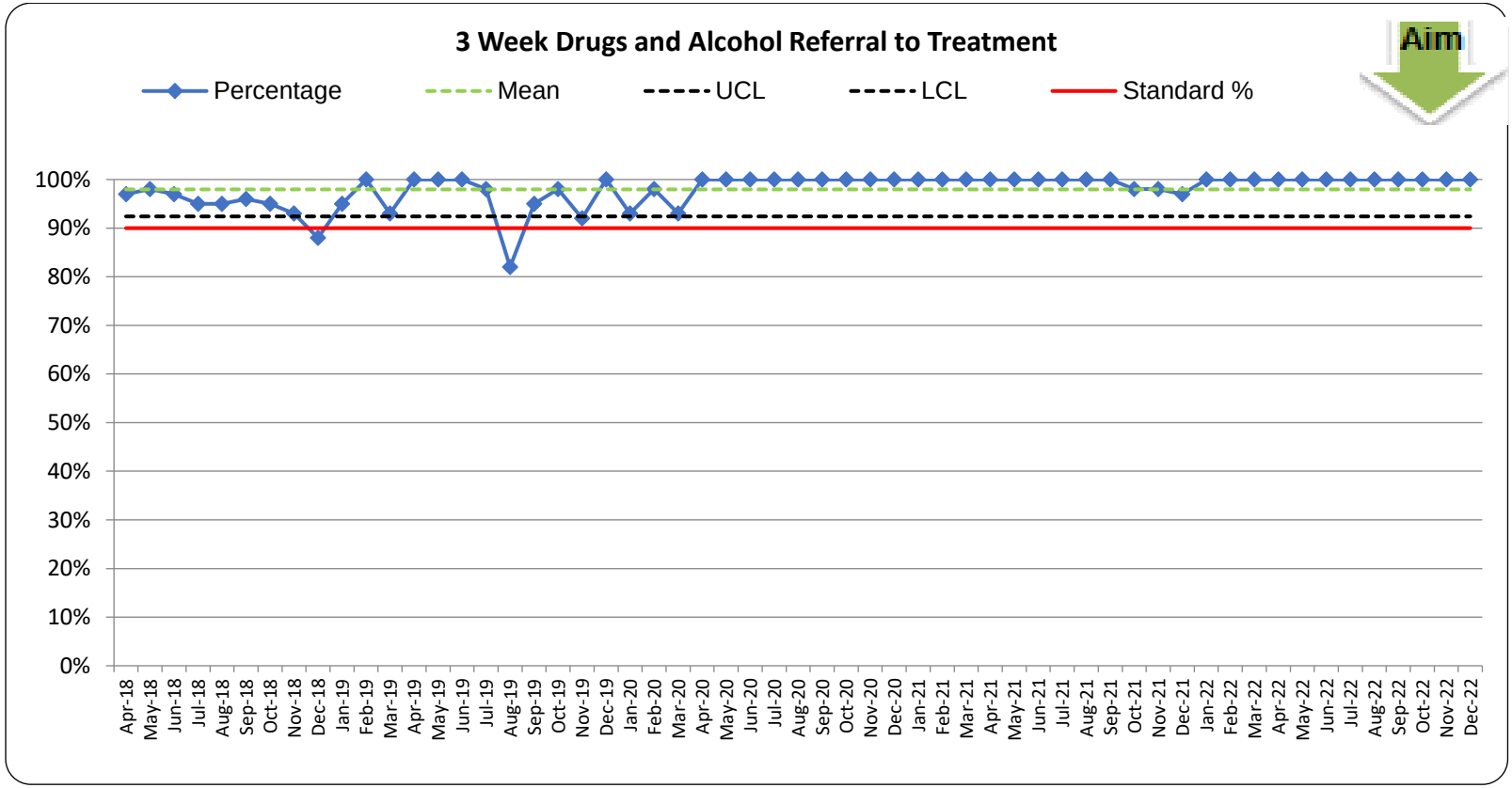


Fig. 21

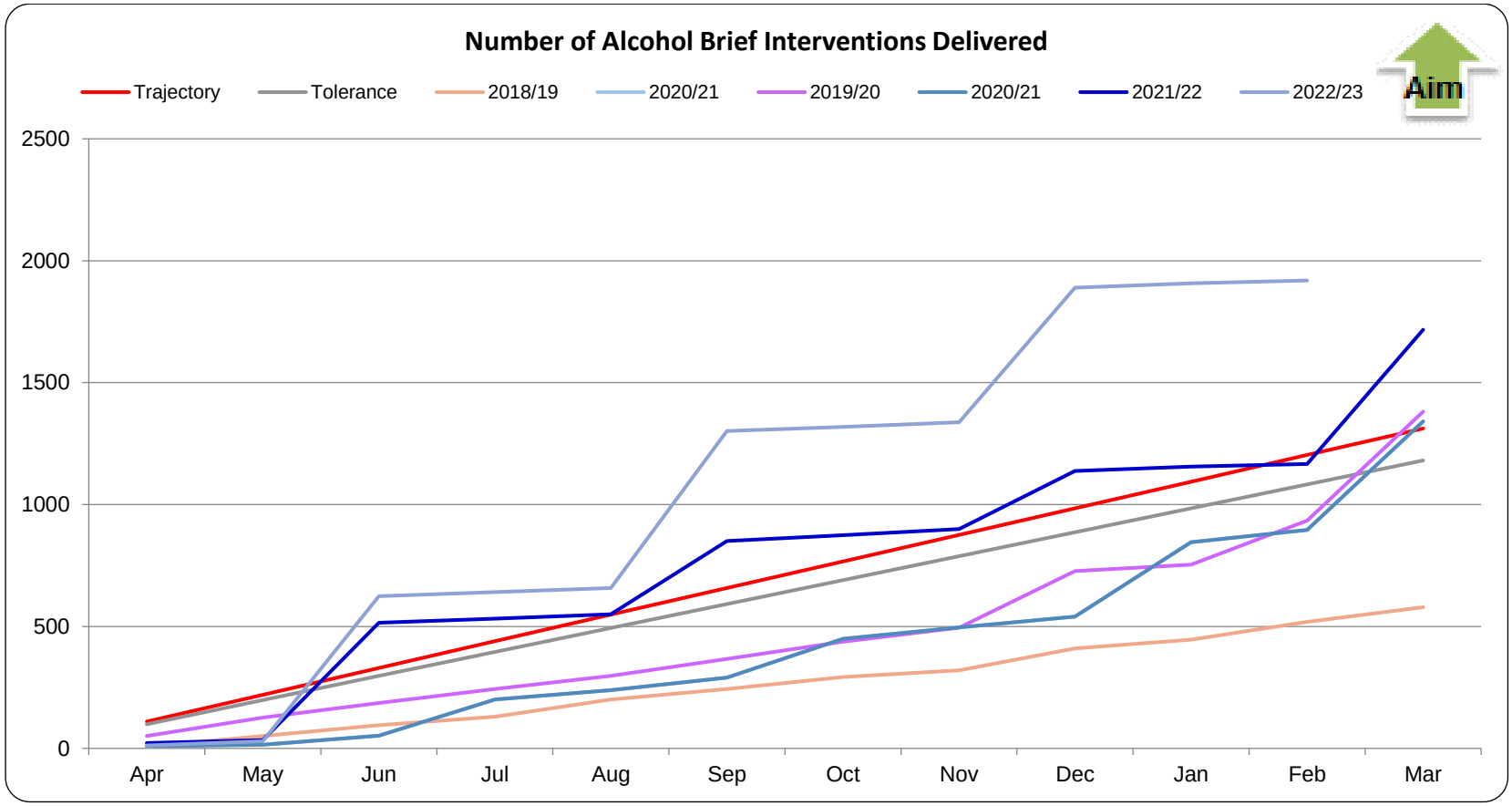

Number of Alcohol Brief Interventions Delivered
Trajectory
Tolerance
2018/19
2020/21
2019/20
2020/21
2021/22
2022/23
Aim
2500
2000
1500
1000
500
0
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar

Fig. 22

Sickness Absence

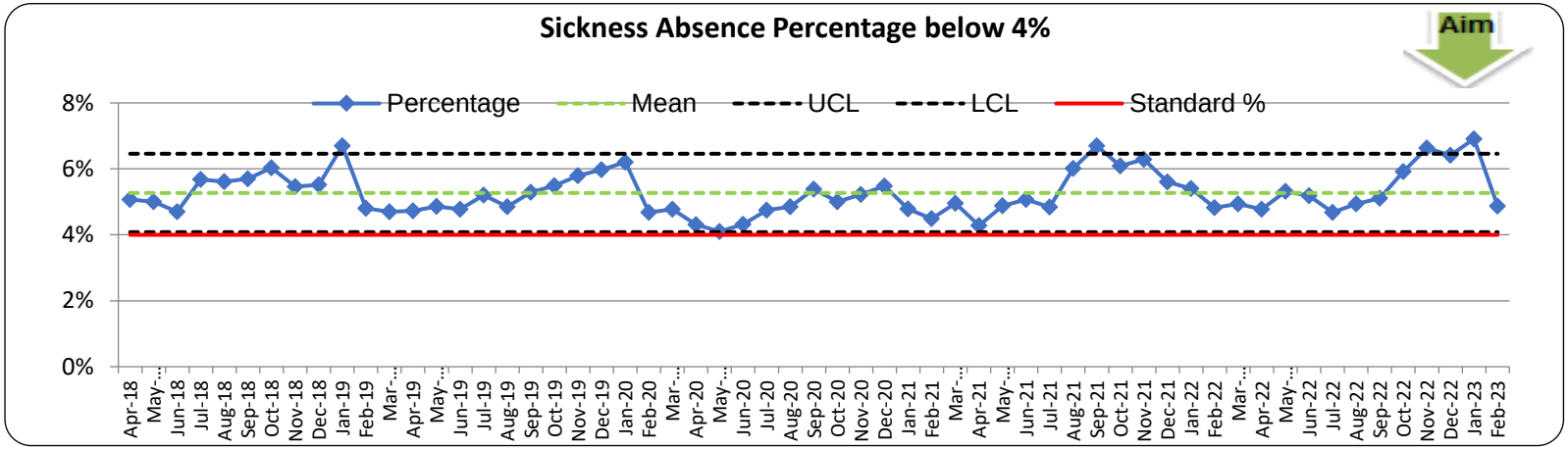


Fig. 23

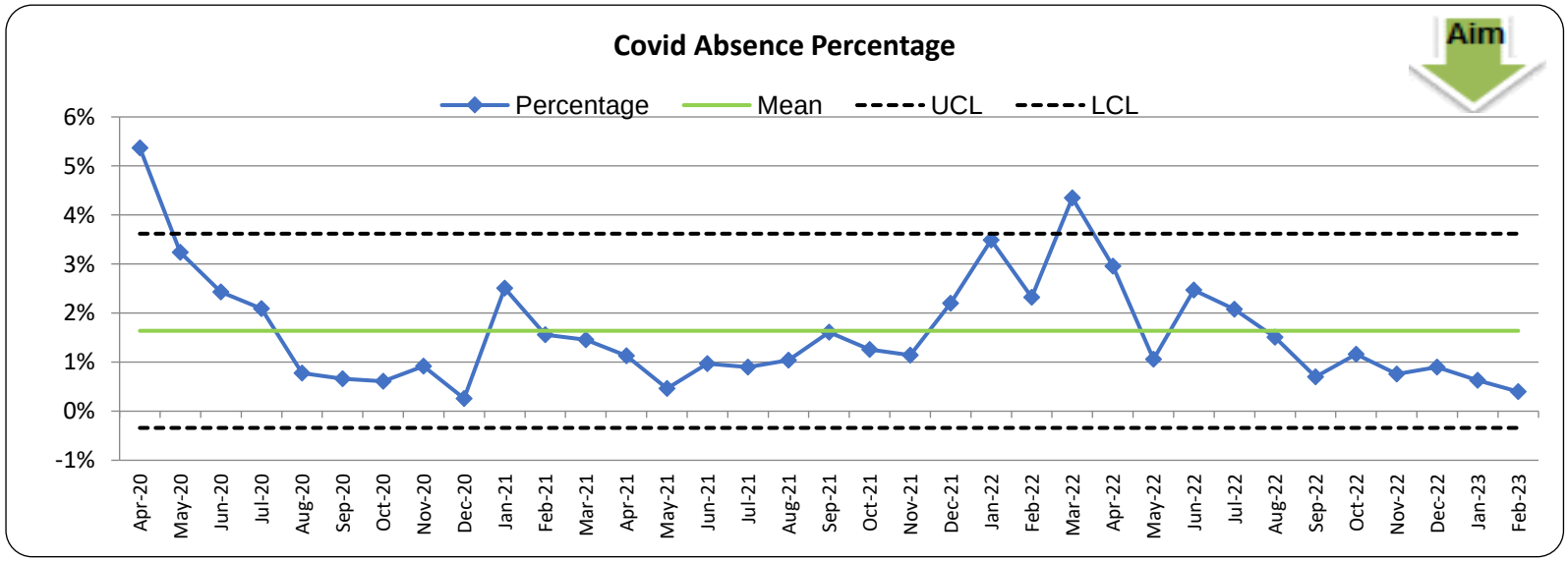


Fig. 24

Smoking Quits *(Please Note: All figures are cumulative. Data is reported quarterly to allow monitoring of the 12-week quit period. There is a 6-month lag time for reporting to allow monitoring of the 12 week quit period.)*

Latest NHS Scotland Performance	NHS Borders Performance (as a comparative)
97.2% (2019/20)	77.4% (2019/20)

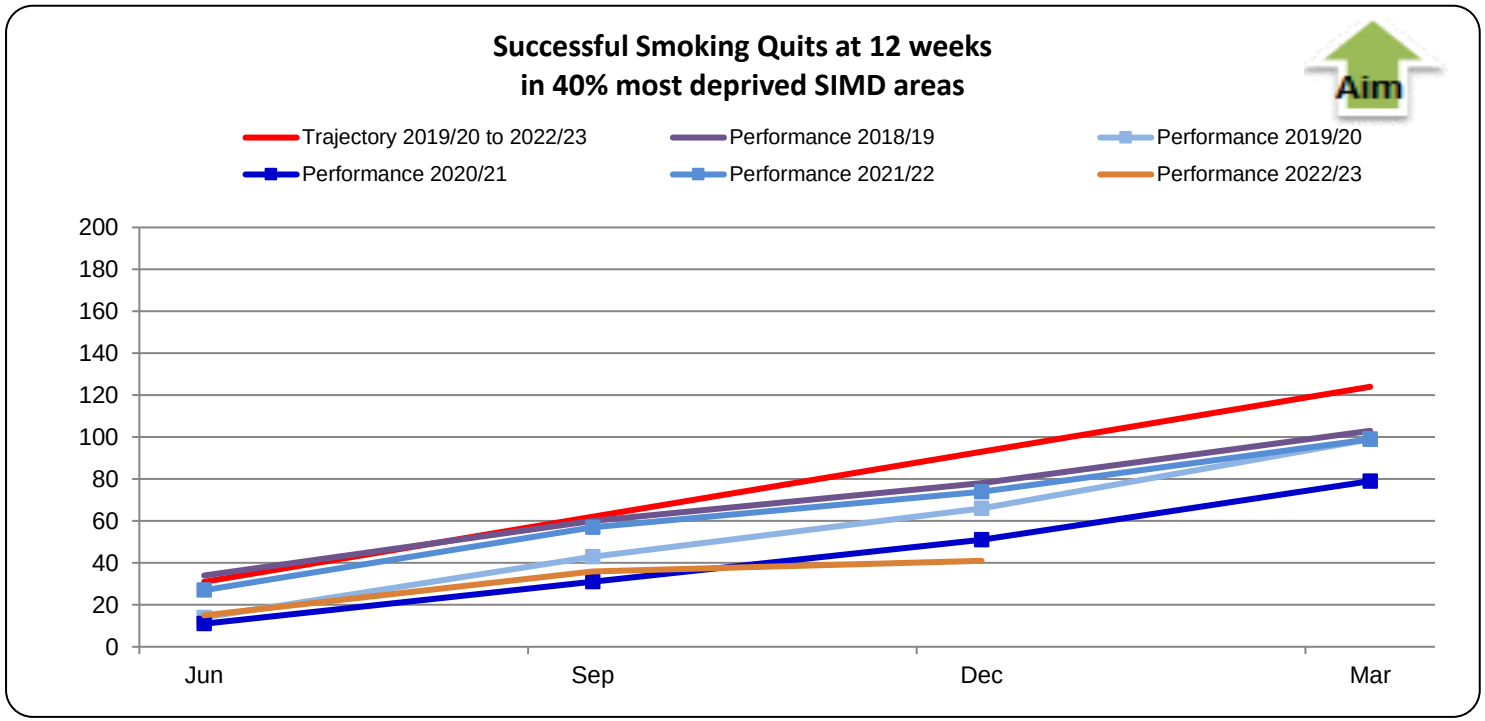


Fig. 25