Borders NHS Board

LOCAL DELIVERY PLAN 2015/16

Aim

This paper is to gain approval of the 2015/16 Local Delivery Plan (LDP). The LDP was submitted to the Scottish Government Health Department on 23rd March 2015, subject to NHS Borders Board approval.

Background

As with the previous years, NHS Borders is required to produce and submit a LDP which forms a performance and delivery agreement between NHS Borders and the Scottish Government Health Department. 2014/15 was labelled a 'transitional year' for the LDP by the Scottish Government. This reflected the change in emphasis in the Government guidance for the plan. This change in emphasis continues for 2015/16. In the past the LDP has focused largely on the delivery of the HEAT (Health Improvement, Efficiency, Access to services and Treatment) targets set by the Scottish Government. From 2015/16 these targets will be known as LDP Standards as progress towards the targets will be complete by March 2015. These Standards will continue to be closely monitored to maintain performance, however this year the LDP guidance focuses on what actions Boards are taking towards achieving the 2020 Vision for health and social care in Scotland and how we are working with our partners and members of the public to achieve this. It also relates to the work that is being undertaken by the Integration Board that will be represented in the Strategic Commissioning Plan when it is created later this year.

The following sections are included in the 2015/16 LDP:

1. Improvement Plan
    a. Health Inequalities and Prevention
    b. Ante-Natal and Early Years
    c. Person-Centred Care
    d. Safe Care
    e. Primary Care
    f. Integrated Care
2. Workforce section
3. NHS Contribution to Community Planning Partnership
4. LDP Standards
5. Map of local strategies and plans to priority areas
6. Financial Plans (submitted separately)

Following the inclusion of an Improvement and Co-Production Plan (ICP) in last year's LDP, this year the Scottish Government has asked Boards to focus on 6 key priority areas that we are being asked to make measurable progress towards to achieve the 2020 Vision. The 2020 Vision was set out by the Cabinet Secretary in 2011 to achieve sustainable quality in the delivery of healthcare services across Scotland, improve efficiency and achieve financial sustainability. Service leads have produced a short

narrative containing the work undertaken and planned for each area, including links to relevant plans or strategies, local and national.

This is the third year that we have included a section on the NHS Contribution to the Community Planning Partnership. This section has been updated since last year and focuses on the key tangible contributions NHS Borders will make towards improved outcomes in: growing the economy; health inequalities and physical activity; and early years and early intervention.

The LDP incorporates the key standards, plans, and levels of performance that NHS Borders will have to achieve during 2015/16. This in turn will inform discussions about performance at the Annual Review.

Since the draft has been created by narrative received from service leads the Planning and Performance team has liaised with national leads to receive advice from them on the final versions of each section.

Summary

There has been significant engagement across the service as the Local Delivery Plan has been developed. The Plan has been reviewed at the Clinical Executive Operational Group, BET, Area Partnership Forum, Public Reference Group and the Strategy and Performance Committee.

The final version was submitted on 23rd March 2015, with supporting Financial and Efficiency plans submitted a week earlier, subject to NHS Borders Board approval.

Please refer to the Financial Plan paper on the agenda with regards to the financial plans underpinning the LDP.

Recommendation

The NHS Borders Board is asked to **approve** the Local Delivery Plan for 2015/16.

Policy/Strategy Implications	The LDP will be the primary mechanism for monitoring the performance of NHS Boards by the Scottish Government.
Consultation	The LDP 2015/16 has been developed in conjunction with the service, the Clinical Executive, Board Executive Team, S&PC and service leads.
Consultation with Professional Committees	See Above
Risk Assessment	The risks for delivery of LDP actions have been factored into the plan. Performance will be monitored proactively throughout 2015/16 through reporting to allow remedial actions to be taken.
Compliance with Board Policy	The LDP has been developed to be fully

requirements on Equality and Diversity	compliant with NHS Borders' Equality and Diversity requirements.
Resource/Staffing Implications	None

Approved by

Name	Designation	Name	Designation
June Smyth	Director of Workforce and Planning		

Author(s)

Name	Designation	Name	Designation
Meriel Smith	Planning and Performance Officer		

NHS Borders

Local Delivery Plan 2015/16

Planning & Performance

Contents

Glossary

ADP	Alcohol and Drugs Partnership
AHP	Allied Health Professional
BECS	Borders Emergency Care Service
BHIH	Borders Health in Hand
BI	Brief Intervention
BIST	Borders Improvement Support Team
BME	Black and Minority Ethnic Communities
BSL	British Sign Language
CAMHS	Child and Adolescent Mental Health Service
CDI	Clostridium Difficile Infection
CEL	Chief Executive Letter
CHCP	Community Health and Care Partnership
CHW	Child Healthy Weight
CPC	Child Protection Committee
CPP	Community Planning Partnership
DCE	Detect Cancer Early
DMARDs	Disease-modifying antiheumatic drugs
DNA	Did Not Attend
ED	Emergency Department
eMART	environment Monitoring and Reporting Tool
ENP	Emergency Nurse Practitioner
EY	Early Years
GCCAM	Good Corporate Citizenship Assessment Model
GRFW	Get Ready for Work
HAI	Healthcare Acquired Infection
HEAT Targets	Health Improvement, Efficiency, Access and Treatment Targets
HLN	Healthy Living Network

HSMR	Hospital Standardised Mortality Rate
IRIO	Integrated Research and Innovation Office
ISD	Information and Statistics Division of National Services Scotland
IUCD	Intrauterine Contraceptive Device
JIT	Joint Improvement Team
KSF	Knowledge and Skills Framework
LASS	Lifestyle Advisor Support Service
LD	Learning Disability
LES	Local Enhanced Service
LTC	Long Term Conditions
LUCAP	Local Unscheduled Care Action Plan
MAU	Medical Admissions Unit
MCN	Managed Care Network
MIU	Minor Injury Unit
NES	NHS Education Scotland
P&CS	Primary and Community Services
QPQOF	Quality and Productivity Quality and Outcomes Framework
SAB	Staphylococcus aureus bacteraemia
SAS	Scottish Ambulance Service
SBC	Scottish Borders Council
SGHD	Scottish Government Health Department
SIGN	Scottish Intercollegiate Guidelines Network
SIMD	Scottish Index of Multiple Deprivation
SME	Substance Misuse Education
SOA	Single Outcome Agreement
SPSI	Scottish Patient Safety Indicator
SWHMR	Scottish Women Hand Held Medical Record
TNA	Training Needs Analysis

VAP Bundle	Ventilation-Associated Pneumonia Bundle
VAW	Violence Against Women
VSM	Value Stream Mapping

Section 1: Improvement Plan

This is the second year of the Improvement Plan which is intended to be a 5 year transformational plan setting out how we will deliver on the 2020 Vision for NHS Scotland. This year follows last in focussing around priority areas of the 2020 Route Map. This plan is structured around 6 key areas of work undertaken and planned that will help us achieve our 2020 Vision for NHS Borders, but it should be noted that this Plan is not inclusive of all the improvement work that is ongoing.

The LDP will be closely aligned to the Strategic Commissioning Plan developed by the Integration Board for Health and Social Care that will set out how services will be planned and delivered for the Scottish Borders.

A 2020 Vision for NHS Borders reiterates and emphasises the commitment to patient safety, and sets out how we want to make things even safer to drive up the quality of our local services and improve the experience of patients, families, carers and our staff.

The **executive leads** for each priority area in the plan are as follows:

	Priority Area	**Executive Lead**
1	Health Inequalities and Prevention	Eric Baijal
2	Ante-Natal and Early Years	Eric Baijal
3	Person-Centred Care	Evelyn Rodger
4	Safe Care	Evelyn Rodger
5	Primary Care	Susan Manion
6	Integration	Susan Manion

Health Inequalities **Executive Lead: Eric Baijal**	
Targeting resources to the most deprived – community & assets-based approaches	The Healthy Living Network (HLN) takes an assets based approach in its work with local communities and with partners. Volunteering development features strongly for example through peer support. HLN also supports community members to undertake the Health Issues in the Community programme. The HLN continues to work in close partnership with key community groups and partners including Registered Social Landlords in areas of high deprivation (Burnfoot, Langlee and Eyemouth) to improve health and enhance access to health and social care. Targeted programmes for protected characteristics groups continue. We will build on consultation and engagement work undertaken with migrants in 2014 to improve access and uptake.

	In relation to welfare benefit reforms, NHS Borders will continue to raise awareness among staff of the impacts of changes with the pending introduction of Universal Credit in Scottish Borders. The launch of the project on Financial Help in Early Years, funded through the SG Health and Welfare Fund, will provide opportunity to build capacity among maternity and child health staff of resources and pathways for families affected. Baseline information gathered in 2014 on current practice to support and promote the physical health of mental health service users will be used to improve service delivery in 2015 across mental health and primary and community health services and with the third sector. Through the Joint Health Improvement Team feasibility work will be undertaken during 2015 within a defined community to develop community referral in order to support those at risk of poor mental health and suicidal behaviour. It is known that men of working age are a particular risk and therefore this group will be a focus for this work.
Targeting resources to the most deprived – service approaches	The local Keep Well service continues to deliver health checks targeted at our more deprived communities to reduce inequalities in health, focusing on CVD risk factors and wider determinants of health such as literacy/numeracy, income and benefits advice, and mental health & well-being. Planning for the withdrawal of central funding by 2017 is well advanced and the service will continue but focus on those at greatest need and become fully integrated with the Lifestyle Adviser Support Service (see Prevention section). Other services that are targeting the more deprived communities and localities to reduce inequalities in health include: • DCE campaign – there is great potential for screening programmes to exacerbate inequalities in health because uptake tends to be lower in more deprived populations. To prevent this the local programme is being proactive in promoting screening in such local populations with some success. • Smoking cessation – the existing HEAT target focuses on those from more deprived areas and the local service is working hard to reach out and encourage uptake in these areas where smoking prevalence is highest. • LTC project – a pilot project working with two general practices is using the House of Care model and implementing a range of changes to improve the shared management of LTCs, which are more prevalent in more deprived populations.
Tackling inequalities faced by people with a	The Learning Disabilities Service and Public Health continue to work together to promote awareness and develop skills and knowledge among service users, carers and frontline staff in town key areas: health living

learning disability	(nutrition and keeping active); and relationships and sexual health. NHS Borders continues to benefit from support through Scottish Government funding for 3 specific health improvement LD projects: • the 'Healthier Me' project - weight management and healthy lifestyle • a sexual health project • iMUSE and intensive interactions which supports and promotes communication, resilience and interaction We carry out proactive screening with all people with Downs Syndrome for dementia from the age of 30 onwards as well as having a reactive pathway for all referrals for dementia screening. We will also be a pilot site later this year for the implementation of a Health Outcomes Framework. ADP is working with Social Work colleagues to develop appropriate approaches to alcohol screening. We have an LD liaison service to the Borders General Hospital supporting people with LD in planned and unplanned admissions. We also have plans to introduce a flag within TrakCare in the hospital for people with LD. There is still a need to improve identification of people with LD in primary and secondary care to ensure effective person-centred responses to needs and to enable data collection. Through our lead in Public Health we have also intimated our interest in engaging with the national work streams regarding data collection and management. An LD representative sits on the Equalities steering group within NHS Borders. We provide an introduction to Learning Disability within corporate induction training within NHS Borders. We intend to work with Scottish Public Health Network (ScotPHN) and the Scottish Learning Disabilities Observatory (SLDO), guided by examples of good practice, to develop: 1. A secure database of adults with learning disabilities in the Scottish Borders complete with CHI numbers 2. A specific plan to measure some aspect of health/health care for this population 3. A health/health care improvement plan for this population and to develop existing ones. The Learning Disability Service, through its Policy and Strategy Group, are leading the development of the Borders action plan towards meeting the recommendations within 'The keys to life - improving quality of life for

	people with learning disabilities' 2013.
Health Inequalities and Physical Activity	This is a Community Planning Partnership priority area and more information and actions planned and undertaken can be found in the NHS Borders Contribution to the Community Planning Partnership section.
Reducing Inequalities Strategy	Much of the background work to developing a local inequalities strategy has been completed and will be finalised in early 2015.

Prevention **Executive Lead: Eric Baijal**	
Anticipatory care	The local Lifestyle Advisor Support Service (LASS) provides an integrated service to support health behaviour change and has three strands: • Mainstream LASS which supports lifestyle change to reduce risk of ill health associated with CVD, diabetes and stroke. The distribution of those attending LASS favours the more deprived and disadvantaged and therefore it contributes to local effort to reduce inequalities in health. • The local Keep Well programme targets hard to reach/more deprived groups (see Health Inequalities section) • Counterweight offering an alternative approach to mainstream LASS to reduce weight focusing on dietary change
Gender Based Violence	NHS Borders continues to support the Pathways project that provides a co-ordinated interagency response to domestic abuse. NHS Borders leads locally on prevention work on behalf of the VAW Partnership. Public Health coordinates awareness raising and training within NHS Borders to improve early identification of domestic and other abuse and appropriate signposting to support for those affected.
Health Promoting Health Service	In 2015 we will continue to build on a significant social marketing campaign for staff, patients and visitors launched mid 2014. Improvements will continue in pathways from secondary care to: smoking cessation services; physical activities opportunities, and support for mental health. Further support for workforce development will continue using capacity developed through national training for trainers programmes in health behaviour change and to incorporate work on health literacy. The availability of Health Psychology within NHS Borders is providing a means to develop motivational interviewing approaches in key services including maternity and services that support those with long term conditions.

	In support of achieving the Gold Healthy Working Lives Award for NHS Borders, staff in the Work and Well-being services have adopted a 'Small Change Big Difference' pledge to do everything they can to support our staff to improve their health and well-being so they are able to deliver high quality patient care. Examples include: lifestyle checks; promoting resilience sessions; and smoking cessation services.
Alcohol whole population approach	Alcohol Brief Intervention delivery continues in priority settings and also LASS, Keep Well and Community Mental Health Teams. Supporting delivery in wider settings including social work, police custody suites, and Anti-Social Behaviour Unit. Also exploring delivery with learning disabilities services. Working with Education and Police colleagues to develop consistent model of substance misuse education in schools and young people's settings. Support will continue to be given to the Local Licensing Forum, and to the development of the annual Alcohol Profile.
Promoting healthy weight	NHS leads on implementation of multi agency approaches to reduce barriers to healthy eating and physical activity in a range of settings across the life span. Priorities are: promoting access to and availability of sustainable food within local communities; and the development of knowledge and confidence in the health and social care workforce.
Sexual health	Through the expertise within the Joint Health Improvement, sexual health services and school nursing, we support capacity in partner organisations to work with young people and other target groups to promote healthy relationships and prevent STIs, HIV and unwanted pregnancy and tackle stigma and discrimination. Education, third sector youth work services and LGBT networks are actively involved in this.
Detecting Cancer Early	A DCE awareness raising programme has been delivered amongst networks working with deprived communities and staff working with vulnerable groups, including those with mental health problems or learning disabilities. Key aims were to promote uptake of cancer screening opportunities, increase awareness of warning signs and symptoms, and encourage those with concerns to make early contact with health services. A survey of staff in NHS and SBC about bowel screening was also carried out to inform future approaches. Key deliverables planned for the DCE programme include embedding this improved knowledge and awareness into routine processes and assessments within community teams and networks; encouraging staff

	to anticipate possible barriers to uptake of screening; and helping patients/clients to overcome these barriers where possible.
Tobacco	We plan to develop a joint Tobacco Control action plan in 2015 involving key partners to maximise the potential of existing initiatives and to take forward the priorities in the national strategy. We will continue with the current tobacco prevention programme with young people in partnership with Community Learning & Development to support the objectives of the Children and Young Peoples services plan. The promotion of Smoke Free Homes will be focused through our Early Years work and other community facing programmes.
Long term conditions management	The long term conditions project will continue into 2015. This is testing out improvements in the supported self-management of long term conditions (LTCs) amongst older people, in the context of two GP practices. The project works closely with primary care nursing staff and a third sector provider which engages volunteers. Overall aims include: • improved access to assessment, information, advice and support (practical and emotional) for individuals and their carers; • improved health and well-being and reduced health inequalities; and • reduced demand for frequent calls and visits to GPs/Practice Nurses; The project evaluation will provide important learning on processes and impact.

Antenatal and Early Years **Executive Lead: Eric Baijal**	
Development of integrated locality model of service delivery	NHS is an active partner in the Early Years Centres in four areas of high deprivation across Borders. Two were established in 2014 -15 and a further two come on stream in 2015 -16, with wider roll out over time and as resources allow. NHS maternity and child health services are being delivered as part of a multi-agency approach, underpinned by the GIRFEC methodology, to support families in these areas with a focus on those who are hard to reach. The locality Early Years Networks are being refreshed to incorporate improvement methods as a means to further local service development. We are already making use of the data from 27 month Child Health Reviews to improve attainment of developmental milestones in particular in relation to child weight / nutrition and to speech and language development. The introduction of the new universal pathway will bring additional opportunity for health improvement work with families through increased health visiting contacts.
Parenting support	The Psychology of Parenting programme will continue in 2015 and health staff are actively involved in this. The Family Nurse Partnership programme will be introduced from July 2015 in the Borders. Transitions work is an important focus with the improvement work of the Early Years Collaborative. The implementation of the GIRFEC practice model will continues to support smooth transitions into and between services.
Maternity care and maternal and infant nutrition	We will continue to implement the renewed antenatal education programme, with a focus on promoting early access and consistency of messages for families across different services. In addition targeted work in selected communities will test out the feasibility of strengthening antenatal contact and support. We will implement pathways to enhance maternal health outcomes and reduce health inequalities in relation to tobacco, alcohol and mental health and will be testing out an intervention on maternal weight management. Further work will be undertaken to maintain Baby Friendly Initiative standards, following the attainment of Stage 3 accreditation for community and maternity services in 2014. This includes an NHS led initiative to promote 'baby welcome' environments using a whole systems approach. Child Healthy Weight programme implementation in early years settings will continue to support the early years workforce in relation to nutrition and will also deliver targeted work with vulnerable families.

Community capacity building	Continued delivery of collaborative programmes through Healthy Living Network and Community Learning and Development and the third sector to develop skills, confidence and opportunities, including volunteering development where appropriate.
Early Years Collaborative	NHS Borders supported one member of staff to complete the Early Years Collaborative Improvement Advisor Programme in 2014 -15 and two further senior managers have been accepted for the 2015 programme. NHS Borders continues to be well represented on the Awayteam, which will work on renewed priorities in 2015, to focus on key thematic areas for improvement, using baseline data collated in 2014 to improve coherence. We anticipate being able to support an agreed set of tests of change so that these can be followed through and learning used for scale up as appropriate.
Early Years and early intervention	This is a Community Planning Partnership priority area and more information and actions planned and undertaken can be found in the NHS Borders Contribution to the Community Planning Partnership section.
Children and young Peoples Act (Scotland) 2014	NHS Borders continues to be actively involved in the implementation of GIRFEC both locally across the CPP and also regionally through the Lothian and Borders GIRFEC Group. There is a Scottish Borders Multiagency GIRFEC plan which sets out the implementation tasks and timelines. In support of this the Health Board has a NHS Borders GIRFEC plan which addresses the specific systems and processes that we have to have in place to support children till they are school age. We have named person training and all midwives and health visitors received named person training in 2014. We rolled out an eGIRFEC learning module as part of our Learnpro resource which all staff across adult and children's services have to complete before progressing to the child protection update eLearning module. We developed and have rolled out the Scottish Borders Information Sharing Guidance this is being supported by a training programme to support the document. We have a single plan which is used for all children who meet the criteria for a multiagency child's plan. We are working nationally through the CEL 13 group to establish the numbers of Health Visitors that we will require to carry out both the duties of the Act and the new universal health visiting pathway. We currently have two health visitors in training.
Performance Measurement	Local improvement measures are being developed to enable monitoring of performance and to demonstrate progress towards the stretch aims and local strategic objectives.
Key Documents	Joint Early Years Strategy Contains Early Years Collaborative stretch aims.

	Y:\early years\Early Years Strategy.pdf NHS Borders Child Health Strategy Desired outcomes and measures of improvement included in strategy appendix. CHILDYP STRATEGY FINAL.pdf NHS Borders GIRFEC Plan NHS Borders GIRFEC Plan.doc Partnership GIRFEC Plan High Level GIRFEC workplan - Version 7 S Maternity Care Action Plan This was reviewed and updated in 2014. The current working draft is attached Maternity Care Action Plan 2014-201

Person-Centred Care **Executive Lead: Evelyn Rodger**	
Learning from and spreading best practice	NHS Borders will continue to develop a work stream of quality improvement activity and a local handbook of good practice to ensure effective delivery of the national Person-Centred Health and Care Programme (2012). This programme of work aims to improve person-centred practices in relation to care experience, staff experience, co-production and leadership. A central theme of these four work streams is promoting caring and person-centred behaviours so that staff are equipped with the skills to offer person-centred care with compassion and kindness.
Seeking and acting on feedback	NHS Borders encourages feedback from patients, carers and family members, and about the services they receive. Feedback and complaints are invaluable sources of learning that help us improve the care and support we provide. NHS Borders welcomed the introduction of the Patient Rights (Scotland) Act (2011) that gives every patient the right to provide feedback or make a complaint and they are given the support they need to do this. Our priority is to make our feedback and complaints processes as accessible as possible and empower front line services to manage and learn from the feedback received. All areas display information on how to provide feedback and how to make a formal complaint. Information is also provided on the NHS Borders internet site and Patient Opinion is available as a route of feedback. Over the last year we have elevated the profile of patient and carer stories, from ward to Board, as they have proved to be a useful learning tool for improving patient care and emphasising person-centeredness. This year we will continue to focus on the use of patient stories as a learning and reflective practice tool. With a focus on embedding their use within training and development offerings, multidisciplinary team learning sessions and decision making processes about improvement priorities in the organisation. In addition, NHS Borders has adopted a proactive approach to gathering feedback. We have recruited a cohort of patient feedback volunteers, refreshed our publicity material and introduced three core patient feedback questions that will provide a single system-wide measure of patient satisfaction. Our feedback volunteers are currently gathering information from patients in the discharge lounge, outpatients, RVS cafeteria seating area and this is now being rolled out to the wards. The information gathered will be displayed in public and clinical areas informing staff, patients and members of the public in the 'You Said' 'We Did' format. . Our aim for the coming year is to develop the system to provide real time feedback to clinical areas and testing work has begun towards this. This information is also regularly reported to the NHS Board.

	'What matters to me' is a tool that a range of clinical areas have adopted to enable them to find out and record what is important to the patient and whether they have any personal goals they are working towards during their care or treatment. This approach is currently being used in our medicine for the elderly ward, the Borders Stoke Unit, Kelso Community Hospital and Huntlyburn Ward. This year we plan to introduce the tool to remaining community hospitals, mental health inpatient areas and to test an approach on to 'what matters to me' in the medical admissions process within BGH. A core question in the '2 minutes of your time' proactive patient feedback system is: "Did the staff providing care understand what mattered to you", which will provide a measure of impact in this area. As above this data is then presented in clinical areas and used to inform improvements, this information will also inform the work of local participation groups. As well as learning from complaints and feedback, NHS Borders involves patients and carers in the design and planning of services to improve the quality of care and support provided. There is a active public involvement structure which will be further developed to support health and social care integration. NHS Borders will continue to take forward the recommendations made in the Participation Standard for Scotland, by continually evaluating and improving the way we involve patients and the public in improving services. NHS Borders is proud of the performance against in relation to the assessment by the Participation Standard and will continue to make improvements to the process. In particular a Public Involvement Strategy will be agreed to focus the priorities of this work for the coming 3 years. NHS Borders has aligned complaints, feedback, advocacy support, carer support, Third Sector engagement, volunteering, patient experience and public involvement work into an overarching work programme. The work streams and priorities are informed by the people that use our services, and along with our local Person-Centred Health and Care Programme it will aim to put patients, their families and carers at the centre of everything we do. We will seek the views of all protected characteristic groups in line with the public sector general equality duty. We are in the process of recruiting a volunteer to assist us with the 'Playlist for Life initiative. Playlist for Life enables relatives and carers to create playlists of songs and tracks that are meaningful and significant to an older person with dementia. This role will involve meeting with patients, relatives and carers to discuss and note the music requested, create the playlists on iTunes then upload to the iPod and give back to the patient. This is one example of the type of volunteering roles NHS Borders is developing. This year we will continue to grow this area to enhance patient experience and to enhance the experience for volunteers. We plan to do this by focusing on how the skills of individual

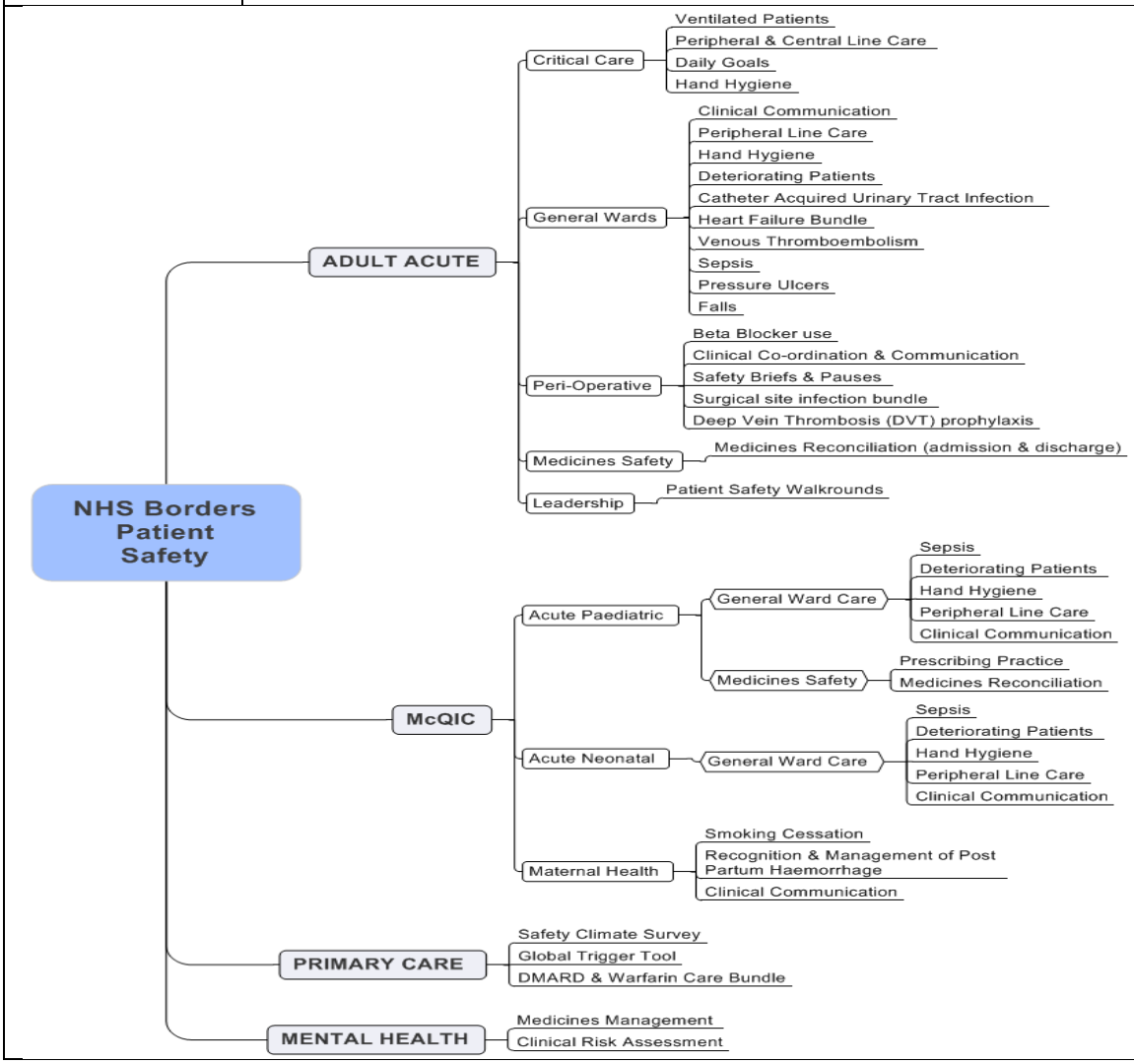
	volunteers can be matched to a need of a service or patient group. A work and wellbeing framework has been approved which recognises the link between staff wellbeing and clinical outcomes. A person centred approach is core to the delivery of this which has a focused year on year action plan through to 2020. NHS Borders is rolling out the iMatters employee engagement indicator tool which will be used to continually improve staff experience and team working. Further reference to some of the person centred initiatives underway, which focus on staff, are contained in the workforce section of the LDP.

Safe Care

Executive Lead: Evelyn Rodger

The provision of safe care has many elements to it but by far the most comprehensive programme of work is the Scottish Patient Safety Programme. The continued implementation and delivery of this programme will continue to be effective in ensuring we are using the latest evidence-based tools and techniques to improve the reliability and safety of everyday health care systems and processes.

Scottish Patient Safety Programme	The following is an update, with an overview of progress, to date, of the implementation of the Scottish Patient Safety Programme (SPSP) and an assessment of spread and sustainability across the programme's key workstreams. <u>Background</u> The diagram below details the current scope of the SPSP within NHS Borders:



Patient Safety in Acute Care	The NHS Borders patient safety programme for acute services was initiated in 2008 focusing on the key improvement priorities agreed by the SPSP. A strategic shift within SPSP was announced through the Chief Executive Letter CEL 19 (2013) and advised of the overall aim, the 10 patient safety essentials and the 9 priority areas. As part of this strategic move, Healthcare Improvement Scotland (HIS) are working with NHS Boards to test the process for both assessing readiness for and demonstrating progress towards universal implementation of the 10 Essentials of Safety. The Adult Acute Safety Programme Measurement Plan (2013) and associate reporting template supports Boards to review their current levels of reliability and spread, consider and perform actions required to close any gaps and articulate methods of self assessment of ongoing reliability of the 10 Safety essentials.
Ten Patient Safety Essentials	These ten interventions have now been proven to reduce harm to patients and therefore it is proposed that a zero tolerance approach will be phased in and adopted within acute services in NHS Borders. The 10 patient safety essentials are: • hand-washing • leadership walkrounds • communications: surgical pause and brief • communications: general ward safety brief • ICU daily goals • VAP bundle • early warning scores • CVC insertion • CVC maintenance • PVC maintenance bundle The current self auditing system of these measures shows good reliability in all acute clinical areas within NHS Borders, and this will continue to be validated by random spot checks, regular mentoring and training of staff, and scrutiny during Executive leadership walkrounds. A revision of the Executive leadership walkrounds occurred in 2014, and this format will continue into 2015. Each clinical area now receives one walkround and one inspection, led by the same Executive. Training is by means of 1:1 nurse education; per ward, by the Patient Safety Programme Manager and Patient Safety Assistant; and as part of a local marketing strategy currently, the Better campaign that has been focused at all staff within the BGH.

Adult Acute SPSP Priorities

In addition to the 10 patient safety essentials the Cabinet Secretary also announced the 'nine plus two' key priority areas to become the ongoing improvement focus of NHS Boards. Workstreams have been established and testing work on all new measures has commenced across the acute inpatient areas.

Point of Care Priorities	**Progress**
Deteriorating Patient/ Cardiac Arrest	The workstream is currently scoping and planning the implementation of the National Early Warning Score (NEWS) as a validated tool to detect and respond to deteriorating patients. Collaboration is also underway with the discharge led criteria workstream group to test a 'structured review' of patients on admission to hospital which encompasses: • Risk of deterioration reviewed and documented • Limited reversibility assessed • Written management plan • Anticipatory care plan • DNACPR considered • Communication with person (patient) and family management plan documented
Sepsis	Monthly data collection for the sepsis workstream is demonstrating good progress and reliability in key measures such as antibiotics given within the hour of between 80- 90%. Spread is now underway throughout the medical and surgical units.
Heart Failure	Monthly data collection for the heart failure workstream is showing 100% reliability for the heart failure bundle. NHS Borders recently presented on a national webex and were commended for their commitment and progress in this area.
Venous Thromboembolism (VTE) Prevention	Monthly data collection continues in three areas with an improvement focus on re assessment at 48 hours.
Pressure Ulcers	Monthly data continues to be submitted by all inpatient areas in the BGH. Risk assessment measures demonstrate no improvement according to run chart rules, but it should be noted that the current median is near the target of 95%. Developed, avoidable pressure ulcer count remains low at ward and site level. Improvement efforts are being focused case review.
Surgical Site Infections	Monthly data is submitted for the theatres bundle which demonstrates reliability. A group has been

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<tr><td></td><td>reformed to bring greater focus to this area.</td></tr>
<tr><td>Catheter Acquired Urinary Tract Infections</td><td>A catheter awareness ‘road show’ is planned for the end of February 2015, to launch the revised catheter passport and the revised policy. Process measures are now being tested in the pilot ward.</td></tr>
<tr><td>Falls</td><td>A revised falls assessment bundle is currently being tested and data reported from one inpatient area. Run charts show normal variation for the rates of falls and falls with harm. All areas have now been trained in the new falls bundle. Improvement efforts are being focused down on a few areas to study the impact of introducing interventions on the falls rate prior to spread.</td></tr>
<tr><td>Medicines</td><td>Medicines reconciliation on admission data is submitted from ward 6 on a monthly basis, with improvement focused on 4 out of the 5 elements of the bundle.</td></tr>
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<tr><td>Scottish Patient Safety Indicator (SPSI)</td><td>The revised measurement plan for the Acute Adult safety programme was published in December 2013. Boards are well engaged in improvement work across the harms of the Scottish Patient Safety Indicator (SPSI).

Following consultation, a proposal to amend the current definition of SPSI to SPSI 3 has been agreed by the Acute Adult Delivery Group and supported by the SPSP Programme Board and Scottish Government. SPSI 3 will be a composite measure collected and reported at ward, hospital and board level describing the percent of patients discharged free of the three currently measured and reported harms (falls with harm, pressure ulcers, cardiac arrests).</td></tr>
<tr><td>Mental Health</td><td>Outcome data continues to be collected on a monthly basis via the reporting template from the Brigs and Huntlyburn. There are no exceptions in the data to note. The national programme is currently scoping 10 safety essentials for Mental Health units which Boards will be asked to test at pilot level in 2015/15.</td></tr>
<tr><td>Maternity, Paediatrics and Neonates (McQIC)</td><td>Data for neonates and maternity continues to be submitted via the reporting template, and paediatrics had their first data submission at the end of January 2015. There are no exceptions to note. The maternity programme officially closed at the end of December 2015, and NHS Boards ‘maternity champions’ finish in post in July. Decisions are awaited from the national team about the future of the maternity programme for 2015/16, with paediatrics and neonates continuing.</td></tr>
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Primary Care	The primary care workstream has recently been issued with a reporting template to complete on a monthly basis. This will be commenced in April 2015. Primary and Community Services will be reinstating bi-monthly bundle reporting for the DMARDs and Warfarin local enhanced services and data collection will commence in April 2015.
Adverse Event Management	NHS Borders have incorporated the actions required of NHS Boards through the National Approach to Learning from Adverse Events Framework cascaded by Health Improvement Scotland and published a revised Adverse Event Management policy. NHS Borders continue to develop the process of reviewing adverse events in a timely manner, with a focus on identifying learning and driving improvements in practice. A focus of this work in 2015/16 will be on working with front line clinical teams to ensure a learning system is developed and that a robust system of support can be offered to patients and staff.
SPSP Measurement Plans	 Mental Health P2 Measurement Plan v0  AcuteAdultSafetyme asurementplan v1 0.p  Maternity Care Measurement Plan FI
Learning Events	As the first in a series of quality improvement learning sessions. NHS Borders welcomed Mrs Margaret Murphy, a patient safety ambassador for the World Health Organisation to speak to 130 staff members over two sessions on 19 November. Margaret relayed the story of how her son Kevin who died in Ireland as a result of a series of errors, mix ups and clinical blind spots in the healthcare system. Margaret focused on the complexities of being open and honest when adverse events, the need to involve patients and families and the learning that can come from these events if managed effectively. This is the first in a series of short learning sessions which will be open to staff to support the organisation's ambition to create a learning culture.
Safety Measurement and Monitoring – Health Foundation Award	In April 2014 the Health Foundation published a Safety Measurement and Monitoring Framework prepared by Charles Vincent. The Health Foundation recently invited key organisations to apply to test the framework. Healthcare Improvement Scotland (HIS) were specifically invited to submit a proposal with two delivery partners. NHS Borders was approached to be one of the delivery partners in recognition of the progress the Board has made in the use of data to drive quality, safety and improvement. Following short listing, representatives from HIS, NHS Borders and NHS Tayside were invited to interview on the 8 September 2014. Confirmation has now been received that the combined proposal from the three organisations has been successful. NHS Borders will begin testing of the framework at Board level and across a frailty pathway for older people. This will offer the opportunity to accelerate our local improvement work in patient safety and the care of older people.

Vale of Leven Inquiry Report	NHS Borders has completed a self assessment against the 65 recommendations in the Vale of Leven report for Health Boards. NHS Borders is fully compliant with 31 of the recommendations and has developed an action plan which is being progressed to ensure compliance against the remaining recommendations. NHS Borders will respond to any national guidance from the implementation Group or Reference Group on the implementation of the recommendations and update the action plan as appropriate. The action plan has been added to the Board Infection Control Work Plan with progress monitored through existing governance processes. The timescale for full compliance is December 2015.

Primary Care **Executive Lead: Susan Manion**	
This section includes work underway and planned within Primary Care that will support increased capacity through increased physical capacity in terms of development of premises and facilities; clinical capacity through service redesign and efficiency initiatives and also through improvements in infrastructure and support networks.	
Leadership and Workforce	i) The joint senior management posts and working practices across senior management have continued to support a single system approach across primary and secondary care. As part of this arrangement, the Associate Medical Director is leading on the Unscheduled Care Project which is looking at improving the patient pathway across care sectors and involves both primary and secondary care clinicians, services and processes. The proposed new management structure for NHS Borders is currently under consultation but will build on the success of joint leadership and management roles. The integration agenda across health and social care will support the continuation and development of shared leadership and working practices. ii) NHS Borders has recently confirmed that a review of all clinical services will be undertaken during 2015/16. The outcomes from this review will inform and shape the ongoing discussions and decisions regarding redesign of treatment rooms and community nursing services. iii) Work has continued to develop a model for medical cover across community hospitals. Options were identified and an option appraisal process is currently underway. 2 clinical sessions have been provided to support closer working with LMC specifically on improving key interface issues and in development of enhanced services. This is in recognition of the need to rationalise and streamline approach akin to national work progressing the GMS Contract. A workforce survey was also carried out along with a GP stress survey looking at retirements over coming years. The findings were presented to the Board. Key areas included shift of workload at the interface, remote access to PCs to facilitate ability to do admin from home and the ongoing provision of protected learning time. Actions are underway to address these areas. Workforce remains a concern. While there are no known unfilled partnership vacancies at present there have been difficulties recruiting and one practice has been unable to recruit to a maternity locum. Actions nationally which would support Practices could be: • Development of a national training programme for Physician Assistants (primary care).

	• A move to 24 hour unscheduled care provision supported by skill mix (for example paramedics/specialist nurse grades). • Removing the central allocation of GP trainees. The removal of GPs being able to recruit their own trainees has led to difficulty in maintaining trainees within Borders after full qualification. In the past GPs tended to recruit registrars who had a desire to live and stay in their area. Many of these went on to become partners. We now find that many trainees who have been allocated form a central scheme prefer to return to the central belt after training is complete. This has significantly reduced the benefit to Practices of training. A review of training is recommended to make this more beneficial and attractive for Practices to participate. • Likewise a review of both the rural fellowship and retainer schemes is recommended to make these more attractive to Boards and Practices alike. A review of the potential unintended consequences of pension changes may be beneficial.
Service Planning and Interfaces	i) The Local Enhanced Services for 2015/16 confirmed to date are: • Prescribing, with a particular emphasis on reducing waste • Alcohol Brief Interventions • Minor Injury • IUCD • Anticoagulant monitoring (warfarin) • Keep Well • Care homes • Contraceptive Implants • Near Patient Testing (DMARDS) • Hep B vaccinations for foster carers Any additional Enhanced Services will be discussed and agreed in liaison with the Local Negotiating Committee, GP Sub Committee and local GP practices. ii) QPQOF has been replaced with national and local Quality Datasets. GP practices will review their individual practice data provided for each dataset, benchmarking against national and local information and will provide NHS Borders with an annual report of their reflections and comments from a quality perspective. There are 5 national datasets of which two are mandatory, with the practice able to choose a further 1 from the remaining three topics. There are 3 local datasets: Physiotherapy which is mandatory and then the practices must choose either Pain or Infertility as their second dataset. iii) As part of the QOF review process, each GP practice will take forward a review of access. They will provide an end of year report to NHS Borders on the outcomes. iii) The integration of health and social care services is now underway

	and locally this will define how the work begun in 2014/15 to develop a new community services model should progress. iv) The Pharmaceutical Care Services Plan is currently under review which will continue into the 2015/16 financial year. The purpose of the plan is to provide information on the pharmaceutical care services currently available from Community Pharmacy Contractors within NHS Borders. This will help to identify any potential gaps in service provision and where a need to develop pharmaceutical services may be required. A secondary function of the plan is to inform and engage members of the public, health professions and planners in the planning of pharmaceutical services. v) Public Dental Services (PDS) was established in April 2014 and provides safe effective, quality NHS dental care for priority group and vulnerable patients. Work has progressed and in the next year the intention is to: 1. Review services to Special needs/ additional needs - Pre-school and school age children - The Elderly - Other priority groups as identified e.g. Mental Health patients, drug and alcohol dependants, homeless, ex-offenders, single parents. 2. Review use of the remaining two mobile dental units (MDU) and establish a forward plan in relation to capital spend. 3. Review services to children in rural schools and schools areas of deprivation. 4. Develop changes in managing children's and adult DNA (did not attend) appointments. 5. Look at profile of oral health in teenagers and consider ways to encourage attendance and motivation for better oral health 6. Implement transitional program for school leavers 7. Review of current emergency services and out of hours to ensure high standard maintained. 8. Review of secondary care anxiety management service and further expansion of primary care anxiety management services. 9. Service review of children's general anaesthesia provision 10. Provision of bariatric dental facility or shared bariatric OPD facility. vi) Lifestyle Advisory (LASS) & Sexual Health – LASS is an integrated service comprising of Lifestyle Advisory Support Service, Keep Well and Counterweight. Outcome data is produced quarterly which evidences the success of the integrated programme. The funding for the Keep Well programme that assesses cardiovascular disease (CVD) risk among those aged 40 – 64 years and from a deprived/disadvantaged background, and more recently has also focused on specific vulnerable groups will cease at the end of 2016. Plans are underway to reconfigure LASS services to continue to support those in the most vulnerable groups. Sexual Health - Sexual health drop in services have been redesigned with a series of 'Pop-up Clinics' located near to major secondary schools

	in order to allow easier access at more suitable times for young people. The sexual health service further increased patient capacity with existing resource and also incorporated routine alcohol and GBV assessment for all under 25s. Fixed term funding for 1 year provided training for 11 GPs in implantable contraception which in parallel with an LES for Implantable contraception introduced in April 2013, supported the 266 implants inserted in general practice through the LES in the Borders in 2013-14. The total number of Nexplanon provided in NHS Borders increased from 674 in 2012-13 to 825 2013-14. The service has launched a Facebook page and a twitter account to improve access for younger people. LARC is promoted to all women as an effective method of contraception. All school nurses participate in the condom distribution scheme, C-card, in partnership where possible and appropriate, with locally trained youth workers. A programme of C-card training for receptionists at health centres where Sexual health clinics are held is in progress, to allow condom provision outwith SH clinic hours. The local strategic assessment is currently being updated and teenage pregnancy and sexual health is identified as areas of strategic priority. The Borders Sexual Health service is currently undertaking an options appraisal to review current model of delivery the process will be completed by June 2015. vii) Following the Primary Care Premises Review, work has been completed within 2014/15 at four health centre sites to provide increased and improved clinical capacity and improved facilities for patients and staff. A podiatry clinical hub has also been created through reconfiguration of rooms at a community hospital site which will provide capacity for more efficient working practices and will free up additional clinical space for use by other services at three other health centre sites. Work is underway to develop design layouts for the four health centre sites identified through the review as highest priority in requiring significant development –Duns, Eyemouth, Melrose and Selkirk. The proposed developments will provide additional and improved clinical space as well as additional and improved staff and patient facilities. Once these design layouts have been completed recommendations will be made to the Health Board for approval for inclusion of the development of the four sites within the Capital Plan 2015–19. viii) Links continue with optometry services delivered in the community to ensure care is in line with local initiatives. Diabetic retinal screening continues to be delivered by local opticians.
Technology and Data	Specific information is reviewed as standard practice to inform day-to-day operational decisions. Ad hoc data reports are used as needs be to support tests of change, individual work programmes, strategic planning

	& service redesign. The issues identified within the Primary Care Strategic Assessment and included in the LDP submission 2014/15 remain and are repeated below. A huge barrier is the inability for IT systems to communicate with each other effectively. Sharing of information across services and agencies is essential if the 2020 Vision of a coordinated, integrated approach to health and social care is to be achieved. IT systems **must** interface appropriately between primary and secondary care and also, crucially, between healthcare services and social work services in order to support our patients and public. The ever–increasing reliance on electronic systems brings with it increasing maintenance, installation and educational issues which impact on the capacity of IM&T support services. We are currently trialling the use of digital pen technology within our district nursing service. Planning is underway to introduce the use of National Early Warning Scoring in a community setting supported by telehealth technology to support decision making in community hospital and care home settings. Testing is underway for use of remote access technology to facilitate GP access to desktop from home or nursing home.
Contracts & Resources	The imminent review of clinical services, the integration agenda, efficiency programme and any subsequent realignment of budgets will influence the shape of future primary care services. No specific projects are in place to increase capacity in Primary Care. Work is underway to review all inpatient services to facilitate redesign. In addition planning is underway via our Integration Board to include GPs in specifying the building blocks to support locality working and capacity building.

Integrated Care

Executive Lead: Susan Manion

The future Integrated Joint Board is recruiting its Strategic Planning Group with a view to having it in place by the end of March 2015. The Group will then be involved in the further development of the second draft of the Strategic Plan over April and May before it is put out to wider consultation from July to late September. Between October 2014 and February 2015, clinical and care professionals have been involved in a series of engagement sessions both centrally and in each locality to raise awareness of: Integration; the national context; the duties it places on us; and our local response to these. As part of this process their views have been captured and fed back into our Integration Programme.

Proposals to establish the Strategic Planning Group were taken to the February meeting of the Integration Shadow Board and the preferred option was agreed by both the Council and the Health Board on the 19th February 2015. Under these arrangements, there will be an 18-member Strategic Planning Group that will include two Health Professional representatives - one of which will be a General Practitioner; and one Social Care Professional. They will have a responsibility to represent their general professional colleagues at both a Borders-wide and locality basis. For the purposes of planning and representation, the Borders will split into the existing five localities: Berwickshire, Cheviot, Eildon, Teviot & Liddesdale and Tweeddale. This Group will focus on the priorities of the national health and wellbeing outcomes and integrated care pathways based on the findings of the Strategic Plan.

Section 2: Workforce

As a health board we are faced by the familiar challenges of constrained resources and greater demand for our services. As such we recognise that in order to provide a sustainable model of service delivery we must promote innovation and encourage different, more efficient ways of working.

In addition we will continue to focus on our staff, our most valuable asset, who are central to the delivery of person centred, safe and sustainable healthcare. Included below is the approach we are taking to implementing *Everyone Matters: 2020 Workforce Vision* and how we plan to engage with staff and partners.

We work to a common set of corporate objectives and values which guide the work we do, the decisions we take and the way we treat each other. By promoting excellence in organisational behaviour we believe we can improve patient experience and the quality of care we provide.

Workforce	**Executive Lead: June Smyth**
Plan for the 5 priority areas for action as set out in Everyone Matters: 2020 Workforce Vision Implementation Framework	**1. <u>Healthy Organisational Culture</u>** NHS Borders will ensure that our corporate and departmental inductions promote the values and behaviours expected of NHS staff through enhancing awareness of our corporate objectives. The mandatory induction standards allow measurement of compliance and success of this approach. Current staff have a responsibility to be aware of our corporate objectives and demonstrate the values and behaviours expected. Mechanisms for implementation include the embedding of good people management; through joint development review process, KSF PDPs and reviewing patient/staff feedback. The staff experience employee engagement tool, **iMatter**, is being developed throughout NHS Borders in a 2-year programme, as we recognise that positive staff experience will lead to better patient care. The roll out commences in February 2015 and there is a project plan for coverage throughout NHS Borders. We see the big message of 2020 Workforce Vision compared to previous workforce plans; is to emphasise and embed our shared values in NHS Borders, these are: • care and compassion • dignity and respect • openness, honesty and responsibility • quality and teamwork. The link between staff health & well-being and improved clinical outcomes is well recognised and reflected in the Workforce 20:20 Vision. In support of this NHS Borders has developed a person centred work and

well-being framework which sets out how we will support staff to keep them motivated, healthy and engaged.

All staff have the primary responsibility for their own health. However, as the employer, NHS Borders has a clear obligation to support staff health and well-being in the workplace. Success will require co-operative effort at all levels, with managers and staff working together and taking collective ownership and responsibility for improvement. This framework identifies the long term ambition NHS Borders has to foster improvement in staff well-being and makes specific commitments to a number of key priority areas.

2. Sustainable Workforce

NHS Borders will continue to facilitate a more joined up approach to Workforce Planning ensuring all relevant stakeholders (internally and externally are involved).

Our Local Workforce Plans will support our newly published Clinical Strategy and outline how we can work differently because of these changes. One example is our Paediatric Hospital at Night service. For this innovative service we have introduced new advanced roles and skill mix between the different professions, to ensure we can sustain our local acute children's health services effectively and safely. Our Clinical Strategy recognises that NHS Borders benefits from a dedicated workforce which is committed to providing the highest quality services for our patients. However our workforce itself is becoming older and we need to plan now how we will address this demographic challenge by the year 2020.

There are 3 key points to be made about our local workforce plan:

1. It describes a range of scenarios tested by using accepted methodologies for workforce planning and workload measurement. We utilise six step workforce planning methodology for line managers and staff involved in a service redesign so a consistent framework applies for the development of the future workforce.
2. Created in partnership with staff and their representatives with discussion at Area Partnership Forum.
3. Workforce projections are based on intelligence gathered from our locally developed workforce tool, which highlights potential workforce changes due to turnover, end of fixed term contracts, potential retirements (crucially based on our age profile), and the out- come of service redesign processes. All service redesign has been subject to a workforce assessment, including risk

	assessment, as part of the project initiation process. Our Workforce Plans incorporate education and training needs assessment and are closely linked with education governance/learning and development strategies. Workforce Risks will be monitored using our existing Workforce Risk Assessment Template as part of all redesign proposals. Workforce risks from ongoing service redesigns are collated onto our central Service Redesign Inventory ensuring management of workforce risks across all services. A significant workforce planning activity in the forthcoming year is the continuing implementation of the new national electronic Employee Support System (eESS). eESS is being rolled out across all NHS Boards to provide a single national HR system. The system is planned to provide: • manager and staff self service (e.g. a benefit is that existing employees will access their own personal details and enable direct electronic updating of changes of address, next of kin etc, reducing paperwork and bureaucracy), • e-payroll interface (reducing the need for paper based payroll instructions), • a national training administration system • an electronic on-line recruitment system. Our staff data has already been migrated from our previous HR system to eESS and the system is “live” in HR Department. All managers have attended an initial training course in preparation for full roll out of eESS as the system will be an important tool for effective people management (e.g. absence and leave management). Online recruitment will be introduced as a core element of the new system, which will modernise our recruitment administration. Our Workforce Plans incorporate education and training needs assessment and are closely linked with education governance/learning and development strategies. Workforce Risks will be monitored using our existing Workforce Risk Assessment Template as part of all redesign proposals. Workforce risks from ongoing service redesigns are collated onto our corporate Service Redesign Inventory ensuring management of workforce risks across all services.

3. Capable Workforce

We see the capable workforce as ensuring that everyone has the skills to deliver safe, effective patient centred care.

In this section we would highlight the **Organisational Training Needs Analysis (TNA)**. We have embarked on a two year programme, developing measures to support managers with assurance that their staff are up to date with statutory and mandatory training and that NHS Borders has sufficient capacity to deliver on training needs. This was very much a partnership endeavour with a sub group of the APF taking the lead in formulation, implementation and evaluation of the programme. In year one the partnership sub-group prepared guidance for line managers on how to update and record training records on EKSF and ensuring monitoring with Statutory and Mandatory training requirements as a feature of departmental performance scorecards. Attention was also paid to the availability and accuracy of local management reports on statutory and mandatory training uptake. Phase 2 has focussed on improved monitoring and ensuring responsiveness to service needs and ensuring sufficient capacity for statutory and mandatory training. In order to do this NHS Borders undertook an Organisational Training Needs Analysis (TNA).

The purpose of the TNA was to establish training needs across NHS Borders and ensure that we create sufficient capacity to meet team and individual statutory and mandatory training requirements. We asked all managers to complete the Training Needs Analysis (TNA) and the communications encouraging participation were sent out from the Chief Executive and Employee Director. Survey monkey technology was utilised for this exercise so responding to the TNA was a swift process and Training and Development personnel were available to support managers with completion both by telephone and face to face visit. The survey was given full executive level and partnership support and there was an encouraging return rate for this type of survey (%). Information obtained has been used to inform the number of training spaces required for each course over the year 2014/2015 to ensure we are reacting to the needs of line managers and staff.

The Statutory and Mandatory training subgroup of the Area Partnership Forum continues to meet on a regular basis to review monitor and to identify methods to be more responsive to service requirements.

NHS Borders has for several years achieved the HEAT Standards for KSF personal development review and KSF PDPs. Managers are supported to do this by service champions who support them to develop realistic trajectories and provide technical support where required. We

	are focussing on quality to ensure that our people have a meaningful face to face conversation with their line manager about performance, development needs and career aspirations. A key commitment in our Staff Governance Action Plan during 2014 – 2015 is to hold a Quality Audit of personal development reviews under KSF utilising recognised tools to measure the impact of appraisals and PDPs. The Senior Charge Nurse Review is an example of where we are building capacity and capability to improve the quality of what we do. NHS Borders are currently piloting having this role as supernumerary and the development of dashboards etc is giving managers information required to improve quality. The Patient Safety Programme and Executive Walkrounds further support our aim to ensure a capable workforce and the exec team use this opportunity to promote corporate objectives, KSF etc. In relation to recruitment NHS Borders are considering introducing mandatory training for managers / recruiting staff re recruitment, and redefining NHS Borders recruitment around caring behaviours and competency based approach. **4. <u>Integrated Workforce</u>** NHS Borders are consulting on revised managerial structures and processes, with a view to providing synergy of services across acute, primary and community services, and a firmer working approach to support patient safety and quality of care for patients. An integrated approach will support discharge planning and patient flow across the system, including with partners from across health and social care, therefore improving the quality of care for our patients. **Specific examples of developing a more integrated workforce include:** • 11 O'Clock Team – Daily patient flow meeting in the BGH. • Community Day Hospitals reference group. • Integrated Workforce Planning and Development Meeting with SBC and NHS Borders • Joint Early Years Network • Joint Learning Disabilities Group • Joint integrated staff forum • Early years assessment team including Surestart midwives **5. <u>Effective Leadership and Management</u>**

	NHS Borders recognises the importance of management and leadership capacity and capability in ensuring the delivery of safe, effective and high quality services for the people of the Scottish Borders and to support the 2020 vision. Using the Engaging Leadership Framework (Beverley Alimo Metcalfe) NHS Borders is committed to promoting and engaging leadership through: • Supporting a developmental culture • Showing genuine concern • Enabling • Inspiring others By building this into local programmes as well as appraisal processes we will ensure that managers and leaders are clear about their role and responsibilities and enable performance to be managed appropriately. In addition the link between engaging leadership and employee engagement will be strengthened through the support of iMatter. Development of further work streams will support the six priority actions identified in the 2020 2015-16 implementation plan, in particular the adoption of value driven approaches, addressing the challenges around middle management and the development of more robust succession and talent management plans. We will continue to support those leading the transition into Health and Social Care Integration. This is likely to involve both individual personal development in leading change in a complex and ambiguous environment, as well as, shared local, regional and national development ensuring collaborative working across health, social care and other agencies. We will continue locally to support our taught programmes with coaching, mentoring, leadership exchanges, 360, action learning and opportunities for embedding skills and knowledge 'on the job' furthering our implementation of a 702010 approach.
Application of nursing and midwifery workload and workforce planning tools	In this past year, NHS Borders have implemented roll out of the nursing and midwifery workload and workforce planning tools - all services review their workload and establishments on an annual basis, and produce a summary report of findings for the attention of the Director of Nursing and Midwifery and the Nursing Workforce Steering Group. An annual report on outcomes is submitted to the full NHS Board to ensure board members are appraised of nursing & midwifery workforce matters. We view use of the planning tools as being an important foundation to balance demands on staff with the supply of staff, to ensure that numbers and skill mix of appropriately trained nursing and midwifery staff are

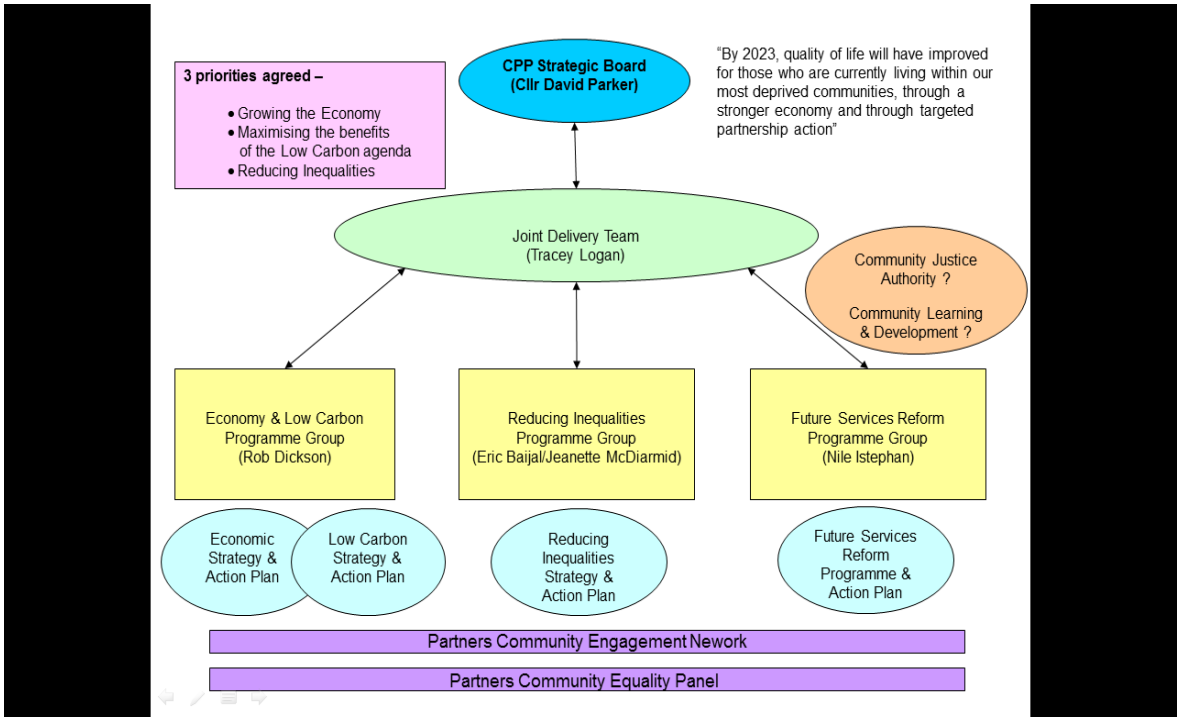
	available, in the right place and at the right time to match service needs. The workforce data obtained helps us understand our workforce and make appropriate decisions about supporting sustainable patient services across the health sector including the redesign of services, available resources, affordability and our clinical strategy. We have implemented new specialty workload and workforce planning tools as they have become available nationally such as the neonatal nursing tool and the community nursing workload tool. Other specialty tools are well established and where there is no available national measurement tool, work has progressed on local workload and workforce planning tools incorporating accepted Time Task Analysis methodology. The Director of Nursing and Midwifery continues this year as a key member of the National Steering Group, ensuring NHS Borders is at the forefront of developments. Where we have found the national tools in need of further development for example, for a Dementia setting, we feedback to national forums for wider sharing and consideration. The current Action Plan for this strand of work is as below:  Nurse and Midwifery Workforce Planning T
Workforce Areas where there is a risk to delivering service	During 2015 NHS Borders will publish a further 3-year Local Workforce Plan in line with the guidance for submission and timetable for workforce planning and workforce projections issued by SGHD. Our Local Workforce Plan will describe a range of scenarios across service areas tested by using accepted methodologies for workforce planning and workload measurement (including the use of Nursing and Midwifery Workload and Workforce Planning tools). We utilise six step workforce planning methodology for line managers and staff involved in a service redesign so a consistent framework applies for the development of the future workforce. All services (clinical and non clinical support services) have either completed or are working on their optimum workforce model through the Productivity and Benchmarking process. A workforce risk assessment model is incorporated in all service redesign plans. The four references regarding workforce risk are best address by citing the example of Borders Emergency Care Services – the Unscheduled Primary Care Service in NHS Borders; which illustrates the need to respond to changing workforce pressures, skill mix approaches and the initiation of service redesign. The service has relied on a Salaried General Practitioner Cohort since inception in 2004 and until recent years, GP applicants exceeded available posts. The vacancy rates are

	now the highest in any service, at present there is an establishment of 10.5 WTE with 2.9 WTE GPs in post and 7.6 WTE vacancies – 75% vacancy rate. We have initiated many on-going recruitment initiatives and rolling advertisements however we have had no applicants in that time. A service redesign was initiated and there have been some service modifications as a result of the workforce challenge. The GP cover has been centralised to a hub at BGH, previously there was some GP presence at peripheral Primary Care Emergency Centres (PCECs) for specified out of hours periods. Additional OOH nurses have been recruited funded from vacancy monies from GP posts (N&MWWP tools used for this purpose and we have devised a more appropriate skill mix). The Out of Hours nursing posts are popular with qualified applicants exceeding vacancies and the staff group is very receptive to role development and extended training. The review of quality measures (primary care contacts, waiting times, 4-hour unscheduled care targets) suggests no dilution in service performance and in fact in some areas improved performance. The one performance target that we will continue to monitor closely is the 1 hour wait for home visit in some of our more remote locations.

Section 3: NHS Borders Contribution to the Community Planning Partnership

Scottish Borders Community Planning Partnership

Scottish Borders' Community Planning Partnership structure can be mapped as shown in the diagram below. NHS Borders' Chair and Vice Chair sit on the CPP Strategic Board with the Chief Executive Officer. Members of NHS Borders' Executive Team sit on the Joint Delivery Team with oversight of the 3 programmes of work: Economy and Low Carbon; Reducing Inequalities and Future Services Reform. The Director of Public Health has led the Reducing Inequalities strand.



This section summarises key tangible contributions that NHS Borders plans to make during 2015/16 towards improved outcomes. These are grouped under 3 priority areas below. Each strand has its own monitoring structures in place to check on progress throughout the year.

Priority	**NHS Board Contribution in 2015/16**	**Current and Planned Performance Levels**
Growing the economy	<u>Workforce</u> Maximising the potential of the NHS workforce through: • Workforce Planning to develop the workforce and align resources with anticipated future demand and priorities. • Supporting workforce health & well-being and productivity • Participation in a scheme to provide jobs, including modern apprenticeships for one year to young people, particularly those from a disadvantaged background. NHS Borders has a relatively low staff turnover NHS Borders' *Health Improvement Strategy for the Working Age Population* recognises that work is a key determinant of health and continues to progress a range of activity that supports this agenda: • Work and wellbeing services designed to keep people at work and support those returning to work. • Rapid access to vocational rehabilitation through Workplace Health Services initiative. • Workplace Health promotion including the Healthy Working Lives Award scheme. • Development of a support pathway and signposting	<u>Key local deliverables in 2015-16</u> • As services are reviewed through our integrated Workforce Planning and Productivity and Benchmarking Process, optimum staffing levels are agreed based on nationally/locally developed workload tools leading to more efficient and effective patient outcomes. <u>Key local deliverables in 2015-16</u> • NHS Borders will progress outcomes of Age as an Asset research conducted by NES to support employees to continue to work. • The Borders Leadership Programme will continue in 2015/16 to motivate and develop the leadership cohort. • NHS Borders Work Place Health Services will continue to expand the number of organisations accessing support and engaging in services.

Priority	NHS Board Contribution in 2015/16	Current and Planned Performance Levels
	resource for healthcare workers to support those to whom health is a barrier to attaining, retaining or returning to work. <u>Infrastructure and economic development</u> Engagement through the CPP and the Transport Commissioning Board of which NHS Borders is a key stakeholder will lead to the development of an effective local infrastructure for Scottish Borders that will provide basis for economic development through the new Borders railway and faster broadband. A stronger infrastructure will contribute to the attraction and retention of staff and provide a platform for increased use of technologies in delivery of health care and related information and advice. <u>Employment</u> The NHS has a role, with other partners, in promoting employability by providing training and work opportunities for those seeking entry or returning to the labour market and by maximising the retention of staff who have or develop health conditions.	<u>Key local deliverables in 2015-16</u> • The Chief Executive of NHS Borders sits on the Broadband Project Board. • The Transport Commissioning Board's priority is to ensure that demonstrable improvements are made to overall commissioning and delivery of transport activity locally. This will include: capturing an accurate picture of transport activity in the Borders, e.g. spend across the CPP, developing community needs and staff involved; assessing whether the overall transport needs are matched to what is provided; explore and exploit opportunities for improved collaboration across passengers, vehicles, systems, commodities, suppliers, training and best practice development in transport and travel such as the Borders Railway and health and social care integration. <u>Key local deliverables in 2015-16</u> • NHS Borders is working with Skills Development Scotland and Borders College to provide training for work opportunities as part of the 'Get Ready for Work' (GRFW) scheme. A partnership agreement will be developed with Scottish Borders Council to encompass all

Priority	NHS Board Contribution in 2015/16	Current and Planned Performance Levels
	In collaboration with partners, NHS is working to ease access to work for patients with a range of conditions including those with mental health problems, learning disability and alcohol or drug issues. NHS Borders are involved in the Joint Staff Forum with Scottish Borders Council.	elements of employability. • Recent discussions have been held with Job Centre Plus to explore further opportunities to support people into employment through the Job Centre Plus sector based work academy scheme within care. Additionally we are offering opportunities in Estates and Facilities who are facing particular aging workforce demography challenges. • 10 young people have recently been selected to commence placements including in Admin, Catering and Estates and 3 for the Care Services programme as Health Care Support Workers. <u>Key local deliverables in 2015-16</u> • Implementing the Joint Development Strategy.
Health inequalities and physical activity	<u>Health Inequalities</u> Borders Healthy Living Network is managed through Public Health in NHS Borders and facilitates a range of health improvement programmes in 5 high deprivation communities across Borders. Priorities are identified in partnership with local communities. Current activities are focused on:	<u>Key local deliverables in 2015 -16</u> • Active partnerships with local communities to review priorities and planned activities • Continued engagement of community health volunteers • Achievement of target adult learning outcomes through health improvement programme participation. • Targeted work with key sectors and communities: older people; young mothers;

Priority	NHS Board Contribution in 2015/16	Current and Planned Performance Levels
	Food and health; building social connectedness; strengthening community capacity through opportunities for volunteering for health; poverty and health; mental health and wellbeing, and growing and cooking. Inequalities related funding is used to reduce barriers to participation in health improvement activities through subsidised access, more local / targeted delivery of specific programmes and by developing more effective partnerships for delivery of support <u>Health Inequalities and Learning Disabilities</u> A health needs assessment for people with learning disability has been undertaken by Public Health in collaboration to inform planning and service development for this population. Health improvement for people with learning disability remains a priority, building on effective work on relationships and sexual health and healthier lifestyles. People with LD, carers, and staff from a range of services are actively involved. <u>Physical activity</u> Active travel is promoted where applicable e.g. through cycle purchase schemes for NHS staff. A range of initiatives is promoted and activities are promoted for NHS staff including subsidised exercise classes and Team Challenge programmes.	fathers and their children. <u>Key local deliverables in 2015 -16</u> • Partnership programmes to continue to improve access to appropriate resources that support decisions and choices about relationships, sexual health and keeping safe. • Development of capacity within service provider organisations to champion and lead work on nutrition and active lifestyles <u>Key local deliverables in 2015-16</u> • Development of NHS Active Travel plan. • Continued support for staff health and wellbeing through physical activity initiatives. • Develop physical activity pathways from appropriate NHS settings (including Secondary

Priority	NHS Board Contribution in 2015/16	Current and Planned Performance Levels
	NHS Borders has implemented a physical activity pathway from Primary Care through the Lifestyle Advisor Service <u>Tobacco</u> NHS specialist smoking cessation advisor resources are focussed on areas of higher deprivation with good outcomes. The service also promotes Smoke Free homes using a range of methods. NHS Borders are developing a Joint Tobacco Control Strategy. Revision of NHS Borders Tobacco policy has extended smoke free grounds to all NHS estate. Smoking Cessation support in pregnancy has been reviewed as part of an integrated approach to antenatal parent education and support, with maternity and primary healthcare services and non NHS community services. <u>Health screening</u> Over 2014/15 a DCE awareness raising programme was delivered amongst networks working with deprived	Care) to community based activity opportunities. • Workforce development to support delivery of physical activity pathways. <u>Key local deliverables in 2015-16</u> • Development of Joint Tobacco Control Strategy action plan and implement. • Further develop roll out of tobacco pathways in secondary care • Implementation of referral pathway for pregnant women <u>Key local deliverables in 2015 - 16</u> Key deliverables for the DCE programme will include embedding this improved knowledge and awareness into routine processes and assessments within

Priority	NHS Board Contribution in 2015/16	Current and Planned Performance Levels
	communities and staff working with vulnerable groups, including those with mental health problems or learning disabilities. Key aims were to promote uptake of cancer screening opportunities, increase awareness of warning signs and symptoms, and encourage those with concerns to make early contact with health services. A staff survey about bowel screening was also carried out to inform future approaches. <u>Mental Health and Physical Health</u> Development work is being undertaken to identify opportunities for prevention, early intervention and supported self management to improve the physical health outcomes of mental health service users. <u>Joint Older Peoples Needs Assessment</u> The older people's health needs assessment along with the joint commissioning has highlighted opportunities for early intervention, prevention and health improvement with this age group. This is being used to inform planning within the new integrated structures for adult health and social care, feeding into the Strategic Plan.	community teams and networks; encouraging staff to anticipate possible barriers to uptake of screening; and helping patients/clients to overcome these barriers where possible. <u>Key local deliverables in 2015 -16</u> • Better information on health needs and on pathways and roles and responsibilities • Delivery of selected health improvement programmes targeted at this group on key topics • Workforce development to support delivery of screening and health behaviour change interventions. <u>Key local deliverables in 2015 -16</u> • Implementation of the Public Health led Change Fund project on management of long term conditions in primary care, in partnership with the voluntary sector, will continue to end of 2015, generating important learning on sustainable approaches • Commissioned work will be undertaken to maximise capacity for health improvement using Integrated Care Funding

Priority	NHS Board Contribution in 2015/16	Current and Planned Performance Levels
	<u>Joint Day Services Transport</u> Joint Day Services transport provision between NHS Borders and Scottish Borders Council is being implemented for older people. This also involves liaison with the Scottish Ambulance Service. NHS Borders has senior representation on the Community Planning Partnership Theme Group which is proving pivotal in developing a Scottish Borders Inequalities Strategy and Action Plan. Strategic aims will include shifting the balance of resource and targeting it. The intention is to, at least in part, take this forward through the new Integrated Health and Social Care Partnership.	<u>Key local deliverables in 2015-16</u> • Shorter travelling times for patients and shorter sessions at the day service will be the main patient benefits.
Early years and early intervention	<u>Early Years</u> Local partners continue to working towards the 'stretch aims' set by the Early Years (EY) Collaborative to reduce infant mortality and increase the achievement of child development milestones. This is framed in the context of the locally defined objectives of the joint Early Years strategy, to develop integrated local systems of information, advice and support for parents and to strengthen community capacity. The first two Early Years	<u>Key local deliverables in 2015 -16</u> • The established Early Years networks are now being reviewed to give clearer focus on service improvement • The staged implementation of a locality model of Early Years provision continues with 2 further Early Years Centres to become operational in 2015 -16 • Implementation of national Psychology of Parenting programme will continue • Introduction of Family Nurse Partnership

Priority	NHS Board Contribution in 2015/16	Current and Planned Performance Levels
	Centres began operation in 2014 -15. Public health nursing services provide a key role in the leadership and development of local Early Years networks to support families from pregnancy working alongside community midwives and other partners. These professionals have been actively involved in a collaborative to improve breastfeeding rates at 6 to 8 weeks to 50% by the end of 2016/17. This has been well supported by advocacy from local elected members. The NHS Early Years Change Fund monies support key activities and resources that contribute to the jointly agreed outcomes, in relation to dental health, nutrition, healthy weight, maternal health and antenatal and postnatal parenting support. Data from the 24 – 30 month reviews are enabling early identification of concerns and opportunities for early intervention in particular aspects of child development, e g nutrition and speech and language. <u>Promoting Healthy Weight</u> Public Health (PH) leads on the implementation of a range of cross cutting actions to promote healthy weight for Borders population. Very much of this relies on collaboration with the Children and Young People's team	programme from summer of 2015 • GIRFEC is now being embedded in practice of maternity and community health staff • Improvement methods are being used to implement pathways of support for women who have increased health and social risks including: smoking in pregnancy, poor nutrition and alcohol or drugs related issues • Improved identification of families affected by financial and benefits concerns to ensure effective signposting from health care to financial advice and support. In 2015 – 16 this will include awareness raising and capacity building with health visitors and midwives. This is supported through SG Health and Welfare Development funding for 12 months • Planning for the new universal pathway will incorporate opportunities and resources to improve health and reduce health inequalities <u>Key local deliverables in 2015 -16</u> • Support towards national outcomes to reduce obesity and overweight at population level and with defined target groups • Community based programmes on healthy eating and active living in areas of high deprivation, supported by toolkit of resources

Priority	NHS Board Contribution in 2015/16	Current and Planned Performance Levels
	within the Council as well as the local sports and leisure trust. The aim is particularly target children and families from more disadvantaged backgrounds in a non-stigmatising way. PH and Dietetics services deliver a range of programmes and interventions on nutrition, weight management and health behaviour change across age groups and settings. A cross service working group involving SBC Education, Catering services and PH is identifying options to improve nutrition for children in school. Tailored training and awareness raising sessions on food and health are being delivered for community based staff and volunteers working with a range of vulnerable groups and this is being developed through adult health and social integration. With wider partners, PH facilitates opportunities for local food networking and awaits with interest the outcome of the consultation on a Good Food Nation. <u>Suicide Prevention</u> The multiagency local suicide prevention action plan, led by the Joint Health Improvement Team, in partnership with NHS services and wider partners was reviewed and updated in 2014, in the light of the national strategy (2013).	and materials • Support improvement planning by schools to integrate national guidelines on nutrition in schools and the food environment around schools. • Further development of training programmes for social care staff, carers and volunteers in learning disabilities on nutrition and food hygiene, with extension to mental health and other care settings as opportunity arises • Support local Food Networks to facilitate access to sustainable food and encourage local growing and skills development. <u>Key local deliverables in 2015-16</u> • Implementation of new action plan on suicide prevention. • Revised training and development programme for frontline staff and community members • Qualitative research to understand the experiences of those who present to A&E in distress. The outputs from this work will be used to inform improvements in access to

Priority	NHS Board Contribution in 2015/16	Current and Planned Performance Levels
	Newly available data on suicide risk within our local population informs priorities for implementation, with particular attention to men of working age Joint guidelines on supporting and managing young people at risk of self harm have been agreed. The successful pilot of a schools prevention programme piloted is being used to develop a whole school approach to social and emotional wellbeing. <u>Anticipatory Care</u> The integrated programme of anticipatory care in NHS Borders brings together lifestyle advice, inequalities targeted health checks and weight management programmes, based in primary care. Work These combined services provide effective screening and assessment to identify early risk of diseases including CVD and diabetes. An option appraisal has been conducted to ensure sustainability in view of the reduction planned in national Keep Well funding. <u>Young people</u> Health Improvement work focused on vulnerable young people is a key component of the work programme led by the JHIT in support of joint Children and Young People's Services Plan:	support and in the quality of service delivery • Roll out of young people and men's programmes supported by Public Health. <u>Key local deliverables in 2015 -16</u> • Implementation of sustainable model of anticipatory care that retains key aspects of inequalities targeted health checks with vulnerable groups <u>Key local deliverables in 2015 -16</u> • Support for the implementation of the refreshed SHARE programme and associated prevention initiatives in schools and youth settings across Borders. • Continued delivery of CHW and related programmes to increase engagement in

Priority	NHS Board Contribution in 2015/16	Current and Planned Performance Levels
	• Tobacco prevention, in partnership with Community Learning. • Sexual health and relationships in partnership with Education and third sector youth work services • Nutrition and Child Healthy Weight (CHW) • Young carers' health and wellbeing <u>Mental health and wellbeing</u> Joint Health Improvement Team supports mental health promotion and prevention in support of recent mental health needs assessment and proposed mental health strategy. <u>CAMHS</u> The service now responds to young people up to age 18 (previously 16). This is intended to assist with transition into adulthood and to reflect the model of service delivery available elsewhere in Scotland.	physical activity and healthy eating • Tailored risk reduction and health improvement with vulnerable young people including young carers and looked after young people, in line with priorities in joint Children and Young People's services plan. <u>Key local deliverables in 2015 -16</u> • Priorities to be agreed for promotion and prevention within new local mental health strategy • Feasibility project planned to improve access to information and support for those at risk of poor mental health /suicidal behaviour, including men of working age <u>Key local deliverables in 2015-16</u> • The service is working towards more partnership working with children and young people by way of focus groups and satisfaction feedback using new technology, as well as current questionnaires. • The CAMHS Integrated Care Pathway will provide a more streamlined access to the service and assessment and treatment will be evidence based and effective. Outcome measures will continue to be used to evaluate this. • To continue to achieve national waiting times for the service. • Implementation of multi agency guidelines on

Priority	NHS Board Contribution in 2015/16	Current and Planned Performance Levels
	<u>Alcohol and Drugs</u> Whole population approach to Alcohol and Drugs misuse. The ADP will continue to support work to reduce substance misuse related problems locally through: • Delivery of Alcohol Brief Interventions (ABIs) in priority and wider settings. • Active membership of Local Licensing Forum.	prevention and management of self harm among young people. <u>Key local deliverables in 2015-16</u> • Delivery of 1,312 ABIs in Borders • Review of ABI delivery in current Social Work settings and roll-out to Integrated Children's Services and Learning Disability. • Update of young people's guidance for provision of injecting equipment. • Development and delivery of action plan to support substance misuse education.

Section 4: LDP Standards

NHS Borders will continue to maintain the standards below. Performance will be monitored on an ongoing basis. 18 indicators showing performance towards the 9 outcomes for Health and Social Care Partnerships continue to be developed. Once these are in place they will become part of the performance management cycle for NHS Borders and the partnership.

Identifier	Standard
Cancer	People diagnosed and treated in 1st stage of breast, colorectal and lung cancer (25% increase)
CWT	Cancer Waiting Times: 31 days from decision to treat (95%) 62 days from urgent referral with suspicion of cancer (95%)
Dementia	People newly diagnosed with dementia will have a minimum of 1 year's post-diagnostic support
TTG	12 weeks Treatment Time Guarantee (TTG 100%)
18WKRTT	18 weeks Referral to Treatment (RTT 90%)
12Week	12 weeks for first outpatient appointment (95% with stretch 100%)
Antenatal Services	At least 80% of pregnant women in each SIMD quintile will have booked for antenatal care by the 12th week of gestation
IVF	Eligible patients commence IVF treatment within 12 months (90%)
CAMHS	18 weeks referral to treatment for specialist Child and Adolescent Mental Health Services (90%)
PsyTher	18 weeks referral to treatment for Psychological Therapies (90%)
CDI	Clostridium difficile infections per 1000 occupied bed days (0.32)
SAB2	SAB infections per 1000 acute occupied bed days (0.24)
Drug&Alc	Clients will wait no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery (90%)
Alcohol	Sustain and embed alcohol brief interventions in 3 priority settings (primary care, A&E, antenatal)and broaden delivery in wider settings
Smoking	Sustain and embed successful smoking quits, at 12 weeks post quit, in the 40% SIMD areas
GPAccess	48 hour access or advance booking to an appropriate member of the GP team (90%)
Sickness	Sickness absence (4%)
4HourA&E	4 hours from arrival to admission, discharge or transfer for A&E treatment (95% with stretch 98%)
Breakeven	Operate within agreed revenue resource limit; capital resource limit; and meet cash requirement

LDP standard performance will be monitored bi-monthly through the LDP Standard Performance Scorecard presented to each Borders Health Board public meeting. These will be available after the meetings on the NHS Borders website as part of the public board meeting papers.

LDP Standard: 12 Weeks for First Outpatient Appointment

The following trajectory has been agreed for the Board to reach the target of all patients to seen for their first outpatient appointment within 12 weeks of referral.

Ongoing Waits: % of Patients waiting under 12 weeks for a New Outpatient Appointment: Month Ending	**Borders**
31-Jul-14	**96.6%**
31-Aug-14	**93.6%**
31-Sep-14	**91.0%**
30-Apr-15	90.0%
31-May-15	92.0%
30-Jun-15	95.0%
31-Jul-15	95.0%
31-Aug-15	96.0%
30-Sep-15	97.0%
31-Oct-15	98.0%
30-Nov-15	99.0%
31-Dec-15	100.0%
31-Jan-16	100.0%
29-Feb-16	100.0%
31-Mar-16	100.0%

Appendix 1: Key Local Plans

NHS Borders has a broad range of local plans and strategies that are being delivered and developed across the organisation. Below is a matrix containing a (by no means exhaustive) list of plans/strategies in place locally that impact upon the delivery of the 12 priority areas of the 2020 Vision. This further demonstrates the interconnected nature of these priority areas and emphasises the necessity of collaborative working.

Priority Area Local Plan/Project/ Strategy	Person-Centred Care	Safe Care	Primary Care	Unscheduled and Emergency Care	Integrated Care	Care for Multiple and Chronic Illnesses	Early Years	Health Inequalities	Prevention	Workforce	Innovation	Efficiency and Productivity
Local Unscheduled Care Action Plan (LUCAP)		X	X	X	X					X		
Connected Care	X	X	X	X	X	X			X	X	X	X
NHS Borders Patient Safety Programme	X	X	X	X		X	X				X	X

Stroke Care LDP Action Plan		X		X					X			
Joint Early Years Strategy	X	X	X				X	X	X	X		
NHS Borders Child Health Strategy	X	X	X				X	X	X			
Maternity Care Action Plan	X	X					X	X	X			
NHS Borders Research Strategy	X	X			X	X		X		X	X	X
NHS Borders Clinical Strategy	X	X	X	X	X	X	X	X	X	X	X	X
NHS Public Involvement Strategy	X	X	X	X	X	X	X	X	X	X	X	X
Reducing Inequalities Strategy	X	X	X	X	X	X	X	X	X			

Borders NHS Board

NHS BORDERS – 2015/16 FINANCIAL PLAN

Introduction

A proposed financial plan has been submitted to SGHSCD in March, as required, as part of the Local Delivery Plan submission. This was subject to approval of the financial plan by the Board on the 2nd April 2015.

The plan covers the next three financial years for revenue and five financial years for capital. The Scottish Government has agreed a one year budget for 2015/16 as a comprehensive spending review is planned during this year.

An integral part of the financial plan is the Efficiency Programme, which currently consists of a series of detailed projects with estimated cost savings, which will be taken forward during the course of 2015/16.

Aim

The purpose of this paper is:-

- **Section 1** - to provide an overview to Board members of the key elements within the revenue financial plan for 2015/16.
- **Section 2** - to explain how it is proposed to address the cost savings challenge which the Board faces in order to achieve a balanced financial outturn in 2015/16.
- **Section 3** - to highlight key assumptions and financial risks.
- **Section 4** - to broadly outline the scale of the financial challenge which the Board is likely to face in 2016/17 and 2017/18 based on information that is currently available.
- **Section 5** - to provide an overview to Board members of the key elements within the capital plan.

Background

The financial challenge that the public sector is embracing is clear and well understood. It is essential that our services are provided and developed appropriately within the financial envelope available and for which the Board is responsible. In order to continue to deliver quality patient care the organisation must keep a firm grip on its finances as well as drive improved quality and efficiency which is critical to service delivery and public credibility. That means having a clear focus that is firmly and openly set on providing patient care that is safe, effective and affordable and includes efficiency plans and goals.

Section 1 - Overview of 2015/16 Financial Plan

(a) Financial Summary

A high level overview of the Board's financial plan for 2015/16 is provided below in Table 1. This shows the overall movement in both recurring and non-recurring funding and expenditure which are anticipated in 2015/16.

TABLE 1 FINANCIAL OVERVIEW

	Funding £000s	Expenditure £000s	Surplus/ (Deficit) £000s	*Note*
Base budget carried forward from 2014/15	**224,931**	**224,931**	**0**	
Recurring funding and expenditure items for 2015/16				
General funding uplift	3,248			
Other Funding Uplifts	3,193			
Projected spending growth		11,561		*See appendix 1*
Recurring cost savings		(5,120)		*Requirement for 2015/16*
	6,441	6,441	0	
2015/16 budget excluding non-recurring funding and expenditure items	**231,372**	**231,372**	**0**	
Non-recurring funding and expenditure items for 2015/16				
Non-recurring cost provisions		1,791		*Specific expenditure items*
Non-recurring cost savings		(1,791)		*Requirement for 2015/16*
	-	0	0	
2015/16 BUDGET	**231,372**	**231,372**	**0**	

(b) Salient Points

A number of key points are important to draw out from the above summary of the Board's 2015/16 financial plan. These are:

i) The Board is able to present a balanced financial plan for 2015/16. However, due to the shortfall in the level of recurring savings identified NHS Borders will achieve balance by delivering additional non recurring cost savings. The recurring deficit

will be carried forward into 2016/17 unless measures to address this are agreed during the course of 2015/16.

ii) The projection of recurring expenditure growth of £11.561m is the aggregate of a range of additional expenditure commitments which the Board is required to meet in 2015/16. Appendix 1 sets out a full list of these additional expenditure commitments. Following review by a shortlife working group these were considered and recommended by the Clinical Executive Strategy Group to be funded. These are unavoidable rather than discretionary commitments.

iii) Short term non recurring funding has been identified in 2015/16 to support the Efficiency Programme and medical staffing issues.

v) There is a sum of £1.0m recurrently and £1.0m non recurrently identified as a contingency in order to manage potential pressures arising during the year. This is set aside given the experience of the organisation previously in managing unforeseen clinical pressures but also to provide sufficient space in which to gain momentum around the efficiency agenda.

vi) Any amendments to the 2015/16 budget will be highlighted to the Board within the regular in year reporting.

vii) As recurring savings targets were over achieved in 2014/15 the savings challenge for 2015/16 is directly related to the funding levels and expenditure commitments identified in the new year. This overachievement will offset the new year's recurring target.

(c) **Funding Uplift**

For 2015/16, SGHSCD has confirmed a funding uplift of 1.8% (£3.248m), plus an uplift linked to the Integrated Care fund 0.2% (£0.401m), new drugs 0.4% (£0.737m) and to address the financial pressures to support the Emergency Department and patient flow 0.4% (£0.639m). Taking all of the above into account the resource allocation for territorial Boards overall has been uplifted on average by 3.8% with a range from 2.8% to 15.4%.

(d) **Expected Expenditure Growth**

As noted above, a full summary of the Board's recurring expenditure projections for 2015/16 is provided at Appendix 1. This explains the approach which has been taken in preparing expenditure growth estimates for each of the main cost drivers and provides background information on key assumptions.

Section 2 - Cost Savings Challenge 2015/16

A key element of the Board's plan to achieve a financial breakeven outturn in 2015/16 will be its efficiency savings programme. The following provides an overview of the programme for 2015/16 and how the Board will approach this challenge.

(a) **Level of Challenge**

NHS Borders must deliver substantial efficiencies in 2015/16 of £6.911m, of which a minimum of £5.120m should be recurrent. Scottish Government set an overall efficiency target of 3% which can be both cash releasing efficiency and non cash releasing schemes. In 2015/16 NHS Borders cash releasing efficiency target equates to 3.66%.

(b) **Approach**

The Board approach continues to be delivery of the required savings through an efficiency savings programme, rather than assigned targets.

The programme for 2015/16 has been developed over the last six months in conjunction with the Clinical Boards, the Clinical Core Strategy Group and other key groups across the organisation.

Table 2 below is a summary of the 2015/16 programme categorised by risk to delivery of savings. For the majority of the schemes detailed below project documentation has been completed and reviewed by the Strategy Group.

There will be a continued intense focus on efficiency and productivity by the Clinical Executive, who will be the main delivery vehicle for this agenda, which will support the delivery of value for money and effective patient care. Monitoring of the programme will be undertaken by the Quality and Efficiency Board.

The Financial Position Oversight Group, a Sub Committee of the Audit Committee, which includes in its membership both Non Executive and Executive Directors of the Board, will receive an update on the efficiency programme at each of its meetings. The Group will also consider in detail schemes where progress has not been as expected.

TABLE 2 2015/16 EFFICIENCY PROGRAMME PROJECT AREAS

Low Risk to Savings Delivery- £2.772m

- Support Services
- Improved Procurement
- Travel Reduced Rates
- Estates Rationalisation
- LD Services
- Suspend Clinical Excellence

Medium Risk to Savings Delivery £2.965m

- Medicines Management and Wastage
- Repatriation
- Non Support Services Admin

High Risk to Savings Delivery £1.174m

- Income Generation - Activity
- Income Generation – Research and Development

(c) **Delivery**

Each scheme will be run as a project, with individual project sponsors responsible for developing and delivering a project plan with key milestones. All projects will be proactively managed through the Aspyre system.

For each project a Project Initiation Document, project plan and savings trajectory has been or will be approved by the Clinical Executive Strategy Group. The strategic direction of the organisation will continue to be progressed by the Clinical Executive Strategy Group taking into account issues of service redesign, modernisation and continuous service improvement.

As schemes are agreed the project plan implementation and savings trajectory will be monitored through the Quality and Efficiency Board and expected to deliver. The Quality and Efficiency Board will receive monthly updates on all plans thereby ensuring any need for corrective action is taken promptly and will report routinely to the Clinical Executive Operational Group.

(d) **Recurring Savings**

Work will continue during the course of the financial year to identify schemes to address the level of recurring savings which are required to be covered non recurrently this financial year. The Board Strategy and Performance Committee will receive an update on progress at each of its meetings.

Section 3 - Key Assumptions and Financial Risks

The key assumptions on which the Board's financial plan for 2015/16 has been based are described within Section 1 above. In addition Appendix 1 describes the assumptions used to project recurring expenditure growth in 2015/16.

There are assumptions which are of particular significance in terms of potential financial risk. These are discussed below, together with an assessment of the likely risk.

(a) **Pay Growth**

Pay Awards for 2015/16 have been finalised. The pay award costs have been calculated at £250 per person for staff earning below £21k, a 1% increase in pay for all staff and the cost of increments as per current terms and conditions – LOW.

(b) **Prescribing Cost Growth**

Detailed work on the projection of increases in costs and volumes and the impact of new drugs and protocols has been prepared by the Board's prescribing advisers for 2015/16. Benchmarking comparisons between Boards on drugs costs and the level of uplift has also been undertaken. Following consideration of all of this an uplift of 12.52% on drugs costs has been set for 2015/16. This uplift assumes that NHS Borders will receive funding from the centrally held new medicines fund to offset some drugs costs. A Short Life Working Group has been convened nationally to establish on how the new medicines fund will be allocated between Boards. Drugs costs will be an area which will continue to be closely monitored during 2015/16 and the past experience of unanticipated pressures arising during the year informs the risk assessment – HIGH.

(d) **Out of Area Referrals**

In the case of out of area referrals, for both acute and non acute, work is ongoing to ensure that all referrals are appropriate and necessary. Good progress has been made

in this area, however due to increased demand this will continue to be a financial pressure in the new year – HIGH.

(e) **Non Pay Uplift**

Non-pay uplift has been estimated at 1.5% for 2015/16. This funding has been set aside in the financial plan but with the support of the Clinical Executive Strategy Group will not be allocated to Clinical Boards and departments. This will require services to manage any inflationary pressure on their supplies costs by reducing wastage or increasing efficiency – HIGH.

(f) **Cost Pressures**

Service cost pressures identified during 2015/16 have been reviewed by the Clinical Executive Strategy Group and on their recommendation only national/SEAT initiatives, External Contracts and recommendations from Productivity and Benchmarking will be funded. There is the risk that pressures not funded, if corrective action is not taken, will become an operational overspend – HIGH.

(g) **Discretionary Spend Controls**

The discretionary spend controls that were put in place previously will remain in place for the foreseeable future in order to support the financial position – LOW.

(h) **Efficiency Delivery Plan**

The financial plan, as outlined at Section 1, requires the delivery of efficiencies of £6.911m to achieve financial balance for 2015/16. Individual schemes within the programme have been identified and are being progressed. The overall level of efficiency required means that this will be extremely challenging. If the recurrently unmet recurring savings target is not addressed by the end of the financial year this will impact on financial challenge of future years. Delivery of efficiency remains the greatest financial risk – HIGH.

Section 4 - 2016/17 and 2017/18

A summary of the Board's outline financial plan for 2016/17 and 2017/18 is provided at Appendix 2. As the Scottish Parliament has agreed a one year budget for 2015/16 these figures should be considered indicative and could change following the planned comprehensive spending review. The plan is based on a series of assumptions regarding expenditure growth. As the allocation figures are indicative and the impact of the spending review is unknown it is difficult to plan with certainty beyond 2015/16, therefore the figures for future years should be considered only a broad outlook at present.

(a) **Funding**

At this stage, the financial plan assumes that the base uplift for 2016/17 and 2017/18 will be 1.8%. These figures should be considered as indicative for planning purposes.

(b) **Expenditure**

The main planning assumptions used to forecast likely future expenditure growth for 2016/17 and 2017/18 are as follows:

	2015/16	2016/17
Revenue Growth	1.8%	1.8%
Pay Awards	1.0%	1.0%
Non Pay Inflation	1.5%	1.5%
Income	1.8%	1.8%
Drugs	6.0%	6.0%
Capital Growth	0%	0%

(c) **Financial Challenge**

Based on the assumptions set out within 4(a) and 4 (b) above, and after providing for currently approved service commitments including a general provision of £2.0m for as yet unidentified cost pressures, the Board would face a financial challenge of £6.4m and £4.87m in 2016/17 and 2017/18 respectively. In addition if the recurring savings met non recurrently in 2015/16 have not been addressed this will increase the size of the challenge by a further £0.7m until recurrently met.

Section 5 - Overview of 2015/16 Capital Plan

(a) **Financial Summary**

The development of the current 5 year rolling capital plan has been under the direction of the Capital Planning Group which is chaired by the Director of Finance with membership from a variety of key stakeholders within the organisation.

In terms of capital, NHS Borders has had to pare down its plans as capital funding has significantly reduced in recent years. Capital investment is key to the delivery of safe and effective patient care and to releasing significant efficiency gains from the rationalisation of the estate and supporting service redesign. The Board continues to improve the link to the SAFR report, recognise the information which will be available from the developing Property and Asset Management Strategy, and as a result NHS Borders has committed resource over the duration of the plan to address priority areas.

The capital plan is in line with the 2015/16 allocation letter adjusted following recent discussions with SGHSCD and reflects the slippage of £500k planned capital expenditure from 2015/16 into 2016/17 to support the national capital programme. NHS Borders welcomes the inclusion of Roxburgh Street, Galashiels and the final phase of the clinical strategy within the capital allocation. It has been agreed that capital receipts generated during 2015/16 will be retained by NHS Borders for local investment. This reflects the situation that properties which were declared surplus during 2014/15 due to market conditions and management of the year end will not be transacted until 2015/16.

Beyond the period of the recent allocation letter from Scottish Government the level of formula has been assumed to be similar to that of 2015/16. It has also been assumed that beyond 2015/16 additional resources will be allocated to NHS Borders to support a number of priority areas including investment in IM&T infrastructure, primary care premises and women's and children's services. If this additional funding does not materialise there will be a significant detrimental impact on the prioritised capital plan.

Work is ongoing to generate £5.5m of charitable funds to support the creation of a Children's and Young Person's Centre on the site of the Borders General Hospital.

Appendix 3 summarises the Board's 2015/16 capital plan. The Capital Planning Group will continue to work to progress development of schemes connected to the patient safety agenda, efficiency and estate rationalisation. The Board will receive an update on the capital plan in June and December.

Recommendation

The Board is requested to **review** this report and **approve** the 2015/16 financial plan and **note** the indicative outline of the financial challenge in 2016/17 and 2017/18.

Policy/Strategy Implications	The Board must agree the financial plan. This report sets out an overview for the 2015/16 year and indicative outline for 2016/17 and 2017/18. The financial plan underpins the strategy of the Board. It impacts upon delivery of statutory financial targets.
Consultation	Regular briefings on the financial outlook are provided to the S&P Committee, Board Executive Team, Strategy Group, Clinical Executive, Clinical Boards and other senior groups throughout the year.
Consultation with Professional Committees	Briefings and discussions are ongoing.
Risk Assessment	The Board has a statutory requirement to remain within its funding limits. Risks are highlighted in the paper and will be reported upon throughout the year.
Compliance with Board Policy requirements on Equality and Diversity	Relevant issues should be addressed in the development of detailed plans and business cases.
Resource/Staffing Implications	Resource implications are described throughout the report.

Approved by

Name	Designation	Name	Designation
Carol Gillie	Director of Finance		

Author(s)

Name	Designation	Name	Designation
Janice Cockburn	Deputy Director of Finance	Susan Swan	Deputy Director of Finance

APPENDIX 1 – 2015/16 FINANCIAL PLAN – PROJECTION OF RECURRING REVENUE EXPENDITURE GROWTH

Each of the main drivers which influence expenditure has been reviewed to assess and project the level of provision which requires to be made for additional expenditure.

These are categorised as follows within the Board's financial plan:

(i) **General:** general cost increases which are driven by factors such as pay awards, non-pay inflation, prescribing growth, scale of capital programme etc.
(ii) **National Initiatives**: where there is an impact on NHS Borders services.
(iii) **Service Development:** cost increases previously agreed which are driven, in the main, by decisions made at local or regional level involving NHS Borders, to fund local service development/improvement.

On the basis of currently available information, the Board's assessment of the anticipated expenditure growth it faces going into 2015/16, within each of these categories, is set out below:

Area of expenditure growth Projected	**Projected Increase £000s**	***Notes***
(i) General		
Pay Inflation	2,378	*Includes £1.2m for increased employers superannuation costs plus 1% for all other staff and an additional increase for those on low pay*
Prescribing cost growth/ inflation.	3,509	*Current projections by prescribing advisers of likely cost increase related to volume and price increases within Acute and Primary Care before cost savings initiatives Includes additional funding which it is assumed will be received from the New Medicines Fund.*
Capital expenditure programme	202	*Reflects the capital programme and the associate revenue costs*
Non pay uplift	586	*Provision for general inflation increase of 1.5%*
Other providers	524	*Estimated provision for inflation increase on all contracts with external providers subject to negotiation but assumed at 1.8%*
Primary Medical Services	108	*Increased estimate at 1% assumed this will be cost neural*
TOTAL	**7,307**	
(ii) National Initiatives		
Support Emergency Department and Patient Flow	639	*NHS Borders has been allocated funding to deal with this pressure*
Integration Fund	401	*Funding to be utilised for integration to add to resources previously for the Change Fund*
SEAT/National Risk Share	175	*Regional Developments and PICU funding*
Vaccination Programme	46	*National vaccination programme*
Other	96	*IT costs and Pharmacy Prescription for Excellence*
TOTAL	**1,357**	
(iii) Service Development		
General Surgery	165	*Increase in service provision for repatriation and activity*
Oncology	50	*Increased nurse staffing*
ENT	120	*Increase in service provision for repatriation and activity*
Accident and Emergency	120	*Additional medical staff*
Other	226	*Productivity and benchmarking including audiology & dermatology*
TOTAL	**681**	
(iv)External Contracts		
Northumberland	600	*Loss of patient income*
Lothian	880	*Loss of patient income including orthopaedic& colonoscopy*
Lothian	700	*Increase activity sent to NHS Lothian*
Other	36	*Including carbon emissions*
TOTAL	**2,216**	
Total Projected Expenditure Growth	**11,561**	

APPENDIX 2 - SUMMARY OF REVENUE FINANCIAL PLAN

	2015/16			2016/17			2017/18			
	Recurring £000s	Non Recurring £000s	Total £000s	Recurring £000s	Non recurring £000s	Total £000s	Recurring £000s	Non recurring	Total £000s	***Notes***
Opening Surplus/(Deficit)	**0**	**0**	**0**	**(704)**	**0**	**(704)**	**(704)**	**0**	**(704)**	*1*
Funding										
General Funding Uplift	3,248		3,238	3,300		3,300	3,360		3,360	*2*
Support Emergency Department and Patient Flow	639		639							*3*
Barnet Consequentials	737		737							*4*
Integration Fund	401		401							*5*
New Medicines fund	1,100									*6*
Other Funding Lift	208		208	213		213	215		215	*7*
FHS NCL	108		108	108		108	110		110	*8*
	6,441	-	6,441	3,621	-	3,621	3,685	-	3,685	
Expenditure General										
Pays (incl Sup &NI inc)	2,378		2,378	3,085		3,085	1,586		1,586	*9*
Supplies & Services	586		586	471		471	478		478	*10*
Drugs	3,509		3,509	1,759		1,759	1,864		1,864	*11*
Capital Charges	202		202	342		342	198		198	*12*
Other Providers	524		524	615		615	626		626	*13*
FHS NCL	108		108	108		108	110		110	*14*
	7,307		7,307	6,380		6,380	4,862		4,862	
Expenditure Other										
National Initiatives	1,357		1,357	500		500	500		500	*15*
Service Developments	681	791	1,472	1,500	600	2,100	1,500	600	2,100	*16*
External Contracts	2,216		2,216							*17*
Contingency		1,000	1,000		1,000	1,000		1,000	1,000	*18*
	4,254	1,791	6,045	2,000	1,600	3,600	2,000	1,600	3,600	
Savings										
Cost Savings Plan	4,416	2,495	6,911	4,759	1,600	6,359	3,177	1,600	4,777	*19*
Deficit carried forward					704	704		704	704	*20*
In Year Surplus/Deficit	**(704)**	**704**	**-**	**(704)**	**704**	**-**	**(704)**	**704**	**-**	*21*

APPENDIX 2 – SUMMARY OF REVENUE FINANCIAL PLAN

Notes of Appendix 2

1 Opening position in 2015/16 with a balanced budget.
2 General funding uplift is 1.8% in 2015/16, 1.8% in 2016/17 and 1.8% 2017/18.
3 New funding to support Emergency Department and patient flow from Scottish Government.
4 Barnet Consequential additional funding.
5 Increase in funding for the new Integration Fund.
6 Assumption of £1.1m from New Medicines Fund.
7 Income received for patient related service to non Borders residents has been uplift by 1.8% in all years.
8 Assumed uplift for FHS non cash limited funding is 1% in each year and is considered to be cost neutral.
9 In 2015/16 this covers general pay uplift of £250 per person for staff earning less than £21k. Pay awards for each year are assumed to be 1% and increments will be paid where appropriate. In 2015/16 includes the increased employers superannuation amount and in 2016/17 the increased employer national insurance contributions are included.
10 This covers anticipated price inflation related to existing contractual commitments and includes 1.5% for general cost inflation and general growth in all three years.
11 This is based on prescribing advisers' detailed cost projections for acute and primary care services for 2015/16 equating to a 12.52% increase and 6% thereafter.
12 Provision for increase in capital charge costs and costs associated with the capital programme.
13 Provision for inflationary uplift of service level agreements with other NHS boards for NHS Borders residents. This has been estimated at 1.8% for all three years.
14 Provision for increased spend on FHS non cash limited services is equal to assumed increase in funding allocation so overall impact is cost neutral.
15 This line includes national initiatives such as support for Emergency Department and patient flow, integration funding and NSAG initiatives.
16. This grouping includes all other service commitments for example, service planning processes in particular general surgery, oncology, ENT and efficiency support staff.
17 External contracts include additional expenditure required for loss of income or increased patient activity.
18 This as held in contingency in anticipation of any unforeseen financial pressures.
19 Cost Savings plan to be achieved during the financial year. NHS Borders achieves the required level of savings in 2015/16 to break even. However there is an imbalance between recurring and non recurring savings.
20 Recurring deficit is carried forward and required to be met non recurrently each year if recurring savings are not identified.
21 From the end of 2015/16 NHS Borders has a recurring deficit which in the three year period shown the Board is unable to clear.

APPENDIX 3

NHS Borders LDP - Capital Resource Limit future 5 year period 2015/16 - 2019/20	**2015/16 £000s**	**2016/17 £000s**	**2017/18 £000s**	**2018/19 £000s**	**2019/20 £000s**
Board Capital Resources					
Formula Allocation	2615	2615	2615	2615	2615
- Roxburgh Street (CRL 2014/15)	-	200	-	-	-
- Theatre Ventilation (CRL 2014/15)	-	550	-	-	-
Clinical Strategy	2100	500	-	-	-
Roxburgh Street HC Replacement	1200	500	-	-	-
Capital Resource Limit Sub Total	5915	4365	2615	2615	2615
Scottish Government Business Case Resources (tbc)					
IM&T Infrastructure Costs	-	-	1000	-	-
Women's Health	-	-	1500	1000	-
Primary Care HC Requirements - Tier 1 and 1a	-	500	1000	-	-
Capital Resource Limit Total	5915	4865	6115	3615	2615
Capital Receipts Applied					
Orchard Park St Boswells	100	-	-	-	-
West Grove	350				
Total Capital Receipts Applied	450	-	-	-	-
Charitable Funds - Children's and Young Persons Centre	-	3500	2000	-	-
Total Board Capital Resource	**6365**	**8365**	**8115**	**3615**	**2615**
Prioritised Capital Schemes					
IM&T					
Programme IM&T	300	300	300	300	300
IM&T Strategy – Infrastructure	650	150	1000	-	-
GP Order Comms	250	-	-	-	-
Estates & Facilities					
Programme Estates	200	200	200	200	200
Risk Assessed Backlog SoTE/Estates Strategy	500	350	350	350	350
	-	-	-	-	-
Theatre Ventilation	950	-	-	-	-
Medical Equipment					
Programme MEC	200	200	200	200	200
Radiology Priority Replacement Gamma and Mammography	-	1000	250	750	300

	2015/16 £000s	2016/17 £000s	2017/18 £000s	2018/19 £000s	2019/20 £000s
Other					
Clinical Strategy	0	0	875	375	825
Estates Rationalisation Galavale Reprovision	975	675	-	-	-
Project Feasibility Works	-	200	200	200	200
Roxburgh Street Replacement Surgery	1075	1050			
Primary Care Health Centres	575	500	1000		
Women's Health Project, BGH	-	-	1500	1000	
Uncommitted Dependent on Sale Proceeds	450	-	-	-	-
Project Management	240	240	240	240	240
Children's and Young Persons Centre - Charitable Funds Project		3500	2000		
Total Capital Expenditure	**6365**	**8365**	**8115**	**3615**	2615
Balance	-	-	-	-	-
Capital Sales Proceeds to Scottish Government*					
Crumhaugh	-	75	-	-	-
Newstead	-	300	-	-	-
Galavale	-		500	-	-
	0	**375**	**500**	**0**	**0**

APPENDIX 3 – CAPITAL PLAN

Notes of Appendix 3

The following describes the **high risks** to the plan:-

- Capital receipts will be retained locally for 2015/16. This is in line with previous agreements and reflects the timing of individual sales. Due to the general condition of the housing market the risk to the achievement of sales proceeds at the level estimated in the plan is high.
- There is a risk associated with the level of additional resources which are assumed from 2016/16 onwards from the Scottish Government and Charitable Funds to take forward a number of prioritised projects.
- Business cases for the elements of the final phase of the clinical strategy have not yet been formally approved by the Board.
- The plan does not include any capital requirements arising from SEAT schemes.
- There is limited opportunity across the plan to allow for opportunistic investment, spend to save schemes or for unforeseen events – th*e risk is high* that investment will be needed.