Borders NHS Board

LOCAL DELIVERY PLAN 2017/18

Aim

This paper is to gain approval of the 2017/18 Local Delivery Plan (LDP). The LDP was submitted to the Scottish Government Health and Social Care Department in draft format on 31st March 2017 and has been updated following a feedback letter received from John Connaghan in May 2017.

Background

As in previous years, NHS Borders is required to produce and submit a LDP which forms a performance and delivery agreement between the Board and the Scottish Government Health and Social Care Department. Supporting guidance was issued on 16th January to all NHS Boards which outlined a requirement for the Plan to outline work towards 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; and that particular cognisance should be taken of the 'triple aim' of better health, better care and better value as outlined in the National Delivery Plan for Health and Social Care that was published in December 2016.

Using last year's format as a guide, the attached LDP is in the format of an Improvement Plan covering the priority areas of the 2020 Route Map to deliver the 2020 Vision, with separate sections on workforce and LDP standards:

1. Improvement Plan
    a. Health Inequalities and Prevention (including Ante-Natal and Early Years)
    b. Person-Centred Care
    c. Safe Care
    d. Primary Care
    e. Integrated Care
    f. Unscheduled Care
    g. Scheduled Care
    h. Mental Health
2. Workforce section
3. LDP Standards

As in previous years, an underpinning Financial Plan was prepared and submitted as part of the LDP process.

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, referencing how improvements will be measured.

The LDP incorporates the key standards, plans, and levels of performance that NHS Borders will have to achieve during 2017/18. This in turn will inform discussions about performance at the Annual Review and Mid Year Review with Scottish Government.

The LDP has been created by narrative received from service leads and managers across the organisation and collaboratively across the Health and Social Care Partnership. Following the May 2017 feedback letter from John Connaghan narrative has been revised or added to the original draft submitted in March, including

- Narrative covering regional collaborative working, a key area in the National Delivery Plan for Health and Social Care has been added *(page 6)*
- An update to the section on Health Inequalities *(page 8)*
- Additions on the National Out of Hours Review in the Primary Care section *(pages 28-29)*
- Psychological Therapy Waits Section has been revised *(pages 47-49)*
- A refresh of the Value and Sustainability section *(pages 55-59)*
- Addition of a sentence to the Workforce section on the new National Health and Social Care Workforce Plan *(page 60)*

Under the original guidance the final LDP was to be submitted to Scottish Government on 30th September 2017 subject to formal Board approval. However, Boards have been notified that they are no longer required to submit a revised LDP for 2017/18.

Summary

Service leads have contributed to the development of the Local Delivery Plan for 2017/18. In addition, feedback was received on the draft plan from the Clinical Executive Operational Group, the Board Executive Team, Area Partnership Forum, Public Reference Group, Strategy and Performance Committee and the Integration Joint Board.

As noted at the NHS Borders Board meeting of 6th April 2017, the draft LDP was submitted to the Scottish Government on 31st March 2017 Additional narrative has now been added following John Connaghan's feedback letter received in May 2017.

Boards have been informed there is no requirement to submit the updated LDP to Scottish Government. The Local Delivery Plan 2017/18 is presented to the Board today for formal consideration and approval.

Recommendation

The Board is asked to **approve** the finalised NHS Borders Local Delivery Plan for 2017/18.

Policy/Strategy Implications	The LDP will be the primary mechanism for monitoring the performance of NHS Boards by the Scottish Government.
Consultation	The LDP 2017/18 has been developed in conjunction with the service, the Clinical Executive, Board Executive Team and service leads.
Consultation with Professional Committees	See Above

Risk Assessment	See Above
Compliance with Board Policy requirements on Equality and Diversity	The risks for delivery of LDP actions have been factored into the plan. Performance will be monitored proactively throughout 2017/18 through reporting to allow remedial actions to be taken.
Resource/Staffing Implications	The LDP has been developed to be fully compliant with NHS Borders' Equality and Diversity requirements.

Approved by

Name	Designation	Name	Designation
June Smyth	Director of Strategic Change and Performance		

Author(s)

Name	Designation	Name	Designation
Meriel Carter	Planning and Performance Officer		

NHS Borders

Local Delivery Plan 2017/18

Planning & Performance

Draft

Contents

Glossary

ADP	Alcohol and Drugs Partnership
AHP	Allied Health Professional
BAS	Borders Addiction Service
BECS	Borders Emergency Care Service
BHIH	Borders Health in Hand
BI	Brief Intervention
BME	Black and Minority Ethnic Communities
BSL	British Sign Language
CAMHS	Child and Adolescent Mental Health Service
CDI	Clostridium Difficile Infection
CEA	Community Empowerment Act
CEL	Chief Executive Letter
CHCP	Community Health and Care Partnership
CHW	Child Healthy Weight
CPC	Child Protection Committee
CPP	Community Planning Partnership
CYP	Child and Young Person
DCE	Detect Cancer Early
DMARDs	Disease-modifying antiheumatic drugs
DNA	Did Not Attend
ED	Emergency Department
ENP	Emergency Nurse Practitioner
EY	Early Years
GCCAM	Good Corporate Citizenship Assessment Model
GIRFEC	Getting it right for every child
GRFW	Get Ready for Work
HAI	Healthcare Acquired Infection

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
SEAT	Regional Planning Area for South East Scotland
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

The following Improvement Plan sets out how we will deliver on the 2020 Vision for NHS Scotland over the next year, 2017/18. We have focused this around the priority areas of the 2020 Route Map. This plan is structured around 9 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. We have taken account of the aims of Health and Social Care National Delivery Plan, published in December 2016, within the following narrative to deliver high quality services and further enhance health and social care services in the local area. To do this the narrative covers work in three areas referred to as the triple aim: delivering better care, better health and better value.

The 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. Regional planning is underway and the finalised version of this Plan will take into account steps towards new arrangements for regional planning and delivery of services to improve patient outcomes.

NHS Borders is committed to maintaining financial balance through integrated and focused working as well as seeking out efficiencies. This is becoming increasingly challenging given the economic environment and the high level of efficiencies to be achieved whilst sustaining the range of services currently provided, ensuring accessible healthcare across remote and rural areas; managing increased demand generated through population growth and public expectations and delivering LDP Standard trajectories.

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

NHS Borders, alongside NHS Lothian and NHS Fife as part of the East Region within NHS Scotland, is working collaboratively to design common pathways of care across a range of clinical specialties, the aim of which is to ensure sustainable services across the region. In response to the national Health & Social Care Delivery Plan the region is developing a Regional Delivery Plan which will set out the collaborative work in more detail.

The **executive leads** within NHS Borders for each priority area in the Local Delivery Plan are as follows:

	Priority Area	**Executive Lead**
1	Health Inequalities	Dr Tim Patterson, Interim Joint Director of Public Health
2	Prevention	Dr Tim Patterson, Interim Joint Director of Public Health
3	Person-Centred Care	Claire Pearce, Director of Nursing, Midwifery and Acute Services
4	Safe Care	Dr Cliff Sharp, Medical Director
5	Primary Care	Elaine Torrance, Interim Chief Officer, Scottish Borders Health and Social Care Partnership
6	Integrated Care	Elaine Torrance, Interim Chief Officer, Scottish Borders Health and Social Care Partnership
7	Scheduled Care	Claire Pearce, Director of Nursing, Midwifery and Acute Services
8	Unscheduled Care	Claire Pearce, Director of Nursing, Midwifery and Acute Services
9	Mental Health	Elaine Torrance, Interim Chief Officer, Scottish Borders Health and Social Care Partnership

Priority Area 1: Health Inequalities **Executive Lead: Dr Tim Patterson** **Interim Joint Director of Public Health**	
Improvement aim	**Actions and Measures**
Health inequalities planning	
NHS Borders as a partner in the Community Planning Partnership	**Action:** NHS Borders plays an active role in implementation of the Scottish Borders Reducing Inequalities Strategy to achieve better health and reduce inequalities **Measure:** Participation in relevant groups by NHS Board and staff. Health Inequalities Impact Assessment of plans and key decisions within CPP
	Action: Promote awareness of Community Empowerment Act (CEA) within NHS Borders **Action**: Promote awareness with partners of the importance of prevention and early intervention to improve the lives of children **Measure:** Increase in understanding of CEA within NHS **Measure:** gap analysis and health inequalities action plan developed for NHS and the Integrated Joint Board **Measure:** increase awareness of Adverse Childhood Experiences among adult services
Health inequalities key priorities are embedded in Health & Social Care locality plans	**Action:** Engagement with locality planning processes, including community engagement **Measure:** Locality plans show how will address priorities
Health inequalities priorities are embedded in Integrated Children and Young People's (CYP) plan	**Action:** Prevention and early intervention to improve the lives of children and young people are prioritised in service planning **Measure:** Performance framework for the Integrated CYP Plan **Action:** Public Health supports children and families services and with maternal and child health services to deliver effective interventions to improve outcomes and reduce health inequalities for vulnerable groups **Measure:** Performance framework for Integrated CYP Plan **Action:** Public Health leads collaborative approach with partners to promote healthy weight and active lifestyles for children, young people and families across ages and stages **Measure:** increase in collaborative initiatives
Child Health services planning	**Action:** NHS Borders Clinical Strategy drives improvement in child health services **Measure:** Strategy and implementation plan in place

Improvement aim	Actions and Measures
Reducing preventable ill health	
Locality plans have identified improvement actions relating to prevention and reducing inequalities	**Action:** Learning and development for Health & Social Care staff to support self management and address health inequalities **Measure:** Locality plans show how will address priorities **Action:** Improved processes and pathways are developed to enable access to: • Support for healthy living and self management for individuals and carers • Information and advice, including welfare benefits, CAB • Health screening • Peer support **Measure:** Pathways in place **Action:** Awareness raising with wider community on risk factors for preventable ill health, signs and symptoms and getting checked early **Measure:** Community engagement plan in place to promote dialogue and communicate key messages **Action:** Develop health literacy within communities with wider partners: pilot starting in 2017 in one learning community board. **Measure:** Evaluation of pilot
Community based health improvement activities	**Actions:** Community food programme delivered in targeted communities with partners, comprising weaning groups, cooking skills courses, growing projects, development of food coops, alternatives to food banks Food Alliance project established **Measure:** Food networking activities held in targeted communities
Mental health	
Promote community wellbeing	**Action:** Develop and deliver programme of awareness raising and training to develop mental health literacy with frontline staff and wider community and to promote access to activities & opportunities for arts, culture, physical activity that improve mental heath and wellbeing. A collaborative programme of activities and events will be launched as 'Six Ways to Being Well in Borders' in Mental Health Awareness Week in May 2017 and continued thereafter. **Measure:** Collaborative programme in place
Promoting health and wellbeing for mental health service users	**Action:** Physical Health Check Tool developed to ensure patients have an assessment for physical health and an action plan for health improvement. The tool is being piloted for people with severe and enduring mental health problems.

Improvement aim	Actions and Measures
	Measure: Wellbeing and Mental Health Steering Group responsible for implementing, monitoring and evaluating actions. Number of Physical Health Checks/Health Improvement plans completed. **Action:** Smoke free mental health settings-Development post supporting mental health service staff to develop smoke free mental health services policy, increase referrals from mental health to smoking cessation support and training for staff to raise the issue of smoking with patients. **Measure:** Referral pathway in place. Monitor referrals from mental health to smoking cessation support
Inclusion and vulnerable groups	
Learning Disability	**Actions:** A Healthier Me continues to run in conjunction with partners in the third sector, with a renewed focus on outcomes for PWLD with partners being supported to identify what activities can support delivery of the programme. Expand reach of 'I am Me and Keep Safe' Continuation of Project SEARCH in partnership with Scottish Borders Council, and Borders College Local Areas Coordination Team continue to support people with a learning disability to live healthier lives and improve their quality of life through developing supportive social networks, and supporting/developing Health Champions roles Employability European funding received till December 2018 to employ 2 staff to support people to engage in voluntary work with a view to broaden employment pathways Weekly weight management group to tackle obesity, which started as a pilot in October 2016, will be evaluated for future delivery/roll out **Measures:** Programmes and pathways in place, activities planned with targeted groups
Carers	**Action:** Public Health input to development of new Carers Strategy that prioritises health and wellbeing of carers. A Carers Health Needs assessment is planned, to support this work. **Measure:** Strategy and action plan in place
Physical Disability	**Action:** Development with Public Health input of new Physical Disability Strategy that prioritises health and wellbeing **Measure:** Strategy and action plan in place

Improvement aim	Actions and Measures
Offenders	**Action:** Develop pathways to support offenders' health. This work will be developed through the Borders Community Justice Board. **Measure:** Pathways developed **Action:** Promote awareness of support needs of offenders who are parents **Measure:** Included in scope of new Parent Support Strategy
Migrant health	**Action:** Collaboration with Migrant Support group to address health and housing issues **Measure:** Improved information sharing
Homelessness	**Action:** Public Health involvement in development of housing and homelessness strategy **Measure:** Housing and Homelessness strategy group established with Public Health Input
Capacity building	
Workforce are equipped to recognize and mitigate health inequalities	**Action:** Joint health improvement team deliver training plan in generic health behaviour change; health literacy programme; and topic based and bespoke training for H&SC workforce. Training sessions are being delivered March – June 17 to local authority staff in Customer Services, Homelessness Service and Employability. **Measures:** Participants in training Qualitative feedback via evaluation
Targeting resources	
Data on deprivation and vulnerability are used to inform resource allocation to improve outcomes achieve better value and	**Action:** Health Improvement programme delivery, including: Smoking cessation - continue to prioritise delivery in areas of deprivation. Engage in co-ordinated marketing to increase referral rates. Nutrition and healthy weight: promotion of healthy eating and active living with community groups through core HLN programme, as part of Food Programme (see above) Mental health: awareness raising and signposting to sources of support including welfare benefits advice, lifestyle support, volunteering opportunities and skills development as part of Ways to Being Well (see above) **Measure:** Programme evaluation **Action:** Improve reach of screening programmes **Measure:** Uptake by vulnerable groups

Improvement aim	Actions and Measures
	Action: Health inequalities impact assessment (HIIA) of health service planning. For example, an HIIA was undertaken in relation to cervical screening and highlighted that there is a gap in training for smear takers with respect to Gender Based Violence (GBV) – specifically for those women who have experienced sexual assault and / or abuse. As a result of this, partners from Safer Communities and Scottish Borders Rape Crisis have agreed to tailor a training session to deliver to practice nurses. This will also aim to encourage those women who are not confident about accessing smear checks to do so as services which engage with women who have experienced GBV will be able to confidently state that staff have been trained and will be mindful of their needs and concerns. **Measure:** HIIA completed on key service development

Priority Area 2: Prevention **Executive Lead: Dr Tim Patterson** **Interim Joint Director of Public Health**	
Improvement aim	**Actions and Measures**
Supporting healthy living	
Improve care and health outcomes for people with Type 2 Diabetes	**Actions:** Implement physical activity and health behaviour change service in low-activity people with Type 2 Diabetes by piloting a six month programme for those recently diagnosed. This uses health coaching and health psychology to support sustainable behaviour change. Support development of diabetes peer support groups in local areas, with key partners **Measures:** Participation and completion rate Physiological and psychological outcomes Number of groups established
Increase in participation in physical activity	**Action:** Development of signposting/referral pathways from NHS settings to community-based physical activity opportunities. Expansion to target key at risk groups. **Measures:** National prevalence data, uptake and outcomes in health classes. Monitor number of referrals to Live Borders from NHS
Reduction in prevalence of smoking and exposure to second hand smoke	**Actions:** Delivery of Tobacco Control Action Plan- Prevention actions. Prevention work targeted at Early Years, Children and youth work settings including vulnerable groups **Measures:** SALSUS data, local SHS data, national prevalence data Tobacco Control Plan/JHIT Performance indicators.
Improved sexual health of people in Borders	**Actions:** Delivery of Borders Sexual Health Strategy including: expanding reach of CCard; school drop-ins; supporting school based education. Workforce training opportunities (1.5) **Measures:** Ccard service information; teenage pregnancy and STI rates
Reduction in alcohol and drugs related harm	**Actions:** Alcohol brief interventions (ABI) continue in priority and wider settings. Support to school based education. Provision of Take Home Naloxone (THN). Workforce training opportunities (1.5)

	Measure: Number of ABI performed and THN kits distributed.
Improvement aim	**Actions and Measures**
Prevention of mental ill health	**Actions:** Develop sustainable approaches to support mental health in primary care, through better coordination and integration of current services Improve supported signposting to sources of advice and support that are accessible to local communities **Measures:** Reach and engagement Service evaluations WEMWBS in SHeS
	Action: By 2018, redesign an integrated early intervention approach to support the mental health of children young people in schools and community **Measure:** New model in place and monitoring information
Suicide prevention	**Action:** Continuation of Suicide prevention training programme **Measure:** Training uptake **Action:** Development of support for those bereaved by suicide: raise awareness with first responders of best practice in supporting those affected by suicide **Measure:** Support initiative in place
Maternal and infant nutrition and child healthy weight	**Actions:** Continue to promote Healthy Start uptake and vitamin use in line with emerging national guidance Support to maternity and early years settings to improve early diet choices and development of preconception health improvement, with key partners Improve pathways to support for families with overweight / obese children **Measures:** Breastfeeding rates Healthy Start uptake 27 month Body Mass Index (BMI) P1 Body Mass Index (BMI)

Improvement aim	Actions and Measures
GIRFEC implementation	**Actions:** Continue to implement the new HV pathway to improve support for families Strengthen HV service with expanded staffing and improved management and support **Measure:** Pathway in place **Actions:** Continue to provide specialist Public Health / Health Improvement advice and support to child health services Continue to embed the recently expanded FNP programme to support young parents **Measure:** FNP indicators

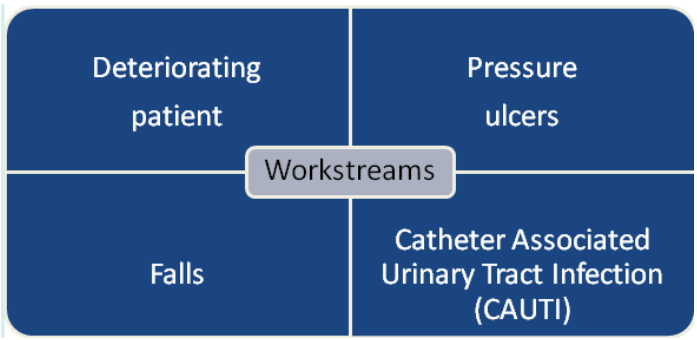
Priority Area 3: Person-Centred Care **Executive Lead: Claire Pearce** **Director of Nursing, Midwifery and Acute Services**	
Patients and Carers	As part of our three year Public Involvement and Community Engagement Strategy 2016 - 2019 we continue to look at ways in which we can further involve the public in developing channels of communication with our patients, families, carers and communities. We are aiming to embed a culture of listening within the organisation ensuring that people have a strong voice when it comes to the design and delivery of services as well as their own care. Our objectives in this priority area are: • Through the introduction of the Supervisory Senior Charge Nurse (SCN) programme in inpatient areas we will focus on collecting real time feedback from patients. Supervisory SCNs will have daily conversations with patients and their families and, where issues arise, work with staff, using a coaching and mentoring approach, to implement immediate changes • Gathering patient, carer and family member feedback on their experience of care and treatment. Using volunteers to help us gather this feedback and extending the use of hand held devices cutting down on administration and speeding up the feedback process to frontline areas to drive improvements • Continue to provide an open and transparent process for formal complaints and feedback, encouraging supported dialogue between patients, carers, families and staff • Testing a new approach to complaints handling which encourages active listening, dialogue and reflective practice with patients, families and staff • Developing our approach to the use of Patient Opinion to provide independent patient led virtual feedback • Continue to commission independent advocacy services and refresh our joint Independent Advocacy Plan with our partners including Scottish Borders Council and the Third Sector identifying any gaps in provision and articulating plans to address these gaps • Work with Scottish Borders Council and the third sector to refresh our Carers strategy identifying any gaps in provision and articulating plans to address these gaps • To communicate through our public involvement groups, local newspapers within communities, in a language that is appropriate for

	these communities, through venues within localities • We have clearly visibly placed feedback boxes and two minutes of your time questionnaires in public places around the hospital. We use patient feedback volunteers and public members who sit on our groups to communicate back to staff issues around the services that we provide
Public Involvement and Community Engagement	NHS Borders continues to strive to provide services that match the needs of our local population and in a way that is accessible to all. In order to achieve this we are committed to involving our public and communities in designing, planning and developing our services. Our key priorities over the next 3 years are: • To ensure that the key principles of public involvement and community engagement are embedded in the day to day work of the organisation with individuals and communities encouraged and supported to contribute to the design, planning and delivery of our services. • Our *Health in Your Hands: What Matters to You* programme of public engagement will test and explore innovative ways of involving the public and capturing the views of seldom heard groups and individuals i.e. students, young mothers. To build on the success of the Learning Disability Citizens Panel and the BGH Participation Group, and actively seek to foster and support participation groups around specific services or service developments. • To develop and strengthen our relationships with our third sector partners in order to support the delivery of existing services and to provide or supplement services not provided by NHS Borders. • To ensure that advocacy services are available and accessible for service user groups, our communities and individuals. • Continue to develop channels of communication with our patients, families, carers and communities to embed a culture of listening within the organisation ensuring the public have a strong voice when it comes to the design and delivery of services as well as their own care. • To expand the membership of our public involvement groups, particularly the Public Partnership Forum, focusing on the localities that have very little or no public representation. • Working alongside our colleagues in the Scottish Health Council to take forward and develop the Our Voice national project to

	support improvements and empower people to be equal partners in their care.
Volunteering	We received the Investing in Volunteers Award in 2014 and as an organisation we are recognised as having achieved this award for 3 years. This is now up for renewal and we have been doing a lot of work to ensure that we continue to meet the required standards. Volunteering continues to play an important role within NHS Borders, our current volunteer roles work to enhance patient experience and help us to gather feedback. We are committed to continuing to expand the number and type of volunteering roles available offering more people from our communities the opportunity to become involved with the work of NHS Borders and to use the skills they have, gain others and satisfaction from their volunteering role. Ongoing financing of this project support is currently provided by the Endowment Funds. A paper is currently escalating to continue with this funding. If accepted then our objectives in this priority area are: • Evaluate the impact of volunteering on patient experience and outcomes • Continue to grow our cohort of volunteers to enhance patient experience by working with departments to explore new volunteering opportunities, support growth in existing volunteer roles and maintain levels when volunteers move on • To continue to ensure that volunteers feel well supported and valued in their roles and have a positive experience while volunteering by building the infrastructure to support and guide volunteers. Also to strengthen and optimise the support to and from volunteers during the year. • Explore and test the use of service user volunteers in the recruitment process, giving the public a strong voice and ensuring openness and transparency • Explore working with the local High Schools to develop a schools programme and engage senior pupils in volunteering giving pupils the opportunity to enhance and develop their knowledge of NHS Borders and the healthcare sector
Staff	Our staff are our most valuable assets, they deliver our services on the front line and behind the scenes and are the first point of contact for people using our services. By recognising our staff to be assets we also recognise NHS Borders responsibility to listen and learn from their experience as well as develop and support them to embed the values of public involvement and community engagement in day to day service

	delivery. Our objectives in this priority area are: • Develop and implement values- based recruitment: recruitment process and induction programme designed around our core organisational values • Review how we engage and communicate with staff currently and look to develop innovative ways of communicating and listening to staff – we are currently testing an approach to learning from adverse events. • Ensure we retain our Carers Positive Award which assesses how we support carers in the workplace • Continue to roll out the iMatter staff experience tool to measure and improve staff experience and well-being • Continue to encourage and support staff to complete the bi-annual Staff Survey and work with partnership to formulate an action plan based on the results • Continue to promote an open and collective leadership culture at all levels of the organisation • Promote the newly amended Whistle Blowing Policy and the Whistle Blowing Group is to develop a toolkit and guidance for all staff to accompany the launch of the refreshed policy.
Frailty pathway for older people	Within the Health Foundation funded Measurement and Monitoring of Safety programme, a workstream was established to test the Framework on a pathway for frail patients within secondary care. To date objectives have been: • Establish a reliable care pathway • A frailty screening tool, adapted from the national screening tool has been developed, tested, embedded into the new rapid risk assessment document and implemented within all admitting areas • Ensuring reliable implementation of the local version of the national 'getting to know me' booklet that reflects needs of frail patients In addition we are now working with HIS to implement the new national Anticipatory Care Plan, being launched spring 2017.

	For 2017/18, the aim is to establish a multi-disciplinary frailty team to manage the care and flow of frail patients. • A multi-disciplinary frailty team meet daily (Monday – Friday) in MAU to plan care for recently admitted frail older patients, following a medical pathway. • We are currently testing a 'frailty coordinator' operating Monday to Friday, at the front door of the hospital; supporting staff to manage care for frail individuals not being admitted. This individual can be a nurse, physiotherapist or geriatrician. We are currently testing a frailty screening 'sticker' completed by SAS crews for elderly patients being conveyed to BGH.

Priority Area 4: Safe Care	**Executive Lead: Dr Cliff Sharp Medical Director**
Improvement aims	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 (SPSP). NHS Borders in collaboration with Scottish Borders Health and Social Care Partnerships will develop our priorities for safety for 2017/18 reflecting where activity is aligned to the Scottish Patient Safety Programme core themes, namely: • Deterioration (Prevention, Recognition and Response) • Medicines • System Enablers NHS Borders has arranged to engage with the National Lead for Quality and Safety in May 2017. The SPSP programme is currently part of a restructure within the Improvement Hub (ihub), part of Healthcare Improvement Scotland to improve the quality of health and social care services with alignment of existing programmes. 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 (SPSP). SPSP is one of a family of national improvement programmes developed over recent years in relation to the national Healthcare Quality Strategy. These programmes draw on improvement methodology advocated by the Institute for Healthcare Improvement. SPSP now contains four distinctly identified workstreams as follows: • Acute Adult • Primary Care • Mental Health • MCQIC (incorporating Paediatrics, Maternal Care & Neonatal) 

	The SPSP has subsequently reorganised itself to focus on the workstreams identified above, plus continued work in: • VenousThromboembolism (VTE), • Heart failure, • Medicines and • Surgical site infections.
Scottish Patient Safety Programme	The Scottish Patient Safety Programme (SPSP), led and coordinated by Healthcare Improvement Scotland, is a unique national programme that aims to improve the safety of healthcare and reduce the level of harm experienced by people using healthcare services. SPSP aims support outcome 7 of the National health and Wellbeing Outcomes *"People using health and social care services are free from harm".*
Adult Acute SPSP	**ADULT ACUTE** This acute programme has been refreshed to focus on the following patient safety essentials as the system has matured: 1 Hand washing 2 Leadership walkrounds 3 Intensive care unit daily goals 4 General ward safety brief 5 Surgical pause and brief 6 Ventilator associated pneumonia (VAP) bundle 7 National early warning score 8 Central venous catheter (CVC) insertion 9 CVC maintenance 10 Peripheral venous cannula (PVC) bundle Please see below a synopsis of the measures that we will prioritise locally in support of the 10 safety essentials: Leadership Walkrounds: The walkrounds and inspections will continue as per the current format with named executive leadership for each clinical area across NHS Borders. These will continue to be prioritised locally with Non-Executive Director attendance included, although we do not have to report to Health Improvement Scotland. Critical Care: Process measures are showing reliability and outcome measures will continue to be monitored. Theatre Measures: Local safety priorities have identified that an improvement programme on the quality of the safety briefs and pauses matches the national approach

	General Ward Measures: Four of the ten essential measures of safety apply to the general ward workstream. These are: • Hand hygiene • General Ward Safety Brief • Peripheral Vascular Cannula Maintenance Bundle, and • National Early Warning Scores These measures will continue to be collected in 2017/18 to ensure the processes are reliably embedded in clinical teams. Deteriorating Patient Workstream: The outcome measure for deteriorating patient is a 50% reduction in cardiac arrests (or 300 days between events). This is achieved through a collection of measures such as identification, escalation and treatment of the deteriorating patient, with one of the main causes of deterioration being sepsis. Communication: The focus of safety improvement work will continue for 2017/18 focusing on ensuring SBAR communication is implemented reliably, with particular emphasis on handovers. As part of the deteriorating patient workstream we will continue incorporating debriefs on cardiac arrests in to the daily hospital huddle, with an emphasis on sharing the learning across sites. This will facilitate improved understanding of cardiac arrest incidence and esclation of deteriorating patient. Sepsis: Sepsis forms a key component of the deteriorating patient workstream. It is recommended that 'Sepsis Six' bundle and the use of visual cues and equipment to prompt reliable delivery of the bundle is developed. Medicines: Nationally, a medicines workstream has been created spanning all specialities. NHS Borders plan to continue to reflect that model locally in 2017/18 with an improvement focus on medicines reconciliation on admission and discharge. This will link with the emerging national Excellence in Care approach when the measures are developed. Venous thromboembolism (VTE): The success of the demonstrator project on VTE hosted by NHS Borders will be considered and a plan to take the interventions to scale developed.

	Falls: The second phase of the Scottish Patient Safety Programme (SPSP) aims to achieve a 25% reduction in all falls and 20% reduction in falls with harm by the end of 2015, while promoting recovery, independence and rehabilitation. Falls measures form an integral part of the revised measurement plan and the local delivery plan for 2017/18. As one of the four priority areas for the Nursing Directorate and of the Older People In Acute Hospitals (OPAH) workstream, the Clinical Improvement Facilitators will continue to undertake tests of change and quality improvement in the areas with the highest numbers of falls, whilst triangulating the outcome data with process data and reported events. Pressure Ulcers: As one of the four priority areas for the Nursing Directorate, the clinical improvement facilitators will continue to undertake quality improvement in this area, whilst triangulating the outcome data with process data and reported events. Catheter Acquired Urinary Tract Infection (CAUTI): Testing and innovation work will continue on the patient catheter passport, containing the insertion and maintenance bundles have been rolled out in BGH and Primary Care. 2017/18 For the adult acute workstream we will focus and prioritise improvement support in to distinct areas: • Frailty (including falls) • Communications (transitions of care, handovers, multi disciplinary team working) • Deteriorating patient • Medicines
Mental Health	The SPSP for Mental Health has a focus on the workstreams identified below, including NHS Borders Acute (Huntlyburn) being a pilot site for Improving Observation in Practice. Early work suggests high level of therapeutic activity benefits and early identification of risks.  Outcome data continues to be collected on a monthly basis via the

	reporting template from the Brigs and Huntlyburn. Medicines reconciliation has been introduced to Cauldshiels, which is also nurse led.
Maternity, Paediatrics and Neonates (McQIC)	Work continues to embed process measures in the deteriorating patient and infection control workstreams in 2017/18. The reporting was person dependant and moving towards a team approach to further embed the reporting of all measures. Recently the team have a focus on reducing still birth with CTG monitoring.
Primary Care	The national team are currently scoping the future of the programme.
Healthcare Acquired Infections	Every SAB case and CDI case is subject to a rigorous review which includes a feedback process to the clinicians caring for the patient as well as the wider organisation through monthly Infection Control Reports. Any learning is translated into specific actions which are added to the Infection Control Work Plan with progress critically reviewed by the Infection Control Committee. SABs are reported by cause to highlight themes and support targeted interventions. During 2015/16, there has been a reduction in each of the top recurring themes identified in 2014/15. Through this approach, NHS Borders has achieved a 33% reduction in SAB cases in 2015/16 compared with 2014/15. This approach will be maintained during 2016/17.
Adverse Event Management	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 2016/17 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.
Safety Measurement and Monitoring – Health Foundation Award	In April 2014 the Health Foundation published a Safety Measurement and Monitoring Framework prepared by Charles Vincent. Healthcare Improvement Scotland (HIS) was 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, along with NHS Tayside and the combined proposal from the three organisations was successful. NHS Borders has begun testing the Framework at Board level and across a frailty pathway for older people. This has offered the opportunity to accelerate our local improvement work in patient safety and the care of older people by establishing a pathway, using a multi disciplinary approach and by liaising with national partners. Several test of change have been undertaken to establish a reliable pathway for the frail population of NHS Borders. From a Board perspective, the Framework is

	being tested at the Joint Executive meeting, such as at the hospital wide safety huddle. Qualitative feedback has been positive, and descriptions about the way safety is discussed and anticipated is evolving.

Priority Area 5: Primary Care **Executive Lead: Elaine Torrance** **Interim Chief Officer**	
Improvement aims	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. Developments in Primary Care will support and be consistent with the nine objectives agreed within the Health & Social Care Partnership's Strategic Plan: 1 - We will make services more accessible and develop our communities 2 - We will improve prevention and early intervention 3 - We will reduce avoidable admissions to hospital 4 - We will provide care close to home 5 - We will deliver services within an integrated care model 6 - We will seek to enable people to have more choice and control 7 - We will further optimise efficiency and effectiveness 8 - We will seek to reduce health inequalities 9 - We want to improve support for Carers to keep them healthy and able to continue in their caring role
Leadership and Workforce	The senior clinical and management arrangements and working practices have continued to support a whole system approach across primary and secondary care and aim to further build upon the positive collaborative relationships across the health and social care partnership. An Associate Director for Primary and Community Services has been appointed to further strengthen the development of the integration agenda across health and social care will support the continuation and development of shared leadership and working practices across a range of services in both the day time and out of hours periods. As part of its Clinical Strategy development, NHS Borders has committed to developing a Primary Care Strategy that will initially inform and shape the requirements regarding redesign of primary care and community based services, including General Practice, Dental Services, Optometry and Pharmacy. The contribution of these independent contractor services alongside NHS Borders nursing and allied health professional services, for example, will be explored in order to ensure the challenges of providing high quality and resilient services can be addressed. We are currently engaging with services to establish priorities around a range of issues, for example; GP Relations, Recruitment and Retention, Contracts and Independent Contractors, Primary and Secondary care interfaces,

	Primary Care Safety and Governance arrangements. Further to the options appraisal work undertaken in 2015/16 to develop a suitable model for medical cover across community hospitals a project has been agreed with the support of Professor John Bolton and Dr Anne Hendry to review the existing arrangements for transitional or intermediate care across NHS Borders and the health and social care partnership. Through this project we aim to agree the future role of the Community Hospital in an integrated Health and Social Care system and design an appropriate clinical and non-clinical workforce to support its delivery. Progress in relation to the Transitional Quality Arrangements set out in the new GMS contract for 2016/17 has been slower than desired. Specifically, there has been limited interest to date from the GP community in relation to the role of the Cluster Quality Lead. The senior management team continue to work on this in order to ensure arrangements are in place by April 2017. Following a successful submission to participate in the introduction of Buurtzorg model of Neighbourhood Care in Scotland we embarked on a programme of community engagement across the region in order to establish interest and commitment from a range of statutory, independent and voluntary care providers, as well as members of the public and the communities themselves. We have identified two communities that will support us as early adopters for the approach and we will monitor and evaluate the impact as part of the test phase. This will be further supported through the 3 Locality Coordination roles introduced to support locality based engagement and planning as well as the development of locality needs assessments and locality plans.
Service Planning and Interfaces	<u>Urgent Care/Out of Hours Care</u> In February 2016 an initial vision and a draft plan for implementation of each of the individual recommendations from the National OOH Review was drawn up, and subsequent to this a focused person-centred, intelligence-led, outcomes-focused and asset-optimised local delivery plan was developed, based on the five main areas: • Design & implementation of a new model of Urgent Care delivery • Configuration of the workforce to meet and manage service need and individual patient needs • Service provision delivered by an appropriately trained and competent professional • Establishment of strategic performance management and joint working arrangements • Support of clinical governance and service improvement methodology, including sharing of information between

	stakeholders There are 31 separate work streams which are being delivered as part of the transformation. Key projects include the development of Advanced Nurse Practitioner (ANP) and Driver-Healthcare-Support-Worker (driver-HCSW) roles to enhance the multidisciplinary urgent care and improve service resilience. The development of the GP Coordinator role is crucial in developing hub-working via professional-to-professional pathways with other key services such as NHS24, SAS and social work. There is on-going work in BECS supporting the training of Specialist Paramedic Practitioners (SPPs) by providing them with clinical experience under the supervision of GPs; in return the SPPs respond to OOH/BECS home calls when not busy with SAS. In April 2017 Prof Sir Lewis Ritchie and his team from the Scottish Government came to NHS Borders to meet with the UC team and relevant stakeholders. In the feedback report it was noted that Sir Lewis was encouraged by progress and was extremely impressed with many of the stems in each workstream having being implemented already, or about to be. He was also heartened to see so many stakeholders "Pulling Together" to move the recommendations on. Sir Lewis also said that the development of the BECS OOH driver role was an innovative idea, and was also encouraged that NHS Borders have good links with SAS. Recruitment of clinicians into the service has also been facilitated by the appointment of two fixed term posts (funded by the Scottish Government GP Recruitment and Retention Fund) which include service interface quality improvement work as well as providing much needed experienced GP hours for service provision. An Urgent Care Clinical Lead was appointed in June 2017 as a fixed term one year post (8 hours per week) to drive forward some of the more complex issues, such as the Falls pathway and Mental Health support, including engaging with the Distress Brief Interventions pilot. Good progress is being made with these by working with other partners including SAS, Social Work and the Police. The development of a working group guided by new key performance indicators will direct future strategy and inform new tests of change. The large geographical area and lengthy journeys between home visits will remain a challenge for our Borders Emergency Care Service (BECS). Taking into account concerns about winter resilience and mileage tolerance in light of repeated mechanical issues, the three BECS vehicles were replaced In January 2017. The Joint Clinical Board and IM&T approved the purchase of Adastra Aremote software and ruggedised laptops to support electronic transfer of patient information and record

	keeping by BECS clinicians working in the community. The system is expected to be in operation by the end of April 2017. An Unscheduled Care Project was established to progress a range of key work streams. The Project concluded in December 2015 at which point the work had progressed to a sufficient degree to mainstream within local services. The work now sits with the operational services and a brief description of progress is listed below; • Urgent Care - Job descriptions are being developed for both an Urgent Care Clinical Lead and Project Manager, and it is hoped to have people in post by April 2017, with the aim of implementing and delivering the project plan during 2017/18. • Community Response – this is being taken forward as the Hawick Paramedic Practitioner Pilot. Two GP Practices are working directly with the Scottish Ambulance Service (SAS) to test a different model of in-hours response to emergency calls to GPs. BECS continue to support the training of paramedic practitioners by offering clinical experience of acute illness, under GP supervision. • Patient re-education - the "Meet ED" pocket guides have been developed (using the NHS D&G template) and printed. They offer the public information and guidance about where to find the support they need e.g. when to go to the pharmacist, when to contact a GP, self help guidance, when to go to the Emergency Department. The guides have now been distributed through a range of venues and organisations across the region. There is currently a small pilot running to redirect afternoon ED patients who present with primary care problems to BECS at 6pm, with the aim of improving patient expectation and appropriate use of services. • Emergency Department Redesign - including a review of the medical model. This redesign programme will continue to move forward during 2017/18 now that ED Consultants have been appointed. • Overnight Governance in the Emergency Department - arrangements have now been established within the specialties to address this. • Ambulatory Care and Acute Assessment - A new Ambulatory Assessment Unit has been established and the model is being evaluated in line with agreed improvement methodologies. • Review Mental Health Crisis Team input to the Emergency Department – discussions are underway to identify the most appropriate location for the team to ensure timely access and support for patients attending in crisis. Resource has been identified within Urgent Care budgets to explore the possibility of an urgent care Mental Health practitioner.

	• Accommodation – BECS and ED – an initial scoping exercise has been done in the light of potential changes in approach, in particular issues arising from the requirement to ensure joint working with Social Care and the third sector. These requirements have been placed on the Board capital register and will be reviewed within the standard local capital planning processes. NHS24 Interface: • BECS will also continue to offer direct access for professional-to-professional advice and patient assessment where appropriate for District and Evening Nurses, Paramedics, Nursing and Residential Homes, and Community Hospital staff i.e. bypassing the NHS24 111 call and subsequent wait for a call back. • BECS have regular partners meetings with NHS24 to discuss service issues, and this route could be used in planning urgent care service delivery. The National OOH Delivery Plan is highly likely to include the development of regional Urgent Care Resource Hubs (linking professionals from primary care OOH, NHS24, SAS and social care directly, or by suitable IT provision, to allow collaboration in the direction of each patient to the most appropriate professional within the most appropriate timescale and in the most appropriate setting). • BECS clinicians are encouraged to continue to engage in NHS24 triage discrepancy feedback to improve the patient pathways. • BECS communicates and negotiates with NHS24 to provide cover for PLT sessions etc. A salaried GP is now in post in BECS financed by the SG Recruitment & Retention (R&R) initiative who is contracted to provide clinical cover for the four central PLT sessions in 2017. BECS will continue to offer direct out of hours access to palliative care patients, without the need to telephone 111 NHS24. The BECS hub number is given directly to palliative care patients by local District Nursing Teams and GPs. We will also look at how to improve access to community based care facilities for palliative care patients who are not coping at home in line with the review of Community Hospital functionality as described above. BECS clinicians, District Nurses and Community Hospital Nursing Staff have all participated in the Deteriorating Patient Project and are now all routinely using National Early Warning Scores (NEWS) and SBAR communication to improve colleague-to-colleague discussion and decision making re the safest place of care for patients. Ongoing collaboration with local GPs and District Nurses to ensure that Anticipatory Care Plans (recorded on eKIS) are updated remains an

	essential focus and will feed in to the Transitional Quality Arrangements for 2016/17 in the revised GMS contract. The new R&R BECS GP is undertaking a project as part of their role in both BECS and daytime primary care to improve the quality and content of Anticipatory Care Plans (ACPs). Focus within the plan will also improve arrangements for key groups of people, for example those presenting with mental health crises, Frail elderly, children, and those with special access requirements. We will also develop strategies that consider raising public awareness of the out of hours arrangements and appropriate self-management strategies through a number of mechanisms including social media, the NHS Borders website, local press articles, engagement with local volunteers and community groups. We will be looking to review our sustainable plan for the out of hours clinical workforce in line with our Strategic Plan. A BECS Band 7 Advanced Nurse Practitioner (ANP) has been appointed and started in post as a supernumerary pilot project in January 2017, to scope the benefits of using ANPs as part of multidisciplinary urgent care delivery in the future. In line with the Transitional Quality Arrangements in the revised GMS contract each GP practice will nominate Practice Quality Leads and each cluster of GP practices will have a Cluster Quality Lead appointed by the practices and overarching services which will have a developing key role in leading clinical or professional groups and the community in planning high quality integrated services at locality level. This will have to take account of existing resources such as Minor Injury Units and Community Hospitals and looking at how best these services/facilities can best serve the people of the Scottish Borders which may not be their current format. Enhanced Services will continue to be discussed and agreed in liaison with the Local Negotiating Committee, GP Sub Committee and local GP practices. <u>Public Dental Services (PDS)</u> Work has progressed and in the next year the intention is to: • Continue to provide Enhanced services to Special needs/ additional needs with core tooth brushing in all schools with special needs units • Continue to expand of core tooth brushing to all pre-school and school age children in primary schools • E-Referral process to be established to support improve clients access specialised dental treatment and domiciliary visits.

	• Offer and support annual programme of dental assessments and treatment within care establishments. • Through more effective communication and interagency work increase the emphasis on ensuring improved access for patients identified as having mental health challenges, drug and alcohol dependencies, the homeless and ex-offenders • Develop an action plan to decommission one mobile dental unit (MDU) by August 2017 • Train additional clinicians to ensure anxiety management services are fully supported within the community and in secondary care • Improve bariatric dental facility within PDS <u>GDP Service</u> Work continues in the following areas: • Dental Practice Advisor and Dental Clinical Lead liaise with the Directorate of Pharmacy regarding prescribing patterns, particularly antibiotics, and monitor prescribing. Performance is encouraging for Borders • Long Term Conditions – GDPs continue to manage their LTC patients with Post Diagnostic Support supporting in terms of mentorship, for example for anxiety and sedation training, where necessary • Patient safety – there are a number of strands of work progressing in this area, including antibiotic audits, monitoring of bed figures, patient scrutiny by Dental Reference Officers where requested, monitoring of outliers at payment verification meetings etc. National Education Scotland (NES) are in the process of devising dental specific programmes and NHS Borders will engage with these when finalised. <u>LASS - Supporting your Lifestyle change</u> With reduction in core budgets and central funding ceasing for Keep Well from April 2017 a sustainable model for the future delivery of LASS has been adopted retaining the most effective elements of the existing service and maximise cost effectiveness. • Increase partnership working to ensure LASS services support for all communities with additional support to those in the most vulnerable groups though targeted partnership work and direct input with users of Criminal Justice Services, Carers Services, Mental Health services, Drug and Alcohol services and services supporting the small homeless population. • With support from GP's offer opportunistic health checks in all GP surgeries. • Following trial fully implement the new adult weight programme Weigh 2 Go Borders that combines a number of evidenced based

	approaches offering wider options to the clients. • Further develop strong relationships with key services within the Borders General Hospital to ensure effective referral pathways are utilised to support patients and reduce the numbers of readmissions. <u>Sexual Health</u> • Consistent >90% recording of alcohol and GBV in all attendees • Continue to link with Lothian to ensure sustainability and succession planning within Sexual Health services • HIV and Hepatitis testing over 5 years to be fed back to individual GP practices in to encourage consideration of appropriate testing and early diagnosis • Review of drug regimes for HIV patients to include first line use of generic antiretrovirals to address costs • Enhance links with all school nurses to further develop the condom distribution scheme, C-card. • Enhanced presence in secondary schools and Borders College to better support young people's access to Sexual Health services • Reinstate pop up clinics in identified areas of need to better support young people's access to Sexual Health services. <u>Optometry</u> Links continue with optometry services delivered in the community to ensure care is in line with local initiatives as they are developed. Diabetic retinal screening continues to be delivered by local opticians. All independent optometrists now have the capability to refer to the Borders Eye Centre electronically using SCI Gateway. In 2016/17 there was an increase in electronic referrals to 80% compared to 70% the previous year. <u>Primary Care Premises Modernisation Programme</u> Progress has continued in 2016/17 with our primary care premises developments. Four "Band 1" highest priority Health Centre sites (Selkirk, Eyemouth, Melrose and Knoll) and two "Band 1a" less significant development sites (Earlston and West Linton) were identified through the Primary Care Premises Modernisation Programme. The scheme at Eyemouth Health Centre will be completed within the first quarter of 2017/18 and the development at The Knoll is scheduled to begin early February 2017 with a 16 week programme of works. The development plans for Melrose are currently being reviewed and finalised; detailed specifications are being developed for Earlston and West Linton.

	In each of the proposed schemes the aim has been to "future-proof" as far as possible the health centre facilities, bearing in mind the projected population figures and patient activity trends which were used to inform the review and prioritisation process. The works will allow increased local access for patients to the range of services provided from these health centre sites, not only from services based "on site" but also from visiting services such as consultant clinics, psychology, mental health services etc. Increasing the available bookable clinical space which can be used flexibly by the wider multi-disciplinary and multi-agency teams and providing additional GP consulting rooms will allow more consultations with GP and other professional staff groups to take place thereby increasing patient activity and reducing patient waits. Improvements to the physical layout and the provision of "safe" interview rooms, accessible WCs and patient showers will improve equality of access issues and will contribute to improved patient and staff safety and the overall patient experience of services provided by NHS Borders. The proposed provision of a designated paediatric therapy suite at the Knoll will allow Berwickshire families to access an appropriate and child-centred therapeutic space within the locality rather than having to travel to central Borders for more specialised therapy intervention.
Technology and Data	Funding from the Primary Care Digital Services fund is being used to enhance parts of the desktop infrastructure within General Practices. This will help improve experience and productivity in practices and give a firm platform for other technologies. All practices have had new servers installed and some are also in line for SWAN bandwidth increases over the next 12 months. This improves resilience in the practices. GPs now have the ability to remotely access their systems from home or any other internet enabled location which has greatly improved their working. We are running a project to re-provide IT systems for Community multi-disciplinary teams. The business case is complete and the contract has been awarded to EMIS. We expect that the new system will deliver functionality that supports staff in their work, facilitates better information sharing across sectors, including General Practice and Social Work, and provides access to information both about individual patients but also for performance and planning purposes. There is a pressing need to replace key parts of the aging IT infrastructure within Primary Care. Desktop PCs still run Windows XP and will need to be upgraded before a new Community IT system can be deployed. Community locations are not Wi-Fi enabled which will restrict our ability to deliver newer ways of working. These issues are being considered for prioritisation through our

	capital investment prioritisation process. In support of new models of care and Buurtzorg we have finalised a design for a Clinical Bridge application. This will allow the community teams to manage their workload and cohort of patients more effectively. This is essentially a view of all the patients on the caseload across a geographic area / locality. We will test this in a couple of areas in a live environment and then after reviewing our learning implement in the remaining settings. The exact timetable is not yet firmed up. We have developed a solution which requests the GP summary direct from GPS and reconciles this to the referral prior to it being reviewed in secondary care. On-going support and equipment refresh for this programme remains an issue with local IT teams not funded to provide this. There will also be some work to be considered nationally to renew and support the remote connectivity currently provided by VPN tokens which will expire within a year. The introduction of EMIS Web and Clinical Bridge will offer us the opportunity to better report on and analyse our activity and workload. This will help inform further service changes and improvements. Electronic Document Transfer – Hub2Hub – we are now connected with the majority of Health Boards across Scotland, allowing traffic both ways. This has helped with costs, time, and manpower at both the BGH and at the Practice end. Laboratory results/letters/X-rays reports now go electronically to GP systems. 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.
Contracts & Resources	The imminent development of a Primary Care Strategy, the ongoing implementation of the Health and Social Care Partnership Strategic Plan and the requirements of the 2017/18 efficiency programme will influence the shape of future primary care services. Primary Care GPs continue to be well represented on both the Integration Joint Board and Strategic Planning Groups and are involved in decision making across a range of existing governance structures. We are continuing to work with GP colleagues to determine very specifically how we wish to see the ongoing joint working with GPs at a practice, locality and strategic level. We recognise that GPs will be critical in that process and are working closely with local GP groups to manage the Transitional Quality Arrangements in the revised GMS Contract.
Pharmacy services	The Scottish Government has invested in pharmacist support to GP practices through the Primary Care Fund. A new pharmacist took up this post in July 2016 to work with a number of practices in a patient facing

	role that will free up GP time. Additional funding was announced in March 2016 and the pharmacy team have now recruited to this post. The postholder will work alongside the senior Prescribing Support team pharmacists to free them up to take on the role of the advanced GP practice pharmacist. Discussions took place with the GP-Sub Committee and practices have now been allocated this additional resource. A plan is in place for the pharmacists working in primary care with GPs to be trained as independent prescribers. Community pharmacy prescribing clinics will continue for a further year. The focus of the work in the coming year will be polypharmacy reviews and reviews of patients using compliance aids. Work is ongoing with care workers to move away from using compliance devices to administer medicines from original packs and using medicine administration record charts. This will improve the safety of medicine administration by care workers. Funding provided for the implementation of Prescription for Excellence has been used to establish a medicine review service in community pharmacy and is currently available in 28 out of 29 pharmacies. Initially the service was to support the introduction of the Sick Day Rules card but will be extended to pain from April 2017. The aim of this service is to increase the clinical role of the community pharmacist and deliver direct patient-centred care. NHS Borders has used the additional funding that was allocated for PfE in Autumn 2015 to appoint a discharge technician. The technician, who started in April 2016, works with complex vulnerable patients at discharge to support safe and effective medicines management and improve medicines reconciliation. Pharmacy submitted 2 bids to the Integrated Care Fund to look at redesigning services in the community. The first bid, which was successful, will look at how pharmacy can work with social care to support medicines safety checks for patients referred for a package of care; the second bid, which was unsuccessful, was to review the management of respiratory patients to help prevent readmission to hospital and GP consultations. An alternative approach will now be considered.

Priority Area 6: Integrated Care **Executive Lead: Elaine Torrance** **Interim Chief Officer**	
Overview	The Integration Joint Board (IJB) agreed the content of the Strategic Plan for 2016-19 and the accompanying financial statement was also approved in March 2016. The Strategic Plan sets out nine local strategic objectives for the Health and Social Care Partnership and this year we have developed key performance information which has been collated to evidence progress made in relation to the objectives. Detailed implementation plans have also been developed related to key work areas and strategies including dementia, mental health and older people. It has also been important to take into account the work taken as a partnership to provide a break even position for the IJB delegated budget whilst maintaining front line services.
National and local standards/targets	The Health & Social Care Delivery Plan sets out the three key areas for Integrated Services: reducing inappropriate use of hospital services; shifting resources to primary and community care; and supporting capacity of community care. Mapping of the patient pathway from home to hospital has been identified as a key priority to identify improvement actions and ensure that any delays from hospital are kept to a minimum. Work is progressing to introduce new intermediate models of care and in 2016 a new step up/step down/transitional care facility was opened with 11 available places increasing to 16 in 2017. Further models to establish more community based re-ablement services will be implemented in 2017. A review has been undertaken to focus on actions to reduce avoidable admissions to hospital in line with the strategic plan including work with the third sector. This, coupled with the above, will assist in reducing unscheduled bed days in hospital. A performance scorecard has been developed to monitor progress against key targets which is being reported regularly to the IJB. The importance of early intervention and prevention strategies is recognised. Two new initiatives will be implemented in 2017 including the introduction of a more flexible service response by developing closer joint working with district nurses, social care and communities (Buurtzorg model) and Community Led Support where introduction of community hubs will be set up which will make better use of resources including staff, finances and community resources. Key to both of these is the promotion of self care and having a different conversation with individuals to build on their own strengths

	and resilience. Work is also underway to develop proposals to integrate health and social care staff in locally based teams across the five localities. This development will improve access to community based health and social care services within communities as well as prevent duplication of assessment by different professionals and greater information sharing amongst professionals at a local level. In support of new models of care and Buurtzorg we have finalised a design for a Clinical Bridge application. This will allow the community teams to manage their workload and cohort of patients more effectively. This is essentially a view of all the patients on the caseload across a geographic area / locality. We will test this in a couple of areas in a live environment ac then after reviewing our learning implement in the remaining settings. The exact timetable Is not yet firmed up. There is a focus on palliative care and there is close joint working to provide support to people at home for as long as possible. The opening of the Margaret Kerr Unit has also provided another choice for people at the end of life and their families. The partnership is committed to shifting resources to the community and there is continued investment planned for social care. In 2016 a plan was implemented that all social care staff in the Borders are now paid a minimum wage of £8.25 and this will increase to £8.45 in April 2017. This coupled with a successful care at home tender and a focus on joint recruitment and retention strategies which will help to maintain the continuity, stability and sustainability of both care home and care at home services. A joint integration workforce plan is being developed during 2017 to ensure that Health, Social Care and the third independent sector have a well trained workforce working together to provide quality services across the pathway.
Locality planning	Significant progress has been made in providing locality plans for the 5 agreed localities in the Borders. Three locality co-ordinators were appointed in April 2016 who have built relationships with established community groups including housing, learning and development, the third sector, carers as well as service users and patient representatives. Each area has a local planning group in place and by working with communities we have co-produced draft action plans for each area which will be further developed with clear agreed actions.

Priority Area 7: Scheduled Care **Executive Lead: Claire Pearce** **Director of Nursing, Midwifery and Acute Services**	
Local improvement aims	Achieve 98% compliance with urgency classification timeframe (for patient access to emergency theatre). Achieve 100% reduction in our sendaways (patients who are currently sent to the Golden Jubilee or private hospitals for their surgery). Achieve a reduction in our elective hospital cancellation rate from our current 4.65% weekly average for 2016 to below the Scottish national average of 2.1%. Increased elective theatre utilisation rates from an average of 61% to 85%. Reduce patient boarding, ensuring patients are placed in the appropriate place and receive the optimal level of care. Reduce pre-admissions for major orthopaedic elective surgery.
Summary of local work to be carried out under the National Scheduled Care Programme (sustainability) in 2017/18	As part of the Planned Care Surgical Flow Programme, supported by the Institute for Healthcare Optimization (IHO), some improvements in patient care have already been agreed and implemented, these are as follows: • Reduced pre-admissions for orthopaedics from week commencing 15 August 2016. • Smoothed inpatient elective procedures across the week from week commencing 26 September 2016. • Combined/interchangeable elective surgical ward implemented from Wednesday 7 December 2016. The following is still to be implemented with timescales for implementation still to be finalised: • Provide a 1.5 combined emergency theatre resource & 3.5 elective theatre resource. This will provide increased emergency theatre resource and better separation from our elective theatres which will result in more timely access for patients to emergency theatre and less cancellations of elective cases due to an emergency taking priority. In order to achieve the increased theatre resource, additional theatre nurses and consultant anaesthetists need to be recruited.

Measures which will be used to assess improvements made	Monthly monitoring of performance metrics as defined by IHO which are as follows: • Elective and emergency case volume • Elective theatre list utilisation • Emergency theatre list utilisation • Theatre list overruns & associated costs • Average waiting time for emergency cases to get into theatre • Compliance rate for patients accessing emergency theatre within their urgency classification timeframe • Reason for non compliance if patients are unable to access emergency theatre within their urgency classification timeframe • Elective case cancellations • Median post op length of stay • Number of smoothable inpatient elective admissions • Patient census • Average theatre recovery area wait • Number of elective surgical patients boarded outwith specialty

Priority Area 8: Unscheduled Care Executive Lead: Claire Pearce Director of Nursing, Midwifery and Acute Services	
NHS Borders Clinical Strategy and Unscheduled Care	Improvements to Unscheduled and Emergency Care are being taken forward through the 6 Essential Actions steering group, led by the Head of Service for Unscheduled Care. The actions focus on the areas identified by the Scottish Government as the key contributors to improved Emergency Access Standard performance and areas identified as opportunities for improvement within the Board. These measures are focused on ensuring effective management of patients flow and prevention of admission. Work to reduce length of stay in Community Hospitals and Delayed Discharges is described elsewhere in this plan, but will be significant contributors to delivery of effective unscheduled care. **<u>EA1 Clinically Focussed and Empowered Hospital Management</u>** **Improvement Aim** – To ensure that patient flow is led at ward, hospital and Board level by clinical staff, supported by management The Hospital Safety Brief is the key daily focus for sharing information on demand and capacity at Board, Hospital and ward level. The HSB is attended by a wide range of clinical and non-clinical staff, ranging from Executive Directors, through senior consultants and nurse leaders to Senior Charge Nurses and ward staff. The Hospital Safety Brief has been developed and now robustly includes a suite of clinical measures as well as visibility of expected demand and required discharges at ward level. This will be further developed: • Attendance daily of community hospital representative and social care to ensure a whole system approach • Addressing patient safety issues will continue to be developed to ensure robust follow up • Ensure attendance from support services, e.g. estates and general services. Clinically-led patient flow management processes continue to be developed; • Providing information on expected demand and required discharges at ward level with support and feedback to address constraints in delivering this capacity • Consolidating the role of the Duty Manager to take the lead in patient flow at hospital level, supporting a whole system approach and enabling early decisions regarding onward patient movement and improving 'pull' systems to take patients out of wards when ready (e.g. from discharge lounge, community hospitals etc). • We have increased medical input to patient flow, building on the

clinical presence at the Hospital Safety Brief, by ensuring senior consultant presence at daily Board Rounds in each ward so that medical staff are integral to planning for patient flow on a daily and ward basis. We will review and streamline the Board Round process to ensure effective use of time and information sharing.

- There is now a twice daily combined medical handover of all patients at risk of deterioration and a focus on discharge pathways. This will be reviewed to ensure a robust process for follow through of actions identified.

The delivery of operational change is being managed through the 6 Essential Actions steering group, led by the Unscheduled Care Clinical Lead. The remit and membership of this group is under review to ensure delivery and monitoring of improvements.

The wider transformational changes in the management of inpatients will be delivered through a number of larger redesign projects in both the acute hospital and the community.

EA2 Hospital Capacity & Patient Flow Realignment

Improvement Aim – Hospital Capacity and Patient Flow Realignment
To ensure that hospital footprint enables the safe, timely and appropriate accommodation of all patients at all times.

We will deliver a programme of work to increase morning discharge rates. This is focused around:

- Advocate and medical presence at all Board Rounds
- Review of IDL process for junior doctors including timetables for ward processes for the team.
- To ensure patients being located outwith their own specialty does not impact on length of stay through their early review. In parallel work towards eliminating patients located outwith their own specialty.
- Discharge bundle of measures for wards to plan morning discharges effectively

We are working to a trajectory to increase morning discharges to 30% by the end of August 2017 and to 40% by the end of December 2017. Performance will be monitored daily at the Hospital safety Brief and Patient flow meetings and reported monthly through performance scorecards

EA3 Patient rather than Bed Management – Operational Performance

Improvement Aim –To provide effective patient flow through BGH by creating early capacity in inpatient areas.

We will continue to develop improved clinical review of patients to increase

	earlier decision-making and planning for discharge. The aim will be to ensure all patients receive a medical review daily that is either led by a consultant or is carried out under the auspices of a consultant: • All medical admissions are now reviewed directly by a senior clinician either in the Acute Assessment Unit or the Medical Assessment Unit, with a focus on opportunities for discharge or triage to most appropriate area. All patients in MAU receive a daily consultant review across the seven days. • We have introduced a model of dedicated consultant cover for downstream medical patients. This will increase continuity of care for inpatients and mean patients receive direct or delegated consultant review on a daily basis. • We will be evaluating the revised medical model in March 2017 to identify further areas for improvement • We are exploring the use of the IHO methodology for medical pathways • We will work on high volume pathways identified through the Effective Care workstream, e.g. chest pain of non-cardiac origin. • We have implemented IHO methodology in surgical elective pathways. We continue to develop the unscheduled surgical pathways to ensure effective use of surgical footprint. • We will increase the availability of Nurse Practitioners out of hours to support medical staff in reviewing and managing patients We intend to reduce patient moves across the hospital to no more than 5% of all occupied bed days. This will be delivered through: • improved patient flow management, including increased morning discharges • Working in partnership with social care colleagues to reduce delays. • Work to improve community hospital length of stay **<u>EA4 Medical & Surgical Clinical Processes arranged for optimal care</u>** **Improvement Aim** – Improve systems for pulling patients from ED in a timely fashion We will continue to consolidate and improve on the now established pathway for GP referrals to medicine. This involves a direct conversation between GP and senior clinician within the medical unit, all patients being assessed within a dedicated Acute Assessment Unit, and the establishment of an Ambulatory Care Unit for patients who require investigation or treatment but do not require admission. We will work to improve pathways for GP referrals to General Surgery and Gynaecology following a similar model. We will: • Develop an approach for ambulatory care for surgical pathways.

	• Develop improved scheduling of acute GP admissions to smooth and level-load activity arrival times into hospital • Complete improved pathways for GP referral into orthopaedics. • Reinforce escalation systems to ensure beds available in MAU at all times, to improve pull from ED • Maintain and embed current Rapid Assessment and Discharge (RAD) team within core AHP and social work services to increase sustainability and extend coverage to pull patients home from ED **EA5 7 day services – to smooth variation across 'out of hours' and weekend working** **Improvement Aim** - to maintain discharge numbers at consistent level throughout the week. We have established a weekend duty team including an on-site senior duty manager. We will: • Establish robust process for identifying patients with an Estimated Date of Discharge (EDD) on Fridays for the weekend. • Continue to develop 'Transforming Urgent Care' and local need and develop new model of Out-of-Hours primary care within NHS Borders. This will include linking closely with NHS24, SAS and social work out of hours services • Review and develop more effective access to social care out of hours and particularly at weekends. This work will be taken forward in conjunction with partners through the Whole System Winter Planning Group. **EA6 Ensuring Patients are cared for in their own homes** **Improvement Aim** – To ensure no patients in hospital who can be cared for in their own home • We will undertake active work to reduce emergency admissions for common conditions, focusing on developing pathways for patients with common respiratory and cardiac conditions to be reviewed and managed within their own homes and on reducing readmission rates • Extension of Day Of Care Audit (DoCA) to Community Hospitals and Mental Health and active use of DoCA data to manage discharge planning • Package of actions to reduce average length of stay in Community Hospitals to 18 days • Development of a community model of care, including hospital at home, discharge to assess facilities and the development of health and social care coordinators to arrange access to social and third

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sector support
• Review readmissions for areas of improvement.

Measures for Assessment

• Achieving the 4 hour 95% Emergency Access Standard and NHS Borders stretch target of 98%
• Reduction in Emergency Access Standard breaches due to lack of beds
• Reduction in number of patients transferred overnight (for non-clinical reasons) to a stretch aim of zero
• Increase in numbers of patients being discharged on same day through Acute Assessment Unit to 35% of all presentations
• Reduction in admissions to Medical Assessment Unit by 5 per day
• Reduction in length of stay in General Medicine to 3.8 days and overall BGH length of stay to 3.32 days
• Increase in number of patients being discharged before midday with a stretch aim of achieving 40% discharges by 12 midday and 30% by 11am
• No reduction in discharge rate at weekend compared to weekdays
• Reduction in number of patients boarding out of specialty to less than 5% of occupied bed days
• No cancellations of planned procedures due to lack of bed availability
• Patients requiring urgent surgery treated within agreed clinical timescales
• Reduction in acute admissions, especially in target conditions
• Increase in patients cared for at home
• Reduction in Community Hospital length of stay to 18 days average
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<td>Compliance with 4 hour LDP Standard</td>
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Over the last year NHS Borders has met the 95% standard in every month apart from August 2016 and January 2017. We will strive to achieve the 98% target during 2017/18. NHS Borders' current performance can be seen below:

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<tr><th>4 Hour Compliance</th><th>Oct-16</th><th>Nov-16</th><th>Dec-16</th><th>Jan-17</th></tr>
<tr><td>Borders</td><td>95.3%</td><td>95.0%</td><td>96.3%</td><td>90.3%</td></tr>
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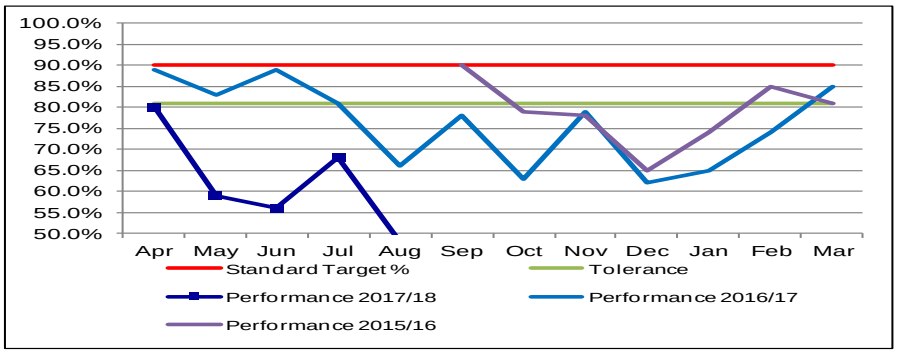
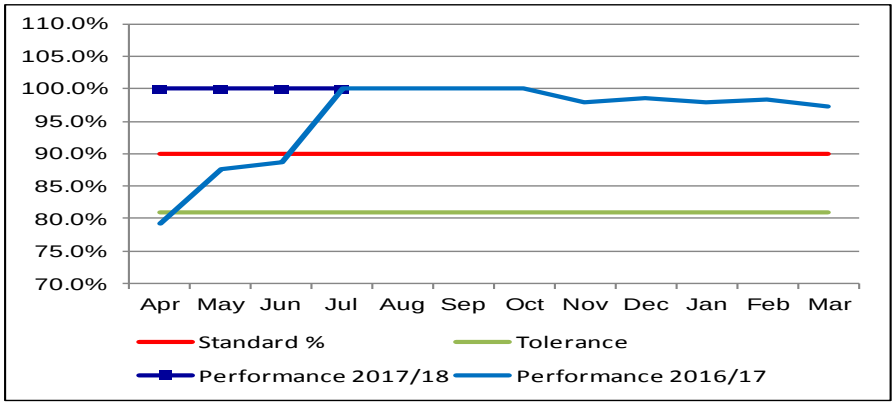
Priority Area 9: Mental Health **Executive Lead: Elaine Torrance** **Interim Chief Officer**	
1. **Psychological Therapies LDP Standard: 90% of Patients will be seen for Treatment within 18 Weeks of Referral**	
Background	This LDP Standard states that 90% of patients referred for a Psychological Therapy (PT) should be seen for treatment within 18 weeks of referral. This was introduced in December 2014. Scottish Government Improving Access funding has been made available for four years from 1st April 2016 to 31st March 2020. This has been used to increase clinical capacity to date.
Current Performance	The Mental Health Service has not consistently met the standard since it was introduced in December 2014 despite additional capacity being put in place on an ad hoc basis. The chart below shows performance against the standard from April 2015 to August 2017 for information. There are no clear trends – performance varies month to month, decreasing to 48% in August 2017. 
Local improvement aims	There is a Psychological Therapies Project Group, that meets weekly to discuss initiatives to increase capacity and therefore improve waiting times performance, and implement relevant actions to make this happen. The overall aim is to meet the 90% referral to treatment standard by 31st July 2018.
Improvement Actions	The main areas of focus to date have been: a. Introducing earlier triage of referrals to ensure only patients suitable for Psychological Therapies are added to the waiting list b. Monitoring diaries to ensure the expected number of appointment slots are booked c. Reviewing appointment booking processes to ensure that any last minute cancellations are re-booked, thus reducing "wasted" appointment slots Moving forward, the following areas of focus will be considered by the project group:

	1. How to manage the backlog of patients currently on the waiting list (e.g. temporarily increasing PT capacity to assess and treat patients on the waiting list) 2. DNA's / DNA Policy 3. Monitoring of caseloads and supervision
Improvement Measures	The following improvement measures will be monitored to ensure the actions being put in place are effective: • Percentage of patients seen for PT treatment within 18 weeks of referral • Number of referrals received, broken down by appropriate and inappropriate • Percentage of DNA's for new PT appointments
2. **Child & Adolescent LDP Standard: 90% of Patients will be seen for Treatment within 18 Weeks of Referral**	
Background	This LDP Standard states that 90% of Child & Adolescent patients referred to the Mental Health Service should be seen for treatment within 18 weeks of referral. This was introduced in December 2014. Scottish Government Improving Access funding has been made available for four years from 1st April 2016 to 31st March 2020. A plan was developed to use this to fund a nurse-led ADHD Clinic, releasing other clinical capacity to meet waiting times; this post has now been recruited to and work is underway to realign caseloads appropriately.
Current Performance	The chart below shows performance against the standard from April 2016 to July 2017 for information (August 2017 data unavailable).  The standard has been achieved since July 2016 onwards. This improvement is due to a review and subsequent revision of the internal recording, monitoring and management process. It is anticipated that performance will continue above the standard of 90% on an ongoing basis.
Local Improvement Aims	The service aims to continue to meet the standard on an ongoing monthly basis, and has introduced a local aim of maintaining 95% performance on an ongoing monthly basis from 1st April 2017

	onwards.
Improvement Actions	The following actions will be undertaken in the next year to ensure performance continues above 90%: • Continue with revised internal recording, monitoring and management processes • Review and consider an alternative to ADHD Nurse post • Consider developing a CAMHS Service Specification to ensure the appropriate resource is focussed on the most appropriate patients • Review and amend admin recording processes to ensure not person-dependant.
Improvement Measures	We will continue to monitor performance against the standard on a monthly basis, and address any change in performance on a case by case basis.

Section 2: Financial Planning

Executive Lead: Carol Gillie
Director of Finance

2.1 NHS Borders Revenue Outturn

2.1.1 2016/17

At this point, not withstanding any unforeseen events, NHS Borders anticipates concluding the year having achieved its financial targets, with a break even position forecast on both revenue and capital.

During the year there have been a number of financial pressures, particularly linked to the patient flow and increasing number of delayed discharges, operational nursing and medical staffing issues within acute services, increased UNPAC activity and cost pressures associated with short supply of some drugs, particularly those prescribed in general practice.

The organisation is working hard to address all of these pressures and will use its contingency funds, slippage on the capital programme and additional funding directed from the IJB to offset overspending areas.

At the end of February NHS Borders has achieved £6.7m of its challenging cash releasing efficiency target of £11.4m. Balance sheet flexibility which will contribute to the delivery the target will be actioned in March. It is anticipated that there will be a £3.3m shortfall on the overall achievement of the target at the end of the financial year. In addition the recurring element of £8.7m will not be fully achieved and based on current information a shortfall of £4.9m will be carried forward into 2017/18. This is an increase from the shortfall of £1.7m which was brought forward from last financial year.

2.1.2 2017/18

The financial outlook the public sector is facing and the challenges this brings are clearly understood. In order to continue to deliver the required quality of patient care the organisation must keep a firm grip on its finances, as well as drive improved quality and efficiency which are critical to ongoing 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.

NHS Borders is committed to maintaining financial balance. Currently this is proving challenging given the economic environment, finite resource allocations and the high level of efficiencies to be achieved whilst sustaining the range of services currently provided, ensuring accessible healthcare across remote and rural areas; managing increased demand generated through population growth and public expectations; and delivering HEAT trajectories. NHS Borders plan must be built on the triple aim of better health, better care and better value.

The level of efficiencies required to allow a balanced financial plan in 2017/18 is greater than those experienced in previous years and the challenges around this have been discussed in a number of fora across NHS Borders.

NHS Borders plan is focused on 2017/18, with high level figures for revenue for the following two years and a direction for capital schemes for the next four years also provided. The Scottish Parliament has agreed a one year budget for 2017/18 and for this reason the financial plan for 2018/19 onwards should be considered with a degree of reservation as these are only planning assumptions at this stage.

The Board's approach to the financial plan is based on the following principles:

- Patient safety is critical to how NHS Borders operates and how it provides services. This will not be compromised.
- Budgets will be set and resources provided based on the level of funding available.

Currently the financial plan for 2017/18 is unable to demonstrate a break even position due to the challenging level of efficiency required in 2017/18. This currently stands at £15.7m. There is a level of identified saving within the efficiency plan that releases an estimated £11.9m, giving an outstanding balance on our efficiency programme of £3.8m. The Board continues to work with services to bridge this gap while continuing to ensure that the quality of care currently provided is not compromised.

This does not detract from the Board's statutory obligation to operate within the financial resources available. The difficulty in reaching a balanced financial plan in order to fulfil this requirement remains a live issue and is subject to ongoing dialogue at Director of Finance and Chief Executive level and the most senior executives of the Scottish Government Health and Social Care Directorates (SGHSCD) involved.

Whilst a balanced financial plan is not yet in place, the delegation of indicative operational budgets and subsequent budget sign off needs to be in place from 1 April 2017 in order to ensure ongoing financial performance management and controls are in place right at the start of the new financial year.

NHS Borders recognises the challenge and the complexity of completing a financial plan has increased with the creation of the Integration Joint Board (IJB) from 1st April 2016. In agreeing a financial plan the Board has considered resources required to be provided to the IJB to undertake the functions delegated to it. A separate paper to inform the Board of the proposed provision of resources to the IJB, and assumptions made on the subsequent Direction of resources is provided separately to the meeting on the 6th April 2017.

Please follow the link to the Indicative Financial Plan 2017/18 paper presented to NHS Borders Health Board:

http://www.nhsborders.scot.nhs.uk/media/473948/Appendix-2017-40-Financial-Plan.pdf

Provision of 2017/18 Resource to the Health & Social Care Integration Joint Board:

http://www.nhsborders.scot.nhs.uk/media/473898/Appendix-2017-46-Provision-of-Resource-2017-18.pdf

2.2 NHS Borders Capital Outturn

2.2.1 2016/17

In terms of our capital position, schemes are continuing to progress as anticipated. The main focus of capital work for 2016/17 has been the final phase of works at Melburn Lodge, programmed construction works at Roxburgh Street Replacement Surgery and Eyemouth Health Centre, and prioritised spend for the estates, IM&T and medical equipment rolling programmes.

The Board remains on course to deliver the CRL.

2.2.2 2017/18

NHS Borders continues to work within the reduced level of capital funding available within NHS Scotland. Capital investment is a key part of delivering safe and effective patient care and to releasing significant efficiency gains from the rationalisation of the estate and the associated supporting service redesign. The Board continues to improve links to the Scottish Asset & Facilities Report (SAFR) and using information available from the Developing Property and Asset Management Strategy, has committed resource over the duration of its plan to addressing priority areas.

The capital plan is in line with the Boards capital allocation and recent discussions with SGHSCD, and reflects the reinstatement of slippage totalling £1.615m as planned capital expenditure from previous years into 2017/18. It has been assumed that capital receipts which were due to be generated during 2016/17 but will not be finalised until 2017/18 will be retained by NHS Borders for local investment. More recently confirmation from Scottish Government of additional support (£0.9m) to the Primary Care Premises Programme has also been factored to the plan over 2017/18 and 2018/19.

2.3 Contribution to Integration Authority

NHS Borders is planning for the 2017/18 contribution to its Integration Joint Board (IJB) for functions delegated to be maintained at levels equal to the recurrent budgeted allocation for 2016/17. This will include the total sum set aside for hospital services. The allocation provided from health budgets for support social care has been treated as an additional allocation.

An outline proposal for provision of resource was discussed by our Integration Joint Board on March 27th 2017 and accepted in principle pending further discussion on identified costs pressures.

A paper on the provision of resource for delegated function as outlined above is expected to be discussed formally at a meeting of NHS Borders Health Boards in April.

2.4 Planned Expenditure on Primary Care and Mental Health

Guidance to NHS Boards as part of the allocation letter issued in February 2017 noted that as it is expected that expenditure levels in Primary Care and Mental Health Services should be maintained at 2016/17 levels of expenditure, with any investment provided in-year to be additional expenditure.

NHS Borders financial plan outlines budgetary proposals that are consistent with guidance issued, and will ensure that recurring funding for both Primary Care and Mental Health Services are consistent with 2016/17 levels.

NHS Borders expects services in Primary Care and Mental Health to manage within this budget level inflationary and activity pressures such as

- Pay awards
- Additional supplies costs due to demographic or inflationary pressures
- National and regional service developments
- The revenue impact of the capital programme
- Any recurring efficiency deficit carried forward from previous years.

2.5 Actions being taken to shift balance of care from acute to community settings, as part of the commitment to deliver more than half of NHS frontline spending on community health services by 2021-22

The following areas of work are underway to shift the balance of care from acute to community settings:

- A detailed piece of work has been commissioned with Professor John Bolton to examine the local processes around patient flow. This work will conclude by the end of March 2017 and the outcomes will inform a review of community and day hospitals to be undertaken during 2017/18. The review will define the future function of community and day hospitals within the system and will contribute to the shift in the balance of care being delivered in community settings rather than in the acute sector.
- A transitional care model has been established in one care home in Central Borders so that patients can be transferred from an acute setting in order to continue their enablement programme. Work is ongoing to spread this model across two further care homes and will be considered alongside the review of community hospitals as outlined above.
- Work is currently underway to develop a network of support workers across the Health & Social Care Partnership in order to enhance the capacity required in the provision of packages of care.
- A clinical productivity programme is due to begin with AHP services and will progress during 2017/18.
- A Community Led Support programme has begun, with several public engagement events having been held. The information gathered from these events will inform the development of the model and associated implementation plan.
- A local project is being established to trial a Buurtzorg model of nurse-led

community services in one area of the Borders. The evaluated outcomes will be used to inform roll-out.

- A Matching Unit has been introduced which will facilitate the delivery of the right care in the right place and in a timely manner for people identified as requiring home care support

2.6 Investment Plans in Prevention and early prevention

We will continue to strengthen the support for early years through the embedding of the health visiting pathway and consolidation of that service and the FNP programme to support young families. Delivery of support for families will be through closer working with non NHS services within localities to make best use of resources and to target those with greatest need. Priorities for investment will continue to be agreed though the Integrated Children and Young People's Plan. It is envisaged that the current redesign of models of support will lead to more holistic coherent responses that are easier for families and young people to access and that reduce the number of small specialist services and the associated overhead costs. This will maximize the use of resources and increase effectiveness.

The reduction of avoidable ill health is a priority in the CPP's Reducing Inequalities Strategy. We are working to bring together the various funding streams and delivery mechanisms for preventative work and coordinate and align activity more effectively within the Health and Social Care Partnership.

Through partnership working with the independent sector we will continue to access additional funding streams where appropriate to support the development of preventative work with and in local communities, to address issues such as food affordability and accessibility and tackling social isolation.

2.2 Approach to ensuring Alcohol and Drug Partnerships (ADP) deliver agreed service levels

The ADP is responsible for the planning and delivery of a range of functions, primarily through the commissioning of services/outcomes from three key partners who provide individual support and treatment for alcohol and drugs. These partners are:

- Action for Children: provides support for children and young people impacted by their own or others alcohol and drug use and parents with alcohol and drugs problems.
- Addaction: treatment and support service for alcohol and drugs users aged over 16; re-integration service to support wider recovery and injecting equipment provision.
- Borders Addiction Service (BAS): treatment (including prescribing and detoxification) service for alcohol and drugs users aged over 16 and the provision of a Substance Misuse Liaison Service in BGH.
- Funding of the ADP has been delegated to the Integrated Joint Board from 1 April 2016 and following a reduction in the budget in 2016-17, transitional funding has been provided to the ADP on the agreement that work is undertaken to redesign commissioned services within the new resource envelope. This work is to be

completed in 2017/18 with the aim of putting in place new service level agreements/contract arrangements for each of the above providers.

2.3 Sustainability and Value Programme

2.3.1 Implementation of the Effective Prescribing Programme

Drug and Prescribing cost increases represent a significant contributing factor to the overall financial pressures faced by the Board during the coming 12 months, and are likely to continue to represent a significant pressure in the future.

As in previous years NHS Borders has developed a significant programme of work aimed at reducing estimated drug and prescribing costs during the course of the 2017/18. The development of the programme has been undertaken by our Director of Pharmacy and senior pharmacists, with programme leadership provided by our Medical Director.

Significant focus within the programme has been given to drug costs and prescribing practice within primary care services to ensure that this is consistent with best and most cost-effective practice. Support has also been identified for formulary review, formulary compliance work, targeted medicines review and poly-pharmacy, aimed at reducing waste and improving overall efficiency in prescribing practice. NHS Border has, and will continue to invest in necessary pharmacy and GP support to ensure opportunities identified are fully explored.

NHS Borders will continue with work to ensure that our local Formulary supports best value. NHS Borders continues to target significant opportunities in terms of cost reductions associated with the use of biosimilar drugs, and is anticipating a significant saving from patent expiry on a number of high volume/high cost drugs during the course of the year.

In the development of the programme the team have utilised information available from within the National Discovery system and Hospital Medicines Utilisation Database to support the identification opportunities and to inform how resources should be deployed to maximise benefit.

To date NHS Borders has identified savings for 2017/18 totalling £2.5m, which represents a planned reduction in current expenditure levels of 7%.

2.3.2 Delivering a quality and cost assessed improvement plan to respond to Productive Opportunities identified from benchmarked performance

NHS Borders have recently identified a lead Director for Transformation who will lead on the development of NHS Border quality & cost improvement plans. It is likely that NHS Borders will take a target approach to this work and will use both national systems (Discovery) and locally available information to ensure that the largest potential productive and cost saving opportunities are prioritised.

Support has been requested from NSS to provide expert advice this initial scoping work is focused, drawing on the recent experience NSS having supported a number of other NHS

Boards through a similar process.

It is expected that key analytical and project management capacity will be redirected to ensure that the pace at which this work is progressed is rapid, recognising the significant contribution this process will make to the long term financial sustainability to service in the Borders.

In terms of work that is already underway, it has been agreed that our Clinical Productivity work stream will continue during 2017/18. This proved successful in supporting our Mental Health Service achieve greater service efficiency during 2016/17, while maintaining the quality of services provided. The approach adopted, including lessons learned, will during 2017/18 be applied to other clinical service teams. Work in relation to our AHP Service is currently underway with an early indication of significant potential benefit.

Work is already progressing around Orthopaedic Services, and this will be continued during 2017/18. Orthopaedics having been identified from national comparative benchmarking as one of the areas of largest variation, and as having significant potential for productive opportunity based on data taken from the Discovery system. This builds on the work undertaken by GIRFT (Getting It Right First Time) team that reviewed Orthopaedic Service nationally during 2016/17, and has been identified at a Regional level as an area with significant potential for benefit from a collaborative approach.

Work associated with The Modern Outpatient work stream will continue, recognising the significant potential productive opportunity within the area. Again a targeted approach is being adopted and the national Discovery system supported by local analysis, and an understanding of relevant service pressures, will determine how resources will be targeted to maximum effect. A particular area of focus will be the use of routine review appointments and their value from a clinical and patient perspective, and how the use of technology may transform current thinking in this area.

An area of particular focus for the Board in the short-term is understanding why comparative data suggests we have a higher than anticipated emergency admission rate to hospital, and if cost effective alternative pathways could improve relative performance, outcome and patient experience in this area. This work is currently being scoped, a range of alternative pathways being considered for impact. The Board are also reviewing comparative theatre productivity data and will give consideration to improvement in this area.

The national discussion relating to Realistic Medicine or Care will form part of the work planned during 2017/18. NHS Borders will review how local clinical teams are provided with data that supports the identification and understanding in relation to clinical variation in all of it forms. Our Performance and Planning team will develop an open dialogue with clinical teams to ensure they have easy access to information, data and analysis that will support them individually and collectively to identify variation in practice, and support them in addressing this where it is demonstrated that it adds no value from the patient's perspective.

2.3.3 Reducing Medical and nursing agency and locum expenditure, as part of a national drive to reduce this spend by at least 25% in year

NHS Borders has seen costs associated with both the use of Medical and Nursing agency staffing rise steeply during 2016/17; this has contributed to the significant financial pressure experienced by the Board during the course of the last year. Containing costs associated with the use of high cost or premium agencies and/or locums is an essential element of NHS Borders' ability to deliver a sustainable financial position.

Medical Agency Costs

The agency spend for agency staff for the first three months was £966,073 and £583,691 in 2017/18. This is a reduction of 31%. NHS Borders has been successful in recruiting to a number of long-term vacancies and is predicting that the agency spend will reduce further once new staff take up post starting from September 2017 in specialities such as anaesthetics and DME.

Medical locums are almost exclusively engaged to maintain core services due to planned (e.g. maternity leave) or unplanned (e.g. sickness or long term vacancies) gaps in key services or rotas. While measures were taken during 2016/17 to address such pressures, particularly in respect of capping fee levels for staff engagement, additional action will be taken during 2017/18 so that NHS Borders meets the national target of at least a 25% reduction in comparable costs. These include :

- Substantive appointments to key medical and anaesthetic specialties have been made recently, with staff expected to come into post during 2017/18. This will significantly improve the underlying position, and NHS Borders will continue to work creatively with regional partners to identify cost effective solutions to long standing vacancies in key clinical specialties, or where work force planning predicts such issues in the future. Areas of key focus for the Board during 2017/18 will be in Ophthalmology, Acute and Emergency Medicine, and Anaesthetics.
- Continuation of the fee cap introduced during 2016/17, and working with regional partners to ensure a consistent approach is taken geographically to manage risks appropriately.
- Continuation of the weekly Medical Oversight Group chaired by the Medical Director. This group reviews all requests for locum support, and ensures all requests are subject to appropriate scrutiny; that alternatives are fully explored; and that risk assessments are considered (locums should only be employed where patient safety would otherwise be compromised). The terms of reference of this group are under review to ensure that it is correctly focused and has the freedom to act.
- Review of the impact Clinical Fellow appointments have had in reducing the Board's exposure to short-notice vacancies in junior medical staff rotas, to ensure that these appointments represent good value and support the objective of reducing locum agency costs.
- Working with regional partners to implement a regional bank of NHS locums to undertaken ad-hoc work, and cover short notice gaps. This builds on the work

undertaken previously in developing a local bank of NHS locums.

Nursing Agency Costs

Nursing agency costs for NHS Borders were higher in 2016/17 than those noted in previous years. This was driven by a combination of factors including some recruitment issues, particularly in some specialist areas, patient dependency, ward occupancy, and unplanned absence often at short notice due to staff sickness. For the first three months was £341,734 and £300,679 in 2017/18. This is a reduction of 12% and we continue to work on achieving an overall 25% reduction and will cease using agency anaesthetic practitioners from 1st September 2017, as we have now reached our minimum level to safely staff theatre. We have six newly qualified nurses starting in the coming months which will help reduce the reliance on agency staff to cover vacancies. NHS Borders will continue to strive to achieve the required reduction but given challenges around the recruitment of registered staff this may prove difficult.

As with medical locum and agency costs, current levels of spend in nursing agency are not sustainable for NHS Borders and in line with directions issued the Board is planning to reduce levels of current expenditure significantly in 2017/18 through the following measures:

- NHS Borders recognises that minimising the number of vacant nursing posts at any one time is central to minimising service dependency on ad-hoc or supplementary staffing solutions in order to maintain safe staffing levels. During 2017/18 NHS Border will be working closely with Educational partners to ensure that we are proactive in anticipating future vacancies, advertising effectively and to maximum value, and streamlining our recruitment process to avoid any unnecessary delays.
- While NHS Borders continues to report one of the lowest sickness absence rates for NHS Borders rates in Scotland, we are not complacent. NHS Borders will continue to focus on ensuring our absence management policies are implemented consistently, and professionally, and that all of our staff receive the support they are entitled to before, during and after any episode of unplanned absence.
- During 2016/17 significant progress has been made ensuring that NHS Borders have in place systems and processes that ensure on a day to day rostering systems are implemented consistently and that our nursing staff resource is deployed effectively right across our health system. NHS Borders will during 2017/18 continue to roll out systems developed that support agile operational decision making, the identification and management of risk, and flexibility in deployment of our nursing work force on that basis.
- In addressing agency spend in specialist areas such as Theatres and Intensive Care, NHS Borders have taken the following action :

    - A number of rotational posts have been introduced to our Intensive Care unit. These posts will allow staff with an interest Intensive Care nursing to develop the request skills, support their professional development, but at the same time increase the pool of staff available to support the unit when they have a short term staffing issue.

Working in collaboration with regional partners a regional bank of staff with specialist skills is being developed and implemented in order to maximise staffing flexibility across current Health Board boundaries for these specialist areas.

2.3.4 Implementation of opportunities identified by the National Shared Services Programme

NHS Borders will continue to engage with the national Shared Services Programme, to ensure NHS Scotland can deliver sustainable and quality services that meet Scotland's health needs now and to shape an effective health service for the future. Options to increase efficiency, reduce costs and maximise returns from continuous improvement will be considered.

With the support of the National Shared Services team some work is being progressed on a regional basis:

- Payroll Services – an options appraisal is planned;
- Procurement – opportunities regional working are being explored;
- As situations arise the Boards in the East region are being asked to consider regional solutions.

We have established a Local Shared Service Working Group to ensure stakeholder engagement is appropriate and sufficient to achieve full definition of Service Requirements for any future Shared Service. This will be achieved through scrutiny of Shared Services engagement activity as well as facilitation of engagement with appropriate service / user groups and professional communities.

Section 3: Workforce

The key principle of our approach to workforce development and people management is 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 our workforce. In partnership we have combined the Staff Governance Action Plan (SGAP) and the 2020 Workforce Vision Implementation Plan (Everyone Matters) to ensure better coordination and resilience of our plans to improve employee experience.

In this last year we have published a 3-year Local Workforce Plan to support evidence based approach to planning and developing the workforce. The key aim is to ensure we can deliver the highest quality of care by having the right workforce which is available, adaptable and affordable. NHS Borders, in common with all public sector organisations, is currently undergoing significant change in response to national policy, local policy and financial restraints. A number of workforce issues and risks are identified including recruitment, workforce supply, age profile of the workforce/demographics and affordability. An annual update to the Plan will be published shortly, taking into account of, amongst other developments, "the National Health and Social Care Workforce Plan, Part 1 – a framework for improving workforce planning across NHS Scotland which was published in June 2017".

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 (our number one action in our Staff Governance Action Plan) we believe we can improve patient experience and the quality of care we provide.

The focus of our Continuing Action Plan is based five priorities as outlined in *Everyone Matters: 2020 Workforce Vision*.

The five priority areas are as follows:

- Healthy Organisational Culture (local priority)
- Sustainable Workforce (Everyone Matters priority)
- Capable Workforce (local priority)
- Workforce to Deliver Integrated Services (Everyone Matters priority)
- Effective Leadership and Management (local priority)

Summary of the 2016/17 Action Plan

Priority Area	NHS Borders will:	Specific Actions
Healthy Organisational Culture "Creating a healthy organisational culture in which our NHS values are embedded in everything we do, enabling a health	Ensure the delivery of iMatter implementation plans, involve staff in decision making and take meaningful action on staff experience for all staff.	Support the Corporate Objective "Excellence in Organisational Behaviour" Complete the implementation and roll out of the diagnostic tools and staff experience

engaged workforce".		indicators of "iMatter". All staff to be given the opportunity to complete iMatter questionnaire. Ensure associated team action plans at all levels from local team to executive director are in place. Publish an overall Employee Engagement score for NHS Borders. Fully implement and mainstream Values Based Induction Fully implement and mainstream Values Based recruitment, assessment and selection. Establish a feedback loop for new recruits who have been recruited and inducted via the values based process. A Line Managers' Value in Action session established and a requirement for all line managers to attend. Hold an annual multi disciplinary workforce conference in partnership, with a values theme.
Priority Area	**NHS Borders will:**	**Specific Actions**
Sustainable workforce "ensuring that the right people are available to deliver the right care, in the right place, at the right time"	Take action to promote health, well being and resilience of the workforce, to ensure that all staff are able to play an active role throughout their careers and are aware of the support available to them.	Publication of a revised process for Personal Development Review. All staff will have an annual meaningful conversation about their performance, their development and career aspirations. Establish a retirement policy supporting staff to work

		longer and seeking to change cultural attitudes to make flexible working part of normal career development. Establish a Returning Process promoting NHS Borders as an organisation that supports to Return to Practice. Implement quality measures to support the Personal Development Plan (P.D.P.) process building on recommendations from a recent quality audit. Establish a recruitment and retention strategy to ensure continuity of services and reduced long term vacancies. Revised monitoring and reporting of turnover rates/trends to inform projections of recruitment and succession planning. Support the planning, roll-out and feedback of Nursing and Midwifery Workload and Workforce Planning tools
Priority Area	**NHS Borders will:**	**Specific Actions**
Capable Workforce "ensuring everyone has the skills needed to deliver safe, effective, person-centred care"	Build confidence and competence among staff in using technology to make decisions and deliver care and encouraging active participation in learning. Work across boundaries (between professions, between primary and secondary care, between sectors and so on) to share good practice I learning and development, evidence	Establish an effective Statutory and Mandatory Training process with agreed protocols for release of staff to participate. E-learning available to all staff and requirement to undertake specific core courses related to KSF dimensions (including dimensions IK1, IK2, IK3 – Information and Knowledge).

	informed practice and organisational development.	
Priority Area	**NHS Borders will:**	**Specific Actions**
Workforce to Deliver Integrated Services "developing a health and social care workforce across NHS Boards, local authorities and third party providers to deliver integrated services"	Working with partners, develop workforce planning capacity and capability in the integrated setting.	Joint Workforce Planning within the Scottish Borders Health and Social Care Partnership to improve understanding of workforce planning issues across organisational boundaries. Establish shared workforce information and methodologies with Scottish Borders Council.
Priority Area	**NHS Borders will:**	**Specific Actions**
Effective leadership and management " leaders and managers lead by example and empower teams and individuals to deliver the 20:20 Vision"	Implement a new development programme for board level leadership and talent management.	Support the Corporate Objective "Excellence in Organisational Behaviour" Develop multi source feedback for our leaders Programme of leader's patient safety "walk-rounds"

Everyone Matters Implementation Plan 2017-18

To accommodate the new Everyone Matters Implementation Plan 2017-18 we are currently developing the Local Workforce Plan 2017-18. We anticipate within this that we will include the actions in the table below.

NHS Board Actions	NHS Borders:
Ensure delivery of their iMatter implementation plans, involve staff in decision making and take meaningful action on staff experience for all staff. (Healthy Organisational Culture).	This is a core component part of the Staff Governance Action Plan linking to each of the staff governance standards. The local implementation plan will be used to drive continuous improvement in the development of local action plans and the overall staff experience.
Take action to promote the health, wellbeing and resilience of the workforce, to ensure that all staff are able to play an active role	This will be driven by the recommendations of our Work & Well-Being Framework 2015-2020 and its associated action plan. Core to

throughout their careers and are aware of the support available to them. (Sustainable)	this is a pro-active comprehensive Occupational Health Service whose activity is aligned to the maintenance of our Healthy Working Lives Gold Award.
Build confidence and competence among staff in using technology to make decisions and deliver care by encouraging active participation in learning. (Capable)	An e-portfolio has been designed with the ability to report compliance at a personal line manager and organisational level. Learners can upload and record evidence of achievement for reviewers to evaluate and approve. Verifiers can quality assure records against IV Therapy and educational standards. This is currently being tested within the Renal Dialysis Unit. As part of the iMatter Programme managers who require assistance in using technology are being given support and training.
Work across boundaries (between professions, between primary and secondary care, between sectors and so on) to share good practice in learning and development, evidence-informed practice and organisational development.	A collaborative model is currently being developed for a leadership and management Academy with NHS, Scottish Borders Council, FE and Third sector organisations. This will provide the Borders community with an accredited approach to development with a focus on building coaching and leadership capacity across all sectors.
Working with partners, develop workforce planning capacity and capability in the integrated setting. (Workforce to Deliver Integrated Services)	Work is currently in the planning and scoping stage. It is expected that a fuller report could be given to the Integrated Joint Board of the Scottish Borders Health and Social Care Partnership later this year.
Implement the new development programme for board-level leadership and talent management. (Effective Leadership and Management)	We are waiting for the development of the plan for board-level leadership and talent management. We understand that this will be available to Boards in the summer of 2017.

Local Workforce Plan and Workforce Risks

During 2016 NHS Borders published a 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 detailed a range of workforce plans 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 service redesign and option appraisal processes. A workforce risk assessment model is incorporated in all service redesign plans and all plans are subject to the affordability test.

We are providing some high level examples below of workforce risks, utilising a workforce risk assessment methodology developed in partnership with our colleagues across the SEAT region.

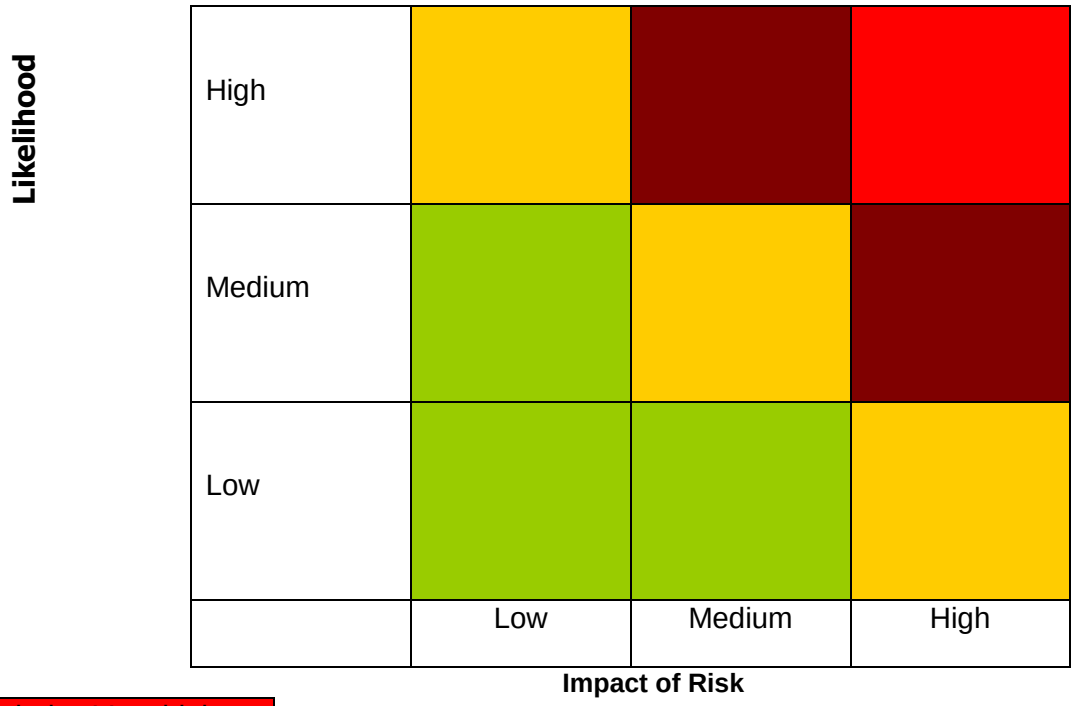
Source of Risk:	**Reduction in Training Grade Doctors Across Key Specialties, due to decreasing numbers in training or substandard provision of medical education within NHS Borders** **Requirement to Achieve Financial Targets Despite Loss of Income**
Risk:	• Patients do not receive appropriate care within NHS Borders • Hospital or individual service closure • High cost replacement – agency staff • Future recruitment
Managed by:	• Investing in Medical Education to improve the education content of posts • Reviewing sustainable ward staffing • Role Development Framework for Advanced Practice • Locum Appointment Policy with scrutiny on supplementary staffing
Risk Level:	• **MEDIUM** Caution: Moderate risk, needs regular monitoring

Source of Risk:	**Recruitment Shortages to Key Specialties (e.g. Theatre Nursing, Intensive Care, Consultant Anaesthetists)** **Financial Plan Does not Reflect Capacity and Demand** **Reliance on Agency and Supplementary Staff to Provide Core Services**
Risk:	• Core Services are not sustained or affordable • Patient Safety not at optimal level • Staff Morale deteriorates, sickness absence increases, staff engagement deteriorates • Financial pressures on existing plans
Managed by:	• Recruitment and retention strategy • Joint working across SEAT to support sustainability – joint appointments e.g. Haematology on-call • Locum Appointment Policy with scrutiny on supplementary staffing
Risk Level:	• **HIGH** Action: High risk, needs immediate attention

Source of Risk:	**Ageing Workforce Demographics in Borders**
Risk:	• Adverse effect on service delivery and workforce • Increased complexity of co-morbidities and patient care needs • Loss of key skills
Managed by:	• Recruitment and retention strategy • Return to Practice schemes across relevant staff groups e.g. AHPs, Nursing and Midwifery • Monitoring and reporting of turnover rates/trends to inform projections of recruitment and succession planning
Risk Level:	• **MEDIUM** Caution: Moderate risk, needs regular monitoring

Assessment of risk

What can be done to reduce the likelihood of a risk occurring?
What can be done to reduce the impact of the risk should it occur?



Priority: Very high risk, needs immediate action

Action: High risk, needs immediate attention

Caution: Moderate risk, needs regular monitoring

Low risk, needs monitoring

Nursing and Midwifery Workload Tools	NHS Borders has utilised the nationally developed Workload and Workforce Planning tools to inform service redesign. All Nursing Ward Areas have implemented a workforce establishment review and Adult Inpatient and Professional Judgement tools have been used to inform redesigned skill mix. Where a national tool was not available (e.g. Outpatients), locally developed tools, based on a Timed Task Analysis approach, have been used to determine Workload. Since revised shift patterns were implemented in 2012, when there is an opportunity to recruit to a post, this is matched much more closely with the hours required by the rota, e.g. a full time member of staff would be recruited to do 37.5 hours, but we would recruit to 34.5 hours when this is the rota requirement. As part of our Nursing & Midwifery Workforce Planning, there was scheduled follow up time aligned to the dates the workload tools were run, to ensure that appropriate analysis was conducted against findings. This includes clinical discussions which will inform the requirement for a business case if seeking additional staff, or reallocation of resources if the tools show an oversupply in a particular area.
Whistle Blowing Policy	NHS Borders wishes to ensure that its employees have the opportunity and confidence to raise concerns that they may have. Through the NHS Borders Whistle blowing Policy, employees are encouraged to be open and are guaranteed to have their concerns considered safely. NHS Borders have an established Whistle blowing group which reviews the effectiveness of the current arrangements within the organisation. This group has recently amended the existing Whistle blowing policy to take into account best practice guidance provided by Public Concerns at Work, the lead organisation in this field and has recently undergone full organisational consultation as per policy development process. The group is also developing a toolkit and guidance for all staff to accompany the launch of the refreshed policy.

Section 4: LDP Standards

NHS Borders aims to maintain the performance against the LDP standards as set out below. Performance will be monitored on an ongoing basis. 23 core suite 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.

NHS Borders looks forward to the findings of the national review of targets and indicators for health and social care being led by Sir Harry Burns and will incorporate any modifications to LDP standards within the final version of this Local Delivery Plan 2017/18.

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

Although significant investment has been made the delivery of waiting times and A&E targets remains a challenge for NHS Borders. The achievement of TTG remains challenging for NHS Borders for a number of specialities.

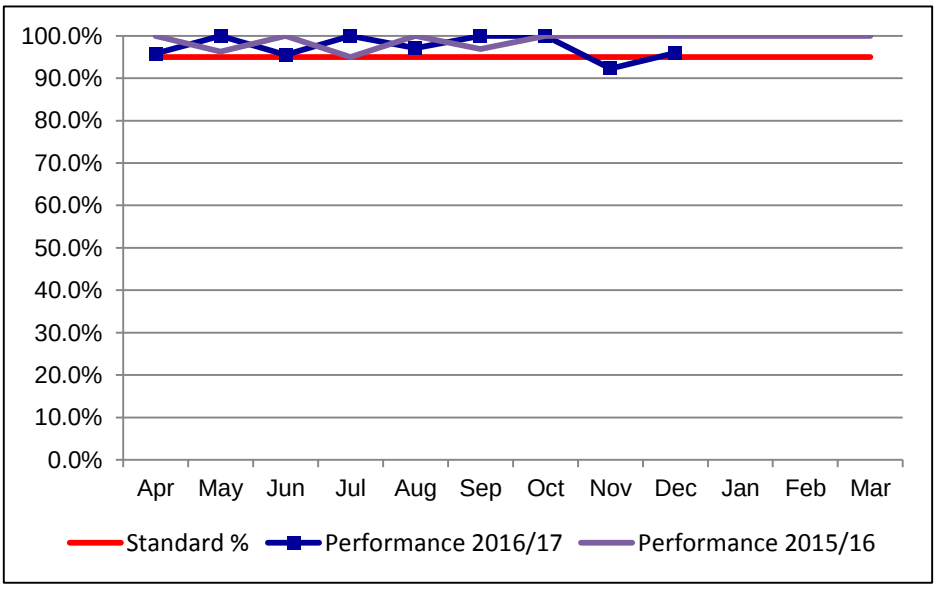
LDP standard performance will be monitored through the LDP Standard Performance Scorecard presented to each Borders Health Board public meeting. These will be available after the meetings on the NHS Borders website as part of the public board meeting papers.

Risks to LDP Standard Achievement

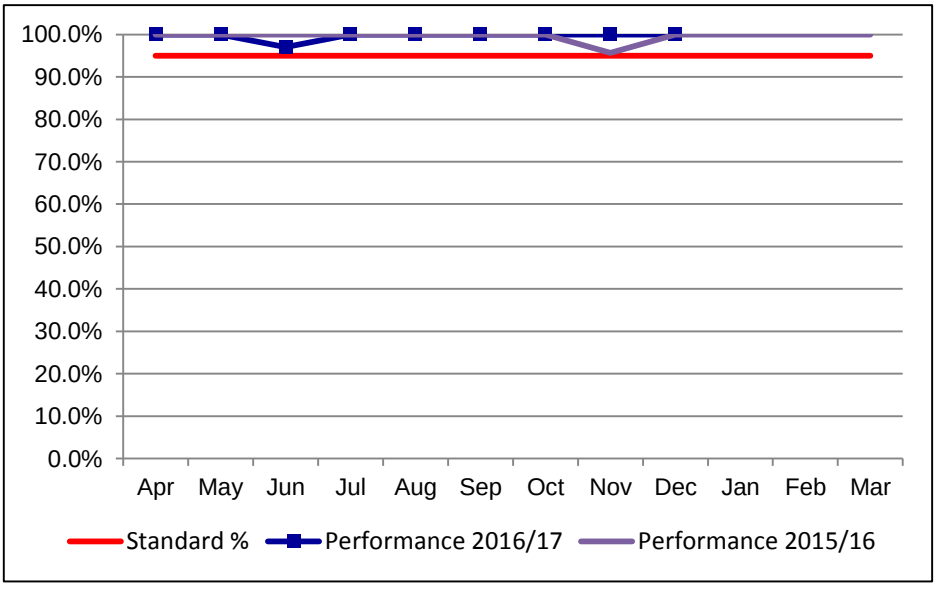
Standards: 95% of all cases with a Suspicion of Cancer to be seen within 62 days
95% of all patients requiring Treatment for Cancer to be seen within 31 days

NHS BOARD LEAD:	Claire Pearce Director of Nursing, Midwifery and Acute Services

95% of all cases with a Suspicion of Cancer to be seen within 62 days



95% of all patients requiring Treatment for Cancer to be seen within 31 days



Delivery and Improvement

Risk	Management of Risk
The services which will present the main challenges for NHS Borders in delivering the national Cancer Waiting Times standards are: • Colonoscopy • Urology in NHS Lothian	**Colonoscopy** Demand and capacity analysis has been undertaken for the Service, which shows a deficit in capacity and options are being investigated as to how to resolve these. A new pre-Colonoscopy test is also being assessed, which would potentially significantly reduce demand. **Urology in NHS Lothian** There are ongoing issues with capacity for some specific specialised procedures in NHS Lothian, due to only having a limited number of surgeons who can perform them. NHS Lothian are looking at increasing capacity for these.

Workforce

Risk	**Management of Risk**
Gastroenterology Consultant has recently tendered resignation.	Nurse Colonoscopist has been undertaking additional lists to increase capacity within the Service.

Finance

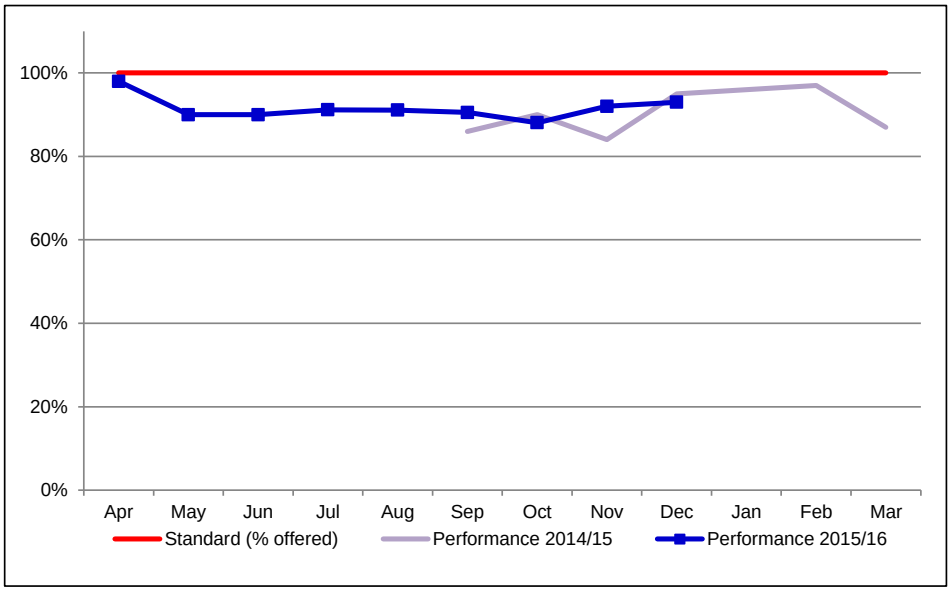
Risk	**Management of Risk**
If potential vacancy within Gastroenterology is not filled, there may be a need for locum cover to maintain the service.	Attempt to recruit a replacement Consultant.

Equalities

Risk	**Management of Risk**
Recognise individual patient needs.	Equality and diversity support and training is available for those teams requiring support.

Standard: People newly diagnosed with dementia will have a minimum of 1 year's post-diagnostic support

NHS BOARD LEAD:	**Elaine Torrance, Interim Chief Officer, Scottish Borders Health and Social Care Partnership**



Delivery and Improvement

Risk	Management of Risk
Available capacity to respond is shown to be inadequate.	Uptake of this new service to be monitored through the Operational management team, and issues escalated timeously.
This new service needs to be responsive to people newly diagnosed with dementia.	Develop appropriate throughput by engagement with other relevant services offering support.

Workforce

Risk	Management of Risk
Service is delivered through a small number of staff and is therefore more at risk with staff leaving.	As the service is delivered within community team staff team and is work is overseen team Manager priority Post-Diagnostic Support will be proportionate.

Finance

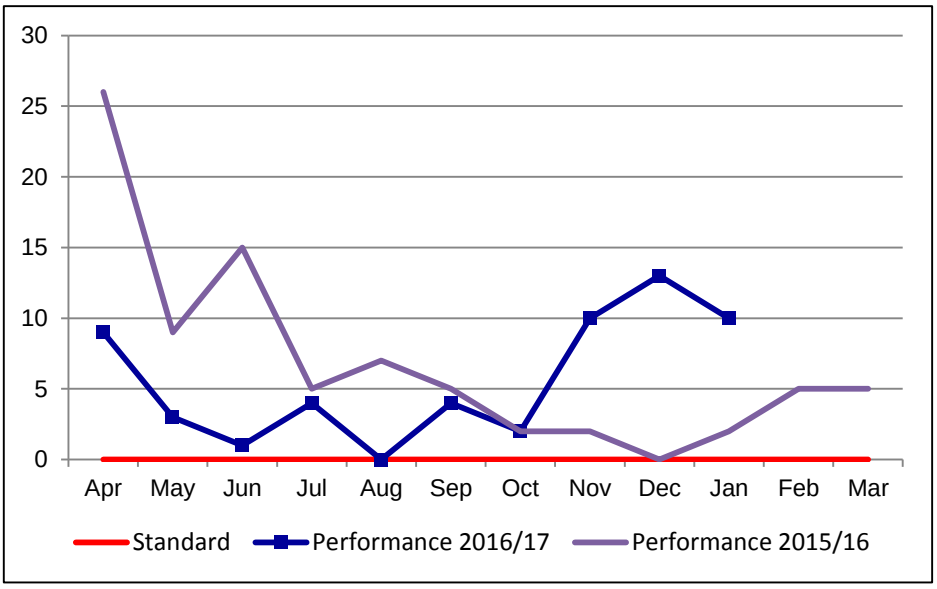
Risk	Management of Risk
Service currently funded through NHS Mental Health Staffing	When assuming LDP Target will rollover, consider future financial sustainability.

Equalities

Risk	Management of Risk
As a new service, requirement to demonstrate that access and delivery is equitable across the Borders.	Monitor activity data to reassure that service access is standardised.

Standard: 12 Weeks Treatment Time Guarantee (TTG 100%)

NHS BOARD LEAD:	Claire Pearce Director of Nursing, Midwifery and Acute Services



Please note: the chart above shows the number of cases waiting over 12 weeks

Delivery and Improvement

Risk	Management of Risk
The service which will present the main challenge in delivering the Treatment Time Guarantee (TTG) in NHS Borders is Orthopaedics. All other specialties have sufficient capacity to meet demand, although there is a risk around short-notice cancellations.	The implementation of IHO should increase the operating capacity available to Orthopaedics from September 2017. This will involve two additional theatre lists per week, and running theatre 50-weeks per year. Short-notice cancellations should also be reduced by work undertaken through the IHO project to 'smooth' admission numbers and ring-fence elective beds.

Workforce

Risk	Management of Risk
Difficulty in recruiting Ophthalmology Consultants	There are currently two locums employed within the Service to maintain capacity.

Finance

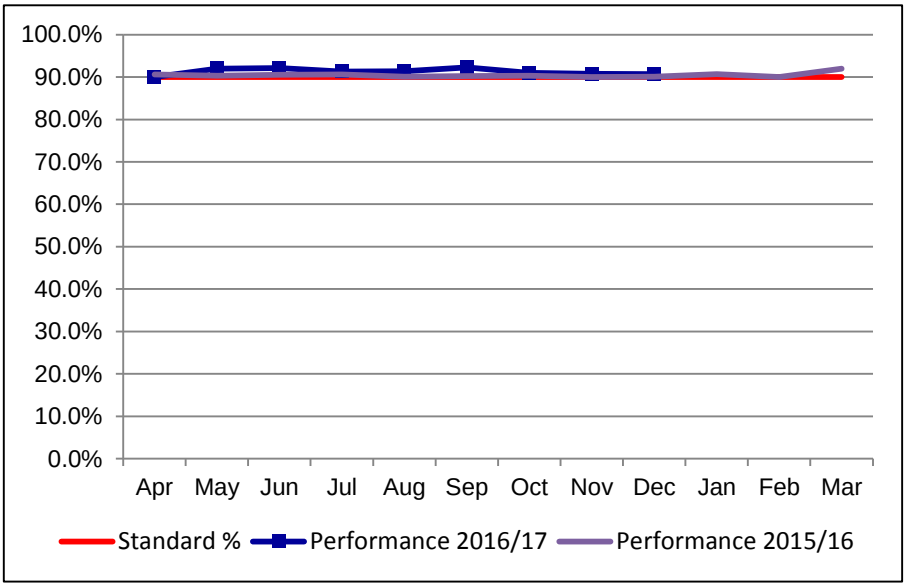
Risk	Management of Risk
Investment will be required to increase operating capacity. The additional lists required to support IHO recommendations will require additional Anaesthetists and Theatre Nurses.	Waiting Times funding will be diverted to support additional staffing. In the longer term it should be possible to repatriate activity from Golden Jubilee.

Equalities

Risk	Management of Risk
Patients may lose the opportunity of treatment at Golden Jubilee.	Communication with patients.

Standard: 18 weeks Referral to Treatment (RTT 90%)

NHS BOARD LEAD:	Claire Pearce Director of Nursing, Midwifery and Acute Services



Please note: The chart above shows the combined pathway performance

Delivery and Improvement

Risk	Management of Risk
The services which will present the main challenges in NHS Borders in meeting the 18-week Referral to treatment standard are: • Dermatology • Orthopaedics • There are some ongoing issues around reporting, which IM&T are looking to resolve.	**Dermatology** A long-term locum arrangement is in place to provide additional capacity, plus there are further actions to improve productivity and manage demand within the Service. **Orthopaedics** The implementation of IHO should increase the operating capacity available to Orthopaedics from September 2017. This will involve two additional theatre lists per week, and running theatre 50-weeks per year. **Reporting** In the meantime, records are being manually validated to ensure compliance.

Workforce

Risk	Management of Risk
Manual validation of patient records reduces capacity to undertake other tasks, such as long-term capacity planning	Steps have been taken to ensure that process is as streamlined as possible. IM&T have been requested to look at and revise the database which is currently in use.

Finance

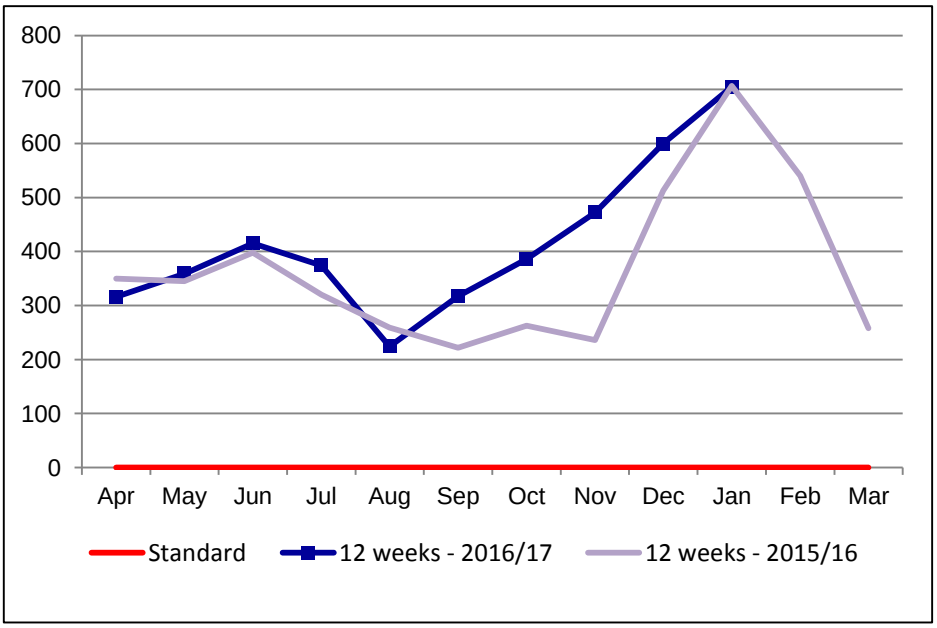
Risk	Management of Risk
Some investment will be required to increase operating capacity in Orthopaedics	The Scottish Government have been asked to provide some additional funding to support this work.

Equalities

Risk	Management of Risk
Recognise individual patient needs.	Equality and diversity support and training is available for those teams requiring support.

Standard: 12 weeks for first outpatient appointment

NHS BOARD LEAD:	Claire Pearce Director of Nursing, Midwifery and Acute Services



Please note: the chart above shows the number of cases waiting over 12 weeks

Delivery and Improvement

Risk	Management of Risk
The services which will present the main challenges in NHS Borders in meeting the 12-week Outpatient standard are: • Chronic Pain • Cardiology • Dermatology • Diabetics & Endocrinology • Gastroenterology	**Chronic Pain** Clinics have been increased in the short-term to clear current backlog of patients requiring appointments, and referral criteria have been amended to reduce demand. **Cardiology** There have been ongoing issues with Cardiology capacity for a number of years, and discussions are ongoing with the Service as to how these can be resolved. **Dermatology** A long-term locum arrangement is in place to provide additional capacity, plus there are further actions to improve productivity and manage demand within the Service. **Diabetes & Endocrinology** Discussions are ongoing as to how to increased

	capacity within the Service on an ongoing basis. **Gastroenterology** Discussions are ongoing as to how to increased capacity within the Service on an ongoing basis.

Workforce

Risk	Management of Risk
There may a requirement to recruit additional Consultant capacity within Cardiology and Gastroenterology. Productivity within Dermatology needs to be improved. Vacant Consultant post within Gastroenterology	If it is shown that additional Consultants are required there will be a recruitment process for these. The Medical Director is taking forward a piece of work to look at productivity within Dermatology. Recruitment process will be required for Gastroenterology.

Finance

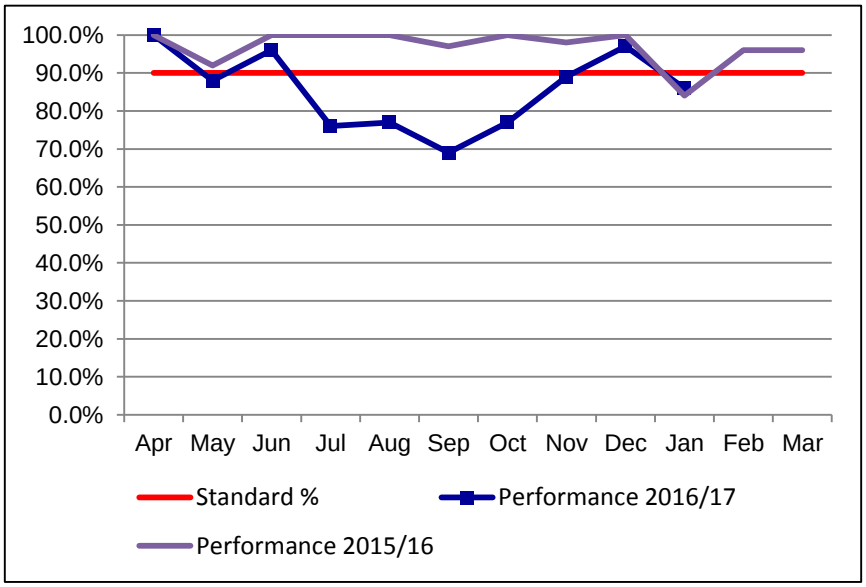
Risk	Management of Risk
If it is shown that additional Consultants are required there will be a cost to support this. The Scottish Government have been funding additional capacity through Synaptik, but as yet this is not confirmed for 2017/18.	If investment is required, an assessment will need to be made as to whether this is affordable.

Equalities

Risk	Management of Risk
Recognise individual patient needs.	Equality and diversity support and training is available for those teams requiring support.

Standard: Clients will wait no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery

NHS BOARD LEAD:	Elaine Torrance, Interim Chief Officer, Scottish Borders Health and Social Care Partnership



Delivery and Improvement

Risk	Management of Risk
This standard is delivered across three services (Borders Addiction Service (BAS); Addaction and Castle Craig (minimal numbers). BAS and Addaction are majority funded through ADP funding which has been subjected to 22.4% reduction. Castle Craig is within our geographical area but we have no influence on performance.	Systems are in place to monitor waiting times within BAS and Addaction to alert managers to potential breaches. Waiting times data is reviewed by the ADP Executive and Data Sub-group. BAS is using improvement data to maximise time available for face to face contact with clients. A review of commissioning was undertaken by the ADP in Autumn 2016 and recommendations from this are being taken forward during 2017-18. Board areas commissioning Castle Craig will have arrangements in place to monitor waits.

Workforce

Risk	Management of Risk
BAS has experienced significant staff turnover and is anticipated some staffing changes.	BAS are actively managing vacancies, staffing and caseloads.

Services staff may become destabilised pending funding arrangements being confirmed for 2018-19.	The ADP Executive has regular contact with service managers. Staff are briefed on decisions when made and were able to contribute to the review of commissioning.

Finance

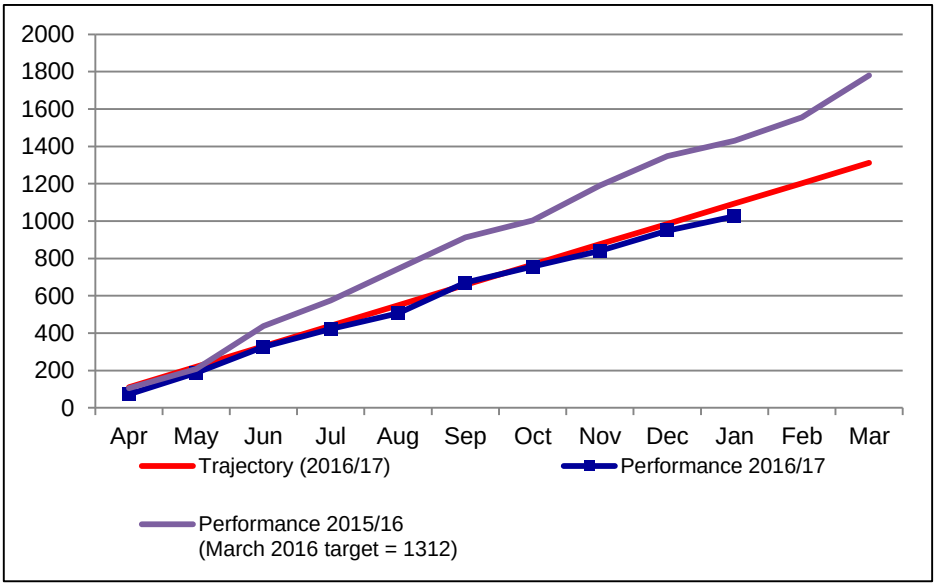
Risk	Management of Risk
BAS and Addaction are majority funded through ADP funding which has been subjected to 22.4% reduction.	IJB EMT is aware of risks associated with the overall budget reduction. Work is ongoing in services to address savings targets. ADP budget is reviewed quarterly by the ADP Board and Executive Group. ADP budget is confirmed for 2017-18 and ADP will to report to IJB EMT in June on plans for 2018 onwards.

Equalities

Risk	Management of Risk
English may not be the first language of those screened and referred on. Those with literacy problems may have problems reading information literature. Targeted groups may not be able to access service.	Information on accessing interpreters and information resources is routinely disseminated to practitioners. Service staff are deployed on a 'locality' basis to increase accessibility for clients.

Standard: Sustain and embed alcohol brief interventions in 3 priority settings (primary care, A&E, antenatal) and broaden delivery in wider settings

NHS BOARD LEAD:	Tim Patterson, Joint Director for Public Health



Delivery and Improvement

Risk	Management of Risk
Delivery has reduced within Primary Care over 2016/17 and is anticipated to continue to reduce with the removal of the Local Enhanced Service (LES). This is as a result of a 22.4% reduction in funding to overall ADP budget and attempts to protect frontline services as much as possible. The agreement to remove this LES was agreed by the Integrated Joint Board Executive Management Team.	Although there is a removal of the LES within Primary Care for alcohol brief interventions it is expected that due to this being in place since 2008, conversations about individual's alcohol consumption will continue within the Primary Care setting but may not necessarily be recorded.
Other settings including Antenatal, Emergency Department and wider settings continue to screen patients as appropriate and deliver Alcohol Brief Interventions (ABIs).	Delivery will continue in other priority settings.

Workforce

Risk	Management of Risk
There is currently no further national training being provided for local areas to provide ABI training for trainers. Any ABI training must be delivered by an accredited trainer. Staff turnover in Borders Addiction Service may impact on capacity to deliver training.	This has been raised with Scottish Government. Borders currently have two accredited trainers. We have asked for this to be on the agenda of the next National ABI Leads meeting (May 2017). Training is scheduled in response to demand and in negotiation with the service.

Finance

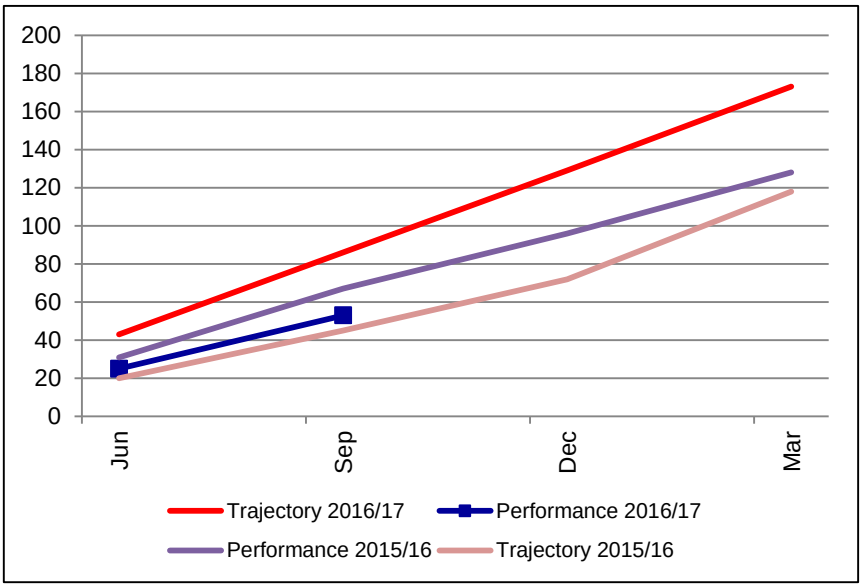
Risk	Management of Risk
The Local Enhanced Service (LES) with Primary Care has been withdrawn in order to meet savings target.	There is no direct financial commitment towards performance. Training is built into Borders Addiction Service SLA.

Equalities

Risk	Management of Risk
Those individuals screened as being appropriate for a brief intervention (by the SMLS) may not always be able to access the BGH easily for a number of reasons (age, disability, transport or financial difficulties, mental health problems). English may not be the first language of those screened and referred on. Those with literacy problems may have problems reading information literature.	GP's are notified of any positive screenings and may choose to intervene when the person is next seen. Information on accessing interpreters and information resources is routinely disseminated to practitioners.

Standard: Sustain and embed successful smoking quits, at 12 weeks post quit, in the 40% SIMD areas

NHS BOARD LEAD:	Alison Wilson Director of Pharmacy



Delivery and Improvement

Risk	Management of Risk
Nationally there is fall of in numbers of people referring to service. This makes delivery of service and target challenging. Significant increase in number of quits required to meet standard is unlikely to be met. Nationally negotiated contract with pharmacies	Leaflets and poster materials redesigned and to be used in a more targeted setting. Trial of dedicated clinic in Teviot Medical Practice Use of radio and Facebook advertising campaigns to increase referrals. Ensure regular communication with community pharmacy lead. Maintain relationship with Smokeline to ensure appropriate signposting. Continue to build links with potential referrers including BGH.

Workforce

Risk	Management of Risk
Staff absence and temporary contracts within the specialist team may result in reduced capacity. Staff movement in other services may reduce knowledge of service and referral routes reduced. Requirement to provide ongoing briefings/training, reduced ability of colleagues to attend due to restriction on training	Managing sickness absence policy followed. Funding for midwifery hours continuing. Training will be built into annual workplan. Pharmacies updated via scheduled NES evenings. Bespoke sessions via team meetings/'drop-in training sessions' to maximise attendance.

Finance

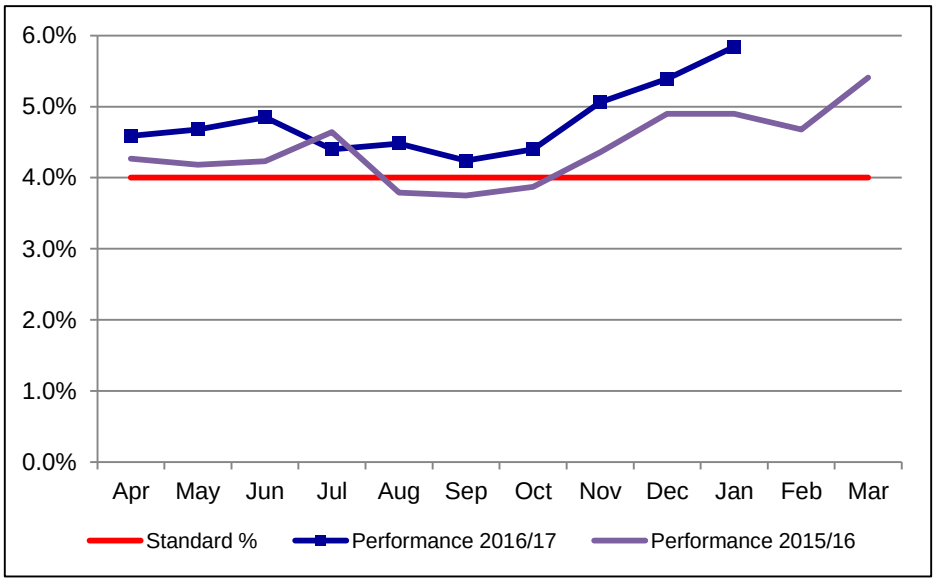
Risk	Management of Risk
Funded via effective prevention bundle which may be subject to reduction centrally.	Ongoing monitoring of service uptake, results and staffing levels.

Equalities

Risk	Management of Risk
People in more vulnerable groups less likely to access service	Services are available via different settings throughout Borders and weekend access is available via pharmacies. Advisors can offer telephone support/home visits to individuals unable to physically access service Close working relationship with key partners in midwifery and mental health continue.

Standard: Maintain Staff Sickness Absence Rates below 4%

NHS BOARD LEAD:	June Smyth Director of Workforce and Planning



Delivery and Improvement

Risk	Management of Risk
Sickness Absence is not appropriately managed	Work continues via the sickness Absence policy group. An extensive work plan which included revision of the existing policy and management training package.
Sickness Absence is not appropriately monitored.	Reports continue to be developed for all Clinical Boards and Directorates. HR advisors have been allocated specific areas so patterns of attendance are noted and highlighted sooner.
Seasonal and/or Infectious diseases cause a significant increase in sickness absence rates.	Flu vaccination programme continues to be offered within NHS Borders. Infection control issues are highlighted at Safety Brief every morning and communicated across NHS Borders.
Working patterns contribute to sickness absence increase	Work continues to test the effects of different shift patterns continues within the facilities department. Electronic rostering is currently being implemented across the nursing and midwifery cohort which might also impact on attendance
Managing of attendance is not seen as a priority	NHS Borders continue to report attendance as part of the Clinical Board Performance Scorecards. This is discussed at each review

Workforce

Risk	Management of Risk
Demographics within NHS Borders staff has highlighted that we have a significantly aging workforce	Work carried out during 2016/17 looking at issues specific to nurses/midwives over 50 will continue
Recruitment becomes challenging	Vacancies are monitored on a weekly basis by the Board Executive Team. Recruitment campaigns continue to be run on a regular basis.

Finance

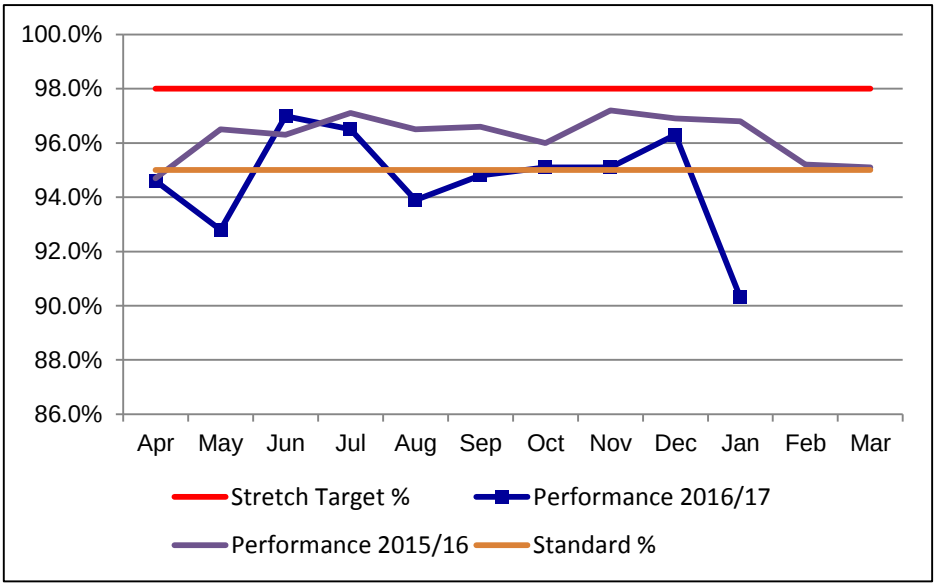
Risk	Management of Risk
Insufficient resources to provide cover to Clinical Areas	Nurse bank recruitment is included within the regular recruitment campaigns. Work continues across the Nursing, Midwifery and AHP Directorate to look at skill mix and alternative delivery models

Equalities

Risk	Management of Risk
Individuals feel they have been discriminated against	HR policy continues to be developed and monitored, In Partnership, via the Policy Development Group. This is a sub-group of the Area Partnership Forum. All HR policies are subject to an Equalities Impact Assessment. Human Resources continue to monitor any complaints of discrimination and support managers to manage appropriately.

Standard: 4 hours from arrival to admission, discharge or transfer for A&E treatment (95% with stretch 98%)

NHS BOARD LEAD:	Claire Pearce Director of Nursing, Midwifery and Acute Services



Delivery and Improvement

Risk	Management of Risk
An inability to achieve timely patient flow due to the number of inpatients inappropriately placed in an acute setting (i.e. do not meet the criteria).	• Senior management attendance at all Multidisciplinary Team Meetings and Board Rounds to unblock, challenge and support resolution of issues blocking timely discharge • Daily oversight of care home capacity to identify vacancies which ca be used to support discharges • Rigorous application of “Choices Policy” and use of interim move method to provide an appropriate setting for the patient • Daily overview of home capacity by START and Social Work Locality Team Leaders
Achievement against standard remains challenging particularly at periods of peak activity and during the late evening and overnight.	• Review and alter medical staff rota to ensure adequately trained and appropriate level of manpower in place to manage safely peaks in patient numbers attending the ED • Availability of senior clinical decision making support both locally and from RIE • Flexible working within Unscheduled Care to ensure ED can either call upon assistance from clinical specialties or redirect patients to the Out of Hours Service where appropriate and safe to do so

Capacity versus demand for service within Acute Assessment Unit.	• Implementation of revised junior doctor rota to enhance clinical continuity and cove for the Unit • Agree and implement nurse staffing model • Review accommodation requirements of the unit and plan/deliver an appropriate alternative solution with due cognisance to the impact upon patient flow, particularly the accommodation needs of the inpatient service
Variation in discharge and transfer processes, in particular timely creation of inpatient capacity (morning discharges).	• Daily input of senior managers to advocate and act on behalf of patients to ensure timely discharge before 11am • Increased consultant led ward rounds and/or appropriate criteria led discharge processes on every ward every day • Same level of emergency patient discharges at weekends and public holidays as at normal week days
Inability to achieve collaborative working across NHS Borders and Scottish Borders Council to achieve EAS by means of admission avoidance, reduced hospital length of stay and supported care in the community.	• Formal Delayed Discharge Group weekly meetings and "Tuesday Huddle" to ensure single system approach • Development of shared care support worker roles and posts • Remodelling of "Rapid Response" to enhance access to home care support out of hours
Ensuring sustainability of improvements delivered by the Transforming Urgent Care Project.	• Appointment of fixed term Clinical Lead and Project support and agree adjustments within BECS budget to ensure long term delivery of improvements

Workforce

Risk	**Management of Risk**
Sustainability of medical workforce in ED with particular reference to the available consultant resource, and reliance on Speciality GP Docs and junior staff.	• Review improvements to new medical rota and further enhance the consultant level resource to provide best practice service provision and support medical workforce
Succession planning for ENP service.	• Further to increasing the number of ENPs nursing roles in Unscheduled Care will be subject to review in terms of aligning core skills to support collaborative working/enhanced cover
Knowledge and skills requisition and maintenance for nurses in minor injury/illness centres across Scottish Borders.	• Nurses in minor injuries/illness centres in Community Hospitals are offered opportunities to refresh skills and knowledge by working in ED

Consistent and competent site management.	• Robust and consistent escalation in both ED and AAU • Touch points – Safety and Flow meetings should be attended without exception by Hospital Bleep Holder and Duty Manager • The decision making sessions which follow the Flow Meetings at 11am and 2.50pm should be facilitated by the Duty Manager and followed up with drafting of robust plans for bed management and staffing
Maintaining safe nurse staffing levels within ED and AAU to ensure flexible response in respect of peaks for service demand.	• Use of "RotaMaster" system for the medical rota in ED • Best practice nurse rota management

Finance

Risk	Management of Risk
Use of ED or AAU for surge capacity.	• Improve management of nurse rotas to ensure level loading and staff resilience with the view to reducing sickness absence and there the need for additional bank or agency
High use of locum or agency staffing.	• Agree budget at beginning of new financial year • Improved scheduling of medical staffing shifts • Manage sickness absence consistently within Board Policy

Equalities

Management of Risk
All HEAT targets should be equality impact assessed to identify positive and negative impacts on equality groups.
NHS Borders must adopt the interpretation and translation policy to ensure that ED personnel are supported and patient care and safety is improved.
Implementation of equality monitoring and patient record markers will support onward referral, treatment and discharge.