Local Delivery Plan 2017/18

Planning & Performance

Contents

Glossary

ADP	Alcohol and Drugs Partnership
AHP	Allied Health Professional
BECS	Borders Emergency Care Service
BHIH	Borders Health in Hand
BI	Brief Intervention
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.

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.

The **executive leads** for each priority area in the 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 Smith, 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 Smith, Director of Nursing, Midwifery and Acute Services
8	Unscheduled Care	Claire Smith, 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 **Measure:** Participation in relevant groups by NHS Board and staff
	Action: Promote awareness of Community Empowerment Act (CEA) within NHS Borders **Measure:** Increase in understanding of CEA within NHS
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:** Public Health supports children and families services and with maternal and child health services to deliver effective interventions to improve outcomes **Measure:** Performance framework for Integrated CYP Plan
Child Health services planning	**Action:** NHS Borders Clinical Strategy drives improvement in child health services **Measure:** Strategy and implementation plan in place
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

Improvement aim	Actions and Measures
	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 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 **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. Tool is being piloted for people with severe and enduring mental health problems. **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:** Maintain delivery of 'A Healthier Me' project with partner agencies 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

Improvement aim	Actions and Measures
	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 **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
Offenders	**Action:** Develop pathways to support offenders health **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. **Measures:** Participants in training Qualitative feedback via evaluation

Improvement aim	Actions and Measures
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 Nutrition and healthy weight Mental health Healthy Living Network **Measure:** Programme evaluation **Action:** Improve reach of screening programmes **Measure:** Uptake by vulnerable groups
	Action: Health inequalities impact assessment of health service planning **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 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. **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 **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 this bereaved 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 Support to maternity and early years settings to improve early diet choices 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)

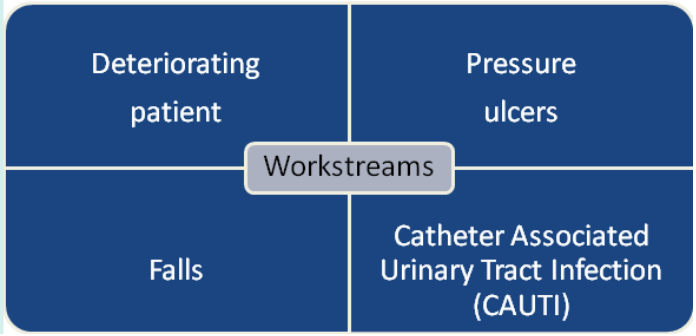
Improvement aim	Actions and Measures
GIRFEC implementation	**Actions:** Continue to implement the new HV pathway to improve support for families Strengthen HV service with expanded staffing and improved management and support **Measure:** Pathway in place **Actions:** Continue to provide specialist Public 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 Smith** **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

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. • To reach out to seldom heard groups and individuals to ensure that we collect and receive feedback and input that is representative of our population as a whole. • 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
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). 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 may not be required 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. <u>Communication:</u> 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. <u>Sepsis:</u> 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. <u>Medicines:</u> 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. <u>Venous thromboembolism (VTE):</u> 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. <u>Falls:</u> 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. <u>Pressure Ulcers:</u> 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.

	<u>Catheter Acquired Urinary Tract Infection (CAUTI):</u> 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. <u>2017/18</u> 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.
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> A local implementation plan will be developed by the Integrated Joint Board during 2016/17 which will support the delivery of the recommendations highlighted in Sir Lewis Ritchie's review of out of hours primary care services. This was detailed in our Integrated Joint Board response letter earlier this year. Sir Lewis is due to visit NHS Borders again on 11 April to review progress to date. 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 IMT 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 March 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; • <u>Urgent Care</u> - 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. • <u>Community Response</u> – 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 (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 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 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 units (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 PDS 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. 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. <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. 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. 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 advances 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, will review the management of respiratory patients to help prevent readmission to hospital and GP consultations.

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 Over the past 12 months key performance information 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 Smith** **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 Smith 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 boarding does not impact on length of stay through early review of boarded patients. In parallel work towards eliminating boarding.
- 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 boarding 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 speciality 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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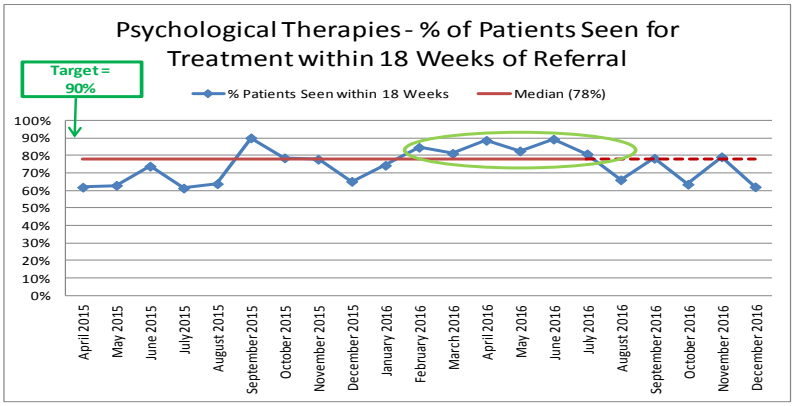
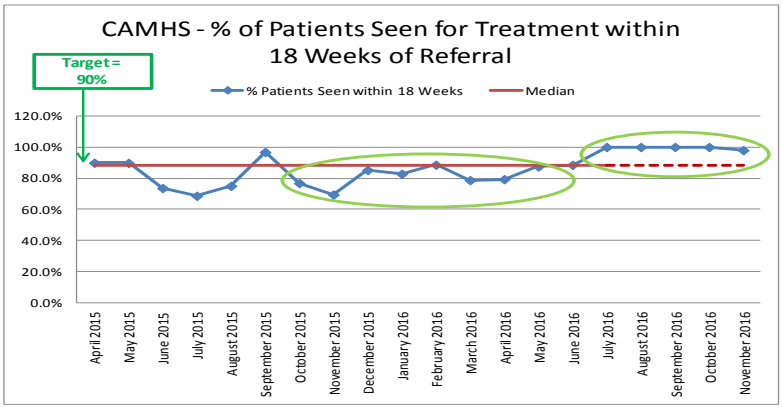
Priority Area 9: Mental Health **Executive Lead: Elaine Torrance** **Interim Chief Officer**	
1. **Psychological Therapies LDP Standard: 90% of Patients will be seen for Treatment within 18 Weeks of Referral**	
Background	This LDP Standard states that 90% of patients referred for a Psychological Therapy (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 in year 1 – plans for additional years are currently being considered and a project plan for Improving Access to Psychological Therapies is being developed.
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 December 2016 for information. From February 2016 to July 2016 there was a shift (circled) in performance above the median line of 78%. There is no clear reason for this. However, this shift was not sustained and performance at the end of December 2016 was 62%. 
Local improvement aims	The Improving Access to Psychological Therapies project plan aims to achieve the standard by focussing on two main improvement areas: a. Reduce Did Not Attend (DNA) and Cancelled by patient (CP) Rates b. Management of Available Appointment Slots

Improvement Actions	The following actions will be undertaken as part of these two improvement areas: a. <u>Reduce DNA/CP Rates</u> i. Review and re-launch the Mental Health Service DNA policy ii. Ensure consistent application of the DNA policy across all Mental Health Teams iii. Introduce a text reminder service for Psychological Therapy appointments b. <u>Management of Available Appointment Slots</u> i. Reviewing clinician job plans ii. Clarify expected number of appointment slots per clinician per week iii. Populating clinician diaries with expected number of appointment slots per week iv. Admin staff to manage bookings directly into clinician diaries using the pre-populated appointment slots
Improvement Measures	The following improvement measures will be monitored to ensure the actions being put in place are effective: • Outcome Measure: percentage of patients seen for PT treatment within 18 weeks of referral • Process Measure: percentage of DNA/CP appointments • Balancing Measure: additional administrative time (in hours) spent populating diaries and sending text reminders
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; however we have been unable to recruit to the ADHD Nurse post. Future plans are now being considered.
Current Performance	The chart below shows performance against the standard from April 2015 to December 2016 for information. The standard was not consistently met between April 2015 and April 2016 and in fact during this time there was a shift below the median line. However performance then increased and the service has achieved 100% performance from July onwards. This is a

	positive shift (circled) and indicates an improvement. This improvement is due to a review and subsequent revision of the internal recording, monitoring and management process. Performance dropped slightly in both November and December 2016 to 98%, and this was due to a known and unavoidable case in each month. 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. We will introduce 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 • Work with HIS to review Neurodevelopmental pathways • Consider developing a CAMHS Service Specification to ensure the appropriate resource is focussed on the most appropriate patients
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: 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.

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 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 indicators of "iMatter".

engaged workforce".		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 informed practice and	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).

	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"

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.

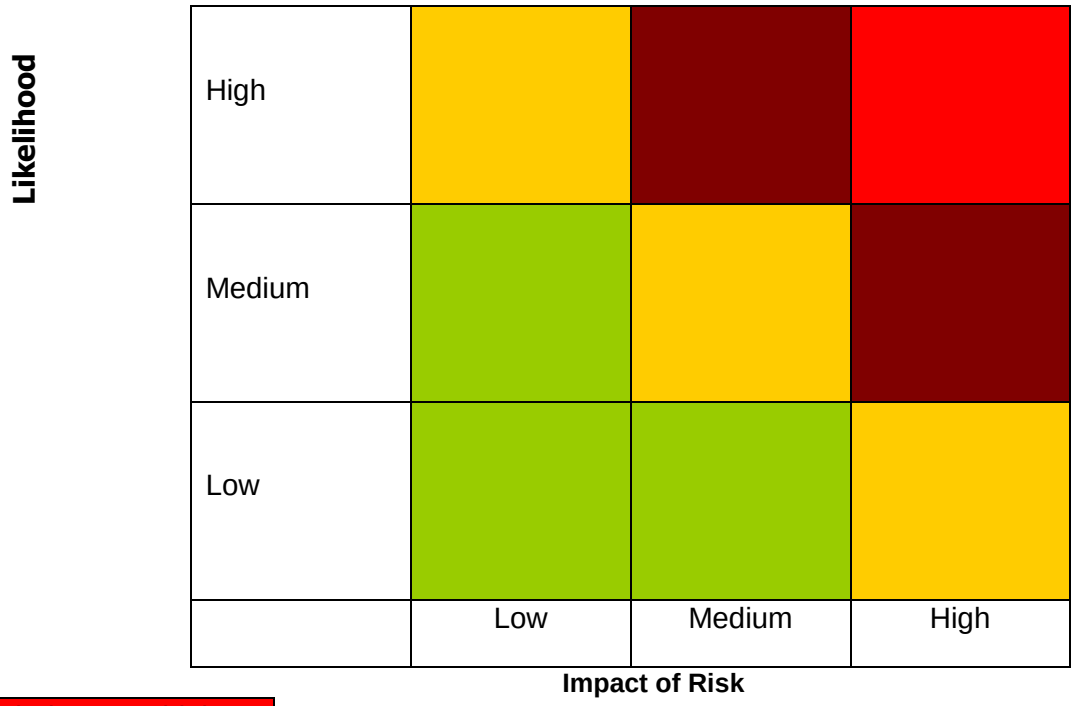
Source of Risk:	**Reduction in Training Grade Doctors Across Key Specialties** **Requirement to Achieve Financial Targets Despite Loss of Income**
Risk:	• Patients do not receive appropriate care within NHS Borders • Hospital or individual service closure • High cost replacement – agency staff
Managed by:	• Role Development Framework for Advanced Practice • Model for Alternative Medical Roles e.g. Consultant delivered services, CDFs. • 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.

Section 3: 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.