NHS Borders

Local Delivery Plan 2016/17

Planning & Performance

Contents

Glossary

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

HLN	Healthy Living Network
HSMR	Hospital Standardised Mortality Rate
IRIO	Integrated Research and Innovation Office
ISD	Information and Statistics Division of National Services Scotland
IUCD	Intrauterine Contraceptive Device
JIT	Joint Improvement Team
KSF	Knowledge and Skills Framework
LASS	Lifestyle Advisor Support Service
LD	Learning Disability
LES	Local Enhanced Service
LTC	Long Term Conditions
LUCAP	Local Unscheduled Care Action Plan
MAU	Medical Admissions Unit
MCN	Managed Care Network
MIU	Minor Injury Unit
NES	NHS Education Scotland
P&CS	Primary and Community Services
QPQOF	Quality and Productivity Quality and Outcomes Framework
SAB	Staphylococcus aureus bacteraemia
SAS	Scottish Ambulance Service
SBC	Scottish Borders Council
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

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

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 HEAT 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.

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

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

	Priority Area	Executive Lead
1	Health Inequalities and Prevention	Tim Patterson
2	Ante-Natal and Early Years	Tim Patterson
3	Person-Centred Care	Evelyn Rodger
4	Safe Care	Cliff Sharp (Interim)
5	Primary Care	Susan Manion
6	Integration	Susan Manion
7	Scheduled Care	Evelyn Rodger
8	Unscheduled Care	Evelyn Rodger
9	Mental Health	Susan Manion

Health Inequalities	
	Executive Lead: Tim Patterson
Targeting resources to the most deprived – community & assets-based approaches	The Healthy Living Network (HLN) takes an assets based approach in its work with local communities and with partners. Volunteering development features strongly for example through peer support. HLN also supports community members to undertake the Health Issues in the Community programme and to support those who complete the programme to use their skills and confidence.

The HLN continues to work in close partnership with key community groups and partners including Registered Social Landlords in areas of high deprivation (Burnfoot, Langlee and Eyemouth) to improve health and enhance access to health and social care.   HLN is an active partner in the Community Learning and Development Strategy and supports implementation in localities.   In addition HLN is making an active contribution to the locality planning processes for health and social care, as these evolve.

Targeted programmes for protected characteristics groups continue.   We have used initial consultation and engagement work with migrants to improve access and uptake and will continue to deliver a range of programmes and initiatives to respond to identified community needs.

In relation to welfare benefit reforms, Public Health continues to raise awareness among staff of the impacts of welfare reform as this impacts on the local population.   The project on Financial Help in Early Years, funded through the Scottish Government Health and Welfare Fund, has provided opportunity to build capacity among maternity and child health staff of resources and pathways for families affected.   The project has been working closely with the Early Years Centres to raise awareness of sources of help and advice and as the project comes to conclusion, the learning and resources developed will be integrated into mainstream services and pathways.   Improvement work has been undertaken, supported by Health Improvement, to increase uptake of Healthy Start entitlements. Maternity services are working increasingly closely with Welfare Benefits services and it is intended to widen this to paediatric services.

 The recent mental health needs assessment and the emerging strategy recognises the need to promote the health and wellbeing of mental health service users. This will be the focus for concerted work in 2016, with support from smoking cessation, health psychology and the LASS service.

Feasibility work is underway within one local community to develop community referral in order to support those at risk of poor mental health and suicidal behaviour.   Men of working age are a focus for this project, delivered in partnership with the third sector. |

Targeting resources to the most deprived – service approaches	The local Keep Well service continues to deliver health checks targeted at our more deprived communities to reduce inequalities in health, focusing on CVD risk factors and wider determinants of health such as literacy/numeracy, income and benefits advice, and mental health & well-being. Planning for the withdrawal of central funding by 2017 is well advanced and the service will continue but focus on those at greatest need and become fully integrated with the Lifestyle Adviser Support Service (see Prevention section).
	Other services that are targeting the more deprived communities and localities to reduce inequalities in health include:
	• Detecting Cancer Early campaign – there is great potential for screening programmes to exacerbate inequalities in health because uptake tends to be lower in more deprived populations. To prevent this the local programme is being proactive in promoting screening in such local populations with some success.
	• Smoking cessation – the LDP HEAT Standard focuses on those from more deprived areas and the local Quit4Good service is currently on target to reach out and encourage uptake in these areas where smoking prevalence is highest and support quits
	• Long Term Conditions (LTC) project – a pilot project working with two general practices is using the House of Care model and implementing a range of changes to improve the shared management of LTCs, which are more prevalent in more deprived populations. This work shows promising positive outcomes for service users in terms of health, well-being and reduced inequalities, and reduced demand on primary care services
Tackling inequalities faced by people with a learning disability	The Learning Disability Service continues to work closely with Public Health to promote awareness and develop skills and knowledge among people with learning disabilities, carers and service providers. There are many interventions planned over 2016-17 which address recommendations within 'The keys to life' 2013 and are captured within a local action plan, structured around 4 priority areas. Some of the following are examples of this:
	The Keep Safe scheme in Scottish Borders in partnership with Safer Communities. This is established in 2 main towns and will be rolled out across the Borders in 2016. This Health Improvement lead responsible for this initiative also coordinates the 'A Healthier Me' action plan with a key leads network of service providers. This network will mainstream the Healthier Me approach to a healthy lifestyle throughout learning disability services in the Borders. An adapted programme of safe relationships and sexual health awareness is being offered to young people with learning disabilities.

	The 5 Locality Citizens Panels continue to meet 5 times a year as part of the Learning Disability Governance Structure and following their evaluation in 2015 have an action plan in place to continue to improve and grow. A celebration event is planned for February 2016 to enable panels to showcase some of their achievements to date and enable people to come together to inform plans for the future. The learning disability nursing team have drawn up a work plan with a number of targeted health intervention plans for people with learning disabilities in 2016. These include among others health groups, screening and health checks. A learning disability liaison service to the Borders General Hospital supports people with learning disability in planned and unplanned admissions. We are progressing the introduction of a flag within Trakcare in the hospital for people with learning disability. The Community Learning Disability Nursing Team implemented the Health Equalities Framework (HEF) in May 2014, completing the HEF tool for all new referrals. All existing referrals had a HEF completed by end Nov 2015. Through identifying levels of exposure to health determinants nurses are able to target interventions and evidence outcomes to improve the health and reduce the impact of health determinants on people with learning disabilities. A small pilot is currently being run across the wider learning disability team to evaluate the use of the tool as a service wide outcomes tool. This is highlighting the need for agreed processes to ensure accurate use of the tool where multi-disciplinary approaches are employed. We continue to carry out proactive screening with all people with Downs Syndrome for dementia from the age of 30 onwards as well as having a reactive pathway for all referrals for dementia screening and a post diagnostic pathway. In 2016, Project SEARCH will be launched as a partnership arrangement between Scottish Borders Council, NHS Borders and Borders College. This initiative aims to bring people with learning disabilities into competitive employment through on-site internship experiences over 1 year. It is for young people with learning disabilities and/or autism, aged between 17-24, who are nearing the end of their time in education and who are committed and ready to progress into paid employment after the course. There will be 8 places in this first group. Integrated Care Fund money has been granted to develop and improve the Transitions Pathway for young people moving into adult learning disability services with a clear project plan overseen by the multiagency Transitions Steering Group.
Health inequalities	Inequalities in Mental Health are a priority for the health inequalities

and Mental Health	action plan in development. This includes: • Promoting the wellbeing of people with mental health problems to reduce barriers to healthy life styles and to support behaviour change • Awareness raising and capacity building to enable more people to access support for mental health and wellbeing from a wider range of sources (including non medical support) • Reviewing how support for people in distress can be improved • Supporting carers including those affected by suicide
Health Inequalities and Physical Activity	NHS Borders through Public Health work with partners to develop physical activity programmes for those who are inactive or with low levels of activity. Programmes continue to be targeted in areas of deprivation and disadvantaged groups. We are working with partners Border Sport and Leisure Trust to signpost NHS patients to community based activity programmes. Work is also underway to develop a physical activity programme for people with diabetes and will be targeted to areas of higher deprivation in 2016.
Reducing Inequalities Strategy	The CPP has produced a Reducing Inequalities strategy in 2015 and this is leading into more focused action planning on health inequalities, led by Public Health. The action planning process is actively engaging with health and social care partners, the third sector, children and young people's planning structures and wider community planning partners.
Health impact of Rurality	Many health issues and impacts in rural areas are similar to those in urban or suburban locations. There are, however, a number of key issues that particularly affect health in rural communities. Many of these interact. So, for example, the problem of lower wages in rural areas compounds the extra costs associated with reliance on motor vehicles and higher food and fuel costs. Other factors include: • Population – youth out-migration and ageing of the population • Economy – lack of major employers and reliable work; lack of diversity • Employment – 'portfolio' careers (seasonal working and seasonal/ transient workforce), lower wages; lack of jobs for young people in some locations; recruitment and retention of high skill workers • Access to Services – need to travel long distances to access services and amenities • Physical Environment – different patterns of land use, physical terrain, water and land use • Infrastructure – vulnerability of supply and distribution chains; higher costs • Cost of living – fuel costs; food costs

	• Resilience of people in rural communities - Many of these issues relate to the physical environment and long distances in rural areas. These pose challenges for the provision of infrastructure and services. The Directorate of Public Health and Scottish Borders Council Planning Department have worked together to give local developers tools and support to undertake Health Impact Assessments in the Borders to ensure that infrastructure and services are supportive of public health and the reduction of health inequalities.
Measures that will be used to assess improvements made	The health inequalities action plan (in development) and the Public Health Scorecard will be used to monitor progress.

Prevention	
	Executive Lead: Tim Patterson
Anticipatory care	The local Lifestyle Advisor Support Service (LASS) provides an integrated service to support health behaviour change and has three strands: • Mainstream LASS, operating in primary care and communities, supports lifestyle change to reduce risk of ill health associated with CVD, diabetes and stroke. The distribution of those targeted and attending LASS favours the more deprived and disadvantaged and therefore it contributes to local effort to reduce inequalities in health. • Keep Well Borders targets hard to reach/more deprived groups and those at higher risk of ill health(see Health Inequalities section) • Tier 2 weight management offering a bespoke approach to reduce weight looking at food behaviours, diet and weight management
Gender Based Violence	NHS Borders continues to support the Pathways project that provides a co-ordinated interagency response to domestic abuse. NHS Borders facilitates and supports the partnership work on prevention within the VAW Partnership. This includes awareness raising and training within NHS Borders to improve early identification of domestic and other abuse and appropriate signposting to support for those affected. Connections between GBV work and early years health improvement are integrated into the early years action plan.
Health Promoting Health Service	Over 2015 we continued to build on the successes of the local social marketing campaign, 'Small changes, big difference', targeting staff, patients and visitors with health improvement messages and

	opportunities (training & development; personal pledges; access to resources to support health improvement conversations). Improvements are continuing in pathways from secondary care to lifestyle support services, including support for those accessing mental health services. 2016 sees a strengthening of the health inequalities focus with the introduction of specific measures around financial inclusion, mental health, homelessness and Managed Clinical Network pathways. Plans are progressing to roll out the marketing campaign to SBC, and to focus on improving staff health and well-being in NHS Borders and the Council (their own health and as providers of health and social care services).
Alcohol whole population approach	Alcohol Brief Intervention delivery continues: In priority settings and also in LASS and Keep Well. Supporting delivery in wider settings including social work, police custody suites, Anti-Social Behaviour Unit, Learning Disabilities Service and Penumbra Youth Project. Working with Education to develop a Borders approach to substance misuse education as part of an integrated approach to health and wellbeing in schools. Support will continue to be given to the Local Licensing Forum and to the development of an annual Alcohol Profile to inform licensing decisions. This will include presentations to Area Forums relating to findings from a local Alcohol Project and information about the Licensing Process to enable communities to become more involved
Promoting healthy weight	Public Health continues to leads on implementation of multi agency approaches to reduce barriers to healthy eating and physical activity in a range of settings across the life span. Priorities are: promoting access to and availability of sustainable food within local communities; and the development of knowledge and confidence in the workforce. This links closely to the physical activity work described above.
Sexual health	The joint sexual health strategy for Scottish Borders is being updated in 2016 and continues to focus strongly on inequalities. Through the expertise within the Joint Health Improvement, sexual health services and school nursing, we continue to support capacity in partner organisations to work with young people and other target groups to promote healthy relationships and prevent STIs, HIV and unwanted pregnancy and to tackle stigma and discrimination. Education, third sector youth work services and LGBT networks are actively involved in this. Education is leading working on relationships education as part of the development of wider integrated approach to health and wellbeing and learning.

Detecting Cancer Early	A DCE awareness raising programme was delivered amongst networks working with deprived communities and staff working with vulnerable groups (mental health & learning disabilities services). Key aims were to promote uptake of cancer screening opportunities, increase awareness of warning signs and symptoms, and encourage those with concerns to make early contact with health services. This awareness is now being embedded into core business via these networks within a broader health improvement and inequalities framework.
Tobacco	A Tobacco Control Plan has been developed involving key partners and has a cross cutting theme to reduce health inequalities. In addition the Joint Health Improvement Team are leading on work to enable NHS Borders and Scottish Borders Council to sign up to Scotland's Charter for a tobacco-free generation. The Charter is aimed at organisations whose work impacts on young people and families and will result in supporting prevention actions to protect children from the harmful effects of tobacco.

We will continue with the current tobacco prevention programme with young people in partnership with Community Learning & Development to support the objectives of the Children and Young Peoples services plan. Tobacco prevention programmes are targeted at areas of higher deprivation and vulnerable groups of young people. The promotion of Smoke Free Homes will be focused through our Early Years work and other community facing programmes. |
| **Long term conditions management** | This 2 year project has been extended to end June 2016 to allow comprehensive evaluation. The project is testing out improvements in the shared-management of long term conditions (LTCs) amongst older people, in the context of two GP practices. Early evaluation results show positive outcomes for patients and practices resulting from holistic assessment and tailored support by the Red Cross, particularly for those with multiple morbidities who are struggling to cope.

Overall aims include:

• improved access to assessment, information, advice and support (practical and emotional) for individuals and their carers;

• improved health and well-being and reduced health inequalities; and

• reduced inappropriate demand on Practices;

Evaluation findings will help to inform future developments as part of the broader integration agenda. |
| **Measures that will be used to assess improvements made** | The health inequalities action plan (in development) and the Public Health scorecard will be used to monitor progress. |

Antenatal and Early Years	
	Executive Lead: Tim Patterson
Improvement aims agreed locally	The Scottish Borders Children & Young People's Health Strategy identifies the aims and outcomes with measures agreed as part of the Improvement Framework.
Development of integrated locality model of service delivery	NHS is an active partner in the Early Years Centres in four areas of high deprivation across Borders. Two were established in 2014 -15 and a further two came on stream in 2015 -16; work continue to provide a 'hub and spoke' model of support in the areas that do not have an Early Years Centre. NHS maternity and child health services are being delivered as part of a multi-agency approach, underpinned by the GIRFEC methodology, to support families in these areas with a focus on those who are hard to reach. The locality Early Years Networks are supported to incorporate improvement methods as a means to further local service development and to take forward the priorities identified by the multiagency Early Years Group. We are already making use of the data from 27 month Child Health Reviews to improve attainment of developmental milestones in particular in relation to child weight / nutrition and to speech and language development. The introduction of the new universal health visitor pathway will bring additional opportunity for health improvement work with families through increased health visiting contacts.
Parenting support	The Psychology of Parenting programme will continue in 2015 and health staff are actively involved in this. The Family Nurse Partnership was introduced from July 2015 as a hybrid model in partnership with NHS Lothian, the monitoring/review of this model will continue throughout 2016/17. Transitions work is an important focus with the improvement work of the Early Years Collaborative. The implementation of the GIRFEC practice model will continues to support smooth transitions into and between services. Improvement work on attachment focused practice is informing how we will implement the universal Health Visiting Pathway.
Maternity care and maternal and infant nutrition	We will continue to implement the renewed antenatal education programme, with a focus on promoting early access and consistency of messages for families across different services. In addition targeted work in selected communities will test out the feasibility of strengthening antenatal contact and support. We will implement pathways to enhance maternal health outcomes and reduce health inequalities in relation to tobacco, alcohol, healthy weight and mental health. Further work will be undertaken to maintain Baby Friendly Initiative

	standards, following the attainment of Stage 3 accreditation for community and maternity services in 2014. This includes an NHS led initiative to promote 'baby welcome' environments using a whole systems approach.
	Child Healthy Weight programme implementation in early years settings will continue to support the early years workforce in relation to nutrition and will also deliver targeted work with vulnerable families.
Community capacity building	Continued delivery of collaborative programmes through Healthy Living Network and Community Learning and Development and the third sector to develop skills, confidence and opportunities, including volunteering development where appropriate.
Early Years Collaborative	NHS Borders supported three members of staff to complete the Improvement Advisor Programme with a key future aim to build capacity and capability in using quality improvement tools and resources.
	NHS Borders are key members of the multiagency Early Years Group, a subgroup of the Leadership Group. The priorities for Early Years have been identified that focus on the key themes from the Early Years Collaborative and using data for improvement.
	We anticipate being able to support an agreed set of tests of change so that these can be followed through and learning used for scale up as appropriate.
Early Years and early intervention	This is a Community Planning Partnership (CPP) priority area and more information and actions planned and undertaken can be found in the NHS Borders Contribution to the Community Planning Partnership section.
Children and young Peoples Act (Scotland) 2014	NHS Borders continues to be actively involved in the implementation of 'Getting it right for every child' (GIRFEC) both locally across the CPP and also regionally through the Lothian and Borders GIRFEC Group. There is a Scottish Borders Multiagency GIRFEC plan which sets out the implementation tasks and timelines. In support of this the Health Board has a NHS Borders GIRFEC plan which addresses the specific systems and processes that we have to have in place to support children till they are school age. We have named person training and all midwives and health visitors received named person training in 2014; with additional training being delivered/planned for 2016.
	We rolled out an eGIRFEC learning module as part of our Learnpro resource which all staff across adult and children's services have to complete before progressing to the child protection update eLearning

	module. We developed and have rolled out the Scottish Borders Information Sharing Guidance this is being supported by a training programme to support the document. We have a single plan which is used for all children who meet the criteria for a multiagency child's plan. We are working nationally through the CEL 13 group to establish the numbers of Health Visitors that we will require to carry out both the duties of the Act and the new universal health visiting pathway. We currently have two health visitors in training.
Performance Measurement – measures that will be used to assess improvements made	Our Children and Young People's Health Strategy was developed in 2013 and includes an Improvement Framework with updated progress in 2014 and 2015. The Improvement Framework highlights the sustained effort by staff in improving services and support for children and young people across the Scottish Borders. Additionally an Early Years Improvement Scorecard with aims and measures has been established to support monitoring of progress and to focus activity for improvement work.
Key Documents	Joint Early Years Priorities Includes review of achievements from Early Years Strategy 2012-15; Early Years Improvement Scorecard provides data to support work re Early Years Collaborative. Y:\early years\Early Years Strategy.pdf Early Years Strategy_priorities 20 EYC Scorecard January 16.pdf NHS Borders Child Health Strategy Desired outcomes and measures of improvement included in strategy appendix and updates for 2014 and 2015 included. CHILDYP STRATEGY FINAL.pdf child health strategy update Sept2014 FIN Childhealthstrategyimprovementupdate C NHS Borders GIRFEC Plan Partnership GIRFEC Plan

	[W] NHS Borders GIRFEC Plan.doc [W] Multi Agency GIRFEC Action Plan V10 Aug1 Maternity Care Action Plan This was reviewed and updated in 2015. The current working draft is attached [W] Maternity Care Action Plan 2014-201

Person-Centred Care	
	Executive Lead: Evelyn Rodger
Patients and Carers	We are continuing 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 are 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	We have a solid foundation of public involvement activities to date, over the next 3 years we are aiming to build on this by involving the public to much greater degree in the day to day activities of the organisation. Our objectives in this priority area are: • To continue to actively embed public involvement as a core element of any policy and strategy development and clearly evidence the impact of the input from the public • To develop and refresh the role of the Public Partnership Forum ensuring that the group is well positioned particularly to support the integration of health and social care; and that the work of the group is valued by the organisation and positive outcomes are communicated both back to the group and to NHS Borders. Membership is to be expanded during the year to include wider and more diverse representation. • To extend and include as a matter of routine public members in decision making in a wider variety of working groups within the organisation • To build on the success of the Learning Disability Citizens Panel and the BGH Participation Group, and actively seek to foster and support participation groups around specific services or service developments • To improve our engagement and communication with communities covering a wide range of ages and locations with a particular focus on hard to reach or seldom heard groups. Our Health in Your Hands: What Matters to You? programme of public engagement will test and explore innovative ways of involving the public and capturing the views of seldom heard groups and individuals • Test approaches and improve how we provide feedback to communities • As our involvement infrastructure expands we will explore a model of locality based coverage ensuring that local needs are met and that we align ourselves with the shift towards planning at a locality level

Volunteering	Volunteering plays 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 gain skills and satisfaction from their volunteering role.
	Our objectives are 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 are 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 • 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 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, which is now in final the stages of development • 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; it is currently being tested with Acute Assessment unit (AAU)and the Emergency department (ED) of Borders General Hospital. • Augmenting, then testing, a local version of the national 'getting to know me' booklet to reflect needs of frail patients For 2016/ 17, the aim is to establish a multi-disciplinary frailty team to manage the care and flow of frail patients.
Palliative Care	Palliative Care has seen national and local developments which will inform our Delivery Plan. The Scottish Government Inquiry into Palliative and End of Life Care and the Strategic Framework for Action which was published in November 2015 along with the Scottish Borders Palliative Care Needs Assessment which concluded in April (and helped inform the SG Inquiry) have identified the priorities. The development of a Palliative Care Network will now be responsible for formulating the action plan.

	Outside of this, and with the support of Macmillan, we have an end of life care facilitator who will be implementing out new unitary patient record for end of life care, as well as co-ordinating the approach to an end of life care strategy. Within our palliative care team, we are developing skills to help patients and families manage symptoms, develop outcome measures and create resilience. We are also leading on improving communication skills within the wider NHS Borders staff group including clinical and non-clinical staff.

Safe Care	
	Interim Executive Lead: Cliff Sharp
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 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 & Neonatest)
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"*. With the current aims of two core programmes within SPSP, Adult Acute and Primary Care, ending in March 2016, a 90 day consultation exercise has been underway. The draft report recommends that the coming year is used to: • Embed and spread existing work • Prototype new areas and • Transition programme delivery in line with recommendations
Adult Acute SPSP	**ADULT ACUTE** Please see below a synopsis of the measures and a recommendation moving forward:

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 will be the focus for 2016/17.

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

- Early Warning Scores

These measures will continue to be collected in 2016/17 to ensure the processes are reliably embedded in clinical teams.

Deteriorating Patient Workstream:

The outcome measure for deteriorating patient is a 50% reduction in cardiac arrests (or 300 days between events). This is achieved through a collection of measures such as identification, escalation and treatment of the deteriorating patient, with one of the main causes of deterioration being sepsis.

Communication:

It is recommneded that a focus of safety improvement work for 2016/17 focuses on ensuring SBAR communication is implemented reliably, with particular emphasis on handovers.

It is recommended that as part of the deteriorating patient workstream, debriefs on cardiac arrests are incorporated 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.

Structured Review and Response:

It is recommended that in line with the Connected Care programme,

some testing work for these measures is undertaken. A pilot ward will required to be identified by the Deteriorating Patient Workstream Team.

Sepsis:

Sepsis forms a key component of the deteriorating patient workstream

It is recommended that 'Sepsis Six' bundle is rolled out across all inpatient areas.

Medicines:

Nationally, a medicines workstream has been created spanning all specialities. NHS Borders plan to reflect that model locally in 2016/17 with an improvement focus on medicines reconciliation on admission and discharge.

Red Allergy Bands:

As a result of the ongoing medicines reconciliation audit and a significant adverse event, the introduction of red wrist bands to indicate if the patient has an allergy is being tested. This is a common practice in other hospitals across the country. Whilst not a component of SPSP, the testing work was undertaken in ward 7 and has proved to be both popular and effective with staff and patients alike. It is recommended that this practice is rolled out across NHS Borders in 2016/17.

Venous thromboembolism (VTE):

VTE will not be a core measure for the revised SPSP measurement plan; instead it will be an optional supplementary measure. NHS Borders have been successful in securing national funding for one year for an Improvement Advisor to focus on VTE in NHS Borders. This post will be nationally recognised and lead the way in diagnosing, testing and implementing a suite of measures for VTE.

Falls:

The second phase of the Scottish Patient Safety Programme (SPSP) aims to achieve a 25% reduction in all falls and 20% reduction in falls with harm by the end of 2015, while promoting recovery, independence and rehabilitation. Falls measures form an integral part of the revised measurement plan and the local delivery plan for 2016/17.

As one of the four priority areas for the Nursing Directorate and of the Older People In Acute Hospitals (OPAH) workstream, the Clinical Improvement Facilitators will continue to undertake tests of change and quality improvement in the areas with the highest numbers of falls, whilst triangulating the outcome data with process data and reported events.

Pressure Ulcers:

As one of the four priority areas for the Nursing Directorate, the clinical improvement facilitators will continue to undertake quality improvement in this area, whilst triangulating the outcome data with process data and reported events.

	Catheter Acquired Urinary Tract Infection (CAUTI):
	Testing and innovation work will continue on the patient catheter passport, containing the insertion and maintenance bundles have been rolled out in BGH and Primary Care.
	<u>2016/17</u>
	For the adult acute workstream, it is recommended that improvement support is prioritised in to distinct areas:
	• Frailty
	• Communications (transitions of care, handovers, multi disciplinary team working)
	• Deteriorating patient
	• Medicines
Mental Health	Outcome data continues to be collected on a monthly basis via the reporting template from the Brigs and Huntlyburn. The national team are currently scoping the future of the Programme. Current focus' for improvement is medicines management and risk assessment processes.
Maternity, Paediatrics and Neonates (McQIC)	The national team are currently scoping the future of the Programme and the expected focus in to embed process measures in the deteriorating patient and infection control workstreams in 2016/17.
Primary Care	The national team are currently scoping the future of the Programme.
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.
Innovating for Improvement – Health Foundation Award	An application for funding was made to the Health Foundation Innovating for Improvement Programme to build a model of recognition of deterioration in the community building on the success of the model already well embedded in acute services. The application was successful and funding of around £75,000 was provided to accelerate and test this work over 15 months until September 2016. The aim of the Project is to ensure 100% of patients in the two test sites, receive reliable and timely early warning scores as their clinical condition dictates, to ensure that nursing staff respond appropriately and in a timely manner, and are able to follow a reliable escalation procedure, by July 2016. Test sites will include one community hospital and the out of hour's service covering one geographic area in the Borders. The out of hour's service will work

	with a care home, Community hospital and out of hours nursing team within a defined test area. A project manager and project team are in place and are currently testing changes in process.
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.

Primary Care	
	Executive Lead: Susan Manion
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 joint senior clinical and management arrangements and working practices have continued to support a whole system approach across primary and secondary care.

The proposed new management structure for NHS Borders is has now been concluded and is now building on the success of the existing joint leadership and management roles. The integration agenda across health and social care will support the continuation and development of shared leadership and working practices across a range of services in both the day time and out of hours periods.

NHS Borders has recently launched its review of all clinical services and work across a range of service areas is underway. For Primary Care the outcomes from this review will continue to inform and shape the ongoing discussions and decisions regarding redesign of community based services, for example treatment rooms and minor injury services as well as supporting the local implications of the national review of community nursing services.

The options appraisal work undertaken in 2015/16 to develop a suitable model for medical cover across community hospitals was concluded and steps will be taken during 2016/17 to implement the preferred option. This will, however need take account of the proposed outcomes of a significant redesign project supported by the Integrated Care Fund to develop a Community Ward model of care in one locality. 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.

The two clinical sessions established in 2015/16 to support closer working with our LMC specifically on improving key interface issues and in development of enhanced services is now embedded. This role will also support the understanding of the Transitional Quality Arrangements set out in the new GMS contract for 2016/17 which will link directly with the recently established Locality Planning arrangements across the partnership.

Further to the workforce survey carried out along with the GP stress survey the findings were presented to the Board. Key issues included a shift of workload at the interface between primary and secondary care, remote access to IM&T to facilitate an ability to do admin from home and |

the ongoing provision of protected learning time. We identified a range of actions to address these issues in the 2015/16 LDP and work on this will continue in 2016/17.

We have recently appointed a new Associate Medical Director for Primary and Community Services and have agreed that the appointment provides an opportunity for us to review and refresh our engagement and communication processes with GPs. We have established a Primary Care Feedback inbox as well as a Secondary Care Feedback box which aims to capture issues from individual GPs or practices and provide a response and source a solution. This will also be reciprocal for secondary care colleagues to enable issues relating to the interface to be highlighted and addressed constructively. This can include sharing the points raised with the relevant service, taking issues for discussion to the appropriate forum, completing Datix incident recording and feeding back to the GP or practice who had submitted the issue to support ongoing improvement, learning and relationship management. We have now collated the information from the GP Stress and Workforce surveys and together with the recurring themes from the Primary Care Feedback inbox this will help inform our more regular dialogue and ongoing planning processes with GP colleagues.

There will be collaboration in planning the better, appropriate use of skill within Primary Care to free GPs up to focus on more complex clinical issues and provide leadership to integration. Lessons from the Inverclyde pilot of practice cluster will be taken forward in planning as well as other innovative projects. Various options are being appraised to enhance recruitment and retention of primary care staff, in particular GPs. The OOHs service (BECS – Borders Emergency Care Service) is also looking at innovative ways to recruit and retain staff and at service provision, enhancing the high quality person centred care they provide to complex patients including palliative care patients. In line with the clinical strategy for Scotland, we will be looking at providing more care in the community learning from projects elsewhere and areas of success within our own region. We will also be looking for sources of funding to support this.

This will be further supported through the establishment of 3 Locality Coordination roles designed to support engagement and planning within the anticipated cluster arrangements for GP practices as well as the development of locality needs assessments and plans.

Actions nationally which would support Practices are referenced below as per previous LDP submission:

- Development of a national training programme for Physician Assistants (primary care).
- A move to 24 hour unscheduled care provision supported by skill mix (for example paramedics/specialist nurse grades).
- Removing the central allocation of GP trainees. The removal of

	GPs being able to recruit their own trainees has led to difficulty in maintaining trainees within Borders after full qualification. In the past GPs tended to recruit registrars who had a desire to live and stay in their area. Many of these went on to become partners. We now find that many trainees who have been allocated form a central scheme prefer to return to the central belt after training is complete. This has significantly reduced the benefit to Practices of training. A review of training is recommended to make this more beneficial and attractive for Practices to participate. • Likewise a review of both the rural fellowship and retainer schemes is recommended to make these more attractive to Boards and Practices alike. A review of the potential unintended consequences of pension changes may be beneficial.
Service Planning and Interfaces	<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 IJB response letter earlier this year. The large geographical area and lengthy journeys between home visits will remain a challenge for our Borders Emergency Care Service (BECS). Planning is currently underway to update and renew our 3 vehicles during the course of the next 12 months, taking into account winter resilience and mileage tolerance. We are considering plans to improve our IT infrastructure and connectivity to ensure ongoing safety and high quality clinical care. 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>Community Response</u> – this is being taken forward as the Hawick Paramedic Practitioner Pilot. Two GP Practices are working directly with SAS to test a different model of in-hours response to emergency calls to GPs. • <u>Patient re-education</u> - 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.

- Emergency Department Redesign - including a review of the medical model. This redesign programme will move forward during 2016/17 now that ED Consultants have been appointed <u>Overnight Governance in the Emergency Department</u>.- arrangements have now been established within the specialties to address this

- <u>Ambulatory Care and Acute Assessment</u> - A new Ambulatory Assessment Unit has been established and the model is being evaluated in line with agreed improvement methodologies.

- <u>Review Mental Health Crisis Team input to the Emergency Department</u> – discussions are underway to identify the most appropriate location for the team to ensure timely access and support for patients attending in crisis.

- <u>Accommodation – BECS and ED</u> – 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.

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. 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.

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.

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.

Public Dental Services (PDS)

Work has progressed and in the next year the intention is to:

- Enhanced services to Special needs/ additional needs with core tooth brushing in all schools with special needs units
- Expansion of core tooth brushing to all pre-school and school age children in primary schools
- The Elderly- all care homes to have named Caring for Smiles champions to ensure improved oral health within all 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, homeless and ex-offender.
- Review use of the remaining two mobile dental units (MDU) and establish a forward plan in relation to capital spend.
- Implement the new model of working identified through improvement methodology and roll this out across PDS to ensure a reduction in the numbers of children who persistently do not attend appointments
- Train additional clinicians to ensure anxiety management services are fully supported within the community and in secondary care.
- Seek approval for Provision of bariatric dental facility or shared bariatric OPD facility within PDS.

LASS - Supporting your Lifestyle change

With reduction in core budgets and central funding ceasing for KW from April 2017 a sustainable model for the future delivery of LASS will be adopted this year retaining the most effective elements of the existing service and maximise cost effectiveness.

- Reconfigure LASS services to continue to support those in the most vulnerable groups.
- Disinvest in Counterweight, further develop and implement a new adult weight programme Weigh 2 Go Borders that combines a number of evidenced based approaches offering wider options to

the clients.

Sexual Health

- Consistent >90% recording of alcohol and GBV in all attendees
- SLA established 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.
- Adoption of Lothian draft HIV treatment protocol to include first line use of generic antiretrovirals to address costs
- All school nurses participate in the condom distribution scheme, C-card, in partnership where possible and appropriate, with locally trained youth workers.
- Enhanced presence in secondary schools and Borders College 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.

Primary Care Premises Modernisation Programme

Some significant progress has been made during 2015/16 in our primary care premises developments. Four health centre sites were identified as the highest priority (Band 1) for major reconfiguration / development and through a robust prioritisation process, the order of build was agreed as:

1. Selkirk
2. Eyemouth
3. = Melrose and Knoll

Two schemes were also identified at West Linton and Earlston (Band 1a) where substantial development work would be required as the next phase of the overall programme.

Capital resource was released through NHS Borders Capital Plan to take forward to completion the Selkirk scheme and Phase One of the Eyemouth scheme within the financial year 2015/16.

The tender process for the Selkirk scheme identified a cost increase from the feasibility stage estimates. Following verification of the costs by external independent cost advisors, approval was given to proceed. The work at Selkirk commenced in November 2015 and is due to be completed by 18th March 2016.

The tender process for Eyemouth concluded in November 2015; the lowest submitted tenders were a significant cost increase from the feasibility stage estimates. External independent cost advisors reviewed

	the cost differences and confirmed that the submitted tenders were fair, reasonable, competent and competitive. The work planned in 2015/16 on the first phase at Eyemouth was therefore paused until adequate resource levels could be sourced. In view of the increased costs for the schemes at Selkirk and Eyemouth, the external cost advisors were asked to review and revise the original feasibility costs for the two remaining Band 1 sites at Melrose and The Knoll and the two Tier 1a sites at Earlston and West Linton. The costs for all four sites have increased.

The cost increases described take the total programme cost out with NHS Borders' annual capital allocation levels and following discussion with Scottish Government, an Outline Business Case has been submitted in request of additional capital allocation of £3m to support the entire programme of Band 1 schemes and Band 1a schemes (at West Linton and Earlston

NHS Borders has followed to date traditional procurement routes for this development programme. In line with Scottish Government requirements due to current indicative levels for the projects and to further evidence the delivery of best value for this overall programme, discussions are underway with colleagues from the hub South East Region Territory Partnering Board.

Completion of the work required at the identified priority sites would bring to a conclusion the requirement for major capital investment in NHS Borders primary care health centre estate for the foreseeable future.

The governance and decision-making framework established to enable primary care premises issues to be considered and progressed will remain in place and future minor schemes will be managed within NHS Borders' standard capital allocation and capital planning processes.

Roxburgh Street, Galashiels

The development of the new health centre for the Roxburgh Street Medical Practice and community services has been progressed separately as the proposal pre-dated the Primary Care Premises Modernisation Programme described above. Procurement has been secured through Hubco. The site is currently being cleared and work is due to begin in May 2016 with an anticipated completion date of February 2017. |
| **Technology and Data** | The provision of technology and use of data is variable across different settings in primary care. Clearly General Practice are quite well served while Community based nursing teams are less so.

We have made some progress in using technology with Digital Pens now in place in two localities. The benefits of this are being reviewed prior to a wider implementation.

Work is underway to introduce the use of National Early Warning Scoring |

	in a community setting supported by telehealth technology to help clinical decision making in community hospital and care home settings.
	We are running a project to re-provision IT systems for Community teams and will develop a business case for investment. We are keen that any new system must 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.
	Access to high quality information to manage and plan services will be part of our focus in 2016/17 and we are exploring what additional support can be provided in terms of data reporting and real time information.
	All of our GP Practices now offer on line repeat prescription ordering and some offer appointments. We plan to work to increase uptake of these services during the course of the coming year.
	We have now deployed remote access to our GP community – giving them more choice and freedom to access information and do work from outside the practice.
	We have also undertaken a major upgrade to our GP IT servers as a significant step forward in the provision of a modern IT infrastructure.
	The issues identified within the Primary Care Strategic Assessment and included in the LDP submission 2014/15 remain and are repeated below.
	A huge barrier is the inability for IT systems to communicate with each other effectively. Sharing of information across services and agencies is essential if the 2020 Vision of a coordinated, integrated approach to health and social care is to be achieved. IT systems **must** interface appropriately between primary and secondary care and also, crucially, between healthcare services and social work services in order to allow staff to work together more productively and provide a better service for patients.
	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 review of clinical services, the integration agenda, efficiency programme and any subsequent realignment of budgets will influence the shape of future primary care services.
	A range of redesign initiatives are being progressed and are resourced by the Integrated Care Fund in line with the local Health and Social Care Strategic Plan. These will focus on community based models of care to help support our most vulnerable people to be cared for as close to home as possible, reducing avoidable emergency admissions and dependence on secondary care services. We will be adopting a 'House of Care'

| | approach to coordinating care and resources around GP practices supported by our Locality Planning development infrastructure, Voluntary and Independent sector colleagues.

Primary Care GPs are well represented on both the IJB and Strategic Planning Group and are involved in decision making in relation to the spend against the ICF allocation.

We are working 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. The Integration Joint Board has already identified five localities and these will be used as the baseline for locality planning. We recognise that GPs will be critical in that process and will be working closely with local GP groups to manage the Transitional Quality Arrangements in the revised GMS Contract. |

Integrated Care	
	Executive Lead: Susan Manion
Overview	The Integrated Joint Board (IJB) has agreed the content of the Strategic Plan for 2016-2019 and will have the accompanying Financial Statement in place by the end of March 2016. The Strategic Plan sets out the nine Strategic Objectives for the Health and Social Care Partnership, an outline of how we intend to deliver what is needed to achieve each objective, and examples of activities identified in our current service strategies which relate to each objective. The Plan also shows how each of the Strategic Objectives maps to one or more of the nine National Health and Wellbeing Outcomes. The Plan is high level and will be supported by the implementation of Strategies related to specific themes (such as Dementia, Mental Health), a more detailed implementation/action plan that will provide additional detail underpinning the high level objectives, and Locality Plans that reflect differing patterns of need across the Borders. To facilitate delivery the IJB will engage as a partner along with the NHS in the community planning process.
National and local standards/targets	The Strategic Plan references specific targets and outcomes against each of the Strategic Objectives. Many of these measures are drawn from the Core Suite of Integration Indicators published at http://www.gov.scot/Topics/Health/Policy/Adult-Health-SocialCare-Integration/Outcomes/Indicators/Indicators. The targets and outcomes referenced in our Strategic Plan are just a starting point. In 2016/17 we will be further developing our draft Performance Management Framework for Integration. From an NHS perspective, the IJB will be keen to assess progress on delivery in relation to key themes such as the national health and wellbeing outcomes. Over the three years of the Strategic Plan, these will be measured by progress in relation to all of the indicators included in our developing Performance Management Framework, where services provided by NHS Borders relate directly or in part to the improvement against that indicator. In year 1 of the Plan (i.e. 2016/17) we are focusing on key target areas – supporting people at home and the wellbeing of our staff. Therefore, we will be prioritising work that will contribute to improving performance against the following indicators:- • Percentage of people who are discharged from hospital within 72 hours of being ready (Health &Wellbeing Outcomes2, 3 and 9) • Number of bed days people spend in hospital when they are ready to be discharged (H&W Outcomes2, 3, 4 and 9) • Overall rates of emergency hospital admissions (H&W Outcomes1, 2, 4, 5 and 7)

	• Readmissions to hospital within 28 days of discharge (H&W Outcome 2,3 , 7 and 9) • Admissions to hospital in the over 65s as a result of falls (H&W Outcome 2, 4, 7 and 9) • Percentage of adults with intensive care needs receiving care at home (H&W Outcome 6) • Proportion of employees who would recommend their workplace as a good place to work (H&W Outcome 8).
Locality planning	Our Locality Planning will take place across our five existing Area Forum localities - Berwickshire, Cheviot, Eildon, Teviot & Liddesdale, and Tweeddale. The Strategic Plan includes summary profiles for each of the five localities, to show some of the differences between them. As part of the planning process, we will build more detailed locality profiles, including a wider range of measures relevant to health and social care. This will allow us to target need most appropriately. Within Borders Health and Social Care Partnership, we have set up a group to oversee the development of planning in each of the five localities during 2016/17 and beyond. We expect to appoint locality co-ordinators in Spring 2016 to act as a focus for planning in each locality. They will: • Build relationships with established community groups, partners across the localities, such as other leads working at locality level for example in Housing, Community Learning and Development, Voluntary and Third Sector, carers, clients and patient representatives. • Map out what is already happening, using and building upon the mapping work already in existence across relevant partnerships - established community groups, many of which are linking up through the Community Learning Partnership approach. • Identify where existing funding is coming from, where there are gaps and where there are ideas or plans. • Clearly define what is happening in the short, medium and longer term, how these priorities have been identified and what the consultation process has been/is going to be. • Co-ordinate action plans, planned expenditure and how these fit with local priorities. Planning at this level will need to take account of existing local plans such as Community Action Plans or Neighbourhood Plans as well as cross-Borders strategies such as the reducing inequalities strategy and health inequalities action plan. The Integration Authority expects to make a significant contribution to tackling

	inequalities at locality level. It will also need to address cross-border issues (between Borders localities, and between Borders and neighbouring areas of Scotland and England). Some priorities are the same across localities but others are different. Locality plans will also need to take account of projects starting at the moment. For example, we are beginning to develop care coordination, which will be undertaken by care coordinators which will be rolled out across the localities in a phased way. This will help us provide more person centred care. Another project is to provide a means for Borders Community Transport providers to work together to make best use of available transport and reduce duplication of journeys. Some projects are specific to a locality such as "the Eildon Community Ward".
	Where appropriate, we will devolve resources towards the delivery of particular local outcomes. For example, we will strengthen the work of the healthy living network in areas of disadvantage to improve the health and well-being of those communities. We will prioritise engagement with vulnerable groups, isolated residents and people who are not already accessing existing groups and local services. We will make the best use we can of community capacity and capability and an asset-based approach to do this. The IJB will want to see local joined up delivery teams, primarily the integrated management of health and social care staff across NHS Borders and Scottish Borders Council.

Scheduled Care	
	Executive Lead: Evelyn Rodger
Local improvement aims	To consistently achieve a 12 week wait for outpatient services To consistently achieve a 12 week wait for inpatient services To consistently achieve a 6 week wait for diagnostic services To reduce the use of non-recurrent capacity for waiting times. 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.

Summary of local work to be carried out under the National Scheduled Care Programme (sustainability) in 2016/17	• Review activity requirements to ensure best possible performance
	• Ensure optimal design and configuration long-term
	
	    – Capacity and design optimisation – recurrent and non-recurrent shortfalls
	
	    – Relate planning and unscheduled care services – manage variation and variability
	
	    – Establish planning cycles
	
	    – Project and plan capacity locally, regionally and nationally

Measures which will be used to assess improvements made	12 week wait for outpatient services 12 week wait for inpatient services 6 week wait for diagnostic services The use of non-recurrent capacity for waiting times.

Unscheduled Care	
	Executive Lead: Evelyn Rodger
NHS Borders Clinical Strategy and Unscheduled Care	The Scottish Government introduced the 6 Essential Actions programme for unscheduled care in June 2015 which included a focus on optimising the admission and discharge balance in hospitals each day and appropriately avoiding admission wherever possible. NHSB have priority actions against each of these Essential Actions and monthly summary sheets of a specific action are submitted to Scottish Government to demonstrate what is being achieved with outcomes and evidence provided as part of this submission. The activity around each of the 6 Essential Actions is as follows: EA1 Clinically Focussed and Empowered Hospital Management **Improvement Aim** – To ensure that patient flow is supported at all levels of hospital management with clear and consistent roles. Other actions include • To further develop the Hospital Safety Brief and extend this to mental health and other services to provide a comprehensive whole systems daily review • The establishment of 7-day senior manager leadership of patient flow through the establishment of a Duty Manager role • Daily Patient Flow Plan providing regular and visible data on expected admissions and required discharges by ward and allocated senior manager support for each ward to assist in delivering these • Establishment of a training programme and competency framework for Hospital bleepholders to ensure that the front-line management of patient flow and the hospital is carried out consistently and that staff are well-supported. • Effective and comprehensive Winter Plan for 2016/17 that minimises requirement for surge beds **Measures for Assessment & Actions** • Achieving the 4 hour 95% Emergency Access Standard and NHS Borders stretch target of 98% • Reduction in the number of patients boarding out of speciality to a stretch aim of zero medical boarders • Reduction in number of patients being boarded overnight to zero • Daily ward Board Rounds with consistent attendances by advocates to focus on forward planning for safe and timely patient discharge **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. • Provision of an Acute Assessment & Ambulatory Care Unit to ensure

that assessment of acutely unwell patients occurs timeously based on clinical condition, with senior clinical decision makers involved as early as possible. The purpose of this process is to assess to discharge rather than admit to assess.

- Remodel medical unit footprint to provide additional acute elderly care capacity, with intention of earlier rehabilitation, improved care for patients and reduced length of stay

- Reduce or eradicate medical boarders through a series of measures including rapid identification of patients needs and early transfer of patients to appropriate area for care

- Remodel urgent and planned surgical inpatient flows to separate and protect elective work

Measures for Assessment & Actions

- Increase in numbers of patients being discharged on same day through Acute Assessment Unit (AAU) to 35% of all presentations
- Reduction in admissions to Medical Assessment Unit by 5 per day
- Reduction in length of stay in General Medicine and overall BGH length of stay
- Establishment of separate emergency and elective surgical flows

EA3 Patient rather than Bed Management – Operational Performance

Improvement Aim – To provide effective patient flow through BGH by creating early capacity in inpatient areas. Thus ensuring all emergency admissions arriving via Emergency Department or AAU are assessed and, if necessary, admitted within the 4 hour Emergency Access Standard (EAS) or discharged if clinically appropriate.

- More effective use of discharge lounge and discharge team to enable more patients to be transferred to the discharge lounge. This includes use of day hospitals as discharge lounges in community hospitals
- Discharge team to coordinate next day and same day discharge arrangements – coordination of discharge tasks, transfer to lounge and transport arrangements
- Collaborative working with Scottish Ambulance Service providing timed transfers from BGH to Community Hospitals (trial beginning in February 2016)

Measures for Assessment & Actions

- Reduced pressure in ED by creating capacity for patients who require to be admitted throughout the 24 hour period – *Reduction in EAS breaches due to lack of beds*
- Reduction in number of patients boarding out of speciality.
- Reduction in number of patients transferred overnight
- Zero GP referrals admitted via ED for all specialties, unless clinically indicated

- Increase in number of patients being discharged before midday with a stretch aim of achieving 40% discharges by 12 midday and 30% by 11:00am.

EA4 Medical & Surgical Clinical Processes arranged to Pull Patients from ED

Improvement Aim – Improve systems for pulling patients from ED in a timely fashion

- Streamlined pathways to orthopaedic and surgical admissions. New protocols for allowing rapid transfer to appropriate surgical ward will be in place. Urgent short-notice review appointments will be established to avoid patients attending ED for review

Measures for Assessment & Actions

- Reduction in Flow 4 ED breaches of EAS standard (patients admitted through ED to surgical beds)

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.

To ensure elective operating is not impacted by emergency patient flow

To provide standard levels of unscheduled care across 24 hours and 7 days a week

- Participation in QuEST/IHO proof of concept testing to remodel elective and emergency surgical patient flow

- The coordination of the various weekend services to support discharge planning and to ensure that patient care within the hospital progresses across 7 days.

- Detailed work to choreograph discharges to increase morning discharge rates, including community hospital transfer

- Reconciliation of planned next-day discharge profile against actual discharge profile to identify causes for failure to discharge

- Re-establishment and roll-out of criteria-led discharge to become norm for discharge planning

Measures for Assessment & Actions

- Reduction in operating cancellations

- Patients requiring urgent surgery treated within agreed timescales

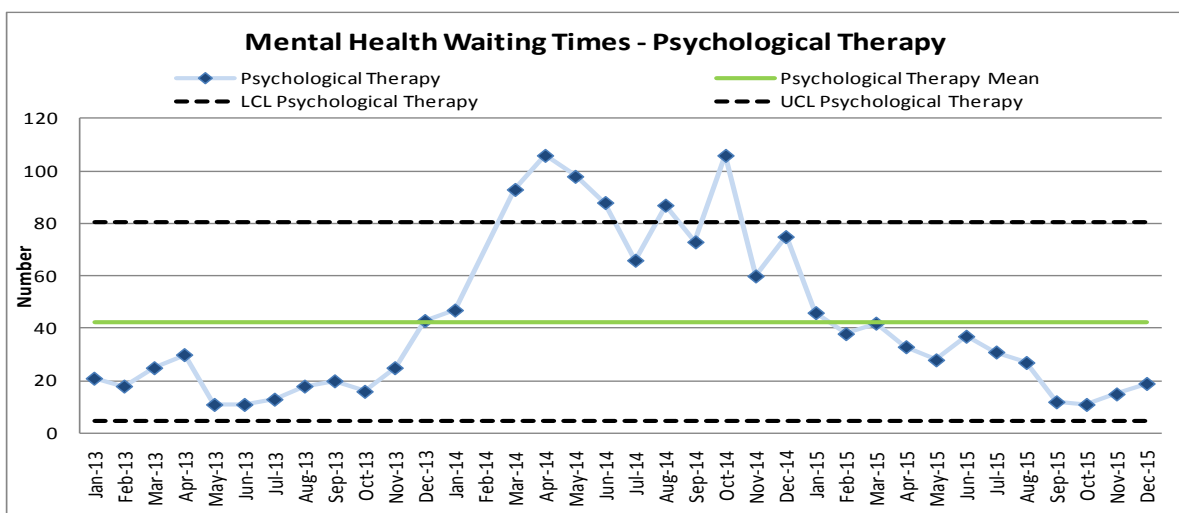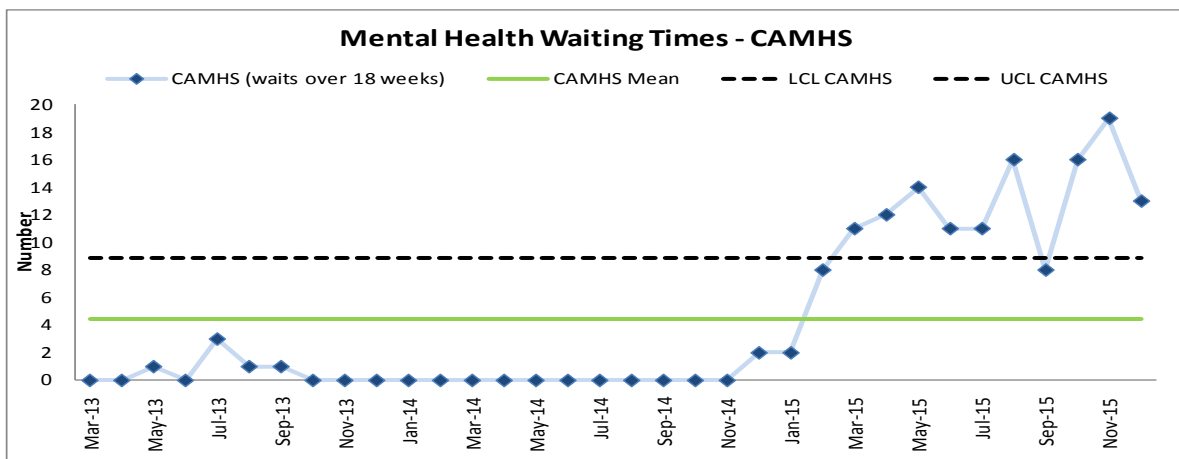- No reduction in discharge rate at weekend compared to weekdays

	• Increase in number of patients being discharged before midday with a stretch aim of achieving 40% discharges by 12 midday and 30% by 11:00am. **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 • Development of a community ward model (Eildon Ward) to provide hospital at home • Extension of Day Of Care Audit (DoCA) to Community Hospitals and Mental Health and active use of DoCA data to manage discharge planning **Measures for Assessment & Actions** • 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
Compliance with 4hr HEAT target	NHS Borders has consistently met the 95% access target since May 2015 and aims to continue to do so during 2016/17. We will strive to achieve the 98% target during 2016/17. NHS Borders' current performance can be seen below: <table><tr><th>4 Hour Compliance</th><th>Oct-15</th><th>Nov-15</th><th>Dec-15</th><th>Jan-16</th></tr><tr><td>Borders</td><td>95.96%</td><td>97.24%</td><td>96.88%</td><td>96.77%</td></tr></table> While the current national target for the access standard is 95%, NHS Borders has committed to maintaining performance at or above 98%. During 2015/16 NHS Borders will continue to plan for service delivery at 98%.

Mental Health

Executive Lead: Susan Manion

The Child and Adolescent Access Target (Referral to Treatment Target reduced from 26 weeks to 18 weeks by December 2014) and the Psychological Therapies Mental Health Access Target (Referral to Treatment within 18 weeks) Scottish Borders Mental Health Service has been unable to meet during the last year. The Child and Adolescent Access Target should be delivered for at least 90% of patients. In Quarter 2, performance for NHS Borders was 78% of patients seen within 18 weeks. In Quarter 3, this decreased slightly to 76.7%. Performance for January 2016 has increased to 83% due to additional resource being allocated to the CAMHS team and we expect to meet the target in February 2016.

Similarly the Psychological Therapies (PT) Access Target should be delivered to 90% of people referred for PT. In Quarter 2, performance for NHS Borders was 71.7% of patients seen within 18 weeks. In Quarter 3, this increased to 74.3%, but was still below the Scottish Average of 83.5% for the same time period.

Mental Health Waiting Times - CAMHS

Mental Health Waiting Times - Psychological Therapy

Local improvement aims	**Child and Adolescent Access Target:**
	Local analysis of the dip in performance has been undertaken using the DCAQ (Demand, Capacity, Activity, Queue) analysis. The Mental Health Service has also enlisted the support of an external management company to assist us in introducing an improvement programme aimed specifically at supporting staff and managers to: utilise to the maximum face to face time with service users; improve quality and to identify where the demands are within the service allowing us to make strategic workforce planning decisions about allocation of resources. Our aim is to meet the Access target of 90% (Referral to treatment) by the end of February 2016.
	Psychological Therapies in Mental Health:
	We have now improved our data collection systems and are now able to identify who is delivering what psychological therapies to whom, and where. Our data shows that we are consistently not meeting the Access to Psychological Therapies Target (our percentage waiting 18 weeks or less sits at around 66.2% (Quarter 2 2015) against the target of 90% and a Scottish average of 80.1% for the same period. Moreover we are only referring a small proportion of our local population for psychological therapies (referrals per 1,000 is 2% for NHS Borders; the highest which clearly identifies this is Dumfries and Galloway at 6.7%). There is no national data clearly identifying levels of need for psychological therapies (or even a map of how this might be derived), thus demand is most commonly used as a proxy for need. We do have prevalence data, which suggests around 1 in 4 people will experience a mental health illness (the most common of which are depression and anxiety, and we know that psychological therapies can be very helpful for these conditions.). These three strands of information show that our demand is currently exceeding our delivery by some way.
	We have a training and development plan for psychological therapies, which identifies priorities and risks based on current evidence-based best practice. Beyond this, we need a workforce plan to improve our capacity within a defined budgetary resource and in a very small service where staff moves and vacancies hit our capacity very strongly. When we look at who is delivering psychological therapies locally, we see that the people who deliver the most are CAAPs (Clinical

	Associates in Applied Psychology). We have invested in multi-professional delivery, and we note that other health boards have successfully employed nursing staff as psychological therapists. We also need to clarify further the local enablers and restrictors on access, and create an action plan to tackle these. We are currently clarifying our improvement aims and action plan through our Psychological Therapies Steering Group which has representation from service users as well as service staff. These are likely to focus on: 1. Meeting the HEAT target by December 2016 2. Increasing the proportion of our local population accessing psychological therapies by a further 1% by December 2016.
Improvement Actions	**Child and Adolescent Access Target:** The Improvement programme includes the introduction of management tools to monitor activity, allocate work more effectively and deliver training for managers. The programme is due to be fully implemented and operational by the end of February 2016 and will then be embedded into management and staffing routines. There is recognition that staffing resources within Child and Adolescent Mental Health Service (CAMHS) are stretched and this has been reinforced through the management data now being routinely collected. The CAMHS workforce capacity is therefore under review. The latest management information indicates that the CAMHS Access Target is now at 85% for December 2015 and we are confident that our trajectory is moving towards meeting the 90% Access to Treatment target by the end of February 2016 **Psychological Therapies in Mental Health:** 1. To clearly understand our current capacity –work here is in hand via the Improvement Programme described earlier. 2. To ensure that people trained in a psychological therapy have clearly specified time allocated in their job plans for the delivery and to ensure this time is utilised;

	3. To refocus job plans where appropriate to enable a greater focus on delivery of psychological therapies using the Improvement Programme data to inform the prioritisation of staffing resource to areas of greatest need; 4. To create a psychological therapies workforce plan focussed on identifying opportunities to recruit more staff who will have job plans clearly focussed on delivery of psychological therapies (such as CAAPS and Nurse Psychological Therapists) whilst maintaining good practices in work pacing, support for staff, supervision and Continual Professional Development; 5. To identify additional local enablers and restrictors on access to psychological therapies and devise further actions depending on what we find.
Measures to assess the improvements made	**Child and Adolescent Access Target and Psychological Therapies in Mental Health:** As described above, the Improvement Programme now allows managers to identify available staffing capacity and allocate work accordingly in a more consistent and efficient manner than before. Management reports are now available on a weekly basis to the teams, managers and senior managers to ensure that staffing resources are targeted at the areas of highest demand. Internal performance data is routinely collated and reported to the Mental Health Clinical Board and Performance meeting which closely track the Child and Adolescent Access to Treatment Target and the Psychological Therapies Access Target. Using both these measures we will be able to assess and monitor our trajectory towards meeting these targets.

Section 2:   Workforce

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

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

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

Workforce	
	Executive Lead: June Smyth
Plan for the 5 priority areas for action as set out in Everyone Matters: 2020 Workforce Vision Implementation Framework	**1. Healthy Organisational Culture** NHS Borders has recently updated our corporate induction to ensure it promotes the values and behaviours expected of NHS staff. The key threads throughout induction are Care and Compassion and Dignity and Respect. The introduction of Values Based Recruitment has ensured that we are recruiting people who share and are able to demonstrate our values, and we are supporting our managers to attend Values into Action Training as they have a responsibility to embed this approach across their teams. The mandatory induction standards allow measurement of compliance and success of this approach. Current staff have a responsibility to be aware of our corporate objectives and demonstrate the values and behaviours expected. Our Staff Governance Action Plan links directly to the Corporate Objectives promoting a collective approach to ensuring full buy in and involvement across the organisation Mechanisms for implementation include the embedding of good people management; through joint development review process, KSF PDPs and reviewing patient/staff feedback. The key theme of our Workforce Conference on the 11th March 2016 is "Living our Values – working in partnership with staff to support positive values in NHS Borders." The conference is aimed at frontline staff and outcomes will feed into our 3 year Local Workforce Plan for 2016-19. The staff experience employee engagement tool, **iMatter**, is being developed throughout NHS Borders in a 2-year programme, as we recognise that positive staff experience will lead to better patient care. The roll out commenced in February 2015 and this is currently being rolled out throughout NHS Borders, with many areas now about to embark on Phase 2. We see the big message of 2020 Workforce Vision compared to previous workforce plans; is to emphasise and embed our

shared values in NHS Borders, these are:

• care and compassion

• dignity and respect

• openness, honesty and responsibility

• quality and teamwork.

The link between staff health & well-being and improved clinical outcomes is well recognised and reflected in the Workforce 20:20 Vision. In support of this NHS Borders has developed a person centred work and well-being framework which sets out how we will support staff to keep them motivated, healthy and engaged. One of our Staff Side reps chairs the Healthy Working Life group which works to ensure we maintain the gold award.

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

2. Sustainable Workforce

NHS Borders continues to facilitate a more joined up approach to Workforce Planning ensuring all relevant stakeholders (internally and externally are involved). NHS Borders and Scottish Borders Council are working together to produce a framework document for the IJB to consider by the end of March 2016 which outlines how we currently develop workforce / people plans, how we look to integrate where possible and how we might develop these in a more integrated fashion, where relevant, moving forward.

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

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

1. It describes a range of scenarios tested by using accepted methodologies for workforce planning and workload measurement. We utilise six step workforce planning methodology for line managers and staff involved in a service redesign so a

consistent framework applies for the development of the future workforce.

2. Created in partnership with staff and their representatives with discussion at Area Partnership Forum.
3. Workforce projections are based on intelligence gathered from our locally developed workforce tool, which highlights potential workforce changes due to turnover, end of fixed term contracts, potential retirements (crucially based on our age profile), and the out- come of service redesign processes. All service redesign has been subject to a workforce assessment, including risk assessment, as part of the project initiation process.

Our Workforce Plans incorporate education and training needs assessment and are closely linked with education governance/learning and development strategies.

Workforce Risks will be monitored using our existing Workforce Risk Assessment Template as part of all redesign proposals. Workforce risks from ongoing service redesigns are collated onto our corporate Service Redesign Inventory ensuring management of workforce risks across all services.

The ability to recruit and retain staff, especially in some specialties and specialist services, remains a significant service as well as financial risk for NHS Borders. The cost of supplementary staff is often significantly higher than substantive staff but is critical to service provision.

A significant workforce planning activity in the forthcoming year is the continuing implementation of the new national electronic Employee Support System (eESS).

eESS is being rolled out across all NHS Boards to provide a single national HR system. The system is planned to provide:

- manager and staff self service (e.g. a benefit is that existing employees will access their own personal details and enable direct electronic updating of changes of address, next of kin etc, reducing paperwork and bureaucracy),

- e-payroll interface (reducing the need for paper based payroll instructions),

- a national training administration system

Our staff data has already been migrated from our previous HR system to eESS and the system is "live" in the HR Department. All managers attended an initial training course in preparation for full roll out of eESS, with update sessions planned over the coming year. The system will be an important tool for effective people management (e.g. absence and leave management) once the SSTS and Payroll interfaces have been fully implemented.

3. Capable Workforce

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

In October 2015 an Internal Audit Report on "Mandatory Staff Training" identified recommendations with an overall rating of high risk. These were subsequently added to by the Audit Committee when they discussed the report in December 2015. An action plan to address these has been put in place. An update is to be available to the Audit Committee in March 2016.

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

NHS Borders has for several years achieved the HEAT Standards for Knowledge and Skills Framework (KSF) personal development review and KSF Personal Development Plans. Managers are supported to do this by service champions who support them to develop realistic trajectories and provide technical support where required. We are focussing on quality to ensure that our people have a meaningful face to face conversation with their line manager about performance, development needs and career aspirations. Following a commitment in our 2014 – 2015 Staff Governance Action Plan, a Quality Audit was undertaken of personal development reviews under KSF utilising recognised tools to measure the impact of appraisals and PDPs. The review identified areas for improvement resulting in a new action in the 2015-2016 Staff Governance Action Plan to "Implement revised process to Support Personal Development Review as an outcome of the previous quality audit" by April 2017.

The Senior Charge Nurse Review is an example of where we are building capacity and capability to improve the quality of what we do. NHS Borders are currently piloting having this role as supernumerary and the development of dashboards etc is giving managers information required to improve quality. 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.

The Patient Safety Programme and Executive Walkrounds further support our aim to ensure a capable workforce and the Executive Team use this opportunity to promote corporate objectives, Knowledge and Skills Framework etc.

4. Integrated Workforce

NHS Borders is introducing revised managerial structures and processes, with a view to providing synergy of services across acute, primary and community services, and a firmer working approach to support patient safety and quality of care for patients. An integrated approach will support

discharge planning and patient flow across the system, including with partners from across health and social care, therefore improving the quality of care for our patients.

Specific examples of developing a more integrated workforce include:

- 11 O'Clock Team – Daily patient flow meeting in the BGH.
- Community Day Hospitals reference group.
- Integrated Workforce Planning and Development Meeting with SBC and NHS Borders
- Joint Early Years Network
- Joint Learning Disabilities Group
- Joint integrated staff forum
- Early years assessment team including Surestart midwives
- Staff and Public Engagement sessions to develop Integration Strategic Plan.

5. Effective Leadership and Management

NHS Borders recognises the importance of management and leadership capacity and capability in ensuring the delivery of safe, effective and high quality services for the people of the Scottish Borders and to support the 2020 vision. Promoting excellence in organisational leadership is embedded into the Staff Governance Action Plan.

Using the Engaging Leadership Framework (Beverley Alimo-Metcalfe) NHS Borders is committed to promoting and engaging leadership through:

- Supporting a developmental culture

- Showing genuine concern

- Enabling

- Inspiring others

By building this into local programmes as well as appraisal processes we will ensure that managers and leaders are clear about their role and responsibilities and enable performance to be managed appropriately. In addition the link between engaging leadership and employee engagement will be strengthened through the support of iMatter.

Development of further work streams will support the six priority actions identified in the 2020 2015-16 implementation plan, in particular the adoption of value driven approaches, addressing the challenges around middle management and the development of more robust succession and talent management plans.

We will continue to support those leading the transition into Health and Social Care Integration. This is likely to involve both individual personal

	development in leading change in a complex and ambiguous environment, as well as, shared local, regional and national development ensuring collaborative working across health, social care and other agencies. We will continue locally to support our taught programmes with coaching, mentoring, leadership exchanges, 360, action learning and opportunities for embedding skills and knowledge 'on the job' furthering our implementation of a 702010 approach.
Application of nursing and midwifery workload and workforce planning tools	NHS Borders are currently rolling out of the nursing and midwifery workload and workforce planning tools - all services review their workload and establishments on an annual basis, and are supported to produce a summary report of findings for the attention of the Director of Nursing. An annual report on outcomes is submitted to the full NHS Board to ensure board members are apprised of nursing & midwifery workforce matters. We view use of the planning tools as being an important foundation to balance demands on staff with the supply of staff, to ensure that numbers and skill mix of appropriately trained nursing and midwifery staff are available, in the right place and at the right time to match service needs. The workforce data obtained helps us understand our workforce and make appropriate decisions about supporting sustainable patient services across the health sector including the redesign of services, available resources, affordability and our clinical strategy. We have implemented new specialty workload and workforce planning tools as they have become available nationally such as the neonatal nursing tool and the community nursing workload tool. Other specialty tools are well established and where there is no available national measurement tool, work has progressed on local workload and workforce planning tools incorporating accepted Time Task Analysis methodology. The Director of Nursing and Midwifery continues this year as a key member of the National Steering Group, ensuring NHS Borders is at the forefront of developments. Where we have found the national tools in need of further development for example, for a Dementia setting, we feedback to national forums for wider sharing and consideration.
Recruitment Issues, Vacancy Rates or Concerns	NHS Borders have developed a Vacancy Monitoring Process where detailed reports are provided to the Exec Team on a weekly basis to monitor the number of current vacancies going through the process and the length of time taken from interview to start date (with a target of less than 8 weeks). We have a commitment to pre-emptive employment within Nursing & Midwifery where we are recruiting staff for a Fixed Term post (e.g. Winter Surge, hard to fill community posts) permanently, with the intention to slot them into future gaps. The APF have been fully engaged with this process which helps to ensure a safe environment for our patients and staff. Despite running regular Nursing and Midwifery

	recruitment events over the past few months we have experienced a shortage of registered nursing applicants and have reviewed our advertising strategy to encourage applicants from further a field. The introduction of a radio advert has been successful and targeting universities (particularly with the introduction of the train line making our main hospital more accessible).

Vacancy rates for consultants are approximately the national average (6%) – we have had some success in the latter part of 2015 in recruiting new consultants to four shortage specialties (including Acute Medicine and Rheumatology). Our most significant recruitment challenge in the acute sector has been to Consultant Anaesthetist vacancies in recent years. We have taken some measures to address recruitment difficulties; including revamped job descriptions featuring NHS values, highlighting the new Borders railway as an attraction and a consultant development programme and mentoring. Our recruitment and selection process for Consultant Anaesthetists is currently underway. |
| **Areas in which services are being developed which may have specific implications for the NHS Workforce, or for individual professions as appropriate and steps to manage these locally.** | During 2016 NHS Borders will publish a further 3-year Local Workforce Plan in line with the guidance for submission and timetable for workforce planning and workforce projections issued by the Scottish Government Health and Social Care Department.

Some of the specific areas where we are developing services, which may have specific implications, are moving to 7 day working within Theatres, and recruiting to Health Visiting. |
| **Demographic Information – i.e. age of workforce impacting on service delivery, local pressures, staff numbers, other workforce factors influencing the sustainability or otherwise of services** | Age Profiles/Succession Planning work is ongoing within Mental Health Services where a high proportion of experienced registered staff are eligible to retire in the next few years. We are currently working to identify the number of staff with Mental Health Officer status to ask staff to let us know their plans for retirement (if they are happy to do so). |
| **How workforce Factors are** | A good example in SEAT where mutual aid has been delivered on Emergency Medicine is when our single handed ED consultant resigned |

being dealt with as part of action being taken to address services which are under stress e.g. A&E Oncology, Radiology	in November 2015, we agreed visiting consultant cover with NHS Lothian on most weekdays Tuesdays to Fridays. The consultant cover included some hands-on clinical work but also more importantly, clinical leadership of the department, clinical governance, complaints advice, training and support for medical and nursing staff. NHS Lothian also now provide overnight remote clinical support on a telephone contact basis to the ED Doctor overnight, which is an essential feature of safe practice overnight – 24/7 services have been maintained by this development.

This is a front line vulnerable service – unacceptable disruption has been avoided by a cooperative approach of mutual aid. It is in the interests of both NHS Boards for the BGH ED to remain operational – avoiding the prospect of 22,000 new attendances going to Edinburgh Royal Infirmary. |

Section 3:   NHS Borders Contribution to the Community Planning Partnership

Scottish Borders Community Planning Partnership

Scottish Borders' Community Planning Partnership structure can be mapped as shown in the diagram below. NHS Borders' Chair and Vice Chair sit on the CPP Strategic Board with the Chief Executive Officer. Members of NHS Borders' Executive Team sit on the Joint Delivery Team with oversight of the 3 programmes of work: Economy and Low Carbon; Reducing Inequalities and Future Services Reform.
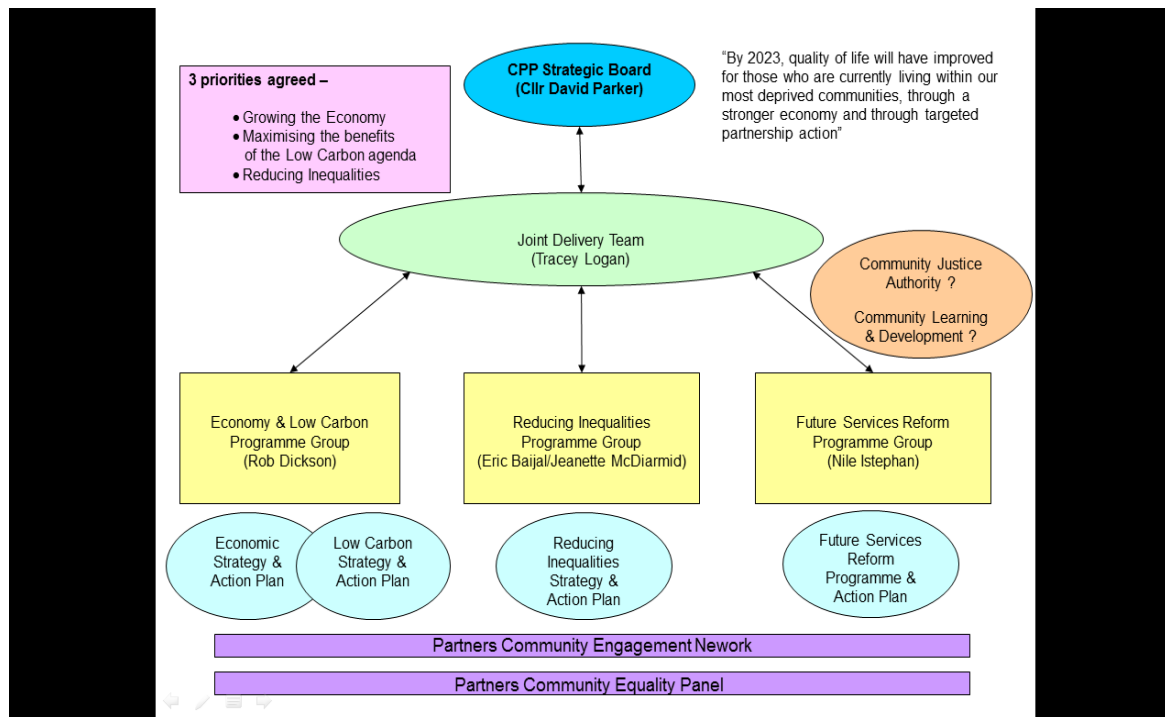
The NHS and Scottish Borders Council have integrated services for Public Health with the Health Improvement Team a joint service. Mental Health and Learning Disability Directorates are hosted jointly. The Director of Public Health and Associate Director for AHPs are a joint posts between both

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

Priority	NHS Board Contribution in 2016/17	Current and Planned Performance Levels
Health Inequalities strategic action planning	NHS Borders Public Health Department leads the development and coordinates implementation of action plans to address health inequalities in support of the Community Planning Partnership's Reducing Inequalities strategy 2015 -20. Reducing Health Inequalities is a key theme for the Integrated Joint Board (IJB). Public Health provides advice and support to the CPP and IJB partners in relation to health inequalities to assess need and ensure effective targeting of evidence-informed interventions through policies, service delivery, and models of practice.	Health inequalities needs assessments are being undertaken using a full range of data across the CPP to understand the particular nature and distribution of health inequalities across Borders. This analysis will be used to inform locality planning and service planning for different life stages, population groups within the CPP and IJB. The health inequalities action plan will enable partners to focus interventions on agreed priorities (to be determined) to ensure that the CPP creates added value.
Early Years	NHS Borders leadership to early years work comes through membership of the CYP Leadership group and chairing of two sub groups including the Early Years Group. NHS Borders leaders are actively engaged in promoting skills and knowledge in improvement methods across early years services and partners locally. NHS Early Years Change Fund monies and additional resources attracted are used to support partnership working.	Early Years priorities led by NHS Borders for the CYP Leadership group include sponsoring improvement in key service and process to improve parenting support, family engagement with services, income maximization and nutrition. The Health Improvement team provides regular support and advice on nutrition and other lifestyle issues to Early Years providers across the CPP. NHS Borders core services such as midwifery and health visiting work closely with local Early Years Centres to deliver integrated support for families. Following the establishment of the 4 Early Years Centres in 2015 -16, NHS Borders will work closely

Priority	NHS Board Contribution in 2016/17	Current and Planned Performance Levels
		with other partners to extend the Early Years locality model to all areas.

Smoking cessation, ABI, adult weight management and mental health pathways are adapted to respond to needs in pregnancy and post-natally, with the support of partner services to promote engagement. |
| **Children and young people** | NHS Borders is committed to the vision and priorities of the Integrated Children and Young Persons Plan 2016 – 18.
The NHS Borders Child Health Strategy aligns with the Integrated Plan
NHS provides leadership to key agendas for the Leadership group e.g. mental health and supports core processes such as performance reporting, service improvement and workforce development. | In partnership with youth services and Scottish Borders Council (SBC), NHS Borders is working with partners towards endorsement of the Tobacco Free Generation Charter and is supporting young people to make informed choices about relationships and sexual health. |
| **Working age** | NHS Borders is committed to promoting healthy lifestyles within the Health Promoting Health Service programme. | Public Health is now extending aspects of this Health Promoting Organisation approach to the Scottish Borders Council workplace, in conjunction with Healthy Working Lives. |
| **Communities and vulnerable groups** | A range of primary care based services offer frontline support to lifestyle change across Borders.

Integration of health and social care and locality planning provide fresh opportunities to target on high needs and to strengthen early intervention and prevention.

The development of long term conditions prevention and | Improvements are planned to provide more integrated approaches to support lifestyle change for health improvement and to maximize engagement and impact with disadvantaged groups. This will include capacity building with workforce to use motivational interviewing, health behaviour change and health literacy skills and techniques.
Our Healthy Living Network will continue to use assets |

Priority	NHS Board Contribution in 2016/17	Current and Planned Performance Levels
	self management approaches, led by Public Health, supports the objectives of the Strategic Plan in reducing health inequalities. The third sector is a key partner in this work.

Core NHS screening programmes are actively promoted through partnerships and networks to raise awareness with target groups and encourage uptake.

NHS Borders is involved in collaborative programmes targeted towards groups that experience multiple barriers in accessing services for example women offenders and Health Improvement make an active contribution through advice and training.

Borders Alcohol and Drugs Partnership maintains a whole population approach and plans and supports the delivery of effective interventions to prevent harm across age range. | based approaches and co-production methods to address priorities affecting local communities.
Health Improvement specialists focus support to priority groups to build capacity in services for health improvement. This includes the development of a health and wellbeing programme with mental health services to address recognized inequalities.
In relation to people with learning disabilities, a collaborative programme on nutrition and healthy eating was developed as a partnership project (A Healthier Me) involving LD services, Public Health and service providers, families and carers. This is now being mainstreamed to sustain the gains and the learning. Additional project work on health relationships, respect and safety has been supported through Public Health with LD, Safer Communities, Education and other partners. |

Section 4: LDP Standards

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

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

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