Borders NHS Board

LOCAL DELIVERY PLAN 2013/14

Aim

This paper is to gain approval of the 2013/14 Local Delivery Plan (LDP). The LDP was submitted to the Scottish Government Health Department on 15th March 2013, subject to NHS Borders Board approval.

Background

As with the previous years, NHS Borders is required to produce and submit a LDP which forms a performance and delivery agreement between NHS Borders and the Scottish Government Health Department. The LDP incorporates the key targets to be met and the levels of performance that NHS Borders will have to achieve in order to meet these targets. This in turn will inform discussions about progress towards the key targets at the Annual Review.

The LDP this year includes 6 sections: NHS Borders Contribution to Community Planning Partnership; LDP HEAT Risk Management Plans; LDP HEAT Delivery Trajectories; LDP Financial Plans including Efficiency Savings and a summary of main workforce issues facing NHS Borders. The targets support delivery of the Scottish Government's National Outcomes and Healthcare Quality ambitions.

Since the draft was submitted to Scottish Government on 15th February 2013, service leads have been working with national leads to revise trajectories and narratives in light of the feedback received.

In previous years we have been asked to focus on a critical issue within the Single Outcome Agreement; however for 2013/14 we have been asked to cover NHS Borders' Contribution to Community Planning Partnership (CPP), focusing on locally developed improvements. The deadline for the draft CPP is 2nd April 2013.

Scottish Government have added a new HEAT target which is additional to those previously reported at the February Strategy & Performance Committee.

> *"95% of patients will wait less than 4 hours from arrival to admission, discharge or transfer for accident and emergency treatment by year ending September 2014"*

A risk narrative has been provided by the service and is included in the LDP.

In addition to the A&E 4 Hour target, the HEAT targets section of the LDP contains 14 targets under the HEAT headings, with the following new targets.

- Dementia post-diagnostic support
- IVF Treatment

- Healthcare Associated Infections

Summary

There has been significant engagement across the service as the Local Delivery Plan has been developed. The Plan has been discussed at the Area Partnership Forum, Clinical Executive Strategy Group, Strategy Group, BET and the Development & Strategy Session during February.

The final version was submitted on 15th March 2013 along with supporting Financial and Efficiency plans, subject to NHS Borders Board approval.

Recommendation

The Board is asked to **approve** the Local Delivery Plan for 2013/14.

Policy/Strategy Implications	The LDP will be the primary mechanism for monitoring the performance of NHS Boards by the Scottish Government.
Consultation	The LDP 2013/14 has been developed in conjunction with the service, the Clinical Executive, Board Executive Team and service leads.
Consultation with Professional Committees	See Above
Risk Assessment	Each narrative within the LDP highlights any particular risks to achievement of the targets and the plans in place to minimise any such risks.
Compliance with Board Policy requirements on Equality and Diversity	Each narrative within the LDP highlights Equality risks to achievement of the targets and the plans in place to minimise any such risks.
Resource/Staffing Implications	Each narrative within the LDP highlights any particular resource/staffing implications that would risk the achievement of the targets and the plans in place to minimise any such risks.

Approved by

Name	Designation	Name	Designation
June Smyth	Director of Workforce and Planning		

Author(s)

Name	Designation	Name	Designation
Carly Lyall	Planning and Performance Officer		

Local Delivery Plan

2013/14

Planning & Performance

Contents

Glossary

ADP	Alcohol and Drugs Partnership
BI	Brief Intervention
BME	Black and Minority Ethnic Communities
BSL	British Sign Language
CEL	Chief Executive Letter
CHCP	Community Health and Care Partnership
CPC	Child Protection Committee
CPP	Community Planning Partnership
CYPHN	Children & Young People's Health Network
CYPPP	Child and Young People's Planning Partnership
DNA	Did Not Attend
EY	Early Years
GCCAM	Good Corporate Citizenship Assessment Model
HAI	Healthcare Acquired Infection
HEAT Targets	Health Improvement, Efficiency, Access and Treatment Targets
HLN	Healthy Living Network
ISD	Information and Statistics Division of National Services Scotland
JIT	Joint Improvement Team
LES	Local Enhanced Service
LTC	Long Term Conditions
MCN	Managed Care Network
MIU	Minor Injury Unit
MMC	Modernising Medical Careers
NES	National Education Scotland
PWLD	People with Learning Difficulties
QAB	Quality Alliance Board
QOF	Quality and Outcomes Framework

SAB	Staphylococcus aureus bacteraemia
SBC	Scottish Borders Council
SGHD	Scottish Government Health Department
SIGN	Scottish Intercollegiate Guidelines Network
SIMD	Scottish Index of Multiple Deprivation
SMHFA	Scottish Mental Health First Aid
SOA	Single Outcome Agreement
TAMFS	Towards a Mentally Flourishing Scotland programme
TNA	Training Needs Analysis
VAWP	Violence Against Women Partnership
WHO	World Health Organisation

Section 1: NHS Borders Contribution to Community Planning Partnership

To be completed in draft format by 02/04/13

NHS Board: NHS Borders

Improving partnerships during 2013/14
Contributing to better outcomes through collaborative gain

Community Planning Partnership: Borders Community Planning Partnership

Summary of the key tangible contributions that the NHS Board will make during 2013/14 towards improved outcomes

Clearly national improvements through HEAT and other programmes play an important role, however, this part of the LDP is expected to focus on locally developed improvements

Strong emphasis on changes to NHS services which reduce future demand by preventing problems arising or dealing with them early on

Priority	NHS Board Contribution in 2013/14	Current and Planned Performance Levels
Economic recovery and growth		
Employment		
Early years and early intervention		
Safer and stronger communities, and offending		

Health inequalities and physical activity		
Older people		

Section 2: Health Improvement for the People of Scotland

Health Improvement	
Antenatal	At least 80% of pregnant women in each SIMD quintile will have booked for antenatal care by the 12th week of gestation by March 2015 so as to ensure improvements in breast feeding rates and other important health behaviours
Suicide	Reduce suicide rate between 2002 and 2013 by 20%.
Child Weight	Achieve agreed completion rates for child healthy weight intervention programme over the three years ending March 2014.
Smoking	NHSScotland to deliver universal smoking cessation services to achieve at least 80,000 successful quits (at one month post quit) including 48,000 in the 40% most-deprived within-Board SIMD areas over the three years ending March 2014
Child Fluoride	At least 60% of 3 and 4 year olds in each SIMD to receive at least two applications of fluoride varnish (FV) per year by March 2014.

At least 80% of pregnant women in each SIMD quintile will have booked for antenatal care by the 12th week of gestation by March 2015 so as to ensure improvements in breast feeding rates and other important health behaviours

NHS BOARD LEAD:	Evelyn Fleck, Director of Nursing & Midwifery

Delivery and Improvement

Risk	Management of Risk
Women not presenting early enough in pregnancy to midwife/GP for confirmation of pregnancy and subsequent booking.	• The keeping childbirth natural and dynamic (KCND) project and introduction of 1st trimester Down's screening (11 – 13+6 week nuchal scan) have already done much to necessitate and encourage early booking with the community midwife. Posters and business cards were distributed in surgeries and other localities e.g. pharmacies directing women to their midwife as 1st point of contact. GP's / surgery staff were made aware that women should be directed / referred to their midwife at around 8 – 10 weeks gestation. These measures need to be refreshed. • The Health Improvement Team will continue to develop and deliver targeted activities to promote early engagement with pregnant women. These include: • Bump to Baby Events. These have been successfully piloted in areas of socio-economic deprivation and allow pregnant women, their partners and peers to access information about their pregnancy in a non-clinical setting. Two events are planned for 2013- 14 and will be delivered in partnership with Early Years locality networks. • Peer Support programme. Following successful piloting, the trained group of peer supporters will provide support to new mothers. Recruitment of further volunteers is planned. • Antenatal Education Parenting Programme. The Board will scope how this programme can be delivered in community settings and develop training for early years partners to support this work. Local PEGS training programme run in September to train 1st cohort of staff. Further programme planned early 2013 with a roll out plan for delivery of consistent parent education being developed currently • The Board is currently working toward stage two accreditation for UNICEF BFI target date is April 2013. • Baby Welcome Scheme. There are proposals to run this jointly with Scottish Borders Council.

If women transfer care to Borders later in pregnancy, they will 'book' in our system i.e. 34 week transfer from another Board. This will skew local data as they will be counted as a 'New' but were unable to book locally prior to 12 weeks.	Ensure that data processes to capture information accurately are implemented to avoid incorrect data being gathered. (see Workforce section)

Workforce

Risk	Management of Risk
Workforce capability is affected by the difficulty in recording gestation at access of booking	The recently updated Scottish Woman Hand Held Maternity Record (SWHMR V6) prompts comprehensive enquiry and recording of health and social status. This is now in use. The need for an IT system fit for maternity services has been identified and options, including the maternity TrakCare module are currently being explored. This is effectively a comprehensive electronic maternity record that mirrors SWHMR, with local functionality for providing most if not all maternity audit data, including gestation at booking. Head of Midwifery, Head of IM&T & Director of Public Health currently reviewing requirements and funding
Surestart midwives are important towards targeting vulnerable and disadvantaged groups	Surestart midwives funding through Scottish Borders Council is ongoing. This provides targeted support to vulnerable women and links with Social Work. Uncertainty remains regarding funding of 2nd Surestart midwifery post and options are being identified for longer term solutions.

Finance

Risk	Management of Risk
Funding is being secured for the 2nd Surestart midwifery post.	

Equalities

Risk	Management of Risk
The most vulnerable families may miss early booking as women tend to present later and have a higher DNA rate.	Early involvement from the Early Years Team to facilitate and enable attendance at appointments will ensure health and social care needs are met. Early year's locality networks are currently being established across Scottish Borders and will strengthen further partnership working to facilitate early engagement with pregnant women.

Health inequalities are perpetuated by ineffectively addressing issues in isolation	Through more integrated planning across disciplines (Midwifery, community services and health improvement, mental health and addictions services), information and support for pregnant women will be better co-ordinated. The Maternity Care action plan will continue to provide a mechanism to make links with other health improvement programmes such as smoking cessation, promoting healthy weight etc. Where available, data on health inequalities within Borders will be used to inform planning and targeting of interventions.

Trajectory

Percentage of Pregnant Women booked for Antenatal Care by 12th Week Gestation in worst performing quintile

Period	Borders
2010/11	79.1%
Jan-Mar 13	84.5%
Apr-Jun 13	85%
Jul-Sep 13	86%
Oct-Dec 13	86.5%
Jan-Mar 14	87%
Apr-Jun 14	87.5%
Jul-Sep 14	88%
Oct-Dec 14	89%
Jan-Mar 15	90%

Reduce suicide rate between 2002 and 2013 by 20%

NHS BORDERS LEAD:	Eric Baijal - Director of Public Health

Delivery and Improvement

Risk	Management of Risk
Engagement of partners in Choose Life locally	The suicide prevention action plan sits under the early intervention strand of work within community planning, enabling wider engagement with relevant programmes and services. Clear connections between suicide prevention and wider work on mental health improvement have been made and developed within the local mental health improvement action plan and the suicide prevention action. Stakeholders met in November 2012 to consider future priorities for suicide prevention in anticipation of a new national strategy in 2013. An interagency steering group will meet in February 2013 to agree an action plan and will meet regularly thereafter to monitor progress. Local priorities for mental health improvement includes actions relating to young people, community mental health, older people and workplaces and are being taken forward through mainstream planning structures and delivery processes. A programme of delivery of SMHFA, ASIST, STORM and safeTALK training to reduce the risk of suicide is ongoing as well as targeted delivery of sessions raising awareness of suicide and its prevention on request. Discussions are to be held to build capacity to deliver and implement training within specific staff groups i.e. mental health staff to deliver STORM. Ongoing discussions continue with clinical boards to identify training needs of staff in frontline services and ensure training delivered meets their need.
Robust learning approach	Development of training with specific staff groups to build on existing skills. Potential development of alternative delivery methods e.g. e-learning and of mentoring. Building capacity within existing structures to deliver training e.g. by training staff to deliver safeTALK.
Perceived lack of flexibility in programmes	Development of sessions in conjunction with specific staff groups to ensure relevance to enhance staff's existing skills base and support for skills and knowledge to be applied in practice.

Workforce

Risk	Management of Risk
Ability to attend training due to competing pressure of training, development & service delivery priorities on frontline staff	Commitment made by Clinical Executive and Clinical Boards within NHS Borders to support ongoing suicide prevention activity, in particular staff training. Ensuring that suicide prevention features in service development and redesign in order to ensure mainstreaming and sustainability in the longer term, including a focus on upstream mental health improvement elements as well as point of crisis and postvention support. An extensive programme of training open to the community will be in place for 2013/14 which will be delivered as part of ongoing suicide prevention training in Scottish Borders. NHS Borders staff will have access to this. Development of training with specific staff groups to build on existing skills. Delivery of additional training at times and locations which will enable staff participation. Discussions have been held to consider short CPD sessions for A&E staff during the early hours of the day at staff crossover times

Finance

Risk	Management of Risk
Funding to support training provision and delivery of other suicide prevention activity	If funding is not continued, alternative funding streams would require to be sought.

Equalities

Risk	Management of Risk
Lack of explicit visibility within local strategies relating to inequalities	Work in partnership strategically to ensure that the suicide prevention work reflects the impact of inequalities on mental health and to recognise more explicitly the potential for suicide and its prevention. Public sector workforce in NHS and SBC to be a primary focus as will further development of a support programme for men. Connections through Community Planning will facilitate links with ongoing work by partners to mitigate the impact of poverty, financial insecurity and the welfare benefit reforms. Continued development of actions identified through local mental health improvement events and dissemination of information gathered through links with Mental Health SIG.
Up take of training by staff in specific areas	Targeting of staff working with clients in the six inequalities strands will be required to ensure inequalities are not exacerbated.

	Train key staff and volunteers who work with those experiencing inequalities.

Previous Suicide Rates per 100,000 Population

Period	Borders
2002/4	17.5
2003/5	13.7
2004/6	13.7
2005/7	13.6
2006/8	17.3
2007/9	14.8
2008/10	15.1
2013 target	**14.2**

Achieve agreed completion rates for child healthy weight intervention programme over the three years ending March 2014.

NHS BORDERS LEAD:	Eric Baijal - Director of Public Health

Delivery and Improvement

Risk	Management of Risk
Rurality & transport To interventions for those living in outlying areas with no car and poor access to public transport attendance can be difficult	Programmes will be offered during school time to schools across the region, specifically in areas of deprivation. The 1:1 interventions are held in community dietetic clinics throughout the Borders.
Identification and Recruitment As parent consent is required for children to have their weight/height taken (to count towards target), we depend on permission being given. As the intervention is in school time, there is a risk parental involvement will be limited.	An 'opt out' letter to parents has worked well and will be continued, in order reduce the risk of letters not being returned. Schools will encourage parents to give consent and to positively answer queries from parents. Parents have the opportunity to contact the HI lead should they have any queries or concerns. Parents will be aware of the child healthy weight (CHW) intervention through letters sent home via school. Schools will be encouraged to involve parents by inviting them into sessions. All children will receive an information pack with worksheets which they can take home at the end to share with their parents. All parents will receive information regarding the 1:1 dietetic intervention and details of whom to contact should they have any concerns about their child's weight. Parents will also be notified that follow up contact may be made if concerns about their child's weight are identified through the CHW programme. In addition to the continuing delivery of the CHW programme in schools, further work is planned with Scottish Borders Council Education services to foster engagement with parents in relation to nutrition and healthy weight messages.
Sustaining changes in weight There is a risk that any changes will not be maintained.	Work will continue with key partners (schools and third sector organisations) to establish longer term physical activity programmes and sign post children and families to local physical activities post CHW interventions. This will be low cost or cost free where possible. Any follow up planned will be scheduled either in school time or at a time more suitable for participants.
There is a need to map the range of contributions that partners are making to address local joint priorities relating to childhood obesity, At present, the	Structures are now in place in the Child Healthy Weight Steering Group and the overarching Promoting Healthy Weight action planning group that will assist in identifying current activity and resources and in indicating both gaps

full benefits of individual pieces of work may not be missed due to a lack of co-ordination and limited opportunities to share good practice. This is particularly important to ensure a focus on early intervention and prevention, whilst also implementing the Child Healthy Weight Interventions	for development and areas of good practice for wider dissemination. The Promoting Healthy Weight action planning is included as an Early Intervention priority within Community Planning. This provides a platform to develop wider links to other relevant strategies and plans.
Embedding of CHW interventions delivery in schools and early years settings Wider delivery of CHW interventions in community settings.	Training and development for the wider workforce will be identified, within the capacity currently available and using a range of media including e learning. Closer integration will be developed where relevant with local Maternal and Infant Nutrition work and work within the Health Living Network As noted above, a substantial programme of work is planned with Education on nutrition and healthy eating in schools, that will include promotion of school meals, awareness raising on healthy snacks and packed lunches, engagement with young people and with parents, review of menus etc. The CHW team will support schools to develop post intervention activities and programmes that further CHW aims and objectives.

Workforce

Risk	Management of Risk
Both strategic and operational leadership is in place from Health Improvement staff on fixed term contracts to March 2013. This has implications for capacity to undertake other food and health work with families and local communities. The intervention identifies children over the 91st centile There is a risk that this will put added pressure onto other relevant services.	Approval is being sought for short term funded capacity to March 2013 to be made permanent. This would secure the necessary robust leadership and management for the programme to continue to achieve good outcomes through collaborative gain. The CHW staff will continue to work in partnership with Scottish Borders Council Education and other sectors to reinforce their contribution to CHW aims and objectives. Work planned for 2013 – 14 includes work to improve nutrition in schools through a range of steps. Continue to work in conjunction with Primary Care service managers and clinical leads in School Health and in Dietetics to further the aims of the CHW programme. Regular liaison with relevant services will ensure that pathways are clear for children whose weight is out with a healthy range. Community Dietetics will continue 1:1 CHW programmes.
Delivery Team The current delivery team comprises two nutrition leaders and admin support, all on fixed term contracts to March 2013.	Approval is being sought for these posts to be made permanent to secure the necessary capacity and expertise for continuing delivery of the programme. Additional capacity for practical nutrition work with schools

	and parents is being developed for 2013- 14 in conjunction with the local Maternal and Infant Nutrition Programme in schools and early years settings. The effective delivery of the CHW programme continues to be contingent on close collaboration with other services, in particular school nurses, health visitors, school staff and the community and the voluntary sector. It will be essential to maintain a collaborative approach to programme delivery to ensure viability. This requires continuing investment of effort in partnership working. The Child Healthy Weight steering group will continue to develop wider community based approaches that complement the schools based Fit4fun programme.

Finance

Risk	Management of Risk
Financial pressures in NHS and local authority poses challenges to sustainability of gains achieved through CHW interventions.	Sustainability will continue to be explored using range of approaches as noted below. Community Dietitians to continue 1:1 programmes. Commitment to promoting healthy weight within joint local Children's Services Plan signals a growing joint commitment to this area of work. The Children and Young People's Planning Partnership also provides clear accountability and governance.

Equalities

Risk	Management of Risk
Engagement and inclusion	All children can participate in the programme whether they are weighed or not. All children and their families will be accepted on to the 1:1 interventions – if appropriate, extra staff will be allocated to provide additional support where required. Translators will be utilised where English is not a first language.
Communication of intervention programmes being made in alternative languages, Communication toolkits for PWLD, BSL for those who are deaf	The CHW Team will continue to ensure that intervention programmes are equality impact assessed and any gaps addressed.
Target families in SIMD quintiles 1 and 2	SIMD indices and local knowledge will continue to be used to ensure the interventions are reaching this target group by focusing programme delivery on areas of higher deprivation.

Trajectory

Completion Rate for Child Healthy Weight Intervention Programme (cumulative)

Year ending	Borders
Apr 11 - Mar 12	121
Apr 11 - Mar 13	221
Apr 11 - Jun 13	246
Apr 11 - Sep 13	246
Apr 11 - Dec 13	296
Apr 11 - Mar 14	331

NHS Scotland to deliver universal smoking cessation services to achieve at least 80,000 successful quits (at one month post quit) including 48,000 in the 40% most-deprived within-Board SIMD areas over the three years ending March 2014.

NHS BORDERS LEAD:	Alison Wilson – Director of Pharmacy

Delivery and Improvement

Risk	Management of Risk
Inability to reach target quit attempts in particular in areas of deprivation	Analysis of activity by Advisors and other providers to enable allocation of resources to fit identified data zones. Annual marketing campaign via local radio to promote awareness of service. Continued use of in-house publications. Maintain relationship with Smokeline to ensure appropriate signposting of callers. Field promotion of Smoke-free homes in identified datazones will include active recruitment of smokers to smoking cessation service. Work with Keep Well Service to explore ways of maximising referrals to service.
Ensuring adequate data capture of community pharmacy Smoking Cessation scheme	Mandatory annual update training includes reminders and support regarding form completion. Robust scrutiny of return rates to ensure all data is being captured

Workforce

Risk	Management of Risk
Ability to release key staff for training to increase appropriate referrals from pregnant women, acute care and mental health services users	Ongoing work to build relationships within the acute setting to ensure access to service is maximised. Development of plans to increase availability of smoking cessation support by hospital patients (Health Promoting Health Service-CEL (1) 2012). Working in partnership with mental health colleagues to ensure training is accessible and to simplify pathways to lifestyle advice for mental health service users. A review of cessation support in pregnancy is underway currently as part of the local Maternity Care action plan and in the context of the new antenatal education syllabus. This will be aligned with the anticipated new national guidance.
A reorientation of service in inequalities areas towards a community development based approach will be resource intensive for advisors and could result in an initial decrease in the number of people seen overall	We will closely monitor the throughput of the overall service and maintain close links with other providers to ensure smooth cross referral. Review of administration systems held to improve efficiency and flow and maximise advisor capacity. Opportunities for closer working with the Healthy Living

	Network are being actively explored.
Reduced advisor hours due to absences in a small staff team may have the potential to impact on service delivery	Develop contingency plans to minimise impact of reduced staff capacity. Options include increasing part time staff hours and short term recruitment of appropriately qualified staff.

Finance

Risk	Management of Risk
Pharmacy contribution equates to 50% of successful quits locally. In the event of the withdrawal of the pharmacy scheme there will be insufficient funding to continue the payments locally.	In the event of any changes to the pharmacy scheme the existing model of delivery will be reviewed. Long-standing positive relationships exist between community pharmacies and the Smoking Cessation Service; this will help facilitate any proposed remodelling of service.

Equalities

Risk	Management of Risk
Potential exclusion of population groups from service	Service is available via different settings throughout breadth of Borders, weekend access is via pharmacies. Advisors can offer telephone support/home visits to individuals unable to physically access service. The monitoring of ethnicity is done via the Minimum Data Set. Recent review of service has refocused specialist advisor hours with increased emphasis on areas of deprivation.

Trajectory

No of People who have Stopped Smoking 4 Weeks Following Input from Smoking Cessation Service in lowest 2 SIMD Quintiles

Figures below provisional based on provisional figures for delivery of 1525 quitters over the 3 years, 838 (55%) from most deprived areas

Cumulative	Lowest 2 SIMD Quintiles
Apr 11 - Mar 12	495
Apr 11 - Mar 13	560
Apr 11 - Jun 13	630
Apr 11 - Sep 13	700
Apr 11 - Dec 13	770
Apr 11 - Mar 14	838

At least 60% of 3 and 4 year olds in each SIMD quintile to have fluoride varnishing twice a year by March 2014.

NHS BOARD LEAD:	Eric Baijal - Director of Public Health

Delivery and Improvement

Risk	Management of Risk
Cooperation with General Dental Practices (GDP) for Childsmile Practice. (We estimate half of the children will need to be seen in NHS dental practice)	Continue to support GDPs in all aspects of Childsmile practice and encourage dental nurses to complete Childsmile training which is now being offered at a local level.
Delivery risks include public perception perhaps due to adverse media reports, less of a problem with consented fluoride varnish application than water fluoridation	Management includes giving up to date evidence based information. Evidence of the safety and effectiveness of Fluoride as an adjunct to dietary control dates back many decades to early observations of differences between naturally fluoridated areas and control areas and evaluation of artificial fluoridation schemes. Any new evidence or publicity that becomes available will be considered and taken into account when providing information within the programme. As this is a national programme, guidance will be obtained from the national steering committee in the event of any significant new evidence being published.
Cooperation with nurseries and targeted schools – so far excellent but always the risk of excess interventions from various disciplines	Provide continued support to the nurseries and schools from oral health promotion team with additional interventions as and when necessary.
Cooperation with salaried dental practices	Continue to ensure all NHS dental registered children 0-5 are part of the Childsmile Practice scheme within Salaried and Community Dental Services, and support the use of Childsmile nurse led clinics within all sites.
Improvement risk could include an element of children being beyond the saturation point on the sigmoid dose response curve of extracellular sugars intake thus reducing the effect of the topical fluoride. In such children the diet is so adverse that decay will occur despite the use of fluorides.	The management of this is by oral health promotion within the Childsmile programme to reduce dietary sugars from plateau maximum damage levels. This will benefit those children who will be targeted for care by the healthcare team very early on in their lives. Evidence from the National Dental Inspection Programme results is positive and suggests that cariogenic effects are reduced to the levels where fluoride application can have a positive additional benefit in many children. Additional Oral Health messages are communicated through Childsmile Core Toothbrushing programme and support for Childsmile Practice.

Workforce

Risk	Management of Risk
Cooperation with general dental practices	Continue to facilitate sign-up and provide training locally to their dental nurses with continued support from the Childsmile coordinator.
Loss of trained staff	Retention of Childsmile Team staff is good with all OHSWs on permanent contracts.
Workforce risks include conflict when Childsmile trained dental nurses are needed for chairside surgery work	A Childsmile Extended duty dental nurse is in post on a temporary contract until March 2014 to support Childsmile school and nursery programme. NHS Borders salaried dental service have trained 9 DNs to support the delivery of Childsmile in both practice and school and nursery programmes.
Pressure on the role of the Oral Health support worker	The oral health support workers now number 7 posts. Capacity and demands will be kept under review when service planning for the future.
Adequate support for all staff involved within Childsmile programmes	Robust support structure is in place to manage and coordinate Childsmile fluoride varnish programmes both within nurseries and practice.

Finance

Risk	Management of Risk
Continuation of central funding	Funding has been agreed and local management plans are being progressed to add to this funding

Equalities

Risk	Management of Risk
Lack of compliance and participation in the more deprived quintiles leading to failure to improve oral health in children living in those SIMD quintiles	Ensure compliance with national monitoring system with participation across all the quintiles. This will avoid the inverse care law where more preventive activity occurs in the least deprived quintiles.
Equalities risk could include any children not attending nurseries missing out	This will be managed by the “Childsmile Practice” programme and also the whole dental team encouraging early attendance for the delivery of preventive messages to attempt to avoid treatment becoming necessary. Recent introduction of an item of service for fluoride varnish application in the NHS dental statement of dental remuneration will enable those children attending family dental practices but not nurseries to be included.

Trajectory

% of 3 and 4 year olds in SIMD quintile having fluoride varnishing

Month	Borders
Mar-12	2.4%
Mar-13	15.0%
Jun-13	26.0%
Sept-13	37.0%
Dec-13	48.0%
Mar-14	60.0%

Section 3: Efficiency and Governance

Efficiency and Governance	
CO2	NHSScotland to reduce CO_2 emissions for oil, gas, butane and propane usage based on a national average year-on-year reduction of 3% each year to 2015-16.
Energy	NHSScotland to reduce energy-based carbon emissions and to continue a reduction in energy consumption to contribute to the greenhouse gas emissions reduction targets set in the Climate Change (Scotland) Act 2009

NHSScotland to reduce energy-based carbon emissions and to continue a reduction in energy consumption to contribute to the greenhouse gas emissions reduction targets set in the Climate Change (Scotland) Act 2009.

NHS BORDERS LEAD:	David McLuckie – Director of Estates

Delivery and Improvement

Risk	Management of Risk
Demand for utility services	Ever increasing demand for electrically powered equipment, both clinical/non clinical and IT. High usage departments to be monitored, where practical, relating consumption to activity. Energy efficiency to be considered in the procurement of all goods and in the planning and design of healthcare property modifications, extensions and new construction. Carbon Management Programme, which identifies capital funded projects, will reduce utility consumption through: energy efficiency, heat recovery, reduced waste etc. In addition the Property Review Strategy is exploring opportunities to reduce the property portfolio and hence reduce utility usage Finally the Building Management System installed in all properties has been utilised to reduce the number of operational hours of heating systems and space temperatures to a minimum
Potential increase in healthcare activity	Monitoring of consumption must at all times reflect the service provision of properties in use. Change of use, increase/decrease in activity, increased reliance in electrically powered equipment, as noted above, must be tracked routinely.
Targets within trajectory to be expanded to incorporate the whole estate	Data contained within baseline figures and trajectories is for Hospital sites only, as listed within the HEAT Phase 2 Energy Performance trajectories, dated 15th December 2010. Community sites will be excluded from national reports pending further work, as noted below.
Receipt of water and electricity usage data in electronic format for community premises	At present all invoices received electronically. . Installation of automatic gas data collectors is complete on all sites; installation of automatic electricity data collectors is underway. Water data will continue to be collected manually.
Modification to eMART, (**e**nvironment **M**onitoring **A**nd **R**eporting **T**ool)	Health Facilities Scotland will take the lead in developing eMART, this in conjunction with contracted utility suppliers. Completion time frame to be clarified but development has commenced.

Ownership	Energy consumption is not solely the responsibility of the Estates department; it is the responsibility of all staff; i.e. NHS Staff, Scottish Borders Council Staff and General Practitioners and their Staff, all of whom share accommodation within NHS premises. Simple actions can contribute to improving energy efficiency. Therefore the leadership of Senior staff is essential in improving awareness of all members of staff which will bring about the change culture and behaviour required to make a real difference.
Capital cost and associated payback period for elements of sustainable technology incorporated within Property, capital investment and improvement programme	Sustainable technology, which within full life costing may prove to be more cost effective, invariably the initial capital outlay will adversely impact on the cost of Property capital projects. Certain costs are unavoidable as certain elements are mandatory requirements for Planning consent. Others will be reported within Project Boards for consideration by same and the Capital Management Team.
Local Authority Planning consent for elements of sustainable development within Property, capital investment and improvement programme	

Workforce

Risk	Management of Risk
Training and awareness raising programme	Essential to identify a dedicated energy management role within the Estates Department, and in addition actively establish the formation of local champions to take the lead in promoting energy efficiency within operational departments, on all sites. Self assessment and registration with GCCAM in 2010 to promote awareness and sustainable development. (Resource and A4C issue).

Finance

Risk	Management of Risk
Identification of Capital investment required to support initiatives identified within the Board's Carbon management programme	Carbon Management Programme will continue to identify a capital investment programme 2012 – 2016, establishing details of costs and pay back periods Additional funding for 2012-2013 and 2013-2014 from the CEEF fund has been agreed for investment in identified projects. Accurate practical (rather than theoretical) revenue, CO2 and energy savings to be identified on completion of the projects
Cost of utility services	Pan Public Sector utility contracts were established, October 2009, the cost of supplies very much influenced by international markets. Out with the control of individual Boards.

Equalities

Risk	Management of Risk
Financial restraints will have an impact on meeting legal requirement to provide staff and patients, for those	Monitor interpretation and translation policy

that require it, information in alternative formats Procurement processes not equality impact assessed	 Build in equality impact assessment of procurement processes

Trajectory

Energy Consumption and CO_2 Emissions

Year		Borders
2009/10	Energy GJ	95,061
2011/12	Energy GJ	91,421
2013/14	Energy GJ	84,157
2014/15	Energy GJ	81,629
2009/10	CO_2 Tonnes	3,358
2011/12	CO_2 Tonnes	3,167
2013/14	CO_2 Tonnes	2,973
2014/15	CO_2 Tonnes	2,883

Section 4: Access to Services

Access to Services	
CAMHS **Psy Ther**	Deliver faster access to mental health services by delivering 26 weeks referral to treatment for specialist Child and Adolescent Mental Health Services (CAMHS) services from March 2013; 18 weeks referral to treatment for Psychological Therapies from December 2014.
IVF	Eligible patients will commence IVF treatment within 12 months by 31 March 2015.
4-hour A&E	95% of patients will wait less than 4 hours from arrival to admission, discharge or transfer for accident and emergency treatment by year ending September 2014

Deliver faster access to mental health services by delivering 26 weeks referral to treatment for specialist Child and Adolescent Mental Health Services (CAMHS) services from March 2013; reducing to 18 weeks from December 2014

NHS BORDERS LEAD:	Jane Davidson – Chief Operating Officer

Delivery and Improvement

Risk	Management of Risk
Final stage of expansion of the service up to age 18 within current resources: • This may result in increased waiting times to treatment • Greater complexity of referrals may ensue.	Demand and capacity modelling has been used to assist identification of issues. A local group continues to drive operational issues across mental health services with CAMHS on moving its upper age limit.
The capacity of the service may be compromised by the increased demand incurred by raising the age limit In particular the recently enhanced Intensive treatment service and the ability to fully implement the SIGN guidelines for neurodevelopmental disorders	The impact on the service will be monitored. Pathways for neurodevelopmental disorders have been revised and two nurses have been trained as prescribers. Whole service undertaking a VSM exercise to identify scope to release additional internal capacity.
IT system to support returns to SGHD not currently fit for purpose	The team continues to work with ISD, supported by the local Planning and Performance and IM&T teams to improve these issues. Recent QuEST funded post to improve data issues across the whole system will provide benefit here.

Workforce

Risk	Management of Risk
Relatively small changes in workforce (e.g. sickness, maternity leave etc) could have significant impact on waiting times for generic CAMHS referrals	Workforce and financial considerations are considered within the service to ensure maximum utility is derived from dedicated funding from SEAT and NES.
The WTT and access to psychological therapies targets along with the delivery of a CAMHS ICP and Balanced Scorecard place considerable demands on the teams admin support and delivery of accurate and timely data.	CAMHS are participating in the whole system Admin review taking place across MH Services.

Finance

Risk	Management of Risk
No additional funding available to support service extending scope to age 18.	Workforce and financial considerations are considered within the service to ensure optimal efficiency.

Equalities

Risk	Management of Risk
• This HEAT target should be equality impact assessed to identify positive and negative impacts on equality groups • NHS Borders must adopt fully the equality impact assessment process • NHS Borders must adopt the interpretation and translation policy to ensure that staff are supported and patient care and safety is improved • Implementation of equality monitoring and patient record markers will support referral, treatment and care • All health improvement activity / projects and other HEAT target activities to take into account cultural diversity; disability equality; gender equality; migrant /BME communities; gypsy/travellers	

Trajectory

Percentage of patients who started treatment within 18 weeks of referral: Quarter of Treatment

Month	Borders
Jul-Sep 12	100%
Apr-Jun 13	90%
Jul-Sep 13	90%
Oct-Dec 13	90%
Jan-Mar 14	90%
Apr-Jun 14	90%
Jul-Sep 14	90%
Oct-Dec 14	90%
Jan-Mar 15	90%

Deliver faster access to mental health services by delivering 18 weeks referral to treatment for Psychological Therapies from December 2014.

NHS BORDERS LEAD:	Jane Davidson – Chief Operating Officer

Delivery and Improvement

Risk	Management of Risk
The breadth of the target (all age, all service) itself creates a potential risk to delivery overall	Governance structure for the target to be finalised and implemented, which is cognisant of the wide ranging nature of the target. Project Plan and Risk Register to be commenced and regularly updated as the service works on sustained implementation of the HEAT Target.
Current IT system not "fit-for-purpose" to capture necessary information to measure referral, access and treatment information	NHS Borders currently implementing a new Patient Management System. Mental Health modules planned for 2013/14. Exploration on whether this timescale could be brought forward indicated limited opportunity for this.
Introduction of 18 week referral to treatment target for Psychological Therapies by December 2014	The Borders Improvement Support Team has a team of skilled improvement facilitators who will support the service to implement change and new ways of working using lean methodology.

Workforce

Risk	Management of Risk
Lack of clarity on current capacity to deliver psychological therapies Lack of clarity on the competence of the current workforce to assess/deliver psychological therapies Non MH Services: lack of staff knowledge and understanding of psychological therapies as may not be seen as core business	Demand and Capacity to be measured utilising Mental Health Collaborative methods. A workforce survey to measure and monitor competency to delivery psychological therapies and identify training and supervision needs to be redone. Continuing attempts to extend membership and inclusion of non MH Service stakeholders in discussions on rolling out target to all services.

Finance

Risk	Management of Risk
Impact could be on resources to train staff (including backfill) to create sufficient capacity to respond to indicated need.	Full measure of the risk outstanding. Requires more detailed DCAQ work to be undertaken.

Equalities

Risk	Management of Risk
Inequity /variable access to psychological therapies current service configuration	Adult Community Mental Health Lean is focussing on the patient pathway from referral to discharge. A clear objective of the project is to reduce variation and standardise access and patient pathway for the Borders population.

	Clear eligibility criteria to be agreed and communicated. Roll out of development work undertaken on contact/activity recording and management of waiting lists will ensure greater transparency and easier analysis to assure on equitable service delivery.

Trajectory

Percentage of patients who started treatment within 18 weeks of referral: Quarter of Treatment

Month	Borders
Apr-Jun 13	80.0%
Jul-Sep 13	80.0%
Oct-Dec 13	85.0%
Jan-Mar 14	85.0%
Apr-Jun 14	90.0%
Jul-Sep 14	90.0%
Oct-Dec 14	90.0%
Jan-Mar 15	90.0%

Eligible patients will commence IVF treatment within 12 months by 31 March 2015

NHS BORDERS LEAD:	Sheena MacDonald – Medical Director

Delivery and Improvement

Risk	Management of Risk
This target is currently being achieved.	There is a cross border contractual arrangement with NHS Lothian to see all referred patients within 3 months of referral, and to commence treatment within 3 months of first being seen.

Workforce

Risk	Management of Risk
No current implications	

Finance

Risk	Management of Risk
Increasing Costs	Referral based on National EAGISS criteria (2007) so no potential to amend these. Consider seeking contract with another Assisted Conception provider.

Equalities

Risk	Management of Risk
Criteria set Nationally EAGISS criteria (2007).	NHS Borders Criteria (2012) give clear guidelines to determine eligible patients.

Trajectory

Trajectory not required to be submitted until SG look at the data and how it can be collected – Sept / Oct 2013

95% of patients will wait less than 4 hours from arrival to admission, discharge or transfer for accident and emergency treatment by year ending September 2014

NHS BORDERS LEAD:	Jane Davidson – Chief Operating Officer

Delivery and Improvement

Risk	Management of Risk
Sustainability of performance against the Emergency Access Target of 95% of attendees admitted/ transferred/ discharged requires collaborative working across NHS Borders and with partner agencies aimed at admission avoidance, reduction in length of stay in acute beds and supported care within the community.	NHS Borders will continue to adopt a whole systems approach working closely with Scottish Borders Council in reduction of length of stay in both Borders General Hospital and our Community Hospitals thus ensuring capacity for unscheduled admissions within admitting areas, reducing the need for these patients to be admitted through the Emergency Department.
Within NHS Borders there remains variation in discharge/transfer processes.	Improvement work on going to address variation.
We continue to see a change in public behaviour whereby the public choose to attend ED rather than access primary care or minor injury services. Work is continuing within our Primary and Community Services Clinical Board aimed at standardisation of minor injury services offered across Scottish Borders.	Focused public education similar to that adopted in NHS Fife and NHS Grampian required across Scottish Borders signposting the public to the most appropriate agency for their ailment e.g self care, pharmacies, minor treatment centres etc.) Supporting redirection from ED to primary care where appropriate by ED triage nurse/medical staff
Although NHS Borders continues to perform above the national average for the percentage of patients assessed, treated, admitted/transferred/ discharged within 4hrs of registration at the Emergency Department sustainability is not assured. Achievement against the standard remains vulnerable in the overnight period particularly when there is a reliance on junior doctors for service provision.	Initiatives such as See & Treat and the Emergency Nurse Practitioner (ENP) service ensure that Flow 1 (minor injury/illness) patients do not breach the emergency access standard during the hours these services are operational. See and Treat initiated between 10.00 and 18.00hrs during periods of high demand in ED. Adopting see and treat during busy periods in ED has proved beneficial in terms of reduction of Flow 1 breaches of EAS. ENP service operational 13.00 – 21.00hrs Monday to Friday and 10.00 – 21.00hrs Saturday and Sunday. Medical rotas across Borders General Hospital recently amended to ensure junior doctor in ED overnight has previous ED experience.
Reducing unnecessary attendances at ED /admissions to Hospital. Successful professional to professional line in place in Out of Hours periods not mirrored during GP daytime hours.	Collaborative working with colleagues in the Scottish Ambulance Service has resulted in a successful professional to professional line in the Out of Hours period between SAS and the Out of Hours Primary Care Service (Borders Emergency Care Service) whereby paramedics can contact BECS GPs directly for advice/support aimed at reducing unnecessary transfers into hospital. The professional to professional line continues to be successful in reducing unnecessary admissions to hospital. This initiative is led by the Clinical Lead for BECS.

Development of SAS paramedic practitioners in assessment and treatment at scene to avoid unnecessary journeys to hospital. Issues relating to skills and knowledge retention as SAS in Borders currently unable to support paramedic practitioner roles.	2 x SAS Paramedics have been supported to complete the Minor Injuries and Acute Illness courses affiliated to Queen Margaret University with consolidation of learning within the Emergency Department at Borders General Hospital. The ultimate aim being to reduce ED attendances using a See and treat model in the community. The consolidation of learning is supported by the ED Consultant at BGH. There may be opportunities to explore paramedics undertaking an ENP role within ED but this will require a Service Level Agreement between NHS Borders and SAS.

Workforce

Risk	Management of Risk
Sustainability of medical workforce in ED, currently ED is medically staffed by 1 ED Consultant and Speciality Doctors who are qualified GPs. The reliance on junior doctors for overnight service provision remains a risk.	Specialty doctors cover a proportion of the overnight period currently and junior medical rotas have been amended to ensure junior doctors in ED overnight have ED experience.
Succession planning for ENP service, currently 4 ENPs, 3 of whom are nearing the end of their working life.	Currently a number of ED nurses have completed minor injuries and acute illness courses with plans to continue to offer nurses the opportunity to complete the minor injuries/acute illness courses.
Knowledge and skills requisition and maintenance for nurses in minor injury/illness centres across Scottish Borders.	Nurses in minor injury/illness centres in Community Hospitals are offered opportunities to refresh skills and knowledge in minor injury/illness management by working in ED. A rolling training programme would prove beneficial to support skills and knowledge requisition.

Finance

Risk	Management of Risk
Borders General Hospital currently has one ED Consultant; this may not be sustainable in the longer term and may require additional investment in order to retain a 24 hour ED in Scottish Borders.	ED Consultant supported by Specialty doctors (all qualified GPs). Medical governance issues out of hours supported by speciality Consultants.
No dedicated data analyst support currently for performance measurement.	Service collates performance data.

Equalities

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

A trajectory is not requested within the LDP

Section 6: Treatment Appropriate to Patient

Treatment Appropriate to Patient	
Cancer	To increase the proportion of people diagnosed and treated in the first stage of breast, colorectal and lung cancer by 25%, by 2014/15
75+bed	Reduce the rate of emergency inpatient bed days for people aged 75 and over per 1,000 population, by at least 12% between 2009/10 and 2014/15
Discharge	No people will wait more than 28 days to be discharged from hospital into a more appropriate care setting, once treatment is complete from April 2013, followed by a 14 day maximum wait from April 2015
SAB **CDI**	Further reduce healthcare associated infections so that by 2014/15 NHS Boards' *staphylococcus aureus* bacteraemia (including MRSA) cases are 0.24 or less per 1000 acute occupied bed days; and the rate of *Clostridium difficile* infections in patients aged 15 and over is 0.25 cases or less per 1000 total occupied bed days
A&E	To support shifting the balance of care, NHS Boards will achieve agreed reductions in the rates of attendance at A&E between 2009/10 and 2013/14
Dementia	To deliver expected rates of dementia diagnosis and by 2015/16, all people newly diagnosed with dementia will have a minimum of a year's worth of post-diagnostic support coordinated by a link worker, including the building of a person-centred support plan

To increase the proportion of people diagnosed and treated in the first stage of breast, colorectal and lung cancer by 25%, by 2014/15

NHS BOARD LEAD:	Dr Eric Baijal, Director of Public Health

Delivery and Improvement

Risk	Management of Risk
Identifying patients at early stages; GPs consider that they currently refer anyone who they suspect of having cancer as soon as possible.	It is crucial to raise awareness to patients around 'spotting the signs' and coming forward early, however, there will be a requirement to explore in detail how GP referral pathways could be improved. This needs to be a fully integrated work stream as many of the solutions will be in secondary care. GPs have been encouraged to use the Scottish Cancer Referral Guidelines to identify patients with features which may indicate cancer and to then refer in urgently. All practices took part in the cancer DES in 2007 and 2008. Subsequent to this all practices were visited by the Lead Cancer GP and other members of the Lead Cancer Team to promote use of the referral guidelines, discuss any anomalies and to gain feedback on any issues for cancer services in NHS Borders. A new Lead Cancer GP is in the process of being appointed. Once in post, the plan will be to undertake a series of visits to all practices to tie in with the review of Primary Care Cancer Referral Guidelines which are due to be completed in April 2013.
Early diagnosis: In order to ensure that greater numbers of patients are identified, it will inevitably require more diagnostic tests to be carried out. This will greatly impact on diagnostic capacity and waiting times There will be real challenges in delivery of additional colonoscopy capacity	Although some capacity may be increased through redesign. NHS Borders has done a considerable amount of redesign of its diagnostics, as other health boards have; therefore it is unlikely that this will release adequate additional capacity. There may be some reduction in activity for patients in later stage cancer, as proportion reduces. However, the implication is that additional capacity will be required and as part of this work we are looking at creating additional colonoscopy sessions. This additional capacity will also contribute to the delivery of an ambitious waiting times target for colonoscopy of around 2-3 weeks.
Treatment: This target should in principle not greatly increase as more complex later-stage cancer treatments are replaced by simpler, less intensive treatment. This may however be offset by reduction in patients where palliative support is only treatment. There may be an increase in diagnostic surgical treatment and in chemotherapy	We need to undertake modelling at both national and local levels to understand and plan for change in treatment pattern.

Follow-up Earlier diagnosis and treatment will result in more patients being managed following cancer treatment for longer. This could impact on outpatient and diagnostic capacity in terms of follow-up.	Modelling required as above to determine likely impact. Increased moves to non-medical follow-up should be pursued. Work on alternatives to traditional follow-up developed through the Regional Oncology Review and supported by the Transforming Care after Treatment Programme will assist in this.
Screening and getting the message out about early detection of cancer: Improved local linkage to screening programmes, especially the breast screening programme, could improve the system. We are aware of the current review of the breast screening service.	Local communication plan in place, which complements national awareness campaign. Key focus is the hard to reach and vulnerable groups, where screening uptake rates are lower. This work is being taken forward by a number of our existing primary and community services networks such as the Lifestyle Advisory Service and Health Living Networks

Workforce

Risk	Management of Risk
The changing pattern of cancer diagnosis may result in more 'fitter' patients needing earlier and longer-term support to live with their cancer. This would impact on current models of CNS and other support provision including primary care.	Consider developing remodelled workforce focused on the needs of the changing patient population. Potential capacity issues.
Earlier diagnosis may change balance of treatment modes. If this results in, say, more chemotherapy or radiotherapy being required, this would need an increase in staff with the required skills	Modelling of impact would indicate where growth is likely to take place. Investment to train addition al staff would be necessary. This will include working with SCAN on modelling for any changes in demand for radiotherapy services

Finance

Risk	Management of Risk
There may be either a short-term or longer-term capacity increase required. This would require additional funding.	There may be potential for some redesign of service delivery models to rebalance resource. However, it is likely that additional funding may be required, either in short term to assist in moving to new model or longer-term if additional capacity is required
Patients diagnosed earlier may require drug treatment for longer. This may be offset by reduction in patients requiring very expensive 3rd & 4th line treatments	Financial modelling of changing pattern of treatment required

Equalities

Risk	Management of Risk
Patients who access health services earlier are generally those in more	Focus on encouraging and enabling these sectors of society to access health services earlier will be an

affluent sectors of society. People in more deprived areas tend to present later	essential element of any programme of work. Our awareness campaign will focus on the more deprived areas of the local population. The direct involvement of third sector groups in delivering DCE will bring user perspectives into the programme and help keep focus on this, and are included in our communication and awareness plan.

Trajectory

HEAT target – To increase the proportion of people diagnosed with breast, colorectal and lung cancer by 25% by 2014/15

Period	Borders
2011	19.4%
2012	21.4%
2013	23.4%
2014/15	24.3%

We are awaiting the 2010/11 data from ISD which will form our baseline for the HEAT target. The trajectory will be updated as soon as this data is received, and will reflect the likely impact of each the specific cancer campaigns.

Reduce the rate of emergency inpatient bed days for people aged 75 and over per 1,000 population, by at least 12% between 2009/10 and 2014/15

NHS BORDERS LEAD:	Jane Davidson – Chief Operating Officer

Delivery and Improvement

Risk	Management of Risk
Availability of robust data across all care settings	The national Links have improved and further to the introduction of TRAK local anomalies across community and local authority have been identified and work is ongoing across IM&T and Performance & Planning to better manage information capture across the different IT systems.
Shared vision of key deliverables within health and social care	Local Single Outcome Agreement includes this target. Joint CHCP Planning and Delivery committee oversees delivery of this element of SOA. Primary and Community Services (P&CS) Clinical Board is leading discussions within NHS Borders to create an "Integrated Cabinet" to develop further a whole system approach to performance management and service improvement.
Interdependency between Social Work & Health to keep older people safe in their own home is dependent upon sufficient resources i.e. staffing, equipment, finance and carer support Dependency on capacity of health staff to support complex care planning to prevent admission / readmission	NHS Borders and Scottish Borders Council are working together through the Reshaping Care Board to plan and resource new ways of working within the community. Intermediate Care has been established in a number of Care Homes and continues to be rolled out across the Borders. This incorporates shared support worker roles and third sector involvement. Having evaluated the STACCATO ACP Project a more focussed trial of the amended tool is underway within one locality prior to roll out. Stay Well Programme, looking at unmet needs and anticipatory care in for example management/prevention of falls.
Unpredictability of clinical presentation at any point in time may result in increase in demand / reason for longer bed stays	"Anticipatory care planning and prevention of admission" Local Enhanced Service has been in place over the last 2 years and has created the foundation for further development in line with revised GP Contract. Very robust whole system winter and festive period planning in place. Continuing to build upon the risk prediction work across primary care and evaluation of supporting community services, self-management programmes to support people to remain at home where possible and avoid hospital admission and to support appropriate early discharge. The rolling LTC Training & Education Programme for Primary Care services continues.

	Pulmonary Rehabilitation programme now established with the use of telemedicine equipment to link to remote classes from a central "hub".
Consistent approach to clinical management of in-patient cohort	Work continues within P&CS to embed new contract for GPs looking after Community Hospitals that will include focus on length of stay and patient pathways. Revisions to nGMS will place ACP at the core of QOF. NHS Borders will use the next round of enhanced services to develop this and build on the work already done. Productivity & Benchmarking reports are now regularly issued to all GP practices highlighting variances in referral rates, admission rates use of investigations offering support where appropriate and highlighting system or individual referrer issues requiring change and development. The MCNs continue to take a key role in developing training and education processes across the in-patient settings. Specific initiatives within BGH are being taken forward by MCNs to support reduction in length of stay e.g. diabetes service.
Consistent and timely approach once patient "fit" for discharge	CHCP Discharge/Transfer policy contains strict timelines and recommendations to minimise delays in discharge. Benchmarking information regarding community hospital lengths of stay being presented on regular basis to senior clinicians. Discharge/Transfer Policy being reviewed and Action Plan for 2013/14 to be developed with a Service Improvement focus/approach driving the implementation of change.
Clinical leadership in particular GP engagement in this agenda as a result of the constraints of independent contractual arrangements with GP	Maximising opportunities of enhanced service funding and use of QPQOF, e.g. • QP QOF on readmission to include significant analysis on readmission • Audit on readmissions based on Advisory Board guidance • Enhanced service for Medicines safety looking at medicine combinations based upon polypharmacy advice. Clear clinical and managerial leadership at board level for developing this agenda through Associate Medical Director Primary Care, General Manager Primary Care and LTC Manager.
Inadequate or poorly supported informal carers resulting in admissions for "social" or care reasons	Enhanced support for carers through local enhanced service for carers including - direct funding to Princess Royal Carers Trust for awareness raising and training, health checks for CHD for carers aged 45-65, promotion of carers pack and local support for carers. Close working with Princess Royal Carers Trust through developed enhanced service has been established as

	standard practice.
Demographics in Borders already show higher than average over 65 population and predicted future changes will show this to increase further	Cross-sector discussions and joint planning oversees ensures reshaping care plans are developed to accommodate future demographic changes.
Difficulties in developing alternative provision to admission e.g. intermediate care, community services input at home	The following actions are planned or underway to improve performance relating to the target: • Development and implementation of a new contract for GPs looking after Community Hospitals that includes a focus on length of stay and patient pathways in those settings. • The Anticipatory Care & Prevention of Admission for people with Long Term Conditions Local Enhanced Service (LES) was continued in 2011/12 across all Borders GP practices. This next phase of the LES has utilised the newly developed anticipatory social care planning tool, STACCATO, designed to support people to remain at, or return to home, wherever possible. This work will continue with the LES in 2012/13. • Outcomes and lessons learned from Intermediate Care Demonstrator Programme informing developments in the Cheviot locality. • Work is underway in P&CS to maximise the benefits of co-location projects that have been implemented in two localities. Lessons learned will inform developments in other areas. • A Diabetes Local Enhanced Service was established for 2010/11 and was ongoing in 2011/12 with the aim of supporting patients to be cared for within community settings and contributed to timely discharge and prevention of admission. Continuation of this LES is under discussion for 2012/13. • COPD Pulmonary rehabilitation programmes are now established across the Borders. • Expansion of intermediate care options across care home settings. • *"Borders Health in Hand",* the Long Term Conditions website is being updated and further expansion is planned.

Workforce

Risk	Management of Risk
Ongoing resources to deliver and support participation in training & education programmes linked with any changes in clinical practice, clinical guidelines and protocols	Links with existing programmes and education processes involving NES, JIT, and enhanced services programmes for GPs. The LTC Training & Education Programme for Primary

	Care services continues and has been expanded.
Appropriate skill-mix and community services to support appropriate early discharge	Primary & Community Services (P&CS) are undertaking the Releasing Time to Care in the Community alongside a workforce review within community nursing services. This will maximise efficiency and enable appropriate redesign and skill-mix. Integration of health and social care at locality level aimed at improving pathways and processes to support earlier discharge.

Finance

Risk	Management of Risk
New Community Hospitals GP contract	Service repercussions are being monitored and addressed through the existing consultation and negotiation network.
Integrated resource framework	Already aligning budgets around intermediate care and pooled budget around delayed discharges. Utilisation of the Change Fund.

Equalities

Risk	Management of Risk
• All HEAT targets should be equality impact assessed to identify positive and negative impacts on equality groups • NHS Borders must adopt fully the equality impact assessment process • NHS Borders must adopt the interpretation and translation policy to ensure that staff are supported and patient care and safety is improved • Implementation of equality monitoring and patient record markers will support referral, treatment and care • All health improvement activity / projects and other HEAT target activities to take into account cultural diversity; disability equality; gender equality; migrant /BME communities; gypsy/travellers	

Trajectory

Rate of Acute Occupied Bed Days for People Aged 75+ per 1,000 population Aged 75+

Month	Borders
Mar-10	6,112
Mar-11	5,569
Mar-12	5,264
Apr-13	4,830
May-13	4,823
Jun-13	4,815
Jul-13	4,807
Aug-13	4,800
Sep-13	4,792
Oct-13	4,785
Nov-13	4,778
Dec-13	4,770
Jan-14	4,763
Feb-14	4,755

Mar-14	4,748
Apr-14	4,741
May-14	4,733
Jun-14	4,726
Jul-14	4,719
Aug-14	4,711
Sep-14	4,704
Oct-14	4,697
Nov-14	4,689
Dec-14	4,682
Jan-15	4,675
Feb-15	4,667
Mar-15	4,660

No people will wait more than 28 days to be discharged from hospital into a more appropriate care setting, once treatment is complete from April 2013; followed by a 14 day maximum wait from April 2015.

NHS BOARD LEAD:	Jane Davidson, Chief Operating Officer

Delivery and Improvement

Risk	Management of Risk
Amend and implement revised NHS Borders/Scottish Borders Council Discharge and Transfer Policy Improve data input and reporting from TRAK and EDISON to support operational management, provide real time information, support monitoring arrangements and ensure accurate submissions to Scottish Government	Using best practice management arrangements (i.e. audits/self assessments) the partnership will ensure "pathway blockages are cleared". Development with Scottish Borders Council of an updated health and social care action plan for 2013/14 reflecting the means by which the aims of the revised policy will be realized. Ensure comprehensive implementation and sustainability Plans are in place within both organisations to ensure adherence to policy.

Workforce

Risk	Management of Risk
Adequately inform, manage and develop staff/teams to deliver target	Comprehensive Implementation and sustainability Plan, which should include revised training arrangements for NHS and Social Work staff. Engage in service redesign work with Scottish Borders Council to support the aim of ensuring no delays more than 14 days as a minimum performance requirement.

Finance

Risk	Management of Risk
Ever increasing demand for service in terms of volume and cost of increased Packages of Care, equipment and alterations to patients homes Ability of partnership to flexibly manage budgets to follow shifts in the balance of care	Redesign Projects within localities to incorporate capacity building for Community Nursing, AHP and Social Work Teams Responsive escalation processes to address patient flow issues with particular regard to resolution of delayed discharges blockages. Reshaping Care Board to support projects that will assist in mapping resource requirements to inform service planning and development.

Equalities

Risk	Management of Risk
Ensuring that successful locality based initiatives are spread throughout the rest of NHS Borders Ensuring that discharge planning	Reshaping Care Board to support partnership in assessing and promoting successful initiatives. New policies must be sensitive to patient condition

arrangements are geared to the needs of individual patient needs	pathways.
Ensuring safe transfers and discharges	Patient safety discharge checklists, audits and other clinical governance arrangements in place to monitor safe patient discharge management. Sharing and consideration of critical incident reports between NHS Borders and Scottish Borders Council by the partnership's Delayed Discharge Group.

Trajectory

No people will wait more than 28 days to be discharged from hospital into a more appropriate care setting, once treatment is complete from April 2013; followed by a 14 day maximum wait from April 2015.

28 DAY TARGET

Period	Borders
Apr-13	0
Jul-13	0
Oct-13	0
Jan-14	0
Apr-14	0
Jul-14	0
Oct-14	0
Jan-15	0
Apr-15	0

14 DAY TARGET

Period	Borders
Oct-12	4
Apr-13	15
Jul-13	13
Oct-13	11
Jan-14	9
Apr-14	7
Jul-14	7
Oct-14	5
Jan-15	5
Apr-15	0

Further reduce healthcare associated infections so that by 2014/15 NHS Boards' *staphylococcus aureus* bacteriamia (including MRSA) cases are 0.24 or less per 1000 acute occupied bed days; and the rate of *Clostridium difficile* infections in patients aged 15 and over is 0.25 cases or less per 1000 total occupied bed days

NHS BORDERS LEAD:	Evelyn Fleck - Director of Nursing & Midwifery

Delivery and Improvement

Risk	Management of Risk
Current trends indicate that this is a challenging target for NHS Borders so there is a risk that the target is not achieved	Every SAB is subject to a Root Cause Analysis (RCA) investigation with any related actions added to the Infection Control Work Plan. Progress against the Work Plan is monitored by Board Committees as well as a monthly SAB Prevention Group. Infection data is collated on a monthly basis and presented in run charts and pareto charts by cause and location. Infection data is correlated with other indicators such as CNS and MRSA screening compliance by location. A CDI Prevention Group is being established in January 2013 which will provide a focus to reviewing learning from CDI cases and oversight on the implementation of resulting action plans. Actions are prioritised taking account of the data analysis and implemented using Patient Safety tools and techniques.
There is a risk that concentration on hospital acquired infections results in lack of focus on HAI across the whole healthcare economy e.g. interventions to minimise all SABs (MRSA or MSSA) and *Clostridium difficile* in hospital and primary care settings	Our surveillance is pan board, taking in both primary and secondary care. As actions targeted to achieve 'quick wins' take effect, focus has moved to addressing issues related to more complex patient journeys.
There is a risk that a failure to implement the three supporting antimicrobial indictors related to prescribing as detailed in CEL 11(2009) will adversely impact on the boards ability to reduce *Clostridium difficile*	There is now an Antimicrobial Pharmacist for NHS Borders in post, working closely with the Consultant Microbiologist as part of the Antimicrobial Management Team. There is also an antimicrobial lead nurse. All prescribing indicators are being audited as recommended.
There is a risk that competing priorities and lack of time and resources do not allow staff to fully investigate cases of SAB and *Clostridium difficile* (through tools such as Root Cause Analysis or the CDI Severe Case Investigation Tool) results in a lack of understanding of where best to target interventions	All cases of SAB have full detailed review. ICNet functionality has been developed to capture the review data. Following a recent upgrade to ICNet, further development will be undertaken in early 2013 to capture learning on ICNet from CDI case reviews. The Prevention of CDI Group will provide a focus on learning from CDI cases and implementing preventative

	measures. The capacity of the Infection Control Team has been enhanced with effect from 7th January 2013, with the successful appointment to two new permanent posts; 1.0wte Infection Control Nurse and 0.5wte Surveillance Support Officer.
There is a risk that care bundles aimed at reducing SABs and *Clostridium difficile* will not be rolled out in the most appropriate way with which to achieve the biggest impact	The enhanced surveillance we have done means that we know which areas to target in order to achieve maximum impact. The Patient Safety lead is a member of the SAB Prevention Group and also attends monthly Infection Control Team meetings.
There is a risk of a lack of business continuity for Infection Control Teams (i.e. through staff leaving or moving posts)	The resilience of the Infection Control Team has been enhanced with effect from 7th January 2013, with the successful appointment to two new permanent posts; 1.0wte Infection Control Nurse and 0.5wte Surveillance Support Officer.
There is a risk that there is a lack of cross working between infection control professionals (e.g. between Infection Control Managers, Infection Control Teams, Antimicrobial Teams and Health Protection Teams)	Members of the Infection Control Team perform dual roles. Cross working is effective at all levels and this is supported by regular meetings with other departments such as Health Protection and Occupational Health. On a monthly basis, the Patient Safety Lead and Antimicrobial Pharmacist join the Infection Control Team meeting.
There is a risk that there is a lack of ownership for the prevention and control of infection at all levels in the organisation	The ICT continue to educate staff across all disciplines and grades, that infection control is a personal responsibility for everyone and not to rely on others to perform it.
There is a risk that there is a lack of clear leadership for infection prevention and control within the board	We have a designated lead for IP&C at the board (Director of Nursing) providing this leadership. There is strong support for all aspects of IP&C from the board in general, including from the CE and Medical Director.
There is a risk that short term focus on targets will not result in sustainable improvement	We are fully committed to sustained improvement and benefit from the expertise and support from national agencies such as HPS, NES, HIS. Infection rates are consistently monitored by our ongoing robust surveillance techniques already in place. Progress against the Infection Control Work Plan is monitored by Board Committees.
The target is not for HAI SABs but for all SABs. In an area with a rural economy and a high elderly population, a significant proportion present from the community. These can be managed but not predicted or prevented.	Risk to be tolerated. People will acquire SAB infections in the community for a whole host of reasons prior to admission. SAB infections do occur without healthcare interventions and the members of the population highlighted are at greater risk. Infections that are contracted prior to health care intervention are picked up during surveillance as part of the diagnostic process.
The parameters that govern the mandatory testing for C.difficile changed in April 2009; diarrhoeal	NHS Borders have been successfully adhering to this protocol since April 2009.

samples from all patients above the age of fifteen (15) years old will be tested	
There is a risk of failure to deliver and sustain improvement due to unfocussed actions and poor implementation of change.	Intelligent use of data is used to prioritise actions to maximum effect (e.g. use of pareto charts). Patient safety methodology is used to test and spread new practice.

Workforce

Risk	Management of Risk
There is a risk that front-line staff don't comply with bundles	Bundles are implemented with support from Patient safety lead using patient safety tools and techniques to embed. The Infection Prevention and Control Team currently conduct regular audits of compliance with PVC bundles.

Finance

Risk	Management of Risk
Finance relating to hand hygiene coordinator and MRSA screening is currently non-recurring.	This funding has been used to appoint to the new permanent posts previously described. This represents a financial risk to NHS Borders. We are currently awaiting confirmation regarding recurring funding associated with the hand hygiene function which will now be performed by the new Infection Control Nurse.
C.difficile screening changed from April 2009 to mandatory testing of all diarrhoeal samples from patients over 15 years – estimated increase of around another 100 samples per month tested at a cost of around £4 -5 each.	No significant resource implications have been made apparent (staff or reagents) since April 2009.
2nd antimicrobial nurse funding is currently not permanent.	If funding is not continued alternative funding streams would require to be sought.

Equalities

Risk	Management of Risk
There is a risk that the importance of infection prevention measures are not adequately communicated to patients whose first language isn't English or who may have learning difficulties	Many of the HAI related public and patient information leaflets are available in multiple languages, including Braille. Mechanisms are in place to produce these on request.

Trajectory

***Staph aureus* Bacteraemia: cases per 1000 acute occupied bed days**

Quarters	Borders
Jun-12	0.37
Mar-13	0.36
Jun-13	0.30
Sep-13	0.29
Dec-13	0.28
Mar-14	0.27
Jun-14	0.26
Sep-14	0.26
Dec-14	0.25
Mar-15	0.24

C. difficile infections: cases per 1000 acute occupied bed days

Quarters	Borders
Jun-12	0.43
Sep-12	0.47
Dec-12	0.45
Mar-13	0.43
Jun-13	0.41
Sep-13	0.38
Dec-13	0.36
Mar-14	0.34
Jun-14	0.32
Sep-14	0.29
Dec-14	0.27
Mar-15	0.25

To support shifting the balance of care, NHS Boards will achieve agreed reductions in the rates of attendance at A&E between 2009/10 and 2013/14.

NHS BORDERS LEAD:	Jane Davidson – Chief Operating Officer

Delivery and Improvement

Risk	Management of Risk
Challenges in accurately measuring and interpreting activity across services. Lack of whole system approach to information analysis that supports stakeholder target setting and performance management	The ADASTRA system was implemented in March 2012 in the Out of Hours service. This will provide improved communication with GP Practices by means of generating more meaningful reports on the reasons for patients presenting to out of hours services both as NHS triages and walk ins. It will also allow quantification of how many admissions and transfers to BGH A/D via SAS are prevented by use of a professional to professional line with BECS GPs. Liaison with ISD A&E Team and this will continue to aid measurement of the target locally. Scoping work to commence to consider data sets between ADASTRA and TRAKCARE. Development of T10 Performance Scorecard, which is monitored by the T10 Project Board and incorporated into the performance management reviews of each clinical board and contract discussions with SAS. Agreed attendance reduction targets to be formally agreed between stakeholders and T10 Project Board, who will monitor performance against these on behalf of NHS Borders.
Slow culture shift of healthcare professionals across the whole system to raise the profile of this target	T10 Project Board to be reconstituted to meet more regularly and its membership will include additional input from SAS, Primary Care Contracts Management, Social Work and Planning and Performance. “GP Protected Learning Time” training sessions and “Whole System Update Sessions” to be used to update on A&E processes, build on existing expertise and introduce standardised clinical guidelines & protocols. T10 Project Board to coordinate. Wider attendance at T10 learning and sharing events to be encouraged to support awareness of good practice from other areas. Continued liaison between A&E and Surgical and Orthopaedic services to develop appropriate service redesign, such as direct admission of surgical cases to a surgical ward is now in place and being monitored. Whole system initiatives supported by the Change Fund e.g. • Ambulatory Care Project to develop clinical

	pathways, test and implement them • Implementation of anticipatory care planning to be continued throughout NHS Borders Development by A&E Lead Consultant with SAS of "See and Treat" arrangements to reduce Ambulance Service referrals. Work related to reducing A&E attendances continues to be incorporated within nGMS Enhanced Services to enable engagement and participation of GP practices and primary healthcare teams. This incorporates the Minor Injuries Enhanced Service for practices without MIUs. Also the Anticipatory Care LES across high risk patients at home and in care homes should start to show results in 2012/13. Piloting additional enhanced service in to 4 care homes to allow planned regular GP review and further reduce risk of urgent transfer
Inconsistency in Minor Injury Unit Services leading to geographical variation in patient flow to A&E	Previous work around clinical protocols to be revisited. Hours of access to MIU to be confirmed to allow public awareness campaign and closer working with NHS 24.
Variable uptake of Minor Injury Enhanced Service in GP practices with marked variation in A and E attendances	New A and E QP QOF indicator to be used to support previous benchmarking discussions and to promote whole system working. GPs will be expected to deliver action plans around frequent attenders, older patients at risk of A and E attendance and admission and children who attend A and E. ED consultant to attend external peer review.
Changing patient behaviour/education of patients is challenging and requires a cultural shift	Promotion of Borders Health in Hand website which explains what services and support are available to patients and how best to access them. Awareness raising T10 Project Board using the free Local Authority newspaper. Further development of the "Who to turn to" Social Marketing Programme. Promotion supported by GP Practices of self-management approaches and expansion of anticipatory care planning including wider use of crisis-management sheets. Increase profile of NHS Inform.
The algorithms used by NHS 24 to refer patients to A&E could have a different local outcome	Continue to work with NHS 24 to identify those patients referred inappropriately and review algorithms for onward referral. NHS 24 local liaison personnel are committed to working closely with NHS Borders to explore and agree specific actions that will support reductions in rates of attendance at A&E. This will be achieved through the monthly partnership meetings. This should help to ensure patients are directed to the appropriate service. (see MIU issue as above).

Preventable or inappropriate referrals continue	NHS 24 to provide activities to help reduce the A&E attendance rate, such as the delivery of self care information, and plans to increase the amount of Category C calls taken from the Scottish Ambulance service, converting the majority of these to Primary Care Outcomes. Continuation of Professional to Professional SAS/NHS Borders line. In addition audit to be carried out of possible in hours patients who could be diverted if a similar arrangement were available in hours and to be taken to GP body for debate/discussion. Further action based upon the outcome of a local pilot of the potential use in hours of prof to prof contact.
Delivering sufficient levels of improvement as required by national EADT	Action plan and internal trajectories developed and in place. Ensure clarity of leadership and timeous implementation of revised performance management arrangements.
Interdependencies with other specialties / departments within BGH	T10 Board to ensure liaison with relevant clinical leads and services. Change Fund Project Coordinators and NHS Borders Service Improvement Leads. A joint improvement plan to be agreed between Primary & Community Services and Secondary Care to achieve a reduction in patient flow. Achieving this goal will provide the primary means by which NHS Borders will achieve this HEAT target.

Workforce

Risk	Management of Risk
Difficulty in developing and maintenance of skill levels across staff groups	Implementation and continued monitoring of: • Appropriate protocols and guidelines • Appropriate training & education programme • Robust links across staff groups & consideration of staff rotation opportunities • Embedding learning from Releasing Time to Care Productive Ward, implemented throughout 2011 to support effective use of time and environment. Actions to be pursued within treatment rooms, MIUs and A&E
Promotion of alternatives e.g. attendance at MIU or treatment room could impact on other work carried out by generic staff teams	MIU and treatment room review to have robust workforce assessment
Single system development	The standard has been jointly managed between Primary and Secondary Care and arrangements - going forward this responsibility will sit with Primary Care as lead driver with secondary care closely tied in.
Inconsistent coding and documentation	Regular updates and reminders to staff on accurate

	coding requirements. Audit of coding and documentation to be carried out by T10 board with appropriate feedback to staff.

Finance

Risk	Management of Risk
Promotion of alternatives e.g. attendance at MIU or treatment room could impact on other work carried out by generic staff teams and funding requirements to support alternative models	Full option appraisal to include detailed financial analysis of any alternative models and consider potential bids to Change Fund for alternative models of delivery
Diversion of work from A&E to alternative locations without shift of resource	Detailed financial analysis of any alternative models will be undertaken and potential bids to Change Fund for alternative models of delivery considered as required.

Equalities

Risk	Management of Risk
NHS processes not fully understood by migrant communities due to cultural difference and presenting at A&E for routine medical care Barriers for migrant communities accessing primary care Management understanding of equalities issues in respect of this target	Build on the good practice and continue to work with migrant support service, equality and diversity team. Dissemination of "welcome to Scottish Borders" handbook which details NHS Borders services and how to access them; available in the most common foreign languages and English. Ensure service redesign option appraisals contain Equality Impact Assessments with cognisance of issues relating to patient ethnicity, geographical base, social status etc. Attendance at Equalities training session. Public Health and Social Work to provide/support analysis of health/social deprivation indices to support appropriate targeting of care to areas/group is with greatest risk/need.

Trajectory

Rate of new and unplanned attendances at A&E per 100,000 population

Month	Borders Rate	Borders Actual*
Sep-12	1759	1817
Jun-13	1598	1800
Sep-13	1593	1794
Dec-13	1588	1788
Mar-14	1582	1782

* Actual numbers are based on the Borders population as at 01/01/2011. This target shows a reduction of 3.5% in attendance rate.

To deliver expected rates of dementia diagnosis and by 2015/16, all people newly diagnosed with dementia will have a minimum of a year's worth of post-diagnostic support coordinated by a link worker, including the building of a person-centred support plan.

NHS BORDERS LEAD:	Jane Davidson – Chief Operating Officer

Delivery and Improvement

Risk	Management of Risk
Available capacity to respond is shown to be inadequate.	Uptake of this new service to be monitored through the multi-agency Dementia Planning Group, and issues escalated timorously.
This new service needs to be responsive to people newly diagnosed with dementia.	Develop appropriate throughput by engagement with other relevant services offering support. Evaluate the initial year of service operation to explore scope for working differently to assist availability and responsiveness as necessary.

Workforce

Risk	Management of Risk
Service is delivered through a small number of staff and is therefore more at risk with staff leaving.	As the service is hosted through a 3rd sector partner, ensure support is available to respond to potential workforce gaps in a timeous way. Through the Dementia Planning Group, explore scope for contingency planning to reduce the risk of delivery shifts through staff vacancies.

Finance

Risk	Management of Risk
Service currently funded through Older Persons Change Fund over 2012/13 – no confirmed funding for majority of 2013/14	Submit a further application for Changer Fund finance during 2013/14. Identify through Dementia Planning Group prospects for alternative funding. When assuming HEAT Target will rollover, consider through same forum future financial sustainability.

Equalities

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

Trajectory

Trajectory not required in LDP until the data definition is released – April 2013

Section 7: Workforce Planning 2013/14

Describe existing and planned new service areas with particular workforce pressures and risks, which could affect the delivery of quality services, and the management of these risks;

The Efficiency Programme has been set up to address our financial challenge, and the resulting service redesigns will impact on future workforce configuration. Examples of some of the key efficiency projects, which have Workforce Implications and are currently being progressed across NHS Borders, are described below;

- The Rebalancing Care Project is an example of an area of work that is being progressed across NHS Board boundaries on a regional basis, increasing the orthopaedic service capacity in NHS Borders in order to repatriate NHS Borders Orthopaedics surgery and assist in providing sufficient elective capacity across SEAT. This will decrease external spend and increase cross boundary income for NHS Borders, retaining patient activity in the NHS which otherwise may be directed to the private healthcare sector.
- Clinical Nurse Specialist Review – this project reviewed the Clinical Nurse Specialist Roles in NHS Borders and utilised Workload Tools to ensure clarity of roles, and resulting appropriate training and education standards. One of the main objectives was to identify an 80/20% Clinical/Non-Clinical split to ensure that specialist nursing services are delivering care in the most efficient and cost effective manner and within an appropriate staffing model. Person Dependency was one of the themes that came out of this review and succession planning/sharing of expertise is being explored to ensure sustainability of specialist nurse led services.
- Repatriation of Dermatology Inpatients – will enable patients admitted to NHS Lothian for severe dermatological conditions to be repatriated to NHS Borders inpatient beds after initial acute treatment. This will lead to an increase in workload locally resulting in enhanced Workforce Efficiency and sustainability.
- AHP Workforce Redesign – following the AHP workforce reviews using the 6 Step Methodology and other tools, new workforce profiles are being implemented in each of the AHP professions to ensure the efficient delivery of clinical AHP services.
- Primary and Community Locality Service Redesign projects have reduced the length of stay and level of admissions to inpatient beds by shifting the balance of care to community based services. These projects are integrated with key partners including social care and the voluntary sector.
- Dementia Services Redesign – is redesigning the delivery of dementia services across NHS Borders, following the model of Poynderview redesign, reducing length of stay and admissions for dementia patients and reviewing the number of inpatient beds for dementia. The Joint Borders Dementia strategy sets out the case for change in terms of an ageing population and the number of people with Dementia climbing rapidly. People's expectations about the care they receive are also changing. Individuals expect and demand an individualised service that will support them to remain independent for as long as possible. These twin challenges, coupled with the financial challenges ahead, make dementia one of the most significant issues facing the Borders over the next 10 years. We must therefore actively seek opportunities to redesign and improve services in line with key national policy and legislation, these include:

- Delivering for Health
- 21st century Social Review
- Changing Lives 2006
- Mental Health Delivery Plan
- The Mental Health (Care and Treatment) (Scotland) Act 2003)
- Adults with Incapacity (Scotland) Act 2000.

- Support Services Workforce Reviews using the Six Steps Workforce Planning Methodology are being taken forward across NHS Borders, ensuring that skill mix is considered when reviewing services/progressing service redesign. Benchmarking against other services/health boards is also an important aspect when reviewing workforce and workload and all Support Services will present their future proposed workforce establishments to the Productivity and Benchmarking board over the coming years.

Advise on significant changes in skill mix across the career framework and the plans to take this redesign forward;

- Nationally developed Workload Tools have been used to support the recent Nursing and Midwifery Review which highlighted significant skill mix changes which continue to be implemented over the coming years. The results of the Workload Tools suggest an increase in Healthcare Support Workers, with a reduction in Band 5 Nurses. The new regulations for Healthcare Support Workers have helped to ensure that our Workforce is appropriately trained and that Services are sustainable. NHS Borders is investing in the skills of the current Healthcare Support Workforce to pro-actively prevent gaps in the workforce.
- The recent Nursing and Midwifery Review highlighted significant skill mix changes which continue to be implemented over the coming years. Particularly an increase in Healthcare Support Workers is envisaged, with a reduction in Band 5 Nurses. The new regulations for Healthcare Support Workers have helped to ensure that our Workforce is appropriately trained and that Services are sustainable. NHS Borders is investing in the skills of the current Healthcare Support Workforce to pro-actively prevent gaps in the workforce.
- Workforce profiling and analysis across Support Services is in the second year of a roll out plan as part of a review of skill mix across the organisation. Scrutiny of Plans is taking place at the Productivity and Benchmarking Group, where benchmarking against similar organisations takes place to ensure Services are using their Workforce in the most appropriate and efficient way.
- Within AHP Services we are progressing towards a more appropriate Skill Mix as a result of Skill Mix Review
- Realising efficiencies within the Theatre Workforce as an outcome of skill mix review and Benchmarking against peer boards, introduction of a healthcare support worker in Theatre.
- Rebalanced Trauma and Orthopaedics to increase elective capacity. Potential Role development of Nursing and AHP Staff has been implemented.
- Extended roles for Out of Hours – Advanced Nursing Roles being embedded.
- Advanced roles e.g. Hospital at Night Practitioners and Paediatric/Neonatal Advanced Nurses have undertaken Clinical Decision Making Module to increase capacity and enhance sustainability. This type of role will continue to be considered as future service provision in preference to Training Grade Doctors.
- New roles for non-medical workforce solutions e.g. Surgical Assistant role to be considered in other areas.
- Specialist Nurses continue to develop anticipatory care plans for chronic disease management; this is successfully avoiding admissions and also providing early support of discharge
- Specialist nurse Workforce Review recommendations support further development of ambulatory care, and development of criteria led discharge services.
- Taking forward Skill Mix within Radiography, a regional 3 tier initiative.

Describe other significant workforce challenges that the Scottish Government should be aware of that may require a national focus to support resolution;

The continuation of no detriment protection facilitates change but hampers opportunities to meet identified savings targets. Turnover rates are low across the service which leads to few opportunities for redeployment which is our main vehicle to achieve Workforce and Service Redesign, particularly because we do not currently have a voluntary severance scheme.

High potential turnover rate due to retirement in District Nursing and Health Visiting, succession planning is being taken forward locally, but there may be requirement for additional training places to be made available nationally to ensure future sustainability.

How the workforce is contributing to efficiency savings;

The Workforce & Planning function is continuing to contribute to efficiency savings by monitoring and supporting services in the following areas;

- Vacancy Control, Internal Redeployment, Skill Mix Redesign
- Review of Non-Permanent Contracts

The NHS Borders Workforce Group continues to be responsible for;

- Overseeing the achievement of reduced workforce costs whilst ensuring that NHS Borders can provide a workforce which is fit for purpose and capable of delivering required health services.
- Ensuring the impact of redesign projects is fully recognised, identified and quantified and fed into the workforce planning system.
- Supporting workforce redesign projects of Clinical Boards.
- Identifying workforce processes and systems arising out of redesign projects and ensure that these are fit for purpose and consistently and equitably applied.
- Providing an overview which would highlight any concerns arising from any workforce projects which may have NHS Borders wide implications.

Describe the processes in place to ensure workforce capacity and capability risk assessments are undertaken in accordance with LDP Risk Management Plans around the delivery of HEAT targets

Workforce assessment and risk assessment has now been mainstreamed and is a key element when taking forward efficiency programme projects and service redesign within NHS Borders. A template (which is part of the PID documentation) has been agreed in partnership, and Workforce Planning Guidance to support managers to carry out appropriate risk assessments, (when opportunities arise to revise the workforce through vacancy management and service redesign) is being followed. Patient Safety will always be at the forefront of Skill Mix Changes and Role Development, through the application of the Career Framework and KSF. NHS Borders came within 3% of achieving the national HEAT target in 2012 to have at least 80% of employees with a Joint Development Review (JDR) completed, recorded and signed-off on eKSF by the end of March 2012. By June 2012 over 80% had been achieved and NHS Borders are driving for this to be continued over the coming years. Patient Safety will always be at the forefront of Skill Mix Changes and Role Development, and, where available approved Workload Tools will be used to determine optimum workforce numbers. Competencies will be assessed, and role changes taken forward through the application of the Career Framework and KSF. NHS Borders were very close (77%) to the national HEAT target to have at least 80% of employees with a Joint Development Review (JDR) completed, recorded and signed-off on eKSF by end of March 2012. Over 80% achieved was achieved by June 2012 and NHS Borders are driving for this to be continued over the coming years.

Equality Impact Assessment Scoping Template

*This form will help you decide if you need to undertake a full Equality Impact Assessment. In using the form, please read the guidance document "**Equality Impact Assessment Procedure & Toolkit".** Equality Impact Assessments need to consider the needs for people covered by the equality strands of Age, Disability, Gender, Race, Religion or Belief and Sexual Orientation.*

Title: *NHS Borders Local Delivery Plan 2013/14*

Which communities, groups of people, employees or thematic groups do you think will be, or potentially could be, impacted upon by the implementation of this policy? Please indicate whether these would be positive or negative impacts

The Local Delivery Plan (LDP) will be directly linked to all services that have committed to delivering a trajectory towards a specific HEAT target.

- *Executive Team*
- *NHS Borders Board*
- *Service Leads*
- *Clinical Boards*
- *Patients and Service Users*

1. Who does the proposed piece of work/policy/proposal affect?

Staff	Patients/Service Users/Carers	Communities/Voluntary Groups	Public
√	√	√	√

2. What are the aims and objectives of the work/policy/proposal being assessed?

Every year the Scottish Government Health Department asks each Health Board to report to them on their performance and delivery plans for the next financial year. This report is called the Local Delivery Plan (LDP) and forms an agreement on what Health Boards will achieve in the next year with Scottish Government Health Department. Boards are asked to work towards a number of key targets for the year which fit with the Government's health objectives. These targets are called HEAT targets because they are separated under 4 different headings:

H Health Improvement
E Efficiency and Governance
A Access to Services
T Treatment for the individual

		Yes	No
3.	**Will the proposal have any impact on equality of opportunity, discrimination between groups or relations between groups?** *The LDP is a national requirement by all NHS Scotland Boards. The 2013/14 NHS Borders LDP outlines the agreement between NHS Borders and Scottish Government Health Department for the HEAT targets that will be delivered. The HEAT targets are standard across NHS Scotland and although trajectories will be different, the actual target remains the same.*	√	
4.	**Is the proposal controversial in any way in terms of equality and diversity (including media, academic, voluntary or sector specific interest)?** *There is no controversy in terms of equality and diversity throughout the LDP. Each of the new HEAT targets will have Impact Equality Assessments carried out by service leads.*		√
5.	**Will the workforce or users of the service be disadvantaged as a result of the proposed work?** *The document is a national requirement from Scottish Government Health Department and includes a summary of the anticipated workforce requirements for the year. The workforce or service users will not be disadvantaged as NHS Borders works towards trajectories that are set and agreed.*		√
6.	**Is there doubt about answers to any of the above questions (e.g. there is not enough information to draw a conclusion)?** *As the LDP is made up of a number of areas, each section will be required to undertake a full impact assessment. This work will be undertaken during April 2013.*	√	

If the answer to any of the above questions is yes or you are unsure of your answers to any of the above a full impact assessment is recommended.

7.	**Given the above statement, do you recommend a full impact assessment is completed?** *Given that the new HEAT targets will require to be individually impact equality assessed along with the financial plans, the recommendation is that a full impact assessment is required.*		
8.	**If a full impact assessment is not required briefly explain why and provide evidence for the decision.**		

Completed By

Name	Carly Lyall	Dept.	Planning & Performance
Post	Planning & Performance Officer	Date	21st March 2013

For your records, keep one copy of this Equality Scoping Assessment form and send an electronic copy plus any supporting documentation to evidence your decision to equality@borders.scot.nhs.uk