Borders NHS Board

NHS BORDERS LOCAL DELIVERY PLAN 2012/13

Aim

To provide members with an opportunity to review and approve the final version of NHS Borders Local Delivery Plan 2012/13 (LDP).

Background

As with 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 toward the key targets at the Annual Review with the Cabinet Secretaries for Health Wellbeing and Public Health.

NHS Borders draft LDP was submitted to the Scottish Government on the 17th February 2012. Following this submission, Scottish Government contacts have reviewed each HEAT target section and have contacted Boards with queries or questions of clarification. Some Risk Narratives and trajectories have been amended in light of these discussions and are included within this final version of the LDP. This final version of the LDP was submitted to the Scottish Government on the 16th March 2012, subject to NHS Borders Board approval.

Once the LDP has been agreed and signed off by the Scottish Government and the Board, any mid-year alterations to trajectories must be agreed between the Scottish Government and the Board.

Each narrative within the LDP highlights any particular risks and resource implications to achievement of the targets and the plans in place to minimise any such implications. The narratives and trajectories have been developed in collaboration with service and clinical leads and lead directors.

Delivery against the HEAT targets contained within the LDP will be reported on a monthly basis through performance reports.

Summary

As with 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.

NHS Borders draft LDP was submitted to the Scottish Government on the 17th February 2012. Following this submission, Scottish Government contacts have reviewed each

HEAT target section and have contacted Boards with queries or questions of clarification. Some Risk Narratives and trajectories have been amended in light of these discussions and are included within this final version of the LDP. This final version of the LDP was submitted to the Scottish Government on the 16th March 2012, subject to NHS Borders Board approval.

Once the LDP has been agreed and signed off by the Scottish Government and the Board, any mid-year alterations to trajectories must be agreed between the Scottish Government and the Board.

Recommendation

The Board is asked to:

- **Approve** NHS Borders Local Delivery Plan 2012/13

Rationale for submission to the Board	The LDP is being submitted as per the requirement for the Board to approve NHS Borders LDP 2012/13.
Policy/Strategy Implications	The LDP will be the primary mechanism for monitoring the performance of NHS Boards by the Scottish Government.
Consultation	The LDP 2012/13 has been developed and agreed in conjunction with the service, the Clinical Executive and Board Executive Team. The LDP has also been presented to, and discussed at, a meeting of the Area Partnership Forum.
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	Interim Director of Workforce & Planning		

Author(s)

Name	**Designation**	**Name**	**Designation**
Meriel Smith	Planning & Performance Officer		

NHS Borders

Local Delivery Plan

March 2012

Planning & Performance

Contents

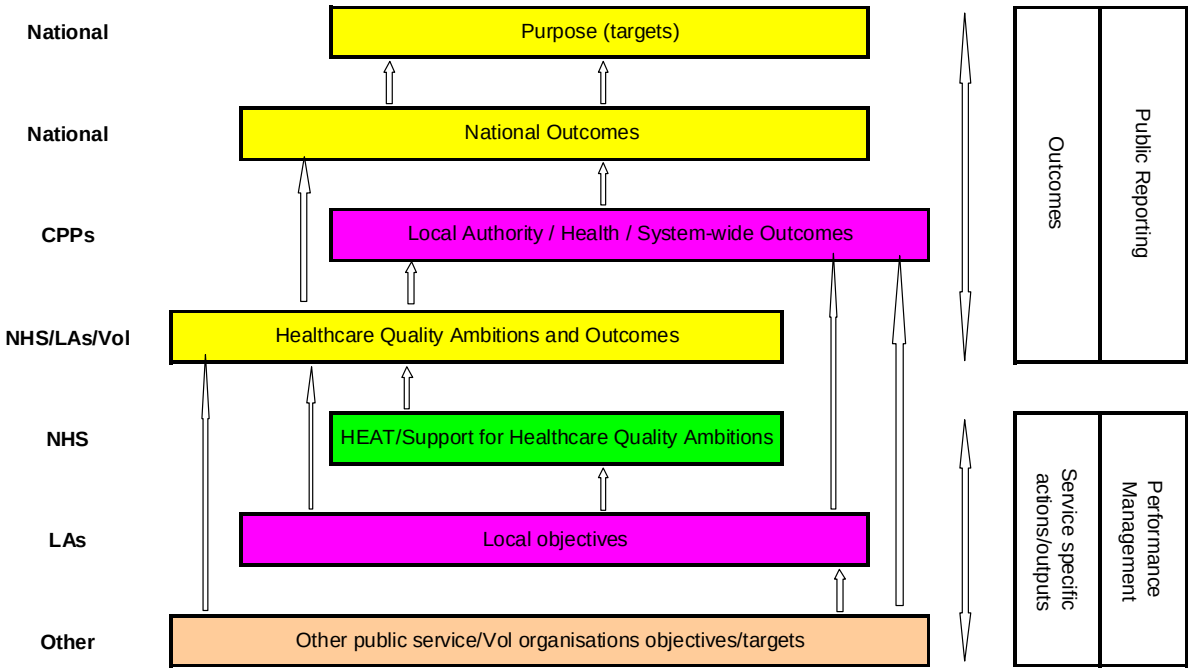
Glossary

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
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: Scottish Government and NHSScotland's Outcomes Approach

Over the last four years NHSScotland has developed its outcome approach.



The Quality Strategy sets out NHSScotland's vision to be a world leader in healthcare quality, described through 3 quality ambitions: effective, person centred and safe. These ambitions are articulated through the **6 Quality Outcomes** that NHSScotland is striving towards:

- Everyone gets the best start in life, and is able to live a longer, healthier life
- People are able to live at home or in the community
- Healthcare is safe for every person, every time
- Everyone has a positive experience of healthcare
- Staff feel supported and engaged
- The best use is made of available resources

Twelve 'direction of travel' Quality Indicators help demonstrate progress towards the six outcomes (these are not targets). Every year a small number of **HEAT targets** are agreed with NHSScotland and partners. These set out the accelerated improvements that will be delivered across Scotland in support of progress towards the Healthcare Quality Ambitions and Outcomes. The latest statistics can be accessed through *Scotland Performs*.

The Scottish Government and NHSScotland are supporting frontline clinicians to adopt international best practice through improvement programmes including the Joint Improvement Team, the Quality Efficiency Support Team, and Scottish Patient Safety Programme. These programmes support delivery of system-wide improvement.

NHSScotland is a publicly funded and publicly delivered service. The services are planned in partnership on a national, regional and local basis. The principles underpinning the approach to performance management are set out in the Local Delivery Planning guidance. Within NHS Borders the Participation Standard self-assessment 2010/2011 demonstrated that the Board has made progress in embedding a culture of public involvement. The focus for 2011/12 has been to use the feedback from the Standard to ensure that robust evaluation processes are in place that can lead to

genuine improvements. NHS Borders has combined the feedback from the NHS Scotland Participation Standard and the Better Together survey results to develop improvement plans. Each Clinical Board has a nominated Senior Lead responsible for developing an improvement plan. NHS Borders continues to work closely with the Scottish Health Council to ensure meaningful involvement of the general public and people that access local health services.

Local outcomes and the approach for their delivery are agreed through Single Outcome Agreements. The Scottish Government's three social frameworks (Equally Well, Early Years Framework and Achieving Our Potential) provide the strategic direction for action to contribution towards delivery on national outcomes.

NHS Borders is committed to Community Planning and tackling the identified Local Outcomes within the Single Outcome Agreement. This is demonstrated through this Local Delivery Plan which describe the contribution to a specific critical issue, derived from an identified Local Outcome, and which relates to the 3 interconnected social frameworks, or to economic recovery.

An integral part of Borders target delivery is the eHealth Delivery Plan. The Borders eHealth Delivery Plan is set within the context of the recently-published NHS Scotland eHealth Strategy 2011-2017 and the NHS Scotland Quality Strategy. NHS Borders has submitted this detailed Plan to the eHealth Directorate at the Scottish Government in response to the allocation of eHealth Strategic Development Funds. The plan was approved by NHS Borders Health Board's Clinical Executive Strategy Group at the December 2011 meeting.

The eHealth Delivery Plan represents a change of emphasis towards an outcomes driven approach for eHealth Programmes based on 5 broadly strategic outcomes that will improve the Health and Healthcare of the people of the Scottish Borders:

- maximise **efficient** working practices, minimise wasteful variation, bring about savings and value for money;
- support people to **communicate** with NHSS, manage their own health and wellbeing, and to become more active participants in the care and services they receive;
- contribute to **care integration** and to support people with long term conditions;
- improve the availability of appropriate **clinical information** for healthcare workers and the tools to use and communicate that information effectively to improve quality; and
- improve the **safety of** people taking **medicines** and their effective use.

NHS Borders' eHealth Delivery Plan has been designed to build on previous achievements, to specifically address the 5 outcomes that are set out in the national strategy, to progress the specific commitments made by Scottish Government and to support the ambitions of the Quality Strategy. Most importantly, it will address local operational demands with specific reference to the safety and efficiency of services and continue progress towards our stated aim of having an Electronic Patient Record.

Section 2: NHS Borders' Contribution to the Borders Single Outcome Agreement

NHS Board Local Delivery Plan 2012/13 — Contributions to Single Outcome Agreements Please refer to the Guidance Notes prior to completing the template.		
1.	**NHS Board:**	**NHS Borders**
2.	**Community Planning Partnership:**	**Scottish Borders**
3.	**Summary of critical issue:**	**Critical issue:** Addressing key wider determinants of health that affect families with young children in a rural context, in order to reduce health inequalities and achieve improved health and social outcomes. **Rationale** for addressing this issue Early Years (EY) has been recognised as an important policy area by the Scottish Government and by Community Planning Partners as a joint priority for health improvement. The recent development of the first joint Early Years strategy for Scottish Borders will ensure that the Early Years have greater prominence in the new SOA. The Early Years strategy aims to break the cycles of poverty, inequality and poor outcomes in and through the early years for children and families within the Scottish Borders. It therefore requires the active engagement across community planning partnership to achieve its goals. The 2011 Annual Report of the Scottish Borders Joint Director of Public Health draws attention to the clustering of health related inequalities from the earliest age in local areas of deprivation and recommends that preventative spend be targeted on reducing poverty and improving the health of those in their early years. It continues, therefore, to be important to develop the contribution of the NHS' and other partners to address wider determinants of health. Health related inequalities follow complex patterns in Scottish Borders, which suffers from the particular features of rural disadvantage and considerable within-area variations. Key wider determinants of health include: a. Poverty and financial exclusion affecting families in early years. Around one in six of the population is in poverty and 44% of Borders children live in low income households. Since 2004, there has been a year on year increase in the proportion of children eligible for free school meals. b. Parental health and health behaviours, especially substance misuse. The Alcohol and Drug Partnership has identified as a priority the development of services to support parents with substance misuse problems. 49% of those using drugs and alcohol treatment services locally are known to have dependent children. c. Domestic violence and violence against women. There is significant under reporting of domestic abuse

		locally. However there is known to a high level of repeat referrals to the police for domestic violence incidents where there are children in the family, indicating that children are living with recurring domestic violence. *The following sections will describe the contribution of the NHS to SOA related outcomes in relation to these three sets of health determinants.*
4.	**Community Planning Partnership Outputs: (activities, products and services)**	Relevant CPP activities include: Scottish Borders Joint Early Years strategy 2012 Strategic Anti Poverty Partnership's Financial Inclusion Strategy (under revision) Alcohol and Drugs Partnership Strategy 2012- 15and Action Plan Violence Against Women Partnership Pathways project Scottish Borders Sexual Health Strategy 2011- 15
5.	**Local Outcome(s):**	Scottish Borders Strategic SOA 2011 • Improved health and wellbeing of Borders residents (06_1) • Children experience high quality early years provision (05_1) • Children grow up in a safe homely environment (08_1) Specific outcomes in the Alcohol and Drugs Strategy, and the Early Years Strategy as well as the strategic priorities of the Violence Against Women (VAW) Partnership focus in on these high level SOA outcomes in more detail as follows: The Early Years strategy aims to break the cycles that lead to poor outcomes for children and their families in the Scottish Borders. NHS Borders is currently working with partners on an action plan with indicators that will link in to the new SOA. The Scottish Borders Alcohol and Drugs Partnership Strategy for 2012 – 2015 aims to protect children and young people from the harmful impact of parental drug and alcohol use by services working together to strengthen local arrangements for screening, identification, communication and early intervention across adult and children's services for children affected by parental substance misuse. The VAW partnership is working towards the following outcomes which are relevant for early years; • Increase the number of referrals to the Juvenile Liaison Officer where children are present when police respond to a domestic incident • Increase the number of children who are identified as needing access to a specialist domestic abuse service • Reduce the percentage of incidents of domestic abuse recorded by the police where incidents against the same victim have been previously recorded (repeat victimisation)

		• Reduce rates of domestic abuse
6.	**National Outcome(s):**	Our children have the best start in life and are ready to succeed We have tackled the significant inequalities in Scottish society We have improved the life chances of children, young people and families at risk We live our lives safe from crime, disorder and danger
7.	**Please detail the specific contribution of the NHS Board in tackling this critical issue?**	*Activities, Resources and Personnel* **a) Poverty and Early Years** Universal and targeted NHS services (community midwives, Surestart midwives GP's, obstetricians, looked after children's nurse and health visitors) identify families in deprivation through screening pre-birth and /or the allocation of Health Plan Indicator after birth and throughout early years continuum. Subsequent interventions are individualised to the needs of the child and family. This work is carried out in conjunction with the multi agency Early Years Assessment team which includes social workers, Surestart midwives and family support workers. The multi agency Integrated Assessment Framework system supports this approach. The Surestart midwives support families to access welfare benefits and housing advice and can draw on the multiagency skills within the team to support the family with budgeting and money management, as appropriate. The implementation of the local Maternity Care Action Plan includes a commitment to review the identification of social as well as health risks by NHS staff to ensure local practice incorporates national guidance and learning and experience from elsewhere in supporting families living in or close to poverty. The NHS is therefore crucial to the delivery of effective interventions. Healthy Living Network (HLN) is managed within NHS Borders and is located within 5 regeneration areas of relative deprivation. In partnership with relevant local authority staff and the third sector, the HLN staff team deliver locality health improvement programmes for children and adults with the long term aim of reducing inequalities in health and empowering local communities to take action on health issues. HLN uses a community development approach to identify and address local health issues and to develop an assets based approach. **b) Substance Misuse and Early Years** <u>Universal Services:</u> Sure start Midwives, Community Midwives, GP's, Looked After Children's Nurse, Obstetricians, Borders Community Addiction Team and Health Visitors specifically identify families with substance misuse issues through screening pre-birth using the substance misuse screening tool and /or the alcohol brief intervention screening tool after birth and throughout early years continuum. Subsequent interventions are individualised to

		the needs of the child and family. This work is carried out in conjunction with the multi agency Early Years team. The Integrated Assessment Framework system supports this approach. These groups in turn work in partnership with the Alcohol and Drugs Partnership (ADP) and with Addaction and Big River Project, (locally based third sector specialist service providers) to deliver support and programmes of intervention. Targeted groups of staff have received further training on substance misuse e.g. the child protection team. <u>Targeted Services</u>: Addaction Families' service provides support for families affected by parental substance misuse with the aims of increasing awareness of the impact of parental behaviour on families; increasing stability, routines and boundaries; improving relationships; and reducing risks, thereby increasing the quality and safety of the child's home environment. Over 2010 /11 Addaction Families exceeded their target of working with 72 and worked with 88 families. Cases were often complex and involved fostering good relationships with all relevant partners. Feedback gathered from referrers and service users demonstrates that the service is highly valued and is found to be accessible, flexible, supportive and knowledgeable. Over 2011/12 the service continued to operate effectively with service users by making concerted efforts to build positive relationships with parents and adopting a persistent attitude to encouraging engagement. The service also arranged an open day to raise awareness and promote a more consistent approach to making referrals and partnership working across localities. The ADP has worked with the service to negotiate an outcomes reporting framework. Core service outcomes are: • Safer children • Better parenting • Reduced drug alcohol use/harm for parents • Reduced drug alcohol/impact on children More detailed outcomes are identified for individual service users including for home safety, routines, diet, physical and emotional health, parent's substance misuse and housing, employment and security issues. The Star Outcomes tool has now been introduced to underpin assessments, monitoring and measuring of progress towards achieving these outcomes. This tool measures and supports progress for service users towards self-reliance on dimensions such as relationships, social networks, self care, and addictive behaviour, and can be adapted for use in different contexts. It is anticipated that an electronic version of this tool will be introduced across all drug and alcohol services in 2012/13. <u>Screening</u>: A screening tool was piloted and introduced in drug and alcohol services to improve early identification of parental substance misuse, and promote referrals for support. Whilst this is working well in terms of identifying relevant cases, it does not always meet with a consistent response from children and families services. It has

		also become clear that not all services working with children and families are including screening questions to identify if parental substance misuse is an issue. This work is being taken forward through workforce development as below. Workforce Development: An inter-agency workshop took place in 2011involving drug and alcohol services, child protection staff and other professionals involved in working with families with the aim to foster greater mutual understanding of roles, of the issues around parental substance misuse, and interpretation of risk and thresholds in making/responding to referrals. A short-life joint ADP/Child Protection Committee Steering Group has subsequently been created to review local practice; consider this alongside recently revised Edinburgh guidelines, and make recommendations designed to strengthen local arrangements for screening, identification, communication and early intervention across adult and children's services. This is chaired by the local Child Health Commissioner. The ADP has allocated finding for awareness raising and training to support the implementation of the renewed guidelines. Through the routine enquiry that has started within the voluntary sector addiction services (Addaction and Big River) as a result of the CEL 41 work, data are fed back to the VAWP to inform the development of joint working between services. **c) Violence Against Women and Early Years** Midwives, GP's, Obstetricians, Child Protection Team, Looked after Children's Nurse and Health Visitors identify families exposed to domestic abuse through screening pre-birth and /or the allocation of Health Plan Indicator after birth and throughout early years continuum. Subsequent interventions are individualised to the needs of the child and family. Over the last 12 months, the VAW Partnership has further developed the integrated pathways model to support women and families affected by domestic abuse. This model will increase access to a more comprehensive range of support services, help families to feel safer and better supported and help children affected by domestic abuse to feel less isolated and more able to cope. In addition, the project will enable communities and agencies in the Scottish Borders to have a greater understanding of the difficulties faced by individuals and children affected by domestic abuse and will be more able to respond to their needs. The outcome of an application for match funding from the Big lottery is currently awaited. NHS Borders has committed resources to this project as a partner and will continue to support capacity for VAW training.
8.	**Please illustrate the ways in which the NHS Board is working in collaboration with**	*Methods and Approach* NHS Borders is an active member of the Strategic Early Years Group that developed the local joint EY Strategy. The Joint Head of Health Improvement, the Child Health Commissioner, the Associate Director Nursing Primary and Community Services, Nurse Consultant Vulnerable Children and Young People and Head of Midwifery sit

	Community Planning Partners to tackle the critical issue? (who, why, what, when, where and how?)	on this group. The Borders Early Years Strategy was approved by both NHS Borders Board and Scottish Borders Council in late 2011. A formal launch will take place in March 2012. Child protection cross cuts the work streams described below. The Director of Nursing and Midwifery and the Child Health Commissioner are both members of the Child Protection Committee. **a) Poverty and Early Years** Public Health provides the NHS representation on the Strategic Anti-Poverty Partnership, which is currently reviewing the Financial Inclusion Strategy and assessing and where possible mitigating the impact of the recession and welfare benefits reforms on vulnerable groups, including families with young children. HLN works closely with Community Learning and Development and Family Centres to develop programmes in response to local need. HLN is represented on Locality Parenting Sub-groups. Local actions have included: ▪ <u>Food work:</u> further development of the successful 'Back to Basics' programme which supports families to maximise household income by increasing knowledge ands skills relating to food and health choices. The programme includes practical advice and demonstrations on food content and labelling, marketing and the media, and the psychology of shopping. One HLN area has implemented a pilot project in partnership with Love Food Hate Waste which brings into play environmental issues and the use of what people buy. Two HLN areas have growing projects, promoting increased access and availability of fresh produce. Both incorporate distribution schemes to support people on low incomes including children and families. HLN Lunch Club provision, run by community health volunteers, offers low cost healthier meals in venues that are warm and offer social support in communities. Bump to Baby events have led to the development of Bump and Babies groups in 2 areas to support skills and knowledge development, for example on weaning, as well as to increase access to services and opportunities. ▪ <u>Parenting work:</u> the "My Main Man" programme proved valuable in 2011 and a further round of the programme is being delivered in 2012. This is an outdoor based programme, delivered in partnership with SBC Education Department and Borders Environmental Education Services; that offers fathers/grandfathers/stepfathers the opportunity to engage with their children in a variety of traditional outdoor activities that encourage communication, co-operation and the development of new skills. The activities are low cost in terms and incorporate 'real life' opportunities that can be adapted/built upon in family life. The Living with Parents programme is also being delivered in one HLN area ▪ <u>Fuel poverty</u>: seminar work has been scaled back over the last year as the Powerdown contract has been completed. However following successful 'Towards a Healthier Berwickshire' events community/partner links

have been strengthened and workshops will be implemented with HLN communities in the coming year.

- Employability: the HLN programme includes opportunities for skills development to promote employability in areas such as food hygiene and first aid as well as volunteering opportunities. HLN will shortly be hosting a peer support pilot for breastfeeding mothers. This aims not only to encourage successful breastfeeding but also to develop the skills and confidence of the peer supporters.

b) Substance Misuse and Early Years

The NHS Borders Children and Young People's Health Network (CYPHN) supports the Children and Young People's Planning Partnership (CYPPP) in all planning and evaluation of the delivery of the Children and Young People's Plan. All subgroups of the CYPPP have a health representative in order to optimise opportunities to work collaboratively. The Children and Young People's Health Improvement Group is chaired by the Head of Health Improvement.

The Strategic Co-ordinator for the Alcohol & Drugs Partnership (ADP) is also the lead officer for NHS Borders involved in the joint commissioning of substance misuse services with SBC. This involves:

- identifying and evidencing the need for services (for example via service reviews and needs assessments)
- supporting bids to draw down external funding e.g. Lottery or Lloyds/TSB
- creating service specifications with key stakeholders
- leading on behalf of NHS throughout the procurement, negotiation and agreeing of service contracts
- monitoring these contracts quarterly to ensure delivery and achievement of agreed outcomes
- working with providers to address performance issues or barriers to delivery

The Child Protection Committee and the ADP have jointly commissioned a review the recently revised draft Lothian guidelines (the 'Orange Book') to suggest necessary amendments to ensure local guidelines are fit for local use and are consistent with practice across L&B region

The ADP Strategic Co-ordinator is also on the Child Protection Committee (CPC) Practice Development Subgroup. This involves close liaison at strategic and operational levels between this group and substance misuse services in order to identify emerging issues and help to create solutions. Examples of this over 2010/11 include:

- the development, piloting and implementation the parental substance misuse screening tool to increase early identification of families affected by parental substance misuse, and proactive referral for additional support (early intervention)
- Responding to concerns amongst substance misuse services by raising them with the CPC subgroup, suggesting potential solutions (inter-agency workshop) then co-leading on the planning and delivery of the workshop to increase knowledge and understanding and improve responses for families.

A second domestic abuse course is planned in 2012 for substance misuse services following the positive

		evaluation of the first course in 2011. This will explore the links between these two issues. **c) Violence Against Women and Early Years** The NHS is an active member of the local VAW partnership and the proposed Pathway project. Health Improvement Specialist and Practitioner posts support prevention and capacity building work in close collaboration with Scottish Borders Community Safety Partnership, police, voluntary sector, SBC, including Education. <u>Capacity building</u> VAWP strategic priorities are supported by the NHS through a range of training and awareness raising activities for staff. This training is planned and delivered by the Health Improvement Team, which co-ordinates the VAW training calendar offering a range of courses. Examples of the NHS contribution in supporting the VAWP priorities are: • Aim: to increase the number of Juvenile Liaison Officer (JLO) referrals made with regards to children being present when police respond to a domestic incident o Police input is included in basic awareness and training for NHS staff in relation to legal rights, etc • Aim: to increase the number of children and young people who are identified as needing access to a specialist domestic abuse service o LetSBsafe2 attend basic awareness training for frontline staff. The specialist 'My family hurts' course which looks at the experiences of children and young people of domestic violence is delivered by the NHS VAW training facilitator in partnership with LetSBsafe2 • Aim: to increase the number of young people identified as needing access to specialist support for rape / sexual assault o Scottish Borders Rape Crisis Centre staff attend the basic awareness training and co-deliver the specialist rape and sexual abuse course with the NHS VAW training facilitator • Aim: to reduce the percentage of incidents of domestic abuse recorded by the police where incidents against the same victim had been previously been recorded (Repeat Victimisation) o Awareness raising enables NHS staff to understand the complex dynamics of domestic abuse and therefore be able to signpost effectively The gender based violence routine enquiry is a requirement for health visitors and midwives. The NHS had an active involvement in the development of the recently launched 'Hear our Voice' DVD resource which, through the voices of four survivors of domestic abuse, highlights the challenges of victims and their families in the Borders. This resource will be used widely in training and awareness locally with staff across agencies and community groups and has already attracted wider interest from partnerships in other parts of Scotland.

		<u>Prevention</u> NHS Borders recognises that VAW is a public health issue that contributes to health inequalities. The new local Sexual Health Strategy acknowledges the synergy between local priorities for sexual health promotion and VAW prevention, with a common focus on relationships free from coercion and harm. The prevention work adopts a multifaceted approach. Prevention is important for long term early years health improvement by promoting healthy relationships, respect and resilience, mostly through education in primary and secondary school settings. Staff training is important to enable women who are experiencing domestic abuse to access support.
9.	**Please explain how the NHS Board is performance managing its contribution to tackling this critical issue?**	*Performance Management* <u>Community Planning Partnership</u> Early Intervention will be one four priorities of the Community Planning Partnership and a revised programme board structure is under development for joint performance management. The implementation of the Early Years strategy and action plan will be also monitored through the joint Strategic Early Years group and the Community Health Care Partnership Board. <u>NHS performance management</u> Relevant indicators for the Maternity Action Plan are being developed for performance management through the relevant Clinical Boards Performance Review processes and through the Child Health Network, supported by NHS Borders Planning and Performance. A profile of women of reproductive age in the Borders is under development which will look at social patterning of health risks within this population and enable more effective targeting of interventions. The Child Health performance scorecard is performance managed through the Child Health Network, supported by NHS Borders Planning and Performance. **a) Poverty and Early Years** Following the launch of the Borders Early Years Strategy the multi-agency Early Years Strategy group will be formalising an Action Plan with associated indicators. **b) Substance Misuse and Early Years** • Quarterly monitoring of service contracts in relation to agreed outcomes (Star outcomes) • Actions built into ADP Action plan and the Children and Young People's Services plan • Review, development and implementation of agreed interagency practice guidelines as at 7(b)

		c) Violence Against Women and Early Years Performance is monitored through the SOA and the Joint Children and Young People's Service Plan outcomes. Training courses are routinely held and CEL training evaluations are submitted to the Scottish Government.
10	**Please explain how the NHS Board will demonstrate continuous improvement in the course of tackling this critical issue?**	*Continuous Improvement* **a) Poverty and Early Years** The development of the local EY strategy is being used to identify areas for improvement and innovation and to ensure clarity about pathways and reporting lines to address wider determinants of health. The NHS Borders Maternity Care Action plan links directly into the joint EY strategy on these pieces of work. Local needs assessments in the HLN areas are used to inform planning and development on community led health issues. An asset mapping exercise is being undertaken in early 2012 in one HLN area (Langlee) to identify key strengths within the community and the assets and solutions that could be mobilised to address poverty. **b) Substance Misuse and Early Years** <u>Services</u> Monitoring/annual reports are already disseminated to commissioners/funders: ADP and Children & Young People's Planning Partnership (CYPPP), and substance misuse practitioners. These include anonymised examples of methods employed and of outcomes for service users. Discussion at both ADP and CPC subgroups regularly provide opportunities to share and discuss emerging issues and solutions, including re. parental substance misuse. <u>Screening tool</u> Initial experiences in the implementation of the screening tool highlighted a number of development issues that are being addressed. Interagency work is planned (see 7b Workforce Development) to clarify procedures and develop practice in screening, identification, communication and early intervention across adult and children's services. **c) Violence Against Women and Early Years** The Health Improvement Team has played an active role in promoting community participation in service redesign. Participatory appraisal has identified key issues that are now being addressed through action planning by the VAW Partnership. Further locality engagement work will inform the piloting of prevention approaches in one area.
11	**Other Relevant Information**	Looking ahead the aims and objectives agreed in the Early Years Strategy and in the Maternity Care Action Plan that sits beneath it will inform the planning of Change Fund priorities for the Early Years.

Section 3: 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.

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NHS BOARD LEAD:	Sheena Wright, 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 scope and develop a range of activities to promote and encourage 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. There are plans to make these regular events working in partnership with Health, Early Years providers and the voluntary sector. • Peer Support Training programme in Hawick- This is currently a pilot but the Board will explore with other early years partners expanding to include peer support programmes for all pregnant women and new mothers. • 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. • The Board are currently working toward stage one accreditation for UNICEF BFI. • Baby Friendly Welcome Scheme- There are proposals to run this jointly with NHS Borders and 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	Ensure that data processes to capture information accurately are implemented to avoid incorrect data being gathered. (see Workforce section)

data as they will be counted as a 'New' but were unable to book locally prior to 12 weeks.	

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 has been ordered and will be in use in the near future. 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.
Surestart midwives are important towards targeting vulnerable and disadvantaged groups	Surestart midwives funded through Scottish Borders Council is ongoing. This provides targeted support to vulnerable women and links with Social Work.

Finance

Risk	Management of Risk
No financial risk as no change to current practice, unless extra staff required as described above.	

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.

Trajectory

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

Period	Borders
2010	82.4%
Apr-Jun 12	83%
Jul-Sep 12	83.5%
Oct-Dec 12	84%
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

Risk	Management of Risk
Engagement of partners in Choose Life locally	Making clear connections between suicide prevention and wider work on mental health improvement. 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 range of different interventions and community awareness training is available covering all aspects from promoting mental health improvement, through SMHFA to suicide intervention training. These are made widely available to anyone living or working in the Borders. A multi agency suicide prevention alliance is being developed to encourage engagement and to ensure that a broad spectrum approach is taken to suicide prevention going forward, spanning mental health improvement to crisis intervention and postvention work. Priorities identified by this group in April 2011 formed the suicide prevention action plan and the group will meet annually to monitor progress and identify future priorities, taking into account the strands of work identified through suicide rate reduction HEAT target work and through the SOA. Multi-agency group have developed a discharge pack which will provide support numbers and information for those discharged from both statutory and voluntary agencies. A discharge planning process has also been developed for those who attend A&E and are not admitted following suicide attempt. Both of these initiatives will be piloted in 2012. Ongoing discussions with clinical boards to identify training needs of staff in frontline services and ensure training delivered meets their need.
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.

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 2012/13 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.

Finance

Risk	Management of Risk
Funding to support training provision and delivery of other suicide prevention activity	Suicide prevention funding currently comes through Scottish Borders Council and is not ring-fenced. If this funding was not continued alternative funding allocation would require to be sought.

Improvement

Risk	Management of Risk
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. Building capacity within existing structures to deliver training e.g. by training staff to deliver safeTALK.

Equalities

Risk	Management of Risk
Lack of explicit visibility within local strategies relating to inequalities	Work in partnership strategically to ensure that the 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. 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

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.	Development of an 'opt out' letter to parents rather than an 'opt in' letter is intended to reduce the risk of letters not coming back to school. Schools will encourage parents to give consent and to positively answer queries from parents. Parents can contact the HI lead should they have any queries or concerns. Parents will be aware of the intervention through letters home. 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. A logic model has been produced with key partners to increase ownership, commitment and referrals as well as to assist in the monitoring and evaluation of H3. Key actions are being progressed to improve awareness of childhood obesity prevention/local interventions with health professionals, key partners, the voluntary sector and the public including the establishment of a multi agency Child Healthy Weight Steering Group that will report to the Children and Young People's Health Improvement Group
Sustaining changes in weight There is a risk that planned reunions of previous participants may be very poorly attended based on previous experience.	Work will continue with key partners to establish physical activity programmes and sign post children and families to local physical activities post 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.

Workforce

Risk	Management of Risk
As the target has progressed there are more demands on time.	This target has now been prioritised over other work within a small food and health team.
Both strategic and operational leadership is in place from existing Health Improvement staff. This has implications for capacity to undertake other food and health work with families and local communities.	Approval is being sought for continuation of additional hours to March 2013 to provide leadership and management for the programme. Engagement within partners in Education and in other sectors will continue to reinforce their contribution to CHW aims and objectives.
There is a risk that if insufficient Health Improvement Specialist capacity leadership and management for effective programme development and delivery will not be available.	Continue to build support from service managers and clinical leads to further the aims of the CHW programme.
The intervention identifies children over the 91st centile and as the intervention develops school nurses may need to be informed of these children. There is a risk that this will put added pressure onto the school nurses role.	Consult with school nurses to examine the best way forward to establish how they can use this information.
Dietetics – additional workload in evaluating and supporting families through intervention	Community Dietetics to continue 1:1 programmes, but will not have separate clinics.
Delivery Team Two nutrition leaders and admin on fixed term contracts to March 2012.	Approval is being sought for continuation of additional hours to March 2013/14 to provide delivery of the programme. The effective delivery of the CHW programme will be contingent on close collaboration with other services, in particular school nurses, health visitors, BSLT, Fitborders, Active Schools, community and the voluntary sector. It will be essential to maintain a collaborative approach to programme delivery to ensure viability. This will require further investment of effort in partnership building with support from senior management. 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
Funding Ring fenced funding guaranteed for 2012/13 but target duration until 2014. Financial pressures in NHS make local pick up unlikely (see mainstreaming below). The risk will be that interventions will not continue past funding period. Programme management and delivery currently funded through ring fenced monies.	Funding guaranteed for 2012/2013 to continue running interventions as per Tier 2. Further funding provision and sustainability will continue to be explored. Community Dietitians to continue 1:1 programmes, but will not have separate clinics. Exploring ways to increase physical activity component with key partners.

Improvement

Risk	Management of Risk
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 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	Structures are now in place in the Child Healthy Weight Steering Group and the overarching Obesity Route Map action planning group that will assist in identifying current activity and resources and in indicating both gaps for development and areas of good practice for wider dissemination.
Mainstreaming Health Improvement Workforce – Schools programme delivery team, admin and management support are funded through ring fenced monies on short term contracts. Dietetics – additional workload in evaluating and supporting families through intervention Finance – Tier 2 intervention requires delivery of programmes which need to be funded. Embedding of programme delivery in schools Wider delivery of CHW interventions in community settings	Workforce training to enable staff/volunteers to participate in initiatives to prevent increase in childhood obesity, its management and treatment is on-going. Renewal of fixed term contracts for delivery team as present (see Delivery team above). Longer term sustainability has yet to be secured. Community Dietitians to continue 1:1 programmes within their current clinic time i.e. not separate clinics. Work with schools to encourage mainstreaming of CHW programme within core school activity through capacity building, incorporation of CHW principles and activities. Strategic planning with partners to develop additional and complementary programmes as funding and programme conditions allow. Explore working with key partners and colleagues who are already providing services which we could tap into at no/limited additional cost other than NHS staff time.

Equalities

Risk	Management of Risk
Engagement and inclusion	All children can participate in the programme regardless of if 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	Ensure that at local level the intervention programmes are equality impact assessed and any gaps addressed by those delivering at local level to ensure strategies are built in to include cultural diversity.
Target families in SIMD quintiles 1 and 2	SIMD indices and local knowledge will 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	100
Apr 11 - Jun 12	130
Apr 11 - Sep 12	145
Apr 11 - Dec 12	180
Apr 11 - Mar 13	215
Apr 11 - Jun 13	245
Apr 11 - Sep 13	260
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

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.

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. Working in partnership with mental health colleagues to ensure training is accessible.
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. In the short term we may be able to offer additional hours. Opportunities for closer working with the Healthy Living Network are being actively explored.
Due to maternity leave there are currently some vacant hours within the Advisor team	We have allocated some of the hours amongst other and wider team members and have alerted other providers in the affected areas to expect increase in demand. Due to short time scales the resources required to recruit, train and induct a staff member were judged to outweigh the benefits in terms of clients being seen. We are monitoring service uptake levels in the affected areas to ensure we pick up any tail off in cover.

Finance

Risk	Management of Risk
Budget for next three years is not yet confirmed. All tobacco staff are on permanent contracts. If the budget stands still there is a risk to service development and publicity programmes as incremental awards will increase salary costs.	In the event of a major reduction in central funding the model of service including skill mix of staff will be reviewed.

Continuance of national pharmacy scheme over next three years is not confirmed. 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.

Improvement

Risk	Management of Risk
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
Budgets not yet confirmed – risk to publicity work if resources not in place	Awaiting confirmation of budget to review activity accordingly. Work through existing informal networks to increase referral rates.

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.

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	280
Apr 11 - Jun 12	350
Apr 11 - Sep 12	420
Apr 11 - Dec 12	490
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

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)	Facilitate sign-up and provide training to GDPs dental nurses with continued support from the Childsmile coordinator. Continue to raise profile of Childsmile Practice and support SGDPs to increase uptake.
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 – so far excellent but always the risk of excess interventions if other health workers and other disciplines wish access to give various talks etc	Provide support and help to the nursery schools from oral health promotion team. Currently we have 87 pre school establishments within the programme with 100% coverage.
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.

Workforce

Risk	Management of Risk
Cooperation with general dental practices	Continue to facilitate sign-up and provide training to their dental nurses with continued support from the Childsmile coordinator.
Loss of trained staff	Retention of Childsmile Team staff is good and where replacement has been necessary a good recruitment response and choice has been received.
Workforce risks include conflict when dental nurses are needed for chairside surgery work with the expanded service and treatment demands are still high and the available workforce pool	An Extended duty dental nurse is in post. This post is part of a team of 16.

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
Inappropriate local management budget savings leading to reduced frontline services	Support Oral Health Team with core budget to ensure targets are met. Plan to minimise the impact of efficiency savings.

Improvement

Risk	Management of Risk
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 extended model and support for Childsmile Practice.

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. Data shows that 63% of nursery children in the most deprived SIMD quintile for the 2010/11 year had two or more Fluoride varnish applications.
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
Jun-12	7.0%
Sept-12	10.0%
Dec-12	13.0%
Mar-13	15.0%
Jun-13	26.0%
Sept-13	37.0%
Dec-13	48.0%
Mar-14	60.0%

Section 4: 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

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.

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
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.

Improvement

Risk	Management of Risk
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	

Equalities

Risk	Management of Risk
Financial restraints will have an impact on meeting legal requirement to provide staff and patients, for those that require it, information in alternative formats	Monitor interpretation and translation policy
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
2010/11	Energy GJ	94,110
2011/12	Energy GJ	93,169
2012/13	Energy GJ	92,237
2013/14	Energy GJ	91,315
2014/15	Energy GJ	90,402
2009/10	CO_2 Tonnes	3,358
2010/11	CO_2 Tonnes	3,257
2011/12	CO_2 Tonnes	3,159
2012/13	CO_2 Tonnes	3,065
2013/14	CO_2 Tonnes	2,973
2014/15	CO_2 Tonnes	2,883

Section 5: Access to Services

Access to Services	
Drug&Alc	By March 2013, 90% of clients will wait no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery.
CAMHS	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;
PsyTher	18 weeks referral to treatment for Psychological Therapies from December 2014.

By March 2013, 90% of clients will wait no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery.

NHS BORDERS LEAD:	Jane Davidson – Chief Operating Officer

Delivery

Risk	Management of Risk
Referral pathways: Final work is outstanding to complete the development of a formal Integrated Care Pathway (ICP).	A draft ICP has been developed using relevant process methodology. This requires finishing off by a 'task and finish' group.
Data Collection systems: Staff from drug and alcohol treatment services (statutory, private and voluntary) are responsible for completing data spreadsheets. This is collected and collated by the ADP Support Team using the existing data collection system (the Waiting Times Framework), and submitted quarterly to ISD. This system is embedded into normal working practice within the services and ADP.	Borders has been heavily involved in piloting the new fit for purpose database now fully in place. BCAT has reviewed its support requirements and secured agreement with the ADP to enhancing Admin capacity towards ensuring consistently robust data collection and submission.
Quality Assurance procedures: ADP Support Team is responsible for processing and checking quality of data, and ensuring the submission of accurate and timely reports. This involves the provision of considerable training and ongoing support to the services.	The Scottish Government is working with ADP's and other partners (ISD) to improve data quality and to collect robust information on which targets will be based. The ADP Support Team previously completed an audit of local data quality. This process identified subsequently discussed with services, ensuring they received training and ongoing support to complete their spreadsheets accurately. This has since been enhanced through the pilot described above. Services using the new web-system have been made aware of their responsibilities on providing data that is accurate, reliable and complete as per the Waiting Times Service Level Agreements.

Workforce

Risk	Management of Risk
The challenge for services is ensuring that adequate trained staff are available to collect and submit required data.	This has been addressed as described above by enhancing the admin support available within service, and the continued support available to new "recording" staff from the ADP Support Team.

Finance

Risk	Management of Risk
Drug service allocation: There had been some additional funding allocated to ADPs or NHS Boards for drug services for several years (the emphasis being on increases in alcohol funding). Risk: This allowed for service expansion resulting in offering more timely assessment appointments for an increasing number of new referrals. This level of delivery is at risk if the level of funding reduces going forward.	Following parliamentary approval, ADP awaits confirmation of the same level of funding being maintained overall by SG for the next 3 years. This will sustain the previous expansion of services resulting from earlier increased alcohol funding (the Borders Community Addictions Team (BCAT) works with drug and alcohol problems). This will maintain capacity of services and should assist in further progressing waiting times.
Primary Care: In addition, few GPs are engaged in providing a service for problem drug users (will refer to the Borders Community Addictions Team for assessment and treatment but not take patients back to monitor once stabilised on treatment programmes). Risk: This results in a delay in new users being able to be seen.	BCAT has previously received additional funding to increase medical cover to offer a prescribing service where this is not in place within local Primary Care Services (GP Practices). However, this has resulted in more GPs withdrawing from the prescribing of substitute medication for those with opiate dependencies (usually methadone). In terms of addressing this unintended consequence, NHS Borders is still committed to developing more integrated service delivery e.g. Shared Care, Primary Care facilitation.

Improvement

Risk	Management of Risk
There have been several developments within drug and alcohol services over recent years, which have been designed to minimise duplication and address identified gaps in services. Risk: Waiting times for services vary across the sectors, but remain highest within the statutory service (BCAT).	The final development and subsequent implementation of an Integrated Care Pathway is aimed at increasing access, reducing waiting times and improving quality of services. This will incorporate recovery as an underpinning philosophy, as described in the national drug strategy for Scotland. BCAT has shown improvements overall in waiting times. It is anticipated that implementation of the ICP with the focus on triage being significantly vested with 3rd sector services will help to sustain such improvements.
Governance and accountability arrangements across the services	Governance and accountability arrangements continue to be refined as the new ADP arrangements become more established.

Equalities

Risk	Management of Risk
The later incorporation of alcohol needs into what originally was a specific drugs target could result in a risk of a less than fully integrated approach to both groups potentially resulting in "longer" waits for one of these groups.	Review of RTT data to provide assurance that this is not occurring. For the ADP commissioning function to ensure that there is equivalent service sufficiency for both groups with continued funding for drug and alcohol service providers across the sectors over 2011/12. We are anticipating denoting specific areas for action as part of the work underway in developing a 3 year joint commissioning strategy for Drug and Alcohol services in the Borders, which is currently out for stakeholder consultation, due to end March 2012.

Trajectory

Referral to Treatment Offered

Quarter	Borders
Apr-Jun 2011	93.8%
Apr-Jun 2012	94.0%
Jul-Sep 2012	94.0%
Oct-Dec 2012	95.0%
Jan-Mar 2013	95.0%

Notes:

1. Boards submitted trajectories during October 2011. These are provided in the table above
2. Percentage of clients referred for drug or alcohol combined treatment are to be treated within 3 weeks from date referral received.
3. Published information for Apr-Jun 2011 is included in the table

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;

NHS BORDERS LEAD:	Jane Davidson – Chief Operating Officer

Delivery

Risk	Management of Risk
Expanding the service to include the expected upper age of 18 within current resources (this may result in increased waiting times to treatment)	Demand and capacity modelling has been used to assist identification of issues. A local implementation group has been established to look at operational issues across mental health services with CAMHS moving its upper age limit. The expansion is being delivered in two phases to ameliorate any potential fallout.
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.

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 new CAMHS ICP and balanced score card place considerable demands on the teams admin support and an effective IT system	A new team secretary is in place and training issues for admin staff are being addressed. IT issues see below

Finance

Risk	Management of Risk
Financial implications associated with any agreed additional staffing	Workforce and financial considerations are considered within the service to ensure maximum utility is derived from dedicated funding from SEAT and NES.

Improvement

Risk	Management of Risk
IT system to support returns to SGHD not currently fit for purpose	Interim solution needed pending availability of PMS/Trak as the sustainable fix. The team is actively working with ISD, supported by the local Planning and Performance and IM&T teams to resolve these issues.

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

No of Patients Waiting Over 26 Weeks from Referral to Treatment for CAMHS Services

Month	Borders
Mar-12	0
Apr-12	0
May-12	0
Jun-12	0
Jul-12	0
Aug-12	0
Sep-12	0
Oct-12	0
Nov-12	0
Dec-12	0
Jan-13	0
Feb-13	0
Mar-13	0

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

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 module planned for 2012/13. Further exploration on whether this could be brought forward to ensure the service has a system that will effectively capture the required information to measure and monitor delivery of the target.

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. 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 and to backfill current work staff undertake to create sufficient capacity.	Unable to measure at this time. Requires more detailed DCAQ work to be undertaken.

Improvement

Risk	Management of Risk
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.

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.

Notes:

1. Trajectories to be agreed by October 2012.
2. Number of patients who waited over 18 weeks from referral to treatment for Psychological Therapies
3. Scottish Government are considering a tolerance for this target and this will be discussed with Boards during the LDP process

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
Stroke	To improve stroke care, 90% of all patients admitted with a diagnosis of stroke will be admitted to a stroke unit on the day of admission, or the day following presentation by March 2013.
SAB **CDI**	Further reduce healthcare associated infections so that by 2012/13 NHS Boards' *staphylococcus aureus* bacteriamia (including MRSA) cases are 0.26 or less per 1000 acute occupied bed days; and the rate of *Clostridium difficile* infections in patients aged 65 and over is 0.39 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

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:	Jane Davidson, Chief Operating Officer

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.
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, implication is that additional capacity will be required. This needs to be modelled and planned for as soon as possible.
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.	

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.

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 affluent sectors of society. People in more deprived areas tend to present later	Focus on encouraging and enabling these sectors of society to access health services earlier will be an essential element of any programme of work The direct involvement of third sector groups in delivering DCE will bring user perspectives into the programme and help keep focus on this.

Trajectory

Proportion of Colorectal, Lung and Breast Cancer Patients Diagnosed at First Stage of Disease

Period	Borders
2005/2009	18.3%
2012/2013	18.8%
2013/2014	19.5%
2014/2015	20.0%

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

Risk	Management of Risk
Availability of robust data across all care settings The recent introduction of a new Patient Management System may affect the quality of data collected over the implementation phase	The national links have improved but work continues: • anomalies between national and local data have been reduced but liaison is ongoing to establish standard approaches • local anomalies across community and local authority have been identified and work is ongoing across IM&T and Performance & Planning to 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. Discussions are ongoing regarding a more coordinated approach to target management both within NHS Borders and with partners.
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	Wider utilisation of the Single Shared Assessment documentation between agency partners to produce the treatment plan for the individual person identifying health and social needs with a contingency plan for carers/family to follow. JIT Intermediate Care Demonstrator Programme is underway. This incorporates development of shared support worker roles, third sector involvement as integral team members and carer support programme. Anticipatory Health and Social Care Planning Tool developed and is being rolled out using locally the developed tool STACCATO as part of enhanced service in 2011/12. Investment will be made through the Change Fund to support additional nursing/SW time to deliver STACCATO. Investment will also be available through redesign of paragraph 40 monies to support Enhanced Service. Successful change fund bid to support additional input by health staff in to intermediate care beds will also support this.
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 in place and will develop further within the next round of Enhanced Services for 2012/13. 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 and has expanded with

	the involvement of the MCNs to support the shift in the balance of care. Pulmonary Rehabilitation programme introduced with the use of telemedicine equipment to link to remote classes from a central "hub". Funding for the programme is however non-recurrent.
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. The anticipatory care Local Enhanced Service (LES) has been in place since 2010/11, with all GP practices participating. This involves care planning for patients with chronic disease and housebound/care home patients and includes protocols to minimise admissions. The GP contract in 2011/12 also required practices to look at emergency admissions and develop three pathways to improve quality or reduce risk of admission – pathways have been developed for fractured NOF, DVT and falls. The 2011/12 LES incorporates the use of the STACCATO anticipatory social care planning tool to support prevention of admission and timely supported discharge. This will be continued in 2012/13. 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 eg diabetes service. Lean redesign projects focused on delivering improvements to whole system LTC pathways which impact positively in length of stay.
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. Further work on discharge processes underway to support standardised approach across all care settings. Intermediate care options across various care home settings have been developed. Standard Operating Procedures for day hospitals are under review and will be implemented across all areas.
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 new QPQOF as above. Clear clinical and managerial leadership at board level for

	developing this agenda through Associate Medical Director Primary Care, General Manager Primary Care, LTC Manager and LTC Clinical Lead in Primary care.
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. Intermediate Care Demonstrator programme working closely with Princess Royal Trust for Carers to establish Information Officer role and wider support networks for carers of people with long term conditions.
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 will provide framework for specific actions.

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.

Finance

Risk	Management of Risk
New Community Hospitals GP contract	Balance between ensuring value for money, efficiency saving and ensuring high standard of clinical care
Integrated resource framework	Already aligning budgets around intermediate care and pooled budget around delayed discharges. Utilisation of the Change Fund.

Improvement

Risk	Management of Risk
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. • Non bed-based Intermediate Care model resourced as part of a JIT Demonstrator programme is underway. This offers assessment and ongoing support post-discharge or to avoid admission. It involves day hospital services, community services, Social Work day services, Red Cross, Carers Centre amongst others and will develop support worker roles. This programme has informed the development of Standard Operating Procedures for day hospitals which are being developed to apply a standardised approach across all sites. • Work is underway in P&CS to explore the co-location of health and social care staff on one day hospital site to support joint working and appropriate use of facilities. • 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 underway and rolling out across Borders. As part of a national telehealth project, the local programme will use telemedicine equipment to run simultaneous sessions remotely from central "hub" which will offer more patients the opportunity to access pulmonary rehabilitation. A COPD SES has run for two years which supports use of appropriate guidelines, reporting processes, a coordinated use of anticipatory care and clinical care plans. • Expansion of intermediate care options across care home settings. • *"Borders Health in Hand",* the Long Term Conditions website has been expanded to incorporate a staff portal which gives staff access to a self management toolkit and educational resource database to support staff with training and education. • Liaison with Local Authority, Voluntary Sector, individuals & carers and also across the LTC and 18 Weeks Collaboratives to establish supportive processes and programmes for people with long term conditions to reduce avoidable admissions and support appropriate timely discharge.

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	6,102
Jun-12	5,330
Sep-12	5,306
Dec-12	5,282
Mar-13	5,258
Jun-13	5,234
Sep-13	5,209
Dec-13	5,185
Mar-14	5,161
Jun-14	5,137
Sep-14	5,113
Dec-14	5,089
Mar-15	5,065

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 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) ensure "pathway blockages are cleared". Consultation with stakeholders by means of Best Practice Event and further policy development. Ensure comprehensive implementation and sustainability Plans are in place 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 partnership staff. Ensure service redesigns 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 Teams. 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 arrangements are geared to the needs of individual patient needs Ensuring safe transfers and discharges	Reshaping Care Board to support partnership in assessing and promoting successful initiatives. New policies must be sensitive to patient condition pathways. Patient safety discharge checklists, audits and other clinical governance arrangements in place to monitor safe patient discharge management.

Trajectory

Patients waiting over 28 days for discharge from hospital into a more appropriate care setting

Period	Borders
Oct-11	4
Apr-12	10
Jul-12	7
Oct-12	5
Jan-13	3
Apr-13	0

To improve stroke care, 90% of all patients admitted with a diagnosis of stroke will be admitted to a stroke unit on the day of admission, or the day following presentation by March 2013.

NHS BOARD LEAD:	Jane Davidson – Chief Operating Officer

Delivery

Risk	Management of Risk
Availability of beds in the stroke unit	Robust management plans and EDDs as well as ensuring twice weekly MDT meetings with all key stake holders in attendance will help. Also working closely with the bed managers to ensure patients are transferred to the appropriate beds in the right speciality in a timely way.
Delay in referral to the Stroke Physician within 24 hours of admission by the acute medical receiving team	Work with the acute physician teams will continue to ensure early referral to the stroke consultant post take ward round Monday to Friday and OOH and weekends transfer to ward 11 with early assessment on at 9am on Monday morning by the Stroke consultant. Again working with bed managers to ensure patients are in the appropriate specialist area for their needs. Ward 4 and 11 work together to pull patients to the Stroke beds at least twice daily.

Workforce

Risk	Management of Risk
Consultant cover is part time Monday to Friday	Early identification of appropriate patients by the acute assessment ward and referral to the Stroke Multidisciplinary Team. Bed managers are aware of the Stroke pathway and protocols.
Stroke Specialist nurse no cover for AL/Study leave/Sickness/Absence	In the absence of a Stroke consultant the senior nurse in charge of ward 4 & 11 along with the bed manager will agree patients to be transferred under the admitting acute physician to ward 11 and will refer to the Stroke consultant as per the acute Stroke pathway.

Finance

Risk	Management of Risk
No additional financial risk	

Improvement

Risk	Management of Risk
Lack of buy in from clinical staff to meet the new target	Implementation of the new Acute Stroke pathway by all of the acute admitting teams. Ensure all MDT stakeholders are aware of the HEAT target with dissemination and display of the current performance in Emergency Department, Medical Assessment Unit and ward 11. Ensure all MDT meetings occur twice weekly with all key professionals present. Escalate through appropriate line management any concerning issues as appropriate. Ensure all staff are aware of their role and responsibilities within the MDT.

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

Quarter	Borders
Jan-Mar 2012	80.0%
Apr-Jun 2012	80.0%
Jul-Sep 2012	83.0%
Oct-Dec 2012	87.0%
Jan-Mar 2013	90.0%

Notes:

1. Percentage of stroke patients admitted to stroke unit on day of or day following, admission to hospital.
2. Patients are assigned to the board of original hospital admission.
3. Monthly management information is available to NHS Boards.
4. Guidance around hospitals to be included will be issued to boards by the end of 2010.

Further reduce healthcare associated infections so that by March 2013 NHS Boards' staphylococcus aureus bacteraemia (including MRSA) cases are 0.26 or less per 1000 acute occupied bed days; and the rate of Clostridium difficile infections in patients aged 65 and over is 0.39 cases or less per 1000 total occupied bed days.

NHS BORDERS LEAD:	Sheena Wright - Director of Nursing & Midwifery

Delivery

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. 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. Once full ICNet functionality has been implemented, further customisation will be undertaken to capture Root Cause Analysis data. All cases of C diff also have full investigation. Both of these are provided within our existing resource.
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.

Risk	Management of Risk
There is a risk of a lack of business continuity for Infection Control Teams (i.e. through staff leaving or moving posts)	Capacity of the Infection Control Team has increased with the appointment of a permanent Microbiologist, full time Infection Control Manager and Infection Control Facilitator. Infection Control Team resources are under review recognising the risk associated with 3 posts linked to non-recurrent Scottish Government funding.
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
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 There is a risk that initial excellent progress against *C difficile* is not sustained	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 samples from all patients above the age of fifteen (15) years old will be tested	NHS Borders have been successfully adhering to this protocol since April 2009.

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 monthly audits of compliance with PVC bundles.

Finance

Risk	Management of Risk
Finance relating to hand hygiene coordinator and MRSA screening is currently non-recurring	Awaiting announcement regarding ongoing national support for MRSA screening
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.

Improvement

Risk	Management of Risk
Resources to enable improvements as a result of changes in screening requirements are yet to be determined	See previous comments.

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
Mar-12	0.27
Jun-12	0.27
Sep-12	0.26
Dec-12	0.26
Mar-13	0.26

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

Quarters	Borders
Mar-12	0.39
Jun-12	0.39
Sep-12	0.39
Dec-12	0.39
Mar-13	0.39

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

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. Data collecting issues from TRAKCARE now resolved. Work on resolving these issues has improved 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 • STACCATO, Anticipatory Care Tool, implementation 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 Treatment Room Services leading to geographical variation in patient flow to A&E	Primary & Community Services are currently reviewing the function & remit of Treatment Rooms. This is led by a Steering Group that will be undertaking an option appraisal later in the year. Once the review has been completed a link with A&E will then be agreed.
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.
The algorithms used by NHS 24 to refer patients to A&E, do not always match local arrangements	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

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.

Improvement

Risk	Management of Risk
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.

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 and MIU per 100,000 population

Month	Borders Rate	Borders Actual*
Jun-12	1618.87	1823
Sep-12	1613.65	1817
Dec-12	1608.44	1812
Mar-13	1603.22	1806
Jun-13	1598.00	1800
Sep-13	1592.78	1794
Dec-13	1587.57	1788
Mar-14	1582.35	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.

Appendix 1

1. Summary of Main Workforce Issues Facing NHS Borders

The local Workforce Plan 2011 updated on some of our main Workforce Planning Priorities

- **Ensure Patient Safety through effective Workforce Redesign**

We have taken this priority forward over the last year by mainstreaming workforce assessment and risk assessment with the efficiency programme projects and service redesign. A template (which is now 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 taking place. 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 exceeded the national HEAT target by March 2011 to have 80% of employees with a Joint Development Review (JDR) completed, recorded and signed-off on eKSF and are driving for this to be continued over the coming years.

- **Ensure Workforce Board has an Oversight of all Efficiency Projects which have Workforce Implications.**

NHS Borders have made a significant reduction in Workforce Costs through each of the following strands;

1. Opportunities from Vacancy Control, Internal Redeployment, and Pay Modernisation redesign.
2. Opportunities from Review of Fixed Term Contracts
3. Opportunities from Medical Workforce Efficiency
4. Nursing and Midwifery & AHP Workforce Efficiency

The Inventory of Service Redesign now contains all signed off projects, and highlights Workforce Implications that may impact wider than one Clinical Board. The Workforce Board and APF therefore have an oversight and scrutiny of the workforce assessment of all redesign projects. This ensures a joined up approach to service redesign and full consideration of the whole workforce as projects are signed off and taken forward.

- **Working Differently**

As services have been redesigned we have used the Career Framework and Role Development to support people to work differently to protect the employment security of current permanent staff.

2. Significant changes in skill mix and the plans to take this forward:

- 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.
- Christmas Tree analysis has been rolled out further to include Support Services 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
- Identifying efficiencies within the Theatre Workforce as an outcome of skill mix review and Benchmarking against peer boards
- Rebalancing Trauma and Orthopaedics to increase elective capacity. Potential Role development of Nursing and AHP Staff
- Extended roles for Out of Hours – Advanced Nursing Roles being embedded.
- Advanced roles e.g. Hospital at Night Practitioners and Paediatric/Neonatal Nurses have undertaken Clinical Decision Making Module to increase capacity and enhance sustainability and will guarantee Out Of Hours cover by August 2012. 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. Physician Assistant (Anaesthesia) programme and Surgical Assistant 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 underway which will support further development of ambulatory care, and development of criteria led discharge services.
- Ongoing development of the whole dental team i.e. across dentists, dental care professionals, oral health educators and dental administrative and clerical staff is key to Dental Services strategy.
- Taking forward Skill Mix within Radiography Regionally

3. Existing and planned new service areas with particular workforce pressures and possible solutions:

Secondary Care – Reshaping Medical Workforce move away from services delivered by doctors in training, although non-medical staff can't be appointed until number of Junior Docs/GP Trainees decreases.

Possible Solutions: Hospital at Night models in Adult and Children's services being rolled out across other services e.g. Obstetrics & Gynaecology, Consultant delivered services, Role development of non medical staff, skill mix /role development review.

Mental Health – Provide supported accommodation in community, therefore shifting the balance of care from inpatient to community setting. Need to ensure a sustainable workforce given age distribution.

Possible Solutions: We will progress workforce related actions from the National Review of Mental Health Nursing. There are possible solutions through strengthening the career framework opportunities in Mental Health, using the appropriate development of Advanced Nurse Practitioner roles.

Primary and Community Services – Creation of the Tweeddale Hub/Closing of one Ward within Haylodge Hospital and closing of 1 Ward (23 bedded unit) in Kelso as part of Cheviot review.

Possible Solutions: Progressing towards required change in Skill Mix, Potential Role Development in Community Posts and Joint Services. Workload Analysis has recently been undertaken to ensure consistency across the localities.

4. Other significant workforce issues that the Scottish Government should be aware of that may require a national focus

The continuation of no detriment protection makes it difficult to progress changes and 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.

5. How the workforce is contributing to efficiency savings

Workforce Planning, Human Resources and Training & Development now sit within the same directorate as Performance and Planning lead by a Director of Workforce and Planning. This has helped to further integrate Workforce and Service Planning – with strong linkages developed in supporting the clinical boards to take forward projects, with the introduction of the Workforce Risk Assessment as part of the Project Initiation Documentation and development of Service Redesign Inventory which presents an overview of Efficiency Projects with identified Workforce Implications.

The Workforce function is contributing to efficiency savings in the following ways;

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

The NHS Borders Workforce Group is 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.

2012/13 LDP HEAT DELIVERY TRAJECTORIES

Version 1.1

This document is to be used by NHS Boards to

Colour Coding Key:

	Colour
Performance required to achieve target	
Baseline position	
Requested trajectories from April 2012 to achieve target delivery (Boards to complete)	

NHS Scotland Performance and Business Management Team
Health Delivery Directorate
Scottish Government

Borders NHS Board

NHS BORDERS – 2012/13 FINANCIAL PLAN

Introduction

A proposed financial plan has been submitted to SGHD in March, as required, as part of the Local Delivery Plan submission. This is subject to approval of the financial plan by the Board on the 29th March 2012.

The financial plan covers three years as the Scottish Government has agreed its 2012/13 budget with indicative figures provided for the following two years

An integral part of the financial plan is the Efficiency Programme, which currently consists of a series of detailed projects with estimated cost savings, which will be taken forward during the course of the 2012/13 and future financial years.

Aim

The purpose of this paper is:-

- **Section 1** - to provide an overview to Board members of the key elements within the revenue financial plan for 2012/13.
- **Section 2** - to explain how it is proposed to address the cost savings challenge which the Board faces in order to achieve a balanced financial outturn in 2012/13.
- **Section 3** - to highlight key assumptions and financial risks.
- **Section 4** - to broadly outline the scale of the financial challenge which the Board is likely to face in 2013/14 and 2014/15.
- **Section 5** - to provide an overview to Board members of the key elements within the capital plan.

Background

The financial challenge that the public sector is embracing is clear and well understood. We are in a period of financial challenge that has not been seen for many years and it is essential that our services are provided and developed appropriately within the financial envelope provided to us and for which the Board is responsible. In order to continue to deliver quality patient care the organisation must keep a firm grip on it's finances as well as drive efficiency which is critical to service delivery and public credibility. That means having a clear focus that is firmly and openly set on providing patient care that is safe, effective and affordable. A focus that is clear on efficiency plans and goals.

Section 1 - Overview of 2012/13 Financial Plan

(a) Financial Summary

A high level overview of the Board's financial plan for 2012/13 is provided below in Table 1. This shows the overall movement in both recurring and non-recurring funding and expenditure which are anticipated in 2012/13.

TABLE 1 FINANCIAL OVERVIEW

	Funding £000s	Expenditure £000s	Surplus/ (Deficit) £000s	*Note*
Base budget carried forward from 2011/12	**211,868**	**211,868**		
Recurring funding and expenditure items for 2012/13				
General funding uplift for 2012/13	3,865			*Uplift including change and access fund*
Projected spending growth in 2012/13		7,770		*See appendix 1*
2012/13 cost savings		(3,905)		*Requirement for 2012/13*
	3,865	3,865	0	
2012/13 budget excluding non-recurring funding and expenditure items	**215,733**	**215,733**	**0**	
Non-recurring funding and expenditure items for 2012/13				
Non-recurring cost provisions		1,999		*Specific expenditure items*
Non-recurring cost savings		(1,999)		*Requirement for 2012/13*
	-	0	0	
2012/13 BUDGET	**215,733**	**215,733**	**0**	

(b) Salient Points

A number of key points are important to draw out from the above summary of the Board's 2012/13 financial plan. These are:

i) The Board is able to present a balanced financial plan for 2012/13 which no longer includes a reliance on an accepted small recurring excess of expenditure commitments over recurring funding sources.

ii) The projection of expenditure growth of £7.77m is the aggregate of a range of additional expenditure commitments which the Board is required to meet in 2012/13. Appendix 1 sets out a full list of these additional expenditure commitments, and shows these are unavoidable rather than discretionary

commitments, and in many cases are existing cost pressures where expenditure is already underway.

iii) There are two tranches of development funding available. Firstly, Invest to Save initiatives, (£300k), based on return on investment and patient safety and, secondly, Clinical Excellence developments, (£500k), focused on patient safety and requiring cost neutrality. Due to the success of these funds last financial year these have been built into the plan with the aim of achieving progress and maintaining momentum throughout the organisation in the Efficiency Programme and the Quality agenda.

iv) Short term non recurring funding has been identified in 2012/13 to fund areas such as, the Commissioning Team and Borders Improvement Support Team.

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

vi) As recurring savings targets were fully achieved in 2011/12 the savings challenge for 2012/13 is directly related to the funding levels and expenditure commitments identified in the new year.

(c) **Funding Uplift**

For 2012/13, SGHD has confirmed a funding uplift of 2.2% which is reflected in the Board's financial plan. This is made up of £247k (0.2%) for the change fund, £1.693m (1.0%) access funding and £1.671m (1.0%) for general uplift. The level of uplift received by territorial Boards ranges from 2.2% to 4.2%. Funding identified as access funding in the baseline uplift was previously received as a ringfenced allocation from SGHD.

(d) **Expected Expenditure Growth**

As noted above, a full summary of the Board's recurring expenditure projections for 2012/13 is provided at Appendix 1. This explains the approach which has been taken in preparing expenditure growth estimates for each of the main cost drivers and provides background information on key assumptions.

Section 2 - Cost Savings Challenge 2012/13

A key element of the Board's plan to achieve a financial breakeven outturn in 2012/13 will be its Efficiency Savings Programme. The following provides an overview of the programme for 2012/13 and how the Board will approach this challenge.

(a) **Level of Challenge**

NHS Borders must deliver substantial efficiencies in 2012/13. The recurring and non recurring targets for 2012/13 gives a base efficiency level of £3.1m added to which is the invest to save(£0.3m) /clinical excellence funding (£0.5m) and the contingency; taking all of this together, the Efficiency Programme, is required to generate £5.9m of funds, of which a minimum of £3.9m should be recurrent.

(b) **Approach**

The Board approach continues to be delivery of the required savings through an Efficiency Savings Programme, rather than assigned targets.

Experience tells us that it is unlikely that we will achieve 100% of initial efficiency plans as, after review and investigation, they may not deliver estimated level of savings. Therefore we have a plan in place that is higher than the savings required to deliver our financial responsibilities in 2012/13. In so doing, we will create the momentum necessary to ease the passage of future year's financial challenges.
The programme for 2012/13 has been developed in conjunction with the Clinical Boards, the Clinical Core Strategy Group and other key groups.

The Board will link closely with the NHS Scotland Efficiency and Productivity Framework and the national meetings of the Efficiency Board Leads Network in order to report progress to the Scottish Government and to make best use of networking to share good practice.

The seven cost reduction workstreams within the Framework are:
- Evidence based care
- Preventative and early intervention
- Outpatients, community and primary care
- Acute flow and capacity management
- Workforce productivity
- Prescribing, procurement, support and/or shared services
- Service redesign, innovation and transformation.

Table 2 below is a summary of the 2012/13 programme categorised by risk to delivery of savings. For the majority of schemes detailed below project documentation has been completed and reviewed by the Strategy Group. A number of schemes still require to be finalised.

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

Further projects will be added to the programme during the year.

TABLE 2 2012/13 EFFICIENCY PROGRAMME PROJECT AREAS

Low Risk To Savings Delivery- £3.3m
- Support Services (new target)
- Improved Procurement
- Redesign of Dementia Services
- Acute Repatriation and Income Generation
- Benefits of Trakcare
- LD services
- Redesign of Huntlyburn Nursing

Medium Risk To Savings Delivery £1.8m
- AHP establishment and skill mix: Physiotherapy
- Equipment and Supplies management

- Estates Property Strategy
- Review of leased car scheme
- Teviot Redesign
- Income Generation

High Risk To Savings Delivery £1.4m

- Review of oncall
- Laboratory review
- Medicines Expenditure
- Summer Acute Capacity
- Specialist Rehab Services in Community Hospitals

(c) **Delivery**

Each scheme will be run as an individual project, with individual project owners responsible for developing and delivering an efficiency plan. All projects will be proactively managed through the Aspyre system. The Project Management Office will support and direct the individual project owners as well as project managers.

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

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

Section 3 - Key Assumptions and Financial Risks

The key assumptions on which the Board's financial plan for 2012/13 has been based are described within Section 1 above. In addition Appendix 1 describes the assumptions used to project recurring expenditure growth in 2012/13.

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

(a) **Pay Growth**

Pay Awards for 2012/13 have been finalised. The pay award costs have been calculated at £250 per person for staff earning below £21k and the cost of increments as per current terms and conditions. It has been assumed that discretionary points will be paid to medical staff in 2012/13. Claims submitted linked to equal pay are being managed on a national basis and no financial liability has been assumed in the financial plan - LOW

(b) **Prescribing Cost Growth**

The financial projections assume that GP prescribing will overspend in 2011/12 and work has been ongoing to understand the reasons for this. In addition detailed work on

the projection of increases in costs and volumes has been prepared by the Board's prescribing advisers for 2012/13. Benchmarking comparisons between Boards on drugs costs and the level of uplift has also been undertaken. Following consideration of all of this an uplift of 6% on drugs costs has been set for 2012/13. The work undertaken provides an assurance on the robustness of this level of uplift. This will be an area which will continue to be closely monitored during 2012/13 and the past experience of unanticipated pressures arising during the year informs the risk assessment – HIGH

(c) **Out of Area Referrals**
In the case of out of area referrals, for both acute and non acute, work is ongoing to ensure that all referrals are appropriate and necessary. Therefore, until referral patterns and levels change this will continue to be a financial pressure in the new year. – HIGH

(d) **Non Pay Uplift**
Non-pay uplift has been estimated at 1.5% and in the case of utilities 17% funding has been put aside for 2012/13. There is a great deal of uncertainty in this area particularly linked to utilities in the world market and the impact this will have on all supplies costs – MEDIUM

(e) **Cost Pressures**
Service cost pressures identified during 2011/12 have been reviewed by the Strategy Group. Where it was considered that these pressures were unavoidable funding has been identified in the financial plan. In the case of pressures not funded a course of action has been agreed - MEDIUM

(f) **Income generation**
A key element of the efficiency programme is the expansion our service provision to make it more resilient and robust by offering to undertake procedures in Borders for non Borders residents. This will require an element of investment which will be recovered by income received from other health authorities. The first major area of expansion is orthopaedics - HIGH

(g) **Discretionary Spend Controls**
The discretionary spend controls that were put in place previously will remain in place for the foreseeable future in order to support the financial position – LOW

(h) **Efficiency Delivery Plan**
The financial plan, as outlined at Section 1, requires the delivery of efficiencies of £5.9m to achieve financial balance for 2012/13. Individual schemes within the programme have been identified and are being progressed. The issue of staff turnover together with the overall level of efficiency required means that this will be extremely challenging. It remains the greatest financial risk - HIGH

Section 4 - 2013/14 and 2014/15

A summary of the Board's outline financial plan for 2013/14 and 2014/15 is provided at Appendix 2. This contains indicative figures for these years as per the Scottish Government allocation letter and based on a series of assumptions regarding expenditure growth. As the

allocation figures are indicative it is difficult to plan with certainty beyond 2012/13 therefore the figures for future years should be considered only a broad outlook at present.

(a) **Funding**

At this stage, the financial plan assumes that funding will be at the level stated in recently issued allocation letter at 2.8% and 2.5 % respectively for 2013/14 and 2104/15. These figures have been presented as indicative for planning purposes.

(b) **Expenditure**

The main planning assumptions used to forecast likely future expenditure growth for 2013/14 and 2014/15 are as follows:

	2013/14	2014/15
Revenue Growth	2.8%	2.5%
Pay Awards	1.0%	1.0%
Non Pay Inflation	1.5%	1.5%
Income	2.8%	2.5%
Drugs	6%	6%
Capital Growth	0%	0%

(c) **Financial Challenge**

In 2012/13, based on the assumptions set out within 4(a) and 4 (b) above, and after providing for currently approved service commitments including a general provision of £2.0m for as yet unidentified cost pressures, the Board would face a financial challenge of £3.7m and £3.2m in 2013/14 and 2014/15 respectively.

The main aspect of the 2012/13 cost savings plan is focused on the repatriation of patients to NHS Borders, income generation by offering our services to other NHS Boards and release of cost savings through service redesign and service reconfiguration. This focus, particularly around income generation, is planned to continue for future years.

As was the case for the 2012/13 efficiency programme during 2012 the Board will further develop its financial plan for 2013/14. Updates on progress will be provided during the financial year with the objective of having a draft financial plan and outline efficiency programme by the end of 2012.

Section 5 - Overview of 2012/13 Capital Plan

(a) **Financial Summary**

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

In terms of capital, NHS Borders has had to pare down its plans as capital funding has significantly reduced in recent years. Capital investment is key to the delivery of safe and effective patient care and to releasing significant efficiency gains from the rationalisation of the estate and supporting service redesign.

The capital plan submitted as part of the 2012/13 Local Delivery Plan is in line with the recent formula allocation of £1.9m and the additional resources totalling £1.9m linked to the health centre schemes in Jedburgh and Lauder. The health centre funding for Lauder and Roxburgh Street is subject to approval of the business cases by NHS Borders Board and the Scottish Government Capital Investment Group. Indicative formula allocations for future years are £2.1m and £2.4m for 2013/14 and 2014/15 respectively with additional allocations detailed for the balance of Lauder in 2013/14 and for Roxburgh Street over financial years 2013/14 and 2014/15.

While the work done to date informs our capital plan, further changes are likely to be made for a variety of reasons. Importantly, the plan should be prioritised and informed by service redesign and the Efficiency Programme, as well as the quality and patient safety agenda. Beyond the period of the recent allocation letter from Scottish Government the level of formula has been assumed to be similar to that of 2014/15.

The capital plan is shown in Appendix 3 and in summary includes:-

- Assumes the provision for the replacement of both Lauder and Roxburgh Street, Galashiels Health Centres. Lauder is scheduled to commence 2012/13 with Roxburgh Street commencing in 2013/14 once the site is vacated by the Scottish Ambulance Service.
- Estimated receipts from the sale of surplus properties will be retained by Scottish Government to support the national capital programme. However, NHS Borders has assumed that the capital proceeds for one specific property which was conditionally sold in 2011/12 will be retained by NHS Borders but this is still to be confirmed by Scottish Government.
- Rolling programmes for IM&T; Estates & Facilities and Medical Equipment are at a reduced level from previous years
- Linking to the recently issued State of the Estate (SoTE) report and recognising the information which will be available from the Asset and Property Management Strategy, NHS Borders has committed resource over the duration of the plan to address priority areas.

Appendix 3 summarises the Board's 2012/13 capital plan. The Capital Planning Group will continue to work to progress development of schemes connected to the efficiency, estate rationalisation and patient safety agenda.

Recommendation

Board members are requested to **review** this report and **approve** the 2012/13 financial plan and **note** the indicative outline of the financial challenge in 2013/14 and 2014/15.

Rationale for submission to NHS Borders Board	The Board must agree the financial plan. This report sets out an overview for the 2012/13 year and indicative outline for 2013/14 and 2014/15.
Policy/Strategy Implications	The financial plan underpins the strategy of the Board. It impacts upon delivery of

	statutory financial targets.
Consultation	Regular briefings on the financial outlook are provided to the S&P Committee, Board Executive Team, Strategy Group, Clinical Executive, Clinical Boards and other senior groups throughout the year.
Consultation with Professional Committees	Briefings and discussions are ongoing.
Risk Assessment	The Board has a statutory requirement to remain within its funding limits. Risks are highlighted in the paper and will be reported upon throughout the year.
Compliance with Board Policy requirements on Equality and Diversity	Relevant issues should be addressed in the development of detailed plans and business cases.
Resource/Staffing Implications	Resource implications are described throughout the report.

Approved by

Name	**Designation**	**Name**	**Designation**
Carol Gillie	Director of Finance		

Author(s)

Name	**Designation**	**Name**	**Designation**
Carol Gillie	Director of Finance		

APPENDIX 1 - 2012/13 FINANCIAL PLAN – PROJECTION OF RECURRING REVENUE EXPENDITURE GROWTH

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

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

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

On the basis of currently available information, the Board's assessment of the anticipated expenditure growth it faces going into 2012/13, within each of these categories, is set out below:

Area of expenditure growth Projected	Projected Increase £000s	***Notes***
(i) General		
Pay Inflation	1,066	*Agenda for Change - Provision for basic pay increase of £250 if less than £21k, increments, additional discretionary points for medical staff*
Prescribing cost growth/ inflation.	1,534	*Current projections by prescribing advisers of likely cost increase related to volume and price increases within Acute and Primary Care before cost savings initiatives.*
Capital expenditure programme	163	*Reflects the capital programme .*
Non pay uplift	719	*Provision for general inflation increase of 1.5% plus utilities at 17%*
Other providers	285	*Estimated provision for inflation increase on all contracts with external providers subject to negotiation but assumed at 1%*
Primary Medical Services	123	*Increased estimated at 1% assumed this will be cost neural*
TOTAL	**3,890**	
(ii) National Initiatives		
Change Fund	247	*NHS Borders increase in change fund from £70m to £80m across Scotland*
CRC Allowance	120	*Carbon reduction legislation*
SEAT	236	*Regional Developments including PET scanning and radiology*
Access Funding	1,693	
Other	130	*AAA screening etc*
TOTAL	**2,426**	
(iii) Service Development		
Orthopaedics	704	*Increase in service provision for waiting times and non borders patient income*
LD Transition Cases	100	*New cases moving into adult service*
Supplies Costs	327	*Increase/changes in supplies such as TVTO,Stoma,Audiology*
New Health Centre Running Costs	80	*Increased running costs*
Staffing	221	*Including Ward 11, Becs, Oral surgery and Oncology*
Other	22	
TOTAL	**1,454**	
Total Projected Expenditure Growth	**7,770**	

APPENDIX 2 - SUMMARY OF REVENUE FINANCIAL PLAN

	2012/13			2013/14			2014/15			
	Recurring £000s	Non Recurring £000s	Total £000s	Recurring £000s	Non recurring £000s	Total £000s	Recurring £000s	Non recurring	Total £000s	***Notes***
Opening Surplus/(Deficit)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	*1*
Funding										
General Funding Uplift	1,671		1,671	4,779		4,779	4,386		4,386	*2*
Deferred Income								250	250	*3*
Access Funding	1,693		1,693							
Other Funding Uplifts	131		131	254		254	242		242	*4*
Change Fund	247		247			-			-	*5*
FHS NCL	123		123	124		124	126		126	*6*
	3,865	-	3,865	5,157	-	5,157	4,754	250	5,004	
Expenditure General										
Pays (incl A4C)	1,066		1,066	1,495		1,495	1,506		1,506	*7*
Supplies & Services	719		719	459		459	466		466	*8*
Drugs	1,534		1,534	1,626		1,626	1,723		1,723	*9*
Capital Charges	163		163	209		209	321		321	*10*
Other Providers	285		285	806		806	740		740	*11*
FHS NCL	123		123	124		124	126		126	*12*
	3,890		3,890	4,719	-	4,719	4,882		4,882	
Expenditure Other										
Access Funding	1,693		1,693							
National Initiatives	733		733	533		533				*13*
Service Developments	1,454	999	2,453	2,310	300	2,610	2,000	300	2,300	*14*
Contingency	-	1,000	1,000		1000	1,000		1,000	1,000	*15*
	3,880	1,999	5,879	2,843	1,300	4,143	2,000	1,300	3,300	
Savings										
Cost Savings Plan	3905	1,999	5,904	2,405	1,300	3,705	2,128	1,050	3,178	*16*
	3,905	1,999	5,904	2,405	1,300	3,705	2,128	1,050	3,178	
In Year Surplus/Deficit	**0**	**0**	**-**	**0**	**0**	**-**	**0**	**0**	**-**	

APPENDIX 2 – SUMMARY OF REVENUE FINANCIAL PLAN

Notes of Appendix 2

1. Opening deficit in 2012/13 has been reduced to zero.
2. General funding uplift is 1.00% in 2012/13 and 2.8% in 2013/14 and 2.5% in 2014/15
3 Assumed gains on non recurring income in 2014/15
4 Other Funding uplifts – this has been estimated at 1% for 2012/13 and 2.8% and 2.5% in subsequent years for other income sources such as healthcare provider and locally collected income.
5. Change Fund – this is an additional uplift to the national fund to be agreed with local authority and third sector.
6. Assumed uplift for FHS non cash limited funding this is estimated at 1.0% each year and is considered to be cost neutral.
7. In 2012/13 this covers general pay uplift of £250 per person for staff earning less than £21k and increments are paid where appropriate. Pay Awards from 2013/14 are assumed to be 1%. Medical discretionary points are also included under this heading for 2012/13 only.
8 This covers anticipated price inflation related to existing contractual commitments and includes 1.5% for general cost inflation and general growth, plus an additional 17% for increased utility costs in 2012/13.
9. This is based on prescribing advisers' detailed cost projections for acute and primary care services for 2012/13 equating to a 6% increase. This level growth has been assumed for future years.
10. Provision for increase in capital charge costs associated with the capital programme.
11. Provision for inflationary uplift of service level agreements with other NHS boards for NHS Borders residents. This has been estimated at 1% for 2012/13 and 2.8% and 2.5% in subsequent years.
12. Provision for increased spend on FHS non cash limited services is equal to assumed increase in funding allocation so overall impact is cost neutral.
13. This cover the change fund and other national initiatives.
14. This grouping includes all other service commitments for example, service planning processes in particular orthopaedics, local developments such as Ward 11, commissioning team, BIST and all other cost pressures
15. This as held in contingency in anticipation of any unforeseen financial pressures.
16. Cost Savings plan to be achieved during the financial year

APPENDIX 3 – CAPITAL PLAN

Capital Plan for 5 year period 2012/13 - 2016/17

	12/13	13/14	14/15	15/16	16/17
	£000s	£000s	£000s	£000s	£000s
Board Capital Resources					
Formula Allocation	1,939	2,144	2,443	2,443	2,443
Jedburgh Health Centre	400				
Lauder Health Centre Lauder	1,515	288			
Roxburgh Street, Galashiels Health Centre		1,066	712		
Capital Resource Limit Total	3,854	3,498	3,155	2,443	2,443
Capital Receipts retained by Board					
Priorsford	273				
Total Capital Receipts Applied	273	0	0	0	0
Total Board Capital Resource	**4,127**	**3,498**	**3,155**	**2,443**	**2,443**
Prioritised Capital Schemes					
Haylodge Phase 2&3	233				
Accident & Emergency	258				
Jedburgh Health Centre	123				
Huntlyburn HSE Assessment	103				
Galavale (Phased Project)	253	350			
Rolling Programme IM&T	200	200	200	200	200
Rolling Programme Estates	200	300	200	200	200
Risk Assessed Backlog SoTE/Estates Strategy	350	350	500	500	500
Rolling Programme MEC	200	200	200	200	200
Efficiency Programme & Service Redesign	502	554	1,153	1,153	1,153
HC Lauder	1,515	288			
HC Roxburgh Street		1,066	712		
Project Management	190	190	190	190	190
Total Capital Expenditure	**4,127**	**3,498**	**3,155**	**2,443**	**2,443**
Capital Receipts returned to SGHD					
Dingleton Flats	400				
71 High Street	80				
Eildonburn	230				
Ayton	100				
Orchard Park	125				
Whiteford	75				
Fenton Lodge	200				
Crumhaugh					
Factors Park		150			
Sime Place			150		
Total Capital Receipts returned to SGHD	**1210**	**150**	**150**	**0**	**0**

APPENDIX 3 – CAPITAL PLAN
Notes of Appendix 3

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

- There is limited opportunity across the plan to allow for opportunistic investment, spend to save schemes or for unforeseen events – the *risk is high* that investment will be needed.
- Revenue savings may not be released due to reduced availability of capital funds
- Due to the reduced level of capital funding available rolling programmes for IM&T, medical equipment and estates are reduced – there is a risk to the organisation linked to the use of ageing equipment and buildings
- NHS Borders has assumed capital receipts within its capital plan will be retained by SGHD with one exception. As a result of a condition linked to the sale of Priorsford the receipt has been delayed into 2013/14. This resource has been committed by NHS Borders in anticipation of the sale in 2012/13 therefore it has been assumed that the receipt will fall to NHS Borders in 2013/14. Due to the general condition of the housing market the risk to the achievement of sales proceeds at the level estimated in the plan is high.
- Options for the future use of Crumhaugh Hospital in Hawick are currently being considered by NHS Borders working in partnership with Scottish Borders Council, therefore at this time it has been assumed that this property will be retained.
- The plan does not include any capital requirements arising from SEAT schemes.