

**Borders NHS Board****NHS BORDERS LOCAL DELIVERY PLAN 2010/11****Aim**

To provide members with an opportunity to review and approve the final version of NHS Borders Local Delivery Plan 2010/11 (LDP).

**Background**

As with the previous four 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 18<sup>th</sup> February 2010. 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 19<sup>th</sup> March 2010, subject to NHS Borders Board approval.

All Annex 6 sections (Additional Local Commitments to support Single Outcome Agreements) are being reviewed by the relevant policy teams across Scottish Government and SG will be providing specific feedback to all Boards outwith the conventional signing off timeframe of the LDP. They plan to provide continuous improvement feedback in early April at which point they will advise the date for any resubmission of Annex 6. As in previous years, the intention is to include NHS Border's overall contribution to the SOA process as an item as part of the Cabinet Secretary's Annual review with the Board.

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 the previous four 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 18<sup>th</sup> February 2010. 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 19<sup>th</sup> March 2010, 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 2010/11

<b>Policy/Strategy Implications</b>	The LDP is being submitted as per the requirement for the Board to approve NHS Borders LDP 2010/11.  The LDP will be the primary mechanism for monitoring the performance of NHS Boards by the Scottish Government.
<b>Consultation</b>	The LDP 2010/11 has been developed and agreed in conjunction with the service, the Clinical Executive and Board Executive Team.
<b>Consultation with Professional Committees</b>	See above
<b>Risk Assessment</b>	Each narrative within the LDP highlights any particular risks to achievement of the targets and the plans in place to minimise any such risks.
<b>Compliance with Board Policy requirements on Equality and Diversity</b>	Each narrative within the LDP highlights Equality risks to achievement of the targets and the plans in place to minimise any such risks.
<b>Resource/Staffing Implications</b>	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.
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**Approved by**

<b>Name</b>	<b>Designation</b>	<b>Name</b>	<b>Designation</b>
Robbie Pearson	Director of Planning & Performance		

**Author(s)**

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# **Local Delivery Plan**

**March 2010**

**Directorate of Planning  
& Performance**

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## Section 1: Supporting the Scottish Government's Outcomes-based Approach

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### Supporting the Scottish Government's Outcomes-based approach

An outcomes-based approach encourages us all to focus on the difference that we make, and not just the inputs or processes over which we have control. Success is about **impact** and should be judged by tangible improvements in the things that matter to the people of Scotland. NHS Borders has been working in partnership across NHS Scotland, with our Community Planning Partners and with the Scottish Government to embed an outcomes-based approach by identifying key priority areas. This has enabled NHS Borders to:

- i. Align activity to explicitly contribute to the Government's over-arching purpose of sustainable economic growth through the National Performance framework.
- ii. Better integrate activities with local government, with other Public Bodies, and in partnership with the Third and private sectors to address the Government's Purpose Targets and National Outcomes through Single Outcome Agreements (SOAs).
- iii. Focus activity and spend on achieving real and lasting benefits for people and as such minimise the time and expense on associated tasks which do not support the national outcomes and purpose.
- iv. Create the conditions to release innovation and creativity in delivering better outcomes.

In 2008, the Government introduced a National Performance Framework, which set out, for the first time, an ultimate purpose of Government, supported by 7 high-level targets, and 15 National Outcomes.

This new context paved the way for the review of the HEAT targets for 2008/9 and allowed HEAT and Local Delivery Plans to be better positioned to support the achievement of the Governments Purpose and National Outcomes by optimizing the contribution of health-related activities. This development resulted in the refinement of a number of HEAT targets. For example, in 2007/8 HEAT contained a target for smoking rates. This is in fact a long-term outcome achievable only through the contributions and actions of a range of public services, private companies and individual behaviours, and is appropriate for consideration as part of an SOA. For 2008/9, the HEAT target was changed to a specific one that supports the long term outcome, but is completely at the hand of the NHS — i.e. successful quit attempts following attendance at smoking cessation clinics. Such targets are agreed to be more appropriate for performance management, and review. Other public sector bodies will similarly identify appropriate activities and targets reflecting their own contributions to reduce smoking rates.

Through our Local Delivery Plan, we set out how NHS Borders will be judged in terms of performance on the priority outputs, which have been agreed with Government and across NHS Scotland to support delivery of the Government's outcomes (the HEAT targets).

For 2010/11, through Borders Strategic Board the local Community Planning Partnership, we will work with Scottish Borders Council and other public bodies to agree the priority local outcomes and related indicators. With our partners, we are also developing our outcomes-based approach, individually and together. This will require each organisation to be clear about their contributions. Each organisation will be responsible for ensuring that they have appropriate local performance management systems in place to ensure the delivery of their particular responsibilities – this local delivery plan is an important aspect of our performance management system.

As described above, progress has been made in reviewing the HEAT targets so that they reflect the NHS contribution to the longer term National Outcomes, and this process continues each year.

The HEAT core set contains a number of nationally set targets, and the national pursuit of these across NHS Scotland, backed up with dedicated and focussed improvement support from the

Government, has been demonstrated to support real progress — e.g. significant reductions in inpatient waiting times and reduced healthcare associated infections. Also, in line with the outcomes-based approach of agreeing shared outcomes with other public sector delivery partners, HEAT has introduced a number of priorities where we set out, in this Local Delivery Plan, our local planned levels of performance — e.g. hospital admissions for selected long term conditions.

Achievement of HEAT targets will demonstrate progress and contribute towards delivery of the Scottish Government's national outcomes (see mapping of the 2010/11 targets on to the national outcomes and targets)


We have also made a range of contributions towards the delivery of the local single outcome agreement over and above the HEAT targets and these are set out in Annex 6 of the Local Delivery Plan. This has been revised to allow a focus on our Board's contributions to the 4 national priority areas:


- Health inequalities
- Early years
- Tackling poverty
- Economic recovery

These areas have been identified as requiring major contributions from a range of partners, but are also areas where there is the potential for significant collaborative gain.

**HEAT 2010/11 Targets and National Outcomes**

HEAT TARGET CONTRIBUTING TOWARD SCOTTISH GOVERNMENT'S NATIONAL OUTCOME	We have tackled the significant inequalities in Scottish society	Our children have the best start in life and are ready to succeed AND We have improved the life chances for children, young people and families at risk	We live longer, healthier lives	Our public services are high quality, continually improving, efficient and responsive to local people's needs	We reduce the local and global environmental impact of our consumption and production	We have strong, resilient and supportive communities where people take responsibility for their own actions and how they affect others.
H3: Child healthy weight intervention						
H4: Alcohol brief intervention						
H5: Suicide prevention training programmes						
H6: Smoking cessation services						
H7: Exclusively breastfed at 6–8 weeks						
H8: Inequalities targeted cardiovascular Health Checks						
H9: SIMD quintile to have fluoride varnishing						
E4: Clinical Productivity						
E5: Financial Balance						
E6: Cash efficiency						
E7: GP outpatient managed electronically						
E8: Carbon emissions and energy consumption						
E10: AfC annual review against KSF post outline						
A8: 48 hour access or advance booking to GP						
A9: Cancer waiting times						
A10: 18 weeks referral to treatment						
A11: Drug & alcohol treatment supporting recovery						
A12: Mental health waiting times						
T6: Long Term Conditions						
T8: Complex care needs receiving care at home						
T9: Early diagnosis and management of dementia						
T10: Shifting balance of care: A&E attendances						
T11: Healthcare associated infection						
T12: Emergency inpatient bed days (aged 65+)						

 clear line of sight in supporting short term progress towards National Outcome or Purpose Target

 indirect or longer term contribution to National Outcome or Purpose Target

## HEAT 2010/11 Targets and National Purpose Targets

HEAT TARGET CONTRIBUTING TOWARD SCOTTISH GOVERNMENT'S PURPOSE TARGETS	HLE	Economic Growth, Productivity, and Participation	Population growth	Cohesion, Solidarity	Sustainability
H3: Child healthy weight intervention					
H4: Alcohol brief intervention					
H5: Suicide prevention training programmes					
H6: Smoking cessation services					
H7: Exclusively breastfed at 6–8 weeks					
H8: Inequalities targeted cardiovascular Health Checks					
H9: SIMD quintile to have fluoride varnishing					
E4: Clinical Productivity					
E5: Financial Balance					
E6: Cash efficiency					
E7: GP outpatient managed electronically					
E8: Carbon emissions and energy consumption					
E10: AfC annual review against KSF post outline					
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clear line of sight in supporting short term progress towards National Outcome or Purpose Target

indirect or longer term contribution to National Outcome or Purpose Target

## **Purpose Targets**

### **Economic Growth (GDP)**

To raise the GDP growth rate to the UK level by 2011

To match the GDP growth rate of the small independent EU countries by 2017 (T)

### **Productivity**

To rank in the top quartile for productivity against our key trading partners in the OECD by 2017 (T)

### **Participation**

To maintain our position on labour market participation as the top performing country in the UK (T)

To close the gap with the top five OECD economies by 2017 (T)

### **Population**

To match average European (EU15) population growth over the period from 2007 to 2017 (T)

Supported by increased healthy life expectancy in Scotland over the period from 2007 to 2017 (T)

### **Solidarity**

To increase overall income and the proportion of income earned by the three lowest income deciles as a group by 2017 (T)

### **Cohesion**

To narrow the gap in participation between Scotland's best and worst performing regions by 2017 (T)

### **Sustainability**

To reduce emissions over the period to 2011 (T)

To reduce emissions by 80 percent by 2050 (T)

## Section 2: Health Improvement for the People of Scotland

Health Improvement	
<b>H3</b>	Achieve agreed completion rates for child healthy weight intervention programme by 2010/11
<b>H4</b>	Achieve agreed number of screenings using the setting-appropriate screening tool and appropriate alcohol brief intervention, in line with SIGN 74 guidelines by 2010/11
<b>H5</b>	Reduce suicide rate between 2002 and 2013 by 20%, supported by 50% of key frontline staff in mental health and substance misuse services, primary care, and accident and emergency being educated and trained in using suicide assessment tools/suicide prevention training programmes by 2010
<b>H6</b>	Through smoking cessation services, support 8% of your Board's smoking population in successfully quitting (at one month post quit) over the period 2008/9 – 2010/11
<b>H7</b>	Increase the proportion of new-born children exclusively breastfed at 6-8 weeks from 26.6% in 2006/07 to 33.3% in 2010/11
<b>H8</b>	Achieve agreed number of inequalities targeted cardiovascular Health Checks during 2009/10
<b>H9</b>	At least 60% of 3 and 4 year olds in each SIMD to have fluoride varnishing twice a year by March 2014.

*Please note: HEAT target numbering is sequential from 2008/09 onwards*

**H3: Achieve agreed completion rates for child healthy weight intervention programme by 2010/11.**

NHS BORDERS LEAD:	Eric Baijal - Director of Public Health
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**Delivery**

Risk	Management of Risk
Rurality & transport to courses For those living in outlying areas with no car and poor access to public transport attendance at twice weekly evening sessions can be difficult.	For those living in outlying areas with no car and poor access to public transport attendance at twice weekly evening sessions can be difficult. To mitigate this, group interventions have been held in various locations and the 1:1 interventions are held in community dietetic clinics throughout the Borders.
Recruitment and Identification. The revised target helps although uptake of recruitment of families remains a challenge both into the group programme and 1:1 referrals to dietetics. The second treatment pathway providing 1:1 intervention provided by community dieticians started in November 2009 but referrals to this are also low.	Hall 4 continues to be an issue with children's weight and height only being measured in P1. However commitment from school nurses has been agreed to continue to measure and calculate BMI at P7, although this is adding to their workload. Positive "marketing" by school nurses, HI Team and Borders Sports Leisure Trust (main partners) and local advertising of the programme (with self referral) is being used to try to increase recruitment and participation and overcome potential stigma. 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.
Sustaining changes in weight	The model of programme delivery adopted locally is viewed as successful although resource intensive. Almost all children participating in the group intervention have shown a decrease in BMI. The following have been developed to create sustainability in terms of programmes or events to help children and their families maintain changes in BMI after programme completion: <ul style="list-style-type: none"> <li>Swim Borders cards have been issued to all children in partnership with Borders Sports &amp; Leisure Trust (BSLT) and Jedburgh Pool</li> <li>In one area the families who have completed the programme have asked BSLT to continue with an exercise session once per week. BSLT is now providing some ongoing post programme support with individual families.</li> </ul>

**Workforce**

Risk	Management of Risk
As H3 has progressed there are more demands on time nationally from SG and Health Scotland re: monitoring and evaluation.	Head of HI working & HI Lead (Food and Health) have produced a system for local monitoring/evaluation.
Programme Manager – Both strategic and operational leadership is in place from existing Health Improvement staff;	HEAT 3 has now been prioritised given current resources within a small food and health team. Other food and health work is now on hold.

<p>which poses a risk for other food and health work</p>	<p>Due to existing Programme Manager seconded to CEL 36 The Health Improvement Lead (Food and Health) is leading on key aspects of HEAT 3 (20 hours + per week) as well as another health improvement staff member with 23 hours per week. The vacancy within the secondment post is being progressed through current vacancy authorisation procedures. This post has built into its new JD significant support to HEAT 3</p>
<p>Delivery Team</p>	<p>Three delivery teams have been appointed with theory leaders employed by the Health Improvement Team along with exercise leaders and programme assistants by Borders Sport &amp; Leisure Trust funded (BSLT) by the ring fenced monies. The operational management of 3 programmes per school term (9 per year) is complex and dedicated time and resources are fundamental. Dietetic 1:1 intervention is being regarded as a complimentary strand and a flexible alternative to recruitment</p>

**Finance**

Risk	Management of Risk
<p>Funding Since April 2008 there has been funding (£61,000 for 3 years) from SG to implement H3.</p>	<p>Further funding for the group intervention (children over 98<sup>th</sup> centile) and 1:1 family interventions pathway (&gt;91<sup>st</sup> centile) will be reviewed during discussions on HI budgets 2010/11.</p> <p>A local group intervention programme has been produced which will decrease some costs currently using MEND purchased from commercial company.</p> <p>Further support to progress the other Childhood Obesity Strategy actions are still required. Actions include: producing a plan to enable assessment, monitoring, support and treatment of childhood obesity in accordance with SIGN guidelines – SIGN 69.</p> <p>Workforce training to enable staff/volunteer to participate in initiatives to prevent increase in childhood obesity, its management and treatment is on-going.</p>

**Improvement**

Risk	Management of Risk
<p>Recruitment &amp; Identification). Revised target will help this but still prove challenging particularly for 1:1 interventions where figures are still low</p>	<p>Local actions to address these areas were outlined above (see R &amp; I under Delivery section above). The present communication plan includes actions to promote children/families into both interventions with local; publicity materials produced.</p>
<p>Strategy - developing and maintaining vigorous action to address all other aspects of the Scottish Borders Childhood Obesity Strategy with partners, particularly those focused upon prevention, whilst also implementing the CHWIP is a challenge.</p>	<p>Progress across this broad front has been delayed due to time and resources spent on H3 target and will need further investment over the next few years across partners. Such work will contribute the SOA (05_1_P07) to “achieve agreed completion rates for child healthy weight intervention programme by 2010/2011. Funding and action being taken forward following CEL 36 on nutrition in women of childbearing age, pregnant women and children below 5 years will be helpful</p>

## Equalities

Risk	Management of Risk
Group Interventions	All children and their families have been accepted on to the group intervention – if appropriate, extra staff have been allocated to more needy children. The Scottish Borders Childhood Obesity Strategy has been equality and diversity risk assessed
National Scottish intervention programmes not recognising cultural and dietary needs of BME communities	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
Communication of intervention programmes being made in alternative languages, Communication toolkits for PWLD, BSL for those who are deaf	Work in partnership with equality and diversity team, Borders Equality Forum, Migrant support service and other key stakeholders to ensure that measures are put in place to be inclusive as possible

## Trajectory

Year ending	Borders
Mar-09	26
Jun-10	135
Sep-10	142
Dec-10	168
Mar-11	194
Cumulative total number of interventions	194

**Please Note:** Projections based on 3 x 6 families per quarter (none in summer) plus 30 from 1:1 intervention per year (2 x 7 2 x 8 quarterly) based on the newly revised target.

#### H4: Achieve agreed number of screenings using the setting-appropriate screening tool and appropriate alcohol brief intervention, in line with SIGN 74 guidelines by 2010/11.

NHS BORDERS LEAD:	Eric Baijal - Director of Public Health
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#### Delivery

Risk	Management of Risk
<p><u>Alcohol LES:</u> Practices are already struggling with the normal QOF work because of H1N1 related vaccinations and related load, so are managing their work accordingly and this will inevitably impact on other work such as the delivery of BIs.</p> <p>Initial problems with IT in primary care due to new system being introduced at same time as LES (Bluebay). This led to poor compliance with reporting initially.</p> <p><u>A&amp;E and Antenatal Care</u> Implementation of BI in these priority settings was delayed due to difficulties in staff being available to access training and competing priorities. Most staff have now been trained (using a cascade model) to screen and refer on for brief interventions to be delivered by the Substance Misuse Liaison Services (SMLS). Referral/reporting arrangements were also agreed and the services became operational on 1<sup>st</sup> December 09. However, as at 11<sup>th</sup> Jan. 2010 activity has been limited (12 screened in antenatal care and referred on but none in A&amp;E).</p>	<p>Services are being encouraged and supported by the new Primary Care Facilitator post to implement agreed contract. Support includes delivery of further training where necessary to GPs and practice nurses, plus dialogue re more complex cases, although offers of support are not always taken up. Monthly monitoring of outputs is in place to identify problems and respond accordingly.</p> <p>IT problems now addressed and support/guidance available for GPs by Assistant General Manager for P&amp;CS and IT.</p> <p>The Consultant for the SMLS has now met with A&amp;E consultant and nursing staff and have agreed to commence screening. May have been some difficulties due to increased activity within A&amp;E due to severe weather conditions. Midwives have also been asked to increase their efforts to implement agreed activities. This activity will be subject to close scrutiny.</p> <p>There will be ongoing communication with the Scottish Government HEAT Delivery Team around performance.</p>

#### Workforce

Risk	Management of Risk
<p>Recruitment of post to lead on the co-ordination and delivery of BI training (this has been delayed due to unsuccessful recruitment). No specific post able to focus on the HEAT4 target and co-ordination of delivery/reporting – very resource intensive. The ADP Support Team therefore has to deliver on this important priority.</p>	<p>Staffs in all priority settings have now all been able to access training.</p> <p>All HEAT4 related work is prioritised and completed but this continues to be an issue.</p>

**Finance**

<b>Risk</b>	<b>Management of Risk</b>
Time-limited nature of funding – exit strategy and sustainability. The Government has also now announced that the expected increase in funding for year 3 (2010/11) will not be forthcoming but will instead remain at the same level as for 2009/10.	All commissioned services/posts already in place were subject to a 3 year contract. In addition, amendments have been made to budget plans for 2010/11 which take account of anticipated reduction. These include reducing the length of contracts for developments that were late in starting by 6 months and identifying slippage from recruitment delays.

**Improvement**

<b>Risk</b>	<b>Management of Risk</b>
There have been significant difficulties in accessing robust and reliable data for some services resulting in an over-estimate of activity in year 1.	Systems for the audit, monitoring and review of service delivery are now in place including frequent communication between the ADP Support Team and trainers, service providers, P&CS and IT.

**Equalities**

<b>Risk</b>	<b>Management of Risk</b>
<p>Those individuals screened as being appropriate for a brief intervention (by the SMLS) may not always be able to access the BGH easily for a number of reasons (age, disability, transport or financial difficulties, mental health problems).</p> <p>English may not be the first language of those screened and referred on. Those with literacy problems may have problems reading information literature.</p> <p>The percentage of women drinking alcohol above recommended limits has risen sharply over recent years.</p> <p>Patients who are homeless may not be easily contactable to arrange appointment for BI.</p>	<p>BIs may be offered outwith the BGH by the Primary Care Facilitator within local health centres. SMLS staff and Primary Care Facilitator all have mental health training and are part of the Mental Health Services.</p> <p>Information resources in different languages have been ordered but not yet supplied. These will be disseminated to practitioners on arrival. Information on accessing interpreter services has already been disseminated to specialist services, including SMLS.</p> <p>Practitioners are all trained in screening, plus in delivery of BI for those remitted to deliver this, to ensure standard application of quality interventions not reliant in literature alone.</p> <p>This trend has been communicated to services and information promoting responsible drinking targeting women has been made available to practitioners.</p> <p>Homeless Unit could facilitate an appointment being made. SMLS will be asked if this is possible and appropriate mechanisms put in place to support this.</p>

## Trajectory

<b>Year ending</b>	<b>Borders</b>
Mar-09	211
Mar-10	904
Jun-10	1481
Sep-10	2058
Dec-10	2634
Mar-11	3210
Cumulative total number of interventions	3,210

**H5: Reduce suicide rate between 2002 and 2013 by 20%, supported by 50% of key frontline staff in mental health and substance misuse services, primary care, and accident and emergency being educated and trained in using suicide assessment tools/ suicide prevention training programmes by 2010.**

NHS BORDERS LEAD:	Eric Bajjal - Director of Public Health
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**Delivery**

Risk	Management of Risk
Engagement of partners in Choose Life locally.	A range of different interventions and community awareness training is provided to involve and engage.
Limited negotiation around target audience, accreditation, needs analysis & a perceived lack of flexibility in programmes.	The above event helped everyone involved to spend some time tapping into their combined resources, to find out from other areas what has worked and to make plans more responsive to the local situation in the Scottish Borders. This has led to a closer working relationship to address suicide prevention across Borders and the SEAT region.

**Workforce**

Risk	Management of Risk
Staff available to attend training due to competing pressure on frontline staff with other training, development & service delivery priorities.	For the period 2010-11 the following training is planned 4 safe TALK 5 ASIST 3 SMHFA In addition service specific training can be delivered. This has enabled over achievement of the target for specific staff groups e.g. Drug and alcohol staff. The availability of training is advertised widely within NHS Borders & Managers are requested to disseminate & identify staff to attend. Areas of good practice have begun to emerge, e.g. within Mental Health, Manager of the admin & clerical staff has identified suicide prevention as a training requirement for individual PDPs. Managers are being encouraged to nominate and support staff to attend. Other areas are encouraging staff to attend Safe TALK which is less labour intensive.  Re-affirm commitment within clinical services to support staff participation in training and ensure that suicide prevention features in service development and redesign in order to ensure mainstreaming and sustainability in the longer term.

**Finance**

Risk	Management of Risk
Funding to support training provision	The training delivery is supported by Choose Life. The Choose Life funding comes through Scottish Borders Council and is currently not ring-fenced. If this funding was not continued alternative funding allocation would require to be sought.

**Improvement**

<b>Risk</b>	<b>Management of Risk</b>
Robust learning approach	Suicide prevention staff are meeting with clinical managers to address the needs of their staff, training courses will be held at suitable times as identified by managers. Use will also be made of the video conferencing safeTALK offered by NES.

**Equalities**

<b>Risk</b>	<b>Management of Risk</b>
Lack of a link to Strategies to link into the Scottish Borders Violence against women action plan and Scottish Borders LGBT Forum	Work in partnership with the violence against women partnership, domestic abuse training facilitator and DA Development officer to ensure that the training reflects the impact of domestic abuse on mental health Work in partnership with LGBT Youth and Stonewall Scotland and the Scottish Borders LGBT Forum to train key staff and volunteers
Up take of training by staff in specific areas	Work to raise awareness of training is being undertaken with Learning Disabilities staff with a number having already completed ASIST. Targeting of staff working with clients in the six inequalities strands will be required to ensure inequalities are not exacerbated.

**Trajectory**

<b>Calendar year</b>	<b>Borders</b>
Staff previously trained	25%
Jun 2009	29%
Jun 2010	43%
Dec 2010	50%

**H6: Through smoking cessation services, support 8% of your Board's smoking population in successfully quitting (at one month post quit) over the period 2008/9 – 2010/11.**

NHS BORDERS LEAD:	Alison Wilson – Director of Pharmacy
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### Delivery

Risk	Management of Risk
<p>Current estimate of quits at 4 weeks by 31 December 2009 is on target and if performance is maintained trajectory will meet requirements.</p> <p>We are aware that our continued success in reach is not guaranteed, particularly if the current economic climate negatively impacts on people's likelihood of remaining abstinent.</p>	<p>We have developed new marketing materials based on a social marketing approach and had a successful re-launch of service in December 2009. We are using these materials to support a proactive marketing campaign during 2010 via various media channels to help sustain uptake.</p> <p>Following successful training with community oral health services which has resulted in some direct referrals we are delivering further sessions this year including private sector dental services.</p>

### Workforce

Risk	Management of Risk
<p>Ability to release key staff for training to increase appropriate referrals from pregnant women, acute care and mental health services users.</p>	<p>This remains a challenge for clinical teams and during 2010 we are gaining access to obstetric teams via 3 protected learning sessions and have planned brief advice sessions for acute staff to fit in with existing meeting times.</p> <p>We have commitment from mental health service manager for staff to engage in a planned session.</p>

### Finance

Risk	Management of Risk
Financial implications not applicable	

### Improvement

Risk	Management of Risk
<p>As identified in last year's submission, as prevalence falls smoking is likely to be more firmly embedded in lower-socioeconomic groups who may face additional barriers to stopping, this is likely to require more intensive support than that of service users to date, thus increasing demand on resources with no further improvement in outcomes.</p>	<p>Successful 'rolling-group' programme model in one area appears to be supporting abstinence in smokers who have previously struggled. This model is being considered for other areas.</p> <p>The revised role of Advisors will enable them to develop local networks to maintain referral rates.</p> <p>Uptake will also be supported by our marketing activities.</p>

**Equalities**

<b>Risk</b>	<b>Management of Risk</b>
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. Monitoring of ethnicity is done via Minimum Data Set.

**Trajectory**

<b>Calendar Year</b>	<b>Borders</b>
Dec 08	334
Mar 09	601
Jun 09	790
Sep 09	910
Dec 09	1000
Mar 10	1200
Jun 10	1300
Sep 10	1400
Dec 10	1500
Mar 11	1600
Cumulative total number of successful quits	1,464

**H7: Increase the proportion of new-born children exclusively breastfed at 6-8 weeks from 26.6% in 2006/07 to 33.3% in 2010/11.**

NHS BORDERS LEAD:	Sheena Wright – Director of Nursing & Midwifery
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### Delivery

Risk	Management of Risk
Improvement in breastfeeding rates requires a whole system approach as well as antenatal education.	Education is required to commence in primary schools with a significant social and cultural change in society to accept breastfeeding as normal. It is hoped that through CEL 36 funding an Infant Feeding Advisor will be appointed to progress education in schools. This will be carried out in conjunction with support from Health Visitors/School Nurses and Public Health colleagues.

### Workforce

Risk	Management of Risk
Appointment of an Infant Feeding Advisor	Funding through CEL 36 agreed. Posts advertised and appointed to. Infant Feeding Co-ordinator Community Food Worker Community Dietician

### Finance

Risk	Management of Risk
Cost associated with training in schools	Consideration is being given to the most cost effective way of delivering training courses.

### Improvement

Risk	Management of Risk
Midwives and Health Visitors are relied on solely to improve breastfeeding rates, this could slow down the rate of improvement.	Targeted as part of Health Improvement agenda to the population as a whole. An Infant Feeding Advisor has now been appointed and this will make a significant contribution towards achieving this target.

### Equalities

Risk	Management of Risk
<ul style="list-style-type: none"> <li>▪ All HEAT targets should be equality impact assessed to identify positive and negative impacts on equality groups</li> <li>▪ NHS Borders must adopt fully the equality impact assessment process</li> <li>▪ NHS Borders must adopt the interpretation and translation policy to ensure that staff are supported and patient care and safety is improved</li> <li>▪ Implementation of equality monitoring and patient record markers will support referral, treatment and care</li> <li>▪ 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</li> </ul>	

## Trajectory

<b>Year ending</b>	<b>Borders</b>
Mar-07	32.6
Mar-08	29.7
Jun-08	32.4
Sep-08	31.4
Dec-08	31.2
Mar-09	32.1
Jun-09	30.7
Sep-09	33.0
Dec-09	33.1
Mar-10	33.1
Jun-10	33.2
Sep-10	33.2
Dec-10	33.3
Mar-11	33.3

**H8: Achieve agreed number of inequalities targeted cardiovascular Health Checks during 2009/10.**

NHS BOARD LEAD:	Eric Baijal - Director of Public Health
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**Delivery**

<b>Risk</b>	<b>Management of Risk</b>
Borders Keep Well launched in the workplace In December 2009 and recently in primary care and pharmacy The community strand is at the planning stage still and roll out to other employers, practices and pharmacies may be challenging.	We have now recruited two staff, with a third about to start, to progress this work.
Difficulty in recruiting practices - although PACS board have given their support, we have only had three GP practices sign up in the chosen locality – Chirnside, Greenlaw and one Duns practice .	We have invited other GP practices in Selkirk and Innerleithen/Walkerburn to participate. Selkirk have declined for now but the Innerleithen/Walkerburn practice have just agreed to participate. Selkirk, the other Duns practice, Coldstream and Eyemouth may come on board after April 2010.
In early 2009 we agreed a HEAT target with SGHD for 2009/2010 of 260 interventions. The revised projection from Dec to March 31 <sup>st</sup> is 60. Shortfall of 200 checks from 2009/10 will be covered in 2010/11. The new target for 2010/11 of 390 (450 cumulative total) is felt to be achievable although still challenging.	We have been monitoring our progress towards meeting the 2009/10 target and are highlighted issues and building in learning for the further roll-out in year 2 (2010/11).  Three strands of the local Keep Well programme (workplace, primary care and pharmacy) are now running and implementation of the fourth (community) will be progressed ASAP. The aim in 2010/11 is to maximise KW checks across all strands and if at all possible to exceed the 390 target.

**Workforce**

<b>Risk</b>	<b>Management of Risk</b>
Difficulty in recruiting and training staff to undertake health checks in the pilot area. There will also be a requirement to train some staff in primary care teams, e.g. receptionists and to secure agreement for staff to be given time off.  Risk that few/no primary care teams agree to deliver health checks themselves or staff fail to attend training later in 2010/11.	Recruitment has been progressed as fast as possible to ensure staff are in place on time. Two of three posts have been successfully filled.  Ensure GP practices are aware of the commitment required early on and can put in place plans to bring in cover. If needed we can provide resources to backfill staff time.  Emphasise benefits to the practice and the health of their population.

**Finance**

<b>Risk</b>	<b>Management of Risk</b>
Funding for Keep Well in Borders is available for two years from 2009/2010 and 2010/2011. Financial pressures in NHS make local pick up of funding extremely unlikely. Risk that programme will stop without some recurring funding.	Planning has and continues to aim to minimise recurring funding tail (<£90,000 per annum). Carry-forward from 2010/11 to 2011/12 is planned and will maintain service for part of 2011/12. Broader health improvement and anticipatory care service re-design will be explored to sustain service. Recurring funding provision will require to be explored further.

**Improvement**

<b>Risk</b>	<b>Management of Risk</b>
We intend to co-ordinate Keep Well with our existing lifestyle change and prevention services, e.g. Workplace LASS and Lifestyle Adviser Support Service. This is a challenge as it requires large scale co-ordination and potential adjustment to existing services.	The Keep Well Programme steering group contains representatives from existing services and there is a will to see effective integration and streamlining.
Confusion and lack of coordination of Keep Well programme with other relevant initiatives, guidance and standards.	We intend to align Keep Well with local implementation of the SIGN 97 guideline, updating of the local statin policy and ensure the programme is consistent with emerging QIS standards and QOF. The Keep Well programme is supported by the local CHD MCN which will help ensure alignment.

**Equalities**

<b>Risk</b>	<b>Management of Risk</b>
Keep Well does not reach those in most need and hard to reach	We will use SIMD indices and council tax bands to create target lists of patients in GP practices and a similar process in pharmacy. Workplaces are focussing lower paid staff and certain groups who may be at greater risk. We will also apply local knowledge to refine lists. We will monitor actual attendees to determine if we have been successful.

**Trajectory**

<b>Quarter ending</b>	<b>Borders</b>
Jun-10	90
Sep-10	190
Dec-10	290
Mar-11	390
Cumulative total number of health checks (2009-11)	390

**H9: 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
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<b>Risk</b>	<b>Management of Risk</b>
Cooperation with general dental practices 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.
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 – a communications strategy will help.
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.  Potentially increase the nurseries targeted from 20% to 30%
Cooperation with salaried dental practices.	Make it an outcome objective for the service providers – salaried service. To ensure all NHS dental registered children are part of the Childsmile practice scheme.

**Workforce**

<b>Risk</b>	<b>Management of Risk</b>
Cooperation with general dental practices.	Facilitate sign-up and provide training to their dental nurses with continued support from the Childsmile coordinator.
Loss of trained staff	Ensure that there is vigorous recruitment, retention and training of all dental staff.
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.	Management includes continuing to improve local training courses for dental nurses so far these have an excellent track record of examination success and around 6 students each year.
Pressure on the role of the Oral health support worker	Increase the capacity of the oral health support worker with additional hours, staff and training.
Adequate support for all staff involved within childsmile programmes	Robust support structure to be in place to manage and coordinate Childsmile fluoride varnish programmes both within nurseries and practice.

**Finance**

<b>Risk</b>	<b>Management of Risk</b>
Continuation of central funding	Funding has been agreed
Inappropriate local management budget savings leading to reduced frontline services.	Ensure that the budget is used correctly for recruitment, retention and training of all dental staff.

**Improvement**

<b>Risk</b>	<b>Management of Risk</b>
Improvement risk could include an element of children being at the saturation point on the sigmoid dose response curve of extracellular sugars intake thus reducing the effect of the topical fluoride	The management of this is by oral health promotion within the Childsmile programme to reduce dietary sugars from plateau maximum damage levels. We have signed up the first practice to the "Childsmile Practice" programme in Galashiels. This will benefit those children who will be targeted for care by the healthcare team very early on in their lives.

**Equalities**

<b>Risk</b>	<b>Management of Risk</b>
The target is designed to ensure an inverse dental care law is not generated.	Ensure compliance with national monitoring system
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.

As far as the trajectory is concerned, the cohort of children is in the order of 1100 per year, ie 2200 3&4 year olds. Therefore with 458 successful fluoride varnish applications within this age group last year we are currently at 21%. We need to apply the Fluoride varnish to around 1500 children spread across the 5 quintiles evenly to achieve 60%.

## Trajectory

<b>Month</b>	<b>Borders</b>
Jun-10	20%
Sep-10	23%
Dec-10	26%
Mar-11	29%
Jun-11	32%
Sept-11	35%
Dec-11	38%
Mar-12	41%
Jun-12	44%
Sept-12	47%
Dec-12	50%
Mar-13	53%
Jun-13	56%
Sept-13	59%
Dec-13	62%
Mar-14	65%

### Section 3: Efficiency and Governance

Efficiency and Governance	
<b>E4</b>	NHS Boards to deliver agreed improved efficiencies for 1st outpatient attendance DNA, non-routine inpatient average length of stay, review to new outpatient attendance ratio and same-day surgery by March 2011 and pre-operative stay by March 2013
<b>E5</b>	NHS Boards to operate within their agreed revenue resource limit; operate within their capital resource limit; meet their cash requirement
<b>E6</b>	NHS Boards to meet their cash efficiency target
<b>E7</b>	To increase the percentage of new GP outpatient referrals into consultant led secondary care services that are managed electronically to 90% from December 2010
<b>E8</b>	NHSScotland to reduce CO <sub>2</sub> emissions for oil, gas, butane and propane usage based on a national average year-on-year reduction of 3% each year to 2015-16.
<b>E10</b>	Boards should ensure that all staff on Agenda for Change permanent contracts take part in an annual review against a KSF post outline. Information on levels of competence and identified training needs must be made available through Boards recording summary information from at least 80% of development reviews on e-ksf by end March 2011.

*Please note: HEAT target numbering is sequential from 2008/09 onwards*

**E4: NHS Boards to deliver agreed improved efficiencies for 1st outpatient attendance DNA, non-routine inpatient average length of stay, review to new outpatient attendance ratio and same-day surgery by March 2011 and pre-operative stay by March 2013**

NHS BORDERS LEAD:	Ralph Roberts – Director of Integrated Health Services
NHS BORDERS LOCAL CONTACT:	Irene Gourlay – 18 Week RTT Programme Manager

**Delivery**

Risk	Management of Risk
Significant challenge in General Surgery day case rates.	Reduce numbers of patients admitted day before surgery for social/geographical reasons Lean redesign of Day Procedure Unit (DPU)
Patients admitted day prior to surgery for assessment.	Pre Op Assessment. Reduction in number of medical boarders on surgical wards
Increased capacity required in DPU	Relocation of non anaesthetic cystoscopies to Endoscopy

**Workforce**

Risk	Management of Risk
Anaesthetic capacity to support pre op assessment and increase in day surgery rates	Increased use of anaesthetic practitioners
Reduction in junior doctor hours	Improved utilisation of advanced practitioner - surgical assistant role

**Finance**

Risk	Management of Risk
Increased activity in Endoscopy to release capacity in DPU	Scope potential resource to support increased activity. Offset against cost pressures

**Improvement**

Risk	Management of Risk
Day case rates for varicose veins and primary repair of inguinal hernia remain below the national average	Pre op assessment and list as day case as default Stricter criteria for varicose vein surgery Establish all day hernia list in DPU

**Equalities**

Risk	Management of Risk
Outpatient staff appropriately trained to recognise individual patient needs e.g. deaf and hard of hearing patients; PWLD; Disabled patients	Increased awareness and training required for staff on equality issues to recognise cultural diversity; disability.  Work in partnership with equality and diversity team to put training and support into place for staff

## Trajectory

### Same Day Surgery

Year ending	Borders
2005/06	77.4%
2006/07	78.4%
2007/08	78.4%
2008/09	79.8%
Jun-09	84.8%
Sep-09	86.0%
Dec-09	87.2%
Mar-10	82%
Apr-10	82%
May-10	83%
Jun-10	84%
Jul-10	84%
Aug-10	85%
Sep-10	85%
Oct-10	85%
Nov-10	86%
Dec-10	86%
Jan-11	86%
Feb-11	87%
Mar-11	88%

### Non-routine inpatients average length of stay

Year ending	Borders
Mar-07	4.9
Mar-08	4.9
Jun-08	5.0
Mar-09	4.9
Jun-09	4.9
Sep-09	4.9
Dec-09	4.8
Mar-10	4.8
Jun-10	4.7
Sep-10	4.7
Dec-10	4.6
Mar-11	4.6

### New outpatient appointment DNA rates

Year ending	Borders
Mar-07	6.4%
Mar-08	6.0%
Jun-08	6.1%
Sep-08	6.0%
Dec-08	5.8%
Mar-09	5.7%
Jun-09	6.1%
Sep-09	6.0%
Dec-09	5.9%

Mar-10	5.8%
Jun-10	5.8%
Sep-10	5.8%
Dec-10	5.8%
Mar-11	5.8%

Pre-operative Stay

Year ending	Borders
Mar-08	0.6
Jun-10	
Sep-10	
Dec-10	
Dec-10	
Mar-11	
Jul-11	
Sep-11	
Dec-11	
Mar-12	
Jun-12	
Sep-12	
Dec-12	
Mar-13	

**Please Note: Pre-operative Stay information to be supplied by Scottish Government**

**E5: NHS Boards to operate within their agreed revenue resource limit; operate within their capital resource limit; meet their cash requirement.**

NHS BORDERS LEAD:	Jane Davidson – Director of Finance
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### Delivery

Risk	Management of Risk
Growth for 2011/12 and beyond is estimated as dependant on the Spending Review. A key factor in planning will be the level of pay inflation which is estimated to match allocation uplift levels. Any divergence from this would significantly impact on financial plans.	NHS Borders has a good track record of achieving financial targets and for sound financial management, although the magnitude is significantly different going forward. NHS Borders will continue to seek out and deliver further efficiency improvements over the period of the plan.

### Workforce

Risk	Management of Risk
Junior Doctor issues relating to MMC and EWTD	It is anticipated that NHS NES will confirm that resources will be released back to Boards to allow essential redesign of services to proceed
The impact of pressures and savings requirements will mean it is likely that NHS Borders will not be able to sustain the current profile of workforce.	This will be largely addressed through service re-design and by improving the efficiency and productivity of the workforce. Workforce planning will be key in this period of change.

### Finance

Risk	Management of Risk
Please see NHS Borders financial risk assessment	

### Improvement

Risk	Management of Risk
Continuing delivery of savings. Agreement on the areas to be taken forward for redesign.	NHS Borders has a good track record of achieving financial targets and for sound financial management. NHS Borders will continue to seek out and deliver further efficiency improvements over the period of the plan. NHS Borders is at an early stage of implementing LEAN. This tool will be extended across the organisation to improve efficiency.

### Equalities

Risk	Management of Risk
Financial decision making not equality impact assessed	Ensure that all financial decision making is equality impact assessed

## Trajectory

Month	Borders
Jun-10	1500
Jul-10	1500
Aug-10	1400
Sep-10	1200
Oct-10	1000
Nov-10	800
Dec-10	600
Jan-11	400
Feb-11	200
Mar-11	0
Jun-11	500
Jul-11	500
Aug-11	450
Sep-11	400
Oct-11	350
Nov-11	300
Dec-11	250
Jan-12	200
Feb-12	100
Mar-12	0
Jun-12	500
Jul-12	500
Aug-12	450
Sep-12	400
Oct-12	350
Nov-12	300
Dec-12	250
Jan-13	200
Feb-13	100
Mar-13	0

**E6: NHS Boards to meet their cash efficiency target.**

NHS BORDERS LEAD:	Jane Davidson – Director of Finance
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**Delivery**

<b>Risk</b>	<b>Management of Risk</b>
Growth for 2011/12 and beyond is estimated as dependant on the Spending Review. A key factor in planning will be the level of pay inflation which is estimated to match allocation uplift levels. Any divergence from this would significantly impact on financial plans.	NHS Borders has a good track record of achieving financial targets and for sound financial management, although the magnitude is significantly different going forward. NHS Borders will continue to seek out and deliver further efficiency improvements over the period of the plan.

**Workforce**

<b>Risk</b>	<b>Management of Risk</b>
Junior Doctor issues relating to MMC and EWTD	It is anticipated that NHS NES will confirm that resources will be released back to Boards to allow essential redesign of services to proceed
The impact of pressures and savings requirements will mean it is likely that NHS Borders will not be able to sustain the current profile of workforce.	This will be largely addressed through service re-design and by improving the efficiency and productivity of the workforce. Workforce planning will be key in this period of change.

**Finance**

<b>Risk</b>	<b>Management of Risk</b>
	Please see NHS Borders financial risk assessment

**Improvement**

<b>Risk</b>	<b>Management of Risk</b>
Continuing delivery of savings. Agreement on the areas to be taken forward for redesign.	NHS Borders has a good track record of achieving financial targets and for sound financial management. NHS Borders will continue to seek out and deliver further efficiency improvements over the period of the plan. NHS Borders is at an early stage of implementing LEAN. This tool will be extended across the organisation to improve efficiency.

**Equalities**

<b>Risk</b>	<b>Management of Risk</b>
Financial decision making not equality impact assessed	Ensure that all financial decision making is equality impact assessed

**Trajectory**

Month	Borders
Jun-10	0
Jul-10	390
Aug-10	780
Sep-10	1170
Oct-10	1560
Nov-10	1950
Dec-10	3218
Jan-11	4486
Feb-11	5754
Mar-11	7024

**E7: To increase the percentage of new GP outpatient referrals into consultant led secondary care services that are managed electronically to 90% from December 2010.**

NHS BORDERS LEAD:	Robbie Pearson – Director of Planning & Performance
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**Delivery**

Risk	Management of Risk
<p>No Technical Solution is developed and implemented in time to meet the target.</p>	<p>As there is no national technical solution provided, NHS Borders will, inline with direction from the SCI Gateway Steering Group commence implementing an e-triage solution using SCI Gateway. (Specific HEAT Target statuses have been incorporated into SCI Gateway to allow for this).</p> <p>In order to meet the 90% target, an interim solution offered by our existing PMS provider (iSoft) will be used.</p> <p>We will subsequently be looking to incorporate e-referral management into our deployment of the new PMS. A change management process will be necessary for the PMS deployment and this will be carried out as a parallel activity.</p> <p>Planning is underway to install and test iSoft module during May/June 2010. The Outpatients team will set the status flag in SCI Gateway via the new functionality in the iSoft Module for all specialities except the current seven that are live. This approach will mean the trajectory for electronic management will remain the same until the iSoft Module is installed, after which time it is expected to increase to 90%. Process re-alignment of each of the specialities will be carried out as a parallel activity to support the migration and implementation of the new PMS system during Q4 2010. If there are delays to the roll-out of the iSoft module for technical reasons and/or lack of clinical engagement then the outpatient team will set the status flag manually for all specialities as a fall back approach. The deadline for this decision will be late summer 2010.</p>
<p>Proposed Technical Solution(s) are not successfully deployed or accepted</p>	<p>We plan to take a holistic approach and review the whole referral management process from GP Practice to Outpatient appointments. This will require significant effort, resources, commitment and 'buy in' from clinical and administrative staff across Primary &amp; secondary care.</p> <p>In order to minimise issues and risks we are in the process of developing a Project Governance structure, with formal Project Management and Project Initiation Documentation to define the program of work required to meet this target. This will be formally approved by NHS Borders Board Executive Team and Clinical Executive. It is anticipated that leadership in the form of the Project Executive will be provided by Director level or Senior Clinical representative.</p>

**Workforce**

<b>Risk</b>	<b>Management of Risk</b>
<p>Resources required to develop and deploy the proposed solution(s) are not available or not sufficiently skilled (Clinical and Technical)</p>	<p>Additional facilitation, redesign, Project Management and Protocol creation resources will be required to deliver this target. Some of this can be absorbed in current resources within IM&amp;T Projects and Development department but there will be a requirement for additional short term resources to support the creation of a suitable infrastructure and change in working practices. There will be specific resource dependency for the interim iSoft solution from the medical records team and NHS Grampian.</p> <p>Training of staff in the new process and technical solution will be required and availability of staff to be trained, along with training delivery resources may present issues. A full project plan will be developed to identify resources, skills gaps and highlight any shortfalls with proposals to plug any gaps.</p>

**Finance**

<b>Risk</b>	<b>Management of Risk</b>
<p>Financial Pressures / Constraints could impact on the ability to deliver any proposed solution.</p>	<p>No specific financial pressures have been identified with achieving this target but it is likely that additional resources will be required within IM&amp;T and Clinical services to facilitate creation of the supporting infrastructure and change in working practices. This is likely to create a short term pressure over the first years in providing adequate staff to support achievement of this target. In addition an existing capital funding of £18000 will be required for the purchase of the interim solution. These issues will be managed within the Project Governance Framework.</p>

**Improvement**

<b>Risk</b>	<b>Management of Risk</b>
<p>GP Practices continue to use alternative paper or email solution to make referrals.</p>	<p>SCI Gateway is now the accepted method of making referrals to all consultant lead specialties. It is also being introduced into a number of AHP's including Physiotherapy and mental health. This will help to encourage GP's to use it as a single point of referral management. The benefit to GP's of having one reliable and fully auditable method of sending and tracking referrals is expected to be sufficient motivation to secure its continued and sustained use. Continued use of SCI Gateway will be encouraged through facilitation.</p> <p>Only 87% of referrals went through SCI Gateway in January 2010. If Borders' ability to meet the electronic management target continues to be limited then this issue will be escalated to Borders GPIT sub-committee.</p>

Performance may present issues when the volume of referrals increases over time.	The wide area network infrastructure will be a key dependency. Both Equalities and uptime of services will be closely monitored.
Resistance to change could present difficulties in making sustained improvements	A comprehensive change management program will be developed to ensure that all affected parties are given an opportunity to participate in / contribute to the decision making processes required to implement the change in their area. Facilitation services will not only support this for the deployment of the interim iSoft solution but also for new PMS.

## Equalities

Risk	Management of Risk
How to build in equality monitoring to primary care to ensure all patient data is captured in relation to their ethnicity, age, gender, disability	Build in "happy to ask happy to tell" into the training plan and implement a communication plan for the public to ensure that they understand why NHS Borders staff are asking equality monitoring questions

## Trajectory

Month	Borders
Aug-09	9.6%
Sep-09	14.5%
Oct-09	15.4%
Nov-09	15.2%
Dec-09	14.1%
Jan-10*	14.1%
Feb-10	15%
Mar-10	15%
Apr-10	15%
May-10	15%
Jun-10	15%
Jul-10	15%
Aug-10	90%
Sep-10	90%
Oct-10	90%
Nov-10	90%
Dec-10	90%
Jan-11	90%
Feb-11	90%
Mar-11	90%

\* actual percentages to date

**E8: NHS Scotland to reduce CO2 emissions for oil, gas, butane and propane usage based on a national average year-on-year reduction of 3% each year to 2015-16.**

NHS BORDERS LEAD:	Ralph Roberts – Director of Integrated Health Services
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**Delivery**

<b>Risk</b>	<b>Management of Risk</b>
Increased demand for utility services	<p>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.</p> <p>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.</p> <p>Carbon Management Programme, which identifies capital funded projects, will reduce utility consumption through: energy efficiency, heat recovery, reduced waste etc.</p>
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	<p>Data contained within baseline figures and trajectories is for Hospital sites only, as listed within Table 2 of Guidance on the new HEAT Energy Performance Target paper, dated December 2008.</p> <p>Community sites will be excluded from national reports pending further work, as noted below.</p>
Receipt of water and electricity usage data in electronic format for community premises	Dependent on ability of contracted utility suppliers
Modification to eMART, (environment Monitoring And Reporting Tool)	Health Facilities Scotland will take the lead in developing eMART, this in conjunction with contracted utility suppliers. Time frame to be clarified.
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**

<b>Risk</b>	<b>Management of Risk</b>
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. (Resource and A4C issue).

**Finance**

<b>Risk</b>	<b>Management of Risk</b>
Identification of Capital investment required to support initiatives identified within the Board's Carbon management programme	Carbon Management Programme will identify a capital investment programme 2009 – 2016, in process of establishing details of costs and pay back periods, to date in excess of £1,000,000 identified.
Cost of utility services	Pan Public Sector utility contracts will be established, October 2009, the cost of supplies very much influenced by international markets. Out with the control of individual Boards.

**Improvement**

<b>Risk</b>	<b>Management of Risk</b>
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**

<b>Risk</b>	<b>Management of Risk</b>
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

Year		Borders
2007/08	Energy GJ	103,886
2009/10	Energy GJ	99,772
2010/11	Energy GJ	98,775
2011/12	Energy GJ	97,787
2012/13	Energy GJ	96,809
2013/14	Energy GJ	95,841
2014/15	Energy GJ	94,882
2007/08	CO <sub>2</sub> Tonnes	7,145
2009/10	CO <sub>2</sub> Tonnes	7,007
2010/11	CO <sub>2</sub> Tonnes	6,797
2011/12	CO <sub>2</sub> Tonnes	6,593
2012/13	CO <sub>2</sub> Tonnes	6,395
2013/14	CO <sub>2</sub> Tonnes	6,203
2014/15	CO <sub>2</sub> Tonnes	6,017

**E10: Boards should ensure that all staff on Agenda for Change permanent contracts take part in an annual review against a KSF post outline. Information on levels of competence and identified training needs must be made available through Boards recording summary information from at least 80% of development reviews on e-ksf by end March 2011.**

NHS BORDERS LEAD:	Louise Hamilton-Welsh – Director of Workforce
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**Delivery**

Risk	Management of Risk
IT literacy; difficulty in accessing pc's; lack of email address could hamper use of the electronic recording system of eKSF.	Mousing Around Training helping to address this. Work with IM&T on email addresses.
Loss of e-KSF expertise. Support for users diminishes. Approval and Management of post outlines not maintained.	Ensure eKSF knowledge is integrated within workforce information expertise and staffing. Champions and Enthusiasts continue to assess training needs across organisation. Build into induction programme for all new staff. (Currently looking at e-learning module) Streamlined Processes for validation of post outlines currently with the APF for signoff. EKSF knowledge now integrated into team through Champions and Enthusiasts. Continuing to support Clinical Board Champions and Enthusiasts will mitigate risk.
Mainstreaming of services principally led by Workforce/ Training and development produces no clear lines of accountability. Potential for duplication of effort or lack of progress.  HEAT target linked to KSF is not met.	Need to ensure clear line of accountability for KSF. – Action Plan clearly defines responsibilities for Workforce/Training and Professional Development.
An underestimate of the amount of time required from managers, clinicians and staff to complete reviews including discussion with individual members of staff and follow-up.	Targeted Support is being provided by Clinical Board Champions. Looking at process for Bands 1-4 to make it easier and quicker to complete. Looking at extending the “complete on paper” option across the services to enable managers to carry out reviews more efficiently.
Use of eKSF is not universal. Data is incomplete which means that the potentially valuable data which could inform workforce planning; training needs assessment and analysis; service redesign and assessment of staff competencies could be lost. Organisation wide monitoring would have to be both electronic through eKSF, and manually with staff/managers having to complete paper records which is duplication of effort and not evidence based.	Ensure maintenance of eKSF. Provide training for all managers in use of system. Continue to provide help desk facility. Some EKSF issues are out with NHS Borders control and they are dealt with nationally. Guidance has been provided on accurate reporting available. National work on reports needs to be complete before local benefits can be realised. Ensure “complete on paper” section is only used where appropriate and that PDP/Training Needs are logged on EKSF to inform future Workforce Planning/Training Provision.

**Workforce**

<b>Risk</b>	<b>Management of Risk</b>
Clinical Board ability to deliver the target diminishes when funding for Clinical Board Champions ends in March 2010.	Assessment of staff availability to carry out Joint Development Reviews, Continuation of Champions essential to mitigate risk.
Staff competencies; knowledge and skills are not assessed and later found to be lacking. Clinical governance risk with potential litigation risk or damage to reputation through adverse publicity.	Apply NHS Borders Joint Development Review Policy across all services. Performance Management Audit being carried out to assess extent of implementation of Joint Development Review Policy.
Managers unable to carry out/employees unable to attend Joint Development Reviews due to time pressures.	Clinical Boards to ensure that carrying out a Joint Development Review discussion is a priority for all managers.
Provision of training and support to managers exceeds expectation. Also the capacity to provide this training.	Use data from eKSF to identify need. At an organisation level prioritise what the service needs in terms of training and manage the risk. Current financial situation focusing efforts on Statutory/Mandatory training only.
Staff expectations for training as identified through PDP and outline may exceed organisations ability to provide. Low staff morale. Potential impact on recruitment and retention.	Identify organisational priorities for both mandatory and statutory training requirements through the use of KSF and eKSF.

**Finance**

<b>Risk</b>	<b>Management of Risk</b>
Inappropriate use of gateways, employees are prevented from passing through gateway to protect budgetary arrangements. Development plans are not agreed and employees pass through gateways without undertaking personal development. NHS Borders can't afford major change factors as result of new Terms and Conditions.	NHS Borders to ensure implementation of KSF and employee appraisals with clear development plans. Awaiting national guidance on the management of Gateway Process. Unlikely to be a risk over 2010.
Clinical Boards cannot absorb funding of champions within their budget when funding ends in March 2009.	Champions are essential to the success of KSF. Ensure Clinical Boards can fund champions to support them to meet this HEAT Target.

**Improvement**

<b>Risk</b>	<b>Management of Risk</b>
The priorities of improved patient experience and patient safety are compromised. Essential training not done leaving organisation exposed in terms of legal requirements/ health and safety.	Identify gap in provision for both mandatory and statutory training requirements through the use of KSF and eKSF.
Insufficient skills and knowledge to undertake redesign of the service.	Identifying current knowledge and skills, through analysis across NHS Borders workforce, to outline training and

	development needs according to service redesign requirements. Workforce Plan.
The priorities of improved patient experience and patient safety are compromised. Essential training not done leaving organisation exposed in terms of legal requirements/ health and safety.	Identify gap in provision for both mandatory and statutory training requirements through the use of KSF and eKSF.

**Equalities**

<b>Risk</b>	<b>Management of Risk</b>
KSF and AFC processes are not fully accessible for staff who have literacy issues, staff who are deaf	PDP paperwork not fully accessible and not applicable to all disciplines in NHS
Core Objective 6 is equality and diversity lack of resource to support NHS	Borders staff to meet core objective 6
Equality impact assess the processes and policies	Look at making reasonable adjustments for staff who are not literate; use BSL and by providing alternative tools

## Trajectory

Month	Borders
Apr-09	0%
May-09	0%
Jun-09	0%
Jul-09	0%
Aug-09	0%
Sep-09	0%
Oct-09	0%
Nov-09	0%
Dec-09*	4.7%
Jan-10	5%
Feb-10	7%
Mar-10	15%
Apr-10	20%
May-10	25%
Jun-10	30%
Jul-10	35%
Aug-10	40%
Sep-10	45%
Oct-10	65%
Nov-10	70%
Dec-10	74%
Jan-11	75%
Feb-11	78%
Mar-11	80%

\* Actual percentage

## Section 4: Access to Services

Access to Services	
<b>A8</b>	Provide 48 hour access or advance booking to an appropriate member of the GP Practice Team by 2010/11
<b>A9</b>	From the quarter ending December 2011, 95 per cent of all patients diagnosed with cancer to begin treatment within 31 days of decision to treat, and 95 per cent of those referred urgently with a suspicion of cancer to begin treatment within 62 days of receipt of referral.
<b>A10</b>	Deliver 18 weeks referral to treatment from 31 December 2011. No patient will wait longer than 12 weeks from referral to a first outpatient appointment from 31 March 2010. No patient will wait longer than 9 weeks from being placed on a waiting list to admission for an inpatient or day case procedure from 31 March 2011.
<b>A11</b>	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. By December 2010, 90% of clients referred to drug treatment will receive a date for assessment that falls within 4 weeks of referral received and 90% of clients will receive a date for treatment that falls within 4 weeks of their care plan being agreed
<b>A12</b>	By March 2013 no one will wait longer than 26 weeks from referral to treatment for specialist CAMHS services.  During 2010/11 the Scottish Government will work with NHS Boards to develop an access target for psychological therapies for inclusion in HEAT in 2011/12.

*Please note: HEAT target numbering is sequential from 2008/09 onwards*

**A8: Provide 48 hour access or advance booking to an appropriate member of the GP Practice Team by 2010/11.**

NHS BORDERS LEAD:	Ralph Roberts – Director of Integrated Health Services
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**Delivery**

<b>Risk</b>	<b>Management of Risk</b>
Target will be delivered through the QOF component of the GP contract.  Measurement will be based on a new centrally managed GP Access Survey, which will be carried out on an annual basis, starting in 2008/09.	All Practices participated in the new Patient Experience QOF Indicators PE07 and PE08, in 2008/09.
Participating in the QOF is voluntary.	Practice participation in the Patient Experience QOF indicators for 2009/10 is expected to be 100%.

**Workforce**

<b>Risk</b>	<b>Management of Risk</b>
No workforce implications have been identified	

**Finance**

<b>Risk</b>	<b>Management of Risk</b>
Practices are paid at the nationally agreed rates and funded through the nationally negotiated elements of the GP contract and its QOF components.	

**Improvement**

<b>Risk</b>	<b>Management of Risk</b>
It is anticipated that all Practices will participate and achieve the required levels against the criteria of the QOF.	The Health Board has been visiting all Practices as part of the Closer Working with GP Practices Enhanced Service. Patient Access has been discussed during the visits, especially with those Practices that failed to achieve 100% in QOF, in 2008/09. Practices have taken action by making more appointments available to patients and reviewing their procedures and training in their reception areas. Primary Care will continue to offer support, as required.

**Equalities**

<b>Risk</b>	<b>Management of Risk</b>
All access to GP services must recognise patients ethnicity; disability;	Equality and Diversity will work with practices to give support

## Trajectory

48-hour Access – GP Practice Team

<b>Year ending</b>	<b>Borders</b>
Mar-11	95%
Mar-12	95%

Advance Booking – GP Practice Team

<b>Year ending</b>	<b>Borders</b>
Mar-10	86%
Mar-11	90%
Mar-12	95%

**A9: From the quarter ending December 2011, 95 per cent of all patients diagnosed with cancer to begin treatment within 31 days of decision to treat, and 95 per cent of those referred urgently with a suspicion of cancer to begin treatment within 62 days of receipt of referral.**

NHS BORDERS LEAD:	Robbie Pearson – Director of Planning & Performance
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### Delivery

Risk	Management of Risk
Processes for tracking patients are not robust	Constant monitoring of tracking issues and missed patients Weekly Cancer Waiting Times review meeting
Treatment is not carried out within 62/31 days	Cancer Tracking system CWT weekly meetings Clear Escalation processes Review of pressures areas in new 31-day target and action plan for addressing
Tracking of 31 days is for all patients	New tracking protocols required – work in progress

### Workforce

Risk	Management of Risk
Insufficient capacity to track all patients due to increased numbers	Review current capacity Employ additional staff Integrate tracking and audit teams to maximise effectiveness
Additional workload for clinical staff due to increased numbers of patients/increased numbers tracked and escalated	Develop streamlined system – minimise need to involve clinical staff Review pressure areas and identify different ways of working/additional resource if required
Failure to deliver 31/62 day targets in potential vulnerable areas due to loss of single handed/small numbers of specialised staff	Review vulnerable areas and identify contingency plans Tracking and escalation systems to identify problems early on

### Finance

Risk	Management of Risk
Additional costs of expanding tracking capacity	Flag up requirements early – feed into LDP
Potential additional costs of expansion in capacity in particular services to deliver 31-day target	Review current achievement and pressure areas Explore potential for redesign of services to deliver CWT Flag up requirements early – feed into LDP

### Improvement

Risk	Management of Risk
Lack of buy-in from clinical staff to delivery of 31 and 62-day targets	Improvement and support work with individual services/clinicians to achieve improved service delivery Negotiation and communication with relevant clinicians Escalation to appropriate managers
Failure to redesign tracking and monitoring processes to achieve targets	Senior Manager Leadership Clear project plan for redesign of systems Communication and monitoring process within NHS Borders for achievement of redesign

## Equalities

Risk	Management of Risk
Recognise individual patient needs if not recognised a patient who is deaf and hard of hearing; PWLD; Disabilities; cultural needs will have an impact on referral and treatment	Equality and diversity team will support teams who need support

## Trajectory

### Suspicion-of-cancer Referrals (62 days)

Quarter ending	Borders
Jun-09	95%
Sep-09	95%
Dec-09	95%
Mar-10	95%
Jun-10	95%
Jul-10	95%
Sep-10	95%
Dec-10	95%
Mar-11	95%

### All cancer treatment (31 days)

Quarter ending	Borders
Jun-08	74.5%
Jun-09	75%
Sep-09	78%
Dec-09	79%
Mar-10	80%
Jun-10	82%
Jul-10	83%
Sep-10	85%
Dec-10	87%
Mar-11	88%
Jun-11	90%
Sep-11	93%
Dec-11	95%

**A10: Deliver 18 weeks referral to treatment from 31 December 2011. No patient will wait longer than 12 weeks from referral to a first outpatient appointment from 31 March 2010. No patient will wait longer than 9 weeks from being placed on a waiting list to admission for an inpatient or day case procedure from 31 March 2011.**

NHS BORDERS LEAD:	Ralph Roberts – Director of Integrated Health Services
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**Delivery**

<b>Risk</b>	<b>Management of Risk</b>
<p>The services which will present the main challenges in NHS Borders in meeting the 9-week outpatient waiting time target are:</p> <ul style="list-style-type: none"> <li>• Dermatology</li> <li>• ENT</li> <li>• Orthopaedics</li> <li>• Oral Surgery</li> <li>• Female Urodynamics</li> </ul>	<p><b>Dermatology</b> The recruitment process is underway to appoint an NHS Borders consultant Dermatologist. The job plan will include protected SPA time for service redesign. We will continue with locum cover until the new consultant is in post</p> <p><b>ENT :</b> Capacity planning is underway as part of the review of Consultant job plans</p> <p><b>Orthopaedics:</b> Review of peripheral clinic utilisation and restructure if appropriate</p> <p><b>Oral Surgery:</b> Stabilisation of Oral Surgery rota from Lothian to deliver additional session locally</p> <p><b>Urodynamics:</b> Redesign of referral triage</p>
<p>The services which will present the main challenges in NHS Borders in meeting the 9-week outpatient waiting time target are</p> <ul style="list-style-type: none"> <li>• Orthopaedic Surgery</li> <li>• Oral Surgery</li> <li>• Female urodynamics</li> </ul>	<p>Orthopaedic Surgery Capacity planning within medical team Lean theatre redesign Locum cover for long term sick leave Prospective cover by locum for AL May - Sept Additional elective operating day each week</p> <p>Oral Surgery Stabilisation of Oral Surgery rota from Lothian to deliver additional session locally</p> <p>Urodynamics Increased capacity for TVTO operations</p>
<p>Diagnostics Reporting of key diagnostic tests during peak holiday periods</p>	<p>Review of process to provide reporting cover</p>
<p>AL cover for Endoscopy</p>	<p>Increase scope of non medical endoscopist to include lower GI endoscopy</p>

**Workforce**

<b>Risk</b>	<b>Management of Risk</b>
<p>Prolonged recruitment process for Dermatology consultant</p>	<p>Continue with locum cover until permanent Consultant is able to take up post.</p>
<p>Delay in reporting key diagnostic tests</p>	<p>Increased number of reporting radiographers</p>
<p>Reduced orthopaedic capacity during AL</p>	<p>Locum cover for sick leave and annual leave</p>

**Finance**

<b>Risk</b>	<b>Management of Risk</b>
Cost of additional sessions / locum consultants	NHS Borders will continue to monitor investment against the waiting times allocation
Additional resource required to meet national 18wk reporting targets	In house IT solutions require increase in analyst and developer time to initiate. Capacity is being built in to the analyst work plan by devolving existing work within the team. IM&T development time to be released through reprioritisation of other IM&T projects

**Improvement**

<b>Risk</b>	<b>Management of Risk</b>
The main risk for NHS Borders remains with Orthopaedic Surgery inpatient / day case waiting lists.	Lean redesign of theatre processes for orthopaedics with planned roll out to Gynaecology, General Surgery and CEPOD Theatre When required work will continue to outsourced to alternative providers
18wk performance reporting requires improved tracking using a Unique Care Pathway Number	In house IT solution to utilise UCPN from SCI gateway

**Equalities**

<b>Risk</b>	<b>Management of Risk</b>
Patients with limited mobility unable to attend OP appointment due to transport issues. New Ways rules allow resetting of 18wk clock for CNAs	Redesign of NHS Borders Transport Strategy to improve access

**Trajectory**

18 weeks RTT: Admitted Performance

<b>Month of treatment</b>	<b>Borders</b>
Apr-10	66%
May-10	68%
Jun-10	70%
Jul-10	72%
Aug-10	72%
Sep-10	75%
Oct-10	77%
Nov-10	80%
Dec-10	82%
Jan-11	82%
Feb-11	82%
Mar-11	84%
Apr-11	85%
May-11	86%
Jun-11	86%
Jul-11	88%
Aug-11	88%
Sep-11	90%
Oct-11	90%
Nov-11	90%
Dec-11	90%

18 weeks RTT: Admitted Completeness

<b>Month of treatment</b>	<b>Borders</b>
Apr-10	62%
May-10	65%
Jun-10	70%
Jul-10	74%
Aug-10	78%
Sep-10	80%
Oct-10	84%
Nov-10	88%
Dec-10	92%
Jan-11	92%
Feb-11	93%
Mar-11	95%
Apr-11	95%
May-11	95%
Jun-11	95%
Jul-11	95%
Aug-11	95%
Sep-11	95%
Oct-11	95%
Nov-11	95%
Dec-11	95%

18 Weeks RTT: Non admitted Performance

<b>Month of treatment</b>	<b>Borders</b>
Apr-10	80%
May-10	80%
Jun-10	82%
Jul-10	84%
Aug-10	84%
Sep-10	85%
Oct-10	87%
Nov-10	89%
Dec-10	90%
Jan-11	90%
Feb-11	92%
Mar-11	92%
Apr-11	93%
May-11	93%
Jun-11	94%
Jul-11	94%
Aug-11	94%
Sep-11	95%
Oct-11	95%
Nov-11	95%
Dec-11	95%

18 Weeks RTT: Non admitted Completeness

<b>Month of treatment</b>	<b>Borders</b>
Apr-10	55%
May-10	60%
Jun-10	65%
Jul-10	70%
Aug-10	75%
Sep-10	78%
Oct-10	82%
Nov-10	88%
Dec-10	92%
Jan-11	92%
Feb-11	93%
Mar-11	95%
Apr-11	95%
May-11	95%
Jun-11	95%
Jul-11	95%
Aug-11	95%
Sep-11	95%
Oct-11	95%
Nov-11	95%
Dec-11	95%

New outpatients: Maximum 12 weeks from referral

<b>As at month end</b>	<b>Borders</b>
Apr-09	0
May-09	0
Jun-09	0
Jul-09	0
Aug-09	0
Sep-09	0
Oct-09	0
Nov-09	0
Dec-09	0
Jan-10	0
Feb-10	0
Mar-10	0
Apr-10	0
May-10	0
Jun-10	0
Jul-10	0
Aug-10	0
Sep-10	0
Oct-10	0
Nov-10	0
Dec-10	0
Jan-11	0
Feb-11	0
Mar-11	0

## Inpatients &amp; Day Cases: Maximum 9 weeks

<b>As at month end</b>	<b>Borders</b>
Apr-09	63
May-09	31
Jun-09	27
Jul-09	23
Aug-09	38
Sep-09	33
Oct-09	75
Nov-09	50
Dec-09	26
Jan-10	49
Feb-10	22
Mar-10	0
Apr-10	0
May-10	0
Jun-10	0
Jul-10	0
Aug-10	0
Sep-10	0
Oct-10	0
Nov-10	0
Dec-10	0
Jan-11	0
Feb-11	0
Mar-11	0

**A11: 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. By December 2010, 90% of clients referred to drug treatment will receive a date for assessment that falls within 4 weeks of referral received and 90% of clients will receive a date for treatment that falls within 4 weeks of their care plan being agreed**

NHS BORDERS LEAD:	Ralph Roberts – Director of Integrated Health Services
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**Delivery**

Risk	Management of Risk
<p><b>Referral pathways:</b> These are currently in place in the form of a referral flowchart. Further work is required to develop a formal Integrated Care Pathway to ensure the inclusion of recent service developments and the adoption of 'recovery' as the context for future service development and provision.</p>	<p>This is to be discussed at the ADP and Commissioning Subgroup and will be a priority action for early 2010-11.</p> <p>Initial work on developing an ICP has commenced.</p> <p>This has been recognised as a whole outstanding area that requires to be mapped out. This is not likely to be as complex as some of the ICPs we are in the midst of developing for MH conditions; one difference being the volume and nature of service delivery against this pathway by the 3<sup>rd</sup> sector. Therefore this work should move quickly.</p>
<p><b>Data Collection systems:</b> Staff from drug 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.</p> <p>This system is embedded into normal working practice within the services and ADP.</p> <p>The current data collection system does not wholly support the delivery of the full RTT target (due date March 2013)</p>	<p>The ADP Support Team will raise this with service providers to identify contingency plans.</p> <p>This is a national issue, and at Jan 2010 SG indicated that a new fit for purpose database will be in place by April 2011, with currently available interim solutions being sustained till then.</p>
<p><b>Quality Assurance procedures:</b> 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.</p> <p>Risk: Due to the complexity of the process data quality has at times been inadequate with some services not completing the spreadsheets accurately.</p>	<p>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.</p> <p>Currently ISD are implementing an audit on the most recent raw data, to try and identify where the biggest quality problems lie.</p> <p>The ADP Support Team has already completed an audit of local data (January 09). This includes the 5 services who submit information (Castle Craig Hospital, Huntlyburn House, BCAT, Big River Project, and Face2Face). This process identified several issues which have since been discussed with services, ensuring they receive training and support to complete their spreadsheets accurately.</p>

**Workforce**

Risk	Management of Risk
<p><b>Training:</b> ISD provide training and support to the ADP's. There was a risk that this work could not be achieved as only one ADP staff member was trained.</p>	<p>This has already been addressed by cascading training within the ADP Support Team to another member of staff.</p>

**Finance**

Risk	Management of Risk
<p><b>Drug service allocation:</b> 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).</p> <p>Risk: This posed challenges for services in offering timely assessment appointments for an increasing number of new referrals.</p> <p><b>Primary Care:</b> In addition, few GPs are engaged in providing a service for problem drug users (will refer to BCAT for assessment and treatment but not take patients back to monitor once stabilised on treatment programmes). This results in a delay in new users being able to be seen.</p> <p>The Social Work Dept. has been providing social worker support to BCAT clients but continued funding for this remains under threat.</p>	<p>ADP was notified earlier in 2008 of an increase of 14% over 3 years. Together with the expansion of services resulting from increased alcohol funding (BCAT works with drug and alcohol problems), this will increase capacity of services and should result in reduced waiting times.</p> <p>BCAT has already 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). NHS Borders aim to look at how to develop this as part of an integrated service (Shared Care).</p> <p>ADP is currently meeting with the Social Work Dept. to negotiate the continued provision of social worker support to BCAT. This support helps to maintain stable users, allowing CPNs to assess new referrals more promptly.</p>

**Improvement**

Risk	Management of Risk
<p>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.</p> <p>Risk: Waiting times for services vary across the sectors, but remain highest within the statutory service (BCAT) due to problems outlined in the 'Finance' section.</p>	<p>As above, ADP has already agreed to prioritise the development of an Integrated Care Pathway to increase access, reduce waiting times and improve quality of services. This will need to incorporate the recovery model underpinning the new national drug strategy.</p> <p>The ADP Commissioning Group recently commissioned a review of clients needs against service provision, and also plans to develop a health and social care strategy on drug and alcohol issues. The review report is being discussed, adopted and finalised by commissioners and providers before being shared with the wider stakeholder group.</p>

Governance and accountability arrangements across the services	Governance and accountability arrangements are to be further refined as the new ADP arrangements become embedded during 2010.
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### Equalities

Risk	Management of Risk
	<ul style="list-style-type: none"> <li>▪ All HEAT targets should be equality impact assessed to identify positive and negative impacts on equality groups</li> <li>▪ NHS Borders must adopt fully the equality impact assessment process</li> <li>▪ NHS Borders must adopt the interpretation and translation policy to ensure that staff are supported and patient care and safety is improved</li> <li>▪ Implementation of equality monitoring and patient record markers will support referral, treatment and care</li> <li>▪ 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</li> </ul>

### Trajectory

#### Referral to Assessment Date Offered

As at month end	Borders
Jun-09	87%
Jun-10	87%
Sep-10	90%
Dec-10	90%

#### Assessment End to Treatment Date Offered

As at month end	Borders
Jun-09	94%
Jun-10	98%
Sep-10	100%
Dec-10	100%

**A12: By March 2013 no one will wait longer than 26 weeks from referral to treatment for specialist CAMHS services.**

**During 2010/11 the Scottish Government will work with NHS Boards to develop an access target for psychological therapies for inclusion in HEAT in 2011/12.**

NHS BORDERS LEAD:	Ralph Roberts – Director of Integrated Health Services
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**Delivery**

<b>Risk</b>	<b>Management of Risk</b>
<p>ADHD Service. The waiting list for this service has reduced overall due to the application of non-recurrent resources.</p> <p>There is a potential risk regarding continued and sustainable improvements if this injection is not repeated.</p>	<p>Non recurrent waiting list monies have been secured for 0.26WTE Associate Specialist and 0.47 WTE CPN from end of December 2008. The impact of this to date (Dec 09) has been to reduce the waiting list to 5 patients waiting over 26 weeks. It is recognised that this is a short-term solution in that it tackles the immediate waiting list issue but moves an additional 24 patients requiring ongoing review as per SIGN guidelines to the existing 70 patients who are currently on the ADHD review list, an increase of some 34%.</p> <p>Development of robust integrated working with CAMHS, Children’s LD Service and Child Health through a Neurodevelopment approach. A multiagency working group has recently been set up to investigate this model for the Borders. Scoping out a bid for recurrent waiting list monies to fund an additional CPN post within CAMHS who along with the existing CPN’s would do non medical prescribing and would input hours to the ADHD team thus helping to embed ADHD into CAMHS as per Neurodevelopment model and move away from project funded team approach</p>
<p>Ongoing capacity issues are likely to impact on the ability to fully implement the relevant SIGN guidelines. Borders CAMHS is currently under resourced according to the 0-16 framework</p>	<p>NHS Borders is working on clearer pathways for developmental disorders and on training nurse prescribers</p>
<p>Expanding the service to include the expected upper age of 18</p>	<p>A local strategic group has been established to consider what a model of service would look like for a service up to 18. This will include workforce and financial considerations</p>

**Workforce**

<b>Risk</b>	<b>Management of Risk</b>
<p>Relatively small changes in workforce (e.g. sickness, maternity leave etc) could have significant impact on waiting times for generic CAMHS referrals</p>	<p>A local strategic group has been established to consider workforce and financial considerations</p>

**Finance**

<b>Risk</b>	<b>Management of Risk</b>
Financial implications associated with any agreed additional staffing.	A local strategic group has been established to consider workforce and financial considerations

**Improvement**

<b>Risk</b>	<b>Management of Risk</b>
Introduction of 18 week referral to treatment target for CAMHS in 2010	Work ongoing nationally regarding CAMHS remit and referral criteria

**Equalities**

<b>Risk</b>	<b>Management of Risk</b>
	<ul style="list-style-type: none"> <li>▪ All HEAT targets should be equality impact assessed to identify positive and negative impacts on equality groups</li> <li>▪ NHS Borders must adopt fully the equality impact assessment process</li> <li>▪ NHS Borders must adopt the interpretation and translation policy to ensure that staff are supported and patient care and safety is improved</li> <li>▪ Implementation of equality monitoring and patient record markers will support referral, treatment and care</li> <li>▪ 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</li> </ul>

**Trajectory**

<b>As at month end</b>	<b>Borders</b>
Mar-09	9
Apr-09	9
May-09	9
Jun-09	9
Jul-09	9
Aug-09	9
Sep-09	9
Oct-09	9
Nov-09	4
Dec-09	4
Jan-10	4
Feb-10	4
Mar-10	4
Jun-10	4
Sep-10	4
Dec-10	2
Mar-11	2

Jun-11	2
Sep-11	2
Dec-11	0
Mar-12	0
Jun-12	0
Sep-12	0
Dec-12	0
Mar-13	0

## Section 5: Treatment Appropriate to Patient

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Treatment Appropriate to Patient	
<b>T6</b>	To achieve agreed reductions in the rates of hospital admissions and bed days of patients with primary diagnosis of COPD, Asthma, Diabetes or CHD, from 2006/7 to 2010/11
<b>T8</b>	Increase the level of older people with complex care needs receiving care at home
<b>T9</b>	Each NHS Board will achieve agreed improvements in the early diagnosis and management of patients with a dementia by March 2011
<b>T10</b>	To support Shifting the Balance of Care NHS Boards will achieve agreed reductions in the rates of attendance at A&E.
<b>T11</b>	To reduce all <i>staphylococcus aureus</i> bacteraemia (including MRSA) cases by 30% by 31 March 2010 and to achieve a further reduction in cases of 15% by 31 March 2011; to reduce the rate of <i>Clostridium difficile</i> infections in patients aged 65 and over by at least 30% by 31 March 2011.
<b>T12</b>	By 2010/11, NHS Boards will reduce the emergency inpatient bed days for people aged 65 and over, by 10% compared with 2004/05

Please note: HEAT target numbering is sequential from 2008/09 onwards

**T6: To achieve agreed reductions in the rates of hospital admissions and bed days of patients with primary diagnosis of COPD, Asthma, Diabetes or CHD, from 2006/7 to 2010/11.**

NHS BORDERS LEAD:	Ralph Roberts – Director of Integrated Health Services
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### Delivery

Risk	Management of Risk
<p>Although data recording and collection has improved, locally there are still some anomalies across all care settings.</p> <p>There may be some differences in the figures for population size being used for national vs local data measurement.</p>	<p>Work is ongoing to identify and eradicate national vs. local data anomalies. The national links have improved but work continues to identify and improve local anomalies across community and local authority.</p>
<p>Lack of capacity in GP practices and wider PHCTs to engage and participate in terms of reduction of admissions</p>	<p>Ongoing support through a number of Enhanced Services and engagement with Primary &amp; Community Services and Scottish Borders Council colleagues. Recent development of a anticipatory care/HEAT target focused enhanced service with all; GP practices participating – start date 1/1/10, involving care planning for patients with chronic disease and housebound/care home patients. Includes protocols to minimise admissions e.g. patient specific plans for end of life care, outpatient DVT and low risk pulmonary embolus protocols</p> <p>Current programme of visits by Associate Medical Director to every practice 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.</p>
<p>Lack of consistency and sustainability of engagement and participation of Secondary Care in terms of reduction of occupied bed days.</p>	<p>This has improved but support will be ongoing and includes engagement with Primary &amp; Community Services and Scottish Borders Council colleagues.</p> <p>Integrated Health Strategy and Productivity and Benchmarking work locally has focused on providing data and engagement for clinicians to review individual practice.</p> <p>Work undertaken through Continuous Improvement (including Lean redesign) designed to engage clinicians in delivering change to reduce length of stay</p>
<p>Delay in development of and access to self-management programmes and processes and the culture shift / awareness required of patients and carers to actively participate.</p>	<p>Ongoing involvement of individuals, carers and voluntary organisations in the design and development of self-management programmes. Expansion of “<i>Borders Health in Hand</i>” website to support self-management. Public awareness raising in terms of active self-management and lifestyle management. Introduction of telehealthcare home-monitoring project. Anticipatory care planning, generic crisis-management and condition-specific care plans. Staff training &amp; education.</p>
<p>COPD Pulmonary Rehabilitation has now been developed and is currently being evaluated but is funded non-recurrently. If this programme is not resourced and continued, there is a risk</p>	<p>The COPD Pulmonary Rehabilitation programme is being trialled and evaluated. A COPD Scottish Enhanced Service has been established to support an integrated and improved approach to delivery.</p>

<p>of increased but avoidable hospital admission and high demand on both primary and secondary care. Most, if not all other mainland Boards provide pulmonary rehabilitation.</p>	
<p>Supporting the ongoing training &amp; education requirements across primary care and managing increased demands on specialist services is also an issue in diabetes and CHD, with increasing capacity issues for consultants, specialist nursing teams and support services such as laboratory services. Lack of investment of recurring resources will mean that progressing some areas of work and development of new services will be difficult.</p>	<p>The Diabetes MCN, CHD MCN and Respiratory MCN continue to work to address these issues and have developed modules of a supportive LTC training &amp; education programme. All five MCNs work jointly to address common issues e.g. skill-mix, redesign of services etc.</p> <p>Lean redesign in key areas will assist in eradicating waste and creating enhanced capacity</p>

### Workforce

<b>Risk</b>	<b>Management of Risk</b>
<p>Lack of ongoing resources to deliver and support participation in training &amp; education programmes as described plus the cost of supporting clinical backfill. It can be difficult for General Practice to release staff as they are often single handed posts with no cover. This also applies in some of the community services and has implications for frequency and timing of CPD and education sessions.</p>	<p>Some aspects of support for participation in training &amp; education programmes have been incorporated within Enhanced Services and within the auspices of TIME. The Enhanced Services support is dependent upon ongoing inclusion within the relevant conditions applied during the time span of each Enhanced Service</p>

### Finance

<b>Risk</b>	<b>Management of Risk</b>
<p>Building capacity into consultant work plans (e.g. to support Lead Clinician roles for the MCNs) and into existing roles across all involved services carries a resource implication which must be managed in terms of managing conflicting priorities, difficult decisions around ceasing some elements of service provision or support with additional investment.</p>	<p>Redesign of Managed Clinical Networks to reduce management load for lead clinicians</p> <p>Guidance will be sought locally to determine strategic overview and prioritisation.</p> <p>Identification of additional funding sources.</p> <p>Continuation of resources through ongoing inclusion within Enhanced Services.</p>

### Improvement

<b>Risk</b>	<b>Management of Risk</b>
<p>Lack of availability of robust data across all care settings. There may be some differences in the figures for population size being used for national vs local data measurement</p>	<p>Work is ongoing to identify and eradicate national and local data anomalies.</p>

<p>The achievement of the reduction of admissions element of the T6 HEAT target is reliant upon engagement and involvement of colleagues and services across all care settings, but especially within Primary and Community Services and Local Authority. If this does not happen, then achievement of the target is at risk.</p>	<p>Ongoing discussion and support at CHCP level and within the Strategic Change programme, Integrated Health Strategy to ensure “whole system” responsibility</p> <p>Ongoing discussion and support through P&amp;CS and inclusion in Enhanced Services.</p> <p>Lean approach to redesign potentially provides a vehicle for direct engagement across whole system</p>
<p>The achievement of the reduction of bed stays element of the T6 HEAT target is reliant upon engagement and involvement of colleagues and services across all care settings, but especially within Secondary Care and their links with Primary and Community Services and Local Authority. If this does not happen, then achievement of the target is at risk.</p>	<p>Ensure robust engagement and involvement of colleagues and services across all care settings, but especially within Secondary Care and their links with Primary and Community Services and Local Authority. The Strategic Change Programme forms the framework for this process.</p> <p>Lean approach to redesign potentially provides a vehicle for direct engagement across whole system</p>

## Equalities

Risk	Management of Risk
<ul style="list-style-type: none"> <li>▪ All HEAT targets should be equality impact assessed to identify positive and negative impacts on equality groups</li> <li>▪ NHS Borders must adopt fully the equality impact assessment process</li> <li>▪ NHS Borders must adopt the interpretation and translation policy to ensure that staff are supported and patient care and safety is improved</li> <li>▪ Implementation of equality monitoring and patient record markers will support referral, treatment and care</li> <li>▪ 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</li> </ul>	

## Trajectory

Year ending	Borders
2006/07	11433
2007/08	11008
2008/09	10809
2010/11	10290

**T8: Increase the level of older people with complex care needs receiving care at home.**

NHS BORDERS LEAD:	Ralph Roberts – Director of Integrated Health Services
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**Delivery**

Risk	Management of Risk
<p>Interdependency between Social Work &amp; Health to keep older people safe in their own home is dependent upon sufficient resources i.e. staffing, equipment, finance and carer support.</p>	<p>Utilise 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.</p> <p>Anticipatory Social Care planning process developed and incorporated within Palliative Care DES</p> <p>Intermediate Care Demonstrator Programme – interagency approach to support rehabilitation, enablement and self-management to support people to remain at home wherever possible. Includes out-of-hours crisis support for people with dementia to maintain them at home rather than admitting to hospital.</p> <p>Telehealth project based around home monitoring as part of wider Telehealthcare programme through joint resources from Scottish Government allocation.</p>
<p>Shared vision of key deliverables within health and social care</p>	<p>Local Single outcome agreement includes this heat target. Joint CHCP Planning and Delivery committee will oversee delivery of this element of SOA.</p> <p>Establishment of interagency Primary &amp; Community Care Partnership Board to oversee aligned budgets linked with supporting timely discharge, supporting people to remain at home etc.</p> <p>Links are also being established between targets where there are acknowledged overlaps. Discussions are underway regarding a more coordinated approach to target management both within NHS Borders and with partners.</p>
<p>Inadequate or poorly supported informal carers resulting in admissions for “social” or care reasons</p>	<p>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.</p> <p>Intermediate Care Demonstrator Programme will support Carers Information Worker post and will enable carers support groups to be established within the two localities. One element of the programme is aimed at out-of-hours crisis support for people with dementia which will reduce admission for “social care” reasons when the informal carer becomes unexpectedly indisposed.</p>
<p>Clinical leadership in particular GP engagement in this agenda as a result of the constraints of independent</p>	<p>Designated clinical leadership within Clinical Boards and specific services. Establishment of Anticipatory Care &amp; Prevention of Admissions in Long Term Conditions LES</p>

contractual arrangements with GP	which incorporates support to housebound patients and those within care homes and also requires nominated GP lead contact for telehealthcare.
Demographics in Borders already show higher than average over 65 population and predicted future changes will show this to increase further	Strategic Change Programme progressing using identified baseline and projections to plan future service provision and redesign. Productivity & Benchmarking information being used proactively across GP practices to inform this agenda.

**Workforce**

<b>Risk</b>	<b>Management of Risk</b>
Capacity across primary care and community services to support the shift in the balance of care	Contingency planning which will incorporate service redesign, skill mix
Out-of hours crisis support	Anticipatory Care planning for individuals with complex needs including risk assessment

**Finance**

<b>Risk</b>	<b>Management of Risk</b>
Cost of care package.	Establish cost of care package between Care Manager and other agencies identifying any potential cost attached to the contingency plan
Access to joint resources	Primary & Community Care Partnership Board established to oversee current and future commitments against aligned and pooled resources

**Improvement**

<b>Risk</b>	<b>Management of Risk</b>
Development of care pathways and redesign of existing systems may require resources or service redesign.	<p>Monitor complex care packages through the Primary &amp; Community Care Partnership Board each month.</p> <p>Telehealth project based around home monitoring.</p> <p>Anticipatory Care LES established.</p> <p>LEAN redesign programme which incorporates discharge, community services, specific care pathways etc.</p>
Co-ordination of agencies to minimise risk to the individual.	SSA should reflect the level of risk to the continuation of the treatment/social plan and establish the action required to ensure the safety of the individual.

**Equalities**

<b>Risk</b>	<b>Management of Risk</b>
Recognise cultural diversity; gender; sexual orientation when putting care package into place	Equality and diversity team will support NHSB and SBC staff

## Trajectory

<b>As at</b>	<b>Borders</b>
Mar-03	26%
Mar-04	27%
Mar-05	28%
Mar-06	28%
Mar-07	26%
Mar-08	26%
Mar-09	29%
Mar-10	30%
Mar-11	31%

**T9: Each NHS Board will achieve agreed improvements in the early diagnosis and management of patients with a dementia by March 2011.**

NHS BORDERS LEAD:	Ralph Roberts – Director of Integrated Health Services
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**Delivery**

Risk	Management of Risk
<p>Meeting this target is dependent on actions taken by GPs who are independent contractors – there is a helpful incentive through the QOF around identifying people with dementia.</p>	<p>Local MH Collaborative colleagues and NHS Borders Service Improvement are working with Primary and Community Services, Mental Health Services, Social Care and the voluntary sector to strengthen existing approaches and develop new ways of joint working that will identify those individuals with dementia and ensure access to appropriate support.</p>
<p>There is a risk around the specialist services capacity to support primary care with early diagnosis and support and additional, previously unmet needs, will need to be met by partner agencies including social work and the voluntary sector.</p>	<p>NHS Borders is currently piloting Primary Care Guidelines for the detection of dementia. New ways of working are also being tested with primary and specialist services. In addition, the development of the ICP for dementia will ensure that there is a clear pathway for individuals with dementia at different stages of their illness.</p> <p>Whilst developing new ways of working, the specialist service will be commencing improvement work looking at demand and capacity to help identify new ways of working.</p> <p>In addition, NHS Borders has recently appointed a Clinical Psychologist for the Mental Health for Older Adults Service which will facilitate the development of the necessary plans to achieve this target, by supporting Primary care diagnosis at an earlier stage.</p> <p>Experience emanating from the Poynder View service pilot will be shared further across the Borders to ensure fit for purpose approaches in such collaboration.</p>
<p>There is a risk that older adult readmission rates will increase due to the significant projected increase in numbers of individuals with dementia if community resources are not able to cope with the increased demand.</p>	<p>This risk will be managed by the aforementioned risk management strategy.</p> <p>The implementation and role out of improved ways of working will increase capacity to identify and support people. This will identify developing crises early and prevent admission and enable more active support following discharge.</p> <p>We have a Dementia Nurse Specialist in post, financially supported by Alzheimer Scotland, with the remit of enhancing the skills of hospital staff. The post role also includes promoting effective discharge with the dementia population with a clear link to reducing readmission.</p>

**Workforce**

<b>Risk</b>	<b>Management of Risk</b>
<p>In early dementia the main pressures for workforce will be specialist services supporting primary care in the diagnosis of dementia, especially where this is initially unclear. Initiating and monitoring drug prescriptions for the specialist service will be an issue, and with social work and the voluntary sector to meet care needs.</p>	<p>New primary care guidelines being developed and piloted. Training/educational sessions to support the roll-out of these will be put in place.</p> <p>Best practice evidence and experience from elsewhere needs considered to explore opportunities for role redesign/working differently in response to this risk.</p> <p>The evolution of existing working practices will enable existing resources to continue to maintain effective monitoring of drug prescriptions with a higher dementia population.</p>
<p>Shifting the balance of care for early dementia will result in individuals being admitted to hospital being those with more complex needs. Specialist services will need to have highly skilled staff to meet the needs of these individuals.</p>	<p>Training Strategy to include training for all levels of dementia care.</p> <p>Successful training across multi-agencies to an agreed standard will enhance the ability to use resources more effectively.</p> <p>As stated, we have a Dementia Nurse Specialist in post, whose role is to enhance the skills of hospital staff to work effectively with people with a dementia regardless of that person's level of need.</p>
<p>There is a significant training programme required to ensure all staff working with older adults have appropriate skills to work with people with dementia. Borders has developed a Dementia Training Strategy to identify which staff should be skilled to what level.</p>	<p>Uptake of training needs to be monitored through relevant mechanisms.</p> <p>Methods of evaluating the effects of training on service delivery need to be developed.</p> <p>As stated above, successful training across multi-agencies to an agreed standard will enhance the ability to use resources more effectively.</p> <p>A multi-agency best practice network is in place to identify and disseminate good practice across all active partners in care.</p>

**Finance**

<b>Risk</b>	<b>Management of Risk</b>
<p>There are financial risks attached to the potential increased prescribing of drugs for dementia This financial pressure will sit within Health.</p>	<p>The ability to meet this target is partially dependent on the redesign of services/financial investment to enable increased support to those in the early stages of dementia.</p>

**Improvement**

<b>Risk</b>	<b>Management of Risk</b>
Key risk to sustainable improvement is the co-dependency on partner agencies to deliver this target and subsequent sustaining of QOF dementia registers.	<p>As above, this area of risk is best responded to by firstly securing a fuller understanding of the size and nature of the challenge faced by better diagnosis and identification. NHS Borders is working with our partners to develop a whole system approach and new ways of working – early work is showing positive results.</p> <p>This includes working in-partnership with Alzheimer Scotland who have funded a Dementia Nurse Specialist for three years.</p>

**Equalities**

<b>Risk</b>	<b>Management of Risk</b>
Development of training to recognise and build in domestic abuse agenda to dementia training strategy and equality and diversity	Equality and diversity team, domestic abuse training facilitator will support the training
Risk that access to specialist services is not equitable as a result of pivoting a new service delivery model within eastern Borders.	NHSB is considering a fuller role out of this pivot approach Borders wide following appropriate service evaluation.

**Trajectory**

<b>Year ending</b>	<b>Borders</b>
Mar-07	595
Mar-08	586
Mar-09	592
Mar-10	791
Mar-11	995

**T10: To support shifting the balance of care, NHS Boards will achieve agreed reductions in the rates of attendance at A&E.**

NHS BORDERS LEAD:	Ralph Roberts – Director of Integrated Health Services
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**Delivery**

Meaningful and robust reporting requirements need to be identified due to the variety of systems used to capture data. Funding has not been approved to support the introduction of an appropriate IT system.	Interrogation of existing data collection and reporting processes in conjunction with patient flow audits in A&E and MIUs have identified the local anomalies and work is ongoing to establish work around information capture system
Working across the whole system to raise the profile of this target and support a culture shift across healthcare professionals.	<p>T10 Project Board established which includes membership from primary and secondary care.</p> <p>Education &amp; awareness raising across care sectors and teams to update on A&amp;E processes, build on existing expertise and introduce standardised clinical guidelines &amp; protocols.</p> <p>LEAN programme has been undertaken within the Medical Assessment Unit. This has impacted positively on flow through A&amp;E. Work will continue to build upon this.</p> <p>Liaison with surgical and orthopaedic services to develop appropriate service redesign.</p> <p>Associate Medical Director currently visiting all GP practices and discussing A and E referral rates, walk in rates and raising profile of minor injury enhanced service. Challenging practices around daytime access to ensure immediate access for minor injury patients.</p>
Variation in approach across MIUs and the links with A&E	Patient flow & profile audits carried out in A&E and MIUs. Outcomes will inform standardisation of approach and redesign.
Changing patient behaviour/education of patients is challenging and requires a cultural shift.	Development of appropriate awareness raising process. Promotion of self-management approaches and anticipatory care plans. Use of crisis-management sheets.

**Workforce**

<b>Risk</b>	<b>Management of Risk</b>
Review of Minor Injury Units (MIUs) in line with patient flow audit outcomes and the links with treatment rooms and A&E. Consideration of maintenance of skill levels across staff groups.	Appropriate protocols and guidelines. Appropriate training & education programme. Robust links across staff groups & consideration of staff rotation opportunities.
The GP role within A&E was developed to support the delivery of the Emergency Access Target. This role is now well established and there is a risk	Development of appropriate awareness raising process for the public and for referring professionals.

that patients attend A&E because it is known that a GP will be present.	
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### Finance

Risk	Management of Risk
Dedicated resource not identified to support appropriate IT data collection system.	Consideration within financial planning process. Ongoing discussion with national EADT

### Improvement

Risk	Management of Risk
Delivering sufficient levels of improvement as required by NEADT	Action plan and internal trajectories developed and in place.  Developing flowmap of activity to help address critical paths
Interdependencies with other specialties / departments within BGH	LEAN programme in MAU, Discharge process. Initiatives within surgical and orthopaedic services.

### 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	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

### Trajectory

Month	Borders
Mar-09	2,127
Apr-09	2,004
May-09	2,045
Jun-09	1,941
Jul-09	1,970
Aug-09	2,057
Sep-09	1,895
Oct-09	1,815
Nov-09*	1,774
Dec-09	1812
Jan-10	1778
Feb-10	1778
Mar-10	1778
Apr-10	1910
May-10	1910
Jun-10	1910
Jul-10	1889
Aug-10	1889
Sep-10	1889
Oct-10	1776
Nov-10	1776

Dec-10	1776
Jan-11	1742
Feb-11	1742
Mar-11	1742

\* Actual activity recorded to November 09

**T11: To reduce all *staphylococcus aureus* bacteraemia (including MRSA) cases by 30% by 31 March 2010 and to achieve a further reduction in cases of 15% by 31 March 2011; to reduce the rate of *Clostridium difficile* infections in patients aged 65 and over by at least 30% by 31 March 2011.**

NHS BORDERS LEAD:	Sheena Wright Director of Nursing & Midwifery
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## Delivery

Risk	Management of Risk
Current trends suggest that the target may not be met. A failure to meet the Board's SAB target for March 2010 will result in a more challenging baseline from which to meet the 2010/11 target of a 15% reduction by 2011.	<p>A paper has been presented outlining the specific actions proposed to manage the SAB's, based on detailed review of all cases had to date. Owing to the increase we have seen in SAB's in recent months, a number of actions are being put into place to reverse this trend.</p> <p>These actions are currently being commenced.</p> <ul style="list-style-type: none"> <li>• Enhanced monitoring of all SAB's using recently provided tool</li> <li>• Audit of all b/c's to monitor contamination</li> <li>• Use of care bundles</li> <li>• Line insertion/care education.</li> <li>• Hospital wide SAB 'countdown' in addition to ward based countdowns.</li> </ul>
There is a risk that work on the national roll out of the MRSA screening programme will result in a lack of focus on other types of HAI, including MSSA bacteraemias and <i>Clostridium difficile</i> infections	We are using the MRSA roll out as an opportunity to increase focus on all HAI, as SAB's are one of the performance indicators for the MRSA screening.
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 <i>Clostridium difficile</i> in hospital and primary care settings.	Our surveillance is pan board, taking in both primary and secondary care, meaning we know which infections are HAI and which are non health care related so that resources can be targeted appropriately.
There is a risk that a failure to implement the three supporting antimicrobial indicators related to prescribing as detailed in CEL 11(2009) will adversely impact on the boards ability to reduce <i>Clostridium difficile</i> .	<p>There is now an Antimicrobial Pharmacist for NHS Borders in post, working closely with the Consultant Microbiologist as part of the Antimicrobial Management Team.</p> <p>There is also an antimicrobial lead nurse. All prescribing indicators are being audited as recommended.</p>
There is a risk that competing priorities and lack of time and resources do not allow staff to fully investigate cases of SAB and <i>Clostridium difficile</i> (through tools such as Root Cause Analysis or the CDI Severe Case Investigation Tool) results in a lack of understanding	<p>All cases of SAB have full detailed review. The new SAB template draft is being used and comments will be submitted to HPS.</p> <p>All cases of C diff also have full investigation. Both of these are provided within our existing resource.</p>

<p>of where best to target interventions.</p>	
<p>There is a risk that care bundles aimed at reducing SABs and <i>Clostridium difficile</i> will not be rolled out in the most appropriate way with which to achieve the biggest impact.</p>	<p>The enhanced surveillance we have done means that we know which areas to target in order to achieve maximum impact.</p>
<p>There is a risk of a lack of business continuity for Infection Control Teams (i.e. through staff leaving or moving posts).</p>	<p>There has been a reduced capacity within the infection control team due to retirement and staff vacancies. However, permanent appointments have now been made for Consultant microbiologist and IC Manager/Lead ICN. Advertisement has gone out for permanent ICN and further recruitment is in process to support the ICM role.</p>
<p>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)</p>	<p>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 Occupation Health</p>
<p>There is a risk that there is a lack of ownership for the prevention and control of infection at all levels in the organisation</p>	<p>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.</p>
<p>There is a risk that there is a lack of clear leadership for infection prevention and control within the board.</p>	<p>We have a designated lead for IP&amp;C at the board (Director of Nursing) providing this leadership. There is strong support for all aspects of IP&amp;C from the board in general, including from the CE and Medical Director.</p>
<p>There is a risk that short term focus on targets will not result in sustainable improvement.</p> <p>There is a risk that initial excellent progress against <i>C difficile</i> is not sustained.</p>	<p>We have fully signed up to the iiiP programme (Including the newly appointed Consultant Microbiologist who has attended the first learning session)</p> <p>We will use the ongoing input from this group to help ensure long term sustainability. Members of the iiiP will visit NHS Borders on the 27<sup>th</sup> May 2010.</p> <p>Infection rates will be consistently monitored by our ongoing robust surveillance techniques already in place.</p>
<p>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.</p>	<p>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.</p>
<p>An ICT action plan and Hand Hygiene action plan is in place and coordinating with the NHS Borders arm of the Patient Safety Initiative to deliver reductions in all HAI including <i>Staph aureus</i> bacteraemias (SABs). MRSA screening is in place and being extended to include all new patient admissions.</p>	<p>Although each individual case is examined by the ICT, Health Protection Scotland (HPS) has acknowledged that the current nationally approved method of presenting reduction rates are not viable for NHS Borders due to the small numbers involved, especially on a monthly basis. However, HPS have assisted us with the development of an alternative, more suitable method of presenting control limits and reduction rates.</p>

<p>There is now an Antimicrobial Pharmacist for NHS Borders in post, working closely with the Consultant Microbiologist as part of the Antimicrobial Management Team.</p>	
<p>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.</p>	<p>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. I am not aware of any community based screening protocol that would pre-empt a community-acquired septicaemia.</p>
<p>The baseline average (2.5 cases per month) is already very low and minor fluctuations will cause major deviations from the trend line.</p>	<p>Risk to be tolerated. A series of measures have been introduced to ensure continuous improvement in this area and these include activities around the SPSP at ward level, PVC care bundles etc. Continuous education and training is in place and monitoring of infection control practice, including hand hygiene and IV therapy/cannulation.</p>
<p>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.</p>	<p>NHS Borders have been successfully adhering to this protocol since April 2009.</p>

**Workforce**

<b>Risk</b>	<b>Management of Risk</b>
<p>Universal MRSA screening is to be introduced by 31<sup>st</sup> January 2010, following pathfinder sites results. There will be significant implications for workload &amp; staffing.</p>	<p>Additional staffing requirements have been identified and funding of this will need to be considered.</p>

**Finance**

<b>Risk</b>	<b>Management of Risk</b>
<p>There are no additional implications arising from this target.</p>	<p>Infection Control Budgets and Hand Hygiene budgets are in place and are already targeted at HAI reduction. Resources identified, and have now been funded, no further risks identified.</p>
<p>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.</p>	<p>No significant resource implications have been made apparent (staff or reagents) since April 2009.</p>

**Improvement**

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

**Equalities**

<b>Risk</b>	<b>Management of Risk</b>
Communication campaign only available in English and not alternative formats	Work towards reaching deaf and hard of hearing staff, patients, and public
Hand hygiene gel contains alcohol and may offend certain cultures / religions/ faiths	Equality and diversity team will work with hand hygiene co-ordinator

**Trajectory**

*Staph aureus* Bacteraemia: 25% Reduction to Mar 2010; Further 15% Reduction Mar 2011

<b>Quarters</b>	<b>No. of SAB's / last 4 quarters</b>
Mar-06	30
Jun-07	31
Sep-07	27
Dec-07	35
Mar-08	36
Jun-08	38
Sep-08	39
Dec-08	35
Mar-09	36
Jun-09	32
Sep-09	25
Dec-09	24
Mar-10	23
Jun-10	22
Sep-10	21
Dec-10	20
Mar-11	19

*C. difficile* infections: at least 30% Reduction achieved between Apr 2010 – Mar 2011

<b>Quarters</b>	<b>No. of CDI's / last 4 quarters</b>
Mar-08	0.67
Sep-08	0.84
Dec-08	0.95
Mar-09	0.96
Jun-09	0.91
Sep-09	0.81
Dec-09	N/A
Mar-10	0.64
Jun-10	0.59
Sep-10	0.54
Dec-10	0.49
Mar-11	0.47

**T12: By 2010/11, NHS Boards will reduce the emergency inpatient bed days for people aged 65 and over, by 10% compared with 2004/05.**

NHS BORDERS LEAD:	Ralph Roberts – Director of Integrated Health Services
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**Delivery**

Risk	Management of Risk
<p>Availability of robust data across all care settings. There may be some differences in the figures for population size being used for national vs local data measurement.</p>	<p>The national links have improved but work continues:</p> <ul style="list-style-type: none"> <li>• To reduce the anomalies between national and local data</li> <li>• to identify and improve local anomalies across community and local authority.</li> </ul>
<p>Shared vision of key deliverables within health and social care</p>	<p>Local Single outcome agreement includes this heat target. Joint CHCP Planning and Delivery committee will oversee delivery of this element of SOA.</p> <p>Links are also being established between targets where there are acknowledged overlaps. Discussions are underway regarding a more coordinated approach to target management both within NHS Borders and with partners.</p>
<p>Interdependency between Social Work &amp; Health to keep older people safe in their own home is dependent upon sufficient resources i.e. staffing, equipment, finance and carer support.</p>	<p>Utilise 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 to be taken forward and evaluated in two locations. This will incorporate development of shared supportworker roles, third sector transport model and carer support programme and also crisis-management support for people with dementia.</p>
<p>Unpredictability of clinical presentation at any point in time may result in increase in demand / reason for longer bed stays.</p>	<p>“Anticipatory care planning and prevention of admission” Enhanced Service introduced</p> <p>Very robust whole system winter and festive period planning in place.</p> <p>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.</p> <p>Telehealthcare home-monitoring project to begin in one location in fourth quarter 2009 / 2010. It is anticipated that this will support reduction in admission, reduction in LOS, referrals to secondary care, reduction in GP consultations, reduction in domiciliary DN visits.</p> <p>A rolling LTC Training &amp; Education Programme for Primary Care services has been established with the involvement of the MCNs to support the shift in the balance of care.</p>

<p>Consistent approach to clinical management of in-patient cohort</p>	<p>P&amp;CS are currently negotiating new contract for GPs looking after Community Hospitals that will include focus on length of stay and patient pathways.</p> <p>Recent development of an anticipatory care/HEAT target focused enhanced service with all; GP practices participating – start date 01/01/10, involving care planning for patients with chronic disease and housebound/care home patients. Includes protocols to minimise admissions e.g. patient specific plans for end of life care, outpatient DVT and low risk pulmonary embolus protocols</p> <p>Current programme of visits by Associate Medical Director to every practice 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</p> <p>The MCNs are taking a key role in developing training and education processes across the in-patient settings.</p> <p>Lean redesign projects focused on delivering improvements to whole system LTC pathways (COPD, Heart Failure etc). This brings with it an approach to standardisation.</p>
<p>Consistent and timely approach once patient “fit” for discharge</p>	<p>Discharge transfer policy signed off by NHS Borders and Scottish Borders Community Health partnership in January 2009 with 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.</p> <p>LEAN Discharge programme agreed and beginning Jan 2010 across one acute ward and one community hospital.</p> <p>Pathway work being taken forward by MCNs e.g. COPD, Stroke.</p> <p>Development of a menu of intermediate care options which will support timely discharge.</p>
<p>Clinical leadership in particular GP engagement in this agenda as a result of the constraints of independent contractual arrangements with GP</p>	<p>Maximising opportunities of enhanced service funding</p> <p>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.</p>
<p>Inadequate or poorly supported informal carers resulting in admissions for “social” or care reasons</p>	<p>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 (applies to T8).</p>
<p>Demographics in Borders already show higher than average over 65 population and predicted future changes will show this to increase further</p>	<p>Strategic Change Programme has identified impact both on in patient and community of changing demographics Cross-sector discussions and planning within the will provide framework for specific actions.</p>

## Workforce

Risk	Management of Risk
<p>Ongoing resources to deliver and support participation in training &amp; education programmes linked with any changes in clinical practice, clinical guidelines and protocols.</p>	<p>Links with existing programmes and education processes involving NES, JIT, and enhanced services programmes for GPs.</p> <p>In addition, a rolling LTC Training &amp; Education Programme for Primary Care services has been established. Work is underway within the MCNs to develop a similar robust process in Secondary Care</p>
<p>Appropriate skill-mix and community services to support appropriate early discharge.</p>	<p>Primary &amp; Community Services (P&amp;CS) have reviewed community services and evaluated Community Healthcare Teams (CHT) to inform wider service redesign. The JIT Intermediate Care Demonstrator Programme and P&amp;CS Shifting the Balance of Care project will be support early discharge.</p> <p>Workforce strand of Strategic Change Programme focused on supporting development of improved skill-mix to support Shifting the Balance of Care</p>

## Finance

Risk	Management of Risk
<p>New Community Hospitals GP contract</p>	<p>Balance between ensuring value for money, efficiency saving and ensuring high standard of clinical care</p>
<p>Integrated resource framework</p>	<p>Already aligning budgets around intermediate care and pooled budget around delayed discharges).</p>

## Improvement

Risk	Management of Risk
<p>Alternative provision to admission e.g. intermediate care, community services input at home</p>	<p>The following actions are planned or underway to improve performance relating to the target:</p> <ul style="list-style-type: none"> <li>• The LTC agenda is linking significantly with the various LEAN redesign programmes underway and planned in Borders. The LEAN service redesign programme has been completed within the Medical Assessment Unit (MAU) which has contributed to improvements in the patient pathway and will impact on LOS. The LEAN Discharge programme is currently being implemented with a specific focus on reducing length of stay in an acute ward and a community hospital ward. This will subsequently be rolled out across inpatient facilities. LEAN pathway work in COPD and Stroke is planned and timetabled.</li> <li>• P&amp;CS are currently negotiating a new contract for GPs looking after Community Hospitals that will include a focus on length of stay and patient pathways in those settings.</li> <li>• An Anticipatory Care &amp; Prevention of Admission for people with Long Term Conditions Local Enhanced</li> </ul>

	<p>Service (LES) is in place across all Borders GP practices. This LES incorporates targets for anticipatory care planning for people with long term conditions including housebound patients or those living in care homes. In addition it requires practices to issue a generic crisis-management sheet to people with long term conditions, identify a named practice lead for telehealthcare and adhere to a redefined protocol for the management of DVT</p> <ul style="list-style-type: none"> <li>• Non bed-based Intermediate Care model resourced as part of a JIT Demonstrator programme will begin in March 2010 for 12 months. This will offer assessment and ongoing support post-discharge or to avoid admission and will also incorporate support for carers. It will be based in 2 day hospital locations and will involve day hospital services, community services, Social Work day services, Mental Health services, Red Cross, Carers Centre amongst others.</li> <li>• The Diabetes MCN has developed a comprehensive education and support programme for primary care and specifically practice nurses to enhance their skills and knowledge in supporting more people with diabetes in a primary care setting. This includes a secondment programme into secondary care and consolidation of patient education programmes, all of which enables the patient to be discharged in a more timely fashion from secondary care, or prevents hospital admission and supports self-management. The next phase of the education programme will be tailored to acute service staff to ensure that inpatient diabetes care is appropriate and supports people to be discharged in a timely fashion.</li> <li>• A Diabetes Local Enhanced Service is currently being drafted by the Diabetes MCN for a proposal to LNC. This will support patients to be cared for within community settings and will contribute to timely discharge and prevention of admission.</li> <li>• COPD Pulmonary rehabilitation programmes are now underway and rolling out across Borders. These will be evaluated and will report at the end of the 12 month programme. A COPD SES is in place which supports a coordinated use of anticipatory care and clinical care plans.</li> <li>• Jointly funded (health and social care) intermediate care project in a residential home now in second six months - early evaluation shows major impact and effectiveness in returning people to their own homes</li> </ul>
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	<ul style="list-style-type: none"> <li>• P&amp;CS Shifting the Balance of Care project to be implemented in one locality.</li> <li>• Self-management support being developed within the LTC agenda e.g. website (see below), self-management programmes, telehealthcare care options to enable people to remain at home or return to home wherever possible.</li> <li>• Work is ongoing to develop the next phase of “<i>Borders Health in Hand</i>”, the Long Term Conditions website to support staff training and education, expand the content and resources and develop an online interactive pathway.</li> <li>• Liaison with Local Authority, Voluntary Sector, individuals &amp; 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.</li> </ul>
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### Equalities

Risk	Management of Risk
	<ul style="list-style-type: none"> <li>▪ All HEAT targets should be equality impact assessed to identify positive and negative impacts on equality groups</li> <li>▪ NHS Borders must adopt fully the equality impact assessment process</li> <li>▪ NHS Borders must adopt the interpretation and translation policy to ensure that staff are supported and patient care and safety is improved</li> <li>▪ Implementation of equality monitoring and patient record markers will support referral, treatment and care</li> <li>▪ 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</li> </ul>

### Trajectory

Year ending	Borders
Mar-05	3605
Mar-06	3803
Mar-07	3870
Mar-08	3652
Mar-09*	3,817
Mar-10	3340
Mar-11	3250

\* Actual activity recorded to March 09

## Appendix 1

### SUMMARY OF MAIN WORKFORCE ISSUES FACING NHS BORDERS

The Local Workforce Plan 2009 set out our workforce planning priorities:

“Our objective over the next three years is to develop a Workforce Plan to ensure that we can provide an affordable, fit for purpose workforce, capable of delivering the required health services as determined in the Integrated Health Strategy – Your Health, Our Future.”

John Glennie  
Chief Executive, 2009

**In this year we have identified our 3 priorities to meet this objective:**

- **Support each of the clinical boards and support services to take forward outcomes of the Integrated Health Strategy.**
- Workforce numbers will need to reduce over the coming months to ensure sustainability of services across NHS Borders. This will be delivered through a combination of strict vacancy controls and some voluntary releases, within the realms of affordability.
- Consider Skill Mix review and Role Development through the application of the NHS Career Framework and KSF to further ensure sustainability of all services across NHS Borders. Given the pressures of the medical workforce, age distribution and a challenging financial environment, support managers through development of extended, advanced or new roles for non-medical solutions using the on-line toolkit when available.
- **Develop workforce-planning capabilities across NHS Borders and progress move towards more dynamic workforce planning.** Contribute to the development of workforce strategies, based on the research evidence available and commission research e.g. into potential modelling of future population service needs for specific specialties. Continue to roll out the Workload and Workforce Planning Educational Toolkits (Nursing and Midwifery and 6 steps methodology) to Service Managers and use accompanying toolkits (Workload Tools) to help inform decisions.
- **Improve data collection and reporting of Workforce Information and Pay Modernisation Benefits Evidence.** Further development of Quarterly Workforce Reports. Analyse trends and patterns of key workforce indicators such as age distribution, turnover rates, sickness absence trends and skill mix analysis (e.g. Christmas tree modelling). Preparation of an annual Pay Modernisation Benefits Delivery Plan, assisting with gathering evidence to demonstrate a return on investment in pay and conditions through productivity, service redesign and improved service for patients.

Workforce planning is a key element of strategic planning, and managing the changes taking place within the workforce, and the wider population, has been recognised as crucial if we are to secure the workforce we require to deliver services to the population of the Scottish Borders.

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

- NHS Borders has published a role development framework tool (this will be an on-line tool in future) to assist our service leads take forward implementation of new roles and extended roles when planning services under our Integrated Health Strategy. We recognize that role development and a revised skill mix is essential to deliver the services envisaged by the Integrated Health Strategy (e.g. increased prevalence of patient self management and intermediate care models);

- We would highlight the Health Care Support Worker role, including Acute and Community Services, Pharmaceutical Services, Maternity Care Assistants and Allied Health Professionals. NHS Borders is investing in the skills of the current Healthcare Support Workforce to pro-actively prevent gaps in the workforce. Maternity Care Assistants relevant to HEAT target H7;
- Extended roles e.g. Senior physiotherapists run their own clinics augmenting the medical support for orthopaedic clinics and successful extension of Radiographer reporting. – HEAT Target A10;
- Advanced roles e.g. Hospital at Night Practitioners and Paediatric/Neonatal Nurses undertaking Clinical Decision Making Module increase capacity and enhance sustainability;
- New roles for non-medical workforce solutions e.g. Physician Assistant (Anaesthesia) programme and Surgical Assistant;
- Specialist Nurses have developed anticipatory care plans for chronic disease management; this is successfully avoiding admissions and also providing early support of discharge HEAT target E4;
- Specialist nurse roles are consolidated within Cardiology, Diabetes, and Respiratory Medicine. Further development of ambulatory care, and development of criteria led discharges services are on-going. HEAT target A10;
- 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.

**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.

Possible Solutions: Hospital at Night models in Adult and Children's services, Consultant delivered services, role development of non medical staff, skill mix /role development review in Theatres.

**Mental Health** – need for a sustainable workforce given age distribution, need to remodel service plans for Older Adults with Functional Mental Illness and Rehabilitation Services for Mental Illness.

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

**Primary and Community Services** – sustainability of the traditional Nursing in the Community workforce model and remodelling of Community Hospital Services.

Possible Solutions: Modernising Community Nursing may lead to new models of care as well as new ways of working within community hospitals and in community settings.

## Appendix 2 Additional Local Commitments to support Single Outcome Agreements

	<b>HEALTH INEQUALITIES</b>		
<p>What are the priority local outcomes for tackling health inequalities?</p> <p>What are the underpinning indicators or targets that support the delivery of the outcome?</p>	<p><b>1.6.1 There is improved health and well-being of Borders residents (Strategic SOA )</b></p> <p><b>7.6 Health inequalities will be reduced in the Scottish Borders (Full SOA)</b></p> <p><b>Indicators attached</b></p>	<p><b>2.6.2 There is a reduction in alcohol problems amongst young people and adults</b></p>	<p><b>3.8.2 Looked After and Accommodated Children and young people have the same life chances as others</b></p>
<p>What are the Board's top 3 actions that contribute to each of these outcomes?</p>	<p>1a. On-going development work through Healthy Living Network health community health-related programmes in 5 designated areas of deprivation. Cooking skills, physical activity and parenting work are 3 priority areas</p>	<p>2a. Assessment of needs of the local community regarding alcohol and drug problems, and review of effectiveness of current services.</p>	<p>3a. There are 205 LAC, 78 who are LAA from Home, 15 in residential placements outwith Borders. Approx. 15 in Kinship Care placement with family/friends and 58 LAAway from Home Children for other authorities who are in foster placement in the Borders.</p>
	<p>1b. Establishment of HEAT 8 Health Inequalities Cardiovascular Health Checks. Project already started Workplace and Pharmacies. Due to start in GP Practices in early February</p>	<p>2b. Delivery of HEAT H4 target: delivery of alcohol brief interventions (16 years +) in priority settings of:</p> <ul style="list-style-type: none"> <li>- Primary care</li> <li>- Antenatal care</li> <li>- A&amp;E.</li> </ul>	<p>3b. All of new SBC children entering care are appointed to attend the BGH for a Full Health Assessment, which is reviewed annually. The under fives with BGH Ward 15 and the school age children with the appropriate School Nurse. The LAC Nurse picks up any children who fall through the net and currently planning a Health Assessment for Kinship Care children via home visits by the LAC Nurse.</p>
	<p>1c. Implementation of Learning Disabilities Equally Well Funds, Regular health screening checks developed for people with Learning Disabilities. Developing systems and tools to support implementation,</p>	<p>2c. The provision of timely, appropriate and sensitive support for young people and adults with alcohol and drug problems (includes delivery of new HEAT A11 target for reducing waiting times to specialist services</p>	<p>3c. The LAC Nurse provides a drop in clinic in residential and supported learning units as the vast majority of these young people are both vulnerable and LAC. Training on range of health topics for</p>

	<p>raising staff awareness of health care needs of people with LD and skills development across both primary and acute care</p> <p>Equality and Diversity. LD Service has worked with BGH to introduce patient record to alert staff to patient with learning disability to ensure appropriate care and treatment</p>		<p>staff and foster carers made available.. LAC Nurse provides a telephone link to advise and support those working with this group of children and young people.</p>
<p>How will the Board performance manage these contributions?</p>	<p>1d.Performance managed through regular reporting to Localities HI Group</p>	<p>2d. Performance being managed by Alcohol &amp; Drugs Partnership (ADP) Commissioning Group:</p> <ul style="list-style-type: none"> <li>• Needs assessment has been commissioned and reported back.</li> <li>• Findings to be presented and priority actions agreed by the ADP to inform 3 year strategy (2011 – 2014)</li> </ul>	<p>3d. Overall accountability through SBC Children/Young People's Planning Partnership.</p>
	<p>1e.Performance managed through LDP/KPI HEAT reports</p>	<p>2e. HEAT H4: Steering Group co-ordinates implementation and quarterly reporting to:</p> <ul style="list-style-type: none"> <li>• NHS Borders Board</li> <li>• ADP</li> <li>• Scottish Govt.</li> </ul>	<p>3e Overall accountability through SBC Children/Young People's Planning Partnership.</p>
	<p>1f. Performance being managed through Learning Disabilities Partnership Board/Health Improvement Partnership Board</p>	<p>2f. HEAT A11: Steering Group co-ordinates implementation and quarterly reporting to:</p> <ul style="list-style-type: none"> <li>• NHS Borders Board</li> <li>• ADP</li> <li>• Scottish Govt.</li> </ul>	<p>3f. Overall accountability through SBC Children/Young People's Planning Partnership.</p>

	<b>EARLY YEARS</b>		
<p>What are the priority local outcomes for the early years?</p> <p>What are the underpinning indicators or targets that support the delivery of the outcome?</p>	<p>1. 5.1 <b>Children experience high quality early years provision</b></p>	<p>2. 8.1 <b>Children grow up in a safe, homely environment</b></p>	<p>3. 5.2 <b>Children are fully supported by effective partners</b></p>
<p>What are the Board's top 3 actions that contribute to each of these outcomes?</p>	<p>1a.SBC commissioned Early Years review and establishment of Early Years Group within Children's Planning/NHS Child Health Network. First phase of review makes recommendations for changes to governance structures</p>	<p>Implementation of HEAT 3 Child Weight Management Programme 2 programmes being developed side by side, one a structured 10wk family programme alongside 1:1 family intervention through Dietetic service</p>	<p>3a. Rollout of national Play at Home Initiative through practitioners in NHS, Local Authority and Voluntary sector who work in Childcare, Early Education Physical activity Health improvement. Training started early February</p>
	<p>1b. NHS support to above through NHS Children/Young People's post and Children's Services Manager with intention to ensure health improvement outcomes embedded into this work</p>	<p>2b. Implementation of CEL 36 Infant Nutrition Programme. Staff now recruited, strategic group to be established to drive implementation plan. Breastfeeding Action plan produced to support this work</p>	<p>3b. Development of Borders Healthy Living Network Parenting Work Parent and Child 4 week cooking courses, weaning programmes and one Stop Shop, i.e. multi-agency approach to supporting parents. Scoping underway for parents' support group for migrant families</p>
	<p>1c. Development of access to opportunities for meaningful engagement in sports and leisure opportunities for families within PWLDisabilities community through Ewell funds</p>	<p>Production of Gender based violence action plan. NHS Borders have an agreed gender based violence action plan (CEL 41) which introduces routine enquiry into addictions, maternal and mental health services</p>	<p>3c. Violence against women partnership established and chaired by Equality and Diversity Lead</p>
<p>How will the Board performance manage these contributions?</p>	<p>1d. SBC Children/Young Peoples' Planning Partnership</p>	<p>2d.LDPlan/monthly KPI reports</p>	<p>3d. Performance managed through Physical Activity, Sports and PE Strategy Implementation Group</p>
	<p>1e. SBC Children/Young Peoples Planning Partnership and NHS</p>	<p>2e. LDPlan/monthly KPI reports</p>	<p>3e. Performance managed through Health Improvement Partnership</p>

	Children's Health Network		Board and Localities HI Group
	1f. Learning Disabilities Partnership Board	2f. Performance managed by Community Safety Partnership	3f. Performance managed through Community Safety Partnership

	<b>TACKLING POVERTY AND SOCIO-ECONOMIC INEQUALITY</b>		
<p>What are the priority local outcomes for tackling poverty and socio-economic inequality?</p> <p>What are the underpinning indicators or targets that support the delivery of the outcome?</p>	<p><b>1.3.2 Life circumstances are improved by maximising participation in education, training and employment, especially amongst people who are economically inactive.</b></p>	<p><b>2.7.2 There is a good supply of high quality affordable housing</b></p>	<p><b>3.7.3 There are fewer people living in poverty</b>  <b>9.4 Adults at risk of harm are protected</b></p> <p><i>Full SOA</i>  <b>7.1 Inequalities will be reduced in the Scottish Borders</b>  <b>7.4 Migrants will be welcomed to the Borders</b>  <b>7.5 Homelessness will be reduced through effective and significant action</b></p>
<p>What are the Board's top 3 actions that contribute to each of these outcomes?</p>	<p>1a. Final stages with production of NHS Borders Health &amp; Well-Being Strategy for the Working Age with obviously links to employability</p>	<p>2a.</p>	<p>3a. Public Health representation on Strategic Poverty Partnership Board in order to identify and embed health anti-poverty actions into Poverty Action/Financial Inclusion and Fuel Poverty Plans</p>
	<p>1b. NHS Health and Employability structures have been submitted to the local Borders Employability Group for inclusion in their employability mapping exercise. NHS representation on this group</p>	<p>2b.</p>	<p>3b. Fuel Poverty –NHS Health Improvement contribution to SBC Energy Adviser post.                      Borders HLNetwork working with Powerdown to address individual home/families fuel bill reductions in designated areas of deprivation</p> <p>NHS Borders and CP partners have produced a 'Welcome to Scottish Borders' guide for migrant communities moving into the area</p>
	<p>1c.Scottish Govt. nationally funded pilot project to provide integrated specialist workplace vocational rehabilitation service.                      Professional links to Keep Well delivered to adults in workplace</p>	<p>2c.</p>	<p>3c Delivering Fairer Borders funding outcomes allocated to NHS for alcohol, physical activity and HealthyLiving Network health outcomes in areas of disadvantage</p>

How will the Board performance manage these contributions?	1d Health Improvement Partnership Board	2d.	3d. Reporting/monitoring systems within Health Improvement Partnership Board and associated steering groups
	1e. SBC Employability Service	2e.	3e.Reporting/monitoring systems for Strategic Poverty Partnership Board
	1f. Health Improvement Partnership Board	2f.	3f.Fairer Borders Group monitoring of funding allocations

	<b><i>ECONOMIC RECOVERY</i></b>		
<p>What are the priority local outcomes for supporting economic recovery?</p> <p>What are the underpinning indicators or targets that support the delivery of the outcome?</p>	<b>1.The physical and communication infrastructure meets the needs of businesses and residents</b>	<b>2.There is both sustained and growing business activity in key sectors of the Borders economy</b>	<b>3.The Borders existing workforce is highly skilled and responsive to the needs of employers</b>
What are the Board's top 3 actions that contribute to each of these outcomes?	<p>We are fully engaged with the Health &amp; Employability Lead from SG Health Improvement team and NHS Borders is represented on the SG Health &amp; Employability Delivery Group</p> <p>We have been allocated further year's funding for our vocational rehabilitation project which links directly to our actions from the Adult Rehabilitation Framework and National Fit For Work Pilot's</p> <p>See above</p> <p>Equality and Diversity. Joint approaches to supported employment to increase access, equality and opp. for socially excluded young people</p>	<p>2a. Healthy Working Lives - sitting at 35 award registrations at the moment, 26 of which are SME's.</p> <p>Series of business network events delivered and co-ordination of training on topics: Mentally Healthy Workplaces, Alcohol Awareness for Managers, as well as being pivotal in supported businesses to access other training such as Health For Life.</p> <p>The Workplace Lifestyle Health Checks (HEAT 8) now part of Keep Well, remains a good in route to take forward Healthy Working Lives</p>	<p>3a. NHS Borders continues to Train and Develop Staff to ensure they have the appropriate knowledge and skills to undertake their post.</p>

	<p>1b. Occupational Health Service are linking the workforce into the HEAT 8 Keep Well Initiative by undertaking checks in the work environment</p>	<p>2b. National Monitoring system Through HWL plus adult hi group locally</p>	<p>3b. NHS Borders are working towards a HEAT Target which ensures that at least 80% of Permanent Staff have a Personal Development Review Discussion by March 2011.</p>
<p>How will the Board performance manage these contributions?</p>	<p>1c. Equal pay and employment. NHS Borders has implemented an equal pay policy and equalities monitoring has been implemented Nhs Borders has a diverse workforce to reflect Borders community</p>	<p>2c.</p>	<p>3c. NHS Borders Staff have a Personal Development Plan which identifies development needs – this helps staff and their managers ensure they remain up to date with mandatory/statutory training etc.</p>
	<p>1d. Employability Service</p>	<p>2d.</p>	<p>Each of the clinical boards has a Sponsor/Champion for KSF and that they would be responsible for ensuring that reviews are taking place, and personal development plans being updated by managers. The champions provide support to managers and record progress towards action plans</p>
	<p>1e. LDPlan/KPI monitoring of HEAT targets</p>		<p>3e.</p>
<p>1f.</p>	<p>2f.</p>	<p>3f.</p>	