Agenda Item 20

DUMFRIES and GALLOWAY NHS BOARD

8 April 2013

2013-14 Local Delivery Plan Submission

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RECOMMENDATION

The Board is asked to note the final Local Delivery Plan trajectories and risk assessments for 2013/14 where these have been changed or amended.

SUMMARY

The Board were presented with a draft Local Delivery Plan in February and endorsed the submission of that plan to Scottish Government. This paper provides a final version of the LDP incorporating any additions or amendments made after feedback from the Scottish Government.

Key Messages:

There are 18 HEAT targets for 2013/14 including two new targets for IVF and Dementia, a refreshed HAI target and since the draft LDP paper was presented to February, a re-launched A&E 4 hour waiting times target.

Updated Risk Narratives and target trajectories are included in the appendices to the paper and a workforce plan is also included as an appendix

A Community Planning Partnership (CPP) statement is required, but due to the timescales around the Single Outcome Agreement, drafts are not required until 2nd April with final submissions due on the 28th June.

A paper covering the Finance element of the LDP is being brought to Board as a separate paper.

The final LDP submission is due on the 15th March with Director General for Health and Social Care sign off scheduled for 31 March 2013.

GLOSSARY OF TERMS

NHS	-	National Health Service
HEAT	-	**H**ealth Improvement, **E**fficiency, **A**ccess and **T**reatment Quality
LDP	-	Local Delivery Plan
SIMD	-	Scottish Index of Multiple Deprivation
CAMHS	-	Child and Adolescent Mental Health Services
A&E	-	Accident & Emergency Department
IVF	-	In Vitro Fertilisation
CPP	-	Community Planning Partnership

MONITORING FORM

Policy / Strategy	*Local Delivery Plan and HEAT Targets*
Staffing Implications	*None*
Financial Implications	*Contained within separate LDP Finance Paper to Board*
Consultation / Consideration	*For initial Local Delivery Plan*
Risk Assessment	*For initial Local Delivery Plan*
Sustainability	*For initial Local Delivery Plan*
Compliance with Corporate Objectives	*Complies with* • *to deliver excellent care that is person-centred, safe, effective, efficient and reliable.* • *to reduce health inequalities across Dumfries and Galloway.*
Single Outcome Agreement (SOA)	*Not applicable*
Best Value	*Complies with key principles:* • *Commitment and leadership* • *Sound governance at a strategic, financial and operational level* • *Sound management of resources* • *Use of review and option appraisal*
Impact Assessment *Not Required*	

BACKGROUND

1. The Scottish Government has used a balanced scorecard of targets and trajectories to performance manage the NHS for several years. The indicators are divided into the following categories:

   - Health Improvement
   - Efficiency
   - Access
   - Treatment Quality

2. The targets are often referred to using the 'HEAT' acronym and are designed to facilitate effective delivery of the government's key objectives and provide an overall framework to assess NHS Board effectiveness. Progress against target trajectories is examined in the Board's Annual Review, a public meeting chaired by the Cabinet Secretary.

3. There has been wide engagement on HEAT target development with proposals considered on the basis of strategy, delivery and measurement.

   For 2013/14 there are 18 targets which set out the 'performance contract' between Scottish Government and NHS Boards – these include three new targets:

   o Dementia – a minimum of one year's post diagnostic support, through a link worker, for people newly diagnosed with dementia including person-centred support plan. This target will be due for delivery by 2015/16. This supports sustained independence within context of strong family and community support and promotes early decision making on future care options as part of person-centred care.

   o Healthcare Associated Infection - to further reduce the levels of staphylococcus aureus bacteraemia (including MRSA) and Clostridium difficile. Reducing preventable HAI directly supports healthcare that is free from avoidable harm.

   o IVF - eligible patients will commence IVF treatment within 12 months by March 2015. This will ensure equitable access to IVF services across Scotland.

4. The Scottish Government will continue to monitor the HEAT standards, NHS Boards are not required to provide delivery trajectories and risk narratives. Performance against HEAT standards is reported through Scotland Performs. For 2013/14 there is one new HEAT standard on drug and alcohol misuse treatment waiting times.

5. NHS Boards are on track to deliver the HEAT target to ensure that 90% of all patients admitted with a diagnosis of stroke will be admitted to a stroke unit on the day of admission, or the day following presentation by March 2013. Statistics will continue to be published on admission to stroke units and NHS Boards will continue to monitor performance locally. The former HEAT standard on early diagnosis of dementia is now included within the new HEAT target on dementia support.

6. Workforce planning is a key factor in enabling NHS Boards to deliver quality frontline services. It is important to ensure that changes to the NHS workforce are driven by patient safety, patient need and service demand. NHS Boards are required to include in their LDPs, a brief summary of the anticipated workforce requirements, based around the following five headlines:

   - describe existing and planned new service areas with particular workforce pressures and risks, which could affect the delivery of quality services, and the management of these risks;
   - advise on significant changes in skill mix across the career framework and the plans to take this redesign forward;
   - describe other significant workforce challenges that the Scottish Government should be aware of that may require a national focus to support resolution;
   - how the workforce is contributing to efficiency savings; and
   - describe the processes in place to ensure workforce capacity and capability risk assessments are undertaken in accordance with LDP Risk Management Plans around the delivery of HEAT targets

   The Workforce Plan is attached as Appendix A

7. The Statement of Ambition issued following the recent Review of Community Planning and Single Outcome Agreements makes clear that effective community planning arrangements will be key strategic building blocks at the core of public service reform. In this LDP NHS Boards are expected to indicate how they will improve their partnership approach during 2013/14, specifically focusing on how they will contribute to better outcomes through collaborative gain.

8. Building on the “critical issue” approach in last year’s LDP, this year LDPs are expected to include a concise summary of the key tangible contributions that the NHS Board will make during 2013/14 towards improved outcomes in economic recovery and growth; employment; early years and early intervention; safer and stronger communities, and offending; health inequalities and physical activity; and older people.

9. Submission of the CPP element of the LDP has been extended in order to give Boards additional time to take account of the Single Outcome Agreements. As such the deadline for submissions of draft CPP contributions by Boards is being moved from the 15th February 2013 to the 2nd April 2013.

The deadline for submission of final CPP contributions is moved from the 15th March 2013 to the 28th June 2013.

10. For compliance with equalities duties, where applicable, boards should outline any risks where the delivery of a target could create unequal health outcomes for people with protected characteristics, and/or for people living in socio-economic disadvantage; and how these risks are being managed. For the existing HEAT targets, the equality impact has been assessed as part of the risk narrative document. However, the new guidance states that NHS Boards are expected to have processes in place to ensure that equality impact assessments for the three new HEAT targets are easily accessible to the public and demonstrate the actions that NHS Boards take following these equality impact assessments. There are existing structures in place within the Board which will allow for Equality Impact Assessments to take place and support is available from the Equality & Diversity Steering Group, directorate 'champions' and our Equality and Diversity Lead. These Impact Assessments will be carried out in due course and will be placed on the Board website as is the case with all previous risk assessments.

11. Final LDPs must be submitted by 15 March 2013, with Director General for Health and Social Care sign off scheduled for 31 March 2013. The signed-off version will be presented to April NHS Board for information.

12. The LDP trajectories and risk templates are prefaced by a narrative setting out the links between Scottish Government's strategic objectives and the individual HEAT targets. This is attached for information at Appendix B.

13. Since the submission of the draft LDP in February 2013, there have been various levels of contact from target leads at Scottish Government. A summary by target is set out in the table below:

H3.1 Healthy Weight of Children	No comments received
H5.1 Suicide Reduction	Confirmation from Scottish Government lead that the risk narrative was acceptable
H6.1 Smoking Cessation	Query from Scottish Government lead regarding the trajectory which was clarified via the local Board lead
H9.1 Fluoride Varnishing	No comments received
H10.1 Detect Cancer Early	No comments received
H11.1 Early Access to Antenatal Services	No comments received
E5.1 Financial Performance	No comments received
E8.1 Reduce Co2 emissions	Confirmation from Scottish Government lead that the risk narrative and trajectory were acceptable
E8.2 Reduce Energy Consumption	Confirmation from Scottish Government lead that the risk narrative and trajectory were acceptable

A12.1 Faster access to Mental Health Services – CAMHS 26 Week Target	Confirmation from Scottish Government lead that the risk narrative was acceptable but that the trajectory was incomplete. A revised trajectory has been submitted and is included in the appropriate appendix in this paper.
A12.2 Faster access to Mental Health Services – Psychological Therapies 18 Week Target	Confirmation from Scottish Government lead that the risk narrative was acceptable but that the trajectory was incomplete. A revised trajectory has been submitted and is included in the appropriate appendix in this paper.
A13.1 IVF Treatment Waiting Times	Confirmation from Scottish Government lead that the risk narrative was acceptable
Axx New 4 Hour A&E Waiting Time Target	Risk Narrative submitted to Scottish Government lead alongside final LDP submission and included in appropriate appendix in this paper
T10.1 Rate of Attendance at A&E	No comments received
T11.1 MRSA/MSSA Bacteraemias	No comments received
T11.2 Clostridium Difficile Infections	No comments received
T12.1 Reduction in Emergency Bed Days for Patients Aged 75+	No comments received
T15.1 14 Days Delayed Discharge	Confirmation from Scottish Government lead that the risk narrative was acceptable but that the trajectory was incomplete. A revised trajectory has been submitted and is included in the appropriate appendix in this paper.
T16.1 Dementia Post-Diagnostic Support	No comments received

HEALTH IMPROVEMENT TARGETS

14. The 2013/14 Health Improvement Targets are:

Detect Cancer Early	To increase the proportion of people diagnosed and treated in the first stage of breast, colorectal and lung cancer by 25% by 2014/15
Early Access to Antenatal Services	At least 80% of pregnant women in each SIMD quintile will have booked for antenatal care by the 12th week of gestation by March 2015 so as to ensure improvements in breast feeding rates and other important health behaviours.
Suicide Reduction	Reduce suicide rate between 2002 and 2013 by 20%
Child Healthy Weight	To achieve 14,910 completed child healthy weight interventions over the three years ending March 2014
Smoking Cessation	NHSScotland to deliver universal smoking cessation services to achieve at least 80,000 successful quits (at one

	month post quit) including 48,000 in the 40% most-deprived within-Board SIMD areas over the three years ending March 2014
Child Fluoride Varnishing Applications	At least 60% of 3 and 4 year old children in each SIMD quintile to receive at least two applications of fluoride varnish (FV) per year by March 2014.

15. Trajectories and risk narratives are at Appendix B

16. The targets build on those that have been delivered largely successfully to date. Data for Detect Cancer Early is currently under review and further information on trajectories will follow. There is also no requirement to provide a trajectory for the suicide reduction target. Instead the performance measure against the national target is the three-year centred moving average European age standardised suicide rate (updated annually by the Scottish Public Health Observatory).

17. With Smoking Cessation and Child Healthy weight, there is a particular difficulty for rural boards where such deprivation tends to be widely dispersed amongst communities and more difficult to reach through targeted interventions.

EFFICIENCY AND GOVERNANCE

18. The 2013/14 Efficiency and Governance targets are

Financial Performance	NHS boards to operate within their agreed revenue resource limit; operate within their capital resource limit; meet their cash requirement
Reduce Carbon Emissions	NHSScotland to reduce energy-based carbon emissions and to continue a reduction in energy consumption to contribute to the greenhouse gas emissions reduction targets set in the Climate Change (Scotland) Act 2009
Reduce Energy Consumption	NHSScotland to reduce energy-based carbon emissions and to continue a reduction in energy consumption to contribute to the greenhouse gas emissions reduction targets set in the Climate Change (Scotland) Act 2009

19. Trajectories and risk narratives are at Appendix C

20. A separate paper has been submitted to the February NHS Board meeting covering the financial aspect of the LDP submission. The guidance states that

this should identify and explain any specific issues, e.g. cost pressures or financial dependencies specifically related to achieving the financial performance target. There is no requirement to repeat generic financial risks that apply to all targets

21. Energy trajectories and targets are at Appendix 2. During 2013/14, a new target will be developed which will align HEAT measurement with the rest of the public sector, following the introduction of the Public Sector Sustainability Reporting (PSSR) Guidance for Public Bodies

ACCESS TO SERVICES

22. The 2013/14 Access to Services targets are:

• Faster Access to CAMHS *and* • Psychological Therapies	Deliver faster access to mental health services by delivering 26 weeks referral to treatment for specialist Child and Adolescent Mental Health Services (CAMHS) services from March 2013; reducing to 18 weeks from December 2014; and 18 weeks referral to treatment for Psychological Therapies from December 2014.
IVF Treatment Waiting Times	Eligible patients will commence IVF treatment within 12 months by 31 March 2015
A&E 4 Hour Waiting Time Target	95% of patients will wait less than 4 hours from arrival to admission, discharge or transfer for accident and emergency treatment by year ending September 2014. This target is a milestone towards the 98% standard for A&E waiting times.

23. Risk analyses and trajectories are set out at Appendix D.

24. The new IVF target is currently under development. Boards are not required to submit trajectories as part of the 2013/14 LDPs, though it is proposed that in-year draft trajectories will be requested in September 2013.

25. In a letter to Chief Executives on 25th February 2013, Director of Workforce and Performance, John Connaghan stated that the Scottish Government is prioritising improvement in 4 hour A&E performance and are introducing a new HEAT target to support sustainable all year round delivery. The Scottish Government expect the first milestone of 95% performance to be delivered in the year ending September 2014. This should be seen as a minimum and NHS Boards should pursue further sustainable improvement towards the 98% 4 hour A&E standard. Performance against the new 4 hour A&E target will be reported through Scotland Performs and monitored as a HEAT target for 2013/14 to 2014/15 and a risk management plan for 4 hour A&E should be

provided as part of the Local Delivery Plan for 2013/14 submitted in March. This is included with Appendix D.

TREATMENT APPRPOPRIATE TO INDIVIDUALS

26. The 2013/14 Treatment targets are:

Dementia Post-Diagnostic Support	To deliver expected rates of dementia diagnosis and by 2015/16, all people newly diagnosed with dementia will have a minimum of a year's worth of post-diagnostic support coordinated by a link worker, including the building of a person-centred support plan
Reduction in Emergency Bed Days for patients aged 75+	Reduce the rate of emergency inpatient bed days for people aged 75 and over per 1,000 population, by at least 12% between 2009/10 and 2014/15
14 Days Delayed Discharge	No people will wait more than 28 days to be discharged from hospital into a more appropriate care setting, once treatment is complete from April 2013; followed by a 14 day maximum wait from April 2015.
MRSA/MSSA Bacterium Clostridium Difficile infections	Further reduce healthcare associated infections so that by 2014/15 NHS Boards' *staphylococcus aureus* bacteriamia (including MRSA) cases are 0.24 or less per 1000 acute occupied bed days; and the rate of *Clostridium difficile* infections in patients aged 15 and over is 0.25 cases or less per 1000 total occupied bed days
Rate of Attendance at Accident and Emergency	To support shifting the balance of care, NHS Boards will achieve agreed reductions in the rates of attendance at A&E between 2009/10 and 2013/14

27. Risk analyses and trajectories are set out at Appendix E.

28. The new dementia target relates to the percentage of people newly diagnosed who receive a minimum of one year of post-diagnostic support (as defined by the commitment) and who have a person-centred plan in place at the end of that support period. Data systems and definitions are currently under development – with a data and definition plan to be agreed by April 2013. Boards are not required to submit trajectories as part of the 2013/14 LDPs.

CONCLUSIONS

29. NHS Dumfries and Galloway have a good track record of delivery against LDP targets. The service is similarly well placed to deliver against the latest set of targets although some of the challenges, particularly in the Treatment section of the scorecard, will require both service redesign and continuation of steep improvement trajectories.

Appendix A

NHS Dumfries & Galloway LDP 2013/14
Workforce Planning

Workforce Issues

Work is ongoing within all Directorate areas to review skill mix across all professions. There are three key drivers which will influence the shape of our workforce in the future; a new Dumfries & Galloway Royal Infirmary; our strategic change programme Putting You First and the Integration of Health & Social Care.

Some of the significant issues within our largest staff groups are described below;

Medical

Medical staffing remains a challenging issue for the Board. The changes of MMC have led to a reduction in numbers of doctors in training, and their service contribution has been limited by the need to comply with the European Working Time Directive, and the requirement that they have a more structured training programme away from patient care. In addition, we have difficulties recruiting to Dumfries and Galloway, and often have unfilled training posts. The locum market has changed significantly, and it can sometimes be very difficult to recruit junior and middle grade locum doctors. Within the middle grade rotas we have severe problems in paediatrics, and some problems in Medicine and A&E.

At consultant level, recruitment challenges are variable and depend on the specialty concerned: We have a number of recent successful appointments, but we have remaining challenges in specialties such as radiology, dermatology, haematology and anaesthetics.

The reduction in medical school intake in autumn 2012 means that there will be fewer junior doctors from 2017 onwards. Opportunities for role redesign incorporating Advanced Nurse Practitioners as members of certain future multi-disciplinary clinical teams is currently being explored, and as models are developed, training needs will be identified. Training of these nurses will have to be in place by 2014 given the 3 years required for completing training.

Nursing

It is anticipated that there will be significant change to practice and to nursing roles over the next 5 years.

The proposed reduction in junior doctor numbers together with the progress within the Health and Social Services agenda will necessitate a greater focus on team working and the development of hybrid roles.

Current professional roles will not be eroded in terms of assessment and planning of care however the delivery of care will be from staff across a range of disciplines. This may be most evident within the unregistered workforce. However our future demographic assumptions indicate an increase in the older population and the

potential for a significant increase in patients with dementia. In order to meet the needs of these patients and to ensure a safe and appropriate placement for care, Mental Health Nurses and General Registered Nurses will be required to work as one team. Training and development will be progressed and led by the newly-appointed Nurse Consultant-Dementia.

Professional boundaries will be crossed and current staff locations will change to meet identified needs. Support Workers across Nursing, Allied Health Professions, and Social Services will work much more closely as an integrated, cohesive workforce in order to maximise capacity. Clinical Nurse Specialists currently have an acute hospital focus. Future developments will necessitate a greater input to the community from an expert adviser/teacher perspective.

A Change Strategy will be developed in 2013. Effective communication and involvement of all staff will be crucial to the change process and staff will be fully supported and developed to meet identified need. Within this process, key changes will be identified and prioritised, and a training needs analysis will follow. Changes to current practice will then be planned and implemented through a staged approach.

There has been a significant amount of work undertaken to date to consolidate the current nursing establishment and implement a 60:40 ratio of registered to unregistered staff within general wards.

Future workforce modelling has also been undertaken and tested against the National Nursing & Midwifery Workload and Workforce Planning Tool and the Professional Judgement Tool. Single rooms do not necessarily require additional staff however detailed workforce planning utilising the national tools, benchmarking and planning change in terms of current working practice will be worked through in great detail.

Plans have been put in place to further develop the Advanced Nurse Practitioner (ANP) workforce with succession planning for the existing cohort and development of the Hospital at Night Team into a day time role from October 2012. Discussions are underway, in conjunction with the Medical Director to assess future ANP need as part of the changing medical workforce of the future. Similarly, we are developing the role of Scrub Practitioners to support the medical workforce in Theatres.

Allied Health Professions (AHPs)

It is likely that there will be changes to ways of working for AHPs as a result of the models of care being developed for the new DGRI. Currently, physiotherapy and occupational therapy assessments are carried out once the patient is admitted, this will need to change to provide input to the Combined Assessment Unit.

In other areas where there is physiotherapy input such as 23 hour care there are likely to be changes to working patterns that will require resource planning due to European Working Time Regulations, however any changes to staffing are likely to be minimal.

Support Services

The move to 100% single rooms within the new hospital will impact on catering, domestic and portering staff and an assessment of that impact is being undertaken alongside the impact of moving into a building with a much larger footprint than the existing.

Work is currently underway in conjunction with Dumfries & Galloway College to assess any training requirements as a result of the cook-fresh model of catering which will be delivered in the new facility.

Within Estates Services there will be changes to the workforce as a result of the procurement scheme adopted for the project which will mean a small number of staff will be subject to TUPE transfers. NHSD&G will retain responsibility for certain tasks and will be required to maintain the retained estate.

It is inevitable in the current financial climate that all services are looking at how they operate and what improvements can be made for them to function at optimum efficiency.

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

The challenge we have in planning our future workforce is the impact of MMC on the structure of the workforce, and the need to engage with clinicians to think creatively about who delivers services in the future.

In general, rurality remains an issue across the region where it continues to be difficult to recruit to certain specialists posts, this is coupled with a largely static workforce with little movement into or out of the region. This board historically experiences fairly static labour turnover which is consistently around 8% per annum, however a slowing labour turnover may become a more significant future issue for the board in terms of managing workforce transition. This makes it absolutely vital that we do not lose our existing workforce to other areas of the local labour market.

How the workforce is contributing to efficiency savings

We continue to hold efficiency workshops at General Manager level to develop local CRES (Cash Releasing Efficiency Savings) and discussions take place within local teams around where efficiencies can be made. Within each directorate CRES plan there is a workforce element.

There is continuing engagement with Area Partnership Forum, who engage at a strategic level with CRES planning and delivery. In addition, at a local level there is involvement by staff teams generating change on the ground. There has been wide participation in the Productive Series across acute, community services, mental health and senior management. The Little Red Book is an locally developed idea which was introduced to capture ideas from staff on the shop floor. The “What If?” Innovation Fund was introduced to spark innovative and creative ideas in the workforce.

Appendix B

OUTCOMES

Quality Strategy

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

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

Our vision is that by 2020 everyone is able to live longer healthier lives at home, or in a homely setting. We will have a healthcare system where we have integrated health and social care, a focus on prevention, anticipation and supported self management. When hospital treatment is required, and cannot be provided in a community setting, day case treatment will be the norm. Whatever the setting, care will be provided to the highest standards of quality and safety, with the person at the centre of all decisions. There will be a focus on ensuring that people get back into their home or community environment as soon as appropriate, with minimal risk of re-admission.

Challenges

The demands for healthcare and the circumstances in which it will be delivered will be radically different in future years.

Over the next 10 years the number of over 75s in Scotland's population – who are the highest users of NHS services - will increase by over 25%. There will be a continuing shift in the pattern of disease towards long-term conditions, particularly with growing numbers of older people with multiple conditions and complex needs such as dementia.

The health budget has received the full Barnett consequentials arising from the Department of Health's 2010 UK Comprehensive Spending Review over the current Spending Review period. This has lifted the resource budget to more than £11.3 billion in 2013-14. Funding for Territorial Boards will increase by £256.0m (3.3%) in 2013-14 and £247.4m (3.1%) in 2014-15. This reflects our commitment to direct resources to protect point of care healthcare services. The NHS will still face considerable budget pressures. These pressures mean that the NHS will need to deliver maximum value from our investment through a focus on improving the quality of care by prioritising changes which also deliver greater efficiencies. Even after recognising the resource Barnett consequentials, there will require to be an ongoing focus on

delivering efficiency savings and increasing productivity based on past success.

While there are no specific efficiency targets for the years 2012-13 to 2014-15, there is a clear expectation that NHSScotland will take steps to deliver annual operational efficiency savings of at least 3 per cent. These savings will continue to be retained by NHS Territorial Boards for reinvestment in frontline services.

Over the next few years NHSScotland must ensure that - in the face of these demands and changing circumstances - it can continue to provide the high quality health service the people of Scotland expect and deserve into the future.

Responding to the challenges

The Scottish Government, NHSScotland and its partners must collectively recognise and respond to the most immediate and significant challenges - which include Scotland's public health record, our changing demography and the economic environment. The Scottish Government and NHSScotland must be bold enough to visualise the NHS that will best meet the needs of the future in a way that is sustainable, and then make the changes necessary to turn that vision into reality.

The Scottish Government remains committed to the values of NHSScotland: the values of collaboration and cooperation partnership working across NHSScotland and wider public sector, with patients and with the voluntary sector; of continued investment in the public sector rather than the private sector; of increased flexibility, provision of local services and of openness and accountability to the public. The Scottish Government opposes the route being considered in NHS England as their response to the global challenges.

The Scottish Government recognises that in order to meet the challenges which face us all, public services in Scotland must go further, reforming their ways of working in order to improve outcomes for the people of Scotland. There is an expectation that all public service organisations pursue reform in line with four pillars of decisive shift towards prevention; greater integration and collaboration between public services at a local level; greater investment in workforce development and leadership; and a sharp focus on improving performance. This vision of reform is consistent with the Quality Strategy in placing people at the centre of public service design and delivery.

Community Planning is a key means through which reform will be delivered. NHS Boards are key partners within Community Planning Partnerships and have a crucial role to play in delivering improvements on a local and national basis. There is widespread agreement that Community Planning Partnerships focus on a small number of key priorities: economic recovery and growth; employment; early years and early intervention; safer and stronger communities, and offending; health inequalities and physical activity; and older people. Like all public bodies, there is an expectation that NHS Boards

as CPP partners have evidence based understanding of local needs and opportunities which is translated in to prioritised plans and delivery of improved outcomes.

The Scottish Government is clear that NHSScotland needs to sharpen its focus on how it will sustain performance, deliver further improvement and transformational change in health and social care. Work is now underway to prioritise a small number of strategic improvement programmes that will provide the basis for NHSScotland to organise its response in the most effective way. These will build on existing and emerging programmes, and will form our plans for pursuing quality and delivering our 2020 vision.

NHS Boards will make contributions to improve outcomes through these strategic programmes, but are also expected to make contributions building on existing local partnership work.

We know from previous Local Delivery Plans, the importance of developing a shared understanding of the goal that is to be achieved, using data to understand what is happening at national and local level; and identifying early gains to create momentum. NHS Boards have increased their capability and capacity to deliver change through the full range of improvement methodologies including performance management, collaboration, benchmarking, and empowerment. The strategic improvement programmes will employ a combination of these methodologies. Where appropriate, the strategic improvement programmes will be underpinned by new HEAT targets – which have supported significant improvements. It is recognised that the targets approach will not be the optimal for every programme. Likewise, not every HEAT target will be appropriate for inclusion in Single Outcome Agreements. The three year Local Delivery Plan, updated annually, and its HEAT targets and standards continue to have a crucial role in sustaining performance, improving performance and transformational change. The following sections, which are by no means comprehensive, help describe the role of HEAT and LDPs going forward.

Sustaining Performance

The NHSScotland Chief Executive's Annual Report and Scotland Performs set out the significant achievements delivered by NHSScotland staff over a number of years. Sustaining achieved performance levels in order to secure better outcomes for the people of Scotland is important – with performance management underpinning this. For example, patients continue to hold prompt access to treatment, delivered as locally as possible, as one of their top priorities, and there is increasing evidence that long waits have a detrimental impact on health and well-being outcomes over the immediate and longer term. Waiting times are at their lowest levels, with over 90% of patients now waiting less than 18 weeks from Referral to Treatment, NHS Boards are achieving cancer waiting times and patients now benefit from the treatment time guarantee that is enshrined in law. Sustaining waiting times performance is crucial and the Unscheduled Care Expert group is redoubling efforts through work with NHS Boards and partners to address access to A&E

waiting times performance through a national action plan which will include a focus on efficient and effective utilization of capacity in both hospitals and the community.

At the same time we must continue to actively identify and pursue opportunities to prevent health problems arising in the first place. Prevention or early intervention provides clear benefits to individuals and families but also reduces the likelihood of more intensive and costly treatment at a later stage. Alcohol Brief Interventions are a highly effective early intervention to help individuals to reduce hazardous or harmful alcohol use which contributes significantly to Scotland's morbidity, mortality and social harm. The ABIs support people to reduce their chances of developing more serious alcohol-related problems. The HEAT target enabled ABIs to be scaled and delivered across Scotland. 97,830 interventions were carried out in 2011/12. On the back of delivery of ABIs in healthcare settings, interventions are now being delivered in youth work, occupational health, and criminal justice settings. The focus of ABIs needs to be sustained going forward.

The HEAT target on drug and alcohol misuse treatment helps ensure more people recover from drug and alcohol problems so that they can live longer, healthier lives, realising their potential and making a positive contribution to society and the economy. The first stage in helping people to recover from drug and alcohol problems is to support action across the country to provide a wide-range of services for individuals and their families that are recovery focused, good quality and that can be accessed when and where they are needed. In the quarter ending June 2012, almost 11,000 clients started their first treatment for drug or alcohol use, with 90.0 per cent of clients experiencing waits of 3 weeks or less. This HEAT target will become a HEAT standard in 2013/14.

Further Improvement

The Scottish Government remains committed to quality improvement underpinned by performance management where appropriate. We have seen significant reductions in HAI, with a 41 per cent reduction in rates of Staphylococcus aureus bacteraemia between 2005/06 and year ending June 2012, and a 78 per cent reduction in Clostridium difficile since 2007/08. The reductions have been underpinned by strong leadership and a comprehensive delivery plan including improved reporting at all levels; and implementation of best practice (hand hygiene, antimicrobial prescribing). Reducing preventable HAI directly supports healthcare that is free from avoidable harm, a new HEAT target has been introduced to further reduce the levels of staphylococcus aureus bacteraemia (including MRSA) and Clostridium difficile.

The establishment of the Scottish Patient Safety Programme which was the first such programme in the world to be implemented across a whole health system is delivering significant improvements which include a renewed focus, improvement methodology and significant reductions in HSMR (11.4% since

2007). The programme has been extended until 2015, with a focus on harm free care in the NHS - focussing on infections, falls, blood clots and pressure sores. There are no specific HEAT targets associated with this programme.

NHSScotland supports a range of clinical audit work which helps drive improvement in care. These audits include stroke, trauma, arthroplasty, intensive care, surgical mortality, musculoskeletal services, electroconvulsive therapy, gastro-intestinal endoscopy, renal and MS registries. The audits have helped drive improvements in treatment outcomes. HEAT targets have supported improvements in access to stroke units and time to hip fracture time to theatre. This has improved the quality of care and treatment outcomes which is a critical measure of success.

Timely access to healthcare is a key measure of quality in mental health and other services. Early action is more likely to result in full recovery and in the case of children and young people will also minimise the impact on other aspects of their life, so improving their wider social development outcomes. Most children's mental health problems can be prevented from getting out of hand. More serious problems, disorders and illnesses too can be helped and improved. Community Child and Adolescent Mental Health Services (CAMHS) treat and help children and young people and their families. There has been a 37% increase in the size of the specialist CAMHS workforce between the end of 2008 and September 2012. NHS Boards have developed, for the first time, systems to measure CAMHS waiting times from referral to treatment. During the quarter ending September 2012, around 2,400 children and young people started treatment at CAMH services in Scotland. The initial estimates from data at an early stage of development indicate that around 89% of people were seen within the 26 weeks HEAT target. The HEAT targets will support further improvement and delivery of 18 weeks waiting times for CAMHS and Psychological Therapies.

Smoking has long been recognised as the biggest single cause of preventable ill-health and premature death. It is a key factor in health inequalities and is estimated to be linked to some 13,500 deaths and many more hospital admissions each year. From April 2008 to March 2011, NHSScotland smoking cessation services reported 89,075 successful quit attempts (at one month post quit). The new HEAT target focuses on targeting smoking cessation in deprived communities, with over 24,000 successful quit attempts in 2011/12.

Transformational Change

Person centred care is not just about doing what we currently do in a more person-centred way. While there are some problems we can fix and some improvements we can make in the short term, a new focus on applying improvement science in person centred care offers an opportunity to work across health and social care settings to agree a shared understanding and approach to achieving the sort of changes that are needed. In order for these transformational changes to be sustainable, they will require action at all levels of our health and care system and in the communities in which people live. Work is underway to assess whether HEAT targets can support delivery.

One of the most important functions of the NHS is prevention of ill health and there is increasing need to take the prevention agenda to a new and more effective level. The increasing incidence of illness, in an ageing population, underlines the importance of finding new ways of detecting illness earlier and treating it at a stage at which significant benefit is possible. Projects such as Generation Scotland will offer new insights into the biological mechanisms of disease and particularly the genetic and epigenetic factors at work in the Scottish population. Such projects are already offering opportunities to translate the knowledge gained in the laboratory into patient benefit and we must be ready to apply that knowledge effectively. In addition, insights into population health inequalities point to significant psychosocial issues as the basis of much of the ill health which has emerged in Scotland over the past few decades. Supporting families and individuals living difficult and chaotic lives in ways which allow them to avoid damaging lifestyles requires better understanding, at an individual level. There is increasing evidence new approaches to data collection and analysis can identify problems much earlier than previously thought. Sophisticated analytical algorithms which allow large datasets to be examined for trends which indicate impending problems well before conventional diagnostic methods confirm the existence of a problem are now available and have the potential to allow intervention before serious, and perhaps tragic outcomes befall individuals. The NHS together with other public sector bodies should begin to explore the use of such analytical methods with a view to developing novel approaches to prevention and early detection of problems.

An emergency admission to hospital may be the right course of action for an older person who has a potentially serious or life threatening health problem that needs urgent specialist investigation or treatment in hospital. However for some older people an admission to hospital can be followed by complications such as a serious loss of confidence that prolong their stay, compromising their independence. While rehabilitation services can minimise this risk it is important to prevent avoidable emergency admissions. Reshaping Care for Older People has a HEAT target on reducing emergency bed days for 75+ which is framed to encourage the development of proactive community support; planning ahead to manage anticipated crises; earlier access to specialist assessment and treatment at home, in the accident and emergency unit or within hospital; and better co-ordination of health and social care support to enable a timely, safe and supported return home. The NHS and its community care partners, Local Authorities, are fully committed to this preventative approach that is intended to ensure older people receive the best possible care whenever they need it. There was a 7.6 per cent decrease in the rate of occupied bed days for patients aged 75+ who were admitted in 2011/12 compared with 2009/10. Tackling delayed discharges continues to be a priority - with a challenging 14 day delayed discharge target from April 2015 already agreed. This builds on impressive improvements delivered through partnership which have seen a drop in six week delayed discharges from almost 2,000 in 2002 to 95 today. Data is now available on bed days lost to delayed discharge and there is an expectation that NHS Boards and their partners make major reductions.

NHS Boards have an important role to play in the economy, as an employer, a consumer and partner. The Scottish Government has a vision to increase partnership working so that NHSScotland can develop its use of new innovative technology and improve the quality of care which patients receive, including the ability for more people to be cared for at home. This will also help to achieve the aim of doubling the economic contribution of life sciences to the Scottish economy. Scottish scientists and businesses' recent developments include a new class of cancer drugs, stem cell treatment which could potentially reverse corneal blindness and a treatment for diabetics which reduces dependence on insulin. NHS Boards are committed to tackling youth unemployment and are providing additional opportunities for unemployed young people including Modern Apprenticeships, student placements and work experience programmes. All NHS Boards are actively working to develop new or existing plans and programmes in order to meet national expectations.

In order to take forward transformational change in the early years of life, we need to build on a range of evidence based preventative interventions. These, applied over the first five years of a child's life will transform their future. For example, the existing HEAT target on booking antenatal care by the 12th week of gestation is based on evidence that those women at highest risk of poor pregnancy outcomes are less likely to access antenatal care early and/or have a poorer experience of that care. Meeting this target will clearly contribute to improved outcomes but it is only one element. The Early Years Taskforce has set out the vision of what needs to be done to ensure the best possible outcomes for our children, the ways families and communities can help improve these outcomes and how services can best be targeted to support them. The Early Years Change Fund represents the Scottish Government, Local Government and NHS Scotland's intention to shift resource where it makes the most difference, by supporting prevention and early intervention. The new Early Years Collaborative is based on the successful Scottish Patient Safety Programme, it will create a structure in which partners can easily learn from each other and from recognised experts in areas where they want to make improvements. Initially this will be a 2 year learning system that brings together Community Planning Partnerships to seek improvement in the Early Years with NHS Boards fully engaged.

Physical inactivity is considered to be the second biggest risk factor for mortality, behind high blood pressure. Getting Scotland fit would increase life expectancy and offset much of the health problems of obesity - releasing cash and improving health outcomes at scale. At present, the NHS offers brief advice interventions from a health professional to encourage physical activity. This preventative approach is highly cost effective but is, in itself inadequate to deliver a step change in population uptake. Those with the greatest need are often the least likeliest to respond to such advice. There is a challenge here in how we deliver the required transformational change.

The earlier that cancer is diagnosed and treated, the better the survival outcomes. Improving the percentage of early stage diagnoses will mean fewer premature deaths from cancer and this will have a positive effect on overall

life expectancy in Scotland. Scottish Government and NHSScotland aim to address this in the Detect Cancer Early programme and improve survival outcomes for people with cancer to amongst the best in Europe. There will be a continued drive to improve on the current high quality cancer service provision and patient and carer experience. Earlier diagnosis will be one route to achieving these aims and will result in fewer recurrences, improvement in cancer mortality rates and longer term wider societal benefits.

The workforce is absolutely central to achieving transformational change, and that is why we are now developing the 2020 Workforce Vision for NHSScotland, a robust plan for the long term which will set out a vision for NHSScotland to unlock its workforce potential. Engaging the workforce in developing the vision and throughout the period of implementation to 2020 is a fundamental part of this work.

In summary, the Local Delivery Plans remain a vital part of the delivery framework and are the 'performance contract' between Scottish Government and NHS Boards, with continued alignment to the strategic improvement priorities for Scotland. This guidance sets out Ministers' key operational targets and performance measures for NHSScotland.

HEAT targets & standards

There has been wide engagement on HEAT target development with proposals considered on the basis of strategy, delivery and measurement.

For 2013/14 there are 15 targets which set out the 'performance contract' between Scottish Government and NHS Boards – these include three new targets:

- *Dementia* – a minimum of one year's post diagnostic support, through a link worker, for people newly diagnosed with dementia including person-centred support plan. This target will be due for delivery by 2015/16. This supports sustained independence within context of strong family and community support and promotes early decision making on future care options as part of person-centred care.

- *Healthcare Associated Infection* - to further reduce the levels of staphylococcus aureus bacteraemia (including MRSA) and Clostridium difficile. Reducing preventable HAI directly supports healthcare that is free from avoidable harm.

- *IVF* - eligible patients will commence IVF treatment within 12 months by March 2015. This will ensure equitable access to IVF services across Scotland.

For 2013/14 there is one new HEAT standard on drug and alcohol misuse treatment waiting times. The former HEAT standard on early diagnosis of dementia is now included within the new HEAT target on dementia support.

HEAT 2013/14 Target	Policy Aim
To increase the proportion of people diagnosed and treated in the first stage of breast, colorectal and lung cancer by 25% by 2014/2015.	To improve Scottish cancer survival outcomes. Late-stage diagnosis accounts for most of the European variation in survival and elderly people and less affluent groups are particularly affected by late diagnosis and a survival deficit. The high rate of avoidable deaths from cancer is due to people being diagnosed with cancer when their tumour is at a stage when life saving treatment will not contain its impact and spread. There is a cancer treatment waiting times HEAT standard.
At least 80% of pregnant women in each SIMD quintile will have booked for antenatal care by the 12th week of gestation by March 2015 so as to ensure improvements in breast feeding rates and other important health behaviours.	To improve early access to antenatal services to support mothers-to-be to breastfeed, improving maternal and infant nutrition, reduce harm from smoking, alcohol and drugs, and improve healthy birth weight. These health behaviours will be monitored through the Maternity care quality indicators.
At least 60% of 3 and 4 year olds in each SIMD quintile to have fluoride varnishing twice a year by March 2014.	To increase the number of children who are decay free at age 5 years, particularly addressing inequalities. Dental decay is almost totally preventable but is the most common reason to admit children to hospital and accounts for significant pain and discomfort to the child and to absence from school.
To achieve 14,910 completed child healthy weight interventions over the three years ending March 2014.	Maintaining a healthy weight during childhood is important for both physical health and mental wellbeing. The best start in maintaining a healthy weight is through breastfeeding. Being overweight or obese during childhood is a health concern in itself, but when it continues into adulthood it can lead to physical and mental health problems, such as heart disease, diabetes, osteoarthritis, increased risk of certain cancers, low self-esteem and depression.
NHSScotland to deliver universal smoking cessation services to achieve at least 80,000 successful quits (at one month post quit) including 48,000 in the 40% most-deprived within-Board SIMD areas over the three years ending March 2014.	The Scottish Government remains committed to driving down smoking levels further. NHS Boards will continue to deliver a universal smoking cessation service, and there is an emphasis on helping people in deprived areas and pregnant mothers to stop smoking. All pregnant women will have smoking status recorded on attendance at antenatal clinic and will be offered smoking cessation support.

HEAT 2013/14 Target	Policy Aim
Reduce suicide rate between 2002 and 2013 by 20%	Evidence indicates that open discussion about suicide reduces its risk. Therefore, the more people who feel confident and willing to explore possible signs of suicide risk and provide support and help, the more lives could be saved.
NHS Boards to operate within their agreed revenue resource limit; operate within their capital resource limit; meet their cash requirement.	NHS Boards have an obligation to operate within their allocated funds and ensure value for money.
NHSScotland to reduce energy-based carbon emissions and to continue a reduction in energy consumption to contribute to the greenhouse gas emissions reduction targets set in the Climate Change (Scotland) Act 2009.	Both the carbon emissions reduction target and efficiency target are designed to not only achieve the Climate Change (Scotland) Act 2009 target, but also ensure that NHSScotland continues to lead by example within the Public sector. This will secure NHSScotland contribution to the Scottish Government's national Outcome to "reduce the local and global environmental impact of our consumption and production".
Deliver faster access to mental health services by delivering 26 weeks referral to treatment for specialist Child and Adolescent Mental Health Services (CAMHS) services from March 2013, reducing to 18 weeks from December 2014; and 18 weeks referral to treatment for Psychological Therapies from December 2014.	Timely access to healthcare is a key measure of quality in mental health and other services. Early action is more likely to result in full recovery and in the case of children and young people will also minimise the impact on other aspects of their development such as their education, so improving their wider social development outcomes. Psychological therapies have an important role in helping people with mental health problems, who should have access to effective treatment, both physical and psychological. These therapies can have demonstrable benefit in reducing distress, risk of harm to self or others, health related quality of life and return to work.

HEAT 2013/14 Target	Policy Aim
Reduce the rate of emergency inpatient bed days for people aged 75 and over per 1,000 population, by at least 12% between 2009/10 and 2014/15.	NHS Boards and their Local Authority and Third Sector partners' change fund is helping to address avoidable hospital admissions and bed days in older age groups, primarily through the provision of upstream support. Over 75s have longer hospital stays and a higher risk of Hospital Acquired Infections, delayed discharge and institutional care.
No people will wait more than 28 days to be discharged from hospital into a more appropriate care setting, once treatment is complete from April 2013; followed by a 14 day maximum wait from April 2015.	To enable and support people to remain in their own home, as independently as possible, for as long as possible. When this is not possible then people should be cared for in as homely a setting as possible. This will seldom be a hospital bed. The norm should be to discharge in hours and days.
To support shifting the balance of care, NHS Boards will achieve agreed reductions in the rates of attendance at A&E between 2009/10 and 2013/14.	A&E attendances across all age groups should decrease with better provision and use of primary care services, better preventative and continuous care in the home, and improved self care.
To deliver expected rates of dementia diagnosis and by 2015/16, all people newly diagnosed with dementia will have a minimum of a year's worth of post-diagnostic support coordinated by a link worker, including the building of a person-centred support plan.	This supports sustained independence within context of strong family and community support and promotes early decision making on future care options as part of person-centred care. This will be aligned with Alzheimer Scotland's 5 pillar of support.
Eligible patients will commence IVF treatment within 12 months by 31 March 2015.	This will ensure equitable access to IVF services across Scotland.
Further reduce healthcare associated infections so that by March 2016 NHS Boards' staphylococcus aureus bacteraemia (including MRSA) cases are 0.24 or less per 1000 acute occupied bed days; and the rate of Clostridium difficile infections in patients aged 15 and over is 0.25 cases or less per 1000 total occupied bed days.	To provide professional and clinical leadership in reducing HAI in hospitals and other settings ensuring safe and effective care and systems as well as maximising healthcare outcomes for patients.

Appendix C

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

NHS BOARD LEAD:	Dr Angus Cameron

Delivery and Improvement

Risk	Management of Risk
Inability to deliver change within primary care to support the early detection of cancer. Inability to deliver service redesign within diagnostics and acute services to cope with increased demand.	Strong GP lead is in place and close links will continue to be developed with secondary care, national work and third sector organisations. Continue to deliver on previous service redesign and ongoing quality and productivity agendas.

Workforce

Risk	Management of Risk
Retirement of key individuals across professional groups. Inability to recruit to skills required for sustainable access to diagnostic testing.	Engage with professional bodies and institutions to raise profile of NHS Dumfries and Galloway as employer of choice. Explore advance practitioner and other developed roles supporting a culture of individual and team development. Explore joint appointments with other Boards to maximise use of appropriately skilled personnel. Better use of current resources, ie follow up appointments

Finance

Risk	Management of Risk
Cost of ensuring capacity to meet predicted increase in demand.	Productivity and efficiency must be at the heart of all demand capacity discussions. Access and secure available national funding.

Equalities

Risk	Management of Risk
Potential increase in waiting times as a result of increase in referrals. Large elderly population not accessing GPs to discuss symptoms. Barriers to access including language, literacy and rural nature of the region.	Data will be used to inform demand and capacity planning. Development of concise communication plan to encourage and support elderly to access GP and screening services. Use of national materials and advertising working in partnership with primary care, public health & communications team colleagues.

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

NHS BOARD LEAD:	Julie White, Chief Operating Officer

Delivery and Improvement

Risk	Management of Risk
Women are unaware of the importance of early access to the service.	Plan to re-run campaign locally in Spring 2013 to raise public awareness -that women can and should access services as early as possible and how they can do that. -that they can access a midwife directly as first point of contact -regarding why this is so important. We will also raise awareness amongst service gatekeepers of the above i.e. pharmacists, sexual health teams, GP practice managers, social services teams.
Women most at risk do not or choose not to access the service early.	We have identified groups of vulnerable women who are most at risk and also those who don't access the service by 12wks. We will use focus groups and questionnaires to understand why and to help to facilitate easier access.
Women do not have access to all relevant information.	Target the information and care to these groups taking into account the way that women from different groups access information and services.
Midwives/maternity care staff are not available as first point of contact and for timeous booking appointments.	Booking information packs are readily available in GP practices for issue to women on confirmation of pregnancy. Midwifery teams are available in each locality to ensure that all women have access to safe and effective maternity care as close to home as possible. Referral processes in place to ensure that there is good communication between GP's and midwives and access to services as quickly as possible, however we have looked at ways that this can be improved. Women can also access care from their GP if they so chose
There is a comprehensive early assessment of health and social care needs and early intervention where risk taking behaviour is identified.	Booking appointments are made as timeously as possible targeting those who are most in need of early assessment and intervention, however we have identified some delays in the process and have a plan in place to speed this up. Midwives and maternity care staff will refer and signpost women so that they have access to the best

	possible care/support/advice. Health behaviours will be monitored through the Maternity Care Quality Indicators.
Data will not be correctly entered into the Scottish Women's Handheld Maternity Record (SWHMR) by midwifery staff.	All midwives will be reminded of the importance of accurate completion of relevant information.
Data from SWHMR is not transferred to SMR02 by coding staff.	"Date of booking" and "gestation at time of delivery" are mandatory fields on SMR02.Coding staff will be made aware and this is not an issue locally
There is submission backlog with regard to data collection.	Coding staff are fully aware of 6wk target for all data submission. This is closely monitored and action taken to prevent delay. This target is currently met. Data will be regularly and routinely analysed, we are getting quarterly local reports. ISD reports and analysis available to support management of performance. Local dashboards will be set up.
Social and lifestyle behavioural risks	Assets/strengths based/motivational approaches will be used to ensure engagement with those most at risk.
Access amongst women in the SIMD quintiles varies and amongst women of different ages and parities i.e. parous women less likely to book by 12wks	Ensure focus on women from all quintiles but particularly those women who are most vulnerable. Monitor on an on-going basis.

Workforce

Risk	**Management of Risk**
Maternity care staff are not aware of the importance of the HEAT target and it is not achieved.	The Head of Midwifery/Midwifery Manager and team leaders will develop the local implementation action plan in partnership with all other stakeholders including health professionals, partnership agencies and service users linking in with community planning partners and third sector. This will be fully implemented and communicated to all.
Staff do not have the knowledge and skills to implement the target.	All team midwives are able to carry out booking and to identify and assess risk. National learning needs analysis has taken place to identify competencies required to deliver the Refreshed Framework for Maternity Services and a national training package has been developed. This will include education to improve knowledge and understanding of the impact of social inequalities, GIRFEC, the assets/strengths based and

	motivational approaches. Solihull training already in place locally.
Staff do not have knowledge with regard to recording data, analysis etc.	Midwifery and coding staff are aware and supported to access and analyse relevant information.
Appropriate model of care in place to support implementation.	The named midwife concept will continue to be implemented with a focus on continuity of carer. The relevant quality measure will be implemented.
Staff attitudes and behaviours	Staff will be made aware of the potential impact of attitudes and behaviours on their communication with women and families and on the caring relationship by means of training and development.

Finance

Risk	Management of Risk
Resource allocation – some available resource will be non recurring	Effective utilisation of existing resources and appropriate allocation of potential resources available.

Equalities

Risk	Management of Risk
Inequalities in access to service.	Identify and effectively address as above
Effective engagement and maintenance of contact with those most at risk.	Appropriate and inclusive information as above. Targeting and tailoring care to meet individual needs. Ensuring follow up when there is non-engagement.
Unequal pregnancy outcomes.	The HEAT target aims to reduce health inequalities between and across groups of women and babies. Evidence improvements in access and health behaviours amongst those groups who are most vulnerable.. Equality and Diversity Action Plan to include this work.

Early Access to Antenatal Care (SIMD)

Percentage of Pregnant Women Booked for Antenatal Care by 12th Week of Gestation in the worst performing quintile	Ayrshire & Arran	Borders	Dumfries & Galloway	Fife	Forth Valley	Grampian	Greater Glasgow & Clyde	Highland	Lanarkshire	Lothian	Orkney	Shetland	Tayside	Western Isles
2010/11			83.8%											
Apr-Jun 13			83.5%											
Jul-Sep 13			83.5%											
Oct-Dec 13			83.5%											
Jan-Mar 14			83.5%											
Apr-Jun 14			83.5%											
Jul-Sep 14			83.5%											
Oct-Dec 14			83.5%											
Jan-Mar 15			83.5%											

Notes:
1. Boards submitted 3-year trajectories for number of interventions in the 2012/13 LDPs. These are provided in the table above.
2. Performance in Jan-Mar 2015 should be at least 80%

Reduce suicide rate between 2002 and 2013 by 20%

NHS BOARD LEAD:	Dr Derek Cox, Director of Public Health

Delivery and Improvement

Risk	Management of Risk
Current trainers become unable to deliver training	• Working with partners (NHS, LA and third sector) to identify new trainers and build capacity to support current training programme • Strengthened relationships with UWS and Mental Health Services have identified trainers and capacity to deliver aspects of the training.

Workforce

Risk	Management of Risk
Managers feel suicide prevention is less important now that numbers are not monitored	• The new national suicide prevention strategy (expected summer 2013) will provide an opportunity to raise awareness among managers of the ongoing importance of the suicide prevention role
Economic constraints mean that staff cannot be freed up for training	• Offer more short courses as appropriate to needs or smaller blocks of training.
Staff are reluctant to attend refresher courses	• Offer more short courses

Finance

Risk	Management of Risk
Funding is no longer available under Choose Life	• Explore more sustainable methods of delivery including a commissioning model for aspects of the training programme
There is no NHS budget to 'backfill' for staff who are training or being trained	• Offer more short courses

Equalities

Risk	Management of Risk
Focus on easier to reach staff groups/organisations/community groups results in differing levels of awareness and focus of suicide prevention across the region	• Review both disciplines and geographic base to ensure as wide a spread as possible • Use of equality and diversity assessment tools
Training is not focused on areas of socio-economic disadvantage	• The refreshed Choose Life Strategy (2010) included more deprived/stigmatised groups, Training will continue to be targeted at organisations/groups working with those vulnerable groups. • Training will continue to be provided in a range of settings, since more people living in deprived circumstances are to be found outside recognised areas of deprivation than inside.

To achieve 14,910 completed child health weight interventions over the three years ending March 2014

NHS BOARD LEAD:	Dr Derek Cox, Director of Public Health

Delivery and Improvement

Risk	Management of Risk
Rurality: access to target population and delivery of CHW programmes	CHW interventions pathway offers one-to-one as well as group/community programmes to ensure flexibility of service provision. Programmes offered across all four localities in region
Recruitment and retention of staff to fixed term posts; redeployment policy requirements regarding 2 year maximum length of fixed terms contracts; loss of skills and experience when staff leave. Situation compounded as we entering last year of target.	Provision of support, supervision, training and learning opportunities for staff. Regular reporting to Child Healthy Weight Working Group Working Group, Community Health Partnership (CHP) and Board Management Team highlighting any medium/long-term risks. Ongoing liaison with Scottish Government regarding any potential future targets/initiatives and participation in any national network discussions on sustainability
Continued reluctance among many families to acknowledge unhealthy weight or participate in programmes	Capacity building and education within existing/wider workforce who work with children and families on initiating discussions about unhealthy weight and the programmes available. Offering a flexible service that includes one-to-one support as well as group programmes. Accessing families who have declined support to explore the reasons why they decided not to participate and reviewing process as appropriate. Encouraging re-referral at a later date. Development of generic health behaviour change competencies among healthy weight programme staff in order to offer strength based, family centred service.
The focus on overweight and obesity has the potential for doing harm (particularly emotional wellbeing) and misses children/young people who are underweight or who have eating disorders	Provision of support, supervision, training and learning opportunities for staff in order to build skills and competencies Working closely with partners from specialist services to provide support and skills development for child healthy weight staff Ongoing review and improvements to referral and feedback processes. Public Health currently developing more generic, strengths based approach to delivery of health behaviour change interventions.

Problems with data entry into the Child Health Surveillance Programme (CHSP) system resulting in delays in completed interventions being counted/reported	Maintaining dialogue with ISD to identify and rectify and administrative issues.
CHSP system does not count small numbers of children/ young people/families who have completed programme but refuse final height and weight measurement.	Maintaining communication with Scottish Government, ISD, Health Scotland and local Board to ensure awareness of actual number of completed interventions

Workforce

Risk	**Management of Risk**
Continued low confidence among many health professionals, and others who work with children young people and families, around raising the issue of child healthy weight	Provision of CPD for staff who work with children and families on initiating discussions about unhealthy weight and the programmes available Provision of feedback and update reports to relevant teams/staff Ongoing awareness raising
Lone worker safety in delivery of one-to-one support to families in homes	Lone Worker Policy Ensuring communication processes in place and adhered to regarding location of workers, as well as return from visits
Retaining staff on fixed term contracts Staffing capacity/provision of cover if staff absent through sickness	Provision of support, supervision, training and learning opportunities Working in partnership with other heath care professionals to maintain contact with families during any periods of staff absence

Finance

Risk	**Management of Risk**
Future funding uncertainty	Ongoing liaison with Scottish Government
Capacity to sustain child healthy weight work over longer term	Development of Child Healthy Weight Sustainability Framework and Healthy Weight Life Course Pathway to identify ways in which Child healthy weight programmes might be sustained over time. Development of Life Course Pathway Commitment to development of life course healthy weight pathway for region

Equalities

Risk	Management of Risk
Potential for stigmatisation and discrimination	Offering one-to-one private/confidential contact. Working with children, young people and families to agree actions that are realistic for their own circumstances. Ongoing awareness raising across all agencies working with children, young people and families. Ongoing partnership working with specialist professional advisors (Dietetics, CAMHS, Psychological Services).
In rural Dumfries & Galloway, a specific focus, as defined by the Scottish Government, on defined areas of deprivation misses high levels of hidden deprivation	Signed off implementation plan regarding the requirement that 40% of interventions are delivered in by SIMD data zones 1&2 states: Programmes are offered region-wide and cover all SIMD areas. However, local data shows that many people are living in very difficult circumstances yet reside outside the most deprived SIMD datazones. Deprivation is scattered and found in some of the most remote and rural parts of the Board area. If the inequalities element of target is not met with reference to SIMD datazone (arguably an unreliable measure of inequality in Dumfries and Galloway), the Child Assessment Framework and Looked After Children's Assessments may be referred to as alternative means of measuring the extent to which the inequalities element of the target had been met.
In regard to socio-economic deprivation and rurality there may be issues around accessing healthy food and food preparation knowledge/skills	Ensuring staff are trained to provide support and advice around food purchasing and preparation Integration of Lets Cook Programme (community based practical healthy cooking sessions and advice) into programme delivery

Child Healthy Weight Interventions

Cumulative Total	Ayrshire & Arran	Borders	Dumfries & Galloway	Fife	Forth Valley	Grampian	Greater Glasgow & Clyde	Highland	Lanarkshire	Lothian	Orkney	Shetland	Tayside	Western Isles
Apr 11 - Mar 12			121											
Apr 11 - Jun 13			314											
Apr 11 - Sep 13			347											
Apr 11 - Dec 13			380											
Apr 11 - Mar 14			413											

Notes:
1. Boards submitted 3-year trajectories for number of interventions in the 2011/12 LDPs. These are provided in the table above (including any 2012/13 LDP Amendments)

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

NHS Board LEAD	Julie White Chief Operating Officer Director / Derek Cox, Director of Public Health

Delivery

Risk	**Management of Risk**
Unable to meet the new target in the universal population (7.5%) owing to a lack of referrals	• Seek agreement that the NHS in the future should be looking at a care package for smokers with certain medical conditions (i.e. long term conditions, pregnancy, patients in secondary care with certain conditions, pre-assessment etc)) • Improve services for relapsed smokers (Specialist and Pharmacy services) by doing more proactive follow -up • Improve effectiveness in Smoking Matters and Community pharmacists focusing on the one month follow up initially (although also maintain and invest further resources in prevalence targets and therefore work more on 3 and 12 month follow up with a possible inclusion of 6 month follow up) • More joined up work with GP practices on QOF patients – agree a pilot site and trial different options for different practices (i.e. new Galloway)
Service unable to meet inequalities part of new target owing to lack of referrals in key areas	• Prioritise the organisation of an enhanced quit attempt for smokers who are more addicted (improve our effectiveness) • Target campaigns in areas of greatest need (identified by ISD)

	• Target and increase access to stop smoking support in places other than clinics i.e. workplaces • Focus campaigns on age groups • Use other messages such as Smoke free homes to provide awareness about stop smoking services • Work more closely with other organisations/partners in key areas using smoke free homes message • Learn from other boards who are performing well in this part of the target
Owing to being successful with the development of "opt-out" services Smoking Matters is unable to cope with demand	• Have a strategy in place where any sudden increase in numbers of referrals can be managed i.e. more group work • Pharmacy services also offered (if specialist support declined) as part of the "opt-out option • Re-design service delivery in certain areas of the region to free-up staff capacity (i.e. walk-in sessions)
Service delivery at risk owing to shortage of trained staff	• All staff in the service will be able to deliver Stop Smoking Support and create a high degree of flexibility of workloads of staff so that the service can cover any short term capacity issues • Be proactive in encouraging referrers to consider making more referrals in off peak times

Workforce

Risk	**Management of Risk**
Summary Ensure all staff who are delivering smoking cessation interventions are working with national and local standards and protocols	• Inform Senior managers of national guidelines and local procedures in smoking cessation • Alert senior managers to issues that can compromise meeting our target
Short term contracts being offered puts the service at continued risk in relation to the workforce	• Alert Senior managers giving advance notice of contractual obligations along with how this may compromise meeting

	targets
Risk of not having a workforce to cope with demand and no possibility of an increase in budgets	• Take all reasonable steps within the service to manage demand and alert senior managers

Finance

Risk	Management of Risk
Service delivery compromised owing to reduction in budget	• Highlight pressures with Senior managers • Manage waiting times through prioritisation process and offer more group work • Stop all developmental work • Liaise with Community Pharmacists to increase their stop smoking support
All future planning of services to meet the HEAT target is jeopardised because of reductions or uncertainty of ongoing funding	• Highlight pressures with senior staff

Improvement

Risk	Management of Risk
Difficulties in improving stop smoking service delivery owing to lack of communication and shared aims within the NHS	• Agree goals for future through an agreed strategy and ensure all necessary partners within the NHS are included in this development

Equalities

Risk	Management of Risk
Smokers from low socio-economic groups and other key priority groups of smokers (young people and pregnant smokers) do not access the service	• Greater need for targeted campaigns with special groups of smokers • Implement NICE guidance on “opt-out services (pregnancy) • Greater need for working with other professionals in maternity services, schools etc • Communicate more widely and provide more shared training and information events
The focus of HEAT detracts from other groups who may also have a high smoking prevalence and be experiencing ill health as a result of this i.e. mental health	• Plan a service that is able to offer a minimum intervention to any smoker who wants to stop smoking and is seeking support
Different areas of the region may request more input than others	• Ensure that any work that is being taken on by the service is

therefore an inequity occurs for smokers	considered on a regional basis and can be delivered in all parts of the region ensuring that the right distribution of staff and resources are deployed across the region

Smoking cessation

Cumulative Total	Ayrshire & Arran	Dumfries & Galloway	Fife	Forth Valley	Grampian	Greater Glasgow & Clyde	Highland	Lanarkshire	Lothian	Orkney	Shetland	Tayside	Western Isles		Scotland
Apr-Jun 2011		180													
Apr-Sep 2011		360													
Apr-Dec 2011		540													
Apr 11 - Mar 12		720													
Apr 11 - Jun 12		900													
Apr 11 - Sep 12		1,080													
Apr 11 - Dec 12		1,260													
Apr 11 - Mar 13		1,500													
Apr 11 - Jun 13		1,700													
Apr 11 - Sep 13		1,900													
Apr 11 - Dec 13		2,100													
Apr 11 - Mar 14		2,496													
Apr 11 - Mar 14		2,496													

Smoking Cessation SIM

Cumulative Total		Dumfries & Galloway			
Apr 11 - Mar 12		534			
Apr 11 - Jun 13		1,025			
Apr 11 - Sep 13		1,150			
Apr 11 - Dec 13		1,275			
Apr 11 - Mar 14		1,373			

At least 60% of 3 and 4 year old children in each SIMD quintile to receive at least two applications of fluoride varnish (FV) per year by March 2014

NHS BOARD LEAD:	Angus Cameron – Medical Director

Delivery and Improvement

Risk	Management of Risk
Complex target presents challenges in monitoring and delivery.	Changes have been made to the reporting method of this target. Local analysis will be undertaken to gain a greater understanding of how the changes in reporting methodology will affect monitoring and delivery.
Local dentists may not feel children should have fluoride varnish applied twice a year.	Practices have received training in evidence based prevention. Oral Health Programme Manager continues to visit practices on a regular basis to provide support and advice regarding Childsmile interventions which include fluoride varnish application. Analysis will be undertaken to determine practices who are outliers in fluoride varnish application and management of these practices will be discussed at the local Dental Performance Support and Governance Group
Parents may be uncertain of the benefits of fluoride varnish application and may not consent to have this applied.	Communications campaign to promote knowledge about the Childsmile Programme and fluoride varnish application will be undertaken in 2013.

Workforce

Risk	Management of Risk
Following service redesign the staffing levels within the Oral Health Team were reduced. We are currently reviewing capacity within the team and will determine if additional staffing is required to deliver all required oral health outcomes.	Childsmile work will be prioritised.

Finance

Risk	Management of Risk
Finances are in place to support this area of work	

Equalities

Risk	Management of Risk
Delivery of the target will focus oral health improvement specifically on the Early Years age group and their families. This may lead to other age groups feeling discriminated .	Work will continue to develop other areas of Oral Health Improvement work in line with the Government's Priority Group Strategy.

Child Fluoride Varnish Applications (SIMD)

Period Ending	Ayrshire & Arran	Borders	Dumfries & Galloway	Fife	Forth Valley	Grampian	Greater Glasgow & Clyde	Highland	Lanarkshire	Lothian	Orkney	Shetland	Tayside	Western Isles
Mar-12			4.4%											
Jun-13			15.0%											
Sep-13			25.0%											
Dec-13			45.0%											
Mar-14			60.0%											

Notes:

1. Boards submitted 3-year trajectories for number of interventions in the 2011/12 LDPs. These are provided in the table above (including any 2012/13 LDP Amendments)
2. Data for June 2012 is available from the HEAT System

Appendix D

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

NHS BOARD LEAD:	Julie White, Interim Chief Operating Officer

Delivery

Risk	Management of Risk
Inability to deliver target on carbon emissions	Biomass Boiler installed to reduce carbon emissions (reduction of 25% off carbon footprint). A further eight Biomass boilers will be installed by April 2013 as part of the Scottish Government Eco-Hospital initiative. A reduction of 20% is currently being achieved. This performance will achieve the target until 2016/17.
	Implementation of the NHS Dumfries and Galloway Carbon Management Plan
	Monitoring of performance on a quarterly basis against carbon emission HEAT target (E8)
Potential risk of failing to deliver target should biomass boiler malfunction.	Availability and performance of the Biomass Boiler has now at a good level
	Carrying out of in house weekly and monthly preventative, planned maintenance
Inability to deliver on energy consumption reduction target	Monitoring of performance on a quarterly basis against energy reduction HEAT target

Workforce

Risk	Management of Risk
Failure to prioritise energy issues	Energy campaign given high profile by Board Executives, local managers becoming involved and held to account on performance locally.
	The campaign was launched in January 2010. This involved the use of questionnaires (online and paper for staff who are not PC users). We now have over 100 environmental champions. We have carried out environmental walkabouts which have raised many issues and helped to identify minor projects to be carried out. This has now developed to include an Environmental Management Group which has targeted two specific sites for a further push on Energy Reduction and Environmental issues.

Finance

Risk	Management of Risk
None identified with Biomass Boiler service costs as these taken account of in business case.	Biomass boiler installed to save approximately £80K per annum if woodchip procured at £50 per tonne. Will also produce £38K savings against climate change levy and Carbon Reduction Commitment legislation
Volatility of price of woodchip	5 year contract with guarantee in line with business case. Increased risk after contract agreement ends. The current contract will expire in December 2013. A tender specification will be produced to have a new supplier in place for June 2013. This will be carried out in co-operation with Procurement Scotland.
Climate Reduction commitment Legislation requirements	The Carbon Reduction Commitment Legislation has and will cost the Board £138,000 p.a. commencing April 2012. Returns to the Carbon Reduction Commitment Scheme have been completed for this financial year.

Improvement

Risk	Management of Risk
Re carbon emissions target, there is a need to establish our plans for post 2014 when we could fail to meet trajectories.	A study has been carried out and report produced assessing the use of Low and Zero Carbon Technology. Options including the potential of Biomass 2, Bio-fuel CHP or cogeneration. Phase 1 of a long term plan will be carried out in 2013 with the installation of a further Biomass Boiler in the Crichton Boilerhouse. Projects for cottage hospitals have been investigated and £2.15M of funding realised to install a further eight Biomass Boilers, Voltage Optimisers and a gas fired Combined Heat and Power unit. Current performance keeps us below the target until 2016/17
Failure of energy reduction projects	Maintain an up to date Project Register Monitoring of the performance of projects e.g. Annual savings so far 2012/13 of £94K, carbon savings of 743 tonnes.

Equalities

Risk	Management of Risk

Reduce Carbon Emissions

Year	Ayrshire & Arran	Borders	Dumfries & Galloway	Fife	Forth Valley	Grampian	Greater Glasgow & Clyde	Highland	Lanarkshire	Lothian	Orkney	Shetland	Tayside	Western Isles	National Waiting Times Centre	State Hospital
2009/10			5,875													
2011/12			5,220													
2013/14			5,201													
2014/15			5,044													

Notes:
1. Values are in tonnes of CO2
2. Information for 2009/10 (baseline) and published data for 2011/12 is included in table
3. For future years, the baseline amounts may be revised to account for site closures/openings or weather correction. Trajectories have been based on the current baseline amounts. Actual targets may vary.

Reduce Energy Consumption

Year	Ayrshire & Arran	Borders	Dumfries & Galloway	Fife	Forth Valley	Grampian	Greater Glasgow & Clyde	Highland	Lanarkshire	Lothian	Orkney	Shetland	Tayside	Western Isles	National Waiting Times Centre	State Hospital
2009/10			183,151													
2011/12			175,793													
2013/14			162,144													
2014/15			157,272													

Notes:
1. Values are in GJ.
2. Information for 2009/10 (baseline) and published data for 2011/12 is included in table
3. For future years, the baseline amounts may be revised to account for site closures/openings or weather correction. Trajectories have been based on the current baseline amounts. Actual targets may vary.

Appendix E

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

NHS BOARD LEAD:	Angus Cameron, Medical Director

Delivery and Improvement

Risk	Management of Risk
Current waiting times for Boards referring into the Glasgow tertiary centre (Ayrshire & Arran, Lanarkshire, Greater Glasgow & Clyde and Dumfries & Galloway) are variable. NHS Dumfries and Galloway has a current waiting time of 18 months	Detailed planning will be required to understand how the Board will be able to achieve the target 12 months performance standard on receipt of the national guidelines
Funding arrangements for the tertiary centres to bring everyone on to the 12 month standard is unclear at present. If the funding is given to the four centres, they are likely to tackle the longest waits first, therefore Boards with shorter waiting times may not be able to reach the target as quickly as they would like to	The Board will have to work with the Glasgow (and possibly other) tertiary centre(s) to establish the forward workplan and assess how this will impact on patients from Dumfries and Galloway and will have to set an improvement trajectory accordingly
The national guidance may require the Board to offer more IVF cycles than it currently provides and DGRI may not have the capacity to increase the number of cycles that they will need to do	The Board will need to discuss whether or not we would be willing for our patients to be treated in Edinburgh, where there appears to be more capacity. It is likely that the four tertiary units will be encouraged to share capacity
The National Infertility Group is due to make recommendations to Scottish Government on access criteria and other issues. Full guidance will not be available until then, but it is likely that if the recommendations are accepted, that access criteria will change as of 1st April 2013	Detailed planning and/or changes will be required to be expedited at Board level depending on the new national guidelines.

Workforce

Risk	Management of Risk

Finance

Risk	Management of Risk

Equalities

Risk	Management of Risk

No trajectory is required at this stage

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

CAMHS

NHS BOARD LEAD:	Julie White, Chief Operating Officer

Delivery and Improvement

Risk	Management of Risk
CAMHS and Psychology have separate management/ Governance arrangements and deliver data on RTT HEAT and PT HEAT separately. Need to ensure necessary infrastructure in place for data collection and reporting. IT infrastructure in development. Managing demand and supply of psychological therapies	Improve joint working across directorates and development of integrated mechanisms. Shared Strategic Planning – Psychology representative sits on CAMHS Multiagency Steering Group. TOPAS development ongoing In relation to managing the demand for the psychological services, the following actions are being undertaken: • Allocation of resource identified to each GP practice - promotes concept of "shared waiting list" • Clearer assessment of current "treatability" and readiness to engage in therapy. • Communication of this back to referrers (usually GPs). • Increased level of discussion of referral criteria (emphasising evidence base) with all referrers. In relation to making the best use of the supply of psychological therapies available, the following actions are being undertaken: • Encouragement of self help resources eg "Moodjuice" online. • Regular clinical supervision to ensure effective use of clinical resource • Adherence to "matched care model of service delivery" where extensive use of skillmix is the norm • Default 6-8 session treatment model defining an episode of care. • Active management/service reorganisation when extensive period of therapist absence eg Maternity Leave

Challenge of capturing data in line with the full scope of the target (including CMHTS)	There is also close monitoring of waiting times outliers and a robust response to addressing outliers. Most psychological therapies locally are delivered in psychology but there is a need locally for us to ensure systems in place to capture all relevant data. This will be taken forward in the mental health directorate (which will also line manage Substance misuse services from 1 April 2012)

Workforce

Risk	Management of Risk
Reintegration of ISS staff who have recorded stats on Frameworki until now. Some ISS staff on Fixed Term Contracts	Records for ISS patients and recording of contacts to be transferred to NHS CAMHS systems from 1 April 2012 Service redesign including consideration of Fixed term contracts ongoing
Capacity to train staff with regard to Psychological Therapies	Identify ways of supporting staff to be released to attend essential training in PT and determine joint working opportunities re – Training [Accredited] and Supervision

Trajectory

Faster Access to CAMHS

Patients who started treatment within 18 weeks of referral: Quarter of Treatment	Ayrshire & Arran	Borders	Dumfries & Galloway	Fife	Forth Valley	Grampian	Greater Glasgow & Clyde	Highland	Lanarkshire	Lothian	Orkney	Shetland	Tayside	Western Isles
Jul-Sep 12			100%											
Apr-Jun 13			100.0%											
Jul-Sep 13			100.0%											
Oct-Dec 13			100.0%											
Jan-Mar 14			100.0%											
Apr-Jun 14			100.0%											
Jul-Sep 14			100.0%											
Oct-Dec 14			100.0%											
Jan-Mar 15			90.0%											

1. Percentage of patients who started treatment within 18 weeks of referral
2. Based on Patients seen during each quarter (Adjusted)
3. The 90% tolerance attached to the target for January to March 2015 is provisional and will be reviewed prior to the issuing of 2014/15 LDP Guidance in November 2013

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

PYSCHOLOGICAL THERAPIES

NHS BOARD LEAD:	Julie White, Chief Operating Officer

Delivery and Improvement

Risk	Management of Risk
Re psychological therapies – balancing demand and supply	In relation to managing the demand for the service, the following actions are being undertaken: • Allocation of resource identified to each GP practice - promotes concept of "shared waiting list" • Clearer assessment of current "treatability" and readiness to engage in therapy. • Communication of this back to referrers (usually GPs). • Increased level of discussion of referral criteria (emphasising evidence base) with all referrers. In relation to making the best use of the supply of psychological therapies available, the following actions are being undertaken: • Encouragement of self help resources eg "Moodjuice" online. • Regular clinical supervision to ensure effective use of clinical resource • Adherence to "matched care model of service delivery" where extensive use of skillmix is the norm • Default 6-8 session treatment model defining an episode of care. • Active management/service reorganisation when extensive period of therapist absence eg Maternity Leave There is also close monitoring of waiting times outliers and a robust response to addressing outliers.

Workforce

Risk	Management of Risk
Need to make most effective use of the clinical resource available	• Regular clinical supervision to ensure effective use of clinical resource • Adherence to "matched care model of service delivery" where extensive use of skillmix is the norm

Finance

Risk	Management of Risk

Equalities

Risk	Management of Risk

Trajectory

Patients who started treatment within 18 weeks of referral: Quarter of Treatment			Dumfries & Galloway										
Baseline (3 months average to Jan 2013)			80.7%										
Apr-Jun 13			81.9%										
Jul-Sep 13			83.1%										
Oct-Dec 13			84.3%										
Jan-Mar 14			85.5%										
Apr-Jun 14			86.7%										
Jul-Sep 14			87.9%										
Oct-Dec 14			89.1%										
Jan-Mar 15			90.0%										
Notes:													
1. Percentage of patients who started treatment within 18 weeks of referral													
2. Based on Patients seen during each quarter (Adjusted)													
3. The 90% tolerance attached to the target for January to March 2015 is provisional and will be reviewed prior to the issuing of 2014/15 LDP Guidance in November 2013													

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

NHS BOARD LEAD:	Julie White

Delivery and Improvement

Risk	Management of Risk
1. Surgical patient flow redesign work is required 2. Daily escalation and alert processes have recently been reviewed and require further evaluation 3. Primary Care Input to A&E could improve further 4. SAS/Transport issues have been shown to affect performance 5. OT and Physio input may negatively affect waiting times	1. Surgeon availability can impact on achievement of 4 hour compliance. The Chief Operating Officer and Acute Medical Director are actively engaged on work to mitigate this risk through the pilot of a Surgical Assessment Unit. Long term, this forms part of the planning for the new build Acute hospital design i.e. a combined assessment unit. 2. The processes around the A&E alert processes have recently been reviewed using electronic alerts to key individuals and following a pre-agreed escalation process. This will be evaluated in due course to ascertain if it having a positive effect on A&E 4 hour compliance. In addition, recruitment has concluded to ensure that a dedicated team of site capacity managers are now in place to proactively manage patients approaching 3 hours in the Emergency Department. 3. More work will be carried out with colleagues in Primary Care to ensure that patients are fully aware of how to access appropriate care through the 'Knowing Who to Turn To' materials. 4. It has been identified that there are some issues regarding availability of transport for patients requiring transport between Galloway Community Hospital and DGRI or patients in DGRI requiring transport to tertiary centres. In addition, some delay is encountered from patients requiring an ambulance upon discharge from A&E. There is a Change Fund initiative in place to provide patient transport out of normal working hours and this is currently being evaluated. 5. OT and Physiotherapy input has been introduced to improve acute flow, however it may have an effect on A&E waits if patients are being treated within the department instead of being admitted to a ward. This will be monitored by the management team.

Workforce

Risk	Management of Risk
1. Minor injuries patient flow 2. Major injuries patient flow	1. Low risk at present as this flow regularly achieves in excess of 98% compliance however a future risk exists in terms of protecting the Board against natural turnover and replacing these individuals in due course.

	2. Low risk at present as this flow regularly achieves in excess of 98% compliance however there are current issues in terms of the middle grade rota and shortfalls are being filled with locum staff. There is an ongoing recruitment issue in terms of attracting middle grade doctors with the appropriate skill set which the Board has to manage on an ongoing basis.

Finance

Risk	Management of Risk
1. The A&E workload is currently being assessed using the national workforce planning tools. This may indicate that additional resource is required beyond the current funded establishment. 2. Paediatric flow impacts on current performance and may require additional funding to deploy fix measures	1. Discussions would take place with the Director of Finance if required to meet these additional needs. 2. Under 5's attendances have been shown to impact significantly on performance. Work will be taken forward to look at alternative pathways based on prevention and support i.e. educational packages however this could have a financial impact to support this work and will involve a discussion with Director of Finance to look at funding options.

Equalities

Risk	Management of Risk
No particular risk is foreseen for any of the protected groups under the Equality legislation	

No trajectory is required at this stage

Appendix F

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

NHS BOARD LEAD:	Julie White, Chief Operating Officer / Angus Cameron, Medical Director

Delivery and Improvement

Risk	Management of Risk
Need agreement on the definition of what "post diagnostic support" means for individuals, and how this translates in to quality/quantity to deliver over the first year post diagnosis	Updated Dementia Integrated Care Pathway recently launched across D&G, outlining the key aspects/ topics to be covered in the initial post diagnosis period.
Lack of robust systems/structures to measure delivery of target.	Potential to analyse variances from ICP to measure adherence to minimum standards for post diagnosis support
Delivery of post diagnosis support currently primarily sits outwith NHS services, therefore unable to utilise NHS IT systems to provide required information to inform performance against target	Opportunity to influence development of MiDIS system within NHS to ensure incorporation of required information and measures Implementation of post diagnosis support via self management groups is being supported via the Putting You First programme. Develop Dementia forum in Stewartry/Wigtownshire similar to those in Nithsdale and Annandale and Eskdale

Workforce

Risk	Management of Risk
Projected increased population of people diagnosed with dementia will place ever increasing demands on link workers, therefore unable to deliver or sustain performance against target. (Nationally, the number of newly diagnosed people with dementia has increased by 67.7% over the past years (2006-2011))	Review roles and responsibilities of memory clinic link workers/ and Alzheimer's Scotland Dementia Advisors to ensure capacity building to deliver required post diagnosis support. Review service configuration in Community Mental Health Teams to assess capacity and role of CPNs and OT staff, and make efficient and effective use of partnership approaches. Consider whole systems redesign opportunities regarding development of specialist dementia services within health, social care and third sector. The lessons learned from the National Dementia Demonstrator sites should be used to inform local considerations and recommendations

Due to increased demands on services, lack of time and opportunity for staff to maintain/ increase skills and knowledge to provide appropriate and timely support	Continue to utilise local and national resources and opportunities to progress delivery of "Promoting Excellence" framework. Ensure that local staff are actively involved in taking forward the "Supporting Change " programme

Finance

Risk	**Management of Risk**
Financial implications regarding increased workforce requirements as described above	Service Redesign options may release potential financial savings

Equalities

Risk	**Management of Risk**
Risk of people under 65 not accessing the same quality/ quantity of service and support if they sit within adult mental health services.	All people with a diagnosis of dementia to be managed/ supported through older adult or specialist services
Risk of people who have been diagnosed prior to the HEAT recommendations not having the opportunity for the same level of support.	Long term support plans need to be accessible to all people with dementia and their carers throughout their whole journey. Increased use of planning ahead and anticipatory care plans currently being promoted through integrated care pathway and Putting You First workstream

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

NHS BOARD LEAD:	Julie White, Chief Operating Officer

Risk	Management of Risk
Time lag for national performance data may adversely impact upon our ability to monitor performance accurately.	Training of health intelligence analyst staff to maximise potential to use national and local datasets to replicate performance data locally.
Pandemic flu and severe winter pressures.	Periods of exceptionally high demand, as experienced during flu outbreaks and the recent winter cold period, impact heavily on emergency admissions. Whilst robust winter plans manage the risk to patients, the resultant peaks in activity may undermine the NHS Board's ability to reduce emergency in-patient bed days in line with this target.
Projected service change may not deliver anticipated reductions.	**Redesign** NHS Dumfries and Galloway is currently working towards a replacement of the Dumfries and Galloway Royal Infirmary building with a resulting smaller acute bed base. Delivery of this exciting change requires that all services are remodelled (*including older people's services*). As a result a range of service improvement/redesign, programmes are being developed/progressed across both acute and community services. This will ensure that the momentum for change is sustained. See next paragraphs. **Anticipatory Care Planning** As part of the Dumfries and Galloway *'Putting You First Change Programme'*, we have developed a Forward Looking Care Framework which will lead to the introduction of pro-active, anticipatory and early intervention approaches to care across the whole system of care. **Integrated Working** Work is currently ongoing to develop 'community hubs' that are exploring new ways of working jointly between the NHS, Council and Third and Independent Sector partners. This work will consider a range of issues in relation to integrated working including co-location, integrated IT systems, single points of contact, single points of access and models of service delivery.

	Reshaping Care for Older People Delivery of this target forms the focus of Reshaping Care for Older People and the "Putting You First" Strategy locally. The past year has seen a significant investment consultation with stakeholders and the development of some key tests of change: • Agreement to recruit a Consultant in Acute Medicine until March 2015 to test the impact of an increase in senior decision making and leadership at the point of the patient presenting for admission and to consolidate, and extend where possible, ambulatory alternatives to admission. This initiative should see a reduction in emergency admissions to the main ward base. • Development of a transport home from hospital service to take patients who are able to return home but cannot get home, out of hours. This initiative already is avoiding admissions. • The year 2013/14 will see the development of closer working between health, social care and voluntary sectors in Nithsdale, leading to a reduction in the need for admissions and supporting earlier discharge. • Changing role for cottage hospitals and other community resources around supporting rehabilitation within their community will support earlier discharge with rehabilitation in the home. **Service Improvement** In addition work will continue to progress service redesign within individual disease/condition pathways in line with clinical best practice and LEAN principles. The Managed Clinical Networks for Stroke, CHD, Diabetes and Respiratory are established and working in a cross service, cross agency way to redesign care pathways. Supporting the patient to manage their own condition within the community or return to the community as quickly as possible are key drivers within their agenda. **Technology** A successful pilot of delivering a telediabetes clinic has been completed and this service has now been mainstreamed Exploration work with further specialities is underway to develop further tele clinics The potential for Telehealth to support people within their own home has been piloted within the heart failure service and supporting access to pulmonary rehabilitation for patients across the region. The heart failure pilot has had a full final evaluation and the learning from this is contributing to the development of a model of Telecare at scale. Both telehealth in Heart Failure and Pulmonary Rehabilitation have a good

	evidence base to support reduction in emergency in-patient bed days. Work is underway to develop a remote monitoring tele health project for people who have COPD in the Annan area.
Financial challenges faced by Dumfries and Galloway Council may impact upon discharge planning.	**Redesign** Close working with council colleagues has developed a model which extends the joint Short Term Augmented Response Service (STARS), by seconding staff employed by the Council Care and Support Services and develops this as the principle vehicle for supported discharge and provision of care packages in the immediate discharge period.

Reduction in Emergency Bed Days for Patients Aged 75+

Year Ending	Ayrshire & Arran	Borders	Dumfries & Galloway	Fife	Forth Valley	Grampian	Greater Glasgow & Clyde	Highland	Lanarkshire	Lothian	Orkney	Shetland	Tayside	Western Isles
Mar-10			5,314											
Mar-11			5,254											
Mar-12			4,586											
Apr-13			4,927											
May-13			4,908											
Jun-13			4,889											
Jul-13			4,870											
Aug-13			4,851											
Sep-13			4,832											
Oct-13			4,813											
Nov-13			4,794											
Dec-13			4,775											
Jan-14			4,756											
Feb-14			4,738											
Mar-14			4,719											
Apr-14			4,700											
May-14			4,681											
Jun-14			4,662											
Jul-14			4,643											
Aug-14			4,624											
Sep-14			4,605											
Oct-14			4,586											
Nov-14			4,567											
Dec-14			4,548											
Jan-15			4,529											
Feb-15			4,510											
Mar-15			4,492											

Notes:
1. Boards submitted 3-year trajectories for emergency bed days in the 2012/13 LDPs. These are provided in the table above
2. The data are the number of emergency bed days in a year per 1,000 population
3. Boards have access to more recent performance management information

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

NHS BOARD LEAD:	Julie White, Chief Operating Officer

Delivery and Improvement

Risk	Management of Risk
The Dumfries and Galloway Discharge Partnership will strive to deliver this improved standard set by Scottish Government. The following are risks that have been identified in attaining this:-	
• Relative fragility of provision of Care Home placements across the region.	• Close collaboration with Joint Commissioners. Work currently being undertaken with regards to provision of long term care
• Lack of provision of home care packages region wide linked to workforce issues within the private home care system. This also has a significant impact on STARS (the joint reablement service)	
• The lack of consistency of the implementation of the Choice guidance following National revision	• Training and Education for all stakeholders once revised policy in place
• Lack of provision of specialist care placements including EMI provision and tenancies for individuals under the care of the Mental Health Team especially in the context of the increasing elderly demographics	• Improved co-ordination/management of allocation process. Shared understanding of purpose of individual facilities including looking at and responding to demographics.
• Under-utilisation of Cottage Hospital beds	• A review of the current discharge process is under way for review and changes to the current process need to be implemented swiftly in order to improve patient flow

Workforce

Risk	Management of Risk
To ensure safe, appropriate and timely discharge from hospital the individual's journey must be co-ordinated and all disciplines and agencies must work collaboratively. The team must be satisfied that all treatment, rehabilitation and enablement is complete or a comprehensive assessment of needs is complete within the agreed timescales. The risks identified for the workforce are :- • The lack of consistency of approach to ensuring assessment completed within the agreed timescales • To maintain effective communication between all stakeholders • To agree and ensure a shared understanding of the Admission, Transfer and Discharge process including Delayed Discharge	• Training and Education for all Stakeholders. Monitoring and Evaluating agreed processes and timescales • Ensuring a more integrated approach by supporting teams to deliver a high level of communication • Training and Education for all Stakeholders. Monitoring and reporting of Delayed Discharges. Reflection and learning via the Delayed Discharge Partnership

Finance

Risk	Management of Risk
Individuals who stay inappropriately in a NHS facility. This does incur cost but may also at peak times of activity delay/cancel elective admissions	Rigorous implementation and monitoring of the Admission, Transfer and Discharge Policy.

Equalities

Risk	Management of Risk
The Delayed Discharge Partnership ensures an equal access to assessment and care provision to all individual's. The following are risks identified :- • Lack of responsive availability of services to meet demand due to reduced timescale to discharge • Potential for some individuals to be placed in an interim placement not within their local community • Through the lack of clarity at	• To continue to develop community based services with a focus on re-ablement. Delivering services in or close to individual's homes. • Ensure that a consistent approach is applied at all times to all individuals. Clear concise information available for all members of the public. • Representations have been made to the

national level regarding the Choice guidelines, the approach to placement may not always be applied equally especially where a guardianship order is in place	national discharge group who are considering making interim changes in March which would require parliamentary approval.

14 Days Delayed Discharge

Census Night	Ayrshire & Arran	Borders	Dumfries & Galloway	Fife	Forth Valley	Grampian	Greater Glasgow & Clyde	Highland	Lanarkshire	Lothian	Orkney	Shetland	Tayside	Western Isles	National Waiting Times Centre
Oct-12			3												
Apr-13			2												
Jul-13			1												
Oct-13			0												
Jan-14			0												
Apr-14			0												
Jul-14			0												
Oct-14			0												
Jan-15			0												
Apr-15			0												

Further reduce healthcare associated infections so that by March 2015 NHS Boards' staphylococcus aureus bacteraemia (including MRSA) cases are 0.24 or less per 1000 acute occupied bed days; and the rate of Clostridium difficile infections in patients aged 15 and over is 0.25 cases or less per 1000 total occupied bed days.

NHS BOARD LEAD:	Hazel Borland, Nurse Director

Delivery

Risk	**Management of Risk**
Possible failure to meet staphylococcus aureus bacteraemia (SAB) and/or Clostridium difficile (CDI) HEAT targets	SAB and CDI action plans in place. Maintaining good communication with HPS to confirm all actions expected are in place Robust root cause analysis process enables the lessons learned from each case to be addressed. These are fed back to clinicians. Reviewing current feedback processes and moving towards more formal single system aligned with HPT methods for GP feedback. Liaison with Scottish Ambulance Service and close working between Infection Control Team & Health Protection Team allows actions to be taken in Acute and Primary Care settings. MRSA clinical risk assessment and screening fully implemented as per National policy. Use of national audit tool starts from February 2013 Surveillance data shared with acute service managers on a monthly basis; and Primary Care and Women & Child Health quarterly. HAI data discussed at Hospital Management Board every month to identify challenges and actions required HAI Exec Group meets monthly to identify barriers and priorities for action HAI report to each bi-monthly Board meeting. HAIRT submitted every month to SGHD. Healthcare Governance Committee receives progress report at every meeting – HAI is standing agenda item. Also receives Infection Control Committee minutes. From January 2013: Microbiology/ICD led ward rounds for CDI patients in DGRI SCIPS (Chapter 1 of the national infection control manual) implemented as required by CNO letter. Baseline audit completed.

Workforce

Risk	Management of Risk
Staff turnover may affect compliance with policy.	Mandatory infection control induction training for all staff prior to commencing work
Staff knowledge with regard specific prevention and control of infection matters can be variable.	Mandatory infection control update training for all staff every two years. ICT working with collaboratively with senior nurses to ensure appropriate staff training for SCIPs is maintained and arrangements for regular audit implemented. Additional targeted Team-based training provided as requested or when identified as a need. Prevention and Control of Infection Nurses undertake walk rounds and working clinically in wards to promote good practice and improve knowledge All staff required to have a relevant HAI objective as part of their APDR
Risk of insufficient Infection Control Team capacity to support necessary actions to reduce infections	Maintain investment in the Infection Control Team. Full ICT in place. Skill mix introduced to ensure succession planning and matching of skill to activity.

Finance

Risk	Management of Risk
Some measures agreed to potentially reduce infection rates e.g. a change of product, may have a financial cost. Though it would be expected that reduced infections will reduce service costs through saved bed days and treatment costs	All changes to products are agreed by the HAI executive group and only on the basis of a cost benefit analysis and in association with the procurement team. Loss of financial support MRSA screening from SGHD anticipated and lab methods have been refined to make this more efficient and for the impact of this to be minimised.

Improvement

Risk	Management of Risk
The physical environment may compromise ability to sustain standards.	Major hospital rebuild will deliver 100% single room accommodation in acute setting (DGRI) in 2017. Members of the Infection Control Team have a key role in the development of designs for rooms and other clinical areas. HAI multidisciplinary walk rounds take place monthly in DGRI. These are also environmental walk rounds every 3 months. This system has been formalised to include a priority for action assessment. The Environmental Hazards Group holds a limited budget to allow issues to be rectified. A two person maintenance team is allocated to visit each ward in DGRI to attend to issues raised using risk based approach These walk rounds also take place on a regular, but less frequent basis, in the cottage hospitals. (bi-annual for cottage; quarterly GCH) Cleaning audits performed using the National facilities monitoring tool and are consistently high.
Risk of not achieving reduced rate infections	Implementing HPS PVC bundle Comprehensive audit programme established across NHS Dumfries and Galloway Antimicrobial prescribing compliance audits (Antimicrobial management team). AMT ensures the effective introduction and consistent implementation of anti microbial policy. Collecting data on prophylactic antibiotic use for national improvement work via SAPG/AMT Antibiotic compliance in hospital settings is reported nationally. Antibiotic usage in primary care is also monitored and reported to the AMT - this has improved significantly Provision of antibiotic prescribing educational sessions for Doctors CAUTI maintenance bundle tested and fully spread in DGRI by end March 2013

Failure to sustain improvement programme	Patient safety and HAI reports to every bi-monthly Board meeting Strong ICT links with SPSP allow frank exchange regarding improvement programmes and identification and assessment of risk and barriers to improvement. Strong ICT and HPT links enable knowledge sharing Integration of ICT into many work streams ensures that when an issue is identified links are already in place to allow these to be addressed. Acute Nurse Manager monthly Quality Improvement meetings – HAI standing item and attended by ICN The ICN responsible for community hospitals in the East and West of NHS D&G attends Senior Charge Nurse meetings where HAI is a standing item.

Equalities

Risk	**Management of Risk**
Intra venous drug users (IDUs) are at high risk of developing blood stream infections including SAB.	Education and harm reduction including the provision of clean injecting equipment has been ongoing in NHS D&G since 2008. Reduction in funding for BBVs may have an impact the harm reduction education provided due to capacity issues within the HPT. Priority for funding remains testing and treatment together with provision of the full range of injecting equipment.
The measures that have been undertaken do not fully take account of the needs of people from minority groups e.g. accessible information for people with learning disabilities and/or people whose first language is not English	Where available, the national leaflets developed by HPS are used; any locally produced leaflets are developed in consultation with a public panel. Nationally produced 'easy read' leaflets for MRSA screening are in use. Where an interpreter is required a company called 'Languageline' provides a telephone interpreter service and who also translate documents when required. Our local Sensory Impairment Unit can put information onto audio tape/CD if required. All policies included in the Infection control manual are Equality Impact Assessed at review.

MRSA/MSSA Bacterium

Year Ending	Ayrshire & Arran	Borders	Dumfries & Galloway	Fife	Forth Valley	Grampian	Greater Glasgow & Clyde	Highland	Lanarkshire	Lothian	Orkney	Shetland	Tayside	Western Isles	National Waiting Times Centre
Jun-12			0.22												
Jun-13			0.22												
Sep-13			0.22												
Dec-13			0.22												
Mar-14			0.22												
Jun-14			0.22												
Sep-14			0.22												
Dec-14			0.22												
Mar-15			0.24												

Notes:
1. Boards are expected to achieve a rate of 0.24 cases per 1,000 acute occupied bed days or lower by year ending March 2015. Boards currently with a rate of less than 0.24 are expected to at least maintain this, as reflected in their trajectories.
2. Boards will be held to account against the 0.24 rate.
3. It is acknowledged that there are particular issues with island board targets given that very small changes in case numbers will have a disproportionate impact on rates. This will be taken into account when assessing whether these boards have effectively delivered their target; but the expectation of zero tolerance of preventable infections will continue to apply.
4. Information for year ending June 2012 is included in the table

Clostridium difficile infections

Year Ending	Ayrshire & Arran	Borders	Dumfries & Galloway	Fife	Forth Valley	Grampian	Greater Glasgow & Clyde	Highland	Lanarkshire	Lothian	Orkney	Shetland	Tayside	Western Isles	National Waiting Times Centre
Jun-12			0.34												
Jun-13			0.33												
Sep-13			0.32												
Dec-13			0.31												
Mar-14			0.3												
Jun-14			0.28												
Sep-14			0.27												
Dec-14			0.26												
Mar-15			0.25												

Notes:
1. Boards are expected to achieve a rate of 0.25 cases per 1,000 occupied bed days by year ending March 2015. This relates to people aged 15 and over. Boards currently with a rate of less than 0.25 are expected to at least maintain this, as reflected in their trajectories.
2. Boards will be held to account against the 0.25 rate.
3. It is acknowledged that there are particular issues with island board targets given that very small changes in case numbers will have a disproportionate impact on rates. This will be taken into account when assessing whether these boards have effectively delivered their target; but the expectation of zero tolerance of preventable infections will continue to apply.
4. Information for year ending June 2012 is included in the table
5. Based on C Difficile Infection (CDI) data from Health Protection Scotland

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

NHS BOARD LEAD:	Julie White, Chief Operating Officer

Delivery

Risk	Management of Risk
Failure to achieve target as A&E activity continues to rise in line with national trends.	The target will be challenging for the Board to achieve, however a number of plans are in place including: **Whole system mapping and analysis of the unscheduled care flow across all key partners within Dumfries and Galloway** • This provides a detailed understanding of the overall patient flow. • Opportunities for redesign and service improvement which were highlighted are progressing: • Good partnership working between Scottish Ambulance Service and our Out of Hours Service supports the ability to offer access to medical advice to appropriate patients who would have otherwise been transferred by the Scottish Ambulance Service to A&E. **Signposting of patients to a more appropriate service** • NHS Dumfries and Galloway is working with their partners to develop algorithms for signposting patients to the Out Of Hours Service, Emergency Dental Service, Community Pharmacy and back to Primary care if more appropriate care could be provided by these services. • A liaison group has been established between dental services and A&E with a particular focus around the flow of dental patients and ensuring these are signposted appropriately to the emergency dental services. • Analysis of patients who attend frequently to the OOHs service and Accident and Emergency is provided to the relevant GP practice/ service provider and work is ongoing on a patient-by-patient basis to ensure these patients' needs are addressed more appropriately. • Analysis of the patients who attend A&E and emergency admissions by GP practice is also provided to the relevant Primary Care team highlighting areas of variation across the region. These issues are among the areas of focus for the newly constituted Area Clinical Activity Committee and two GP facilitators have been appointed to engage with GPs around the flow of patients and possible actions from within primary care which could reduce attendance and admission rate. This work is supported by the new GP contract Quality and Outcome Framework.

	Informing the public about access to appropriate information and unscheduled care services. • NHS Dumfries and Galloway has developed a local website to host the information provided within the Know Who to Turn to Campaign linking to post code searchable information within NHS 24 and NHS Inform websites. • Detailed analysis is underway to identify key populations who are high users of A&E and plan a programme of targeted social marketing. **Improving the integration of mental health services/ alcohol services to demands for unscheduled care** • A liaison group comprising key senior clinicians from Accident and Emergency, Out of Hours, Mental Health and Substance Misuse meet regularly to explore any opportunities for service improvement. • The Mental Health and Substance misuse teams are actively involved in supporting the management of patients, known to their services, who attend Accident and Emergency and OOHS on a frequent basis. • Analysis of paediatric alcohol services highlighted two key areas within Dumfries and Galloway where there is a higher incidence of attendances. Work is ongoing with the School Nurses and Public Health Practitioners to explore the most efficient route to tackle this problem. There are good links to the local Education Department's school clusters and a range of alcohol or risky behaviours educational initiatives currently underway. • Frequent attendee information around A&E and Out of Hours attendances for the 0 – 5 age group is shared with Health Visitors with the focus upon supporting (where appropriate) parents of these younger patients to become less dependent upon unscheduled care services for routine advice. • Work is ongoing with NHS 24 to explore initiatives that will support reductions in rates of attendance at A&E and work to identify and resolve any issues with A&E referrals to reduce the number that are queried by hospital clinicians or GPs. **Performance Management Actions:** A multi-disciplinary team led by the Medical Director are taking forward a number of new initiatives to reduce the A&E attendance levels. These include: • Focus on reducing A&E Attendance which is a major part of QiP/QoF • Consideration is being given to implementing a '3 day rule' at DGRI and GCH • Initiating a media campaign around A&E attendance • Discussions regarding more psychological input being made available for repeat attendees (The GPs are informed of patients who are attending A&E on a regular basis and are asked to review the patient's needs and consider a multi-disciplinary group approach to try to address the underlying problem. Where this relates to psychological problems a referral can be made to the psychology department) • Performance is being fed back to the department each month

Workforce

Risk	Management of Risk
There are no particular workforce challenges associated with this target.	

Finance

Risk	Management of Risk
There are no particular finance challenges associated with this target.	

Improvement

Risk	Management of Risk
There are no particular improvement challenges associated with this target.	

Equalities

Risk	Management of Risk
There are no particular equality challenges associated with this target.	

Rate of Attendance at Accident & Emergency

Year Ending	Ayrshire & Arran	Borders	Dumfries & Galloway	Fife	Forth Valley	Grampian	Greater Glasgow & Clyde	Highland	Lanarkshire	Lothian	Orkney	Shetland	Tayside	Western Isles
Sep-12			2,589											
Jun-13			2,599											
Sep-13			2,591											
Dec-13			2,583											
Mar-14			2,575											

Notes:
1. Boards submitted 3-year trajectories for number for attendances in the 2011/12 LDPs. These are provided in the table above (including any 2012/13 LDP Amendments)
2. Trajectories show anticipated monthly average attendance rates per 100,000 population at specified departments for year ending in the months shown. The target will be monitored using the 12 month moving average - based on attendances at these sites as reported by ISD, and relevant NRS mid-year population estimates.
3. Latest published information for financial year of 2011/12 is included in the table