



LOCAL DELIVERY PLAN

2010/11

ANNEX 1

Supporting the Scottish Government's Outcomes-based approach

An outcomes-based approach encourages a focus on making a real difference, and having an impact of what matters to the citizens of Tayside. NHS Tayside has been working in for the past three years with other organisations in NHS Scotland, with Community Planning Partners and with the Scottish Government to develop an outcomes-based approach based upon agreed priority areas. This allows NHS Tayside to:

- i. Align what it does to contribute to the Government's over-arching purpose of sustainable economic growth through the National Performance Framework.
- ii. Better integrate activities with local government, with other Public Bodies, and in partnership with the Third and private sectors, to address the Government's Purpose Targets and National Outcomes through Single Outcome Agreements (SOAs).
- iii. Concentrate effort on achieving real and lasting benefits for people locally.
- iv. Create the conditions to release innovation and creativity in delivering better outcomes.

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

This new context paved the way for the review of the HEAT targets for 2008/9 which meant that the HEAT targets and Local Delivery Plans were designed more clearly to make explicit the contribution of the NHS to the Government's Purpose and National Outcomes. (See mapping of the 2010/11 targets on to the National Outcomes and targets. The process of review will continue each year.) This has resulted in the refinement of a number of HEAT targets. For example, in 2007/8 HEAT contained a target for smoking rates. This is in fact a long-term outcome achievable only through the contributions and actions of a range of public services, private companies and individual behaviours, and is appropriate for consideration as part of an SOA. For 2008/9, therefore, the HEAT target was changed to one that supports the long term outcome, but is under the direct influence the NHS — i.e. successful quit attempts following attendance at smoking cessation clinics. Such targets are agreed to be more appropriate for performance management and review. Other public sector bodies will similarly identify appropriate activities and targets reflecting their own contributions to reduce smoking rates.

Through its LDP, NHS Tayside sets out how it will be judged in terms of performance on the priority outputs which have been agreed with Government to support the delivery of the Government's outcomes.

Through the three Community Planning Partnerships in Tayside (Angus, Dundee, and Perth & Kinross) NHS Tayside has worked with the councils, other public bodies, and the third and private sectors to agree the local priority outcomes and related indicators. The outcomes based approach allows each organisation to be clear about the contribution it has to make to the wider aims of the Community Planning Partnerships. Each partner organisation is responsible for ensuring that it has appropriate performance management systems in place to ensure the delivery of its specific responsibilities. The Local Delivery Plan is one important aspect of that performance management system, both within NHS Tayside through regular review and monitoring of the HEAT targets, and between NHS Tayside and the Scottish Government principally through the Annual Review with the Cabinet Secretary.

The HEAT core set contains a number of nationally set targets. The effort both locally and nationally to achieve the targets has resulted real benefits for service users — e.g. significant reductions in inpatient waiting times and reduced healthcare associated infections. A number of the HEAT targets in the LDP however very clearly contribute – in line with an outcomes based approach - to outcomes shared across the Community Planning Partnerships, e.g. drug and alcohol treatment supporting recovery.

NHS Tayside also has and will continue to contribute towards the delivery of the three local Single Outcome Agreements over and above the HEAT targets. The contributions are set in Annex 6 of the Local Delivery Plan. This has been revised to allow a focus on our Board's contributions to the 4 national priority areas:

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

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

NHS Tayside is in the process of developing long term outcomes in line with its four strategic aims of:

Contribute to closing the health inequalities gap within a generation;
Improve healthy life expectancy by supporting people to look after themselves; Ensure services meet agreed quality standards, especially patient experience;
Be cost effective in all decisions, actions and services

The outcomes will –as appropriate – be agreed with Community Planning Partners to take further the process of developing shared outcomes that will deliver long term improvements for local people.



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



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

indirect or longer term contribution to National Outcome or Purpose Target

HEAT TARGET CONTRIBUTING TOWARD SCOTTISH GOVERNMENT'S PURPOSE TARGETS	HLE	Economic Growth, Productivity, and Participation	Population growth	Cohesion, Solidarity	Sustainability
H3: Child healthy weight intervention					
H4: Alcohol brief intervention					
H5: Suicide prevention training programmes					
H6: Smoking cessation services					
H7: Exclusively breastfed at 6–8 weeks					
H8: Inequalities targeted cardiovascular Health Checks					
H9: SIMD quintile to have fluoride varnishing					
E4: Clinical Productivity					
E5: Financial Balance					
E6: Cash efficiency					
E7: GP outpatient managed electronically					
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T9: Early diagnosis and management of dementia					
T10: Shifting balance of care: A&E attendances					
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T12: Emergency inpatient bed days (aged 65+)					

 clear line of sight in supporting short term progress towards National Outcome or Purpose Target
 indirect or longer term contribution to National Outcome or Purpose Target

Purpose Targets

Economic Growth (GDP)

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

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

Productivity

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

Participation

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

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

Population

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

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

Solidarity

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

Cohesion

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

Sustainability

To reduce emissions over the period to 2011 (T)

To reduce emissions by 80 percent by 2050 (T)

Annex 2: LDP Risk Narrative

Health Board: NHS TAYSIDE

Use of Narrative

Please insert Health Board name in the space provided above.

Please insert in the space provided for each target, the Health Board Lead responsible for the target.

Boards should, as in previous years, use the LDP Risk Narrative to provide contextual information on key risks to delivery of each target and how risks are being managed. Within the template, the description of the key risk should be provided in the first column and detail on how the risk is being managed should be provided in the second column. Cross-reference to local plans should be made where necessary.

- **Delivery:** briefly highlight local issues and risks that may impact on the achievement of targets and/or the planned performance trajectories towards targets and **how these risks will be managed**.
- **Workforce:** brief narrative on the workforce implications of each of the HEAT targets **where appropriate and relevant**. This should include an assessment of staff availability to deliver the target, the need for any training and development to ensure staff have the competency levels required, and consideration of affordability cross referenced to the Financial Plan.
- **Finance: Where applicable** boards should identify and explain any specific issues, e.g. cost pressures or financial dependencies specifically related to achieving the target. There is **no need to repeat generic financial risks** that apply to all targets.
- **Improvement: Where applicable**, boards should outline any risks to sustainable improvement, particularly in respect of their national improvement programmes and implementation of lean methodology, required to deliver and sustain targets and how these are being managed.
- **Equalities: Where applicable**, boards should outline any risks that the delivery of the target could create unequal health outcomes for the six equalities groups, and/or for people living in socio-economic disadvantage; and how these risks are being managed.

Health Improvement for the People of Scotland

Health Improvement

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

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

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

H6: Through smoking cessation services, support 8% of your Board's smoking population in successfully quitting (at one month post quit) over the period 2008/09–2010/11

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

H8: Achieve agreed number of inequalities targeted cardiovascular Health Checks during 2010/11

H9: At least 60% of 3 and 4 year olds in each SIMD quintile to have fluoride varnishing twice a year by March 2014.

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

NHS BOARD LEAD:	Peter Williamson
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Delivery

Risk	Management of Risk
<p>Insufficient children and their families are seeking access to weight management support. This arises from the current culture whereby families and parents do not recognise 'unhealthy weight' in their children, as well as children being unhappy to have their weight issues discussed. There is evidence to suggest that parents feel judged and consider themselves being seen as inadequate parents when weight issues are discussed. These issues are seen nationally and are a problem for all Scottish Health Boards. To date there is no Scotland-wide approach to trying to help overcome these very substantial barriers to enabling more children and families to wish to engage in a childhood weight management programme.</p>	<p>POST team will continue to raise the profile of the POST service to health professionals, other partner organisations and to the general public. POST has been working with the NHS Tayside Communications Department to ensure a productive working relationship with the local press.</p> <p>POST team is currently undertaking a social marketing exercise aimed at increasing referral to and uptake of POST.</p>
<p>Obtaining early agreement from the Education Departments to achieve the projected numbers through the school based intervention programmes by March 2011.</p>	<p>Closely negotiate with the Education Departments and target resources towards a workable programme that could be piloted within Tayside schools over the next 12 months.</p>

Workforce

Risk	Management of Risk
<p>The funding from the Scottish Government is insufficient to enable the establishment of a fully comprehensive service to cover all the areas of Tayside. This is partly due to the selected interventions (these are evidence-based), which involves intensive behavioural change techniques used in the programmes. Therefore clinics are concentrated in Perth city, Dundee city (Kirkton and Fintry) and Arbroath.</p> <p>There are sufficient staffing levels to cover these clinics and there is capacity to meet the Scottish Government's projection of 440 children, provided applicable children and their families are referred to POST and subsequently choose to attend.</p>	<p>Part of current staff time is being utilised in promoting the service in various venues across Tayside e.g. in schools, supermarkets and to other service providers.</p> <p>A POST staff member is also leading on the Tayside social marketing exercise aimed at improving the referral rates to the service.</p>
<p>There is a need for training of the main gate keepers to a childhood weight management service in, correct diagnosis of childhood obesity (use of BMI charts), and to help increase their confidence in discussing this sensitive subject. This has been instigated by the POST team and training has been offered to all partner organisations working with children in Tayside (free-of-charge).</p>	<p>Further discussion with the GMC GP sub-Committee is planned, to encourage GPs to undertake training.</p> <p>Further wide spread advertising of POST training.</p>

<p>To date over 100 professionals have attended these training sessions. Further sessions are planned across the 3 Community Health Partnerships (CHPs) during 2010. To date General Practitioners have not taken up offers of training sessions.</p>	
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Finance

Risk	Management of Risk
<p>In December 2008 a report was prepared for NHS Tayside's Executive Team outlining the financial requirements for implementation of the NHS Tayside weight management pathway for children & young people. There has been no resource given nationally to carry out national social marketing nor to help the general public with the recognition of childhood obesity and to underline the help available locally for families.</p>	<p>The POST team in conjunction with Dr Drew Walker (Director of Public Health), Paul Ballard (Deputy Director of Public Health) and Joyce Thompson (Dietetic Consultant in Public Health Nutrition) are contributing to the development and implementation of a local social marketing exercise in Tayside to establish ways to increase the number of referrals being made into the paediatric weight management service.</p>

Improvement

Risk	Management of Risk
<p>Prior to the provision of HEAT3 funding a weight management service for children in Tayside did not exist. Therefore in the absence of an explicit funding stream for this service e.g. from the Scottish Government, it is doubtful that the POST service will be able to continue in Tayside. The POST has been funded from HEAT3 money only with no additional funding from NHS Tayside.</p> <p>It is anticipated that the provision of training to professionals across agencies will leave the start of a legacy of staff with improved knowledge, skills and understanding in childhood obesity.</p>	<p>Currently awaiting the outcome of the Scottish Government's next 3-year spending review to ascertain if there will be further HEAT3 funding. If no Scottish Government funding is planned then proposals will need to be submitted to NHS Tayside to consider future funding arrangements for the service.</p> <p>In the absence of funding for POST, discussions will need to take place regarding plans to run down the POST service in 2011.</p>

Equalities

Risk	Management of Risk
<p>No particular risks are perceived in these areas. Locations for POST are particularly focused towards low socio-economic groups. However, the one inequity that could be seen in the service relates to geographical location i.e. those not living close to Perth or Arbroath. There is insufficient funding to allow for clinics to be more widely dispersed across Tayside.</p>	<p>Information on why families do not opt into the service is being sought and will be interrogated. Views of both service users, gate keepers and those not opting in are being sought as part of the overall evaluation and the social marketing exercise.</p>

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

NHS BOARD LEAD:	Peter Williamson
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Delivery

Risk	Management of Risk
Required increase in activity in Year 3 to compensate for poor performance in Year 2 may not be achieved.	<p>Locally Enhanced Service to be reviewed and revised in consultation with the GP Sub Committee.</p> <p>Additional training to be provided to primary care.</p> <p>Liaison and support to primary care from Tayside Alcohol Problem Service (TAPS) to be improved and targeted at low performing practices.</p> <p>Roll out of programme in Maternity Services to be supported and monitored.</p> <p>Screening to be extended to all Minor Injury Units in Angus and Perth and Kinross</p>
Activity reporting is delayed and problems with performance are not identified in a timely manner.	Reporting arrangements to be closely monitored. Tayside will hold ongoing engagement with the Scottish Government on progress with delivery of this target.

Workforce

Risk	Management of Risk
<p>Training in the delivery of alcohol screening and brief interventions will continue to be required to ensure this becomes a routine feature of the NHS.</p> <p>Regular refresher/update training will be required to maintain skills.</p>	A training post funded by Health Scotland has been established and is integrated with the TAPS liaison service. Training will be co-ordinated and delivered by this service.

Finance

Risk	Management of Risk
<p>Significant investment has been made across all services and agencies to support the delivery of screening and brief interventions in a range of settings and to increase the capacity and capability of treatment and support services.</p> <p>No deficit has been identified or is anticipated at this stage.</p>	All associated costs will be met from existing resources or the ring fenced new alcohol funds.

Improvement

Risk	Management of Risk
Failure to really embed the techniques into routine practice at this stage.	Investment of staff time in sustainable training programmes.

<p>Insufficient time available to staff within their one to one encounters with patients to deliver effective health improvement alongside meeting the immediate issues raised by patients themselves.</p>	<p>Consideration given to the place of supporting health improving behavioural change in routine health care interventions.</p> <p>Expansion of the settings where ABIs may be delivered as additions/alternatives to clinical settings following evaluation of national and local pilots (e.g. criminal justice).</p>
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Equalities

Risk	Management of Risk
<p>Alcohol related health harm is demonstrably greater among those living in socio-economic disadvantaged circumstances. Failure to identify people at risk and provision of appropriate interventions through routine screening is likely to lead to continued higher rates of alcohol health harm among this group.</p>	<p>Through the collation and interpretation of activity data assess the proportion of those being screened who are among this group and identify geographical areas or service settings that are more likely to improve screening rates.</p>
<p>People living in socio-economic disadvantaged circumstances, particularly young men, are less likely to attend their general practitioner and therefore the opportunity to screen will be lower among this group.</p>	<p>A pilot programme to use community pharmacies to opportunistically screen and deliver BIs has been established to determine whether this will increase activity and uptake of interventions among this group.</p>

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

NHS BOARD LEAD:	Peter Williamson
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Delivery

Risk	Management of Risk
<p>In-house training has been developed to address H5 target. Awaiting confirmation of approval from NES/Health Scotland – information submitted at Health Scotland's request following H5 event in October 2008, revised content in March 2009 and again to suit revised Framework in February 2010 – awaiting results of accreditation process.</p> <p>From our discussions with Health Scotland, we believe that the risk of this accreditation not being granted is very low, however this would have the following impact on our training statistics: <u>Split at 31 December 2009</u> 20% trained in accredited courses 16% trained in-house (awaiting results of accreditation process) – total 35.7% Trajectory 36.5%</p>	<p>We will continue to hold dialogue with Health Scotland and if necessary ensure revision of in-house training courses to achieve accreditation. If necessary, we will revise the training programme schedule, increasing the proportion of approved courses, with intensive roll-out to staff.</p>

Workforce

Risk	Management of Risk
<p>Identification of trained and motivated individuals to deliver training.</p>	<p>Pool of trainers identified and reviewed – resource identified to “buy-in” trainers where necessary (see Finance).</p>
<p>50% of identified staff group to receive training by 31 December 2010.</p> <p>Implications for service managers around release of staff, requiring potential back-fill or locum costs.</p>	<p>Training programme schedule and content has been revised following dialogue with Health Scotland. We are planning intensive negotiation with service managers to facilitate release of staff.</p>

Finance

Risk	Management of Risk
<p>Resource identified through Scottish Government ‘Delivering for Mental Health’ ring-fenced funding.</p> <p>Should we need to increase the number of purchased training programmes this will have a significant financial impact to cover costs of training, backfill and locum cover.</p>	<p>Funding source: Delivering for Mental Health Implementation. £10K pa identified for 2009/10 and 2010/11 to cover materials, backfill, etc.</p> <p>Further finance may need to be identified to cope with potentially increased backfill and locum costs. There are 350 staff yet to be trained, with a contingency plan to address a potential shortfall of 850 staff, should in-house training require further revision.</p>

Improvement

Risk	Management of Risk
Ongoing training of staff.	Ongoing staff training programmes will be managed locally, with training requirements highlighted through PDP/ KSF.

Equalities

Risk	Management of Risk
Skewed delivery and/or take up of training by staff in parts of Board with an affluent population might exacerbate inequalities among these groups.	Ensure training is spread across all staff groups and localities. Ensure planned delivery takes account of the need to target staff in settings characterised by deprivation.

H6: Through smoking cessation services, support 8% of your Board’s smoking population in successfully quitting (at one month post quit) over the period 2008/09 – 2010/11.

NHS BOARD LEAD:	Peter Williamson
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Delivery

Risk	Management of Risk
NHS Tayside is making good progress towards achieving the target, however, inadequacies in the data capture system has resulted in this not being demonstrated through the national data set.	A number of actions are being undertaken to address this, however, we are not confident that we will completely address the deficiencies in time to achieve 100% compliance with the HEAT target in 2011.
Under GMS, GP practices are not directly reimbursed to provide smoking cessation services. Only about 40% of smokers prescribed Varenicline by their GP receive smoking cessation support and few are recorded on the National Database. In 2008 it is estimated that Tayside lost 1,500 patients from the reported national figures.	Work with practices is ongoing across all three CHPs to raise awareness of the problem and audit the effectiveness of Varenicline therapy. These audits have been incorporated into the prescribing leadership work stream. Working with IT, a prompt system for Vision has been designed and is being implemented to improve referral rates. We are seeking agreement on the initiation of a locally enhanced service for general practice in which practices are incentivised to refer patients to smoking cessation services.
Community pharmacists are reimbursed for smoking cessation services through the Community Pharmacy Contract. A separate data submission to the Board is required as part of the service specification for the Public Health Services. In 2008, it is estimated that Tayside lost about 800 patients through this effect.	Work is ongoing nationally and locally to raise awareness of the issue. Locally, the Community Pharmacy Development Officer is working with individual pharmacies to ensure a high rate of submission.
Tayside loses about 40% of quit attempts to follow up. The national system applies a rigid interpretation and assumes that this is because smokers have failed their quit attempt and resumed smoking. In 2008, Tayside lost 1,063 smokers at follow up from the National Database.	A robust system of follow up by letter has been in place since 2006. In an attempt to improve follow up rates, Tayside is currently trialling a telephone call-based follow up system.
As the proportion of the population who smoke decreases, then the remaining smokers tend to be less likely to engage because of higher degrees of nicotine dependence and higher levels of social disadvantage.	A comprehensive marketing plan is used to publicise services using local and national media. The plan is derived from patients’ consultation and research and utilises insights gained from this work and provision of social proof to encourage smokers to quit.

Workforce

Risk	Management of Risk
Provision of smoking cessation support requires skilled health promotion officers. The NHS Tayside Smoking Team currently has no vacancies, but if one arises then it will be unlikely that we will be able to recruit internally. An inability to fill a vacancy in 2007 led to a decrease in numbers of smokers engaging in services in Dundee.	The impact of any vacancy on the delivery of smoking cessation targets will be reviewed and appropriate actions taken according to NHS Tayside’s staff recruitment policy.

On-going training is provided for staff wishing to learn health behaviour change skills. This training is run using materials provided by Health Scotland and is positively evaluated by staff undertaking it. Less community nurses now have opportunities to use training provided.	It is expected that training provision will continue.
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Finance

Risk	Management of Risk
The smoking cessation programme is resourced from ring-fenced monies provided for the implementation of the Government strategy, <i>"A Breath of Fresh Air"</i> . This funding stream comes to an end at March 2011 and no indications of future plans have yet been announced. Additional funding of £260K has been gained from the Scottish Government and Health Scotland to support the implementation and evaluation of Quit4U.	A review of smoking cessation services and effectiveness is due to commence in March 2010, in anticipation of the next spending review. The risks to services will be examined as part of this exercise. Funding of the main smoking cessation programme and the Quit4U intervention may therefore be at potential risk.

Improvement

Risk	Management of Risk
Risks identified in delivery section above.	

Equalities

Risk	Management of Risk
The NHS Tayside Best Value Review on Smoking Prevention and Cessation Services was designed to focus resources and opportunities on smokers from disadvantaged communities.	Diversity documentation has been drawn up to support the smoking services plan.
There are no identified risks to the six equality groups.	

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

NHS BOARD LEAD:	Peter Williamson
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Delivery

Risk	Management of Risk
Redesign of community nursing has had an adverse effect on how breastfeeding is prioritised within the workload. Many women will opt to formula feed and stop breastfeeding in order to go home from hospital. Targeted support for this population will optimise continuation rates.	CEL 36 funding has enabled the opportunity to provide additional breastfeeding support within the maternity service and community nursing services. This will be in place by April 2010.
Release of staff to attend training due to clinical workload pressures.	Negotiation with training and development teams to prioritise breastfeeding in PDP of all clinical staff.
Maternity services in Ninewells currently do not have the UNICEF Baby friendly accreditation.	Implementation of UNICEF UK Baby friendly Initiative will continue to ensure optimal care standards.

Workforce

Risk	Management of Risk
Requirement to recruit an additional number of staff.	Will be appropriately addressed within the Workforce Plan. In addition, through CEL 36 funding, existing Dundee CHP staff have been redeployed to work within maternity services. Fixed term contracts will also be managed according to NHS Tayside HR policies.
Breastfeeding training requires to be available as part of NHS Tayside Breastfeeding policy and strategy.	The redesign of community nursing and subsequent skill mix within community nursing team has resulted in further training on breastfeeding management for new staff. The existing breastfeeding programme will continue in existing work plan of Breastfeeding Co-ordinator and will be offered to the three NHS Tayside Community health Partnerships.

Finance

Risk	Management of Risk
No funding implications - CEL 36 funding has been available since September 2008 and agreement on allocation of the funding across the three CHP areas and maternity services finalised in October 2009. This has resulted in a considerable delay in the implementation of action plans for improvement.	

Improvement

Risk	Management of Risk
<p>Historically breastfeeding is a difficult behaviour to influence. The population of pregnant women changes annually providing a short window of opportunity to influence behaviour. Allocation of sufficient time to support breastfeeding has been identified as a risk to any long term improvement in breastfeeding rates.</p>	<p>Identification of innovators and early adopters for improvement ideas by (breastfeeding champions), provision of training was completed in October 2008. Process mapping and identification of barriers and challenges with appropriate PDSA rapid improvement cycles and tests of change have commenced in January 2009.</p> <p>This additional work is incorporated into existing work patterns of midwifery staff with a specific focus on lean methodology to improve efficiency and create time to provide breastfeeding information.</p> <p>Process mapping in each of the CHP across NHS Tayside is planned during 2010. Local action plan have been completed.</p> <p>The current participation in community baby friendly practice standards (currently 13/76 health centres participating) is low. As a result women living in the community are exposed to variable practice.</p>

Equalities

Risk	Management of Risk
<p>In order to meet the target for NHS Tayside an increase of 366 women breastfeeding at 6-8 week review is required. There are insufficient numbers of breastfeeding women living in the most deprived areas of Tayside to meet this required increase.</p>	<p>Interventions will be targeted in the most deprived areas of NHS Tayside from CEL 36 funding.</p>

H8 Achieve agreed number of inequalities targeted cardiovascular Health Checks during 2010/11.

NHS BOARD LEAD:	Peter Williamson
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Delivery

Risk	Management of Risk
The target for new populations once known is likely to be at risk because of the current vacancy management controls which will impact on the ability to recruit staff to these posts.	Issues with vacancy management are being highlighted to NHS Tayside workforce directorate. Where staff have the appropriate level of skill to deliver on the new groups the policy will be adhered to but it is likely that as this is a new approach to care that some of the skills will not be available internally.
The workload for immunisation of H1N1 is not currently known as the groups for this keep changing. If significant new groups are added this is likely to impact on the ability of general practice to deliver keep well	Management of this risk is outwith the control of NHS Tayside.

Workforce

Risk	Management of Risk
If the intention of the Scottish Government is that part of the allocation should be to add new groups for assessment, rather than supporting current groups, there will be a need to recruit staff. The work with prison leavers requires new staff that may be difficult to recruit to, or be in key posts within NHS Tayside which will be hard to fill if they move. There is also a number of staff on fixed term contracts which may be reviewed and considered at risk.	We will work with the Workforce Directorate to optimise this but there is a risk that we will not be able to deliver and that funding will have to be returned to the Government and targets not met. Likewise a range of supporting interventions for this target is at risk, including the ability to evaluate the effectiveness and value of the programmes components parts.
Staff delivering Keep Well require a range of competencies, and although the numbers involved are not large the range of skills required are broad. This is challenging in terms of developing competencies and monitoring the quality of the service provided.	A key area of training is to support health behaviour change training. A range of staff support this but the capacity is limited and we are looking at how we increase this. A Co-ordinator Post is being recruited, in conjunction with long term conditions, and this will help develop this training. We work closely with clinical staff and the Managed Clinical Networks to support clinical requirements.

Finance

Risk	Management of Risk
<p>The funding allocated by the Scottish Government for this year is adequate to cover the cost of the programmes already agreed and the new groups proposed. However there is a potential financial issue as the funding is not committed beyond the current year but there is ongoing work once patients have been identified. (For example patients should routinely be reassessed at least every 5 years and potentially every year for some groups.) There is a key risk therefore in terms of supporting the ongoing workload generated from this work, both in general practice and other teams.</p> <p>The Scottish Government is expecting a broadening of the programme delivery and groups targeted but this has the potential to increase financial risks in the longer term.</p>	<p>There are a range of discussions with regards to sustaining Keep Well in the longer term at a range of levels. Evaluation is key to assessing if what is being delivered is effective and of value. We are working to improve and broaden the range of information we have in this context but given the complex nature of the process and patient journey this is challenging.</p>

Improvement

Risk	Management of Risk
<p>As highlighted the keep well assessment is part of a complex journey for many patients give the health and social needs identified in this group. All of this journey needs supported effectively to really improve inequalities in health. The lack of commitment to future funding puts this at risk.</p>	

Equalities

Risk	Management of Risk
<p>Keep Well is targeted at inequalities and although this was initially based on Scottish Government status this has been broadened to include other groups with health inequalities. It is aimed at reducing the gap that currently exists.</p>	<p>The EQIA was recently updated to assess for issues around equalities. As data has become available decisions have been made as to whether different interventions are required for specific groups. The outreach nurse role for example includes those who have not attended general practice, potentially because of a disability. Data would suggest that gender and ethnicity is not discriminated in relation to attendance rates. Monitoring of data and practitioner feedback will be used to highlight issues if/when they arise.</p>

H9: At least 60% of 3 and 4 year olds in each SIMD quintile to have fluoride varnishing twice a year by March 2014.

NHS BOARD LEAD:	Peter Williamson
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Delivery

Risk	Management of Risk
There is no risk to NHS Tayside achieving the targets set for 2010/2011 as these have already been exceeded.	

Workforce

Risk	Management of Risk
Over the next four years there would be a risk in the potential recruitment and retention of some staff. This would be especially so if national funding for the Childsmile Programme was reduced or financial constraints were imposed that could impact on the delivery of these targets.	All Childsmile programmes are directly dependent upon external finances for their implementation.

Finance

Risk	Management of Risk
Current financial resources for this Childsmile programme come separately from Scottish Government to NHS Tayside. Providing that this remains ongoing at a sufficient level, there will be no financial implications to the Board.	

Improvement

Risk	Management of Risk
No risks to sustainable improvement providing sufficient manpower available to implement the work (as detailed in workforce section above).	

Equalities

Risk	Management of Risk
No risks identified.	

Efficiency and Governance

Efficiency and Governance

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

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

E6: NHS boards to meet their cash efficiency target.

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

E8: 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.

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

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

NHS BOARD LEAD:	Peter Williamson
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Delivery

Risk	Management of Risk
With the move towards 18 Weeks RTT, the time to arrange 1 st out-patient appointments from receipt and assessment of referral to treatment is reduced. Many specialties wish to move away from Patient Focussed Booking (PFB) to advising patients of when and where to come for their appointment. This is likely to increase the DNA rate as there is no negotiation around the date and place of treatment.	Discussion and agreement of the NHS Tayside Single Delivery Unit required on the long term arrangements relating to the process and principles for booking patients to clinics.
Insufficient engagement with General Practice around patient responsibilities when the need to refer is appropriate.	Engagement with General Practice and CHPs to agree information to be given to patients at the point referral is determined. Agreement with General Practice around arrangements to follow-up patients who consistently DNA, but who require medical services.
Delayed agreement on application of local guidelines for dealing with patients whom DNA. In accordance with New Ways, some Clinicians offer only one additional appointment, some offer more.	Review of Access Portfolio to commence in 2010 which will take account of New Ways and 18 Weeks RTT principles.
Centralised booking office for Out-patient Services in Ninewells Hospital being transferred to clinical specialties.	Expertise and capacity being developed in the clinical specialties to manage out-patient bookings

Workforce

Risk	Management of Risk
No workforce implications.	

Finance

Risk	Management of Risk
No financial implications.	

Improvement

Risk	Management of Risk
No risks identified. Lean methodology being applied across the organisation.	

Equalities

Risk	Management of Risk
Equality and impact on service currently being addressed through participation in the National pilot on collection of patient data relating equality and diversity.	

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

NHS BOARD LEAD:	Peter Williamson
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Delivery

Risk	Management of Risk
There are no risks identified for 2010/11. At present NHS Tayside's performance is 3.3 days – below the target of 4.5 days by March 2011. The focus will be upon maintaining this performance.	

Workforce

Risk	Management of Risk
No workforce implications identified.	

Finance

Risk	Management of Risk
No financial implications identified.	

Improvement

Risk	Management of Risk
No risks identified.	

Equalities

Risk	Management of Risk
No risks identified.	

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

NHS BOARD LEAD:	Peter Williamson
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Delivery

Risk	Management of Risk
<p>It is acknowledged that NHS Tayside has performed less favourably at a national level.</p> <p>Current daycase rate percentage is 61.6% BADS with a total procedures at 78% (to include Nurse led procedures currently not captured at National level).</p> <p>A local performance target has been set 72.1% by March 2010 and a HEAT target of 77.3% by March 2011.</p>	<p>In 2009/10 NHS Tayside has focussed on developing systems and processes to support a policy to treat same day surgery as the norm. Measurement of daycase trajectories commenced in February 2009 within general surgery.</p> <p>Recently, with support form the National data Team at ISD and NHS Tayside Operational IT, five other elective pathways where there is significant opportunity to improve BADS daycase rates have been identified.</p> <p>Rigorous analysis of data, taking cognisance of inconsistencies in reporting of same day surgery activities and case mix variation between geographical sites is being undertaken to develop a robust benchmarking data set that will ensure accurate and complete recording of surgical procedures undertaken in an outpatient setting.</p> <p>In addition the use of OPCS codes is being scrutinised and implemented/ improved across all specialties in conjunction with clinical outcomes to capture all activity undertaken in an outpatient setting.</p> <p>Daycase trajectories and action plans are now being developed in conjunction with Strategic Improvement Plans underpinned by Lean methodology.</p> <p>Regular reporting to NHS Tayside Board with risk log to identify risks to project implementation.</p>
<p>Day case trajectories are strongly aligned to pre-assessment. Currently there is non-standardisation of processes for pre-operative assessment and admit on day of surgery.</p>	<p>Improvement work is being undertaken in two phases. NHS Tayside aims to reduce pre-op length of stay, with a target of 60% of elective surgery patients to be admitted on day of surgery by March 2011.</p>

Workforce

Risk	Management of Risk
<p>No workforce implications identified. However, to increase day surgery rates NHS Tayside expects to utilise existing resources for present improvement plan. There may be a future need for additional staff resources and training of staff to develop a robust pre-operative assessment service and for sustainability.</p>	<p>Mapping of existing resources currently underway and staff identified.</p> <p>For future expansion to include all specialties by March 2011 a further analysis of staff requirements will need to be undertaken.</p> <p>Regular reporting to NHS Tayside Board with risk log to identify staff constraints.</p>
<p>No risk to current plan, however there may be a future need to train staff to competency levels required fro pre-assessment of day surgery patients.</p>	<p>For future expansion to include all specialties by March 2011, a further analysis of staff requirements will need to be undertaken.</p> <p>Regular reporting to NHS Tayside Board with risk log to identify any training requirements.</p>

Finance

Risk	Management of Risk
<p>No financial implications. – NHS Tayside expects to utilise existing resources. However for future development of the pre-assessment service aligned to day case rates and achievement of this target there may be a financial dependency in relation to equipment, training, additional staff costs and estates.</p>	<p>Service Improvement using LEAN methodology to map future state to include a cost-benefit analysis.</p> <p>Regular reporting to NHS Tayside Board with risk log to identify financial cost pressures.</p>

Improvement

Risk	Management of Risk
<p>No risks identified.</p>	

Equalities

Risk	Management of Risk
<p>No risks identified. Equality and Diversity Impact Assessment currently being written in conjunction with National 18 week RTT Team.</p> <p>Implementation of referral governance and access policy.</p>	

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

NHS BOARD LEAD:	Peter Williamson
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Delivery

Risk	Management of Risk
<p>It has been suggested that Boards aim for around a 15% reduction in pre-operative stay; however for some Boards the reduction will be higher.</p> <p>Baseline - Tayside</p> <p>The baseline for Tayside across all surgical specialities for elective patients for 2007/08 is 0.72 days</p> <p>NHS Tayside is working towards a baseline in reduction for pre-operative stay at 20% by 2012/2013. However, this is dependent in part on the implementation of a robust pre-assessment service.</p>	<p>NHS Tayside aims to reduce pre-op length of stay, with a target of 60% of elective surgery patients to be admitted on day of surgery by March 2011. Improvement work is being undertaken in two phases:</p> <p>1st Phase Aim:</p> <ul style="list-style-type: none"> • 60% elective orthopaedic in-patients admitted on day of surgery by March 2010. • 60% elective general surgery/urology in-patients admitted on day of surgery by March 2010. <p>2nd Phase Aim:</p> <ul style="list-style-type: none"> • 60% of all elective surgery in-patients in other specialties i.e. plastics, neurosurgery, ENT admitted on day of surgery by March 2011. <p>However this will, in part only be achieved through robust surgical pre-assessment. This has been recognised as a core element in achieving 18 week Referral to Treatment targets and is a high priority for the NHS Tayside Strategic Improvement Programme. Currently work is underway to support work to achieve these targets and develop trajectories.</p> <p>Regular reporting to NHS Tayside Board with risk log to identify risks to project implementation.</p>

Workforce

Risk	Management of Risk
<p>No workforce implications – NHS Tayside expects to utilise existing resources for present improvement plan. However, there may be future need for additional staff resources and training of staff to develop a robust pre-operative assessment service and for sustainability.</p>	<p>Mapping of existing resources currently underway and staff identified.</p> <p>For future expansion to include all specialties by March 2011, a further analysis of staff requirements will need to be undertaken.</p> <p>Regular reporting to NHS Tayside Board with risk log to identify staff constraints.</p>

No risk to current plan, however there may be a future need to train staff to competency levels required.	For future expansion to include all specialties by March 2011, a further analysis of staff requirements will need to be undertaken. Regular reporting to NHS Tayside Board with risk log to identify any training requirements.
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Finance

Risk	Management of Risk
No financial implications – NHS Tayside expects to utilise existing resources. However, for future development of the pre-assessment service to achieve this target there may be a financial dependency in relation to equipment , training, additional staff costs and estates	Service Improvement using LEAN methodology to map future state to include a cost-benefit analysis. Regular reporting to NHS Tayside Board with risk log to identify financial cost pressures.

Improvement

Risk	Management of Risk
No risks identified. Lean methodology being implemented within this project.	

Equalities

Risk	Management of Risk
No risks identified. Equality and Diversity Impact Assessment currently being written in conjunction with National 18 week RTT Team. Implementation of referral governance and access policy.	

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

NHS BOARD LEAD:	Peter Williamson
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Delivery

Risk	Management of Risk
<p>Budget managers fail to identify and achieve cost reduction target.</p> <p>Medicines cost increases may be greater than planned and/or savings targets not fully achieved.</p>	<p>Identification and achievement of savings are monitored closely by the NHS Tayside Executive Team and the Single Delivery Unit Executive Management Team throughout the year.</p> <p>Performance is also monitored through NHS Tayside Taystat, the Single Delivery Unit Committee and NHS Tayside Strategic Policy and Resources Committee.</p>
<p>The source of the planned carry forward and deferred expenditure at March 2011 (£23m) is uncertain at this stage.</p> <p>The provision for successful Agenda for Change reviews may be insufficient</p> <p>The cost of volume growth and service pressures may be greater than anticipate</p>	<p>The revenue and capital position is monitored by the NHS Tayside Executive Team and the Single Delivery Unit Executive Management Team throughout the year.</p> <p>Performance is also monitored through NHS Tayside Taystat, the Single Delivery Unit Committee and NHS Tayside Strategic Policy and Resources Committee.</p>
<p>Price inflation may be higher than the planned level of 1.5%.</p> <p>Pay award settlements may be higher than anticipated.</p> <p>Cost of planned developments may be higher than anticipate</p>	<p>The revenue and capital position is monitored by the NHS Tayside Executive Team and the Single Delivery Unit Executive Management Team throughout the year.</p> <p>Performance is also monitored through NHS Tayside Taystat, the Single Delivery Unit Committee and NHS Tayside Strategic Policy and Resources Committee.</p>

Workforce

Risk	Management of Risk
No risks identified.	

Finance

Risk	Management of Risk
No risks identified.	

Improvement

Risk	Management of Risk
No risks identified.	

Equalities

Risk	Management of Risk
No risks identified.	

E6: NHS Boards to meet their cash efficiency target.

NHS BOARD LEAD:	Peter Williamson
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Delivery

Risk	Management of Risk
Budget managers fail to identify and achieve cost reduction target.	Identification and achievement of savings are monitored closely by the NHS Tayside Executive Team and the Single Delivery Unit Executive Management Team throughout the year. Performance is also monitored through NHS Tayside Taystat, the Single Delivery Unit Committee and the Strategic Policy and Resources Committee.

Workforce

Risk	Management of Risk
No workforce implications.	

Finance

Risk	Management of Risk
No financial implications.	

Improvement

Risk	Management of Risk
No risks identified.	

Equalities

Risk	Management of Risk
No risks identified.	

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

NHS BOARD LEAD:	Peter Williamson
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Delivery

Risk	Management of Risk
Tayside has experienced a recent downward trend in electronic referral submission.	<p>A contingency plan to address the level of performance was agreed at a meeting with the Scottish Government on 28 January 2010.</p> <p>A focus of the contingency plan was a better understanding of the reasons behind the reduction in electronic referral submission and the appropriate action to be taken to reverse the recent downward trend.</p> <p>Following a questionnaire exercise, actions are now being taken forward to address those issues affecting the reduction within general practice.</p> <p>At this point in time it is difficult to determine the exact level of improvement but it is certainly anticipated that a change in referral trend should start to be seen by April 2010.</p> <p>Referral trends will be closely monitored and any required action will be taken towards improvement. Tayside will hold ongoing engagement with the Scottish Government on progress with delivery of this target.</p>

Workforce

Risk	Management of Risk
Protocol based referrals – training requirements would need to be identified in General Practice to educate usage of the style sheets and the availability and access.	IT Facilitation will assist in taking forward the required training.
Clinical messaging.	An Implementation Plan has been developed for roll-out to General Practice.

Finance

Risk	Management of Risk
No financial implications.	

Improvement

Risk	Management of Risk
No workforce implications.	

Equalities

Risk	Management of Risk
No risks identified.	

E8: 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:	Peter Williamson
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Delivery

Risk	Management of Risk
No risks identified.	

Workforce

Risk	Management of Risk
In order to collate carbon emissions data for HEAT and CRC, staff time must be allocated appropriately.	Administrative staff to support Energy Co-ordinator and Environmental Manager to ensure data is collected timeously.
Staff collating the information will require some level of training.	In-house training will be provided.
Staff using any energy management systems and control systems (heating and electrical) must be trained to ensure that equipment is used for maximum energy efficiency.	Suitable training will be provided to staff operating equipment.

Finance

Risk	Management of Risk
Cost pressure from the requirement to invest in new technology with longer than acceptable payback, in light of pressure on finance to continue to provide front line services.	Look to existing CEEF funding to cover all or part of project. In conjunction with the Estates and Finance departments, holding regular meetings to review available funds.

Improvement

Risk	Management of Risk
Risk is high due mainly to the capital and revenue shortfall in the service.	Move forward sustainability – where projects can be funded appropriately.

Equalities

Risk	Management of Risk
No risks identified.	

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

NHS BOARD LEAD:	Peter Williamson
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Delivery

Risk	Management of Risk
Retention of e-KSF Training Co-ordinators for individual directorates in line with projected time schedule. Limited funding resources to recruit required number of e-KSF Training Co-ordinators, leading to possible extended timescales past National HEAT target.	Monitor retention and recruit as a matter of urgency as and when required from existing <u>staff with</u> KSF skills. Secure required funding until the end of Project (March 2011).
Numbers of staff that will require access to a PC and associated IT skills required to work through the e-KSF system therefore further training implications. Planned operational release of staff by line managers to meet training requirements. Backup and recovery of IT systems linked to e-KSF.	Identify specific departments with PC access/ IT skill issues and arrange for IT training and access to NHS Tayside PCs. Managers to prioritise and identify best training options for staff. Backup and recovery organised nationally for e-KSF system.
The number of reviews line managers have to undertake and associated training for line managers to support staff through the PDP review process.	Consideration needs to be given regarding how the KSF will be mainstreamed across NHS Tayside and the levels of staff that will be responsible for undertaking the appraisal process, particularly with large departments where there is a flat management structure, as it is recommended that the maximum number of staff any one individual should be responsible for is 10.

Workforce

Risk	Management of Risk
Retention of e-KSF Training Co-ordinators for individual directorates in line with projected time schedule. Limited funding resources to recruit required number of e-KSF Training Co-ordinators, leading to possible extended time scales past National HEAT target.	Monitor retention and recruit as a matter of urgency as and when required from existing KSF skills Secure required funding until the end of Project (March 2011)

<p>80% of all NHS Tayside Agenda for Change permanent contract employments (number of posts as opposed to staff members) must have information on levels of competence and identified training needs must be made available through recording summary information of development reviews on e-KSF by end of March 2011. In order to meet this target, initial training for managers, reviewers and staff must therefore be completed no later than March 2010.</p> <p>Manager, reviewer and staff training on the e-KSF system will require 2.5 hours per staff member, equating to approximately 35,000 operational hours across 14,000 staff members. Use of the e-KSF system will be encompassed in the appraisal time normally spent with staff.</p>	<p>Training provision will be provided in a number of different formats, IT workshops, online training and e-KSF training Co-ordinator, individual or group training sessions, a combination of these methods will be used to maximise efficiency and best suit individual departments.</p>
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Finance

Risk	Management of Risk
<p>No funding implications.</p> <p>Employment costs for 2009/10 were offset against the Agenda for Change budget. Funding of £280,672 has now been secured and approved for 2010/11.</p>	

Improvement

Risk	Management of Risk
<p>No risks identified.</p>	

Equalities

Risk	Management of Risk
<p>Staff with particular disabilities relating to IT and/or literacy abilities may experience more difficulties using the electronic system compared to those who do not have IT or literacy difficulties.</p>	<p>Managers are required to support and assist staff with evidence of compliance with KSF dimension levels and requirements for PDP regardless of IT/literacy.</p> <p>For staff who require special support, there is a third option "complete on paper" where competence levels can be inputted by the manager and signed off by both parties at appraisal session and evidence can be recorded on paper.</p>

Access to Services

Access to Services

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

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

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

A11: By March 2013, 90% of clients will wait no longer than 3 weeks from referral received to appropriate drug treatment that supports their recovery. Waiting times appropriate to alcohol treatment will be defined and incorporated into a target covering both drugs and alcohol by April 2011.

A12: By March 2013 no one will wait longer than 26 weeks from referral to treatment for specialist CAMHS services. During 2010/11 the Scottish Government will work with NHS Boards to develop an access target for psychological therapies for inclusion in HEAT in 2011/12.

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

NHS BOARD LEAD:	Peter Williamson
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Delivery

Risk	Management of Risk
48 Hour access is now formally included in the QOF and although the risk is low there may be practices who decide not to undertake the indicators - QOF and the various indicators are not mandatory but are voluntary.	Close links will be maintained with practices with early identification of issues arising, and action plans developed to address.

Workforce

Risk	Management of Risk
No workforce implications.	

Finance

Risk	Management of Risk
No financial implications.	

Improvement

Risk	Management of Risk
No risks identified.	

Equalities

Risk	Management of Risk
No risks identified.	

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

NHS BOARD LEAD:	Peter Williamson
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Delivery

Risk	Management of Risk
As we have not previously reported on screened positive patients and our data collection methods are still in the process of being put into operation, we do not currently have the data to allow us to accurately assess our performance.	<p>Cervical – collection of data from screening will commence mid February.</p> <p>Colorectal – collection of data from screening commenced February 2010 and will give us the data we require to assess our performance.</p> <p>Breast – collection of data from screening will commence mid February 2010 and will give us the data we require to assess our performance.</p>
Issues resulting in delays in Urology pathway (clinical & administrative processes).	In discussion with General Manager, Surgical Directorate to address Urology issues. Visioning Event planned for end of March 2010.
Sick leave within Urology tracking/audit and MDT support.	In discussion with General Managers to agree short term resource deployment to address immediate priorities.
<p>Unsustainable IT infrastructure in order to identify all urgent patients and 31 day treatment patients, track their journey through to treatment and produce accurate up to date reports. Current systems are not robust, mainly manual, resource intensive and largely person dependent:</p> <ul style="list-style-type: none"> • No dedicated IT support for e-case developments. • Cervical Screened Positive Patients – IT issues necessitate double entry of data into 2 separate databases to allow reporting. • Increasing numbers of referrals (in particular skin lesions & endoscopy). 	<p>Implementation of new tracking system (Aridhia). Scheduled implementation for cancer patients approximately June 2010.</p> <p>In discussion with Head of Information Services to identify solution.</p> <p>Being taken forward via Head of Information Services with the owners of the GCS system.</p> <p>Timed pathways are in use and are under ongoing development within each clinical group.</p> <p>Revised monitoring & escalation process to be implemented Feb 2010 to identify areas of particular pressure & put contingency plans in place where appropriate – links with capacity plans as part of longer term sustainability & in line with 18 weeks RTT.</p>

<p>A significant amount of paper referrals received, which creates difficulty in identifying 'suspicion of cancer' referrals and can create a delay in the patient pathway.</p>	<p>Electronic referrals through SCI gateway continue to play an important part in identifying those patients whom the GP indicates may have a suspicion of cancer, to ensure we are focussing our efforts on the correct cohort of patients. Feedback to GPs from paper referrals which result in a diagnosis of cancer will commence from mid February to emphasise the importance of electronic referral and using the tick box appropriately.</p>
<p>Cancer Audit staff plays a vital role in collating and tracking the cancer patient journey. As such their audit role has been diminished due to time constraints. This needs addressed in order to provide accurate quality audit data.</p>	<p>Review underway of all waiting times roles within the organisation to align with new directorates systems and processes and ensure maximum efficiency.</p>

Workforce

Risk	Management of Risk
<p>It has been suggested that the new targets will in future require us to collect data on cancer sites we do not currently collect data for. Although it is not possible to scope the requirement until further guidance is available from Scottish Government, this will require additional staffing resource.</p>	<p>To be addressed once further guidance available from Scottish Government.</p>
<p>Additional time constraints in pulling together weekly reports for new targets.</p>	<p>This will be measured and weekly process altered accordingly to accommodate requirements.</p>
<p>There may be implications for clinical staffing resources (e.g. surgical/medical physics/radiotherapy) in terms of achieving the 62 day target for screened positive patients.</p> <p>Radiation Physics Staffing – difficulties recruiting staff due to unresolved Agenda for Change grading issues. Currently 1 vacancy difficulty recruiting to.</p> <p>Medical Staffing – particularly Oncology – consultant vacancy - difficulty recruiting to. No applicants for recently advertised specialty doctor post.</p> <p>Nuclear Medicine – difficulties recruiting to Clinical Scientist post.</p>	<p>This will be measured via the cancer waiting times monitoring process and linked to capacity planning ongoing within the relevant clinical service.</p> <p>Post will be re-advertised.</p> <p>Will re-advertise in next few months.</p> <p>Looking at alternative ways of covering workload.</p> <p>Have recruited trainee which has meant that the postholder will not be fully registered until two/three year's time.</p>
<p>Ongoing training and development of tracking and audit staff in application of new definitions.</p>	<p>Training for tracking and audit staff will continue to be carried out as required, identified through analysis of reports and patient pathways at the cancer waiting times weekly operational meetings.</p>

Finance

Risk	Management of Risk
Current tracking staff costs are not budgeted for. We have had some financial assistance non-recurrently from Scottish Government but posts are filled on short-term contracts and this is unsustainable.	The implementation of the new 62 day target means a change from tracking all urgent referrals to only those with a suspicion of cancer. This will significantly reduce the tracking resource requirement from referral to diagnosis stage, however affected postholders require to be found alternative employment within the organisation. An ongoing cost pressure will remain for the ongoing tracking requirement and a business case is currently being prepared in this regard.
There may be future cost pressures associated with the above highlighted risks.	Ongoing measurement of target and above risks. Any cost pressures will be identified and a business case prepared as appropriate.

Improvement

Risk	Management of Risk
The key risk to sustainable improvement is the current lack of an appropriate tracking and reporting system.	We anticipate our new system (currently in development) to be available by June 2010 to deliver the improvements we require in the longer term.

Equalities

Risk	Management of Risk
No risks identified.	

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

NHS BOARD LEAD:	
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18 Weeks RTT - Admitted Performance

Delivery

Risk	Management of Risk
Admitted performance at February 2010 is 77%. No significant risk has been identified to achieving 95% admitted completeness by March 2011.	Performance and Completeness Trajectories are being developed locally and work continues to measure and capture clock stops utilising the Aridhia systems interface and link pathways locally as well as continuing to work toward measuring and maintaining stage of treatment targets.

Workforce

Risk	Management of Risk
Training and development of staff to use the Aridhia tool.	The Aridhia programme will be fully validated and signed off by July 2010. A programme of training sessions for all relevant staff will be implemented following the final release of the system.

Finance

Risk	Management of Risk
No risks identified.	

Improvement

Risk	Management of Risk
No risks identified.	

Equalities

Risk	Management of Risk
No risks identified. Equality and diversity impact assessment currently being written in conjunction with National 18 week RTT team. Implementation of referral governance and access policy.	

18 Weeks RTT - Non Admitted Performance

Delivery

Risk	Management of Risk
<p>Unavailability of robust data and clinical outcomes for Audiology and Dental specialties to report and measure 18 week RTT and clock stops.</p> <p>Limited access to Auditbase and R4.</p>	<p>Audiology</p> <ul style="list-style-type: none"> • Auditbase upgrade and support for New ways rules. • Auditbase training and additional licences to be implemented as soon as possible. • Ongoing exploration of linkages to Aridhia from Auditbase. <p>Dental</p> <ul style="list-style-type: none"> • Permissions being sought to gain access to R4. • Capture of Clinical outcomes to be implemented as soon as possible.
<p>TOPAS system continues to collect existing outcome codes whilst awaiting the changes in functionality that are needed in order to input RTT status codes directly into Aridhia.</p> <p>Lack of a robust inter-referral process.</p>	<p>18 week RTT codes have been matched and validated against existing and new outcome codes. A meeting with Cambric is due to take place this month to clarify timescales to implement a change in functionality.</p> <p>Inter-provider transfer form agreed and signed off. Immediate implementation of an inter-referral form.</p>
<p>Non-Admitted performance has remained stable at 99% in August 2009 to 100% in February 2010.</p> <p>No significant risk has been identified to achieving the aspirational milestone of 70% admitted completeness by March 2010.</p>	<p>Performance and Completeness Trajectories are being developed locally and work continues to measure and capture clock stops utilising the Aridhia systems interface and link pathways locally as well as continuing to work toward measuring and maintaining stage of treatment targets.</p>

Workforce

Risk	Management of Risk
<p>Although work continues to progress well to capture clinical outcomes for new and return out-patient appointments in all specialties in Ninewells Hospital it has been identified that there will need to be an increase in administrative staff in PRI in order to complete the rollout of the form across Tayside.</p>	<p>An additional 12.5 hours administrative staff time has been requested – awaiting response from Access Directorate.</p>
<p>Training and development of staff to use the Aridhia tool and PTLs.</p> <p>No current staff training programme to use inter-referral form.</p>	<p>The Aridhia programme will be fully validated and signed off by July 2010. A programme of training sessions for all relevant staff will be implemented following the final release of the system.</p> <p>Analysis of training needs to be carried out and programme of training.</p>

Finance

Risk	Management of Risk
<p>Cost of extra licences and access to Auditbase.</p>	<p>An ongoing analysis of needs is currently being undertaken- temporary licences in place for 3 months.</p> <p>Additional staff to validate waiting lists (300hrs).</p>

Improvement

Risk	Management of Risk
No risks identified.	

Equalities

Risk	Management of Risk
No risks identified. Equality and diversity impact assessment currently being written in conjunction with National 18 week RTT team. Implementation of referral governance and access policy.	

18 Weeks RTT - Admitted Completeness

Delivery

Risk	Management of Risk
Admitted completeness at February 2010 is 79%.	Performance and Completeness Trajectories are being developed locally and work continues to measure and capture clock stops utilising the Aridhia systems interface and link pathways locally as well as continuing to work toward measuring and maintaining stage of treatment targets.

Workforce

Risk	Management of Risk
Training and development of staff to use the Aridhia tool.	The Aridhia programme will be fully validated and signed off by July 2010. A programme of training sessions for all relevant staff will be implemented following the final release of the system.

Finance

Risk	Management of Risk
No risks identified.	

Improvement

Risk	Management of Risk
No risks identified.	

Equalities

Risk	Management of Risk
No risks identified. Equality and diversity impact assessment currently being written in conjunction with National 18 week RTT team.	
Implementation of referral governance and access policy.	

18 Weeks RTT - Non Admitted Completeness

Delivery

Risk	Management of Risk
<p>Unavailability of robust data and clinical outcomes for Audiology and Dental specialties to report and measure 18 week RTT and clock stops.</p> <p>Limited access to Auditbase and R4.</p>	<p>Audiology</p> <ul style="list-style-type: none"> • Auditbase upgrade and support for New ways rules and 18 week RTT Outcome codes. • Auditbase training and additional licences to be implemented as soon as possible. • Ongoing exploration of linkages to Aridhia from Auditbase to measure performance and completeness. • Use of Lean methodology and DCAQ for service redesign and pathway management. <p>Dental</p> <ul style="list-style-type: none"> • Permissions being sought to gain access to R4. • Capture of Clinical outcomes to be implemented as soon as possible. • OPCS codes to be implemented. • Use of Lean methodology and DCAQ for service redesign and pathway management. <p>Dental specialties and Audiology services are fully integrated in the 18 week RTT programme of improvement.</p>
<p>TOPAS system continues to collect existing outcome codes whilst awaiting the changes in functionality that are needed in order to input RTT status codes directly into Aridhia.</p> <p>Lack of a robust inter-referral process.</p>	<p>18 week RTT codes have been matched and validated against existing and new outcome codes. A meeting with Cambric is due to take place this month to clarify timescales to implement a change in functionality.</p> <p>Inter-provider transfer form agreed and signed off. Immediate implementation of an inter-referral form.</p>
<p>Non-Admitted completeness at February 2010 was 53%.</p> <p>Linkages to TOPAS across all NHS Tayside sites.</p>	<p>Performance and Completeness Trajectories are being developed locally and work continues to measure and capture clock stops utilising the Aridhia systems interface and link pathways locally as well as continuing to work toward measuring and maintaining stage of treatment targets.</p> <p>Work continues to progress well to capture clinical outcomes for new and return out-patient appointments in all specialties. Aspirational aim for 90% by the end of March 2010.</p> <p>In addition, this has been expanded to capture outcomes for AHPs and a scoping exercise has been undertaken. Clinical outcomes dependent on TOPAS linkages – to be complete by July 2010.</p> <p>In Mental Health - work is due to commence in March 2010.</p>

Workforce

Risk	Management of Risk
<p>Although work continues to progress well to capture clinical outcomes for new and return out-patient appointments in all specialties in Ninewells Hospital it has been identified that there will need to be an increase in administrative staff in PRI in order to complete the rollout of the form across Tayside.</p>	<p>An additional 12.5 hours administrative staff time has been requested – awaiting response from Access Directorate.</p>
<p>Training and development of staff to use the Aridhia tool and PTLs.</p> <p>No current staff training programme to use inter-referral form.</p>	<p>The Aridhia programme will be fully validated and signed off by July 2010. A programme of training sessions for all relevant staff will be implemented following the final release of the system.</p> <p>Analysis of training needs to be carried out and programme of training.</p>

Finance

Risk	Management of Risk
<p>Cost of extra licences and access to Auditbase.</p> <p>Source of funding for TOPAS upgrade with Cambric not yet agreed.</p>	<p>An ongoing analysis of needs is currently being undertaken- temporary licences in place for 3 months.</p> <p>Additional staff to validate waiting lists (300hrs).</p> <p>Funding is currently being sought for TOPAS upgrades to implement 18 week RTT outcome codes by eHealth.</p>

Improvement

Risk	Management of Risk
<p>No risks identified.</p>	

Equalities

Risk	Management of Risk
<p>No risks identified. Equality and diversity impact assessment currently being written in conjunction with National 18 week RTT team.</p> <p>Implementation of referral governance and access policy.</p>	

9 Weeks Inpatient or Day Case

Delivery

Risk	Management of Risk
Applying Stage of treatment targets to Non-admitted pathways.	<p>For non-admitted specialities where most patients are treated in an outpatient setting such as Rheumatology, Audiology, Neurophysiology, Pain, and Dermatology it would be beneficial to service delivery, quality of care and financial pressures to deliver these specialist patient services through whole 18 week pathways rather than 'chunking' to SOT.</p> <p>In addition, NHS Tayside now has the capability within Aridhia to measure whole 18 week pathways to report to ISD and provide information for service delivery.</p>
From 2008, NHS Tayside has achieved 0 patient waits over 12 weeks for inpatient and day case. NHS Tayside is currently working toward a target of 0 waits at 9 weeks by March 2010.	<p>Reports have been collated and circulated to all specialties detailing all IP/DC who require to be seen by the end of April 2010 to meet their 9 week personal guarantee up to and including 01/05/10.</p> <p>Individual specialties are currently actioning on these reports with monthly data analysis and risk reporting to waiting times accountability group.</p> <p>In addition these 'count-down' reports will be produced on a weekly basis to monitor our progress towards meeting the 12wk and 9wk personal guarantees by the end of March 2010.</p> <p>As per the previously agreed timetable, further reports will be issued on Thursday each week to indicate volumes to be seen up to and including 1 May 2010 to maintain the personal guarantees.</p>

Workforce

Risk	Management of Risk
Additional clinics/theatre sessions scheduled.	Waiting times funding agreed with each speciality to reach this target.

Finance

Risk	Management of Risk
Additional clinics/theatre sessions scheduled.	<p>Waiting times funding agreed with each speciality to reach this target.</p> <p>NHS Tayside and the 18 week RTT Team are currently undertaking a rigorous programme of service improvement and pathway redesign aligned to strategic improvement projects to align services to waiting times targets and sustainability.</p>

Improvement

Risk	Management of Risk
No risks identified.	

Equalities

Risk	Management of Risk
<p>No risks identified. Equality and diversity impact assessment currently being written in conjunction with National 18 week RTT team.</p> <p>Implementation of referral governance and access policy.</p>	

A11: By March 2013, 90% of clients will wait no longer than 3 weeks from referral received to appropriate drug treatment that supports their recovery. Waiting times appropriate to alcohol treatment will be defined and incorporated into a target covering both drugs and alcohol by April 2011.

NHS BOARD LEAD:	Peter Williamson
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Delivery

Risk	Management of Risk
Planned introduction of new clinical information system is not completed before introduction of target, leading to delays in the processing of referrals and appointments not being offered within target time.	Introduction of new system to be monitored to identify and resolve barriers to full implementation.
Failure to deliver anticipated improvements to access to specialist service through current service improvement programme.	Progress with implementation to be monitored and barriers to progress to be identified and resolved.

Workforce

Risk	Management of Risk
An additional Consultant post has been funded but no appointment made following two attempts due to a national shortage of suitably skilled and qualified candidates. Similar difficulties have been experienced with other key posts e.g. Clinical Psychology.	Post being re-advertised. Further failure to recruit to the non-medical posts will result in a further review of the skill mix.

Finance

Risk	Management of Risk
Cost of substitute prescribing will increase as more patients are brought into treatment. Current budget assumes 1,500 patients in treatment. Average of 1,700 in treatment in 2009/10 leading to additional cost of £280K.	Through the improvement programme introduce centralised dispensing for Dundee patients during initial stages of treatment thereby reducing some costs incurred through contracts with community pharmacists.
Modelling would indicate a further net rise in patients in treatment in 2010/11 leading to an estimated further cost pressure of £100K.	Increase the number of patients becoming drug free to reduce net increase in patients in treatment.

Improvement

Risk	Management of Risk
The number of people stabilising or recovering from their problem drug misuse and being discharged from treatment services is not increased to match or exceed the numbers of additional patients entering treatment due to improvements in access. This will lead to the treatment services exceeding their capacity and waiting lists and times increasing correspondingly.	Service Improvement Plan will incorporate rehabilitation and recovery elements of the service in Phase 2.

Equalities

Risk	Management of Risk
Problem drug use is more prevalent among those living in socially/economically deprived areas. Failure to improve access to drug treatment by delivering the target will have a disproportionate adverse impact upon all people living in those areas.	Through the monitoring of activity across and among local populations, identify and investigate at an early stage any variations from anticipated patterns of activity. Targeting of specific areas in Dundee City by establishing additional points of access to treatment services.

A11: By March 2013, 90% of clients will wait no longer than 3 weeks from referral received to appropriate drug treatment that supports their recovery. Waiting times appropriate to alcohol treatment will be defined and incorporated into a target covering both drugs and alcohol by April 2011.

NHS BOARD LEAD:	Peter Williamson
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Delivery

Risk	Management of Risk
Failure to develop information systems that are able to support the management of referrals within the required timescales and to report on these.	New information system being introduced in 2010.
The number of patients that can be seen is currently limited by the lack of clinical space.	Additional locations/times to see patient to be identified and brought into use.
The referral rate to specialist alcohol services has doubled in the past 24 months. Further rises would lead to demand exceeding capacity of service.	Services have received considerable additional investment to increase their capacity. This will be monitored and changes to ways of working and deployment of staff will be adjusted accordingly.

Workforce

Risk	Management of Risk
An additional Consultant post has been funded but no appointment made following two attempts due to a national shortage of suitably skilled and qualified candidates. Similar difficulties have been experienced with other key posts e.g. Clinical Psychology.	Post being re-advertised. Further failure to recruit to the non-medical posts will result in a further review of the skill mix

Finance

Risk	Management of Risk
Additional resources have been invested in specialist alcohol services. Based on estimated increase in workload. These assumptions will be tested and monitored.	Any further service enhancement will be achieved through service redesign and within existing resources.

Improvement

Risk	Management of Risk
The underlying trend in rates of alcohol consumption continues to rise leading to much higher numbers of people drinking at hazardous or dependent levels.	There is a very significant reliance upon legislation and Government policy that will constrain availability and increase price. Significant programmes of primary prevention are underway or being developed with the community planning partners.

Equalities

Risk	Management of Risk
Alcohol related harm is disproportionately higher among those living in socio-economic disadvantaged circumstances and therefore greater access to treatment will be required.	Making treatment and support readily available close to where people live. Integrate the delivery of alcohol treatment into other health services specifically designed to support those in socio-economic disadvantaged services, eg, homeless services.

A12: By March 2013 no one will wait longer than 26 weeks from referral to treatment for specialist CAMHS services. During 2010/11 the Scottish Government will work with NHS Boards to develop an access target for psychological therapies for inclusion in HEAT in 2011/12.

NHS BOARD LEAD:	Peter Williamson
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Delivery

Risk	Management of Risk
Referrals to specialist CAMHS services continue to rise year on year. If this trend continues and there continues to be difficulties in recruiting appropriately trained staff then there is a risk that the target will not be met.	Funding has been invested into CAMHS for additional medical and nursing posts to increase capacity to address the existing waiting times and increasing referral rate. TOPAS has been implemented in the service in order to accurately monitor waiting times and highlight breaches at an early stage. Additional administrative staff have been appointed to assist with managing the waiting lists.

Workforce

Risk	Management of Risk
National shortage of CAMHS clinicians is presenting challenges for the service in recruiting to vacant posts.	Due to difficulty in recruiting to specialty doctor post funding has been diverted in order to recruit and train nurse prescribers to enable them to undertake tasks previously done by specialty doctors.
Identified nurses would require to undertake nurse prescriber course to enable them to undertake new role.	Established training package for nurse prescribers is available. The service is actively trying to recruit nurses to these posts.

Finance

Risk	Management of Risk
The clinical staffing level within Tayside CAMHS is just below 50% of the capacity recommended in "The Mental Health of Children and Young People: A Framework for Promotion, Prevention and Care (Scottish Government 2005).	This has been addressed within NHS Tayside Workforce Plan.

Improvement

Risk	Management of Risk
Increased nursing resource required on long term basis for sustainability 0-5 years.	

Equalities

Risk	Management of Risk
No risks identified.	

Treatment Appropriate to Patient

Treatment

T6: To achieve agreed reductions in the rates of hospital admissions and bed days of patients with primary diagnosis of COPD, Asthma, Diabetes or CHD, from 2006/07 to 2010/11.

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

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

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

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

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

T6: To achieve agreed reductions in the rates of hospital admissions and bed days of patients with primary diagnosis of COPD, Asthma, Diabetes or CHD, from 2006/07 to 2010/11.

NHS BOARD LEAD:	Peter Williamson
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Revised risk narrative: Bed-day rate rather than admissions rates

Agreed trajectory reduction in bed days by 5%

Delivery

Risk	Management of Risk
Considerable progress and improvements have been made towards this target. However, challenges remain. Cumulative disease reporting for this target negates the potential for analysis of condition specific related to improvements and/or variations. In addition, analysis is required of the impact, causes and areas for improvement of long term conditions scheduled, unscheduled hospital admissions, length of stay and effectiveness of care management for complex care patients.	Local measures for improvement in place for case managed. A quality indicator will be introduced this year for patient experience feedback. Further condition specific data analysis required of scheduled, unscheduled admissions and bed days. This will be progressed system wide and utilise Managed Clinical Networks (MCNs) in data review and pathways.

Workforce

Risk	Management of Risk
Change in work force practices to deliver new models of care to meet the changing needs of the population.	Introduction of case management principles within community nursing progressed with plans to accelerate this to underpin Virtual Ward models of care. Collaboration with MCNs and other work streams re patient pathways and flows through the system.

Finance

Risk	Management of Risk
Proactive identification of patients at risk eligible for case management may increase the number of admissions.	Admissions when necessary should be planned to maximise appropriate interventions and minimise lengthy stays. Further analysis of case management model to be progressed to assess impact on admissions and length of stay.

Improvement

Risk	Management of Risk
Enabling a workforce with the appropriate skill mix and competencies to meet the potential increase in demand of patients meeting the criteria for care management for complex patients.	Work is underway to mitigate this risk by releasing capacity within community nursing teams and AHPs to enable patients to receive care through case management principles. A tool kit for case management has been designed and will be implemented to support staff education.

	Monitoring mechanisms are in place and reported monthly to NHS Tayside LTC Delivery Group.
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Equalities

Risk	Management of Risk
No risks identified at this stage.	An equality and diversity impact assessment will be written in conjunction with the Long Term Conditions Collaborative and Managed Clinical Networks.

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

NHS BOARD LEAD:	Peter Williamson
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Angus Partnership

Delivery

Risk	Management of Risk
<p>In relation to the Best Value Review of Older People's Services in Angus, the shift from residential care to supported housing will take some time to achieve as it requires significant investment in property. As a result the reduction in the overall number of people with high care needs will not, in the short term, be matched with a reduction in the number of people supported in care homes.</p> <p>The consequence of this is that the trajectory for this measure in Angus is unlikely to improve in the short term. Indeed the more successful the roll-out of enablement, the 'worse' will be our performance on this measure until significant expansion of supported housing is achieved.</p>	<p>Management of risk will be undertaken by the Community Care Change Programme Board in Angus which meets every two months.</p> <p>Development of enablement teams has now commenced with the first of the teams to be in place in Forfar/Kirriemuir in early summer 2010. This will be monitored by the Community Care Change Programme Board.</p>

Workforce

Risk	Management of Risk
No workforce implications. A fully costed implementation plan was approved by Angus Council on 17 December 2009.	

Finance

Risk	Management of Risk
No financial implications. A fully costed implementation plan was approved by Angus Council on 17 December 2009.	

Improvement

Risk	Management of Risk
Risks to improvement are as outlined within the section on delivery.	Management of risk are as outlined within the section on delivery.

Equalities

Risk	Management of Risk
No risks identified.	

Dundee Partnership

Delivery

Risk	Management of Risk
<p>The severe financial limitations on the Social Work Department's Revenue Budget will prevent Dundee City Council from improving performance from the current 28.16% to the target of 30% during the next 6 months.</p> <p>It must be noted that although the pace of increase will not be sufficient to shift the balance of care, that there are a significant number of people with long term and complex needs, whose health and care needs are currently being sustained on less than 10 hours of home care per week.</p>	<p>The Social Work Department will continue to identify ways of increasing efficiencies within the home care service to release hours which can then be re-invested. An example of this is through the enablement model currently being implemented. The Department will also explore the possibility of increasing the externalisation of service delivery.</p>

Workforce

Risk	Management of Risk
<p>Dundee Social Work has an ageing workforce which will continue to result in a significant staff turnover.</p>	<p>Dundee Social Work will continue to work in partnership with Dundee College and Job Centre Plus to attract and recruit into social care, as well as participating in the new Scottish Recruitment Portal.</p>

Finance

Risk	Management of Risk
<p>Mathematical modelling has informed us that it would take an additional 380 (plus) staff hours per week, to reach the target of 30% by March 2011.</p> <p>The Social Work Department will direct some of the additional financial resources included in the 2010/11 Revenue Budget towards homecare provision but this would still leave a deficit of approximately £154k.</p>	<p>To ensure that we are prioritising services for people with long term and complex needs we will:</p> <ul style="list-style-type: none">- Continue to monitoring waiting lists.- Use eligibility criteria.- Review balance of internal / external purchasing.- Introduce a programme of enablement.

Improvement

Risk	Management of Risk
	<p>The Social Work Department works closely with health partners in Dundee CHP in the areas of service redesign, intermediate care, re enablement and virtual wards. This ensures that models of service delivery meet the needs of people with complex needs.</p>

Equalities

Risk	Management of Risk
<p>No risks identified.</p>	

Perth & Kinross Partnership

Delivery

Risk	Management of Risk
Our projections indicate it will take more than a year to reach 30% target. We are currently on 22% and are working towards 30% by 2012.	Our Resource Allocation Group places those with high level of care needs in care homes or in home care with more intensive package of care and monitors placements that continue to shift the balance of care. We anticipate being at 26% by 2011 and being able to meet the national target of 30% by 2012. This will involve increasing the number of people receiving 10+ home care by 6 per month and reducing the number receiving care in a care home/long term care by 4 per month. Our assumptions also include reducing our 2 geriatric care beds to zero by this time. The work will be monitored through the Resource Allocation Group and by our Senior Management Team routine monitoring reports.

Workforce

Risk	Management of Risk
We are currently implementing a strategic review of older people's services which includes the redesign of our care at home service and a focus on a re-ablement model of care. This will involve change management and organisational development with key staff involved.	

Finance

Risk	Management of Risk
No financial implications.	

Improvement

Risk	Management of Risk
No risks identified.	

Equalities

Risk	Management of Risk
No risks identified.	

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

NHS BOARD LEAD:	Peter Williamson
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Delivery

Risk	Management of Risk
Equity of the provision of diagnosis and support across Tayside.	An action plan has been established and was agreed by NHS Tayside Executive Team in December 2009. This contains a series of planned actions that accumulatively will contribute to the achievement of the target and to ensure equity across Tayside.

Workforce

Risk	Management of Risk
No workforce implications.	

Finance

Risk	Management of Risk
Once the priorities for service redesign within dementia care have been identified the cost of service improvements will need to be calculated. Some improvements will be achievable via reallocation of funds, however, there may be some bridging funding and/or new monies required.	All service redesign will be planned in a realistic manner and programmed way. Any resultant bids for funding will be submitted via the appropriate financial channels to ensure appropriate financial governance.

Improvement

Risk	Management of Risk
Any risks to improvement are being addressed with a strong focus on sustainability in the coming year with the support of the Regional and National Collaborative developing a sustainability plan across Mental Health for all improvement work streams.	<p>The Dementia Calculator, which has been developed through the Collaborative, will be rolled out to all Tayside GP practices following a pilot test within Angus. This will assist monitoring of numbers on the QOF Register on a sustained basis.</p> <p>Identification of prevalence within the local population will be conducted. The results of which will be built into future capacity plans.</p>

Equalities

Risk	Management of Risk
	<p>NHS Tayside hosted the pilot for the 'Raising Awareness' Campaign run by the Scottish Government. From this, areas of good practice have been adopted.</p> <p>An Event facilitated by NHS Tayside's Equality & Diversity Team will be held in March 2010 to explore and address any issues of equality for the older people's agenda.</p>

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

NHS BOARD LEAD:	Peter Williamson
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Delivery

Risk	Management of Risk
An Action Plan for NHS Tayside was approved by the Emergency Access Team for 2009/10. Further amendments to the Action Plan will be made to reflect the milestones to be delivered within 2010/11. It is not possible to be certain about the risks until further analysis of the data is undertaken because the risks will relate to specific patient sub-groups who have yet to be identified.	

Workforce

Risk	Management of Risk
To manage medical careers, senior consultants are required to undertake other duties which can impact on the time available for them to exercise influence over what cases are seen within A & E.	

Finance

Risk	Management of Risk
None identified until the analysis has identified what alternative services will be needed, including any funding issues.	

Improvement

Risk	Management of Risk
No risks identified.	

Equalities

Risk	Management of Risk
No risks identified.	

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

NHS BOARD LEAD:	Peter Williamson
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Delivery

Risk	Management of Risk
<p>To the end of December the total number for the year was 167. To reach the target of 146 there needs to be a reduction of 21 episodes in the first quarter of 2010. Though there have been months with small numbers these have not been achieved systematically.</p> <p>NHS Tayside will not attain the SAB target for 2010.</p> <p>A second reduction is required for end March 2011.</p>	<p>Hand hygiene, blood culture technique, management of intravascular devices with the CVC and PIVC bundles are all being targeted to reduce the number of preventable infections.</p> <p>30-40% are deemed to be community acquired. Further work is being undertaken to see what proportion of these, if any, are amenable to prevention. One third of CA SABs are in IVDUs.</p> <p>The biggest and most sustainable reductions have been with MRSA as efforts to reduce MRSA acquisition have been successful.</p>
<p>The introduction of new strains of <i>C difficile</i> with different characteristics in terms of spread, virulence or response to treatment is unpredictable.</p>	<p>Continue with multidisciplinary approach to antimicrobial prescribing, hand hygiene, early detection, environmental cleaning and fabric issues.</p> <p>Existing controls and surveillance should enable early detection. Use of PCR technology is allowing early detection of strains with 027/078 characteristics.</p> <p>027 strain nationally seems to be reducing. NHS Tayside is in line with HEAT target.</p>

Workforce

Risk	Management of Risk
No workforce implications.	

Finance

Risk	Management of Risk
No financial implications.	

Improvement

Risk	Management of Risk
No risks identified.	

Equalities

Risk	Management of Risk
No risks identified.	

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

NHS BOARD LEAD:	Peter Williamson
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Delivery

Risk	Management of Risk
<p>The HEAT target to reduce the number of emergency inpatient bed days for the over 65 population is an important measure of success for the Tayside Strategic Framework for Older People's Services. The measure is contained in the Framework document which has been agreed by the Health Board along with the three Councils across Tayside. Work will concentrate on moving patients through the acute hospital service, while recognising the need for improvement across Tayside as a whole.</p> <p>The main thrust – in part reflecting the admission rates and bed days position - will be to concentrate on two areas: discharge; and multiple admissions.</p> <p>Policy standards have been developed and to which NHS Tayside and the councils will look to sign up to; these will support HEAT T12 by emphasising the importance of being clear about a patient's status as medically/care fit for discharge and organising systems then to make sure delays are absolutely minimised. This will be based upon a standard time limit for discharge once a patient is declared fit. This will require the development of post-acute services including rehabilitation which is already under development. However, the main point is that, to some important extent people will be moving on to the same care setting, only without unnecessary delays in the acute hospital. Extra capacity will be needed, but not de novo. This drive to speed up discharge will improve the outcomes for patients as well as their general well-being. One of the standards that will also be adopted will be to make sure that older people move to the care setting that is most appropriate to their care needs following proper assessments (even if this means a longer hospital stay). Similarly good practice standards will be laid down for the engagement of carers and relatives.</p> <p>Detailed analysis is being undertaken to examine the make-up of patient population in more detail, and in particular to identify</p>	<p>The risks associated with the target are most prominent around the pace at which the reduction can be achieved. (Progress is definitely expected) Close monthly monitoring of the position – and the analysis of the factors behind any difficulties – will be the main means to manage this, i.e. ongoing monitoring and review.</p> <p>Further work is being done on gaining a better strategic understanding of multiple admissions which will help to inform better management of avoidable admissions through better targeting of resources in the community.</p> <p>Early engagement of GPs will be required to obtain buy-in for the greater engagement of at risk patients, but positive results around primary support to care homes suggests that progress is possible.</p> <p>The 'cost cube' or Integrated Resource Framework will enable resources and effort to be more effectively targeted.</p> <p>Strong partnership working and ongoing dialogue with social work will be used to address pressures on community resources to accommodate the shift out of hospital care. Modelling work will be done to highlight the expected resource requirements to support stronger discussion and planning of resources demand, and to make them and their management explicit.</p>

those admitted for the same underlying reason or reasons. Working in conjunction with the Tayside long term conditions programme to offer ways to prevent these admissions. The analysis will be complete by the summer, and it is intended that a more proactive management of older people at risk will be taken forward. The main thrust of this will be on better engagement of primary care in the assessment and management of older people. Evidence on case management has made this a less appealing approach. This work is expected to reduce the number of admissions in relatively small terms but to have a significant impact upon the number of bed days

The leadership for this target is through the Chief Executive's TayStats monthly performance monitoring meeting which will review progress, while the Director of Health Strategy has executive responsibility for overall progress with the Older People's Strategic Framework and the various initiatives to improve care.

There is little doubt that the various initiatives will help to move towards the target. The principal risk in terms of the target per se is that the relationship in quantitative terms between the movement of bed days numbers and the impact of particular initiatives. The other area of risk is that additional capacity will be needed in community services either to take earlier discharge or manage admissions. Pressure on council budgets has highlighted a possible risk around home care.

Workforce

Risk	Management of Risk
None specific to moving along trajectory, although many issues for workforce behind wider shift in balance of care.	Some community services have experienced recruitment difficulties in the past, but these are expected to be manageable in the future.

Finance

Risk	Management of Risk
Funding of community services.	Difficult to manage because of the position on <i>Council</i> budgets. Part of the answer lies in partnerships making sure that existing funding is used to be effect, e.g. Angus Older People's Service BVR.

Improvement

Risk	Management of Risk
No risks attached.	

Equalities

Risk	Management of Risk
No risks identified.	

SUMMARY OF MAIN WORKFORCE ISSUES FACING BOARDS

A quality workforce is based on skills, competency and capability. Effective Workforce Planning is the correct deployment of the appropriate skills and competencies to meet service and patient need. Therefore, predicting skill requirement is at the heart of workforce planning, and the co-ordination and commissioning of internal and external training and education is therefore an inherent part of Workforce Planning & Development. The Knowledge and Skills Framework (DoH 2004) and the Career Framework (Skills for Health) provide a consistent approach to supporting the workforce to develop skills and competencies required in their post and NHS Career. It is vital that there is equity of development opportunities across the Career Framework, and that these opportunities assist in meeting service profiles, and predicted need. The 2008 NHS Tayside Review of Training and Development (Audit Scotland 2008) made a number of recommendations for improving the current allocation training and development resource to ensure it better aligned to the needs of patients and service. In response NHS Tayside developed an Education and Training Strategy approved by the Board Executive Team in December 2009. The Strategy prioritises education needs based on population, the content was also influenced by two, month long consultations with staff. An Action Plan has been produced for implementation by the Learning & Development Department throughout 2010/11 and beyond. These actions will assist in aligning departmental Training and Development budgets with the delivery of corporate objectives and predicted patient need. This model will also enable the effectiveness of training and development investment to be measured.

A Force for Improvement (SGHD 2009) acknowledges that demographic change is one of the most significant issues affecting NHS Scotland and its workforce. The document describes the resulting need to focus on the following areas;

- Providing care closer to home
- Promoting self care
- Providing joined up health and social care
- Long term conditions
- Meeting the increased requirements of cancer, mental health and older peoples services

NHS Tayside workforce planning and development priorities are consistent with these areas, aligning departmental and individual training needs with the delivery of these priorities would maximise the organisational skills to achieve these goals.

Patient profiling will play an important role in understanding what core skills and competencies are required across operational and patient groups, care environments, and professional groups. The NHS Tayside workforce needs to be planned around patient pathways, core skills and competencies should be based on patient/service information, with a focus on flexibility and transferability. An example of this is the GROS data in 2007, the three most common causes of death were cancer 27 percent (within this statistic lung cancer was the most common), ischaemic heart disease 17 percent and cerebrovascular disease 10 percent, these three diagnosis accounted for 54 percent of deaths, this can provide insight into the core skills, at all levels required to meet patient need in a wide variety of settings.

In addition to demographic change the following areas need to be acknowledged as significant I relation to future proofing the workforce;

Shifting disease burden – increased incidence of chronic conditions arthritis, COPD and infectious diseases

Population risk factors – obesity, sexual behaviour and alcohol and drug misuse

Health Inequalities

Public Expectations – rising expectations due to increased availability of information

Medical advances – new forms of diagnosis and treatment have contributed to long term improvements in population health. Developments in genomics and stem cell research will influence future healthcare.

Resource availability – requirement for increased productivity and efficiency.

The focus for development is not just on clinical education need but across the spectrum of professions, groups and departments.

We need to foster skill mix and team working in ways that harness the collective expertise of all those involved in healthcare to focus on the best way to meet patient and service need, quality, improvement and safety as part of everyday service delivery.

The Knowledge and Skills Framework (KSF) is key to identifying the Education and Training needs of our workforce, this in turn will enable a organisational profile of the training needs to be established.

The KSF;

- defines and describes the knowledge and skills that staff need to apply in their work, to deliver quality services
- provides a single consistent, comprehensive and explicit framework for staff reviews and development
- allows the operation of the AfC pay progression system, without which the contractual commitment to an equitable pay system cannot be met
- is a generic competency framework developed from existing best practice

The KSF is applied by identifying the knowledge and skill requirements for each NHS post (the KSF outline) and ensuring that each post holder has an annual review against their KSF outline, to identify any development needs. A personal development plan is then agreed and carried out. At two points on each of the AfC pay bands, incremental progression is dependent on fulfilling the appropriate KSF outline for the post.

The Local Delivery Plan (LDP) has the 'requirement of major training programme' assigned to the delivery of all but one of the targets. The delivery of the LDP targets should be an inherent part of everyone's role. The skills profile of the substantive workforce should be examined and training aligned to assist in delivery of the targets.

Recruitment hotspots change throughout the year, these are monitored on a month by month basis. The stability of the NHS Tayside internal labour market is a critical feature of any workforce planning projections, in any areas where substantial expansion of workforce resource is anticipated the use of the 6 Step Planning Model would be helpful in identifying the labour market supply route to be targeted to enable successful recruitment, and maintenance of substantive services. This demonstrates the importance of aligning Workforce, Service and Financial Planning to ensure optimal service delivery within the available internal and external labour market resource.

The integration of the delivery of LDP targets into the core NHS roles, will assist in transferring today's innovation into tomorrow's core role, to enable both an exit strategy from fixed term funding but also to support the targets in hard to recruit areas.

Another clear area of growth is Health Informatics, Information Management and IT trainers. As eHealth increasingly becomes a core part of healthcare delivery recruitment and career pathways within this workforce group will need explored in greater detail.

Regular dialogue will be maintained with the Local Delivery Plan leads to ensure integration of the planning process with workforce planning.

CONTRIBUTION TO SINGLE OUTCOME AGREEMENTS

Community Planning Partnership : ANGUS

Context of Collaborative Working - Angus CHP is a key partner in the Angus Community Planning Partnership and minutes from the CPP meetings are presented to the Angus CHP Committee. The collaborative work of the CPP is delivered through eight thematic partnership groups, of which senior managers from the CHP are members:

- Angus Economic Development Partnership
- Lifelong Learning Partnership
- Community Safety Partnership
- Health Improvement Action Group
- Alcohol and Drug Partnership
- Community Care and Health Executive Group
- Children's Services Executive Group
- Angus Rural and Environment Partnership

Single Outcome Agreement Implementation Group:

As part of the Angus Community Planning Partnership, the Single Outcome Agreement (SOA) Implementation Group role and remit is to:

- monitor and review the work of the thematic partnership groups on a regular basis
- challenge performance in relation to the delivery of the SOA for Angus
- drive and support progress against stated targets
- identify unintended consequences from actions taken by one thematic group on another and consider the implications of these
- consider and facilitate resource issues
- report to the Angus Community Planning Partnership and Angus CHP Committee on a six monthly basis

Community Planning Partnership : DUNDEE

The CHP General Manager is a member of this group.

- CHP General Manager sits on Dundee Partnership Management Group, chairs the CHP Committee and co-chairs the Health & Local Authority Management Group (HALAMG)
- CHP Strategy & Performance Manager chairs Healthy Dundee, a theme group for Dundee Partnership's charged with monitoring the SOA delivery plans regarding Health Inequalities and Health improvement Outcomes

HEALTH INEQUALITIES - ANGUS

<p>What are the priority local outcomes for tackling health inequalities?</p>	<p>Harm caused by the misuse of drugs and alcohol is reduced resulting in improved quality of life in Angus.</p>	<p>Children and young people will enjoy the highest attainable standard of physical and mental health, with access to suitable healthcare and support for safe and healthy lifestyle choices.</p>	<p>Smoking – The health of the Angus population is improved.</p>
<p>What are the underpinning indicators or targets that support the delivery of the outcome?</p>	<p>Achieve agreed number of brief intervention screenings (Tayside target 12,000 – Angus tba)</p>	<p>Maintain proportion of obese P1 children at the 5% baseline from 07/08 until 2010/11 (2008/09 - 9.4%)</p>	<p>Reduce percentage of adult Angus smokers to 22% by 2010</p>
<p>What are the Board's top 3 actions that contribute to each of these outcomes?</p>	<p>Support Happy, Healthy, Communities Project in Kirriemuir and Brechin to support communities to address alcohol related issues.</p>	<p>Monitor heights and weights of P1 and P7 children to allow accurate benchmarking.</p>	<p>Extend present work in schools by developing prevention and cessation work in more informal community youth settings.</p>
	<p>Through Healthy Working Lives deliver alcohol awareness sessions across all socio-economically areas.</p>	<p>Action Plan being developed in response to findings from the Mapping of Exercise of Child Healthy Weight/Overweight/Obesity Services in Angus.</p> <p>Increase number of Winning Weigh and Counterweight management classes across Angus with a focus on lower income areas.</p>	<p>Increase numbers of quit smoking support groups using social marketing concepts to promote services.</p> <p>Increase workplace cessation groups and target companies with large numbers of low-paid employees.</p>

	Develop brief intervention capacity within workforce in line with SIGN74 has resulted in a series of joint staff training sessions arranged throughout 2010 focussing on brief interventions and behavioural change.	Roll out of Happy, Healthy Communities model to Arbroath focussing on healthy child weight and establishment of "Young Mums" Group.	Targeting of Angus Give it Up for Baby scheme on Arbroath as the area with the highest levels of deprivation.
How will the Board performance manage these contributions?	The Angus Health Improvement Action Group of the Community Planning Partnership is responsible to the implementation of the actions in the Health Improvement Action Plan. Progress against each action is monitored through Angus Council's Excelsis performance management tool with reports on progress considered by the HIAG on a six monthly basis. This is further overseen by the SOA Implementation Group and the CHP Committee.		

EARLY YEARS - ANGUS

What are the priority local outcomes for tackling health inequalities?	Children of substance misusing parents are supported in order to maximise their potential	Children and young people will be protected from abuse, neglect and harm by others at school and in the community.	All children in Angus are nurtured and have the best start in life.
What are the underpinning indicators or targets that support the delivery of the outcome?	Increase the number of children identified and supported from agreed baselines on 'Link-Up' Database.	Targeting of relevant and other staffing groups with appropriate levels of training and information.	Professionals across sectors have an increased focus on pre-birth to 3 years. Parents feel confident and equipped to be effective parents Increase the proportion of babies exclusively breastfed at 6-8 weeks in deprived areas, extra support for promotion and maintenance of breastfeeding across three areas of Angus where the rates are lowest.

<p>What are the Board's top 3 actions that contribute to each of these outcomes?</p>	<p>Provide support to the Montrose Multi Agency Link Up Project</p>	<p>Implementation of three year CPP inter-agency training strategy for 2008 – 2011for Child Protection</p>	<p>Multi-agency shared training opportunities. Identified shared values and fostered the development of broader and more complementary roles</p>
	<p>Engagement with child service users through feedback of their views through Viewpoint. This is an online consultation tool for children and young people between the age of 5 years to 16+ years which seeks their views through specific age related and issue based questionnaires</p>	<p>Further development of the multi agency Early Screening Group, who co-ordinate concerns arising primarily as a result of Police enquiries. It aims to identify cases for early intervention and therefore reduce the number of referrals to the Scottish Children's Reporter Administration.</p>	<p>Provide clear and effective information on benefits of breast feeding and good nutrition.</p>
	<p>Joint "Listen Up" campaign developed around statements made by local schoolchildren about how their parents' alcohol misuse affects them.</p>	<p>Partnership working to promote public awareness of child protection and referral to appropriate services through local events and provision of promotional materials.</p>	<p>Implement HEAT 7 action plan, CEL36 proposal</p>
<p>How will the Board performance manage these contributions?</p>	<p>Evaluation of results of Link Up Steering Group interventions are monitored through the Alcohol and Drugs Partnership (ADP).</p> <p><u>Monitoring</u> - Angus has been identified as a 'learning partner' to explore the interface between CAPSM and the principles of GIRFEC. The Scottish Government is funding action research to improve the identification, assessment, recording and information sharing of CAPSM and to demonstrate progress from activity within the Link-Up initiative.</p>	<p>Through performance review reports to the Angus Child Protection Committee</p>	<p>Performance reports to HIAG and CHP Committee</p>

	The CPP's Children's Executive Group has adopted the 7 national indicator of well-being as the drivers for the 2009/12 SOA and progress against each action is monitored through Angus Council's Excelsis performance management tool and further overseen by the SOA Implementation Group.
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TACKLING POVERTY AND SOCIO-ECONOMIC INEQUALITY - ANGUS

What are the priority local outcomes for tackling health inequalities?	Improvement in health and service provision for homeless people in Angus through a needs-led, integrated approach to service planning and delivery.	The Angus teenage population have a positive and responsible attitude towards sexual health	Local services respond better to depression, anxiety and stress through increasing access to counselling and psychological therapies.
What are the underpinning indicators or targets that support the delivery of the outcome?	Reduction in number of repeated homeless presentations to Angus Council.	<i>Reduction in the teenage pregnancy rate per 1,000 females aged 13 to 15 (FSF) Angus Target - 5.6%</i>	<i>Number of suicides per 100,000 population (2006-08 16.1, 3yr average)</i>
What are the Board's top 3 actions that contribute to each of these outcomes?	Needs assessment and mapping of current services and intervention pathways.	Provision of long acting reversible contraception (LARC) to contribute towards reducing teenage pregnancy rates; the target for LARC is 60/1000 with the current Angus rate standing at 58.4/1000.	Increase referrals to Insight Counselling and Beating Blues Programmes
	Work with Homeless Peer Support Project established by Volunteer Centre, Angus to identify potential trigger points for preventative/early interventions.	Increase C-Card usage across Angus; Over 400 young people across Angus have accessed the scheme.	Increase numbers seen by psychological therapies team
	Awareness raising training for front line staff across CPP.	Training in sexual health needs	Increase numbers accessing psychological therapies within the CMHS

How will the Board performance manage these contributions?	Action Planning Subgroup established and performance reports through Health and Homelessness Partnership Group on a quarterly basis.	Through CPP Angus Sexual Health & Relationships Action Group and overseen by the SOA Implementation Group and the CHP Committee.	Through Angus CHP AMH Accountable Group, and reports to CHP Committee
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ECONOMIC RECOVERY - ANGUS

What are the priority local outcomes for tackling health inequalities?	Angus residents are well equipped for employment through extending opportunities for people to take part in volunteering within health, particularly young people and those from disadvantaged communities.	Welcoming International Workers	No further local health-related outcomes
What are the underpinning indicators or targets that support the delivery of the outcome?	% of working age population who are economically active	NI registrations to adult overseas nationals entering Angus (Annual/DWP).	
What are the Board's top 3 actions that contribute to each of these outcomes?	Consult, target and support individuals and groups to be engaged in co-production to improve health in their own communities.	Raise awareness of health services within Angus in our temporary, international communities.	
	Develop awareness raising programmes of value of volunteers.	Raise awareness of health promoting messages within our international communities.	
	Build volunteer management and support capacity to ensure long term sustainability.	Raise staff awareness of translation services and other support services.	

How will the Board performance manage these contributions?	Through quarterly performance progress reports to CHP Volunteering Working Group and reports to CHP committee.	CPP European & International Communities working group report to HIAG and onto CHP Committee.	
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HEALTH INEQUALITIES - DUNDEE

<p>What are the priority local outcomes for tackling health inequalities?</p>	<p>Improved health for people living in community regeneration areas</p> <p>Reduced risk taking behaviour in young people, particularly in community regeneration areas</p> <p>Improved health for older people</p> <p>Reduced rate of teenage conception in community regeneration areas</p>	<p>People will have more physically active lifestyles</p> <p>Improved mental health and wellbeing</p> <p>Reduced harm caused by substance misuse</p>	<p>Our care services are accessible and of high quality</p> <p>Care and support are provided in the community as opposed to long stay care settings</p> <p>People who receive care services achieve positive social outcomes</p>
<p>What are the underpinning indicators or targets that support the delivery of the outcome?</p>	<p>Number of participants in Quit4U, and other NHS smoking cessation services, in disadvantaged areas stopped smoking at 3 months</p> <p>Number of Keepwell health checks</p> <p>Reduction in the number of young people reporting alcohol and drug use</p> <p>Reduced incidence of malnutrition in older people in own homes, care homes and community hospitals</p> <p>Reduce the gap in conception rate between the least and most disadvantaged communities</p>	<p>Reduce inactivity and increase participation in 'barrier free' physical activity within disadvantaged communities</p> <p>Improved community well being</p> <p>Number of brief interventions delivered for alcohol misuse</p> <p>Reduction in Waiting Times for substance misuse services</p>	<p>Reduction in the number of people aged 65+ admitted as an emergency twice or more to acute specialities</p> <p>Reduction in the number of readmission within one year for those who have had a psychiatric admission of over 7 days</p> <p>Percentage of people waiting longer than 6 weeks to be discharged into a more appropriate care setting.</p>

What are the Board's top 3 actions that contribute to each of these outcomes?	Delivery of smoking cessation and health improvement activities in disadvantaged communities: eg Keepwell, Quit4U, Give It Up For Baby.	Support the development of Equally Well social prescribing/community referral pilot to generate evidence around non-clinical interventions and improved mental wellbeing.	Review the Care and Assessment Service in Royal Victoria Hospital.
	Implementation of phase3 of the Dundee Nutrition Standards programme.	Support the development of a Focus on Alcohol project in Dundee aimed at reducing alcohol harm within the community.	Maintain and review the early supported discharge schemes in line with the introduction of the enablement model.
	Implement social marketing approaches to improving sexual health & relationships	Work with ADP to ensure the implementation of HEAT targets for access to services.	Pilot the virtual ward model in one part of Dundee and evaluate for wider implementation.
How will the Board performance manage these contributions?	Performance reports to CHP Committee.	Performance reports to Healthy Dundee.	Performance reports to HALAMG.

EARLY YEARS - DUNDEE

What are the priority local outcomes for tackling in early years?	All children in Dundee are nurtured and have the best start in life.	All children and young people in Dundee are healthy.	All children will be safe.
What are the underpinning indicators or targets that support the delivery of the outcome?	Professionals across sectors have an increased focus on pre-birth to 3 years. Parents feel confident and equipped to be effective parents. Increase the proportion of babies exclusively breastfed at 6-8 weeks in	Reduction in BMI and obesity levels. Number of category C letters sent (oral health).	Child protection protocols agreed across SOA partnership.

	deprived areas.		
What are the Board's top 3 actions that contribute to each of these outcomes?	Multi-agency shared training opportunities (workforce development) have enhanced skills. Identified shared values and fostered the development of broader and more complementary roles.	Promote healthy eating and physical activity with families, pre-school settings, schools and communities, targeting a reduction in BMI and obesity levels.	Redesign of community nursing including focusing on health visitors' contribution to child protection improvement plan and early years framework.
	Provide clear and effective information on benefits of breast feeding and good nutrition.	Promote oral health and hygiene to families through pre-school settings, schools and communities.	Partnership work to deliver the redesigned New Beginnings service to pregnant women with compromised parenting skills due to health concerns e.g. substance misuse.
	Implement HEAT 7 action plan, CEL36 proposal.	Development of Growell Café.	
How will the Board performance manage these contributions?	Performance reports to CHP Committee.	Performance reports to Healthy Dundee.	Performance reports to CHP Committee.

TACKLING POVERTY AND SOCIO-ECONOMIC INEQUALITY - DUNDEE

What are the priority local outcomes for tackling in poverty and socio-economic inequality?	Reduce inequality gap between Community Regeneration Areas and Dundee Average.	Reduced financial exclusion, income inequality and fuel poverty.	Dundee people will be better educated and skilled.
What are the underpinning indicators or targets that support the delivery of the outcome?	Improve targeting of partner agencies' resources to community regeneration areas.	Increase take up of money, debt and fuel poverty advice. Numbers with positive outcomes accessing Fit for Work: Working towards Health in Dundee.	More people at risk of exclusion engage in learning. Partners target services of those most at risk of exclusion.

What are the Board's top 3 actions that contribute to each of these outcomes?	Support for Healthcare Academy.	Support for Fit for Work pilot and working with the employability pipeline in Dundee.	Support for Healthcare Academy.
	Increasing volunteering opportunities in NHS.	Develop partnership working with Dundee Volunteer Centre.	NHS participates in literacy of numeracy initiative.
	Delivery of Health Equity Strategy.	Implementation of Health Equity Action Plans & Community Framework.	Delivery of Health Equity Action Plan.
How will the Board performance manage these contributions?	Performance reports to CHP Committee.	Performance reports to Healthy Dundee.	Performance reports to CHP Committee.

ECONOMIC RECOVERY - DUNDEE

What are the priority local outcomes for economic recovery?	Dundee will achieve business growth.	Dundee will have effective pathways to employment. Dundee will have access to job opportunities and support.	Dundee will be a regional centre with better job opportunities and increased employability.
What are the underpinning indicators or targets that support the delivery of the outcome?	Number of businesses and enterprises.	Overall job numbers. Percentage of working-age population in employment.	Number of Community Regeneration residents accessing activities in the Dundee Employability Programme.
What are the Board's top 3 actions that contribute to each of these outcomes?	Promoting access to health employment.	Improving access to vocational health services for workforces in Dundee.	Support Condition Management Programme through the Working Towards Health Initiative.
	Support for Healthcare Academy.	Support for Healthy Working lives project for SME workforces in Dundee.	Support the Fit for Work Service Pilot. Support development of Case Management.
How will the Board performance manage these contributions?	Reports to NHS Board and other Standing Committees.	Performance reports to CHP Committee.	Performance reports to CHP Committee.

HEALTH INEQUALITIES - PERTH & KINROSS

<p>What are the priority local outcomes for tackling health inequalities?</p>	<p>Local Outcome 10 Our people will have improved health and well-being.</p>	<p>Local Outcome 8 Our Communities and people experiencing inequalities will have improved quality of life, life chances and health.</p>	<p>Local Outcome 7 Our children are nurtured and supported and have the best start in life.</p>
<p>What are the underpinning indicators or targets that support the delivery of the outcome?</p>	<p>Number of attendances at sport and active recreation activities. Target 2010/11 940,002</p>	<p>Prevalence of problem drug users Target for 2011/12 reduced by 5%</p>	<p>% of babies aged 6-8 weeks in - (a) Perth and Kinross 1) exclusively – 40%, (2) mixed breastfeeding – 49% - 2011/12 (b) Deprivation areas 1) exclusively, (2) mixed breast feeding – narrowing the gap</p>
	<p>Alcohol related hospital admissions – per 100,000 Target – 2011/12 reduce by 2% areas of deprivation Target 2011/12 reduce by 4%</p>	<p>Prevalence of adults smoking Target 2010/11 reduce by 8% Areas of deprivation target 2010/11 reduce by 8%</p>	<p>% of women smoking in pregnancy (a) Perth and Kinross – Target 17.6% (b) Deprivation areas – narrow the gap</p>
	<p>Agreed improvements in the early diagnosis and management of patients with dementia will be achieved – 2011 – 33% increase</p>	<p>Suicide rate per 100,000 per year Target 2013 reduce by 20%</p>	<p>Severe obesity levels in P1 children Half the obesity increase – target 2011/12 – 3.8%</p>

			<p>Pregnancy rates per 1000 women</p> <ul style="list-style-type: none"> (a) Under 16 year old – maintain / reduce national target 6.8% (b) Under 20 year old – to be agreed (c) Under 20 year old in deprivation areas – narrow gap <p>% P1 children free of disease at dentine level -</p> <p>Narrow the gap between those schools achieving baseline and those below</p>
<p>What are the Board's top 3 actions that contribute to each of these outcomes?</p>	<p>Achieve the end of year trajectory of 1,565 health checks against the (Local Delivery Plan) target to deliver the agreed number of inequalities targeted cardiovascular Health Checks during 2009-10.</p>	<p>Achieve the end of year trajectory of 2,105 successful quits against the (Local Delivery Plan) target that through smoking cessation services, supports 8% of Tayside's smoking population in successfully quitting (at one month post quit) over the period 2008/9- 2010/11.</p> <p>Achieve the end of year trajectory of 35% staff trained against the (Local Delivery Plan) target of 50% of key frontline staff in mental health and substance misuse services, primary care, and accident and emergency being educated and trained in using suicide assessment tools/ suicide prevention training programmes by December 2010.</p>	<p>Achieve the end of year trajectory of 865 interventions against the (Local Delivery Plan) target of agreed completion rates for child healthy weight intervention programme by 2010/11.</p> <p>Achieve the end of year trajectory of 79% against the (Local Delivery Plan) target that 80% of all three to five year old children to be registered with an NHS dentist by 2010/11.</p>

			Achieve the end of year trajectory of 28% against the (Local Delivery Plan) target to increase the proportion of new-born children exclusively breastfed at 6-8 weeks from 26.6% in 2006/07 to 33.3% in 2010/11.
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EARLY YEARS - PERTH & KINROSS

<i>EARLY YEARS - PERTH & KINROSS</i>			
What are the priority local outcomes for tackling health inequalities?	Local Outcome 7 Our children are nurtured and supported and have the best start in life.	Local Outcome 8 Our communities and people experiencing inequalities will have improved quality of life, life chances and health.	Local Outcome 9 Our communities will be safer.
What are the underpinning indicators or targets that support the delivery of the outcome?	% of babies aged 6-8 weeks in - (c) Perth and Kinross 1) exclusively – 40%, (2) mixed breastfeeding – 49% - 2011/12 (d) Deprivation areas 1) exclusively, (2) mixed breast feeding – narrowing the gap	Reduction in number in 20% worst data zones in Scotland	% children on the child protection register over 18 months – Targets not appropriate
	% of women smoking in pregnancy (c) Perth and Kinross – Target 17.6% (d) Deprivation areas – narrow the gap	% households accepted as in priority need who have been assessed as homeless or potentially homeless – 100%	Breaches of unsuitable accommodation orders (families in B&B 14+ days) – 7 (2011/12)

	Severe obesity levels in P1 children Half the obesity increase – target 2011/12 – 3.8%	% households experiencing fuel poverty – 23% (2010/11)	
	Pregnancy rates per 1000 women (d) Under 16 year old – maintain / reduce national target 6.8% (e) Under 20 year old – to be agreed. (f) Under 20 year old in deprivation areas – narrow gap.		
	% P1 children free of disease at dentine level - Narrow the gap between those schools achieving baseline and those below.		
What are the Board's top 3 actions that contribute to each of these outcomes?	Achieve the end of year trajectory of 28% against the (Local Delivery Plan) target to increase the proportion of new-born children exclusively breastfed at 6-8 weeks from 26.6% in 2006/07 to 33.3% in 2010/11.	Develop agreed action plans with partner agencies that will result in priorities being identified for implementation in 2010/11 in response to the Scottish Government/COSLA joint policy framework "Early years Early Intervention".	
	Achieve an estimated outcome of 450 quitters towards the target of 900 quitters by 2010/11 through the 'quit4u' Initiative.		

	Maintain the current performance within Tayside of 61% (against the national target of 60% by 2010) of primary one school children having no obvious decay experience, and work towards increasing this performance to 70% within 2010/11, particularly focusing upon certain areas of deprivation.		
TACKLING POVERTY AND SOCIO-ECONOMIC INEQUALITY - PERTH & KINROSS			
What are the priority local outcomes for tackling health inequalities?	Local Outcome 4 Our area will provide well paid employment opportunities for all	Local Outcome 5 Our people will be well skilled and trained	Local Outcome 8 Our communities and people experiencing inequalities will have improved quality of life, life chances and health
What are the underpinning indicators or targets that support the delivery of the outcome?	Increase the social economy turnover (Baseline to be set)	% school leavers moving onto positive and sustained destinations – 92% (2010/11)	Average monthly earnings for people whose workplace is within Perth and Kinross – £1,700 (2010/11)
	% of working age population unemployed – 2.5% (2011/12)	Number of young people in the More Choices, More Chances category – 350 (2009/10)	
	Labour participation rate – Maintain current levels		

	% of working age people on benefits - 11% (2011/12)	Residents surveyed who are satisfied with areas they live in – target 2010/11 - 93%.	
What are the Board's top 3 actions that contribute to each of these outcomes?	Develop a model for both Angus and Perth & Kinross Community Health Partnerships that will address the health inequalities and variances across the geographical areas in respect of Keep Well.	Develop the 'working well' initiative to promote and improve the health, well being, safety and experience of staff to improve service delivery, efficiency and quality of patients and the public.	Develop an action plan to address the Scottish Government's workforce response to Better Health, Better Care 'A Force for Improvement' to ensure delivery of the NHS Tayside Workforce Plan and response to the 2008 staff survey.
	Increase the number of clients supported by the 'Working Towards Health' Initiative to 300 in 2009/10 compared to 246 within 2008/09 to support people to overcome their health conditions and to assist them towards meaningful employment.		

ECONOMIC RECOVERY - PERTH & KINROSS

What are the priority local outcomes for tackling health inequalities?	Local Outcome 1 Our area will have a thriving and expanding economy.	Local Outcome 5 Our people will be well skilled and trained	Local Outcome 4 Our area will provide well paid employment opportunities for all
What are the underpinning indicators or targets that support the delivery of the outcome?	% working age population on benefits - 11% (2011/12)	% school leavers going on to positive destinations – 92% (2010/11)	% working age population unemployed – 2.5% (2011/12)
	Number of new business bank accounts – 2010 target - 550	Number of young people in the More Choices, More Chances category – 350 (2009/10)	

<p>What are the Board's top 3 actions that contribute to each of these outcomes?</p>	<p>Develop a model for both Angus and Perth & Kinross Community Health Partnerships that will address the health inequalities variances across the geographical areas in respect of Keep Well.</p> <p>Tourism revenues - target 2011/12 - £468m</p>	<p>Develop the 'Working Well' Initiative to promote and improve the health, wellbeing, safety and experience of staff to improve service delivery, efficiency and quality of patients and the public.</p>	<p>Develop an action plan to address the Scottish Government's workforce response to Better Health, Better Care 'A Force for Improvement' to ensure delivery of the NHS Tayside Workforce Plan and response to the 2008 staff survey.</p>
	<p>Increase the number of clients supported by the 'Working Towards Health' Initiative to 300 in 2009/10 compared to 246 within 2008/09 to support people to overcome their health conditions and to assist them towards meaningful employment.</p>		