

NHSScotland

LOCAL DELIVERY PLAN 2013/14

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Appendix 1 NHSScotland's Ten Performance Management Principles

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Contact details for Scottish Government HEAT target leads will be issued to NHS Board Contacts separately, by 5 December.

1 Outcomes

Quality Strategy

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

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

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

Challenges

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

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

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

delivering efficiency savings and increasing productivity based on past success.

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

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

Responding to the challenges

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

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

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

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

opportunities which is translated in to prioritised plans and delivery of improved outcomes.

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

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

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

Sustaining Performance

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

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

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

Further Improvement

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

The establishment of the Scottish Patient Safety Programme which was the first such programme in the world to be implemented across a whole health system is delivering significant improvements which include a renewed focus, improvement methodology and significant reductions in HSMR (11.4% since 2007). The programme has been extended until 2015, with a focus on harm free care in the NHS - focussing on infections, falls, blood clots and pressure sores. There are no specific HEAT targets associated with this programme.

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

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

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

Transformational Change

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

One of the most important functions of the NHS is prevention of ill health and there is increasing need to take the prevention agenda to a new and more effective level. The increasing incidence of illness, in an ageing population, underlines the importance of finding new ways of detecting illness earlier and treating it at a stage at which significant benefit is possible. Projects such as

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

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

NHS Boards have an important role to play in the economy, as an employer, a consumer and partner. The Scottish Government has a vision to increase partnership working so that NHSScotland can develop its use of new innovative technology and improve the quality of care which patients receive, including the ability for more people to be cared for at home. This will also help to achieve the aim of doubling the economic contribution of life sciences to the Scottish economy. Scottish scientists and businesses' recent

developments include a new class of cancer drugs, stem cell treatment which could potentially reverse corneal blindness and a treatment for diabetics which reduces dependence on insulin. NHS Boards are committed to tackling youth unemployment and are providing additional opportunities for unemployed young people including Modern Apprenticeships, student placements and work experience programmes. All NHS Boards are actively working to develop new or existing plans and programmes in order to meet national expectations.

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

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

The earlier that cancer is diagnosed and treated, the better the survival outcomes. Improving the percentage of early stage diagnoses will mean fewer premature deaths from cancer and this will have a positive effect on overall life expectancy in Scotland. Scottish Government and NHSScotland aim to address this in the Detect Cancer Early programme and improve survival outcomes for people with cancer to amongst the best in Europe. There will be a continued drive to improve on the current high quality cancer service provision and patient and carer experience. Earlier diagnosis will be one route to achieving these aims and will result in fewer recurrences, improvement in cancer mortality rates and longer term wider societal benefits.

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

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

2 Process and Timescales

Local Delivery Plans are expected to be signed-off by NHS Boards and Scottish Government by 31 March 2013, before the start of the 2013/14 financial year.

The proposed timetable for the next 12 months is:

| Date | Action |
|----------------------|---|
| 29 November 2012 | HEAT Targets & LDP guidance issued. |
| ... | NHS Boards prepare draft LDPs; discussion with Health and Social Care Directorates. |
| 15 February 2013 | NHS Boards submit draft LDPs. |
| ... | Health and Social Care Directorates review draft LDPs and discuss any outstanding issues with NHS Boards. |
| 15 March 2013 | NHS Boards submit final LDPs. |
| 31 March 2013 | DG Health & Social Care signs-off LDPs |
| End June 2013 | Scottish Government and Health Boards resolve any outstanding issues. |
| Summer 2013 | NHS Boards' Annual Review. NHS Boards publish workforce plans. |
| Throughout 2013 | Review period for HEAT/LDPs. Mid-year Stock takes. |
| Autumn 2013 | DG Health & Social Care issues revised LDP guidance for 2014/15. |

NHS Boards will develop their LDPs with their partners and in consultation with stakeholders and will seek board sign-off during March 2013. LDPs will cover a three year period, with the opportunity to review and adjust future years' plans each year.

The 10 LDP performance management principles which help improve understanding of NHSScotland's approach to performance management continue to be relevant. These principles have been refreshed this year and recognise the increasing importance of partnership working. These are attached at Appendix 1, and are set out in the context of sound accountability.

3 HEAT targets & standards

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

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

- Dementia – a minimum of one year's post diagnostic support, through a link worker, for people newly diagnosed with dementia including person-centred support plan. This target will be due for delivery by 2015/16. This supports sustained independence within context of strong family and community support and promotes early decision making on future care options as part of person-centred care.
- Healthcare Associated Infection - to further reduce the levels of staphylococcus aureus bacteraemia (including MRSA) and Clostridium difficile. Reducing preventable HAI directly supports healthcare that is free from avoidable harm.
- IVF - eligible patients will commence IVF treatment within 12 months by March 2015. This will ensure equitable access to IVF services across Scotland.

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

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

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

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

| HEAT 2013/14 Standard | Policy Aim |
|---|--|
| 95% of all patients diagnosed with cancer to begin treatment within 31 days of decision to treat, and 95% of those referred urgently with a suspicion of cancer to begin treatment within 62 days of receipt of referral | Timeliness and access are integral to a quality service and can contribute to improved survival outcomes. |
| 90% of planned / elective patients to commence treatment within 18 weeks of referral | Access is a key measure of quality and faster access to diagnosis and treatment services reduces patients' uncertainty and stress and improves their quality of life. |
| No patient will wait longer than 12 weeks from referral (all sources) to a first outpatient appointment (measured on month end Census) | |
| Provide 48 hour access or advance booking to an appropriate member of the GP Practice Team | Often a patient's first contact with the NHS is through their GP practice. It is vital, therefore, that every member of the public has fast and convenient access to their local primary medical services to ensure better outcomes and experiences for patients. |
| To respond to 75% of Category A calls within 8 minutes across mainland Scotland (Scottish Ambulance Service) | Patients in situations categorised as potentially immediately life threatening need the ambulance service to respond as quickly and safely as possible in order to maximise the outcome for the patient. |
| 98% of patients will wait less than 4 hours from arrival to admission, discharge or transfer for accident and emergency treatment | Medical evidence shows that long waits impact on patient experience and the quality of care. |
| 90% of clients will wait no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery. | To ensure more people recover from drug and alcohol problems so that they can live longer, healthier lives, realising their potential and making a positive contribution to society and the economy. The first stage in helping people to recover from drug and alcohol problems is to support action across the country to provide a wide range of services for individuals and their families that are recovery focused, good quality and that can be accessed where and when they are needed. |
| NHS Boards to achieve a sickness absence rate of 4% | Sickness absence can result in cancelled appointments and procedures, increased pressure of staff, and increased cost. |
| NHS Boards and Alcohol and Drug Partnerships (ADPs) will sustain and embed alcohol brief interventions (ABI) in the three priority settings (primary care, A&E, antenatal). In addition, they will continue to develop delivery of alcohol brief interventions in wider settings. | ABIs are a highly effective early intervention to help individuals to reduce hazardous or harmful alcohol use, thereby reducing their chances of developing more serious alcohol-related problems. The standard will ensure that NHS Boards and ADPs sustain and embed delivery of ABIs in the three established settings as well as enabling them to extend into wider settings, contributing to the developing evidence base. This will ensure that ABIs remain a core |

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| | component of local strategies to reduce alcohol related harm. |
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4 Local Delivery Plans

Local Delivery Plans

Local Delivery Plans will record agreement on NHS Boards' planned progress towards meeting key national targets. They will cover a period of three years, with the opportunity to review and adjust future years' plans each year.

The 2013/14 LDP Methods and Sources describes the performance measures used to monitor performance.

NHS Board Contribution to Community Planning Partnership

The Statement of Ambition issued following the recent Review of Community Planning and Single Outcome Agreements makes clear that effective community planning arrangements will be key strategic building blocks at the core of public service reform. It highlights the importance of removing barriers to effective partnership working and the need to ensure that leadership and cultures, systems and structures, and accountability arrangements across the public sector fully enable the delivery of better outcomes for communities. Work is now in hand to deliver on that Statement of Ambition, including the establishment of a National Group on Community Planning which will provide strategic oversight for how this overarching vision for community planning and Single Outcome Agreements develops.

NHS Boards are key partners within Community Planning Partnerships and have a crucial role to play in delivering improvements on a local and national basis. There is widespread agreement that Community Planning Partnerships focus on a small number of key priorities: economic recovery and growth; employment; early years and early intervention; safer and stronger communities, and offending; health inequalities and physical activity; and older people. Like all public bodies, there is an expectation that NHS Boards as CPP partners have evidence based understanding of local needs and opportunities which is translated in to prioritised plans and delivery of improved outcomes.

In this LDP NHS Boards are expected to indicate how they will improve their partnership approach during 2013/14, specifically focusing on how they will contribute to better outcomes through collaborative gain.

Building on the "critical issue" approach in last year's LDP, this year LDPs are expected to include a concise summary of the key tangible contributions that the NHS Board will make during 2013/14 towards improved outcomes in economic recovery and growth; employment; early years and early intervention; safer and stronger communities, and offending; health inequalities and physical activity; and older people. Clearly national improvements through HEAT and other programmes play an important role,

however, this part of the LDP is expected to focus on locally developed improvements with a strong emphasis on changes to NHS services which reduce future demand by preventing problems arising or dealing with them early on. Helping people understand why this is the right thing to do, the choices it implies as well as the benefits it can bring will be crucial. These contributions are expected to be developed through the SOA and NHS Boards will be developing the planned contributions through local Community Planning Partnership and NHS Board structures. Where appropriate current performance and planned improvements in performance should be included.

The Scottish Government will discuss progress against these commitments at mid year stock takes and Annual Reviews.

LDP Risk Management Plans & Delivery Trajectories

Boards should, as in previous years, include LDP Risk Management Plans to provide contextual information on key risks to the delivery of each target and how the risks are being managed. Cross-reference to local plans should be made where necessary.

- **Delivery and improvement:** 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:** provide a 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.
- **Equalities:** Where applicable, boards should outline any risks that the delivery of the target could create unequal health outcomes for people with protected characteristics, and/or for people living in socio-economic disadvantage; and how these risks are being managed.

NHS Boards are expected to have processes in place to ensure that equality impact assessments for the three new HEAT targets are easily accessible to the public and demonstrate the actions that NHS Boards take following these equality impact assessments.

Setting out planned performance against key measures will enable NHS Boards and DG Health & Social Care to track actual operational performance against Boards' plans. The delivery trajectories therefore provide an objective, factual basis to discuss with Boards any operational performance

issues that may arise during the plan period and to offer support to achieve improvement if that is needed.

In order to minimize delivery risks, it is expected that delivery trajectories will generally see uniform improvements over time, avoiding reliance on significant improvements in the final stages of delivery. The Directorate for Health Workforce & Performance will continue to support Boards in benchmarking their performance, and will work on spreading good practice associated with improving performance.

This quantified and measured approach to performance planning and monitoring does not imply any reduction in the importance of the qualitative aspects of performance. Providing assurance to the Board, its Clinical Governance Committee (or equivalent) and the public about the quality of healthcare services continues to be a vital task for each Board. Local monitoring of quality will continue to be augmented at the national level by Healthcare Improvement Scotland and their Healthcare Scrutiny Model. This model will provide a framework for scrutiny activity, including inspections, peer review and accreditation and these reports will continue to be monitored by DG Health & Social Care.

Trajectory Change Control Process

Once an LDP has been agreed and signed off by DG Health & Social Care and the NHS Board, any mid-year alterations to trajectories need to be agreed between the Directorate of Health Workforce & Performance and the NHS Board. The trajectory change control process to alter trajectories will be operated by the performance management teams in the Directorate of Health Workforce & Performance.

LDP Financial Plans

The Draft Budget 2013-14 can be found at <http://www.scotland.gov.uk/Publications/2012/09/7829>. Final NHS Board allocations will be agreed through the Scottish Budget.

Financial planning is an integral component of LDPs. To ensure that Boards plan over the longer term, financial plans are generally required for a three year period. However, a five year plan is required where any of the following apply: major infrastructure development, brokerage arrangements are in place, underlying deficit of over 1% of baseline resource funding, major service redesign. In terms of capital, a five year plan is required from all Boards. Boards are notified individually regarding the period of their financial plan.

NHS Boards should include draft financial plans as part of their LDP submission, in line with the timetable presented. In particular, NHS Boards are asked to complete the financial templates. Particular emphasis should be placed on workforce planning and NHS Boards should provide assurances

that their proposed workforce requirements are driven by and reflect service change and are affordable. The detailed financial information included in the templates will be used to assess each Board's financial projections, including key risks/assumptions, to ensure achievement of financial targets.

The Scottish Government is supporting NHS Boards to improve the quality of services, and to eliminate waste and variation. The NHSScotland Efficiency and Productivity Framework for SR10 published in February 2011 identify priority areas to improve quality and efficiency. The Framework underpins NHS Boards' Efficiency Savings Plans. As part of the Financial Plans efficiency savings are required to be categorised by seven themes: Service Productivity, Drugs and Prescribing, Procurement, Workforce, Shared Services, Support Services, and Estates and Facilities.

Monthly performance assessment of the agreed financial plan / trajectories will continue to be based on the monthly Financial Performance Returns (previously called the Monthly Monitoring Returns, MMRs).

Workforce Planning

Ensuring the correct workforce is available to deliver the required clinical and supporting services is central to the delivery of key policies and targets, and the Quality Strategy. The three central workstreams within our Workforce 20:20 Vision – Governance & Engagement; Leadership & Capability; Capacity & Modernisation will help to describe our future workforce needs. Development and implementation of the NHSScotland workforce are also being taken forward through a number of workstreams including those linked to efficiency and productivity.

The Scottish Government set a target 25% reduction in NHSScotland senior management posts by the end of the next Parliament (2014/15). Guidance has been issued to enable NHS Boards to contribute towards the delivery of this target in ways that reflect individual Boards circumstances and their wider service plans.

Workforce planning is a key factor in enabling NHS Boards to deliver quality frontline services. It is important to ensure that changes to the NHS workforce are driven by patient safety, patient need and service demand. Service & workforce change should be designed to maintain and enhance the quality of care for patients while increasing efficiency. Staff should be empowered to use their local knowledge and professional judgment to do 'the right thing'. They should be supported to develop the skills both to work in partnership with other professionals and to actively engage with patients to co-produce care. The workforce narrative in the LDP Risk Management Plans therefore helps to ensure that the workforce capacity & capability implications of key HEAT targets are fully taken into account in NHS Boards' LDPs, and further reflected in Board Annual Workforce Plans and Projections. It is acknowledged that HEAT targets and LDPs do not represent the complete range of NHS Board services which rely on a multi-professional workforce mix for successful delivery but they contribute to an assessment of the total required capacity and skill requirements.

CEL 32(2011) Revised Workforce Planning Guidance 2011, this guidance reflects the 6 Step Methodology to Integrated Workforce Planning and is applied across the whole NHSScotland Workforce. The guidance and six steps methodology makes reference to workforce projections as part of the wider workforce planning process, NHS Boards are required to submit projections annually. The Scottish Government template for these projections, includes specific guidance on coverage and completion, and requires detailed projections for most staff groups for a 3 year period. This timeframe aligns the projections exercise with the normal Spending Review period, but consideration of longer term future workforce planning continues to be important to support decisions on undergraduate training numbers for the “controlled” staff groups of medical, dental and nursing and midwifery, and the wider education agenda across all staff groups to allow for preparation time and effective succession planning.

NHS Boards will be required to publish their wider workforce plan during 2013. Further guidance on the timings and process for submitting these, and workforce projections to the Scottish Government will follow in due course. Nursing & Midwifery have developed a series of Workload & Workforce Planning Tools, the application of these tools is mandatory to support evidence based decisions in relation to Nursing & Midwifery establishments. The tools use rigorous statistical analysis to calculate the whole time equivalent for current workload. These tools should form part of a triangulated approach to incorporate professional judgement and quality measures which will enable flexibility in decision making on staffing needs at local level. The Workload Tools available on the IT Platform via SSTS. The Scottish Government will work closely with Boards to refresh and continue to develop these workload tools to ensure they capture and reflect the changing case mix and modes of health care delivery.

NHS Boards are required to include in their LDPs, a brief summary of the anticipated workforce requirements, based around the following five headlines:

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

NHS Island Boards and mainland NHS Boards Partnerships

The Scottish Government is committed to retaining and ensuring the long term sustainability of Scotland's three island Boards (NHS Orkney, NHS Shetland and NHS Western Isles). The independence of these Boards allows them to develop and deliver services that meet the needs of their local population in ways that reflect the challenges of providing high quality services for island communities.

Each island Board has, over many years, played a full and active part within the regional planning process under which Boards agree to collaborate in order to develop and sustain healthcare services. It has been agreed to provide the support funding to enable NHS Boards to extend the concept of collaborative working to non clinical as well as clinical issues. Additional funding has been allocated to each island Board to enable them to enter into arrangements with their respective partners to strengthen their capability in areas such as: Human resources; Finance / Payroll; Governance; and Planning. It will enable Boards to set out an agreement that describes joint programmes of work between:

- NHS Orkney and NHS Grampian;
- NHS Shetland and NHS Grampian; and
- NHS Western Isles and NHS Highland

The three island Boards will remain independent and the precise shape and form of these partnership arrangements will be a matter for the members of the partnership themselves. They will be developed as a partnership of equals and it is anticipated that a Non Executive Director from each partner will attend the Board meeting of the other partner in order to ensure effective and ongoing liaison at the very highest level. The annual service agreement will form an addendum to the 2013/14 Local Delivery Plan of each partner. There may be some exceptional circumstances in which partners agree that the identified mainland partner Board is unable to provide a particular service, and in such cases, the island Board will be able to source this requirement from an alternative partner. Boards have formal arrangements in place to keep these arrangements under regular review.

HEAT Standards

The Scottish Government will continue to monitor the HEAT standards, NHS Boards are not required to provide delivery trajectories and risk narratives. Performance against HEAT standards is reported through Scotland Performs.

For 2013/14 there is one new HEAT standard on drug and alcohol misuse treatment waiting times. NHS Boards are on track to deliver the HEAT target to ensure that 90% of all patients admitted with a diagnosis of stroke will be admitted to a stroke unit on the day of admission, or the day following presentation by March 2013. Statistics will continue to be published on admission to stroke units and NHS Boards will continue to monitor performance locally. The former HEAT standard on early diagnosis of dementia is now included within the new HEAT target on dementia support.

NHS Board Planning

NHS Boards should ensure robust and clear planning arrangements at local level, engaging appropriately with local partners across the full range of health and social care policy, planning, service redesign and delivery issues.

Boards should consider the Review of Regional Planning in NHS Scotland Report 2012 collectively within regions and agree how best to consolidate and improve the benefits to date derived from regional approaches.

A number of HEAT targets cannot be delivered by NHS Boards alone. The Reshaping Care for Older People Programme and the introduction of the Change Fund are driving radical reforms to improve outcomes for individuals. The principles have been embraced by local government, the third sector and the independent sector and they should continue to be fully involved as partners in the delivery of relevant HEAT targets. These principles involve releasing resources tied up in institutional care, to support preventative and upstream interventions and to provide more appropriate support for older people. These are all issues that will be addressed by the integration of adult health and social care and should immediately be tackled through joint work on developing strategic commissioning plans. NHS Boards, along with their local authority and third and independent sector partners, are expected to have in place joint strategic commissioning plans by March 2013. Guidance on developing commissioning plans for older people issued in November 2012. The Change Fund should continue to be used as bridging finance to make better use of the overall combined resources for older people, investing in more preventative interventions and enabling partners to disinvest in institutional care. Partners will then jointly decide on how best to use the total resource envelope for older people. Joint strategic commissioning will be a key component of the Scottish Government's proposals to integrate adult health and social care. NHS Boards should consider how to embed future LDPs within the broader partnership agenda.

In terms of Early Years, NHS Boards should continue to play an active role in developing their local Integrated Children's Services plan along with other relevant members of the Community Planning Partnership. The Integrated Children's Services Planning process centres on understanding local needs, taking forward actions to address these and to improve outcomes for children. The Early Years Change Fund is a combination of existing funds currently committed and new funds yet to be allocated. The Scottish Government have always been clear that the monies in the Change Fund are a starting point and the partners should collectively consider how to increase the impact of the totality of spend. Given that the work of the Taskforce is now a year in, the Taskforce has signalled its intention to review how the Change Fund is currently operating and, consider how consistency and coherence across the country is accelerated.

NHS Boards working with Community Planning partners have a key role to play in implementing the Getting it right for every child (GIRFEC) approach. The GIRFEC approach requires services to work together to co-ordinate the design, planning and delivery of support for the child, when and where it is needed. The formal consultation on proposed provisions for key components

of the approach in the Children and Young People Bill has just finished. NHS Boards should continue to work with partners in taking forward implementation in anticipation of legislation.

Boards' planning for healthcare should meet the needs of prisoners and prisons and ensure that agreed standards are delivered.

Boards should ensure that all of these activities and their LDPs are consistent with the quality ambitions outlined in The Healthcare Quality Strategy for NHSScotland and the direction set in Better Health, Better Care.

Boards should ensure that they continue to fulfil their statutory obligations on co operation and public involvement and are encouraged – in line with the public service reform approach – to go beyond this, actively engaging individuals and communities in the co-production of services. Boards should also ensure that local and regional planning supports their performance agreement with Scottish Government set out in the LDP, and that focus and alignment is maintained across the full range of local service planning and delivery to ensure achievement of planned progress towards meeting the key targets in the LDP.

Clearly the efforts and performance of CHPs will continue to be vital in shifting the balance of care and improving outcomes for local people and communities. NHS Boards need to ensure that CHPs play their full part in helping to meet the targets as planned and support the delivery of broader health improvement strategies. NHS Boards need to ensure that CHPs are able to develop effective, integrated community based services that have been robustly tested through the Integrated Resource Framework. CHPs should draw together health, social care and third sector partners, and seek to evidence the impact on targets and quality improvement which is an essential part of this process. NHS Boards should be mindful of Ministers' plans to further integrate adult health and social care and the development of joint strategic commissioning.

The achievement of targets set out in LDPs is also underpinned by service delivery and improvement work across NHSScotland, including QuEST and JIT. This detailed underpinning work will continue to play a vital role in supporting Boards to meet the targets set out in the LDP.

Special Health Boards (SHBs)

SHB LDPs should include a section describing how their objectives support National Outcomes, Quality Ambitions and quality outcomes.

SHBs are required to complete the Financial Templates and workforce summaries.

The State Hospital and National Waiting-Times Centre will also be required to complete risk management plans and delivery trajectories for the target 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. The remaining SHBs will be required to develop local targets to reduce carbon and energy consumption.

The National Waiting-Times Centre Board will also be required to complete risk management plans and delivery trajectories for the relevant HEAT targets.

Health Directorate lead sponsors will provide guidance and advice on LDP content. It is anticipated that for 2013/14 this is likely to focus on delivery of key priorities and the support provided to territorial Boards in achieving key HEAT targets across Scotland measured through SMART targets and performance measures.

Publishing Local Delivery Plans

NHS Boards should ensure that the final Local Delivery Plans are published on their local websites by end of June 2013.

Mid-Year Stock-Take and Annual Reviews

The Annual Review will continue to focus on progress made on key priorities, performance against HEAT targets, and the contribution towards delivery of the outcomes.

NHS Board Chief Executive and senior management team mid-year stock-takes with the Scottish Government Health & Social Care Directors will provide the opportunity to take stock of 2012/13 performance, and also to look ahead to 2013/14.

We plan to continue to report progress against HEAT targets through the Scottish Government's Scotland Performs website.

The HEAT Performance Management IT system will be updated with HEAT 2013/14 targets (www.bic.scot.nhs.uk).

2013/14 Development Targets

This year three developmental HEAT targets will be taken forward.

- Workforce - Engagement is underway with a range of stakeholders including HR Directors, Deputy HR Directors and Employee Directors to develop proposals for a HEAT target to support implementation of the Staff Governance Standard. A developmental HEAT target will be tested during 2013/14. It is expected to take account of the range of Workforce transactional measures such as attendance rates, PDP review uptake, turnover rates, grievance and disciplinary process measures; and Workforce transformational measures such as vision, values, behaviours, staff experience/engagement, wellness/wellbeing.
- Musculoskeletal AHP Waiting times – During 2013/14, the Scottish Government will work with NHS Boards on a developmental HEAT target to

reduce Musculoskeletal AHP waiting times – with detailed target definitions agreed in year. MSK is a high volume speciality with conditions that are most commonly reported type of work-related illnesses. There is significant variation in referral rates and waiting times across Scotland. A new MSK pathway has been designed, which has the potential to release significant efficiency savings for reinvestment in frontline services.

- Carbon Reduction - The introduction of the Public Sector Sustainability Reporting (PSSR) Guidance for Public Bodies in January 2012 provides the opportunity to align HEAT target measurement with the rest of the public sector. Scottish Government and Health Facilities Scotland will engage with NHS Boards to develop baseline data, measurement systems, and definitions for a new target during 2013/14. The existing targets for reductions of 3% per annum in carbon and 1% per annum in energy consumption will continue to be in place for 2013/14.

Appendix 1: NHSScotland's Ten Performance Management Principles

The following performance management principles have been developed to help improve understanding of NHSScotland's approach to performance management in the context of significant change in recent years. These principles are prefaced by sound accountability.

1. NHSScotland's Performance Management Framework supports delivery of the Scottish Government's outcomes and Health Directorates strategic objectives

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| Summary | LDP 2013/14 |
| Local Delivery Plans set out some of the key improvements NHS Boards will deliver to contribute towards the delivery of the Scottish Government's outcomes. | <p>The HEAT targets are aligned with the six quality outcomes.</p> <p>Proposals for new HEAT targets are considered on the basis of strategy, delivery and measurement.</p> |

2. Performance measures demonstrate the progress towards delivering our strategy for improving the quality of patient care

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| Summary | LDP 2013/14 |
| Delivery of targets and performance measures give Ministers, staff and the public the confidence that we are making progress in implementing our key strategies for NHSScotland and improving the quality of patient care. | NHSScotland reports performance through Scotland Performs. |

3. Performance measures help deliver a wider system aim, and the impact on the whole system must be considered

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| Summary | LDP 2013/14 |
| Performance measures are not an end in themselves but are a proxy measure for a wider system change. | <p>The system is wider than NHS Boards, which reinforces the importance of partnership to deliver.</p> <p>Focus on reducing future demand by preventing problems arising or dealing with them early.</p> <p>The LDP clearly sets out the intended policy aim for all HEAT targets.</p> <p>Performance measures are one of the methodologies available to deliver</p> |

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| | improvement. |
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4. Design the system, deliver the performance

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| <p>Summary</p> <p>The delivery of targets should be the consequence of well designed systems of care which take account of best evidence and local needs. Well designed systems of care ensure that individual patients are not disadvantaged to ensure compliance with targets.</p> | <p>LDP 2013/14</p> <p>Wide range of collaborative and business transformation initiatives.</p> |
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5. Clinical decision making in the interest of the patient is always more important than unequivocal delivery of targets

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| <p>Summary</p> <p>Patients are always diagnosed and treated according to their clinical need.</p> | <p>LDP 2013/14</p> <p>Guidance for delivery of targets will reinforce this principle.</p> |
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6. Local flexibility in delivery

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| <p>Summary</p> <p>Through the Local Delivery Planning process, Scottish Government and NHS Boards will consider local circumstances (e.g. Community Planning Partnership priorities, baseline performance, service models, workforce, risk, governance, the needs of local people) in defining performance measures, performance management, improvement support, and delivery.</p> | <p>LDP 2013/14</p> <p>NHS Boards responsible for delivery and innovation encouraged.</p> |
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7. Targets should support diversity and reduce inequalities

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| <p>Summary</p> <p>The Scottish Government and NHS Boards in defining, performance managing, and delivering targets, always ensure that performance targets do not result in inequity in the quality of service provided for any patient.</p> | <p>LDP 2013/14</p> <p>In developing HEAT target proposals the differing impacts on equality groups are assessed.</p> <p>NHS Boards explicitly set out inequality risks associated with delivery of HEAT targets and how these risks are being</p> |
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| | managed. |
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8. Staff should be engaged in target setting and target delivery

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| <p>Summary</p> <p>Targets can help staff realise improvements in care and contribute to system wide priorities. Staff should be involved in local delivery planning and review of performance against targets, including lessons learned and encouraged to actively identify and implement improvements.</p> | <p>LDP 2013/14</p> <p>Continued engagement in development of new targets</p> |
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9. Best practice in Performance Management & Delivery is shared

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| <p>Summary</p> <p>NHS Boards have their own individual performance management systems, building on national requirements. There is scope to share best practice in performance management and delivery and to share best practice in Board's contributions to Single Outcome Agreements with their community planning partners.</p> | <p>LDP 2013/14</p> <p>Best practice shared through a number of channels (including Efficiency & Productivity Programme, Quality Improvement HUB, NHSScotland's Performance Forum)</p> |
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10. Data and measurement are key aspects of Performance Management

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| <p>Summary</p> <p>Performance measures are specific, measurable, achievable, realistic and time-bound. Performance measures are short to medium term outcomes, clearly identifying key contributions that NHS Boards make. We always work to recognise any data quality issues that may arise with performance measures and will ensure a wider understanding of the nature and uses of data and information within delivery.</p> | <p>LDP 2013/14</p> <p>LDP Methods and Sources clearly define performance measures.</p> <p>Scotland Performs provides easy access to NHS performance.</p> <p>NHS Board board meetings consider performance on an ongoing basis.</p> |
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ISBN: 978-1-78256-285-6 (web only)

The Scottish Government
St Andrew's House
Edinburgh
EH1 3DG

Produced for the Scottish Government by APS Group Scotland
DPPAS13717 (12/12)

Published by the Scottish Government, December 2012

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