LDP Risk Management Plan

Health Board: TAYSIDE

Use of Risk Management Plan

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 Management Plan 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

Achieve agreed number of screenings using the setting-appropriate screening tool and appropriate alcohol brief intervention, in line with SIGN 74 guidelines during 2011/12.

Achieve agreed number of inequalities targeted cardiovascular Health Checks during 2011/12.

Reduce suicide rate between 2002 and 2013 by 20%

Achieve agreed completion rates for child healthy weight intervention programme over the three years ending March 2014.

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.

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

Achieve agreed number of screenings using the setting-appropriate screening tool and appropriate alcohol brief intervention, in line with SIGN 74 guidelines during 2011/12

NHS BOARD LEAD:	Peter Williamson

Delivery

Risk	Management of Risk
This is a continuation of a 3 year target which we achieved. However performance varied during this three year period and activity in 2011/12 will need to be at the level of the best previous periods throughout the year.	Robust additional analysis and improvement methods put in place in year three led to the improved performance in that year and these will have to be maintained to deliver the increased level of activity required in 2011/12.
Existing settings delivering ABIs will require continuing support to sustain activity.	Negotiation of the continuation (with any appropriate revisions) of the Locally enhanced service agreement with Primary Care to support the routine delivery of Alcohol screening and brief interventions (ASBI) in routine primary care consultations. Spot audits of recording and reporting arrangements will be conducted in Primary care to identify variance from previous pattern at an early stage Training, liaison and improvement plans tailored to each delivery setting will be in place The co-ordination and oversight of data collection by Health Strategy Directorate will be maintained. An adequate number of staff with the necessary expertise are trained and supported to deliver required level of activity in each setting.

Workforce

Risk	Management of Risk
A small key group of staff provide the support, organisation and training for the delivery of this target. Should any of these posts become vacant there is a risk that this will disrupt performance.	Ensure that activities associated with key posts such as Primary Care Liaison Officer and Alcohol Programme Manager are maintained throughout the period of the target during any absence of the post holder by diverting staff from other activities.

Finance

Risk	Management of Risk
No financial issues identified.	

Improvement

Risk	Management of Risk
No risks identified.	

Equality

Risk	Management of Risk
Evidence would indicate that people living in socially deprived circumstances are more likely to experience alcohol related health harm. Some people living in such circumstances and are at higher risk, particularly younger men, may not commonly access routinely provided health services and may therefore be less likely to be screened in the approved settings.	Healthy living programmes which include alcohol screening are targeted at socially deprived communities in Dundee.

Achieve agreed number of inequalities targeted cardiovascular Health Checks during 2011/12

NHS BOARD LEAD:	Peter Williamson

Delivery

Risk	Management of Risk
The HEAT target for the past 2 years has been met. There is a risk that practices will choose not to continue their input to the programme. For Dundee practices involved in wave 1 the group left are increasingly difficult to engage. The community pharmacy input to the HEAT target is small but there are issues with this progressing and being sustained which could impact potentially. Staff changes, particularly to the outreach team may also impact.	All services delivering Keep well will be supported by the core team as much as possible around issues with capacity or sustainability. It is hoped that the future begin clearer for the programme over the next few years will be an incentive for practices to continue. The input of independent contractors is beyond our control however. Wider workface issues for the central team are critical to reach a number of those who are not engaging with the practice. NHS24 will also be expanded to support both practice and outreach engagement.

Workforce

Risk	Management of Risk
Increasing difficulty in filling posts due to the short term nature of the work being undertaken. The change in policy of NHS Tayside for secondment posts opposed to internal fixed term posts is likely to impact on recruitment to Keep Well posts, for both clinical delivery and admin.	Will be appropriately addressed within the NHS Tayside Workforce Plan. Efforts are being made by the organisation to support staff in short term posts. Once the new model of delivery from 2012 onwards is known an early decision will be sought by the organisation around the continuation of posts to avoid staff leaving due to uncertainty.

Finance

Risk	Management of Risk
Uncertainty on the level of funding for the Keep Well Programme beyond March 2012. This limits what may be currently developed because of issues around sustainability beyond March 2012	The commitment from Scottish Government to support Keep well for a limited period beyond 2012 is helpful. Key decisions will be required as to which parts of the services provide the most added value and will therefore be continued. Linked to work within the Health Equity Strategy opportunities beyond mainstream provision which can also support the agenda are being considered.

Improvement

Risk	Management of Risk
Sustaining the performance that has been previously delivered. This is particularly applicable in Dundee for those practices who have participated in the programme for three/four years, and for those practices in Angus who have delivered a high percentage in the time they too have been participating.	The current Dundee based role of the 'outreach nurse' has been reviewed for a range of posts to allow for delivery of both outreach and in-reach for practices that have been unable, for a range of reasons, to deliver Keep Well. This will commence in February for two practices and will expand if the three remaining practices agree. This model is already used in Perth & Kinross to support practices and works well. The 'nurse role' in Angus will focus more upon outreach working in the coming year. NHS24 phone engagement pilot commenced in January and if successful will assist in increasing Keep Well numbers. The pilot will be undertaken in Dundee but will be extended to all three community health partnerships if required and finance demonstrates added value for money.

Equality

Risk	Management of Risk
The Keep well health checks are specifically targeted at socioeconomic groups. We have considered the other groups highlighted and where we can we monitor for any issues related to this. We are able to do this for age, gender and ethnicity. There is no difference in uptake of services for these groups. Disability can prevent access to services but the outreach nurses will see people at home so this reduces any impact on this group. There is no indication that the other categories are impacted negatively by Keep well.	We will continue to monitor those groups highlighted in this section to ensure that as time progresses there is no negative impact on these group, and in fact try to establish if there is a positive impact. If any negative impact is identified we will take steps to address this as appropriate to the need.

Reduce suicide rate between 2002 and 2013 by 20%

NHS BOARD LEAD:	Peter Williamson

Delivery

Risk	Management of Risk
In line with the national trend the three and five year rolling averages of suicide rates in Tayside has been reducing since 2003. Fortunately suicides are relatively rare events but small variations in numbers of suicide within relatively small populations can have an impact on rates (hence the need to use rolling averages over a number of years). It is known that a "cluster" of six suicides occurred in Dundee during summer 2010 but it is not known what, if any, impact this will have on the averaged rate.	Suicide prevention activities, e.g. training in awareness and prevention approaches is delivered across agencies and communities under the auspices of "Choose Life". It is not possible to demonstrate any correlation between this activity and suicide rates. NHS Tayside delivered the supporting measure of training 50% of designated frontline staff in suicide prevention by March 2011 in October 2010. Arrangements are in place or being developed to sustain such training in future years.

Workforce

Risk	Management of Risk
No workforce issues identified.	

Finance

Risk	Management of Risk
No financial issues identified.	

Improvement

Risk	Management of Risk
Young people who present to the NHS and other services at times of crises and who have been using alcohol and or other substances do not always thereafter engage with the services offered which does not allow the risk they may pose to themselves to be managed effectively.	In collaboration with partner agencies undertake a review of current responses to re-evaluate what can and should be done to support people at a time of crisis or following an adverse incident who misuse substances.

Equality

Risk	Management of Risk
No risks identified.	

Achieve agreed completion rates for child healthy weight intervention programme over the three years ending March 2014

NHS BOARD LEAD:	Peter Williamson

Delivery

Risk	Management of Risk
The Scottish Government's new guidance on the child healthy weight target in respect of the whole school approach changes the conditions under which the programme can be undertaken which have to be addressed. Until these have been addressed there is a risk around being able to undertake the whole school part of the programme to the levels required to achieve the target. Specifically Additional Time Agreement has to be obtained from schools to the additional time that will be needed to undertake the required number of sessions for each programme. Similarly there will have to be discussion with the agencies that actually deliver the interventions to gain their agreement. Weight Measurement of Individual Children	Paediatric Overweight Service Tayside (POST) to engage with the Directors of Education and relevant staff within each of the three local authorities. Discussions and a plan of the forecast numbers that will go through the whole school approach will be produced by June at the latest.
The introduction of the individual BMI calculation and height/weight measurement for each child – in contrast to the previous normative rate of 23.1% - places a question over recruitment of sufficient obese children. The requirement to measure weight and height (in order to calculate BMI centile) on entry to and completion of programmes (in order to calculate BMI SD changes) will put parents/carers off allowing their children to participate.	POST will ensure that height and weights are measured and recorded as an integral part of a whole class activity and actively avoid categorising whether a child is overweight/obese or not within this setting to avoid stigmatising the child. POST will inform parents and carers ahead of delivering the programme to explain the above and provide the option to 'opt out' of the weighing and measuring if preferred. POST will target schools in areas it is believed present higher levels of overweight and obesity based on P1 data.
The risk of the difficulty identifying, referring and recruiting children and their families to the one-to-one interventions.	POST has an explicit communication strategy; training programme; and social marketing activities to address this risk.

Workforce

Risk	Management of Risk
There is a risk to maintaining the staffing of the POST Team who help to deliver the programme. Specifically - Size of Team The POST Team is small (3 WTE) and would be vulnerable to a sudden loss of a member of staff, eg, long term sickness absence.	Consultant in Public Health Medicine and POST Team Leader with workforce staff will review the current contractual constraints with the intention of coming up with a plan to have in place the workforce needed for the next three years and beyond.

Staff are on fixed term contracts which can encourage them to seek other employment opportunities leading to staff leaving before the end of their contract period. This obviously would also be an issue for recruiting any placements. In addition, recruitment of replacement staff in any circumstances has to recognise that those recruited will have to have or develop the necessary skills which could present delays in replacing lost capacity.	POST Team Leader will review and develop proposals to consider how the necessary skills can be further extended within the organisation, specifically within mainstream services.

Finance

Risk	Management of Risk
At this time there has been no agreement of national funding for the 2011-2014 period. However there is anticipation that an allocation of £154K for one year will be made available to NHS Tayside.	Ongoing dialogue with Scottish Government regarding budget to March 2014. Ongoing monitoring of risk through financial planning. If no further funding beyond year 1 is available then NHS Tayside will need to identify alternative or mainstream funding.
The 2011-2014 target is three times that of H3 and so requires more whole class sessions to be delivered within a similar financial envelope to that of H3 i.e. without any increase in POST team capacity.	POST will devise a service improvement/delivery plan for child healthy weight 2011-2014. POST to test the application of child healthy weight community volunteers. Management to consider how to further develop the child healthy weight capability of mainstream services for the next 3-year period and beyond.

Improvement

Risk	Management of Risk
No specific risks identified. Any relevant risks are outlined in the delivery section above.	

Equality

Risk	Management of Risk
Risk of increasing rather than reducing health inequalities through the programmes.	We will review the likelihood that this will happen. It will be very difficult to assess health risks, but it is accepted that there could be inequity of uptake.
Potential stigmatisation or discrimination arising as a result of participation in programmes.	All discussions with the schools are designed to ensure that the outcome of this programme is that no children are stigmatised.

The risk of excluding families where English is not their first language or who have literacy problems.	There will be discussions with NHS Tayside's Equality & Diversity Manager to identify whether there is a specific risk for this service given that these children are already in mainstream education, and if there is what in line with NHS Tayside's Equality Strategy needs to be done.

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

NHS BOARD LEAD:	Peter Williamson

Delivery

Risk	Management of Risk
Pressure on the medicines budget discourages prescribers from providing pharmacological support. Smoking cessation attempts are less successful and fewer patients make the one month target.	Good quality information is provided to prescribers to reinforce the cost-effectiveness of prescribing to smokers.

Workforce

Risk	Management of Risk
Smoking cessation staff leave posts and cannot be replaced because of organisation recruitment policy. The service does not have the capacity to deliver sufficient services.	Staff are supported to deliver their role and jobs are enriched where possible. Any issues regarding the recruitment and retainment of staff will be appropriately addressed within the Workforce Plan.

Finance

Risk	Management of Risk
No financial issues identified.	

Improvement

Risk	Management of Risk
General practices do not fully engage in and utilise the smoking cessation Locally Enhanced Service to refer quitters to smoking cessation services Operational restrictions and access to information technology inhibit the ability of the Pre-admission clinic to refer patients to smoking cessation services.	The LES is marketed to practice managers and staff. Feedback on performance and comparative performance in relation to other practices is provided. Work to address operational problems is undertaken. Solutions to IT access are sought.

Equality

Risk	Management of Risk
Processes and information systems are often too difficult to understand for those groups who have literacy issues. This is particularly pertinent within Dundee.	Continue to assess this and develop systems and improved methods to ensure that information is available in a meaningful and understandable way for this particular group.

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

Delivery

Risk	Management of Risk
As at June 2010, NHS Tayside had 87.1% of 3 -5 year old children registered with a dentist. However work is required to encourage dentists to carry out fluoride varnish applications.	Childsmile Practice is being introduced in Tayside and it is intended that this programme will continue to expand. Over time, this dental practice based initiative will provide a large input into the achievement of the fluoride varnish target.

Workforce

Risk	Management of Risk
No workforce implications identified.	

Finance

Risk	Management of Risk
No financial implications identified.	

Improvement

Risk	Management of Risk
Childsmile Nursery fluoride varnish application consent uptake is on average 58%, with 86% of these then going on to receive the intervention. Work is required to improve these figures. However, due to the product requiring a prescription and updated medical history every 6 months, this has and will continue to be a challenge.	The oral health improvement team is currently recruiting a further 3.7wte Childsmile dental health support workers to support this programme specifically working with Childsmile practices, health visitors and educational establishments to support the indirect service e.g. facilitating the registration of patients and increasing the consent rate within both nursery and school.

Equality

Risk	Management of Risk
An Equality Impact Assessment has been completed.	

Efficiency and Governance

Efficiency and Governance NHS Boards to operate within their agreed revenue resource limit; operate within their capital resource limit; meet their cash requirement. NHS Boards to deliver a 3% efficiency saving to reinvest in frontline services 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 Boards to operate within their agreed revenue resource limit; operate within their capital resource limit; meet their cash requirement.

NHS BOARD LEAD:	Peter Williamson

Delivery

Risk	Management of Risk
The past record of performance, which shows that all statutory financial targets have been achieved over the past 10 years, suggests that the financial monitoring systems in place are sufficiently robust and flexible to ensure achievement of all three targets in 2011/12.	

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.	

Equality

Risk	Management of Risk
No risks identified.	

NHS Boards to deliver a 3% efficiency saving to reinvest in frontline services

NHS BOARD LEAD:	Peter Williamson

Delivery

Risk	Management of Risk
Actual savings achieved have consistently exceeded targets since the introduction of the Efficient Government Initiative in 2005/06. Savings plans for 2011/12 are well advanced with circa 70% of the provisional LDP target of £25.0m already being identified.	

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.	

Equality

Risk	Management of Risk
No risks identified.	

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

Delivery

Risk	Management of Risk
The target for 2009/10 was achieved. The prolonged and colder weather over the period November to January 2010 will have resulted in a marked increase in energy consumption and as a result will impact on the performance for the third and fourth quarter of the year.	Ongoing changes in current and planned service will directly assist in improving performance. These include - site retraction and site closures and the inclusion of energy efficiency as part of the estates investment criteria. A co-ordinated approach to heating and ventilation plant operation is being reviewed to maximise energy efficiency across all sites in Tayside. For example, a review of building utilisation, operating hours and better use of the building management systems. Use of FMS KPI benchmarking, monitoring of energy consumption for all sites using EMART and other monitoring and targeting systems.

Workforce

Risk	Management of Risk
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.	Increasing awareness and profile for carbon reduction commitments throughout NHS Tayside and engaging staff through awareness programs, website and other means of communications. This is vital in raising staff awareness of their ability to contribute towards energy conservation and reducing the carbon footprint of NHS Tayside.

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
Capital and revenue shortfall in the service.	Coordinating a Tayside wide strategy on energy improvement via capital funding and other possible funding streams. This work includes reinforcing the links in communication between the four Operational Estates Managers and the Energy Co-ordinator to ensure and promote a collective approach towards energy efficiency. Investigation and investment in more efficient controls for lighting and heating. This involves engaging with in-house expertise and building users. Review of current energy centre arrangement at Ninewells Hospital to identify and design a more efficient and effective energy solution. Outcomes may include collaborative working with third party providers, utility suppliers and local partnership working across Tayside. (To be completed by 2016).

Equality

Risk	Management of Risk
No risks identified.	

Access to Services

Access to Services

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.

Deliver 18 weeks referral to treatment from 31 December 2011.

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

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; and 18 weeks referral to treatment for Psychological Therapies from December 2014.

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

Delivery

Risk	Management of Risk
Although targets are being met there is an increased focus on data quality through improved accountability and responsibility for waiting times data and reporting within Cancer Audit Team. This will include improved escalation processes and close collaboration with the cancer sites clinicians and managers.	Review existing cancer pathways to ensure ongoing delivery of targets and any additional quality improvements within each cancer sites are progressed. e.g. Work already commenced in Lung, agreed improvements include: • Revised pathway with clearly identifiable trigger points to highlight any potential issues with performance early • Testing new ways of working to collate data for local reporting, establishing a feedback mechanism with the clinical team to review any failures to meet the target Revise Inter Hospital Transfer arrangements (Lothian / Tayside).

Workforce

Risk	Management of Risk
No workforce implications identified.	

Finance

Risk	Management of Risk
No financial implications identified.	

Improvement

Risk	Management of Risk
No specific risks identified.	

Equality

Risk	Management of Risk
Equality Impact Assessment was carried out under the auspices of the 18 Week RTT.	

Deliver 18 weeks referral to treatment from 31 December 2011.

NHS BOARD LEAD:	Peter Williamson

Delivery

Risk	Management of Risk
Overall there is a high level of confidence in achieving the 18 week RTT. Not unexpectedly, some specialties are pressure areas. Specifically, there are pressures in audiology and orthopaedics where the current position falls somewhat short of the target.	For each of these there is an improvement plan in place so the issues are already been addressed. The audiology plan has been in place for some months and the one for orthopaedics is ready to be implemented. At this stage we are confident that these improvement plans will produce the results required and that across the Board there will be achievement of the 18 week RTT. An improvement plan is also in place for the dental specialty. 90% of clinical outcome will be recorded for all new and return patient appointments across the acute specialties by 31 March 2011 which is a key requirement of measuring achievement of 18 weeks pathways. This is also consistent with the revised national measurement methodology for measuring and reporting 18 weeks RTT. 100% of clinical outcomes will be recorded by April 2011. Validation of waiting lists is ongoing and the application of New Ways Guidance applied to ensure accurate waiting times can be reported for 18 weeks Referral to Treatment Pathways. This applies to inpatient and daycase, outpatient and diagnostics waiting lists as all form a key part of the 18 week pathway. Demand, Capacity, Activity & Queue exercises have been undertaken for the high volume specialties to improve the use of data for improvement and performance reporting. Development of Arhidia system.

Workforce

Risk	Management of Risk
No workforce implications identified.	

Finance

Risk	Management of Risk
A financial plan to underpin delivery of 18 weeks RTT and any ongoing stage of treatment targets is currently being finalised to indicate any potential financial risk for 2011/12. There are regular discussions with Scottish Government Access Support Team regarding any additional recurring or non-recurring monies that might become available.	

Improvement

Risk	Management of Risk
No specific risks identified.	

Equality

Risk	Management of Risk
Equality Impact Assessment carried out.	

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

NHS BOARD LEAD:	Peter Williamson

Delivery

<table>
<tr><th>Risk</th><th>Management of Risk</th></tr>
<tr><td>
The required trajectory for year 1 was being met by Tayside in 2010/11. However, the reported measures do not show the overall wait between referral and first treatment date. Other data sets demonstrate that patients may wait a considerable time between initial appointment and their care plan being agreed. The true baseline is therefore not known but the measured performance in 2010/11 indicates that a further stepped improvement is required. There is also variation across Tayside with higher volumes of activity and more waiting in the City of Dundee than elsewhere.
Although the alcohol service was not included in formal reporting in 2010/11, testing of recording and reporting arrangements was conducted and from this we know that 88% of clients were assessed within 4 weeks of referral and 92.7% were in treatment within 4 weeks of their care plan being agreed in quarter 2. Again there is local variation in performance with the lowest level of activity and the longest waits in Angus.
The target measures performance across all agencies - NHS Local Authority and commissioned voluntary sector organisations. NHS Tayside does not have any direct control of the performance of the external agencies and is reliant upon the partnership arrangements of the three Alcohol and Drug partnerships to co-ordinate and manage performance. The highest volume of activity is however within the NHS services.
</td><td>
A service improvement programme for NHS Tayside Drug Problem Service has been established in Dundee this will improve the capacity of the service and increase the flow of patients into treatment in the area where there is by far the highest demand. This includes

Revising the role of ‘Addaction’ to provide initial assessment and direct referral into treatment and other services within a target of 48 hours.
The streamlining of processes in NHS drug problem service in the initiation of substitute prescribing or detoxification regimes
The introduction of direct dispensing.
Improving capacity and flow within out-patient clinics
Improved flow of patients from assessment and treatment team to rehabilitation support services
Development of peer support

This programme will be completed by Spring 2011.
Review and revision of access arrangements, service capacity and flow of patients within drug services in Angus and Perth and Kinross, including:-

Arrangements for referral and assessment
Transition of patients from assessment and treatment initiation to services to support recovery and rehabilitation to improve capacity and flow
Access to mainstream services and supports e.g. employment support.

To be completed in March 2012.
</td></tr>
</table>

	Review and revision of access arrangements, service capacity and flow of patients within alcohol services across Tayside, including:- • Referral mechanisms • Joint "triage" of referrals between TAPS and TCA • Access to mainstream services and supports. To be completed in March 2012. Performance of other agencies will be reported through the ADPs and any required service improvements negotiated and agreed.

Workforce

Risk	Management of Risk
Recruitment to specialist medical and psychology posts has been much delayed. Any future vacancies are likely to prove as difficult to fill due to the shortage of professionals with the relevant skills and experience. Developing and maintaining a skilled nursing workforce at full, or near full, complement will be required. Reduction in current vacancy levels and improved attendance rates will be required.	Will be appropriately addressed within the NHS Tayside Workforce Plan.

Finance

Risk	Management of Risk
Impact of efficiency savings on service delivery is not yet quantified.	This will be monitored periodically through the year.

Improvement

Risk	Management of Risk
No risks identified.	

Equality

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.

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; and 18 weeks referral to treatment for Psychological Therapies from December 2014

NHS BOARD LEAD:	Peter Williamson

Delivery

Risk	Management of Risk
A detailed scoping exercise is required to understand performance and identify any risks associated with achievement of the target. Current delivery of services for tier 4 outpatients is geographically inequitable.	Scoping work will include an options appraisal for redesign of some service components (specifically ADHD Continuing Care Services and intake PMHT Liaison). Additionally, there will be a review of referral criteria and current systems of referral management. This will include the potential for the introduction and use of CAPA models and service benchmarking against the CAMHS Matrix for Service Improvement. Previous recommendations for a review of A & C support and the appointment of a Waiting Times Facilitator are being addressed.

Workforce

Risk	Management of Risk
Difficulty in recruiting locum placements. A Consultant post will require to be filled in the Summer due to the retirement of the current postholder. Five other senior and experienced staff (nursing and psychological therapies) are also retiring this year.	Will be appropriately addressed within the NHS Tayside Workforce Plan.

Finance

Risk	Management of Risk
No financial implications identified.	

Improvement

Risk	Management of Risk
Improvement work on waiting times has resulted in capacity issues within other service components. Increase in capacity of service has resulted in lack of availability of clinical space thus limiting further development and target achievement.	Will be addressed through Options Appraisal for Continuing Care (above).

Equality

Risk	Management of Risk
No risks identified.	

NHS BOARD LEAD:	Peter Williamson

Delivery

Risk	Management of Risk
NHS Tayside Clinical Psychology Services have significantly reduced waiting times over the past three years, with all but two sub-specialties (Clinical Health Psychology and Neuropsychology) now consistently achieving waiting times of less than 18 weeks. Waiting times in the two sub-specialties identified (Clinical Health Psychology and Neuropsychology) have remained high despite service improvement work and further action will be required.	Expansion of capacity of neuropsychology and clinical health psychology through redesign and/or allocation of resources. Review of arrangements to deliver services to adults at Tier 3 to ensure equitable access for all ages. Consolidation of matched psychological care arrangements to provide Primary Care with alternatives to referral. A Psychological Therapies Steering Group which reports to the Mental Health Joint Clinical Board has been established to oversee the development and performance of psychological therapy services.

Workforce

Risk	Management of Risk
In general there are no recruitment difficulties although unexpected vacancies arising in some sub-specialties would be difficult to fill.	

Finance

Risk	Management of Risk
Additional resources to expand the capacity of two identified sub-specialties (neuropsychology and clinical health psychology) may be required.	Expansion of capacity of neuropsychology and clinical health psychology through redesign and allocation of resources.

Improvement

Risk	Management of Risk
No specific risks identified.	

Equality

Risk	Management of Risk
No risks identified.	

Treatment Appropriate to Patient

Treatment

Reducing the need for emergency hospital care, NHS Boards will achieve agreed reductions in emergency inpatient bed days rates for people aged 75 and over between 2009/10 and 2011/12 through improved partnership working between the acute, primary and community care sectors.

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

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

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.

Reducing the need for emergency hospital care, NHS Boards will achieve agreed reductions in emergency inpatient bed days rates for people aged 75 and over between 2009/10 and 2011/12 through improved partnership working between the acute, primary and community care sectors.

NHS BOARD LEAD:	Peter Williamson

Delivery

Risk	Management of Risk
The HEAT target to reduce the number of emergency bed days for the over 75 is an important measure for the success of the Tayside Strategic Framework for Older Peoples Service, and more broadly to shift the balance of care. It is an assumption within the target and held by NHST that reducing the extent to which older people use inpatient beds should be reduced. This is based on evidence that a significant proportion of the time older people in general spend in hospital is in effect unnecessary. This precludes the ability to use resources in ways of greater benefit to older people, or is indeed harmful to their best interests, and therefore should be avoided. There are three stages in the process of care that together determine total bed usage. These are: Admissions/admission rates; Length of stay while medically/socially unfit; and Length of delay while medically/socially fit. There are different variables at each stage which have been identified locally and nationally as the main influences on overall bed usage. These are where the main opportunities and risks lie, and hence will become the focus of individual attention. They are as follows: Admissions: Changing age structure of population (treated as fixed variable); level of morbidity and mortality (treated as a long term variable); long term conditions management to reduce the frequency and extent of acute exacerbations of the condition (medium term); medicines management (poly-pharmacy); risk assessment 'in advance of admission' to prevent admission (within year); developing alternatives to admission at time of acute crisis (immediate); making sure that alternatives are properly accessed and 'referrers' know about them (immediate); and thresholds for admission (immediate). Length of Stay while Medically Unfit/Unstable: effective triage of patients on admission; planning for discharge; patient transfers and boarding; access time to diagnostics; access time	In relation to the risks, there are therefore two broad responses. These are to some extent interlinked. Impact Deficit Firstly, there will be an extension of the range and effectiveness of the initiatives undertaken. A major plank of this will be the Change Plans. A number of the targets within the Change Plans in year 1 will affect factors that directly influence the use of inpatient beds by older people. (At the time of finalising the draft LDP the Change Plans had been reviewed by the Government but no decision communicated.). The next step in developing the Change Plan will be to connect more explicitly changes to services to bed use and hence to the HEAT Target. In addition, it will be necessary to identify factors that are outside the Change Plans but which will also impact upon bed days. For example, work done by medicine for the elderly teams have introduced a more goal driven approach to care of older people in hospital with the emphasis on planning for discharge which has reduced lengths of stay. This is planned to continue with a greater role for community teams. Similarly, virtual wards have been operating in the each of the three partnerships since last summer, and there is a major push to speed up discharges and to tackle poly-pharmacy. In summary, NHS Tayside will be taking initiatives forward across a wide number of fronts, which reduces the risk by not 'having all the eggs in one basket'. The next step must be to quantify better the extent to the various new and extended initiatives add up to a greater effort than in the past when the impact was of the order of 1-2% reduction in the rate. This will reduce the risk around the target, at least in terms of having more realistic trajectories against which to assess progress. More broadly, it will highlight whether we are actually planning to do enough.

to specialist opinion; cycle time for decisions on fitness for discharge.

Length of Stay while Medically Fit/Stable: cycle time for assessment for onward care; cycle time for involvement of relatives; cycle time for organisation of discharge including communications, medicines, transport, etc.; funding available for social care; speed of responsiveness of community services (including housing) to discharges;

What it has not in the past been possible to do to any great extent is to assess the impact of changes to these factors have on the number and rate of emergency inpatient bed days for older people. We know the issues are; we are much less certain of **the scale** of many of them in terms of unnecessary bed days and of what works best to reduce bed usage. This has made it difficult to: link initiatives/programmes that are planned to a direct impact on bed day numbers (forecast effectively); retrospectively review what has had the greatest impact on bed numbers (evaluate); and to determine the impact of other variables, most obviously the ageing of the population but also including a wide range of other influences (understand risks extraneous to initiatives and programmes).

The consequence of this is that it has been difficult to assess with any degree of certainty the risks associated with this target and also to formulate plans to manage the risks.

Since 2004/05, in terms of the over 65 bed days, by September 2010 (the latest data that was available) NHS Tayside had seen approximately a 1.5% decrease in the rate. This clearly falls short of the 10% target. This was despite the fact that over that period a wide range of initiatives designed to develop and improve alternative ways of delivering care for older people outside hospital and a major exercise to reduce the problems of delayed discharges were pursued.

What clearly needs to be done therefore is to accept that there are two sides to the risk around delivery of the target. Firstly, the evidence since 2004/05 demonstrates that there is a need to extend the range and effectiveness of efforts to bring about this particular shift in the balance of care. There is an historic ***impact deficit*** that shows some signs of improving recently, but which still shows a major shortfall. Secondly, it prospectively and retrospectively it is difficult to understand what works There is an ***assessment deficit***.

Assessment Deficit

Secondly, more time and effort will be invested in "modelling" the impact that the key variables are expected to and do have on bed days. This will be built around the variables listed above under the three key stages. This work to improve understanding of what works and by how much will enable the programme around older people to managed in a more directive way, rather than as in the past hoping that over time the various initiatives would have the desired impact. This is a target with high uncertainty simply because of the number of variables involved, but we will reduce this significantly through better modelling.

It is our expectation that, within some limited margin of variation, each of the partnerships locally should be making an equal contribution towards the target. This is based on the assumption that in all three localities there still exists considerable scope to shift the balance of care away from the use of inpatient beds, and will have a proportionate share of the Change Fund. Over the past 12 months we have seen differential contributions from the three partnership areas to the overall reduction (October to September figures) achieved against the rate of emergency bed days for over 65s. One of the benefits of the new ISD reporting is to know in a more up to date basis the differences in progress, and the Board will now be engaged much more directly with partnerships in taking forward the target.

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.	

Equality

Risk	Management of Risk
No risks identified.	

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

NHS BOARD LEAD:	Peter Williamson

Delivery

Risk	Management of Risk
NHS Tayside has remained at the trajectory level for this target from April 2010. Although it is envisaged that there is minimal risk around delivering the 2012 milestone of 80%, there will be a requirement to improve performance to achieve the target of 90% by 2013.	The two Stroke Improvement Boards in Tayside will focus on patient flow within both Ninewells and PRI, ensuring timeous identification of stroke patients and ensuring that bed management processes enable patients to be moved to the acute stroke facilities with the minimum of delay. Other elements of this work will be the introduction of 24/7 thrombolysis throughout Tayside; scrutiny of length of stay in stroke facilities; and scrutiny of discharge planning arrangements/rehabilitation/community services.

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.	

Equality

Risk	Management of Risk
The process of identifying any specific requirements of the equality groups has been addressed through the implementation of the stroke standards.	

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

NHS BOARD LEAD:	Peter Williamson

Delivery

Risk	Management of Risk
NHS Tayside has not met the 2009/10 or 2010/11 SAB target. With an accumulating number over the target the new 2013 target may be compromised as we will be at a higher baseline. Half of these episodes are present on admission and are thus difficult to predict and prevent. Of those that are acquired after admission Ninewells would account for the majority (given the number of beds and specialities) but there is no consistent or predictable pattern as to where these are occurring.	Actions are concentrating on the following risk areas: 1. Renal cases: MSSA/MRSA screening in place. CVC insertion bundle and surveillance in place. 2. Community cases: hand hygiene initiative with harm reduction team for IVDU. Looking at skin prep options with HRT Review of 2010 community cases with GP 3. Device associated: embedding PCV/CVC bundles. 2% chlorhexidine in 70% skin prep already implemented. 4. Hand hygiene: continuing work around opportunities and technique. 5. Blood culture technique: work with clinical teams to reduce the number of Coag neg staph contaminants. 6. National initiatives: e.g. 90 improvement initiative, SAB action group. 7. Antimicrobial prescribing: ensure prophylaxis is given as per local policy. 8. Multidisciplinary working with SPSP, infection control, microbiology and clinical staff.

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.	

Equality

Risk	Management of Risk
SAB and CDI targets apply across all equality groups and are based on a laboratory diagnosis.	

NHS BOARD LEAD:	Peter Williamson

Delivery

Risk	Management of Risk
NHS Tayside has historically performed well against this target. However, outbreaks of other infections which may require treatment with broad spectrum antibiotics, occurrence of new strains or change in strain types, and outbreaks of CDI can have an impact on sustaining this performance for the new target in 2011/12.	Actions ongoing: • Antibiotic prescribing policy in place. • Antibiotic audit in place and reported monthly to Board. • Surgical site surveillance in place which also includes prophylaxis monitoring. • Infection control interventions as per policy. • Training and education in CDI and antibiotic prescribing. • Hand hygiene and environmental cleaning.

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.	

Equality

Risk	Management of Risk
SAB and CDI targets apply across all equality groups and are based on a laboratory diagnosis.	

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

NHS BOARD LEAD:	Peter Williamson

Delivery

Risk	Management of Risk
NHS Tayside has been working towards achieving the target for two years although performance against the target is variable throughout the year. This represents seasonal variation both in the summer and winter months. For April – December 2010 there was an overall reduction of attendances by 0.21% however, this ranged from a 9.1% increase to a 6.9% decrease.	A number of areas of work are underway to reduce A & E attendance rates including work with NHS 24 and the Scottish Ambulance Service to reduce inappropriate attendances, with primary care specifically in relation to frequent attendees, attendance rates per GP practice, and also work with the mental health teams and paediatric admissions. A social marketing project has also commenced following the results of a patient survey which was completed in Spring 2010. This will have a two-pronged approach whereby a widespread social marking campaign will be closely followed by targeted campaigns for the population who it is known attend A & E both frequently and inappropriately. Other improvement projects including the Out of Hours Service Review and the Mental Health Strategic Improvement Programme will have the potential to impact on performance against this target, but it is unlikely that any impact will be demonstrated before 2012.

Workforce

Risk	Management of Risk
Senior medical staff play a significant role in reducing attendances by redirecting patients with primary care problems and advising ambulance crews and NHS 24 staff on more appropriate destinations for their patients. However, Emergency Medicine is currently facing challenges in relation to medical staffing and the proposed changes to training numbers. NHS Tayside is likely to have a further reduction of trainees by August 2011 and despite approval being granted for the appointment of two additional Emergency Medical Consultants, there remains a significant gap in junior and middle grade rotas.	This will be appropriately addressed within NHS Tayside's Workforce Plan.

Finance

Risk	Management of Risk
Dedicated funding is currently available through the Scottish Government and this funding has enabled additional investment in key staff to work specifically on this target. However, this funding is time limited.	Ongoing dialogue with the Scottish Government regarding national funding.

Improvement

Risk	Management of Risk
No risks identified.	

Equality

Risk	Management of Risk
Plans are underway to undertake an Equality Impact Assessment.	