

## NHS LANARKSHIRE LOCAL DELIVERY PLAN 2006/7 - 2008/09

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## Introduction

This is NHS Lanarkshire's first Local Delivery Plan (LDP), developed in line with Scottish Executive Health Department guidance of 1 December 2005 and 31 January 2006 (*Ministers' Key Objectives, Targets and performance Measures for the NHS and Local Delivery Plans: Guidance 2006/07*). It covers the 3-year period from 2006/07 to 2008/08, and focuses on the four Key Objectives of Health Improvement (H), Efficiency (E), Access (A) and Treatment (T). Key Targets have been set under each of the 4 Objectives, 27 of which are applicable to NHS Lanarkshire.

The Plan is organised by Key Target and sets out for each:

- the Target;
  - its performance measure(s);
  - NHS Lanarkshire recent past performance;
  - NHS Lanarkshire planned performance 2006/07 - 2008/09;
- and
- a brief explanatory narrative.

In addition, there are two separate but associated documents:

- An Excel schedule which re-iterates in tabular form the planned future performance figures by Target;
- A Finance Plan.

In tackling this first LDP, NHS Lanarkshire has built upon systems developed in support of the previous Performance Assessment Framework arrangements. In particular, each Target has a designated lead Executive with overall responsibility for its delivery, and who has completed the relevant section of this Plan, in liaison with appropriate colleagues and partners.

The LDP itself a top-level performance commitment, with the delivery of individual Targets underpinned by a range of strategic business activities, e.g.:

- Picture of Health - service re-configuration and development plans;
- Pay Modernisation;
- Regional Planning;
- Financial Recovery Plan;
- Development of CHPs and single system working.

Local monitoring and reporting systems were well established under the Performance Assessment Framework, and these are now being reviewed in line both with the needs of the LDP and the development of structures associated with CHPs.

## NHS Scotland Objective 1:

Health Improvement for the people of Scotland - improving life expectancy and healthy life expectancy.

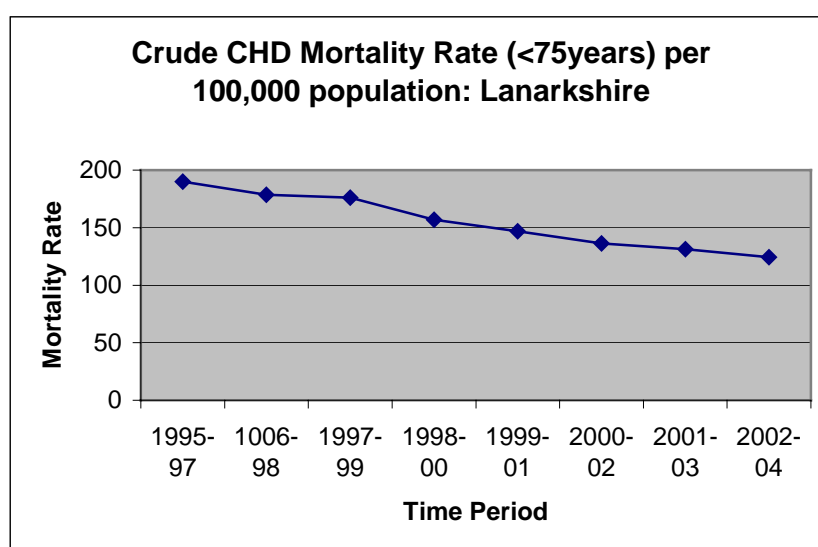
Target No.	Target
H.01T	Reduce health inequalities by increasing the rate of improvement for the most deprived communities by 15% across a range of indicators including; CHD, cancer, adult smoking, smoking during pregnancy, teenage pregnancy and suicides in young people: target date 2008.
H.02T	Reduce rate of smoking among adults (16+) in all social classes from 26.5% (2004) to 22% (2010) ( <i>revised 31/1/06</i> )
H.03T	Reduce incidence of exceeding the weekly alcohol limit of 21 units to 29% for men, and of 14 units to 11% of women: target date 2010.
H.04T	50% of all adults (aged 16+) accumulating a minimum of 30 minutes per day of physical activity on 5 or more days per week.
H.05T	95% uptake target for all childhood vaccinations (ongoing).
H.06T	Reduce suicide rate between 2002 and 2013 by 20%.
H.07T	Reduce by 20% the pregnancy rate (per 1000 population) in 13-15 year olds from 8.5 in 1995 to 6.8 by 2010.

Target H.01T - Reduce health inequalities by increasing the rate of improvement for the most deprived communities by 15% across a range of indicators including; CHD, cancer, adult smoking, smoking during pregnancy, teenage pregnancy and suicides in young people: target date 2008.

Lead: D C Moir, Director of Public Health  
B O'Suilleabhain, Consultant in Public Health Medicine

### 1.01.K Health Inequalities - CHD (linked to target H.01T)

Crude mortality rate, per 100,000 population, (3 year average) for coronary heart disease in people aged less than 75 years living in the most deprived areas. Data are sourced from deaths registered with the General Registrars Office for Scotland.



Data in above table:

1995-97	1996-98	1997-99	1998-00	1999-01	2000-02	2001-03	2002-04
189.9	178.7	176.0	156.9	146.9	136.2	131.3	124.4

NHSL Delivery Plan 2006/07 - 2008/09:

2003-05	2004-06	2005-07	2006-08	2007-09
119	111	104	97	90.7

## Narrative

### What is the problem?

Historically, the health of the people of Lanarkshire has been poor compared to other parts of Scotland and the UK. While CHD mortality in those under 75 is steadily decreasing, the gap between Lanarkshire and Scotland is not reducing, nor is the gap between the most and least deprived areas within Lanarkshire. It is estimated that only 25% of variation in population health is explained by the health care (treatment) system, while 50% is explained by the social and economic environment. Therefore, to bring about the desired changes, the focus must be on improving life circumstances and influencing lifestyle choices, as well as better health care services (*Annual Report of Director of Public Health, 2004*).

### **How are we tackling it?**

Over the years, Lanarkshire has developed a substantive programme of health improvement work in its communities, ranging from individual health promotion initiatives (e.g., smoking cessation, Health Promoting Schools) to social inclusion/regeneration partnerships, which take a whole-community integrated approach to improving life circumstances, and in so doing, health and well-being. A significant number of projects and programmes are underway, targeting most deprived communities in both urban and rural settings, many of which will directly impact upon CHD (e.g., smoking cessation, exercise, healthy eating). Full details are contained in the Joint Health Improvement Plans, Community Safety Plans and Regeneration Agreements, all agreed with Community Planning partners, and which have their own performance reporting frameworks.

However, the initiatives described above have been running for a number of years, are not specific to CHD, and are unlikely to have a short-term incremental impact on inequalities in premature death rates from CHD. Additional impetus has been given to this latter agenda by the Prevention 2010 Initiative, currently pending final approval. This aims to reduce premature deaths from CHD in the most deprived communities by identifying people most at risk, acting to reduce their risk, and by more proactive management of people with existing CHD.

### **Expected impact**

The impact of social and economic change in our most deprived communities, as driven by Regeneration Partnerships and others, will be a longer-term outcome.

It is estimated that around 20,000 people in this population (the most deprived quintile) are at high risk (where annual risk of a major CHD event exceeds 1.5%). An unknown number will have risk factors already managed and under control. Between 7,000 and 10,000 people in this population will have CHD, of whom an unknown number will already be identified and well managed.

The Prevention 2010 Initiative, together with the Lanarkshire CHD MCN, aims to engage with deprived communities in order to identify more people with CHD, or that are at high risk of developing it, and to adopt a more structured approach to their management. Additional nursing staff will be appointed to case find, assess, advise, refer people to other services, monitor progress and follow up as necessary. Additional medical staff will also be appointed to assess, diagnose, and organise treatment for people with CHD and/or at risk factors. It is expected that the appointment of additional staff will enable practices in deprived areas of Lanarkshire to adopt a more anticipatory approach to care of people with CHD than would otherwise be possible. In order to be successful it is essential that the additional staff fit in with, and augment, the existing service delivery infrastructure in primary care and in the CHD MCN.

**Target H.02T - Reduce rate of smoking among adults (16+) in all social classes from 26.5% (2004) to 22% (2010)**

*(Revised target - 31/1/06)*

*Note: In a separate letter from the Minister to NHS Boards (17/1/2006), the above national Target has been further developed into specific local Board Targets, of which the NHS Lanarkshire one is:*

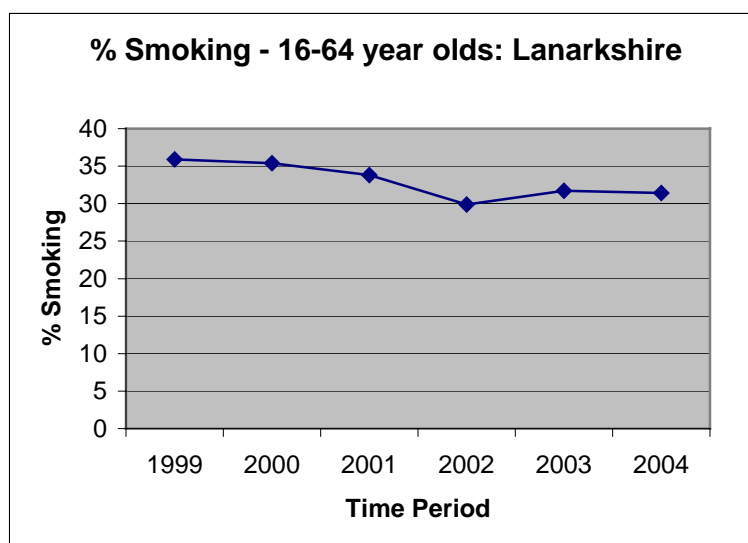
2004      28.8%  
2010      23.9%.

**Lead:**            D C Moir, Director of Public Health  
                      L Armitage, Consultant in Public Health Medicine

### **1.02.K Numbers Smoking (linked to target H.02T)**

Number of smoking adults in the 16-64 age group expressed as a percentage of the sample population. Sample population extracted from the Scottish Household Survey.

*The revised Target (31/1/06) changes the definition to all adults 16+; therefore the data in this measure are incomplete, covering only those people aged up to 65 years.*



Data in above table:

1999	2000	2001	2002	2003	2004
35.9	35.4	33.8	29.9	31.7	31.4

NHSL Delivery Plan 2006/07 - 2009/10:

2005	2006	2007	2008	2009	2010
28.5%	27.9%	27.1%	26.2%	25.1%	23.9%

## Narrative

### What is the problem?

Historically, Lanarkshire has had high levels of smoking, associated with socio-economic conditions and deeply entrenched cultural factors. The impact on health has been to contribute to our higher than average levels of smoking related diseases such as cardio-vascular disease, COPD, and cancers. As with CHD above, this needs to be viewed at the three levels of life circumstances, life style choices, and health interventions.

### How is it being tackled?

At community level, health improvement is integral to community planning work in areas such as Regeneration, where whole-system approaches are designed to tackle the inter-related problems of poor opportunities, poor aspirations, poor attainment levels, and poor lifestyle choices. Sustainable and long-term improvement will only be achieved by lifting our most failing communities out of the cycle of deprivation. Regeneration Outcome Agreements, together with Joint Health Improvement Plans, and their associated work programmes, seek to address this agenda in the longer term in each of the two Community Planning Partnerships in Lanarkshire.

At group level, health promotion work has targeted a number of areas including schools (e.g., Smokebusters, Health Promoting Schools), and workplaces (SHAW scheme).

Smoking cessation services have developed over a number of years in Lanarkshire and are currently undergoing review with the following aims:

- development of a pan-Lanarkshire Tobacco Policy/Smoking Cessation Strategy, taking advantage of single system working by harmonising and standardising approaches, arrangements and services;
- appointment of a manager to provide leadership, set standards and monitor, and conduct audit and research to inform future development;
- development of targeted marketing campaigns, engagement with the wider NHS family (e.g., GPs, practice nurses) to improve services and prescribing of NRT;
- engage with wider partners, e.g., local authorities, voluntary organisations, to develop brief intervention skills;
- develop new approaches to engage with hard to reach groups, e.g., peer support, self-help groups. Prevention 2010 Initiative funding (£400,000) is being accessed in support of this.

### Expected Impact

Taken together, the above activities are expected to reduce levels of smoking within the population, with longer term outcomes in reduction in mortality and morbidity from smoking-related diseases, demonstrated by reduced incidence, delayed onset, and slower deterioration, especially COPD, lung cancer and cardiovascular disease.

Target H.03T - Reduce incidence of exceeding the weekly alcohol limit of 21 units to 29% for men, and of 14 units to 11% for women: target date 2010

Lead: D C Moir, Director of Public Health  
P Wright, Alcohol Development Officer

### 1.05S Numbers drinking excessively (linked to target H.03T)

Numbers as a % of relevant population, derived from the Scottish Health Survey.

*(SEHD have advised that the measure is under review and so there is neither historical data provided, nor a requirement to complete forward trajectories in 2006/07)*

### Narrative

#### What is the Problem?

Alcohol misuse is a national problem, reflected at local level in Lanarkshire. Alcohol consumption *per se* is not correlated with deprivation (drinking more is associated with prosperity, and alcohol is a drug used when people are happy as well as sad); however, alcohol related problems are correlated with deprivation.

The Scottish Health Survey (SHS) does not break down figures by NHS Board area. The national picture is as follows, and, in the absence of any other survey data, we might reasonably assume the Lanarkshire position to mirror this:

#### SHS Reported Drinking

Men	1995	1998	2003
Weekly mean	20.1	19.8	18.2
% Exceeding limits	33%	34%	29%
Women			
Weekly mean	6.3	7.1	7.6
% Exceeding limits	13%	15%	17%

The above apparent decline in trend in male drinking should be viewed with some caution, as it is not consistent with other measures, e.g., NHS Quality Improvement Clinical Indicators 2005 show increasing levels of alcohol related illness especially among men.

The consequences of alcohol misuse are serious and wide-ranging. At an individual level, there are adverse effects on health and well-being such as liver disease, brain damage and mental health problems, including suicide. At group/family level, there can be family strife, breakdown of relationships, financial difficulties, aggression and domestic abuse. At societal level, we see the impact in crime, aggression, accidents and other social problems.

#### How are we tackling it?

Treatment and support services targeting the consequences of problem drinking are provided by GP services, NHS Alcohol and Drug services, Local Authority Substance Misuse services, and voluntary organisations. However, dealing with

problems only after they have developed is not enough; the need is for prevention. At a societal level, community approaches as part of Regeneration Agreements seek to tackle the underlying causes of deprivation, and include work with disaffected young people to engage them in alternative pursuits to street drinking and binge drinking. The Health Promoting Schools scheme aims to raise awareness at an early age of the consequences of alcohol misuse, and to guide young people in other directions. Workplace health promotion under the Scotland's Health at Work (SHAW) scheme encourages employers to take a pro-active approach in developing alcohol policies that raise awareness and offer support to anyone who feels they may have a problem. These efforts on their own will not be enough to promote the necessary cultural change.

International research (e.g., *Alcohol: No Ordinary Commodity - Research and Public Policy*, Thomas Barbor et al, Oxford and London: Oxford University Press, 2003) makes clear what affects populations and their drinking. The most effective interventions are price and restricting access by law. At a local level, it is hoped that the coming changes in Scottish Licensing Laws will have a beneficial impact upon consumption and thereby lessen the amount of alcohol related illness. The review of licensing in Scotland included the principle of promoting public health (not part of the review in England). The new law aims to reduce access by young people to alcohol, to reduce excess drinking on licensed premises, and to curtail irresponsible drinks promotions. The NHS is a partner in the local Alcohol and Drug Action Team (ADAT), which will work with community planning, community safety and Licensing Boards to implement the new laws. The ADAT is also supporting the development of counselling services with partners, development of brief interventions, increased substance misuse liaison services and support for implementation of SIGN guideline 74 (*The Management of Harmful Drinking and Alcohol Dependence in Primary Care*, Scottish Intercollegiate Guideline Network, 2003) and QIS Health Technology advice (Report 3 - *Prevention of relapse in alcohol dependence*, Slattery, J et al, 2003). In terms of structural frameworks, Community Health Partnerships will allow increased integration of alcohol and drug services in each local authority area.

### **Expected outcome**

Changing long-standing cultural and behavioural factors will be long term and will require concerted effort. The changes to licensing laws are welcomed. At local level, in addition to treatment of the consequences, the NHS role is to raise awareness and influence change in behaviour. Efforts as outlined above will continue, and be developed as experience determines. It is hoped that they will lead to reductions in excessive drinking. However, given the weaknesses in data (i.e., self-report survey, conducted every three years and not broken down by NHS Board), and the fact that results are not correlated with other findings (e.g., levels of alcohol related illness in men), there is a need for caution, both in accepting current estimates and in determining what levels might be in future years.

Target H.04T - 50% of all adults (aged 16+) accumulating a minimum of 30 minutes per day of physical activity on 5 or more days per week

Lead: D C Moir, Director of Public Health  
G Docherty, Health Promotion Manager

### 1.06S Exercise (Linked to target H.04T)

Numbers as a % of the relevant population, derived from the Scottish Health Survey

*(SEHD have advised that the measure is under review and so there is neither historical data provided, nor a requirement to complete forward trajectories in 2006/07)*

## Narrative

### What is the Problem?

The health effects of an inactive life are serious. Inactivity results in obesity, which contributes to over a third of deaths from heart disease and threatens progress made in reducing morbidity and mortality from CHD. Added to this is disability and poor mental health that is associated with growing levels of obesity and lack of physical strength. Physical inactivity has been called the 'silent killer of our time'. Research shows that inactive people have:

- twice the risk of coronary heart disease than active people have;
- higher blood pressure - which in itself is major risk factor for coronary heart disease and stroke;
- a higher risk of colon cancer - 3.6 times more at risk than active people;
- a higher risk of developing type II diabetes - regular activity can reduce diabetes by 50%;
- lower bone density leading to greater risk of osteoporosis leading to fractures - up to 50% of hip fractures could be avoided with regular activity;
- a greater risk of being overweight or obese - which also increases risks of other types of cancer as well as osteoarthritis and back problems;
- more injuries and accidents.

Conversely, evidence shows that active people have:

- a longer life;
- less risk of developing many diseases;
- greater well-being;
- fewer symptoms of depression;
- increased opportunities for social contact and support;
- lower rates of smoking and substance misuse;
- more ability to function better at home and work.

### How are we tackling it?

Strategic development of this topic is through partnership working with both local authorities and the voluntary sector. NHS Lanarkshire provides the strategic leadership for physical activity, and convenes and chairs the Physical Activity Working Groups in each local authority area. These groups report direct to the Community Planning Partnerships. Most physical activity is, however, delivered by the local authority and the voluntary sector.

Examples of action include:

- implementation of the Up for It Programme in South Lanarkshire;
- implementation of Active Futures Programme (Clearing Hurdles) in South Lanarkshire regeneration and rural areas, with particular emphasis on women aged 17-25, those from ethnic minorities, and those with disabilities;
- Promotion of active living through walking programmes in both South and North Lanarkshire;
- Provision of a range of opportunities through Active Schools Co-ordinators in both local authority areas.

Issues to be addressed include:

- Continuing to promote opportunities for participation in physical activity for those living in community regeneration areas, women, particularly those aged 16-25, those who are socially excluded and children of all ages with particular emphasis on teenage girls;
- promoting awareness of the active living message;
- providing training for NHS staff on active living.

The NHS Health Scotland physical activity health alliance website will allow NHS Lanarkshire and other NHS Boards to share good practice in promoting health related physical activity.

### Expected outcome

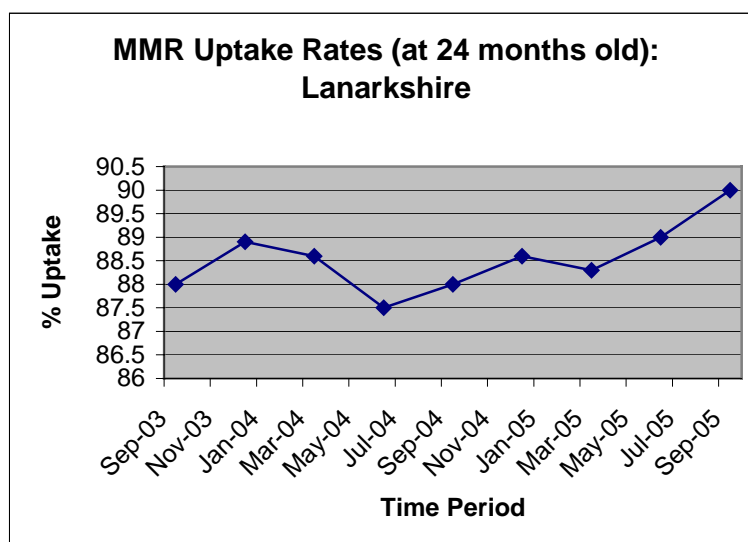
The aims of the joint physical activity initiatives are to increase participation in physical activity and to raise awareness of the benefits of active living. Each programme will be evaluated. Until such time as there is an agreed method of recording current levels of physical activity, and tracking changes in this, it is difficult to express changes in a population context.

Target H.05T - 95% uptake target for all childhood vaccinations (ongoing).

Lead: D C Moir, Director of Public Health  
D Cromie, Consultant in Public Health Medicine

### 1.03.K Immunisations - MMR (linked to target H.05T)

MMR uptake rates (at 24 months old). Data sourced from Standard Immunisation & Recall System (SIRS) and Grampian Immunisation & Recall System (GIRS).



Data in above table:

30 Sep 03	31 Dec 03	31 Mar 04	30 Jun 04	30 Sep 04	31 Dec 04	31 Mar 05	30 Jun 05
88%	88.9%	88.6%	87.5%	88%	88.6%	88.3%	89%
30 Sep 05							
90							

SEHD suggested trajectory to reach target:

Sep 05	Dec 05	Mar 06	Jun 06	Sep 06	Dec 06	Mar 07	Jun 07
95%	95%	95%	95%	95%	95%	95%	95%
Sep 07	Dec 07	Mar 08	Jun 08	Sep 08	Dec 08	Mar 09	
95%	95%	95%	95%	95%	95%	95%	

NHSL Delivery Plan 2006/07 - 2008/09:

*MMR is subject to high levels of media interest and scare stories which adversely impact upon uptake rates. It is therefore difficult to predict with any accuracy what future uptake rates might be. The NHS Lanarkshire provisional position is that it is not seen as helpful to set targets that themselves may precipitate further media attention. We arranged for this to be considered at the National Immunisation Co-ordinators Group meeting on 16 February 2006. The meeting, at which SEHD was represented, agreed that this matter required further consideration, which we understand is now underway.*

## Narrative

### What is the Problem?

The MMR vaccine is subject to high levels of media interest, due to a number of scare stories in recent times, leading to some parental and professional concern and thus reduced uptake. Uptake locally is on a par with the Scottish average. In 1999/00, it was 92.9%, reducing to 86.6% in 2002/03, linked to parental anxieties about the safety of the vaccine. Over the last 2 years it has been 88.2% and 88.1% respectively, thus there has been a definite halt in its decline. Addressing this problem requires a very careful and considered approach as any publicity or promotion - however positive - carries the risk of re-igniting the debate about vaccine safety, and thus having the opposite effect to that intended.

Measles and mumps have very low case fatality rates for the general population but have high fatality rates for immuno-compromised people, for example, those with transplants/leukaemia. Measles, mumps and rubella can give significant morbidity in the form of brain damage, deafness and severe congenital syndromes, in 1/1000 of affected people, as well as unpleasant short-term self-limiting illness for 85+% of the population.

### How are we tackling it?

MMR education is a standing item on vaccine update seminars (tend to be held annually) covering MenC, Hib, and new IPV vaccines. In addition, where specific professional training needs have been identified, e.g., lack of knowledge, refresher/ update sessions have been held with small groups of health visitors.

Locally, the date of first MMR invite (recommended between 12 & 15 months) was brought forward in two 4-week steps (to 60 and then 56 weeks) allowing more time to complete within the target timescale whilst maintaining parent and professional confidence.

### Expected impact

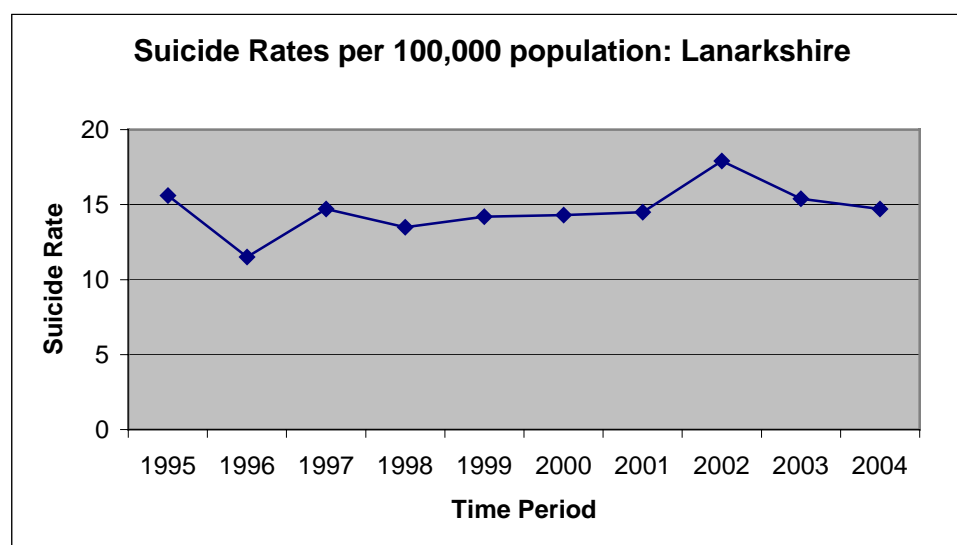
Uptake has risen to 90.0% in Lanarkshire (September 2005 data), and hopefully this will continue as predicted by higher cumulative uptake in cohorts of children less than 24 months, published by ISD 12 Sept 2005.

Target H.06T - Reduce suicide rate between 2002 and 2013 by 20%.
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Lead: D C Moir, Director of Public Health  
J Logan, Consultant in Public Health Medicine

#### 1.04.K Suicide Rates (linked to target H.06T)

Deaths from intentional self-harm and events of undetermined intent as a rate per 100,000 population. Data are sourced from deaths registered with the General Registrars Office for Scotland.



Data in above table:

1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
15.6	11.5	14.7	13.5	14.2	14.3	14.5	17.9	15.4	14.7

NHSL Delivery Plan 2006/07 - 2008/09:

2005	2006	2007	2008	2009
16.9	16.6	16.3	15.9	15.6

*(The starting point for 2005 is higher than the actual level for 2004 as the target is to reduce by 20% from 2002 levels)*

#### Narrative

##### What is the Problem?

The suicide rate for Lanarkshire residents during 2002 (17.9) was high compared to preceding and subsequent years. The figures below use the 2002 figure of 17.9 suicides per 100,000 population, however, an analysis has also been completed using a figure of 14.6 which is an average of figures for the years 1999, 2000, 2001, 2003 and 2004.

Performance of NHS Lanarkshire is only one contributing factor to the population suicide rate. Other key factors are the performance of Local Authorities, multi-agency partnerships, the Lanarkshire and Scottish economy and wider cultural

influences. During the 10 years from 1995 to 2004 there has been no overall reduction in the Scottish suicide rate.

Suicide usually has a profound impact on the mental health, and sometimes, directly or indirectly, on the physical and social health of family members, friends, work colleagues, and carers - unpaid and paid. Family members of several different generations may be affected.

#### **How are we tackling it?**

Continued multi-agency working and implementation of the North Lanarkshire and South Lanarkshire Choose Life Action Plans, including use of Choose Life support funds. Funding has been allocated via local authorities - £141K to North Lanarkshire Council, and £136K to South Lanarkshire Council, during each of the years 2006-07, and 2007-08. The SEHD Choose Life letter of 19 December 2005 has directed community planning partners to agree local plans to secure the sustainability and mainstreaming of suicide prevention actions, programmes and initiatives by March 2007.

The ongoing development of Lanarkshire's mental health services, including primary mental health care, consultant psychiatrist recruitment, and strengthening of the workforce, will increase the extent to which the needs of people who may have an increased risk of committing suicide are met.

The lead NHS Lanarkshire Health Promotion Officer for Choose Life work in Lanarkshire has moved to another NHS Board area recently. The vacant post should be filled to enable delivery of the National Programme for Improving Mental Health and Well-being in Lanarkshire including the Choose Life component.

Work is on going in Lanarkshire and nationally to improve recording of ethnicity data to enable analysis of health service data by ethnicity. At national level, suicide among people in minority ethnic groups is a key issue that may be taken forward by the National Centre for Ethnic Minority Health in response to the report *Equal services*.

#### **Expected impact**

Investment in the development and strengthening of mental health care in Lanarkshire will result in increased ability to respond to the needs of people who may be at risk of committing suicide.

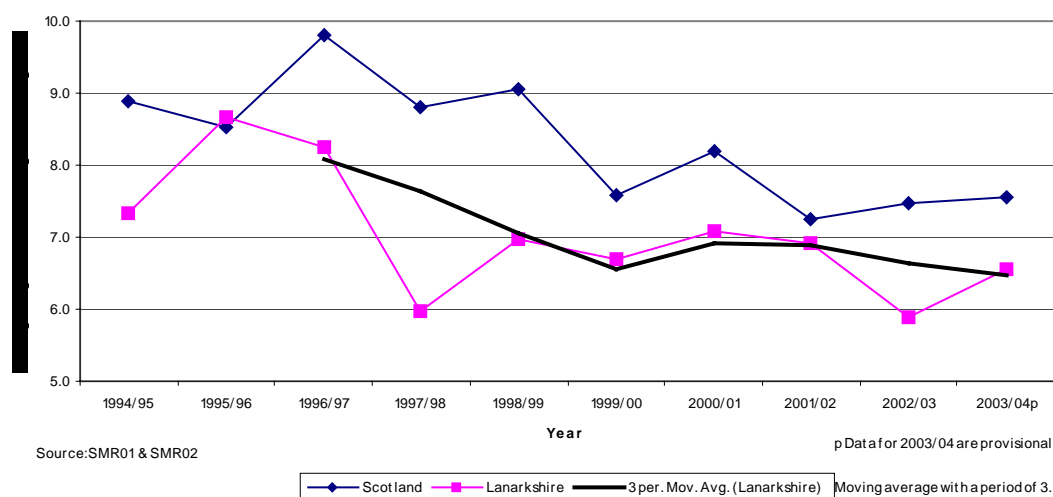
By meeting the Target, during the period 2002 to 2013, 118 Lanarkshire residents would choose life and not commit suicide. They would be able to live and enjoy their own lives, contribute to the lives of their families and friends, and to their communities and local economies. Using an average age of committing suicide of 40 years and an average life expectancy of 75 years, this would result in an additional 4,130 years of life lived.

**Target H.07T - Reduce by 20% the pregnancy rate (per 1000 population) in 13-15 year olds from 8.5 in 1995 to 6.8 by 2010**

Lead: **D C Moir, Director of Public Health**  
**J Logan, Consultant in Public Health Medicine**

*(SEHD has advised that the measure for this Target is under review / development, and so historical data has not been provided, nor is there a requirement to provide forward trajectories in 2006/07. The undernoted chart has been developed locally to aid understanding).*

**Teenage pregnancies, females aged 13 - 15 years at conception,  
 Lanarkshire and Scotland, 1994/95 to 2003/04**



Data in above table:

	94/95	95/96	96/97	97/98	98/99	99/00	00/01	01/02	02/03	03/04
Scotland	8.8	8.5	9.8	8.8	9.0	7.6	8.2	7.3	7.5	7.5
Lanarkshire	7.3	8.7	8.3	6.0	7.0	6.7	7.1	6.9	5.9	6.6

*2003/04 data are provisional*

## Narrative

### What is the Problem?

Becoming pregnant at age 13-15 can have a significant detrimental impact on the quality of life of the girl, her sexual partner, and her wider family. While Lanarkshire rates are generally lower than those for Scotland, the number of girls affected has ranged from 83 in 1994/95 to 69 (provisional) in 2003/04.

### How are we tackling it?

A multi-agency Lanarkshire sexual health strategy and action plan has been developed which includes consideration of teenage pregnancy and how current rates should be reduced. The strategy and action plan take a holistic approach

with appropriate focus on the promotion of positive sexual health. It is in this context that the issue of teenage pregnancy has been considered and actions agreed to address the various factors that may lead to unintended and unwanted teenage pregnancy.

In January 2006 NHS Lanarkshire appointed its first consultant in sexual and reproductive health care. This consultant will play a key role in developing clinical sexual health services and linking with others in the Lanarkshire clinical sexual health services network. The clinical sexual health services action plan is being implemented. Redesign activity is taking place as part of this. The clinical sexual health work force is being increased and strengthened. This is taking place using SEHD clinical sexual health services funding and several new posts have been approved. Progress is being made with the development of an integrated clinical sexual health service with family planning and genitourinary medicine being key components. £480K of funding was awarded by the SEHD for investment in clinical sexual health services in 2005-06 and the same amount has been provisionally awarded for 2006-07, and for 2007-08.

A specification for the sexual health IT system has been developed. Work is progressing in collaboration with clinical and IT colleagues nationally.

There has been an increase in the use of long acting contraception among 13-15 year old girls. As well as using oral, injectable or implant contraception, young people are encouraged to use condoms to reduce the risk of acquiring a sexually transmitted infection. Emergency contraception is now accessible to young females via family planning clinics, young persons sexual health clinics and out of hours services.

Continued development of the Lanarkshire sexual health web site [www.lanarkshiresexualhealth.org](http://www.lanarkshiresexualhealth.org) has taken place during 2005. This site provides information about all aspects of sexual health including contraception and sexually transmitted infections.

Three condom distribution schemes operate in Lanarkshire. One of these - the C Card scheme - has been developed since 2002 and in 2004-05 48 centres (GP surgeries and health centres) provided this service in response to 8,905 presentations with a total of 221,800 condoms being distributed. Uptake data has been analysed by township and Carstairs deprivation index and shows a trend of increasing uptake in areas of deprivation. Annual reports are available at the Lanarkshire sexual health web site.

Development of the West of Scotland NHS Boards (Greater Glasgow, Ayrshire & Arran, Lanarkshire) sexual health social marketing campaign is on going with recent development of materials specifically for young people. [www.equalonline.com](http://www.equalonline.com). NHS Lanarkshire is supportive of moves to develop a West of Scotland GUM service, which would contribute to influencing the quality of sexual health services provided which would influence rates of 13-15 year old pregnancies.

The NHS Lanarkshire Health Promotion Department has continued to support primary and secondary school teachers in North and South Lanarkshire to provide Sexual Health and Relationships Education (SHRE) by providing two-day training courses. A staff tutor secondment has been supported and a curricular framework and resource pack, containing materials to support this work, has been developed.

Work has continued with voluntary sector partners including PHACE Scotland to help to address the sexual health needs of young people.

An equality and diversity impact assessment training day has been arranged to provide training for staff involved in the development of sexual health services.

The "Aw'right" project aims to provide support and training for those working with young men's groups around masculinity and sexual health. This is a partnership project with fpa Scotland and has been funded by the New Opportunities Fund.

A three-day training course entitled "Sex & Relationships Education for Looked After Children and Young People" took place for North Lanarkshire Council Throughcare and Housing staff.

Redesign of termination of pregnancy services has taken place and changes have been implemented with termination of pregnancy taking place at Wishaw Hospital. Funding has been allocated to reduce the waiting time for this service from 4 to 5 weeks to 2 to 3 weeks.

The availability of staff to provide sexual health services, together with cultural factors that influence sexual activity among young people, are risk factors in achieving the target.

### **Expected outcomes**

A 20% reduction in the rate of pregnancy among 13-15 year olds from 8.0 (the Lanarkshire average for 1994-95 and 1995-96) to 6.4 pregnancies per 1,000 13-15 year olds equates to 23 fewer pregnancies each year in girls of this age. The rate for Lanarkshire in 2003-04 (provisional figures) was 6.6 and the trend line suggests the target of 6.4 will be met in the coming years.

Such a reduction would lead to improved quality of life for girls who do not become pregnant at the age of 13-15 years. There are greater educational, employment, financial and social opportunities for girls who do not become pregnant when aged 13-15 years. Prevention of pregnancy is also beneficial to partners, parents, siblings and friends who would be adversely affected by a 13-15 year old girl becoming pregnant. There would also be a reduced need for input of health and social care services.

**NHS Scotland Objective 2:**

**Efficiency and Governance Improvements - continually improve the efficiency and effectiveness of the NHS**

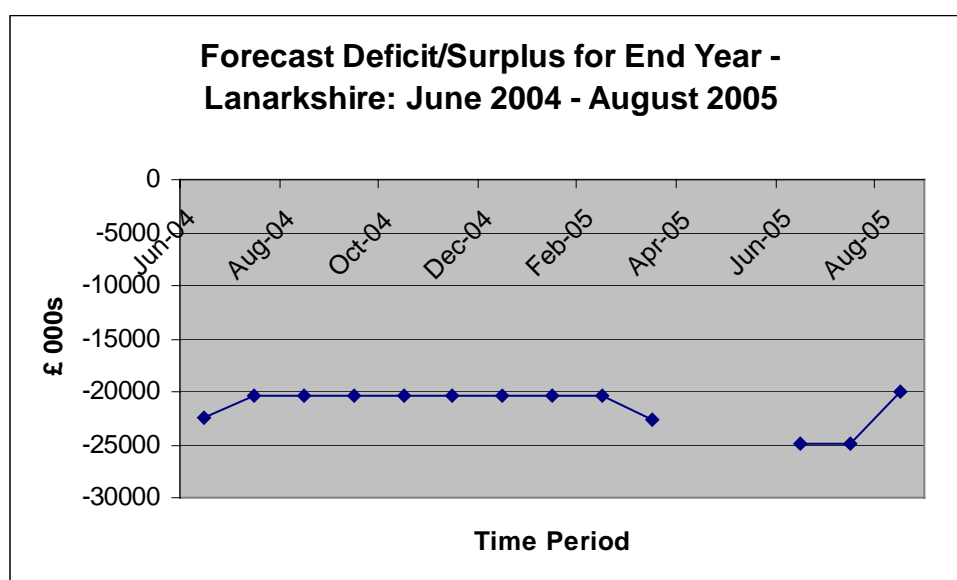
Target No.	Target
E.01T	NHS boards to operate within their revenue resource limit; operate within their capital resource limit; meet their cash requirement.
E.02T	Sickness Absence Rate: 4% by 31 March 2008.
E.03T	Productivity: increase in consultant productivity by 1% pa over the next 3 years.

Target E.01T - NHS boards to operate within their revenue resource limit; operate within their capital resource limit; meet their cash requirement.

Lead: S Goldsmith, Director of Finance

### 2.01.K Forecast Revenue Expenditure (linked to target E.01T)

Forecast Deficit / Surplus for 'End Year' against total revenue resource limit. Data are extracted from monthly financial monitoring returns.



Note - Data not submitted by NHS Boards for April and May 2005

Data in above table

Jun 04	Jul 04	Aug 04	Sep 04	Oct 04	Nov 04	Dec 04	Jan 05	Feb 05	Mar 05
22539	20418	20418	20418	20418	20418	20418	20418	20418	22710
Jun 05	Jul 05	Aug 05							
24959	24959	19959							

NHSL Delivery Plan 2006/07 - 2008/09:

Sep 05	Oct 05	Nov 05	Dec 05	Jan 06	Feb 06	Mar 06	Jun 06
-19959	-16788	-16788	-9534	-9368	-9368	-9368	121
Jul 06	Aug 06	Sep 06	Oct 06	Nov 06	Dec 06	Jan 07	Feb 07
121	121	121	121	121	121	121	121
Mar 07	Jun 07	Jul 07	Aug 07	Sep 07	Oct 07	Nov 07	Dec 07
121	2210	2210	2210	2210	2210	2210	2210
Jan 08	Feb 08	Mar 08	Jun 08	Jul 08	Aug 08	Sep 08	Oct 08
2210	2210	2210	3343	3343	3343	3343	3343
Nov 08	Dec 08	Jan 09	Feb 09	Mar 09			
3343	3343	3343	3343	3343			

### Narrative

A separate Financial Plan is provided as an Annex to this Local Delivery Plan. This narrative provides an overview of the NHS Lanarkshire draft financial plan for the five year period 2006/07 to 2010/11. It sets out the detailed plan for 2006/07, with an outline for subsequent years. In addition, the following areas are covered:

- Forecast outturn for 2005/06
- Planning assumptions
- Financial recovery plan
- Risks

At this time, no further detail is provided on the capital plan, although work is ongoing to further develop the approved capital plan presented to the Board in September 2005.

## 1. Overview

Formal notification of the 2006/07 Revenue Resource Limit was issued by the Scottish Executive Health Department on 20 February 2006. An uplift of 6.75% has been received for 2006/07, with a further 1.07% in recognition of the move toward Arbutnott parity. These uplifts equate to £49.803m in total, bringing the NHS Lanarkshire total general allocation to £686.476m for the forthcoming financial year. This excludes funding for Primary Medical Services.

The table below provides a summary of the current position for 2006/07. It should be noted that a number of additional allocations are anticipated from the SEHD during the year, including Sexual Health, Smoking Cessation and Anticipatory Care. These have been included within the additional non-recurring resources along with an estimate of £1.5m relating to slippage on other general allocations. The latter relates to allocations received during the financial year where timing issues result in start dates later than expected, enabling funds to be used to offset other pressures on a non-recurring basis.

Further clarity is awaited on central funding from the SEHD for Waiting Times initiatives. The draft financial plan includes an investment in waiting times both locally and within Glasgow, although there is an assumption that there will be a contribution from the SEHD, to ensure achievement of national targets.

<b>Draft Financial Plan 2006/07</b>			
	<b>Recurring</b>	<b>Non recurring</b>	<b>Total</b>
	<b>£m</b>	<b>£m</b>	<b>£m</b>
<b>Opening deficit</b>	<b>(21.659)</b>		<b>(21.659)</b>
<b>Additional resources</b>			
Uplift	42.975		42.975
Arbuthnott	6.828		6.828
Property Receipts		15.000	15.000
Other	1.000	4.309	5.309
	<b>50.803</b>	<b>19.309</b>	<b>70.112</b>
<b>Utilisation of resources</b>			
Local pressures	(3.700)	(0.802)	(4.502)
Picture of Health	(1.000)		(1.000)
Pay	(15.407)		(15.407)
Non Pay	(6.070)		(6.070)
Drugs	(4.266)	(0.400)	(4.666)
National / Regional Priorities	(5.365)	(1.234)	(6.599)
Waiting Times	(5.000)		(5.000)
Other	(2.695)	(0.351)	(3.046)
Cumulative deficit		(10.042)	(10.042)
	<b>(43.503)</b>	<b>(12.829)</b>	<b>(56.332)</b>
<b>CRES / CRP Target</b>	<b>5.000</b>	<b>3.000</b>	<b>8.000</b>
<b>Forecast Surplus</b>	<b>(9.359)</b>	<b>9.480</b>	<b>0.121</b>

## 2. Forecast outturn 2005/06

The forecast year-end surplus for 2005/06 has been estimated within the range £7.009m and £13.509m, as presented to the Board in January 2006. This is a major achievement for NHS Lanarkshire and is substantially in excess of the surplus anticipated during the previous financial planning exercise. If the actual outturn position remains within this range, this will enable a significant proportion of the cumulative deficit to be cleared. The draft financial plan for 2006/07 assumes that £10.0m will be achieved by 31 March 2006, thus reducing the funding required to clear this in future years.

### 3. Planning Assumptions 2006/07

#### *Property Receipts*

The sale of the Law Hospital site is still planned to be completed in 2006/07. An estimate of the profit on sale has been included as a source of funding in the financial plan.

#### *Pay and prices uplift*

Basic pay increases of 3.225% have been assumed and a supplies uplift of 2%. In view of the additional costs arising through increased energy prices, a further sum of £2.5m has been allocated for utilities, based on the actual costs arising during 2005/06.

#### *Prescribing*

Analysis of actual prescribing expenditure during 2005/06, and initial estimates of future prescribing trends suggest that the existing funding level is sufficient to cover the costs of prescribing for 2006/07. This takes account of potential new drugs as well as a 2% inflationary increase, and allows for a 6.9% increase on the forecast outturn for 2005/06. The uplift received from the SEHD on the general revenue allocation for 2006/07 reflects a similar trend across Scotland, and recognises the reduction in the annual increase on the drugs bill evident during 2005/06. As a result, all NHS Boards are expected to meet additional costs, for example, those relating to the new pneumococcal vaccine, from within existing resources.

#### *Hospital Drugs*

Provision of £1.5m has been made for the impact of both an inflationary uplift on hospital drugs and the introduction of drugs approved by the Scottish Medicines Consortium (SMC). Specific funding of £1.9m has been identified in relation to Cancer drugs, also based on information from the SMC. During 2005/06, actual cost increases in hospital drugs reached 15% in comparison to previous expenditure levels. The additional funding included in the plan for 2006/07 does not reach this level, and a further review of actual and anticipated costs is required as part of the ongoing financial planning process. This will include any potential impact of the roll out of the Patient's Own Drugs programme and Original Pack Dispensing.

#### *Pay Modernisation*

The financial plan for 2005/06 included funding in excess of £17.0m to meet the ongoing costs relating to Agenda for Change. Work is continuing across Scotland and locally within Lanarkshire to assimilate staff onto their new terms and conditions. It will be only as and when the final member of staff is assimilated that the true costs of Agenda for Change will be known. The existing level of provision is maintained in the financial plan for 2006/07.

In relation to the Consultant Contract, additional funding of £1.5m has been set aside to recognise the impact of seniority payments and pay progression.

The full impact of Modernising Medical Careers is not yet known, however an estimate of the costs for 2006/07 has been included at £0.5m.

### *Local Investment*

In view of a number of pressures / service developments across both the Acute and Primary Care Operating Divisions, funding of £3.7m has been set aside. This includes the first stage of the development of the Community Nursing service, the potential impact of the market testing of the Hairmyres PFI contract, an additional Renal Consultant, an additional Neonatal Consultant, and recognising pressures in methadone prescribing.

### *Picture of Health*

Work is not yet complete on the financial modelling of the Picture of Health proposals. An early estimate of the recurring impact of the capital investment in both Primary Care and Acute Services has been included within the financial plan, albeit there is no impact in 2006/07.

### *National & Regional Issues*

Considerable resources are required to meet national priorities and regional developments across the West of Scotland. During 2005/06 funding was 'top-sliced' for a number of national services and the full year impact of £0.7m has been recognised in the 2006/07 financial plan, along with other known developments. In addition, the impact of an ongoing increase in the number of high cost, low volume treatments undertaken in the North Glasgow acute hospitals, such as Bone Marrow Transplants, has been taken into account, with funding of £0.6m set aside in respect of this.

The West of Scotland Regional Planning Group has recently considered a number of developments in Cardiac services; in particular Interventional Cardiology procedures such as Implantable Defibrillators, CRT and Atricure. An initial estimate of the financial impact of these has been estimated at £0.4m for 2006/07.

### *Cumulative Deficit*

It is assumed that the balance of the cumulative deficit brought forward to 2006/07 will be repaid to the SEHD during the year. This will only be achievable through the use of profits arising from property receipts.

## **4. CRES / Financial Recovery Plan**

A key component of the Financial Plan is the delivery of both recurring and non-recurring savings. High level assumptions have been included in the draft financial plan at this time and further work is required to firm up plans to achieve the targets set. These will include a CRES programme for both Divisions and continued work around the Corporate Recovery Plan commenced during 2005/06, including further corporate management savings.

Delivery of the CRES targets and overall financial recovery programme is a key component in achieving a balanced financial plan. In addition, an Efficient Government target has been set by the SEHD, to be achieved over a three year period. Although NHS Lanarkshire is likely to exceed the 2005/06 target, every effort is required to ensure the overall target of £20.389m can be achieved by the end of 2007/08.

## 5. Financial Plan 2006/07 - 2010/11

(Fuller details are provided in the accompanying Financial Plan Annex)

Initial indications have been received from the SEHD in relation to the uplift on the general allocation for 2007/08, along with the funding required to move to Arbutnott parity by the end of the same year. Beyond that time, no further information is available. Through discussion with other NHS Boards, an estimate of 5.5% has been assumed as the overall increase in the general allocation.

Due to the significant changes in the terms and conditions for staff under Agenda for Change and the new Consultant Contract, it is difficult to estimate the pay inflation in later years. A net pay uplift of 4% has been assumed at this time, taking account of a general inflationary uplift and any pay progression / incremental drift.

Non pay increases have been estimated at 2%, with higher uplifts for prescribing and hospital drugs, based on historic trends / current forecasts.

One of the key changes to the financial plan in future years is the inclusion of the initial assessment of the revenue impact of the capital investment to support Picture of Health.

It is evident that the level of additional funding from the SEHD is unlikely to continue at the levels seen over recent years. This factor, combined with ongoing pay and service developments, is likely to present further financial pressure on NHS Lanarkshire during the coming five year period.

## 6. Risks

Whilst every effort has been made to ensure all likely cost pressures and national, regional and local priorities have been incorporated into the five year plan at this time, a number of risks remain.

These include

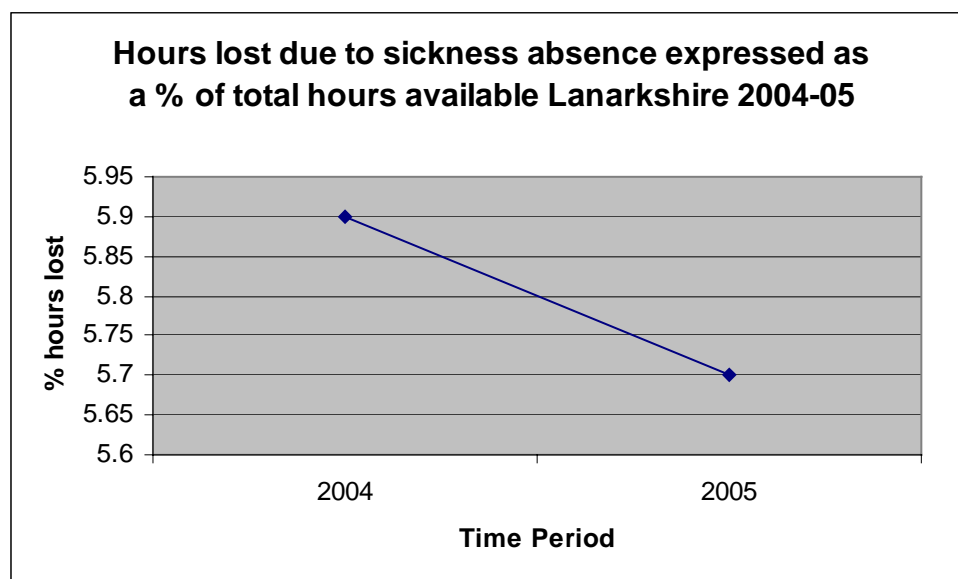
- Prescribing
- Waiting times
- Agenda for Change
- Pay and prices, in particular new drugs and utilities
- Further roll out of the national tariff for cross boundary flows
- Impact of Modernising Medical Careers
- Picture of Health developments
- Ongoing achievement of CRES / CRP / Efficient Government targets

Target E.02T - Sickness Absence Rate: 4% by 31 March 2008.
--

Lead: G Walker, HR Director

### 2.02.K Absences (linked to target E.02T)

Hours lost due to sickness absence expressed as a percentage of total hours available. This measure is based on all NHS employed staff working in NHS Scotland excluding private contractors (e.g. GPs and dentists) and their staff. Data are sourced from ISD (M) 39 - Occupational Health & Safety Minimum Dataset.



Data in above table (source: ISD):

2004	2005
5.9%	5.7%

NHSL Delivery Plan 2006/07 - 2008/09 (source: SWISS system):

2006	2007	2008	2009
5.8%	5.0%	4.0%	4.0%

*(2004 and 2005 figures were derived using ISD methodology. With effect from 2006, the SWISS system will provide this information. The SWISS figure for NHSL for 2005 was 5.85, hence the 2006 estimate being 5.8)*

### Narrative

#### What is the Problem?

High levels of sickness absence have a negative impact on service delivery, costs, and staff morale. While the recent trajectory in Lanarkshire is downward between 2004 and 2005, this is too short a time span to indicate a trend, and so there is a need for further action to reach the target of 4%.

#### How are we tackling it?

A sickness absence initiative has been launched through the partnership process. This will drive a reduction in sickness levels through improved occupational health

services, better reporting and training for managers. The action to be taken includes:

- Implement sickness absence project
- Implement training programme for managers
- Introduce new occupational health arrangements
- Develop the capacity to produce regular absence reports

#### **Expected Outcomes**

With lower absence levels, patient care should be improved with an improved staffing ratio. There will be a better working environment and there will be financial savings through a reduced requirement for sickness absence cover. No extra staff will be required in working towards this target.

**Target E.03T - Productivity: increase in consultant productivity by 1% pa over the next 3 years.**

**Lead: J D Browning, Medical Director**

### **2.03.K Productivity - Total (linked to target E.03T)**

Average Inpatient / Day Case case-mix adjusted activity per whole time equivalent (medical and nursing staff). Data are sourced from: SMR01, HRGs, The Medical and Dental Workforce Census and The Consultant Contract Uptake Census.

*(Insufficient data to produce a graph of recent performance in relation to this measure).*

NHSL Delivery Plan 2006/07 - 2008/09:

Sep 05	Dec 05	Mar 06	Jun 06	Sep 06	Dec 06	Mar 07	Jun 07
29.3	29.4	29.4	29.5	29.6	29.7	29.7	29.8
Sep 07	Dec 07	Mar 08	Jun 08	Sep 08	Dec 08	Mar 09	
29.9	29.9	30	30.1	30.2	30.2	30.2	

### **2.04.K Productivity - Consultants (linked to target E.03T)**

Average Inpatient / Day Case case-mix adjusted activity per whole time equivalent (clinical programmed activities). Data are sourced from: SMR01, HRGs, The Medical and Dental Workforce Census and The Consultant Contract Uptake Census.

*(Insufficient data to produce a graph of recent performance in relation to this measure).*

NHSL Delivery Plan 2006/07 - 2008/09:

Sep 05	Dec 05	Mar 06	Jun 06	Sep 06	Dec 06	Mar 07	Jun 07
519.6	520.9	522.2	523.5	524.8	526.1	527.4	528.7
Sep 07	Dec 07	Mar 08	Jun 08	Sep 08	Dec 08	Mar 09	
530	531.4	532.7	534	535.3	535.3	535.3	

## **Narrative**

### **What is the Problem?**

To continue to meet increasing demands on services within existing resources, and in a clinically safe and sustainable manner, substantive service re-design is required. Related to this is an increase in productivity.

### **How are we tackling it?**

Medical and nursing productivity (2.03K) will be increased through:

- Impact of previous concentration of inpatient ENT services onto a single site within Lanarkshire;
- Concentration of urology and gynaecology onto single inpatient sites from February 2006;
- Concentration of emergency psychiatry onto two instead of three sites from February 2006;

- Further redesign of services over the next five years resulting from “A Picture of Health” project;
- Implementation of changes within the Unscheduled Care Collaborative project including roll-out of MINTS during 2006; Implementation of streaming and development of nurse-led minor injuries services;
- Refocusing and further development of clinical teams around services rather than specialties during 2006;
- Implementation of outpatient referral management centre during 2006;
- Implementation of NHSL Cancer Network focusing on waiting times during 2006.

Many of the actions identified above in relation to 2.03K will apply equally to improving consultant productivity (2.04K). In addition, the following will form part of the action plan:

- Concentration of inpatient resources onto reduced numbers of sites allows reduction in the proportion of consultants’ time covering out of hours on-call and increase in the time available during normal working hours;
- Redesign of outpatient services with greater focus of consultant time on complex new referrals with overall reduction in return appointments, and development of nurse-led clinics;
- Further development of pre-assessment for inpatient and day-case surgery;
- Development over next five years of extended day working and moving towards consultant presence 24-hours a day within acute medicine/A&E, acute surgery and obstetrics;
- Further developing roles for nurse and AHP practitioners allowing consultants to focus on more complex patients.

### **Expected outcomes**

The above developments, as they are implemented, are expected to raise productivity levels in line with the trajectories under 2.03K and 2.04K.

### NHS Scotland Objective 3:

Access to Services - recognising patients need for quicker and easier use of NHS services.

Target No.	Target
A.01T	Ensure that anyone contacting their GP surgery has guaranteed access to a GP, nurse or other health care professional within 48 hours from April 2004.
A.02T	60% of 5 year old children (primary 1) will have no signs of dental disease by 2010
A.03T	No patient with a guarantee should wait longer than 6 months for inpatient or day case treatment from 31 December 2005, reducing to 18 weeks from 31 December 2007.
A.04T	By the end of 2005, no patient will wait longer than 6 months from GP referral to an outpatient appointment, reducing to 18 weeks from 31 December 2007.
A.05T	By end 2007 no patient will wait more than 4 hours from arrival to discharge or transfer for accident and emergency treatment.
A.06T	By end of 2007 the maximum wait for cataract surgery will be 18 weeks from referral to completion of treatment.
A.07T	By end of 2007, the maximum wait for admission to a specialist unit for hip surgery following fracture will be 24 hours.
A.08T	Women who have breast cancer and need urgent treatment will get it within one month where appropriate.
A.09T	By 31 December 2005 no patient urgently referred for cancer treatment should wait more than 2 months.
A.10T	From June 30 2004 the maximum wait from angiography to surgery or angioplasty will be 18 weeks.
A.11T	By end 2007, the maximum wait for cardiac intervention will be 16 weeks from GP referral through rapid access chest pain clinic or equivalent.
A.12T	By the end of 2007 patients will wait no more than nine weeks for any MRI or CT scans and other key diagnostic tests
A.13T	From the end of 2007, no patient will wait more than 16 weeks for treatment after they have been seen as an outpatient by a heart specialist and the specialist has recommended treatment.
A.14T	By end 2007, 75% of 999 emergency calls responded to within 8 minutes.

Target A.01T - Ensure that anyone contacting his or her GP surgery has guaranteed access to a GP, nurse or other health care professional within 48 hours from April 2004.

Lead: C Sloey, Chief Executive, Primary Care Division  
S Mackie, Associate Medical Director

### 3.01.K Primary Care Team Access (linked to target A.01T)

Percentage coverage of Health Board population, using list sizes for GP practices, taking part in Primary Care Collaborative.

*(Insufficient data to produce a graph of recent performance in relation to this measure).*

NHSL Delivery Plan 2006/07 - 2008/09:

*(local performance against the target, based on QOF points, rather than participation in the Collaborative)*

Apr 05	Apr 06	Apr 07	Apr 08	Apr 09
97%	99%	100%	100%	100%

#### **Narrative**

The Scottish Executive in partnership with the NHS and Professional bodies have identified that they will ensure that patients in every part of Scotland have access to an appropriate member of the primary care team within 48hrs.

NHS Boards submitted a baseline assessment of their positions in 2002 and in line with the definition '*anyone contacting the GP surgery has guaranteed access to a GP, Nurse or other Health care professional within 48 hours*', had to achieve the target by 31<sup>st</sup> March 2004.

#### **What is the Problem?**

Across Scotland patients have raised concerns that they are not able to access primary care services quickly enough and within Scotland's Health White paper; *Partnership for Care*, Boards have been tasked to ensure that not only, everyone is achieving the target, but, that there are systems in place to monitor it.

#### **How are we tackling it?**

Following the initial audit carried out in Lanarkshire in 2003 an action plan was drawn up to work towards 100% achievement. In September of 2005 it was reported to the Scottish Executive Health department that following the QOF information received, 96 practices from 99 were in a position to claim the QOF 48hr access point. From the remaining 3 practices, two of them had joined the next wave of the Primary Care Collaborative and were expected to be in a position to claim for the 2006 QOF point. The Primary Care department are working closely with the remaining practice to resolve the issues that prevented them from achieving the access standard. It is, therefore anticipated that Lanarkshire will have a 100% coverage of practices achieving 48hr access by 2007.

In tandem with this process NHSL is working with practices to participate in the Primary Care Collaborative. Lanarkshire now has 56 practices that have adopted the methodology and are working within the framework to meet the access targets set for the Primary Care Collaborative.

Practices need to review receptionist/nursing/general practice work in the practice to achieve 48-hour access per patient. They have to ensure not only immediate same day access to appointments, but also planned appointments booked in advance.

**Expected outcome**

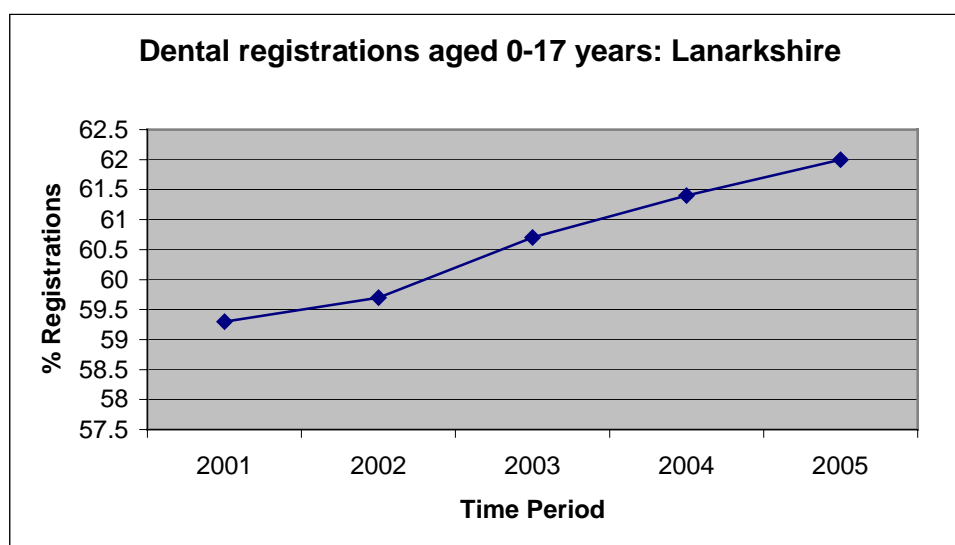
Equity of access for patients across Lanarkshire to GP or member of primary healthcare team (as per definition from Partnership Agreement: *Partnership for a Better Scotland, 2003*).

Target A.02T - 60% of 5 year old children (primary 1) will have no signs of dental disease by 2010

Lead: D C Moir, Director of Public Health  
M Taylor, Consultant in Dental Public Health

### 3.02.K Dental Registrations (linked to target A.02T)

Percentage of children aged 0-17 years registered with an NHS dentist. Data are sourced from the Management Information & Dental Accounting System (MIDAS).



Data in above table:

31 Mar 00	31 Mar 01	31 Mar 02	31 Mar 03	31 Mar 04	31 Mar 05
60.8%	59.3%	59.7%	60.7%	61.4%	62%

NHSL Delivery Plan 2006/07 - 2008/09:

31 March 06	31 March 07	31 March 08	31 March 09
64%	*70%	*75%	*80%*

\*These figures are estimates and are based on the following:

- Patients currently attending the CDS becoming registered;
- 2 new practices opening and 3 current practices extending by one surgery;
- registration time being extended to 3 years;
- Childsmile programme extended by 2008;
- Account taken of patients resident in Lanarkshire attending Glasgow dentists.

## Narrative

### What is the Problem?

Oral health in Lanarkshire's population is poor and is a long-standing problem, linked to wider social, cultural and behavioural factors. Currently, approximately 47% of 5 year olds are caries free, however, distribution of disease is unequal with about 10% of the population accounting for 50% of the teeth with established decay. There is therefore some way to go to reach the target of 5 year olds being 60% caries free by 2010. One element in this will be to increase the number of children registered with a dentist, and thus able to access regular check ups, and appropriate and timely care. Dental registrations levels are an important but relatively small part of meeting the target. The main contribution towards achieving the target will be through the preventive work carried out by the health visitors, oral health promoters, nursery staff, dental health support workers, and dental nurses.

### How are we tackling it?

A number of strands of action are underway:

- The Dental Action Plan is being implemented. 95% of nurseries are on the toothbrushing programme, health visitors are distributing packs to the children under a year, all nursery children and children starting school are being given packs for home use;
- Lanarkshire is participating in the West of Scotland Demonstration project "Childsmile" targeting children at risk of developing dental disease;
- Oral health promotion staff will be recruited and additional dentists will be attracted via the Dental Access Initiative;
- Related financial investment of £200,000 is supporting this agenda.

### Expected outcome

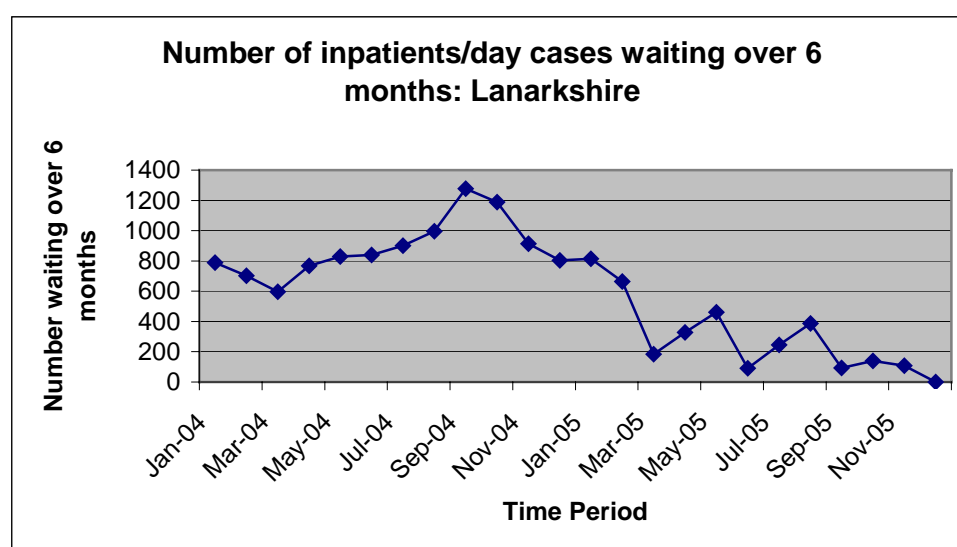
Assuming a cohort of 7000 children, approximately an additional 910 5 year old children will be decay free each year if the target is met. With increased registrations, demand for dental care will increase. Estimates of target achievement have been given for each of the four years, but are subject to a number of assumptions that have been set out above. The position will be closely monitored to track any changes in assumptions, and to adjust activities and projections accordingly.

**Target A.03T - No patient with a guarantee should wait longer than 6 months for inpatient or day case treatment from 31 December 2005, reducing to 18 weeks from 31 December 2007.**

Lead: I Ross, Chief Executive, Acute Division  
R Garscadden, Head of Planning, Acute Division

### 3.03.K Inpatient / Day Case Waiting Times over 6 months (31 December 2005) (linked to target A.03T)

For all acute specialties, number of inpatient / day cases waiting over 6 months excluding ASCs. Data are sourced from Monthly Management Information.



Data in above table:

Jan 04	Feb 04	Mar 04	Apr 04	May 04	Jun 04	Jul 04	Aug 04	Sep 04	Oct 04
789	702	597	768	830	839	901	997	1277	1189
Nov 04	Dec 04	Jan 05	Feb 05	Mar 05	Apr 05	May 05	Jun 05	Jul 05	Aug 05
913	803	814	665	185	327	462	90	246	388
Sep 05	Oct 05	Nov 05	Dec 05						
92	140	108	0						

NHSL Delivery Plan 2006/07:

Jan 06	Feb 06	Mar 06	Apr 06	May 06	Jun 06	Jul 06	Aug 06	Sep 06	Oct 06
0	0	0	0	0	0	0	0	0	0
Nov 06	Dec 06	Mar 07	Dec 07						
0	0	0	0						

## Narrative

### Objective

NHS Lanarkshire has achieved the objective that no patient should wait longer than twenty-six weeks for inpatient or day case treatment by 31 December 2005. The

next stage is to sustain that position and to deliver further improvement in waiting time standards.

### **Patient Benefit**

The advantage to the patient is that they are seen at an earlier date.

### **Achievement of Guarantee**

NHS Lanarkshire developed a capacity plan in 2004/05 (updated in 2005/06) to identify the activity required to deliver and sustain a twenty-six week maximum wait. This looked at demand as well as supply. The conclusion was that there was insufficient internal capacity to deliver the guarantee. During 2004/05 internal capacity has been increased by recruitment of additional clinical and support staff. In addition, NHS Lanarkshire was allocated ENT, General Surgery and Orthopaedic slots at the National Golden Jubilee Hospital. Internal waiting list initiatives were also undertaken. The remaining shortfall in capacity was met through use of the Independent Sector.

Delivery of the waiting time guarantee was therefore achieved through routine activity, permanent investment in staff recruitment, some internal waiting list initiatives and through purchase of activity at Golden Jubilee and the Independent Sector. The extent to which each contributed towards delivery of the waiting time guarantee was determined by a number of factors:

- Routine performance to a level anticipated in the Capacity Plan;
- Recruitment of all permanent staff identified in the Investment Plan;
- The agreement of staff to undertake internal waiting list initiatives;
- Number of slots allocated at Golden Jubilee.

What happened in practice was that NHS Lanarkshire was unable to recruit to all posts and in particular Anaesthetics (although some progress has been made recently in attracting staff from Eastern Europe), less slots were allocated at Golden Jubilee than had been requested (although additional slots were negotiated for Orthopaedics), staff were not prepared to undertake internal waiting list initiatives due to payment changes under Agenda for Change and funding was a limiting factor in accessing capacity in the Independent Sector. The monitoring of routine performance was constrained by use of historical activity performance (it is intended in future to link more closely to consultant work plans in determining individual and collective outputs). There was also an impact on activity due to implementation of the Consultant Contract and European Working Directives.

The outcome was that each of those elements was managed on each acute hospital site and increasingly across sites to deliver the guarantee. There was close monitoring of the situation on an ongoing basis. The proposed change in the management arrangements across NHS Lanarkshire and the commitment to service redesign and improvement reflected in 'Picture of Health' will facilitate that process.

### **Financial Implications 2005/06**

The financial cost of delivering the national waiting time guarantee is as follows:

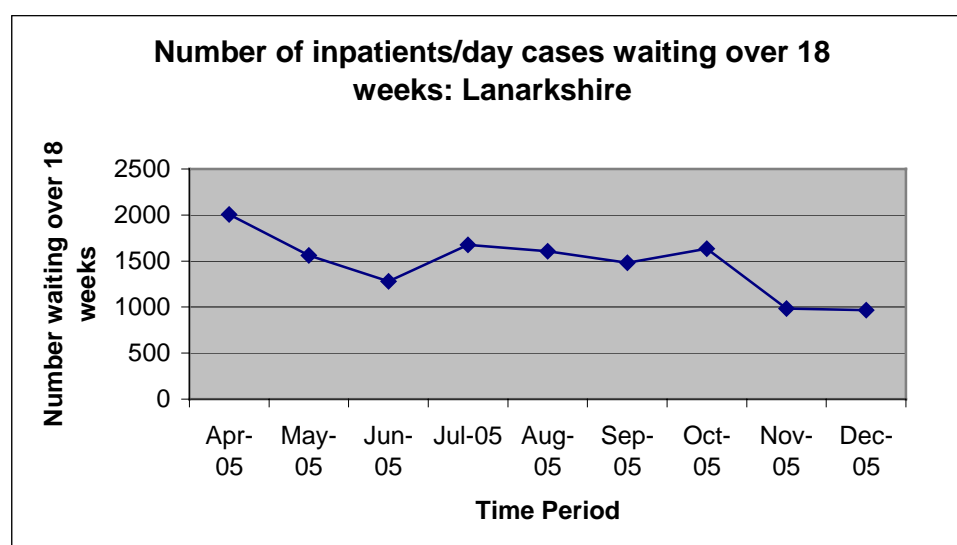
- Permanent Investment - £1,806,903 (part year) - £3,147,135 (full year)
- Golden Jubilee - £1,725,400
- Internal Initiatives - £1,473,490
- Independent Sector - £2,549,200

Target A.03T - No patient with a guarantee should wait longer than 6 months for inpatient or day case treatment from 31 December 2005, reducing to 18 weeks from 31 December 2007.

Lead: I Ross, Chief Executive, Acute Division  
R Garscadden, Head of Planning, Acute Division

### 3.04.K Inpatient / Day Case Waiting Times over 18 weeks (31 December 2007) (linked to target A.03T)

For all acute specialties, number of inpatient / day cases waiting over 18 weeks excluding ASCs. Data are sourced from Monthly Management Information.



Data in above table:

Apr 05	May 05	Jun 05	Jul 05	Aug 05	Sep 05
2006	1560	1278	1675	1607	1481
Oct 05	Nov 05	Dec 05			
1634	984	967			

NHSL Delivery Plan 2006/07:

#### *Excluding Orthopaedics:*

Jan 06	Feb 06	Mar 06	Apr 06	May 06	Jun 06	Jul 06	Aug 06
890	870	830	750	670	620	570	460
Sep 06	Oct 06	Nov 06	Dec 06	Mar 07	Dec 07		
355	235	110	0	0	0		

#### *Orthopaedics only:*

Jan 06	Feb 06	Mar 06	Apr 06	May 06	Jun 06	Jul 06	Aug 06
270	260	249	232	218	190	160	130
Sep 06	Oct 06	Nov 06	Dec 06	Mar 07	Dec 07		
100	80	50	0	0	0		

## Narrative

### Objective

NHS Lanarkshire has to ensure that no patient waits longer than eighteen weeks for inpatient or day case treatment by 31 December 2007.

### Patient Benefit

The advantage to the patient is that they will be seen at an earlier date.

### Position Statement

The capacity plan for inpatient/day cases has been updated to demonstrate progress during 2006/07 from the current maximum wait of twenty-six weeks to eighteen weeks. There is a commitment, reflected in the capacity plan, to achieve the eighteen-week maximum wait for all specialties by 31 December 2006. This is in line with a management guarantee set by the National Waiting Times Unit.

The commitment to accelerate delivery of the guarantee assumes full implementation of the investment programme for recruitment of staff identified in 2005/06. This will be extended further in 2006/07 to create extra capacity to deliver additional activity. Further permanent investment will include those initiatives taken forward in 2005/06 linked to service redesign and funded, to date, through Change and Innovation. It is also anticipated that the broader agenda around service redesign (involving both primary and secondary care and, as appropriate, other agencies) will provide potential for improved process, practice and performance with subsequent benefits in respect of activity and quality. Continued access is anticipated to Golden Jubilee although at an increased level reflected in the bid submitted for 2006/07 to the National Waiting Times Unit. It also anticipates a level of return on routine activity that is no less than in 2005/06.

Orthopaedics represents the most significant challenge in 2006/07 and progress is dependent largely on further recruitment of consultant and supporting staff accompanied by a commitment to service redesign. Access to the Independent sector will be required, the nature and extent of which will be determined by routine activity, the level of access to orthopaedic slots at the Golden Jubilee and the impact of service redesign reflected, in part, in work to date at Hairmyres Hospital.

### Risks

There are, however, risks associated with delivery of the waiting time guarantee:

- Progress in service redesign with, where required, appropriate funding (short and long term);
- Ability to recruit and retain clinical and non-clinical staff;
- Access to slots at Golden Jubilee to the required level;
- Access to capacity in the Independent Sector with the required funding stream;
- Increased conversion rate (inpatient/day cases) through impact of delivering out patient guarantee;

- Lack of flexibility to undertake internal waiting list initiatives at significantly less cost than through other options;
- The challenging agendas associated with service change and redesign whilst delivering an improved service to patients within national waiting time guarantees.

### **Delivery Plan**

The action proposed to respond to those risks include:

- Introduction of new management arrangements across Lanarkshire with appointment of a General Manager and Clinical Director on a Lanarkshire wide basis;
- Establishment of Planned Care Collaborative to provide single focus for taking forward service redesign and other aspects of the change agenda. The Collaborative will also monitor action and progress towards delivery of national waiting time guarantees (daily monitoring of waiting lists/times to continue with a Lanarkshire wide focus);
- Negotiate increased access to Golden Jubilee;
- Factor increased conversion rate to capacity plan;
- Negotiate changes to conditions around Agenda for Change to facilitate increase in internal waiting list initiatives;
- Effective communication with clinical and non-clinical staff to ensure awareness of agenda and progress around implementation;
- Negotiate, where possible, a long-term contract with Independent Sector to access capacity.

### **Financial Implications (Indicative)**

The anticipated cost of continuing to improve waiting time standards across inpatient and day cases in 2006/07 is:

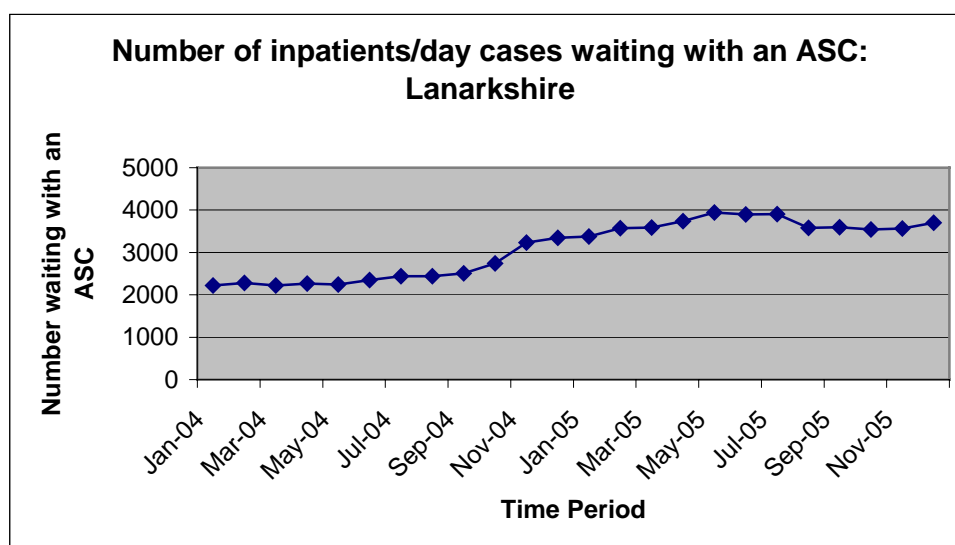
- Permanent Investment - £4,200,000 (part year) - £4,900,00 (full year)
- Golden Jubilee - £2,100,000
- Internal Initiatives - £500,000
- Independent Sector - £3,100,000

Target A.03T - No patient with a guarantee should wait longer than 6 months for inpatient or day case treatment from 31 December 2005, reducing to 18 weeks from 31 December 2007.

Lead: I Ross, Chief Executive, Acute Division  
R Garscadden, Head of Planning, Acute Division

### 3.05.K Inpatient / Day Case ASCs (linked to target A.03T)

For all acute specialties, number of inpatient / day cases waiting with an ASC. Data are sourced from Monthly Management Information.



Data in above table:

Jan 04	Feb 04	Mar 04	Apr 04	May 04	Jun 04	Jul 04	Aug 04	Sep 04	Oct 04
2222	2281	2222	2266	2245	2346	2441	2439	2506	2739
Nov 04	Dec 04	Jan 05	Feb 05	Mar 05	Apr 05	May 05	Jun 05	Jul 05	Aug 05
3234	3349	3377	3569	3590	3740	3942	3894	3905	3581
Sep 05	Oct 05	Nov 05	Dec 05						
3595	3545	3565	3701						

NHSL Delivery Plan 2006/07:

Jan 06	Feb 06	Mar 06	Apr 06	May 06	Jun 06	Jul 06	Aug 06	Sep 06
3560	3470	3375	3270	3165	3053	2970	2890	2811
Oct 06	Nov 06	Dec 06	Mar 07	Dec 07				
2720	2625	2525	2245	1560				

### Narrative

### Objective

NHS Lanarkshire has to ensure that there are no patients with an ASC code by 31 December 2007.

In reality the target of zero cannot be achieved, as there will always be patients who will be 'suspended' or have their waiting time clock reset. The Scottish Executive has estimated this number to be around 1500 by December 2007.

### **Patient Benefit**

The benefit to the patient is that their status will be determined and if they require an appointment (following assessment) it will be made within a maximum of twenty-six weeks.

### **Position Statement**

There are currently 3560 patients in Lanarkshire with an ASC code. Those are distributed as follows:

- ASC2 - where the patient has asked to delay admission for personal reasons or has refused a reasonable offer of admission;
- ASC3 - individual cases where, after discussion with the patient, the treatment has been judged of low clinical priority;
- ASC4 - with highly specialised treatments identified at the time of placing the patient on the waiting list;
- ASC8 - where the patient did not attend nor give any prior warning;
- ASCA - patients under medical constraints (condition other than that requiring treatment) that affected their ability to accept an admission date if offered;

There is currently work in progress to reduce the number of patients with an ASC code. This is achieved by periodic assessment of patients with an ASC code and, as appropriate, booking them an appointment. An increasing number of patients with an ASC code have been factored into the capacity plan with an even distribution of patients to be seen spread over each of the two calendar years 2006 and 2007. In addition, NHS Lanarkshire has ceased to apply codes 3 and 4 and existing patients with these codes are being treated or removed from lists. ASC waiting lists are also subject to routine clean to determine whether the procedure is still required.

A position has also recently been taken on the application of New Ways Guidance that was issued last year by the Scottish Executive. This will inform how the NHS Board will in future respond to patients who do not attend for their appointment, are medically unfit with no agreed date on when the procedure will be undertaken or who refuse a reasonable offer of appointment. A consistent application of New Ways Guidance that will effectively remove in certain circumstances a patient's right to assessment or treatment within national waiting time guarantees. Dialogue is continuing with GP colleagues on implementation of New Ways Guidance.

### **Risks**

There are, however, risks associated with reducing the number of patients with an ASC code.

- GP resistance to application of New Ways Guidance due to anticipated impact on workload;
- Inability to factor in the required number of patients with an ASC code to existing clinics due to demand and limited capacity;
- Time pressure on clinical staff to review cases of patients with an ASC code.

### **Delivery Plan**

The action proposed to respond to those risks include:

- Dialogue with GP colleagues to achieve a phased implementation of New Ways Guidance. Application of New Ways Guidance will by itself offer the potential for a significant reduction in the number of existing patients waiting with an ASC code and will reduce the future application of ASC codes;
- Funding to support that phased implementation;
- Ongoing review of current patients with an ASC code to be completed within an agreed timescale;
- Through the Planned Care Collaborative a mechanism to enable colleagues in primary and secondary care to communicate with each other to address issues around referral, availability for assessment and treatment and feedback on the patient journey.

### **Financial Implications**

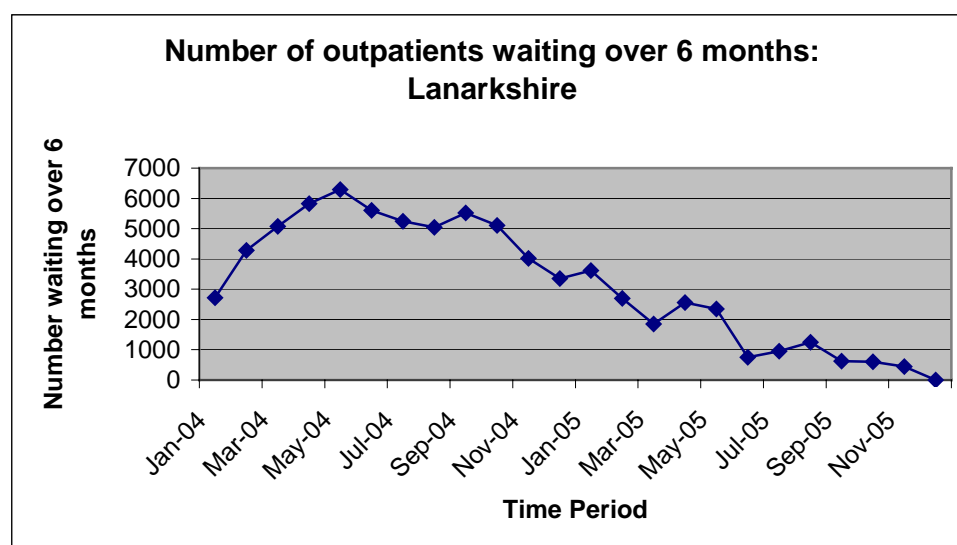
The anticipated financial implications of reducing the number of patients with ASC codes are contained within the indicative costs identified for inpatients and day cases.

Target A.04T - By the end of 2005, no patient will wait longer than 6 months from GP referral to an outpatient appointment, reducing to 18 weeks from 31 December 2007.

Lead: I Ross, Chief Executive, Acute Division  
R Garscadden, Head of Planning, Acute Division

### 3.06.K Outpatient Waiting Times over 6 months (31 December 2005) (linked to target A.04T)

For all acute specialties, number of new outpatients (GP/GDP referrals) waiting over 26 weeks excluding ASCs. Data are sourced from Monthly Management Information.



Data in above table:

Jan 04	Feb 04	Mar 04	Apr 04	May 04	Jun 04	Jul 04	Aug 04	Sep 04	Oct 04
2721	4281	5077	5826	6292	5601	5245	5047	5519	5104
Nov 04	Dec 04	Jan 05	Feb 05	Mar 05	Apr 05	May 05	Jun 05	Jul 05	Aug 05
4021	3350	3621	2694	1854	2564	2348	756	951	1247
Sep 05	Oct 05	Nov 05	Dec 05						
626	606	444	0						

NHSL Delivery Plan 2006/07:

Jan 06	Feb 06	Mar 06	Apr 06	May 06	Jun 06	Jul 06	Aug 06	Sep 06
0	0	0	0	0	0	0	0	0
Oct 06	Nov 06	Dec 06	Mar 07	Dec 07				
0	0	0	0	0				

### Narrative

#### Objective

NHS Lanarkshire has achieved the objective that no patient should wait longer than twenty-six weeks for an outpatient appointment by 31 December 2005. The next

stage is to sustain that position and to deliver further improvement in waiting time standards.

### **Patient Benefit**

The advantage to the patient is that they are seen at an earlier date.

### **Achievement of Guarantee**

Delivery of the outpatient waiting time guarantee was achieved through effective management of the waiting lists within and across sites based on historical numbers and types of referrals. In addition, work was undertaken as part of a programme of change and innovation in selected specialties including ENT, Dermatology, Orthopaedics, Vascular and Back Pain. Those initiatives have received short term funding (ends on 31 March 2006) through the Centre for Change and Innovation. Those enabled some GP referrals to be streamed to clinicians other than Consultants including Nurses as well as Extended Scope Practitioners in both Physiotherapy and Podiatry. Over the twelve-month period it was necessary to undertake some internal waiting list initiatives to address pressures in particular specialties. It was also necessary to utilise the Independent Sector to address a capacity pressure in Neurology. This is a regional service with consultant staff from NHS Greater Glasgow undertaking clinics in Lanarkshire for Lanarkshire patients.

There is work in progress to develop an outpatient capacity plan to inform future operational and investment plans.

### **Financial Implications**

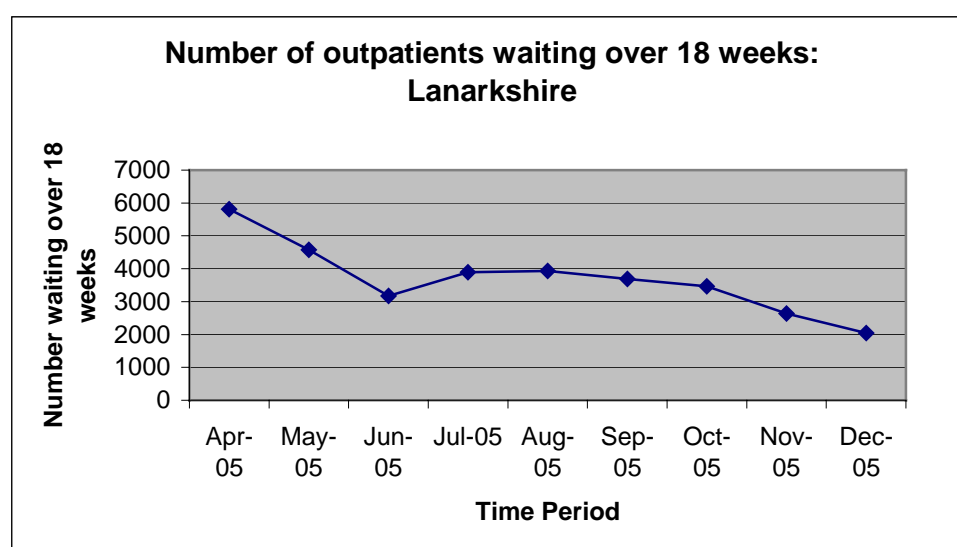
There was a need for some internal waiting list initiatives. Those costs were around 300K. Those are contained within the costs shown against waiting list initiatives in 2005/06 for inpatients and day cases. In addition, use was made of the Independent Sector for Neurology the cost of which is 160K. There was no cost to the NHS Board for those outpatient initiatives taken forward under change and innovation.

Target A.04T - By the end of 2005, no patient will wait longer than 6 months from GP referral to an outpatient appointment, reducing to 18 weeks from 31 December 2007.

Lead: I Ross, Chief Executive, Acute Division  
R Garscadden, Head of Planning, Acute Division

### 3.07.K Outpatient Waiting Times over 18 weeks (31 December 2007) (linked to target A.04T)

For all acute specialties, number of new outpatients (GP/GDP referrals) waiting over 18 weeks excluding ASCs. Data are sourced from Monthly Management Information.



Data in above table:

Apr 05	May 05	Jun 05	Jul 05	Aug 05	Sep 05
5810	4572	3178	3894	3934	3694
Oct 05	Nov 05	Dec 05			
3464	2641	2040			

NHSL Delivery Plan 2006/07:

Jan 06	Feb 06	Mar 06	Apr 06	May 06	Jun 06	Jul 06	Aug 06
2170	2140	2110	2080	2030	1980	1930	1880
Sep 06	Oct 06	Nov 06	Dec 06	Mar 07	Dec 07		
1830	1780	1730	1680	1400	0		

### Narrative

#### Objective

NHS Lanarkshire has to ensure that no patient waits longer than eighteen weeks for an outpatient appointment by 31 December 2007.

#### Patient Benefit

The advantage to the patient is that they will be seen at an earlier date.

### Position Statement

It is intended to adopt a phased approach to reducing the maximum wait for an outpatient appointment with an equal reduction over each of the next two calendar years. It will however be necessary to increase capacity to enable more patients to be seen over a shorter period. The detail of that will be informed by development of an outpatient capacity plan that is currently under discussion. This looks at both demand and supply with regard taken to the significant number of factors that will impact on that. Reference is made to those factors in the next paragraph.

It will be necessary also to apply New Ways Guidance that will replace the current system of Availability Status Codes (ASC) that are currently applied by the NHS and remove in certain circumstances a patient's right to assessment and treatment within national waiting time guarantees. It will also be essential to encourage and promote service redesign with the provision of permanent funding to enable work undertaken to date in ENT, Dermatology, Orthopaedics, Vascular and Back Pain to continue. This will be accompanied by the introduction of robust referral criteria between primary and secondary care and the promotion of electronic referral in the context of a single referral centre. Dialogue will also be required with Golden Jubilee to enable new services to be provided there on a 'see and treat' basis and with neighbouring NHS Boards to ensure sufficient capacity is in place to enable their consultant lead services to deliver a service to patients in Lanarkshire within the waiting time guarantee.

In addition, Patient Focussed Booking has been introduced during 2005/06 with a phased programme targeting, in the first instance, ENT, Dermatology and Orthopaedics. This introduces patient choice to booking appointments with the intention of providing flexibility but also reducing the number of patients who do not attend. In parallel the opportunity is being taken to review clinic profiles across specialties.

### Risks

There are, however, risks associated with delivery of the waiting time guarantee:

- Completion and application of the outpatient capacity plan;
- Available funding for additional staff to increase internal capacity;
- Available funding to mainline Change and Innovation initiatives developed over recent two years;
- Acceptance of and engagement by clinicians in both primary and secondary care to introduce and operate New Ways Guidance;
- Preparedness by Golden Jubilee to provide additional capacity for 'see and treat';
- Agreement with neighbouring NHS Boards on the level of capacity required to deliver waiting time guarantees for outpatient services provided regionally;
- Ability to secure agreement on referral criteria between primary and secondary care and participation in use of electronic referral;
- Ability to establish a single referral centre and extend patient focussed booking.

## Delivery Plan

The action plan proposed to respond to those risks include:

- Introduction of new management arrangements across Lanarkshire with appointment of a General Manager and Clinical Director on a Lanarkshire wide basis;
- Establishment of Planned Care Collaborative to provide single focus for taking forward service redesign and other aspects of the change. The Collaborative will also monitor action and progress towards delivery of national waiting time guarantees (daily monitoring of waiting list/times to continue with a Lanarkshire wide focus);
- Finalise and apply the capacity plan to confirm investment proposals (to be confirmed);
- Implement New Ways Guidance in dialogue with clinicians in primary and secondary care;
- Develop robust outpatient referral protocols for each specialty (to include review of those already in place);
- Establish a single referral centre in Lanarkshire, expand use of electronic referral and extend further patient focussed booking within an agreed programme;
- Agree a capacity plan with neighbouring NHS Boards for those outpatient services delivered regionally.

## Financial Implications

The anticipated cost of continuing to improve waiting time standards across outpatients in 2006/07 is:

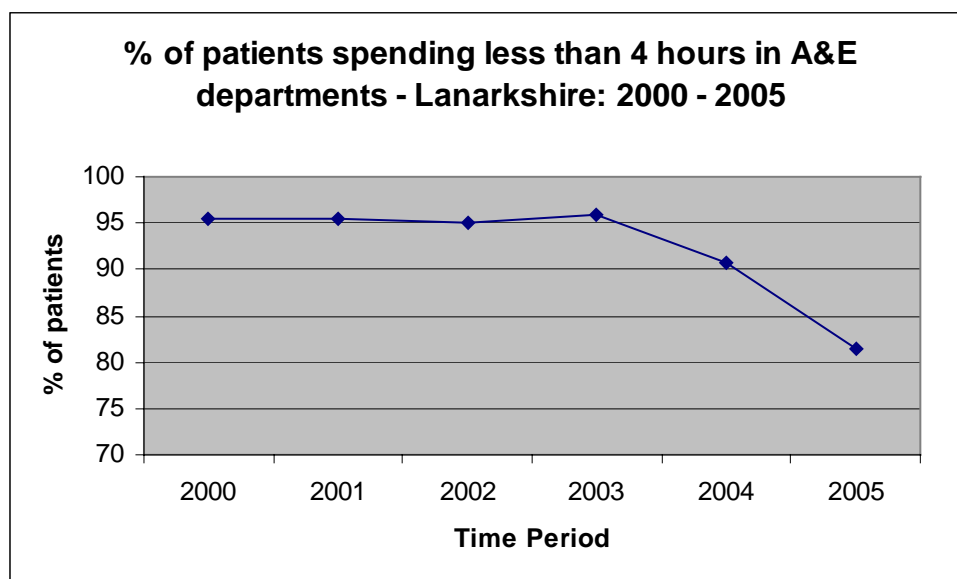
- Permanent - to be determined
- Internal Initiatives - c. £500k

**Target A.05T - By end 2007 no patient will wait more than 4 hours from arrival to discharge or transfer for accident and emergency treatment.**

**Lead:** I Ross, Chief Executive, Acute Division  
D Hume, General Manager, Acute Division

### 3.08.K A&E Waits less than 4 hours (linked to target A.05T)

The percentage of patients spending less than 4 hours in Accident & Emergency Department. Historical data are sourced from SMR30C (A&E Survey).



Data in above table:

Mar 00	Apr 01	Apr 02	Apr 03	Apr 04	Apr 05
95.5%	95.5%	95.1%	95.8%	90.8%	81.5%

NHSL Delivery Plan 2006/07:

Jan 06	Feb 06	Mar 06	Apr 06	May 06	Jun 06	Jul 06	Aug 06
87%	87%	87.5%	88%	88%	88%	90%	91%
Sep 06	Oct 06	Nov 06	Dec 06	Mar 07	Dec 07		
92%	93%	94%	95%	96%	98%		

## Narrative

### Objective

NHS Lanarkshire has to ensure that no patient waits longer than four hours for treatment in A&E from time of arrival by 31 December 2007.

### Patient Benefit

The advantage to the patient is that they will be seen at an earlier time.

### Assessment

The current level of compliance with the waiting time guarantee is 85%. To improve performance, NHS Lanarkshire has established an Unscheduled Care

Collaborative. Its remit is to review clinical process through admission, treatment and discharge and, through service redesign, improve the patient pathway. The Centre for Change and Innovation (CCI) sponsors the Collaborative with funding provided over a two year period. The Collaborative has sub-divided the programme into four separate work streams, i.e., Minor Injury and Illness, Assessment, Medical Admissions and Surgical Admissions. Using the UCCP (PDSA) of service redesign, the NHS Board is undertaking a whole system review of all clinical processes within each flow stream.

To date, there has been support of senior clinicians and managers, robust real time patient monitoring through all patient pathways to inform daily operational decision making and optimising patient flows through service bottlenecks by linking the processes of admission, treatment and discharge. In addition, there has been first phase capacity planning with an analysis of demand to enable matching of resources with demand across a range of services.

New management arrangements will be introduced across Lanarkshire from 1 April 2006. This will provide a pan-Lanarkshire focus on Accident and Emergency and Emergency Admission and will, with implementation of the HAS (EDIS) database in each acute hospital site, provide the opportunity to deliver the guarantee.

#### Risks

- Available funding to increase capacity (if required);
- Acceptance and engagement by clinicians in both primary and secondary care to adopt new ways of working;
- Effective engagement with and participation by other agencies.

#### Delivery Plan

- Introduction of new management arrangements across Lanarkshire with appointment of a General Manager and Clinical Director on a Lanarkshire wide basis;
- Effective communication with clinical and non-clinical staff to ensure awareness of agenda and progress around implementation;
- Expand 'see and treat' model to cover peak periods seven days a week;
- Clarify the assessment function across acute hospital sites and ensure the availability of senior clinical decision makers to carry out assessment once;
- Improve the flow of surgical and medical admissions by ensuring the early availability of specialist opinion;
- Restructure the clinical and organisational arrangements for the discharge of complex patients across the clinical division;
- Further develop the work of Unscheduled Care Collaborative to provide single focus for taking forward the agenda and for monitoring action and progress to include delivery of the waiting time guarantee;
- Further refine software to improve capture and reporting of patient information.

**Financial Implications**

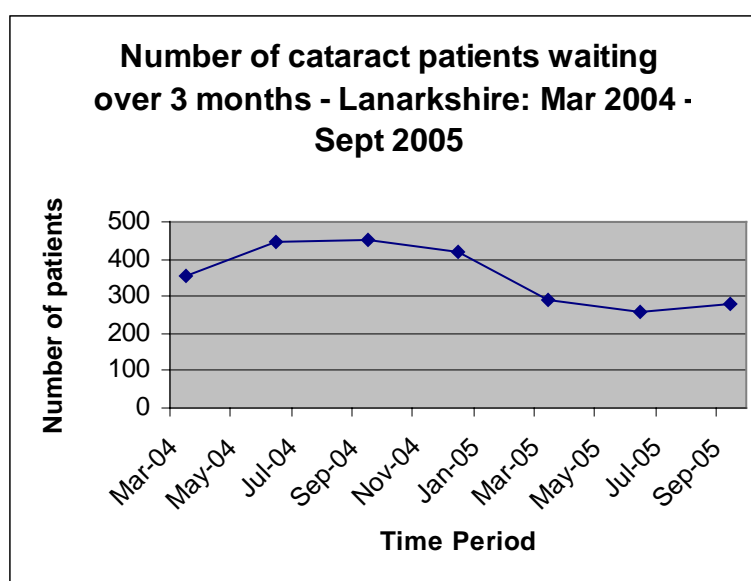
Work to date would appear to indicate the need for investment in specific areas including 'see and treat'. The work of the Collaborative will inform the detail of any investment. The NHS Board will continue to maximise all available monies allocated to it by CCI.

Target A.06T - By end of 2007 the maximum wait for cataract surgery will be 18 weeks from referral to completion of treatment.

Lead: I Ross, Chief Executive, Acute Division  
R Garscadden, Head of Planning, Acute Division

### 3.09.K Cataract Waiting Times over 3 months (linked to target A.06T)

Number of Inpatient / Day cases waiting over 3 months for a cataract operation. Data are sourced from SMR3 records. Measurement of this will be improved when total journey information becomes available.



Data in above table:

31 Mar 04	30 Jun 04	30 Sep 04	31 Dec 04	31 Mar 05	30 Jun 05	30 Sep 05
357	445	453	417	293	256	279

NHSL Delivery Plan 2006/07:

Jan 06	Feb 06	Mar 06	Apr 06	May 06	Jun 06	Jul 06	Aug 06
238	228	217	207	196	186	176	166
Sep 06	Oct 06	Nov 06	Dec 06	Mar 07	Dec 07		
155	144	134	124	94	0		

## Narrative

### Objective

NHS Lanarkshire has to ensure that no patient waits longer than eighteen weeks from referral to treatment by 31 December 2007.

The information provided to date by the Scottish Executive is based on assumptions around the day case element of the patient journey. There is work in progress on a regional and national basis to validate the optimum patient journey. There is therefore a possibility that the target may alter during 2006/07. This would apply if the outpatient/pre assessment element of the journey was

longer than five weeks then the sustainable number of day cases on the list would have to reduce.

### **Patient Benefit**

The advantage to the patient is that they will be seen at an earlier date with the potential for an improved health outcome.

### **Assessment**

NHS Lanarkshire has an established ophthalmology service delivering a significant number of cataract procedures each year. In addition there is access to capacity at the National Golden Jubilee Hospital. It is intended to improve and strengthen that service through establishment of a Cataract Collaborative involving colleagues from primary and secondary care to include also patient representatives. The Collaborative is being sponsored by the Centre for Change and Innovation (CCI) with funding support over a two year period. This will examine current process and practice with a view as appropriate to service redesign. It will also inform development of a capacity plan to deliver the waiting time guarantee.

### **Risks**

- Lack of clarity around definitions;
- Progress in service redesign with, where required, appropriate funding (short and long term);
- Ability to recruit and retain clinical and non-clinical staff;
- Access to capacity at Golden Jubilee to the required level;
- Acceptance of and engagement by clinicians in both primary and secondary care to introduce and operate new ways of working.

### **Delivery Plan**

- Establishment of Collaborative to provide single focus for taking forward the agenda and for monitoring action and progress to include delivery of national waiting time guarantees;
- Agree and apply capacity plan to confirm investment proposals;
- Effective communication with clinical and non-clinical staff to ensure awareness of agenda and progress around implementation;
- Introduction of new management arrangements across Lanarkshire with appointment of a General Manager and Clinical Director on a Lanarkshire wide basis.

### **Financial Implications**

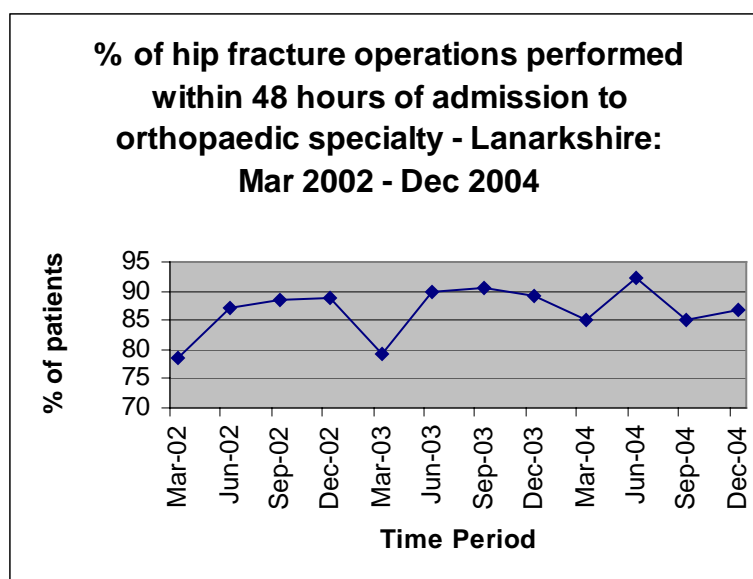
It is difficult at this stage to be precise over the financial implications of delivering the guarantee. This will be informed by the work of the Collaborative. NHS Lanarkshire will ensure effective utilization of allocations received from the National Waiting Times Unit and CCI to improve the patient journey and deliver guarantees.

Target A.07T - By end of 2007, the maximum wait for admission to a specialist unit for hip surgery following fracture will be 24 hours.

Lead: I Ross, Chief Executive, Acute Division  
R Garscadden, Head of Planning, Acute Division

### 3.10.K Hip Surgery Waiting Times over 48 hours (linked to target A.07T)

Percentage of hip fracture operations performed within 48 hours of admission to orthopaedic speciality. Data are extracted from the August 2005 version of the linked SMR01 catalogue of Inpatient and Day case admissions.



Data in above table:

Mar 02	Jun 02	Sep 02	Dec 02	Mar 03	Jun 03	Sep 03	Dec 03	Mar 04	Jun 04
78.6%	87.2%	88.5%	88.7%	79.1%	89.9%	90.7%	89.2%	85%	92.1%
Sep 04	Dec 04								
84.9%	86.8%								

NHSL Delivery Plan 2006/07:

Jan 06	Feb 06	Mar 06	Apr 06	May 06	Jun 06	Jul 06	Aug 06	Sep 06	Oct 06
70.9%	71.3%	71.7%	72.1%	72.5%	72.9%	73.3%	73.7%	74.1%	74.5%
Nov 06	Dec 06	Mar 07	Dec 07						
74.9%	75.3%	80%	100%						

## Narrative

### Objective

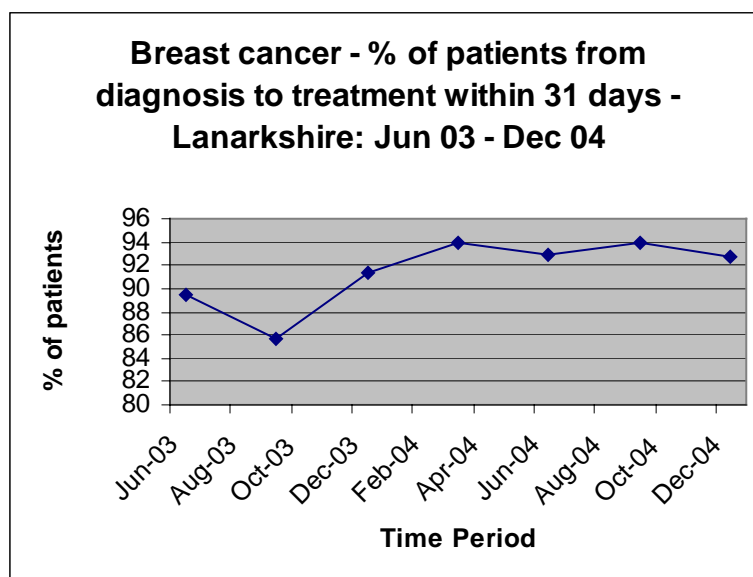
Following discussion with the National Waiting Times Unit there is a lack of clarity around the target set for hip surgery waiting times. This is shared by NHS Lanarkshire and the National Waiting Times Unit. There is work in progress to clarify the position. The projections shown reflect information provided by the Performance Directorate at Scottish Executive.

Target A.08T - Women who have breast cancer and need urgent treatment will get it within one month where appropriate.

Lead: I Ross, Chief Executive, Acute Division  
R Garscadden, Head of Planning, Acute Division

### 3.11.K Breast Cancer Waiting Times over 31 days (linked to target A.08T)

Percentage of patients diagnosed with breast cancer treated within 31 days. Data are sourced from Regional Cancer Networks.



Data in above table:

30 Jun 03	30 Sep 03	31 Dec 03	31 Mar 04	30 Jun 04	30 Sep 04	31 Dec 04
89.5%	85.7%	91.3%	94%	92.9%	94%	92.8%

NHSL Delivery Plan 2006/07:

Jan 06	Feb 06	Mar 06	Apr 06	May 06	Jun 06	Jul 06	Aug 06	Sep 06	Oct 06
92.8%	92.8%	93.8%	94.2%	94.8%	95%	95%	95%	95%	95%
Nov 06	Dec 06	Mar 07	Dec 07						
95%	95%	95%	95%						

#### Narrative

#### Objective

NHS Lanarkshire has to ensure that no patient waits longer than 31 days from diagnosis of breast cancer to first treatment.

#### Patient Benefit

The advantage to the patient is that they will be seen at an earlier date with the potential for an improved health outcome.

**Assessment**

The current compliance with this guarantee exceeds 90%. Delivery of this guarantee is linked to delivery of the sixty-two day guarantee as described in 3.12K above. Further improvement in the 31 day guarantee will follow the same delivery pathway as for 3.12K.

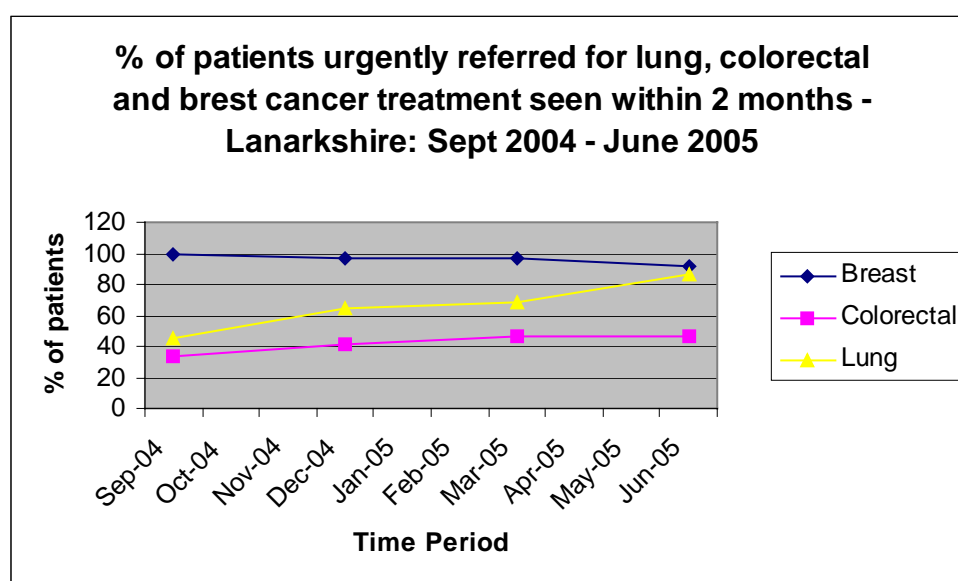
**Target A.09T - By 31 December 2005 the maximum wait from urgent referral to treatment for all cancers will be 2 months.**

*(revised target 31/1/06)*

Lead: I Ross, Chief Executive, Acute Division  
R Garscadden, Head of Planning, Acute Division

### **3.12.K Cancer Waiting Times over 2 months (linked to target A.09T)**

Percentage of patients urgently referred for lung, colorectal and breast cancer treatment seen within 2 months. This will be extended to cover an increasingly wider range of cancers as information becomes available. Data are sourced from Regional Cancer Networks.



Data in above table:

	Sep 04	Dec 04	Mar 05	Jun 05
Breast	100%	97%	97%	91%
Colorectal	33%	41%	47%	46%
Lung	45%	64%	69%	86%

NHSL Delivery Plan 2006/07:

	Jan 06	Feb 06	Mar 06	Apr 06	May 06	Jun 06
Breast	95	95	95	95	95	95
Colorectal	45.5	50	55	60	65	70
Lung	88.5	88.5	90	90	90	95
	Jul 06	Aug 06	Sep 06	Oct 06	Nov 06	Dec 06
Breast	95	95	95	95	95	95
Colorectal	80	90	95	95	95	95
Lung	95	95	95	95	95	95
	Mar 07	Dec 07				
Breast	95	95				
Colorectal	95	95				
Lung	95	95				

## Narrative

### Objective

NHS Lanarkshire has to ensure that the maximum wait from receipt of urgent GP referral to first treatment for main tumour types does not exceed sixty-two days. This guarantee was to be delivered by 31 December 2005 but (with other West of Scotland NHS Boards) was not achieved.

No revised timescale has been provided nationally although it is proposed that NHS Lanarkshire seek to comply with the guarantee for each main tumour type by September 2006. The indication is that compliance with the guarantee equates to 95% delivery.

### Patient Benefit

The advantage to the patient is that they will be seen at an earlier date with the potential for an improved health outcome.

### Position Statement

The current compliance with each of the main tumour types is:

- Breast - 90%
- Lung - 88%
- Colorectal - 45%

During 2005/06 there has been investment in clinical and support staff with procurement also of equipment to facilitate diagnosis and treatment. This has been funded by NHS Lanarkshire with financial support also from the National Waiting Times Unit. This will continue during 2006/07.

There is recognition that real time patient information is required to inform identification of 'bottlenecks' that disrupt the patient journey. Historically patient information has been gathered retrospectively by Clinical Effectiveness. Whilst that information source is crucial to improve service quality it does not inform effective management of waiting times. Additional resources have recently been invested to provide real time patient information designed to provide clinicians and managers with patient information on which discussion can take place and decisions taken to improve the patient journey.

A referral protocol has recently been agreed between primary and secondary care for each main tumour type designed to improve the referral process. This has been accompanied by encouragement to GPs to refer electronically. Further work is required to examine the whole patient journey and that will be taken forward as part of service redesign. This will link to work in progress around diagnostic services.

Lead clinicians are in place for each main tumour type. The opportunity is however being taken, as part of new management arrangements being introduced from April 2006, to reflect on the role and responsibilities of Lead Clinicians and

their engagement with the Lanarkshire Cancer Group. The focus will be on delivery of improved services on a Lanarkshire wide basis. This will include links to regional and national services.

### Risks

There are, however, risks associated with delivery of the waiting time guarantee:

- Progress in service redesign with, where required, appropriate funding (short and long term);
- Secure agreement of appropriate patient pathway and development of a capacity plan;
- Access to diagnostic services;
- Access to real time patient information to inform decision making;
- Coordinated working with regional and national networks.

### Delivery Plan

The plan proposed to respond to those risks includes:

- Introduction of new management arrangements across Lanarkshire with appointment of a General Manager and Lead Clinician for Cancer services;
- Development of the Lanarkshire Cancer Group/Collaborative to provide a single focus for taking forward different aspects of the agenda and for monitoring action and progress to include delivery of national waiting time guarantees;
- Development of a Clinical Manager to capture real time patient information;
- Mainline appointment of patient trackers for main tumour types;
- Implementation of referral protocols for each main tumour type with emphasis on electronic referral by General Practitioners;
- Improving communication links between primary and secondary care and with other agencies including patient organizations to ensure an inclusive approach;
- Strengthen links with regional and national cancer networks.

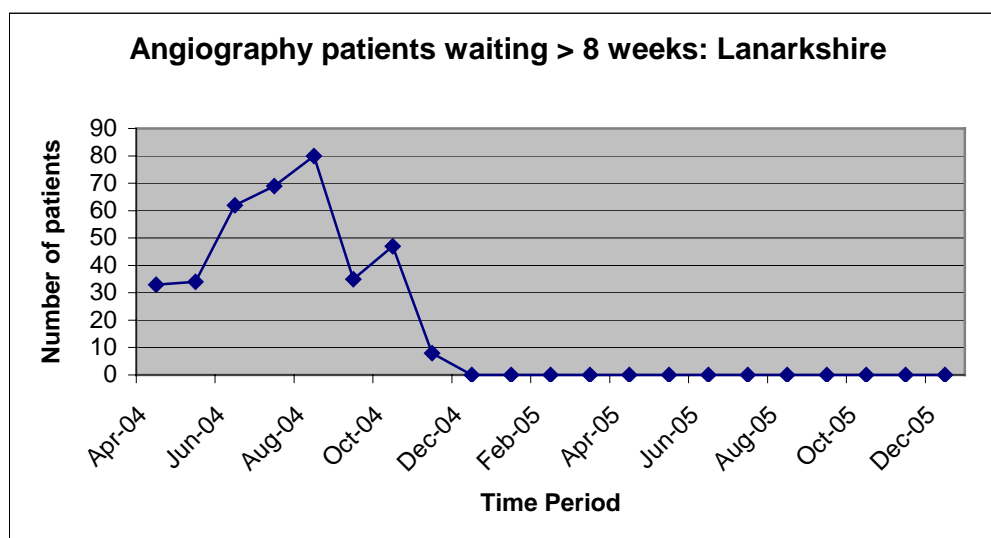
### Financial Implications

It is not possible at this stage to be precise over financial implications of delivering guarantees. The work in progress is designed to identify 'bottlenecks' through improved process that will inform future investment decisions. Monies will be allocated during 2006/07 from National Waiting Times Unit although the full detail of this is not currently available.

Target A.10T - From June 30 2004 the maximum wait from angiography to surgery or angioplasty will be 18 weeks.

Lead: I Ross, Chief Executive, Acute Division  
R Garscadden, Head of Planning, Acute Division

**3.13.K Angiography Waiting Times over 8 weeks (associated with target A.10T)**  
Angiography patients waiting longer than 8 weeks excluding ASCs. Data are sourced from Monthly Management Information.



Data in above table:

Apr 04	May 04	Jun 04	Jul 04	Aug 04	Sep 04	Oct 04	Nov 04	Dec 04	Jan 05
33	34	62	69	80	35	47	8	0	0
Feb 05	Mar 05	Apr 05	May 05	Jun 05	Jul 05	Aug 05	Sep 05	Oct 05	Nov 05
0	0	0	0	0	0	0	0	0	0
Dec 05									
0									

NHSL Delivery Plan 2006/07:

Jan 06	Feb 06	Mar 06	Apr 06	May 06	Jun 06	Jul 06	Aug 06
0	0	0	0	0	0	0	0
Sep 06	Oct 06	Nov 06	Dec 06	Mar 07	Dec 07		
0	0	0	0	0	0		

## Narrative

### Objective

NHS Lanarkshire has achieved the objective that the maximum wait for angiography and for revascularization should not exceed eight and eighteen weeks respectively by 30 June 2005.

### Patient Benefit

The advantage to the patient is that they are seen at an earlier date with the potential for an improved health outcome.

**Achievement of Guarantee**

NHS Lanarkshire developed a capacity plan for angiography and angioplasty in 2004/05 (updated in 2005/06) to identify the activity required to deliver and sustain the eight and eighteen week guarantees. This examined supply and demand. The conclusion was that there was insufficient internal capacity to deliver the guarantee. During 2004/05 internal cath lab capacity was increased by four sessions at Hairmyres Hospital to provide the additional activity to deliver the guarantee. This was achieved through permanent investment.

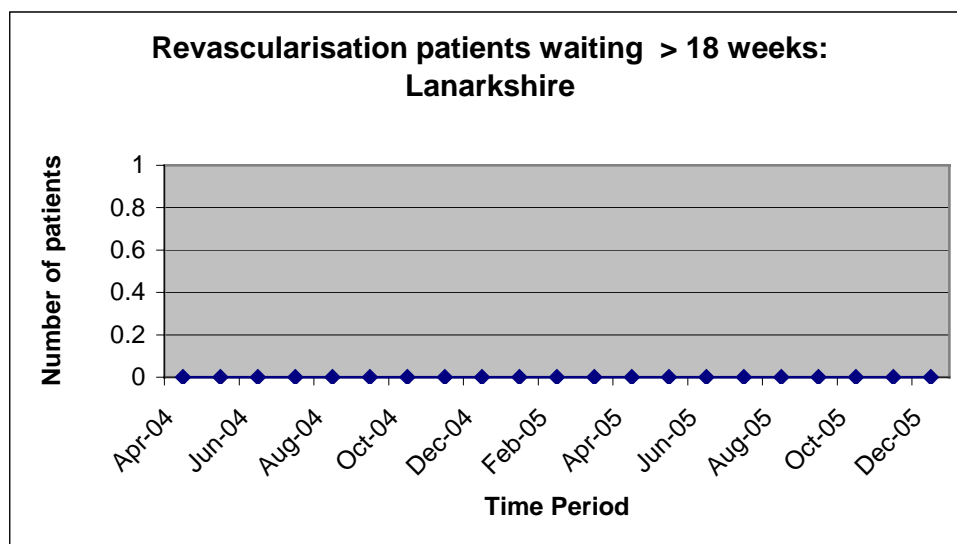
**Financial Implications 2005/06**

The financial cost of delivering the national waiting time guarantee was around £900,000.

Target A.10T - From June 30 2004 the maximum wait from angiography to surgery or angioplasty will be 18 weeks.

### 3.14.K Revascularisation Waiting Times over 18 weeks (linked to target A.10T)

Revascularisation patients waiting longer than 18 weeks excluding ASCs (includes angioplasties and CABGs). Data are sourced from Monthly Management Information.



Data in above table:

Apr 04	May 04	Jun 04	Jul 04	Aug 04	Sep 04	Oct 04	Nov 04	Dec 04	Jan 05
0	0	0	0	0	0	0	0	0	0
Feb 05	Mar 05	Apr 05	May 05	Jun 05	Jul 05	Aug 05	Sep 05	Oct 05	Nov 05
0	0	0	0	0	0	0	0	0	0
Dec 05									
0									

NHSL Delivery Plan 2006/07:

Jan 06	Feb 06	Mar 06	Apr 06	May 06	Jun 06	Jul 06	Aug 06
0	0	0	0	0	0	0	0
Sep 06	Oct 06	Nov 06	Dec 06	Mar 07	Dec 07		
0	0	0	0	0	0		

### Narrative

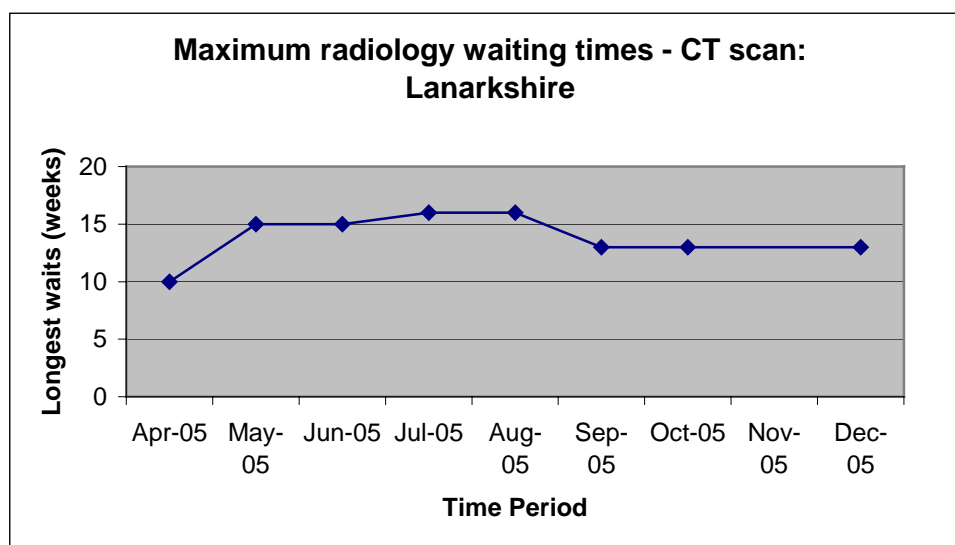
(see above, 3.13K)

Target A.12T - By the end of 2007 patients will wait no more than nine weeks for any MRI or CT scans and other key diagnostic tests.

Lead: I Ross, Chief Executive, Acute Division  
R Garscadden, Head of Planning, Acute Division

### 3.15.K Maximum Radiology Waiting Times: CT Scan (linked to target A.12T)

Longest wait for CT Scan. Data are sourced from Monthly Management Information.



Data in above table:

Apr 05	May 05	Jun 05	Jul 05	Aug 05	Sep 05
10	15	15	16	16	13
Oct 05	Dec 05				
13	13				

NHSL Delivery Plan 2006/07:

Jan 06	Feb 06	Mar 06	Apr 06	May 06	Jun 06	Jul 06	Aug 06
18	16	13	13	13	13	13	13
Sep 06	Oct 06	Nov 06	Dec 06	Mar 07	Dec 07		
12	12	12	11	11	9		

*Narrative (the undernoted narrative also applies to 3.16K below)*

#### Objective

NHS Lanarkshire has to ensure that no patient should wait no more than nine weeks for diagnostics (radiology) by 31 December 2007.

#### Patient Benefit

The advantage to the patient is that they will be seen at an earlier date with the potential for an improved health outcome.

## Assessment

It is intended to adopt a phased approach to reducing the maximum wait for radiology with a reduction spread over each of the next two calendar years. This will be facilitated by establishment of a Diagnostics Collaborative, an element of which will focus on radiology. The Collaborative will comprise colleagues from primary and secondary care with participation also by patients and public. Financial support is being provided to the Collaborative through the Centre for Change and Innovation (CCI).

The first priority will be to identify current processes and practices applied currently across Lanarkshire with a view to agreeing a preferred model for delivering future services. This will be informed by process mapping.

The new management arrangements that will be introduced from April 2006 will have a General Manager and Clinical Director with specific responsibility for radiology services on a Lanarkshire wide basis. This will provide the opportunity for delivery of consistent services based on single system working.

There has been investment in 2005/06 with the procurement of equipment to facilitate diagnosis. Further investment will be informed by the work of the Collaborative.

## Risks

There are, however, risks associated with delivery of the waiting time guarantees:

- Establishment of the Collaborative with full participation by clinical and non clinical staff;
- Agreement of the capacity plan;
- Acceptance of and engagement by clinicians in primary and secondary care to deliver consistent and improved ways of working;
- Access to funding (short and long term) to deliver the preferred model of working with sufficient capacity to deliver waiting time guarantee.

## Delivery Plan

- Establish the Diagnostics Collaborative (one element of which addresses radiology) to provide single focus for taking forward the agenda and for monitoring action and progress to include delivery of national waiting time guarantees;
- Introduction of new management arrangements with appointment of a General Manager and Clinical Director on a Lanarkshire wide basis;
- Convene a mapping event to identify current process and practice;
- Agree preferred future service model;
- Identify current capacity;
- Identify future demand based on agreed assumptions and agree capacity plan for diagnostics;
- Apply the capacity plan and confirm investment proposals.

## Financial Implications

It is not possible at present to be precise over the financial implications of delivering the guarantee. This will emerge through the work of the

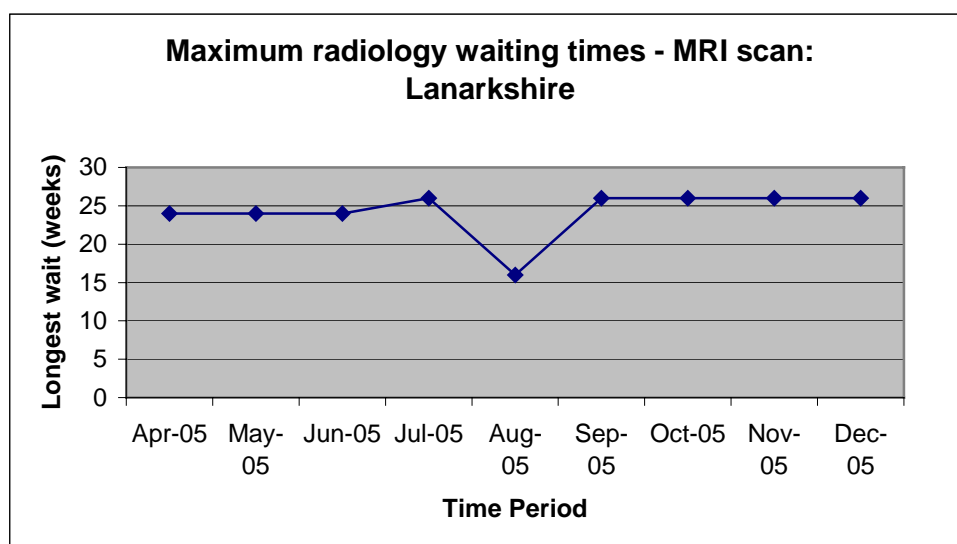
Collaborative. The opportunity will be taken to maximize funding received through the National Waiting Times Unit and CCI.

Target A.12T - By the end of 2007 patients will wait no more than nine weeks for any MRI or CT scans and other key diagnostic tests.

Lead: I Ross, Chief Executive, Acute Division  
R Garscadden, Head of Planning, Acute Division

### 3.16.K Maximum Radiology Waiting Times: MRI Scan (linked to target A.12T)

Longest wait for MRI. Data are sourced from Monthly Management Information.



Data in above table:

Apr 05	May 05	Jun 05	Jul 05	Aug 05	Sep 05
24	24	24	26	16	26
Oct 05	Nov 05	Dec 05			
26	26	26			

NHSL Delivery Plan 2006/07:

Jan 06	Feb 06	Mar 06	Apr 06	May 06	Jun 06	Jul 06	Aug 06
32	29	26	26	26	25	25	24
Sep 06	Oct 06	Nov 06	Dec 06	Mar 07	Dec 07		
24	23	23	22	18	9		

### Narrative

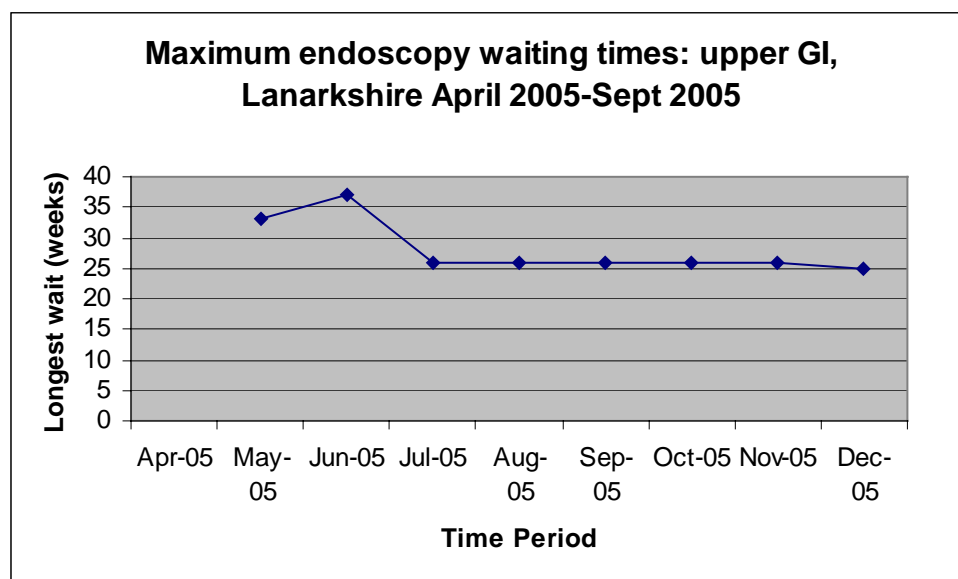
*(narrative at 3.15K above applies)*

Target A.12T - By the end of 2007 patients will wait no more than nine weeks for any MRI or CT scans and other key diagnostic tests.

Lead: I Ross, Chief Executive, Acute Division  
R Garscadden, Head of Planning, Acute Division

### 3.17.K Maximum Endoscopy Waiting Times: Upper GI endoscopy (linked to target A.12T)

Longest wait for upper GI endoscopy. Data sourced from Monthly Management Information.



Data in above table:

Apr 05	May 05	Jun 05	Jul 05	Aug 05	Sep 05
0	33	37	26	26	26
Oct 05	Nov 05	Dec 05			
26	26	25			

NHSL Delivery Plan 2006/07:

Jan 06	Feb 06	Mar 06	Apr 06	May 06	Jun 06	Jul 06	Aug 06
26	26	26	26	25	24	23	22
Sep 06	Oct 06	Nov 06	Dec 06	Mar 07	Dec 07		
21	20	19	18	15	9		

*Narrative (the undernoted narrative also applies to 3.18K below)*

#### Objective

NHS Lanarkshire has to ensure that no patient should wait no more than nine weeks for diagnostics (endoscopy) by 31 December 2007.

#### Patient Benefit

The advantage to the patient is that they will be seen at an earlier date with the potential for an improved health outcome.

## Assessment

It is intended to adopt a phased approach to reducing the maximum wait for an endoscopy with a reduction spread over each of the next two calendar years. This will be facilitated by establishment of a Diagnostics Collaborative, an element of which will focus on endoscopy. The Collaborative will comprise colleagues from primary and secondary care with participation also by patients and public. Financial support is being provided to the Collaborative through the Centre for Change and Innovation (CCI).

The first priority will be to identify current processes and practices applied currently across Lanarkshire with a view to agreeing a preferred model for delivering future services. This will be informed by process mapping.

The new management arrangements that will be introduced from April 2006 will have a General Manager and Clinical Director with specific responsibility for endoscopy services on a Lanarkshire wide basis. This will provide the opportunity for delivery of consistent services based on single system working.

There has been investment in 2005/06 with the appointment of additional nurse endoscopists and procurement of diagnostic equipment. Further investment will be informed by the work of the Collaborative.

## Risks

There are, however, risks associated with delivery of the waiting time guarantees:

- Establishment of the Collaborative with full participation by clinical and non clinical staff;
- Agreement of the capacity plan;
- Acceptance of and engagement by clinicians in primary and secondary care to deliver consistent and improved ways of working;
- Access to funding (short and long term) to deliver the preferred model of working with sufficient capacity to deliver waiting time guarantee.

## Delivery Plan

- Establish the Diagnostics Collaborative (one element of which addresses endoscopy) to provide single focus for taking forward the agenda and for monitoring action and progress to include delivery of national waiting time guarantees;
- Introduction of new management arrangements with appointment of a General Manager and Clinical Director on a Lanarkshire wide basis;
- Convene a mapping event to identify current process and practice;
- Agree preferred future service model;
- Identify current capacity;
- Identify future demand based on agreed assumptions and agree capacity plan for diagnostics;
- Apply the capacity plan and confirm investment proposals.

## Financial Implications

It is not possible at present to be precise over the financial implications of delivering the guarantee. This will emerge through the work of the

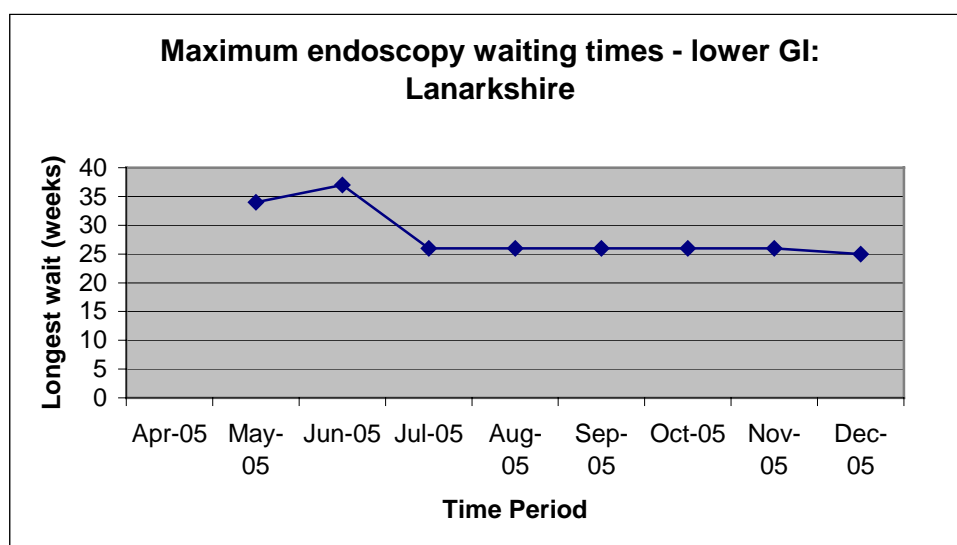
Collaborative. The opportunity will be taken to maximize funding received through the National Waiting Times Unit and CCI.

Target A.12T - By the end of 2007 patients will wait no more than nine weeks for any MRI or CT scans and other key diagnostic tests.

Lead: I Ross, Chief Executive, Acute Division  
R Garscadden, Head of Planning, Acute Division

### 3.18.K Maximum Endoscopy Waiting Times: Lower GI endoscopy and colonoscopy (linked to target A.12T)

Longest wait for lower endoscopy or colonoscopy. Data sourced from Monthly Management Information.



Data in above table:

Apr 05	May 05	Jun 05	Jul 05	Aug 05	Sep 05
0	34	37	26	26	26
Oct 05	Nov 05	Dec 05			
26	26	25			

NHSL Delivery Plan 2006/07:

Jan 06	Feb 06	Mar 06	Apr 06	May 06	Jun 06	Jul 06	Aug 06
26	26	26	26	25	24	23	22
Sep 06	Oct 06	Nov 06	Dec 06	Mar 07	Dec 07		
21	20	19	18	15	9		

**Narrative**

*(covered in narrative for 3.17K above)*

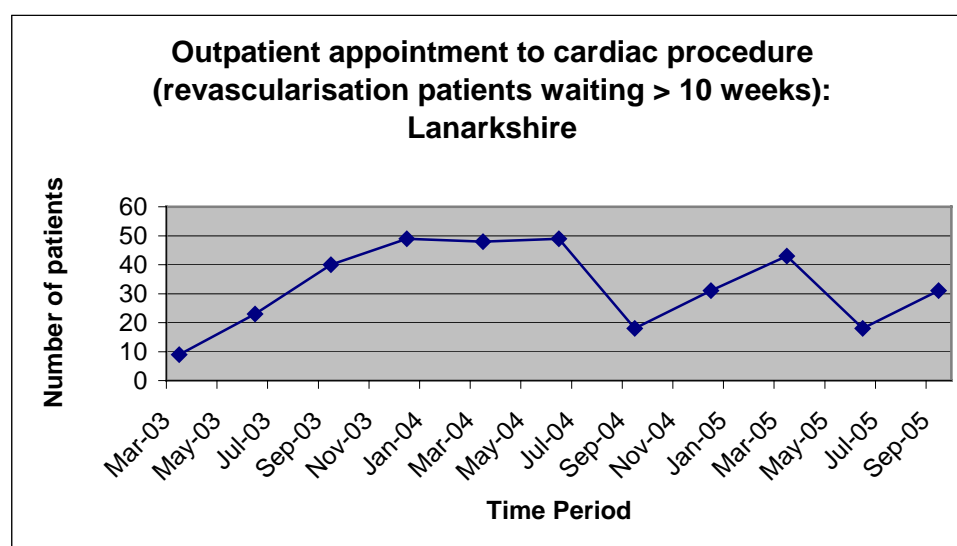
Target A.11T - By end 2007, the maximum wait for cardiac intervention will be 16 weeks from GP referral through rapid access chest pain clinic or equivalent.

Target A.13T - From the end of 2007, no patient will wait more than 16 weeks for treatment after they have been seen as an outpatient by a heart specialist and the specialist has recommended treatment.

Lead: I Ross, Chief Executive, Acute Division  
R Garscadden, Head of Planning, Acute Division

### 3.19.K Outpatient Appointment To Cardiac Procedure (linked to target A.11T & A.13T)

In the absence of total journey information, the numbers waiting over 10 weeks from date added to waiting list for a revascularisation procedure is used. Data are sourced from SMR3 records.



Data in above table:

Mar 03	Jun 03	Sep 03	Dec 03	Mar 04	Jun 04	Sep 04	Dec 04	Mar 05	Jun 05
9	23	40	49	48	49	18	31	43	18
Sep 05									
31									

NHSL Delivery Plan 2006/07 - 2008/09:

Jan 06	Feb 06	Mar 06	Apr 06	May 06	Jun 06	Jul 06	Aug 06
23	22	21	20	19	18	17	16
Sep 06	Oct 06	Nov 06	Dec 06	Mar 07	Dec 07		
15	14	13	12	10	0		

## Narrative

### Objective

Following discussion with the National Waiting Times Unit there is a lack of clarity around the target set for outpatient appointment to cardiac procedure. This is

shared by both NHS Lanarkshire and the National Waiting Times Unit. There is work in progress to clarify the position. The projections shown reflect information provided by the Performance Directorate at Scottish Executive.

## NHS Scotland Objective 4:

Treatment Appropriate to Individuals: ensure patients receive high quality services that meet their needs.

Target No.	Target
T.01T	We will reduce the number of people waiting to be discharged from hospital into a more appropriate care setting by 20% year on year between 2005 and the end of 2008, cutting to a minimum the number of people waiting more than 6 weeks to be discharged.
T.02T	By 2008-09, we will reduce the proportion of older people (aged 65+) who are admitted as an emergency inpatient 2 or more times in a single year by 20% compared with 2004/05.
T.03T	Cervical screening target 80%, ongoing
T.04T	QIS clinical governance and risk management standards improving

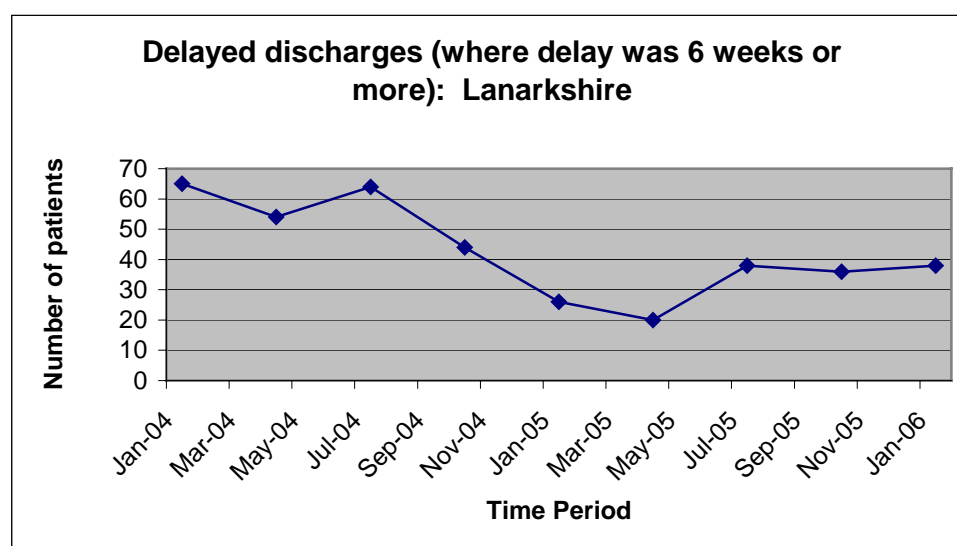
**Target T.01T - We will reduce the number of people waiting to be discharged from hospital into a more appropriate care setting by 20% year on year between 2005 and the end of 2008, cutting to a minimum the number of people waiting more than 6 weeks to be discharged.**

*(New SEHD guidance dated 23/02/06 sets a target of 50% reduction in 2006/07, and to zero by 2007/08)*

**Lead:** I Ross, Chief Executive, Acute Division / C Sloey, Chief Executive Primary Care Division  
R Garscadden, Head of Planning, Acute Division / Roy Watts, Head of Planning, Primary Care Division

#### **4.01.K Delayed Discharges over 6 weeks (linked to target T.01T)**

Patients experiencing a delay in discharge where the delay was 6 weeks or more. Data are sourced from the Delayed Discharge Census.



Data in above table:

15 Jan 04	15 Apr 04	15 Jul 04	15 Oct 04	15 Jan 05	15 Apr 05
65	54	64	44	26	20
15 Jul 05	15 Oct 05	15 Jan 06			
38	36	38			

Provisional NHSL Delivery Plan 2006/07 - 2008/09:

*(based on new SEHD guidance of 23/02/06 - see narrative below)*

January 06	38
50% reduction by March 07	19
Zero by March 2008	0

#### **Narrative**

#### **Objective**

NHS Lanarkshire has to ensure that for 2006/07 it has to reduce all delayed discharge delays over six weeks by 50% and to free up 50% of all beds occupied by delayed discharge patients in short stay beds. In 2007/08, the NHS Board has to

reduce to zero, patients delayed over six weeks and reduce to zero those delayed in short stay beds. Those guarantees have been received from the Scottish Executive in correspondence dated 23 February 2006.

### **Assessment**

There are currently 38 delayed discharge patients waiting over six weeks. Further discussion is required with the Scottish Executive from what point the 50% should apply, and over its definition of short stay beds.

The total number of delayed discharges across Lanarkshire is 101. This is in line with the level achieved at April 2005 although exceeds the guarantee identified for April 2006. The Lanarkshire Partnership however remains a high performer in relation to the number of delayed discharges when compared with other Partnerships across Scotland.

### **Next Steps**

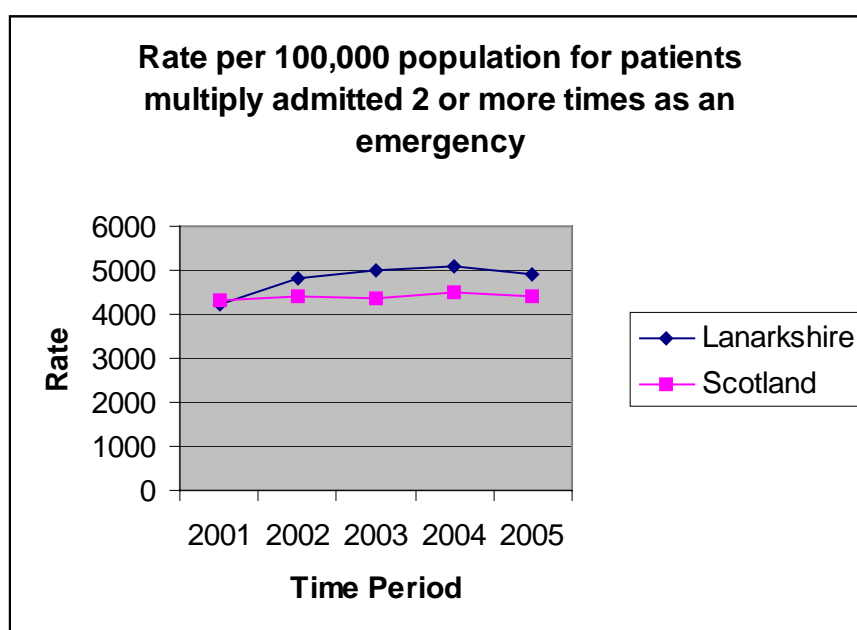
Discussions will be initiated with the Scottish Executive to understand fully the detail of the new guarantees and its implications for the Lanarkshire Partnership. This will include identification of risks and financial implications. It will also inform the delivery plan.

Target T.02T - By 2008-09, we will reduce the proportion of older people (aged 65+) who are admitted as an emergency inpatient 2 or more times in a single year by 20% compared with 2004/05.

Lead: C Sloey, Chief Executive, Primary Care Division  
A Armstrong, Associate Nurse Director

#### 4.02K Emergency Re-admissions (aged 65+) (linked to target T.02T)

Rate of emergency re-admissions per 100,000 pop (aged 65+). Data are sourced from SMR01 records. (Rate changed from 3+ per annum to 2+ per annum, SEHD guidance, 31/1/06)



Data in above table:

	31 Mar 2001	31 Mar 2002	31 Mar 2003	31 Mar 2004	31 Mar 2005
Lanarkshire	4223.18	4833.36	5008.01	5076.23	4910.19
Scotland	4297.27	4405.33	4367.69	4497.70	4426.57

*Boards requested to complete planned levels to March 09, to improve on current position with respect to national average.*

NHSL Delivery Plan 2006/07 - 2008/09:

31 March 2006	31 March 2007	31 March 2008	31 March 2009
4910	4910	4861	4813

*Note:*

*The above figures are estimates only. The pilot projects described below will only start in 2006, and cover 3 localities. They need to be proven, and then rolled out to the rest of NHS Lanarkshire. Roll out will likely be in 2007, and so it is unlikely that there will be any discernable impact until 2008 at the earliest. Therefore, we are estimating no change in 2006 and 2007, and a 1% reduction*

*each year in 2008 and 2009. These estimates will be refined in the light of the outcome of the pilot projects in 2006.*

## Narrative

### What is the Problem?

The links between deprivation and ill health are well recognised. Lanarkshire has some of the worst levels of deprivation and ill health within Scotland. This is evidenced in national data such as the Standard Ratio of Not Good General Health (SHR), which is 22% higher than the national average, whilst the Standardised Ratio of Limiting Long Term Illness (SIR) is 14% higher than the rest of Scotland.

Building a Health Service Fit for the Future (Scottish Executive, 2005) estimated that 215,000, or 40%, of the people in Lanarkshire are living with a long-term condition. The Department of Health's Health & Social Care Model identifies that 5% of people with a long-term condition will have complex rapidly changing needs. It is therefore estimated that up to 10,000 people in Lanarkshire have long-term conditions with complex rapidly changing needs. Approximately 1,700 will be over the age of 75 years.

Inevitably a number of these patients may have 2 or more emergency inpatient admissions in a single year.

### How are we tackling it?

To address this NHS Lanarkshire will undertake a proactive approach to care provision as detailed below:

- A partnership approach to Care Management with North and South Lanarkshire Councils will be piloted in Coatbridge, East Kilbride and Clydesdale. The pilot will target people over the age of 75 living at home with long-term conditions that have complex rapidly changing needs. The aim being to improve the management of their condition enabling them to continue to be cared for in the community. It is anticipated that this approach will reduce the need for emergency admissions to hospital. To achieve this, staff undertaking Care Management within the pilot locations will continue to have direct access to Home Care and equipment, as well as the introduction of rapid access to diagnostics via day hospitals. A full evaluation of the Care Management approach will be undertaken and implemented across NHS Lanarkshire based on a positive outcome;
- The Care Home Liaison Service will continue to support Care Homes to reduce the number of unnecessary admissions from the Care Homes sector;
- The Out of Hours Community Nursing Service will continue to develop links with Home Care and the Scottish Ambulance Service to support vulnerable elderly people within the community, reducing unnecessary admissions to hospital;

- Given the strong links between deprivation and poor health, a GP alignment model for the allocation of District Nursing will be implemented. This will enable the District Nursing Service to focus on people with the greatest need with a view to maintaining their care within the community;
- A proactive approach to case finding and care provision will be piloted and evaluated as part of the national Prevention 2010 Project.

### **Expected Outcomes**

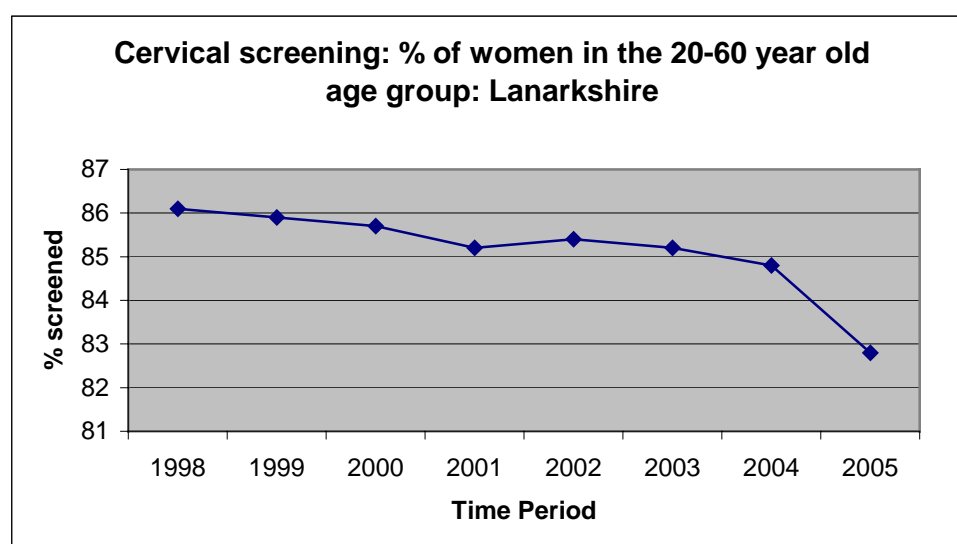
NHS Lanarkshire expects that the range of activities described above, designed to identify those most at risk and ensure that they have prompt and effective interventions in the community, will, when they are fully implemented, reduce unnecessary admissions to hospital.

Target T.03T - Cervical screening target 80%, ongoing
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Lead: D C Moir, Director of Public Health  
J Darnborough, Consultant in Public Health Medicine

#### 4.03.K Cervical Screening (linked to target T.03T)

Percentage of women in the 20-60 year old age group attending for screening within a 5 year period. Data are sourced from ISD (D) 4.



Data in above table:

31 Mar 98	31 Mar 99	31 Mar 00	31 Mar 01	31 Mar 02	31 Mar 03	31 Mar 04
86.1%	85.9%	85.7%	85.2%	85.4%	85.2%	84.8%
31 Mar 05						
82.8						

NHSL Delivery Plan 2006/07 - 2008/09:

Expected uptakes at:

31 March 2006	31 March 2007	31 March 2008
In excess of 80%	In excess of 80%	In excess of 80%

## Narrative

### What is the Problem?

By ensuring that all eligible women take advantage of screening by optimising screening uptake, it is expected that this would lead to early detection and treatment of abnormalities, thus reducing mortality and morbidity related to cervical cancer.

Lanarkshire is currently meeting the target for screening uptake, however the trend has been downwards both locally and nationally in recent years, allowing no room for complacency. Although it is anticipated that the 80% target will continue to be reached (based on the uptake over the preceding 5 year period), it is possible that the slight but constant falling trend both nationally and locally will

continue to be observed. It will be difficult to predict the impact of the GMS contract in future years, but in the first year of its introduction, it appears to be making a further contribution to the decline in uptake both nationally and locally for cervical screening.

### **How are we tackling it?**

We are continuing to meet the essential NHS QIS criterion on uptake:

1. The Cervical Screening Uptake Subgroup (of the Lanarkshire Cervical Screening Working Group) is looking at uptake by GP practice in order to identify variations at local level and to offer targeted support where DNAs are highest. There is Public Health Practitioner involvement in this work. Work is underway with the learning disability service to ensure that community learning disability nursing staff have the appropriate training and resources to adequately support breast and cervical cancer screening in their client group.
2. A 3-year Big Lottery project recruited staff in December 2005, comprising 2 community health educators. One will work with minority ethnic groups and one in regeneration areas, using a community development approach to exploring and identifying cultural and social factors that might be acting as barriers to uptake.

As noted above, uptake levels may be influenced by the new GP contract which was introduced in April 2004, and which specifies a target range of between 25% and 80%. Thus, practices attaining 80% achieve maximum points for the uptake aspect of screening and have limited incentive to move above this and pursue recurrent defaulters. This is being monitored closely.

Introduction of a new centralised call/recall system for cervical screening across Scotland (Scottish Cervical Call Recall System, SCCRS) will standardise procedures, allow easy audit of and access to data and reduce administration associated with cervical screening. While this is nationally funded, there are some local costs to be met in relation to ensuring adequate IT capacity/access by all smear takers to the SCCRS system which requires networked PC and printer access. The need is greatest locally within Family Planning Services.

### **Expected outcome**

It is expected that levels will be maintained above the target of 80%. Since this is in line with current uptake, there will be no discernable impact upon life expectancy from the status quo.

Target T.04T - QIS clinical governance and risk management standards improving.

Lead: J D Browning, Medical Director

#### 4.04K QIS Standards Improving (linked to target T.04T)

Measurement for this proxy indicator is based on the sum of the scores for the 3 standards within the QIS Clinical Governance and Risk Management assessment.

*(Insufficient data to produce a graph of recent performance in relation to this measure).*

NHSL Delivery Plan 2006/07 - 2008/09:

2005/06	2006/07	2007/08	2008/09
7	8	9	10

## Narrative

### What is the Problem?

Services delivered to the people of Lanarkshire must be clinically effective, with risk adequately managed. An Interim Review of healthcare governance was undertaken by QIS early in 2005. While this demonstrated progress, there were elements requiring further work. The new (October 2005) QIS Standards on Clinical Governance and Risk Management build upon previous QIS guidance, and NHS Lanarkshire will be assessed against these Standards during 2006. Work is on-going towards full compliance in 2008/09.

### How are we tackling it?

Within NHS Lanarkshire, clinical effectiveness and risk management are being brought together within a single-system Clinical Governance Department under the leadership of the Director of Clinical Governance.

Work on action planning following the interim review of healthcare governance is being subsumed within the project team which is taking forward action planning required in relation to the recently published NHS QIS Clinical Governance and Risk Management Standards targeted at ensuring as full compliance as can be achieved by the NHS QIS review date for NHS Lanarkshire of 6 September 2006. The project group is led by the NHS Lanarkshire Medical Director, but will be taken over by the Director of Clinical Governance when appointed.

The new standards of:

- Safe and Effective Care and Services
- The Health, Wellbeing and Care Experience
- Assurance and Accountability

do not coincide exactly with the headings within the Interim Review of:

- Clinical Governance
- Risk Management
- Single System Working

The details, however, of the new standards and the associated self-assessment documentation will cover fully the issues within the Interim Review which were flagged as requiring attention.

**Expected outcome**

In light of work undertaken to date, and that currently underway, we expect to achieve the ratings set out above in each of the forthcoming years.