

LOCAL DELIVERY PLAN 2007/08

1. Scottish Executive guidance on completion of the 2007/08 Local Delivery Plan was issued during November and December 2006, requesting that Plans be prepared and submitted in the required format by 16 February 2007.
2. NHS Lanarkshire's draft Plan was considered at the Board meeting of January 24 2007, and in more detail at the Performance Management Group meeting of 25 January 2007.
3. The Final Draft was completed in line with Performance Management Group requirements and submitted by the due date of 16 February.
4. During the period to 22 March, a number of queries and requests for more information were received from Policy Leads at the Scottish Executive Health Department. These have all been responded to, with brief details summarised below:

Target	Topic	Change
H06T	Suicide	Additional information provided in narrative
E04T	CHI	Modest adjustment to trajectory for 2007; additional information provided in narrative
A01T	48 hour access	Additional information provided in narrative
T05T	Anti-depressants	Additional information provided in narrative
T06T	Psychiatric re-admissions	Additional information provided in narrative
T07T	HAI	Additional information provided in narrative

5. Following application of the above changes, attached is the final version of the Local Delivery Plan 2007/08. This is now with Scottish Executive Health Department for final sign off which we understand will be completed very soon.

MARTIN F HILL
MODERNISATION DIRECTOR
(STRATEGIC PLANNING AND PERFORMANCE MANAGEMENT)

NHS LANARKSHIRE LOCAL DELIVERY PLAN 2007/08 – 2009/10**Contents:**

Introduction	2
Objective 1 – Health Improvement (8 key targets)	3
Target H01T – CHD mortality	4
Target H02T – Smoking	6
Target H03T – Alcohol	8
Target H04T – Physical activity	10
Target H05T – Childhood vaccinations	12
Target H06T – Suicide	14
Target H07T – Teenage pregnancy	17
Target H08T – 5 year olds without dental disease	20
Objective 2 – Efficiency & Governance (3 key targets)	21
Target E01T – Operate within RRL	22
Target E02T – Sickness absence & productivity (day cases)	23
Target E04T – Universal use of CHI	27
Objective 3 – Access to Services (9 key targets)	28
Target A01T – 48 hour access	29
Target A03T – Inpatient / day case waits – 18 weeks, ASCs	31
Target A04T – Outpatient waits – 18 weeks	35
Target A05T – 4 hours in A&E	37
Target A06T – Cataract waits – 18 weeks	40
Target A07T – Hip fracture waits – 24 hours	43
Target A08T – Cancer waits – 62 days / 31 days	45
Target A11T – Cardiac intervention within 16 weeks	49
Target A12T – Diagnostic tests – 9 weeks	52
Objective 4 – Treatment appropriate to individuals (7 key targets)	56
Target T01T – Delayed discharges	57
Target T02T – 65+ emergency re-admissions and inpatient bed days	59
Target T03T – Cervical screening	63
Target T04T – QIS Clinical Governance & Risk Management	65
Target T05T – Anti-depressants	66
Target T06T – Psychiatric re-admissions	68
Target T07T – HAI	70

Introduction

This is NHS Lanarkshire's second Local Delivery Plan, developed in line with Scottish Executive Health Department guidance of November and December 2006. It covers the 3-year period from 2007/08 to 2009/10 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 four objectives, 27 of which are applicable to NHS Lanarkshire.

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

- o the Target;
- o its performance measure;
- o NHS Lanarkshire recent past performance;
- o NHS Lanarkshire planned performance trajectories to 2009/10;
- o a brief explanatory narrative outlining key actions, risks, and risk management.

In addition, there is a separate Excel finance schedule expanding the details summarised at Target E01T.

Each section of this Plan has been completed and signed off by its named lead Executive, involving other key partners and colleagues as appropriate. The overall delivery of individual targets will be underpinned by achievement of strategic corporate objectives including:

- o Implementation of the framework for service change - *A Picture of Health*;
- o Pay modernisation;
- o Workforce Plan;
- o Regional planning;
- o Financial Recovery Plan;
- o On-going development of single system working.

Local performance management arrangements were reviewed during 2006/07, resulting in the establishment of a Board Performance Management Group that receives monthly reports in line with the Citistat approach. NHS Lanarkshire will continue to develop systems during 2007/08 and welcomes the opportunity to participate in the national pilot of the Citistat model later in 2007.

NHS Scotland Objective 1:

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

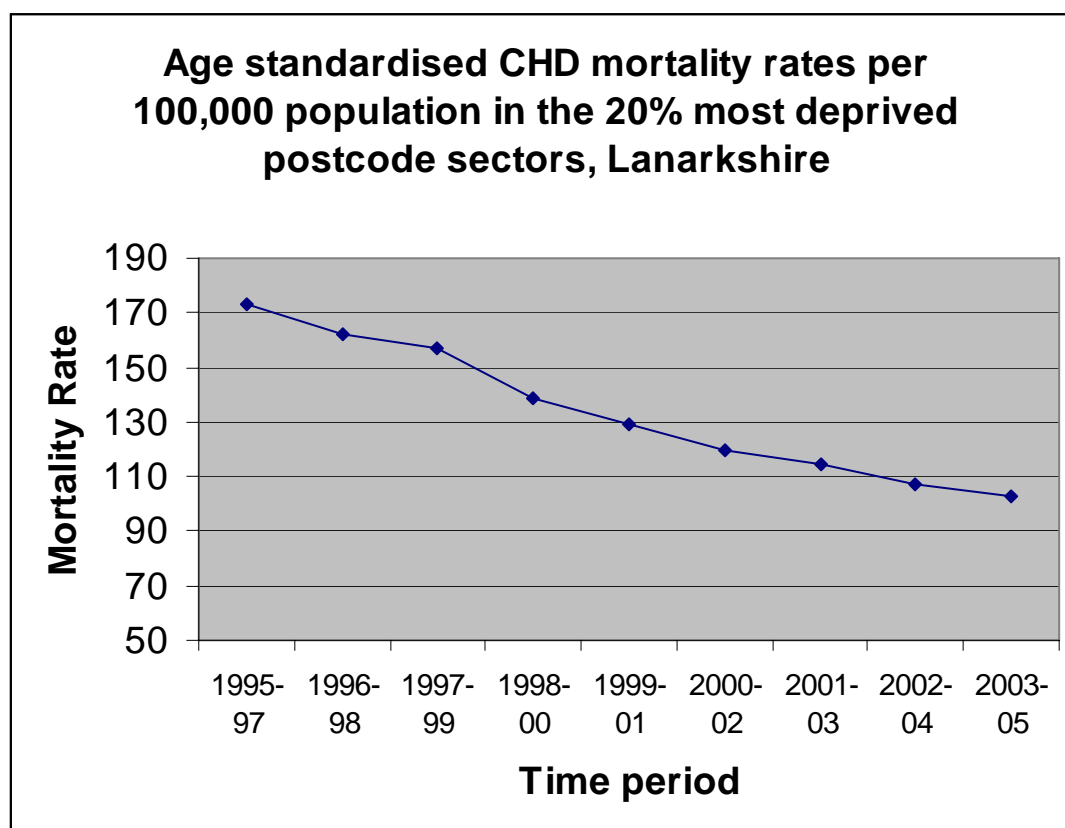
Target Identifier	Target Details
H.01T	Reduce health inequalities by increasing the rate of improvement for the most deprived communities by 15% across a range of indicators including; CHD, cancer, adult smoking, smoking during pregnancy, teenage pregnancy and suicides in young people: target date 2008.
H.02T	To reduce adult (16+) smoking rates from 26.5% (2004) to 22.0% (2010).
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
H.08T	60% of 5 year old children (primary 1) will have no signs of dental disease by 2010

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.
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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)

Age standardised CHD Mortality Rate (per 100,000 population), for people aged under 75, in the 20% most deprived postcode sector areas in Scotland, defined by the Carstairs Deprivation Index. Source: GROS and SEHD (ASD). (*Amended by SEHD letter dated 16 January 2007 from R Williams*)



Trajectory 2004/06 – 2008/10:

2002-04	2003-05	2004-06	2005-07	2006-08	2007-09	2008-10
107.1	102.8	96.6	90.4	84.3	78.1	78.1

Mortality Rate in Most Deprived Quintile, NHSL

Narrative:

Objective

The objective is to increase by 15% the rate of improvement in mortality rates from CHD in Lanarkshire's most deprived quintile.

Actions

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.

Keep Well (the Prevention 2010 Initiative), together with the Lanarkshire CHD MCN, is engaging with deprived communities and is identifying more people with CHD, or that are at high risk of developing it, to adopt a more structured approach to their management. Additional nursing staff and health care assistants have been appointed to case find, assess, advise, refer people to other services, monitor progress and follow up as necessary. Additional medical staff have been appointed to assess, diagnose, and organise treatment for people with CHD and/or at risk factors. With this additional staffing input, practices in deprived areas of Lanarkshire are now adopting a more anticipatory approach to care of people with CHD than would otherwise be possible.

Further data will become available from Keep Well during 2007 and will allow plans to be refined and developed.

In the longer term, social and economic change as part of Regeneration Outcome Agreements in both local authority areas are expected to make a positive contribution to this target.

Risks & Risk Management

There are two main areas of risk:

- Prescribing costs will increase due to likely increased use of statins, and this will require to be managed;
- Entrenched lifestyle behaviours may mean that some clients do not wish to modify their habits, and will need more tailored approaches to successfully influence the desired changes and achieve compliance.

Costs

The Keep Well initiative is fully funded as part of the national pilot programme. Prescribing costs will require to be closely monitored and managed. NHS Lanarkshire allocates a proportion of its health improvement funds via Regeneration Partnerships.

H.02T	To reduce adult (16+) smoking rates from 26.5% (2004) to 22.0% (2010).
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(In a separate letter dated 17/1/06, the Minister confirmed individual NHS Board targets. The NHSL target is to reduce from 28.8% in 2004 to 23.9% in 2010).

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)

Numbers smoking as a % of relevant (16+ years) population.

(There is no historical chart as previous definition was 16-64 years)

Trajectory 2006 – 2010:

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

Narrative:

Objective

The objective is to reduce the percentage of the adult population smoking to 23.9% by 2010. This will be achieved by a combination of (a) helping current smokers to quit and (b) discouraging people from starting.

Actions

Key actions by NHSL include:

- Development of an NHS Lanarkshire smoking cessation service, providing specialist support to help people quit;
- Research into the barriers to using smoking cessation services for vulnerable groups – adults in deprived areas, pregnant women, children and young people - providing indicators for potential action to be implemented in 2007/08;
- Tobacco Control Strategy being developed, incorporating education and communication plans;
- Brief intervention training provided to staff in South Lanarkshire Council;
- Part of the 'Keep Well' project in North Lanarkshire will identify people at risk of CHD, including smokers, and will encourage attendance at smoking cessation groups;
- Implementation of a strategy to signpost people referred to hospital outpatients and who are smokers, to target them with information and encouragement to attend smoking cessation groups;
- Health Promotion programmes incorporating smoking / health messages, e.g., SHAW, Health Promoting Schools, Smokebusters;
- Community Planning Regeneration Outcome Agreements / Healthy Living Initiatives include a variety of projects and activities designed to bring about life circumstances and lifestyles changes, including tackling smoking;
- Pilot of a Smoke Free Homes Initiative in one of our most deprived communities, as part of Regeneration Area work;

- Joint work with both local authorities to maximise impact of Joint Health Improvement Plan opportunities to tackle smoking in communities.

Risks & Risk Management

There are two main areas of risk:

- First, measurement data frequency and quality. The Scottish Household Survey is annual, with an 18 month time lag, therefore we do not know how well/badly we are doing until a year or so after the period in question. The survey itself is a sample of the population, is voluntary, and is based on self-reports, therefore caution must be exercised in its interpretation. NHSL is developing proxy measures related to local actions (e.g., numbers going through smoking cessation services) as a means of assessing progress locally and more frequently, although some people need more than one quit attempt.
- The decision to smoke is rooted within wider socio-economic and cultural factors, and is linked to wider life circumstances that informed lifestyle choices and behaviours. NHS Lanarkshire is only one influencing factor, with wider community planning partners, and in particular regeneration programmes, playing a significant role in lifting our most deprived communities out of the cycle of deprivation.

Costs

The smoking cessation service is fully funded. NHS Lanarkshire contributes a proportion of its health improvement budget to Regeneration Programmes and Healthy Living Initiatives in each Community Planning Partnership.

H03T	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.
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Lead: D C Moir, Director of Public Health
P Wraight, Development Officer

1.05S Numbers drinking excessively (linked to target H03T)

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

(SEHD has clarified (12/12/06) that there is no requirement to produce either a forward trajectory or a narrative for this target in the 2007/08 LDP. Although this remains a key target, the measure is supplementary, and will not be monitored as part of the national HEAT system. The last Scottish Health Survey was conducted in 2003. It is understood that it is currently under review nationally and that the next survey is due to commence in 2008. The narrative below has been prepared for this local version of the LDP, recognising that this remains a key target, albeit without a key measure.)

Narrative:

Objective

The objective is to work towards reducing the proportion of the Lanarkshire population who are drinking above the recommended weekly levels.

Actions

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 figures provided by the Scottish Health Survey should be viewed with some caution as confidence is low due to the small sample size. Nevertheless, they indicated that in Lanarkshire in 2003, 30% of men and 12% of women were drinking in excess of recommended weekly limits, with 6% and 1% respectively drinking at levels of over double the recommended weekly limits. 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.

What specific actions is NHSL taking to address the problem and meet targets?

NHS Lanarkshire is a strategic partner in the Lanarkshire Alcohol & Drug Action Team and directly supports the specialist Lanarkshire Alcohol & Drugs Service. The ADAT includes Local Authority, police, and non-statutory agencies to provide the strategic oversight of services for those with alcohol (and drug) problems. The responsibility for these services lies with Community Health Partnerships, with Joint Future Community Planning structures and with Community Safety Partnerships. NHS Lanarkshire both directly and via the GMS contract provides primary care and acute health services to those suffering alcohol related illness. Via CHPs, NHS Lanarkshire provides Health Promotion services in relation to alcohol problems; and supports health initiatives such as Keep Well, aimed at reaching individuals to provide lifestyle advice and health interventions in relation to alcohol and other issues.

What actions by other agencies will impact on meeting the targets?

Much NHS work is after the event – dealing with the consequences of excessive alcohol consumption. However, many of the factors influencing alcohol consumption lie outwith the NHS remit. International evidence favours policies that challenge the availability of alcohol – taxation and licensing.

NHS Lanarkshire is a partner in the Lanarkshire ADAT and in Community Safety Partnerships supporting initiatives such as Street Base (targeted at young people) to promote individual and community wellbeing.

What other factors will impact on meeting the targets, e.g., smoking ban; rise in taxation on alcohol?

Interestingly the promotion of Public Health is adopted as one of the guiding principles of the new Licensing Act. NHS Lanarkshire will play its part with Licensing Boards and other ADAT partners to curb the availability of alcohol, especially to young people. In addition, it may be that the smoking ban will encourage less drinking.

We also need to support the training of health and other frontline staff and raise the awareness of SIGN and QIS (HTBS) guidance and advice.

Risks & Risk Management

The extent of the problem is possibly not fully reflected in the Scottish Health Survey results, notwithstanding that they are now some 3 years old. For example, alcohol related discharges are 5.8 times greater in the most deprived 20% when compared with the least deprived quintile. Lanarkshire has a significant proportion of its population in deprived areas. In the past 5 years, the proportion of alcohol-related hospital discharges in Lanarkshire has risen from 4% to 5% for males and from 1% to 2% for females. In numbers terms this equates to a 25% increase for males and a 16% increase for females. The lack of information to demonstrate progress against this target is disappointing. The

Scottish Health Survey will not be repeated until 2008 and in the meantime, short of conducting our own survey at considerable expense, there is no way of knowing whether we are progressing towards the target or not.

Tackling excessive drinking is a society wide problem, and its solutions lie beyond the NHS. For example, international evidence has shown that taxation and licensing law stand the best chance of influencing changes in behaviours. NHS Lanarkshire will continue to use its community planning partnership structures to influence social, political and legislative processes, and to support improvement of life circumstances through Regeneration Programmes and associated work in our most deprived communities.

Costs

NHS services are funded from core budgets. Health Improvement fund monies are allocated via Regeneration Partnerships and Community Safety Partnerships to a variety of projects that are expected to have an impact on health and well-being including alcohol.

H04T	50% of all adults (aged 16+) accumulating a minimum of 30 minutes per day of physical activity on 5 or more days per week.
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Lead: **D C Moir, Director of Public Health**
G Docherty, Health Promotion Manager

1.06S Exercise (linked to target H04T)

Numbers as % of relevant population, derived from the Scottish Health Survey
(SEHD has clarified (12/12/06) that there is no requirement to produce either a forward trajectory or a narrative for this target in the 2007/08 LDP. Although this remains a key target, the measure is supplementary, and will not be monitored as part of the national HEAT system. The last Scottish Health Survey was conducted in 2003. It is understood that it is currently under review nationally and that the next survey is due to commence in 2008. The narrative below has been prepared for this local version of the LDP, recognising that this remains a key target, albeit without a key measure.)

Narrative:

Objective

The objective is to work towards 50% of adults taking 30 minutes physical activity on 5 days per week.

Actions

Encouraging people to become more active is about influencing changes in habits and behaviour. It is a social and cultural issue, with its determinants beyond the NHS, however, the NHS is an important influencing partner in shifting public attitudes and thus changing behaviour over time.

Actions in Lanarkshire are strategically driven by the Physical Activity Working Groups in each local authority area. In South Lanarkshire, the Group has amalgamated work on the Sports 21 Strategy, and has produced its own Strategy with part of its focus targeting those groups in the community who do not traditionally use leisure centres / gyms etc. to encourage them to get more active in everyday ways. The South Lanarkshire Joint Health Improvement Plan (JHIP) was reviewed in 2006/07 and all actions pertaining to physical activity were completed. The next JHIP will be developed in 2007/08/

In North Lanarkshire, a Leisure Trust has been established, presenting similar opportunities to those in South to merge work with Sports 21, and in so doing integrate the sports and physical activity agendas.

In both local authorities, Big Lottery Active Futures programmes target those most excluded, e.g., minority groups and those with special needs. Active Schools programmes have been very successful in raising levels of participation in physical activity and will continue to be developed in both local authority areas.

The aim now is not to launch further new initiatives, but to build and sustain existing programmes to maximise their impact.

Within the NHS, work has begun to develop more local accountability and ownership of this agenda by building it into quarterly reviews of localities and linking it to local area partnerships under the auspices of community planning.

Risks & Risk Management

Choosing to become more active or not is part of a complex web of personal and social beliefs and circumstances, and the NHS is only one influencing partner. Tackling this problem requires a coherent approach across all sectors, hence the focus on joint structures and arrangements embedded within broader community planning and regeneration.

The lack of information to demonstrate progress against this target is disappointing. The Scottish Health Survey will not be repeated until 2008 and in the meantime, short of conducting our own survey at considerable expense, there is no way of knowing whether we are progressing towards the target or not. Clearly, our individual programmes each have their own targets (participant numbers, coverage etc.) but it is not realistic to derive from these an impact on the whole population of NHS Lanarkshire. NHS Lanarkshire is looking to develop proxy measures related to local actions as a means of assessing progress locally and more frequently.

Costs

All programmes are funded, with the bulk of the funding non-NHS (e.g., local authority education, leisure, Big Lottery, Regeneration)

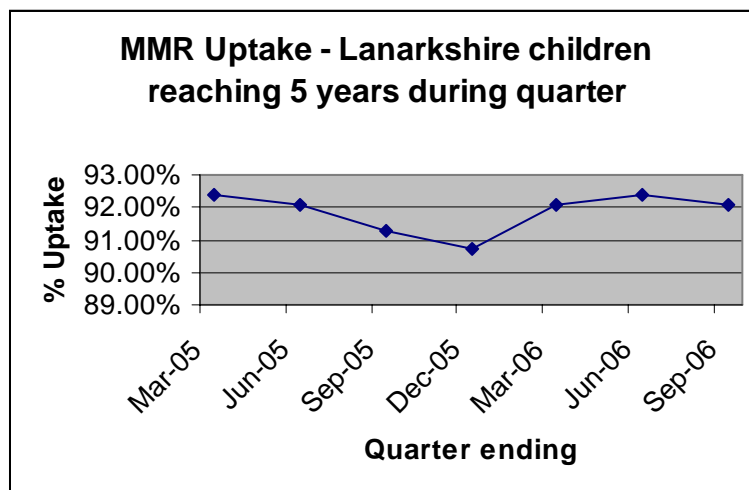
H05T	95% uptake target for all childhood vaccinations (ongoing).
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Lead: D C Moir, Director of Public Health

D Cromie, Consultant in Public Health Medicine

1.03.K Immunisations – MMR1 (5 year olds) (linked to target H.05T)

MMR1 uptake rates (% at 5 years old).



Trajectory March 2007 – March 2010:

Mar 07	Jun 07	Sep 07	Dec 07	Mar 08	Jun 08	Sep 08
92%	92.5%	92.5%	93%	93%	93.5%	93.5%
Dec 08	Mar 09	Jun 09	Sep 09	Dec 09	Mar 10	
94%	94%	94.5%	94.5%	95%	95%	

Narrative:

Objective

To achieve a 95% uptake rate at 5 years for MMR as soon as possible.

Actions

MMR education is a standing item on vaccine update seminars, plus specific targeted sessions are organised where particular needs are identified. The last universal education sessions were held in June 2006, and a similar programme will be planned for 2007/08, based on needs.

During 2007/08, it is planned to review uptake by Health Visitor in order to identify any further service development or training needs. A sub-group of the Area Advisory Group on Immunisation – the Education and Peer Review Group – meets approximately thrice per annum and will lead on this in 2007/08. A new web-based education package has been released by Health Protection Scotland.

This will be rolled out to lead Health Visitors in each locality in the first instance. Nationally, it is envisaged that anyone undertaking vaccinations should have completed this course, with this requirement being phased in over a 3-5 year timescale.

Following on from current work associated with flu vaccine and new childhood vaccines, it is planned to write to all parents/carers of 3-4 year olds and who have not yet taken up the offer of MMR, to encourage them to do so.

In the event of a local outbreak relating to MMR, consideration will be given to the use of the media to raise awareness and encourage uptake, however, care must be exercised as this continues to be a highly sensitive topic.

Risks & Risk Management

The current relatively low uptake of MMR is linked to the legacy of media-propagated health scares, which are outwith NHS control, and which can re-ignite. The NHS seeks to respond appropriately to these 'scares' as and when they arise.

Positive advertising must be undertaken with great caution as it can result in a backlash from a small but vocal anti-vaccine lobby.

The strategy locally is to continue to foster work between Health Visitors, GPs and parents on a one-to-one basis, to build and strengthen confidence, and thus encourage increased uptake.

Costs

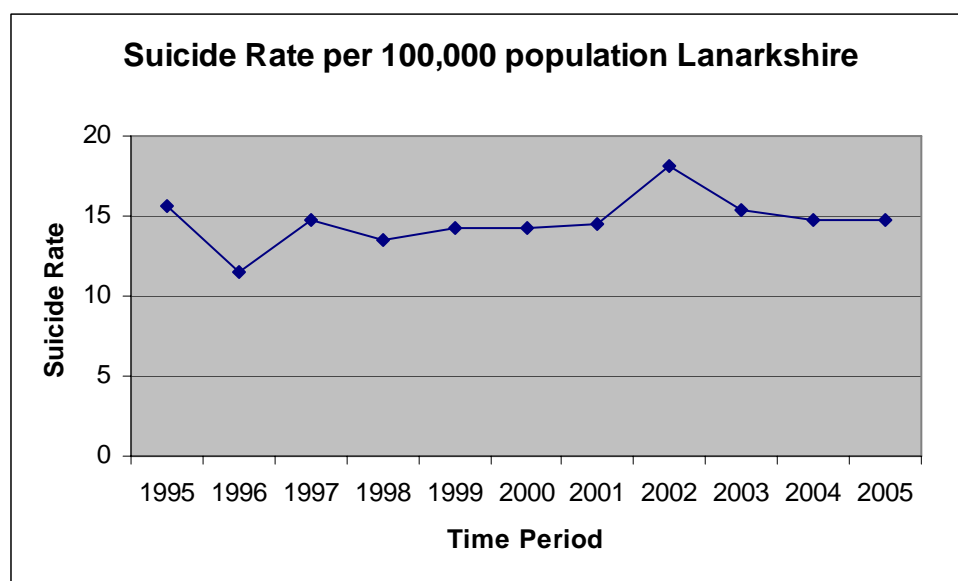
Services are core funded.

H06T	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
 K O'Neill, Mental Health & Well-being Needs Assessment & Service Development Manager

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

Deaths caused by intentional self harm and events of undetermined intent expressed as a rate per 100,000 population. Source: GROS and SEHD.



Trajectory 2006 – 2010:

2006	2007	2008	2009	2010
≤16.8	≤16.5	≤16.1	≤15.8	≤15.5

(The rate for 2006 is higher than the actual rates recorded for 2003, 2004 and 2005, as the target is to reduce by 20% from the baseline year of 2002, and as can be seen from the above table, the 2002 rate for Lanarkshire residents was higher than usual)

Narrative:

Objective

To reduce suicide rate between 2002 and 2013 by 20%.

Actions

Multi-agency partnership steering groups, with membership from NHS Lanarkshire, have been formed in response to the Choose Life national strategy in North and South Lanarkshire. This includes representatives of addiction services. Each group has developed local action plans in order to deliver on the priority areas and objectives of the strategy. 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 action plans are endorsed at a strategic level via inclusion in both the North and South

Lanarkshire Joint Health Improvement Plans and have been supported via the mental health Joint Future agenda. Local performance management arrangements require local areas to demonstrate their commitment and action to meet the target. The Choose Life agenda is also closely linked with the wider mental health improvement agenda through the Lanarkshire Partnership for Mental Well-being and the Lanarkshire Health Improvement Project Board, which has a focus on the prevention of mental ill-health and the promotion of well-being.

Two fulltime Choose Life Co-ordinators have been appointed and are facilitating the delivery of the action plans. Key activity has focused on the delivery of Applied Suicide Intervention Skills Training (ASIST) with over 150 NHS Lanarkshire staff completing this training. Training has also been targeted at people working with vulnerable groups, such as looked after and accommodated young people. Four NHS Lanarkshire staff have been trained as trainers to deliver Skills Training on Risk Management (STORM). This training is being delivered to key clinical staff across Lanarkshire. A review is under way to assist the development of a training programme that will support progress towards meeting the mental health delivery plan target of having 50% of key frontline staff trained in suicide prevention by 2010 – this includes staff working in addiction services. Protocols and procedures are being developed to embed effective suicide prevention actions in practice. This includes an assessment and intervention pathway for those who present at services, and guidance for schools on managing self-harm.

The present focus of suicide prevention activity is building capacity and sustainability through links with existing programmes such as health promoting schools, healthy working lives and health promotion training programmes, and existing networks such as housing and the police. Action is influenced by the production of a document entitled *Evidence Base for Lifestyle Intervention for Health Improvement 2006*, compiled by the Director of Public Health, which is being used to develop integrated health improvement plans, with a focus on prevention and promotion, as well as care and treatment. The Consultant in Public Health Medicine with the remit for the mental health of adults and older people, and the Mental Health Needs Assessment Programme Manager are both involved in the development of local strategic and operational approaches to suicide prevention.

The core messages running through the different strands of the national programme - Choose Life, recovery, 'see me' and increasing well-being - are being delivered using an effective, non-competitive and integrated approach. The three key aims of these initiatives are that people will have a good understanding of mental health – what helps and how to help others, positive attitudes about mental illness, and know what help is available and use it as required. These messages are being delivered via training, workshops, media, health promotion and 'element', Lanarkshire's new mental health and well-being website www.lanarkshirementalhealth.org.uk. An alliance of 60 organisations ranging from NHS, Local Authorities, Voluntary Organisations, Service User and Carer groups, Motherwell Football Club, Strathclyde Police, Strathclyde Fire and Rescue, Secondary Schools, employers and local newspapers have all signed a pledge and joined forces to commit to work with 'see me', Choose Life and the Lanarkshire Recovery Network in the promotion of mental health and well-being. Examples of the prevention work include the distribution of wallet cards with support contact numbers and social marketing campaigns delivered via advertisements, media and Lanarkshire's professional football teams. Another is being delivered through co-operation with both North and South Lanarkshire Councils' Education Departments. A mental health curricular resource, which was developed in Glasgow, is being adopted in Lanarkshire and will be delivered in every secondary

school in Lanarkshire, four sessions per year from S1 to S6, commencing next year. This will focus on building emotional resilience.

During 2007/08, the Lanarkshire Mental Health Strategy will be implemented and will reduce reliance on hospital / secondary care, while increasing provision of services in primary / community based settings. Associated with this, the local *Delivering for Mental Health* Action Plan will ensure that NHS Lanarkshire meets its commitments in the relevant timescales.

Targeted implementation of local Choose Life action plans will contribute towards a reduction in inequalities in health by providing information, support and services for those who are most vulnerable and who experience poor health. The plans aim not only to reduce the suicide rate among people who live in deprived areas of Lanarkshire, but also to increase the mental health and well-being, including mental health resilience, of all people who live in such areas.

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*.

Risks & Risk Management

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. Partnership working seeks to maximise the contribution of all parties to address this issue.

Costs

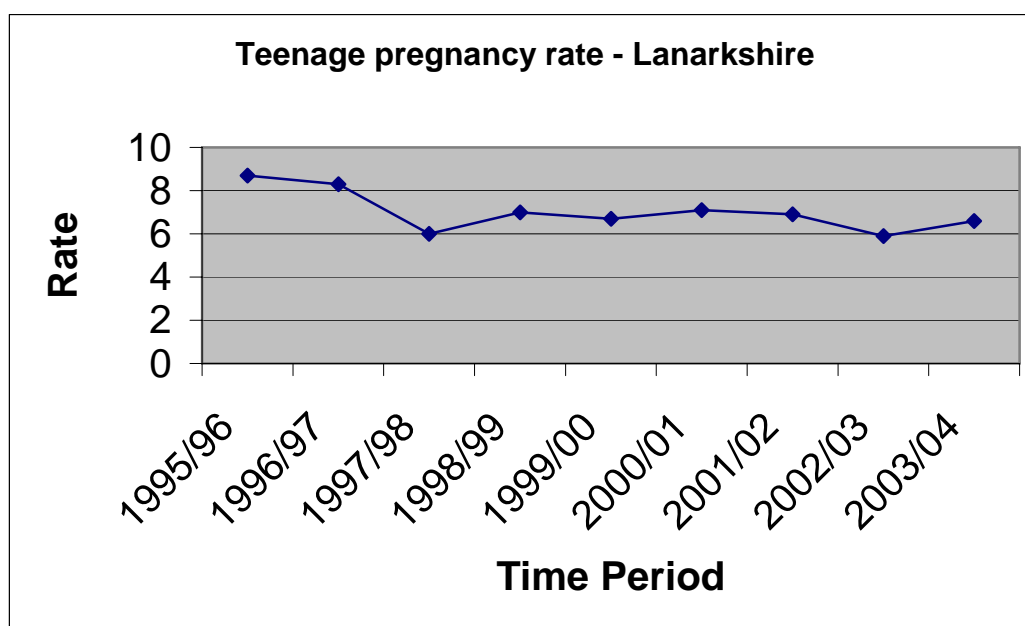
Choose Life support funds deployed as above.

H07T	Reduce by 20% the pregnancy rate (per 1000 population) in 13-15 year olds from 8.5 in 1995 to 6.8 by 2010
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Lead: **D C Moir, Director of Public Health**
 J Logan, Consultant in Public Health Medicine
 A McLellan, Consultant in Sexual & Reproductive Health Care

1.09.K Teenage Pregnancies (linked to target H.07T)

Pregnancy rate (per 1000 population) for 13-15 year olds. Source: ISD.



Trajectory:

(In the 2007/08 LDP Guidance – Annex 3b Trajectories – Lanarkshire’s target for March 2011 was defined by SEHD as 7.0. Lanarkshire’s position as at 2003/04 was 6.6, and so we have set a forward trajectory to sustain this.)

Mar 05	Mar 06	Mar 07	Mar 08	Mar 09	Mar 10	Mar 11
6.6	6.6	6.6	6.6	6.6	6.6	6.6

Narrative:

Objective

To maintain a downward trend in the 13-15 years teenage pregnancy rate and to ensure that a rate of less than or equal to the SEHD target of a rate of 7.0 per 1,000 population is achieved.

Actions

Key actions being taken in 2007/08 include:

C:\WEB DEVELOPMENT\Content Development\Board Papers\March 2007\Board Meeting 28 Mar 07 - LDP.doc
 26/03/2007

- Ratification of the Lanarkshire Sexual Health Strategy and Action Plan. A final version of the Lanarkshire (multi-agency) Sexual Health Strategy and Action Plan has been completed. It is currently being considered by joint partnership boards and may be ratified by the end of 2006/07;
- Implement the multi-agency Lanarkshire Sexual Health Strategy and Action Plan;
- Continued development and integration of clinical sexual health services led by NHS Lanarkshire's first Consultant in Sexual and Reproductive Health Care who was appointed in May 2006;
- Further implementation of clinical sexual health services action plan;
- Following a successful bid by NHS Lanarkshire, pilot the new national sexual health IT system on behalf of NHS Scotland;
- Implementation of the recommendations of a report of a review of Lanarkshire termination of pregnancy data management;
- Continued development and evaluation of the Lanarkshire sexual health website www.lanarkshiresexualhealth.org ;
- Further expansion of the 3 condom distribution schemes which operate in Lanarkshire;
- Further development of the West of Scotland NHS Boards sexual health social marketing campaign and use of materials specifically for young people www.equalonline.co.uk ;
- NHS Lanarkshire's Health Promotion Team for Blood Borne Viruses and Sexual Health will continue to support primary and secondary school teachers in North and South Lanarkshire Councils to provide sexual health and relationships education;
- Work will continue with voluntary sector partners including THT Scotland to help to address the sexual health needs of young people;
- Increase the number of sexual health clinics for young people, particularly in deprived areas, and re-organise clinics relative both to deprivation and demographics so that those areas with greatest deprivation and highest numbers of young people are prioritised. Associated with this, Big Lottery funding has been awarded for a service in Larkhall called 'Just Ask';
- Establish 2 Long Acting Reversible Contraception (LARC) clinics, one each in Coatbridge and Hamilton;
- Joint work with local authority partners to focus on looked-after and accommodated young people. The aim is to establish a fast-track referral system to prioritise such clients within the service. The deployment of a liaison nurse role, to follow up young people at time of transition from care into adult life, is being explored in this context;
- Undertake an assessment of sexual activity of under 17s to inform future service planning and design.

Risks & Risk Management

Lanarkshire is currently achieving this target, however, with small numbers, the rate could increase if there were a modest increase in numbers in any one year. This would need to be investigated further in order to determine what additional action could be taken.

Wider cultural and social factors play a part in influencing beliefs and behaviour including sexual health activity among young people. For example, one influence may be considered to be 'youth culture'. This is currently going through a period of continuous change and young people may respond to the behaviour of popular 'celebrities', or to changes in technology, by changing sexual health activity. Such changes are beyond significant influence of NHS Lanarkshire, however, they would be monitored in order to try to respond effectively.

Costs

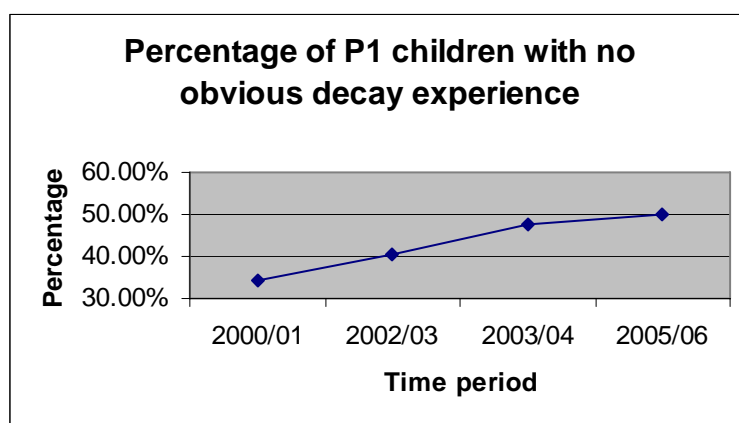
£480,000 was awarded by SEHD each year for 3 years from 2005/06, and NHS Lanarkshire has given a commitment to ensure that this funding is made recurring thereafter.

H08T	60% of 5 year old children (primary 1) will have no signs of dental disease by 2010
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Lead: D C Moir, Director of Public Health
M Taylor, Consultant in Dental Public Health

1.08.K Dental Caries in Primary 1 children (linked to target H.08T)

Percentage of P1 children with no obvious decay experience. Source: NDIP.



Trajectory:

2005/06	2006/07	2007/08	2008/09	2009/10
50.2	53%	55%	57%	60%

Narrative:

Objective

To continue to make progress towards the national target.

Actions

To maintain implementation of the Dental Action Plan:

- To distribute via the Health Visitors, toothbrush and toothpaste packs to all children under a year;
- To distribute to all children at nursery school twice a year toothbrush and toothpaste packs;
- To offer supervised toothbrushing to all children in nursery schools across Lanarkshire;
- To expand the 'Childsmile' demonstration programme to involve more practices in areas of deprivation and provide oral health promotion in the general dental practice setting.

Risks & Risk Management

It is difficult to accurately estimate the additional ongoing impact at this stage as the Childsmile programme is subject to ongoing evaluation.

Costs

Programmes are fully funded through Dental Action Plan.

NHS Scotland Objective 2:

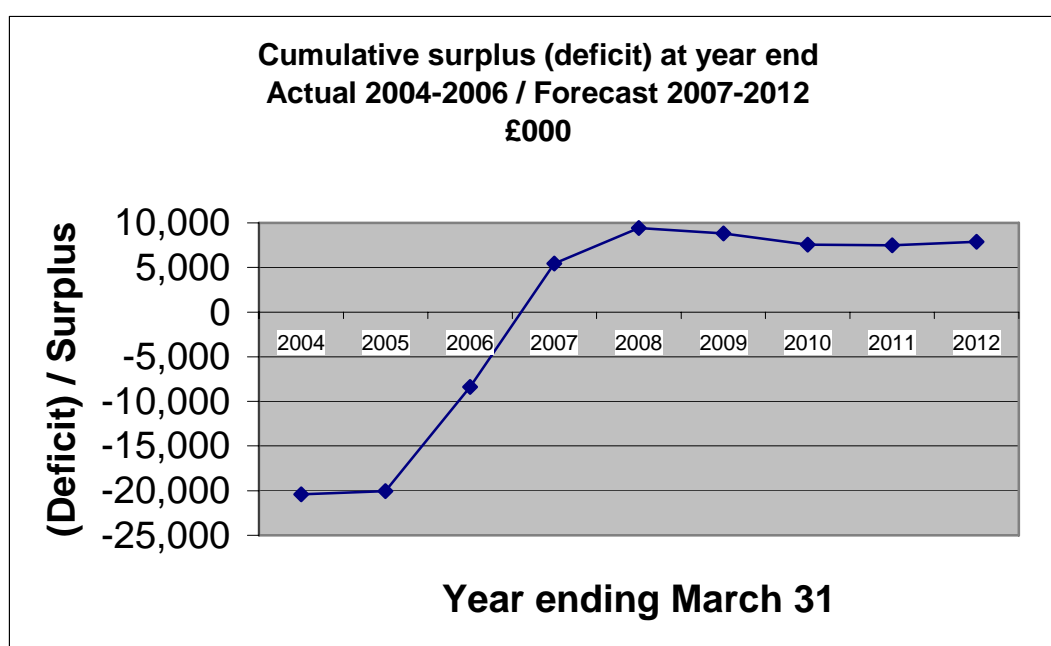
Efficiency and Governance Improvements – continually improve the efficiency and effectiveness of the NHS.

Target Identifier	Target Details
E.01T	NHS boards to operate within their agreed revenue resource limit; operate within their capital resource limit; meet their cash requirement ; meet their cash efficiency target
E.02T	NHS Boards to achieve time-releasing savings including an increase in consultant productivity by 1% pa over the next 3 years and a sickness absence rate of 4% by 31 March 2008.
E.04T	Universal utilisation of CHI

E01T	NHS boards to operate within their agreed revenue resource limit; operate within their capital resource limit; meet their cash requirement; meet their cash efficiency target
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Lead: S Goldsmith, Director of Finance

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



Narrative:

Objective

To achieve a balanced revenue financial position against the total revenue resource limit, recognising any cumulative surplus / (deficit) brought forward from future years.

Risks & Risk Management

- Planning assumptions are high level from 2009/10 onwards;
- No certainty around future uplifts from SEHD;
- Impact of Arbuthnott formula changes;
- Revenue impact of capital investment (PoH developments) – timing / transitional costs;
- National and regional prioritisation, e.g., new Children's Hospital;
- Impact of investment to meet waiting times targets;
- Prescribing levels;
- Pay and prices uplifts;
- Ongoing impact of Agenda for Change;
- Impact of Modernising Medical Careers;
- Ongoing achievement of CRES.

Tight financial control and ongoing robust financial planning is critical in managing the risks associated with the achievement of financial balance.

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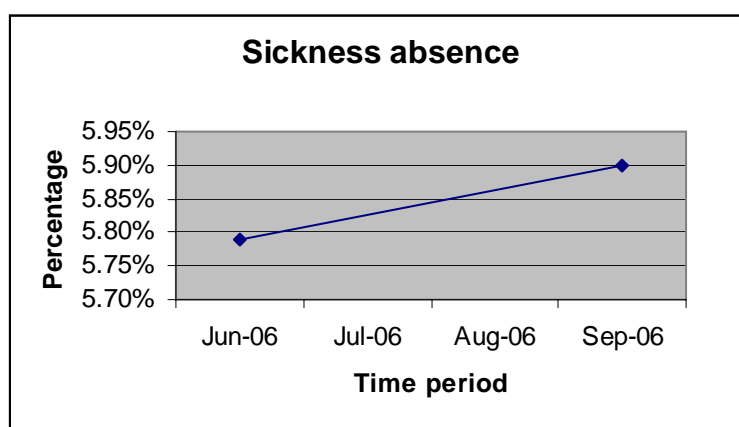
26/03/2007

E02T	NHS Boards to achieve time-releasing savings including an increase in consultant productivity by 1% pa over the next 3 years and a sickness absence rate of 4% by 31 March 2008.
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Lead: G Walker, HR Director (2.02K)
 I A Ross, Director of Acute Services (2.16K)
 R Garscadden, Head Of Planning, Acute Services

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

Hours lost due to sickness absence expressed as a percentage of total hours available. Source: SWISS.



Trajectory:

Mar 07	Mar 08	Mar 09	Mar 10
5%	4%	4%	4%

Narrative:

Objective

To reduce sickness absence to 4% by 31 March 2008.

Actions

A sickness absence initiative was launched in 2006 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 that has been taken includes:

- o Sickness absence project implemented;
- o Training programme for managers implemented;
- o New occupational health arrangements introduced;
- o Capacity to produce regular absence reports being developed.

Sickness levels are reported regularly at Divisional level to enable further management action to be taken.

Risks & Risk Management

Under Agenda for Change, certain groups of staff will now be paid enhancements when off sick, resulting in a perverse incentive. Management will need to monitor the situation and take action as appropriate.

There is a need to produce data at more detailed levels (e.g., Directorate / Department) to support management in identifying problems and targeting action. Resources and systems continue to be developed, however, individual managers have access to their own records in the meantime.

Sustaining and improving upon management action to tackle problem areas will be a continuing need.

Costs

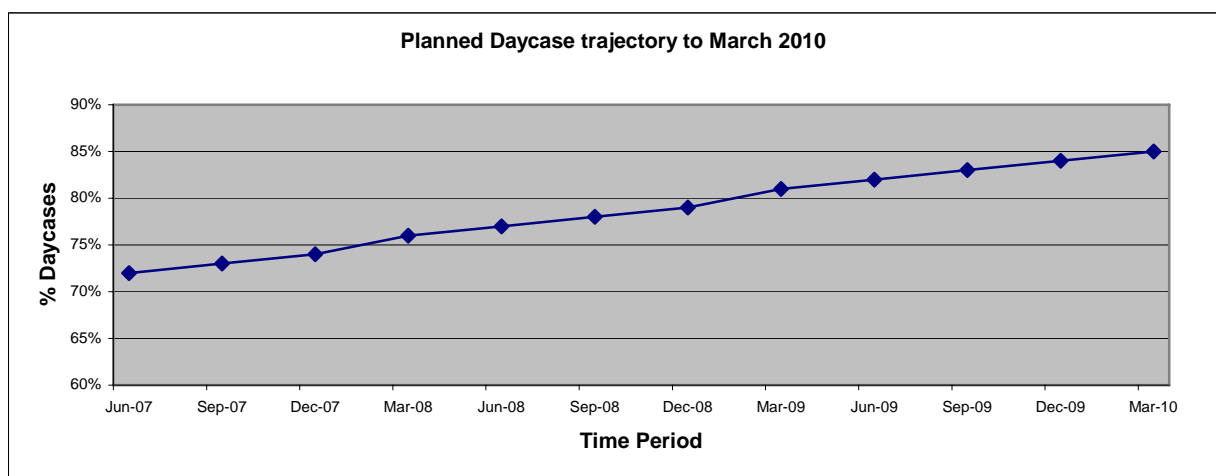
No additional costs; achievement of the target will result in savings to the organisation.

2.16.K Day Case Rates(linked to target E.02T)

Number of procedures performed in surgical specialities in a day case or outpatient setting expressed as a percentage of the total number of procedures performed in surgical specialities including inpatients. Target relates to 2005/06, 2006/07 and 2007/08. Source: ISD.

Trajectory:

Dec 06	Jun 07	Sep 07	Dec 07	Mar 08	Jun 08	Sep 08	Dec 08
71%	72%	73%	74%	76%	77%	78%	79%
Mar 09	Jun 09	Sep 09	Dec 09	Mar 10			
81%	82%	83%	84%	85%			



Narrative:

Objective

The objective will be to establish day case surgery as the norm. All other modes of surgery will require to be clinically justified and evidenced. Evidence based clinical protocols will be further developed to actively promote shift from inpatient to same day surgery, to 23 hour care, to procedure at specialty and consultant level. Day case rates will be reviewed in recognised BADS 'basket' and for other common procedures by specialty. Current performance will be benchmarked against the first phase target of 75% of elective surgery with a review at consultant and specialty level to identify variations across procedures. Reasons for variance in clinical practice will be identified with a view to adopting a standardised approach to improve day case performance.

This work will be taken forward as a specific work stream within the Planned Care Collaborative.

Actions

- o Prioritise specialties based on their performance;
- o Increase the percentage of patients treated as day cases and introduce performance measures to identify shifts in resource use;

- Achieve the first phase target of 75% of elective surgery carried out as day cases;
- Establish clinical acceptance of the pre assessment process;
- Achieve 100% pre assessment for all planned surgery whether day case or inpatient;
- Reduce the level of patient and service led cancellations;
- Extend patient focused booking;
- Reduce patient length of stay;
- Reduce waiting times;
- Increase percentage of same day admissions.

Risks & Risk Management

- The time available to clinical and non-clinical staff to fully participate in the work programme;
- Recruitment of appropriately trained staff to deliver the preferred clinical model for each specialty;
- Capacity deficits associated with delivering a shift in the balance of care;
- Effective engagement of primary and secondary care to deliver sustainable whole system outcomes;
- The pace of implementation linked to available capital and revenue investment;
- Effective engagement with partner agencies, patients, carers and the wider community to develop clinical models and deliver sustainable services.

Costs

Scottish Executive has contributed 240K for two-year period to facilitate provision of infrastructure to support work programme that includes day case redesign. The cost profile to effect day case service redesign will emerge during the work programme that will be undertaken in the context of *A Picture of Health*.

E04T	Universal utilisation of CHI
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Lead: A Lawrie, Director – CHP South
R Wright, Head of IM&T

2.17.K CHI Usage (linked to target E.04T)

Laboratory requests that include a CHI number, expressed as a percentage of all laboratory requests made. Source: NHS Board sampling.

(There is no historical chart as this is a new target / system)

Trajectory:

Sep 06	Apr 07	May 07	Jun 07	Jul 07	Aug 07	Sep 07	Oct 07
86%	88%	89%	90%	91%	92%	93%	94%
Nov 07	Dec 07	Jan 08	Feb 08	Mar 08	Apr 08	May 08	Jun 08
95%	96%	97%	97%	97%	97%	97%	97%
Jul 08	Aug 08	Sep 08	Oct 08	Nov 08	Dec 08	Jan 09	Feb 09
97%	97%	97%	97%	97%	97%	97%	97%
Mar 09	Apr 09	May 09	Jun 09	Jul 09	Aug 09	Sep 09	Oct 09
97%	97%	97%	97%	97%	97%	97%	97%
Nov 09	Dec 09	Jan 10	Feb 10	Mar 10			
97%	97%	97%	97%	97%			

Narrative:

Objective

To reach 97% target by January 2008, and sustain that level of compliance.

Actions

- Use of CHI on diagnostic requests must increase;
- Re-numbering project to continue;
- Patient Management System to be populated with current patients only and a population index created through CHI download;
- A&E attendances to have CHI available through linkage to PMS population index.

Risks & Risk Management

- In relation to diagnostics, the risk is associated with cultural change and the management / training of junior medical staff to ensure usage of patient identification labels on test requests. Clinical Divisions to re-issue Label Policy and enforce usage;
- Clinical risks associated with re-numbering to be addressed to allow project to move forward and PMS to be updated;
- In A&E, achievement is dependent on delivery of software upgrades, with attendant supplier risks.

Costs

External funds available to support programme.

NHS Scotland Objective 3:

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

Target Identifier	Target Details
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.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 out-patient 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 admission, 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 from admission to a specialist unit to hip surgery, following fracture, will be 24 hours.
A.08T	The maximum wait from urgent referral to treatment for all cancers is two months ; women who have breast cancer and need urgent treatment will get it within one month where appropriate.
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 <i>and</i> 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.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.

A01T	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.
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Lead: **A Lawrie, Director – CHP South**
S Mackie, Associate Medical Director

3.01.K Primary Care Team – 48 hour access (linked to target A.01T)

The measure is percentage of practices, in a HB area, claiming to meet the requirements for the DES payment. Source: ISD/PSD

(There is no historical chart as this is a new measure for 2007/08)

Trajectory:

Sep 06	Jun 07	Sep 07	Dec 07	Mar 08	Jun 08	Sep 08	Dec 08
100%	100%	100%	100%	100%	100%	100%	100%
Mar 09	Jun 09	Sep 09	Dec 09	Mar 10			
100%	100%	100%	100%	100%			

Narrative:

Objective

To 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.

Actions

Between April 2004 and March 2006, the mechanism for evaluating 48 hour patient access to a relevant health care professional was via the Quality & Outcomes Framework (QOF). This was introduced as part of the new GP contract from April 2004.

In addition to this, there are a number of practices participating in the Scottish Primary Care Collaborative, which is deemed to meet the criteria for meeting the 48 hour access target.

In 2004/05, 89 out of 100 practices in Lanarkshire claimed QOF points for 48 hour access. Following investigation and support, it was established that due to a number of reasons, primarily confusion and being overly cautious, 99 out of 100 practices met the 48 hour access criteria.

In 2005/06, 98 out of 99 practices claimed the QOF points for 48 hour access. Following investigation, it was established that one practice had forgotten to claim the QOF points and were in fact meeting the 48 hour access criteria, giving 100% compliance.

In 2006/07 the 48 hour access indicator was taken out of the QOF and a new Scottish Directed Enhanced Service (DES) was introduced from April 2006. Practices wishing to participate in the Access DES had to:

- o Formally 'opt in' to the DES, which required them to agree to meet the standards in the DES;
- o Agree to provide quarterly monitoring reports to NHS Lanarkshire confirming they continue to meet the requirements of the DES.

All 99 (100%) Lanarkshire medical practices have 'opted in' to the Access DES for 2006/07. Quarterly monitoring will continue to verify that compliance is sustained in 2007/08.

NHS Lanarkshire continues to take a pro-active approach to ensuring DES take up across the Board, and is working to ensure compliance. This is done alongside LMC colleagues to ensure that we abide by both the spirit and detail of the monitoring arrangements.

During 2006/07 100% (99) of NHS practices opted in to provide 48 hour access via the Access DES and practices provide, on a quarterly basis, documentation which demonstrates the criteria on how they are achieving 48 hour access. This is in line with the Primary Medical Services (Directed Enhanced Services) (Scotland) Directions 2006. It is anticipated that the same will apply for 2007/08. Further details of the evidence that is collected quarterly can be provided if required.

In addition to the monitoring requirements of the Primary Medical Services (Directed Enhanced Services) (Scotland) Directions 2006, QOF review visits are undertaken which, in addition to a range of items as outlined in the Winter II guidance, reviews practices ability to meet the requirements of the Access DES. NHS Lanarkshire actively promotes participation in the Scottish Primary Care Collaborative to practices, with the fifth wave now underway, and this is contributing to the 100% compliance of achievement for 48 hour access to patients. As part of the pre-payment verification process, details of the patient survey results are required to be submitted, which provides additional evidence regarding compliance.

Risks & Risk Management

Significant improvement has been made in achieving universal 48 hour access throughout NHS Lanarkshire, evidenced by the quarterly monitoring returns. The drive to meet the 48 hour access target may, however, impact on practices' ability to offer planned appointments booked in advance. Continued dialogue takes place with practices, particularly during QOF visits, and access features prominently in such discussions.

The Access DES is clear that anyone contacting their GP surgery has guaranteed access to a GP, nurse, or other health care professional within 48 hours according to their clinical needs. There may be a risk that the public perceive 48 hour access as the normal maximum waiting time, regardless of clinical need, and with a GP only. Health Boards and practices need to communicate these issues to patients, which may not always be easy. It is understood that a national leaflet is in preparation and will be issued to NHS Boards for public distribution during 2007.

It is recognised that as a DES, all NHS Boards must commission these services to cover their relevant population. However it must be recognised that not all practices are obligated to provide them. Given the nature of this DES, which is 'Access to Contractor-based Primary Care Services', if practices choose not to participate in the DES, it will be extremely difficult for NHS Boards to provide DES as intended. NHS Lanarkshire actively promotes the benefits of appropriate

access to a health care professional for patients, and this is reflected in the 100% uptake by practices in the Access DES.

As far as risk is concerned, the Regulations provide that as part of its Access to Contractor-based Primary Medical Services, Health Boards may enter into arrangements with any primary medical services contractor – the provision of this DES via any other route is unlikely to work. NHS Lanarkshire is aware of the risks of contractors not electing to participate in the Access DES and actively promotes the benefits to patients for practices to participate in this DES. This is reflected in the 100% participation in the Access DES by Lanarkshire practices. Regular discussions are held between NHS Lanarkshire and Lanarkshire Local Medical Committee (LMC) regarding all enhanced services, which include access.

Costs

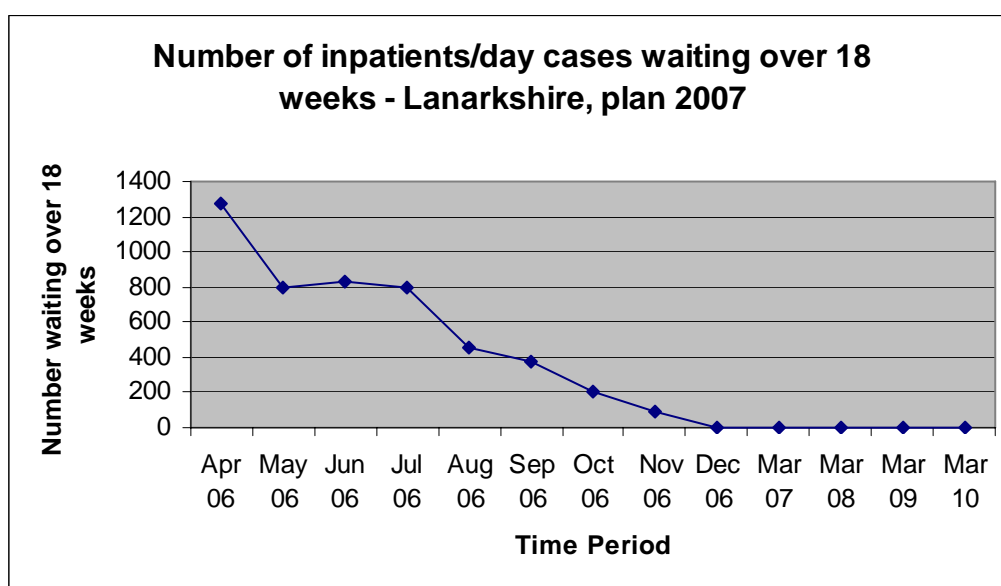
The total funding available for the Access DES will be equal to the value of 50 QOF points including superannuation, each QOF point is worth £124.64, which is £6232 per annum. The funding for the Access DES was transferred from the QOF.

A03T	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.
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Lead: I A Ross, Director of Acute Services
R Garscadden, Head of Planning, Acute Services

3.04.K Inpatient/Daycases waiting over 18 weeks ; excl ASCs (linked to target A.03T)

Number of patients waiting over 18 weeks excl ASCs; (acute specs recorded on MMI only).



Trajectory:

Dec 06	Mar 07	Mar 08	Mar 09	Mar 10
0	0	0	0	0

Narrative:

Objective

NHS Lanarkshire has delivered the waiting time guarantee that no patient should wait longer than eighteen weeks for inpatient or day case treatment at 31st December 2006. This is twelve months ahead of the timescale for delivery of the guarantee. The next stage is to sustain that position and to deliver further improvement in waiting time standards.

Actions

- o Introduced new management arrangements with the appointment of General Managers and Clinical Directors into a Lanarkshire wide remit;
- o Developed a capacity plan that looked at demand as well as supply;

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26/03/2007

- During 2006/07 internal capacity has been increased by recruitment of additional clinical and support staff. In addition, NHS Lanarkshire was allocated capacity 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;
- Established Planned Care Collaborative in the context of a *Picture of Health* to improve patient and carer experience through improving the patient journey.

Risks & Risk Management

- Routine performance delivered to a level anticipated in the capacity plan;
- Recruitment of permanent staff to undertake internal waiting list initiatives;
- The agreement of staff to undertake internal waiting list initiatives;
- Access to slots at the National Golden Jubilee Hospital;
- Impact on capacity through improvement in maximum waits for out patient services;
- Clinical ownership of the agenda
- Impact of MMC.

Costs

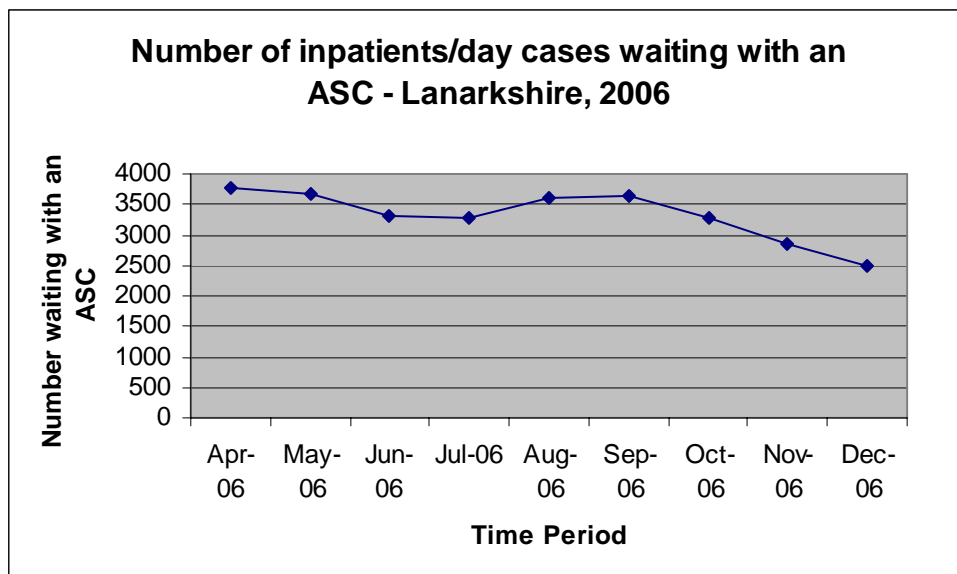
The financial cost of delivering and sustaining the national waiting time guarantee in 2006/07 is as follows:

Permanent Investment	£2,809,305
Golden Jubilee	£2,456,000
Internal Initiatives	£3,022,662
Independent Sector	£1,949,000

Full year costs on permanent investment will increase in 2007/08 to £7,801,411. It is anticipated that access to Golden Jubilee will also increase with less reliance on internal waiting list initiatives and use of the Independent Sector.

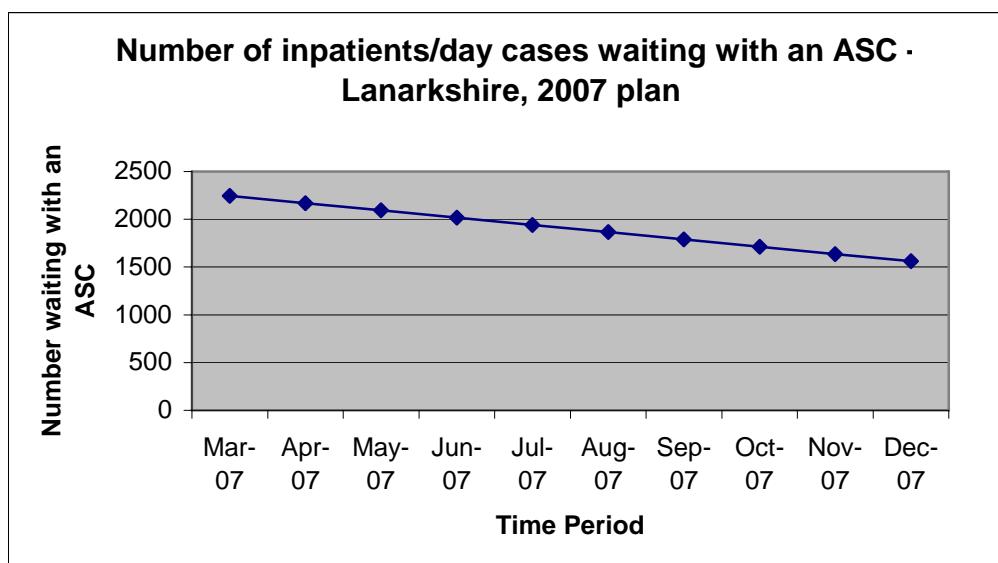
3.05.K Inpatients/Daycases waiting with an ASC code (linked to target A.03T)

Number of inpatients/daycases on waiting list with an ASC (acute specs recorded on MMI only).



Trajectory:

Mar 07	Apr 07	May 07	Jun 07	Jul 07	Aug 07	Sep 07	Oct 07
2245	2169	2093	2017	1941	1865	1789	1713
Nov 07	Dec 07	Jan 08	Feb 08	Mar 08	Apr 08	May 08	Jun 08
1637	1560	-	-	-	-	-	-
Jul 08	Aug 08	Sep 08	Oct 08	Nov 08	Dec 08	Jan 09	Feb 09
-	-	-	-	-	-	-	-
Mar 09	Apr 09	May 09	Jun 09	Jul 09	Aug 09	Sep 09	Oct 09
-	-	-	-	-	-	-	-
Nov 09	Dec 09	Jan 10	Feb 10	Mar 10			
-	-	-	-	-			



Narrative:

Objective

NHS Lanarkshire has to ensure that there are no patients with an ASC code by 31st December 2007. In reality the target of zero will not 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.

Actions

- An increased number of patients with an ASC code have been factored into the capacity plan;
- NHS Lanarkshire has ceased to use ASC codes 3 and 4;
- Waiting lists are subject to routine clean and review;
- NHS Lanarkshire has adopted New Ways with a Project Board in place to manage implementation of agreed action plan;
- Software will be piloted during 2006/07 and 2007/08 to facilitate management and implementation of New Ways;
- Implementation of training awareness procedures for staff;
- Dialogue with clinical and non-clinical staff in primary and secondary care to ensure awareness of and compliance with New Ways protocols.

Risks & Risk Management

- GP resistance to application of New Ways;
- Inability to factor in the required number of patients with an ASC code to existing clinics due to demand and limited capacity;
- Impact of MMC;
- The pressure on clinical staff to review cases of patients with an ASC code;
- Software does not deliver anticipated benefits.

Costs

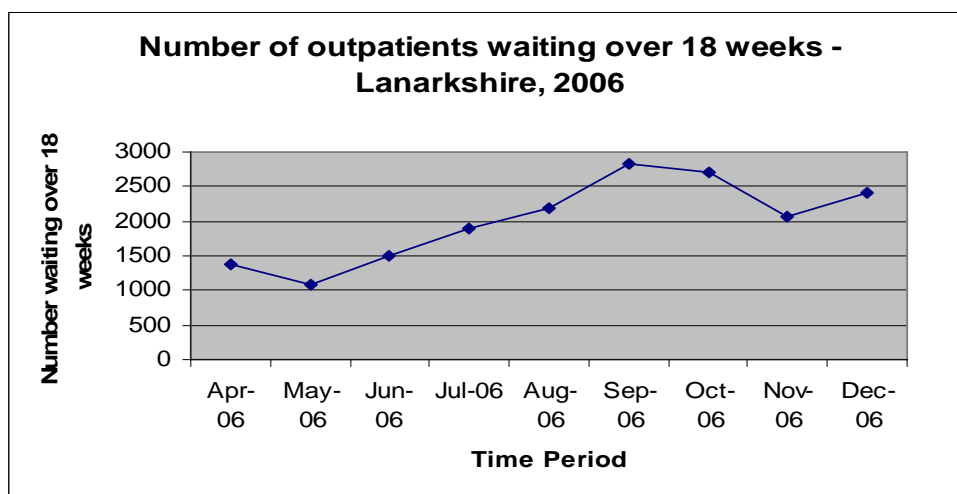
The cost of reducing the number of patients with an ASC code is contained within costs identified for delivery of inpatient and day case waiting time guarantees.

A04T	By the end of 2005, no patient will wait longer than 6 months from GP referral to an out-patient appointment, reducing to 18 weeks from 31 December 2007.
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Lead: I A Ross, Director of Acute Services
R Garscadden, Head of Planning, Acute Services

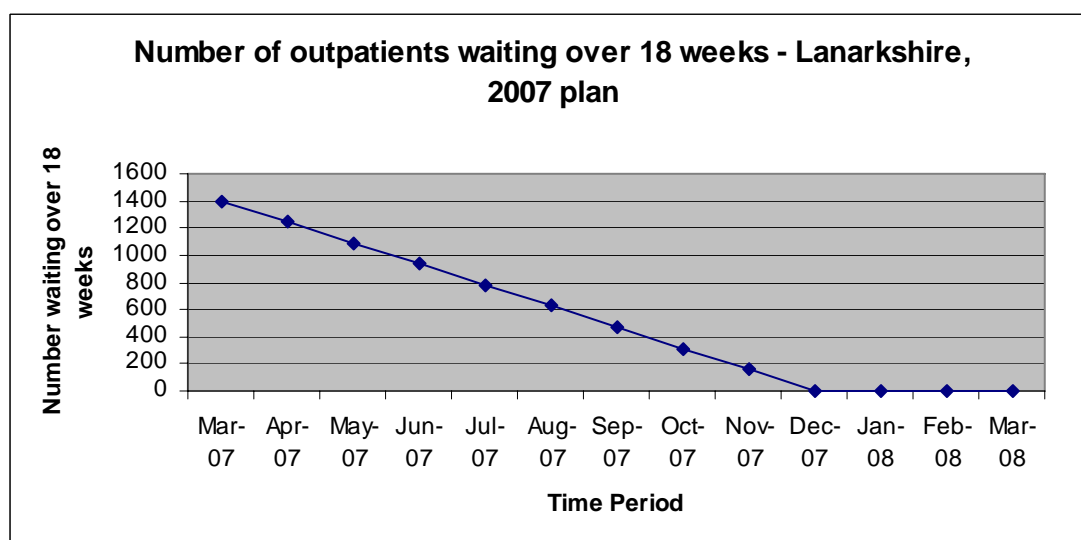
3.07.K Outpatients waiting over 18 weeks from GP referral ; excl ASCs (linked to target A.04T)

Number of outpatients waiting over 18 weeks excluding ASCs;(acute specs recorded on MMI only); GP/GDP referrals.



Trajectory:

Mar 07	Apr 07	May 07	June 07	Jul 07	Aug 07	Sept 07	Oct 07
1400	1245	1090	935	780	625	470	315
Nov 07	Dec 07						
160	0						



Narrative:**Objective**

NHS Lanarkshire has to sustain the twenty six week maximum wait for out patient appointment and improve that position to a maximum wait of eighteen weeks by 31st December 2007.

Actions

- o Introduce new management arrangements with the appointment of General Managers and Clinical Directors into a Lanarkshire wide remit;
- o Provide permanent investment to maintain service improvements initiated through CCI Outpatient Programme;
- o Work in progress to refine and improve capacity planning in out patients;
- o Establish a Referral Management Service;
- o Promote electronic referral based on agreed referral criteria;
- o Reduce ratio of return to new outpatient appointments;
- o Initiate dialogue with GPs on demand management;
- o Establish Planned Care Collaborative in the context of a *Picture of Health* (one work stream is around referral management service, eliminating unnecessary follow up and extending patient focused booking.)

Risks & Risk Management

- o Capacity to deal with demand (including physical capacity);
- o Inability to recruit staff;
- o Consistent application of referral criteria by General Practitioners;
- o Clinical ownership of agenda;
- o Impact of outpatient conversion linked to increased activity in inpatients and day cases and the impact of delivering the waiting time guarantee;
- o Funding to address backlog of patients to deliver and sustain eighteen weeks.

Costs

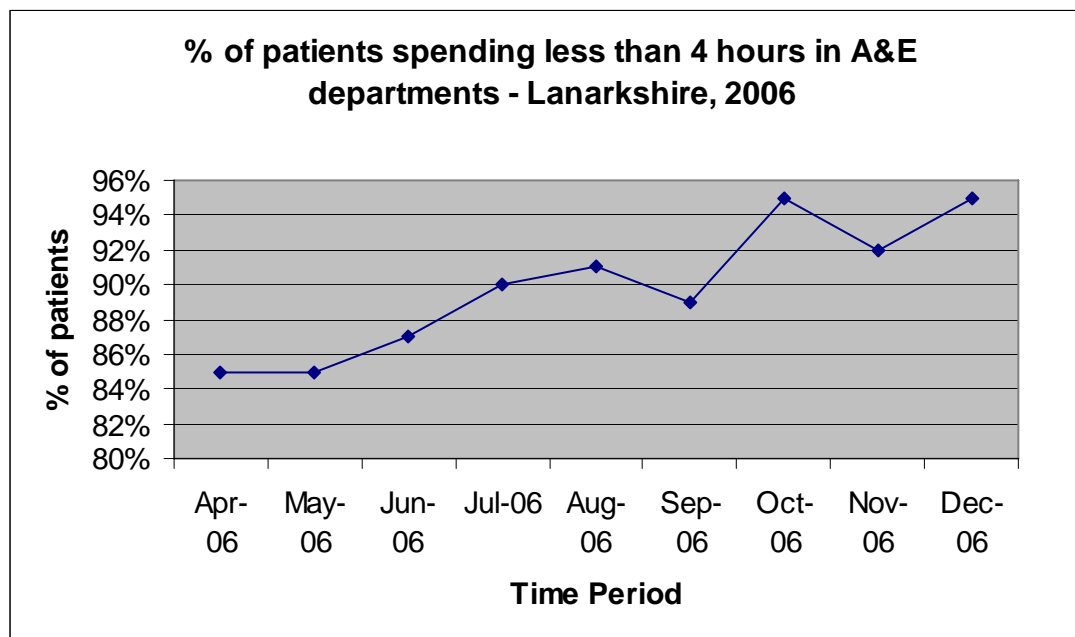
Identification of costs represents work in progress. The costs could however be considerable both in terms of permanent investment and short-term initiatives to address activity backlog.

A05T	By end 2007 no patient will wait more than 4 hours from arrival to admission, discharge or transfer for accident and emergency treatment.
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Lead: I A Ross, Director of Acute Services
D Hume, Divisional General Manager

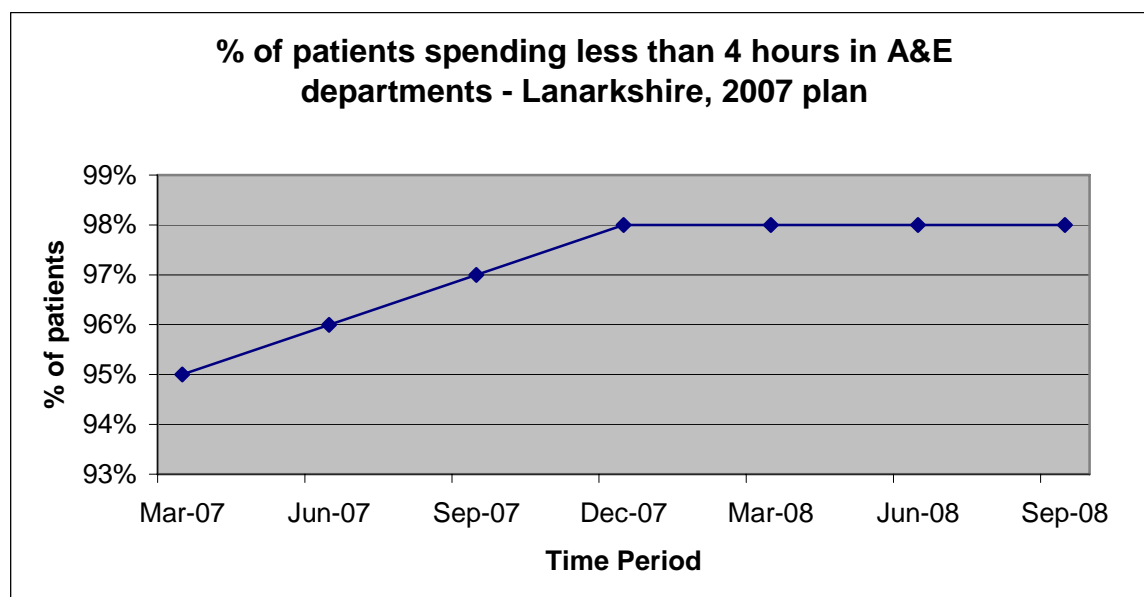
3.08.K A&E waits to be a maximum of 4 hours (linked to target A.05T)

The percentage of patients seen waiting no more than 4 hours from arrival to admission, discharge or transfer for accident and emergency treatment. Source: A&E systems.



Trajectory:

Dec 06	Mar 07	Apr 07	May07	Jun 07	Jul 07	Aug 07	Sep 07
95%	95%	96%	96%	96%	96%	96%	97%
Oct 07	Nov 07	Dec 07					
97%	97%	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 2006. Compliance has to be at 95% by 31 December 2006.

Actions

New management arrangements providing a pan Lanarkshire focus on Unscheduled Care have now been implemented. Daily operational decision making is now being supported by data from the EDIS system in all three Accident and Emergency Departments.

The following actions have been implemented to support the delivery of the target:

- Performance Management – clinical and operational escalation policy has now been implemented and is linked to key journey time measures;
- Robust daily reporting of breaches to clinicians and managers to inform the debriefing process and facilitate progress;
- Communication of the agenda and key improvement initiatives delivered through multidisciplinary awareness sessions and newsletters;
- Establishment of an out of hospital care group to ensure the awareness of the agenda remains whole system;
- See and Treat – Additional nursing resources are now in place to support the delivery of a See and Treat service in all three Accident and Emergency Departments with performance in this flow group at 98%;
- Operational procedures in place for reporting of planned and potential discharges with a focus on discharge before 12 midday, supported by the use of the three discharge lounges and initiatives such as estimated date of discharge;
- Working across the whole system to ensure organisational arrangements are in place to support the discharge of complex patients across the clinical division.

Risks & Risk Management

The following have been identified as risks to delivery:

- Modernising Medical Careers – FY2 changeover now happens every 4 months within the A&E departments therefore increased awareness of the target is required and will be included as part of the induction process. It is unclear the exact impact of MMC in relation to medical resources, however there are plans to utilise the skills of MINTS major trained nurses to support the assessment and admission processes with the acute setting;
- Increased Activity and Understanding Why – Daily monitoring of activity against each flow group continues. Particular areas of concern are potential increased minor activity due to the success of See and Treat and increased emergency admissions. Detailed analysis of admission profiles is being carried out and work in collaboration with primary care to ensure the UCCP agenda is supported. Further work to be carried out on potential increasing population and the impact on activity.

Costs

In 2006/07 up to 350K was invested in clinical staff to support delivery of the waiting time guarantee. It is anticipated that further investment will be required during 2007/08 linked to service redesign. This will emerge through the Unscheduled Care Collaborative.

A06T	By end of 2007 the maximum wait for cataract surgery will be 18 weeks from referral to completion of treatment.
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Lead: I A Ross, Director of Acute Services
R Garscadden, Head of Planning, Acute Services

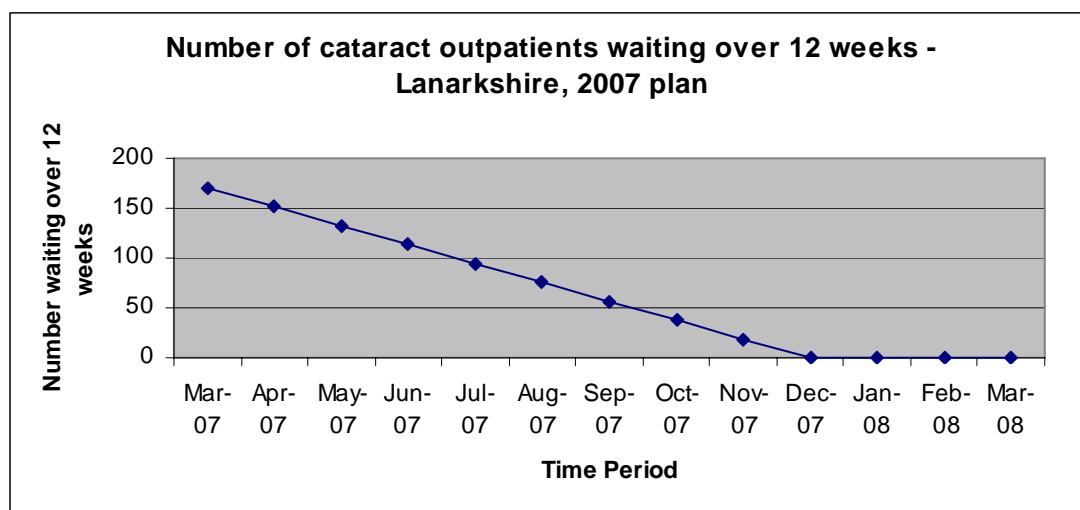
3.09.A.K Wait for cataract surgery (outpatient) (linked to target A.06T)

A measure of the outpatient chunk of the total wait for cataract surgery; this measure is the number of patients waiting over n weeks for first outpatient appointment. The wait (n) is agreed with each Board. (*n = 12 weeks in NHSL*).

(There is no historical chart as this is a revised measure for 2007/08).

Trajectory:

Mar 07	Apr 07	May 07	Jun 07	Jul 07	Aug 07	Sep 07	Oct 07
171	152	133	114	95	76	57	38
Nov 07	Dec 07	Jan 08	Feb 08	Mar 08	Apr 08	May 08	Jun 08
19	0	0	0	0	0	0	0
Jul 08	Aug 08	Sep 08	Oct 08	Nov 08	Dec 08	Jan 09	Feb 09
0	0	0	0	0	0	0	0
Mar 09	Apr 09	May 09	Jun 09	Jul 09	Aug 09	Sep 09	Oct 09
0	0	0	0	0	0	0	0
Nov 09	Dec 09	Jan 10	Feb 10	Mar 10			
0	0	0	0	0			



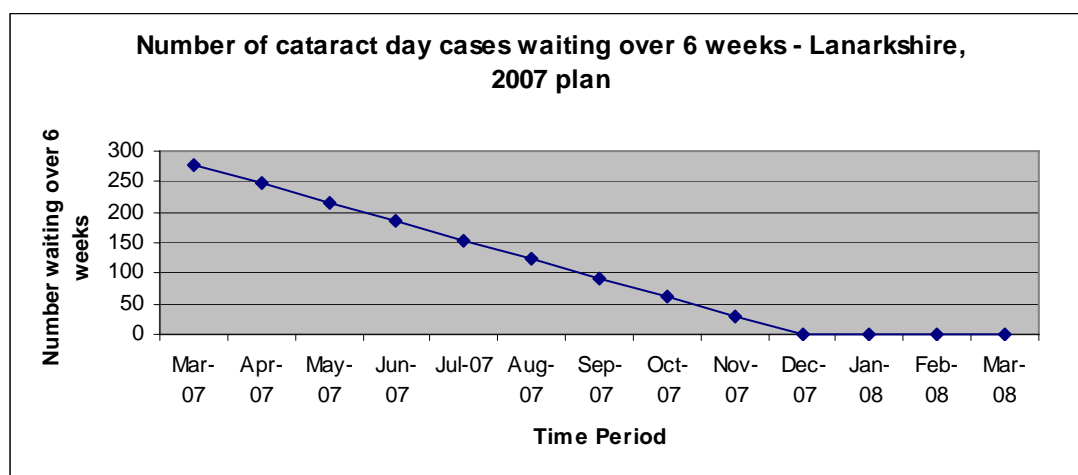
3.09.B.K Wait for cataract surgery (inpatient) (linked to target A.06T)

A measure of the inpatient/day case chunk of the total wait ; this measure is the number of patients waiting over n weeks for inpatient/day case treatment from the decision to proceed to surgery. The wait (n) is agreed with each Board. ($n = 6$ weeks for NHSL).

(There is no historical chart as this is a revised measure for 2007/08).

Trajectory:

Mar 07	Apr 07	May07	Jun 07	Jul 07	Aug 07	Sep 07	Oct 07
278	247	216	185	154	123	92	61
Nov 07	Dec 07	Jan 08	Feb 08	Mar 08	Apr 08	May 08	Jun 08
30	0	0	0	0	0	0	0
Jul 08	Aug 08	Sep 08	Oct 08	Nov 08	Dec 08	Jan 09	Feb 09
0	0	0	0	0	0	0	0
Mar 09	Apr 09	May 09	Jun 09	Jul 09	Aug 09	Sep 09	Oct 09
0	0	0	0	0	0	0	0
Nov 09	Dec 09	Jan 10	Feb 10	Mar 10			
0	0	0	0	0			

***Narrative:*****Objective**

NHS Lanarkshire has to ensure that no patient waits longer than eighteen weeks from referral to treatment by 31st December 2007. This will require a separation of outpatient and day case on the basis of a twelve week and six week split.

Actions

- Introduced new management arrangements with the appointment of General Managers and Clinical Directors into a Lanarkshire wide remit;
- A cataract collaborative has been established with implementation of an agreed action plan and performance monitoring;
- Capacity has been increased through service redesign and capital and revenue investment;

- Referral protocols have been revised following a patient pathway event. This includes cataract referral by the optometrist to a single referral point in NHS Lanarkshire;
- Introduction of cataract only theatre lists;
- Mechanism for capture and recording of information by outpatient and day case to enable robust tracking of patient.

Risks & Risk Management

- Ability to recruit and retain clinical and non-clinical staff;
- Measurement of eighteen-week maximum wait;
- Compliance with referral protocols;
- Accommodation and equipment constraints.

Costs

There has been investment in equipment to improve capacity and performance.

A07T	By end of 2007, the maximum wait from admission to a specialist unit to hip surgery, following fracture, will be 24 hours.
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Lead: I A Ross, Director of Acute Services
R Garscadden, Head of Planning, Acute Services

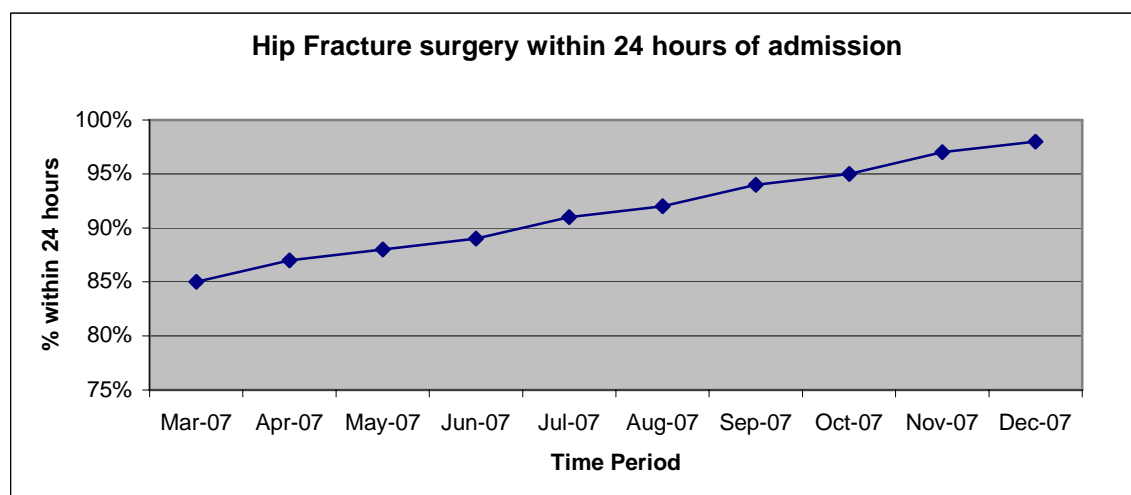
3.10.K Hip fracture surgery within 24 hours (linked to target A.07T)

By end of 2007, the maximum wait from admission to a specialist unit to hip surgery, following fracture, will be 24 hours. Source: Scottish Hip Fracture Audit.

(There is no historical chart as data has not been available until late 2006)

Trajectory:

Dec 06	Mar 07	Apr 07	May07	Jun 07	Jul 07	Aug 07	Sep 07
78%	85%	87%	88%	89%	91%	92%	94%
Oct 07	Nov 07	Dec 07					
95%	97%	98%					



Narrative:

Objective

NHS Lanarkshire has to ensure that the maximum wait from admission to specialist unit for hip surgery following fracture will be 24 hours by 31st December 2007.

Actions

- o Appointment of audit nurse on each acute hospital site reporting to the General Manager with responsibility for Surgical Services across NHS Lanarkshire;

- Consistent capture and reporting of activity information across NHS Lanarkshire with opportunity to compile action plan to improve performance;
- Service redesign on each acute hospital site to ensure consistent, effective and efficient process and practice.

Risks & Risk Management

- Retention of staff;
- Funding to facilitate service redesign to provide additional capacity and improve process and practice
- Pressure from paediatric trauma on Wishaw General site;
- Difficulty in attracting trained orthopaedic theatre nursing staff.

Costs

There has been recruitment of audit staff at a cost of around 80K. Further service redesign work may necessitate pump priming and some additional investment. The nature and extent of future investment remains to be identified and quantified.

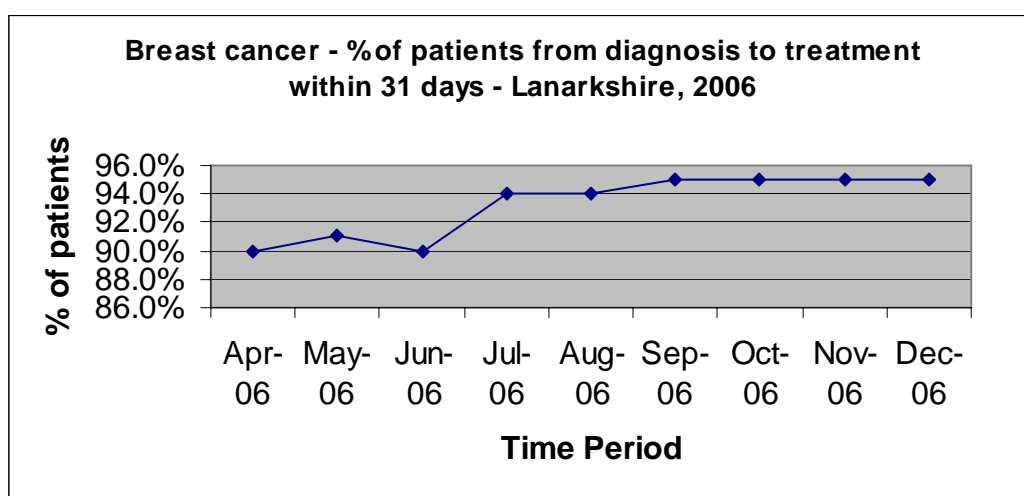
A08T	The maximum wait from urgent referral to treatment for all cancers is two months; women who have breast cancer and need urgent treatment will get it within one month where appropriate.
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Lead: **I A Ross, Director of Acute Services**
 R Garscadden, Head of Planning, Acute Services

3.11.K Breast cancer waiting times (31 days) (linked to target A.08T)

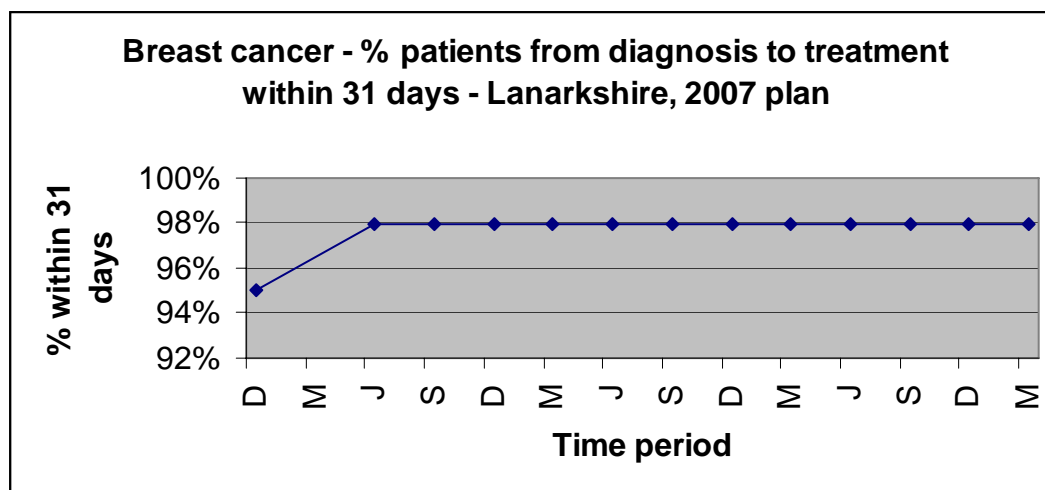
Percentage of patients treated within 31 days of diagnosis of breast cancer.

Source: Regional Cancer Network data.



Trajectory:

Dec 06	Jun 07	Sep 07	Dec 07	Mar 08	Jun 08	Sep 08	Dec 08
95%	98%	98%	98%	98%	98%	98%	98%
Mar 09	Jun 09	Sep 09	Dec 09	Mar 10			
98%	98%	98%	98%	98%			



Narrative:

Objective

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

Actions

- Breast Co-ordinators in place on each acute hospital site to maintain the patients journey;
- Software introduced to capture and report on patient journey and facilitate patient tracking;
- New management arrangements in place to view patient journey on NHS Lanarkshire wide basis;
- Clinical lead in place linking to NHS Lanarkshire wide cancer steering group;
- General Manager appointed with Lanarkshire wide responsibility for cancer services;
- Link to Diagnostic Collaborative with establishment of protocols around patient journey and access to capacity;
- Dialogue with General Managers in Surgery and Medicine to ensure efficient and effective communication to facilitate service delivery to patient;
- Purchase of equipment across a number of departments including laboratories, radiology and surgical to ensure patients are seen timeously and within waiting time guarantee;
- Dialogue with external service providers including the Beatson Institute to ensure appropriate access to treatment services.

Risks & Risk Management

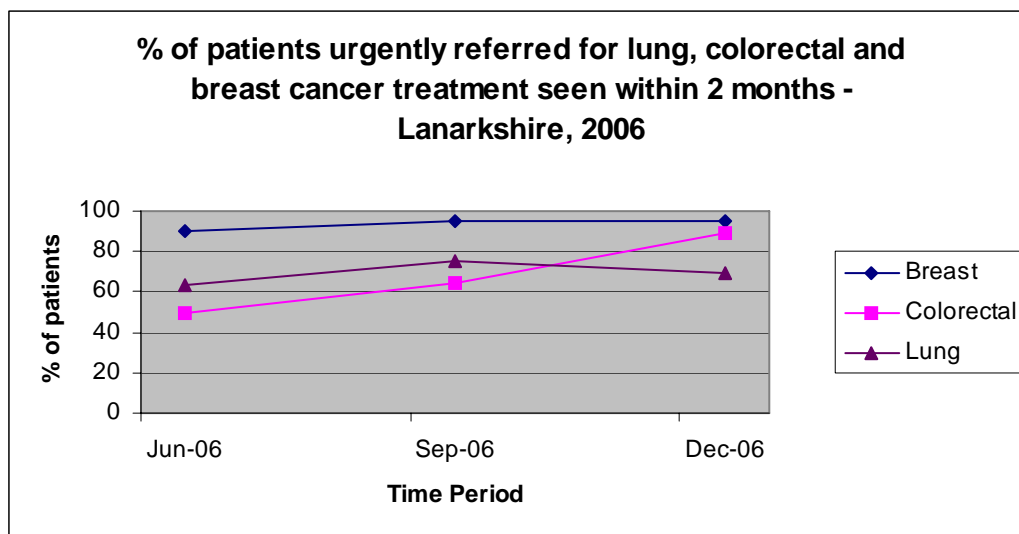
- Recruitment and retention of clinical and non-clinical staff;
- Access to diagnostic services;
- Available capacity in Lanarkshire and in external NHS Boards.

Cost

Delivery at present within existing resources.

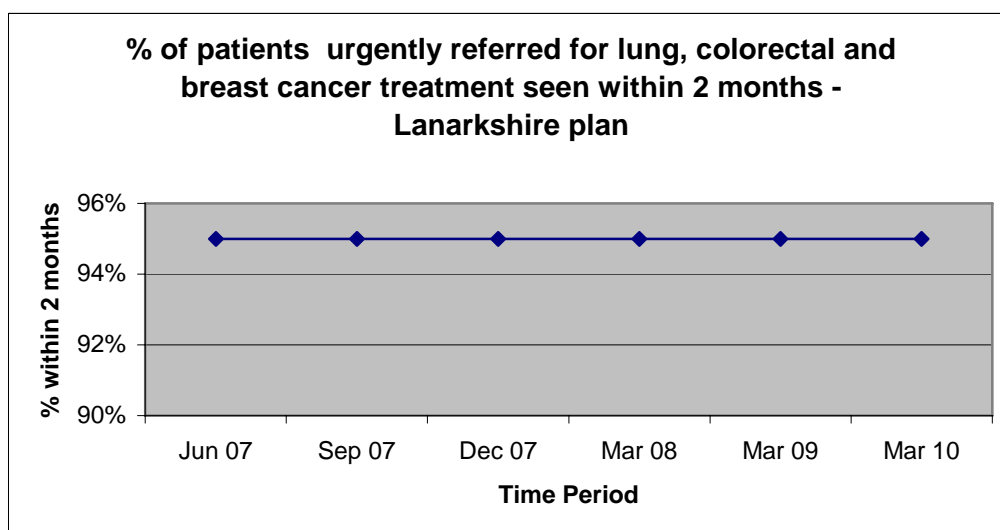
3.24.K All cancer waiting times (62 days) (linked to target A.08T)

Percentage of patients treated within 62 days of urgent referral. Source: Regional Cancer Network data.



Trajectory:

Jun 07	Sep 07	Dec 07	Mar 08	Jun 08	Sep 08	Dec 08	Mar 09
95%	95%	95%	95%	95%	95%	95%	95%
Jun 09	Sep 09	Dec 09	Mar 10				
95%	95%	95%	95%				



Narrative:

Objective

NHS Lanarkshire has to ensure that the maximum wait from receipt of urgent GP referral to first treatment is 62 days. The timescale for delivery of this guarantee was 31st December 2005. NHS Lanarkshire has routinely met the waiting times guarantee for breast cancer but has fallen below the guarantee timescale in respect of colorectal and lung. A revised timescale of 31st December 2006 was established within which the guarantee had to be achieved for the remaining two tumour types. Significant progress has been made with both remaining tumour types with colorectal increasingly meeting the waiting time guarantee and lung delivering around 80% compliance. A mechanism to capture and report on six further tumour types commenced in December 2006 with activity and waiting time baselines for all currently being identified. This will be followed by agreement on the most appropriate patient pathway and as appropriate identification of actions to increase activity.

Actions

- Patient trackers have been recruited to track patient journeys across four main tumour types (breast, lung, colorectal and ovarian);
- Software is being piloted to facilitate capture and reporting of real time patient information;
- The Diagnostic Collaborative has been established that has resulted in investment in additional staff in endoscopy and radiology linked to service redesign. Those actions have improved access to tests;
- Referral criteria have been revisited as part of the Diagnostic Collaborative and as part of service redesign;
- Lead Clinicians have been appointed for each tumour type;
- Introduced new management arrangements with the appointment of General Managers and Clinical Directors into a Lanarkshire wide remit;
- Co-ordinated working with regional and national networks;
- Mechanisms have been established to address other tumour types to include Head & Neck, Urology, Upper GI, Lymphoma, Ovarian and Melanoma.

Risks & Risk Management

- Sustaining capacity to meet demand;
- Ability to recruit and retain staff;
- Clinical ownership of service change;
- Interface between primary and secondary care.

Costs

Patient trackers for lung and colorectal were appointed during 2006/07 at a cost of around 130K. This complemented three breast coordinators already in post. Further investment is planned for 2007/08 with the appointment of at least one further patient tracker. A consultant lead has been appointed for each tumour type with additional funding in place to ensure back fill to enable each clinician to play a full part in taking the service forward linked to service redesign.

The improvement in performance to date is also linked directly to increased investment in diagnostics linked to service redesign through the work of the Diagnostic Collaborative.

A11T	By end 2007, the maximum wait for cardiac intervention will be 16 weeks from GP referral through rapid access chest pain clinic or equivalent <i>and</i> 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.
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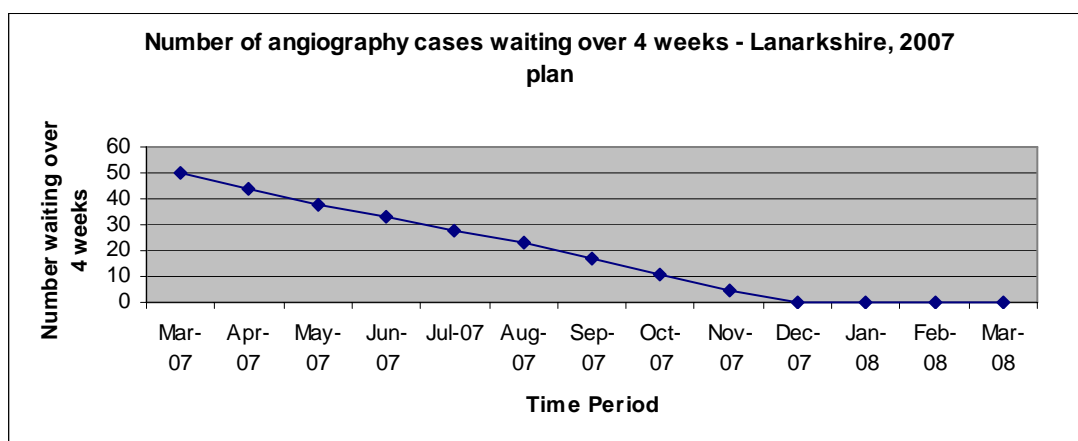
Lead: I A Ross, Director of Acute Services
R Garscadden, Head of Planning, Acute Services

3.19.A.K Wait for cardiac intervention (angiography) (linked to target A.11T)

Waiting time to angiography as defined for Cardiac Monthly Management Information. The number of inpatients/day cases waiting more than n weeks for angiography; n to be agreed with each Health Board; OPCS4 code for procedures have been defined by ISD.

Trajectory:

Mar 07	Apr 07	May07	Jun 07	Jul 07	Aug 07	Sep 07	Oct 07
50	44	38	33	28	23	17	11
Nov 07	Dec 07	Jan 08	Feb 08	Mar 08	Apr 08	May 08	Jun 08
5	0	0	0	0	0	0	0
Jul 08	Aug 08	Sep 08	Oct 08	Nov 08	Dec 08	Jan 09	Feb 09
0	0	0	0	0	0	0	0
Mar 09	Apr 09	May 09	Jun 09	Jul 09	Aug 09	Sep 09	Oct 09
0	0	0	0	0	0	0	0
Nov 09	Dec 09	Jan 10	Feb 10	Mar 10			
0	0	0	0	0			

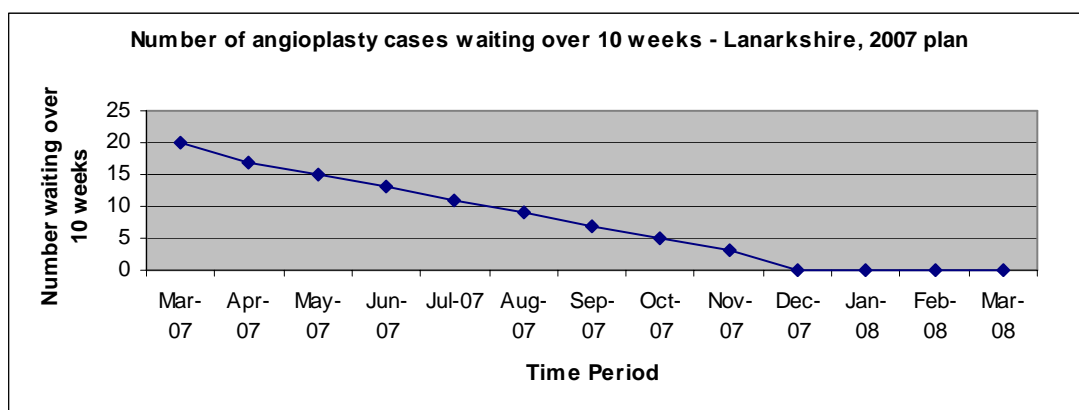


3.19.B.K Wait for cardiac intervention (angioplasty and CABG surgery) (linked to target A.11T)

Waiting time to angioplasty and CABG surgery as defined for Cardiac Monthly Management Information; The number of inpatients/day cases waiting more than n weeks for angiography; n to be agreed with each Health Board; OPCS4 code for procedures have been defined by ISD.

Trajectory:

Mar 07	Apr 07	May07	Jun 07	Jul 07	Aug 07	Sep 07	Oct 07
20	17	15	13	11	9	7	5
Nov 07	Dec 07	Jan 08	Feb 08	Mar 08	Apr 08	May 08	Jun 08
3	0	0	0	0	0	0	0
Jul 08	Aug 08	Sep 08	Oct 08	Nov 08	Dec 08	Jan 09	Feb 09
0	0	0	0	0	0	0	0
Mar 09	Apr 09	May 09	Jun 09	Jul 09	Aug 09	Sep 09	Oct 09
0	0	0	0	0	0	0	0
Nov 09	Dec 09	Jan 10	Feb 10	Mar 10			
0	0	0	0	0			



Narrative:

Objective

NHS Lanarkshire has to ensure that by 31st December 2007 the maximum wait for cardiac intervention will be 16 weeks from GP referral through rapid access chest pain clinic or alternative and 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.

NHS Lanarkshire has interpreted that as requiring a two week maximum wait from referral to being seen at the rapid access chest pain clinic, a further four weeks to angiography and ten weeks to angioplasty for those patients requiring that procedure.

Actions

- o A capacity plan is in place that identifies additional capacity to deliver guarantee;

- A Business Case has been agreed that involves recruitment of additional staff;
- Existing catheter laboratory and associated areas are being expanded to provide additional bed space;
- Additional accommodation is being identified to provide potential to expand catheter laboratory capacity;
- Dialogue is taking place to explore extended working to maximise capacity;
- The whole patient journey is subject to service redesign to deliver the optimum patient pathway;
- Dialogue with neighbouring NHS Boards to ensure that patients referred for other procedures are tracked.

Risks & Risk Management

- Ability to recruit and retain staff;
- Ownership of service change/redesign;
- Upgrade of catheter laboratory facility within agreed timescale;
- Continued development of the service within the financial framework.

Costs

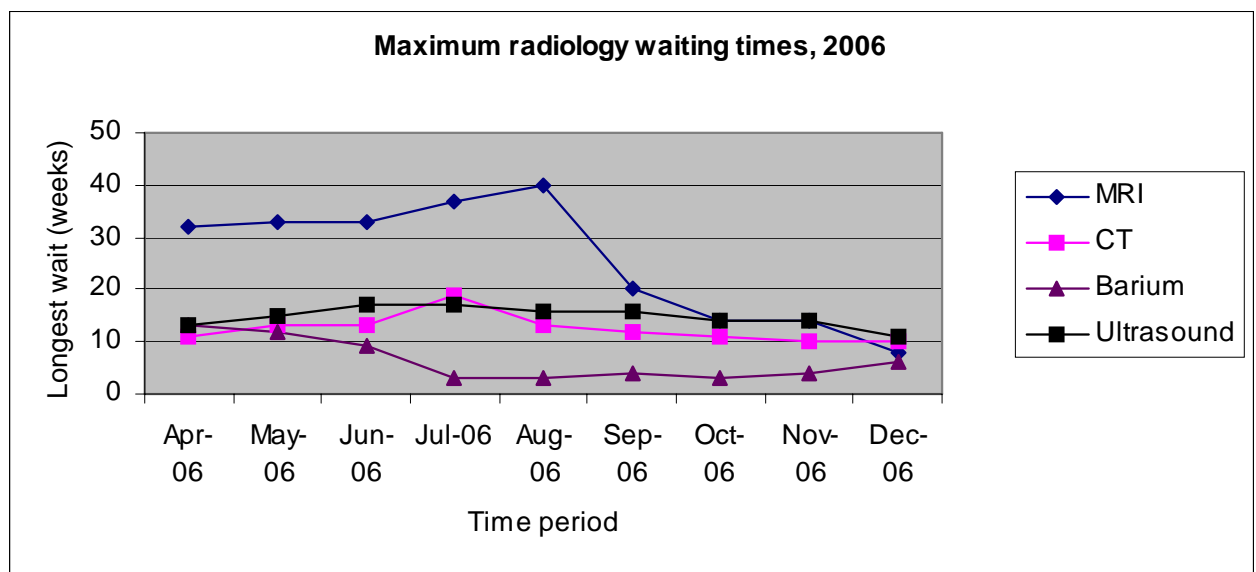
Up to one million pounds investment to increase Catheter Laboratory capacity.

A12T	By the end of 2007 patients will wait no more than nine weeks for any MRI or CT scans and other key diagnostic tests.
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Lead: I A Ross, Director of Acute Services
R Garscadden, Head of Planning, Acute Services

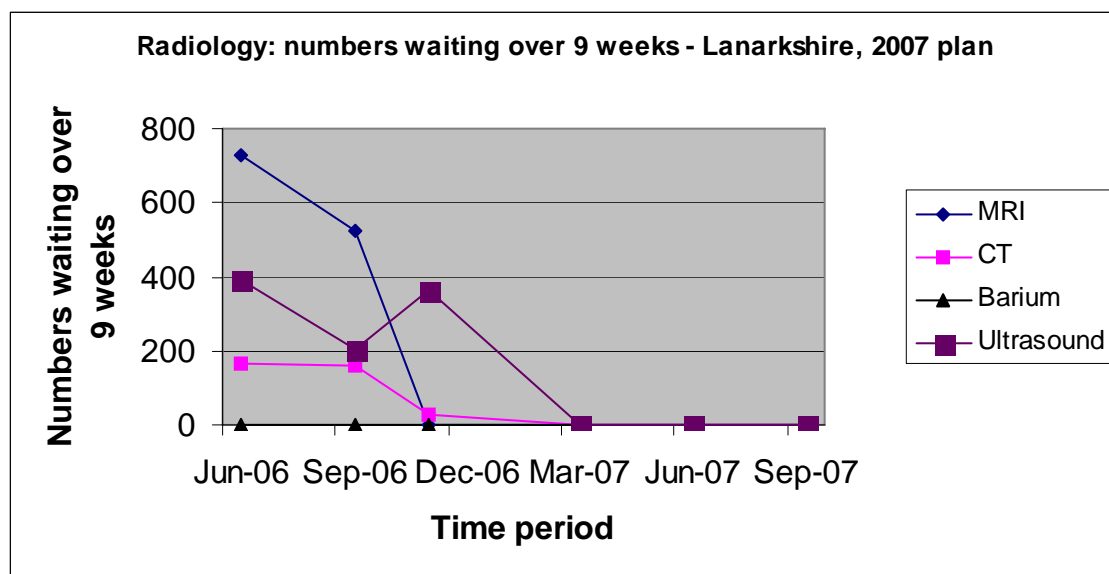
3.25.K Waiting times for diagnostic scans (MRI /CT/barium studies/ultrasound non-obstetric) (linked to target A.12T)

Number of patients waiting over 9 weeks for: MRI /CT /barium studies /ultrasound non-obstetric.



Trajectory:

	Numbers waiting over 9 weeks					
	Jun 06	Sep 06	Nov 06	Mar 07	Jun 07	Sep 07
MRI	726	525	1	0	0	0
CT	166	161	26	0	0	0
Barium	0	0	0	0	0	0
Ultrasound	390	206	364	0	0	0



Narrative:

Objective

NHS Lanarkshire has to ensure that no patient will wait more than nine weeks for any MRI or CT scan and other key diagnostic tests by 31st December 2007. For most investigations, delivery of that guarantee has been achieved. The objective will be to sustain that position and as appropriate improve on it.

Actions

- Radiology Steering Group has been established in the context of the Diagnostic Collaborative;
- A lead clinician has been identified supported by a project manager;
- A mapping event has been undertaken to identify optimal patient pathway for each modality on a NHS Lanarkshire wide basis;
- An action plan has been agreed to deliver the optimal patient pathway and waiting time guarantee (this has included investment in staff and equipment);
- Software has been upgraded and replacement equipment procured to increase capacity and improve quality;
- Establish close links with national and regional networks to ensure awareness of good practice.

Risks & Risk Management

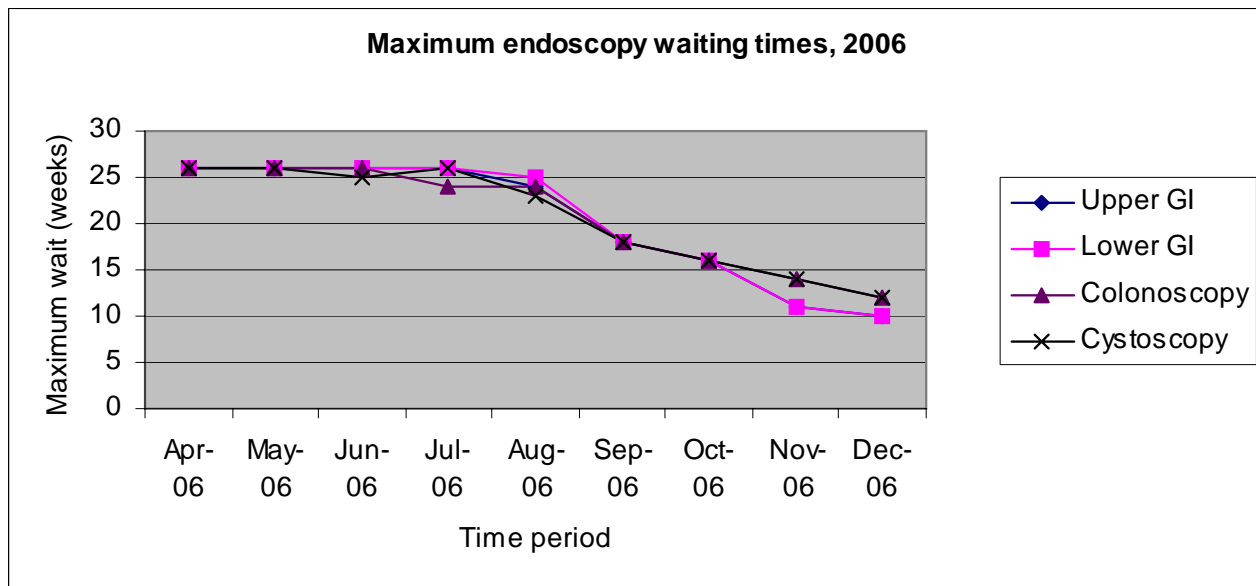
- Ownership of patient pathways;
- Recruitment and Retention of staff;
- Maximisation of use of new/replacement equipment;
- Increased demand on services and continued ability to respond (to contribute towards delivery of a range of waiting time guarantees including cancer);
- Acceptance of the trajectory by clinicians in primary and secondary care to deliver consistent and improved ways of working.

Costs

Funded £1,147,000 in 2006/07 (extends over all diagnostic services as part of the Diagnostic Collaborative.) That will increase to at least £1,500,000 during 2007/08.

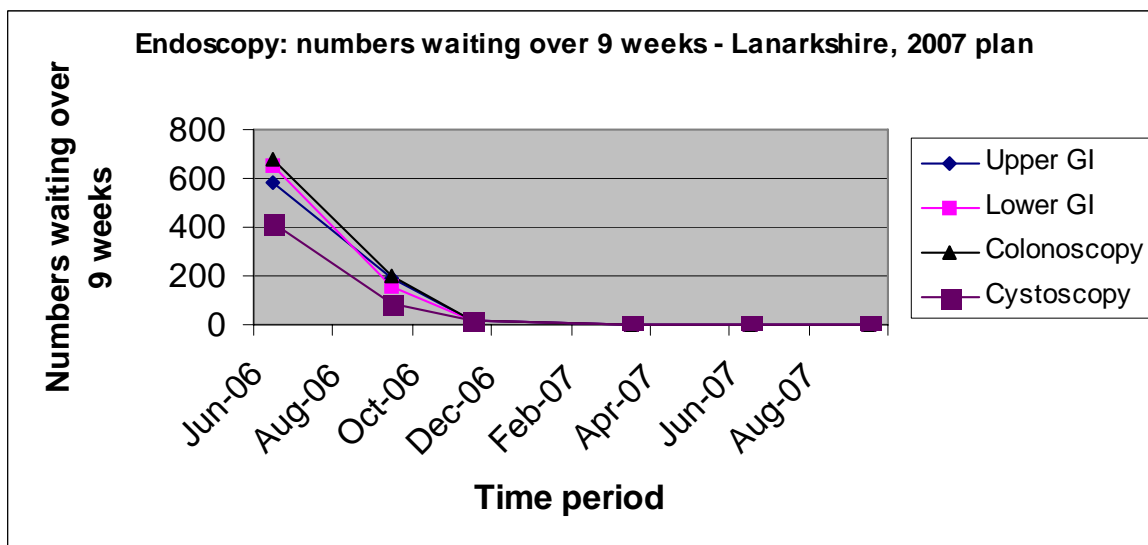
3.26.K Waiting times for diagnostic scopes (gastroscopy/ sigmoidoscopy/ colonoscopy/ cystoscopy) (linked to target A.12T)

Number of patients waiting over 9 weeks for : gastroscopy/ sigmoidoscopy/ colonoscopy/ cystoscopy.



Trajectory:

	Numbers waiting over 9 weeks					
	Jun 06	Sep 06	Nov 06	Mar 07	Jun 07	Sep 07
Upper GI	585	189	14	0	0	0
Lower GI	655	154	19	0	0	0
Colonoscopy	676	204	17	0	0	0
Cystoscopy	420	90	18	0	0	0



Narrative:

NHS Lanarkshire has to ensure that no patient will wait more than nine weeks for endoscopy by 31 December 2007. This guarantee has already been delivered and the objective will be to sustain and as appropriate improve on the guarantee over that period.

The actions, risks and costs are similar to those listed for radiology. Work is taken forward through the Endoscopy Steering Group that forms part of the Diagnostic Collaborative.

NHS Scotland Objective 4:

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

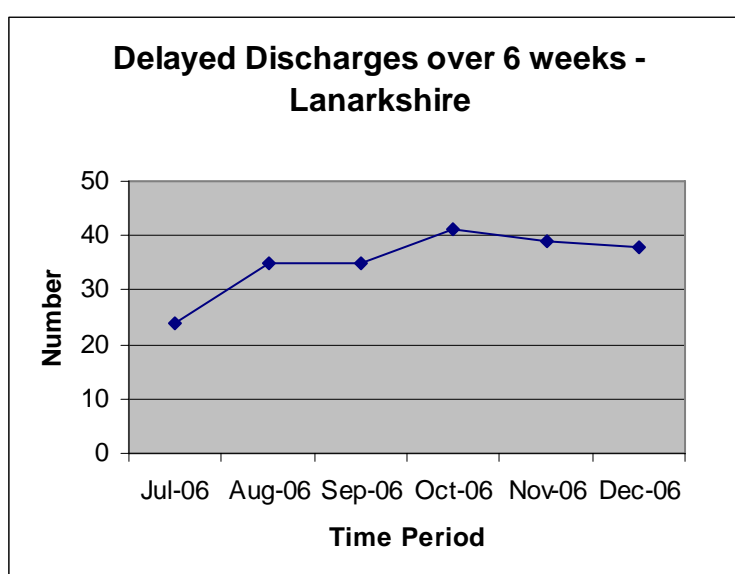
Target Identifier	Target Details
T.01T	The number of people waiting more than 6 weeks to be discharged from hospital into a more appropriate care setting will be reduced by 50% from April 2006 to April 2007 and to zero by April 2008. Additionally, the number of patients delayed in short-stay beds will be reduced by 50% from April 2006 to April 2007, and to zero in April 2008.
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 <u>and</u> reduce, by 10%, emergency inpatient bed days for people aged 65 and over by 2008
T.03T	Cervical screening target 80%, ongoing
T.04T	QIS clinical governance and risk management standards improving
T.05T	Reduce the annual rate of increase of defined daily dose per capita of anti-depressants to zero by 2009/10.
T.06T	Reduce the number of readmissions (within one year for those that have had a psychiatric hospital admission of over 7 days by 10% by the end of December 2009)
T.07T	To reduce all staphylococcus aureus bacteraemia (including MRSA) by 30% by 2010

T01T	The number of people waiting more than 6 weeks to be discharged from hospital into a more appropriate care setting will be reduced by 50% from April 2006 to April 2007 and to zero by April 2008. Additionally, the number of patients delayed in short-stay beds will be reduced by 50% from April 2006 to April 2007, and to zero in April 2008.
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Lead: I A Ross, Director of Acute Services
R Garscadden, Head of Planning, Acute Services

4.01.K Delayed Discharge (Over 6 weeks) (linked to target T.01T)

The total number of people waiting more than 6 weeks to be discharged. Source: National DD Census.



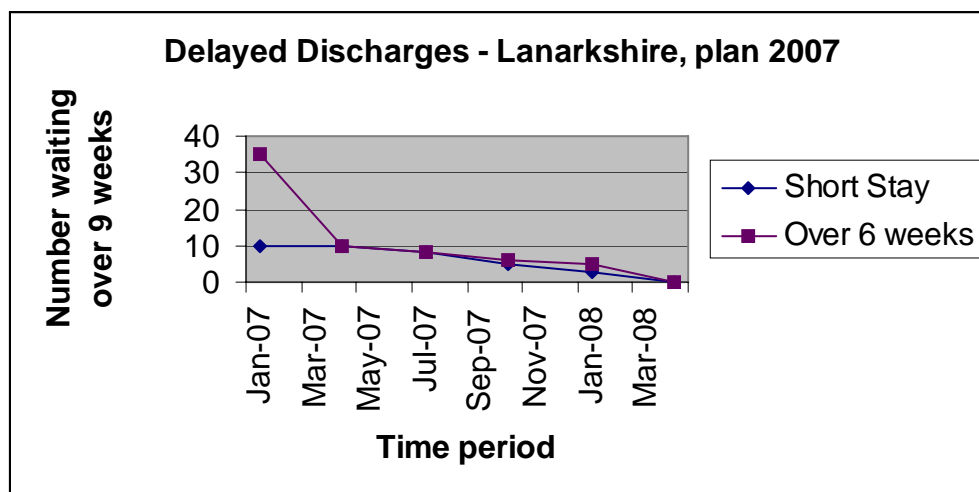
Trajectory:

Short Stay

Jan 07	Apr 07	Jul 07	Oct 07	Jan 08	Apr 08	Jul 08	Dec 08	Jan 09
10	10	8	5	3	0	0	0	0

Over 6 weeks

Jan 07	Apr 07	Jul 07	Oct 07	Jan 08	Apr 08	Jul 08	Dec 08	Jan 09
35	10	8	6	5	0	0	0	0



Narrative:

Objective

NHS Lanarkshire (as part of the Lanarkshire Partnership) has to ensure that by April 2007 delays over six weeks will be reduced by 50% and also that delays in short-term (acute) beds will be reduced 50%. The target in each category is 10 and 10 respectively. By April 2008 the Partnership will reduce delays in both categories to zero.

Actions

- Monitor on a weekly basis delayed discharge patients on each hospital site;
- Manage off site and GP Hospital beds to ensure maximum use of all beds;
- Implement action plan to be designed to support people at home and in community setting, prevent unnecessary emergency admissions to hospital and speed up the assessment process and discharge planning. (This forms part of a range of Local Authority and Health Care Services);
- Maintain and improve on delayed discharge performance through Locality Area Groups and Central Monitoring Group;
- Initiated a review of service delivery funded through delayed discharge initiatives to evidence impact and demonstrate value for money;
- Linking process, practice and performance through work currently being taken forward through Joint Futures and Unscheduled Care Collaborative.

Risks & Risk Management

- Competing demands on Local Health and Social Care Services;
- Ability to recruit and retain staff;
- Achieving flexibility in use of available resources;
- Availability of funding;
- Evidencing that initiatives funded to date demonstrate best practice and represent value for money.

Costs

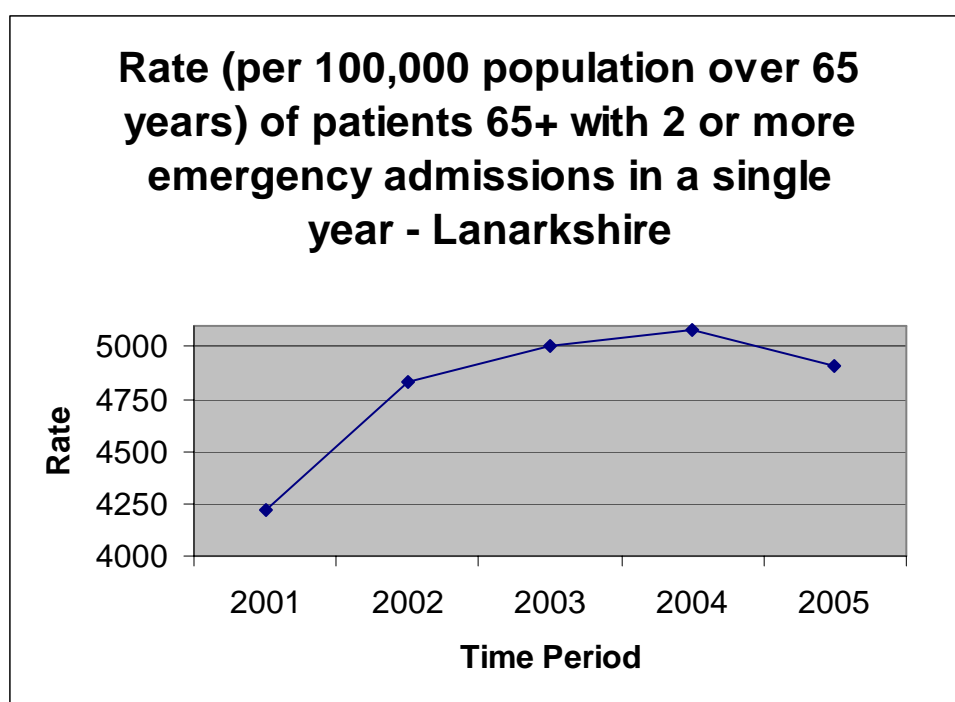
£3.1 million per annum supplemented by mainline funding by both agencies.

T02T	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 <u>and</u> reduce, by 10%, emergency inpatient bed days for people aged 65 and over by 2008
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Lead: C Sloey, Director – CHP North
A Armstrong, Associate Nurse Director

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

The rate (per 100,000 65+ population) of patients (65+), admitted, for any reason, two or more times in one calendar year, as an emergency to acute specialties. Source; linked SMR01.



Trajectory:

31 Mar 05	31 Mar 06	31 Mar 07	31 Mar 08	31 Mar 09	31 Mar 10
4910	4910	4910	4861	3928	3928

Narrative:

Objective

To 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.

Actions

1. Care Management Pilots are underway in 3 localities within Lanarkshire as a means of assessing the impact of this approach across a number of key targets including HEAT target T02T. The approach focuses on improving the management and outcomes for people with Long Term Conditions who account for 70% of all emergency admissions. Key principles are:
 - o to better resource and modernise clinical models in Primary Care;
 - o to improve access to care which is better coordinated and systematic;
 - o to proactively identify and treat people who are likely to require unscheduled care;
 - o to provide holistic assessment and care plans which also include risk assessment;
 - o to involve patients and carers;
 - o to clearly identify a lead person responsible for a person's care;
 - o to ensure appropriate services and treatments are delivered;
 - o Education of patients and carers to recognise signs and symptoms of deterioration;
 - o Maintenance of involvement of primary care team when hospital admission is required;
 - o Effective working across boundaries.

The achievement of these principles is subject to independent evaluation. The evaluation will be carried out jointly with N&S Lanarkshire Councils and will focus on outcomes including admission rates, ALOS, pharmaceutical care, GP attendances, clinical consultations, equipment, social care service utilisation as well as patient, carer & staff satisfaction.

2. Keep Well is a national anticipatory care programme which seeks to address access to health services within deprived communities and is currently focussed on prevention of cardiovascular disease. It aims to address the main risk factors of high blood pressure, cholesterol, smoking, obesity and diabetes. The current focus is in North Lanarkshire, but will be progressively extended to the whole of the NHSL area.

It is expected that this approach will in time reduce the numbers of people who suffer from long term conditions and therefore reduce the number of emergency admissions.

3. Community Nursing Services have been redesigned and are now organised into Long Term Conditions teams and Public Health teams. This focus on Long Term Conditions and Health Improvement within the overall workforce will contribute to achievement of the above target, and steps will be taken to monitor the impact.
4. A further significant development relating to community nursing is the alignment of Out of Hours Nursing with Home Care Services. This has been in place in North Lanarkshire for the past two years and is being extended to the whole of the NHSL area. This has had a demonstrable impact on reducing A & E attendances and admissions, particularly for catheter care.
5. The closer alignment of community nursing and Ambulance services would also appear to have the potential to reduce emergency admissions, and this is subject to further examination.

6. The Care Home Sector is a significant and increasing source of emergency admission and re-admission. The current development of the Primary and Community Care Strategy for NHSL and GMS services to Care Homes will focus on support for Care Homes in the development of pro-active anticipatory care and the skills of care home staff.
7. System wide scrutiny of service provision, comparison with care pathways and resulting service re-design is a key feature in implementing, " A Picture of Health; A Framework for Health Service Improvement in Lanarkshire". This will include re-design that will have a positive impact on 65 + readmissions, for example the Rapid Assessment, Diagnostic and Rehabilitation service at Hairmyres Hospital.

Risks & Risk Management

Evidence of the impact on emergency admission/readmission around the Care Management approach is inconclusive, hence the pilot approach and independent evaluation.

The criteria for access to care management are based on work carried out as part of a project with NHS Education Scotland in 2005/06 that identified a number of risk factors related to age, medication, mobility and cognitive impairment. These will be closely monitored throughout the pilot period and their validity in the identification of appropriate individuals will be an important part of the evaluation.

Similarly, Keep Well may improve reach and access for people in deprived communities, however this does not guarantee that people will then use those services or change their lifestyles significantly.

Costs

Keep Well - we have allocated £590k for expenditure in 2006/07 with a full year cost in 2007/08 of £1.42m.

Care Management has not been separated out from the Community Nursing Review monies as this is seen as an integral part of DN work and as such CNR will contribute to achieving this target. The estimated spend in 2006/07 is £718k and in 2007/08 £1.47m (this figure reduces by c. £300k in 2008/09 as clawback for skill mix).

The establishment of Care Home Teams, again targeting the +65 age group, will require additional investment of £663k in 2007/08.

4.08.K Reduction in emergency bed-days for patients aged 65+ (linked to target T.02T)

The number of emergency bed days, in acute specialties, for patients aged 65+. Source: SMR01.

Trajectory:

Mar 05	Mar 06	Mar 07	Mar 08	Mar 09	Mar 10
290,412	283,152	275,892	268,632	261,371	261,371

Narrative:**Objective**

To reduce the number of emergency bed-days for patients aged 65+.

Actions

The actions above for 4.02K will be largely the same for 4.08K, however in addition, a review is currently underway looking at services that are designed either to prevent admission or to facilitate early discharge, to see how these can be redesigned to best effect, ensuring they are consistent across Lanarkshire and appropriately integrated with Care Management activity. Reducing lengths of stay for those who do require admission is a key component of Care Management, through better integrated work between Health and Social Care and between Primary and Acute care.

Through the development of Minor Injury Units and through improved access to diagnostics and telemedicine, it is anticipated that fewer elderly people will be admitted to hospital simply to receive diagnostic tests.

Risks & Risk Management

Again, the evidence in support of care management is inconclusive. In addition, our elderly population is growing and therefore there will be more people within the category who may be admitted.

We need to be careful not to shorten lengths of stay at the expense of proper recovery which could then lead to more admissions.

Costs

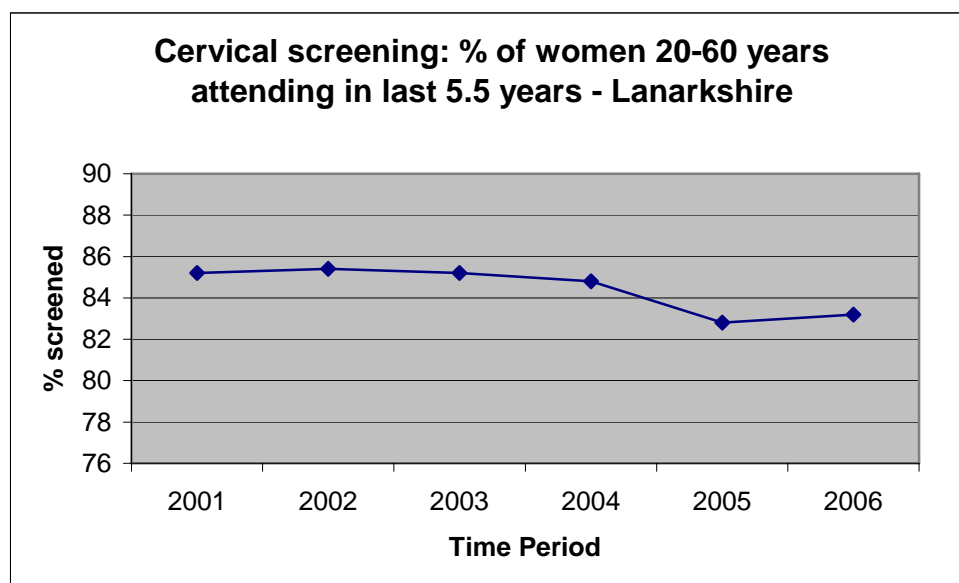
See 4.02K

T03T	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 (80%) (linked to target T.03T)

The percentage of women in the 20-60 year old group attending a screening in the last 5.5 years. Source: ISD (D) 4



Trajectory:

Mar 07	Mar 08	Mar 09	Mar 10
80%	80%	80%	80%

Narrative:

Objective

To achieve at least 80% of women in the 20-60 year old group attending a screening in the last 5.5 years.

Actions

NHS Lanarkshire is currently achieving the target (83.2% at 31 March 2006), however, both local and national trends have been downwards in recent years although there appears to be a slight increase at 5.5 years for the period 2005/06 in Lanarkshire compared with 2004/05. When this is measured over 3.5 years, this slight improvement is not seen. The following actions are being taken to maintain and improve uptake of cervical screening:

- The Cervical Screening Working Group continues to review uptake by GP practice, and offers targeted support where appropriate;

- Recognising that 20-24 year olds are least likely to attend for screening, a local audit has been undertaken. This revealed that uptake in NHSL by 20-24 year olds at 31 March 2006 was 57.8%, and that this too had been declining over recent years. The results of this audit will now be used to inform a campaign to encourage attendance by women in this age group;
- The initial Big Lottery Project, comprising two development workers (ethnic minorities and deprived areas) is now underway. A further bid is being made to Big Lottery to fund further workers to target areas across NHSL.

Risks & Risk Management

Personal choice, often strongly influenced by lay beliefs, affects whether women take up the offer of screening. The NHS in Lanarkshire continues to try to achieve true informed consent for women invited to participate in cervical screening through the appropriate education and awareness raising initiatives. The GP contract specification range of 25-80% and the ability to exclude recurrent defaulters for payment purposes may have an impact on sustaining levels above 80%, although this cannot be quantified at present.

Costs

The service is fully funded, with the Big Lottery Project operating within the requirements of the Lottery grant.

T04T	QIS clinical governance and risk management standards improving
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Lead: J D Browning, Medical Director (to 31/12/06)
A Graham, Medical Director (from 12/03/07)

4.04.K QIS: improving clinical governance and risk management standards (linked to target T.04T)

Number of points achieved (max 12) for 3 standards within QIS Clinical Governance and Risk Management assessment. Source: QIS.

(There is no historical chart as the Standards were launched in 2005 and the first QIS assessments made during 2006)

Trajectory:

Mar 05	Mar 07	Mar 08	Mar 09	Mar 10
5 (estimate)	6	7	8	9

Narrative:

Objective

Services delivered to the people of Lanarkshire must be clinically effective, with risk adequately managed. In pursuit of these aims, NHS Lanarkshire is working towards full compliance with the QIS Standards.

Actions

Clinical effectiveness and risk management have been brought together within a single system Clinical Governance Department. A programme of action is underway in relation to the 2005 QIS standards. External assessment by QIS took place in September 2006, with the draft report indicating a score of 6 for NHS Lanarkshire. Following on from the visit and report, a further action plan will be developed, overseen by the Health & Clinical Governance Steering Group.

Risks & Risk Management

The scoring within the NHS QIS assessment process results in criteria and standards which are in transition dropping to very low levels during the transition period and it is considered very unlikely, in view of the extent of change being undertaken within the NHS, that any system will achieve consistently high scores. NHS QIS appears reluctant to accept that monitoring processes currently used within the NHS meet their standards and it is concluded that despite best efforts it is unlikely that any system will be able to score higher than 9 and this is therefore identified as the end trajectory point.

Costs

The work towards meeting the clinical governance and risk management standards will be taken forward within existing resources.

T05T	Reduce the annual rate of increase of defined daily dose per capita of anti-depressants to zero by 2009/10.
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Lead: C Sloey, Director – CHP North
A Cook, Associate Medical Director

4.10.K Prescribing of anti-depressants (linked to target T.05T)

The rate of increase of defined daily dose (DDD), per capita, for anti-depressants.
Source: ISD.

(There is no historical chart as this is a new Target from 2007/08)

Trajectory:

Jun 06	Jun 07	Sep 07	Dec 07	Mar 08	Jun 08	Sep 08	Dec 08
0.48%	0.52%	0.50%	0.50%	0.46%	0.40%	0.36%	0.30%
Mar 09	Jun 09	Sep 09	Dec 09	Mar 10			
0.25%	0.15%	0.10%	0.05%	0.00%			

Narrative:

Objective

To reduce the annual rate of increase of defined daily dose per capita of anti-depressants to zero by 2009/10.

Actions

As part of its action towards Commitment 4 in *Delivering for Mental Health*, NHSL will increase the availability of evidence-based psychological therapies to all age groups and in all settings. Money saved from the prescribing of anti-depressants for 2007/08 will be used to fund a new service, which will increase availability of psychological therapies in primary care. The service will be staffed by 'Clinical Associates in Applied Psychology'.

During 2007/08, we will implement NICE guidance on the Management of Anxiety and Depression, promoting the use of alternatives to medication as first line responses. We will also implement the NHS QIS standard on an Integrated Care Pathway for Depression, once published.

We plan to increase the availability of training for mental health and other community based staff, and support to GPs, to assist them to deliver relevant psychological therapies in primary care.

Fuller details of our overall plans for the development of mental health services locally have been provided in the separate *Delivering for Mental Health Implementation Progress* return, submitted to Scottish Executive on 15 March 2007. An integral part of that submission was our progress template in relation to the mental health nursing review ('Rights, Relationships and Recovery').

Risks & Risk Management

By increasing understanding and awareness of anxiety and depression, it is likely that there will be a rise in case finding and demand for treatment. This will be

managed by ensuring that all treatment services are in place according to plan and timescale.

There is a risk that despite increasing psychological therapies, people will still be prescribed medication. A local medication management guideline will be developed during 2007/08, and overall this will be managed as part of the Primary Care Prescribing Action Plan, which is updated annually.

Increasing availability of psychological therapies requires associated staffing capacity. Nationally, NES is funding an increase in places and NHSL provides a number of placements designed both to provide training and attract candidates to work here.

If demand for psychological therapies is greater than anticipated, cost will be higher. Similarly, a reduction in prescribing may not necessarily bring about a reduction in prescribing costs (e.g., newer, more costly drugs). The overall financial plan will be closely monitored to enable any remedial action or further work to be taken promptly.

Costs

Services are funded as part of core budgets / agreed projects.

T06T	Reduce the number of readmissions (within one year for those that have had a psychiatric hospital admission of over 7 days by 10% by the end of December 2009)
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Lead: C Sloey, Director – CHP North
A Cook, Associate Medical Director

4.11.K Reduction of psychiatric readmissions (linked to target T.06T)

Reduce the number of readmissions (within one year) for those that have had a psychiatric hospital admission of over 7 days (in a Scottish psychiatric hospital) by 10% by the end of December 2009.

The baseline year is year ending December 2005. Analysis based on Health Board of Residence. Includes all psychiatric specialties except learning disabilities; admissions can be elective/emergency but not an inter-hospital transfer. Source: SMR04.

(There is no historical chart as this is a new Target from 2007/08)

Trajectory:

Dec 05	Jun 07	Sep 07	Dec 07	Mar 08	Jun 08	Sep 08	Dec 08
483	483	483	483	477	471	465	459
Mar 09	Jun 09	Sep 09	Dec 09				
453	447	441	435				

Narrative:

Objective

To reduce the number of readmissions (within one year) for those that have had a psychiatric hospital admission of over 7 days by 10% by the end of December 2009.

Actions

During 2007/08, the Mental Health Strategy will be implemented and will reduce reliance on hospital / secondary care, while increasing provision of services in primary / community based settings. Associated with this, the local *Delivering for Mental Health* Action Plan will ensure that NHSL meets all the Commitments in the relevant timescales.

With support from the National Leadership Programme, a project team will take forward the design and implementation of a new model of care for those

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presenting in acute crisis. This new service will meet the crisis standards referred to in Commitment 8 of *Delivering for Mental Health*. We will also develop Acute Inpatient Fora as required under Commitment 9, and will develop a new clinical model within our acute in-patient units based around the separation of acute assessment and treatment beds and the forging of better linkages between acute and community psychiatry. This will be supported by the development of Integrated Care Pathways as required by Commitment 6.

Discharge and care planning will be improved by development of Integrated Care Pathways, and revision of the Care Programme Approach, by 2008/09.

New acute inpatient facilities will allow a more effective care model to be developed, with increased emphasis on psycho-social / recovery models, and hence preparation for discharge. This work will continue through to 2009/10.

Fuller details of our overall plans for the development of mental health services locally have been provided in the separate *Delivering for Mental Health Implementation Progress* return, submitted to Scottish Executive on 15 March 2007. An integral part of that submission was our progress template in relation to the mental health nursing review ('Rights, Relationships and Recovery').

Risks & Risk Management

Mental health services developments are part of the wider service modernisation framework agreed for NHSL for the next 5 years. This is a major service change programme, with many inter-related factors and critical paths. Alterations or slippages in one arena are likely to impact elsewhere. Therefore, a robust control mechanism has been put in place, headed by a Project Board.

The readiness and capacity of the service to deal with change is being addressed by a local change management programme. NHSL will participate in the national change management programme and as a result will develop its own change champions to provide skills and expertise to the local programme.

Initial stages of the change programme have been planned on a cost neutral basis. The overall pace of change will however be linked to the availability of resources and will be subject to close monitoring both as part of the Mental Health Project Board's remit, and as part of the wider *Picture of Health* control system referred to above.

Costs

Services are funded from core budgets, with changes and developments agreed as part of the overall financial plan underpinning NHSL's service modernisation framework *Picture of Health*.

T07T	To reduce all staphylococcus aureus bacteraemia (including MRSA) by 30% by 2010
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Lead: D C Moir, Director of Public Health
D M Harris, Infection Control Manager

4.09.K Healthcare Associated Infection (linked to target T.07T)

Number of identifications of *Staphylococcus aureus* bacteraemias (including MRSA and MSSA) as detailed in Health Protection Scotland SSHAIP surveillance protocols. Base year is 2005/06.

(There is no historical chart as this is a new Target from 2007/08)

Trajectory:

Mar 06	Jun 07	Sep 07	Dec 07	Mar 08	Jun 08	Sep 08	Dec 08
242	235	228	221	214	207	200	193
Mar 09	Jun 09	Sep 09	Dec 09	Mar 10			
186	179	172	165	157			

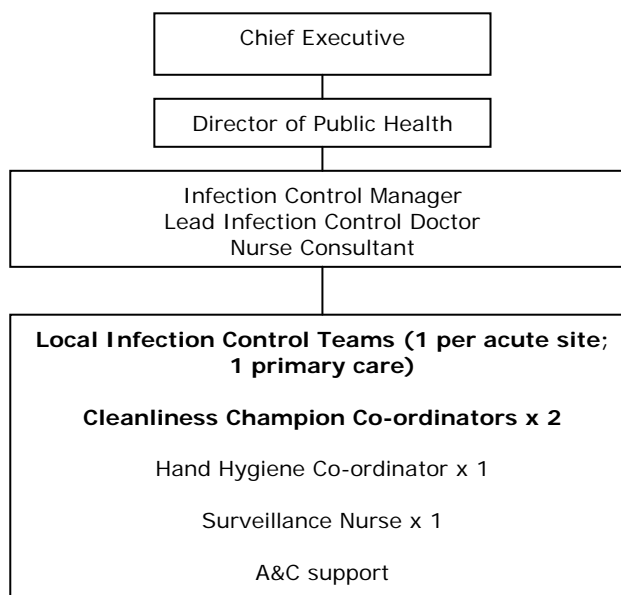
Narrative:

Objective

To reduce all staphylococcus aureus bacteraemia (including MRSA) by 30% by 2010.

Actions

There is in place a structure of key staff as follows:



Management of HAI in Lanarkshire is facilitated by a laboratory based ward surveillance system. All local Infection Control Teams receive daily reports from the laboratories on the following:

- Micro organisms of particular importance in the hospital setting and/or defined patient groups;
- Micro organisms with unusual resistance patterns;
- Significant positive blood cultures;
- Micro organisms commonly associated with the community setting, which may have the potential to spread within the hospital setting.

The Infection Control Nurse or Doctor visits or contacts the relevant ward or department or other health care delivery area to determine if the referred patient has significant infection or is merely colonised and to establish any contributing factors. Advice is then given on the appropriate management of the patient.

MRSA/MSSA bacteraemia data continues to be reported to Health Protection Scotland (HPS) as part of the national reporting programme. Data is fed back by HPS to the Lanarkshire Infection Control Service on a quarterly basis, and is reviewed and acted upon locally as required. Presently MRSA rates in Lanarkshire are in line with the Scottish mean.

The following actions are planned for 2007/08:

- Developments within laboratories to improve information and reporting. Will provide better information to Infection Control Nurses, enabling them to deal with issues more effectively;
- Develop, pilot and implement enhanced surveillance system for all staphylococcus aureus bacteraemia;
- Prepare proposals to develop more detailed local analysis system in relation to investigation of all positive laboratory reports notified by Health Protection Scotland (HPS);
- Pilot installation of 'voice-boxes' to give automatic (movement activated) verbal reminders at key points. This is aimed at encouraging people to be more attentive to hand hygiene at key locations. Movement sensors will trigger automatic verbal reminder regarding hand hygiene. Will commence in high risk areas and be evaluated;
- Continue to implement and develop the range of existing actions, including: effective management of patients identified as MRSA positive; promotion of use of alcohol hand gels; posters, leaflets and publicity; proactive relationship with local press to build public confidence; Cleanliness Champions programme; induction programmes; training and topical sessions / study days, use of Infection Control Week to maximise publicity and further raise awareness;
- Participate in national Hand Hygiene campaign from January 2007;
- New Infection Control Surveillance Nurse post will be responsible for co-ordination of all SSI surveillance;
- Develop Central Line Care Bundles as per IHI or 100,000 Lives protocols for management of central lines in acute areas including ITUs;
- 1.5 WTE Co-ordinators appointed to Cleanliness Champions programme, to improve throughput of programme;
- On-going liaison with Communications Team regarding development of material, literature and publicity for staff, visitors, patients and general public;
- Hand Hygiene Co-ordinator appointed January 2007, and first audit completed;

- Infection Control Nurses increased from 0.5WTE to 1.0WTE in order to fulfil HDL (2006) 38 requirements;
- Safer Patient Initiative around care bundles (groupings of best practice with respect to a disease process that individually improve care, but when applied together result in substantially greater improvement. The science supporting each bundle component is sufficiently established to be considered the standard of care), in line with national recommendations.

Risks & Risk Management

Four main areas have been identified:

- This is not a static population, and NHS Lanarkshire cannot control who enters the system with staphylococcus aureus bacteraemia. The enhanced surveillance system noted above is designed to tackle this;
- The improvement in numbers has been shown above as a linear trajectory, however, in reality it may have peaks and troughs at different times during the year. In-year monitoring will ensure investigation of any sustained divergence from the overall plan;
- There is a need to develop systems to investigate the root causes of all positive samples notified by HPS. There is no standard national system to do this, or to allow comparison across Boards. Local proposals will be developed in 2007/08;
- If clinical practice changes, in that the threshold for taking blood cultures alters, this may affect the number of falsely positive results that are obtained.

Costs

Existing services are fully funded. New systems proposals will require to have business cases prepared and will be subject to agreement and funding.