

NHS LANARKSHIRE LOCAL DELIVERY PLAN 2008/09 – 2010/11

Contents:

Introduction	2
Objective 1 – Health Improvement	
Target H1 – CHD mortality	3
Target H2 – Dental	5
Target H3 – Childhood obesity	7
Target H4 – Alcohol	8
Target H5 – Suicide	11
Target H6 – Smoking	13
Target H7 – Breastfeeding	15
Objective 2 – Efficiency & Governance	
Target E1 – Universal use of CHI	17
Target E2 – Sickness absence	19
Target E3 – KSFs	21
Target E4 – Improved efficiencies	23
Target E5 – Operate within RRL/CRL/CR	30
Target E6 – Cash efficiency	32
Target E7 – Referrals triaged online	33
Objective 3 – Access to Services	
Target A1 – 48 hour access	35
Target A2 – Cancers 2 months	36
Target A3 – Ambulance response times	38
Target A4 – Outpatient waits – 15 weeks by March 2009	39
Target A5 – Inpatient waits – 15 weeks by March 2009	41
Target A6 – Diagnostics – 6 weeks by March 2009	43
Target A7 – A&E attendances and 4 hours	45
Objective 4 – Treatment appropriate to individuals	
Target T1 – 65+ emergency re-admissions and inpatient bed days	49
Target T2 – QIS Clinical Governance & Risk Management	53
Target T3 – Anti-depressants	55
Target T4 – Psychiatric re-admissions	58
Target T5 – HAI	60
Target T6 – Reduce admissions for COPD, asthma, diabetes, CHD	62
Target T7 – Improve quality of healthcare experience	64
Target T8 – Older people receiving complex care at home	65
Target T9 – Dementia	67

Introduction

This is NHS Lanarkshire's third Local Delivery Plan, developed in line with Scottish Government Health Directorate guidance of December 2007. It covers the three year period from 2008/09 to 2010/11 and focuses on the four Key Objectives of Health Improvement (H), Efficiency (E), Access (A) and Treatment (T). Thirty targets have been set across the four Objectives, 29 of which are directly applicable to NHS Lanarkshire.

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

- o The target;
- o Its performance measure;
- o NHS Lanarkshire planned performance trajectory to 2010/11;
- o A risk narrative outlining key risks and how these will be tackled in relation to delivery, finance, workforce and continuous improvement.

In addition, there is a separate Excel finance schedule that expands upon the details contained under Targets E5 and E6.

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

- o Implementation of strategic service change framework;
- o Workforce Plan;
- o Finance Plan;
- o Regional Planning.

H1	Reduce mortality from coronary heart disease among the under 75s in deprived areas
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Lead: **D C Moir, Director of Public Health**
 B O'Suilleabhain, Consultant in Public Health Medicine
 L Bell, Chairman, CHD MCN

Measure:

H1.KPM1	European Age-Standardised CHD Mortality Rate per 100,000 population for people aged under 75 years, in the 15% most deprived datazone areas in Scotland, defined by Scottish Index of Multiple Deprivation 2006. (Three year rolling average). (GROS/SG – HAS)
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Trajectory:

2002-04	2003-05	2004-06	2007-09	2008-10	2009-11
130.5	133.4	123.9	118	116	113

Risk Narrative:

Delivery

The *Keep Well* national pilot is the main NHS vehicle for delivery of this target, focusing as it does on screening and anticipatory care in most deprived areas. The current pilot is due to finish screening in October 2008, and, following evaluation, it is intended that its lessons and approaches will be developed as an integral part of existing primary and community services.

Broader social and economic factors play a part in tackling deprivation, and its associated health consequences. Key in this are Community Planning Partnerships and, in particular, Joint Health Improvement Plans, Regeneration Outcome Agreements and Local Outcome Agreements, to tackle both life circumstances (e.g., education, employment) and lifestyles (e.g., diet, exercise). The main challenge for NHS Lanarkshire is to ensure that these broader activities are directed at the most effective interventions, and the most deprived communities, thus contributing positively to an overall reduction in CHD mortality. Pro-active engagement with partners using the structures and mechanisms referred to above is the route to success in such areas. Ongoing efforts across Lanarkshire to reduce CHD mortality rates in the whole population will also impact on these targets. These activities include re-organisation of smoking cessation services, providing better care in general practice through the new contract and improving care in hospital through the increased use of thrombolytic drugs, angioplasty and other interventions. The Lanarkshire Coronary Heart Disease Managed Clinical Network is also planning further service changes in the light of the SIGN Guidelines for CHD that were launched in 2007.

Finance

While the *Keep Well* pilot is nationally funded for 2 years, it is expected that the lessons learned will be integrated into existing primary and community services, re-focused to take a more anticipatory and preventive approach to care. This will be reliant upon introducing new ways of working through learning and development, rather than new services or staff *per se*. Financial plans associated

with cross-system service change and development have been developed to underpin our service modernisation framework and will be finalised following confirmation of the decision regarding revised proposals for A&E services in spring 2008.

Workforce

As noted above, the NHS workforce development required will be focused on re-shaping existing provision and approaches rather than new additional services. This is already an integral part of our planned service modernisation framework.

Improvement

Longer term sustainability of the improvement trajectory will require on-going efforts to tackle harder to engage groups who may be unwilling to consider lifestyle changes. Wider social and cultural change will be necessary to challenge deep rooted beliefs and behaviours, and the opportunities afforded by partnership working and community development (e.g., Regeneration Partnerships) are viewed as key levers in this regard.

H2	80% of all three to five year old children to be registered with a dentist by 2010/11
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Lead: **D C Moir, Director of Public Health**
 C Sloey, Director, CHP North
 C A Yeung, Consultant in Dental Public Health

Measure:

H2.KPM1	Percentage of 3-5 year olds registered with an NHS dentist. (MIDAS)
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Trajectory:

Jun 07	Jun 08	Sep 08	Dec 08	Mar 09	Jun 09	Sep 09	Dec 09
68.6%	70.5%	71%	73%	74%	75%	75.5%	78%
Mar 10	Jun 10	Sep 10	Dec 10	Mar 11			
79%	80%	80%	80%	80%			

Risk Narrative:

Delivery

Despite the efforts and influence of the *Childsmile* programme, there is still the possibility that parents will choose not to register their children with a dentist. It will be important to continue with publicity and targeted interventions, especially in the most deprived areas, to combat apathy and increase awareness and understanding.

Availability and capacity of General Dental Practitioners to take on new NHS patients is not a particular problem in Lanarkshire at present, however, this requires close monitoring and application of initiatives (e.g., SDAI) to continue to sustain and encourage NHS provision.

Finance

Childsmile is the main vehicle for delivery of this target and the national programme is centrally funded, recurring and ring-fenced.

Incentives to GDPs will be maximised as required, e.g., SDAI. There is also local funding in place for community dental services.

Workforce

There is a need to continually encourage GDPs to participate in the *Childsmile* programme, to increase coverage across Lanarkshire. Incentives are promoted among practices to increase those enlisted. In addition, expansion of practices' capacity, both in numbers and in types of patients seen, is encouraged by means of the various grants and allowances schemes agreed at national level.

On-going recruitment and retention activities are pursued to ensure that there is a supply of suitably qualified dental health support workers to underpin the *Childsmile* programme.

Improvement

The *Childsmile* programme is viewed as key to this target, identifying and encouraging good oral health from the earliest opportunity. This programme is a 3 year national demonstration and it will be important that its approach and thrust is continued beyond this period to ensure that subsequent generations of 3-5 year olds are captured by the system, thus sustaining registration levels in the future.

H3	Achieve agreed completion rates for child healthy weight intervention programme by 2010/11
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Lead: **D C Moir, Director of Public Health**
 R Campbell, Public Health Nutritionist
 M Lees, Professional Lead for Dietetics

Measure:

H3.KPM1	Number of children aged 5-15 years completing Scottish Government approved healthy weight intervention programmes. (Developmental measure; to be reviewed after year 1)
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The above revised measure was confirmed in guidance from Scottish Government Health Directorate (SGHD) on 14 April 2008. In light of this new measure, and associated guidance, Boards have been asked to complete a revised trajectory and narrative and to submit these to SGHD by 26 May 2008. Therefore, the remainder of this page will be completed as soon as its contents have been agreed with SGHD.

Trajectory:

Year ending:

March 2009	March 2010	March 2011	Cumulative total
			2,263

Risk Narrative:

Delivery

Finance

Workforce

Improvement

H4	Achieve agreed number of screenings using the setting-appropriate screening tool and appropriate alcohol brief intervention, in line with SIGN 74 guidelines by 2010/11
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Lead: **D C Moir, Director of Public Health**
V Tallon, ADAT Co-ordinator
C Sloey, ADAT Chair / North CHP Director

Measure:

H4.KPM1	Achieve agreed number of screenings using the setting-appropriate screening tool and appropriate alcohol brief intervention, in line with SIGN 74 guidelines by 2010/11. A number of different sources have been suggested. This is a developmental measure, with baselines and information systems to be developed in year 1, leading to firmer trajectories and targets in year 2.
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Trajectory:

Year ending:

March 2009	March 2010	March 2011	Cumulative total
1,200	4,657	10,200	16,057

Risk Narrative:

Delivery

The roll out of the implementation of the SIGN 74 Guideline will be a phased approach in Lanarkshire. NHS Lanarkshire is a key partner in the Lanarkshire ADAT, and the ADAT will take the responsibility to lead on HEAT target H4. Year 2008-9 will be the **Developmental Phase** to develop appropriate information systems and flows to capture the number of screenings and brief interventions delivered:

Phase 1 (2008-09)

The first phase will:

- Set up an NHS multi-disciplinary working group to develop a 3 year strategy for the implementation of the SIGN 74 Guideline across NHS Lanarkshire;
- Identify the number of staff requiring brief intervention training & SIGN 74;
- Develop a training specification to tender for trainers to deliver awareness on SIGN 74 and Brief Interventions, using the FRAMES style;
- Influence and set firmer trajectories for year 2009-11;
- Progress capacity planning of Alcohol services (both nationally and locally);
- Prioritise and initiate training in primary care.

Phase 2 (2009-10)

The second phase will be concerned with:

- o Data capture and monitoring of staff training, screening and interventions carried out;
- o Review and revision of trajectories based on information captured.

Phase 3 (2010-11)

This phase will continue to capture data and to monitor and analyse the improvements made.

Finance

The table below shows the proposed contributions from partner agencies for the implementation:

Staff	Training Provider	2007-08 Development	2008-09 Phase1	2009-10 Phase2	2010-11 Phase 3	Funding Source
Public Health Staff	Tendered by ADAT (AFS/STRADA)	£6,000				ADAT
NHSL Staff	Brief Intervention Posts ¹		£28, 075	£28, 075		Part funded by Keep Well
Keep Well staff (Airdrie, Coatbridge, Wishaw)	NHS, Health Scotland ²	N/A				Health Scotland
GP's & Practice Nursing staff	Proposed Band 7 Specialist including admin		£60,000	£60,000	£60,000 (A & E and Antenatal)	ADAT Recurring
TOTAL		£6,000	£88, 075	£88, 075	£60,000	

1. Generic brief intervention training, not specifically on alcohol or SIGN 74

2. Health Scotland is providing training on SIGN 74 and Brief Intervention for the 3 Keep Well localities only

NHSL has secured funding from the *Keep Well* monies for 2 Brief Intervention training posts that will deliver generic brief intervention training across NHS Lanarkshire. Lanarkshire ADAT has received a proposal for a specialised post in brief interventions, substance misuse and mental health. Both training bids include administration for organising training.

Lanarkshire ADAT has accounted for £6,000 of non-recurring from 2006/07 funding to support the initial roll out of training for Public Health Staff within the developmental phase.

Additional costs:

Resource	Funding	Funding Source
Breathalysers for GP Practices ¹	100 x £200 = £20,000	NHSL
Support material ²	£6,000	ADAT Communications

1. Breathalysers to measure Blood alcohol concentration as recommended in SIGN (BAC)

2. Support material and resources to support Health Staff, Clients and family

Workforce

Workforce development will be considered in line with the NHS Board Workforce Plan 2008. During this transitional year, 2008-9 will be used to consider and determine the affordability and availability for the proposed workforce (GPs, Practice Nurses, Public Health, A & E and Antenatal staff). It is anticipated workforce adaptability may become more apparent in 2010-11. The multi-disciplinary strategy working group established will ensure that key personnel involved with NHS staff development will be involved, including: Organisational Development, Keep Well, ADAT Workforce Development Sub-group and Health Scotland.

Improvement

This will depend on availability of trainers, staff released to access training to ensure an increase in: screening, assessment, brief intervention and referral (when required). Improvement should/could lead to an increase in referrals to local Councils on Alcohol, structured day and abstinence programmes, which may impact on the waiting times for these services.

H5	Reduce suicide rate between 2002 and 2013 by 20%, supported by 50% of key frontline staff in mental health and substance misuse services, primary care, and accident and emergency being educated and trained in using suicide assessment tools / suicide prevention training programmes by 2010.
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Lead: **D C Moir, Director of Public Health**
 J Logan, Consultant in Public Health
 K O'Neill, Mental Health & Well-being Needs Assessment & Service Development Manager
 C Sloey, Director, CHP North
 T Bryce, Locality General Manager

Measure:

H5.KPM1	50% of key staff trained in suicide prevention relative to the established baseline and learning levels. Data sources as per Commitment 7 in <i>Delivering for Mental Health</i> . Baseline figures and trajectory to be developed in year 1.
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Trajectory:

Calendar year:

2008	2009	2010
20%	35%	50%

Risk Narrative:

Delivery

Nationally there is lack of clarity around the future funding and support provided via the National Choose Life team post 2008, and we would benefit from national clarity being established as soon as possible. By the end of March 2008 NHSL is increasing the number of trainers to provide the range of suicide intervention training. A performance management system is being developed that will report performance on a Locality basis. Multi agency protocols and procedures are being developed to embed training into every day practice. It is acknowledged that there are competing priorities around training and development and this may adversely impact on the achievement of training 50% of frontline staff. Indeed, we have to compete for access with other agencies for some of the training that is provided on a multi-agency basis. In this respect we will be training more trainers to provide training.

Substance misuse staff will be identified as a single group for training recording purposes. Suicide prevention training is available to all staff working within NHS Lanarkshire, with applications for courses accepted from individual staff members to course co-ordinators. Three staff from NHS Lanarkshire have applied for the forthcoming T4T STORM course, one of whom is a substance misuse nurse. This trainer will provide background knowledge to the application of suicide prevention training within the substance misuse services.

Finance

Ring fenced 'Choose Life' money will no longer be available from March 2008 under the terms of the Single Outcomes Agreement. Therefore whilst we will have access to train trainers at no cost, we will have to pick up on-going costs for the provision of training such as venues and on-going material costs. There are on-going issues around back-filling staff to allow them to attend training. This will be addressed by the Mental Health Modernisation Programme Board and through links with local authority partners to establish local financial agreements.

Workforce

NHSL will have to train approximately 1160 staff across the range of staff groups. We are confident that we will achieve the target for some groups of staff more easily than for others, for example, those working in mental health services. We anticipate that there will be challenges around gaining access to particular groups of staff such as Primary Care staff, General Practitioners and Accident & Emergency staff. We will provide training dates as far in advance as possible to allow for forward planning. We will also be engaging with appropriate heads of service to establish and agree a workable training programme.

Improvement

Performance of NHSL is only one contributing factor to the population suicide rate. Although we are confident of reaching the 50%, and probably more, this will not in itself necessarily result in a fall in the 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 these issues, and it is therefore essential that this agenda continues to be progressed via the North and South Partnership Groups, supported by the National Implementation Support Team.

H6	Through smoking cessation services, support 8% of your Board's smoking population in successfully quitting (at one month post quit) over the period 2008/09 – 2010/11.
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Lead: **D C Moir, Director of Public Health**
 L Armitage, Consultant in Public Health Medicine
 G Docherty, Head of Health Promotion, North CHP / Smoking Cessation Manager

Measure:

H6.KPM1	Smoking cessation data from ISD – National Smoking Cessation Database. Smoking population calculated using the Scottish Household Survey estimates of smoking prevalence and GROS estimates.
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Trajectory:

Calendar year:

2006	2008	2009	2010	Cumulative total
3,205	3,579	3,579	3,579	10,737

Risk Narrative:

Delivery

Strategies have been developed to target hard to reach groups:

- o a pathway for pregnant women who smoke has been agreed with midwifery services;
- o young people are being engaged in developing services suitable for their age groups;
- o services target deprived areas (e.g., *Keep Well*) and staff are encouraged to identify more effective ways of working;
- o efforts directed to ensuring that there is sufficient support staff time for data inputting to ensure accuracy and limit delays in reporting;
- o active targeting of relapsed smokers to engage further attempts;
- o single telephone number, text campaign, bus campaign, to raise awareness and ease of contact;

Finance

Services are fully funded from mainstream budgets.

Workforce

All staff are in post and there is pro-active recruitment when required. All staff have PDPs to ensure up-to-date knowledge and skills.

A brief intervention training programme is in place for NHS staff and others to help engage smokers to consider quitting.

Improvement

Sustaining quit levels is contingent upon people wanting to give up smoking, and being encouraged and supported to do so. As we move into groups of smokers

who may be less keen to stop, efforts will need to be increased to maintain and improve throughput of cessation services. Quitters known to have a high relapse rate may need several quit attempts before they are finally successful and this will have an impact upon prevalence.

H7	Increase the proportion of new-born children exclusively breast-fed at 6-8 weeks from 26.6% in 2006/07 to 33.3% in 2010/11.
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Lead: **P Wilson, Director of Nursing and AHPs**
 R Campbell, Public Health Nutritionist
 A Lee, Breastfeeding Co-ordinator

Measure:

H7.KPM1	Number of babies being recorded as exclusively breastfed at their 6-8 week review as a percentage of all babies receiving a 6-8 week review. (CHSP-PS)
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Trajectory:

Mar 07	Jun 07	Sep 07	Dec 07	Mar 08	Jun 08	Sep 08
18.8	19.1	19.4	19.7	20.0	20.3	20.6
Dec 08	Mar 09	Jun 09	Sep 09	Dec 09	Mar 10	Jun 10
20.9	21.2	21.5	21.8	22.1	22.4	22.7
Sep 10	Dec 10	Mar 11				
23.0	23.3	23.5				

Risk Narrative:

Delivery

There is clear evidence that low breastfeeding rates have a direct relationship with deprivation and this is evident in Lanarkshire. Key objectives from the Lanarkshire Breastfeeding Strategy focus on initiatives to increase breastfeeding in areas of low uptake. The Community Mothers (CM) breastfeeding peer support programmes provide additional support for breastfeeding women from North Lanarkshire, Blantyre/North Hamilton, Cambuslang/Rutherglen and East Kilbride/Strathaven. East Kilbride CM is funded by the Locality. CM North is funded by (Sure Start) North Lanarkshire Council and in Blantyre/North Hamilton Cambuslang/Rutherglen by Regeneration, Changing Places. Both funding streams come to an end in March 2008.

In view of the issues around inequity and fixed term funding for CM peer support programmes, NHS Lanarkshire has commissioned a two pronged study to: evaluate the effectiveness of CM in terms of increasing the uptake and continuation rates for breastfeeding; the feasibility of rolling out CM across Lanarkshire; retaining the volunteer element of CM and employing CM supporters who would provide intensive levels of breastfeeding support in the first 72 hours in the maternity and the community. Continuation of partnership funding from North Lanarkshire Council and Regeneration Funds is being pursued.

Finance

Continuation of partnership funding from North Lanarkshire Council and Regeneration funding to support the sustainability and further development of the CM Programme post March 2008 is currently being pursued. NHS Lanarkshire has commissioned an Evaluation and Feasibility Study to examine the effectiveness, sustainability and development of CM as outlined.

NHS Lanarkshire has fully funded all Localities to implement the Unicef/UK Baby Friendly Staged Approach to accreditation over the next three years.

Workforce

The Lanarkshire Breastfeeding Policy supports a number of objectives to improve the uptake and continuation rates. Included is mandatory training for staff, at a level appropriate to their role. A consistent approach to training that includes evaluation and review in line with annual re-appraisal of the Breastfeeding Policy exists. Target groups include midwifery and public health nursing staff, medical staff and reception staff and other key staff groups. New staff will receive the training within six months of taking up post, with update training after two years. Audit of all staff regarding practice will be ongoing.

Engaging GPs in breastfeeding training has been problematic. NHS Lanarkshire is committed to achieving Unicef / Baby Friendly Initiative (BFI) accreditation through implementation of the BFI Staged Approach across the Board. The BFI will support the engagement of GPs at a Locality level. The potential for using an e-learning tool for GPs will be explored.

Improvement

The NHS Lanarkshire Breastfeeding Strategy (2004-2007) is currently being reviewed. A revised Action Plan will outline a series of objectives to achieve compliance with the Breastfeeding Policy; implementation of Infant Feeding Guidelines and progress with the Staged Approach to UNICEF accreditation across the Board.

E1	Universal utilisation of CHI
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Lead: **A Lawrie, Director, CHP South**
 R Wright, Head of IM&T
 J Duncan, Head of Health Records

Measure:

E1.KPM1	Laboratory requests that include a CHI number, expressed as a percentage of all laboratory requests made.
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Trajectory:

Sep 07	Apr 08	May 08	Jun 08	Jul 08	Aug 08	Sep 08
83.2%	97%	97%	97%	97%	97%	97%
Oct 08	Nov 08	Dec 08	Jan 09	Feb 09	Mar 09	Apr 09
97%	97%	97%	97%	97%	97%	97%
May 09	Jun 09	Jul 09	Aug 09	Sep 09	Oct 09	Nov 09
97%	97%	97%	97%	97%	97%	97%
Dec 09	Jan 10	Feb 10	Mar 10	Apr 10	May 10	Jun 10
97%	97%	97%	97%	97%	97%	97%
Jul 10	Aug 10	Sep 10	Oct 10	Nov 10	Dec 10	Jan 11
97%	97%	97%	97%	97%	97%	97%
Feb 11	Mar 11					
97%	97%					

Risk Narrative:

Delivery

The Board has found the delivery of this target difficult and has not met the monthly targets during the current year where compliance has remained around 88%. The main areas of concern are within the Acute Operating Division. To reach 97%, and sustain that level of compliance, specific actions are:

- o Use of CHI on diagnostic requests must increase;
- o Re-numbering project to continue;
- o Patient Management System to be populated with current patients only and a population index created through CHI download;
- o A&E attendances to have CHI available through linkage to PMS population index;
- o A revised action plan is to be implemented to support the implementation of the label policy. This will engage Clinical Divisions to review their own performance through monitoring by the Clinical Directors and Laboratories to identify specific areas of non-compliance. The performance against the target will be a standing agenda item on the Acute Division Management Team who will continually review the need for a 'no label no test' policy to be implemented. In addition to this it is planned to use PMS labels within the A&E department and to review issues within Obstetric wards around new borns.

It should be noted that this target is extended to improve the utilisation of CHI across all community services and an improvement programme has been started in these areas.

Finance

Resources to support of re-numbering and creation of a single number on PMS will be the means by which a long-term sustainable improvement is sustained. This requires non-recurrent resources over the period 2007/08 – 2009/10. There will be a requirement for investment in Community Services IT Solutions within the context of the emerging eHealth Strategy.

Workforce

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 will monitor and enforce use of Label Policy, with support from the Senior Management Team. Any decision to implement a 'no label no test' policy will require full support of Acute DMT. Some structural impediments to access to CHI in community settings will be removed by increased access to information technology and systems in these areas.

Improvement

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 as part of a national implementation of EDIS. Alternatives are currently being explored to minimise risk of delay in software delivery.

E2	NHS Boards to achieve a sickness absence rate of 4% by 31 March 2009.
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Lead:
G Walker, HR Director
R Lyness, Director of Acute Services
A Lawrie, Director, South CHP
C Sloey, Director, North CHP

Measure:

E2.KPM1	Hours lost due to sickness absence expressed as a percentage of total hours available. (SWISS)
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Trajectory:

Oct 07	Apr 08	May 08	Jun 08	Jul 08	Aug 08	Sep 08
6.7%	5.7%	5.5%	5.3%	5.2%	5.0%	4.9%
Oct 08	Nov 08	Dec 08	Jan 09	Feb 09	Mar 09	Apr 09
4.7%	4.6%	4.4%	4.3%	4.1%	4%	4%
May 09	Jun 09	Jul 09	Aug 09	Sep 09	Oct 09	Nov 09
4%	4%	4%	4%	4%	4%	4%
Dec 09	Jan 10	Feb 10	Mar 10	Apr 10	May 10	Jun 10
4%	4%	4%	4%	4%	4%	4%
Jul 10	Aug 10	Sep 10	Oct 10	Nov 10	Dec 10	Jan 11
4%	4%	4%	4%	4%	4%	4%
Feb 11	Mar 11					
4%	4%					

Risk Narrative:

The figures provided in the trajectory describe the objectives we aspire to, and will make every effort to achieve. The challenge to reach a sickness absence figure of 4% by April 2009 continues to test managers and staff in NHS Lanarkshire. Despite a wide range of measures, sickness rates have not reduced at the rate anticipated previously, and the impact of increased sick pay under Agenda for Change continues.

Delivery

NHSL continues to take a robust approach to the management of sickness absence through a partnership approach. The following supporting mechanisms are in place:

- Sickness absence project group meets monthly;
- Training programme continues for managers, with 674 individuals having attended since commencement of this project;
- Occupational health arrangements include:
 - 20 day target for referrals to OH;
 - Pilot survey of reasons for sickness to establish whether family friendly policies are being used appropriately and to get a better understanding of the reasons for short term absence; this pilot commences end January 2008 and will help inform next steps in our challenge to tackle this issue;

- Fast track Physio service to be implemented for staff;
- OHS Extra project continues;
- Employee Counselling Service in place to support all staff;
- The management of sickness absence is on the agenda of all management teams and partnership forums.

Finance

The non-recurring costs of the project are in the region of £100k and there would be cost avoidance of additional bank staff if the target were achieved.

Workforce

A sickness absence Project Manager continues in post to support these initiatives. Funding has been agreed for physiotherapy support. Fixed term part time posts have been established to take forward the pilot survey.

Improvement

NHSL will continue to strive to reduce sickness absence amongst the workforce. Improvement will address spend in Bank staff and improve the quality of care.

E3	NHS Boards to ensure that all employees covered by Agenda for Change have an agreed KSF personal development plan by March 2009.
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Lead: **K Small, Director of Organisational Development**
S Dunne, Deputy Director of Organisational Development

Measure:

E3.KPM1	Number of staff within each Board covered by AfC with a PDP (Source: eKSF online tool), as a percentage of number of staff within each Board covered by AfC.
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Trajectory:

Apr 08	May 08	Jun 08	Jul 08	Aug 08	Sep 08	Oct 08
0%	1%	2%	3%	4%	15%	40%
Nov 08	Dec 08	Jan 09	Feb 09	Mar 09	Apr 09	May 09
50%	53%	60%	70%	100%	100%	100%
Jun 09	Jul 09	Aug 09	Sep 09	Oct 09	Nov 09	Dec 09
100%	100%	100%	100%	100%	100%	100%
Jan 10	Feb 10	Mar 10	Apr 10	May 10	Jun 10	Jul 10
100%	100%	100%	100%	100%	100%	100%
Aug 10	Sep 10	Oct 10	Nov 10	Dec 10	Jan 11	Feb 11
100%	100%	100%	100%	100%	100%	100%
Mar 11						
100%						

Risk Narrative:

Delivery

Local risks in relation to the delivery of this target include the need to mobilise around 10,000 staff to a new way of working at the same time; encouraging managers and staff to maintain focus on KSF in a climate of significant organisational change; delivering training to support KSF implementation when competing with other priority, statutory and mandatory training initiatives and availability of access to the internet for staff. Steps to manage these risks will include: the maintenance of a partnership based management approach, ongoing communication around KSF and continued dialogue with managers and staff. Moreover e-KSF training times will be kept to a minimum and training delivered locally for staff where possible, using an on job coaching model. A paper based system will be available for staff in non-IT enabled environments.

The trajectory figures rise steeply towards March 2009. This is to accommodate significant preparatory work and training being carried out between April and November 2008. From November, resources will be fully redirected to provide targeted support for implementation at departmental level. Monthly tracking will be undertaken to identify deviations from the trajectory and facilitate the transition to full e-KSF implementation.

Finance

In terms of finance a key issue is the need to fund support staff to manage the e-KSF system and support its implementation, including staff training. Funding will also be needed for support training material (CDRom). Funding has been provided and extended for a small temporary core team and additional funding just awarded from the Board for e-KSF coaches and support material across 2007/8 and 2008/9.

The second issue is in relation to the roll out of internet access to staff as part of the local eHealth strategy. The ability to enable personal development plans through the e-KSF will be affected by the technology available to them at work. A paper based system (mirroring the e-KSF system) will be available for all staff unable to access e-KSF while internet access is extended incrementally.

Workforce

The chief workforce issue is the volume of training needed for all staff (managers, reviewers and individuals) who need to know how to use the new system. Secondly there will be additional training issues for staff who are not IT literate. Additionally, staff availability and backfill funding for staff to be released for training will be an issue. A further risk to implementation is the time that it will take people to complete personal development plans in the new system – especially in the first learning year as they develop competence in the new way of doing things.

For managers and reviewers training time will be minimised and sessions offered as locally as possible. For individual staff members the adoption of a coaching approach, delivered at the desk or on the ward, will minimise staff release time and be supported with appropriate materials. Further, through an integrated approach with the IT and general training teams, basic IT skills development will be offered. Ongoing communication with managers will be used to alert them to the need to plan ahead for personal development plan reviews more rigorously than in the past.

Improvement

In terms of sustaining improvement key issues include the need to embed the e-KSF process and the need to support the ongoing development and management of KSF post outlines to ensure they are pertinent to posts and are supporting appropriate learning for individuals and continuous development for the organisation. Meeting learning needs identified in personal development plans will be an ongoing challenge.

To address these issues the KSF (partnership) sub group will continue to monitor progress, support managers and staff with outline development for changing and new posts and provide ongoing training to maintain the new system. Internal education providers, OD and training teams will provide guidance to managers in meeting needs Overall learning activity will be monitored.

E4	NHS Boards to deliver agreed improved efficiencies for: first outpatient attendance DNA, non-routine inpatient average length of stay, review to new outpatient attendance ratio and day case rate by March 2011
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Lead: **R Lyness, Director of Acute Services**
R Garscadden, Head of Planning, Acute Services

Measure:

E4.KPM1	Number of BADS surgical procedures performed in a day case or outpatient setting (same day care) expressed as a percentage of the total number of BADS procedures including outpatients
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Trajectory:

Jun 07	Jun 08	Sep 08	Dec 08	Mar 09	Jun 09	Sep 09
69.8%	70%	72%	75%	78%	78%	80%
Dec 09	Mar 10	Jun 10	Sep 10	Dec 10	Mar 11	
80%	84%	84%	86%	86%	90%	

Risk Narrative:

Delivery

The Planned Care Collaborative prompted reflection by clinical staff on use of day surgery. That highlighted variations in practice between specialties and between consultants within the same specialty. Whilst the average for Lanarkshire is currently around 70% there is considerable potential for improvement. A standardised approach for listing patients as day cases/inpatients has been agreed. This follows the introduction of a revised pre admission assessment process. Consultants have identified those procedures they consider are suitable for day surgery (subject to refinement). This information will be used to measure actual against expected day surgery rates. In parallel, individual rates will be benchmarked against local, national and BADS rates. It will also inform pre admission assessment of the default admission type for procedures. To provide confidence in the ability to manage cases through day surgery, a protocol has been agreed for overnight admission (if required). This will enable patients to remain overnight on a site with no specialty inpatient cover provided there is no ongoing surgical issue.

Whilst the Planned Care Collaborative will cease at 31 March 2008 the work streams associated with Planned Care will continue. This will include the day case and 23 hour work streams. Through this process (led by clinicians) pathways will be developed and refined (building on the work already completed) and improvement targets will be set for individual specialties. An inclusive approach is being adopted with monitoring and measuring of progress undertaken by each work stream (the inclusion of outpatients in the target will require a change to current measurement calculations). The information now available by specialty and consultant has made this task more achievable. The local targets for each specialty will include number and proportion of patients seen as day cases, cancellation rates and length of stay. The opportunity will also be taken to assess patient satisfaction. It also offers the potential to protect elective activity and maximise theatre resources. A modest improvement has been set for 2008/09

although this represents the minimum that it is hoped to achieve. The risk is non-compliance by consultant staff although engagement to date gives optimism that further progress will be made. The continued active involvement of key clinical staff is however crucial.

Finance

The Planned Care Collaborative facilitated release of clinical and information management staff to engage with clinical colleagues to secure agreement on the way forward and their individual and collective role and responsibility to deliver the agenda. The budget of 250K released annually through the Collaborative has supported and facilitated that process. That funding will cease with the end of the Collaborative at 31 March 2008. Funding of improvements to date including introduction of improved pre assessment arrangements have been met by NHS Lanarkshire.

Workforce

Recruitment and retention of trained staff represent a challenge. This applies also to support staff. The ability to attract and recruit new staff with appropriate skills and competencies is difficult in view of the limited availability of those key staff. Good communication is essential to ensure understanding of and involvement by key staff. Backfill arrangements are required to provide time to engage and to enable training to be provided. There is a cost associated with each initiative.

Improvement

The current strategy of clinical involvement in identifying procedures that can be undertaken as day cases and improvement in the patient journey particularly associated with pre assessment will deliver an improvement in the number and proportion of patients seen as day cases. Improved management of theatres (through the application of Lean techniques) will ensure that theatre usage is maximised with increased throughput. There has during 2007/08 been investment in pre assessment and other parts of the patient journey and that improvement programme will continue.

Measure:

E4.KPM2	Reduce the average length of stay in hospital for acute inpatients discharged following an urgent, emergency or other non-routine, unplanned admission, including emergency transfers. (SMR01)
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Trajectory:

Mar 07	Jun 07	Jun 08	Sep 08	Dec 08	Mar 09	Jun 09
3.1	3.1	3.1	3.1	3.1	3.0	3.0
Sep 09	Dec 09	Mar 10	Jun 10	Sep 10	Dec 10	Mar 11
3.0	3.0	2.9	2.9	2.9	2.9	2.9

Risk Narrative:

Delivery

It is important that all patients who are admitted to hospital have a discharge date that is worked to and complied with unless there is a change in their clinical condition. A process was introduced during 2007/08 linked to a traffic light system that was designed to prompt staff to take necessary steps to facilitate discharge linked to an identified discharge date. Benchmarking was undertaken to inform the steps to be followed. A reduction in length of stay required effective communication with colleagues in the hospital including pharmacy as well as colleagues in other agencies. The outcome of this process is subject to evaluation and the findings will be reported in April 2008 (to date random sampling has taken place to monitor compliance with the new arrangement – it was also subject to close scrutiny during the winter period due to increased pressure on beds). The finding from the winter review evaluation will also be available in April 2008. The same principles will apply to those patients who have had an urgent, emergency or other non routine, unplanned admission including emergency transfers. A constraint at present is the ability to discharge patients at their discharge date due to delays in provision of home care and care home funding. Discussions to resolve this are ongoing with colleagues in the Local Authority.

Finance

There has been limited investment in introducing the new arrangements. There are however potential increased costs in the future associated with improved throughput and the delivery of services to more acutely ill patients.

Workforce

There has been no increase in staffing although there has been increased emphasis on discharge planning and communication with colleagues internal and external to the organisation to facilitate discharge. The option to recruit Acute Physicians is actively being considered with the potential that provides to facilitate patient throughput.

Improvement

Following on from the success of the Unscheduled Care Collaborative, there is an increased awareness by staff of the importance of managing the hospital phase of the patient journey from admission to discharge. The tools to facilitate that will continue to be refined with implementation the subject of increased monitoring and review. The linking up of services to facilitate hospital discharge is also being progressed with colleagues in pharmacy, local authority and transport designed to minimise avoidable delay for non clinical reasons.

Measure:

E4.KPM3	Reduce the ratio of return to new outpatient attendances in all specialities. (SMR00)
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Trajectory:

Mar 07	Jun 07	Jun 08	Sep 08	Dec 08	Mar 09	Jun 09
2.07	2.08	2.05	2.05	2.05	2.00	2.00
Sep 09	Dec 09	Mar 10	Jun 10	Sep 10	Dec 10	Mar 11
2.00	2.00	1.9	1.9	1.9	1.9	1.9

Risk Narrative:

Delivery

There are a considerable number of factors that will influence the pace at which improvements are achieved. Within community and primary care there is a programme of new build that will provide increased space in purpose built accommodation that will offer the potential for patients to be seen closer to home. In parallel, whole system examination of patient pathways and determination of the most appropriate clinical model of care will provide the potential for patients to be seen locally by General Practitioners, specialist nurses and allied health professionals (subject to protocol). Those requiring referral to hospital could receive any follow up locally. The focus on and commitment to long term conditions also provides the potential to treat conditions locally with referral to hospital only when required.

It is acknowledged that some patients are given return appointments that may not be necessary. This can reflect the inexperience of junior medical staff and/or historical practice. An external and internal review has been initiated into the outpatient journey. Information will be gathered and analysed that will inform future discussions with clinical colleagues. In addition, there is work in progress in selected specialties to capture information on appointment outcome that includes the volume and nature of return appointments. This will inform discussion with consultant staff in those specialties.

Finance

At this stage it is difficult to give an indication of the anticipated financial impact of 'shifting the balance' and of avoiding unnecessary return appointments. The introduction of any change will still require management of a considerable number of patients who are already in the system with expectations of being seen. Spend to save initiatives have recently been agreed for two disease groups, the impact of which on patients and services will be closely monitored. This will inform work on other initiatives. There are considerable efforts being made to improve communication within and between primary and secondary care and the success of that will influence future behaviour. The impact of the enhanced service programme is also being closely monitored.

Workforce

A change in historical practice of 'bringing patients back' has the potential to free up resources either to deliver improved waiting time guarantees or to be redeployed in other related areas. It is possible however that necessary skill sets and competencies will not be available in the existing workforce. This may require recruitment of new staff or retraining of staff in primary and secondary care.

Improvement

The introduction of Managed Care Networks in Diabetes and Respiratory has demonstrated service improvement with recent decisions to invest on a 'spend to save' basis in both areas. The approach has been truly multi disciplinary with clinical ownership over the direction of travel and prioritised action plan. That process will be further informed by ongoing work in long term conditions and other service improvement programmes. There are significant challenges with this approach although there is the potential for significant benefits in service delivery and quality to the patient.

Measure:

E4.KPM4	10% reduction in all Boards in the first outpatient appointment DNA rate between year ending March 2007 and March 2010. Based on the percentage of first outpatient appointments where a patient did not attend (DNA), all specialities. (ISD S 1)
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Trajectory:

Mar 07	Jun 07	Jun 08	Sep 08	Dec 08	Mar 09	Jun 09
10.6%	10.6%	10.6%	10.6%	10.6%	10.5%	10.5%
Sep 09	Dec 09	Mar 10	Jun 10	Sep 10	Dec 10	Mar 11
10.5%	10.5%	10%	10%	10%	9.5%	9.5%

Risk Narrative:

Delivery

The introduction of New Ways with the opportunity for patient choice provides the opportunity for appointment details to be agreed with individual patients for a suitable date/time. Patients are being reminded of the importance of keeping their outpatient appointment or notifying the hospital if the agreed date/time becomes unsuitable. General Practitioners have received full details on the operation of New Ways and the responsibilities they have to encourage patients to keep their hospital appointment. A Referral Management Centre has been introduced that centralises the majority of clinic booking. The intention is to extend this to include booking for all specialties within an agreed period. This offers the potential for more effective and efficient management of the booking process. It also provides a single contact point for patients who are booked through the Centre. There has been a considerable increase in non-attendance for clinic appointments that are arranged at short notice. They relate in particular to referrals where there is a high risk of cancer. Options to improve this are being explored. Those include positive booking and new innovative options on messaging.

Finance

The training of staff in New Ways in terms of using new software and applying the 'rules' of New Ways has required considerable staff training that is ongoing. Establishment of the Referral Management Centre has had both revenue and capital implications. Extension of that process to include the impact of eighteen week referral to treatment will have further financial implications although a proportion of work will replace tasks currently undertaken by other staff. The detail of this is being worked through.

Workforce

Staff recruitment/retention is a major challenge in areas where the work pressure is considerable and the avoidance of error (due to direct patient contact) the subject of close scrutiny. This represents a considerable change agenda in service delivery that has significant staff and management time implications.

Improvement

Establishment of the Referral Management Centre represented a significant step forward in more effective booking of appointments for patients. This will be built upon with commitments to extend this to include endoscopy and radiology. Protocols will continue to be refined and improved with improved communication with patients and users to increase effectiveness and service quality. The

opportunity will continue to be taken to stress to patients and community groups the importance of keeping appointments and the service impact of not doing so.

E5	NHS Boards to operate within their agreed revenue resource limit; operate within their capital resource limit; meet their cash requirement.
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Lead: S Goldsmith, Director of Finance

Measure:

E5.KPM1	Monthly financial monitoring returns
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Trajectory:

Jun 08	Jul 08	Aug 08	Sep 08	Oct 08	Nov 08	Dec 08
14982	14982	14982	14982	14982	14982	14982
Jan 09	Feb 09	Mar 09	Apr 09	May 09	Jun 09	Jul 09
14982	14982	14982	14417	14417	14417	14417
Aug 09	Sep 09	Oct 09	Nov 09	Dec 09	Jan 10	Feb 10
14417	14417	14417	14417	14417	14417	14417
Mar 10	Apr 10	May 10	Jun 10	Jul 10	Aug 10	Sep 10
14417	12763	12763	12763	12763	12763	12763
Oct 10	Nov 10	Dec 10	Jan 11	Feb 11	Mar 11	
12763	12763	12763	12763	12763	12763	

Risk Narrative:

Delivery

It should be noted that the level of additional recurring resources anticipated during the period is increasingly required to meet the likely uplifts for pay, prices and drugs, with the level of 'new money' available for investments and developments reducing over the period.

The affordability of the financial plan, in particular the ability to maintain recurring balance, is predicated on the level of funding assumed through NRAC.

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

These include:

- o Capital investment programme:
 - o Transitional / double running costs;
 - o Revenue impact of capital investment;
 - o Timing of developments;
- o New Children's Hospital in Glasgow;
- o Prescribing, including the treatment of the category M savings and the loss of prescription income;
- o Waiting times funding, particularly the £90m available nationally for the 18 week referral to treatment target;
- o Agenda for Change;
- o Pay and prices, in particular new drugs and utilities;

- o Impact of Modernising Medical Careers;
- o Ongoing achievement of CRES / Efficient Government targets;
- o Uplift / NRAC funding;
- o Availability of non recurring slippage from 2007/08;
- o Impact of IFRS, particularly in relation to the accounting treatment of PFI schemes;
- o Release of delayed discharge funding from the local authorities.

E6	NHS Boards to meet their cash efficiency target.
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Lead: S Goldsmith, Director of Finance

Measure:

E6.KPM1	Monthly financial monitoring returns
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Trajectory:

Jun 08	Jul 08	Aug 08	Sep 08	Oct 08	Nov 08	Dec 08
15210	15210	15210	15210	15210	15210	15210
Jan 09	Feb 09	Mar 09	Apr 09	May 09	Jun 09	Jul 09
15210	15210	15210	30907	30907	30907	30907
Aug 09	Sep 09	Oct 09	Nov 09	Dec 09	Jan 10	Feb 10
30907	30907	30907	30907	30907	30907	30907
Mar 10	Apr 10	May 10	Jun 10	Jul 10	Aug 10	Sep 10
30907	47106	47106	47106	47106	47106	47106
Oct 10	Nov 10	Dec 10	Jan 11	Feb 11	Mar 11	
47106	47106	47106	47106	47106	47106	

Risk Narrative:

Delivery

Whilst every effort will be made to ensure the cash efficiency target is achieved, risks remain in relation to the organisation's ability to manage an ongoing CRES programme whilst covering all potential cost pressures national, regional and local, and releasing resources for further investment.

E7	To increase the percentage of new GP outpatient referrals into consultant led secondary care services that are triaged online for clinical priority and appropriate recipient service to 90% from December 2010.
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Lead: **R Lyness, Director of Acute Services**
 A Lawrie, Director, CHP South
 R Garscadden, Head of Planning, Acute Services
 R Wright, General Manager, eHealth

Measure:

E7.KPM1	Status change in SCI gateway (or alternative E-triage mechanism) as a % of number of new GP outpatient referrals from monthly MMI statistics.
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Trajectory:

Apr 08	May 08	Jun 08	Jul 08	Aug 08	Sep 08	Oct 08
0%	0%	0%	0%	2%	4%	6%
Nov 08	Dec 08	Jan 09	Feb 09	Mar 09	Apr 09	May 09
8%	10%	10%	10%	10%	10%	10%
Jun 09	Jul 09	Aug 09	Sep 09	Oct 09	Nov 09	Dec 09
15%	20%	20%	20%	25%	25%	30%
Jan 10	Feb 10	Mar 10	Apr 10	May 10	Jun 10	Jul 10
30%	35%	35%	40%	50%	60%	70%
Aug 10	Sep 10	Oct 10	Nov 10	Dec 10	Jan 11	Feb 11
80%	90%	90%	90%	90%	90%	90%
Mar 11						
90%						

Risk Narrative:

Delivery

Delivery will be dependent on development of both locally enhanced IT Solutions and further development of SCI Referrals and non-GPASS GP Systems. In addition the target will require universal use of the Referrals Management Service (RMS) and changes in working practice within both administrative and clinical service areas supported by increased use of clinically agreed protocols. The modest incremental progress set out in the trajectory reflects the extent to which this change will present a challenge in both Primary and Secondary Care. It is anticipated that a service/specialty approach to introduction of the revised processes will enable individual and organisational learning prior to wider adoption. NHS Lanarkshire has a sound platform from which to develop these new processes given the relatively high number of electronic referrals that are currently being generated. There will however require being a clear focus on clinical risk with specific need to ensure data integrity and management controls that provide assurance against the risk of misappropriation or loss of referrals. Clinically agreed protocols will require early development as these will be essential in supporting the triage progress. A multi-agency approach to the

development and approval of protocols will be essential as will a considered approach to the testing of new systems and processes.

Finance

Financial resources will be required to procure/develop appropriate software, to develop clinical protocols and to underpin the change agenda. An action plan will be agreed with colleagues from Scottish Government eHealth and Implementation Support Team and it is assumed that a contribution of financial support will be available from them. The impact on staffing requires to be quantified in the wider context the '18 week' target for waiting times between now and 2011.

Workforce

The workforce implications will need to be assessed in terms of the impact on Consultant Job Plans and the workload changes in primary and secondary care administration. The increased focus on IT enabled processing will also require additional IT Support roles to be established.

Improvement

Improvement will be incremental and a project managed approach to the realisation of benefits and the management of risks will assist in the success of the improvement process. NHS Lanarkshire will focus the early implementation of eTriage on evaluation and learning to ensure that lessons learned can be applied to further development of the concept of eTriage.

A1	Ensure that anyone contacting their GP surgery has guaranteed access to a GP, nurse or other healthcare professional within 48 hours.
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Lead: **A Lawrie, Director, South CHP**
S Mackie, Associate Medical Director

Measure:

A1.KPM1	Percentage of practices claiming to meet the requirement of the DES payment.
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Trajectory:

Sep 07	Jun 08	Sep 08	Dec 08	Mar 09	Jun 09	Sep 09
100%	100%	100%	100%	100%	100%	100%
Dec 09	Mar 10	Jun 10	Sep 10	Dec 10	Mar 11	
100%	100%	100%	100%	100%	100%	

(The undernoted narrative builds on the information and details previously set out in our 2007/08 Local Delivery Plan)

Risk Narrative:

Delivery

48 hour access criteria are laid down in a Directed Enhanced Service (DES) and the requirements of the DES are monitored on a quarterly basis which requires practices to confirm that they meet the criteria in the DES. A record of all returns is kept and payment is authorised by the Board. For each quarter in 2007/08, there is a 100% positive response from practices. Should a practice indicate they have not met the access criteria, NHS Lanarkshire Primary Care Manager would visit the practice to offer support and guidance to re-establish appropriate 48 hour access facilities for patients.

Finance

Projected costs for 2008/09 are c £668,000 and this money is ring fenced for the DES.

Workforce

Primary Care department staff work closely with practices to resolve any issues that arise in the DES, providing advice and guidance as required.

Improvement

Practices continue to declare 100% coverage of achieving 48 hour access, however, where there is deviation from making 48 hour access available to all patients in Lanarkshire, the support and intervention structures outlined above would be initiated.

A2	The maximum wait from urgent referral to treatment for all cancers is two months.
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Lead: **R Lyness, Director of Acute Services**
R Garscadden, Head of Planning, Acute Services

Measure:

A2.KPM1	Percentage of patients treated within 62 days of urgent referral.
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Trajectory:

Jun 07	Jun 08	Sep 08	Dec 08	Mar 09	Jun 09	Sep 09
75.3%	95%	95%	95%	95%	95%	95%
Dec 09	Mar 10	Jun 10	Sep 10	Dec 10	Mar 11	
95%	95%	95%	95%	95%	95%	

Risk Narrative:

Delivery

At December 2007, the maximum wait from GP referral to treatment for nine tumour types was 62 days. There was a 95% compliance with that target (unvalidated data) across the tumour types. There was a significant change agenda implemented during 2007/08 with the introduction of time lined patient pathways for each tumour type, investment in patient tracking and specialist clinical staff and management and clinical support (including escalation protocol) and investment in new/replacement equipment to improve service delivery. Further investment is planned during 2008/09. Work is coordinated through the Cancer Action Group. A Head of Cancer Services will take up post from April 2008 with management responsibility for cancer services reporting to the Director of Acute Services. There will be further refinement of patient pathways with extensions to those to include all tumour types with an encouragement also to electronic referral. Compliance with time lined patient pathways has significant implications for diagnostics and work continues to improve pathways to facilitate early access.

Finance

There was significant investment in staff and equipment in 2007/08 and this will continue to be linked to service improvement. The impact of patients not attending appointments for investigation/outpatient appointment has had an impact on capacity with the need to increase capacity to meet that situation. In addition the anticipated future screening programmes, e.g., bowel cancer, will impact on capacity and will have resource implications. In addition, whilst those implications have been identified (based on information currently available) it will be challenging to recruit and retain scarce staff in certain specialties.

Workforce

A recruitment plan for additional specialist nursing staff is in place. It is challenging to retain scarce professional staff and to attract new ones. There has been a significant awareness and training programme emphasising the importance of complying with time lined patient pathways and working with colleagues to improve the patient journey. Additional demand for diagnostics has

prompted increased attention to referral practice for all tests to ensure appropriate compliance with standards adopted for each pathway.

Improvement

A strong service delivery and management baseline has been established for each tumour type during 2007/08. This will be further enhanced by implementation of the agreed investment plan that will see an increase in specialist nursing and other staff. Senior management will be further strengthened with the appointment of a Head of Cancer services. There is a clear acceptance of the importance of time lined patient pathways and compliance of those and every opportunity will be taken to further improve those to the benefit of the patient. Options to develop more effective electronic solutions for patient tracking are also being explored.

A3	Respond to 75% of category A calls within 8 minutes from April 2008 onwards across mainland Scotland.
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Lead: (Scottish Ambulance Service)

Measure:

A3.KPM1	Percentage of category A (999) calls responded to within 8 minutes
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Trajectory:

Risk Narrative:

Delivery

While this target is for Scottish Ambulance Service to deliver, NHS Lanarkshire recognises the link between delays in hospital transfers / turnaround times and the ability of SAS to respond to further calls.

Joint work is underway in Lanarkshire to identify the level of such delays and to then assess the reasons for each delay. This will produce information to allow review of reasons for delays and where appropriate and practicable their elimination.

Work is also underway, in partnership with Scottish Ambulance Service, NHS 24 and Out of Hours Services, to develop the Lanarkshire Emergency Response Centre.

Finance

(Will follow in light of work outlined above)

Workforce

(Will follow in light of work outlined above)

Improvement

(Will follow in light of work outlined above)

A4	As a milestone in achieving 18 weeks referral to treatment, no patient will wait more than 15 weeks from GP referral to first outpatient appointment from 31 March 2009.
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Lead: **R Lyness, Director of Acute Services**
R Garscadden, Head of Planning, Acute Services

Measure:

A4.KPM1	Number of outpatients waiting over 15 weeks at month end census, GP/GDP referrals only
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Trajectory:

Apr 08	May 08	Jun 08	Jul 08	Aug 08	Sep 08	Oct 08
880	800	720	640	560	480	400
Nov 08	Dec 08	Jan 09	Feb 09	Mar 09	Apr 09	May 09
320	240	160	80	0	0	0
Jun 09	Jul 09	Aug 09	Sep 09	Oct 09	Nov 09	Dec 09
0	0	0	0	0	0	0
Jan 10	Feb 10	Mar 10	Apr 10	May 10	Jun 10	Jul 10
0	0	0	0	0	0	0
Aug 10	Sep 10	Oct 10	Nov 10	Dec 10	Jan 11	Feb 11
0	0	0	0	0	0	0
Mar 11						
0						

Risk Narrative:

Delivery

The maximum wait at March 2008 for all specialties remains at eighteen weeks. It is intended as a minimum to reduce that to fifteen weeks by March 2009. Selected specialties will reduce to twelve weeks within the same timescale. There are factors that influence the pace at which waiting times will fall. The recent service improvement process has informed the optimal patient pathway for each specialty. The detail of that will be implemented during 2008/09. It is anticipated that in time this will impact on demand for some specialties but it is difficult to estimate when that will take effect. There is continued work in progress to better understand demand and supply in each specialty and through improved efficiency and productivity increase capacity. The increased role of specialist nurses and allied health professionals also offers the potential to increase capacity for new referral slots through streaming off referrals to nurse and AHP lead clinics with the opportunity also for those staff to see an increased number of return patients. The adoption of New Ways, the introduction of more effective referral management arrangements and the introduction of improved performance management and benchmarking provide further potential for increasing capacity through better use of existing capacity. A key consideration on the pace of change in reducing waiting times is the impact of conversion from outpatient to inpatient/day case. This applies in particular to orthopaedics.

An initial trajectory has been agreed for each specialty for 2008/09 against which progress will be monitored. For the purposes of the Local Delivery Plan a single trajectory has been prepared for outpatients.

Finance

There have already been considerable investments in clinical and non clinical staff recruitment to deliver the improved waiting time targets. It is anticipated that further investments will be required in some specialties to reduce backlog to deliver and sustain improved waiting times. The nature and extent of that is currently being determined. It is also anticipated that recruitment of selected staff accompanied by improved training/retraining of existing staff may be necessary to reflect the anticipated changes in the way, and from where, services will be delivered in the future.

Workforce

There are constraints with space and access to the available skills and competencies to progress changes in the way services are in future delivered. There will be implications for consultant job plans and work priorities. There are also implications associated with the change to medical careers that will impact on available capacity.

Improvement

The concept of 'straight to test' has already been introduced for some patients particularly in endoscopy and radiology. General Practitioners have been encouraged to refer electronically to agreed protocols. This will be refined and extended as part of a service improvement programme. The need for time lined patient pathways for each stage of the journey is recognised and this will represent a significant task to be taken forward. Responsibility for this will rest with whole system service improvement groups that will be established by specialty/disease group in the near future. Increased emphasis will be placed on more effective scenario planning based on an improved understanding of capacity and demand.

A5	As a milestone in achieving 18 weeks referral to treatment, no patient will wait more than 15 weeks for inpatient or day case treatment from 31 March 2009.
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Lead: **R Lyness, Director of Acute Services**
R Garscadden, Head of Planning, Acute Services

Measure:

A5.KPM1	Number of inpatients / day cases waiting over 15 weeks at month end census
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Trajectory:

Apr 08	May 08	Jun 08	Jul 08	Aug 08	Sep 08	Oct 08
132	115	108	101	95	77	59
Nov 08	Dec 08	Jan 09	Feb 09	Mar 09	Apr 09	May 09
42	39	35	18	0	0	0
Jun 09	Jul 09	Aug 09	Sep 09	Oct 09	Nov 09	Dec 09
0	0	0	0	0	0	0
Jan 10	Feb 10	Mar 10	Apr 10	May 10	Jun 10	Jul 10
0	0	0	0	0	0	0
Aug 10	Sep 10	Oct 10	Nov 10	Dec 10	Jan 11	Feb 11
0	0	0	0	0	0	0
Mar 11						
0						

Risk Narrative:

Delivery

The maximum wait at 31 March 2008 for all specialties will be sixteen weeks. This will represent a reduction from the eighteen week maximum wait that was achieved at 31 December 2007. It is intended as a minimum to reduce that to fifteen weeks by 31 March 2009. Selected specialties will reduce to twelve weeks within the same timescale. There are factors that influence the pace at which waiting times will reduce. The Planned Care Collaborative has prompted specific work streams to increase day surgery rates, more effectively manage pre assessment and admission to hospital and maximise theatre capacity. The foundation provided by that work is already being actioned and will be further implemented during 2008/09. Any variation from current conversion rates will prompt careful scrutiny as this will impact on demand and capacity. New Ways will be applied as will the continued improvement of performance monitoring and benchmarking. The programme to provide new and/or replacement equipment during 2007/08 will continue based on measurable performance improvement to service quality and/or capacity. The Golden Jubilee National Hospital will remain an integral part of the capacity available to Lanarkshire patients although it is recognised that the nature and extent of that relationship may change in the future. The option of the Independent Sector will remain to respond to unplanned events. The main priority will be to learn from and build on the work initiated in 2007/08.

An initial trajectory has been agreed for each specialty against which progress will be monitored. For the purposes of the Local Delivery Plan a single trajectory has been prepared for inpatients/day cases.

Finance

There have already been considerable investments in clinical recruitment to deliver the improved waiting time targets. It is anticipated that further investments will be required in some specialties to remove backlog to deliver and sustain improved waiting time targets. The nature and extent of that is currently being determined. Any variation in assumptions on demand and supply has the potential to increase/decrease the volume of activity to be treated. As a consequence increased scenario planning will be undertaken. It is also anticipated that changes to working process and practice will have training implications for staff with necessary backfill to enable that to be provided.

Workforce

There will be implications for job plans and work priorities. There will also be implications to medical careers and the implications of that for available capacity. The option of a joint appointment with Golden Jubilee is being piloted in orthopaedics and the value of that will be evaluated during 2008/09. The anticipated changes in use of day surgery and theatres will have implications for staff and changes to work routine and practice may be required to improve throughput and overall productivity.

Improvement

The work on inpatients and day cases will link to outpatients as part of the overall service improvement programme (in the context of eighteen week referral to treatment). The emphasis in inpatients and day cases will be to increase the proportion of patients seen as day cases, maximise theatre capacity with innovative use of theatre time as well as effective utilisation of the National Golden Jubilee Hospital and as appropriate the Independent Sector. This to be taken forward in the context of a more refined capacity plan with effective monitoring linked to performance management. There already is strong clinical participation in work streams that were formed as part of Planned Care Collaborative and this will be built upon as the agenda is moved forward.

A6	As a milestone in achieving 18 weeks referral to treatment, no patient will wait more than 6 weeks for one of the 8 key diagnostic tests from 31 March 2009.
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Lead: **R Lyness, Director of Acute Services**
R Garscadden, Head of Planning, Acute Services

Measure:

A6.KPM1	Number of patients waiting over 6 weeks for 8 key scans / tests
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Trajectory:

Oct 07	Apr 08	May 08	Jun 08	Jul 08	Aug 08	Sep 08
357	350	350	200	200	200	100
Oct 08	Nov 08	Dec 08	Jan 09	Feb 09	Mar 09	Apr 09
100	100	0	0	0	0	0
May 09	Jun 09	Jul 09	Aug 09	Sep 09	Oct 09	Nov 09
0	0	0	0	0	0	0
Dec 09	Jan 10	Feb 10	Mar 10	Apr 10	May 10	Jun 10
0	0	0	0	0	0	0
Jul 10	Aug 10	Sep 10	Oct 10	Nov 10	Dec 10	Jan 11
0	0	0	0	0	0	0
Feb 11	Mar 11					
0	0					

Risk Narrative:

Delivery

The maximum wait for all eight key tests remains at nine weeks at March 2008. It is intended to reduce that to six weeks by 31 December 2008 with a further reduction to four weeks by 31 March 2009. This reflects the high importance attached to diagnostics and the key contribution that diagnostic services make to delivery of other waiting time guarantees, e.g., cancer. The Diagnostic Collaborative has played a significant role in progressing improvements in process and practice in endoscopy and radiology. Their proposals prompted investment plans during 2007/08 to increase capacity linked to service improvement in each area. Key work streams have been taken forward through steering groups in both areas. Their main focus has been development of patient pathways with protocols to improve patient access. This has included 'straight to test' in both areas. This has been a whole system approach working with colleagues in primary and secondary care with input also from community representatives. This will continue during 2008/09. An outcome audit has been initiated (as part of Collaborative process) to assess outcome against the Project Initiation Document (PID) and the impact of investments against the business cases agreed for service investment during the period of the Collaborative. This will inform future decision making. Regard will also be taken to known future service developments including increased screening programmes that will impact on diagnostic services. The Golden Jubilee will remain an integral part of the capacity available to Lanarkshire patients although it is recognised that the nature and extent of that may change in the future. There has been a significant programme of new/replacement equipment undertaken in 2007/08 and this will continue. Further improvement in the referral process is anticipated with an

extension of the referral management process to include endoscopy and radiology.

An initial trajectory has been agreed for each element of diagnostics although for the purposes of the Local Delivery Plan a single trajectory has been agreed for diagnostics.

Finance

There have already been considerable investment in diagnostics to deliver improved waiting times. It is anticipated that this will continue linked to service redesign. The nature and extent of that is currently being determined. Any variation on the assumptions on supply and demand has the potential has the potential to increase/decrease the volume of activity to be delivered to meet waiting time targets. As a consequence increased scenario planning is being undertaken.

Workforce

The increase in capacity in 2007/08 was achieved through investment in new staff linked to service improvement that included extended day working and changes to working practices with increased consistency around patient access. Recruitment of staff proved difficult in some areas and this may continue. Emphasis in analysing current requests by consultants for diagnostic tests may impact on future demand. This represents work in progress. Changes to non clinical practice and process are also being reviewed that may necessitate some retraining of staff.

Improvement

The evaluation of the Diagnostic Collaborative and its component parts will inform the next stage of the service improvement plan. An independent evaluation is currently underway. The clinical leadership in diagnostics has been significant and this will continue with increased emphasis on improved capacity planning linked to service change. Improved linkage to other specialties with more effective dialogue on the anticipated/actual impact of changes to patient pathways and nature and type of tests to be undertaken in future will be an integral part of delivering coordinated progress with measurable outcomes.

A7	NHS Boards will achieve agreed reductions in the rates of attendance at A&E, from 2006/07 to 2010/11; and from 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: **R Lyness, Director of Acute Services**
 R Garscadden, Head of Planning, Acute Services
 C Sloey, Director, North CHP
 A Lawrie, Director, South CHP

Measure:

A7.KPM1	Numbers of A&E attendances per 100,000 population
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Trajectory:

Sep 07	Apr 08	May 08	Jun 08	Jul 08	Aug 08	Sep 08
2,895	2,626	2,613	2,600	2,587	2,574	2,561
Oct 08	Nov 08	Dec 08	Jan 09	Feb 09	Mar 09	Apr 09
2,548	2,535	2,523	2,510	2,497	2,485	2,473
May 09	Jun 09	Jul 09	Aug 09	Sep 09	Oct 09	Nov 09
2,460	2,448	2,463	2,423	2,411	2,399	2,387
Dec 09	Jan 10	Feb 10	Mar 10	Apr 10	May 10	Jun 10
2,375	2,363	2,352	2,340	2,328	2,317	2,305
Jul 10	Aug 10	Sep 10	Oct 10	Nov 10	Dec 10	Jan 11
2,293	2,282	2,271	2,259	2,248	2,237	2,225
Feb 11	Mar 11					
2,214	2,203					

Risk Narrative:

Delivery

This is a challenging target and delivery is dependent on a range of factors that require a whole system approach including active involvement of colleagues in NHS 24, the Scottish Ambulance Service, the Local Authority and voluntary organisations. It also places responsibility on individuals to access those services that provide the most appropriate response to their symptoms. Clarity on what services are available and how those can best be accessed and the criteria for accessing those services will be essential if progress is to be made. Some preliminary multi agency work has been undertaken associated with development of an emergency referral service but this is at an early stage. The principles currently being developed will inform future work.

A reduction in attendance at Accident and Emergency assumes the availability of a network of services and support in settings other than hospital. There are currently a varied number of forums where multi agency discussion takes place on assessment of existing provision and the identification and development of appropriate services to support people at home and/or in community settings. This work has in future to be more effectively managed with decision making on current provision and future investment to be founded on evidenced based outcomes.

Finance

The baseline information on current services and its current impact is variable in quality and completeness. It is not possible at this stage to indicate the financial implications of achieving this target.

Workforce

There is work in progress by agencies individually and collectively that may contribute to delivery of this target. From a health perspective they include work associated with long term conditions and planned adjustments to roles and responsibilities of community nursing staff to multi agency work linked to joint improvement (previously joint futures). It will be necessary in future to link those work strands into a coherent and coordinated approach to maximise available resources and where appropriate more effectively manage future service delivery.

Improvement

The priority will be to better understand the impact of work that is taking place in Lanarkshire and elsewhere and the evidence to support any published results on prevention of hospital admission. Patient information is available on reason for admission to hospital with the suggestion (following analysis) that admission was avoidable and could have been dealt with in another setting. The intention is for colleagues in primary and secondary care to review that information to agree the quality of that information and to consider what alternative options might have better met the needs of those patients. This will in time form the basis of discussion with colleagues from other agencies as part of a partnership response to the issues raised.

Measure:

A7.KPM2	Percentage of patients seen waiting no more than 4 hours from arrival to admission, discharge or transfer for A&E treatment
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Trajectory:

Sep 07	Apr 08	May 08	Jun 08	Jul 08	Aug 08	Sep 08
97%	98%	98%	98%	98%	98%	98%
Oct 08	Nov 08	Dec 08	Jan 09	Feb 09	Mar 09	Apr 09
98%	98%	98%	98%	98%	98%	98%
May 09	Jun 09	Jul 09	Aug 09	Sep 09	Oct 09	Nov 09
98%	98%	98%	98%	98%	98%	98%
Dec 09	Jan 10	Feb 10	Mar 10	Apr 10	May 10	Jun 10
98%	98%	98%	98%	98%	98%	98%
Jul 10	Aug 10	Sep 10	Oct 10	Nov 10	Dec 10	Jan 11
98%	98%	98%	98%	98%	98%	98%
Feb 11	Mar 11					
98%	98%					

Risk Narrative:

Delivery

At December 2007 there was compliance with the target that 98% of patients wait no more than four hours from arrival to admission, discharge or transfer for A&E treatment. There was a significant change agenda introduced during 2007/08 that was managed through the Unscheduled Care Collaborative. A range of work streams were established through which an analysis of existing process and practice prompted an in depth review leading to changes to the patient journey that was subject to robust monitoring and review. This enabled use of existing resources to be maximised as well as inform utilisation of additional investment. Key improvements included introduction of time lined patient pathways with additional appropriately trained staff to assess patient need and direct the patient down the appropriate path. This included establishment of a minor injuries facility. It also required increased dialogue with colleagues in community and primary care as well as out of hours and NHS24 to provide a more effective and efficient coordinated response to patient need. A consequence of that was that patients were seen more quickly and by the most appropriate clinician. The whole system approach extended to the inpatient environment and the importance of tracking patients through the hospital system and facilitating discharge. The process of that journey has improved but there is potential for further improvement though improved links with carers and the Local Authority. Whilst the Unscheduled Care Collaborative will cease with effect from 31 March 2008, the infrastructure that has been put in place will continue and where appropriate enhanced.

Finance

There was significant investment in unscheduled care during 2007/08 and this will continue to be linked to service improvement. In line with national waiting time guarantees the expectation is that referrals will in future decrease. That has to be set in the context of the demographics of Lanarkshire where the number of older people over 75 and 85 is increasing. Evidence has shown that this age group accesses health services in greater quantity than other age groups. This situation will be closely monitored and will inform future investment decisions.

An ongoing issue will be the retention and recruitment of staff with required skills and competencies.

Workforce

There has been significant investment in staff and equipment to deliver the target during 2007/08. It will be challenging to retain those staff and to increase their number if this is considered necessary. There have been changes to working practices and those will continue to be refined and developed. This will have training and resource implications. There has been a significant change agenda to achieve the level of progress required to deliver and sustain the target. The recent winter period provided a further test of the system to deliver a quality service. A review of that experience will be reported on in April 2008.

Improvement

The intention will be to build on the effective work undertaken over recent months with continued robust monitoring of inputs and outputs. There will be further refinement of patient pathways/streaming and learning from experience within and out with Lanarkshire.

T1	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 and reduce, by 10%, emergency inpatient bed days for people aged 65 and over by 2008
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Lead: **A Lawrie, Director – CHP South**
 C Sloey, Director – CHP North
 R Watts, Head of Planning & Performance – CHP South

Measure:

T1.KPM1	Number of patients (65+) admitted, for any reason, two or more times in one calendar year, as an emergency to acute specialties, defined as a rate per 1,000 population.
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Trajectory:

Year ending:

March 05	March 07	March 09	March 10	March 11
49.7	48.5	39.8	39.8	39.8

Measure:

T1.KPM2	The rate per 1,000 population of occupied emergency bed days, in acute specialties, for patients aged 65+.
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Trajectory:

Year ending:

March 05	March 07	March 09	March 10	March 11
3515.0	2611.6*	3163.5	3163.5	3163.5

**Provisional data, likely to increase*

Risk Narrative:

Delivery

The target trajectory performance for emergency readmissions in 2006/07 was 49.1 per thousand population 65+. Actual performance was 48.5 as reported by ISD. The outturn required by 2008/09 is 39.28, and it is proposed to retain the trajectory set out in the Local Delivery Plan 2007/08 – 2009/10, i.e., 48.61 at 31 March 2008 and 39.28 at 31 March 2009.

To continue this downward trend, account is taken of:

- The significant difference in readmission rates between North and South Lanarkshire, reflective of the high levels of deprivation in many areas within North Lanarkshire;
- The significantly lower readmission rates in the rural (Clydesdale) area of South Lanarkshire.

Specific actions are to:

- Complete evaluation of the three care management pilots, one in North and two in South Lanarkshire. The pilots were implemented from September 2006; an interim evaluation was conducted in November 2007 to be followed by the full evaluation in March 2008. The population covered by the pilots is approximately 20,000. They incorporate the production and use of SPARRA data, which enables the identification and targeting of patients with the most complex needs in the community and interventions to prevent inappropriate care;
- Analyse data now available on emergency admissions for 'preventable conditions' for each CHP area. Nineteen ambulatory care sensitive conditions are covered. The top 2 are COPD and Influenza/Pneumonia, both for admission and bed days. Influenza/Pneumonia is the predominant condition for both in North Lanarkshire; COPD predominates in South. Linkage between this data and SPARRA will be used to inform interventions that avoid inappropriate hospital admission/readmission;
- Further develop falls services, with particular reference to fractured necks of femur. This will include partnerships with community safety, together with the increasing use of assisted technology;
- Give impetus to the further alignment of out of hours nursing and home care services, particularly in South Lanarkshire. The aligned service in North Lanarkshire recorded 188 interventions for catheter care in the period April – December 2007. From previous experience, many of these interventions will have prevented accident/emergency attendance/admission;
- Examine the clinical and service model in Clydesdale for good practice that may be transferable to other Localities. Use of the facilities in the three community hospitals and outreach into the community are focused on rehabilitation and avoidance of admission/readmission to the District General Hospital. The need to improve community rehabilitation is a priority in all Localities, albeit the model will vary depending on local resources, i.e., with one exception, other Localities do not have community hospitals;
- Evaluate the RADAR (Rapid Assessment, Diagnosis and Rehabilitation) service at Hairmyres hospital;
- Improve the support given to care homes by Primary and Community Care services, recognising that these are a significant source of emergency admission/readmission. This is focused on giving one practice responsibility for providing these services to a specific care home or group of care homes, supported by aligned District Nurses and nurse liaison with acute hospitals. Further liaison posts in Physiotherapy and Community Pharmacy are being recruited. This approach is now being implemented in the East Kilbride locality of South Lanarkshire as the first stage in the roll out to other Localities;
- Apply work recently completed to enable the routine local reporting of performance in reducing bed days. The baseline is 3515.0 bed days per 1,000 population at March 2005 making the target 3163.5 by 2008. Provisional performance for 2006/07 was within target at 2611.6, but it is likely to increase when the data are finalised;

- The North and South Lanarkshire Partnerships have completed reviews of their frail older people's strategy and delayed discharge arrangements. A renewed framework for the Strategy including recommendations from the delayed discharge review will be produced and implemented during 2008/09;
- Maintain the impetus in the development of the anticipatory care programme *Keep Well* in North Lanarkshire (see commentary under T6).

These initiatives should cumulatively produce a reduction in emergency inpatient bed days even if, as maybe the case initially in care management, they produce an increase in admissions/readmissions.

Finance

Recognising that shifting the balance of care in line with this target is a partnership activity, work continues to refine and develop joint financial strategies for older people. Specific areas of investment for NHS Lanarkshire are:

- *Keep Well*, with £1m of recurring funding in 2008/09 to consolidate anticipatory care teams in the localities;
- Care Management, an integral part of the community nursing review and recurring investment of £0.7m;
- Care Home Teams and recurring investment from 2008/09 of £0.7m, which includes additional payments to General Medical Practitioners as well as an additional Care Home Liaison Nurse, Physiotherapist and Pharmacy support;
- Community Emergency Old Age Psychiatry teams with recurring investment of £0.2m;
- Community Hospital review with revised specifications and recurring investment of £0.2m.

Workforce

The redesign of community nursing services has been completed so that they are now:

- o organised into long term conditions and public health teams;
- o refocused and aligned into areas of greatest need as a result of the demographic profiling of Localities.

The impact that this has on reducing inappropriate admission/readmission is to be monitored and reported.

An interface group between health and social care is examining the relative roles of health and homecare staff with a view to redesign that makes between use of skills to improve services. The HR implications will be clarified by the outcome of this work.

Improvement

The actions noted under 'Delivery' must be viewed in the context of the fact that Lanarkshire has the lowest number of District Nurses to population of the mainland Boards in Scotland at 6.9 per 100,000 weighted GP list population. This is second only to Western Isles for all NHS Board areas. Lanarkshire also has the lowest net cost per District Nurse visit of any NHS Board at £14. Improving this position and appropriate skill mix arrangements will be important if the full potential of these actions is to be realised in practice.

Key tasks are to improve community rehabilitation services and intermediate care to achieve a sustained change in the balance of care away from institutions. A scoping of the necessary resources and their availability will be carried out.

T2	QIS clinical governance and risk management standards improving
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Lead: P Wilson, Director of Nursing and AHPs

Measure:

T2.KPM1	Demonstrate improvement against baseline published by NHS QIS October 2007.
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Trajectory:

2006/07	2008/09	2009/10	2010/11
6	7	9	9

Risk Narrative:

Delivery

Delivery of the anticipated improvements against baseline will be dependent on (a) at least maintaining performance for those criteria where progress has been acceptable (assessed by QIS as being at the 'monitoring' or 'review' stage) and (b) improving performance for criteria where progress has not been as required. The NHS QIS Report 'Vital Systems – the health of NHS Scotland', and Lanarkshire's associated Local Report, has highlighted 8 (of 11) criteria that, at the time of review, had reached only the 'development' or 'implementation' stage.

The main risk to delivery is that these specific areas do not progress adequately – at least to the 'monitoring' and preferably the 'review' stage. From January 2008, the risk is increased at the early stage of implementation of the Patient Safety Programme as there is the potential that current support staff groups will require to re-prioritise activity. Conversely, there is the opportunity as the programme evolves for developments to contribute to the compliance of the standards.

The Health & Clinical Governance Steering Group has the responsibility for managing these risks; it will do so through formal monitoring of progress against action plans produced to address the criteria highlighted above. It will also be responsible for monitoring the status of the currently 'acceptable' criteria and the integration of patient safety activity towards compliance with the standards.

Finance

It is not envisaged that adherence to the improvement trajectory will be dependant on any major new investment. The re-structuring of the various clinical governance support functions will have some associated costs – see 'Workforce' below. These costs will not be significant, and the financial risk to achievement of the envisaged improvements is low.

Workforce

The existing clinical governance support departments within Lanarkshire (i.e., Clinical Effectiveness / Governance, Risk Management, Research & Development, Patient Affairs) do not operate as a single, cohesive department. This presents a risk to the efficient delivery of the improvement trajectory, as these departments provide the core support for a number of the criteria where progress is required.

The risk will be managed through the planned re-structuring of the various departments under one senior manager. The newly created post – the Head of Clinical Governance and Risk – will have responsibility for ensuring that adequate clinical governance support is provided as appropriate.

Improvement

The Board recognises that any improvements achieved through implementation of action plans must be sustainable. The Board's approach will therefore be to implement systemic changes within the organisation, rather than to implement changes with the narrow aim of improving its baseline score. This comprehensive, multi-professional approach will help ensure sustainability by further embedding good governance practices within the daily operation of the organisation.

T3	Reduce the annual rate of increase of defined daily dose per capital of anti-depressants to zero by 2009/10, and put in place the required support framework to achieve a 10% reduction in future years.
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Lead: C Sloey, Director, CHP North
S Kerr, Head of Planning & Performance, CHP North

Measure:

T3.KPM1	Number of anti-depressant DDDs per capita is less than or equal to the number of antidepressant DDDs per capita in year ending December 2009.
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Trajectory:

Jun 06	Sep 06	Dec 06	Mar 07	Jun 07	Jun 08	Sep 08
32.9	33.3	33.8	34.5	35.2	38	38.6
Dec 08	Mar 09	Jun 09	Sep 09	Dec 09	Mar 10	Jun 10
39.1	39.5	39.7	39.8	39.9	39.9	38.9
Sep 10	Dec 10	Mar 11				
37.9	36.9	35.9				

Risk Narrative:

Delivery

As part of its action towards Commitment 4 in *Delivering for Mental Health*, NHSL is continuing to 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 has been used to fund a new service staffed by Clinical Associates in Applied Psychology, which has increased the availability of psychological therapies in primary care. We have also introduced Gateway Workers to assist us in ensuring that we treat patients appropriately and ensure that the focus of our Psychology service is on treating patients with the most complex issues. This will be rolled out across Lanarkshire in 2008/9.

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

We are increasing 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.

In 2008/9 it is our intention to review the delivery of our clinical models within Mental Health Services in terms of the whole patient journey from primary care interventions and referrals management, through standardised assessments, clinical protocols etc to recovery, with an emphasis on ensuring that the processes and protocols are understood and controlled at all stages of the journey.

Pilot schemes within Bellshill and Airdrie Localities have commenced and will be externally evaluated and closely monitored to ensure that they are impacting on the target, albeit that we recognise that there is likely to be significant unmet need that may be identified as part of the pilot programme. The pilot will increase the availability of and access to psychological interventions as an alternative to anti-depressant prescribing. Six Clinical Associates in Applied Psychology have designated practices in each locality. Two Gateway Workers will provide services to both localities. As part of the pilot's commitment to increase the availability of evidence based psychological therapies, staff will be trained to implement the following models: Cognitive Behavioural therapy (CBT), Solution Focused Therapy (SFT) and Mindfulness training. The pilot will also provide modular training for a range of common health issues to a larger client audience. The pilot will monitor the impact of short term psychological interventions for clients presenting with mild / moderate mental health issues. Clients will be monitored using Patient Health Questionnaire (PHQ 9) and Clinical Outcomes in Routine Evaluation (CORE 10).

In addition to the above we have successfully recruited to a Nurse Consultant post in Psychological therapies and this post will be key to providing leadership and direction, and establishing the necessary links between mental health and primary care. Additional recent investment in psychological therapies including a post funded by NES will support improved access to psychological services.

All of the above actions are based on evidence based approaches, however we will require to evaluate over time, whether individually or collectively, they will assist us in achieving the target. There are also issues around whether those currently receiving Anti-depressants are treated to target and if not, whether this would result in increased usage in the short term.

Finance

The evaluation of the above will determine future service provision and associated costs. Some additional budget has been identified in anticipation of a successful outcome and roll out. It may also be that the level of service required will vary significantly from locality to locality which may allow us to roll out at less cost. Some costs, e.g., the Project Manager, may be able to be shared across Lanarkshire.

If the evaluation is not positive, then we will require to re-think our actions in pursuit of the target.

Workforce

We have successfully recruited the following staff;

1.00 wte	Project Manager
6.00 wte	Clinical Associates in Applied Psychology (CAAPs)
2.00 wte	Gateway Workers
1.00 wte	Administration support

There may be issues around recruitment of staff in sufficient numbers to roll out across Lanarkshire, assuming the pilot goes well

Improvement

The new services will take time to bed in and critical to our success will be our ability to ensure that these new clinical models and processes are understood and adhered to by GPs and staff within Mental Health. This is reflected in our trajectory. We will support their introduction through attendance at Clinical Forums, through discussion as part of the Protected Learning Scheme and

through face to face meetings with individual GPs and Practice Managers where necessary. We will also support mental health staff and others through clinical supervision.

Implementation of the NICE guidelines along with an increased awareness generally around anxiety and depression may result in increased case finding, demand for treatment and may identify some patients on anti-depressants who are not treated to target. We will address this by linking in with GPs to identify and explore alternatives to prescribing of anti-depressants for these patients.

Longer term sustainability will be contingent upon success of the pilot and funding of roll out.

NHS Lanarkshire is also committed to the Mental Health Collaborative programme which will enable dedicated support through a Project Manager and Information Analyst to use the Plan, Do, Study, Act methodology to effect the necessary changes. This approach will be initiated in two pilot sites, Airdrie and Bellshill, before roll out to other localities in accordance with the spread principles inherent in the methodology.

T4	Reduce the number of re-admissions (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 Langa, Associate Medical Director
 S Kerr, Head of Planning & Performance, CHP North

Measure:

T4.KPM1	Baseline year is 2004. Includes all psychiatric specialities except learning disabilities, but not inter hospital transfers. Source: SMR04
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Trajectory:

Dec 04	Sep 05	Jun 08	Sep 08	Dec 08	Mar 09	Jun 09
513	497	497	497	490	483	476
Sep 09	Dec 09	Mar 10	Jun 10	Sep 10	Dec 10	Mar 11
469	462	462	462	462	462	462

Risk Narrative:

Delivery

NHSL is currently scoping out what is required to introduce an Intensive Home Treatment Service and has recently recruited a Consultant Psychiatrist with expertise in this field.

We also intend to extend our Psychiatric Assessment Teams at each of our DGH sites to provide 24 hour cover ensuring rapid access to assessment and to avoid unnecessary admissions.

In 2008/9 it is our intention to review the delivery of our clinical models within Mental Health Services in terms of the whole patient journey from primary care interventions and referrals management, through standardised assessments, clinical protocols etc to recovery, with an emphasis on ensuring that the processes and protocols are understood and controlled at all stages of the journey. This will ensure that all alternatives to admission are considered prior to a referral being made for in-patient assessment.

The above plans will take some time to implement and may be at risk from any delays around unexpected complexity, human resource issues, issues re organisational culture etc. We will address any such issues through close partnership working with staff, ongoing review, monitoring and evaluation.

Finance

Budget has been set aside to fund a 2 year pilot. The scoping exercise will identify what is affordable in terms of new service models within the current finances available and what would be desirable in terms of future service development. The more we are able to develop this service towards the ideal model, the more effective it will be. Conversely, the more costly the minimum level of service is, the greater the risk of a mismatch of funds available versus those required. We will make every effort to identify necessary funds and to ensure our models are consistent with the level of funding available. If necessary, we will have to decide what priority this service would have within our overall

Mental Health Strategy and whether we de-prioritise some of our other service developments in order to fund the Intensive Home Treatment Service.

Workforce

Workforce requirements will emerge from the scoping exercise, however there are certain to be some Human Resource issues to manage in the process of introducing new clinical models, especially as we move away from more traditional models of community services based around 9-5 working patterns. These circumstances will generate risks around change management, acceptance of the new models amongst staff, training and development capacity and associated costs. Any costs will be identified as part of the planning process around the new models. Training and development requirements will be built into the capacity plans for each part of the service and there will be ongoing monitoring of staff compliance with any new ways of working.

Improvement

One of our main risks is around our ability to effect the necessary cultural change, which will be essential to the delivery of new, more modern service models. This will require significant attention to the change management agenda, including close engagement with front line staff by clinical and senior managers along with partnership colleagues.

NHS Lanarkshire is committed to the Mental Health Collaborative programme which will enable dedicated support through a Project Manager and Information Analyst to use the Plan, Do, Study, Act methodology to effect the necessary changes. This approach will be piloted in the Acute Mental Health In-Patient Unit in Wishaw General Hospital, before roll out to other In Patient Units, in accordance with the spread principles inherent in the methodology.

T5	To reduce all staphylococcus bacteraemia (including MRSA) by 30% by 2010.
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Lead: **A Graham, Medical Director**
 E Anderson, Consultant in Public Health Medicine
 D Harris, Infection Control Manager
 A Armstrong, Associate Nurse Director

Measure:

T5.KPM1	Number of identifications of staphylococcus aureus bacteraemias (including MRSA and MSSA) as detailed in Health Protection Scotland SSHAIP surveillance protocols.
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Trajectory:

Mar 06	Jun 07	Jun 08	Sep 08	Dec 08	Mar 09	Jun 09
254	214	196	192	188	183	179
Sep 09	Dec 09	Mar 10	Jun 10	Sep 10	Dec 10	Mar 11
175	170	165	165	165	165	165

Risk Narrative:

Delivery

Risks to delivery, and actions being taken to minimise these, can be summarised as follows:

- o Community / public carriers bringing staphylococcus aureus into NHS settings – on-going public awareness and education campaigns, particularly hand hygiene;
- o Spread of staphylococcus aureus within NHS settings due to lapses in infection control – there is a suite of standard precautions and policies in place, plus audit of such policies, education and training, and audits of cleanliness, both environmental and equipment;
- o Carriers of staphylococcus aureus – measures are in place to identify these in high risk settings or individuals, and a package of interventions (e.g., isolation) is aimed at reducing the risk of this carriage becoming invasive in the carrier;
- o Individuals who are at high risk of SAB (because of personal staphylococcus aureus carriage or spread from others) and who are receiving invasive treatments – introducing care bundle approach to management of invasive devices;
- o Anti-microbial prescribing policy in place to help reduce risk of resistant strains emerging as these are more difficult to treat;
- o National and local surveillance systems allow identification of trends, clusters and identifying high risk areas, as well as a way of monitoring the effectiveness of interventions.

Finance

National funding (supporting the infection control team) is for a three year period, now into its second cycle of three years. The uncertainty regarding longer term funding means that posts cannot be offered permanently, adding to recruitment and retention challenges (cross refers to Workforce section below).

Workforce

While current infection control staffing is in place (subject to on-going national funding – see Finance section) the pool of skilled professional infection control staff in Scotland is small, and training is lengthy (up to 5 years), thus recruitment and retention challenges are constant. To help alleviate these, we have a competency based structure in place to complement the specific academic training and offer secondments to suitably qualified and experienced nursing staff. While Agenda for Change had an adverse effect during 2007, this is now expected to be resolved following completion of the review process.

In addition to the specialist staff, the aim is to make infection control 'everyone's business' by broadening out accountability to senior ward staff, and integrating it across the organisation using such vehicles as personal objectives, risk management and governance structures, education strategies and PDPs. In so doing, a general cultural change will be fostered, prioritising infection control at all levels and in all settings.

Improvement

The anticipated demographic change and associated change to case mix in the NHS indicates an increase both in higher risk groups and in more complex invasive procedures among such groups. Increased efforts will be required to achieve sustained improvement in the longer term.

Implementation of new national initiatives (e.g., universal screening) will support and inform ongoing development of approaches in future.

T6	To achieve agreed reductions in the rates of hospital admissions and bed days of patients with primary diagnosis of COPD, asthma, diabetes or CHD, from 2006/7 to 2010/11.
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Lead: **A Lawrie, Director – CHP South**
 R Watts, Head of Planning & Performance, CHP South

Measure:

T6.KPM1	Numbers of hospital episodes for specified long term conditions, per 100,000 population.
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Trajectory:

Year ending:

March 07	March 09	March 10	March 11
2,434	2,352	2,269	2,187

The principle adopted in setting this target is one of convergence; that Lanarkshire should achieve at least the current Scotland level of performance, 2186.891 per 100,000 population. This is a provisional target that will be subject to continuing discussion and review, also taking into account that the timing of this draft Local Delivery Plan means that the baseline data is incomplete. It is also the intention to refine targets in terms of individual conditions – see below.

Risk Narrative:

Delivery

Milestones in the development of services for people with Long Term Conditions since May 2006 include: development of the NHS Lanarkshire Long Term Conditions Strategy; launch and initial review of *Keep Well* in North CHP; approval of LTC CHP Self Assessment Tool by Board; establishment of National LTC Improvement Programme and recruitment of local programme manager/information manager; and final evaluation of integrated care management pilots.

This process has linked closely with local Managed Care Networks and their development: Stroke; Diabetes; CHD; Vascular; Palliative Care.

The outputs from these activities are incorporated in the parallel development of the Primary and Community Care Modernisation Plan.

Key Elements of the Self Assessment Tool Kit and Action Plan include: development of disease specific action plans by MCNs; links to implementation of the Carers information Strategy, with clear recognition of carers as partners in care; establishment of clinical communities to ensure whole system approach; implementing a partnership approach through engagement at Locality level through Health and Care Partnerships, Joint Services, Public Partnership Fora etc.; developing frameworks, policies and role descriptions that ensure effective multi-disciplinary and multi-agency working to deliver seamless care; ensuring a consistent approach to patient held care plans and self management tools; devising strategies to reach 'hard to reach' groups in the most deprived areas; improvement of Primary and Community Care Services to Care Homes – implemented in East Kilbride as first stage in area wide roll out; the continuing development of *Keep Well* against its key success factors.

Implementing the LTC Strategy and Action Plan requires effective partnership working on a major scale, significant service redesign and staff commitment. In managing this process, the Action Team is led by the Director of South CHP with managerial support.

In order to develop local understanding and intelligence in relation to this new target, admission and bed day rates for Ambulatory Care Sensitive Conditions (considered preventable) for the five years 2002/3 – 2006/7 are being reviewed. It is intended to look at the key conditions individually in considering future targets. Trends over the period 2002/03 to 2006/07 for the primary diagnoses used for the purposes of this target – CHD (angina and congestive heart failure), Asthma, COPD, Diabetes will be examined.

An initial rationale for setting admission and bed day targets and trajectories for 2010/11 has been identified and will provide the basis for further discussion:

- o Take the data for 2005/06 as the baseline, given that the 2006/07 data is incomplete;
- o Compare the North Lanarkshire, South Lanarkshire and Scotland data for 2005/06 and make the lowest figure the target for 2010/11;
- o Set trajectories by taking the difference between the 2005/06 baseline and 2010/11 targets and spreading movement of one to the other proportionately over the period from 2007/08 to 2010/2011. Ignore incomplete 2006/07 figures for present purposes.

This is very much a provisional approach. Further discussion will test its realism, including reference to the 2006/07 figures as these are finalised. Initial calculations have allowed the setting of a provisional trajectory for the purposes of this Local Delivery Plan.

Finance

Implementing the Strategy and Action Plan will require investment over time. There is a firm commitment by the Partnerships to investigating the resources that will be required to ensure that long term changes are made to the service user/carer journey. This is work in hand and it is too soon to spell out the overall financial implications.

Workforce

The deployment of existing Community Nursing staff has been refocused and aligned into areas of greatest need as a result of the demographic profiling of Localities. The requirements for additional staffing and skills to underpin Strategy implementation will be informed by the outcome *Keep Well* and supported self help pilots.

In the meantime, the Self Assessment underlined the significant programme of training and development that will be needed to bring about the desired changes, including values based training to support patient and carer empowerment.

Improvement

The LTC Action Team with strong membership under Executive Director Leadership and appropriate management support is the key to the change management process, managing risk and delivering this overall improvement programme.

T7	Improvement in the quality of healthcare experience
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Lead: **Paul Wilson, Director of Nursing**
Shona Welton, Head of Patient Affairs

Measure:

T7.KPM1	Better Together – NHS Scotland’s Patient Experience Programme. Details of measure to be determined in partnership with Boards. Data will be published after first survey is completed (autumn 2008).
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Trajectory:

(No trajectory for 2008/09)

Risk Narrative:

Delivery

NHS Lanarkshire welcomes this new target and, through representation on the national Programme group and sub-groups and participation in related events, will contribute directly to the development of the target and its measure in 2008.

Our previous work with ‘Picker’ in 2001/02 and in relation to the national pilot in 2005 will be useful experience to draw upon, and we have already contributed to the development of the new approach by means of a local focus group to help inform design.

We note that the first inpatient survey will be completed in autumn 2008 and that this will inform further developments. In the meantime, we plan to put in place a local group with responsibility for overseeing and co-ordinating activities.

Finance

(Details will emerge as work progresses in 2008/09)

Workforce

(Details will emerge as work progresses in 2008/09)

Improvement

(Details will emerge as work progresses in 2008/09)

T8	Increase level of older people with complex care needs receiving care at home.
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Lead: **A Lawrie, Director – CHP South**
R Watts, Head of Planning & Performance, CHP South

Measure:

T8.KPM1	(Definitions being developed. Baseline to be agreed in 2008/09, followed by trajectory).
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Trajectory:

(Trajectory to be developed in 2008/09)

Risk Narrative:

Delivery

The focus provided by this target is welcomed, particularly in enabling the presentation of the full spectrum of complex needs being met at home. Local experience is that the population of older people with these needs is not homogeneous. Whilst some require health and social care, a significant element need one or the other but not both.

In order to ensure that these needs are met in a timely and appropriate manner, Out of Hours Nursing and Home Care Services have been aligned across North Lanarkshire and within the Clydesdale Locality of South Lanarkshire for some years. This service has been effective in preventing Accident and Emergency attendances and hospital admission. The development of this service is being considered as part of the renewal of the Partnerships Strategy for Frail Older People.

Information on social care, provided as part of a joint care package or on its own, is well represented through JPIAF 10. This incorporates the Spending Review target on intensive care needs and has shown that both the North and South Lanarkshire Partnerships have consistently exceeded the national 30% target for intensive home care services (including care at home and geriatric long stay), i.e., 42% in North Lanarkshire in both 2005 and 2006; 33% in South Lanarkshire in 2005 increasing to 35% in 2006. This target is included within the Local Improvement Targets for both Partnerships for routine monitoring, reporting and review.

A priority is to set information alongside this about home care for those with complex health needs. This will come from two main sources and will be influenced by the definitions being developed through the Community Care Outcomes Framework Design Authority:

- The progressive extension of care management, currently established in three areas including Clydesdale Locality, and the generation of SPARRA data;
- The analysis of data on hospital admissions for a range of conditions that are generally recognised as being preventable.

As with all aspects of Community Care, there will be a clear focus on Outcomes and specifically the National Community Care Outcomes Framework. Both Lanarkshire Partnerships will respond fully to the current guidance on performance reporting for Community Care in 2007/08, including commentary on the six interlocking themes and their interaction across Partnerships. They look forward to the further development of the Framework and Outcomes reporting in 2008/09 and beyond.

The local commitment to the Outcomes approach will also be apparent from the recent Partnership response to the consultation on the National Minimum Information and Data Standards. The development of the standards is welcomed for a variety of reasons, particularly in facilitating the measurement, reporting and development of outcomes.

NHSL will work with the Health Delivery Directorate in 2008/09 to agree a baseline position and thereafter a trajectory for 2009 – 11.

Finance

Financial arrangements to support achievement of this target will be determined by the framework provided by agreement on the baseline position and trajectories. This is in the context of the medium term financial strategies agreed by the Partnerships, the increased investment in community nursing through the community nursing manpower plan and the alignment of nursing and home care services.

Workforce

Workforce implications will also be worked through in the light of the agreement on the baseline and trajectory, set in the context of the community nursing manpower plan and further work on clinical and service models around the interface between health and social care.

Improvement

The assessment of risks will take place in due course.

T9	Each NHS Board will achieve agreed improvement in the early diagnosis and management of patients with dementia by March 2011.
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Lead: C Sloey, Director – CHP North
S Kerr, Head of Planning & Performance, CHP North

Measure:

T9.KPM1	Number of people with a diagnosis of dementia on the QOF dementia register.
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Trajectory:

Year ending:

March 07	March 09	March 10	March 11
2,838	3,150	3,462	3,775

Risk Narrative:

Delivery

The Quality and Outcomes framework is voluntary, therefore there is no compulsion on practices to undertake all or any part of the QOF, however all Lanarkshire practices do participate in the QOF, some more than others.

At present, in order to achieve the points within the contract, the practice need only produce a register of patients diagnosed with dementia. There is no requirement for practices to increase the numbers of patients on the register.

In the baseline year, all 99 Lanarkshire practices achieved the points associated with the production of the register, therefore there are no new practices to bring on board as a means of increasing the figures.

There will have to be careful negotiations around this to ensure every effort is made at practice level and within Primary care based teams to identify and diagnose patients with dementia. All GPs in Lanarkshire can currently refer patients to Memory Clinics where diagnoses can be confirmed. An ICP for Early Onset Dementia is currently being developed.

Finance

There are no financial risks around this target unless it becomes necessary to reward GPs, in order to get their buy in to the required focus on increasing the numbers on the register

Workforce

No additional staff required.

Improvement

We are reliant on practices to assist us in achieving this target. There are also risks around progressing from a strong baseline. We will need to heighten awareness amongst those staff likely to be in contact with patients who have dementia and to enlist their support in working with Practice Managers to make sure these patients are on the register. We will also cross reference registers with clients known to services for dementia, day hospitals etc.