NHS LANARKSHIRE LOCAL DELIVERY PLAN 2016/17

1 INTRODUCTION 2

2 STRATEGIC IMPROVEMENT AREAS: 4

Realistic Medicine in Lanarkshire 5

- **2.1 Health Inequalities & Prevention** 6
- **2.2 Antenatal & Early Years** 9
- **2.3 Safe Care** 12
- **2.4 Person Centred Care** 16
- **2.5 Primary Care** 18
- **2.6 Integration** 23
- **2.7 Scheduled and Unscheduled Care** 25
- **2.8 Mental Health** 30
- **2.9 Community Planning Partnerships** 34
- **2.10 Workforce** 39

3 LDP STANDARDS: 43

- **1 Early Detection of Cancer** 43
- **2 Cancer 31 days** 44
- **3 Cancer 62 days** 44
- **4 Dementia post-diagnosis support** 45
- **5 TTG** 46
- **6 18 weeks RTT** 46
- **7 12 weeks Outpatient** 46
- **8 Antenatal booking** 47
- **9 IVF 12 months** 47
- **10 18 weeks RTT CAMHS** 48
- **11 18 weeks RTT Psychological Therapies** 49
- **12 HAI – C diff rate** 49
- **13 HAI – SABs rate** 50
- **14 3 weeks Drug & Alcohol treatment** 50
- **15 ABIs** 50
- **16 Smoking cessation** 51
- **17 Primary care - 48 hour access** 52
- **18 Primary Care – advance booking** 52
- **19 Sickness absence** 53
- **20 A&E 4 hours 95% / 98%** 53
- **21 Finance – RRL, CRL and CL** 54

4 FINANCIAL PLANS 55

Annex A: List of Local Strategies and Plans 56

1 INTRODUCTION

This is NHS Lanarkshire's eleventh Local Delivery Plan (LDP), developed in line with Scottish Government Health Directorates (SGHD) guidance of 13 January, 18 February and 15 March 2016.

The 2016/17 LDP is reflective of the Government's national ambitions articulated in the 2020 Vision for Health & Social Care in Scotland (May 2013), now being refreshed through the National Conversation, the development of the national Clinical Strategy, and the review of Out of Hours Services in line with the Ritchie report (2015). Nationally, new investment will also support the transformation of primary care by developing new and improved models of care, with multi-disciplinary teams working together to meet the needs of their communities. A number of new national treatment centres are also planned, to equip the NHS with additional elective capacity (hip replacements and cataract operations) to meet the growing needs of an older population.

Taken together, the above policies and approaches are designed to drive forward fundamental changes in the way our NHS delivers care, where prevention, through anticipation and early intervention, is the focus, and where care and treatment are provided in a holistic and comprehensive manner in community and home settings. In hospital settings, day case treatment should be the norm, and where hospital admission is required, this should be managed in a cohesive and pro-active manner to ensure that there is a smooth, timely and safe transition towards discharge that includes all necessary supports in the community and home settings. The integration of health and social care will be pivotal to achieving the above transformation and thus this LDP has been developed in collaboration with our two Health & Social Care Partnerships. Our aims are mutual and we have worked to ensure that there is coherence and congruence between this LDP and our Partnerships' first Strategic Commissioning Plans that will come into being on 1 April 2016.

As required by the SG guidance, we have set out brief details of our plans for 2016/17 in the following strategic improvement areas:

- Health Inequalities & Prevention;
- Antenatal and Early Years;
- Safe Care;
- Person Centred Care;
- Primary Care;
- Integration;
- Scheduled and Unscheduled Care;
- Mental Health;
- Community Planning Partnerships;
- Workforce.

The key actions and activities in each of the above areas will support achievement of the overall ambitions articulated above, and will also underpin our continuing pursuit to achieve and/or sustain achievement of the 21 LDP Standards continued from previous years and described further in section 3.

Overarching these ten areas, we have chosen to insert an additional short opening section setting out our response to the Chief Medical Officer's Annual Report for 2014-15 on Realistic Medicine.

By its very nature, this LDP can only provide a very brief summary of the workstreams in the areas indicated, and it is important to note the wider range of local service strategies

that will contribute and also aim to ensure that we continue to deliver high quality, safe and effective care to the people of Lanarkshire. Our overarching planning framework – *A Healthier Future 2012-2020* - set out our ambitions and will continue to drive forward progress towards the Government's 2020 Vision for Health and Social Care in Scotland. During 2016/17, we will consult on our Healthcare Strategy, that will seek to identify and put in place the most effective and safe models of care and service configurations. We will also continue to implement our Quality Assurance and Improvement Strategy *Transforming Patient Safety and Quality of Care in Lanarkshire 2014-17.*

Risks

Across NHS Lanarkshire, a substantial programme of work is underway to identify the required level of savings, and to put in place the necessary actions, to achieve financial balance in 2016/17. At time of writing (May 2016) the impact of this on the programmes of work that underpin the LDP is ongoing, with further details included in each section as these have been firmed up and confirmed.

Calum Campbell
Chief Executive

2 STRATEGIC IMPROVEMENT AREAS

This section of the LDP provides a summary of NHS Lanarkshire's key actions under each of the care areas as defined in the Scottish Government guidance, together with an overview outlining our response to the recent 'Realistic Medicine' approach promoted by the Chief Medical Officer:

Realistic Medicine in Lanarkshire

2.1 Health Inequalities & Prevention
2.2 Antenatal and Early Years
2.3 Safe Care
2.4 Person Centred Care
2.5 Primary Care
2.6 Integration
2.7 Scheduled and Unscheduled Care
2.8 Mental Health
2.9 Community Planning Partnerships
2.10 Workforce.

Realistic Medicine in Lanarkshire

The Chief Medical Officer's Annual Report for 2014-15 on Realistic Medicine gives food for thought and signals many areas for review. It challenges our thinking about how we share decision making with our patients and whether some of the treatments we offer are not ones that we would wish for ourselves. Whilst aiming to apply evidence based medicine guidance in managing our patients, these can be focused on managing single system disease, so we have a duty to consider the benefits in those with multiple co-morbidities where the evidence is less clear in terms of effectiveness. The CMO sums this up well in her report when she states:

"Doctors generally choose less treatment for themselves than they provide for their patients.

In striving to provide relief from disability, illness and death, modern medicine may have overreached itself and is now causing hidden harm – or at best providing some care that is of lesser value.

We must deliver healthcare that focuses on true value to the patient. Waste in healthcare should be assessed not in terms of what might be thrown away, but in interventions that don't add value for patients. This includes avoiding unwarranted variation in clinical practice and resultant outcomes."

Some of the key questions that are posed by the Report include:

- How can we further reduce the burden and harm that patients experience from over-investigation and overtreatment?
- How can we reduce unwarranted variation in clinical practice to achieve optimal outcomes for patients?
- How can we ensure value for public money and prevent waste?
- How can people (as patients) and professionals combine their expertise to share clinical decisions that focus on outcomes that matter to individuals?

Senior clinicians have been asked to give this report their consideration both within their specialty teams and at primary / secondary care interface groups with the aim of identifying any areas they would wish to pursue or any areas where they may feel that additional information would help to give this concept further consideration. Senior Medical Managers have also been asked to consider how they can help to build a clinical consensus on this.

The financial challenges for 2016-17 have been articulated as part of this engagement as it forms part of the context around the need for evidence of the efficacy, efficiency and cost effectiveness of everything that we do. We anticipate through clinical support that we may be able to decommission £3-5m worth of services through this alternative approach.

2.1 Health Inequalities & Prevention

Lead: **H Kohli, Director of Public Health & Health Policy**
J Hewitt, Chief Officer, North Lanarkshire H&SCP
H Stevenson, Chief Officer, South Lanarkshire H&SCP

Governance Committee(s): **HQAIC**
North JIB
South JIB

Background

NHS Lanarkshire (NHSL) has developed a comprehensive Health Inequalities Action Plan that was approved by the Healthcare Quality Assurance and Improvement Committee on 16 December 2015. The plan covers eight key areas:

- Early years and young people;
- Employment as an asset for health: maximising NHSL's role as an employer to address inequalities;
- Tackling poverty and minimising the impact of welfare reform;
- Place Standard: To work with both local authorities to achieve the 'Place Standard' in one area in each local authority area;
- Reshaping NHSL's services to address inequalities;
- Preventative services that support the most deprived populations in Lanarkshire;
- Utilising the Assets based approach to improve health and wellbeing within our most deprived communities;
- Identifying and developing 'person-centred' approaches to those who are vulnerable.

The plan identifies a range of actions, current status, anticipated outcomes and timescales for delivery. Progress will be monitored by, and reported to, the Health Improvement/Health Protection SIB, with governance oversight by the Healthcare Quality Assurance and Improvement Committee (HQAIC). This plan will form the basis of our actions in conjunction with both Health and Social Care Partnerships and both Community Planning Partnerships to address inequalities in 2016/2017. Specific focus will be placed upon Early Years, NHSL as an employer, and reshaping NHSL services to address inequalities.

NHS procurement policies should support employment and income for people and communities with fewer economic levers

In addition to complying with national guidelines, NHSL will utilise additional specifications to promote local employment and community benefit. Applicants will be expected to demonstrate previous involvement in community benefit initiatives and how this would be affected and monitored if successful in winning the contract, how they will support economic development, engage with the community and other key partners and support community capacity building, provide training and employment opportunities and demonstrate a commitment to pay a living wage.

Actions relating to employment policies that support people to gain employment or ensure fair terms and conditions for all staff

NHS Lanarkshire is committed to working with other government partners, to help develop the workforce by training and employing individuals who are often overlooked by traditional recruitment methods and have considerable talent that could be utilised within the organisation. There are a wide range of other partners who participate and support routes to employment and targeted employment support. These include DWP, North Lanarkshire Council, South Lanarkshire Council, SERCO, ISS, New College Lanarkshire, NLC Regeneration Services and Routes to Work.

Current activity includes:

Health Assistant Programme
In 2003 a partnership comprising of Job Centre Plus, Cumbernauld College, Scottish Enterprise and NHS Lanarkshire was established to target local unemployed people and those facing redundancy. This programme was devised to help support the development of the Nurse bank and introduce a new innovative approach to recruitment, training and retention of a skilled and flexible workforce.

The course is for an 8 week period. The first 2 weeks is provided by New College Lanarkshire. They will focus on communication skills, team working and customer care. They will also during the first week work towards completion of the IOSH Certificate (Institute of Occupational Health & Safety). It also aims to help increase the individual's confidence, ultimately increasing their employability. The following 2 weeks is more theory based covering Moving & Handling Training, Management of Violence & Aggression, Basic Life Support, Infection Control, Clinical Practice and Dignity Workshop. The candidates are then placed in a general ward for a period of 4 weeks to allow them to consolidate the theory and obtain clinical experience. A mentor is allocated to assist with this. Over the last twelve months 50 individuals have completed this programme all of whom have joined NHSL's staff bank, of this 50, 11 were between the ages of 16 – 24 years. The intake for 2016 is scheduled to increase to 80. Since implementation approximately 650 candidates have successfully completed this course. The course continues to date and provides an access point to entry level employment in care.

Work with Schools
NHS Lanarkshire is proactive in engaging with young people and competing for its share of new entrants to the workforce through visits to various schools & colleges within North & South Lanarkshire and most recently to school careers evenings at Lanark and Coltness High Schools. The purpose is to ensure that people are aware of career and vocational pathways that may be available to them in health. Additionally work is ongoing with educational facilities to invite students into the workplace to obtain further information regarding the various roles available.

Work Experience
Work experience provides an opportunity for an individual to learn in a contextualised working environment. It also aims to increase the individual's employability by developing transferable skills and the right attitude to work. By supporting work experience programmes operating in partnership between schools, colleges and health facilities, NHS Lanarkshire is engaging with young people at the right time in their lives when they are making important career choices. NHS Lanarkshire's policy is currently under review and will aim to move away from traditional boundaries of offering placements to school children only and instead incorporate various routes to employment, whilst widening the applicable age group.

Project Search

Project Search is a partnership model that aims to help individuals with learning disabilities to secure and retain employment, NHSL works in partnership with North Lanarkshire Council, Serco and New College Lanarkshire on this initiative. The first year commenced in September 2010. Since the Project started, 79 students have graduated, with 49 students securing employment. North Lanarkshire was the first local authority area to have adopted the Project Search model which originated at the Cincinnati Childrens Hospital, USA and has some 150 sites worldwide. The model blends work based education and practical work experience to deliver a unique preparation and induction to employment.

Modern Apprenticeships

NHSL has introduced a programme of modern apprenticeships in partnership with Job Centre Plus and both South Lanarkshire Council and North Lanarkshire. In this financial year there have been 7 positions appointed to within South Lanarkshire, 5 of which completed an SVQ in Business Administration (MA). 18 positions have been appointed to within North Lanarkshire with 8 completing an SVQ in Business Administration (MA).

Actions to support staff to support the most vulnerable people and communities

NHSL will continue to support our most vulnerable populations. This work will be delivered mostly through both Health and Social Care Partnerships. Both have undertaken substantial health needs assessments and are developing plans with communities to address the needs of specific groups and communities. These plans will identify key actions, timescales and anticipated outcomes. Key health improvement services such as the Stop Smoking Service and Keep Well in North H&SCP will focus activity on people living in our most deprived data zones and vulnerable populations. A health needs assessment for homeless people was completed with the input of colleagues from ISD in North Lanarkshire and will be undertaken in South in 2016/17. The findings and recommendations will be considered and appropriate action taken. Learnpro and face to face training will be utilised to develop staff's knowledge in areas such as gender based violence and welfare reform. Systems will also be utilised to enable staff to make appropriate referrals to support services more easily. The Health Promoting Health Service framework will be utilised to encourage staff in the Acute Sector to engage in wider health improvement work.

Health improvement actions to promote healthy living and better mental health

Health improvements actions will focus on the prevention of major diseases such as CHD and cancers, addressing life circumstances and promoting positive mental health and wellbeing. With regards to the latter, NHSL will seek to achieve the aims set out in Good Mental Health for All. Focus will be placed on working with individuals to enable them to self manage whenever possible and on social prescribing. Crucially we will work with our Third Sector partners and with communities to develop interventions based upon need. NHSL, mostly through both Health and Social Care Partnerships, will continue to address the issue of adult and child healthy weight through the delivery of a range of programmes in line with the ambitions of the Lanarkshire Healthy Weight Strategy, which will be published in spring 2016. In addition, support will be given to increasing the reach of the Get Walking Lanarkshire programme, a multi agency and third sector approach to creating a network of walking programmes throughout the area. We will continue to work with Lanarkshire Community Food and Health Partnership to deliver community based healthy eating programmes, food co-ops and support to the network of food banks in Lanarkshire. Specific focus will be placed upon addressing the issue of alcohol in our communities, and smoking prevention and tobacco control through the revised Lanarkshire Tobacco Control Strategy 2016-21.

2.2 Antenatal & Early Years

Lead: I Barkby, Director of Nursing, Midwifery & AHPs

Governance Committee: HQAIC

Children and Young People's Health Plan

NHS Lanarkshire has developed a Children and Young People's Health Plan 2015-2018 that provides direction and supports improvement to specific priority areas within the NHS Lanarkshire. It is important, however, to recognise the importance of all statutory, voluntary and independent partners working together to achieve the greatest impact on the lives of children and young people and which requires the health plan to be seen in the context of the North and South Lanarkshire Single Outcome Agreements. Outcome measures have been agreed for both the Health Plan and Single Outcome Agreements.

The priorities set out in the Single Outcome Agreements are:

- Improved outcomes for all children and young people;
- Solutions built with, and around children, young people and their families;
- Children get the help they need when they need it;
- Everyone is working together to make sure things get better.

Ante Natal Access

NHS Lanarkshire has achieved the standard of 80% of pregnant women booking for pregnancy by 12 completed weeks of pregnancy in all 5 deprivation quintiles. Work will continue to further improve access, particularly in more vulnerable groups.

27-30 Month Assessment

82% of children who attend for 27-30 month assessment currently achieve developmental milestones. It is however recognised that only 86% of eligible children attend for review. A number of programmes are underway to improve uptake and to ensure early intervention and attainment of the Early Years Collaborative stretch aim of 85% of all children achieve developmental milestones is achieved.

Implementation of the Universal Health Visiting Pathway

In order to implement the pathway it will be necessary to expand the health visiting workforce. This will be in line with the national funding allocation received by NHS Lanarkshire. Implementation of the Universal Pathway will be in line with the resource available. Recruitment campaigns have been undertaken and 15 student health visitors were supported through the programme in September 2014 and completed in August 2015, however this did not allow for workforce expansion due to the number of vacancies in the service due to the age profile of the workforce.

A further 30 students have been supported in September 2015/16, with a further 30 required in 2016/17 to increase the Health Visiting workforce. Whilst there is Scottish Government funding, there is a significant risk that funding will not be sufficient to meet the cost of the additional staff, and therefore a risk to full implementation of the Universal Pathway.

Despite no increase in funded establishment, initial implementation of the pathway has commenced for women who booked for pregnancy from October 2015. To date an antenatal pathway has been implemented which ensures health visitors are informed of pregnant women and are allocated a health visitor as their Named Person during pregnancy and will be provided with information about the role of the Named Person. Implementation of the Universal Pathway will be in line with the growth of the Health Visiting workforce, with those interventions yielding the greatest projected impact being prioritised.

Children and Young People Act 2014 parts 4, 5 and 18

Multi-agency groups have been established in North and South Lanarkshire to lead implementation of parts 4, 5 and 18 of the Act. In addition a health implementation group has been established. The GIRFEC practice model is embedded in health visiting practice, however work is progressing in development of practice guidance for named person role, chronologies and development of child's plans. In addition the named person service and information sharing solutions are currently being developed. Effective implementation of the named person role for the pre 5 population by August 2016 will be achieved. It is also anticipated that there will be additional administration costs and work is similarly in hand to assess the additional need and associated funding. Key elements are detailed further below.

Child's Plan:
A template has been prepared with partner agencies that will allow all partners in Lanarkshire to meet the requirements of the Children and Young People's Act. This template includes a summary and analysis of the wellbeing assessment to facilitate ease of access for the 'network of support' and families. The production of a Child's Plan will be initiated when a targeted intervention takes place. This plan will follow the format of existing assessment documentation with additional information only being required where the plan becomes statutory. Staff training will therefore be minimal. Guidance for when a statutory plan is required is currently being developed.

Raising Awareness:
A communication plan has been developed based on the GIRFEC Partner Communication Toolkit.

A tailored Local publicity campaign co-ordinated with key partner agencies and in line with national publicity campaign will be undertaken as the go live date approaches. National resources and materials for staff and public will be produced centrally with the ability to input local information. These will be utilised in Lanarkshire and form part of the communication plan.

A learning plan has been developed as part of the NHSL implementation group. The educational requirement consists of two key elements:

- Ensuring Health Visitors and Family Nurses have the skills and competence to undertake this role: Implementation of this programme is well underway. All will have completed the programme by November 2016;

- Create understanding of the named person role and the requirement to share relevant information with the named person. This will be a requirement for directly managed and contracted services such as General Practice, Optometry, Pharmacy, and Dentistry. In taking this forward eight attendees from a wide range of services attended the Master class organised by Scottish Government on

22nd and 23rd March and will be responsible for cascading key messages and learning.

NHS Education Scotland are preparing an online education/awareness training tool which is now available on the GIRFEC Knowledge Hub to give a general awareness of the Act and the statutory requirements to all staff.

Information Sharing and Systems:
A joint protocol, operational process and associated guidance have been developed with partners to ensure that all statutory agencies are fully compliant with the responsibilities placed on them by the Act and the additional Statutory Guidance.

Strong links have been established with the LDSP e-Care Children's subgroup and cross representation on the C&YP Act. The requirement for sharing information with partner agencies is widely recognised and work is underway to ensure that systems are established to facilitate relevant and proportionate information sharing across NHSL and with Police, Education Social Work and other partner agencies. The Information Sharing Protocol has been re-written in SASPI format recognising the changes which the Act brings in relation to the need for consent in relation to a wellbeing concern.

An information sharing web based training programme for practitioners is in development and will be implemented from Spring 2016 remaining available to all partner staff from that point forward

Systems development to facilitate information sharing has been identified as a requirement of all partners and the intention is to develop the functionality of the existing multi agency store to deliver the Lanarkshire wide solution.

The commencement of this work will be driven by establishing the business requirements of agencies in delivering their individual and joint requirements under the Act. At present there is no definitive timescale for this work to be completed. The next steps are:

- Development of business requirements and IT infrastructure to support secure information storage and sharing;
- IT infrastructure to support single Child's Plan.

2.3 Safe Care

Lead: I Wallace, Medical Director
I Barkby, Director of Nursing, Midwifery and AHPs

Governance Committee: HQAIC

Aims

NHS Lanarkshire's vision is to achieve transformational improvement in the provision of safe, person centred and effective care for our patients, and for our patients to be confident that this is what they will receive, no matter where and when they access our services. To achieve our vision, we are committed to transforming the quality of health care in Lanarkshire and through this we aim to:

- be the safest health and care system in Scotland;
- have no avoidable deaths;
- reduce avoidable harm;
- deliver care with patients that is responsive to their needs;
- meet the highest standards of evidence based best practice;
- be an employer of choice;
- develop a culture of learning and improvement;
- deliver effective and inclusive services so that all individuals, whatever their background, achieve the maximum benefit from the services and interventions provided, within available resources.

Scottish Patient Safety Programme

NHS Lanarkshire continues to make progress with implementation of the Board's *Patient Safety Strategic Prioritised Plan* (*2014-17)* and can demonstrate how it is providing safe care.

Significant progress has taken place over the past year with the testing and implementation of key processes recognised to impact on the outcomes and assist with achieving the strategic aims set out within the Board's plan.

A Reducing Harm Collaborative was launched with 285 members of staff in attendance at the first the first learning session on 9 June 2014 and subsequent learning sessions have taken place as the vehicle to support implementation and build capacity and capability in patient safety and quality improvement. A further 4 learning sessions held during 2015/16 had a total of 920 staff in attendance.

An organisational completeness and coverage matrix has been developed to support our local plans for spread and sustainability of both the 10 Safety Essentials and the Board's Strategic patient safety aims set out within the Board's Plan.

As part of the Boards Prioritised Patient Safety Plan, work is being progressed in relation to two of the 3 national 'points of care' interventions as part of the Peri-operative workstream. This will include:

- Reliable implementation of Venous Thromboembolism (VTE) prophylaxis and the development of a spread plan to ensure completeness and coverage across all relevant clinical areas;

- A focus on reducing Surgical Site Infections in colorectal patients with initial testing and implementation of the Surgical Site Infection Bundle with a Lead Clinician at one acute site.

All patients that have to go into hospital for surgery are at risk of getting an infection and some patients are also at risk of developing a blood clot with potentially serious consequences. It is recognised that focused improvement work in these areas will bring substantial benefits to patients by reducing the risk of developing post-operative infections and blood clots.

The work of the Reducing Harm Collaborative, where relevant, has taken a whole system approach and teams from both acute and primary care have participated in this work to reduce avoidable pressure ulcers and Catheter Associated Urinary Tract Infection (CAUTI).

NHS Lanarkshire has already progressed work on implementation of the SSKIN bundle within nursing homes. The SSKIN bundle refers to the following key areas that staff must focus attention to, and are recognised to reduce the risk of developing a pressure sore:

- Surface;
- Skin inspection;
- Keep moving;
- Incontinence;
- Nutrition.

During the early part of 2016/17, work will be progressed to set out how NHS Lanarkshire's Patient Safety Plan and strategic aims will be broadened to encompass the integrated health and social care agenda. This work will be taken forward in partnership with both Health and Social Care Partnerships to identify pilot nursing home sites for us to progress this work with, and a draft paper setting out the safety priorities and plans for implementation will be presented to the Corporate Management Team, Integrated Joint Boards, Patient Safety Strategic Steering group and NHS Lanarkshire Board. The Board's Patient Safety Strategic Plan will then be updated to reflect this.

Achievements and Improvements in Patient Safety

Several pilot teams have achieved improvement of key processes and can demonstrate reliability of processes and impact on outcomes.

Falls – Sustained improvement in process reliability has been achieved across 11 teams participating in our Reducing Harm Collaborative. Early signals of a sustained improvement in outcome (All Falls) for one of the pilot wards.

Catheter Associated Urinary Tract Infection – sustained improvement in reliable delivery of insertion & maintenance bundles across collaborative teams. Reduction in catheter usage achieved.

Cardiac Arrest - increased reliability of clinical observations, and both recognition and response processes in some pilot teams with early indications of a reduction in Cardiac arrests.

Sepsis - Progress made across 3 emergency departments in reliable delivery of the Sepsis 6 with a reduction in mortality achieved.

Pressure Ulcers - increased reliability achieved in risk assessment and implementation of the SSKIN bundle.

Maternity- increased reliability of Modified Early Obstetric Warning System (MEOWS) and post partum haemorrhage prevention and management bundles.

Mental Health - Reduction in restraint and seclusion and increased reliability of Medicines Reconciliation.

Walkrounds - 92 patient safety leadership walkrounds have taken place since February 2014, with 254 patient safety issues identified of which 87% have been resolved. Commenced measuring staff experience as part of the walkround process.

Culture Survey – Additional to undertaking an organisational patient safety culture survey in 2014, in September 2015 a collaborative pilot team patient safety climate survey was undertaken and findings analyzed and presented.

Case Note Reviews – Patient safety case note reviews in the following area took place throughout 2015:

- 50 deaths from Sepsis;
- 2 x 3 Matrix Mortality reviews of 50 deaths at Wishaw;
- 50 deaths from Cardiac Arrest.

An Integrated Site Visit by the national Scottish Patient Safety Programme (SPSP) Team in November 2015 highlighted the significant progress that had taken place over the past two years and the work of that NHS Lanarkshire teams had achieved thus far on our improvement journey. They acknowledged a cultural shift in these areas, as well as commending the work of the collaborative in supporting teams with implementation of the Board’s Strategic Prioritised Plan. It is our intention to continue this work and to demonstrate continued improvement outcomes during 2016/17.

Infection Prevention and Control

The HIS standards for Healthcare Associated Infection (2015) will continue to provide the main focus for delivery of the Infection Prevention and Control Service in 2016/17.

Despite a recognised national shortage of IPC Nurses, NHSL has successfully recruited to a number of key senior posts within the IPC Department during 2015. There is now a platform for a robust team to develop working relationships with acute and health and social care partnerships during 2016/17. Ongoing professional development of trainee IPC nurses will assist with succession planning and future proofing of the service.

The surveillance of alert organisms, transmissible infections and surgical site infections will continue to be a priority for the Infection Prevention and Control Team in 2016/17. A complete revision of all surveillance methodologies and processes has been completed by the IPC team, in association with eHealth and NHS National Services Scotland (NSS), ensuring that the IPCT surveillance service is better equipped to meet local and national demands. This revised method of working along with centralisation of the IPC Team to one location will significantly reduce the risks currently associated with surveillance and skill mix. Progress with this will be reported via the HAIRT (Healthcare Associated Infection Reporting Template) report bi-monthly to the NHS Board.

NHS Lanarkshire will drive further improvement towards the LDP Standards for C diff and SABs set out in section 3 (Standards 12 and 13). In an effort to reduce our SAB rate for 2017/17 a number of actions are planned with a focus on invasive devices and hand hygiene. Hand Hygiene is acknowledged as the single most effective method of reducing the risk of cross transmission of infection and appropriate management of invasive devices is crucial to reduce the number of SAB.

Local surveillance activity has identified that further education is required around the management of invasive devices such as Peripheral Venous Catheters (PVC) and Central Venous Catheters (CVC). Recent inspections by the Head of Infection Prevention and Control as well as the Healthcare Environment Inspectorate have demonstrated good compliance with the care of invasive devices however further work is planned in 2016/17 to improve completion of the Care Bundles for PVC and CVC.

The Infection Prevention and Control Team plan to conduct quarterly PVC and CVC audits to measure compliance with the care bundles across a range of inpatient specialities in 2016/17 and will report on audit findings to Patient Safety Strategic Committee and NHSL Infection Control Committee. The action plans and recommendations following the audits will also be included in the HAIRT report to the NHSL Board

In tandem with improvement work for invasive devices, the IPCT are focusing on Hand Hygiene for 2016/17 in an effort to improve compliance across all grades of healthcare workers. Local intelligence has demonstrated non compliance with Moment 5 of the WHO 5 moments of Hand Hygiene.

In conjunction with improvement advisors from Healthcare Improvement Scotland, a series of workshops are planned for sites across NHSL to stimulate conversations with staff around barriers to hand hygiene and to raise awareness of correct techniques.
A number of Hand Hygiene road-shows are planned for delivery across NHSL involving staff from acute services and Health and Social Care services. The NHSL policy for Hand Hygiene has also recently been refreshed.

2.4 Person-Centred Care

Lead: **I Barkby, Director of Nursing, Midwifery & AHPs**

Governance Committee: HQAIC

NHS Lanarkshire is working with Healthcare Improvement Scotland to identify and drive improvements in person-centred care through targeted activities. The following is a summary of key actions planned for 2016/17:

By May 2016:

A minimum of five test teams will have been identified whose work will help inform the methods and resources required to gather, analyse and report on patient and carer experience feedback as follows:

Real-time feedback

We will have engaged public partners to consider and develop the approaches to be used to gather feedback. Local Care Teams will have been established to receive real-time feedback during each calendar month. This is feedback that is collected from patients and carers at the point of care and shared with the healthcare team within 48 hours of collection.

This will enable teams to measure overall care experience, personal outcomes and the 5 Must Do elements of care. Teams will then be able to identify areas for improvement and demonstrate activity related to the feedback received.

All test teams will have:

- agreed Project Charters, including actions, timelines and reporting;
- fully tested at least one Local Care Team meeting and identified at least one change idea which has been woven into daily work, every patient, every time.

Right-time feedback

We will have engaged public partners to consider and develop the approaches and process to be used to gather right-time feedback. This is feedback that is collected two - three weeks after discharge / the episode of care has finished.

This will enable the test teams to consider right time and real-time feedback to measure overall care experience.

By November 2016:

All test areas will be using multi-source feedback at the‘Local Care Team Meeting to:

- measure overall experience of care and personal outcomes;
- allow the 5 Must Do elements of care to be measured regularly;
- demonstrate that feedback is used to drive improvement.

All areas inviting and gathering solicited feedback will be able to:

- demonstrate the use of feedback methods at different times and in different ways, e.g., at the point of care and after an episode of care;
- demonstrate that 90% of the people who use their services report a positive experience of care and get the outcomes they expect.

Real-time feedback shared and considered by Local Care Teams will be an integral part of the work, ensuring the patient voice is heard as an **individual** at point of care, with staff also utilising other information and data sources such as Datix, complaints and Patient Opinion to enable learning and drive **local** improvement.

All test areas will be able to demonstrate that all applicable Must Do elements of care are reliably implemented / delivered for the people who use their services.

By March 2017:

A spread plan will have been developed that provides:

- models of Local Care Team composition and working practices;
- a variety of approaches and tools for collecting experience feedback that can be spread across the organization;
- regular and consistent measurement of person-centred health and care at different times and in different ways (real-time and right-time);
- evidence that this feedback is used to drive improvement;
- evidence of good practice and interventions for all 5 Must Do elements of care.

Other activities:

We will continue to promote and monitor all systems that are available for the public to provide feedback about their health and care. The NHS Lanarkshire Public Reference Forum will routinely review feedback and be invited to identify and consider potential areas for improvement at a local level through quarterly meetings.

The National Person-Centred Health and Care Programme will inform our working as we take this plan forward so that by December 2017 person-centred care is a central component in improving health and care services.

NHS Lanarkshire will participate in the national review of the NHS complaints procedure that is due to conclude by October 2016. In advance of the anticipated implementation date of April 2017, staff will be supported to deliver the requirements of the revised arrangements.

2.5 Primary Care

Lead: **H Stevenson, Chief Officer, South H&SCP**
C Cunningham, Head of Health, South H&SCP

Governance Committee: South JIB

Note: Further guidance from Scottish Government (18 February 2016) asked us to consider organising material in this section using the headings 'Leadership & Workforce', 'Planning & Interfaces', 'Technology & Data', and 'Contracts & Resources'. At this juncture our draft LDP had already been written and submitted to CMT and PPRC for approval. A subsequent review has identified that these areas are covered within the narrative below and to re-structure it by different headings would reduce its meaningfulness in terms of describing clearly and coherently the programme of work underway in Lanarkshire. We have therefore added the four headings to show SG colleagues where relevant material can be found. We have also included reference to the Primary Care Transformation Funding (we received confirmation of this on 28th April 2016) that we have received and will be crucial in supporting change in primary care.

Background

Throughout the healthcare system, changes in population demographics, complexity of illness and public expectation are creating increased pressure on the way services are currently delivered. It is recognised that these challenges require a different approach to care, as the current models are not sustainable when faced by them. This is felt especially in Primary Care, where 90% of care is contained and delivered alone without input from specialist services.

Addressing the Challenges – *'Leadership & Workforce'*

There is a requirement now to examine new ways of working, adopting an approach that places the person at the centre of care, dismantles the traditional interfaces, utilises the entire assets within communities and directs professionals to where they may have the most significant impact on patient care.

Four priority drivers of change have already been agreed as part of the national approach:

- Testing at scale new models of care;
- Improving the contractual and legal framework for our independent contractors;
- Improving data and our measurement framework;
- Engaging local areas to own their improvement process and developing an infrastructure that supports this.

Currently, the model of general practice that predominates across Lanarkshire has been in existence for decades. It is top-heavy in GPs providing care and as a consequence results in many 'low value' consultations that could be undertaken by an expanded, integrated workforce with different skills, supported by appropriate technology to allow increasing incidence of self care without face to face consultation.

2016/17 Work Plan – 'Planning & Interfaces', 'Technology & Data' and 'Contracts & Resources'

During 2016/17, the Primary Care Clinical Strategy will be introduced and an implementation plan developed. The programme will cover all independent contractors and stakeholders. This will be an integral part of the Strategic Commissioning Plans of both Health & Care Partnerships and will link to the NHS Lanarkshire Healthcare Strategy.

Confirmation has been received that NHS Lanarkshire's proposed Primary Care Transformation Programme (PCTP) proposal has been approved through the Primary Care Transformation Fund and other primary care investments. The PCTP in Lanarkshire will take a structured, managed programme approach on a system wide scale covering new ways of accessing General Practice, accessing the right person first time, urgent care and out of hours, pharmacy independent practitioners working with those in greatest need, testing out new models of care for the provision of psychological services in primary care and also increasing capacity and capability of primary care staff to support mental health. The new model of health care delivery in the community will test new models of care and new ways of working with multi-agency and multi-professional teams, supported by third sector providers, maximise all assets to support patients to self-care and those more in need of supported self-management, improving appropriate access and allowing more clinical time with those who require it most. Team based working models with the support of social care staff, mental health staff and pharmacists will be vital to that process and the respective bid reflects the need to grow these resources in support of primary care.

The Primary Care Transformation Fund (PCTF) comes with two underpinning principles that reflect our key areas for action:

1. A vision for the future role of the GP that will see them focus on complex care, undifferentiated presentation and quality and leadership;
2. A multi-disciplinary approach to patient care that will involve the right mix of expertise and services required to ensure that patients are provided with the most appropriate treatment in the most appropriate setting, when they need it.

Desired components of the Lanarkshire PCTF will be to:

- Roll out alternative models of care such as House of Care to general practice, allowing a greater focus on biographical, person-centred and increasing focus on complex co-morbidity. Work will be undertaken to implement and test a new model of collaborative, community-facing health services, starting in East Kilbride and Coatbridge localities, with independent contractors, including optometry and dentistry, integrated with Health and Social Care Partnership employed staff and with well developed links to third sector assets. Confirmation has been received that support funding through the PCTP is available and the 'House of Care' model is being utilised to test future ways of working across the wider primary, community and acute health services. Feedback from initial workshops has already been positive. A programme of events has been set out for the remainder of the year with key milestones as below:

    - The lead Clinician and one Clinical Champion have been trained to deliver House of care training in Lanarkshire, with a second Clinical Champion identified to become a trainer in the autumn. A series of awareness sessions is currently underway, targeted at individual GP practices within the East Kilbride and Coatbridge areas, as well as Diabetes and Respiratory Services. The first round of training will be run during May

and June 2016, with delegates from seven GP practices and two Independent Pharmacy Prescribers attending. A further two rounds of training have been scheduled for September / October 2016 and February / March 2017 with the capacity to run one further round of training during this financial year if required. Facilitation training for Practice Managers and IT Facilitators is also being organised for June 2016;

  - In parallel with the clinical training, the HoC Management Team are also exploring the development of a local LTC (generic) patient self-management programme based on the Thistle Foundation model. Initial contact has been established with a variety of Voluntary and Partnership agencies to support the 'More than Medicines' infrastructure required to support patient actions following their LTC Care and Support Planning Consultation. The Lead GPs within East Kilbride and Coatbridge are actively progressing future workforce planning and development discussions to support new ways of working, expanding the community health and social care teams and progressing meaningful collaboration between the HoC Programme and the emerging Locality Clusters;

  - The HoC Steering Group has been established with a wide variety of representation from across Lanarkshire providing strategic leadership, operational service delivery, partnership and third sector involvement, and patient representation, thus ensuring that each aspect of the 'House' is supported as we move forward. This includes the involvement of an expert researcher to design and progress the evaluation to assess immediate and long-term outcomes of the programme.

- Explore how GP Practices might group together in larger clusters to provide greater efficiencies in the way that care is delivered and supported. This will be consistent with the recent announcements regarding individual practice and cluster quality leads with work ongoing with LMC colleagues to agree how this will be rolled out in a way that is affordable, sustainable and achievable, and also in keeping with the established H&SCP locality model and respective planning;

- Build on the existing clinical and organisational infrastructure, such as the Integrated Community Support Team (ICST) and Locality Modeling, as a basis on which to build services for individuals. (The ICST – and Locality Modeling work in North – involve community care nursing staff, AHPs and other key staff working together to ensure joined up care packages in continuing to support patients in their own homes and/or communities);

- Develop greater involvement of specialists (medical, nursing, AHPs, pharmacists and others) in the management of specific physical illness within the community setting, with a focus on COPD; Diabetes; Neurology; Cancer; Heart Failure and GI. Specific work in support of redesigned Orthopaedic Services with increased focus on community rehabilitation will be a key priority in 2016/17;

- Work with GP practices, their extended primary care teams and other independent contractors to create better, appropriate access to care and advice that results in patients seeing the right professional at the right time;

- Develop a strategic Primary Mental Health Care transformation Fund Multi-agency Group, as a sub-group of the Primary Care Transformation Fund Group;

- Build capacity and increase capability in the wider primary care and locality workforce to meet the mental health needs of the client groups with whom they work, through training and development programmes;

- Provide in-reach support to GP practices to improve direct access to support and information, building on successful examples including information points and local services providing direct services to the practice such as mental health information, employment and financial advice;

- Enhance the role of technology enabling care to support mental health outcomes such as 'Beating the Blues', computerized CBT, 'Making Life Easier' online self-management planning tool, Florence SMS self-management system and web-GP to support delivery and co-ordination of self-management;

- Improve co-ordination and support person-centred care for people with co-morbid conditions such as long term conditions, reducing inequalities. It is recognised that information based programmes without the necessary supports to help people with the greatest risks to engage and connect, risks widening inequalities. Learning from the Deep End Practice Link Worker Pilot in Glasgow and the Link worker programme in Stobswell, Dundee has seen the testing of a Link Worker in one practice in Lanarkshire with positive results. The Primary Care in Mental Health funded resource will be used to upscale supported access building on the local and national learning;

- Deploy and enhance e-Health solutions, such as electronic consulting software, that provide additional value in assisting the management of patients and telehealth / telecare platforms that complement the health and social care teams where patients with complex disease are felt likely to benefit;

- Ensure that GPs are involved in the locality planning processes so that they can fulfil their role as community health leaders and assist in the identification of local health priorities and interventions. Alongside GPs, ensure that all primary care professionals are able to meaningfully engage in the development of locality strategic plans;

- Continue to take forward the implementation of Prescription for Excellence and develop effective models of care that maximise the skills of community pharmacy, nursing and general practice working collaboratively. This will be a feature both in the in and out of hours context. The Chief Pharmacist will lead specific work on this that will in turn inform the development of the Primary Care Clinical Strategy;

- Continue to work collaboratively with General Dental Practitioners (GDPs) to deliver the Childsmile Programme. This has already achieved particular success in delivery of the fluoride varnishing programme and overall reduction in DMFT rates;

- Continue to develop pathways to support unscheduled dental care presentations with a Lanarkshire-wide 24/7 emergency dental service;

- Linked to the success in maintaining independent contractor services (GDPs) and staffing levels, the salaried Community Dental Service has been able to focus greater attention on those with special needs and vulnerable groups, and this will continue;

- Build on the existing work in Optometry (the Lanarkshire Eye Network Service – LENS – that enables direct referral by optometrists to specialist secondary care) to develop skills in managing a greater proportion of acute and chronic presentations of eye conditions in the population. This will involve further development and embedding of pathways of care delivered through the LENS service.

In relation to Out of Hours care, a review of the Out of Hours GP service was undertaken in 2015/16, in which NHS 24, Scottish Ambulance Service and Social Work colleagues were key partners in informing the detailed proposals. Following an options appraisal exercise and public consultation an interim model of care was introduced. Since the publication of Professor Sir Lewis Ritchie's National Review of Out of Hours Services – Pulling Together, the opportunity has been taken to revise the interim model such that it is meeting the key recommendations of the review. Accordingly, 2016/17 will see further revision to the current model and to provide the Integrated Joint Boards with sufficient information as to allow them to set out the model of care they would wish to commission.

This complex programme of work began during 2015/16 and will continue into 2016/17.

In parallel, a smaller number of tests of change using the improvement model will be undertaken where proof of concept or innovative approaches to care is required.

Specifically in this regard, confirmation has been received that NHS Lanarkshire has been successful in securing support to develop increased use of community psychiatric nurses to manage mental health issues alongside GPs in the out of hours period as well as developing new models of nurse led children's services in consultation with Paediatric and Acute colleagues. Whilst these will initially focus on the out of hours period, it is recognized that similar approaches could be deployed to support unscheduled care in hours.

The future proposals around Out of Hours also involve increased access to and use of tele-health options looking to support patients in residential areas, e.g., nursing homes, GP hospitals, with a view to precluding the need for onward transfer to acute hospital sites. This will also support the minor injury units in two of the existing GP hospitals.

Critical to the success of these initiatives is the creation of the correct conditions for change and this requires appropriate resource to support the transition to a shared vision of care built around people and delivered by an engaged and sustainable workforce. The development of the Lanarkshire Healthcare Strategy, and its integral Primary Care Clinical Strategy, will be underpinned by a detailed financial plan that identifies current and future resource allocation, and supports the shift towards new models of care. The deployment of such resources will also form part of the Strategic Commissioning Plans of both Health & Social Care Partnerships.

2.6 Integration

Lead: **J Hewitt, Chief Officer, North H&SCP**
H Stevenson, Chief Officer, South H&SCP

Governance Committee: **North JIB**
South JIB

Background

In response to the Public Bodies (Joint Working) (Scotland) Act 2014, both Lanarkshire Partnerships have taken forward a significant amount of work to establish arrangements for health and social care integration.

The Integration Schemes for North and South partnerships were approved in June and September 2015 respectively, allowing the formal introduction of the two Integrated Joint Boards.

Joint Strategic Needs Assessments

Work on the Joint Strategic Needs Assessment is at an advanced stage, providing critical information to both partnerships, whilst also underpinning the development of NHS Lanarkshire's Healthcare Strategy. Integration signals a move towards Locality-based planning, providing Localities with the autonomy to identify priorities and shift resources appropriately. Locality profiles have been developed in each partnership providing an assessment of activity, demand and resource within each of the ten Localities, supporting the identification of key actions to enable the delivery of better outcomes for the people of Lanarkshire.

Strategic Commissioning Plans

Both partnerships are developing Strategic Commissioning Plans, setting out the framework for how the Integration Boards will take forward the commissioning of services over the next ten years. Following significant engagement within Localities and the Strategic Planning Groups, draft plans are currently published for wider engagement, with a view to final sign off for 1st April 2016.

The inclusion of some acute based services (including an element of unscheduled care) along with adult social care and all of the services previously delivered by CHPs, constitutes a major planning challenge and it will be important to ensure synergy between strategic planning in NHS Lanarkshire, North Lanarkshire Council, South Lanarkshire Council, and the new H&SCPs whilst ensuring that these new partnerships can deliver real and sustainable changes to service models and a real shift in the balance of care over time. In order to achieve this we will continue to work very closely with, and invest in, the Third Sector, recognising that much of what we need to achieve can be enhanced or delivered more effectively through working with our communities supported by the Third Sector Interfaces.

Locality Management & Engagement

Integrated Health and Social Work Managers in North and Locality Lead Officers in South are now in post. The new managers continue to develop their portfolios and share information in advance of full implementation of their new roles on 1st April 2016. Hosting arrangements for area wide services have also now been confirmed.

Significant engagement has taken place with a rolling programme of Locality events across all 10 Localities underway, involving all key stakeholders including frontline staff, GPs, users, carers and the third and independent sectors.

Critical to the success of the H&SCPs will be the engagement of GPs within the localities and the creation of integrated systems which bring together primary and secondary care along with Social Work services, the Third and Independent Sectors.

Through ring fenced Scottish Government funding, Organisational Development Manager posts are in place in each partnership, developing organisational development plans that are in the process of roll out.

Financial and Performance Management

The financial due diligence exercise that will assist in confirming the funding envelope, which the Integration Boards will be required to align to the Strategic Commissioning Plans, is nearing a conclusion.

An Integrated Performance Framework for both partnerships, linked to the nine national health and wellbeing outcomes, is at an advanced stage. This will be critical in supporting the demonstration of progress in key areas such as Unscheduled Care and Delayed Discharge performance as well as improved outcomes for people accessing advice, information, support and care and improvements in prevention and early intervention.

Work has been progressing to identify strategic risks for the Integrated Boards as set out in the requirements of the integration scheme. Senior managers from partnership organisations have attended workshops to identify key risks with relevant risk ratings.

2.7 Scheduled and Unscheduled Care

Lead: **H Knox, Director of Acute Services**
J Hewitt, Chief Officer, North H&SCP
H Stevenson, Chief Officer, South H&SCP

Governance Committee: Acute OMC

Background

Our LDP needs to be set within the context of our emerging Healthcare Strategy. The overall aim within the strategy for acute care delivery is to reduce the proportion of care we deliver which is emergency or unscheduled in nature, using inpatient hospital services as a last resort. This will, in turn, allow us to allocate a greater proportion of our resources to the delivery of elective care. We will work with our partner agencies to ensure the demand for elective and emergency services is delivered by the most appropriate healthcare professional, in the most appropriate location, through the development of clinical and services models. We will seek to maximise the benefits to as many patients as possible by redesigning those services used by the highest number of patients. We will build new models of care or expand existing best practice models of care across NHS Lanarkshire.

Reducing Unscheduled Care demand and increasing Planned Care

An overarching objective is to strive to reduce unscheduled care demand and increase planned care demand, using inpatient hospital services as the last resort. We will:

- Respond to increasing demands associated with an ageing population;
- Promote development of new clinical and service models in partnership with patients and carers and improve clinical outcomes;
- Ensure where possible variation is minimised through:
    - Standardisation of clinical care and processes whilst supporting innovation;
    - Patient flow and synergy with planned and unscheduled care;
    - Maximising the use of our clinical and theatre resources through optimal scheduling.
- Ensure efficiency and productivity is maximised by reducing DNAs, cancellations and delivering national guarantees, targets and standards;
- Improve access for treatment by patients by ensuring the most appropriate practitioner delivers the care in the most appropriate setting;
- Develop integrated locality-based services and supports that enable people to maintain their health and wellbeing, with a greater focus on proactive and preventative health;
- Through greater patient education and the use of tele-health and assistive technology supports, people will have a better understanding of their health

conditions and have tools available to support monitoring and rapid access to support when necessary;

- Ensure Day Surgery is the norm for elective procedures and where appropriate using technical advances move Day Surgery procedures into the outpatient setting in Acute and Primary Care;

- Improve referral and diagnostic pathways using enablers such as eHealth platforms to support and further develop electronic referral, clinical advice;

- Proactively manage admissions to hospital using specific models of care such as pre assessment;
- Proactively managing discharge, length of stay and patients expectations using models such as Enhanced Recovery After Surgery;

- Proactively manage follow up if required by the right clinician in the right care setting preferably the community but if within acute services use clinical reviews and planned review list.

The financial environment is challenging and forms a core part of the context to both our scheduled care capacity plan, and also the resource envelope within which we deliver unscheduled care. Local authorities, along with Health Boards, are experiencing a significant reduction in real terms in available resources. Efficiency and productivity measures need to be fully developed and agreed in collaboration with the Health and Social Care Partnerships to enable a whole system patient pathway approach to the delivery of our strategy.

In the interim, the national guarantees, targets and standards for waiting times management, local efficiency and productivity measures (e.g. activity, DNAs, cancellations, new:return ratio, length of stay, theatre efficiency measures and outpatient efficiency, delayed discharges) provide us with baseline measures. These will need to be kept under review in the light of the available resources.

Development of our Capacity Plan

NHSL has a well developed methodology for the development of the elective care capacity plan. This is based on the robust analysis of a range of data to assess activity requirements to ensure the best possible performance against elective waiting time targets in 2016/17. This includes the 8 diagnostic tests and also the management of return outpatient waiting times through planned review lists. A key component of the plan is the use of demand and capacity dashboards which are available to service management teams on a 'self serve' basis. This in effect means that data is readily available by specialty by site to inform decision making. The individual specialty capacity plans provide information on the following areas:

1. What is the actual demand (trend)?
2. What is the actual capacity?
3. What is the gap?
4. What is the actual funded baseline capacity, i.e., recurrent activity?
5. What is the waiting list size?
6. What additional activity / efficiency / productivity / measures are planned to achieve a waiting list size that is in line with the waiting time target to be delivered? For example, reducing DNA rates, improving N:R ratios, and a review of current scheduling arrangements. This will also include backlog clearance and plans for service sustainability.

7. Narrative on what managerial and clinical actions need to be taken to optimise the use of core available capacity. This will include plans for service sustainability.
8. Risks to delivery of the capacity plan are identified together with the likelihood, and the impact, and the mitigation actions.

The Capacity Plan also informs strategic decision making in NHSL and at a regional level and provides information to support the optimal design and configuration of elective services in the medium and long term – the extent to which any capacity imbalance identified may be addressed through further benefits realisation, strengthening of local provision, regional or national solutions, or mid- to longer-term investment. As part of this NHSL considers orthopaedic and ophthalmology capacity at the Golden Jubilee National Hospital a key component of our core activity and seeks to maximise this through the formal Service Level Agreement that is in place. Both these specialties have imbalances between demand and capacity and are nationally recognised specialties which require particular focus through the ACCESS programme (Addressing Core Capacity Everywhere in Scotland Sustainably).

The Healthcare Strategy through the respective work streams will optimise the opportunity for service design and clinical capacity to address any projected shortfalls in recurrent and non-recurrent activity. The planned care and unplanned care work streams are already working in tandem to integrate the planning and management of elective and non-elective services as a priority. Planning cycles will be established with the objective of reducing and managing variation and variability.

The ScotPFA project has already been taken forward at one of the acute hospitals with significant input and analysis of theatre activity. This will be used to drive efficiency and productivity and will be rolled out across all three sites.

Unscheduled Care Plans

Within unscheduled care we continue to work to progress the 6 Essential Actions on each of our 3 acute sites in partnership with the delivery arms of our 2 Joint Improvement Boards. Our priorities around the 6 Essential Actions for 16/17 are as follows:

Wishaw Hospital
Unscheduled care remains a priority and focus at Wishaw. From December 2015 there has been a refresh of the Improvement Plan focusing on the 6 Essential Actions. This also includes the development of the Quality and Safety Improvement Group to oversee progress. These priorities will be further reviewed in the light of the report from Scottish Government review conducted by the national unscheduled care team. Priorities for action for 2016/17 include:

- Addressing workforce challenges in ED through recruiting consultants to reach agreed establishment;
- Reducing variation in ED performance at weekends by aligning demand with capacity;
- Development of Advanced Nurse Practitioner roles;
- Development of the MSK role in ED;
- Development of nurse-led pathways in ambulatory care;
- Development of an orthopaedic ambulatory care unit;

- Implementation of pull models in ambulatory care;
- Continued development of site manager role to support oversight of safety and flow on a daily basis;
- Augmenting the bed management team on a substantive basis and improving processes of work;
- Rolling out of board rounds and EDDs to all wards for proactive management of the in-patient journey across seven days;
- Refocusing work on medical pathways to ensure optimum journey for in-patient care;
- Continued partnership working with social care colleagues to reduce to delays to discharge once patients are clinically fit.

Hairmyres Hospital

Unscheduled care remains a priority at Hairmyres Hospital and actions continue to build on the significant improvements over the last year. This has seen our performance against the 4 hour standard to 90% and above for six consecutive months (from June to December 2015) for the first time since 2013. We have experienced challenges in performance in January with a rise in both attendances and admissions. The plan for improvements in unscheduled care, linking into the 6 Essential Actions includes:

- Continued improvement in processes of managing in-patient flow;
- Further development of both medical and surgical ambulatory care;
- Specific focus on pathways for patient requiring vascular, orthopaedic and older people’s services;
- Continue to develop models that support discharge over seven days;
- Continuing to work in partnership with social care colleagues to reduce delays to home once patients clinically fit for discharge.

With the closure of the Victoria Hospital we have seen a step-change seen in attendances and admission which is statistically significant and (if annualised) would equate to a 4-5% increase in both ED attendances and emergency admissions at Hairmyres.

Monklands Hospital

The Monklands team have developed a site plan to progress a series of redesign and improvement initiatives to enhance quality and improve patient flow. The actions are closely aligned to the 6 Essential Actions and will also be reflected in the site’s winter plan:

- Clinically focused and empowered hospital management: The team aim will further develop clear clinical leadership model and populate model with clinicians;
- Hospital capacity and patient flow alignment: Using the Basic Building Blocks/Bed Capacity Toolkit the team will map the hospital capacity with the current flow patterns and also the planned realigned flow patterns;
- Patient rather than bed management: A Schedule of Huddles has been created and incorporates the daily admission predictor and barometer;

- Medical and surgical clinical processes to pull patients form ED: The team will establish triage to the appropriate assessment/flow through ED with early access to Senior Decision Maker/ Assessment/Diagnostics;
- Seven day services: The team will scope the demand and identify a suitable location for a Medical Planned Investigations unit to smooth admissions by reducing the elective admissions when there is pressure on the beds for emergency patients to be admitted. Through the Winter plan and associated funding the team will explore tests of change related to 7 day working;
- Ensuring patients are cared for in their own homes: The team will seek to avoid admission to hospital by further developing the Ambulatory Emergency Care Service to reduce avoidable admissions and also developing a Frailty Assessment Unit.

Working in partnership with the Integration Joint Boards (IJBs) and their delivery teams

In addition to commissioning services that deliver on the aims of the 6 Essential Actions, both IJBs intend to commission services that support people in the community and avoid hospital admission. Both will aim to better align social work and community health supports and services for people who are admitted to hospital so discharge processes are as smooth as possible. The delivery of the unscheduled care targets is contingent upon achieving an improvement in the number of patients in delay.

Within the North Lanarkshire partnership the commissioning plan will aim to extend the reach of specialist acute clinicians into the community through locality teams to maximise the specialist support that can be offered in each of our six localities, helping to support people at home. The JIB has commissioned a leadership programme involving acute, community health, social work and third sector representatives to develop shared approaches to supporting people across organisational barriers. The JIB is exploring how best to link systems and processes to aid communication between hospital and community based professionals so they have the right information to better support people. This will include Locality Teams taking a more proactive role in supporting safe, timely and person-centred discharge.

Within South Lanarkshire the Integrated Joint Board will similarly be aiming to commission services that provide increased opportunity for traditionally acute based care to be delivered in a community setting. Key to this will be maximising the opportunities created by the new GMS contract and to this end, the intention will be to test 'House of Care' type models to support improved management of long term conditions in a community setting. Additionally, the IJB, following extensive consultation with a range of key stakeholders, has set out 10 priority areas that will seek to maximise resource use in meeting the future needs of the population in general and tackling the current level of unscheduled care admissions in particular.

Notwithstanding the foregoing, the need to ensure financial balance may impact on the availability of key clinical staff in the community to assist in efficient and safe discharge from hospitals. This may also impact on the availability of staff to ensure that patients are seen in community AHP settings to the current 12 week waiting time standard.

2.8 Mental Health

Lead: J Hewitt, Chief Officer, North H&SCP

Governance Committee: North JIB

Psychological Therapies

A comprehensive restructuring of Psychological Services took place in 2011, towards improving access to psychological therapies. However, this resulted in a spike in waiting times for treatment, which reached a peak of 62 weeks in September 2011. A review of demand, capacity, activity and unmet need was carried out in 2014, using DCAQ methodologies. This identified a number of areas for development. Effective implementation of a revised service model, along with enhancements in clinical service delivery via investment in staffing, training, and development, has seen a significant reduction in waiting times, to a median wait of 8 weeks, and with 98.6% of patients commencing treatment within the 18 week LDP Standard, as at 31st December 2015.

In the service restructuring, and subsequent development of a matched, stepped care model, many ways have been explored with which to deliver appropriate assessment and treatment. Specifically, we provide Stress Control groups, which regularly operate across Lanarkshire. Similarly, referrers are encouraged to signpost patients to the Well Connected social prescribing programme, supported by the Elament website. The number of visits to the Elament website continues to rise, evidencing its increasing use both by service users, and by referrers. Libraries across Lanarkshire continue to provide a range of self-help material, supporting the work of mental health services. We also signpost to the NHS24 Living Life, and promote this via Well Connected programme.

NHS Lanarkshire is also participating in the EU-funded *MasterMind* online CBT programme. The package in use is 'Beating the Blues', an 8-session programme of evidence-based cognitive behavioural therapy delivered online, for the treatment of mild-to-moderate anxiety and/or depression. Patients can be referred to the programme via their GP, through a CMHT, or from Psychological Services. In future, self-referral will be possible. The programme is designed to be a stand-alone treatment. It can also be seen as a component of stepped-care, or as an adjunct to ongoing psychological therapy. In the past 12 months, we have had over 1000 patients commence treatment using this online CBT programme, and GPs have welcomed the ease of access to this evidence based treatment.

Through service redesign and development, the vast majority of patients commence treatment within 18 weeks of referral. With the 90% threshold for RTT having been met, the focus has shifted towards:

- Minimising waiting time variation across localities;
- Reviewing clinical resource allocation across localities;
- Improving upon failure to attend rates, both new and return appointments;
- Improving referral processes and appropriateness of referrals, including signposting to other, more appropriate, services or supports.

A review is underway across the Adult Psychological Therapies Teams to assess balancing of demand with capacity, equity of resources, patterns of referral, and models of service. Pilot projects are exploring assessment clinics, self-referral, and appointment reminder service. Initial evidence suggests that there needs to be greater flexibility in allocation of clinical resources across localities, and this is being addressed to minimise

variation in waits. However, the pattern is of rising demand for psychological services across primary care. This may reflect the vastly reduced waiting times such that GPs are not much more likely to refer patients than they would when waits were over 60 weeks.

NHS Lanarkshire welcomes the announcement of the Mental Health Access Improvement Support Team and the ongoing work of NHS Education for Scotland around workforce development to provide further support around improving access as, despite the progress made to date, there are a number of areas requiring further development. Specifically, these relate to:

- Older adults psychology;
- Physical health, long-term conditions, and medically unexplained symptoms;
- Neuropsychology.

With people living longer, there has been a significant increase in demand for services for older people. Within Lanarkshire, however, the older adult psychology service has not seen concomitant increase in workforce to meet this demand. Indeed, the increased need to develop the older adult psychology workforce is recognised by the Scottish Government, and NES.

Similarly, demand has increased for access to psychological assessment and treatment for patients who have long term physical health conditions, and medically unexplained symptoms. This includes, for example, renal, endocrinology/diabetes, cardiology, cancer/palliative care, and bariatric services, and extends to patients with ME-Chronic Fatigue Syndrome. Within Lanarkshire, there is limited access to specialist clinical health psychologists, with only 1.4wte clinicians working within the Monklands Hospital catchment.

The third area of need, with very limited access to specialist psychologists, is neurology. Significant investment was made in neurology services, but that was not accompanied with investment in the neuropsychology services that are required to support the work of neurologists.

Whilst adult psychological therapies has been developed to provide a stepped care service designed to meet both low intensity, high-volume, and high intensity, low volume needs, the longest waits are now within the areas outlined above.

Having identified the need for 6wte additional Psychologists from local service review, due to current financial pressures it is likely that the service will require to live within its existing resource envelope and potentially contribute to corporate savings, necessitating further development and re-prioritisation.

Over the past 12 months, NHS Lanarkshire, NHS Greater Glasgow and Clyde and NHS Tayside are the only three Boards to have consistently met the RTT target, highlighting the strong performance emanating from the work described above.

CAMHS

When the CAMHS 18-week RTT (90% target) came into effect in December 2014, NHS Lanarkshire performance against the RTT was 92.7%. Performance was maintained against the target until June 2015 when it dipped below 90%.

A downward trend continued over the summer months into early autumn, due to a mixture of vacancies and maternity leave and also the expansion and restructuring of

the service to include the Rutherglen/Cambuslang and Northern Corridor areas through the Health Board boundary changes.

An increase in recruitment to existing vacant posts combined with the establishment of waiting list clinics (one North and one South) improved performance with this positive trend continuing to bring performance back above the 90% target by December 2015.

The table below sets out NHS Lanarkshire's performance against the LDP Standard with performance rates against the Scottish average and other comparative services.

% of patients seen 0-18 weeks												
	Oct 2015	***Nov 2015***	***Dec 2015***	***Jan 2015***	***Feb 2015***	***Mar 2015***	***Apr 2015***	***May 2015***	***Jun 2015***	***Jul 2015***	***Aug 2015***	***Sep 2015***
NHS Scotland	77.0	77.9	82.1	78.8	76.9	81.1	78.5	75.9	75.8	75.7	72.3	71.1
Lanarkshire	84.5	87.8	92.7	95.1	95.8	94.6	89.3	90.1	89.4	83.7	83.5	68.8
Lothian	57.4	52.3	52.9	50.6	50.0	62.2	57.5	56.7	60.2	70.7	75.8	59.1
Grampian	45.6	48.8	60.2	71.8	74.5	74.5	74.1	70.9	69.6	64.4	47.6	46.9
Tayside	58.1	46.6	52.2	38.9	30.2	35.9	41.0	34.6	34.9	29.0	28.5	37.1

The as yet unpublished performance data (restricted for management purposes until 24th February 2016) is as follows:

% of patients seen 0-18 weeks			
	Oct 2015	***Nov 2015***	***Dec 2015***
NHS Scotland	75.2	73.9	83.1
Lanarkshire	83.6	86.9	97.7
Lothian	61.4	53.6	64.6
Grampian	57.1	41.2	52.5
Tayside	32.9	73.6	91.4

NHS Scotland ISD maintains a national CAMHS workforce database and the latest available data from 30th September 2015 is noted below:

Workforce Ranking of Mainland CAMHS Services

Area	WTE per 100,000 population total
Tayside	26.1
Lothian	23.6
Dumfries and Galloway	22.1
NHS Scotland	**18.3**
Ayrshire and Arran	14.6
Lanarkshire	**14.1**
Highland	13.1
Fife	12.9
Forth Valley	10.9
Borders	9.5
Grampian	9.5

NHS Lanarkshire CAMHS, with the 3rd largest overall population, has a below average workforce, and ranks 7th out of the 11 mainland Board areas for workforce. The service remains at an above average performance level against the RTT, and is overall one of the highest performing services against RTT.

Our performance level is maintained by service level, team and individual capacity plans with regular and robust performance management against the capacity plans. Experience and data over the past year and a half highlights that when at full establishment, and assuming referral rates do not rise, then performance against the 90% target is likely to remain positive.

Maternity leave, a significant variable given the staff profile, and vacancies, have a major impact on the ability of the service to meet demand. With the vast majority of CAMHS budget being invested in staff, any future budget pressures could also have a negative impact on capacity and ability to meet the target.

Referral rates to the service increased by 23% in 2013, but have remained static in 2014 and 2015, highlighting another potential variable that could impact on performance. Assuming the age range of the service remains the same (0-18 if still in high school, upper limit of 16 if out of high school), and no further increase in referral rates is experienced, then there is a good level of confidence that performance against the RTT will be maintained.

Mental Health Funding 2016-20

On 3rd March 2016, Scottish Government confirmed the allocation of a total of £54.1 million over 4 years to support the delivery of both the Psychological Therapies and the CAMHS Access Standards described above. This sum is to be used to build capacity, develop the workforce, and fund national support and expertise in the form of a Mental Health Access Improvement Programme and Support Team. NHS Lanarkshire will receive £534,250 in 2016/17 and £844,861 in each of the subsequent three years.

At time of writing (4th May 2016), a meeting of local stakeholders has been arranged for 18th May to begin the process of planning and undertaking the necessary work to inform how best these monies should be deployed within Lanarkshire, to achieve improvements in access in both Psychological Therapies and CAMHS services. Lanarkshire is also represented on the supporting national Scottish Government group that is meeting for the first time on 5th May, the outcome of which will further assist local deliberations on the 18th. As noted above, much work has already been undertaken in Lanarkshire to better understand demand, capacity and unmet need, and there is ongoing work to review and improve services, in order to sustain our performance against the LDP Access Standards. We expect that this new funding will provide further impetus to this work.

Our performance against the Standards in 2016/17 will continue to be monitored locally, at Integrated Joint Board level and as part of the online Integrated Corporate Performance Report submitted to our Planning, Performance & Resources Committee. In recognition of the importance of the LDP, an extract of performance against LDP Standards is also provided to our NHS Board quarterly.

2.10 Community Planning Partnerships

Lead: **J Hewitt, Chief Officer, North H&SCP**
H Stevenson, Chief Officer, South H&SCP

Governance Committee: **North IJB**
South IJB

Across both Lanarkshire Partnerships – North and South – key NHS Lanarkshire (NHSL) staff are involved at all appropriate stages in the planning processes. This includes the Chair and Chief Executive of NHSL, the respective Chief Officers of the Health & Social Care Partnerships (H&SCPs), and others being members of the Community Planning Partnership Boards as well as key senior officers being involved in the respective delivery groups.

In so doing, this allows NHSL to effectively contribute to debates around service issues that can have an impact on health. Similarly, it allows for NHSL to maximise such benefit and, importantly, to ensure that the impacts can be measured as well as sharing examples of where initiatives have worked well in other locations.

North Lanarkshire:

In North Lanarkshire, the Community Plan (Single Outcome Agreement) forms a key element in the delivery of public service reform in line with the outcomes for the review of Community Planning and also with the introduction of the Community Empowerment Act.

The North Lanarkshire Community Planning Partnership is committed to an improvement ethos and adapting to the wider policy context. The North Lanarkshire Partnership Board is supported by the Joint Resourcing Group which includes representation from all of the strategic partners.

The Board, with the support of the Joint Resourcing Group, is engaged in the Enabling Collaborative Leadership programme which is a pioneer programme delivered by the Scottish Leaders Forum. During 2016/17, the programme will use an action inquiry approach with key community planning partners to gather evidence of what enables collaborative working, effective leadership and better outcomes for communities, particularly in relation to tackling inequalities.

During 2016/17, we will also be involved in a mid-term review of the Community Plan (SOA) with a view to prioritising the key outcomes of the partnership. This work will inform the development of our Local Outcome Improvement Plan, as required by the Community Empowerment Act, and will offer an opportunity to build on and strengthen the links between the shared outcomes of the North Lanarkshire Partnership, NHS Lanarkshire and the North Lanarkshire Health & Social Care Partnership.

Similarly, during 2016/17 we will be developing Locality Plans as a requirement of the Community Empowerment Act. Again, this is an opportunity to build on our current local community planning arrangements and Local Area Partnerships, and also to ensure appropriate links are made with the new Health & Social Work locality teams.

The North H&SCP will play a key role in tackling health inequalities in North Lanarkshire and will work with community planning partners to tackle some of the longstanding and fundamental causes of social inequality. The North H&SCP recognises that if we are to address the increasing demand for health and social care services and support people to

take responsibility for their own health and wellbeing, we need to take action to prevent, mitigate and reduce the severity and impact of health and social inequalities.

South Lanarkshire:

Within South Lanarkshire, the Community Planning Partnership has been working with the national group to progress implementation of benchmarking across CPPs. This has supported better understanding of performance locally and the development of a consistent national profile including core measures and outcomes. Currently the South Lanarkshire Framework contains 20 core indicators spread over 8 themes that are consistent with the Government's national priorities for CPPs. Performance is updated regularly at the CPP Board and a report also made to the NHS Lanarkshire Board.

The CPP already has agreed priorities for improvement that sit within each thematic Partnership Improvement Plan (PIP) and these feed into the Single Outcome Agreement (SOA) and are also in line with the national strategic priorities.

The emerging Joint Commissioning Plan of the H&SCP will also feed into the updated SOA and associated PIP.

It is worth noting that an early decision was made to produce the Joint Commissioning Plan through a 'health inequalities lens' such that each of the respective sections point to prevention and self care as a starting point.

Examples of NHS Lanarkshire contribution to CPP Priority Areas:

Priority	NHS Board Contribution
Economic recovery and growth	There is a multi-agency group that develops pan-Lanarkshire responses to Scottish and UK Government programme priorities, e.g., we have a strategic group dealing with the impact of welfare reform and ensuring that we maximise available resources to address issues that arise. Deliver the Scottish Healthy Working Lives programme, targeting small and medium sized enterprises. Through employment initially in South Lanarkshire, NHSL has funded a post (Funding & Development Officer – Health) that is now NHSL wide and has assisted in supporting local groups to access external funding awards. This has been instrumental in attracting £12,797,604 via support of NHSL and third sector partners over the past 8 years.
Employment	Support programmes such as Project Search and other employment programmes. These are described more fully in section 2.1 of this LDP.
Early years and early intervention	Partnership work is described in section 2.2 of this LDP.
Safer and stronger communities, and offending	Participation in the Community Safety Partnership groups in the Community Planning Partnerships. Developing and extending community based activities, e.g., in the North, the Friday Night Partnership Programme; the Tower

<table>
<tr><td></td><td>Strategy; and linking with the Early Years Collaborative to provide support to young mothers and fathers who are in the criminal justice system. The Friday Night Partnership programme is also in the South, as well as initiatives such as Lightheaded, the smoking and fire raising theatre production in schools, and Life etc in East Kilbride that aims to reduce alcohol misuse and anti-social behaviour in the home.</td></tr>
<tr><td>Health inequalities and physical activity</td><td>NHSL plays a key role in delivering the agreed action plans that are embedded in the respective SOAs.

These include:
Lanarkshire Child Healthy Weight Strategy, developed and embedded in partnership plans;
Delivery of a range of supports to address adult obesity;
Promoting recovery and reduce stigma around mental ill-health;
Promotion of breastfeeding;
Supporting employment;
Smoking cessation;
Delivering the Active Health, Get Active Lanarkshire and Get Walking Lanarkshire programmes that aim to promote a legacy from the Commonwealth Games.
In partnership, our approach will deliver:
Actions that mitigate or reduce the severity of the health and social consequences of social inequalities. These include providing specialist and targeted supports to particular population groups (e.g. homeless, looked after children);
Actions that prevent harmful environmental influences and help individuals and communities resist the effects of inequality on health and wellbeing, These include community development activities that increase social capital, and improvements to the physical environment in deprived areas; and
Actions that undo the underlying structural inequalities in power and resources. These comprise provision of high quality universal services including education, housing and employment, and economic policies that support social mobility and prevent high wage differentials.
Actions 2016/17:
To work with CPPs to provide stronger leadership and direction in tackling inequalities across Lanarkshire, e.g., Enabling Collaborative Leadership Pilot with NLP;
To work with partners to achieve the stretch aims of the EYC workstreams and ensure every child has the best start in life and placing a focus on the needs of looked after children;
To develop assets based approach to improving health and wellbeing within our most deprived communities;</td></tr>
</table>

	• To maximise role as employers in supporting young people, those with learning disabilities and those living in our most deprived communities into employment; • To work with community planning partners to identify and address the needs of vulnerable populations with complex health and care needs; • To minimise the impact of Welfare Reforms; • Many of the programmes available to support increased health improvement, tackling the effect of revised welfare arrangements on the inequalities agenda, and other linked work, will be impacted upon by the 7.5% reduction across the range of initiatives covered by the Scottish Government 2016/17 Outcomes Framework letter of 3 March 2016.
Older people	NHSL has been heavily involved in the development of the Strategic Commissioning Plans, which describe how the strategic partners will plan and deliver supports and services for older people over the lifetime of the Plans. NHSL and partners recognise the key role that the CPP plays in the delivery of outcomes within the Plans including the required Community Capacity Building and the provision of safe and effective alternatives to institutional care such as intermediate care and integrated community teams. The ground breaking co-production work in North Lanarkshire has seen significant sums of money devolved to the third sector with a clear commitment to ensuring that the voices of older people in local communities are enabled to take part in decisions about how funding is used. The Community Capacity Building and Carer Support programme was developed to deliver on this commitment to co-production and involved all partners including: • Senior NHS and local authority officers on the programme planning group and governance sub-group; • Members of the community who were part of the local operating partnerships – known as 'consortia'; • Representatives of small community groups that both planned and delivered services, often in partnership with formal local third sector organisations; • NHS Health Improvement workers; • Representatives of national charities: Age Scotland and Alzheimer's Scotland. Several partner organisations took on the role of 'thematic leads' to ensure key themes were addressed across North Lanarkshire and to work with all the consortia. This co-commissioning approach and local knowledge of the members of each consortium enabled the thematic lead organisations to focus work where it was most needed. Each of the thematic leads and locality hosts met regularly to share practice and progress and to ensure that all themes linked together.

	This work has been acknowledged nationally through inclusion on a recent publication 'Co-production – how we make a difference together' to promote co-production in Scotland. It is recognized that the approach needs to be outcome based and working with older people as assets to the wider community capacity resource. There are national and local performance frameworks under development to support this strategy. In South Lanarkshire, work to shift the balance of care builds upon a solid foundation of partnership working, both strategically and operationally. The main initiatives that the Partnership has focused on developing are as follows: 1. Preventive and Anticipatory – investment in third sector provision and carers' support; **2.** Proactive Care and Support at Home – **Integrated Community Support Team Approach**; **Hospital at Home;** 3. Effective Care at Time of Transition – **Supporting Your Independence**; 4. Hospital and Care home – **Integrated Discharge Hub.** From the outset, we have sought to understand the progress and impact being made from the above inputs. In addition to regular performance reporting, more detailed impact based evaluation has been undertaken in the form of contribution analysis. This work has given the Partnership some valuable information about progress and the following are some examples: • More people feel included, connected to their communities and safer as a result of the ICST model; • Improved goal oriented outcomes for older people resulting from the Supporting Your Independence approach and the extension of Anticipatory Care Planning; • Reduction in length of hospital stay due mainly to ICST and Hospital Discharge Hub activity. Additionally, the reablement approach has allowed for between 15-25% reduction in home care hours for those completing an intervention; • Active third sector involvement in service development and delivery through VASLan Development Officers to signpost people to local supports via the development of an online Locator Tool. £650,000 is being invested to grow capacity in the third sector to support achievement of the nine national health and wellbeing outcomes for health and social care integration; • Improved carer health and wellbeing through the activity of Welfare Rights Officers in supporting carers through benefits maximisation to reduce financial stress associated with their caring role.

2.10 Workforce

Lead: K A Small, HR Director

Governance Committee: Staff

Everyone Matters: 2020 Workforce Vision

NHS Lanarkshire continues to successfully develop and implement an annual Everyone Matters: 2020 Workforce Vision Implementation Plan. The Plan for 2016/17 has been developed to build on progress to date and incorporates the additional NHS Board Actions arising from the Implementation Plan 2016/17 published under DL (2015) 25.

The Implementation Plan 2016/17 continues to focus NHS Lanarkshire actions to deliver continuous improvement in the areas of:

- Healthy Organisational Culture;
- Sustainable Workforce;
- Capable Workforce;
- Workforce to deliver Integrated Services;
- Effective Leadership and Management.

The Implementation Plan 2016/17 will specifically focus on a number of efficiency and quality of service related workforce initiatives, including:

- More effective management of sickness absence;
- Management of our temporary workforce (Rostering/eRostering, Staff Bank/Agency arrangements and Vacancy management);
- Delivery of progress in the implementation and use of iMatter (Staff Experience Model);
- Promote understanding of and commitment to addressing Health Inequalities and deliver enhanced access to supported work and training opportunities for disadvantaged communities;
- Continued support for Occupational Health, Safety and Staff Wellbeing and implementation of the associated recommendations from the NHS Employers Working Longer Review;
- Design and delivery of Organisational Development plans in support of enhanced collaborative and flexible working across Primary and Secondary care and Health and Social Care;
- Continued investment in leadership and management development programmes to support integration, quality improvement and change.

Delivery against the Implementation Plan 2016/17 will be routinely assessed and monitored by the NHS Lanarkshire Staff Governance Committee, Corporate Management Team, Area Partnership Forum and HR Forum.

Workforce Overview

As at December 2015, NHS Lanarkshire (NHSL) had 10630.26 WTE workforce, an increase of 146.29 WTE year-to-date and exceeding our projected increase of 78.49 WTE for 2015/16 by 67.8 WTE. The growth in the workforce has been across a range of staff groups but the highest level of unexpected growth has occurred in Administrative staffing (43.73 WTE). Table 1 below provides an overview.

38% of the current NHSL workforce are over 50 years and 66% are over 40 years.

Job Family	2015/16 Change (WTE)		Comments
	Projected	Actual (Y-T-D)	
Administrative Services	13.68	43.73	Unexpected growth across Corporate, PSSD and Procurement.
Allied Health Professions	2.00	17.89	Increase in Physiotherapy and Dietetics.
Healthcare Sciences	-	-4.87	
Medical & Dental	1.50	20.71	Trainee numbers varies year on year depending on start date.
Medical & Dental Support	-	-1.25	
Nursing/Midwifery	61.31	71.98	10 WTE over projections to date.
Other Therapeutic	-	18.84	Increase in workforce across Pharmacy Technicians and Psychology Services.
Personal Social Care	-	5.28	-
Senior Managers	-	-3.36	-
Support Services	-	-22.67	Decrease in workforce across the service, 7WTE within Transport Services and 8 WTE within Estates Services.
Total	**78.49**	**146.29**	Y-T-D actual change exceeds full year projection level by 67.8 WTE

Nursing and Midwifery Workload and Workforce Planning

The Nursing and Midwifery Workload and Workforce Planning tools (NMWWP) are implemented across NHS Lanarkshire. Currently, NHSL is reviewing the NHSL NMAHP Workforce considering specific staffing issues (e.g., recruitment, vacancies, funding) and the impact on service quality and delivery. Collation of this data will enable NHSL to identify existing workforce risks, develop risk management strategies, and inform the timetable for the future NMAHP workforce / workload analysis.

Recruitment

Medical staffing continues to present a challenge for recruitment within NHS Lanarkshire. The Board has been successful in recruiting to Consultant vacancies in Paediatrics, Orthopaedics, Anaesthetics, Ophthalmology, Care of the Elderly, Acute Medicine, General Surgery, Breast Surgery, Urology and Rheumatology. Neonatology, Histopathology and Dermatology have regrettably been unsuccessful.

There continues to be a mixed response to recruitment for Specialty Doctors with success in Emergency Medicine, Care of the Elderly, Breast Surgery, Sexual Health and Orthopaedics but with on-going challenges in Mental Health and General Surgery.

In addition to the traditional recruitment routes, which include advertising and sourcing Agencies, there have been further initiatives undertaken within the Board which include:

- International Medical Recruitment;
- International Medical Training Fellowship;
- Joint Academic and Service Consultant.

It is hoped that these initiatives will help address some of the recruitment challenges.

There are also some recruitment challenges within Nursing. There has been a high volume of Band 5 Acute Nursing vacancies (c.400 in 2015), the majority have been successfully filled with around 50 still being processed. Currently within the Acute Division, challenges are faced in recruiting Band 5 Nurses to Monklands Hospital, this is being addressed by scoping out varying recruitment methods. Health Visiting continues to present recruitment difficulties and to help address this, in September 2015, NHSL sponsored 20 people to do the Health Visiting Specialist Practitioner Qualification (SPQ) with a further 10 starting the qualification in January 2016. District Nursing has also been identified as a difficult to recruit to area and to aid this NHSL has adopted an alternative training method to the District Nursing SPQ course.

Other specialist nursing areas continue to be difficult to recruit to, e.g., theatres, experienced neonates.

Healthcare Strategy

NHS Lanarkshire, together with North and South Lanarkshire Councils, is working to develop a Healthcare Strategy that will deliver better health and healthcare outcomes for the people of Lanarkshire.

The work that is underway takes account of the new integrated approach to health and social care provision and is aimed at supporting future Public Service reforms to ensure safe, effective, person-centred and sustainable services are delivered through a workforce that has the right skills and competencies and is able to achieve the best possible outcomes for our patients.

It is recognised that the future workforce must be based on a robust availability, adaptability and affordability model.

i. Workforce Availability

There are issues with Medical staffing availability in Lanarkshire and across Scotland and an on-going reliance on Medical staffing is unsustainable. With this the Lanarkshire Healthcare Strategy will require a higher reliance on a range of Advance Practitioner roles. It is proposed that these roles will develop from several professional backgrounds (nursing, allied health professions, pharmacy and physician associates), and will be trained to take on traditional medical roles/tasks, that will become a significant component of the future NHS Lanarkshire workforce.

The ageing population will not only change the service demands, it will also be reflected in the availability of NHS Lanarkshire workforce. In effect, NHSL will have an older workforce in 2025 and a higher volume of retirements year on year. With this, NHSL is considering different approaches to support older staff to remain in employment whilst succession planning for potential loss of skills and knowledge.

To provide safe, effective and person centred care, the workforce of 2025 should match the workload demands both in the care context / location and hours of service. This could see a shift in staffing into the community workforce and may require a change in patterns of work, e.g., greater 24 x 7 working.

ii. Workforce Adaptability

To ensure sufficient staff are developed in new roles by 2025, scoping work will be undertaken in the near future to determine the core components of the future Advanced Practice and generic support worker roles with a view to initiating development with an appropriate educational provider.

On-going work is required with Regulators, Scottish Government and Higher Educational Institutions (HEIs) to ensure that the undergraduate programmes are designed in line with the future healthcare need, with sufficient focus on community care.

A programme for specific staff skill development needs to be introduced to support extended scope roles (e.g., IV therapy) and succession planning (SPQ for DNs/ HVs).

Focussed supervision and coaching approaches may also be required to enable staff, with appropriate skills and competency, to transition to different clinical environments.

iii. Workforce Affordability

There are no additional resources available to deliver the Healthcare Strategy, and with a predicted increase in healthcare demand, it will only be achievable if all opportunities of improved efficiency are considered.

The workforce to support the Lanarkshire Healthcare Strategy will not be 'more of the same'. The workforce will be older and have a greater reliance on Advanced Practitioners and roles with extended scope. All staff groups will work to the 'top of their license' with work aligned to their skills. The workforce may be redistributed to match the increased workload demand in the community.

To achieve this requires training and development to commence immediately, working with the service and HEI to design, commission and develop staff in new roles. At the same time we need to develop and, where appropriate, extend the skills of our existing staff.

3 LDP STANDARDS

For 2016/17, the previous 21 Standards and associated measures are continued, each listed below with details of measure(s) and data, lead Director(s), and known risks.

1	**NHS Scotland to achieve a 25% increase in the percentage of breast, colorectal and lung cancer cases that were diagnosed at stage 1 in 2010/11 (this refers to the two calendar years combined from January 2010 to December 2011). This is to be achieved by 2014/15 (January 2014 through to December 2015).**

Lead: **H Knox, Director, Acute Division**
H Kohli, Director of Public Health & Health Policy
A Khan, Clinical Lead (Cancer)
J Park, Director of Access
M Kelly, Cancer Manager

Measure & Data: A 25% increase on the baseline performance in 2010/11 equates to 29% of breast, colorectal and lung cancer patients to be diagnosed at stage 1 by 2014/15. Detect Cancer Early Staging Data (ISD). Published annually, with a 7 month time lag.

2014/15*	29%

Risks:

Within the Acute Division, i.e., in terms of actual diagnostics, this would not be affected by the 2016/17 CRES plan.

However, in Public Health, it is clear that increasing participation in the cancer screening programmes would have the greatest impact on early detection for the relevant cancers - breast, colorectal and cervical. The sort of work which can change hearts and minds in our most deprived communities requires considerable planning and input from key individuals. CRES savings could reduce our public health and heath improvement capacity to support early detection through limiting our capacity to actively promote the cancer screening programmes, support volunteers, and achieve community engagement. An analysis of the opportunity cost of a week-long community based intervention involving Lanarkshire staff and all 6 trained lay bowel champions is currently being evaluated and may assist us to quantify the opportunity costs of this sort of work more fully, thus allowing us to consider steps to mitigate any potential negative impacts of savings measures.

**This target was due to be delivered by December 2015, however, data is more than a year in arrears, therefore we will not know if we have achieved it until late 2016/17.*

2	**Proportion of patients beginning cancer treatment within:** • **31 days of decision being taken to treat (95%)**

Lead: **H Knox, Director, Acute Division**
A Khan, Clinical Lead (Cancer)
J Park, Director of Access
M Kelly, Cancer Manager

Measure & Data: Proportion of patients beginning treatment within 31 / 62 days. Cancer Waiting Times (ISD), published in March, June, September and December with a 3 month time lag.

2016/17	95%

Risks:

This would not be affected by the 2016/17 CRES plan.

3	**Proportion of patients beginning cancer treatment within:** • **62 days from urgent referral with suspicion of cancer (95%)**

Lead: **H Knox, Director, Acute Division**
A Khan, Clinical Lead (Cancer)
J Park, Director of Access
M Kelly, Cancer Manager

Measure & Data: Proportion of patients beginning treatment within 31 / 62 days. Cancer Waiting Times (ISD), published in March, June, September and December with a 3 month time lag.

2016/17	95%

Risks:

This would not be affected by the 2016/17 CRES plan.

4	**People newly diagnosed with dementia will have a minimum of one year's post-diagnostic support.**

Lead: **J Hewitt, Director, North H&SCP**
S Kerr, Head of Planning & Performance, North H&SCP

Measure & Data: Number of people newly diagnosed who receive a minimum of one year of post-diagnostic support (as defined by the commitment. Number will be determined by the result of the Scottish diagnosed incidence project) and who have a person-centred plan in place at the end of that support period. Data systems and definitions have been finalised. Boards are required to submit monthly returns. ISD has developed a data collection tool to support local services without networked IT systems to collect the local and national information required to implement the Standard.

Data collected includes date of diagnosis, first substantive contact by link worker, evidence that post-diagnostic support is in place within 1 month of diagnosis, and evidence that a care and support plan is in place one year after diagnosis. The target is that all people newly diagnosed will have this in place.

An initial data release from ISD at January 2015 had a number of caveats around, for example, missing data and the fact that denominator for this target (expected number of people diagnosed with dementia) is still being worked on by SG and ISD. This is still awaited thus we have no defined target (in terms of expected numbers / %, against which to measure actual throughput) at time of writing, although we understand that the national work around this is due to be published early in 2016.

Risks: Additional input is required to provide each person with support. While resource planning is ongoing in light of demand experienced, there is evidence of a waiting list developing. As outlined above, target numbers are still to be set based on national work around incidence. Our CRES plan for mental health is proposing to forego re-investment of 10 WTE in 2016/17 from bed reconfiguration which will mean that capacity to deliver PDS remains at approximately 930 open cases at any one time. The waiting list at April 2016 is estimated to stand at 818 people, with 70% waiting over 3 months. By April 2017, 1,408 will be waiting, and by April 2018, 1,998 people will be waiting. These figures assume a constant rate for dementia diagnosis (which is likely to increase) and thus should be considered as a best case scenario. Delays to advance planning in dementia are particularly relevant owing to the degenerative nature of the condition and opportunities to plan for deterioration will be lost. We will monitor the situation closely and develop plans to mitigate any negative impact.

5	**Proportion of patients that were seen within the 12 week Treatment Time Guarantee, 100% compliance required.**

Lead: **H Knox, Director, Acute Division**
J Park, Director of Access

Measure & Data: Proportion of patients that were seen within the 12 week Treatment Time Guarantee, 100% compliance required. NHS Waiting Times, Stage of Treatment (ISD), published in February, May, August and November, two month time lag.

2016/17	100%

Risks: This is likely to be negatively impacted by the 2016/17 CRES plan. Further detail is currently being assessed on a specialty by specialty basis. All clinically urgent patient access will be protected, and plans will be developed to mitigate negative impacts once these are clarified.

6	**90% of patients seen and treated within 18 weeks from initial referral.**

Lead: **H Knox, Director, Acute Division**
J Park, Director of Access

Measure & Data: 90% of patients seen and treated within 18 weeks from initial referral. 18 weeks RTT (ISD) published in February, May, August and November, time lag 2 months.

2016/17	90%

Risks: This is likely to be negatively impacted by the 2016/17 CRES plan. Further detail is currently being assessed on a specialty by specialty basis. All clinically urgent patient access will be protected, and plans will be developed to mitigate negative impacts once these are clarified.

7	**12 weeks first outpatient appointment (95% with stretch 100%)**

Lead: **H Knox, Director, Acute Division**
J Park, Director of Access

Measure & Data: Percentage of patients waiting no more than 12 weeks from referral (all sources) to first outpatient appointment. A 95% Standard applies. NHS Waiting Times Stage of Treatment (ISD) published in February, May, August and November, two month time lag.

2016/17	95%

Risks: This is likely to be negatively impacted by the 2016/17 CRES plan. Further detail is currently being assessed on a specialty by specialty basis. All clinically urgent patient access will be protected, and plans will be developed to mitigate negative impacts once these are clarified.

8	**At least 80% of pregnant women in each SIMD quintile will have booked for antenatal care by the 12th week of gestation.**

Lead: **I Barkby, Director, NMAHPs**
S Stewart. Associate Director, N&M

Measure & Data: The Standard is for at least 80% of pregnant woman in each SIMD quintile to have booked for antenatal care by the 12th week of gestation. The denominator is all women who give birth in Scottish hospitals.

For Board level SIMD quintiles, the datazones in each Board are to be divided into five groups according to SIMD 2012 rank. The allocation of datazones to quintiles within Health Boards is given in column G of the Health Board (SIMD) tab of the spreadsheet at www.scotland.gov.uk/Topics/Statistics/SIMD/localHBquin09

Board performance will be calculated for each of their five quintiles and the lowest performance will be reported.

A summary of performance at Scotland level will be shown based on the grouping of datazones by national SIMD 2012 quintiles and may therefore show inconsistent results with the Board level results, which group datazones by local quintiles. The Standard can be considered to be met if Scotland-level performance is at or above 80%.

ISD Births in Scottish Hospitals, annual, time lag of at least a year between collection and publication.

2016/17	80%

Risks: CRES may have an impact on this standard, particularly amongst the most vulnerable groups as posts currently being considered for savings are relating to the specialist midwives posts for vulnerable groups. Should there be any negative impacts identified, then plans would be developed to mitigate these.

9	**Eligible patients will commence IVF treatment within 12 months (90%).**

Lead: **C Sloey, Director of Strategic Planning & Performance**
C Lauder, Head of Planning

Measure & Data: 90% of eligible patients screened for IVF treatment within 12 months of the decision to treat made by one of the four IVF centres. This is based on adjusted completed waits. Data is being collected and published quarterly by ISD. The

publication shows the proportion of patients who were screened within 12 months of a decision to treat, split by NHS Board, being collected from the four IVF centres. Published quarterly with a time lag of two months.

2016/17	90%

Risks: NHSL's funding for 185 cycles of IVF treatment in NHS GG&C is included in the SLA. Any reduction in ring-fenced funding to IVF Centres would be expected to have an impact on performance, however, NHS GG&C will be responsible for managing the available funding to ensure that the standard continues to be achieved. There appears to be no immediate risk to NHSL given that our current waiting times are significantly shorter than the standard of 365 days (9 months as at end February 2016).

10	18 weeks referral to treatment for specialist Child & Adolescent Mental Health Services (90%)

Lead: **J Hewitt, Director, North H&SCP**
S Kerr, Head of Health, North H&SCP

Measure & Data: 90% of patients referred for Child & Adolescent Mental Health Services (CAMHS) are to start treatment within 18 weeks of referral. This is based on adjusted completed waits. CAMHS Waiting Times (ISD) published quarterly with a two month time lag.

2016/17	90%

Risks: With recent recruitment to unfilled vacancies, the CAMHS forecast is to exceed a 90% performance against the target this year. Additional 3 year funding from Scottish Government will add to the capacity to drive waits down further.

CRES, if applied to CAMHS, will affect this performance at rate of 400 fewer contacts per annum per each 1.0 WTE reduced. Budgetary pressure on partners could lead to a reduction in funded posts within CAMHS by 1.0 WTE. Two social work posts embedded in South Lanarkshire CAMHS are currently being reviewed by South Lanarkshire Council Child & Family Social Work Team. Fairer Scotland funded posts may also be affected by a reduction in funding. It will not be clear what the full impact will be until all the likely reductions are finalised, and in the event of any negative impacts being identified, then plans would be developed to mitigate these.

11	18 weeks referral to treatment for Psychological Therapies (90%)

Lead: **J Hewitt, Director, North H&SCP**
S Kerr, Head of Health, North H&SCP

Measure & Data: 90% of patients referred for Psychological Therapies are to start treatment within 18 weeks of referral. This is based on adjusted completed waits. Psychological Therapies Waiting Times (ISD), published quarterly, two month time lag.

2016/17	90%

Risks: Target CRES savings of £240K have been identified for this service. Removal of posts to this level would result in performance at around 80%. There is a plan in place to achieve the savings target for 2016/17 by a) giving up 0.35WTE vacant post; b) skill mixing band 8b to 8a and c) managing the remainder through vacancy management. The service's normal turnover suggests this would be achievable as does examination of the spend profile for recent years. This will be better for patients and give more chance of performing better against the 18 week RTT. The impact may be partially offset by SG investment nationally of £54m over next 4 years. Plans will be developed to mitigate any negative impacts arising from CRES measures.

12	The Standard is for a maximum rate of 0.32 of Clostridium difficile infections in patients aged 15 and over per 1,000 total occupied bed days.

Lead: **I Barkby, Director of Nursing, Midwifery and AHPs**
E Shepherd, Head of HAI (Prevention & Control)

Measure & Data: Rate of C diff per 1,000 total occupied bed days. Data published by Health Protection Scotland quarterly, Standard calculated against quarterly rolling year, three months time lag.

2016/17	0.32

Risks: (None identified)

13	**The Standard is for a maximum rate of 0.24 of staphylococcus aureus bacteraemia (including MRSA) per 1,000 total occupied bed days.**

Lead: **I Barkby, Director of Nursing, Midwifery and AHPs**
E Shepherd, Head of HAI (Prevention & Control)

Measure & Data: Rate of SABs per 1,000 total occupied bed days. Data published by Health Protection Scotland quarterly, Standard calculated against quarterly rolling year, three months time lag.

2016/17	0.24

Risks: (None identified)

14	**Clients will wait no longer than 3 weeks from referral received to appropriate drug of alcohol treatment that supports their recovery.**

Lead: **J Hewitt, Director, North H&SCP**
S Kerr, Head of Health, North H&SCP
H Stevenson, Director, South H&SCP
C Cunningham, Head of Health, South H&SCP

Measure & Data: 90% of clients referred for drug or alcohol treatment are to be treated within 3 weeks from date of referral received. Data published in Drug & Alcohol Treatment Times Database (DATWTD) by ISD, quarterly, three months time lag.

2016/17	90%

Risks: (None identified)

15	**Sustain and embed alcohol brief interventions in 3 priority settings (primary care, A&E, antenatal) and broaden delivery in wider settings.**

Lead: **J Hewitt, Director, North H&SCP**
S Kerr, Head of Planning & Performance, North H&SCP
H Stevenson, Director, South H&SCP
C Cunningham, Head of Planning & Performance, South H&SCP

Measure & Data: Number of alcohol brief interventions (ABIs) delivered in 2016/17. NHS Boards will report levels of delivery, by individual setting, directly to ISD on a quarterly basis. All reported ABI delivery will be in accordance with the ABI standard guidance. As part of the LDP Standard, ISD will publish an annual figure of ABI delivery. This will be broken down by NHS Board, delivery in each of the 3 priority settings, and a

fourth data category that will aggregate all delivery in wider settings. Annual reporting (financial year) with a 3 month time lag.

The last annual figure for NHS Lanarkshire was issued by SG on 5 March 2015 and was 7,381. Figure for 2016/17 awaited.

2016/17	

Risks: Numbers to be achieved in 2016/17 are still to be notified by SG making risk assessment at this point in time more challenging. We are assuming that we will be expected to achieve similar numbers as in previous years. Keep Well makes a significant contribution to this target. With this service ceasing in the South, and being slimmed down in the North, there is a real risk that we will not be able to sustain the levels of numbers achieved in previous years. Plans will be developed to mitigate any negative impacts that are identified.

16	Sustain and embed successful smoking quits at 12 weeks post quit, in the 40% most deprived SIMD areas.

Lead: **J Hewitt, Director, North H&SCP**
S Kerr, Head of Health, North H&SCP
H Stevenson, Director, South H&SCP
C Cunningham, Head of Health, South H&SCP

Measure & Data: Number of successful quits for people residing in the 40 per cent most-deprived datazones in the NHS Board (i.e. two most-deprived local quintiles). The number of 12 week quits to be delivered over year ending March 2017 will be notified by SG, following review of achievements in 2015/16. ISD SCS Database, annual data, 6 month lag.

2016/17	Number of 12 week quits requested by SG	Number of 12 week quits proposed by NHSL
Q1 Apr-Jun	352	305
Q2 Jul- Sep	353	305
Q3 Oct - Dec	353	305
Q4 Jan – Mar	353	305
Total	1,411	1,220

Risks: Footfall to smoking cessation services both overall and from SIMD 1 and 2 areas has reduced year on year between 2011/12 and 2014/15 however the data available for 2015/16 suggests this trend may be slowing with throughput for 2015/16 just slightly less than 2014/15. Although this is really welcomed there is no evidence to strongly argue that a levelling of the trend will continue in future years. Most positively, however, we have seen a year on year improvement in conversion of footfall to 12 week quits in SIMD 1 and 2, mainly due to improvements in pharmacy data recording.

The total number of 12 week quits to be achieved by NHS Lanarkshire in 2016/17 is **1,411** which is a **26% increase** on the target set for 2015/16 and is significantly more than the increases made in the last two years (based on projected year end position for 2015/16 as full year data is not available).

A new Tobacco Control Strategy for Lanarkshire is due to be published which outlines a range of improvement areas for smoking cessation however, the reduction in footfall to services, increasing use of e-cigarettes, and an overall reduction in resources will make achievement of this new target extremely challenging. The reduction in overall smoking prevention and cessation monies has resulted in efficiencies in programme delivery. Reductions have been made in areas which are not frontline services, however, the efficiencies will nevertheless negatively impact on services and programmes that are delivered to engage people into cessation services. In addition, the one year funding allocation makes staff recruitment and retention challenging and this may also have a detrimental impact on service delivery.

Given all these considerations it is therefore proposed the target trajectory be revised to aim to maintain performance at the same level as 2015/16, despite the 7.5% reduction in resources. This demonstrates an improvement in service efficiency and effectiveness.

Based on the conversion rate of footfall to quits in the first three quarters, it is estimated that our year end position will be approximately **1,220** against a trajectory of **1,118**. We would therefore propose revising the target for 2016/17 to **1,220 (305 per quarter)** which is 86% of the actual trajectory set.

17	**48 hour access or**
18	**advance booking to an appropriate member of the GP team (90%).**

Lead: **H Stevenson, Director, South H&SCP**
C Cunningham, Head of Health, South H&SCP

Measure & Data: Information comes from the Health & Care Experience Survey (successor to the GP and local NHS Patient Experience Survey). Measures used for the Standard are:

- The proportion of positive responses for 48 hour access to an appropriate healthcare professional; *and*
- The proportion of positive responses for booking an appointment with a GP three or more working days in advance.

For both measures the Standard is 90%.

The Health & Care Experience Survey is biennial, with previous results for 2013/14 and next results for 2015/16, due to be published in May 2016. The questionnaire asks about experiences 'within the last 12 months'. Responses for the most recent survey were gathered between December 2013 and February 2014 and results published at the end of May 2014, around 3 months after the survey closed.

48 hour access	90%
Advance booking	90%

Risks: The key risk in this area is the decreasing numbers of doctors coming into general practice and the subsequent extended periods of vacancies whenever a partner leaves and has to be replaced. Our plans for development of primary care as outlined in section 2.5 of this LDP would be expected to tackle this and other areas, and overall to contribute positively to these targets.

19	Sickness absence (4%)

Lead: **K A Small, HR Director**

Measure & Data: NHS Scotland Workforce Statistics: Sickness Absence Rate (from SWISS). Sickness absence is defined as normal sick leave, unpaid sick leave, industrial injury, accident involving a third party and injury resulting from a crime of violence. Reported annually, by financial year, with a two month time lag.

2016/17	4%

Risks: The key risk is that we fail to achieve a 4% sickness absence rate in important staff groups and there is a consequential additional cost burden in securing backfill (Bank or Agency) for lost and necessary clinical capacity. The risk will be mitigated through prioritised management and partnership focus on implementation of the Sickness Absence Policy, enhanced Occupational Health support, improved rostering (eRostering) arrangements and associated targeted reduced reliance on Bank and Agency backfill.

20	4 hours from arrival to admission or discharge or transfer for A&E treatment (95% with stretch 98%).

Lead: **H Knox, Director, Acute Division**
D Sweeney, Risk Management Facilitator/Flow Team
J Hewitt, Chief Officer, North H&SCP
H Stevenson, Chief Officer, South H&SCP

Measure & Data: Standard is for 95% of patients attending emergency departments to wait less than 4 hours from arrival to admission, discharge or transfer for accident and emergency treatment (with a stretch aim of 98%). Emergency Department Activity and Waiting Times (ISD) published February, May, August and November (ISD intends to increase publication frequency to monthly during 2015), time lag 2 months.

2016/17	Standard	Stretch
	95%	98%

Risks: This may be affected by the 2016/17 CRES plan and the uncertainty around funding in this area. The availability of clinical decision makers at the front door continues to be a risk. This is currently especially at Wishaw. Plans will be developed to mitigate the impact of any negative impacts arising from these challenges.

21	**NHS Boards to operate within their agreed revenue resource limit, capital resource limit, and meet their cash requirement.**

Lead: **L Ace, Director of Finance**

Measure & Data: Separate, detailed guidance is issued concerning financial plans that are submitted to SG directly – see (4) below.

Risks: Details covered in separate LDP Financial Plan.

4 FINANCIAL PLANS

A series of bespoke financial templates are submitted separately to the Scottish Government Health Directorates (SGHD) finance section to support the Local Delivery Plan. These demonstrate how we will achieve our financial targets as well as subdividing our financial plans across the multiple separate funding streams for technical reasons.

The Local Delivery Plan for Lanarkshire includes a commitment to deliver a balanced Financial Plan. This is contingent upon the realisation of efficiency savings of the order of £46.5m, c.£35.7m of which can currently be identified locally, although some of these have a high risk profile.

In addition to the financial impacts highlighted in the Local Delivery Plan, a further £10.4m needs to be found to ensure financial balance.

A range of NHS wide initiatives and policy changes are being discussed at national level. If these were progressed in line with the initial estimates of potential savings, they might deliver the means by which to close this gap but they are not yet at a stage to include them with certainty.

Annex A – List of Key Local Strategies and Plans supporting the LDP

Health Inequalities Action Plan 2015
Person Centred Care Prioritised Plan 2014
Transforming Patient Safety and Quality of Care in NHS Lanarkshire 2014-17
Patient Safety Strategic Prioritised Plan 2014-17
Quality Improvement Capability and Capacity Plan 2015-19
A Healthier Future 2012-2020
Everyone Matters: 2020 Workforce Vision Implementation Plan 2015/16
Joint Strategic Commissioning Plans (North and South)
Procurement Strategy 2014
Children & Young People's Health Plan 2015-2018
Single Outcome Agreements – North & South CPPs
Lanarkshire Healthcare Strategy
Primary Care Clinical Strategy

In preparation at May 2016