NHS LANARKSHIRE LOCAL DELIVERY PLAN 2017/18

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1 INTRODUCTION

This is NHS Lanarkshire's twelfth Local Delivery Plan (LDP), developed in line with Scottish Government Health Directorate's (SGHD) guidance of 16 January 2017.

As required by the SGHD guidance, we have set out brief details of our plans for 2017/18 in the following areas:

- Work that we are taking forward in support of the national Health & Social Care Delivery Plan published by SGHD in December 2016;
- Workforce Planning;
- Safe Care;
- Person Centred Care.

The key actions and activities in each of the above areas will also support our ability to achieve and/or sustain achievement of the 21 LDP Standards continued from previous years and described further in section 6.

By its very nature, this LDP can only provide a very brief summary of the work streams in the areas indicated, and it is important to note the wider range of local service strategies that will contribute to ensuring that we continue to deliver high quality, safe and effective care to the people of Lanarkshire. Our overarching planning framework – our Healthcare Strategy *Achieving Excellence* - sets out our ambitions for person-centred, innovative healthcare to help Lanarkshire flourish and will continue to drive forward progress towards the Government's 2020 Vision for Health and Social Care in Scotland. A link to a copy of this is provided in section 2.2. 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 2017/18. At the time of writing (March 2017) 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 NATIONAL HEALTH & SOCIAL CARE DELIVERY PLAN

The Health & Social Care Delivery Plan (H&SCDP) was published by Scottish Government in December 2016 and sets out a number of inter-linked programmes designed to further enhance health and social care for the population. Its focus is on prevention and early intervention, and a shift in the balance of care from hospital to community where evidence shows this to be more effective. Implicit in this is a re-design of services and the introduction of new models of care including new treatments and technologies, and the development of a workforce that has the capacity and capability to deliver these both now and in the future.

The LDP guidance asks that we describe how we are taking forward the key actions in the H&SCDP locally. We have chosen to describe these using headings of the H&SCDP itself:

- Health & Social Care Integration
- National Clinical Strategy
- Public Health Improvement
- NHS Board Reform
- Cross-cutting Actions:
    - Getting it Right for Every Child (GIRFEC)
    - National Health & Social Care Workforce Plan
    - R&D and Innovation
    - Engagement and Public Involvement

2.1 Health & Social Care Integration

Leads: J Hewitt, Chief Officer, North H&SCP
V de Souza, Chief Officer, South H&SCP

Governance Committees: Integrated Joint Boards, North & South

2.1.1 Measuring Performance under Integration

Work is continuing to produce trend information regarding the 6 key areas identified in the Scottish Government's letter of February 2017 to Chief Officers of H&SCPs, i.e.,

1. Unplanned admissions;
2. Occupied beds days for unscheduled care;
3. A&E performance;
4. Delayed discharges;
5. End of life care;
6. The balance of spend across institutional and community services.

In turn, this data will be used to set targets for each of the above, together with agreeing associated actions.

The first drafts of the data trends and proposed trajectories have been shared with Scottish Government and, pending feedback, are also subject to ongoing discussion across acute, H&SCPs and NHS Lanarkshire to understand how these trajectories might both be refined and delivered.

Annual reports will be compiled for both partnerships by the end of July 2017, which will include performance reporting against the 9 national health and wellbeing outcomes and the associated 23 integration indicators.

2.1.2 Reducing inappropriate use of hospital services

The approach being adopted to reduce inappropriate use of hospitals is built upon the work areas agreed as part of our Healthcare Strategy - *Achieving Excellence* (see 2.2 for details) – and will be linked to the respective Strategic Plans of our two Health & Social Care Partnerships. These will focus on:

- Building community capacity;
- Managing long term conditions;
- Acute planned care;
- Mental health and learning difficulties;
- Maternity and early years;
- Frailty.

Specifically, each of the main clinical specialty areas that typically manage unplanned care has been set a target of reducing reliance upon inpatient care by 25% over the next 5 years. To achieve this, many of the traditionally hospital based approaches to care will need to be transformed with increased capacity created in communities and the associated input of key clinical staff in community settings. As well as utilising additional funding made available from Scottish Government to invest in primary care and mental health services, this will also be reliant on changed care pathways across acute and primary care.

To further support this work, there will be:

- A continued focus on providing community alternatives to reduce the volume of A&E attendances;
- A continued focus on delayed discharge and associated action plans to address same;
- Review of all average length of stays across specialties to identify any outliers both locally and nationally;
- Maximising the role of patients in managing their own disease, relying on clinical intervention only when indicated;
- Maximising the use of telehealth / telecare;
- Building community capacity and use of Third Sector supports;
- Increased joint working between traditionally hospital and community based clinicians;
- Maximising opportunities for people to be supported to die at home.

2.1.3 Shifting resources to primary and community care

Significant resource is being utilised to support more sustainability in the delivery of General Medical Services and, in turn, this should facilitate the increase of service provision in a community setting.

Work to be undertaken in refocusing the predominance of Long Term Care to community based approaches will also assist in supporting the shift to primary care, together with the appropriate resources. Specifically, each of the main clinical specialty areas that typically manage unplanned care have been set a target of reducing reliance upon

inpatient care by 25%, with the associated transfer of work and resources to the community to maximise care provided outside the hospital environment.

There is a series of work streams identified to support different approaches to the provision of primary care. These aim to extend the range of services available and to support a wider group of staff to provide services traditionally only available from, or through, an appointment with a GP. These work streams cover in and out of hours urgent care; IM&T; mental health; recruitment and retention; extended support from pharmacists and general sustainability opportunities. It is envisaged that this work will be key to identify how the additional monies being made available by Scottish Government (£500m Scotland-wide) will be used in an NHS Lanarkshire context.

2.1.4 Supporting capacity of community care

The 'Building Community Capacity' short life working group will work with the full range of community partners with a view to maximising supports in the community. In many instances, the aim will be to develop services with little or no involvement of the statutory public sector.

Both Partnerships will also be reviewing existing contractual arrangements associated with home care provision. Similarly, the review of community capacity will also review the range and use of beds across all sectors and settings.

2.2 National Clinical Strategy

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

Governance Committee(s): **PP&RC, Board**

In Lanarkshire, we developed and published our own local Clinical Strategy *Achieving Excellence,* mirroring the aims of the National Strategy, during 2016. A copy can be found on our website or by clicking this link:

http://www.nhslanarkshire.org.uk/news/news/Pages/AchievingExcellenceConsultation.aspx

We believe this fully supports the National Clinical Strategy, covering as it does:

- The case for change, including the aim of shifting towards a focus on prevention, anticipation and supported self-management, based on the needs of local communities, with secondary care organised in centres of excellence and a new clinical understanding that is based on minimally disruptive realistic medicine;
- The changing health and social care needs of the people of Lanarkshire;
- The significant and evolving role of our Health & Social Care Partnerships (*Achieving Excellence* is one of a trilogy of strategic plans alongside the Joint Strategic Commissioning Plans of each Partnership);
- Programmes of improvement planned for:
    - Primary Care;
    - Long Term Conditions;
    - Older People's Services;
    - Mental Health and Learning Disability;
    - Alcohol and Drugs;
    - Maternity, Early Years, Children and Young People;
    - Planned and Unscheduled Acute Care;
    - Orthopaedic Services;
    - Cancer Services;
    - Stroke Services;
    - Palliative Care.
- Development programmes for supporting services:
    - Pharmacy;
    - Property;
    - eHealth;
    - Transport.
- Workforce planning and development to underpin service changes;
- Outline change plans and timescales;
- Financial implications.

2.3 Public Health Improvement

Lead: H Kohli, Director of Public Health

Governance Committee(s): HQAIC

NHS Lanarkshire, in collaboration with both Health and Social Care Partnerships, will lead the public health improvement effort in Lanarkshire. Critical to this will be working collectively with Community Planning Partners, the third sector, people in communities, and communities of interest.

Addressing the social determinants of health is critical to success and NHSL will continue to deliver its High Level Inequalities Action Plan. We will continue to support the Children and Young People's Improvement Collaborative and deliver the Children and Young People's Health Plan, which includes addressing the health and wellbeing needs of Looked After Children, implementation of the Maternal and Infant Nutrition Framework and ensuring children achieve their developmental milestones. The impact of Adverse Childhood Experiences is widely recognised and during this year we will investigate how to address the needs of those who have been adversely affected. Continued focus will be placed on vulnerable populations and we will seek to develop our work to support the homeless population. We will continue to contribute to a range of partnership programmes that seek to mitigate the impact of welfare reform, food and child poverty. NHSL will continue its commitment to supporting people into employment and will support the delivery of programmes such as Project Search.

NHSL and both Health and Social Care Partnerships will continue to deliver the Tobacco Control Strategy (2017-22). We will deliver smoking cessation through the Specialist and pharmacy services, and focus delivery in our most deprived areas. Emphasis will be placed upon prevention and a range of initiatives will be put in place that encourage all adults in Lanarkshire to be positive anti-tobacco role models, whether they smoke or not. This is to reduce the visibility of smoking in Lanarkshire and make not smoking the social norm. We will continue to implement prevention programmes that encourage, empower and support young people not to start smoking.

NHSL recognises the need to address obesity and, with both Health and Social Care Partnerships, will seek to implement a range of actions highlighted in our Healthy Weight Strategy.

Encouraging the population to be physically active is critical to achieving healthy weight. Through the Health and Social Care Partnerships, we will continue to deliver a range of programmes in partnership with both Leisure Trusts, promote Get Walking Lanarkshire and deliver innovative programmes. The Active Health programmes will focus on helping people manage their health conditions, promoting mental wellbeing and supporting people to live independently.

NHSL and both Health and Social Care Partnerships recognise the impact that poor mental health and alcohol misuse has on the population and upon our services. We will continue to play an active role in the Alcohol & Drug Partnership (ADP) and will continue to deliver Alcohol Brief Interventions (ABIs).

Mental Health Improvement remains a public health priority and is delivered through 'Towards a Mentally Flourishing Lanarkshire Action Plan'. The Action Plan is being refreshed through 'Good Mental Health for All' which has a focus on maximising

opportunities provided through integration, utilising collective assets for collective impact. Proportionate investment has improved access to a wide range of accessible community based programmes, with an increase focus on primary care supported through the primary care transformation fund. Anti-stigma, suicide prevention and recovery focussed programmes continue with success, complimented by Lanarkshire hosting the National Distress Brief Intervention Programme on behalf of the Scottish Government.

2.4 NHS Board Reform

Lead: **C Sloey, Director of Strategic Planning & Performance**
K Small, HR Director

Governance Committee(s): **PP&RC, Board, Staff**

2.4.1 Regional Planning and Shared Services

The Health and Social Care Delivery Plan recognises the importance of the National Clinical Strategy and the need for service review and planning at population levels beyond the boundaries of territorial Boards. Within the West of Scotland Regional Planning Group there is already a programme of collaborative work that considers the ever changing population needs and how these are influenced by demographic changes and the emergence of new treatments and technologies at a time of constrained resources, including the availability of specialist clinicians across both primary and acute hospital care. This programme of work includes:

- Interventional Cardiology including Primary Reperfusion Service;
- Major Trauma;
- OMFS;
- Urology including Minimally Invasive Resection of Prostate;
- Vascular Services;
- Regional Child Health Services including Child Protection, critical care and specialist shared services;
- Regional Child and Adolescent Mental Health;
- Medium and Low Secure Psychiatric Services;
- Systemic Anti-Cancer Treatments;
- Aseptic Pharmacy Services;
- Maternity and Neonatology;
- Interventional radiology;
- Ophthalmology;
- Workforce Planning;
- Prescribing.

It is recognised by the WoS Regional Planning Group that a regional transformational plan needs to be developed over the next 6 to 12 months that is underpinned by detailed analysis of:

- the needs assessment of the 2.7 million people served by the West of Scotland Boards;
- changing patterns of demand for future treatment and care for this population;
- the current capacity to safely and effectively meet these treatment and care needs;
- new service models and care pathways;
- Resource Plans including workforce, estate and specialised equipment.

This regional planning activity will complement the service planning and change in each NHS Board area which will be required to address the current service and financial pressures. This will also complement work on the strategic direction for acute services, which each Board has been developing to transform acute services, working alongside their Integration Joint Boards. When taken together with Board level plans this transformational plan will clearly set out how West of Scotland Boards and their partners

will deliver safe, efficient and sustainable treatment and care over the next 10 to 15 years.

2.4.2 Leadership and Talent Management

NHS Lanarkshire is fully supportive of the aspirations and actions set out in the Scottish Government's Health and Social Care Delivery Plan issued in December 2016 to establish a new approach to leadership development and talent management across NHS Scotland.

The new approach will focus on:

- Leadership development for the future;
- Understanding the complexity of cross-sectoral working;
- A values led approach which is underpinned by honest dialogue, partnership working and effective performance review and performance management;
- A committed and resourced focus on developing our people, leadership development and talent management;
- Effective leadership and engagement with our people and across the wide range of our teams.

NHS Lanarkshire will work closely with colleagues in Scottish Government and fellow NHS Boards supporting the design and delivery of National, Regional and NHS Board initiatives which promote and deliver the new National arrangements for leadership and talent management to secure the ambitions of the Delivery Plan.

2.5 Cross – cutting Actions

2.5.1 Getting it Right for Every Child (GIRFEC)

Leads: **J Hewitt, Chief Officer, North H&SCP**
V de Souza, Chief Officer, South H&SCP
I Barkby, Director of Nursing, Midwifery & AHPs

Governance Committees: Integrated Joint Boards, North & South

NHS Lanarkshire is committed to delivering the principles of Getting it Right for Every Child (GIRFEC) by improving services for children and young people through the provision of more effective and widespread prevention and early intervention; and better cooperation amongst and between professionals, the child or young person, and their family.

This will be evidenced by:

- Implementation of the Children and Young People (Scotland) Act 2014, in particular every 0-5yr old will have a Named Person, and every child will have a Child Plan;
- Continuing to deliver and, as appropriate, expand the programme to build capacity to offer the programme to eligible women aged 19 and under by 2018;
- Implement the Health Visitor Pathway, specifically the Health Visitor Home Visiting Pathway and report on the performance;
- Expansion of the Health Visitor workforce by 37 wte by 2019.

Family Nurse Partnership (FNP)

The Programme successfully achieved compliance with fidelity goals for some 258 Cohort 1 clients, and graduations will complete by April 2017.

The current service comprises 2.0 wte Supervisors and 9.0 wte Family Nurses divided across two Teams. Small Scale Permanence has been approved and recruitment of 231 clients to Cohort 2 is due to complete July 2017. Team A has capacity for a further 3.0 wte and Team B additional capacity for 4.0 wte nurses, which would increase the client caseload capacity by 175.

ISD statistics show that the number of eligible births has fallen by approximately 6% per year in Lanarkshire since 2010. Assuming a conservative trend of a 5% reduction, there will be 219 eligible first time teenage mothers per year. As the FNP programme lasts for 2.5 years from enrolment to graduation, the total nurse requirement in NHS Lanarkshire to meet the Scottish Government commitment is 21.3 wte, plus an additional 0.2 wte Supervisor. A Draft Expansion modelling exercise has been completed to inform discussions of future service provision to support the Scottish Government commitment to offer FNP to all entitled clients.

2.5.2 National Health & Social Care Workforce Plan

Lead: **K Small, HR Director**

Governance Committee(s): **Staff, Board**

Scottish Government plans to produce a National Discussion Document on Workforce Planning in Health and Social Care in early 2017. Thereafter a comprehensive engagement exercise will be undertaken with Health and Social Care colleagues to inform and influence production of a final version of the National Health and Social Care Workforce Plan in Spring 2017.

The National Workforce Plan will have a strategic focus, will make coherent links between National, Regional and Local workforce issues, and will be active and useable with frameworks for practical workforce planning across NHSS and Social Services sectors.

NHS Lanarkshire has, and will continue to, contribute to the development of the National Workforce Plan and will fully utilise the information, guidance and frameworks contained within the Plan to further develop and enhance the process and production of an integrated Health and Social Care Workforce Plan in Lanarkshire. This Plan will also integrate with the development work and workforce planning in support of *Achieving Excellence*, NHS Lanarkshire's Healthcare Strategy.

2.5.3 R&D and Innovation

Lead: **C Sloey, Director of Strategic Planning & Performance**
I Wallace, Medical Director

Governance Committee(s): **PP&RC, HQAIC, Board**

NHS Lanarkshire welcomes and fully-endorses the Scottish Government's affirmation that "*…research is central to all high-performing health systems, leading to better targeted and more personalised treatment and improved patient outcomes… [and that]…R&D and innovation are core activities for our health and social care services in Scotland…*"

The updated NHS Lanarkshire R&D Strategy will be published early in 2017; the prime drivers for this are the Scottish Government's **Health and Social Care Research Strategy-Delivering Innovation through Research**, October 2015, and the broader Scottish Government **Health and Social Care Delivery Plan** 2016.

The NHS Lanarkshire R&D Strategy will focus on a number of objectives, including:

- Increasing the opportunities we provide for our patients to participate in research by expanding the number of research-active clinicians and clinical specialties within the NHS Board, and increasing the number of high-quality, ethically-approved research studies and clinical trials that we participate in;
- Diversifying the Board's research portfolio by increasing the volume of Pharmaceutical Industry-funded clinical trials that we participate in, thereby facilitating access to new cutting edge treatments for our patients, and creating a valuable income stream to increase our capacity to support research;

- Identifying opportunities to increase entry to cancer clinical trials and research studies specifically, in support of the Scottish Government's comprehensive approach for targeting cancer care as a priority;
- Identifying and securing dedicated facilities in each of NHS Lanarkshire's three acute hospitals to host the increasing volume of research and clinical trials, thereby enabling realisation of the benefits this will bring to patients and to the NHS Board;
- Implementing enhanced performance management arrangements to improve on the Board's delivery of research study contractual targets, and specifically in terms of minimising delays in study start-up and maximising recruitment-to-target;
- In what is an increasingly competitive UK and global research community, the ability to demonstrate excellent performance in the above key metrics to Sponsors will be vital in attracting commercial / Pharmaceutical Industry and academic research to NHS Lanarkshire, and winning competitively awarded research funding;
- Expanding the network of external research organisations with which we work – in particular, developing and exploiting opportunities for academic research collaborations will be a key component of the Board's developing formal relationships with local Universities.

The R&D Department is fully integrated with the existing national NHS Research Scotland (NRS) structure, and collaborates closely with other Health Boards, Universities and commercial and non-commercial research organisations.

We will continue to actively collaborate with colleagues as part of the regional NRS West Research Node R&D Management Group (*NHS Lanarkshire, NHS Dumfries & Galloway, NHS Greater Glasgow & Clyde, NHS Ayrshire & Arran, and the National Waiting Times Centre*). The Group will develop regional approaches to improve efficiency and effectiveness. As an example, an innovative regional model agreement is being developed by NHS Lanarkshire's R&D and HR Departments on behalf of the NRS West Node and this will be implemented in 2017; this will allow clinical research staff – *Clinical Trials Nurses and other NHS researchers* – employed by any one Board to easily move between all other NRS West Node Boards to support on-going research studies.

NHS Lanarkshire works closely with Scottish Health Innovations Limited (SHIL) to support the commercialisation of local innovations. During 2017 work will continue on a new and innovative healthcare product that we expect to come to market during the fiscal year. We will continue to work with SHIL and the Scottish Government's Innovation work stream to raise the profile of innovation, and will actively participate in and take advantage of opportunities presented by new national support structures as these emerge.

NHS Lanarkshire recognises the important role that technology enhanced care (TEC) will provide in the future. We have developed a range of TEC solutions to support high quality service provision. In the coming years we will build on the early success of remote monitoring, text messaging prompts, self-management support and videoconferencing to enable more people to remain at home for longer or to access services in ways that better suit their busy lives. In addition, we will continue to innovate with new technologies as they become available to ensure our health system maximises its efficiency and effectiveness.

We will continue to build on the partnership agreement signed with the digital health institute. It is anticipated that a small number of innovative *test of change* projects will be implemented to improve patient care. These projects will be clinically lead with a view to delivering improvements across a number of key areas across the six dimensions of care: safe, effective, efficient, timely, patient centred and equitable. The projects will

be evaluated by Strathclyde University and, based upon their success, they could be adopted across NHSL and the wider healthcare system.

2.5.4 Engagement and public involvement

Lead: **I Barkby, Director of Nursing, Midwifery & AHPs**
C Sloey, Director of Strategic Planning & Performance
J Hewitt, Chief Officer, North H&SCP
V de Souza, Chief Officer, South H&SCP

Governance Committee(s): **HQAIC, PP&RC**

North:

Communications & Engagement Strategy
The North IJB signed off its Communications and Engagement Strategy in January 2017 and this will be implemented during 2017/18. The strategy outlines the wide range of forums and groups that will support all engagement and public involvement activities.

North Lanarkshire Public Partnership Forum
Work with the PPF continues, with an increased focus to include the wider health and social care agenda. The working agreement is being updated accordingly. In addition, a User and Carer Forum has been established through Partnership For Change, which supports the service user and carer representatives on the Integration Joint Board to provide a wider and more representative opinion to the group.

Locality Engagement Events
A series of locality based engagement events, involving both staff and the public, have taken place to inform the development of the Strategic Commissioning Plan, support networking and keep all key stakeholders apprised of progress. These sessions will continue to inform local service delivery and design. A conference is planned for September 2017 to bring together the work of the Partnership to date and inform the next stage of developing the Commissioning Plan.

South:

Communication Strategy
A Communication Strategy is in place to support all operational and strategic functions of South Lanarkshire Health and Social Care Partnership. Communication has also supported, and will continue to support, all engagement and public involvement activities. This includes South Lanarkshire Health and Social Care Forum and Locality Staff and Stakeholder Engagement Events. An updated Communication Strategy is currently being refined and sets out practical steps detailing how a strategic approach to communications will measurably support the attainment of nine national health and wellbeing outcomes, as set out by The Scottish Government, and ten 'themes to be developed' in the Strategic Commissioning Plan. The implementation of this updated Strategy will commence in 2017/18.

South Lanarkshire Health and Social Care Forum
The South Lanarkshire Public Partnership Forum, operating within NHS Lanarkshire, has evolved to be the South Lanarkshire Health and Social Care Forum (SLH&SCF). The Forum is being supported into their role as the Community Engagement mechanism for

the SLH&SCP. This development work was initially facilitated by NHS Education for Scotland (NES) and Scottish Social Services Council (SSSC). It is being continually supported by the Partnership's Organisational Development Team. Using an Appreciative Inquiry model, outcomes emerged around the recognition of the need to increase volume and diversity of membership, and also the need to develop different ways of engaging with communities to be fit for Partnership purpose. An action plan is being implemented to meet these outcomes.

Locality Staff and Stakeholder Engagement Events
For the past couple of years, engagement seminars have been key to informing developments, including priorities that are set out in the Strategic Commissioning Plan. Staff have been invited from NHSL and SLC, as well as paid and unpaid stakeholders from the Third Sector. In addition to using the output of practical workshops to inform Partnership planning, the events have also served the purpose of informing people of national and local progress and providing a networking/relationship building opportunity. Moving forward, events will be more locality focused, to enhance effectiveness and ownership at this level.

Achieving Excellence:

During 2016 NHS Lanarkshire and its partners conducted an extensive public consultation on the proposals contained within the Healthcare Strategy *Achieving Excellence*. The feedback from that process was used to revise and improve the Strategy to reflect the views of our patients, staff and other stakeholders. The Strategy is aligned to - and its goals are dependent upon - the implementation of the strategic commissioning plans of Health & Social Care North Lanarkshire, and South Lanarkshire Health and Social Care Partnership.

Achieving Excellence will now form the basis of an extensive programme of healthcare redesign across primary, community, hospital and social care. The successful implementation of this programme of change (which will extend over 10 years) is dependent on effective communications with all of our stakeholders, and on constructive engagement with those affected by change.

NHS Lanarkshire has established the Communications & Engagement Working Group which will take an overview of this aspect of the *Achieving Excellence* delivery programme. Working with the various groups across health and social care responsible for taking forward change, this working group will build on the engagement which led to *Achieving Excellence* and will ensure a consistent, effective and proportionate communications and engagement process is in place for all proposed and agreed service changes.

The working group includes the Lanarkshire Patient and Public Forums, the Scottish Health Council, and senior managers from the HSCPs, communications, planning and equality/diversity areas.

Person Centred Care:

Person-centred care is a central component in improving health and care services and NHS Lanarkshire's Person-Centred Care strategic aim is described further at Section 5.

3 WORKFORCE PLANNING

Lead: K Small, HR Director

Governance Committee(s): 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 2017/18 will be developed to build on progress to date and will incorporate the additional NHS Board Actions arising from the Scottish Government Implementation Plan 2017/18.

The Implementation Plan 2017/18 will continue 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 2017/18 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 the comprehensive implementation and use of iMatter (Staff Experience Model) across NHS Lanarkshire staff teams. Exploration of use of iMatter across the North and South Lanarkshire Health and Social Care Partnerships;
- 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 2017/18 will be routinely assessed and monitored by the NHS Lanarkshire Staff Governance Committee, Corporate Management Team, Area Partnership Forum and HR Forum.

NHS Lanarkshire's Healthcare Strategy *Achieving Excellence* outlines the framework NHSL is working towards to achieve the objectives of the national Health & Social Care Delivery Plan and the National Clinical Strategy. This approach focuses on the "triple aim" of "better care, better health and better value" and recognises that NHS Lanarkshire's workforce will be instrumental in successful delivery and will require the "right skills, flexibility and support".

The workforce, in all professions and at all levels, will have a part to play and staff will be supported and developed to ensure they can fully engage and commit to the revised service delivery models. The future workforce will be based on teams of staff rather than individual practitioners to develop effective multi-disciplinary teams working with the appropriate knowledge and skills. It will integrate more closely the work of hospital based specialties alongside community based teams, with a clear understanding and value of each others' roles and a culture which supports people with long term conditions and their carers to be the lead partners in decisions about their health and wellbeing.

Ultimately, this will require more integrated workforce planning arrangements between NHS Lanarkshire and the North & South Lanarkshire Health & Social Partnerships in line with the proposed National Health & Social Care Workforce Planning arrangements expected in Spring 2017.

The future model for the workforce is currently under development but will be realistic and consider the workforce availability, adaptability and affordability to deliver the revised clinical model in the specified timeframe. In effect, the workforce model requires:

- Early projection and preparation of staff to meet the future demand if different skills sets are required;
- Adequate opportunity for staff to be developed to meet these requirements;
- All this to be framed within a financially viable workforce model.

The Staff Governance Standards and the Fair Work Framework provide the foundation for engagement with our staff in shaping the future Workforce to deliver the NHSL Strategy.

1. Workforce Availability

There are issues with medical staffing availability, particularly GPs, in Lanarkshire and on-going reliance on medical staffing is unsustainable. With this NHS Lanarkshire's Healthcare Strategy plans to adopt a workforce model with a higher reliance on a range of Advance Practitioner roles from several professional backgrounds, e.g., nursing, allied health professionals, pharmacy and physician associates.

The ageing population will not only change the service demands, it will be reflected in the availability of the NHS Lanarkshire workforce. In effect, we will have an older workforce in 2025 and a higher volume of retirements year on year. With this, NHS Lanarkshire is considering approaches to support older staff to remain in employment while recognising and succession planning for potential loss of skills and knowledge. A "Working Longer in NHS Lanarkshire" webpage will be launched in Spring 2017.

To provide safe, effective and person-centred care, the workforce of 2025 should match the workload demands in the care context, location and hours of service. This will see a shift in staffing into the community workforce and will require a change from the existing patterns of work towards 24 x 7 day working.

NHS Lanarkshire recognises the importance of being an Employer of choice which attracts and retains staff, supported by recruitment, selection, induction, performance management, strong leadership and staff development processes. To maximise workforce availability and reduce agency/locum spend, NHSL will promote Lanarkshire as a place to work and where possible review workforce strategies and policies to reflect and support this both for substantive and bank staff.

2. Workforce Adaptability

NHS Lanarkshire will undertake detailed multi-professional workload and workforce planning, using where appropriate the Nursing & Midwifery Workforce & Workload Planning Tools. This will consider effective use and likely retention of the existing workforce to inform future remodelling work.

The identification of skills and competency gaps will be equally important in ensuring appropriate training and development is on-going to ensure the workforce is appropriately prepared and supported for the future.

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

It is envisaged that advanced practice roles will be an integral part of building capacity and capability within the community. The developments for extended roles, such as intravenous therapy, advanced practice, non medical prescribing and extension of health care support worker roles to support the future community care, will require engagement with HEIs in conjunction with NHS Lanarkshire's Practice Development Team and GP practices.

3. Workforce Affordability

To maximise the efficiency of service delivery, several workforce redesign factors are being considered such as integrated roles across health and social care, skill mix, and extended scope.

In addition, there are other opportunities for efficiency which would support the workforce. These include: increased use of technology; engagement with the Third Sector; greater integration across contractor disciplines such as community pharmacists, dentists, optometrists, and introduction of pharmacists in GP practices.

The workforce to support *Achieving Excellence* 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 licence" with work aligned to their skills. The workforce may require to be redistributed to match the increased workload demand in the community.

It is difficult at this stage to indicate the exact numbers and development requirements for each role until more detailed workload and planning has been undertaken. The work streams within this Strategy have identified key areas of role requirements that have already been developed in other areas within NHS Lanarkshire and the approach can be used to support the development and extend the roles of our existing staff. In addition, leadership and team development approaches are well embedded within NHS Lanarkshire and can be utilised to further develop the knowledge and skills required to achieve the required outcomes.

4 SAFE CARE

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

Governance Committee(s): **HQAIC**

Background

NHS Lanarkshire's quality 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 quality vision, we are committed to transforming the quality of health care in Lanarkshire aiming to:

- be the safest health and care system in Scotland;
- have no avoidable deaths;
- reduce avoidable harm;
- deliver care in partnership 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.

A Transforming Patient Safety & Quality of Care Strategy Implementation Plan is in place which supports the delivery of our quality vision.

Safe Care

We have set two high-level targets in relation to our goal of minimising harm to patients. These are:

- a 10% reduction in Hospital Standardised Mortality Ratio (HSMR) by December 2018;
- a 30% reduction in Falls with Harm and a 50% reduction in Falls with Serious Harm by December 2017.

The NHS Lanarkshire Patient Safety Strategic Prioritised Plan, which sets out our improvement approach to reduce patient harm, was refreshed during 2016. The reductions identified are in line with national and local goals which are deliberately ambitious. These harms will be addressed across primary, community care and acute care patient pathways. The revised plan includes the following:

- the Ten Patient Safety Essentials as set out in CEL 19 (2013);
- a focus on spread of current work to other areas within the organization;
- specifically reflects the revised corporate priorities:
    - Deteriorating Patients (including the recognition and management of Sepsis);
    - Safer Use of Medicines;
    - Reduction in Harm from Falls;
    - System Enablers:

    - Promoting a Safety Culture;
    - Effective communication;
    - Effective management of care at transitions between services.
    - Effective Multidisciplinary Team (MDT) working.
- recognises the integration of health and social care and the importance of aligning work to the National Health and Wellbeing Outcome 7: "People using health and social care services are safe from harm."

A Patient Safety Measurement Framework has been developed and endorsed by the Patient Safety Strategic Steering Group (PSSSG) with the detail of all related patient safety process and outcome measures including progress reporting levels to include: pilot teams; Board level, site level and external reporting. Progress against all these measures will be reported on a bi-monthly basis during 2017/18.

A second, organisation-wide patient safety culture survey was run throughout October 2016 so that all members of staff could give their views as we plan our future priorities in this area. Over 700 responses were received. The results were considered by the organisation and will be used to inform our improvement plan for 2017/18.

We have a structured programme of patient safety Leadership Walk rounds in place. These occur weekly in both acute and community settings and we are currently planning to increase the number that take place during out-of-hours (during the evening, overnight and at weekends). The programme will continue in 2017/18.

As part of the Patient Safety Strategic Prioritised Plan a programme of mortality and patient safety specific case note reviews has been progressed over the past two years. Following each review, reports are produced to provide the detailed findings, themes and case studies and propose recommendations on improvements and actions that can be taken to contribute to reducing harm, mortality and improving systems, processes and quality of care. As part of the recommendations set out within the reports, site based mortality improvement plans have been developed and will be implemented during 2017/18. A programme of reviews will continue during 2017/18.

Adverse Event Management

NHS Lanarkshire has an Adverse Event Management Policy in place that aims to ensure that all adverse events are reported, acted upon and analysed as appropriate and that the knowledge thus gained is regularly disseminated to improve quality, patient safety, staff safety and performance of the organisation. This will encourage and strengthen a learning culture in which the quality of care for patients and working lives for staff will continuously be improved.

During 2017/18, we will continue with a programme of work to ensure effective implementation of the Adverse Event Management Policy and Procedures to ensure transparency, prompt remedial action and learning for quality improvement so that recurrence of adverse events is minimised. This will include ensuring that:

- high quality Significant Adverse Event Reviews are carried out with prompt remedial actions agreed within agreed timescales;
- Actions Plans are implemented and regularly monitored to ensure delivery of the necessary improvements;
- regular reports on adverse events are considered by appropriate groups and used to drive improvement.

Duty of Candour

The Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016 received Royal Assent on 1 April 2016 and introduced a new organisational duty of candour on health, care and

social work services. The implementation date for the duty of candour to come into effect is 1 April 2018.

The overall purpose of the new duty is to ensure that organisations are open, honest and supportive when there is an unexpected or unintended incident resulting in death or harm, as defined in the Act. This duty requires organisations to follow a duty of candour procedure which will include notifying the person affected, apologising and offering a meeting to give an account of what happened. The procedure will also require the organisation to review each incident and offer support to those affected (people who deliver and receive care).

During 2017/18 we will develop and implement new processes and procedures to ensure we are compliant with the duty of candour requirements from 1 April 2018.

Effective Care

NHS Lanarkshire is committed to ensuring that the most appropriate treatments, interventions, support and services will be provided at the right time to everyone who will benefit, and wasteful or harmful variation will be eradicated.

The Transforming Patient Safety & Quality of Care Strategy identifies the importance of providing accessible information on the quality of care (on a close to real time basis) that can support clinicians to focus their improvement activity and monitor the impact of changes made. During 2017/18, we will therefore continue to implement a programme of Quality Dashboard development at Site, Service and Specialty level ensuring data is being used to drive improvements in care over time.

We are committed to responding to key clinical priorities for quality improvement identified through internal and external audits and reviews. During 2017/18 we will further develop the process for review, evaluation & reporting of national and regional audit and benchmarking reports to include systematic follow up and reporting of action plans. This will be reported and monitored through the appropriate governance groups.

We have agreed specific targets at an organisational level which will continue to be monitored on a regular basis by the Healthcare Quality Assurance and Improvement Committee. These include:

- increase the % of patients who require Haemodialysis who have AV fistula for vascular access (ref annual Renal Registry Report);
- improve compliance with the standard of 80% of patients undergoing carotid intervention within 14 days of CVA with symptomatic carotid stenosis (ref annual Stroke Audit).

We will work with clinical services during 2017/18 to identify further organisational priorities and monitor these as described above.

Prescribing Quality and Efficiency

NHS Lanarkshire has the highest cost per patient for prescribing for primary care in Scotland. There is no comparative data for secondary care; however we know that there are opportunities for more cost-effective prescribing in secondary care and that choices made by hospital clinicians have a direct influence on primary care prescribing.

A Prescribing Quality and Efficiency Programme was established in 2016 as an improvement programme to ensure that clinicians support patients receiving seamless, high quality health care in both hospital and community settings by prescribing in the most safe, person-centred and cost-effective way.

The programme will continue in 2017/18 with a focus on quality and efficiency across the themes of harm, variation and waste. Three high level priority areas have been identified:

- Harm – Polypharmacy;
- Variation – Use of analgesics;
- Waste – Management of repeat prescribing.

Infrastructure

Building organisational capacity and capability in quality improvement is seen as a key priority in order to deliver continuous quality improvement. In 2017/18 we will continue to implement the Quality Improvement Capability and Capacity Building Plan 2014-2019 to:

- develop a QI Knowledge and Skills Framework based on the following levels:
  - Delivering (Frontline staff);
  - Driving (Middle Managers);
  - Directing (Senior Managers and Board;
  - QI Support Team;
- undertake a diagnostic and planning exercise to establish an optimum model for a Quality Improvement support team incorporating large complex improvement and smaller local improvement;
- develop and implement a programme of dedicated capacity and capability building events in patient safety and quality improvement.

5 PERSON CENTRED CARE

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

Governance Committee(s): HQAIC

The NHS Lanarkshire Person-Centred Care strategic aim is that person-centred care is a central component in improving health and care services. This will be demonstrated in the way that services are designed and delivered so that:

- People have a positive experience of care and get the outcomes they expect;
- Staff are valued and supported to work collaboratively;
- People are empowered to be active partners in their care.

Person-centred approaches to care and support will be developed, tested and implemented across health and care settings to achieve this. We will achieve this by enabling and empowering our patients, their carers and families to share their experiences with us so that we can listen, learn and act. Examples of these approaches include:

- Solicited feedback experience programmes (at point of care and following discharge);
- Unsolicited mechanisms such as NHS Complaints Handling Procedure, Patient Opinion and comment cards.

Public engagement to involve people in service design and improvement will be achieved through the NHS Lanarkshire Public Reference Forum and the North & South Lanarkshire PPF.

NHS Lanarkshire acute hospitals signed up to John's Campaign during 2016; our community hospitals will sign-up to the campaign, make their pledges and implement associated visiting access during 2017/18.

NHS Lanarkshire will develop approaches and initiatives for the '*What Matters to You? Day 2017* on 6th June to engage with and support patients, carers and their families.

NHS Lanarkshire will continue to work with Healthcare Improvement Scotland to identify and drive improvements in person-centred care through targeted activities and share learning with other Health Boards.

6 LDP STANDARDS

For 2017/18, the previous 21 Standards with 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 29.9% 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	29.9%

Detect Cancer Early - Stage One					
	Baseline **2010/11**	**Year 1** **2011/12**	**Year 2** **2012/13**	**Year 3** **2013/14**	**Year 4** **2014/15**
Breast	37.9%	40.1%	36.5%	39.7%	41.4%
Colorectal	19.4%	19.0%	18.7%	16.4%	15.2%
Lung	14.9%	18.0%	17.3%	16.6%	18.6%
Combined - Breast, Colorectal & Lung	23.9%	26.1%	24.5%	24.8%	25.7%

Year 1 combined % shows a 9.1% increase from baseline data
Year 2 combined % shows a 2.4% increase from baseline data
Year 3 combined % shows a 3.6% increase from baseline data
Year 4 combined % shows a 7.4% increase from baseline data

NHS Lanarkshire target is 29.9%

Risks:

As at December 2015, the original end point for this Standard, Lanarkshire had achieved 25.7% against our target of 29.9%, thus demonstrating an increase of 7.4% from the initial baseline data 2010/11 year-on-year.

Within the Acute Division, i.e., in terms of actual diagnostics, this would not be affected by the 2017/18 CRES plan.

However, in Public Health, and now working in partnership with the recently appointed Cancer Research UK Facilitator for Lanarkshire, there is the opportunity to raise awareness of cancer prevention and early detection through structured learning sessions and resources available to help facilitate primary and secondary care interface. The facilitator role will enhance any current, or introduce novel, methods that would target reducing any barriers identified, aiming to increasing uptake within screening and incorporate the use of Clinical Decision Support Tools into Cancer Safety Netting guidance and training. 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 where the intervention and support from the Cancer Research UK Facilitator will be valuable. CRES savings and utilisation of ‘Teachable moments’ to promote Healthy Lifestyles within Clinical Teams 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.

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.

2017/18	95%

Risks:

This would not be affected by the 2017/18 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.

2017/18	95%

Risks:

This would not be affected by the 2017/18 CRES plan.

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

Lead: **J Hewitt, Chief Officer, North H&SCP**
R McGuffie, Head of Planning, Performance & Quality Assurance. 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.

Work is ongoing nationally in relation to this, latest position is reflected in the 'Risks' section below.

Risks:

There are still lengthy waiting lists for Post Diagnostic Support. A number of novel approaches and very dedicated work within community mental health teams and within Alzheimer's Scotland link workers has resulted in a lower rise in the number waiting that

expected. There are 1,859 people currently receiving PDS, however there are still 332 people yet to have their first contact, and 67% of these have been waiting for over 3 months. This is a progressive condition with a limited window in which to plan ahead and this number is still too high. Locally, it is planned to further extend our investigation of innovative approaches through pilots looking at trialling different models of PDS support, using more person centred approaches, and also consideration of primary care based link workers. It is unlikely, however, that such approaches will solve the waiting list issue.

An ISD incidence report published in December 2016, to which NHS Lanarkshire contributed, has highlighted that the previous calculations used by ISD to predict demand for PDS were flawed. It is apparent that people are diagnosed later in their illness than previously thought, meaning that prevalence figures include more people with advanced disease who will die, and a higher incidence of those newly diagnosed. As we now have data on incidence rather than just prevalence, we now know that this shows the diagnosed incidence per year to approach 2,000 rather than 1,100. This explains why local services have been unable to meet the expected demand, and ties in closely with the above figures on waiting lists. This figure is projected to increase annually and as it is drawn partly from local data can be viewed as more reliable.

The first national performance data was due to be published on 24 January 2017 but is still awaited. As this data reflects the first year of the target / standard then the picture is likely to be more positive than the data will be for the following year.

There are now quarterly national meetings for PDS leads to examine best practice and discuss with Scottish Government. As part of this there are ongoing efforts from ISD to change the spreadsheet feedback to be more useful to the leads for PSD, and a quality framework is being constructed to ensure that the PDS is meeting people's needs. A new national network has been set up for front line PDS staff, focusing on best practice and peer support.

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.

2017/18	100%

Risks:

During 2016/17 we have reduced our proportion of spend in the independent sector, however, this target is likely to be negatively impacted by the 2017/18 CRES plan. We are starting 2017/18 in a significantly more challenging position than 2016/17. 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.

2017/18	90%

Risks:

This is likely to be negatively impacted by the 2017/18 CRES plan. Further detail is currently being assessed on a specialty by specialty basis. We are starting 2017/18 in a significantly more challenging position than 2016/17. 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.

2017/18	95%

Risks:

This is likely to be negatively impacted by the 2017/18 CRES plan. Further detail is currently being assessed on a specialty by specialty basis. We are starting 2017/18 in a significantly more challenging position than 2016/17. 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: **H Knox, Director, Acute Services**
L Clyde, Head of Midwifery / Operational Services Manager - Women's Services

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.

2017/18	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.

2017/18	90%

Risks:

NHSL's funding for 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 achieving the target.

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

Lead: **J Hewitt, Chief Officer, North H&SCP**
R McGuffie, Head of Planning, Performance & Quality Assurance, 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.

2017/18	90%

Risks:

Referrals to tier 3 Locality CAMHS Teams rose by 23% in 2016 over 2015. Whilst there have been a number of helpful fixed term funding streams from Scottish Government in the last year, a number are for early intervention and not direct RTT work. NHSL CAMHS are vying with other Boards in a small workforce pool, making recruitment challenging. Since December 2016, additional evening clinics have supported the service to remain above the 90% target, which will now continue into 2017/18.

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

Lead: **J Hewitt, Chief Officer, North H&SCP**
R McGuffie, Head of Planning, Performance & Quality Assurance, 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.

2017/18	90%

Risks:

In 2016, Psychological Services received an additional £428k (part year funding) from the Scottish Government to improve access to psychological therapies. This funding is specifically targeted at increasing the delivery of psychological therapies to those patient groups that had received limited access previously. This included, for example, patients with multi-morbid long term physical health conditions; neuropsychology; young onset dementia; liaison psychology to acute old age psychiatry; in-patient units; and LD CAMHS. In 2017/18, full year funding is £676k. Following comprehensive DCAQ in 2015/16, service models for psychological therapies have been re-focused upon matched, stepped-care interventions through Tier 1 to Tier 3. At the low-complexity, high-volume end of the spectrum, social prescribing, locality based open access stress control groups, and online cognitive behavioural therapy programmes are now widely used. IN turn, this enables services to better address the needs of Tier 3 patients presenting with more complex, serious and enduring mental health problems. Whilst referrals for psychological therapies continue to increase, it is anticipated that the additional Scottish Government funding will support continued delivery above the 90% threshold for the 18 week Referral to Treatment target.

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.

2017/18	0.32

Risks:

NHS Lanarkshire has a comprehensive programme of work in place to prevent HAI and to monitor performance closely. We expect that 2017/18 will present challenges as in previous years, and will respond to these promptly taking whatever action is deemed appropriate.

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.

2017/18	0.24

Risks:

NHS Lanarkshire has a comprehensive programme of work in place to prevent HAI and to monitor performance closely. We expect that 2017/18 will present challenges as in previous years, and will respond to these promptly taking whatever action is deemed appropriate.

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, Chief Officer, North H&SCP**
R McGuffie, Head of Planning, Performance & Quality Assurance, North H&SCP
V de Souza, Chief Officer, 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.

2017/18	90%

Risks:

Despite previous CRES savings, the service has been able to maintain strong performance against the waiting times target through revised assessment processes in recent years. Future CRES savings could impact on waiting times performance, but plans will be developed to mitigate in-year.

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, Chief Officer, North H&SCP**
R McGuffie, Head of Planning, Performance & Quality Assurance, North H&SCP

V de Souza, Chief Officer, 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.

2017/18	7,381

Risks:

Numbers to be achieved in 2017/18 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. Performance against the target has remained strong in Lanarkshire, however, the reduction of the Keep Well service poses a risk as the service was a strong contributor towards the target. Plans are being 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, Chief Officer, North H&SCP**
R McGuffie, Head of Planning, Performance & Quality Assurance, North H&SCP
V de Souza, Chief Officer, 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.

2017/18	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:

Based on Scottish Government guidance our understanding is the number of 12 week quits required will remain at the 2016/17 level of 1,411, which was a 26% increase from 2015/16. In 2016/17, NHS Lanarkshire agreed a reduced target of 1,220 12 week quits.

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, more recent data suggests this trend may be slowing. Although this is really welcomed there is no evidence to strongly argue that a leveling of the trend will continue in future years. More 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. Locally there has been a 2% decrease in footfall, against a national trend of a 5% annual reduction. The rise in the use of electronic cigarettes to help quitting may have contributed to this change.

The reduction in overall smoking prevention and cessation monies has resulted in efficiencies in programme delivery. Reductions have been made in areas that 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 to maintain performance at the same level as 2016/17. If, however, further reductions are applied to the budget for 2017/18 then this position may need to be revised.

Based on the conversion rate of footfall to quits in the first three quarters, the service is on track to meet the amended target agreed for 2016/17 of 1,220. We would therefore propose to continue in 2017/18 with the target agreed for 2016/17, 1,220 (305 per quarter).

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

Lead: **V de Souza, Chief Officer, 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 most recent results for 2015/16 published in May 2016. The questionnaire asks about experiences 'within the last 12 months'. The next survey is expected to be conducted in 2017/18 with results published in spring 2018.

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 are noted in sections 2.1 and 2.2 of this LDP, and would be expected 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.

2017/18	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
V de Souza, 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 monthly, time lag 2 months.

2017/18	Standard	Stretch
	95%	98%

Risks:

This may be affected by the 2017/18 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. Our focus is to sustain the improvements we have made in this area.

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 (7) below.

Risks: Details covered in separate LDP Financial Plan.

7 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.

In 2017/18, £13.4m of new resources will be invested in social care to fund policy initiatives such as the living wage and support for carers and veterans. It is expected that approximately £4.4m of new money will be made available in-year for transforming primary care and for enhancing mental health services, health visiting and family nurse practitioners. The Board will make available funding to support a national agreement to increase funding for the Children's hospice, for a range of national specialist services, and for the full year effect of the robotic prostatectomy service in Glasgow.

For all other services, the overall funding available remains at the same level as in 2016/17. More cost effective ways of delivering services will have to be found in order to fund pay rises, the apprenticeship levy, new drugs, and supplies inflation. It is estimated that a minimum of £36.1m of efficiencies are needed to achieve this. A range of proposals have been worked up, but a further £6.6m will be needed in order to have a viable plan to breakeven. As well as the risk posed by starting the year with an unidentified gap, the ability to deliver the plan is dependent on a number of external factors such as the pace of introduction of new drugs and the availability of workforce, with the rising cost of medical locums being a particular cost pressure.

During 2016/17, many services experienced rising demand, with the pressures in A & E departments, emergency admissions and the need for social care in particular making it very challenging to maintain performance levels. The extent to which 2017/18 finances are already stretched means there is no additional funding to set aside for any potential increase in demand in 2017/18. The Board needs to work closely with the Integrated Joint Boards in North and South Lanarkshire to find the most effective solutions to caring for people.

During 2016/17 additional funding was provided by SG and the Board to increase performance against access targets. The financial plan assumes the same level of funding will be available in 2017/18. Even with this, additional pressure means maintaining 16/17 performance levels will be challenging.

Looking forward, the Board is planning to reshape its services in line with its clinical strategy "Achieving Excellence" and the Integrated Joint Boards' commissioning plans. Finance will be a major constraint. With 0% funding uplifts forecast for 2018/19 and 2019/20, it is estimated at least a further £68m of efficiencies will be needed over these 2 years to fund inflationary cost rises.

The clinical strategy will shape the plans for replacing the ageing facilities at Monklands District General Hospital. Keeping the Monklands infrastructure functioning in the meantime will continue to be a major call on the Board's capital funding in the medium term. Other infrastructure projects in 2017/18 include replacing the cardiac catheterisation laboratory at Hairmyres, which provides cardiac reperfusion for Lanarkshire and Ayrshire, and potentially Dumfries and Galloway going forwards. The Laboratory information system needs replacing in 2017/18 and the Board is well advanced in plans to introduce electronic prescribing in its hospitals which should enhance quality and safety.

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
Everyone Matters: 2020 Workforce Vision Implementation Plan
Joint Strategic Commissioning Plans (North and South)
Procurement Strategy 2014
Children & Young People's Health Plan 2015-2018
Single Outcome Agreements – North & South CPPs
Achieving Excellence – NHS Lanarkshire's Clinical Strategy 2017