NHS LANARKSHIRE LOCAL DELIVERY PLAN 2013/14 – 2015/16

Contents:

1 INTRODUCTION

General

This is NHS Lanarkshire's eighth Local Delivery Plan, developed in line with Scottish Government Health Directorate (SGHD) guidance of 29 November 2012. It focuses on delivery of the four key objectives of Health Improvement, Efficiency, Access and Treatment. Also included are brief details of our contribution to local community planning partnerships to secure better outcomes through collaborative gain, a brief note of key workforce issues, and a summary of our financial plans that are submitted to Scottish Government as a separate element of the Local Delivery Plan.

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

- Delivery of the quality ambitions through our Strengthening Quality in Lanarkshire work programme (see below);
- Financial Plan, including Efficiency and Productivity work streams;
- Our Strategic Planning Framework *A Healthier Future;*
- Workforce development;
- National and regional service planning and development.

Quality Strategy and Quality Improvement

As part of *A Healthier Future*, NHS Lanarkshire is committed to establishing a quality driven organisation that delivers the quality ambitions of person centred, safe and effective care. These ambitions will be taken forward in 2013/14 as follows:

- Person centred care through the implementation of Person Centred Health & Care programme, using the feedback from the national Better Together surveys and our local patient experience indicators for learning, and through implementing the Patient Rights (Scotland) Act 2011 and the NHS Lanarkshire patient Focus and Public Involvement Strategy 2012-16;
- Safe care through reducing mortality and harm and the extension and continued implementation of the Scottish Patient Safety Programme. Also on-going reductions in preventable Healthcare Associated Infection and ensuring the protection of all vulnerable people whether adults or children;
- Effective care through the continued implementation of national standards, quality indicators and clinical audit with the aim of providing the right care and reducing variation.

A Healthier Future and the quality ambitions will be reflected in the NHS Lanarkshire workforce plan 2013, ensuring NHS Lanarkshire develops its staff to implement the 2020 vision. This will be progressed through and organisational development plan to achieve a culture supporting quality.

The NHS Lanarkshire Quality Hub will provide leadership and develop capacity and capability for quality improvement.

2 HEAT TARGETS

Targets are organised in the order Health Improvement, Efficiency, Access, and Treatment. For each target, a standard layout has been adopted which shows:

- The target description;
- Lead Executive Directors and managers;
- Associated performance measure(s);
- NHS Lanarkshire's planned performance trajectory;
- A risk narrative outlining key risks and how these will be managed under the four headings of Delivery & Improvement, Workforce, Finance, and Equalities.

Health Improvement:

To increase the proportion of people diagnosed and treated in the first stage of breast, colorectal and lung cancer by 25%, by 2014/15

Lead: **A Lawrie, Director, Acute Division**
H Kohli, Director of Public Health & Health Policy
H Ben Younes, Clinical Lead (Cancer)
M Mark, General Manager (Cancer)
R Garscadden, Head of Planning, Acute Division
M Kelly, Cancer Manager

Measure:

By December 2015, to achieve a 25% increase in those diagnosed in the first stage.

Trajectory:

2010/11	23.9%
2012/13	25%
2013/14	27%
2014/15	29%

Risk Narrative:

Delivery & Improvement

Risk	Management of Risk
Impact of social marketing campaign on demand including potential increase in incidental findings. Level of awareness and response from specific sections of the community to the benefits of early presentation. There are 'hard to reach' members of the public as reflected in recent screening uptakes. There is also the 'worried well'. Both will represent a major challenge. Ownership of the target by both Primary and Secondary Care with major input from Public Health. The impact on diagnostic services and in particular to CT, MRI, Ultrasound, Endoscopy and Mammography. Clarity on measurement of target	Detecting Cancer Earlier is managed through the NHSL Cancer Improvement Group chaired by the Lead Cancer Clinician with representation from Primary and Secondary Care, Public Health, Clinical Audit and Community Representation. The target is a whole system target and is reflected in the approach. A high level action plan has been prepared and accepted by NHSL. The Plan sets out six key work areas-Health Improvement, Primary Care Engagement, Screening Programmes, Data, Diagnostics and Treatment. There is work in progress to translate the Plan into an operational document to be progressed during 2013/14. This is being achieved through the individual tumour type groups (breast, colorectal and lung). Initial demand assumptions have been made which has informed an outline investment plan to respond to anticipated demand during 2013/14. This includes investment in diagnostics and surgical capacity. It will represent good practice to establish a mechanism for information capture and reporting that enables performance measurement of individual tumour types (breast, colorectal and

and effective mechanism for performance monitoring and reporting.	lung). Historically reporting has been on an aggregated basis. There is work in progress to achieve that. Activity baselines are being examined and as appropriate updated. Data definitions have been reviewed in conjunction with ISD. There is on-going discussion with Scottish Government on performance measurement to ensure clarity on information captured and reported. An initial review of cancer audit data processes, MDT working, data collection, data storage and extraction has been initiated. Investment has been agreed in Clinical Audit to facilitate that work.

Workforce

Risk	**Management of Risk**
Sourcing increased staffing capacity (with appropriate skills and competencies) to respond to anticipated increased activity. Respond to unplanned surges in demand.	It is intended to increase capacity during 2013/14 through improved efficiency and by recruitment of additional selected staff. There is on-going dialogue with staff to ensure understanding of direction of travel and priorities for each tumour type and their contribution to achieving progress and improvement. Staffs have been flexible and responsive to the increases in demand that have occurred as a consequence of screening. This will be a recurring feature (with further social marketing planned with unknown consequences) but will be assisted by the decision to appoint additional staff Additional diagnostic equipment has also been purchased to facilitate future diagnosis and treatment. Demand will be monitored on a routine basis. Employment and recruitment principles will be agreed with Partnership colleagues and will inform investment, recruitment and as appropriate service redesign and improvement.

Finance

Risk	**Management of Risk**
Impact of increased investigations, diagnosis of cancers at an earlier stage with improved survival rates resulting in increased follow up demand. It may also result in other incidental findings.	Scottish Government has released non-recurring monies over a three year period (commencing 2011/12) to the NHS Board to support delivery of the guarantee. Beyond 2015/16 the Scottish Government has indicated that recurring monies will be released. The non-recurring allocation has to date been used to respond to the increase in colorectal demand contributed to by the bowel screening programme. Further social marketing programmes are planned during calendar year 2013 that has the potential to further increase demand. The allocation will therefore in 2013/14 be used to increase diagnostic and surgical capacity through recruitment of additional staff and service redesign and improvement.

Access to capital monies to support procurement of medical and diagnostic equipment.	The NHS Board has in recent years invested considerable capital sums to refresh and add to the range and type of equipment to support diagnosis and treatment. That approach will as required continue.

Equalities

Risk	**Management of Risk**
Access to socially deprived areas where uptake and response is routinely low. Avoid further widening of health inequalities.	Recent uptake of the bowel cancer screening programme in Lanarkshire is low. Further initiatives are planned during 2013/14 to increase awareness amongst those sections of the population that historically have proved hard to reach.

Health Improvement:

At least 80% of pregnant women in each SIMD quintile will have booked for antenatal care by the 12th week of gestation by March 2015 so as to ensure improvements in breastfeeding rates and other important health behaviours.

Lead: **R Lyness, Director, NMAHPs**
S Stewart. Associate Director, N&M

Measure:

The national target is for at least 80% of pregnant woman in each SIMD quintile to have booked for antenatal care by the 12th week of gestation by March 2015. NHS Scotland will be judged on performance against the national target.

The denominator is all women who give birth in Scottish Hospitals.

Boards have already submitted 3-year trajectories for antenatal care bookings. The second and third years of those trajectories (2013/14 and 2014/15) have been included in this LDP, along with the percentage of women booked for antenatal care by the 12th week of gestation in the lowest performing SIMD quintile during 2010/11 financial year.

For Board level SIMD quintiles, the datazones in each board are to be divided into five groups according to SIMD 2009 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 2009 quintiles and may therefore show inconsistent results with the Board level results, which group datazones by local quintiles.

The target can be considered to be met if Scotland-level performance is at or above 80%.

An updated SIMD 2012 is due to be published in December 2012. Following this, future updates will be aligned with the newer SIMD. The impact of switching from SIMD 2009 to SIMD 2012 on NHS Board-level results is anticipated to be minimal. However, Boards will be kept informed as this work develops.

Trajectory:

2010	70.2%
Apr-Jun 13	78%
Jul-Sep 13	78%
Oct-Dec 13	79%
Jan-Mar 14	79%
Apr-Jun 14	80%
Jul-Sep 14	80%
Oct–Dec 14	80%
Jan-Mar 15	80%

Risk Narrative:

Delivery & Improvement

Risk	Management of Risk
Organisation of services to ensure quality outcomes of HEAT target can be achieved.	A collaborative approach has been taken with the University of the West of Scotland to implement policies launched under the Best Possible Start (BPS) national framework. The BPS Programme Board is now in place and chaired by the Director of Nursing – Primary Care, which will lead strategy, service and workforce development. This group reports directly to the Child and Maternity Service Improvement Board, which is key in ensuring that all aspects of Children / Maternity services work is driven forward. Planning group infrastructure has been established in recognition of the key themes within the Refreshed Framework for maternity Care, i.e., Workforce Development, Pathways of Care, e0Health and Data Collection. A further planning group on Evaluation and Research has been established and is an addendum to the NHSL/UWS collaborative agreement. Each of the groups, which were established in September 2012, is reviewing current service provision, systems, processes and practice within their remit to ensure the required quality improvements are made in the context of the Programme. A Programme Manager has been appointed to support programme delivery and implementation plans have been developed across all planning groups that are overseen by the Programme Board. A GP Champion has been appointed to the programme to support a range of key deliverable areas including promoting the midwife as 'first point of contact' for early access to maternity Care. Both multi-disciplinary and multi-agency support has been sought in promoting the early access HEAT target and particularly to our most vulnerable groups of women across NHSL in the form of SBAR communication. BPS communication plan will continue to renew and refresh a consistent message to promote early access to antenatal care.
Ensuring women engage with maternity services early in pregnancy.	Implementation of Keeping Childbirth Natural and Dynamic within NHS Lanarkshire has influenced the promotion of systems and processes for the midwife to be the first point of contact for women accessing maternity services. Local data suggests however that the most vulnerable women are less likely to attend for care early in pregnancy. A national social marketing campaign by NHS Health Scotland was launched in 2011 advising women to access their local midwife as early as possible. However, this did not evaluate well and a local awareness raising and engagement campaign will be implemented January – March

	2013. This will include scoping of a central contact number / text service to expedite access to maternity care teams. Local processes ensure that timely booking appointments are arranged locally and quickly after women engage with maternity services. Work will be undertaken with GP practices / multi-disciplinary colleagues and multi-agency partners to ensure facilitated access for vulnerable groups of women within their service. Local insight / patient involvement work to explore the reasons why women do not engage early will be undertaken as part of the BPS communication plan.
Ensuring accurate data collection of quality outcomes achieved.	Implementation of the Scottish Women Held Maternity Record has provided a common data set for maternity services across Scotland. SMR and clinical dashboard data is currently collected manually from the paper record as NHS Lanarkshire does not currently have an electronic patient records system within maternity services. A backlog of data has resulted in a local action plan to support reporting of contemporary data by ISD. Implementation of this HEAT target will require more extensive data collection which will necessitate implementation of an electronic patient record. BPS e-Health group has led a scoping exercise of electronic maternity / neonatal systems during September – December 2012 to include maternity TRAK, BADGER and MIDIS systems. A draft system service specification is in place and a consultation period is underway with key stakeholders, to be concluded in January 2013. The procurement process will commence March 2013. The proposed maternity system specification includes an interface requirement with: • TRAK patient management system; • MIDIS public health nursing system; • BADGER system, which will be implemented within neonatal services by March 2013.

Workforce

Risk	**Management of Risk**
Ensuring that a sustainable medical, midwifery and public health nursing workforce is in place to deliver quality outcomes.	The BPS workforce development group has conducted an analysis of current midwife / neonatal nursing and public health nursing workforce profiles using six steps methodology to integrate workforce planning. The group has also explored universal patient pathway provision in the context of workforce requirements for the future and will make workforce modernisation recommendations that ensure a sustainable workforce for the future including potential introduction of new roles. Skill mix and new ways of working across acute and primary care services including interface with multi-agency partners. A

	training needs analysis of the Best Possible Start workforce is currently underway via University of the West of Scotland and will be concluded March 2013. A workforce development programme will be put in place to support TNA outcome analysis.
Need to ensure workforce have the necessary skills and knowledge to ensure quality outcomes achieved.	The TNA will inform educational needs and priorities across the workforce. A comprehensive risk assessment is currently undertaken by midwives at time of booking for maternity care which takes account of clinical risk as well as health and social needs of individuals. A person centred care approach is also being taken to apply a strengths and asset based approach to behavioural change. GIRFEC training has been completed by community midwives with subsequent practice implementation and is currently being rolled out across acute services provision to ensure both a consistent and consolidated approach to care provision to achieve improved outcomes.

Finance

Risk	**Management of Risk**
Identification of resources to purchase and support an electronic patient record system in maternity services.	This has been identified within the e-health strategy with a proposed date of implementation of 2013/14.
Continued efficiency savings required within midwifery and public health nursing against a need to create additional capacity to ensure quality outcomes are achieved.	Current workforce capacity and working practices are currently being reviewed by the patient pathway and workforce development group including a significant review of antenatal and universal child and family pathways with an application of LEAN methodology to ensure maximum efficiency is achieved. There is a risk that additional resource may be required as a result of this review as well as national policy influence. Skill mix and workplans are being reviewed.

Equalities

Risk	**Management of Risk**
Women in most vulnerable groups may not engage with maternity services in early pregnancy to ensure quality outcomes are met.	In terms of health and social needs assessment specific areas of work have been undertaken within maternity services and public health nursing in relation to drug and alcohol abuse, gender based violence, smoking cessation, maternal and infant nutrition and teenage pregnancy. These targeted pieces of work have resulted in a variety of outcomes including development of specialist services for the most vulnerable. Best Possible Start will oversee implementation of the Family Nurse programme across NHSL, which will target first time young mothers up to 19 years of age and one of our most vulnerable antenatal groups of women. A referral process to the programme will be established across multi-

	disciplinary / agency partnerships as well as within maternity services and primary care to expedite access to maternity care early. The First Steps programme has also been rolled out into North Lanarkshire. A First Steps support worker is aligned to the public health nursing teams and will provide 1:1 support using asset based approach to behavioural change during pregnancy and also in the post natal period to first time mums who fit defined criteria in relation to vulnerability. Midwives will refer women to the programme and the midwife, First Steps worker and public health nurse will develop a plan with the woman based on her individual need in order to maximise parenting capacity. First Steps will also support BPS local leadership midwives in local 'insight work' with vulnerable women to understand some of the barriers and challenges they experience in the context of early engagement to services. GIRFEC assessment documentation will be used by the midwife at booking to identify additional needs at the earliest opportunity, to work with families to assess parenting capacity focussing on the wellbeing indicators for the child and to obtain additional support as necessary. The maternity dashboard will be further developed to host a range of BPS equality outcome indicators. The Programme will fund the secondment of a clinical quality facilitator to support this work from January 2013.

Health Improvement:

At least 60% of three and four year olds in each SIMD quintile to receive at least two applications of fluoride varnish (FV) per year by March 2014

Lead: **K Small, Director, CHP South**
H Kohli, Director of Public Health
M Devine, Head of Salaried Dental Service
A Yeung, Consultant in Dental Public Health
C Cunningham, Head of Planning & Performance, CHP South

Measure:

The HEAT performance measure separately asks whether all children who were 3 years old one year ago had two varnishings in the intervening 12 months and whether all children who were 4 years old one year ago had two varnishings in the intervening 12 months. It will report the performance of the worst performing age and SIMD 2009 quintile combination. Thus, if the performance of the worst performing age/SIMD 2009 quintile is above 60% then the performance of every other age/SIMD 2009 quintile combination must be above 60% and the target will have been delivered.

The intervention will be delivered via primary dental care services twice yearly, with a further two applications of fluoride varnish available to those children attending designated nurseries (which have a majority of enrolled children residing in the lowest SIMD quintile in each NHS Board).

The measure will be defined as follows:

The datazones in each Board are to be divided into five groups according to SIMD 2009 rank. The allocation of datazones to quintiles within NHS Boards is given in column G of the Health Board (SIMD) tab of the spreadsheet at:

www.scotland.gov.uk/Topics/Statistics/SIMD/localHBquin09

For each group the following should be calculated:

3-year-olds
Numerator - number of children who were 3 years old (i.e., who have reached their 3rd birthday) one year ago and who received two or more FV applications in the intervening 12 months.
Denominator – closest NRS mid year estimates for the number of 3-year-old children one year ago.

4-year-olds
Numerator - number of children who were 4 years old (i.e. who have reached their 4th birthday) one year ago and who received two or more FV applications in the intervening 12 months.
Denominator – closest NRS mid year estimates for the number of 4-year-old children one year ago.

Performance should be calculated for each of the ten age–quintile combinations 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 2009 quintiles and may therefore show inconsistent results

with the Board level results, which group datazones by local quintiles. The target can be considered to be met if Scotland-level performance is at or above 60%.

Boards have already submitted 3-year trajectories for percentage of children receiving at least two applications of FV. The final year of these trajectories (2013/14) has been included in this LDP, along with % of children receiving at least two applications in the 12 months to March 2012.

An updated SIMD 2012 is due to be published in December 2012. Following this, future updates will be aligned with the newer SIMD. The impact of switching from SIMD 2009 to SIMD 2012 on NHS Boards level results is anticipated to be minimal. However, boards will be kept informed as this work develops.

Trajectory:

Mar 12	4.7%
Jun 13	35%
Sep 13	45%
Dec 13	55%
Mar 14	60%

Risk Narrative:

Delivery & Improvement

Risk	Management of Risk
Consent – failure to obtain consent for Toothbrushing Programme of FVA programme	Formal consent process adopted in NHSL complies with national guidance. Cannot deliver fluoride varnish applications or toothbrushing to children unless parents give informed consent. Changes at national level have made the process form obtaining consent simpler in that once consent is obtained it remains active for the time the child is in any given establishment.
Ensuring GDPs apply fluoride varnish as part of Childsmile Practice.	GDPs are independent contractors and so not directly managed by NHS Lanarkshire. Support and encouragement to apply fluoride varnish comes via the Childsmile Practice initiative. The Childsmile Team will continue to support and encourage practices to apply fluoride varnish, and will encourage new practices to join Childsmile Practice while working to retain those already participating. Changes to the payment system for GDPs means that FVA is now included in the Statement of Dental Remuneration so dentists are paid via their monthly schedules for any FVAs they carry out. By streamlining the paperwork it has made it easier for GDPs to get paid for taking part in the FVA programme.
Adverse Weather	If required, additional staff will be called upon (hygienists and salaried dentists) to deliver FVA a period of intense 'catch up' activity.

Supplies of Fluoride Varnish	Currently there are no supply problems but this position could change and would affect delivery of the target. The product has a shelf life of two years so it is our intention to build up a reserve store of the product.

Workforce

Risk	Management of Risk
Absence of all types but particularly Maternity Leave	Existing staff members are all stretching themselves by taking on an increased number of establishments while colleagues are on maternity leave. DHSW have been redeployed from Toothbrushing programme into the FVA and additional admin support has been provided.

Finance

Risk	Management of Risk
Funding is tight as staff are now all getting to top of pay scales via incremental drift. Allocation based on 4th from top point of pay scales for each post. The annual allocation does not rise each year. So no contingency funding in place.	Sensible budget management combined with ongoing review of costs. Recognised need to reduce number or grade of posts over the next 2-3 years to achieve financial balance.

Equalities

Risk	Management of Risk
No significant risk. Programme is structured so that all children get access to some elements of Childsmile (Universal) but additional resources are targeted to the children living in the in the most deprived quintile.	Ensuring that the Childsmile Programme is delivered according to the National Requirements

Health Improvement:

To achieve 14,910 completed child healthy weight interventions over the three years ending March 2014

Lead: **C Sloey, Director, CHP North**
S Kerr, Head of Planning & Performance, CHP North
M Reid, Assistant Health Promotion Manager

Measure:

The performance measure is the number of children aged 2–15 years completing Scottish Government approved healthy weight intervention programmes over the period 2011/12 to 2013/14. Boards have already submitted 3-year trajectories for child healthy weight interventions. The final year of those trajectories (2013/14) has been included in this LDP, along with the number of interventions delivered during 2011/12 (the first year of the target).

There are several requirements underpinning this target (such as the requirement that 40% of Health Boards original targets should comprise children from the 40% most deprived within-Board SIMD areas) which are detailed in the guidance notes. In order for an intervention to count towards this HEAT target all requirements in the guidance should first be met.

Trajectories and the reporting of performance against them will remain based on total completed healthy weight interventions. The additional information on the proportion of interventions delivered in the most deprived areas will be published annually.

Trajectory:

Cumulative total

Apr 11 – Mar 12	1,140
Apr 11 – Jun 13	1,650
Apr 11 – Sep 13	1,650
Apr 11 – Dec 13	1,745
Apr 11 – Mar 14	1,745

Risk Narrative:

Delivery & Improvement

Risk	Management of Risk
Lack of engagement of children and their parents and carers in the interventions.	The initial 3 year H3 target has been used to refine the method of invite to the intervention, the language and approach that is used and the supporting literature for parents. Whole school and whole class interventions, which will operate within Tier 2 interventions in an integrated systems approach, allow both treatment and prevention interventions to be delivered and pre-engagement with target group families who will subsequently be invited to more specialist, but still Tier 2, community based family interventions. These large scale education programmes also raise awareness amongst families and partner

	organisations. Where appropriate pre-engagement strategies will be used with families to raise awareness of the programme and increase potential engagements. This includes utilising local partners, including Community Learning and Development and Integrated Children's Services Teams, whose existing relationships with families support identification, referral and engagement. Resources that were previously developed by NHS HS for parents, children and professionals and which aimed to raise awareness of issues around child healthy weight are being revised and updated to meet the current needs of the programme. Closer working links are being made with Locality HI staff, who will be offered Health Scotland Raising the Issue of Child Healthy Weight training. These staff will be engaged in delivering awareness raising sessions to NHSL and partner organisation staff. NHS HS is looking into launching a national social marketing campaign to support the identification of childhood overweight and the acceptance of engagement with interventions to address this.
The NHS Lanarkshire target is set at 1,745 completed interventions over 2011-2014.	During the previous H3 target period delivering effective interventions was of primary concern and in achieving the target, ensuring that the quality of the interventions was not compromised. Through this process NHSL developed a suite of interventions that both supported the initial H3 target but also exceeded the recommendations of the guidance. H3 guidance for the 2011-14 period has been revised and key requirements have been increased and extended. However, existing NHSL programmes already exceeded the new requirements and therefore, could be immediately delivered from the start of the new target period with few amendments. NHSL has set a front loaded trajectory to guard against future difficulties posing a risk to achieving the target. This has put pressure on the year 1 trajectory as a majority of the interventions will be delivered in the first year. However, lower quarterly targets in year 3 and the existing suite of programmes and infrastructure developments provide a delivery capacity that will allow NHSL to achieve the 3 year target. In addition NHSL has the capacity to allow the flexibility to increase delivery when required.

Identification of children that are over the 91st centile as routine recording of height and weight of children is only undertaken at P1 in the NHSL area.	NHS Lanarkshire will continue to deliver interventions with children identified via routine P1 child health surveillance. School based interventions incorporate BMI centile screening as standard practice and allow the identification of children with BMI above the 91st centile. NHSL is currently exploring the most appropriate methods to use school based interventions to refer and engage target group children in secondary community based family programmes. Discussions with NHSL departments and key partners in Education, Local Authorities, Leisure Trusts, Primary Care are underway to agree and implement additional referral and identification routes.
Identification and engagement of children from 2-5 years old and their families.	Revised H3 guidance has lowered the age of children eligible for CHW interventions to 2-5 years old. This lower age group will present some additional problems and considerable challenges in terms of identification, acceptance of the issue from parents and staff and engagement in effective evidence based interventions. There will be a requirement to work more closely with PHN teams in order to identify overweight and obesity in this age group and to deliver brief interventions and engagement work with families. Revision of HALL 4 may provide an opportunity to develop closer links with PHN teams to support this age group. The primary setting for this pre-school work will be within Nursery & Early Years establishments. Implementation of a CHW Intervention programme to support is currently being planned with Local HI staff, Education and Nursery staff.
Contributing to the evidence base of "what works" in Child Healthy Weight interventions, and in parallel delivery of completed interventions per the H3 guidance.	NHSL operates a variety of H3 delivery methodologies for different target groups, using multi-disciplinary staff across different settings, which offer a range of interventions designed to both meet the target and support the emerging evidence base. As NHSL already has a Child Healthy Weight Strategy we have endeavoured to ensure that the intervention delivery will meet with the strategy ambitions as far as possible. The other key elements of the strategy focus on the actions/interventions in the Early Years and with primary age children. It will be difficult to identify which inputs with children achieve the best and most sustainable outcomes. An evaluation and monitoring framework has been

	developed and will feed into the National Core Data Set in order to provide quality observations about inputs, processes, outputs and outcomes. The BMI data collected for all children will be fed into the Child Health Surveillance Programme – School System (CHSP-S). This will allow the impact of interventions to be determined within and across Health Boards using Business Objects Reports. The H3 interagency steering group, a sub group of the Child Health Weight Strategy Group, will ensure a synergy of aspirations and the greatest contribution to achieving the target as achievable. NHSL has been selected as a case study area for the National CHW evaluation, which will help to develop evidence in this area. Furthermore, PhD research has been commissioned through UWS that will focus on the impact and effectiveness of NHSL CHW Programmes.
There is potential that the identification, referral or intervention process could have a negative impact on the mental or emotional wellbeing of participants and their families.	The primary concern of the CHW interventions is to do no harm. Great care is taken to ensure that the process for identifying families, contacting them and engaging them in interventions is done sensitively and confidentially. Correspondence and conversations regarding the reasons for referral and potential implications of this process are cognisant of the potential negative impact they may have on participants. There is a clear effort to avoid participants believing that we are apportioning any blame of judgement and there is an understanding of participant's fears of being identified, labelled or stigmatized due to this process.
Increase in the prevalence of underweight children or eating disorders.	Monitoring of the impact of interventions, such as whole class group school-based services, on the weight status of underweight participants. No significant reductions in BMI centile have been identified in underweight participants to date and this monitoring process will continue.

Workforce

Risk	**Management of Risk**
Availability and capacity of suitably trained, multi-skilled staff to deliver the interventions as per the guidance.	A majority of delivery staff are employed through partners and therefore have no ongoing cost implications for NHSL. These staff have existing skills and competencies which support working on H3 programmes and receive additional CPD training by NHSL.

	New staff are regularly recruited to support the delivery of interventions and on-going workforce development is based on National Occupational Standards for overweight and obesity management staff. Community based family interventions utilise NHSL dieticians who deliver sessions on top of existing workloads.
Availability and capacity of staff (nursing or health care support) to identify children over 91st centile who are not in P1 and P7.	Capacity of staff within Public Health, Healthcare Support, Nutrition & Dietetics teams does not allow for significant involvement in programme delivery. There is however, scope to explore their roles and responsibilities, along with those of GPs, physiotherapy and paediatrics in terms of identification and referral of children and families.
Lack of support and buy in by the wider workforce involved with care of children due to attitudes and perceptions about a healthy child weight.	NHSL will continue to work more directly and actively to "raise the issue" of child weight with many staff groups, e.g., GPs, nurses, teachers. To this end, key H3 delivery staff and selected Unit HI staff will attend Raising the Issue of Child Healthy Weight. The Consultant Paediatrician will also support these efforts.

Finance

Risk	**Management of Risk**
Associated costs to deliver the volume of interventions as per the guidance.	NHSL has already achieved support from key partners either "in kind" or with actual costs associated with programme and resource development, training, delivery of the interventions and exit routes. To overcome the risks associated with any reduced allocation in year 3, the trajectory has been front loaded with reduced targets in years 2 and 3 being easier to achieve if the budget is reduced. Revised H3 guidance requires more robust monitoring and evaluation mechanisms resulting in additional associated costs. Additional funds have been provided by the SG to cover this. Intervention methodologies have been assessed to determine the most cost effective programmes. The least cost effective interventions have been phased out and this process will continue as further reductions in quarterly targets, due to the front loaded trajectory, take effect. The long term plan for financial sustainability is for interventions to become embedded in the education service and delivered by teachers with little input from, and therefore cost to, NHSL. To support this ambition, one teacher will be seconded from each Local authority within year 3.

Equalities

Risk	Management of Risk
While delivering Child Healthy Weight Intervention Programmes it is essential that they do not contribute to increasing the inequalities gap and that all children & families have equity of access.	Community based family programmes are run where there is demand and this is often in areas of high population density, regularly including areas of deprivation. Furthermore, sessions are run within areas that are easily accessible and on public transport routes. One of the H3 programmes, Fit Start, within the North CHP, operates only within data zones for children who are eligible for the lowest cost school breakfasts. Fit for School is the major strategic driver for the H3 target. The planned ongoing rollout of this programme is phased to cover all areas and is designed to ensure all schools in Lanarkshire have the opportunity to take part. There is a requirement within the CHW target 2011-14 for 40% of completed interventions to be with children from the bottom 2 quintiles of deprivation. This will, therefore, determine the areas in which the programme is delivered and ensure equity of access for children and families from more deprived areas.

Health Improvement:

NHS Scotland to deliver universal smoking cessation services to achieve at least 80,000 successful quits (at one month post quit) including 48,000 in the 40% most deprived within-Board SIMD areas over the three years ending March 2014

Lead: **C Sloey, Director, CHP North**
H Kohli, Director of Public Health
S Kerr, Head of Planning & Performance, CHP North
G Docherty, Head of Health Promotion, North CHP / Smoking Cessation Manager

Measure:

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). NHSScotland to deliver 48,000 quits from April 2011 to March 2014.

Boards have already submitted 3-year trajectories for number of successful quits in the 40% most deprived datazones. The final year of these trajectories (2013/14) has been included in this LDP, along with the number of successful quits delivered during 2011/12 (the first year of the target).

An updated SIMD 2012 is due to be published in December 2012. Following this, future updates will be aligned with the newer SIMD. The impact of switching from SIMD 2009 to SIMD 2012 on NHS Boards level results is anticipated to be minimal. However, boards will be kept informed as this work develops.

Trajectory:

Cumulative total

Apr 11 – Mar 12	3,242
Apr 11 – Jun 13	4,447
Apr 11 – Sep 13	4,941
Apr 11 – Dec 13	5,435
Apr 11 – Mar 14	5,929

Risk Narrative:

Delivery and Improvement

Risk	Management of Risk
NHS Lanarkshire continues to perform well against the target and has exceeded the trajectory for the first two quarters of 2012/13. Whilst overall performance of services has improved with increased quit rates for both community pharmacy and specialist services, returns received to date	The Lanarkshire Tobacco Control Strategy Cessation Action Plan includes a range of actions to increase both the reach and improve the quality of services provided. For 2013/14 key service developments to increase reach include the roll out of an Integrated Care Pathway for inpatients beyond the pilot site to all three acute hospitals and extending the opt-out pathway for pregnant

suggest a slight decline in throughput to services compared to the same period of the previous year. If this decline continues into the third year of the target this may present a risk for delivery.	women to all localities. Awareness of training sessions have also been delivered to over 800 staff members across a range of disciplines and agencies. CHP unit Health Improvement Plans outline local partnership actions being taken forward between cessation services, Unit Health Improvement Teams, primary care teams and wider community planning partners to promote cessation services. These plans are monitored quarterly through the Performance Assessment Framework. A Communications Strategy has been developed to ensure the service is appropriately marketed and includes a campaign with Motherwell Football Club and utilising social media to promote cessation services. Opportunities to undertake communications work with neighbouring NHS Boards was initiated in 2012/13 with the Evening Times Clearing the Air campaign and further opportunities to work collaboratively will be taken forward in 2013/14. To increase reach and accessibility Lanarkshire Stop Smoking Service will also be piloting drop in clinics both in acute sites and in health centres in 2013/14.
Whilst there has been much improvement over the last year, there continue to be issues with pharmacy data in terms of quality of returns and forms not being returned within the required timeframe. This results in delayed and inaccurate reporting against the performance trajectory.	The return of pharmacy data has been centralised on to one site in order to monitor and manage MDS returns and data entry. This allows areas of concern to be identified promptly and mitigating action taken. An action plan has been implemented to triangulate pharmacy returns and outcomes against payment claims in order to target support to poorer performing pharmacies, particularly those in 40% SIMD most deprived. An ongoing programme of training is delivered to pharmacies in groups and individually and a good supportive relationship has developed between community pharmacy and the nurse led cessation services. NHS Lanarkshire is contributing to national plans for improving and simplifying data flows and payment systems for the Community Pharmacy Service, which will hopefully be adopted for 2013/14.
Many clients receive Varenicline through their GP but do not also attend the specialist service for	The pharmacotherapy support available to smokers through the nurse led service was extended in 2012 to include both dual NRT

behavioural support. These potential lost quits present a risk to the HEAT target.	therapy and Varenicline. Some pharmacies are also offering Varenicline. GP prescribing of Varencline and NRT has reduced in the first six months of 2012/13 compared to previous years and ongoing communications to GPs will continue to encourage referrals to specialist cessation services in line with national guidance.

Workforce

Risk	Management of Risk
Due to annual budget allocations and uncertainty regarding future funding there is an increased reliance on fixed term and sessional bank staff to support service delivery. Whilst this model provides increased flexibility this has resulted in a higher turnover of staff and vacancies and an increased requirement for sessional staff training and support.	A training plan has been developed for all staff and mentoring and shadowing arrangements are in place for sessional staff to ensure practice standards are maintained. Following the application of LEAN principles administration staff are supporting more frontline service delivery to ensure efficient use of staffing skill mix and reduce the requirement for sessional staff.
The current financial climate has led to necessary restrictions around recruitment processes which in turn limits opportunities for staff promotion and progression.	Where possible, the PDP process has been used to encourage job enrichment through providing staff with opportunities to be involved in specific service developments in addition to service delivery.
The capacity of the wider NHS workforce and community planning partners to support this workstream is reduced, particularly with respect to staff getting released for training.	Smoking cessation training has been reviewed to include shorter awareness sessions to impart simple key messages to staff and an e-learning module is under development and will be available by 2013/14. Unit Health Improvement teams are also supporting delivery of awareness and training through their wide networks with the statutory and third sector.

Finance

Risk	Management of Risk
Further reductions to the service budget as a result of Scottish Government or local efficiency savings will reduce available funding for effective promotion of services.	Work will continue with the Communications team, local partners, neighbouring Boards and the Scottish Government to maximise opportunities to work together to promote services.
Further reductions to the service budget as a result of efficiency savings will reduce opportunities for service developments.	The Lanarkshire Tobacco Control Strategy outlines the key service developments to be achieved over the next three years. Where resources are restrained a prioritisation exercise will be undertaken to identify which developments should be supported.
The cost effectiveness of the different smoking cessation services in terms of their contribution to	In line with the draft national Tobacco Control Strategy, a review is being undertaken of cessation services across Scotland and NHSL will

HEAT needs to be regularly reviewed and actions taken to mitigate unnecessary financial risks to the organisation.	consider the recommendations of this review for future service delivery models.
The availability of suitable community venues to run clinics may be reduced as a result of proposed Local Authority financial savings plans.	HEAT targets are reflected in local Community Plans and Single Outcome Agreements and there is partnership commitment to target delivery. In addition, other suitable premises have been identified for clinic delivery such as local Fire Stations and football clubs.

Equalities

Risk	**Management of Risk**
Cessation services may fail to meet the needs of the client group they serve and in particular smokers in SIMD 40% most deprived.	NHS Lanarkshire has always placed an increased focus on attracting and supporting smokers from deprived areas. Work will be undertaken to review current service delivery in line with the SIMD datazones recently released to ensure a targeted approach in the most deprived areas. Nurse led clinics are offered in a range of easily accessible venues including community centres, health centres and workplaces and at different times of day to accommodate shift workers or those with carer responsibilities. Pharmacies offer readily accessible cessation support across all areas of Lanarkshire, and targeted communication takes place with those pharmacies within SIMD 1 and 2 to highlight the value of their contribution to target delivery. Work is being undertaken during 2012/13 to review the services delivered from the user perspective in order to identify areas for improvement.
The Lanarkshire Tobacco Control Strategy and Action Plan highlights the need to increase service reach to specific target groups including young people, older people, mental health patients, pregnant smokers, ethnic minority groups, LGBT population, people with disabilities, prisoners, and people experiencing homelessness. Cessation services may fail to meet the needs of these groups due to reduced capacity to develop targeted programmes of work.	Through working with existing services and client groups, opportunities have been sought to work differently and creatively to meet the needs of these groups, e.g., through training staff who work with these client groups, identifying champions within services to link with cessation services, and ensuring clear and consistent pathways are in place for clients to receive the support that meets their needs. During 2012/13 specific programmes of work have been developed for the LGBT population, mental health service users, young vulnerable first time mothers and prisoners. These programmes will be built upon during 2013/14 in line with the timescales outlined in the local Tobacco Control Strategy and Action Plan.

Health Improvement:

Reduce suicide rate between 2002 and 2013 by 20%

Lead: **C Sloey, Director, CHP North**
H Kohli, Director of Public Health
S Kerr, Head of Planning & Performance, CHP North
J Logan, Consultant in Public Health Medicine

Measure:

NHS Boards are not requested to supply trajectories.

The performance measure against the national target is the three-year centred moving average European age standardized suicide rate (updated annually by the Scottish Public Health Observatory). The target is for the 2011–2013 rate to be 20 per cent less than the 2002–2003 rate of 17.4 suicides per 100,000 population.

For the purposes of this performance measure, suicides are deaths as a result of intentional self-harm (ICD-9 codes E950-959; ICD-10 codes X60-X84 plus Y87.0) or an event of undetermined intent (ICD-9 codes E980-989; ICD-10 codes Y10-Y34 plus Y87.2).

NHS specific actions that contribute to the delivery of the target include:

- Discharge planning
- Brief interventions
- Front line training
- Response to depression, including Breathing Space phone line and rollout of psychological therapies
- Crisis management

Trajectory:

(There is no trajectory – see box above)

Risk Narrative:

Delivery & Improvement

Risk	Management of Risk
Ensure training is embedded in practice. Balancing the need to address the wider determinants of health and well-being and improving the service response when people require support.	Previous HEAT training target (H5) was complete December 2010. NHSL has met and continues to maintain and exceed this target with 61% (1381) of frontline staff trained as at 30th October 2012, exceeding the 50% (1160) target. A Lanarkshire Suicide and Assessment Treatment Pathway (SAT) has been developed to ensure a consistent approach to suicide assessment, referral, treatment and follow up is embedded in practice. The pathway has been designed, supportive guidance produced and a training programme developed. Supportive risk management tools are embedded with all ICP to make appropriate suicide prevention intervention

	practice the standard. Reaching A&E colleagues and GPs has remained a challenge however progress has been made. An on-line briefing resource has been launched and implemented via LearnPro. The evaluation of training and evaluation of the suicide assessment and treatment pathway (interim results) demonstrates that staff are more confident in the assessment and prevention of suicide, have improved attitudes towards those presenting with suicidal behaviour and are more likely to work within an evidenced based framework when working with people presenting with suicidal ideation. The extended CMHT services into the evening and weekends are supporting people at risk of suicide through this enhanced support in the community at these critical times. Systems have been improved for making most effective use of the learning from Critical Incident Reviews related to a number of issues including suicide. This has included the production of quarterly reports ensuring staff and key partners are aware of the key learning and the resultant supports and actions. A programme of reviewing and improving relevant policies and procedures related to suicide reduction has been undertaken. These include 'Observation Policy', 'Missing Person Policy' and 'Did Not Attend Policy'. An improved response to depression is being supported through the GMS contract, increasing access to psychological therapies programme, depression ICP and increased access to non-clinical intervention, i.e., Biblio-therapy via Lanarkshire libraries (15,000 resources borrowed per month), on-line support (element eLanarkshire Mental Health Resources www.element.org.uk receiving 2500 visits per month). An extensive programme of social prescribing 'Well Connected' was launched in February 2012 to improve access to benefit, welfare and debt advice; employment; leisure; learning; arts and culture; and volunteering opportunities. There is continued good partnership working with North and South Lanarkshire Councils who lead the Choose Life Strategic Implementation Groups across the prevention and care and treatment agenda.

	A short-life working group has been convened to improve the clinical responses to self-harm including assessment, follow up, treatment and case management. This is being led by a consultant psychiatrist, with the strong involvement of a senior GP and A&E clinicians and supported by Health Scotland and Choose Life. This work links into the wider prevention agenda via Choose Life. Significant progress has been made in integrating the wider prevention of mental ill-health, suicide and self-harm and promotion of well-being agenda in the High Level North and South Lanarkshire Health and Well-being Partnerships via representation at partnership meetings, and connecting with the existing performance management structures and integration with SOA and HEAT. Mental Health is visible in priorities such as early years, curriculum for excellence, equally well, healthy working lives, keep well, choose life, see me, community planning, regeneration, and the Lanarkshire Alcohol and Drug Partnership and recovery and social inclusion. Choose Life North Lanarkshire commissioned the University of Leeds to undertake an evaluation of the suicide prevention social marketing campaigns being delivered in North Lanarkshire. Interim results show an enhanced level of awareness of the Choose Life programme including how to support individuals and what supports are available in those localities were the activities were focused. Action is progressing through the learning. Performance of NHSL is only one contributing factor to the population suicide rate. Other key factors are the performance of local authorities, multi-agency partnerships, the Lanarkshire and Scottish economy, and wider social and cultural influences. We remain committed to partnership working via the North and South Lanarkshire Choose Life Partnership Groups, which Local Authorities lead on, supported by the National Implementation Support Team, which is increasingly focused on inequalities and high risk groups. There is strong evidence to suggest that Lanarkshire is being disproportionately negatively impacted upon due to the current economic climate which will have consequences for the health and well-being of the Lanarkshire population. However, every effort is being made to minimise this, through strong partnership working.

Workforce

Risk	Management of Risk
Sustaining suicide prevention activity.	North Lanarkshire and South Lanarkshire suicide prevention strategies and activity continues to be coordinated via the separate North Lanarkshire and South Lanarkshire Choose Life Implementation Groups (with NHSL active membership), led by local authorities and two local Choose Life Co-ordinators linking closely with NHS Health Scotland. Sustainability for on-going training is built into the NHS Lanarkshire Practice and Professional Development Team for STORM delivery. Choose Life, resourced by North and South Lanarkshire Councils, continue to provide and manage ASIST and safeTALK, with NHS Lanarkshire providing trainers in kind and benefiting from places on the courses. Uptake of training will continue to be monitored via current staff training database and performance management systems.

Finance

Risk	Management of Risk
Sustaining the necessary financial resources to support suicide prevention.	NHSL appreciates access to the nationally funded training for trainers programme and on-going support from NHS Health Scotland. NHSL has absorbed the costs of delivery through building the capacity for delivery of training into staff groups and using NHSL or partner venues for delivery. There are ongoing issues around backfilling staff in unplanned care settings. While NHSL endeavours to meet the cost from within its budget allocation, national consideration to these financial issues would be appreciated. Both North and South Lanarkshire Councils continued to allocate financial resources, which are no longer ring fenced since SOA (April 2008), to the North and South Lanarkshire Choose Life Steering Groups to support the delivery of the respective North and South Lanarkshire Choose Life Action Plans. Suicide prevention is embedded across the prevention, care and treatment agenda.

Equalities

Risk	Management of Risk
People from the 20% least affluent communities are seven times more likely to complete suicide than those from the 20% most affluent.	Interventions to address the wider determinants of health and well-being are supported through mental health and well-being being embedded within the Lanarkshire Equally Well Action Plan which aims to reduce health inequalities, with a focus on high risk groups and those living with deprivation. An extensive programme is underway to promote financial security and minimise the negative impact of the UK Welfare Reform and

	economic downturn. Targeted populations for mental health improvement have included: • People who are homeless; • Veterans; • Looked after and accommodated young people; • People who are unemployed or living with financial insecurity; • People living with long-term conditions; • People in prison; • Black and minority ethnic communities; • Keep Well (high risk populations); • Deprived communities.

Efficiency:

NHS Boards to operate within their agreed revenue resource limit; operate within their capital resource limit; meet their cash requirement.

Lead: L Ace, Director of Finance

Measure:

(Boards are not required to submit trajectories or risk narratives for the financial performance target as this will be covered in their financial plans – see section 5).

Efficiency:

NHS Scotland to reduce energy-based carbon emissions and to continue a reduction in energy consumption to contribute to the greenhouse gas emissions reduction targets set in the Climate Change (Scotland) Act 2009

Lead: **C Sloey, Director, CHP North**
D Browning, General Manager, Property & Support Services

Measure - CO_2:

NHS Scotland to reduce CO_2 emissions for oil, gas, butane and propane usage based on a national average year-on-year reduction of 3% each year up to and including 2014/15.

Percentage change on baseline 2009/10 eMART data, represented by tonnes of CO_2 and climatically adjusted.

For 2013–14 the performance measure will not apply to NHS24, NHS Education, NHS Health Scotland, NHS National Services, NHS Healthcare Improvement Scotland and Scottish Ambulance Service. All Boards, including those not covered by the target, should complete risk narratives for this target, stating what actions are being taken in this area.

This is an NHS Scotland target and an assessment of whether the target has been delivered will be made after 2014/15; progress will also be considered on an annual basis. At NHS Board level indicative trajectories are set out in this LDP, and these, alongside defined carbon-reduction projects, will be used to assess progress. Where the annual target is not achieved in the interim years, NHS Boards will require to demonstrate that they have plans in place that will ultimately achieve the 2014/15 target.

During 2013/14, a new target will be developed that will align HEAT measurement with the rest of the public sector, following the introduction of the Public Sector Sustainability Reporting (PSSR) Guidance for Public Bodies.

Trajectory:

2009/10	11,542
2011/12	11,474
2013/14	10,218
2014/15	9,911

Risk Narrative:

Delivery & Improvement

Risk	Management of Risk
Failure to achieve or adequately monitor performance.	Energy Audits carried out as part of the Carbon Trust / HFS audit programme have identified a number of energy efficiency projects that will result in a reduction in emissions in 2012/13 and further.
Staff Awareness Campaign fails to	A Communications Plan which is updated

deliver savings.	annually has been developed with key milestones for delivery of awareness material to all sites. Energy reports will be issued for all sites and energy consumption will be monitored with exceptions quickly identified and actioned for improvement.
Working with Local Authority and sustainability partnerships towards joint agreements on CO_2 reduction and the impact on operational practices within NHSL.	Signed addendum to Scotland's Climate Change Declaration with SLC. Fully participate in joint arrangements with the partnership including Grant Funding for low carbon vehicle procurement and ensure that they are compatible with the objectives of NHSL with regard to energy and CO_2 reduction measures.
Ensure that measurable reductions in CO_2 emissions are achieved.	NHSL will demonstrate achievements through reports issued from the monitoring and targeting database and eMART national reporting tool.
Defining the contribution that NHSL has on the environment and health of the general population.	The Good Corporate Citizenship Assessment Model (GCCAM) is a tool to be used by all Boards to enable them to become more sustainable. NHSL will produce an action plan by April 2013.

Workforce

Risk	Management of Risk
Failure of NHSL staff to engage with the energy awareness campaign.	League tables will be issued to all sites for performance comparison. Healthy Working Lives representatives will continue to support the initiatives identified and assist in delivery of the material at site level.

Finance

Risk	Management of Risk
Invest to save funding not allocated to fund future energy saving initiatives.	Alternative sources of funding to be identified, including CEEF, Carbon Reduction Programme and the Low Carbon Vehicle Procurement Schemes.

Equalities

Risk	Management of Risk
No risks identified as all NHSL staff will be expected to participate in energy saving and waste minimisation initiatives staff awareness campaign.	

Measure - Energy:

NHS Scotland to continue to reduce energy consumption based on a national average year-on-year energy efficiency target of 1% each year up to and including 2014/15. Percentage change on 2009/10 baseline climatically adjusted, represented by absolute energy values in GJ. For 2013–14 the performance measure will not apply to NHS24, NHS Education, NHS Health Scotland, NHS National Services, NHS Healthcare Improvement Scotland and Scottish Ambulance Service. All Boards, including those not covered by the target, should complete risk narratives for this target, stating what actions are being taken in this area. This is an NHS Scotland target and an assessment of whether the target has been delivered will be made after 2014/15; progress will also be considered on an annual basis. At NHS Board level indicative trajectories are set out in this LDP and these, alongside defined energy-reduction projects, will be used to assess progress. Where the annual target is not achieved in the interim years, NHS Boards will require to demonstrate that they have plans in place that will ultimately achieve the 2014/15 target. During 2013/14, a new target will be developed that will align HEAT measurement with the rest of the public sector, following the introduction of the Public Sector Sustainability Reporting (PSSR) Guidance for Public Bodies.

Trajectory:

2009/10	336,959
2011/12	337,381
2013/14	298,310
2014/15	289,347

Risk Narrative:

Delivery & Improvement

Risk	Management of Risk
Gas and electricity are currently procured centrally (Scottish Procurement) and as such contract rates are directly influenced by external factors. Electricity will be tendered by April 2012.	The monitoring and targeting database is used to validate the utility invoices prior to reporting for accuracy.
Invest to save funding not allocated to fund future energy saving initiatives.	Alternative sources of funding to be identified, including CEEF, Low Carbon Vehicle Procurement Schemes. Alternative sources of funding to be identified.
Ensure that measurable reductions in energy consumption- are achieved.	NHSL will demonstrate achievements through reports issued from the monitoring and targeting database and eMART national reporting tool.
Defining the contribution that NHSL has on the environment and health	The Good Corporate Citizenship Assessment Model (GCCAM) is a tool to be used by all Boards

of the general population.	to enable them to become more sustainable. NHSL will produce an action plan by April 2013.

Workforce

Risk	Management of Risk
Failure of NHSL staff to engage with the energy awareness campaign.	League tables will be issued to all sites for performance comparison. Healthy Working Lives representatives will continue to support the initiatives identified and assist in delivery of the material at site level.

Finance

Risk	Management of Risk
Gas and electricity are currently procured centrally (Scottish Procurement) and as such contract rates are directly influenced by external factors.	League tables will be issued to all sites for performance comparison and the possibility of prizes for sites meeting targets will be explored. Healthy Working Lives representatives will continue to support the initiatives identified and assist in delivery of the material at site level.
Invest to save funding not allocated to fund future energy saving initiatives.	Alternative sources of funding to be identified.

Equalities

Risk	Management of Risk
No risks identified as all NHSL staff will be expected to participate in energy saving and waste minimisation initiatives staff awareness campaign.	

Access:

Deliver faster access to mental health services by delivering 26 weeks referral to treatment for specialist Child and Adolescent Mental Health Services (CAMHS) services from March 2013; reducing to 18 weeks by December 2014; and 18 weeks referral to treatment for Psychological Therapies from December 2014.

Lead: **C Sloey, Director, CHP North**
S Kerr, Head of Planning, CHP North

CAMHS Measure:

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. The 90% tolerance attached to the target for January to March 2015 is provisional and will be reviewed prior to the issuing of the 2014/15 LDP Guidance in November 2013.

Where available, Boards have been provided with adjusted waiting times data for completed waits during July to September 2012. Should Boards achieve higher than 90% of patients seen within 18 weeks before January to March 2015, they should aim to maintain that higher rate. However, Boards will be held to account against the 90% rate, pending any review of that rate prior to next year's LDP Guidance.

CAMHS Trajectory:

Patients who started treatment within 18 weeks of referral:

Quarter of treatment	
Jul-Sep 12	89%
Apr-Jun 13	89%
Jul-Sep 13	89%
Oct-Dec 13	89%
Jan-Mar 14	90%
Apr-Jun 14	90%
Jul-Sep 14	90%
Oct-Dec 14	90%
Jan-Mar 15	90%

Risk Narrative:

Delivery & Improvement

Risk	Management of Risk
(HEAT target is 26 weeks by March 2013. 18 weeks will be introduced with Psychology target December 2014). Ability to meet target by due date.	The service is meeting 90% plus of patients RTT by 26 weeks consistently since ISD began reporting earlier this year. The use of MiLAN to track waiting times and to provide feedback to staff on activity performance has increased the

	focus on personal performance. On track to meet 26 weeks RTT by March 2013 and to meet under 18 weeks by December 2014. Cost pressures have been escalated to highlight the need for investment to bring the service up to 16.5 WTE per 100,000 population to address the need to provide services up to 18 years from December 2015. The impact of operational policy and referral criteria, along with increased capacity with the new North team is beginning to be realised. Waiting times across the board are now reduced to around 28 weeks from 52 weeks in August 2010. A Waiting List Initiative was underway from October 2011 to March 2012 to further close the gap. IT and ISD colleagues are progressing with the implementation of the waiting time and Psychological therapies data capture requirements. CAMHS are now on TrakCare. The service will require to continue to operate PiMS until migration to MiDIS can take place. Operation of two systems will be required to support clinical service delivery and New Ways Waiting Time information as no single system can deliver both.

Workforce

Risk	Management of Risk
CAMHS workforce is thin on the ground nationally and therefore issues of recruitment and retention may arise.	Intensive Home Treatment now operational and working to reduce under 18 admissions. The service will require significant investment to cover up to 18 years. There are issues in recruiting appropriately experienced staff. Early investment and recruitment would allow less experienced staff to be brought up to speed prior to moving to 18 years. A number of vacancies are being actively recruited to within both the locality and functional teams. Demand and Capacity issues remain significant and are subject to ongoing review. NDP funding being used to actively recruit intensive home treatment staff.

Finance

Risk	Management of Risk
Service is under funded to meet 18 weeks RTT. To make local target of 12 weeks referral to 1st Assessment would require investment of c £500,000.	Te need for investment to move to both 18 years and 18 weeks RTT is essential to meet these targets. This has been escalated to the Mental Health Service Improvement Board. NHS Lanarkshire has agreed to increase the funding into CAMHS services locally which will facilitate an increase in staff numbers, reorganisation of

	management structures, provide a one stop shop for referrals and expand the tier 2 service.

Equalities

Risk	Management of Risk
Inability to provide services up to 18th birthday.	The three teams will initially accept referrals to 18 for children still in school education from January 2013. Further investment will be required prior to moving up to 18 years. NHS Lanarkshire investment will increase staffing. To this end we will adopt a staged approach to 18th birthday delivery; all functional teams are currently accepting referrals to 18th birthday. Tier three teams will initially accept referrals to 18 for children still in school education. This will be reviewed in evaluation of the implementation of the recent review and investment in relation to any increase in demand.
Epidemiological studies suggest that there is a large unmet need which may surface over time, especially as access improves.	We will continue to skill mix where possible and work with partners to provide a multi-agency approach to meeting need within the community. Whilst additional resources may be a necessary part of the solution, we will continue to strive to release any potential in terms of improving productivity through some of the capacity planning measures described earlier. These will include referrals management, triage, service models, managing discharge effectively.

Psychological Therapies Measure:

90% of patients referred for Psychological Therapies are to start treatment within 18 weeks of referral. This is based on adjusted completed waits. The 90% tolerance attached to the target for January to March 2015 is provisional and will be reviewed prior to the issuing of the 2014/15 LDP Guidance in November 2013. Boards should use their local intelligence to complete target trajectories (up to 90% target for January to March 2015). Should Boards achieve higher than 90% of patients seen within 18 weeks before January to March 2015, they should aim to maintain that higher rate. However, boards will be held to account against the 90% rate, pending any review of that rate prior to next year's LDP Guidance.

Psychological Therapies Trajectory:

Patients who started treatment within 18 weeks of referral:

Quarter of treatment	
Jul-Sep 12	89%
Apr-Jun 13	95%
Jul-Sep 13	95%
Oct-Dec 13	96%
Jan-Mar 14	96%
Apr-Jun 14	97%
Jul-Sep 14	97%
Oct-Dec 14	98%
Jan-Mar 15	90%

Risk Narrative - Psychological Therapies:

Delivery & Improvement

Risk	Management of Risk
Challenge of meeting the HEAT target of 18 weeks referral to treatment by Dec 2014.	NHS Lanarkshire Psychological Services were reviewed and restructured in 2011. The Adult Psychological Therapies service is now locality-based, delivering a service based around the nine major townships / conurbations in Lanarkshire. A single point of access to a range of mental health expertise has facilitated a stepped-care model of service delivery, based on a tiered service. The Service is now operationally managed by the Head of Psychological Services, who took up post in May 2012. Investment in staffing, along with the transfer of primary care counselling services, has seen whole time equivalent clinical staff rise from 86.8 WTE in June 2011 to 117.5 WTE in December 2012.
Inability to capture and report accurate data to demonstrate progress towards target.	The Psychological Therapies Steering Group, chaired by the Head of Psychological Therapies, leads on setting interim waiting time targets. As

	at 30 November 2012, the longest wait from referral to appointment was 20 weeks (n=1), and only 4 referrals out of 1,476 had been waiting over 18 weeks (i.e., 0.003%). Standardised Referral Criteria have been developed for all Psychological Therapies Teams, consistent across Lanarkshire. These are being disseminated to GP and other referrers, along with details of services provided at different tiers. Development continues around Tier 1 group-based interventions for stress/anxiety and these are now being delivered across all localities. Work is underway to offer group-based interventions for mood-related mental health problems. Access to non-clinical intervention is being maximised via: Biblio-therapy through Lanarkshire libraries (15,000 resources borrowed since launch in 2010), on-line support (element eLanarkshire Mental health Resources www.element.org.uk, receiving 2,500 visits per month). An extensive programme of social prescribing 'Well Connected' was launched in February 2012 to improve access to benefit, welfare and debt advice; employment; leisure; learning; arts and culture; and volunteering opportunities. Work continues in the development and implementation of IT services to support (a) referral management – TrakCare; and (b) clinical management – MiDIS. These systems will support management of reporting of both adjusted and unadjusted waiting times, and will also facilitate the recording, analysis, and reporting of outcome data towards improving the quality of service provision.
Impact of economic downturn impacting on all tiers of service.	It is recognised that socio-economics do impact upon the incidence of mental health difficulties. Lanarkshire has a number of datazones falling within the 155 most deprived areas in Scotland (SIMD data). A DCAQ exercise is underway to examine the relationship between demand and capacity in 3 of the 9 localities. The data gathered from this exercise will inform decision making around future allocation of clinical resources within Psychological Services. Discussions continue with both North and South Local Authorities in working collaboratively on those issues known to have a negative impact on individuals (e.g., benefits, housing, employment, citizenship).

Workforce

Risk	**Management of Risk**
The target will only be met if there are appropriate levels of staff with	As highlighted above, investment in staffing has seen a significant decrease in waiting times across

suitable training, support and supervision.	all localities. Service development, with regards to training, supervision and consultancy, will maintain waiting times and improve service quality.

Finance

Risk	**Management of Risk**
NHS Lanarkshire has invested and supported the development of the service to meet the target despite the financial challenges facing the public sector.	Significant redesign of existing resource and additional investment has increased productivity and efficiency. This has contributed towards meeting the HEAT target and the anticipated additional demand across all tiers of service.

Equalities

Risk	**Management of Risk**
Service not accessible to all groups, particularly those experiencing highest degree of disadvantage or inequality.	Through restructuring of Psychological Services, psychological therapies are available from nine teams operating on a consistent and cohesive basis across Lanarkshire. In addition to individual group, and family-based interventions, the Service provides teaching, training and consultancy services to other professionals within Lanarkshire, in other agencies, and in academic settings.

Treatment appropriate to individuals:

Reduce the rate of emergency inpatient bed days for people aged 75 and over per 1,000 population, by at least 12% between 2009/10 and 2014/15.

Lead: **K Small, Director, CHP South**
C Cunningham, Head of Planning & Performance – CHP South

Measure:

Occupied emergency bed days, in general acute specialties, for patients aged 75+ per 1000 population aged 75+.

Boards have already submitted 3 year trajectories for 75+ emergency bed days. The second and third years of those trajectories (201314 and 2014/15) are in this LDP, along with the rate of emergency bed days for patients 75+ in 2011/12.

Whilst a 12% reduction will deliver appropriate performance across Scotland as a whole it is important that each NHS Board (and partnerships within that) set trajectories based on local demographic projections, which may differ from the Scotland-wide figure.

Trajectory:

Mar 10	5,068	Feb 14	4,373	Mar 15	4,097
Mar 11	4,728	Mar 14	4,361		
Mar 12	4,206	Apr 14	4,349		
Apr 13	4,628	May 14	4,337		
May 13	4,616	Jun 14	4,325		
Jun 13	4,603	Jul 14	4,190		
Jul 13	4,457	Aug 14	4,179		
Aug 13	4,445	Sep 14	4,167		
Sep 13	4,433	Oct 14	4,155		
Oct 13	4,421	Nov 14	4,144		
Nov 13	4,409	Dec 14	4,132		
Dec 13	4,397	Jan 15	4,120		
Jan 14	4,385	Feb 15	4,109		

Risk Narrative:

Delivery & Improvement

Risk	Management of Risk
Achievement of target is dependent on strong partnership working and cannot be met by NHSL alone. The Reshaping Care (Change Fund) process provides the base to take forward this work.	Both North and South Partnerships have robust governance arrangements in place and associated work streams which oversee the development of plans and respective spend against these. In taking forward the various initiatives associated with the respective work streams, it is anticipated that both Partnerships will utilise the full allocations in 2013/14 and be well placed to set out the future financial

	requirements for coming years. The Acute Operating Division of NHS Lanarkshire is a key partner on both Partnerships and respective senior clinicians are involved fully in the Change Fund process. Both Partnerships also include the independent care sector, third sector (voluntary groups) and also carers as integral members of the respective planning groups. PPFs are similarly represented. The overall goals of the Reshaping Care process could be described as: a) the elimination of any delays in the patient journey once clinically ready for discharge and that all community care assessments (CCAs) be undertaken in the home environment (or place of previous residence) thereby moving this process from an acute hospital environment; b) the establishment of specialist clinical and other support services in the community to allow assessment of patients in their own homes thereby precluding the need for hospital admission – where possible; A range of investments in community based services from the NHS, Social Work and Housing, as well as associated investment in the services provided by the Third and Independent Sectors have started to reduce the number of >75 bed days, thereby allowing a reduction in circa 200 institutional beds across NHS Lanarkshire. The resources released will be the primary source of funding into the community services once transitional funding via the Change Fund ceases. The main work areas are described below. **Hospital Discharge Arrangements** An Integrated Discharge Hub was established in Hairmyres Hospital and is working such that there has been a significant reduction in the numbers of patients awaiting homecare packages occupying beds on the acute hospital site. As well as the progress made in reducing home care delays, the hospital based social work staff have been freed up to assist in completion of CCA/AWI patients thereby resulting in a change in the number and complexity of these patients. A similar approach has now been adopted across

	the other 2 DGH sites. Work is ongoing in identifying the demand and capacity associated with the anticipated home care requests being generated from each hospital such that these can be base-lined and future revisions to such demand anticipated and funded accordingly. The proposal to extend the CARS (Community Assessment and Rehabilitation Services) teams across Lanarkshire (formerly ESR/RADAR/Rapid Response) to cover weekends has been approved. A similar demand and capacity process is ongoing with the CARS teams. It is recognised that these services will ultimately transfer to a community based model as part of the Integrated Community Support Teams (South)/ASSET Team (North) developments. A key bit of work over the coming 12 months will be to ensure close communication between the Hospital Discharge Group and the ICST/ASSET Groups to allow measured transition of activity from the current hospital based model to the proposed community based model of assessment, rehabilitation and on-going care. In support of both the Hospital Discharge and development of community services work streams, both Councils have invested in additional homecare staff to augment significant service re-design in implementing the 'Re-ablement' approach to all future assessments. **Development of Community Teams to Avoid Admission to/Support Earlier Discharge from Acute Hospitals** The ICST/ASSET Groups are developing community based models of assessment, rehabilitation and on-going care. They are assessing the most appropriate linkages between the role of the Geriatricians and the GPs as well as scoping up the various tasks that will be required of the team and the respective staffing to undertake this role. In the South, it is anticipated that the ICST model, having been successful in East Kilbride, will move to provide a similar service South Lanarkshire-wide. This will ensure close linkages with existing LTC Nursing and SWD re-ablement/home care teams and move the CHP towards the revised H&SCP management

	arrangements. In the North, the ASSET development will work across the Monklands/Cumbernauld area in the first instance. Provision has been made for both additional Out of Hours home-care and nursing staff to provide a response other than hospital admission during the traditional OOH period. It is anticipated that this service will operate in an integrated manner - ideally in advance of the peak winter period thereby assisting in the management of winter bed pressures. **Community Capacity Building** It is recognised that Community Capacity Building will be a key feature as part of the wider development of the Reshaping Care for Older People agenda. A range of core services, e.g., befriending, transport, café, can be provided in this manner as well as an extended range of services which can assist in supporting older people in their own homes. VASLan/VANLan (Voluntary Action South Lanarkshire/Voluntary Action North Lanarkshire) are the key linkages with the respective voluntary sectors and the CEOs from each are represented on the various governance groups and are co-signatories to the Change Fund submission(s). Given the nature of this work, it is anticipated that this workstream will take some time to develop fully. However, there is an argument that this workstream has the potential to make the biggest impact in terms of relieving pressure on both the statutory services in general and hospital/residential beds in particular. Further work is also required in linking the work of the enhanced Community Assessment/Rehab teams – as described above, with the potential inputs the voluntary/not for profit sector can provide. The Hospice sector is also looking to provide a 'hospice at home' scheme which could also augment the traditional community services. Work is also progressing in identifying opportunities to make better use of current day care facilities and how the Third Sector may similarly be involved in providing services from SWD premises. Similarly, scope exists for statutory services to utilise the range of other premises available in community settings to

	provide services traditionally provided from a hospital/residential setting. The Independent Sector is represented in the Reshaping Care agenda by Scottish Care. They are similarly assisting in developing innovative models of care and are represented on each of the main governance groups. North Lanarkshire is an Early Implementer Site for the National Community Care Outcomes Framework. Work is also currently ongoing looking at embedding an outcomes focus in assessment and care planning across North and South Lanarkshire partners. These measures will assist us in supporting greater numbers of older people with complex needs at home. Key principles of the management of long term conditions such as anticipatory care, supported self management and management of complex care needs have been embedded as part of the legacy of the LTC Collaborative Programme within NHS Lanarkshire The vital role of carers is recognised in achieving this target. Accordingly, Carers representatives feature at all levels of strategy development across the Partnerships.

Workforce

Risk	**Management of Risk**
Major cultural and organisational development challenges exist for staff in moving to a new model of working.	Joint HR groups have been established, involving Staff Side representatives as well as OD staff/HR staff from both Councils and NHSL. It is recognised that as we move to a community based model of care and the subsequent reduction in the reliance on hospital beds, so there will require to be the respective development of new skills and opportunities to ensure we can manage the transition smoothly. Both Councils similarly recognise the potential to move staff across the various organisations such that employment protection is maintained whilst creating new and innovative opportunities for staff.

Finance

Risk	**Management of Risk**
Ongoing costs associated with delivery.	Financial arrangements to support achievement of this target will be determined in partnership with local authorities. This is in the context of the medium term financial strategies agreed by

	the Partnerships, the increased investment in community nursing through the community nursing manpower plan and the alignment of nursing and home care services. Long term financial implications will also be set out in the Joint Commissioning Strategies of both Partnerships.

Equalities

Risk	**Management of Risk**
It is not anticipated that the delivery of the target could create unequal health outcomes for the six equalities groups, and/or for people living in socio-economic disadvantage.	Full Equality Impact Assessments will be undertaken for each of the main areas of work.

Treatment appropriate to individuals:

No people will wait more than 28 days to be discharged from hospital into a more appropriate care setting, once treatment is complete from April 2013; followed by a 14 day maximum wait from April 2015.

Lead: **K Small, Director, CHP South**
C Cunningham, Head of Planning & Performance, South CHP

Measure:

Quarterly census data on Delayed Discharge is published by ISD. This includes numbers of delayed discharges split by the time patients waited for a discharge into a more appropriate care setting, by NHS Board.

Boards have been provided with statistics on the number of people waiting more than 2 weeks (14 days) for discharge as at census night in October 2012.

Trajectory:

Census night	
Oct 12	57
Apr 13	53
Jul 13	49
Oct 13	45
Jan 14	40
Apr 14	35
Jul 14	30
Oct 14	20
Jan 15	10
Apr 15	0

Risk Narrative:

Delivery & Improvement

Risk	Management of Risk
Delivery of this target is dependent upon both the internal health pathway management leading to an agreed medical readiness date, and the ability to place patients within the agreed care setting without delay (e.g., Home Care, Care Homes). The management of patients within the AWI framework is also critically important. As such, there will be major emphasis on the shared ownership of this target between NHS Lanarkshire and the two Councils	A key plank of the Reshaping care for Older People agenda within NHS Lanarkshire is to maintain people within their own homes thereby reducing the reliance on traditional institutional care beds. Part of this process will be the identification and securing of suitable care packages at the earliest possible time, thereby reducing the number of delayed discharges. The actions described above can only happen if there is early and responsive access to community based health assessment and rehabilitation opportunities; homecare packages; funding for care home placements where appropriate; and full utilisation of all partners in

with the development of shared action plans with appropriate timescales to attain the in-year reductions necessary to fully achieve this target.	the future care delivery packages for older people – including the Third and Independent sectors. In this respect, much of the work described in the >75 bed days reduction is equally relevant to this target. NHS Lanarkshire will also use the findings of the QUEST report and associated action plan to seek to identify early opportunities to turn around/discharge patients who may otherwise have been admitted and subsequently end up as one of the delayed discharge patients as a result of an extended stay in the hospital environment. The action plan will also link closely to the main areas identified in the Expert Group on Delayed Discharges, focussing on Patient Pathways, Hospital Process, System Inertia, Capacity and Resources. In the past year, there has been a reduction in home care delays – especially on acute hospital sites. This will be maintained in the current year – 2013/14, and a subsequent push in terms of introducing more CCA processes in the community and reduced reliance on hospital beds for CCA. In addition, the opportunity is being taken to review the use of care homes as intermediate care establishments. In this way, it is envisaged that a number of patients who would previously have occupied a hospital bed for CCA could have this process undertaken in an intermediate care environment, e.g., suitably staffed/resourced care home beds. There continue to be challenges in terms of the time taken to undertake and complete the CCA itself within the Social Work Department, and also in terms of Care Home availability and patient choice. Both of these will be addressed on an inter-agency partnership approach during February/March 2013 to help meet the new 28 day target on 15 April 2013. In addition, there will be pilots in both North and South Lanarkshire to undertake and complete CCAs within the patient's home or in an Intermediate Care setting rather than an acute in-patient setting.

Workforce

Risk	**Management of Risk**
To implement the full system change required to provide additional services in the community to avoid admission/allow earlier discharge will require major cultural and job	Joint HR groups have been established, involving Staff Side representatives as well as OD staff/HR staff from both Councils and NHSL. It is recognised that as we move to a community based model of care and the subsequent

changes.	reduction in the reliance on hospital beds, so there will require to be the respective development of new skills and opportunities to ensure we can manage the transition smoothly. Both Councils similarly recognise the potential to move staff across the various organisations such that employment protection is maintained whilst creating new and innovative opportunities for staff.
Access to appropriate level of decision making medical staff at hospital receiving/A+E areas.	Plans are in place to recruit additional senior medical staff to cover these areas. In addition, measuring access to specialist geriatric assessment post admission will be a feature of the Change Fund performance measurements.

Finance

Risk	**Management of Risk**
If there is a growing demand for care home placements, this will have a significant impact on Council and health services.	By introducing the various areas described above, we would seek to reduce – or at least maintain current demand – this against a background of increasingly older demographics. In addition, money released from traditional hospital care maybe available to assist in the development of alternative care options.

Equalities

Risk	**Management of Risk**
Risk that services may be seen to be inequitable.	Full Equality Impact Assessments will be undertaken for each of the main areas of work.

Treatment appropriate to individuals:

To support shifting the balance of care, NHS Boards will achieve agreed reductions in the rates of attendance at A&E, between 2009/10 and 2013/14.

Lead: **K Small, Director, CHP South**
C Cunningham, Head of Planning & Performance, CHP South

Measure:

The number of *new and unplanned* attendances at A&E (i.e. follow-up / planned appointments are excluded) per 100,000 population per month.

The target will be met if the monthly average rate of attendance over the financial year 2013/14 is an agreed level below the monthly average rate in 2009/10.

Boards have already submitted 3-year trajectories for rates of attendance at A&E between 2011/12 and 2013/14. These are provided in this LDP trajectory, along with monthly average rate for A&E attendances for 2011/12.

Trajectory:

Sep 12	2,846
Jun 13	2,636
Sep 13	2,631
Dec 13	2,625
Mar 14	2,619

Note: The above trajectory is the original trajectory that was set and agreed. Work was done on re-setting trajectory with a variety of scenarios produced, based on different assumptions and exclusions. In recognition of work about to be undertaken to review unscheduled care – including that which can be done outwith the acute hospital environment – advice has been received from Scottish Government to use pre-existing trajectory until there is national agreement as to which aspects of A&E / emergency inpatient flow should be counted as attendances.

Risk Narrative:

Delivery & Improvement

Risk	Management of Risk
Ability to reduce number of patients presenting at Accident and Emergency Departments.	Referral and activity information captured and analysed on a daily basis. Daily information from the Emergency Response Centre (ERC) with its facility to offer alternative options to attendance at hospital for GP referrals. Analysis of data at GP practice level to understand factors driving high attendance at ED from certain practice populations. Further Primary Care/Acute integrated work to take forward actions based on this analysis.

	Strengthening the focus of the ERC to offer robust alternatives to attendance at hospital over a twenty four/seven basis. Information/outcomes/trends shared with General Practitioners and colleagues in Community Health Partnerships, Scottish Ambulance Service, Local Authorities and Independent Sector (Nursing Homes). Exploring how best to consider and analyse added value of actions / initiatives taken and/or proposals to delay / avoid referral to hospital. This will include examining the outcomes of projects / initiatives such as Integrated Community Support Team (South Lanarkshire) and ASSET (North Lanarkshire). Implementation of Professional to Professional Pilot project between SAS and NHS Lanarkshire, throughout the month of March 2013. (This is at present an awareness raising and data gathering exercise funded by SG that will provide insight into the potential for SAS to participate in work that will reduce attendances at EDs). Ensuring that staff in Primary and Secondary Care and NHS 24 are more aware and informed of service delivery options available across health and social care. Continued liaison with NHS 24 to ensure that their algorithms ably support the principles of T10 with agreement that they will be regularly discussed, analysis and review of lessons learned / potential re-direction of future patients. Improved identification and analysis of patients that attend Accident and Emergency on a frequent basis. Increased analysis on a multi disciplinary and multi agency basis, with potential for case management and proactive intervention in Primary Care to avoid unnecessary repeat attendance. Improving understanding of mental health, alcohol and other substance misuse services and agreeing patient flows, access arrangements in and out of hours and lines of communication to improve awareness and service delivery. Implementation of personalised care plans / strategies for users of mental health and substance misuse services who are known to be frequent A&E attenders, with access to data for managers of these services. Dialogue with colleagues in Local Authority over identification of alternative places of safety, e.g., homeless

	people. Dialogue with Independent Sector nursing homes to increase staff and owner awareness of appropriate interventions to avoid referral to hospital. Increased linkage of General Practitioners to individual and groups of nursing homes to deliver and support effective patient care. Dialogue with community groups, schools and representatives to increase awareness and understanding of health services in both Primary and Secondary Care to include the appropriate use of Accident and Emergency. Developing local social marketing approaches to advise and support the community on the appropriate services to be accessed and how that is best achieved. Enable patients to appropriately access Emergency Care services by way of a range of targeted information to support appropriate service use. Social marketing approach to targeted populations identified as high net users of Emergency Department (ED) services to inform them of appropriate alternatives. Specific interventions based on new service developments in dentistry, optometry, community pharmacy and physiotherapy to expand the alternatives to ED attendance. Integrated work with LTC and Falls Services and SAS and Reshaping Care for Older People will develop community based alternatives to ED attendance/admission. Extending evidence based initiatives in community settings to support patients in their own homes, e.g., care management and anticipatory care management. Developing evidence based schemes to support self management. This will include an audit of >65 admissions during February with a view to identifying opportunities where alternatives to admission may have been utilised. Targeted work in conjunction with Paediatric Services, Primary Care to understand attendance patterns for under and over 5s to assess the impact of attendance for minor conditions and develop an action plan to ensure timely and appropriate access to care for this vulnerable group.
Lack of Clinical Ownership of reducing attendances across Primary Care and Acute.	Multidisciplinary working group to address milestones for delivery with senior clinical input from both Primary Care and Acute Divisions.

Workforce

Risk	Management of Risk
Sufficient number and type of staff with appropriate skills and competencies to deal with volume of patients presenting at Accident and Emergency and general staffing of GP Out Of Hours (GPOOH).	Provision of senior decision-makers including recruitment of additional consultants for all 3 sites under way. Continuous monitoring of staffing numbers and type to ensure delivery of a safe service at Accident and Emergency. Multidisciplinary group addressing these issues and review of operational arrangements within Emergency Departments to ensure pan Lanarkshire approach to service delivery. Developing patient flows with emphasis on providing appropriate alternatives to presentation at Accident and Emergency, such as admission direct to specialty Assessment Areas avoiding ED where possible. Review of GP OOH arrangements underway.
Reconfiguring staff inputs/priorities in community and primary care and in local authorities to support actions/initiatives to delay and/or avoid patient presentation at Accident and Emergency.	Increased engagement between Primary and Secondary Care and colleagues in Local Authority to improve understanding of respective roles and responsibilities and their individual and collective contribution to improved service delivery. This will include alternatives to how and where services are provided in alignment of delivery of milestones. Dialogue regarding extending current process for redirection from ED to PCECs to GP practices in hours for appropriate patients is ongoing with re-direction practice already occurring.
Ability to retain and recruit staff in context of budget constraints.	Developing patient flows with emphasis on providing appropriate alternatives to presentation at Accident and Emergency, such as admission direct to specialty Assessment Areas avoiding ED where possible. Supporting staff and ensuring that there is clarity on future direction of service delivery with clear information and awareness of individual roles and responsibilities of staff from each of the key agencies. Standard Operating Procedure developed to set out operational standards and define staff roles.

Finance

Risk	Management of Risk
Impact of budget constraints on Primary and Secondary Care, Local Authorities and the Voluntary Sector. Constraints on investment due to	Dialogue with all agencies on service and finance plans to ensure awareness of impact of budget changes on services delivery. Exploring opportunities for 'pooled budgets' in selected areas to address specific areas of service delivery. A decision has been taken to invest £2.0 million

budgetary pressures.	to increase clinical staffing to provide an improved environment in each Accident and Emergency Department. This is linked to service redesign to deliver effective and consistent process and practice to the benefit of the patient. There will however be significant challenges in managing that change whilst continuing to deliver a safe service in a changing environment. Use of T10 specific funding to provide co-ordination of stakeholders and implementation of actions identified.

Equalities

Risk	**Management of Risk**
Equity of Access.	The detail will be reflected in action plans.

Access:

From September 2014, no patient will wait more than 4 hours from arrival to admission or discharge or transfer for A&E treatment.

Lead: A Lawrie, Director, Acute Division

Measure:

95% of patients will wait less than 4 hours from arrival to admission, discharge or transfer for A&E treatment by year ending September 2014.

Trajectory:

(Submitted to SG as part of Local Unscheduled Care Action Plan, 29 June 2013)

	Monthly performance	12 month rolling performance
Jun 13	94.69%	90.33%
Jul 13	93.0%	90.15%
Aug 13	94.0%	90.26%
Sep 13	95.5%	90.64%
Oct 13	96.0%	91.09%
Nov 13	95.5%	91.57%
Dec 13	95.0%	92.45%
Jan 14	92.0%	93.14%
Feb 14	93.5%	93.36%
Mar 14	94.5%	93.59%
Apr 14	95.0%	94.19%
May 14	96.0%	94.58%
Jun 14	95.0%	94.6%
Jul 14	96.0%	94.85%
Aug 14	96.0%	95.03%
Sep 14	96.0%	95.0%

Risk Narrative:

Delivery and Improvement

Risk	Management of Risk
Lack of alignment of Board Unscheduled Care Improvement Plan to NHS Scotland National Unscheduled Care Improvement Plan.	NHS Lanarkshire Board Unscheduled Care Improvement Plan had been developed on background of recent involvement of NHS Scotland Quality and Efficiency Support Team (QuEST) and in alignment with information available on the National Improvement Plan in development. The Unscheduled Care Improvement Board will ensure local Board Improvement Plans continue to evolve

	as further information emerges regarding the national work commencing in April 2013. This will include active engagement with the work of the Breakthrough Collaborative on Patient Flow and be informed by representation from NHS Lanarkshire on the Scottish Government Unscheduled Care Expert Group and Care in Acute Hospitals Group.
Unscheduled Care Improvement Plans for 3 sites require sustained managerial and clinical engagement to ensure delivery.	Structures have been put in place to ensure engagement and accountability – Site Flow Groups on each site will report to the Unscheduled Care Improvement Board, which will report through OMC to the Board. Clear roles and responsibilities for delivery have been articulated.
Lack of Board focus to drive improvement.	Unscheduled Care is a high priority on the Board's Risk Register, which will maintain focus on activities to drive improvement.
Site Unscheduled Care Improvement Plans fail to prioritise correct actions to deliver against target.	Detailed Improvement Plans for each site have been developed informed by recent QuEST Team visits and ongoing input and advice from them over the last 18 months. Recommendations from these inputs have been designed specifically to improve performance against the 4 hour standard. Site Improvement Plans will be reviewed weekly and refined to accommodate new pieces of work informed by best practice evidence available from National Improvement Programmes. The Board remains fully engaged with Scottish Government Performance Support to assist with delivery of this standard.
Lack of improvement support to deliver scope of improvements required to meet the target.	Stocktake of available improvement expertise is currently underway within the Board, led by the Quality Hub. Improvement needs assessment is underway for Unscheduled Care to identify skills required to deliver against Improvement Plans. Realignment of existing improvement experts to support work across the 3 sites will take place to ensure staff are supported in delivery of aims.
Lack of appropriate bed capacity to accommodate unscheduled care demand.	Reassessment of current bed configuration will be undertaken to ensure correct availability of beds by site and specialty by end 2013. Based on this work, realignment of bed base will be undertaken in 2014.
Inability to eradicate 12 hour waits as a system feature.	The root cause of 12 hour waits is imbalance in capacity and demand in terms of timing and number of beds available. Review of bed configuration will aim to provide appropriate numbers of beds to match demand on site by site

	and specialty basis. Timing of bed availability will be improved by advanced discharge planning, active management of length of stay and a focus on timing discharge to meet demand. This will result in a higher proportion of morning discharges. Predictors will be refined to maintain a focus on expected time of arrival of heralded patients. Further engagement will be required with Primary Care to understand the pattern of housecalls within each practice and therefore understand a source of variation in patient arrival times. Operational dashboard development will include these data to improve operational control of beds, capacity/demand planning and organisational resilience in the face of demand swings.
Lack of alternatives to admission drive high emergency admission rates when ambulatory care alternatives may be available.	Hairmyres: Clinical Decisions Unit is in place with limited range of pathways to provide an alternative to admission. This range will be expanded during 2013 with the aim of managing 15% of the medical take through the CDU by end of 2013. Monklands: First stage plans are in discussion to develop the current ERU footprint to include formal ambulatory care facilities. These plans will be developed further during 2013/2014. Wishaw: Plans have been developed to alter existing floorplans to accommodate a new GP assessment area and ambulatory care facility. These are being re-costed and will be brought forward again during financial year 2013/2014.
Lack of availability of timely and appropriate data to manage demand.	Refined operational dataset has been developed and work has commenced on development of an interactive Operational Dashboard to support day to day decision making in the Acute Division, and to support advance planning for seasonal variations in activity across elective and unscheduled care.
NHS Lanarkshire Unscheduled Care Improvement Plan fails to link effectively with other work ongoing, specifically in Planned Care, Reshaping Care for Older People, Reducing ED Attendances and Hospital Standardised Mortality Rates (HSMR).	There will be cross representation of members on the Unscheduled Care and Planned Care Improvement Boards. Close links will be developed with Reshaping Care for Older People and with Primary Care around reducing ED attendances and with the project group established for reducing HSMR.

Workforce

Risk	**Management of Risk**
Imminent risk of unsustainable middle grade rotas in Emergency	A range of options to mitigate this risk is in development:

Department due to loss of further middle grade trainees in August 2013.	1.Alteration to existing consultant rotas to provide extended cover, with possibility of locum shifts to ensure 24/7 senior decision making presence in all 3 EDs as short term solution; 2. Further attempts at recruitment to Specialty Doctor level posts with possibility of overseas recruitment options; 3. Medium to long term planning will be carried out to establish and mitigate risks to maintenance of 24 hour ED service on 3 sites.
Acute Medicine rotas on Monklands and Wishaw sites are non compliant with national standards in terms of continuity of care and may lead to recurrent flow issues. Further recruitment may be required to sustain rotas and improve the service.	Review of the Acute Medicine rota model is underway on Monklands and Wishaw sites. Proposals for compliant rotas in terms of meeting evidence based quality standards will be developed by end 2013 and implemented by August 2014.
Level of junior and middle grade doctor support in general acute medicine and Care of the Elderly is insufficient to support timely flow through the hospital.	Proposals will be developed to ensure an appropriate workforce is in place to support consultants across Acute Medicine and Care of the Elderly. This will include non medical support with the requisite skills including ACE (acute care of the elderly) nurses, MINTS Majors nurses and prescribing pharmacists as well as AHPs where appropriate.
Nursing workforce capacity to develop extended roles may be insufficient to meet current and future needs.	Detailed nursing workforce planning utilising national workforce tools where available, is underway to ensure correct numbers, skillmix and competencies are developed to support required changes for core nurse staffing and any additional roles that may support advanced assessment.
Development of advanced practitioners may deplete established nursing workforce from high risk areas such as ED as new roles develop.	Workforce planning will ensure that source areas and departments maintain requisite skillmix.
Medical, nursing and AHP workforce currently do not support fully functional 7 day working.	National best practice statements indicate the need to move to 7 day a week functioning for the acute hospital with regard to emergency care. Review of consultant working patterns is under way for medicine in order to match capacity to demand. A pilot of 7 day a week working for AHPs has taken place over the winter period. The outputs of the evaluation of this are awaited and will inform next steps in developing new working patterns.

Finance

Risk	**Management of Risk**
Insufficient funds to support recruitment of medical and non	The Board will commit resources in addition to the share of nationally available funds allocated to

medical workforce required.	support the national Unscheduled Care Improvement Plan. This will cover both delivering a safe service and improving hospital flow and overall efficiency.
Insufficient funds to support scope of work needed to support improvement plans.	A review of all improvement support and project management resource will be undertaken to ensure an equitable allocation of resource to priority areas.

Equalities

Risk	**Management of Risk**
Isolated improvements to services on individual sites risks the development of inequality of access for all patients, e.g., differing levels of access to specialty opinion for acute medicine or Care of the Elderly based on hospital catchment area.	Improvements to services will be developed with reference to national best practice and quality standards to ensure equality of access to high quality emergency care. NHS Lanarkshire has adopted a modified version of the NHS London Joint Commissioning standard for Emergency Care. These standards are evidence based standards which cover emergency department and emergency medical and surgical care. An initial self assessment against these standards took place in February 2013 with the support of Critical Friend input from senior clinical members of the QuEST team who helped develop these standards. Outcomes of this self assessment have informed the content of the Unscheduled Care Improvement Plans which have been designed with consistency across the 3 sites. Further assessment against these standards will take place in October 2013. Inconsistencies in service provision and delivery have been identified as a result of these assessments. Work will take place to develop agreed models of care for Care of the Elderly and Acute Medicine which ensure equality of access across the sites in Lanarkshire during 2013. The Site Action plans which will form the basis of the Board's submission to SGHD will undergo an Equalities Impact Assessment.

Treatment appropriate to individuals:

Further reduce healthcare associated infections so that by 2012/2013 NHS Boards' *staphylococcus aureus* bacteraemia (including MRSA) are 0.26 or less per 1000 acute occupied bed days; and the rate of *Clostridium difficile* infections in patients aged 65 and over is 0.39 cases or less per 1000 total occupied bed days

Lead: **I Wallace, Medical Director**
H Gourlay, Infection Control Manager

Measure:

MRSA/MSSA:

The target is for all Boards to reduce their rate of *Staphylococcus aureus* bacteraemias down to 0.24 or less cases per 1,000 acute occupied bed days by year ending March 2015.

Should Boards achieve a rolling year rate lower than 0.24 before year ending March 2015 they should aim to maintain that lower rate. However, Boards will be held to account against the 0.24 rate.

As a supporting milestone NHS Boards will comply with antimicrobial policies as detailed in CEL 11(2009).

Trajectory:

MRSA / MSSA bacterium:

Jun 12	0.30
Jun 13	0.26
Sep 13	0.26
Dec 13	0.26
Mar 14	0.25
Jun 14	0.25
Sep 14	0.25
Dec 14	0.24
Mar 15	0.24

Measure:

Clostridium difficile:

The target is for all Boards to reduce from their current rate of *Clostridium difficile* infections down to 0.32 or less cases per 1,000 total occupied bed days in patients aged 15 and over by year ending March 2015.

Should Boards achieve a rate lower than 0.32 ahead of the March 2015 then they should aim to maintain that lower rate. However, Boards will be held to account against the 0.32 rate.

As a supporting milestone NHS Boards will comply with antimicrobial policies as

detailed in CEL 11(2009).

Trajectory:

C diff:

Jun 12	0.50
Sep 13	0.48
Dec 13	0.45
Mar 14	0.42
Jun 14	0.39
Sep 14	0.36
Dec 14	0.34
Mar 15	0.32

Risk Narrative:

Delivery & Improvement

Risk	Management of Risk
NHSL may not meet the SABs trajectory for March 2013 which may impact on trajectory for 2015.	NHSL SAB compliance group will continue to drive improvement towards trajectory utilising further initiatives within the continuous improvement SAB high impact multidisciplinary action plan. Following peer review by HPS in 2012 the plan has been reviewed and will continue to focus on the prevention of invasive device related SABs and further surveillance of those cases reported as unknown cause. MRSA screening now fully implemented and compliance will be measured through specific key performance indicators set by Scottish Government.
There is national controversy over the definition of hospital acquired infection, healthcare associated infection and community acquired infection in relation to SAB.	The Scottish Infection Control Doctors network and HPS have reviewed Scottish *S. aureus* bacteraemia surveillance and have agreed a minimum data set that should be collected on each SAB episode and used to inform epidemiology. NHSL has agreed to participate in this data collection process.
Risk of maintaining sustainable reduction of CDI when competing with 027 outbreaks.	NHSL CDI compliance group will continue to drive improvement towards trajectory utilising the continuous improvement CDI high impact multidisciplinary action plan. Further use of local PCR-based determination of 027 ribotype may allow early recognition of hypervirulent strain. In addition, enhanced surveillance data of all cases will continue and LanQIP development will ensure data returned to clinical areas is meaningful and in real time. The antimicrobial team will continue to monitor empirical prescribing and drive compliance with the CDI HEAT target antibiotic indicator. The ICT will

	support antimicrobial stewardship education in conjunction with the antimicrobial pharmacy lead.
The current National Hand Hygiene Campaign, including the collection, analysis and publication of bi-monthly hand hygiene data by Health Protection Scotland (HPS) will conclude on 31 March 2013. The proposed next step is that NHS Boards adopt or continue to use an existing hand hygiene compliance-monitoring tool that reflects the critical elements specified in Chapter 1 Standard infection Control Precautions policy of the National Prevention and Infection Control Manual and continue to report hand hygiene compliance data via the HAIRT.	NHSL can access and extract hand hygiene compliance data via local data collection systems and will consider adopting the use of the 8-step multi-modal approach as adjuncts to an internal NHSL quality assurance process for hand hygiene improvement. Monthly monitoring of hand hygiene opportunities and technique linked to other NHSL improvement programmes where appropriate, e.g., Scottish Patient Safety Programme, will continue. An NHSL measurement and monitoring SICPs tool and compliance tool that reflect the key elements of the National SICPS Compliance and quality Improvement Data Collection tool have been developed. In addition, NHSL will re-align and develop the configuration of the current National Hand Hygiene Co-ordinator post to an Improvement Advisor role.

Workforce

Risk	Management of Risk
Loss of qualified Infection Control staff will continue to contribute to recruitment and retention challenges of a skilled workforce fit for purpose.	Opportunities to join the HAI team on a secondment basis to expand knowledge base of HAI related issues and prevention of infection continue. Band 5 posts undertaking nationally recognized Infection Control higher education modules. Discussion ongoing with practice education facilitators to explore the opportunity for student nurse placements within the team to influence manpower for the future.

Finance

Risk	Management of Risk
Potential for reduced government funding for some posts that still have deliverable outcomes related to performance.	Exit strategy for key posts ongoing and process of assurance being built into performance delivery. Continue to monitor service development against allocated funds, stakeholder support, and value for money.

Equalities

Risk	Management of Risk
The language of Infection Control Information leaflets may not meet the needs of the developing wider range of non English speaking groups utilising the service.	The ICT continues to liaise with the Head of Patient Affairs and the Patient Information Manager to ensure all information is available in identified core languages and formats.

Treatment appropriate to individuals:

To deliver expected rates of dementia diagnosis by 2015/16, all people newly diagnosed with dementia will have a minimum of a year's worth of post-diagnostic support coordinated by a link worker, including the building of a person-centred support plan.

Lead: **C Sloey, Director, CHP North**
S Kerr, Head of Planning & Performance, CHP North

Measure:

Percentage of people newly diagnosed who receive a minimum of one year of post-diagnostic support (as defined by the commitment) and who have a person-centred plan in place at the end of that support period. Data systems and definitions are currently under development – with a data and definition plan to be agreed by April 2013. Boards are not required to submit trajectories as part of the 2013/14 LDPs.

This target is also designed to help sustain and build on the former HEAT standard on dementia diagnosis. Using the Eurocode prevalence model, the latest available (March 2012) data showed that around 50% of the estimated number of people with dementia were diagnosed in Scotland. This data will continue to be collected and published by ISD. For Lanarkshire, the data shows that an additional 115 diagnoses would have to be made for the 50% level to be maintained at March 2014.

Trajectory:

(not required – see box above)

Risk Narrative:

Delivery & Improvement

Risk	Management of Risk
From the March 2012 level, NHS Lanarkshire requires an additional 115 diagnoses to be made by march 2014 to achieve the target.	It is anticipated that the measures previously put in place by NHS Lanarkshire to ensure improvements in making and recording diagnoses of dementia should be robust enough to ensure delivery of this target. Progress against the target continues to be monitored locally, so any issues can quickly be addressed should the need arise.
It is not yet known what data will be required to evidence delivery of the post diagnostic support target.	NHS Lanarkshire staff, from both clinical and information analysis backgrounds, will be involved in the national consultation around data development. They will therefore be able to quickly develop local systems for data collection once the data parameters have been nationally agreed.
The delivery of post diagnostic support to this model will require a degree of change to existing	North Lanarkshire is currently one of the sites piloting a model for delivering post diagnostic support. The results of this pilot will provide

practice of CMHTs for Older People.	evidence as to the local efficacy of the model, which will determine the detail of delivery across NHS Lanarkshire.

Workforce

Risk	Management of Risk
It is not yet clear which members of the workforce are best placed to deliver the post diagnostic support and take on the role of co-ordinator.	The North Lanarkshire pilot will provide information around this. Once the results of this pilot are available, they can be used to determine the most appropriate staff, including multi-agency partners, to deliver aspects of post diagnostic support.
There may be training needs for some staff delivering some aspects of care.	Again, the results of the North Lanarkshire pilot will inform this work. There is a considerable amount of training material available from NES, ands locally we have both a Nurse Consultant and an AHP Consultant in dementia who have significant educational remits.

Finance

Risk	Management of Risk
Although all of NHS Lanarkshire's CMHTs for Older People currently provide post diagnostic support, it is not consistent to the model required here. The provision of enhanced post diagnostic support may require either additional investment of a re-distribution of existing resource.	As above, the North Lanarkshire pilot will inform decision making in this regard. Close working with both Local Authorities in the NHS Lanarkshire area and Alzheimer Scotland will allow for multi-agency working and an appropriate distribution of aspects of individual care.
It is well known that the number of people with dementia in Scotland is expected to double in the next 25 years (Alzheimer Scotland). For the delivery of this target to be sustainable in the face of an increase in demand of this magnitude, additional phased resources will be required.	NHS Lanarkshire's Mental Health programme Board has begun to consider this issue, and a briefing paper is being prepared for presentation to the Board, detailing the level of investment likely to be required.

Equalities

Risk	Management of Risk
As the target is to be phased in over 3 years, there is the potential for initial inequalities.	Once the target has been fully implemented in 2015/16 any inequalities will have been removed, as the standard will by then be applied to everyone newly diagnosed with dementia.

Treatment appropriate to individuals:

Eligible patients will commence IVF treatment within 12 months by 31 March 2015.

Lead: **I Ross, Chief Executive**
C Lauder, Head of Planning

Measure:

Currently under development. Boards are not required to submit trajectories as part of 2013/14 LDPs, though it is proposed that in-year draft trajectories will be requested in September 2013.

Trajectory:

(see box above)

Risk Narrative:

Delivery & Improvement

Risk	Management of Risk
Eligible NHSL couples currently commence IVF treatment in NHS Greater Glasgow & Clyde (GG&C) within 12 months of referral. This may be affected by the needs of other Boards to purchase more activity from NHS GG&C in order for them to meet the target. In addition NHS GG&C may not have spare capacity.	Continue to monitor waiting times on a monthly basis. Liaise with NHS GG&C to assess their capacity. Due to concerns about the success rate, NHS GG&C theatre and lab work was relocated in November 2012 on a temporary basis to the Nuffield Hospital and ongoing patient management is carrying on as normal in the Unit.
National changes to the criteria for acceptance for IVF treatment, some of which take effect from 1 April 2013, may increase the number of eligible NHSL couples.	Ensure that GP colleagues are aware of changes to the criteria as soon as they become available. Continue to monitor waiting times on a monthly basis.

Workforce

Risk	Management of Risk
Staff are employed by NHS GG&C. No direct impact on NHSL.	

Finance

Risk	Management of Risk
Risk that NHS GG&C will ask Boards for additional funding to cope with cost of contingency arrangements in the Nuffield Hospital (see above). Should the waiting times for NHSL couples rise above 12 months due	Consider the options on a regional basis using central funding if available.

to the factors outlined above, it would be impossible to make and improvement without additional investment.	

Equalities

Risk	Management of Risk
No risk. Target and national criteria apply across all Boards. Same sex couples are not discriminated against.	

3 NHS BOARD CONTRIBUTIONS TO COMMUNITY PLANNING PARTNERSHIPS

Improving partnerships during 2013/14
Contributing to better outcomes through collaborative gain

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 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 seek 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 Community Planning Partnership, we are committed to an improvement ethos and as such have changed our governance structures to include a new **Developing the Partnership Group.** The strategic priorities of this group will be to ensure further development of:

- Effective partnership structures;
- Effective thematic groups and co-ordinated resource management;
- Robust evidence base;
- Clearer outcome focus;
- Effective performance management.

The Developing the Partnership Group includes representation from all of the strategic partners and provides support to the North Lanarkshire Partnership Board. The Community Plan (SOA) will form a key element in the delivery of public service reform in line with the outcomes for the review of Community Planning and the Statement of Ambition.

Effective community planning arrangements provide the foundation for effective partnership working within wider reform. To achieve this, North Lanarkshire Partnership Board requires strong governance and accountability processes which hold all partners to account for their contribution to delivery of this Community Plan (SOA). These Community Planning structures need to:

- reflect local circumstances;
- understand local needs and opportunities supported by relevant and reliable data;
- monitor effectively over time, and
- demonstrate continuous improvement.

During 2012 the North Lanarkshire Partnership Board completed a self evaluation exercise. The Improvement Service (IS), in partnership with Scottish Government, delivered a project to support capacity building in Community Planning Partnerships through the roll out of a self assessment framework using a partnership survey and the Public Service Improvement Framework (PSIF). This self evaluation journey consisted of an Awareness Session, the completion of an outcomes focused partnership checklist by partnership organisations and a

consensus workshop. An Improvement Action Plan was developed which included the priorities, outcomes and milestones and this will be driven forward through NLP Board and the Developing the Partnership group.

The priorities identified focused on strengthening the governance, accountability and operating arrangements of the partnership to ensure a systematic and encompassing approach to performance management and improvement and through this decisive change and increased impact.

Local Outcomes – Developing the Partnership

Over the next five years we will achieve the following outcomes:

- Improved accountability and partnership;
- Improved engagement;
- Improved early intervention and prevention;
- Improved evidence and information sharing;
- Improved monitoring, measurement, and scrutiny.

South Lanarkshire:

In South Lanarkshire, the new SOA will relate to the 6 National Priorities:

- Early Years and Early Intervention
- Economic Growth and Recovery
- Employment
- Health Inequality and Physical Activity
- Outcomes for Older People
- Safer and Stronger Communities.

Each Priority section will contain a local context providing detailed information on the situation in relation to that Priority, outlining relevant strategies and policies, both local and national in respect of this Priority, as well as the agreed outcomes at both the Priority level and the local level.

It will also outline the agreed preventative approaches to tackling the issues under the Priority, the preventative measures drawn from the Partnership Improvement Plan, and how the activity under this Priority links to the 16 National Outcomes.

In relation to target setting - detailed numbers, aspirations, direction of travel etc - this section has been developed following more discussion within the Partnership and with the Scottish Government. There are areas - such as with police and fire & rescue target setting - that are revising local targets in line with national targets as they emerge, and there are areas like Early Years outcomes where the agreed outcomes are included in the SOA.

The Partnerships will monitor all of the official Priority Outcome indicators where data exists and report to the Community Planning Partnership Board. This work will sit alongside the general performance monitoring and reporting of the SOA. (In South Lanarkshire, the system will also include the monitoring of the Partnership Improvement Plans through the IMPROVe system that will provide quarterly update reports issued to the Board at quarters two and four. These reports will cover a description of the improvement, type, lead agency/ officer and where relevant any funding commitments).

The NHS Board Chief Executive also participated in the SOA quality assurance programme as part of the Scottish Government process and, in turn, the Partnership was pleased to note the positive feedback received in terms of the approach that had been adopted to the production and future monitoring of outcomes associated with the SOA.

Community Planning Partnership: North Lanarkshire

Summary of the key tangible contributions that the NHS Board will make during 2013/14 towards improved outcomes

Priority	NHS Board Contribution in 2013/14	Current and Planned Performance Levels
Economic recovery and growth	Contribute to Lanarkshire's Routes to Inclusion programme. Deliver the Scottish Healthy working Lives programme, targeting small and medium sized enterprises.	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. The Scottish Centre for Healthy Working has established a revised outcome focused approach to the delivery of Healthy Working Lives. The Centre is currently establishing a single performance management framework. When available, this will enable NHSL to establish a baseline against this and agree KPIs with the Centre.
Employment	Support programmes such as Project Search and Young People Employment programmes	Project Search: A Project Search Programme will be delivered in both Monklands and Wishaw Hospitals. A maximum of 8 students will

		participate. A target of achieving a minimum of 50% employment after graduation. Young People Employment: Places will be agreed with NLC in accordance with the framework established by the relevant funding source. Salus: Performance measures set by the relevant funding programme.
	Salus Salus provide input into DWP programmes to assist and enable people back into the workforce.	
Early years and early intervention	Delivery of required work streams of the national Early Years Collaborative, under the auspices of Community Planning and in line with Scottish Government requirements and timescales. NHSL will play a key role in the delivery of the Early Years Collaborative (EYC) and will lead two of the three workstreams. The Early Years Collaborative (EYC) commits NHSL to the overall ambition of making Lanarkshire the best place to grow up by improving outcomes and reducing inequalities for all babies, children, mothers, fathers and families across Lanarkshire, to ensure that all children have the best possible start in life and are ready to succeed: • Continue to implement the GIRFEC practice model across NHSL and review and embed practice with the practitioners; • Implement CMO (2012) 10 27-30 month review – new look Hall 4 - and develop training plans to support staff and parents / carers;	Baseline measures will be established for the stretch aim for each workstream and performance measures will be agreed by the EYC

	• Ensure the key actions included in the Best Possible Start programme are aligned to the development within the EYC programme in North and South Lanarkshire, specifically: o Implement the revised Maternity Services Framework and ensure at least 80% of pregnant women in each SIMD quintile will have booked for antenatal care by 12th week of gestation by March 2015, so as to ensure improvement in breastfeeding rates, improved outcomes for babies affected by substance misuse and other important behaviours; o Improve maternal and infant nutrition as set out in the detailed action plan, the plan itself setting out clear action and leads maintained through the Best Possible Start Programme Board. Looked after and accommodated children: • Continue to implement Action 15 of We can and must do better report, and monitor performance against this; • Progress the development of a screening tool for mental health assessment for implementation by 2015; • Develop a focused team approach to support improved outcomes for	

	this vulnerable group.	
Safer and stronger communities, and offending	Participation in the Community Safety Partnership groups in the Community Planning Partnerships Local work plans through Local Area Partnerships reference some of this activity. Developing and extending the Friday Night Partnership Programme. Contribute to the Health Improvement aspects of the Tower Strategy. Linking with the Early Years Collaborative to provide support to young mothers and fathers who are in the criminal justice system. Creating environments to promote participation in physical activity.	Each programme will agree a performance framework within the Community Planning context.
Health inequalities and physical activity	NHSL will play a key role in delivering the agreed action plan of the Health and Wellbeing Partnership ranging from the group. The plan covers issues ranging from promotion of breastfeeding, supporting employment through to smoking cessation. Deliver the Get Active Lanarkshire programme that aims to promote a legacy from the Commonwealth Games.	Performance measures have been set and performance monitored by NLP. Achieve a minimum of 10,000 people making a Get Active Pledge by 31 March 2014
Older people	As South – see below.	There are national and local performance frameworks under development to support this strategy.

Community Planning Partnership: South Lanarkshire

Priority	NHS Board Contribution in 2013/14	Current and Planned Performance Levels
Economic recovery and growth	See North entry - NHSL contribution is equally applied across both Partnerships.	See North entry
Employment	As above.	As above, with addition of Hairmyres and AHPs.
Early years and early intervention	As above.	As above.
Safer and stronger communities, and offending	Participation in the Safer South Lanarkshire Board as part of the CPP process. Local work plans through Local Area Partnerships reference some of this activity. Developing and extending the street based community five-a-side project in conjunction with other initiatives, e.g., the local problem solving groups developed to tackle antisocial behaviour at a local level in each of the six problem solving group areas. This includes the provision of targeted additional youth diversionary activities reactive to the needs of communities experiencing high levels of youth disorder. All activities are delivered by experienced partner agencies / youth work practitioners at peak times from Thursday to Sunday, targeting young people currently engaged in youth disorder or in danger of becoming involved during these times. Linking with the Early Years Collaborative to provide support to young mothers and fathers who are in the criminal justice system.	Each programme will agree a performance framework within the Community Planning context.

	Creating environments to promote participation in physical activity.	
Health inequalities and physical activity	NHSL plays a key role in delivering the agreed action plan that is embedded in the SOA and for which there is a specific Partnership Improvement Plan. This includes: • Lanarkshire 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. Deliver the Get Active Lanarkshire programme that aims to promote a legacy from the Commonwealth Games.	Performance measures have been set and will be measured via the SL CPP Improve performance management system.
Older people	NHSL has been heavily involved in the production of the Reshaping Care for Older People Joint Commissioning Plan, which describes how the 4 strategic partners will plan and deliver supports and services for older people over the lifetime of the strategy. NHSL and our partners recognise the key role that the CPP plays in the delivery of key outcomes within the strategy 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. It is recognized that the approach needs to be outcome based and working with older people as assets to the wider community capacity	There are national and local performance frameworks under development to support this strategy.

	resource.	

4 SUMMARY OF MAIN WORKFORCE ISSUES FACING THE BOARD

To support 2012/13 Cash Releasing and Efficiency Savings (CRES) programmes, NHS Lanarkshire is currently implementing targeted voluntary severance (circa 10 WTE), with NHS Lanarkshire Redeployment Register being the largest group targeted.

As part of the NHS Lanarkshire plan for Re-Shaping Care for Older People (Change Fund), further reduction of institutional beds is anticipated across NHS Lanarkshire by March 2015. The reduction in beds will result in significant re-training and re-deployment of associated staff in nursing, administrative, and support services roles.

In addition, the Mental Health Modernisation strategy is proposing to enhance community mental health services and thus reduce the need for acute adult mental health beds. Potentially this could create the opportunity for re-training and re-deployment of staff from acute to community based Mental Health services.

Following a review of acute nurse staffing levels using the SGHD nursing workforce tools, an increase in Acute nurse staffing funded establishments is being implemented across NHS Lanarkshire. The first phase will see an increase of 26.8 WTE staff by March 2013. Additional investment will be considered in October 2013; dependant on the impact of the first stage investment.

NHS Lanarkshire is supporting ATOS Healthcare to undertake the assessment of individuals in Scotland for the Personal Independence Payment for the Department of Work and Pensions. Around an additional 60 WTE administrative and clinical staff will be employed by NHS Lanarkshire to support this initiative.

5 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. These will be prepared and submitted in line with financial planning timescales.

The Board expects to receive £27.1m of additional recurring general funding in 2013/14. Although further work is needed on estimates of the rise in costs through inflation, changes in pay and new drugs, initial projections suggest these could be covered by the funding uplift. This would leave any further cost pressures or developments to be funded through efficiency.