

**LANARKSHIRE NHS BOARD
ANNUAL OPERATIONAL PLAN 2019/20**

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1 INTRODUCTION

This is NHS Lanarkshire's second Annual Operational Plan (AOP), replacing Local Delivery Plans, and produced in line with guidance received from the Scottish Government's Chief Performance Officer, NHSScotland and Director of Delivery and Resilience on 25th February 2019.

In it, we provide:

- The longer term strategic context of our plans for 2019/20 by way of reference to our Healthcare Strategy *Achieving Excellence*;
- A template setting out access performance information, and a link to our financial plan for 2019/20;
- A summary of plans developed with North and South Lanarkshire Joint Boards to reduce delayed discharges, avoidable admissions and inappropriately long stays in hospital, with a focus to reduce bed days in hospital care;
- An overview of the actions we are taking, in collaboration with partners, to improve the health of the public, particularly with reference to the prevailing burden of disease and requirement to tackle addictions.

We have received assurance of 10.3m for waiting time targets, with the potential of an additional £2.2m following review of performance in September 2019. This will be sufficient to achieve the waiting times trajectories described in this document.

Please note that NHS Lanarkshire delivered against agreed improvement trajectories.

Calum Campbell
Chief Executive

2 *Achieving Excellence* – NHS Lanarkshire’s Clinical Strategy

While this Annual Operational Plan (AOP) is for the year 2019/20, it is important to set this single year within the context of our overarching healthcare strategy to drive forward transformational change in health and care and services for the people of Lanarkshire in the longer term.

In Lanarkshire, we developed and published *Achieving Excellence*, mirroring the aims of the National Clinical Strategy, and the National Delivery Plan for Health & Social Care. A copy can be found on our website or by clicking on this link:

<https://www.nhslanarkshire.scot.nhs.uk/download/achieving-excellence/>

In summary, *Achieving Excellence* sets out:

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

Over the two years since *Achieving Excellence* was first published, actions to achieve the ambitions set out with the initial document have been progressed through whole-

system working groups, with governance through the NHS Board, IJBs and associated committees. These delivery plans are also reflected in the revised JSCPs for the two local authority areas in Lanarkshire.

Further progress on the realisation of NHS Lanarkshire's Clinical Strategy is dependent upon a decision on the future location of University Hospital Monklands. The MRR Project Board met in March 2019 to consider the impact on the programme and costs associated with the ongoing Independent Review, which will not now report until 31st May 2019. The Outline Business Case cannot now be completed in 2019, and this delay means that future inflation will now add some £1.5m per month to the overall Project cost.

3 ELECTIVE WAITING TIMES - WAITING TIMES IMPROVEMENT PLAN (WTIP)

3.1	Proportion of outpatients waiting less than 12 weeks to be seen
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Lead: H Knox, Director, Acute Division
J Park, Director of Access

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

Target:

2019/20	80% by October 2019
2020/21	85% by October 2020
2021/22	95% by October 2021

Risks/Challenges:

NHSL has completed a comprehensive capacity planning exercise detailing DCAQ analysis for all specialties together with costs and risks. The aim of the plan is to sustain the improved level of performance achieved during 18/19 and whenever possible to move to a position where independent sector activity is provided within the NHS.

To maintain existing momentum NHSL has committed, at risk, to £6.8m of expenditure in the independent sector for quarters 1 and 2 of 19/20.

Annual outpatient demand for acute services is 133,601 and core capacity is 111,392, giving a capacity gap of 29,000.

Appendix 1 details the required trajectories and details by specialty.

All performance is contingent on available funding from the Scottish Government.

3.2	Proportion of inpatients/daycases (eligible under the treatment time guarantee) waiting less than 12 weeks to be treated
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Lead: H Knox, Director, Acute Division
J Park, Director of Access

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

Target:

2019/20	75% by October 2019
2020/21	85% by October 2020
2021/22	100 % by October 2021

Risks/Challenges:

NHSL has completed a comprehensive capacity planning exercise detailing DCAQ analysis for all specialties together with costs and risks. The aim of the plan is to sustain the improved level of performance achieved during 18/19 and whenever possible to move to a position where independent sector activity is provided within the NHS.

To maintain existing momentum NHSL has committed, at risk, to £6.8m of expenditure in the independent sector for quarters 1 and 2 of 19/20.

Annual TTG demand for acute services is 24,550 and core capacity is 18,320 giving a capacity gap of 4,449.

Appendix 1 details the required trajectories and details by specialty.

All performance is contingent on available funding from the Scottish Government.

3.3	6 weeks Diagnostics
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Lead: **H Knox, Director, Acute Division**
J Park, Director of Access

Target:

2019/20	95%
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Measure & Data: Proportion of patients waiting for one of the eight key diagnostic tests and investigations would be waiting no longer than six weeks

Risks/Challenges:

NHS Lanarkshire has consistently delivered the 6 week standard for the key diagnostic tests. However, demand for diagnostics continues to increase and a programme of work is under way to manage endoscopy demand/consider alternatives. This is linked to the realistic medicine programme. Access to CT remains a risk and this is primarily due to scanner capacity and Consultant Radiologist vacancies.

All performance is contingent on available funding from the Scottish Government.

3.4	Proportion of patients beginning cancer treatment within 31 days of decision being taken to treat
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Lead: **H Knox, Director, Acute Division**
A Khan, Clinical Lead (Cancer)
J Park, Director of Access
L Mack, Cancer Manager

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

2019/20	95 % by October 2019
2020/21	95 % by October 2020
2021/22	95 % by October 2021

NHS Lanarkshire has clear operational policies detailing roles and responsibilities for those staff involved in managing cancer patient pathways. Robust two-way communication processes for the management of patients between hospitals/boards have been established with clear, agreed pathway timelines and escalation points.

NHS Lanarkshire has robust escalation processes that involve close discussion with the clinical service teams including weekly face to face meetings. In addition to this we have robust breach analysis and reporting processes to ensure learning.

Robust multidisciplinary team (MDT) arrangements are in place with adequate resource to support and record outcomes that are visible for all clinical teams to review with established communication through timely feedback to GP on decisions made at MDT.

Due to significant ongoing internal investment and robust management, NHSL is not requesting recurring investment in this area.

Risks/Challenges:

Risk of failure in the robust communication processes following MDT to notify the Tracking Team of a 31 day patient with a cancer diagnosis on the pathway. The mitigation around this will be to ensure robust communication between the clinical team and the MDT co-ordinator in order to minimise administrative delays.

There are currently challenges around the Regional Gynaecology Oncology Service due to operating capacity. This is impacting on the 31 day standard for patients within NHS Lanarkshire board of residence. The mitigation around this will be to maintain weekly calls to ensure robust inter- hospital communication in order to minimise delays and escalate concerns within the pathway that will help better understand the challenges in the delays to surgery.

Capacity within the Regional Cancer Centre to accommodate radical radiotherapy treatments that require intense planning, from date of decision to treat for NHS Lanarkshire residents being tracked on the 31 day pathway is also a challenge. The mitigation around this will be to maintain robust inter-hospital communication in order to minimise delays and escalate concerns within the pathway that will help better understand the challenges in the delays to radiotherapy.

There is also a risk that Systemic Anti Cancer Treatments (SACT) demand increases significantly either from an increased detection/incidence or the introduction of new treatment regimes. The mitigation of this for NHS Lanarkshire is to continue to work collaboratively to maximise available clinical space for treatment and work closely with the West of Scotland Regional Horizon Scanning Group.

All performance is contingent on available funding from the Scottish Government.

3.5	Proportion of patients beginning cancer treatment within 62 days from urgent referral with suspicion of cancer
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Lead: **H Knox, Director, Acute Division**
 A Khan, Clinical Lead (Cancer)
 J Park, Director of Access
 M Mack, Cancer Manager

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

2019/20	95 % by October 2019
2020/21	95 % by October 2020
2021/20	95 % by October 2021

NHS Lanarkshire has embedded a clinical prioritisation of cancer waiting time's performance underpinned by robust Primary Care involvement and engagement.

NHS Lanarkshire ensures that all patients are tracked across the full pathway from referral to diagnosis and treatment, and has therefore consistently achieved the cancer waiting times standards. Robust relationships between cancer pathway trackers, outpatient and diagnostic booking teams are in place to accommodate urgent suspicion of Cancer referrals and minimise any administrative delays.

NHS Lanarkshire has a well-trained tracking/pathway co-ordinator workforce with responsibility for the whole patient journey where possible. This had enabled the development of strong relationships; robust communication and engagement between tracking staff and those responsible for the clinical service delivery enabling an influencing partnership across boundaries. The strong partnership working supports the early identification of any underlying issues that may be causing delays and enables improvements and actions to be taken that can mitigate future delays.

NHS Lanarkshire has introduced enhanced vetting to ensure all patients get diagnosed and seen via the optimum pathway with clear processes for managing downgraded referrals.

Robust IT and reporting systems for cancer pathway management with MDT arrangements and adequate resources to support and record outcomes resulting on timely feedback to GPs on decisions made at MDT.

Due to significant ongoing internal investment and robust management, NHSL is not requesting recurring investment in this area.

Risks/Challenges:

Periodically there are challenges through the Regional diagnostic services for PET scanning due to radioactive liquid delivery issues. This impacts on the timely booking for patients

who require a PET scan as part of their diagnostic pathway with the risk of breaching the 62 day cancer waiting time standard. The mitigation around this will be to continue to work in partnership with the Regional Cancer Centre to ensure good communication at times when supply is low however the stock maintenance of the radioactive liquid will be monitored within the Regional Service provision.

It is important to continually reinforce and ensure that there is clarity of roles and responsibilities for those staff involved in managing cancer patient pathways to ensure that the Urgent Suspicion of Cancer pathway is highlight to all necessary departments planning diagnostic tests and investigations within the agreed milestones. The mitigation around this will be to develop a briefing crib sheet to be included within junior doctor induction packs with the aim of raising awareness and the importance of the Cancer Waiting Times Standards for patients on 62 or 31 day pathways. This will aim to improve the triaging of diagnostic investigation requested for services and support the timely booking within the urgent suspicion of cancer pathway timelines.

All performance is contingent on available funding from the Scottish Government.

4 UNSCHEDULED CARE WAITING TIMES

Unscheduled Care waiting times and compliance is monitored and presented monthly as part of the Regional (West) Programme Manager Action Planning. Additional to this on site hospital support is provided by SG improvement members who also partake of site unscheduled care groups. Their advice and guidance includes robust escalation to mitigate crowding and delays; to balance capacity and demand and to support methods that influence timely in-patient discharge across 7 days. Likewise work streams are reflective to eliminate boarding; to work closely with partnership north and south colleagues thus reduce unnecessary attendances and or admission avoidance and to reduce length of stay.

Whilst variance in performance exists University Hospital Monklands (UHM) has a more stable 4hr emergency performance and regularly achieves within the 95% target. On occasion when this falls, escalation and interrogation of cause robustly mitigates against a sustained dip. University Hospital Hairmyres (UHH) & University Hospital Wishaw (UHW) meantime have had occasion for enhanced monitoring when continued performance is below 92%. Both hospital sites have structured review processes to understand what influences reduced performance and these are formed as part of their overall improvement and 6EA actions.

4.1	HOSPITAL 6EA IMPROVEMENT ACTIONS
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Lead: **H Knox, Director, Acute Division**
V de Souza, Chief Officer, South H&SCP
R McGuffie, Interim Chief Officer, North H&SCP

The table detailed at Appendix 2 describes the 6EA NHSL anticipated outcomes and improvement actions assigned with each acute hospital. The improvement actions are agreed within each hospital, are presented on as part of the West region monthly meetings and within NHSL Unscheduled Care Board and core DMT. Monthly recording reflects on a 306090 days format thus updating on progress and projections going forward. This format enables the mitigation on issues and or challenges thus maintaining project improvement timescales.

All performance is contingent on available funding from the Scottish Government.

4.2	4 hours from arrival to admission or discharge or transfer for A&E treatment (95% with stretch 98%).
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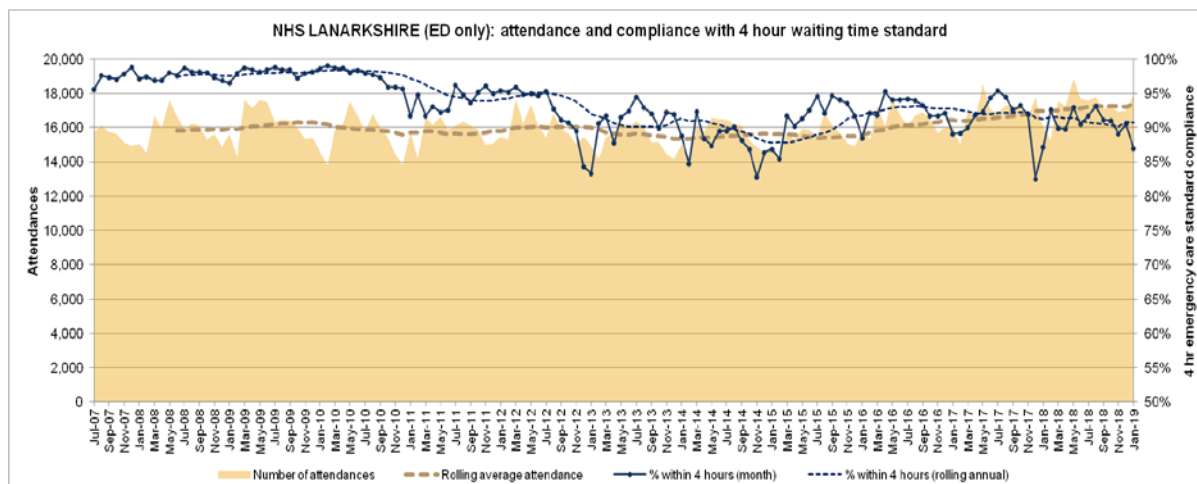
Lead: **H Knox, Director, Acute Division**
V de Souza, Chief Officer, South H&SCP
R McGuffie, Interim Chief Officer, North H&SCP

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

Target:

2019/20	95%
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NHSL Emergency Department Activity and Waiting Times are demonstrated in the graph below. Attendances have increased year on year yielding 10% over time. In the past year overall attendance is up by 11.6%, of which UHH has seen an increase of 14%, UHM by 12% and UHW by 9%. Despite this increase NHSL rolling average has in the main been within 90-95% parameters. Individual site performance when dipped has and is managed as part of their improvement programmes.



All performance is contingent on available funding from the Scottish Government.

4.3 Hospital Performance Trajectories (92% with stretch 98%).

Lead: H Knox, Director, Acute Division
 V de Souza, Chief Officer, South H&SCP
 R McGuffie, Interim Chief Officer, North H&SCP

Reflective on present performance compliance, individual hospital trajectories have been set to enable realistic and achievable aims. These performance aims will be achieved as part of hospital improvement planning with their timescales directed as per the trajectory timescales provided.

	UHH	UHW	UHM
2019/20	92.5%	92.5%	95%
2020/21	93%	92%	96%
2021/22	95%	95%	98%

Risks/Challenges:

As with all sites, there has been an increase in emergency attendances. Challenges continued throughout 18/19 in relation to staffing in the ED, with significant junior/middle grade doctor gaps as well as gaps within the ANP rota. This risk continues to be mitigated by use of locum staff at all grades. UHW continue to implement an improvement plan for ED and the front door including sustainable implementation of the REACT model, daily breach analysis and review and further improvement on escalation and co-ordination. UHM likewise has recognised the need to support ANP roles within general medicine thus enhance the gaps within wards that can delay the discharge planning processes. UHH has had a sustained occupancy over 94% and in view of this NHSL wide review is being undertaken to support equitable occupancy.

All performance is contingent on available funding from the Scottish Government.

5 INTEGRATION OF HEALTH & SOCIAL CARE

**Lead: R McGuffie, Interim Chief Officer, North H&SCP
V de Souza, Chief Officer, South H&SCP**

North Lanarkshire

Within North Lanarkshire, a section 44 review of the Integration Scheme has been initiated, offering the opportunity to reflect on progress to date and identify areas for action to streamline, reduce bureaucracy and inject pace to the integration agenda.

A major element of the review is a self-assessment against the Audit Scotland report on the progress of integration and the MSG Review of Progress with Integration of Health and Social Care.

The Section 44 review of the North Lanarkshire Integration Scheme is due to report in June 2019.

The partnership's commissioning intentions for 2019/20 include:

- continued roll out of integrated Locality teams;
- development of the Discharge to Assess process across all six Localities;
- continued roll out of action 15 plans, including supporting a range of staff at emergency departments and GP Practices to provide quick and compassionate responses with onward referral where required;
- roll out of whole-system unscheduled care action plans across the two North acute sites, focusing on frailty, frequent attenders and the front door;
- expansion of Making Life Easier, North Lanarkshire's portal offering information, professional advice, self-assessment and direct access to services and supports; and
- developing routine enquiry and generic assessments for all staff in North Lanarkshire to maximize the opportunity for early intervention and anticipatory care

South Lanarkshire

A self-assessment of the progress made under integration will be undertaken in line with the recently produced national template. In turn, this will help shape a local action plan which seeks to identify where further progress can be made in the implementation of the content and spirit of the Public Bodies Act.

South Lanarkshire H&SCP, in conjunction with NHS Lanarkshire, has instituted a range of actions to deliver a shift in the balance of care which has resulted in a significant reduction in 24,000 unscheduled bed days.

The actions have been grouped around the 6 main indicator areas as noted below:

- ◆ unplanned admissions;
- ◆ occupied bed days for unscheduled care;
- ◆ A&E performance;
- ◆ delayed discharges;
- ◆ end of life care;
- ◆ the balance of spend across institutional and community services.

The detail of these actions are shared with the IJB and Health Board and reports provided regularly to chart progress against each.

Further work will be undertaken in consultation with acute colleagues to identify means by which this figure might be further reduced in the coming year(s).

More detailed work is underway to seek to review current care pathways – especially for the main ‘Long Term Conditions’ - with a view to providing more self-care and out of hospital care, thus reducing the number of admissions and associated bed stays.

Other notable areas of work include:

- delayed discharge action plans;
- increased provision of rehabilitation/intermediate care approaches in a hospital setting;
- 24/7 community based response services;
- increased community palliative care services;
- full enactment of HBCC such that as few people as possible are receiving on-going care in a hospital setting;
- extensive publicity campaigns re alternative to A&E attendance;
- increased work with the Third Sector to provide community based support;
- increased home care provision;
- less variation in weekend working;
- greater use of Estimated Date of Discharge;
- increased access to an extended range of OOH services;
- bed modelling plans to reduce the number of hospital beds;
- locality planning to maximise community based care.

All performance is contingent on available funding from the Scottish Government.

6 MENTAL HEALTH

Key actions against the three identified Mental Health areas are included in Appendix 3

6.1	18 weeks referral to treatment for specialist Child & Adolescent Mental Health Services (90%)
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Lead: R McGuffie, Interim Chief Officer, North H&SCP

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

Risks/Challenges:

Referrals to tier 3 Locality CAMHS teams have doubled since 2012 and in 2018, the service saw a 68% increase in urgent referrals, placing greater pressure on the RTT. Recruitment also remains a constant pressure, with the service vying with other Boards in a small workforce pool. High levels of maternity leave are also impacting on capacity. A range of actions have taken place to try to mitigate these risks and an action plan formed to support the service to reach the 90% target by December 2020.

All performance is contingent on available funding from the Scottish Government.

6.2	18 weeks referral to treatment for Psychological Therapies (90%)
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Lead: R McGuffie, Interim Chief Officer, North H&SCP

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

Risks/Challenges:

While the specialist Psychological Therapies teams continue to meet the 90% target, the Locality services continue to struggle under increasing demand, despite the development of the stepped care model. High maternity leave (peaking at 10% of the service's funded establishment during 2018/19), increasing demand (NHSL referral rate is 5.8 per 100k population at Q3 18/19, an increase from 5.3 per 100k population in Q4 2017/18) and recruitment challenges (despite relatively low turnover) remain a risk to meeting the target. A range of service developments and improvement actions are in place as part of a 2 year action plan formed to support the service to reach the 90% target in 2019/20.

All performance is contingent on available funding from the Scottish Government.

6.3	Mental Health Waiting Times in Emergency Departments
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Lead: R McGuffie, Interim Chief Officer, North H&SCP

Measure & Data: The AOP Standard for Waiting Times for all presentations at ED is 4 Hours. Data source tbc.

Risks/Challenges:

Data on Mental Health ED waiting times is not currently gathered separately, so a new system for collecting the data will need to be created and a baseline established. A trajectory of performance to December 2020 can only be identified once this process has taken place.

All performance is contingent on available funding from the Scottish Government.

7 PRIMARY CARE

Lead: V de Souza, Chief Officer, South H&SCP

Primary Care services in Lanarkshire are hosted in South Lanarkshire H&SCP. In keeping with the MoU and other guidance, a PCIP has been produced and is being enacted through the work streams listed below.

1. Community Treatment & Care/Urgent Care In Hours
2. Vaccination Transformation Programme
3. Premises Group
4. Pharmacotherapy
5. Digital

In turn, these are being supported by groups looking at workforce, digital solutions and finance.

GP Sub Committee colleagues are involved in all of these work streams and in the GMS Oversight group.

The updated PCIP and subsequent tracker updates will be submitted to Scottish Government in due course.

In terms of the wider infrastructure supporting the implementation of the PCIP, the following summary is provided:

- Finance – the programme is supported by the Deputy Director of Finance who sits on the majority of work streams;
- Premises - NHS Lanarkshire and the Lanarkshire IJBs are undertaking a significant range of service change projects, as set out in "Achieving Excellence." This is a whole-system change process incorporating primary care, community, acute and third sector services. As such, the accommodation requirement of changed functions, new teams and new ways of working will have to be reflected in our property and premises. Over the next 18 months a refreshed property strategy and asset plan will be developed to support our change programme across Lanarkshire.
- Digital - The Primary Care Programme GMS Digital group first met in December of 2018. The purpose of the group is to support the Primary Care Improvement Programme through the identification, evaluation and provision of IT solutions required by the programme. Ensuring that these solutions comply with Information Governance (IG) and security standards. The group's membership is a broad representation of staff working in Primary Care including senior colleagues at Medical Director level as well as senior nursing staff, General Practitioners, pharmacy and Information Governance colleagues as well those within Public Health. The group meets on a monthly basis and to date has focused its attention on the review and up-date of existing programmes of work in Primary Care including Community System replacement and GP re-provisioning. Early in 2019 the group decided to host a workshop in order canvas the views of a wider range of staff working in Primary Care about how technology could help them deliver a better service to patients. This workshop was subsequently held on the 16th of April and was well attended. It is anticipated that once the findings of this event are summarised it will further influence the Digital plan.

8 HEALTHCARE ASSOCIATED INFECTION

8.1	The Standard is for a maximum rate of 0.32 of Clostridium difficile infections in patients aged 15 and over per 1,000 total occupied bed days.
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Lead: I Barkby, Director of Nursing, Midwifery and AHPs
E Shepherd, Head of HAI (Prevention & Control)

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

2019/20	0.32
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Risks/Challenges:

- NHS Lanarkshire has a comprehensive annual work programme in place to support the prevention of HAI and robust performance systems to enable the IPCT to monitor the local CDI position closely.
- NHSL achieved the national standard for two consecutive years (16/17 and 17/18).
- There has been a further reduction in the overall number of number of CDI cases by 18% (equates to 26 cases) compared to 2016/2017.
- There has also been a reduction in the overall number of healthcare associated infections (HCAIs) by 11% in 17/18 (equates to 15 cases) compared to 2016/2017.

8.2	The Standard is for a maximum rate of 0.24 of staphylococcus aureus bacteraemia (including MRSA) per 1,000 total occupied bed days.
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Lead: I Barkby, Director of Nursing, Midwifery and AHPs
E Shepherd, Head of HAI (Prevention & Control)

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

2019/20	0.24
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Risks/Challenges:

- NHS Lanarkshire has a comprehensive yearly work programme in place to support the prevention of HAI and robust performance systems to enable the IPCT to monitor the local SAB position closely.
- There has been a reduction in the overall number of number of SAB cases by 11% in 17/18 (equates to 20 cases) compared to 2016/2017.
- There has also been a reduction in the overall number of healthcare associated infections (HCAIs) by 11% in 17/18 (equates to 15 cases) compared to 2016/2017.

9 IMPROVING THE HEALTH OF THE PUBLIC

NHS Lanarkshire seeks to improve the health and wellbeing of the population through the delivery of effective services, supporting both Health and Social Care Partnerships in their efforts to promote health, functioning as a key partner in both Community Planning Partnerships and supporting the implementation of the Local Outcome Improvement Plans (LOIPs). Support will be given to actions to address poverty, inequalities and the impact of Adverse Childhood Experiences (ACEs) and to develop the role of communities in taking a greater role in improving health.

Focus is placed upon inequalities and Lanarkshire NHS Board (NHSL) has committed to achieving the delivery of actions outlined in its High Level Inequalities Action Plan. NHSL has prioritised actions to improve health in early years, maximising our role as an employer to tackle inequalities, addressing the health needs of vulnerable populations such as the homeless, and developing inequalities sensitive practices in terms of care. Work continues to address the impact of Adverse Childhood Experiences (ACEs).

NHSL will support the ongoing work in both North and South Lanarkshire in relation to addressing needs around addictions, and will continue to support people to make lifestyle changes and seek to achieve agreed targets for smoking cessation and Alcohol Brief Interventions. NHSL will focus our efforts to improve the health of the population in meeting the 6 key public health priorities as set out by Scottish Government in the Public Health Priorities for Scotland document.

NHSL will also continue to utilise the framework provided by the Health Promoting Health Service to focus the health improvement efforts within NHS settings.

Links to key plans are listed below.

South Lanarkshire Local Outcomes Improvement Plan:

https://www.southlanarkshire.gov.uk/cp/downloads/file/93/local_outcome_improvement_plan_-_2017-2020

South Lanarkshire Strategic Commissioning Plan:

https://www.southlanarkshire.gov.uk/slhscp/downloads/file/176/south_lanarkshire_integrated_joint_board_meeting_monday_25_march_2019_agenda_pack_and_notice

At the time of submission a public-facing version of the Strategic Commissioning Plan was in the latter stages of graphic production, with a view to publishing on the partnership website, www.slhscp.org.uk

North Lanarkshire Local Outcomes Improvement Plan:

<https://www.northlanarkshire.gov.uk/CHttpHandler.ashx?id=21277&p=0>

North Lanarkshire Strategic Plan:

http://www.hscnorthlan.scot/wp-content/uploads/2016/05/nlc_strat_doc_v13.pdf

North Lanarkshire Commissioning Plan:

<http://www.hscnorthlan.scot/wp-content/uploads/2018/02/Achieving-Integration-Final.pdf>

North Lanarkshire Integration Scheme:

<https://www.northlanarkshire.gov.uk/CHttpHandler.ashx?id=22525&p=0>

10 FINANCIAL PLANS

Lead: L Ace, Director of Finance

NHS Lanarkshire has consistently delivered a well-balanced performance across the AOP targets within its existing financial envelope.

During 2018/19 NHS Lanarkshire received 0.8% less than its NRAC share (c £9.2m) and previously received c £0.9m less than its share of the specific funding for Health Visitors. (This was on the grounds that it had already put in place more Health visitors from its general allocation compared with other NHS Boards). Although it achieved financial breakeven, recurring costs exceeded recurring income by £7.389m. Some £2.2m of NRAC parity funding will help reduce this historic underfunding, but the Board still starts 2019/20 with an opening gap which increases further to £17.753m once the 2019/20 cost increases are factored in.

For the last decade cost growth has outstripped income growth and achieving breakeven has required a strong focus on cost control plus a significant effort in identifying and delivering efficiency savings. The stream of ideas for continued savings and the ability to extract cash to recirculate are diminishing. Although the Board has approved a rollover financial plan that, combined with further reliance on non-recurring funding, could if delivered lead to breakeven there could be no realistic assumption that further savings could be squeezed out in year to support any additional investment over and above the plan. Modelling forward, with high pay and drug costs forecast for 2020/21 the scale of the savings challenge increases. Given current difficulties identifying and implementing genuine cash releasing savings in the face of other service pressures, financial sustainability could only be achieved by a strong discipline in restricting discretionary investment and diverting time from other improvement activities on to trying to find ways to reduce costs.

Additional funding for Mental Health and Primary Care is passed in its entirety to the IJBs who develop the plans for its use in meeting strategic objectives.

Leading up to 2015/16 the Board had made cumulative investments of c £19m in additional recurring capacity to support waiting times. Since then, the gap between demand and capacity has grown and the Board has relied on SG funding supplemented by any windfall or slippage funding the Board can release from elsewhere in that years plan. Where NHS Lanarkshire has received in year SG funding, it has a good track record of delivering the agreed reductions in waiting times.

Recently the Board received assurance of £10.3m of Waiting Times funding from Scottish Government, with potential for an additional £2.2m following a review of our performance in September 2019. As putting in place additional capacity has a lead time of over 2 months and waiting until funding was announced would mean there would be a hiatus after 1 April 2019 when waiting lists would rise steeply. To avoid this the Board has made commitments for the first 6 months, including a £6.8m commitment to the private sector, but in doing so has created an immediate financial risk of £3m by assuming that at least that amount of SG funding will be forthcoming. In addition, the Board has invested £0.8m recurringly to support reductions in orthopaedic length of stay, committed a £2.9m contingency reserve, all 12 months internal budget for additional capacity plus an additional £5m from other internal non-recurring sources to supporting the first 6 months. As well as increasing the financial risk profile, this means there is no internal funding left for additional activity in the second half of the year. Given there is already an unidentified savings gap and a risk profile associated with delivering those schemes already identified,

the amount already put in place to support the first six months is the maximum the Board could consider.

An Unscheduled Care Delivery Board (including both IJBs' Chief Officers and the Acute Division Director) has developed an action plan for improving flow, reducing reliance on the Acute Hospitals and increasing care in the community. In 2017/18 and 2018/19 there had been transfers out of the set aside budget into the budgets directly managed by the IJB Chief Officers. This was due to successful changes in the location of care and further work will take place in 2019/20.

Since their inception, the IJBs have achieved a reduction in bed days but admissions and A & E attendances have increased year on year. So although initiatives such as Hospital at Home, as well as a far more integrated approach to avoiding delayed discharge, have delivered significant benefits they have served to mitigate the impact of demographic growth on the use of acute services.

IJBs were given full funding for the services delegated to them in 2015/16 and this has been increased each year by the allocation uplift. The delegated community and primary care spend has been within budget each year and underspends have been retained in IJB reserves. In 2019/20 the IJB budget will be uplifted by 2.5%. In addition, the NHS Board is making a substantial investment in upgrading the community IT system. With this uplift and taking account of the cost pressure required to fund the national upgrading of health visitors, the minimum savings needed to breakeven on the IJB sits just under 1%. Both IJBs have approved plans for achieving this.

Increased access to new high cost drugs is expected to result in 16.6% growth in this area of spend. The £11.7m predicted rise can be partly offset by the increase in the new medicines fund and savings from drugs switches and other prescribing efficiencies but it still represents a bottom line pressure that requires other services to find ways to reduce costs to transfer funding to cover these drugs. Energy costs and major contracts linked to RPI such as the PFI contracts are all expected to grow at a higher rate than the allocation uplift requiring savings to be made to fund them. E Health expenditure is also growing steeply in response to increased cyber security threats, a stricter data protection regime and system upgrades. As these higher cost pressures sit in the non IJB areas, this means the acute, estates and the other (much smaller) corporate support budgets are having to make a higher level of savings, equating to around 2.5 times that of the IJBs.

Although the 2018/19 savings plans covered a spectrum of service review and redesign aspirations, once options were worked through no cash releasing proposals emerged. More common was the identification of the need for additional investment. The savings plans for 2019/20 are mostly of a housekeeping or financial management nature and are not sufficient to close the recurring financial gap which is predicted to grow to £11.509m. On a non-recurring basis, it is feasible that the Board will be able to identify and deliver enough on a non-recurring basis to stay within budget in 2019/20 but has no capacity for additional investments.

If an allocation uplift of 2.5% is assumed for 2020/21 and, set against the rise on the pay bill of over 4% in year 3 of the national deal alongside continued high growth in drugs, this gap grows wider. The Board has an excellent track record in delivering financial breakeven, but looking forward the scale of this gap alongside the drying up of the flow of proposals for further cash releasing efficiencies will require significant additional attention to this aspect. A programme approach to savings is expected to be recommended and set up in early 2019/20.

The combination of a high level of business continuity work at Monklands, medical, laundry and IT equipment replacements, alongside proposals needed to reshape services for the future (such as the regional systemic anti-cancer strategy, trauma and orthopaedics and

vascular surgery) means capital funding is oversubscribed. The Board met as a Planning, Performance and Resources committee on 11th April to review the Monklands risk and agreed to develop a capital plan for approval at the May 2019 Board. The prolonged period to which the Board is likely to be exposed to the infrastructure risks at Monklands combined with the current national focus on healthcare environment brings a high risk that the level of expenditure needed to safely provide the services currently on Monklands may escalate considerably.

11 AOP 2020/21 & AOP 2021/22

Under development

APPENDICES

- APPENDIX 1 12 WEEKS OUTPATIENT & TTG TRAJECTORIES (WTIP) – separate excel attachment**
- APPENDIX 2 HOSPITAL 6EA IMPROVEMENT ACTIONS – see over**
- APPENDIX 3 MENTAL HEALTH TEMPLATE - separate word attachment**
- APPENDIX 4 FINANCIAL PLANS - to be submitted separately to SG**

HOSPITAL 6EA IMPROVEMENT ACTIONS

APPENDIX 2

6EA	UHH	UHW	UHM	Anticipated Outcomes
6EA 1 Clinically focussed and Empowered Hospital Management	Focussed Senior Management <ul style="list-style-type: none"> Review of escalation plan & barometer across NHS Review of Milan reporting Breach analysis increased frequency & feedback Visible leadership in duty manager role 	Focussed Senior Management <ul style="list-style-type: none"> Refocused UC Improvement Board – MDT Approach Reviewing site escalation and barometer in line with other sites Continued development of morning huddle and huddle template Develop weekly reporting of performance Visible leadership in duty manager role 	Focussed Senior Management <ul style="list-style-type: none"> Revamped UC Improvement Group Board – MDT Approach Reviewing site escalation and barometer in line with other sites Visible leadership in duty manager role Newly established control and command centre enabling whole system overview and management 	Clinical Leadership and management are in place to support and determine appropriate staffing levels, clear escalation policies. The triumvirates (quadumvirates) and duty managers are visible across all services and targets. They are central to each hospital around performance and management on a day to day basis ensuring a whole system approach. Emergency access performance meet with the national target of 95%
6EA 2 Capacity and patient flow realignment	Understanding demand & Alternatives <ul style="list-style-type: none"> Postcode re-alignment work ED redirections Revised & upgraded dashboards to inform on demands and capacity NHSL wide flow workshop – May 17th 	Microstrategy dashboards <ul style="list-style-type: none"> Refreshed basic building blocks Revised & upgraded dashboards to inform on demands and capacity NHSL wide flow workshop – May 17th 	Understanding demand & Alternatives <ul style="list-style-type: none"> Postcode re-alignment work ED redirections Revised & upgraded dashboards to inform on demands and capacity NHSL wide flow workshop – May 17th 	Established reporting mechanisms are utilised to support appropriate performance management that ensure the correct resources are applied at the right time, right place and in the right format. System reports will establish the footprint of flow into, through and out of the hospitals and identify where capacity meets or does not meet demand. Emergency access performance meet with the national target of 95%
6EA 3 Patient Rather than Bed Management	Discharge Workstream <ul style="list-style-type: none"> Spread & refocus of DDD & MDT board rounds Discharge Lounge relocation 7 day discharge Priority patient/pre noon discharge 	Discharge Workstream <ul style="list-style-type: none"> Daily Dynamic Discharge working group Discharge Lounge SLWG 	Discharge Workstream <ul style="list-style-type: none"> Criteria Led Discharge 7 day discharge Pre Noon Discharge 	Key factors that assist in coordinated planning and implementation of appropriate discharge are recognised and supported. This includes a focus on early morning and weekend discharges. This does include engagement with all disciplines as well as discharge lounges and transport services. Reduced patients boarding out of specialty, earlier in the day discharges to achieve 40% guide and streamlined 7 day discharges thus maintaining demand capacity.
6EA 4 Medical and Surgical Processes for Optimal Care	Front Door <ul style="list-style-type: none"> Medical pathways Medical directorate action plan Surgical assessment unit 	ED /Front door <ul style="list-style-type: none"> Implement sustainable REACT model Implementation of ED/Front Door improvement Plan Further development of Surgical AECU Development of Frailty pathway 	Front Door, Frailty & Surgical Workstreams <ul style="list-style-type: none"> AECU Pathways Frailty Pathway Surgical Assess & AEC PIU 	Patient pathways across all hospitals ensure there is prompt access to appropriate assessment and clinical interventions. This enables the patient to be in the right place at the right time with the right team. Additionally wider NHSL and North & South partners work to support unnecessary admission thus provide optimal care in the right place within the community setting. Reduced patients boarding out of specialty and streamlined 7 day discharges thus maintaining demand capacity.
6EA 5 7 Day services	Support for 7 Day Services <ul style="list-style-type: none"> 7 day frailty EDD Weekend discharge focus NHSL DDD workshop planned for 4th June 	Working with MDT - Day of Care <ul style="list-style-type: none"> Realistic Rehabilitation Site development NHSL DDD workshop planned for 4th June 	Discharge Workstream <ul style="list-style-type: none"> Criteria Led Discharge 7 day discharge Pre Noon Discharge NHSL DDD workshop planned for 4th June 	Priority is to reduce weekday and weekend variation. Access to assessment diagnostics and support services is available over 7 days however work is progressing to enhance turning the unplanned to planned. Streamlined 7 day discharging.
6EA 6 Ensuring Patients are Cared for in Their Own Homes	Frailty/Partnership working <ul style="list-style-type: none"> Frailty team in ED H&SCP integration LOS/DD meetings Discharge to Assess Medicines alignment 	Community Workstream - Working in partnerships <ul style="list-style-type: none"> Further development of D2A with North HSCP Link with South HSCP around prof to prof 	Frailty & Front Door Workstreams <ul style="list-style-type: none"> Frailty Pathway AECU PIU 	H@H covers all areas of Lanarkshire thus optimising when acute care can be delivered at home. Further work is developing with integrated partners to deliver at home acute 'therapies' such as intravenous medication which would previously necessitate a hospital admission. Likewise, professional to professional integration supports admission/attendance avoidance thus enabling 5% reduction for patients to be cared for within their own homes and or communities.