EMBARGOED UNTIL DATE OF MEETING

NHS Greater Glasgow and Clyde

Greater Glasgow and Clyde NHS Board

Board Meeting

Tuesday 18th April 2006 **Board Paper No. 2006/13**

Director of Corporate Planning and Policy

LOCAL DELIVERY PLAN

Recommendation:

The Board is asked to:

- note the Scottish Executive's response to the Board's Local Delivery Plan;
- approve the Board's proposed actions;
- note the Board's internal implementation timetable at Annex 2.

A. BACKGROUND AND PURPOSE

1.1 At its September seminar Board members were advised that the Scottish Executive was changing its approach on performance management and introducing for 2006-07 a new system of local delivery plans (LDPs). Guidance was issued by the Scottish Executive in December which emphasised that the Board's LDP would form the basis of a formal contract with the Executive around 28 key tagets (Annex 1). The Board's LDP was approved by the Board earlier this year and submitted to the Executive on 28 February. The Executive's process had indicated that during March it would be in touch with individual Boards to address and resolve issues arising from their LDPs with a view to these being formally signed off by the Chief Executive of NHS Scotland by the end of that month.

B. SCOTTISH EXECUTIVE RESPONSE

2.1 During March the Scottish Executive communicated with us on the following issues arising from its submitted LDP. The approaches from the Executive focused primarily on either the trajectory for the target and/or the rigour of the risk assessment. As a consequence a series of amendments as indicated below have now been made to the Board's original LDP.

2.2 (A.04T) Outpatient waiting times. The Executive asked us to reconsider our original trajectory which predicted a rise in the number of waits during 2006. This has been re-examined at Chief Executive's Waiting Time Group and a revised trajectory has been submitted and accepted by the Executive.

2.3 (T.02T) 65+ Multiple emergency admissions. The Executive is concerned that our trajectory undershoots the 2008 target. Following are-consideration of our position we confirmed our original trajectory with the Executive which indicated that we would be rated as a "fail" on this target.

2.4 (E.03T) Consultant productivity. The Executive sought confirmation of our trajectory. Further discussions with Medical Director and acute general managers has agreed a realistic trajectory and initial risk assessment to deliver the target by March 2009. This has been accepted by the Executive.

2.5 (E.03T) Total productivity. The Executive sought confirmation of our trajectory. Though this does not relate directly to the target a similarly realistic trajectory as for consultant productivity has been agreed locally and accepted by the Executive.

2.6 (A.05T) A&E waiting times. The Executive is seeking confirmation of our trajectory to hit December 2006 and December 2007 targets by 30 April with detailed action plan to follow by 12 May. A local action plan to fulfil these requirements has been agreed and is being implemented.

2.7 (A.12T) Diagnostic waiting times. The Executive asked us to revise our original trajectories in light of the bringing forward of the target from December to June 2007 to link with the target on outpatients. Revised trajectories to fulfil this requirement have now been agreed and accepted by the Executive.

2.8 (A.14T) Ambulance Waiting Times The Scottish Ambulance Service has initimated that it has incorporated the "reducing hospital admissions target" into its LDP and has asked the Board in a reciprocal move to include in its LDP the target "achieve a 30% reduction in average turnaround time for emergency incidents at MHS Board hospitals by 2008/09". Further work is underway to assess the implications of these proposals.

2.9 We have received further feedback on the LDP which will be formalised in a letter to the Board's Chief Executive as the final act in formally signing off our LDP. The Executive concludes that delivering the plan should enable us to achieve 27 of the 28 targets.

2.10 The exception concerns T.01T multiple emergency admissions 65+ where the Executive professes to being "disappointed" that we have not committed ourselves to achieving the 20% reduction and is now insisting that we submit a compliant trajectory by 30 April. When submitting its LDP the Board's concerns were primarily:

- the lack of evidence around the target to justify either its selection or level of reduction;
- our presently limited depth of understanding of make up of multiple admissions and therefore also the potential to reduce these;
- the interpretation of the target as a measure of the success rather than failure of community care policies by returning older people to the community and retaining them there for as long as possible;
- the precision of the target is in doubt by not differentiating by reason for admission on each of the separate episode;
- insufficient account is taken for effect of deprivation on multiple admissions;
- the lack of consideration of alternatives linked for example to length of stay or re-admission within 7 or 28 days.

In making its response to the Executive the Board will seek to emphasise these points as part of its risk assessment and to engage in further debate.

2.11 In terms of other issues we need to ensure that in commenting on the financial risks associated with bringing Clyde into financial balance the wording reflects that agreed in the Joint Communiqué which stresses the shared responsibilities of both the Board and Scottish Executive in addressing the risks and achieving recurring financial balance by 2008-09.

2.12 On other targets the Executive acknowledges that there is further work being undertaken between the Board and the Executive's Delivery Group. These are:

- (A.08T & A.09T) cancer waiting times;
- (A.12T) diagnostics;
- (A.05T) A&E waiting times;
- (A.06T) cataracts;
- (A.07T) hip surgery;
- (A.11T & A.13T) cardiac intervention/cardiac outpatient waits.

2.13 On (H.02T) smoking and (H.05T) MMR immunisation the Executive has noted our concerns about achievements and management of both targets.

2.14 On (A.14T) the Executive has noted that we are working with SAS to agree a local SMART target (performance on this target is not currently broken down by Health Board).

2.15 The Executive is presently working with us to disaggregate NHS Argyll and Clyde's LDP into its Clyde and Argyll constituent parts

C. CONCLUSION

3.1 We will continue to work with the Executive to finalise an agreed LDP for Greater Glasgow and for Clyde against which we will be held to account for our performance. Locally, arrangements are being put in place to allocate the LDP targets out to each of the main operational units as part of their overall performance management framework, to establish supporting information systems and reporting disciplines and to ensure that proper processes are in place led by the appropriate lead officer to ensure that we deliver the promised performance against each LDP target. The first scrutiny of the LDP is due this summer and will feature in our next Annual Review.

Publication: **The content of this Paper may be published following the meeting**

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ANNEX 1

KEY TARGETS

Notes : The first letter of the identifier denotes the associated ministerial priority:
H : Health ; E : Efficiency ; A: Access ; T : Treatment.
The suffix of T denotes a target.

Target Identifier	Target
H.01T	Reduce health inequalities by increasing the rate of improvement for the most deprived communities by 15% across a range of indicators including; CHD, cancer, adult smoking, smoking during pregnancy, teenage pregnancy and suicides in young people: target date 2008.
H.02T	Reduce rate of smoking among adults (16-64 age group) in all social classes to 29%: target date 2010.
H.03T	Reduce incidence of exceeding the weekly alcohol limit of 21 units to 29% for men, and of 14 units to 11% of women: target date 2010.
H.04T	50% of all adults (aged 16+) accumulating a minimum of 30 minutes per day of physical activity on 5 or more days per week.
H.05T	95% uptake target for all childhood vaccinations (ongoing).
H.06T	Reduce suicide rate between 2002 and 2013 by 20%.
H.07T	Reduce by 20% the pregnancy rate (per 1000 population) in 13-15 year olds from 8.5 in 1995 to 6.8 by 2010
E.01T	NHS boards to operate within their revenue resource limit; operate within their capital resource limit; meet their cash requirement.
E.02T	Sickness Absence Rate: 4% by 31 March 2008.
E.03T	Productivity: increase in consultant productivity by 1% pa over the next 3 years.
A.01T	Ensure that anyone contacting their GP surgery has guaranteed access to a GP, nurse or other health care professional within 48 hours from April 2004.
A.02T	60% of 5 year old children (primary 1) will have no signs of dental disease by 2010
A.03T	No patient with a guarantee should wait longer than 6 months for inpatient or day case treatment from 31 December 2005, reducing to 18 weeks from 31 December 2007.
A.04T	By the end of 2005, no patient will wait longer than 6 months from GP referral to an out-patient appointment , reducing to 18 weeks from 31 December 2007.
A.05T	By end 2007 no patient will wait more than 4 hours from arrival to discharge or transfer for accident and emergency treatment.
A.06T	By end of 2007 the maximum wait for cataract surgery will be 18 weeks from referral to completion of treatment.
A.07T	By end of 2007, the maximum wait for admission to a specialist unit for hip surgery following fracture will be 24 hours.
A.08T	Women who have breast cancer and need urgent treatment will get it within one month where appropriate.
A.09T	By 31 December 2005 no patient urgently referred for cancer treatment should wait more than 2 months.
A.10T	From June 30 2004 the maximum wait from angiography to surgery or angioplasty will be 18 weeks.
A.11T	By end 2007, the maximum wait for cardiac intervention will be 16 weeks from GP referral through rapid access chest pain clinic or equivalent.

Target Identifier	Target
A.12T	By the end of 2007 patients will wait no more than nine weeks for any MRI or CT scans and other key diagnostic tests
A.13T	From the end of 2007, no patient will wait more than 16 weeks for treatment after they have been seen as an outpatient by a heart specialist and the specialist has recommended treatment.
A.14T	By end 2007, 75% of 999 emergency calls responded to within 8 minutes.
T.01T	We will reduce the number of people waiting to be discharged from hospital into a more appropriate care setting by 20% year on year between 2005 and the end of 2008, cutting to a minimum the number of people waiting more than 6 weeks to be discharged.
T.02T	By 2008-09, we will reduce the proportion of older people (aged 65+) who are admitted as an emergency inpatient 2 or more times in a single year by 20% compared with 2004/05.
T.03T	Cervical screening target 80%, ongoing
T.04T	QIS clinical governance and risk management standards improving

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ANNEX 2

LOCAL DELIVERY PLAN TIMETABLE

6th January 2006	:	Circulation to Leads of Local Delivery Plan guidance.
9-13th January 2006	:	David Walker one-to-one briefing and discussion with Leads.
24th January 2006	:	Performance Review Group – presentation of paper on requirements and implications of Local Delivery Plan.
By 31st January 2006	:	Completion by Leads of text for Local Delivery Plan commentary
21st February 2006	:	Board - agreement on Local Delivery Plan submission.
28th February 2006	:	Completion of final draft and submission.
March 2006	:	Negotiation/Dialogue with Scottish Executive on submitted Local Delivery Plan.
		Performance Review Group - report on outcome of Local Delivery Plan negotiations.
18th April 2006		Board - report on outcome of Local Delivery Plan negotiations.
June 2006	:	First monthly scrutiny of Local Delivery Plan by Scottish Executive.
July 2006	:	Corporate Policy, Planning and Performance Group - report on outcome of first monthly scrutiny.
August 2006	:	Performance Review Group – review of preparations for Annual Review with Minister including initial scrutiny of Local Delivery Plan.