



New Horizons



Strathclyde Park Lanarkshire 'Swans at Sunrise'

A Plan for Modernising Primary Health Care Services

Issue: Final Draft April 2008

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1. FOREWORD

This document has been prepared over the past 18 months and includes contributions from a range of clinicians and managers from across a wide range of services in Lanarkshire. Its aim is to outline a clear path for the development of primary and community services in NHS Lanarkshire (NHSL) over the next ten years.

The need for change is overwhelming, given both the increasing demands being placed on the NHS by the population and also the need to tackle the current burden of illness within our communities.

The plan sets out the case for change, identifies four cornerstones of care, and describes the outcomes we wish to see, along with the mechanisms for delivery. As such it sets out the improvement required and defines the supporting infrastructure to deliver this change. In delivering the plan, we will build on current strengths and capacity, and further develop joint working with partner organisations and agencies.

We recognise that this document will need to evolve to reflect emerging government policies, as well as changes in local systems, clinical models, and in line with the financial climate.

The plan refers to work that is being developed by NHS Lanarkshire in a range of areas including mental health, learning disabilities and children's services. It identifies key issues relating to these services that may impact on primary care.

NHS Lanarkshire currently spends some £378m annually on primary care services. This plan has already identified the need for an additional £11.575m in recurrent funding during the life of the plan. Of this, £6.025m is in the current financial plan, and it is anticipated that £0.693m will be funded centrally by the Scottish Government.

This plan sets the direction for the modernisation of primary care services in Lanarkshire, and will evolve to reflect emerging thinking and new evidence.

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2. INTRODUCTION – Why do we need a modernisation plan?

2.1 Setting the scene

Across the UK it is estimated that over 90% of patient contact with the NHS takes place in primary care settings. There is widespread recognition that to respond to demographic changes and building a healthcare system that is sustainable well into the 21st century will require an even greater level of patient care in the community. This will mean providing care closer to where people live, and at a time and place which is convenient for them. This plan describes how we will achieve this.

2.2 The population we are treating

Lanarkshire's population has a relatively high level of social deprivation, while primary care, mental health and community-based health services are relatively underdeveloped. There is an earlier onset of morbidity across Lanarkshire, with people becoming ill at a younger age than the Scottish average. The county's population has experienced changes in recent years, and these will continue over the next 10–20 years. The result of this will be a greater demand on services due to the growth in the number of people with one or more long-term conditions such as diabetes, respiratory disease, heart disease or stroke.

Since April 2006 Lanarkshire's two community health partnerships have included parts of NHS Greater Glasgow and Clyde (NHSGGC) such as Cambuslang and Rutherglen. This edition of the plan does not include these former NHSGGC areas, but future versions will do so.

NHSL covers a large geographic area (883 square miles), stretching from Crawford in the south to Kilsyth in the north, and from East Kilbride in the west to Shotts and Biggar in the east. It has a population of over 558,000, with at least 80% living in urban areas.

There are an increasing number of housing and care home developments underway across the county, and in particular in the Cumbernauld and Wishaw areas. It is not clear whether these are being populated by existing Lanarkshire residents moving into improved housing, or by new residents from elsewhere. What is apparent is that population changes, resulting from initiatives such as the development of the former Ravenscraig site will impact upon existing primary and community care services.

Projected population change

The estimated resident population of NHS Lanarkshire is 558,139 (General Register Office for Scotland, mid-year population estimate 2006), of which 268,154 are males and 289,985 females. The total is projected to reach 567,874 by 2024, although substantial recent house-building and prospective developments such as the new urban centre at Ravenscraig may alter this (Table 1).

Table 1: Population projections for NHS Lanarkshire and Scotland to 2024

	2006	2010	2014	2024
NHS Lanarkshire	558,139	563,500	565,700	568,000
Scotland	5,094,800	5,118,300	5,123,800	5,118,900

Data source: General Register Office for Scotland

The ethnic mix from the 2001 census showed that 98.8% were from white ethnic groups and 1.2% (6,560) from a range of other minority ethnic groups. However, this does not reflect subsequent population changes, notably significant immigration from Poland.

In common with the rest of Scotland, NHS Lanarkshire's resident population is ageing. Over the past 20 years the number of people aged 15–34 has decreased steadily, while the proportion of those aged 35–49 has risen equally steadily. There has been a slight increase in the 50–64 age bracket. At present Lanarkshire's population is marginally younger than the Scottish average, with 17.9% aged

under 15 (Scotland 16.7%) and 15.3% 65 and over (Scotland 16.4%). However, the proportion aged 65 and over is estimated to rise to 21.2% by 2024 (Scotland 22.6%).

An ageing population, combined with greater incidences of long-term conditions, will result in an increased demand for healthcare. Services must be planned and delivered so that they target the changing needs of the local population effectively. Additionally, there is a clear link between deprivation and ill health, and NHS Lanarkshire has large areas of social deprivation. Any increase in deprivation will again place greater pressure on primary care services.

Table 2: Types of health contacts among Lanarkshire residents, 2003

	GP consultations (multiple reasons)		Hospital discharges		Deaths	
	No.	%	No.	%	No.	%
Infectious and parasitic diseases	72,126	3.6	2,079	1.2	68	1.1
Cancer	26,476	1.3	20,844	12.2	1,557	25.6
Endocrine, nutritional, metabolic and immunity disorders	45,783	2.3	3,369	2.0	103	1.7
Mental disorders	179,646	9.0	3,580	2.1	259	4.3
Nervous system and sense organ diseases	105,106	5.2	6,206	3.6	124	2.0
Circulatory system diseases	124,945	6.2	18,489	10.8	2,313	38.0
Respiratory system diseases	230,211	11.5	11,235	6.6	815	13.4
Digestive system diseases	71,823	3.6	20,584	12.1	347	5.7
Genitourinary system diseases	90330	4.5	9,219	5.4	107	1.8
Pregnancy, childbirth and the puerperium	-	-	17,005	10.0	1	0
Skin/subcutaneous tissue diseases	121,436	6.1	6,718	3.9	14	0.2
Musculoskeletal and connective tissue diseases	198,829	9.9	6,211	3.6	29	0.5
Symptoms, signs and ill-defined conditions	185,149	9.2	20,821	12.2	25	0.4
Injury and poisoning	59,996	3.0	10,861	6.4	253	4.2
Other conditions and reasons for contact [†]	494,891	24.7	13,190	7.7	68	1.1
Total	2,006,745	100	170,411	100	6,083	100

† For example, screening, immunisation, administrative contacts, GP consultations for pregnancy, and healthy baby checks

Table 2 shows that a quarter of Lanarkshire's estimated 2,000,000 annual GP consultations are for activities such as disease screening, immunisation and pregnancy. A decrease in the younger age groups may result in a drop in general practice contacts for reasons such as cervical screening and immunisation.

The most common causes of death are circulatory system diseases and cancer. This is not reflected in GP consultations, where the commonest conditions are respiratory disease and musculoskeletal / connective tissue diseases, which can affect people of all ages. A significant proportion of respiratory disease is due to smoking and the effects of industry, both of these are expected to decrease. Statistics such as these are useful in providing an indication as to where our resources should be targeted.

Cambuslang/Rutherglen and the Northern Corridor

Cambuslang and Rutherglen ('Camglen') are unusual in that they are within the NHS Greater Glasgow & Clyde area, but come under the jurisdiction of South Lanarkshire Community Health Partnership (CHP). Camglen's population is around 58,000, with 13 GP practices and around 33 GPs. Plans have recently been agreed under which further responsibility for the area will be transferred from NHSGGC to South Lanarkshire CHP. This will ensure that multi-agency issues such as primary care strategy development can be taken forward consistently across the whole Lanarkshire CHP area.

A similar process is underway in the Northern Corridor, which includes Moodiesburn, Muirhead, Gartcosh, Mollinsburn, Auchinloch, Chryston and Stepps. The area has a population of around 18,000; with four GP practices and 11 GPs. Health services are currently provided by NHSGGC.

2.3 NHS Lanarkshire's current primary care services

The aim of this plan is to improve the provision of health services across the community. Primary care is defined as:

All those health services provided outside hospital by **family health** services, which include general practitioners, dental practitioners, pharmacists and opticians, and **community health** services, which include community doctors, dentists, nurses, midwives and health visitors, and other allied health professionals such as podiatry and physiotherapy. These health services play a central role in the local community.

To put this into context, within NHS Lanarkshire:

- 40,000 GP consultations take place each week
- 800,000 prescription items are dispensed monthly, costing on average £9.5 million per month
- community nurses (district nurses and health visitors) carry out over 18,000 visits per month
- the primary care out of hours service deals with 2,400 calls each week
- the cost of providing these primary care services in 2006/07 amounted to £370m or £650 for each of the residents of Lanarkshire

As part of *A Picture of Health*, NHSL undertook a major review of its services. This involved the public, patients, carers, staff and other agencies, and concluded that primary and community services were often fragmented, could be uncoordinated, and that there was a need to improve the premises from which services are delivered.

2.4 Why services need to change

There are many reasons why we cannot continue to provide the same services in the same way. One of these is the importance of closing the gap between those with the best health outcomes and those with the worst.

Key factors that will drive the health and social care needs of Lanarkshire's population over the next ten years include:

- the growth in the number of older people, and in particular the number of frail older people
- the increasing number of people with long-term conditions
- the need to address the influence of socioeconomic deprivation on health
- opportunities to use new technologies to empower people to take a greater responsibility for their own health

In addition to broad demographic changes, there have been more subtle changes such as a shift in the social profile of older people. For example the number of people aged over 85 years living alone in Scotland increased by almost 50% between 1991 and 2007. This alone presents a significant challenge to the way health services are currently delivered.

Medical and pharmaceutical advances are providing opportunities to deliver healthcare more quickly and more effectively than before. An increasing range of treatments and procedures can now be provided in primary care settings, leading to better outcomes for patients and avoiding the need for hospital stays.

In 2005 the Scottish Executive published *Delivering for Health*, which set out a new vision for NHS Scotland based on responsive and localised care that empowered patients to take control of their own treatment. Within NHS Lanarkshire, *A Picture of Health (APoH)* built upon the ambitions of *Delivering for Health*, sets out NHS Lanarkshire's strategy for providing both acute and primary care services over the next five-plus years.

This process clearly illustrated the need for a well-trained and well-supported workforce of health professionals equipped with the knowledge and skills to deliver effective, modern services. This will involve continuously educating and training staff to meet accreditation standards and legislative requirements.

The vision is one of strong and visible primary care service, based within the community but with rapid access to specialist hospital service as required. This primary care modernisation plan has been developed through a partnership approach, and sets out how this will be delivered in the future.

2.5 What evidence and work is modernisation based upon?

This plan takes a very close lead from the national agenda described in *Delivering for Health (2005)*, and *Better Health, Better Care (2007)* as well as emerging strategic thinking from elsewhere in the UK.

We were keen to learn from evidence-based work elsewhere in the NHS and looked to the NHS Institute for Innovation for guidance. The Institute recently reviewed current NHS experience in making shifts of care. In particular, it identified to what extent progress has been made, and examined areas of common experience and factors that are perceived as supporting or inhibiting successful change. The review identified a number of mechanisms that can refocus care into the community. The following table summarises where health systems should really place their emphasis if the evidence-base is to be used.

Table 3: Summary of evidence-based factors to support shifts in care

a) Factors that help to facilitate shifts

<p>Integration of services</p> <ul style="list-style-type: none"> • broad managed care programmes • changes in the attitudes and behaviours of staff • partnership working with voluntary groups • self management education <p>Segmentation</p> <ul style="list-style-type: none"> • targeting people at highest risk <p>Simplification</p> <ul style="list-style-type: none"> • direct GP access to hospital-based tests • direct GP access to specialist treatment 	<p>Substitution (facilitating factors for change)</p> <ul style="list-style-type: none"> • developing multidisciplinary hospital teams • utilising the skills of service users • substituting nurses for doctors • multidisciplinary community mental health teams • discharge planning to include primary and secondary care • patient initiated follow-up after discharge • primary care follow-up after hospital discharge • hospital-at-home • home visits added to usual care • ongoing long-term care in primary care • shifting care to non-health venues • telecare information and support • automated telemonitoring • self monitoring
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b) Factors which may also help to shift care

<p>Integration of services</p> <ul style="list-style-type: none"> • shared care <p>Segmentation</p> <ul style="list-style-type: none"> • dividing the population into sectors or types <p>Simplification</p> <ul style="list-style-type: none"> • formal care pathways • rapid access clinics 	<p>Substitution (facilitating factors for change)</p> <ul style="list-style-type: none"> • general practitioners with special interests • relocating specialist services to other venues • GPs performing minor surgery* • inserting secondary care specialists into primary care teams • intermediate care • outpatient clinics in primary care • hospital observation units • telemedicine consultations • substituting telephone calls for clinic visits • information alone to support self management • patient-held records
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Source: Institute for Innovation and Improvement Making the Shift July 2006

This plan has taken these factors into account in determining how to deliver the outcomes that are required in Lanarkshire.

2.6 What outcomes will we be judged against?

To be considered successful, this plan must demonstrate significantly improved outcomes for patients, including real and beneficial choice. The benchmarks by which success will be judged include the following:

A. *Delivering for Health*

- new integrated health and social care services created across the main care groups
- health inequalities gap addressed and demonstrably narrowed
- greater levels of non-medical prescribing
- enhanced levels of community rehabilitation

B. *Better Health, Better Care*

- working in a coordinated way across Government
- continuous Improvement in healthcare, putting the patient at the centre
- improving the patient care experience
- focusing on anticipatory care and long-term conditions
- service improvement based on a collaborative approach
- investment to develop sustainable services which will meet the needs of a changing population

C. Scottish Government Health Department / NHS Lanarkshire HEAT targets

- delivery of integrated primary care solutions which in conjunction with secondary care ensures that NHSL attains and sustains the four-hour A&E target
- achieving ministerial waiting times guarantees
- reducing to targeted levels the number of emergency inpatients and readmissions for over-65s

D. *A Picture of Health (APoH) outcomes*

- strong, visible and modern primary care
- consistent high quality out-of-hours care
- effective integrated care management implemented across Lanarkshire
- seamless and coordinated care for those with long-term conditions

E. The aspirations of stakeholders

The consultation process for APoH gave key stakeholders the opportunity to contribute their views about all aspects of primary care. The points listed below are summarised from these and provide a strong message about how primary care services should be developed over the next five years:

- implement the key actions out of the Long-Term Conditions (LTC) Strategy
- provide integrated care management for people with more complex health and social needs

- co-ordinate disease management delivered by multidisciplinary teams
- implement greater supported self-care/patient information/education
- research and implement best practice using new technology solutions
- deliver health improvement and anticipatory care which is proactive and reduces the onset of long-term conditions
- improve access to high quality, local healthcare services that reduce waits and delays
- maximise joint working to realise the potential of working across geographical and organisational boundaries, including the need for better integration with the voluntary and independent sector
- improve the accommodation used for primary and community care services by developing health centres and GP-owned premises
- build capacity to deliver better, more accessible and more specialist care closer to patients
- utilise technology to deliver robust and reliable communication systems to share information and good practice
- develop the workforce to ensure healthcare delivery is a team activity

2.7 Public expectations and involvement

NHS Lanarkshire will continue to engage and involve the public, service users and carers in all aspects of the modernisation process. This partnership approach will ensure that decision-making processes which influence the future shape of health services are accessible to all.

NHS Lanarkshire's accountability to the people of Lanarkshire will involve a two-way dialogue taking the form of:

- ongoing public engagement and involvement
- stakeholder workshops
- engagement with 'hard to reach' groups
- partnership with voluntary and statutory bodies
- closer working with users, carer organisations and individuals

This engagement will ensure that services are delivered by the right person in the right setting, first time around.

2.8 What the strategy does not consider

This primary care modernisation process is considered to be an example of good practice for system-wide modernisation.

However, it is recognised that while the majority of patient contacts take place in the community, it is impossible to develop a primary care agenda for the future without taking other parts of the healthcare system into consideration. The impact of ongoing and future developments in the acute sector, mental health, learning disabilities and children's services are outlined in Chapter 4.

3. THE CORNERSTONES OF CARE

3.1 INTRODUCTION

This section of the plan describes the cornerstones of care; the outcomes which we expect to achieve for each and detail covering the key measures that we will use to demonstrate progress and achievement. For the purposes of this plan, we are looking mainly at process outcomes. Actual outcomes in terms of individual and population health gain will be monitored through public health population information and other systems and processes.

It should be noted that, although we have identified some specific key measures for each cornerstone, in reality there are many others, many of which are cross cutting, i.e. make a contribution to more than one of the cornerstones or associated outcomes. These are mainly drawn from existing national targets such as NHS HEAT targets, Community Care Outcome Measures and Single Outcome Agreement targets derived from the concordat between COSLA and the Scottish Government.

The full suite of measures to be used, is provided as appendix x and these are cross referenced to the cornerstones. To gain a full understanding of the range, scope and interrelationship of these measures, it is necessary for readers to familiarise themselves with the entire list in the appendix.

It is our intention to benchmark our performance against other Board areas and other partnerships through examination of nationally published performance reports in terms of HEAT targets, Community Care Outcomes and GMS Contract performance information.

3.2 Unscheduled care outside of hospital

The aim of managing unscheduled care is to improve the patient and carer experience through better access within a reasonable timeframe. We will aim to ensure that such care is delivered within the local community using a multidisciplinary team based approach.

The expected outcomes

- improved access for patients by providing better care, delivered closer to home
- a reduction in the number of avoidable inpatient admissions
- a reduction in the number of avoidable attendances at A&E (specifically for minor injuries)
- a more streamlined point of access to primary care services across NHSL both in and out-of-hours, and coordination of this with secondary care services
- development of a range of options to facilitate self-care and support for people with long-term conditions, thereby reducing the likelihood of relapse and subsequent admission to hospital
- more local access to treatment for minor ailments and injuries, some of which will avoid the need to attend A&E
- an increase in the range of access options in the community through both extended opening hours and an increase in the number of professionals able to deal with patients' complaints appropriately, thus ensuring fewer attendances at A&E due to lack of access to the primary care team at key times in the day/night
- improved outcomes for those benefiting from packages of care delivered at home in familiar surroundings, by staff they know and who know them and close to family and friends

We will demonstrate our progress towards achieving these outcomes by monitoring our performance against a range of measures including the following

- Extend opening hours of primary care services through implementation of a Directly Enhanced Service in 2008
- Maintain current 48 hour access to a health care professional and improve access to pre bookable appointments
- Develop an Emergency Response Centre for Lanarkshire by (Date TBC)
- Increase percentage of people accessing minor ailments service provided by Community Pharmacies. Service began July 2006. Provisional estimate is that this service may save 3500 visits a year to G.P. Surgeries.
- Achieve targets for percentage of patients accessing Chronic Medication Service (to be established 2008/9)
- Increase percentage of people accessing supported self care programmes and monitor through the Long Term Conditions Collaborative.
- Reduce by 20%, the proportion of people over 65 years of age admitted as an emergency two or more times in a year
- Reduce by 10% the number of days spent in hospital by over 65s following emergency admission
- Increase by 10% the number of people appropriately accessing community nursing service rather than presenting at A&E or via NHS 24
- Increase by 20%, the number of people supported at home through assistive technology (Alert Systems etc)
- Increase percentage of minor injuries treated in Primary Care by x% (% TBC)
- Increase the level of older people with complex care needs receiving care at home

- Maintain the proportion of older people receiving more than 10 hours of home care per week at 30% of all those receiving long term care

The delivery mechanisms

To achieve these outcomes, a range of service developments, improvements and redesign will be required:

A. Development of a streamlined point of access to unscheduled care

Developing a more streamlined point of access into primary care has the greatest potential to improve the management of unscheduled care. This access point must direct patients into the service best able to meet their needs, and allow the NHS to provide a consistent response.

Part of the infrastructure required to support NHS Lanarkshire in better managing unscheduled care is an improved mechanism for getting patients to the right place at the right time, to be seen by the right person. It is equally important that we get this right first time. The concept of the Emergency Response Centre (ERC) project is to direct patient referrals to the most appropriate person and place at an early stage of the patient's journey. The access point (ERC) will:

- be available 24 hours a day, seven days a week
- be for all patients who currently access services through existing channels, i.e. A&E, NHS 24, out-of-hours providers, ambulance services and dental services
- be able to give clinical assessment and advice (via software that is currently used widely across the NHS)
- consolidate existing call handling arrangements into an integrated hub that handles all emergency activity

At present NHS 24 deals with all out-of-hours GP calls (including dental triage) and provides an advice service during working hours.

To take this forward, Lanarkshire must develop an 'NHS 24 plus' model which will provide additional services during the day, offer a streamlined method of access to a wider range of community alternatives and services, and be able to deal with the following:

- advice and self-care
- repeat prescriptions
- arranging urgent GP appointments
- providing referrals into other services (i.e. physiotherapy, podiatry and community nursing)
- linking into together agencies and rapid response services (i.e. social work and community loans)
- providing integrated mental health service signposting for secondary care and primary psychiatry care

An NHSL clinic has been proposed for each locality which is a bookable 'twilight' service (4 p.m. to 8 p.m.). This would consist of a clinical team made up of GPs, nurses, physiotherapists and podiatrists. Patients would be referred directly by NHS 24, thus reducing inappropriate attendances at A&E and freeing up GP time to deal with anticipatory care or more complex cases. This will be considered alongside the extended hours Directly Enhanced Service (DES) in 2008.

B. NHS 24 / out-of-hours triage service / primary care OOH service

In advance of the streamlined method of access, we will look at enhancing the local triage centre. Additional capacity will be introduced to enable NHS Lanarkshire to address a greater proportion of Lanarkshire derived contacts. To ensure sustainability of the service, dual role nurse posts will be developed to enable nurse advisors to have face-to-face contact with patients, as well as offering assessment and advice over the phone.

The primary care OOH service will continue to evolve, focusing on enhancing the skills of the nursing and paramedic workforce. General practice-trained doctors will continue to play a major part in service provision. In the longer term, paramedics and community nurses are likely to provide the home visiting service, with doctors offering advice from current bases in the community and district general hospitals, and managing the more complex medical problems.

C. New Pharmaceutical Care Services contract

Implementation of the new Pharmaceutical Care Services contract will see the provision of a range of additional services delivered by approximately 200 community pharmacists working from 115 pharmacies across NHS Lanarkshire.

Four key services will be provided by every pharmacy in Scotland. Three of these will have a positive impact on unscheduled care, as outlined below. The contract places an obligation on each pharmacy to participate, and this will ensure equitable access to services. The concept will be further enhanced with the development of a pharmaceutical care services plan in which service accessibility is rationally planned.

E-Minor Ailments service. This service will facilitate the treatment of minor ailments by NHS staff within community pharmacies. This will improve access and choice for patients, as well as transferring some demand away from GP surgeries and out-of-hours services. The service was established in July 2006 and approximately 7,000 prescriptions are now being written each month within community pharmacies. This remains a new service, and the challenge is to further publicise and support it so that it becomes the primary access route for patients with minor ailments.

E-Acute Medication Service. This service will dispense acute medications in a manner which quality-assures the complementary advice given about lifestyle and using the medicine. It will also generate an electronic record to be shared with the GP and Practitioner Services Division (PSD). The service is anticipated to start in April 2008. While from a clinical perspective this system is very like the traditional dispensing system, the e-Health aspects offer many more opportunities to track the journey of patients and their prescriptions through the acute care journey. In the long run this will provide a greater understanding of the choices patients make and help with the design of better systems. It may, for example, identify a sizable number of situations which currently require GP time, but which could be readily attended to by other members of the primary care team working in locations more easily accessed by the patient.

E-Chronic Medication Service. This will allow pharmacists to contribute to the ongoing care of patients requiring medicines to treat chronic conditions. The service is due to commence in 2008/9, and will initially focus on rheumatoid arthritis and COPD. As well as making a clinical contribution to the safe and effective use of medicines, there will be other practical benefits. The service should greatly reduce the administration burden within GP surgeries by allowing GPs to potentially write a single prescription for a 12-month supply of medication. This will then be dispensed from the pharmacy when it is convenient to the patient at a clinically appropriate frequency. Furthermore, there will be a clinical review prior to each instalment being supplied. The system has major strengths in minimising prescribing time by GPs, providing flexibility in supply arrangements, and offering patients a clear and accessible supply route when they run out of medicines. This flexibility will also play a part in reducing demand on out-of-hours services. Electronic communication will ensure that both the GP surgery and PSD receive information about any dispensing activity.

D. New optometry contract

It is estimated that up to 6% of GP consultations are eye-related, and there is the potential for community optometrists to see and treat many of these patients.

On 1 April 2006 a new contract was introduced for ophthalmic practitioners in Scotland. One of its key elements was a free eye examination (rather than sight test) for every person in Scotland. The impact of this change is significant, and in effect means that optometrists – rather than GPs – should become the first point of contact for eye problems. The detailed eye examination will mean that patients' needs and symptoms are assessed more fully in the community, and it is anticipated that this will significantly reduce inappropriate referrals to secondary care.

Positive early indicators following the introduction of the new contract include a drop in cataract referrals to hospitals, and an increase in eye examinations of around 20%.

E. Dental services

A new out of hours system managed by the community dental service (CDS) became operational in Lanarkshire in March 2006. This caters both for patients registered with participating GPs, and for unregistered patients. It is made up of three main elements:

- a triage service based at Hairmyres Hospital. All calls are initially taken by NHS 24, but are passed to dental triage nurses at peak times. Since October 2007, there have been two dental triage nurses on duty at peak times on Saturdays and Sundays
- a weekend and public holiday service based at Wishaw General Hospital, to which patients can be referred following dental nurse triage. Currently the rota is made up of 83 dentists and 22 nurses. Many of the dental nurses who work on the clinic sessions also work as the dental triage nurses
- a weekday service provided by a rota of local GPs. On any given day, seven dentists are available to each see up to three unregistered patients in their own practice. They provide next-day care to patients who have been referred by NHS 24 following dental nurse triage

F. Public health and public information services

NHSL will develop public information services in partnership with the local authorities call centres which will include education and access to the right service, direction on where to go outside hospitals and guidance regarding the options relevant to their individual circumstances to ensure everyone self-cares optimally.

G. Directory of services

A Directory of Services will be developed by the Long Term Conditions Action Team as a core element of management of complex care cases and to help avoid unnecessary hospital admissions, particularly during out-of-hours periods. This will be a partnership initiative that will link into knowledge held by NHS 24 and feature as a key component of the Emergency Response.

H. Provision of healthcare to care homes

A local study, carried out by the care of the elderly department in Hairmyres, found that emergency admissions had risen from 300 per annum in 2003, to approximately 470 in 2005. A significant factor behind this has been the increasing number of new care homes opening in Lanarkshire. General practices have also experienced an escalation in the volume of calls from care homes.

In response to these findings, a short-life multidisciplinary working group was set up to review current input into care homes, and develop a model of healthcare provision which would address the increase in demand. This model is now being implemented and consists of 'virtual' multidisciplinary teams

made up of general practices, liaison and link nurses, AHPs, pharmacists and specialist services i.e. care of the elderly and old age psychiatry. Each team looks after approximately 90 patients located at one or more care homes.

The new model will enable more effective use of personnel. Each home will only be visited by one practice, and it is more likely that consistent care will be delivered when a single specification is in place across Lanarkshire. By providing increased anticipatory care, there should be a reduction in emergency admissions, A&E presentations and calls to the OOH service from care homes.

3.3 Care for people with long-term conditions

Our aim is to deliver effective and proactive management of long-term conditions closer to the patient. This will mean focusing on improving and maintaining health, shifting the balance of care from acute hospitals to primary care, and delivering a quicker, more personal and preventative service, (*Delivering for Health, 2005; Better Health Better Care, 2007*).

The expected outcomes

- improved quality of care and health outcomes; long-term health improvement
- delivery of person-centred holistic care
- a reduction in avoidable hospital admissions for people with complex and rapidly changing needs
- sufficient support to equip people to manage their own conditions through a number of supported self-care and self management strategies
- full engagement of patients in the management of their own healthcare
- improved quality of life for individuals and their carers
- improved access to appropriate services within community and primary care

We will demonstrate our progress towards achieving these outcomes by monitoring our performance against a range of measures including the following.

- Improve GP Practice performance in relation to Quality and Outcomes Framework (QOF), e.g. disease registers, percentage of patients optimally controlled re BP, cholesterol, HbA1C etc .
- By 2011, increase by 33%, the number of people with a diagnosis of a dementia on the QOF dementia register.
- Reduce the rate of increased use of anti depressants (Defined Daily Doses : DDDs) to zero by 2009/10 and a 10% reduction in future years
- Increase the number of patients included in anticipatory care monitored through the Long Term Conditions Action team
- Increase to x,000 the numbers of people enabled to access screening through the Keep Well programme by March 2009
- Increase number of electronic single shared assessments and % of those completed to national standards (measure to be defined)
- From 2008/9 achieve agreed reductions in rates of hospital admissions and the number of days spent in hospital for people with Chronic Obstructive Pulmonary Disease, Asthma, Diabetes or Coronary Heart Disease
- For those receiving Community Care (and their carers), increase the percentage of users feeling safe, percentage of users and carers satisfied with their involvement in the design and delivery of care packages and percentage of users satisfied with opportunities for social interaction

The delivery mechanisms

A. Local intelligence

The availability of local intelligence on the numbers of people – especially high-risk patients – who have received support, advice, medication management or treatment, will enable services to be planned and delivered in a more proactive way.

The nationally developed risk prediction tool SPARRA (Scottish Patients at Risk of Readmission) will provide a means of identifying patients at risk of unplanned hospital admission. We will mainly work with colleagues in local authority social work departments to undertake multi-source case finding and case allocation on a locality basis, ensuring that services are delivered timeously to people with complex rapidly changing circumstances.

B. Joint working

Working more closely with the wider health and social care community on a range of services being delivered in the community is a key component of the Long-Term Conditions Strategy. Joint Working will be implemented across all stakeholder groups, including the public, voluntary organisations, users and carers, local authority partners, and in association with the independent sector, where relevant.

Joint training will be delivered to ensure that health and social care professionals have the skills and capability to promote optimal management of long-term conditions. The work already undertaken on the single shared assessment will be a good foundation for this.

A multi-agency Long-Term Conditions Action Team will be established to direct and review the implementation of the Long-Term Conditions Strategy. This will provide regular reports to the corporate management team and Scottish Government Health Department.

C. Care pathways

Care pathways and individualised care plans will be used to deliver integrated, whole-system care approaches for people with long-term conditions across all care settings. This will improve communication between healthcare, social care, community services and hospital services.

D. Integrated care management

This will provide coordinated support and treatment, where required, to people with complex conditions, delivered within the community by a multidisciplinary team. Access to relevant services in both hospital and community settings will be integrated with other providers where necessary. This will be achieved by linking enhanced primary care services, delivered in the community, with extended primary care services such as early supported discharge, rapid response, use of community hospitals and supported individual care plans. Provision of a greater number of coordinated care packages will avoid hospital admissions by providing support for people at home.

E. Disease management

Better disease management will be achieved by working with GPs and primary care teams to ensure that patients are treated to target. Quality standards and clinical guidelines will be developed by NHS QIS and disseminated through clinical communities and managed clinical networks. This will mean that disease management becomes standardised across the patient pathway. The GMS Quality and Outcomes Framework has resulted in GP practices setting up disease registers for the most common long-term conditions. This has involved the introduction of systems which review and recall patients, ensuring their conditions are being properly monitored, managed – and crucially entered on to the practice IT systems – thereby enabling long-term follow-up. In the future individuals will be proactively managed, leading to a decreased risk of complications, fewer emergency admissions and an improved quality of life.

F. Supported self-care

The development of both disease-specific and generic supported self-care programmes is a key feature of the Long-Term Conditions Strategy. All managed clinical networks will work to deliver the Long-Term Conditions Strategy in partnership with patients, carers and the voluntary sector. The aim is to develop and implement self-care and self-management programmes in areas such as diabetes, stroke, coronary heart disease and chronic obstructive pulmonary disease.

G. Anticipatory care

The Long-Term Conditions Strategy will use population-based proactive anticipatory care models designed to engage all care and age groups with the aim of reducing the onset of long-term conditions. To facilitate this, NHSL will roll out successful methods applied in the Keep Well pilot, carried out in North Lanarkshire Community Health Partnership. This aims to screen 40,000 people during 2007/8, tackling 'hard-to-reach' communities and those at greatest risk of cardiovascular disease. Increased provision of smoking cessation, weight management, and leisure services will be provided to meet the increased demand for those services as a result of anticipatory care. In addition, health promotion and health improvement campaigns will target those in greatest need of information and support, and encourage better uptake of health services.

3.4 Extended Primary Care Services

The changing spectrum of ill-health (with a rise in complex, chronic disease) in an increasingly elderly population means that service delivery must be adapted to create the capacity to meet these additional demands. *Delivering for Health* (2005) made it clear that the focus of care had to move from acute settings into the community. Extended primary care will facilitate this shift, with the emphasis on increased management of complex care across community and hospital and proactive anticipatory care, provided in the community by multidisciplinary teams offering specialist interventions when required. Current patient pathways will be reviewed, with revised clinical models established – agreed by acute and primary care clinicians.

New pathways of care will ensure that patients are seen by appropriately trained clinician at the most appropriate locations such as extra community based clinics, extended opening hours, training GP specialists and better heart and cancer services which will deliver local improvements to reflect NHS priorities.

The expected outcomes

- Demonstrable shift in the balance of care from acute hospital settings to Primary Care
- Improved access to a range of services in and out of hours
- Development of GP, nursing and AHP skills to deliver agreed range of appropriate interventions
- Improved outcomes for patients through faster access to diagnosis, assessment and treatment in Primary Care settings and places and times that are most convenient
- Faster access to secondary care services when required

We will demonstrate our progress towards achieving these outcomes by monitoring our performance against a range of measures including the following.

Primary/Secondary Care Interface

Sections 3.2 and 3.3 above include reference to many of the measures which will be cross cutting, reliant on a number of departments and operating divisions working together across the organisation to demonstrate outcomes in relation to Extended Primary Care.

Waiting Times

- 9 week maximum wait from referral to first assessment in all Primary Care AHP Services
- a whole journey waiting time target of 18 weeks from general practitioner referral to treatment by December 2011 (currently applies to acute services, including Paediatrics and Audiology)

From 2008/09 – HEAT targets : As a milestone in achieving 18 weeks referral to treatment, no patient

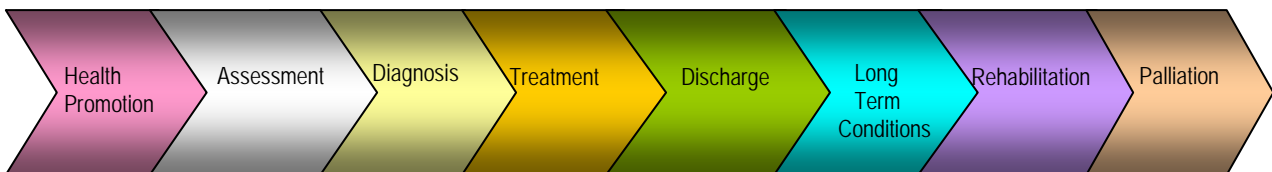
- Will wait longer than 15 weeks from GP referral to a first outpatient appointment from 31 March 2009.
- Will wait longer than 15 weeks for inpatient or day case treatment from 31 March 2009.
- Will wait longer than 6 weeks for one of the 8 key diagnostic tests from 31 March 2009)
- NHS Boards will achieve agreed reductions in the rates of attendance at A&E, from 2006/7 to 2010/11; and from end 2007 no patient will wait more than 4 hours from arrival to admission, discharge or transfer for accident and emergency treatment.)

- The maximum wait from urgent referral to treatment for all cancers is two months ; women who have breast cancer and need urgent treatment will get it within one month where appropriate
- The maximum wait for cataract surgery will be 18 weeks from referral to completion of treatment.
- The maximum wait for cardiac intervention will be 16 weeks from GP referral through rapid access chest pain clinic or equivalent and 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.

The delivery mechanisms

(i). Review of clinical/service models

Clinical models describe the range of care required for patients with specific types of disease. They include what needs to be done to prevent disease; how to manage it (assessment, diagnosis and treatment); requirements for long-term support; and how to promote independence and provide end-of-life care. The models are underpinned by disease-specific pathways and evidence-based practice.



Approximately 22 clinical groups (15 specialty groups and 7 support service groups) – (*there will shortly be a refreshing of the terms of reference for these group to be known as service improvement groups*) covering areas such as renal medicine and urology – have been established and are developing clinical models for a range of diseases. Where managed clinical networks (MCNs) exist they have been integral to the development of the clinical models and will contribute to the next phase of work on service models.

(ii). Review of the role of community hospitals

Our community hospitals have been providing excellent services to local communities, some of them for many years. *Delivering for Health* indicated that “community hospitals are now in a position to look at developing new services in new ways”. The current and future role of community hospitals has recently been reviewed to ensure they realise their full potential. Four community hospitals operate within NHSL: Lady Home (Douglas), Lockhart (Lanark) Kello (Biggar) and Victoria (Kilsyth).

Some of the ways in which community hospitals can meet the changing needs of primary care include:

1. providing additional local services such as nurse-led clinics, falls assessment/advice, and day services for adult psychiatry, old age psychiatry and early onset dementia
2. developing extended roles for GPs, for instance in the provision of minor surgery and postoperative care
3. continuing to offer intermediate care that is too complex to be provided in a community setting
4. facilitating partnership working with local authority colleagues to provide fast-track carer assessment and access to respite services where appropriate
5. improving partnership working with the voluntary sector to support patients during their journey of care

6. offering additional training to both staff and carers (in particular providing information and support on the management of long-term conditions)
7. developing an in-house programme of job shadowing/rotation to enable staff to improve skills and promote career progression

(iii). Enhancing intermediate care and rehabilitation services

This part of this modernisation plan aims to fulfil the recommendations of *Coordinated, Integrated and Fit For Purpose, A Delivery Framework for Adult Rehabilitation in Scotland* (Scottish Executive, February 2007). The framework describes three target groups:

- older people
- people with long-term medical conditions
- people with prolonged absence from employment, intending a phased return to employment

Key goals include:

- preventing unnecessary admissions
- better identification and management of the 'at risk' population
- safe early discharge
- the prevention of dependency on care services
- the health benefits of returning to work

The framework emphasises the need for greater integration with local authority partners, including social work, housing and leisure. It also stresses the importance of working in partnership with the voluntary sector and vocational rehabilitation agencies. NHSL has established a steering group to take the framework's recommendations forward.

In addition, a Falls and Bone Health Protection Group has been set up to review the current falls prevention and bone health services. Community health partnerships will appoint a falls coordinator with responsibility for liaising with relevant agencies within their geographical region. This should ensure that falls prevention and bone health services across NHSL become standardised.

3.5 Health Improvement

This part of the modernisation plan aims to improve the health of Lanarkshire's population by focusing on key causes of morbidity and mortality and the factors which contribute to them.

While Lanarkshire's death rate, when adjusted for age and sex, has steadily improved since the early 1980s, it has remained consistently worse than Scotland's over the same period. The incidence of coronary heart disease and stroke is higher in Lanarkshire than in Scotland, while the rate of cancer is approximately the same.

Figure 1: Life expectancy at birth (years) both sexes combined

Years	Lanarkshire		Scotland		Lanarkshire variance from Scotland			
	Male	Female	Male	Female	Number		%	
					Male	Female	Male	Female
1996	71.7	76.8	72.1	77.7	-0.4	-0.9	-0.5	-1.1
2006	73.7	78.7	74.6	79.6	-0.9	-0.9	-1.2	-1.1
Change	+2.0	+1.9	+2.5	+1.9				
%	+3	+2	+4	+2				

Source: GROS

Life expectancy at birth for males in Lanarkshire increased by two years or 3% between 1996 and 2006, whereas in Scotland as a whole the increase was slightly greater at 2.5 years (4%). For females, life expectancy increased by 1.9 years or 2% for both Lanarkshire and Scotland over the same period. In 1996, females in Lanarkshire were expected to live 0.9 years less than the Scottish average, and there has been no change in this variance ten years on. For males, life expectancy was 0.4 years less than the Scottish average in 1996, but the gap has now doubled to 0.9 years.

The expected outcomes

- More people able to make healthier choices for their diet and nutrition
- More people enjoying the benefits of having a physically active life
- Reduction in the harmful consequences and impact of alcohol and substance use
- Reduction in the consequences and impact of smoking
- Improvement in the emotional wellbeing of the population

We will demonstrate our progress towards achieving these outcomes by monitoring our performance against a range of measures including the following

1. Reduce mortality from coronary heart disease among the under 75s in deprived areas
2. Achieve agreed completion rates for child healthy weight intervention programme by 2010/11
3. Achieve agreed number of screenings using the setting-appropriate screening tool and appropriate alcohol brief intervention, in line with SIGN 74 guidelines by 2010/11
4. Reduce suicide rate between 2002 and 2013 by 20%, supported by 50% key frontline staff in mental health and substance misuse services, primary care and accident and emergency being educated and training in using suicide assessment tools/suicide prevention training programmes by 2010
5. Through smoking cessation services, support 8% of the board's smoking population in successfully quitting (at one month post-quit) over the period 2008/9–2010/11
6. Increase the proportion of new-born children exclusively breastfed at 6–8 weeks from 26.6% in 2006/07 to 33.3% in 2010/11
7. Ensure that 80% of all three to five year old children are registered with an NHS dentist by 2010/11

The delivery mechanisms

Lifestyle interventions

Many diseases are caused or worsened by lifestyle factors. To help address this, the Director of Public Health produced the *Evidence Base for Lifestyle Interventions for Health Improvement (2006)*, which has been approved for implementation by NHS Lanarkshire. The paper focused on nine priority areas and set out a range of actions for each of these, based on good evidence of effectiveness. These priority areas are:

- smoking cessation
- physical activity
- alcohol abuse
- mental health and wellbeing
- healthy eating
- sexual health
- oral health
- drug misuse
- ultraviolet radiation

Many of the actions recommended in this evidence-based document will contribute to addressing the HEAT targets listed above. Locality health improvement teams have been established to take forward this agenda at a local level.

Community Planning

Agreement on, and prioritisation of, single-system working is essential if progress is to be made in reducing health inequalities in our most deprived communities. No one service or agency can resolve these issues, and neither should they be tackled in isolation from each other. Nevertheless, primary care will have a significant contribution to make.

Both CHPs have established strong working relationships with community planning partners. Strategic plans and planning processes are being jointly developed, and mechanisms are in place to ensure that localities are actively engaged in this process.

In the North Lanarkshire CHP area, neighbourhood plans have been developed in each locality, whereas in the South Lanarkshire CHP area plans have developed by the local partnership groups. These include actions to address health improvement priorities locally, as well as system-wide activity. For example, health promotion in schools and nurseries has been developed in partnership with the respective education departments and delivered across Lanarkshire as a whole, but is nonetheless very much part of the locality health improvement action plan. Likewise, much of the physical activity action plan is delivered by the respective leisure trusts or education departments.

Agreement has been reached through the community planning partnerships in both North and South Lanarkshire for five priority areas for joint action. These are:

- smoking
- alcohol
- physical activity
- nutrition
- mental health and wellbeing

These priority areas are among the nine topics covered by the *Evidence Base for Lifestyle Interventions* and are included in, or will contribute to, achieving the HEAT targets detailed above. The overarching themes are to improve health and reduce health inequalities.

Acute sector

NHS Lanarkshire's acute sector also has a key role to play in health improvement. It has endorsed the World Health Organization's Health Promoting Hospital framework, and action plans are being developed to deliver systematic health promotion/improvement in Monklands, Wishaw and Hairmyres hospitals. The managed clinical networks for key diseases (which include primary care representatives) also have a role to play in this, and all of them have been encouraged to develop health improvement plans.

Impact on Primary Care

Health improvement is everyone's business. Staff working in all areas of primary care and community services can make a significant contribution to the health of Lanarkshire's population in settings including GP practices, clinics, schools and even people's homes. Delivering health improvement will involve:

- embedding health promotion into existing services
- focusing on the five key priority areas listed above
- being aware of key health promotion messages and campaigns linked to health improvement strategies
- developing an understanding among staff of how they can personally contribute to health improvement
- being aware of the importance of a 'whole system' approach to health improvement
- ensuring that staff receive relevant training, for example in Brief Interventions and motivational support
- being aware of ethnic differences which may impact on how staff deliver health improvement services and messages
- knowing about specialist support services, for example smoking cessation and Keep Well, and how to refer patients/clients to them
- agreeing how patients' records will be marked so that all relevant staff are aware of their personal health improvement issues

Pharmacy Public Health Service

Community pharmacists will engage with their clients in a structured way to deliver key preventative healthcare messages. During 2007 the Health Department organised coordinated campaigns across all community pharmacies to increase the impact of their work.

At a local level there are opportunities to commission relevant campaigns that complement national programmes. One example that has been suggested is commissioning community pharmacists to highlight medication use issues, as contained within locally agreed carers strategies. Messages which promote safer and more effective use of medications will reduce the demand for unscheduled care.

Implementing the recommendations described above will involve a significant programme of training and awareness-raising.

4. INTERDEPENDENT STRATEGIES

4.1 Mental Health Services

A significant proportion of our mental health services are already community-based. In adult mental health there are community-based teams in each CHP locality.

Proposed future model for community provision

The concept of a 'resource network' of services linked together within a locality remains valid. A key part of such a network will be the statutory services based within that locality. Our strategy is to develop the locality-based teams, while retaining some of the benefits of increased specialisation.

One community mental health team that fulfils a variety of functions will serve each locality. All mental health staff will be locality-based except the few that are wholly based in hospital services. Only ward-based nursing staff, any ward admin staff, the psychiatric assessment team and liaison psychiatry and psychology services will be hospital-based, as they develop. The multidisciplinary forensic team will remain a separate team attached to the complex needs unit in South Lanarkshire.

The team in each locality will have three main functions:

- serving those aged 16–65 with severe and/or enduring mental health problems (core CMHT function)
- providing a menu of interventions for those requiring psychological therapies and interact with local practices to support the management of mental health problems in primary care (primary care mental health function; not age-specific).
- supporting over-65s with severe and/or enduring problems (community elderly function)

In addition there will be team members who carry a specific type of caseload due to specialist skills or function.

Historically, NHS Lanarkshire has populated community services with nurses who have acquired experience working in inpatient services and then moved into a community post at a higher grade. However, we acknowledge that newly qualified nurses are suitably prepared to work in either inpatient or community settings. Furthermore, it is likely that in future NHSL's decreased bed numbers will mean it is not always possible to provide newly qualified nurses with inpatient posts. Coupled with the commitment in *Rights, Relationships and Recovery* to provide rotational posts for newly qualified nurses, this will enable us to develop additional nursing resources at band 5. These nurses will deliver services under the direction and supervision of colleagues at grade 6 or 7 who may be providing more specialist interventions.

We will develop specialist functions within locality teams wherever possible. An example would be a service for those with very complex needs and high risk. Rather than develop a specialist rehabilitation team (or one for each CHP locality), one or more team members would be assigned to work with this group. They would carry a smaller caseload to reflect the complexity of their cases, and many clients would be seen by the complex needs consultant rather than a locality consultant.

Those team-members would meet regularly, probably weekly, with the complex needs consultant and community psychiatric nurses from other localities with responsibility for complex needs cases. These meetings would provide peer support, supervision and opportunities to sharing best practice. The benefits of being part of the locality team would included access to local knowledge and availability of resources such as support workers and voluntary sector services. There would also be scope to transfer cases back to either the core team or primary care as the need for specialist input ceases.

Similar models of care would be developed for particular groups such as those with eating disorders, personality disorders, early onset dementia or dual diagnosis. The potential of using similar models for crisis management and early intervention would also be explored.

NHS Lanarkshire will also expand the range of specialist services currently offered, to provide appropriate levels of community-based treatments aligned to commitments outlined in national policies and strategies. Services that need to be expanded include learning disabilities, children's services, sexual health services, managing blood borne viruses, and palliative care.

4.2 Learning disabilities

Community services for those with learning disabilities are currently provided by multidisciplinary community learning disability teams, based within each of the CHP areas. Several factors have been influential in taking forward learning disabilities services within Lanarkshire. Recommendations from the national review *The Same as You*, and the local framework document *We Want a Life*, provided opportunities to reshape and reorganise services for people with learning disabilities. These recognised that due to specific health needs this group requires access to specialised services.

Proposed future service provision

People with learning disabilities have a range of complex health needs that often require additional services and support. In partnership with other agencies, NHS Lanarkshire will provide integrated healthcare which encompasses both everyday and specialist health needs. *Promoting Health, Supporting Inclusion* (2002) provided a clear framework for service delivery, while *Health Needs Assessment for People with Learning Disabilities in Scotland* (2004) presented an evidence-base for the specific needs of this client group.

Development of the community multidisciplinary teams has included the provision of five additional practitioner posts: autistic spectrum disorder, forensic, acute liaison, epilepsy, and transition. These team-members coordinate and facilitate services across Lanarkshire for people with learning disabilities. As highlighted in *Promoting Health, Supporting Inclusion*, learning disabilities services in Lanarkshire support a primary-care based approach to service delivery.

Learning disabilities services have taken forward the strategic development of a 12-bed assessment and treatment centre, which will provide services for individuals who present with diverse or complex health needs. The centre will operate within agreed patient pathways, using appropriate protocols for admission and discharge. Information will be shared across all agencies, ensuring that patients receive effective and high-quality care.

The centre is an integral part of our community-based learning disabilities services, and in addition to providing inpatient beds will offer some outpatient clinics and therapies. However, these will be limited to services that cannot be provided within the community.

Services for those with learning disabilities are delivered using an integrated care pathway approach. This supports and emphasises collaborative working and clinical networking as a means of ensuring equitable access. Joint working with a range of services is central to the model of care.

4.3 Children's services

Childhood and youth are stages of life which are associated both with natural illness and high expectations of good health. Most children suffer minor ailments and injuries which are considered to be a normal part of childhood. Despite this, there are links between several of the topics covered elsewhere in this strategy and children's services. For example, long-term conditions, mental health issues, learning disabilities and health improvement can all be relevant to children. Furthermore, other complex challenges face children and young people that cannot solely be addressed by the health service. These include deprivation, social inclusion and vulnerability.

Aims and targets

In *Delivering for Health*, the Minister for Health and Community Care made a commitment to develop a framework for children and young people's health in Scotland. Called *Delivering a Healthy Future – Action Framework for Children and Young People's Health in Scotland*, this was published in 2007.

In Lanarkshire, integrated children's services plans have brought together a range of agencies to plan, commission and deliver services based on jointly agreed objectives and outcomes. Plans are in place detailing the actions, timeframe and lead individual/s for each target. This structured approach provides the strategic direction for children's services within NHSL.

The Children's and Maternity Service Modernisation Programme Board is leading the coordination and prioritisation of NHSL's action framework. 14 sub-groups report to the programme board, each leading on specific areas of service development. These are supported by a range of working groups with the existing children's services strategy groups provide an additional delivery mechanism.

Impact on primary care services

Improving services

The Scottish Executive's *Action Framework* document acknowledged that the service needs of children and young people are often materially different from those of adults. Because of this, arrangements for planning and commissioning services must reflect these differences. Getting it Right for Every Child (GIFREC) provides guidance on the best way to deliver appropriate children's services, and stresses the need for childcare to be consistent and coordinated. Achieving this will involve:

- effective inter-agency working
- sharing information
- well organised discharge planning
- structured resourcing of care packages
- coordination of care through an identified key worker, lead professional and planned multi-agency review

Significant emphasis has been placed on providing care locally and in a more integrated way. This was reinforced by the *Integrated Children's Services Plan* (2004), which highlighted the role of local systems and plans in delivering services and addressed the issues highlighted in *For Scotland's Children* (2001). Specific guidance has since been drawn up, including *Health for All Children* (2005) and *A Scottish Framework for Nursing in Schools* (2003).

Specific areas that have been identified as requiring attention include children with complex needs, mental health services, long-term conditions and hospital services. The SNAP *Needs Assessment Report on Child and Adolescent Mental Health* (2003) provided valuable information about children and young people's mental health needs. This was supported by *The Mental Health of Children and Young People: A Framework for Promotion, Prevention and Care* (2005). Within Lanarkshire a draft Children and Adolescent Mental Health Strategy (CAMHS) strategy has been developed, and is due for submission to NHSL for approval. While it is acknowledged that the finances required to fully implement the strategy may not be available this financial year, there is an awareness of the need for the service to develop in line with the agreed strategy direction.

The *Emergency Care Framework for Children and Young People in Scotland* (2006) describes four levels of care, and provides a comprehensive approach to the delivery of emergency care for children and young people. In Lanarkshire, emergency care for children is provided at levels 1–3. The current review of A&E services at Monklands Hospital will provide further clarity in relation to the future model of emergency services.

Acute and selective inpatient provision for children in Lanarkshire has undergone significant changes over the past five years, with medical paediatric services now concentrated at Wishaw General Hospital. A wide range of services are provided in community settings, i.e. home ventilation, which is coordinated by colleagues at Yorkhill Hospital.

As proposals for service developments within children's services are drawn up, a business case for each of them will be put together and resources applied for.

4.4 Sexual health services

Both Scotland and Lanarkshire have poor levels of sexual health. Scotland has the highest rate of teenage pregnancy in western Europe, and sexual infections are rising, particularly in the under-25 age-group. Lanarkshire's high levels of deprivation compound many of the issues relating to sexual health.

Respect and Responsibility (2005) emphasised the importance of promoting positive sexual health, and the need for a much wider range of service provision. *Enhancing Sexual Wellbeing In Scotland: A Sexual Health & Relationship Strategy* (2003) formed the basis for the *Lanarkshire Sexual Health Strategy and Action Plan* (2005–2008).

Improving the sexual health of Lanarkshire's population is not limited to contraception and treating sexually transmitted infections. A much broader range of work is involved, including good social religious education in schools and partnership working with the voluntary sector and faith groups. In addition, links to addiction services are being promoted in recognition of the fact that alcohol and drugs can lead to risk-taking behaviour, including unplanned and or unprotected sexual intercourse.

Aims and targets

The *Lanarkshire Sexual Health Strategy and Action Plan* is addressing many of the issues described above, and ongoing work will improve provision of sexual health services over the next few years.

The development of national Key Clinical Indicators for Sexual Health has highlighted areas where improved performance is needed, and has also helped move services forward. NHS Quality Improvement Scotland has launched a sexual health services project, and this includes a set of standards which are currently out for consultation. It is anticipated that these will catalyse additional service development.

Delivery mechanisms

In Lanarkshire genitourinary medicine and family planning services have now been integrated and form part of primary care. Almost all NHS's sexual health services are community-based.

The lead clinician has been extensively involved in the West of Scotland Regional Workforce Group, and from this a regional protocol for future service provision has been developed, based on the HUB model in Glasgow. Implementation will involve close working with community health partnerships.

Impact on primary care services

A survey of general practice in Lanarkshire has provided information on services that are currently being provided and where the gaps are. Based on this, a plan will be devised to bridge the gaps. A comprehensive training programme for primary care will be progressed in 2008, and where services are not provided by GPs or practice nurses information will be provided on signposting patients to the appropriate sexual health service.

4.5 Blood borne viruses

Primary healthcare services have an increasingly important role to play in the testing, diagnosis and referral of patients with blood borne viruses such as hepatitis C, HIV and hepatitis B. They are also involved in other measures to control the spread of these infections such as contact tracing, hepatitis B vaccination and health promotion.

The Scottish Government has indicated that it will invest significantly (£6.0m in 2008–09; £18.2m in 2009–10; £21.1m in 2010–11) in Phase II of the Scottish Hepatitis C Action Plan (www.hepcscotland.co.uk). Staff at the Lanarkshire HIV, AIDS and Hepatitis Centre will collaborate with primary healthcare services in supporting patients with hepatitis C infection using appropriate care pathways.

The Chief Medical Officer and Chief Nursing Officer recently wrote to all doctors and nurses in NHS Scotland highlighting the importance of increased testing for HIV infection. Close collaboration

between primary and secondary healthcare services will be key to ensuring that cases are identified and appropriate treatment and care is provided. As lifestyle factors such as smoking, and conditions such as hypertension, hypercholesterolemia and heart disease become the main causes of morbidity and mortality in HIV-infected individuals – rather than AIDS-defining illnesses – close liaison between primary care and specialist HIV services will become increasingly important.

4.6 Palliative care

The need for continued development of palliative care services is highlighted in the Scottish Executive's cancer strategy, *Cancer in Scotland: Action for Change (2002)*.

Palliative care is an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.

This general palliative care approach should be followed in all Healthcare settings by all Healthcare professionals. Specialist palliative care, provided in hospitals, specialist palliative care units (hospices) and by specialist community palliative care teams supports this approach by providing advice and treatment for those with complex needs through a multidisciplinary team approach.

The main policy threads are:

- Integration of planning and delivery of service, particularly involving voluntary organisations in cancer managed clinical networks.
- Managed clinical networks for palliative care and symptom management with particular emphasis on the implementation of the SIGN guideline for the management of pain
- The development of standards for palliative care as part of generic standards for the care of people with cancer, and development of standards for specialist palliative care
- Ensuring continuity of specialist palliative care, particularly for patients in hospital, through the development of hospital palliative care resources.
- Increasing the provision of care at home for people with significant palliative care needs.
- Closer co-operation between NHS Boards and hospices
- Improving skills through education and training for all health professionals, but with particular emphasis on members of the primary care team
- Ensuring that the planning needs of the palliative care workforce are considered by Regional Cancer Networks.

Significant developments in palliative care in Lanarkshire have taken place over the last 10 years through pursuing a strategy written in 1996. Developments have included hospital care, community services and increased access to hospice facilities. There have also been significant developments in palliative care for children, palliative care education, information and support, and spiritual and psychological care.

Development of palliative care services in Lanarkshire will take place in the overall context of the NHS Lanarkshire Health Plan. It will also need to take cognisance of the overall direction of services in Lanarkshire, as laid out in *A Picture of Health*. The broader context in which palliative care plans will be developed is the Kerr Report and the Scottish Executive response to it.

The following extract from the Kerr report accurately pinpoints the diagnosis and remedies identified in this strategic review.

“The delivery of palliative care within the home setting reduces hospitalisation during the last three months of life, preventing avoidable admissions close to death. The delivery of co-ordinated care,

particularly palliative care, involving practice based teams; specialists and social care can reduce avoidable hospital admission.

All patients with cancer in Scotland should have timely and supported discharge and follow-up care and should have access to a cancer specific rehabilitation programme. However patient perspectives on the quality of care received in the community after discharge indicate that current service provision is inadequate and that many patient needs are unmet.”

A Picture of Health will lead to a decision about the future configuration of hospital services in NHS Lanarkshire. Until this is complete, any decision about future numbers and disposition of palliative care in-patient beds would be premature.

Palliative care development also needs to sit within the overall financial strategy for NHS Lanarkshire. In practice this means that there is limited new money for developments. However, the wide range of partnership funding and voluntary fundraising in the field of palliative care provides opportunities for NHS Lanarkshire to work with partners to maximise the effectiveness of the overall money available.

5. SUPPORTING INFRASTRUCTURE

5.1 eHealth Information Management and Technology (IM&T)

Background

NHS Lanarkshire has agreed a tactical work plan for eHealth covering the period 2007–10. This remains broadly consistent with the National eHealth Strategy recently published by the Scottish Government.

The plan will ensure that the strategic priorities of NHS Lanarkshire and its partner agencies are supported by information that is acquired, stored and shared electronically. This will be secured and protected using a robust system of information governance. The plan will support core clinical services and the sharing of information – where appropriate – through universal use of the Community Health Index (CHI).

An eHealth strategy will be developed in 08/09 and will be delivered through the eHealth executive group, which has executive responsibility for the overall direction of eHealth. This will be supported by a clinical delivery group with wide stakeholder participation. The clinical delivery group will be responsible for ensuring that investments in eHealth are delivered in accordance with agreed plans and provide the anticipated benefits.

The delivery mechanisms

Specific initiatives relating to primary care

A number of priorities have been agreed that will impact directly and indirectly on the *Plan for Modernising Primary Healthcare Services*:

Integrated primary and community care system.

NHS Lanarkshire supports the proposed national procurement of an integrated information system for primary care services. The board aims to be an early adopter of such a system, and in anticipation of this will discourage GP colleagues from changing systems during the planning period for the new system. In addition, work has begun to define the requirements of community nursing and health visiting, with a view to ensuring that the needs of these services are addressed by new electronic systems.

CHI number.

The CHI number will be used across all primary and community care services to identify patients and as the basis for exchanging information with partner agencies.

Referral Management Service.

NHS Lanarkshire has set up a centralised referral management service (RMS), which has initially focused on the interface between primary and acute care. Over time, the RMS will encompass the wider referral needs of primary care and include AHP and nurse-led community clinic management. Ongoing development of the RMS will further streamline the pathway from primary to acute services.

Through this process NHSL will achieve more effective dialogue with General Practitioners to further develop and agree electronic protocols by specialty/disease. In addition the opportunity for General Practitioners to refer directly to secondary care for tests (recent examples of Endoscopy linked to cancer) speeds up the referral process with patients being seen more quickly.

Diagnostic results and discharge documentation.

All diagnostic test results and discharge documentation will be transmitted electronically to the requesting clinician by March 2008. This will build on the previous achievement of 90% of laboratory results being available online, and will see the inclusion of radiological test results.

eCare.

NHS Lanarkshire and its partners have been at the forefront of developing eCare systems to support electronic Single Shared Assessment (eSSA) and electronic Child Protection Messaging (eCPM). These will be further developed to include eSSA for all care groups, and the provision of eCPM across all relevant health services.

Information Management & Technology

A project is underway to supporting long-term conditions management and self-care through telehealth. Early work, piloting the systems and processes, will involve patients with Chronic Obstructive Pulmonary Disease (COPD). Over time it will be extended to support patients with other long-term conditions.

Single patient record.

NHS Lanarkshire will work within the national eHealth strategy to provide a single representation of patients' records electronically. The first iteration of this involves the Electronic Care Summary. This will be further developed and made more widely available during the period of this plan.

Dental services.

An Information Technology system that supports the salaried dental service has been in place since 2006. A system to support general dental practitioners is being procured nationally and will be implemented when it becomes available.

Pharmacy services.

All community pharmacies are being connected to the NHS communications network. This is the first stage of development in this area, which will subsequently include access to Emergency Care Summaries (ECS) and the ability to manage prescriptions electronically.

5.2 Workforce – How many people and with what skills?

National Workforce Plan

The *National Workforce Plan*, published in April 2006, provided a framework for workforce development in support of *A Picture of Health*. The future workforce composition will focus on a multidisciplinary/multi-agency/team-working approach. While it is not possible to quantify precisely the number and competencies of staff who will be required in the future, this information will begin to emerge as clinical models are agreed. The roles and responsibilities of independent contractors are in the process of being redefined through the introduction of new contractual arrangements.

5.2.1 Primary care medical staff

Lanarkshire has the lowest number of GPs per 100,000 of population in Scotland. As a result, list sizes per GP are higher than the national average. Lanarkshire has also seen slower growth (5.7%) in GP numbers over the past ten years than the rest of Scotland (17%). There are many reasons for this, including high levels of deprivation and poorer working environments and some with a lack of accommodation for additional staff. Furthermore, the introduction of the new General Medical Services contract has meant that many practices have not appointed additional staff until they have been sure that their practice incomes will be able to support them over the longer term.

The GP to patient ratio varies from 1:946 to 1:3,802, with the average list size per principal standing at 1,580 (compared with 1,188 in Scotland as a whole). However, recent data indicates an upward trend in the number of GP-trained doctors working in primary care in Lanarkshire.

Key issues for this staff group are outlined below.

Population shifts/growth.

There are an increasing number of new housing developments in Lanarkshire, ranging from under 100 to several thousand units. Through the CHPs, approaches are being made to local authority planning departments to determine a variety of issues relating to these. Information is being sought about the precise number of current and future developments; the extent of population growth/shift; the likely population profile; and the timescales within which developments will be built.

The increasing population is already beginning to have an impact on primary and community health resources. Three areas are experiencing particularly significant pressures – Wishaw, Hamilton, Motherwell/Carfin and Cumbernauld. It is not yet clear whether the residents of these new developments are from outwith Lanarkshire, or whether they represent a shift of the local population to new housing.

Many GP practices feel they have reached an optimal size, both in terms of staff and patient numbers, and do not wish to expand. Where practices are taking this view, and local primary care services have reached capacity, NHSL will look at supporting and pump priming the introduction of new clinics into existing practices, and creating new practices in the longer term. In some areas, practice accommodation is also a factor limiting expansion.

It is anticipated that the current population shift/growth will continue, with a corresponding demand for additional primary care resources. The financial impact of these changes in areas experiencing increased levels of pressure must be determined, and all options for providing additional capacity considered.

Staff Skill mix.

The new GMS contract makes it easier for practices to evaluate the broader healthcare needs of their populations and put in place resources to address these needs. Practices can potentially fill vacancies with healthcare professionals other than GPs, and there is evidence to suggest that departing partners are being replaced by salaried doctors and/or additional practice nurses or phlebotomists. NHS Lanarkshire is evaluating the role that physician assistants can play in primary care. The introduction of these skilled professionals may provide a way of diversifying the workforce in primary care in the future.

Clinical Modelling.

Chapter 3 looked at clinical modelling and described a process of shifting the balance of care from the acute sector to the community. Over the coming year it will become apparent what impact this remodelling process will have on the primary care workforce. There will be scope for developing GPs with special interests (GPwSIs) and the Lanarkshire Addiction Service has already developed GPwSIs in addictions. The provision of primary care services to care homes will be carried out by GPs who have an interest in the care of the elderly through an enhanced service arrangement.

The Out-of-hours workforce.

The primary care OOH service continues to recruit salaried doctors. Currently the service has twelve WTE doctors working both full-time and part-time. It is not currently possible to reduce the number of doctors working in the OOH service due to a lack of appropriately skilled nurses/paramedics, who are needed to ensure the service is covered safely and effectively at all times.

Modernising Medical Careers – future training.

NHS Lanarkshire has benefited from the additional registrar posts which have been allocated to general practice through MMC. Four extra posts have been created, and these registrars have initially been based in existing training practices. Two additional practices are currently undergoing training which will enable them to take on registrars. NHS Lanarkshire will actively approach practices and encourage them to take on registrars, particularly in North Lanarkshire. This is in line with a policy to place more registrars in areas of deprivation. Factors limiting the development of new training practices include access to training for trainers, duration of training (at present, two years), and accommodation.

5.2.2 Nursing

The current community nursing workforce

A number of factors have seen significant investment in the community nursing service since the financial year 2005/06. These include elements of the review of nursing in the community; implementation of the Long-Term Conditions Strategy; and the need to strengthen and enhance primary care services in the most deprived areas of Lanarkshire. As a result, the community nursing workforce has increased by the equivalent of 55 full-time employees. Deployment of these staff has been targeted at the areas of greatest need, based on the health profiles of local communities.

The aim is to provide a flexible, responsive and highly skilled workforce that will meet the future needs of the people of Lanarkshire. A number of factors will lead to greater flexibility within community nursing, and improve partnership working with social work and other partners. These include implementation of practice alignment where each GP practice has a named District Nurse and Public Health Nurse, combined with training and development of staff to provide integrated care management and anticipatory care. Collectively, these measures will support the shift in the balance of care advocated by this modernisation plan.

Key issues facing this staff group include:

Role development.

Implementation of many elements of this Primary Care Modernisation Plan will mean that over time the role of community nurses will need to develop to reflect changing clinical and service models. New roles will include first-point-of-contact, triage and primary care practitioner. There will also be increasing scope for nurse-led interventions. These developments will capitalise on the distinct clinical expertise and knowledge-base of nurses, contributing to the ongoing professional development of nurses, and supporting the health improvement agenda within local communities.

An example of role development in practice is the evaluation of treatment room nursing staff and facilitation of an extended skill-mix using MINTS training. This has the potential to reduce the number of inappropriate attendances at A&E departments.

Healthcare support workers are being trained to undertake a wider range of interventions, enabling community nursing teams to take on work that involves higher level skills.

Expansion of the community children's nursing service and inclusion of special needs schools nursing staff within the directorate will support the aspirations of NHS Lanarkshire's Child Health Review.

Review of nursing in the community.

Visible, Accessible and Integrated Care, the report of the review of nursing in the community, was published in 2006. This proposed a radical move away from traditional community nursing roles and the introduction of a new discipline of community health nurse. This is currently being piloted in four sites, and the national roll-out will potentially have far-reaching implications for the future organisation and delivery of community nursing services.

Staff Skill mix.

Greater attention will be paid to the opportunities afforded by a mix of skills and bands which better reflects the needs of communities. Such a mix will enable experienced nurses to undertake activities more appropriate to their level of expertise.

Integrated Working.

NHS Lanarkshire has put long-term conditions and public health nursing teams in place, as well as adjusting the skill-mix of nurses to ensure the most effective use of nursing resources. The board has also recruited one whole-time equivalent nurse consultant. Alongside other partner organisations, NHSL will seek to maximise the benefits of integrated care management pilots. The final evaluation of these pilots will be available March 2008.

5.2.3 Pharmacy

The pharmacy workforce includes staff directly employed by the NHS within the managed services, and independent contractors providing community pharmacy services to NHS patients. Both groups are currently undergoing a great deal of change, driven largely by implementation of *Delivering for*

Health and the new community pharmacy contract. These changes will require significant development of pharmacy personnel, both in terms of skills and numbers.

The positive impact of pharmacists is increasingly being recognised, along with a growing awareness of the potential for pharmacy services to contribute to the objectives of *Delivering for Health*, unscheduled care and planned care.

Pharmacy support staff will play an ever greater role in supporting patient care, both in hospital and community pharmacies. Examples of this work includes assessing the suitability of patients' medicines, providing further supplies and information on medicines, and assembling patients' drugs prior to discharge.

The key issues facing this staff group include:

Recruitment and retention.

Community pharmacies are independent companies which provide a service to the NHS under contract. It is recognised that there will be a growing requirement for Lanarkshire's 112 community pharmacies to fully implement the new pharmacy contract. Eighty per cent of registered pharmacists work within the private sector, and for the hospital/managed service to be an attractive career option it must be able to offer comparable rates of pay and flexible working. It must also continue to provide education and development opportunities for staff at all levels.

Role development.

There will be a growing need for pharmacy support staff, leading to a substantial increase in the number of qualified pharmacy technicians. Pharmacy will have to review its skill mix and ensure that support staff are equipped with the skills to enable them to take on an enhanced role. There will be a need to increase the number of qualified dispensary checking technicians to support the introduction of the new community pharmacy contract and the introduction of pharmacists as prescribers. There are currently not enough technicians in training to meet the demands of the service.

Funding and administrative arrangements.

The provision of pre-registration training in Scotland has been revised, and from 2008–09 placements will be organised, administered and funded by NHS Education for Scotland (NES), rather than locally via NHS boards. This new scheme has been developed to ensure that all pre-registration trainees funded by NHS Scotland receive the same opportunities and standard of training.

The increasing demand for part-time and flexible working requires support, and must be managed carefully to ensure continuity of services and meet the needs of patients. Working as a self-employed locum is well-established in community pharmacy practice, and nationally it is reported that 25% of pharmacists who are actively employed are classified as a retail locum. If managed service pharmacy is to remain attractive, it must be able to offer flexible working.

5.2.4 Allied health professionals

Allied health professionals (AHPs) provide services to people of all ages across all health specialties. Their expertise forms part of many clinical teams delivering care in community health partnerships. AHPs are helping to achieve waiting times targets, and are contributing to reduced working hours through the development of new roles and extensions to the traditional scope of practice.

NHS Lanarkshire employs seven of the nine professions within the AHP cohort: audiologists, dietitians, occupational therapists, orthoptists, physiotherapists, podiatrists, radiographers (diagnostic) and speech and language therapists. The AHP workforce consists of 896.34 whole-time equivalent staff, 90% of whom are female and 10% male.

There is a need to develop skill-sets within these categories to support patient care. This *Plan for Modernising Primary Healthcare Services* will have a major impact on AHPs within, Lanarkshire and it is vital that their contribution is maximised through careful implementation of the plan.

The key issues for this staff group include:

Recruitment and retention.

Recruitment and retention remain constant for the majority of AHP posts within NHS Lanarkshire. However, there are a number of issues, notably an oversupply of candidates for basic grade physiotherapy posts, which has been highlighted nationally.

NHS Lanarkshire is in the process of recruiting a consultant musculoskeletal physiotherapist, following a successful bid for one year's pump-prime funding from the Scottish Government. A consultant AHP is an expert working in a specialist clinical field who brings innovation, clinical leadership and strategic and research direction to that particular field. The consultant will play a pivotal role in the integration of research evidence into practice, and delivery of the musculoskeletal clinical governance agenda.

Role development.

NHS Lanarkshire's AHPs recognise the need for structures to be put in place to develop support worker roles through the provision of accredited training for generic workers. There is also an understanding that such training should be built around a competency-based framework with clarity around new roles. This approach is currently being developed in conjunction with the AHP, Nursing and Midwifery Practice Development Centre.

Shifting the Balance of Care.

There is a requirement to critically examine those elements of AHP practice that are suitable for transfer into primary care. Discussions regarding the development of AHP services under the modernisation umbrella will be another key element of workforce planning. As service models are progressed, there will also be opportunities for AHPs to develop their roles, particularly in areas such as long-term conditions and minor injuries.

New Roles.

Given the challenges facing the orthoptic profession, which is one of the smallest groups in the AHP cohort, a number of regional approaches to service delivery, recruitment and retention have been examined. At NHS board level, a significant proportion of an orthoptist's workload involves non-clinical duties. Consideration will be given to reducing the workload of orthoptists by increasing the level of administration/clerical support and/or through deployment of healthcare support workers. This would provide more time for orthoptists to undertake direct clinical work.

5.2.5 Dental services

Primary care dental services

The majority of dental services in Scotland are provided by independent contractors, and no change in this model is foreseen. However, if shortages occur there will be the opportunity to employ salaried dentists, funded from the non-discretionary primary care allocation. The community dental service (which is due to become the public dental service) will also be funded from the same source.

The need for dental care within Scotland is predicted to grow steadily over the next five years as the population grows, with a target level of one dentist per 1,750 heads of population strived for. As Scotland's elderly population grows, so demand for community dental officers is increasing. This trend is expected to continue over the next five years.

The key issues facing this staff group include:

Recruitment and Retention.

As the number of dentists, community dental officers and dental therapists increase, so must the number of dental nurses. These must be recruited at a steady rate to ensure that the service can operate at full capacity and maintain the appropriate level of care. The main requirements at present

relate to the recruitment of dental nurses, therapists, health support workers and health promotion specialists.

Following a sophisticated needs assessment by NHS Education for Scotland (NES), the number of dental students and therapy students has been increased. The current challenge facing NHS Lanarkshire is ensuring that those who train in this area to remain here. A number of initiatives are in place to encourage recently trained dentists to stay in Lanarkshire, as well as motivating others to move to Scotland to work, and providing opportunities for those returning to work. These include the recruitment and retention allowance, or 'golden hello'.

Role Development.

A NES initiative to develop the role of oral health therapists (OHTs) will rapidly increase the workforce pool, as the training period is two years rather than the five years for dental students. Priorities for OHTs will include prevention and treatment of decay in children, maintenance of oral health in adults, and support for the ageing dentition in the elderly.

Salaried primary care services.

These services encompass the community dental service and salaried general dental service. The *Review of the Primary Care Salaried Dental Service (2007)* included a recommendation to amalgamate these services and create a new public dental service. It is likely that this will offer an improved career structure, with additional training posts developed so that specialists can be trained in the community. The availability of practitioners in this service will be governed by the same issues as those in the independent sector.

The figures for salaried dentists in Lanarkshire do not follow the national trend, where there has been a considerable increase in numbers over the last few years. This is because there has not been a problem of access to general dental services in NHSL to date. Instead, salaried general dental practitioners have been used to deliver specific services. This may change over the next few years as a result of the Government's Dental Action Plan targets.

In recent years the community dental service has developed to fulfil a number of roles, including:

- providing specialist children's dental services
- providing a general anaesthetic and sedation service on referral
- providing treatment for people with special needs (adults and children)
- introducing the National Dental Inspection Programme

Whilst proposals for the future include a greater role for therapists in the National Dental Inspection Programme, there is likely to be an upward trend in the community dental service (or equivalent staff).

5.3 Primary Care capital programmes

Background

A Picture of Health detailed an ambitious capital plan featuring investment of around £170m to greatly enhance the delivery of good quality care in primary and community settings. This modernisation strategy was approved by the Scottish Executive, In June 2007 the Cabinet Secretary of the new Scottish Government reversed the decision of the previous administration and asked NHS Lanarkshire to review its accident & emergency services. An independent scrutiny panel (ISP) was appointed to assist the Cabinet Secretary in this review, and NHSL worked closely with the panel to develop alternatives to the model drawn up in *A Picture of Health*. In February 2008 the NHS Board submitted revised proposals which were endorsed by the Cabinet secretary. In March 2008 the NHS Board approved a 5 year financial revenue and capital plan.

Primary care, mental health and learning disabilities

Prioritisation of the revised proposals was undertaken on the capital investment programme to re-examine and assess the schemes for affordability and deliverability.

An event held prioritised the 14 projects within the capital programme which did not already have secured funding from the Government. The criteria considered during the scoring event were those outlined by the Scottish Government Cabinet Secretary:

- **safe** – project should provide a safe service with any clinical risks assessed and managed
- **quality** – care and treatment should be clinically effective in terms of quality of outcomes
- **sustainable** – project should facilitate both retention and recruitment of high calibre staff and be flexible in terms of changing patterns of care and population needs
- **patient-centredness** – the project should be patient-centred
- **accessible** to service users
- provide **satisfaction** and a positive experience for service users
- be **responsive** and tailored to patient needs and preferences based on appropriate care pathways
- be **consistent** with national policy

The various groups were asked to score each of the projects and prioritise them first into three categories – ‘essential’, ‘highly desirable’ and ‘desirable’ – after which they had to rank them in order. Table 6 shows the results following collation, with some sensitivity analysis applied.

Table 7 (Projects to be delivered 2008- 2012)

No	Project	Revised ranking	Original ranking	Combined two lowest scores
1.	Caird House	1	1	27.5
2.	Coathill Hospital	2	2	25
3.	LD Assessment Centre	3	3	24
4.	Airdrie Resource Centre	4	4	20.5
5.	Monklands Mental Health	5	5	17.5
6.	Coatbridge PC Centre	6=	6	15.5
7.	Carlisle Health Centre	6=	7	15.5

Table 8 (Project that will further developed 2013/14)

No	Project	Revised ranking	Original ranking	Combined two lowest scores
8	Hairmyres Mental Health	8	8	11.5
9	East Kilbride Civic Dev	9	9	10.5
10	Clydesdale Hospital	10	10	8
11	Hamilton Resource Centre	11=	11	5
12	Wishaw Resource Centre	11=	12	5

Primary Care capital projects

The General Medical Services Premises Group has highlighted the need to review the overall provision of primary care premises in Lanarkshire, and what will be needed to provide modern-day healthcare to patients in the future. This process will also look at non-health board premises, which cannot be dealt with through the capital route.

The majority of practices do not have the current maximum space allowance for effective operation, and many are not even up to the minimum level. Work is continuing to prioritise practices and make funding available to address space requirements. Each practice has been allocated an initial score as a means of prioritising sites for future development. Initial analysis indicates that recurring investment of £2m–£3m would be required to address this, based on current levels of expenditure.

Many of the top priorities are being dealt with through the capital schemes identified above, but premises in the following areas need to be addressed:

- Kirkmuirhill
- Holytown
- Carnwath
- Lesmahagow
- Douglas
- Forth
- Carstairs

GP Practices in non-health board/private owned premises can approach NHSL at any time to discuss improvements. Initial projections indicate that it would cost c.£160k per practice for the sites listed above to be taken up to the minimum space allocation, based on current payments. Funding to address these issues totalling £2.5m over 5 years was approved in March 08.

In relation to proposed new/replacement accommodation the opportunity will be taken to explore opportunities to use space that delivers improved pathways of care for patients which in turn will enable NHSL to advance 'shifting the balance' between primary and secondary care.

Dental premises

Providing appropriate premises is probably the greatest challenge in developing dental services over the next ten years. The situation has been made more urgent by recommendations from the Glennie Report on decontamination, which requires all dental practices to have a separate room for instrument decontamination by 31 December 2009.

Capital funding has been allocated to NHS Lanarkshire by the Scottish Government for two projects

1. establishment of a training centre in Coatbridge. This will provide ten outreach training places for dental students, four training places for OHTs, facilities for specialist services, and an opportunity for local GDP practices to move into fit-for-purpose premises
2. extension of an existing general dental practice in Greenhills Health Centre in East Kilbride, with the addition of four new surgeries and a decontamination room. (Completed July 07)

A directive from the Scottish Government Health Department has stipulated that health boards must take dental practices into account in any capital projects that are being planned. Dentists in Airdrie, Hamilton and Wishaw have expressed interest in being included in the new premises development.

6. PARTNERSHIP AND INTEGRATED WORKING

NHS Lanarkshire has long and well established arrangements with North and South Lanarkshire Councils for joint planning and working across almost all of the major community care groups – children, older people, people with mental health problems, learning disabilities and alcohol and drugs problems.

Least developed and perhaps most relevant here are the joint planning and working arrangements for people under 65 with a physical disability and/or long-term conditions.

Many of the components of the Joint Future programme for older people also apply to this group:

- the alignment of nursing and home care services and steps towards integration, changing roles and skill mix for health and social care staff as part of the action needed to increase the capacity to keep people in their own homes
- streamlining equipment and adaptations services through the creation of a single system and one door access
- improving rapid response services to avoid inappropriate care, particularly emergency (re)admission where this is avoidable
- timely and effective multi-agency assessment of need, Single Shared Assessment (SSA) and service delivery, including direct access to services across agency boundaries
- extending the role of health and social care staff significantly in relation to health improvement and wellbeing, and ensuring that this is properly supported

The key issues are:

- reviewing relevant services to know where the gaps in service currently exist
- building rapidly on the foundations laid by the Disabilities Partnership Board (North) and Joint Future Implementation Group for Physical Disability (South) to have fully functioning joint planning and working arrangements that will deal effectively with these gaps and improve services generally
- being clear about the relative roles of health and local authority services in relation to long-term conditions, with a focus on what we do together for this group of people and how this is expressed in targets for joint action

7. RESOURCING THE PLAN – A STRATEGIC FINANCIAL FRAMEWORK

The total funding deployed by NHSL on primary care services amounts to £378.3m.

Turning the plan into a reality will mean ensuring that current resources are being used as efficiently as possible. We have begun to identify the gaps and are currently applying agreed new resources in a timely and efficient manner.

A number of the developments covered in this plan require one-off funding to pump prime the activity. Other developments are aspirational or are anticipated to be funded centrally.

The following section outlines:

		Total	Timeframe
7.1	Current resources deployed in primary care	£378.3m	present
7.2	New resources already agreed	£13.514m	over 4 years
7.3/7.4	Non-recurring funding agreed	£13.9m	over x years
7.5	Schemes seeking funding over time	£3.75m	to be defined
7.6	Areas of activity anticipated to be funded centrally	–	–
7.7	Areas of activity not yet costed	–	–

Implementation will rely on resource availability, which is clearly dependant upon issues such as the A&E review and the spending review uplift from National Resource Allocation Committee.

Taking the above into account, Table 7.7 represents an action plan highlighting the named responsible person, timeframes for action and a description of the financing of the developments.

7.1 Current Resources

	Pay £000s	Non Pay £000s	Total £000s
Community Services			
Mental Health	42,592	3,599	46,191
Learning Disability	4,782	381	5,163
Paediatrics	7,983	265	8,248
Community Services	42,245	7,360	49,605
Health Promotion	1,431	497	1,928
Community Dental Service	3,982	421	4,403
Sexual Health	1,055	376	1,431
Continence Service	258	1,880	2,138
Dietetics	539	611	1,150
Audiology	963	877	1,840
Joint Home Loan Store	0	490	490
Out of Hours	6,348	513	6,861
Macmillan Nursing	426	29	455
Health and Homeless	281	26	307
Diabetic Retinal Screening	218	129	347
Infection Control	875	102	977
Cancer Services	475	13	488
Keep Well	502	137	639
Other Services	0	5,914	5,914
Medical Director	2,272	399	2,671
Nursing Director	698	509	1,207
CHP Management	1,105	304	1,409
Total Community Services	119,030	24,832	143,862
Personal Medical Services			
General Medical Services		63,660	63,660
General Dental Services		32,090	32,090
General Ophthalmic Services		7,767	7,767
General Pharmacy Services		12,914	12,914
Other PMS Services		2,312	2,312
Prescribing		115,695	115,695
Total Personal Medical Services		234,438	234,438
Total Current Resources (October 2007)	119,030	259,270	378,300

7.2 Increasing Existing Primary Care Capacity – Recurring

Activity	£m 2007/2008	£m 2008/2009	£m 2010/2011	£m 2011/2012	Totals
Community Nursing (Including Care Management)	0.738	1	–	–	1.738
Care Home Teams	0.638	–	–	–	0.638
Paediatrics Waiting Times	0.125	–	–	–	0.125
Primary Care (GP Own Premises)	–	0.5	0.5	0.5	1.5
Audiology Capacity Planning	–	0.375	–	–	0.375
Mental Health	1.796	1.157	–	–	2.953
Scottish Enhanced Services	0.692	0.693	–	–	1.385
Diabetes – Extended Primary Care	–	0.3	–	–	0.3
Pharmacy Contract	3.5	–	–	–	3.5
Increase NHS 24 Hub Seats					
Community Hospitals	–	0.2	–	–	0.2
Total	7.489	4.225	0.5	0.5	13.714

7.3 Initiatives – Non Recurring

Activity	£m 2007/2008	£m 2008/2009	£m 2010/2011	£m 2011/2012	Totals
Keep Well	0.603	1	–	–	1.603
Smoking Cessation	–	0.4	–	–	0.4
Community Nursing	0.297	–	–	–	0.297
Community Services*	2	1.3	0.3		3.6
Total	6.4	4.2	1.8	1.5	7.9

*Redesign Initiatives/Pump priming funding e.g. Diabetes/COPD Self-care, Home Treatment and Crisis resolution.

7.4 E Health

Activity	£m 2007/2008	£m 2008/2009	£m 2010/2011	£m 2011/2012	Totals
eHealth Capital & Revenue	3.5	1.5	1.5	1.5	8

7.5 Areas of activity for which funding sources have still to be identified.

Activity	£m 2007/2008	£m 2008/2009	£m 2010/2011	£m 2011/2012	Totals
GP Owned Premises	–	0.5	1	1.5	3
Public Health & Public Information Services	0.5	0.25	–	–	0.75
Totals*	0.5	0.75	1	1.5	3.75

NB. Costs shown on this table are indicative only at this stage.

7.6 Areas of Activity anticipated to be funded centrally

Activity	£m 2007/2008	£m 2008/2009	£m 2010/2011	£m 2011/2012	Totals
New Optometry Contract					
New General Dental Practitioners					
E Health IPACC					
Totals*					

7.6 Areas of Activity not yet costed

Activity	£m 2007/2008	£m 2008/2009	£m 2010/2011	£m 2011/2012	Totals
Clinical Modelling: Whole System					
Emergency referral Centre		0.1	0.3	0.1	0.5
Dental Services via Oral Health Plan					
Totals*		0.1	0.3	0.3	0.5

* The totals in the tables above will change as further information is added.

APPENDIX 1

7.7. PRIMARY CARE MODERNISATION PLAN

Section	Work area	Lead person	Timescales	Cost £	Financial reference
3	THE CORNERSTONES OF CARE				
3.1	Unscheduled Care Outside of Hospital				
A	Development of Streamlined Point of Access to Unscheduled Care (Emergency response Service)	Alan Lawrie	2010/11	TBC	7.2
B	NHS24 - Out of Hours Triage Service/Primary Care OOH Service	Liz Duncan	2008		7.2
C	New Pharmaceutical Care Services Contract	George Lindsay	2008/10	3.5	7.2
D	New Optometry Contract	Medical Director	2008/10	TBC	7.5
E	Dental Services (In/Out of Hours)	Mike Devine/Kieran Matters	2010	TBC	7.6
F	Public Health & Public Information Services	Corporate Communications Dept	ONGOING	300K	7.4
G	Directory of Services	VJ Sonthalia	2008	0.15	7.3
H	Care Homes Team	Medical Director	2007/08	0.638	7.2

Section	Work area	Lead person	Timescales	Cost £	Financial reference
3.2	Care for People with Long-term Conditions				
C	Integrated Care Management	Anne Armstrong	2008	CNR* 3.13m	7.1
D	Disease Management	Medical Director	2007/10	N/A	7.1
E	Care Pathways	Clinical Redesign Group	2009	100k	7.1
F	Supported Self-care	Managed Clinical Networks	2009	800k	7.3
G	Anticipatory Care	Long Term Conditions Action Team	2007/10	Hold 3.13m	7.2/7.3
3.3	Extended Primary Care Services				
	Clinical/Service Modelling & Resign	Clinical Redesign Group	2009/12	TBC	7.6
	Community Hospitals	Marilyn Aitken	2009	200	7.4
	Intermediate Care & Rehabilitation Services	Peter McCrossan	2009	500	7.6
	Dealing with population Shifts	Alan Lawrie/Colin Sloey	2008/09	1.6	7.4
4	Interdependent Strategies				
4.1	Mental Health	Colin Sloey			
4.2	Learning Disabilities	Colin Sloey			
4.3	Children's Services	Colin Sloey			
4.4	Sexual Health Services	Colin Sloey			
4.5	Blood Borne Viruses	Dorothy Moir			
4.6	Palliative Care	Ian Ross			

Section	Work area	Lead person	Timescales	Cost £	Financial reference
5	SUPPORTING INFRASTRUCTURE				
	E-Health				
	Specific Initiatives Related to Primary Care	Robin Wright	2009/10	Capital	7.1/7.4/7.5
	Primary Care Capital Schemes	Primary Care Capital Investment Group	Dates for Completion		7.4
	Caird House	Robert Peat,	2010	8,123,000	
	Carluke	Marilyn Aitken	2009	11,970,000	
	Coathill Hospital	Tom Bryce	2009	5,540,000	
	Learning Disabilities Centre	?	2009	6,431,000	
	Airdrie Resource Centre	Owens Watters	2010	27,000,000	
	Monklands Mental Health	Tom Bryce	2009	33,532,000	
	Coatbridge PC Centre	?	TBC	11,842,000	
	Hairmyres Mental Health	TBC	TBC	28,890,000	
	East Kilbride Civic Centre	TBC	TBC	19,186,000	
	Clydesdale Hospital	TBC	TBC	6,660,000	
	Hamilton Resource Centre	TBC	TBC	7,952,000	
	Wishaw Health Centre	TBC	TBC	8,280,000	
	Kilsyth Health Centre	TBC	TBC	16,647,000	
	Total	TBC		209,365,000	
	Primary Care Premises/Equipment	Primary Care Property Group	2008–11	3.000	7.4
	Dental Premises	Mike Devine		TBC	7.6

APPENDIX 4 LINKING TARGETS TO PRIMARY CARE MODERNISATION

APPENDIX 2 LINKING TARGETS TO PRIMARY CARE MODERNISATION

Cornerstone 1, Unscheduled care = **Red** Cornerstone 2, Long Term Conditions = **Blue** Cornerstone 3, Extended Primary Care = **Green**
 Cornerstone 4, Health Improvement = **Orange**

SOURCE	TARGET/MEASURE/INDICATOR	DRAFT LANARKSHIRE LDP 08/09		SECTION
HEAT 2008/09	HEAT Targets : Health Improvement	Past/current measure	Target	
	H1 : Reduce mortality from Coronary Heart Disease among the under 75s in deprived areas.	130.5 deaths per 100,000 pop (2002/4)	113 deaths 100,000 pop (2009/11)	4.2.
	H2 : 80% of all three to five year old children to be registered with an NHS dentist by 2010/11	71% at June 2008	By June 2010 80% will be achieved	4
	H3 : Achieve agreed completion rates for child healthy weight intervention programme by 2010/11	At March 2009 = 0	March 2010 100, March 2011 =200*	4.2
	H4: Achieve agreed number of screenings using the setting-appropriate screening tool and appropriate alcohol brief intervention, in line with SIGN 74 guidelines by 2010/11.	At March 2009 1,200	March 2011 = 10,200 to 16,057*	4.1.2
	H5 : Reduce suicide rate between 2002 and 2013 by 20%, supported by 50% of key frontline staff in mental health and substance misuse services, primary care, and accident and emergency being educated and trained in using suicide assessment tools/ suicide prevention training programmes by 2010	At 2008 = 20%	At 2010 we will achieve 50%	4
	H6 : Through smoking cessation services, support 8% of your Board's smoking population in successfully quitting (at one month post quit) over the period 2008/9 – 2010/11	At 2006 = 3,205	By 2008/10+ 3759 raising to 10,737*	4.1.2
	H7 : Increase the proportion of new-born children exclusively breastfed at 6-8 weeks from 26.6% in 2006/07 to 33.3% in 2010/11	At Mar 07 = 18.8	By March 2011 23.5 (Should we cross refer to initiatives being taken to improve this projection ? Isn't there a new	4.2

			appointment in midwifery ?)	
	HEAT Targets : Efficiency and Governance			
	E1 : Universal utilisation of CHI	At Apr 08 = 83.2%	By Mar 2011 = 97%	1
	E4 : NHS Boards to deliver agreed improved efficiencies for 1 st outpatient attendance DNA, non-routine inpatient average length of stay, review to new outpatient attendance ratio and day case rate by March 2011	At June 07 = 69.8%	By Mar 2011 = 90%	1
	E7 : To increase the percentage of new GP outpatient referrals into consultant led secondary care services that are triaged online for clinical priority and appropriate recipient service to 90% from December 2010.	At Aug 2008 = 2%	By March 2011 = 90%	1.3
	HEAT Targets : Access to Services			
	A1 : Ensure that anyone contacting their GP surgery has guaranteed access to a GP, nurse or other health care professional within 48 hours	Sept 2007 = Achieved 100%	At Mar 2011 = Achieved	1.3.2
	A2 : The maximum wait from urgent referral to treatment for all cancers is two months	At Sept 08 = 95%	By March 2011 = 95%	3.1
	A4: As a milestone in achieving 18 weeks referral to treatment, no patient will wait longer than 15 weeks from GP referral to a first outpatient appointment from 31 March 2009	At Apr 08 = 259	By Mar 09 = 0	3
	A5 : As a milestone in achieving 18 weeks referral to treatment, no patient will wait longer than 15 weeks for inpatient or day case treatment from 31 March 2009	At Apr 08 = 132	Mar 09 = 0	3
	A6 : As a milestone in achieving 18 weeks referral to treatment, no patient will wait longer than 6 weeks for one of the 8 key diagnostic tests from 31 March 2009	At April 08 = 357	By Dec 08 = 0	3
	A7 : NHS Boards will achieve agreed reductions in the rates of attendance at A&E, from 2006/7 to 2010/11; and from end 2007 no patient will wait more than 4 hours from arrival to admission, discharge or transfer for accident and emergency treatment	At March 07 = 2,895	At Mar 2011 = 2,895	1.3
	HEAT Targets : Treatment			
	T1 : 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. Reduce, by 10%, emergency inpatient bed days for people aged 65 and over by 2008	At March 2005 = 49.7% At March 2005 = 3515	By March 2011 = 39.8% By March 2011 = 3163.5	1.3
	T3 : Reduce the annual rate of increase of defined daily dose per capita of antidepressants to zero by 2009/10, and put in place the required support framework to	At June 06 = 32.9	By March 2011 = 35.9	3

	achieve a 10% reduction in future years			
	T4 : Reduce the number of readmissions (within one year for those that have had a psychiatric hospital admission of over 7 days by 10% by the end of December 2009)	At Dec 04 = 513	By March 2011 = 462	1.3
	T6 : To achieve agreed reductions in the rates of hospital admissions and bed days of patients with primary diagnosis of COPD, Asthma, Diabetes or CHD, from 2006/7 to 2010/11. Trajectory in draft LDP 2008/09 seeks to achieve convergence with Scottish average bed days/100.000 population. This is a provisional target:	At March 07 = 2,434	By March 11 = 2,187	2.3.1
	T7 : Improvement in the quality of healthcare experience	Not available as yet	Not available as yet	4
	T8 : Increase the level of older people with complex care needs receiving care at home	Not available as yet	Not available as yet	1.3.2
	T9 : Each NHS Board will achieve agreed improvements in the early diagnosis and management of patients with a dementia by March 2011. (33% increase against base line[2006/07] by 2011)	Not available as yet	Not available as yet	2.3.1

PERFORMANCE REPORTING FOR COMMUNITY CARE		Current Measure	Target Measure	
User satisfaction				
	% of community care service users feeling safe			3.2.1
	% of users and carers satisfied with their involvement in the design of care package			3.2
	% of users satisfied with opportunities for social interaction			3
Faster access				
	No. of people waiting longer than target for assessment, per 000 population			1.3
	No of people waiting longer than target time for service, per 000 population			3.1
Support for carers				
	% of carers who feel able to continue their role			2.3.1
Quality of assessment and care planning				
	% of care plans reviewed within agreed timescale			1
Identifying those at risk				
	No of emergency bed days in acute specialties for people 65+, per 100,000 pop.	Reduce emergency bed days by 10% by 2008 against 2004/05 Baseline = 3515	3163.5	1.3.2
	No. of people 65+ admitted as an emergency twice or more to acute specialties, per 100, 000 pop	Reduce no. by 20% compared to 2004/05		1.3.2
	No of people 65+ admitted twice or more as an emergency who have not had an assessment, per 100, 000 population			3.1.2
Moving services closer to users/patients				
	Shift in balance of care from institutional to 'home based' care			1.3.2
	% of people 65+ with intensive needs receiving care at home	42% (North Lanarkshire) 35% (South Lanarkshire)	30% get care at Home by 2008	1.3.2.

* Cumulative Total

APPENDIX 3

Membership of Primary and Community Care Programme Board

Role	Programme 2 Primary Care & Community Care	Title
Executive Lead	Alan Lawrie	CHP Director
Programme Manager	Kate Bell	Change & Innovation Manager
Lead Planner	Roy Watts	Head of Planning and Performance South CHP
Lead Clinicians	Dr Shiona Mackie	Medical Director Primary Care
	Dr Chris Mackintosh	Lead GP East Kilbride Locality and Diabetes MCN Lead
	George Lindsay	Chief Pharmacist
	Kieran Watters	General Dental Practitioners
	Peter McCrossan	AHP Lead
Long-Term Conditions Action Team Lead	Anne Armstrong	Nurse Director Primary Care
Long-term Conditions Lead (GP)	Dr Pali Mahal	GP
Locality General Management Lead for PB 02	Eleanor Wilson	General Manager
Representative other PB	Roy Garscadden	Head of Planning Acute
Other managers	Jim Loudon	Service Development Manager
Area Clinical Forum	VJ Sonthalia	GP/Lanarkshire Medical Committee
APF	Alison Drinnan (GMB) Margo Crammer (UNISON)	Team Leader for CMHT OP Treatment room Nurse
Human resources	TBC	
Finance	Fiona Porter	Head of Function Management Accounts
IMT	Robin Wright	General Manager IM&T
Communications	Calvin Brown	Communications Manager Primary Care
P&SS	David Browning	General Manager Property Services
Ambulance Service	Andrew Wemyss	Regional Service Redesign Manager
Services Users/Carers	John Mitchell (South PPF)	Public Partnership Forum Links
Council Representatives	Jamie McDermott	North Lanarkshire Council
Clinical Models Lead	Cathy Dunn	Change & Innovation Manager
Programme Manager Acute	Pamela Milliken	Head of Change & Innovation

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Document Purpose

This document sets out the emerging views of how NHSL will modernise primary care services. This will be done with a view to exploring how the new (clinical and service) models of care will be translated into service provision and how these will operate to enhance and strengthen primary care to ensure improved access and whole system working.

The views of the NHS and its stakeholders are vital. You are asked to share this document with as wide an audience as possible – of staff, partner organisations especially Local Government, patients and interested voluntary organisations.

The consultation period will be over an 8 week period for further and final engagement on the content of the document. This will commence April 13th 2008 with all comments returned no later than May 31st, 2008.

Target Audience

NHS Board members, NHS Lanarkshire Corporate Management Team (CMT), Medical Directors, Directors of Public Health, Directors of Nursing, Lead GP's, Locality General Managers, Secondary Care General Managers, Clinical Communities Leads, Managed Clinical Network Leads, Social Care Directors

Circulation List

Community Health Partnership Management Committees North and South, Local Authorities (LA) CMT, South Lanarkshire Council Health & Care Partnerships, North Lanarkshire Council Health & Care Partnership, Scottish Health Council, Public Partnership Forums, Area Partnership Forum, Area Clinical Forum, Local Medical Committee, North Lanarkshire Council, North Lanarkshire Carers Together, South Lanarkshire Carer's Network

Action required

Please provide feedback and comments on the form allocated for this purpose. Your comments will influence the final document and any subsequent implementation plans.

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