SCOTTISH EXECUTIVE

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NHS Board Chairs and Chief Executives

Copy to: NHS Special Board Chairs and Chief Executives

NHS Board Local Delivery Plan Contacts

Our ref: eRDM F490775

Date: 1 November 2006

Dear Colleague

**MINISTERS' KEY OBJECTIVES, TARGETS AND PERFORMANCE MEASURES FOR THE NHS AND LOCAL DELIVERY PLANS: GUIDANCE 2007/08**

Following the introduction of the new Local Delivery Planning process in December 2005, we have carried out a wide-ranging review of both the process itself, and the Core Set of Targets and Performance Measures. We would like to thank the Planning Network and all those Boards who made such a valuable contribution to the review. Our overall approach has been underpinned by a principle of consistency and stability, together with an acceptance that we should only consider/propose major changes where necessary.

We have now produced the Guidance for the 2007/08 process, reviewed and updated where necessary to take into account the outcomes from the review and the Guidance is attached to this letter. The Annexes 3(a) LDP Narrative, 3(b) LDP Trajectory, Annex 4 and supporting information on the 4 new Key Targets will be issued to Board LDP co-ordinators in the near future.

The Guidance is clear and straightforward but there is one crucial deadline which we would wish to draw to your attention ie, the submission date for LDPs will be **Friday 16 February 2007**. If you would like further information, please contact:

1. **For information on the overall approach:**
   Andy Smith 0131 244 6918
   Robert Kirkwood 0131 244 2556

2. **For information on technical issues and the LDP templates:**
   Rosemary Jamieson 0131 244 4070
   James Boyce 0131 244 3450

3. **For information on the Financial templates:**
   Jillian Boyle 0131 244 2361



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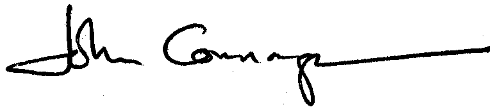
I would also like to take this opportunity to draw to your attention a seminar we will be holding for all NHS Boards in the morning of Friday 15 December in the Scottish Health Services Centre, Edinburgh. The seminar is to introduce the LDP Core Set and Guidance 2007/08 and to provide an opportunity for dialogue and discussion to help share understanding of what we are aiming to achieve. You are invited to send representatives and we would ask you to let us know by **24 November** who will be attending. We expect the seminar to be relevant to LDP co-ordinators and colleagues from planning and information. Please contact Claire Ferguson by e-mail: claire.ferguson@scotland.gsi.gov.uk or by telephone on 0131 244 2033. A further letter with more information on the seminar will be issued in due course.

Yours sincerely



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# MINISTERS' KEY OBJECTIVES, TARGETS AND MEASURES FOR THE HEALTH PORTFOLIO; AND LOCAL DELIVERY PLANS FOR NHS BOARDS

## GUIDANCE 2007/08

1. This guidance sets out Ministers' "core set" of objectives, targets and measures for the NHS; describes work in progress in developing performance measures further in the future and takes into account views/comments received as a result of the Review this summer. The guidance reiterates the purpose of Local Delivery Plans (LDPs), their format and content, timescales for completing them, and further relevant information to help NHS Boards complete plans for 2007/08.

2. The Guidance issued in December 2005 acknowledged that, to a certain extent, the first year of LDP/HEAT would be a transitional year. The Review we have just completed was designed to take account of this transitional year and to provide an opportunity to learn from the first year's experience and to implement changes arising from this.

3. The principal changes are summarised below and set out, in more detail, in the following Guidance:

- changes to Key Targets (paragraphs 4 and 5 and Annex 1);
- changes to Key and Supplementary Measures (paragraph 6 and Annex 2);
- introducing the new HEAT web based system (paragraph 9);
- re-name Supporting as Supplementary Measures (paragraph 10);
- revised procedures for completion of LDPs (paragraph 18);
- a new timetable for LDP submission and sign-off (paragraph 19);
- introduction of change control processes for Trajectories and Key Targets and Measures (paragraphs 21 and 22);
- alignment of LDPs with Delivering for Health (paragraph 23);
- introduction of new financial planning arrangements (paragraphs 26/27 and Annex 4);
- introduction of Citistat (paragraph 30);
- new Developmental Section in LDP Guidance (paragraph 32).

**Ministers' Core Set of Objectives, Targets and Measures (HEAT)**

4. Annexes 1 and 2 set out the objectives, targets and measures that Ministers have agreed as the Core Set for NHS Boards over the next 3 years. Ministers have agreed that there will be 4 new Key Targets. These are:

1. Mental Health:

    a. Reduce the annual rate of increase of defined daily dose per capita of anti-depressants to zero by 2009/10.

    b. Reduce the number of re-admissions (within one year) for those that have had a psychiatric hospital admission of over 7 days by 10% by end of December 2009.

2. HAI – to reduce all staphylococcus aureus bacteraemia (including MRSA) by 30% by 2010.

3. CHI – Universal utilisation of CHI.

5. Ministers have also agreed to the following changes to the HEAT/Core Set of targets:

<u>Remove Targets from HEAT Core Set</u>

A10T Angiography

<u>Expanding an existing Key Target with one from Delivering for Health</u>

Reduce, by 10%, emergency inpatient bed days for people aged 65 and over by 2008.

<u>Concatenate 2 Targets into One</u>

E02T and E03T into E02T – Time Releasing Savings.
A11T and A13T into A11T - Cardiac intervention and treatment.
A08T and A09T into A08T – Cancer Waiting Times.

<u>Modifications to Targets</u>

E01T Add "agreed" and "meet cash efficiency target" to the Target. Revised Target to read: NHS Boards to operate within their *agreed* revenue resource limit, operate within their capital resource limit, meet their cash requirement; *meet cash efficiency target*. .

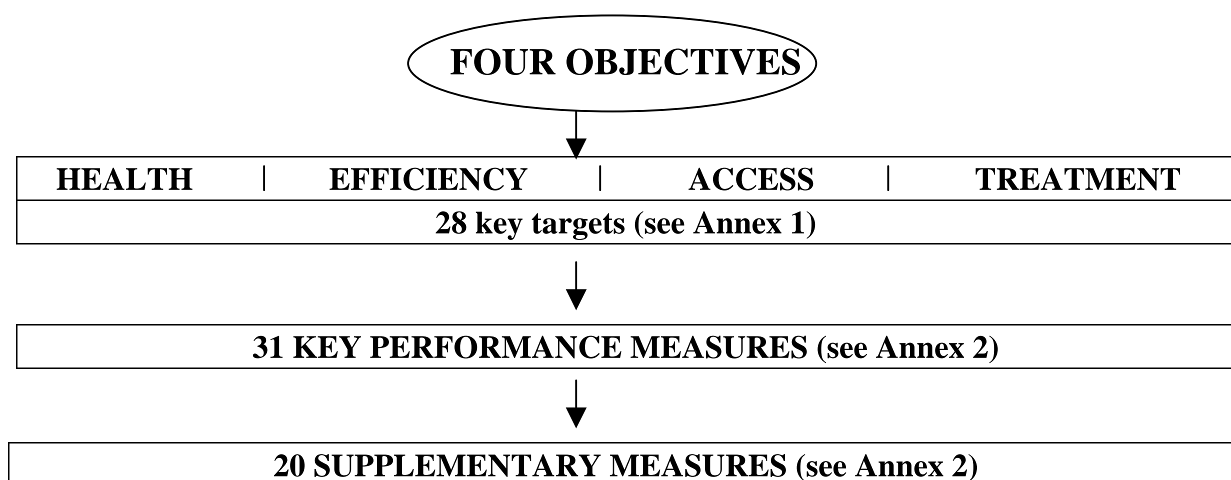
A09T Delete "by 31 December 2005". Revised Target to read: No patient urgently referred for cancer treatment should wait more than 2 months.

6. As a result of developmental work over the last year, and arising from views, comments and discussions as part of the LDP Review this summer, we have introduced a number of changes to Key Performance and Supplementary Measures. These changes

include, for example, those for productivity, mental health and cataracts. The changes are summarised in Annex 2.

7. We will keep the HEAT/Core Set under review with the help of the Service and we have introduced a HEAT Change Control Process to achieve this (paragraph 22). We aim to make any necessary changes once a year, and to keep the targets and measures as stable as possible over time. Changes will be approved by the Health Minister. Figure 1 below illustrates how the overall ministerial objectives, the key targets, the key and supporting measures for 2007/08 relate.

## Figure 1 – The 2007/08 'Core Set'




8. As well as the targets and measures that form the Core Set, the Health Department has set a number of other targets for NHSScotland since 1999. We will continue to monitor NHS Boards' performance against these targets and to make the results public in the same way as at present. However, we have not included these targets in the Core Set or in the scope of LDPs.

9. The HEAT Performance Management system is scheduled for roll-out to NHSScotland in December 2006 and will be updated with the latest performance information on a monthly basis. The system includes: 'traffic lights', charts, and tables at Scotland and Board level for each key performance measure. These provide an assessment of whether a Board has achieved its planned level (agreed in the LDP) for the most recent period of measurement. They are not making an assessment as to whether the long-term national target is at risk of not being met.

10. During the LDP review NHS Boards raised a considerable number of issues relating to the role of the Supporting Measures. On the basis of these views and our experience of the LDP process in its first year we have decided to "de-couple" the Supporting Measures (SMs) from the LDP process and re-name as Supplementary Measures. This better reflects the role they play in providing Boards and the Department with additional and contextual information. We do not ask for the performance information from the SMs to be included in LDPs and we do not ask for trajectories. This means that information from these measures will not be assessed or presented using traffic lights in the HEAT system but will simply be recorded as charts showing trends. However, the SMs do provide information on important

aspects of delivery/performance and we will continue to collect, analyse and act upon the information as and when necessary. This would be within the overall context of delivery and performance rather than within the specific framework of the LDP.

11. The key targets and measures form the basis of the LDP: each Board will set out in the LDP what their planned level of performance is against each of the key performance measures over the period of the plan – for the 2007/08 plan, the period to the end of 2009/10.

**Local Delivery Plans - Purpose**

12. LDPs will set out a delivery agreement between SEHD and each NHS area Board, based on the key Ministerial targets. LDPs will reflect the HEAT Core Set – the key objectives, targets and measures that reflect Ministers' priorities for the Health portfolio. The key objectives are as follows:

- Health Improvement for the people of Scotland – improving life expectancy and healthy life expectancy;

- Efficiency and Governance Improvements – continually improve the efficiency and effectiveness of the NHS;

- Access to Services – recognising patients' need for quicker and easier use of NHS services; and

- Treatment Appropriate to Individuals – ensure patients receive high quality services that meet their needs.

**LDPs - Format and Content**

13. The format and content of the LDPs will support their purpose of recording agreement on Boards' planned progress towards meeting key targets. They will cover a period of 3 years, with the opportunity to review and adjust future years' plans each year. The LDP templates for 2007/08, to be completed by all area Boards, are attached as Annexes 3(a) and 3(b).

14. Setting out planned performance against key measures in the LDPs will enable you and us to track actual operational performance against Boards' plans. It therefore provides an objective, factual basis to discuss with you any operational performance issues that may arise during the plan period and to offer support to achieve improvement if that is needed. The narrative section of the LDP is intended to allow Boards the opportunity to provide locally based contextual information. This information should outline local issues and in particular highlight risks which may impact adversely on the achievement of targets and/or the planned trajectories towards targets. The amount of narrative is expected to be commensurate with the complexity of local issues and degree of risk but should not normally exceed 2/3 paragraphs.

15. The Directorate of Delivery will also continue to support Boards in benchmarking their performance against one another. In addition, the Directorate will work on spreading good practice associated with good and improving performance in respect of the key targets, and on specific benchmarking projects.

16. This quantified and measured approach to performance planning and monitoring does not imply any reduction in the importance of the qualitative aspects of performance. Providing assurance to the Board, the Clinical Governance Committee and the public about the quality of healthcare services continues to be a vital task for each Board. Local monitoring of quality will continue to be augmented at the national level by NHS QIS's reviews of NHS Boards' performance against national clinical standards, which may prompt action by the Department to secure improvements.

17. While the Department will agree LDPs with each Board focusing on the core set, Boards should continue with their own local, community and regional planning arrangements involving their partners, staff and communities. This will ensure that the full range of NHS activity will continue to be properly and comprehensively planned for. It will also ensure that local and regional partners can continue to play a full role in helping to plan for and deliver health care and related services.

**LDPs: Completion**

18. For the 2007/08 LDP process we are supplying 2 pro formas:

- LDP Narrative – a pro forma which, for each of the key objectives, contains details of the relevant key targets. Boards are asked to complete the narrative under each key measure describing how they will achieve the planned levels of performance.

- LDP Trajectory – a pro forma for Boards to enter the planned levels of performance for each key performance measure to March 2009. It is *essential* that Boards complete the blank pro forma to requested standards. This includes: submitting the pro forma in EXCEL and not as a WORD document, submitting the pro forma as a stand-alone document and not embedded within the LDP Narrative and ensuring that planned levels are entered according to the correct metric, to the requested time frequency and are completed to March 2009. Completing the blank pro forma to these standards will help minimise the number of avoidable queries. Pro formas not adhering to these standards will be returned to Boards for re-submission.

These pro formas are also supplemented with a table of specifications describing the sources and methods for each of the key and supplementary measures.

**LDPs: Process and Timescales**

19. The proposed timetable for LDPs for the 2007/08 year is set out below:

| | | |
|---|---|---|
| end October 2006 | - | Final LDP guidance and NHS "core set" of key objectives, targets and measures issued to Boards. |
| November 2006 to Feb 2007 | - | Boards prepare draft LDPs (including financial plans); informal discussion with HD. |

| | | |
|---|---|---|
| Mid February 2007 | - | Boards submit LDPs to SEHD. |
| February/March 2007 | - | LDPs discussed and signed off between SEHD and each Board as the performance delivery agreement for the planning period (paragraph 20). |
| By end March 2007 | - | All LDPs agreed and signed off by Boards. Implementation of Trajectory Change Control Process (paragraph 21). |
| Summer 2007 | - | NHS Boards participate in Annual Review for delivery performance. |
| Late summer 2007 | - | HEAT Change Control Process implemented (paragraph 22). |
| Autumn 2007 | | SEHD issues revised guidance on core set and LDPs for 2008/09. |

20. During the review of HEAT Boards offered a significant number of views of their experience of the process between submission and sign-off of their LDP. We accept that this process needs to be improved and it will now be co-ordinated by the 2 Regional Performance Management Teams.

**Trajectory Change Control Process**

21. Once an LDP has been agreed and signed off by SEHD and the Board, any mid-year alterations to trajectories need to be agreed between the Department and the Board. The Trajectory Change Control Process to alter trajectories will be co-ordinated by and organised through the 2 Regional Performance Management Teams in the Directorate of Delivery and will commence once the LDPs have been signed off.

**HEAT Change Control Process**

22. The HEAT Change Control Process (for HEAT Targets and Measures) will be implemented on a once-a-year basis, or as a result of exceptional and pressing circumstances, and be co-ordinated by the Directorate of Delivery. There would be a review period over the summer, similar to the one in 2006 but less complex and involving written consultation with Boards and detailed discussions across the Department. The results of this would be a set of recommendations which would go to Ministers to form the basis of the following year's LDP/HEAT Core Set. Any changes agreed by Ministers would be incorporated into the LDP Guidance issued in October of each year.

**NHS Area Board Planning**

23. As noted in paragraph 17 above, NHS area Boards should continue with planning arrangements at local and regional level, engaging with local and regional partners across the full range of health policy, planning, service re-design and delivery issues. Boards should

ensure that these activities and their LDPs are consistent with the direction set in Delivering for Health. Boards are free to use the formats and timings that suit them and their partners, within existing agreements and guidance on local, community and regional planning. Boards should ensure that they continue to fulfil their statutory obligations on co-operation and public involvement. Boards should also ensure that local and regional planning supports their performance agreement with the Department set out in the LDP, and that focus and alignment is maintained across the full range of local service planning and delivery to ensure achievement of planned progress towards meeting the key targets in the LDP.

24. The LDP process is consistent with the current work being undertaken by NHS Boards in developing, supporting and setting objectives for CHPs. Clearly the efforts and performance of CHPs will be vital in meeting some of the key targets and Boards need to ensure that CHPs play their full part in helping to meet the key targets as planned.

25. The LDP process sits within the broader planning framework for NHS Boards. The LDP therefore does not make this planning framework redundant: other elements of the current planning arrangements will continue. For example, Pay Modernisation Plans (HDL 2005/28), Regional Planning (HDL 2004/46), the requirement for local workforce plans as set out in the National Workforce Planning Framework and NHS Board Development Plans should continue to be prepared as at present. The achievement of targets set out in LDPs is also underpinned by current detailed planning and service delivery work across the Service co-ordinated by, for example, the Support and Improvement and Access Teams in the Directorate of Delivery and policy leads within SEHD. This detailed underpinning work will continue and will play a vital role in supporting Boards to meet the targets set out in the LDP.

**Financial Planning**

26. Financial planning is considered an integral component of the LDP process. NHS Boards should include draft financial plans as part of their LDP submission, in line with the timetable presented in paragraph 19. In particular, NHS Boards are asked to complete the financial templates presented at Annex 4. (Further supporting guidance is available on the Health Finance Division website at http://www.show.scot.nhs.uk/sehd/fpma).

27. The detailed financial information included in the templates will be used to assess each Board's financial projections, including key risks/assumptions, to ensure achievement of financial targets. Monthly performance assessment of the agreed financial plan/trajectory will continue to be based on the SEHD Monthly Monitoring Returns.

**Freedom of Information**

28. LDPs will be releasable under the Freedom of Information Act and Boards will want to make arrangements locally to place them in the public domain alongside other local plans.

**Special Health Boards**

29. This LDP guidance applies to NHS area Boards. We have moved to similar arrangements for LDPs for Special Health Boards (SHBs) over the last year. We wish to continue this process and now wish to see all NHS Boards' LDP processes fully aligned. Therefore we expect all SHBs to submit their LDPs by mid February 2007, together with

their associated financial plans. SEHD lead sponsors will provide further information and advice should this prove necessary.

**Citistat**

30. Following the evaluation of the Citistat approach, NHS Boards are expected to review and if necessary augment their performance management systems to incorporate the core principles underlying Citistat. These are 1) regular collection and reporting of rigorous, accurate, relevant data 2) analysis of this data to provide an accurate and timely view of activity and outputs that support progress towards well-defined outcomes 3) regular review and discussion of this data at monthly (or sometimes more frequently) scrutiny meetings led by chairs and Board Members and/or by top management, focussing on the data and actions required to improve performance and 4) active follow-up from the data and the meetings, overseen by senior management. Support for implementing the Citistat principles will be available from the Improvement & Support Team and Boards will be expected to report on progress by end January 2007 and again by June 2007.

**Annual Review 2007**

31. The expected Annual Review process in summer 2007 is expected to feature a significant role for LDPs. Each Board's trajectories and past performance towards targets is likely to form an important part of each Board's Annual Review.

**Developmental Work**

32. Following the experience of the first year of HEAT/LDPs, taking into account topics raised during the LDP Review this summer, and reflecting ongoing work, there are a number of issues which we will take forward in the near future. These issues include:

- delivering outcome measures for Community Care;
- ensuring alignment with Delivering for Health, in particular shifting the balance of care;
- introducing new measures on productivity;
- delivering outcome measures for community health including access;
- strengthening the patient experience intelligence;
- developing proposals for child health;
- potential measures for workforce;
- delivering new measures for health improvement;
- chronic disease management.

Taken as a whole, this developmental work will help bring about a balance of the HEAT Core Set across the broad range of NHS services. This work will be undertaken within a process of engagement with NHS Boards and other key stakeholders.

**JOHN CONNAGHAN**
Director of Delivery
Scottish Executive Health Department
31 October 2006

**LDP GUIDANCE**

**ANNEXES**

1. NHS Key Targets

2. NHS Key Performance and Supplementary Measures in place for 2007/08

3(a). LDP Templates WORD

3(b). LDP Templates EXCEL

4. Financial Templates

## SUMMARY OF REVISED TARGETS FOR HEAT 2007/8

# H

| Target Identifier | Target 2006/7 | Note |
|---|---|---|
| H.01T | Reduce health inequalities by increasing the rate of improvement for the most deprived communities by 15% across a range of indicators including; CHD, cancer, adult smoking, smoking during pregnancy, teenage pregnancy and suicides in young people: target date 2008. | No change |
| H.02T | To reduce adult (16+) smoking rates from 26.5% (2004) to 22.0% (2010). | No change |
| H.03T | Reduce incidence of exceeding the weekly alcohol limit of 21 units to 29% for men, and of 14 units to 11% of women: target date 2010. | No change |
| H.04T | 50% of all adults (aged 16+) accumulating a minimum of 30 minutes per day of physical activity on 5 or more days per week. | No change |
| H.05T | 95% uptake target for all childhood vaccinations (ongoing). | No change |
| H.06T | Reduce suicide rate between 2002 and 2013 by 20% | No change |
| H.07T | Reduce by 20% the pregnancy rate (per 1000 population) in 13-15 year olds from 8.5 in 1995 to 6.8 by 2010 | No change to target but measure to be added |
| H.08T | 60% of 5 year old children (primary 1) will have no signs of dental disease by 2010 | This was formerly **A.02T** but updated data source for measure moves it to **H**. The suggested updated data source is the National Dental Inspection Programme (NDIP) which can provide data on Primary 1 children for 2005/6 around Dec 06 / Jan 07 ; thereafter this would be updated every two years. |

## SUMMARY OF REVISED TARGETS FOR HEAT 2007/8

## E

| | | |
|---|---|---|
| E.01T | NHS boards to operate within their agreed revenue resource limit; operate within their capital resource limit; meet their cash requirement ; meet their cash efficiency target | Words ‘agreed’ and ‘meet cash efficiency target’ added |
| E.02T | NHS Boards to achieve time-releasing savings including an increase in consultant productivity by 1% pa over the next 3 years and a sickness absence rate of 4% by 31 March 2008. | E.02T and E.03T merged |
| E.04T | Universal utilisation of CHI | new |

## A

| | | |
|---|---|---|
| A.01T | Ensure that anyone contacting their GP surgery has guaranteed access to a GP, nurse or other health care professional within 48 hours from April 2004. | No change to target but measure changed |
| A.03T | No patient with a guarantee should wait longer than 6 months for inpatient or day case treatment from 31 December 2005, reducing to 18 weeks from 31 December 2007. | No change |
| A.04T | By the end of 2005, no patient will wait longer than 6 months from GP referral to an out-patient appointment, reducing to 18 weeks from 31 December 2007. | No change |
| A.05T | By end 2007 no patient will wait more than 4 hours from arrival to admission, discharge or transfer for accident and emergency treatment. | No change *(Measure from A&E IT system from late 2006)* |
| A.06T | By end of 2007 the maximum wait for cataract surgery will be 18 weeks from referral to completion of treatment. | No change to target but change to ‘chunked’ measure |
| A.07T | By end of 2007, the maximum wait from admission to a specialist unit to hip surgery, following fracture, will be 24 hours. | No change *(Measure from Scottish Hip Fracture Audit from Sep 06)* |
| A.08T | 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. | Two cancer targets merged |
| A.11T | By end 2007, the maximum wait for cardiac intervention will be 16 weeks from GP referral through rapid access chest pain clinic or equivalent ***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. | Target A.11T concatenated with former A.13T ; new ‘chunked’ measure |

## SUMMARY OF REVISED TARGETS FOR HEAT 2007/8

| | | |
|---|---|---|
| A.12T | By the end of 2007 patients will wait no more than nine weeks for any MRI or CT scans and other key diagnostic tests | Target unchanged but measure will include : MRI ; CT ; Barium studies ; non-obstetric ultrasound ; gastroscopy; sigmoidoscopy; colonoscopy; cystoscopy |
| A.14T | To respond to 75% of Category A calls within 8 minutes in Quarter 4 of 2007/08. (mainland Health Boards only) | No change |

# T

| | | |
|---|---|---|
| T.01T | The number of people waiting more than 6 weeks to be discharged from hospital into a more appropriate care setting will be reduced by 50% from April 2006 to April 2007 and to zero by April 2008. Additionally, the number of patients delayed in short-stay beds will be reduced by 50% from April 2006 to April 2007, and to zero in April 2008**.** | Wording of target amended but actual target is unchanged |
| T.02T | By 2008-09, we will reduce the proportion of older people (aged 65+) who are admitted as an emergency inpatient 2 or more times in a single year by 20% compared with 2004/05 and reduce, by 10%, emergency inpatient bed days for people aged 65 and over by 2008 | Wording enhanced to include reduction in emerg. bed days |
| T.03T | Cervical screening target 80%, ongoing | No change |
| T.04T | QIS clinical governance and risk management standards improving | No change |
| T.05T | Reduce the annual rate of increase of defined daily dose per capita of anti-depressants to zero by 2009/10. | **new** |
| T.06T | 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) | **new** |
| T.07T | To reduce all staphylococcus aureus bacteraemia (including MRSA) by 30% by 2010 | **new** |

Removed/altered from 2006/7 list :
A10.T (angiography/angioplasty wait) removed
A.11T and A.13T concatenated into A.11T (cardiac interventions)
T.02T (2+ emerg readmissions of 65+) enhanced with target for emergency bed days reduction
A.08T and A.09T concatenated into A.08T (cancer)
E.02T and E.03T concatenated into E.02T

## ‘KEY PERFORMANCE’ AND ‘SUPPLEMENTARY’ MEASURES FOR 2007/08

*(ordered by related target and using measure title (field 2) from draft meta data)*

| MEASURES | TYPE |
|---|---|
| **HEALTH** | |
| Health Inequalities - CHD | KEY |
| Numbers Smoking | KEY |
| Immunisations- MMR | KEY |
| Suicide Rates | KEY |
| Teenage Pregnancies | KEY |
| Dental caries in Primary 1 children | KEY |
| Numbers Drinking Excessively | SUPPLEMENTARY |
| Exercise | SUPPLEMENTARY |
| Obesity | SUPPLEMENTARY |
| | |
| **EFFICIENCY** | |
| Forecast Revenue Expenditure | KEY |
| Absences | KEY |
| **Day Case Rates** | KEY |
| CHI usage | KEY |
| Ratio of return/new Consultant Outpatients | SUPPLEMENTARY |
| Productivity - Total | SUPPLEMENTARY |
| Cancelled Admissions | SUPPLEMENTARY |
| Efficiency savings | SUPPLEMENTARY |
| Throughput measure | SUPPLEMENTARY |
| SMR Return rate | SUPPLEMENTARY |
| Average length of stay (emergency admissions) | SUPPLEMENTARY |
| Average length of stay (elective admissions) | SUPPLEMENTARY |
| | |
| **ACCESS** | |
| Primary Care Team – 48 hour access | KEY |
| Inpatients/Daycases waiting over 18 weeks ; excl ASCs | KEY |
| Inpatients/Daycases waiting with an ASC code | KEY |
| Outpatients waiting over 18 weeks from GP referral ; excl ASCs | KEY |
| A&E waits to be a maximum of 4 hours | KEY |
| Wait for cataract surgery | KEY |
| Hip fracture surgery within 24 hours | KEY |
| Breast cancer waiting times (31 days) | KEY |
| All cancer waiting times (62 days) | KEY |
| Wait for cardiac intervention | KEY |
| Waiting times for diagnostic scans (MRI /CT /barium studies /ultrasound non-obstetric) | KEY |
| Waiting times for diagnostic scopes (gastroscopy/ sigmoidoscopy/ colonoscopy/ cystoscopy | KEY |
| Ambulance response times | KEY |
| Inpatient/Daycase waiting times target (31 December 2005) | SUPPLEMENTARY |
| Outpatient waiting times target (31 December 2005) | SUPPLEMENTARY |
| Angiography waiting times (> 8 weeks) | SUPPLEMENTARY |

| | |
|---|---|
| Revascularisation waiting times (> 18 weeks) | SUPPLEMENTARY |
| Inpatient/daycase waiting list size | SUPPLEMENTARY |
| Outpatient waiting list size | SUPPLEMENTARY |
| Outpatient ASCs | SUPPLEMENTARY |
| | |
| **TREATMENT** | |
| Delayed Discharges (over 6 weeks) | KEY |
| Emergency re-admissions (aged 65+) | KEY |
| Reduction in emergency bed-days for patients aged 65+ | KEY |
| Cervical screening (80%) | KEY |
| QIS : improving clinical governance and risk management standards | KEY |
| Prescribing of anti-depressants | KEY |
| Reduction of psychiatric readmissions | KEY |
| Healthcare Associated Infection | KEY |
| DNAs | SUPPLEMENTARY |
| Expenditure on anti-depressants | SUPPLEMENTARY |

## GLOSSARY OF ABBREVIATIONS USED

| | |
|---|---|
| ASC | AVAILABILITY STATUS CODE |
| CHD | CORONARY HEART DISEASE |
| CHI | COMMUNITY HEALTH INDEX |
| CT | COMPUTERISED TOMOGRAPHY |
| DNA | DID NOT ATTEND |
| GDP | GENERAL DENTAL PRACTITIONER |
| GP | GENERAL (MEDICAL) PRACTITIONER |
| HAI | HEALTHCARE ASSOCIATED INFECTION |
| IP/INPAT | INPATIENT |
| MMI | MONTHLY MONITORING INFORMATION |
| MMR | MEASLES, MUMPS, RUBELLA |
| MRI | MAGNETIC RESONANCE IMAGING |
| QIS | QUALITY IMPROVEMENT SCOTLAND |
| SMR | SCOTTISH MORBIDITY RECORD |