III Health Plan

Castilla y León

Short Version

Junta de Castilla y León

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Short Version

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Introduction

Since the early days of health jurisdiction, Castilla y León has had a modern health system, with the latest technology and services, with the sole aim of improving the health of the population.

In our Autonomous Community we work with the conviction that healthcare systems must be subject to the following principles: a person's dignity, equity, support and professional ethics. All of these serve to meet the needs of the people of Castilla y León and make continuous improvements in the quality of health care. To achieve this, effective management is essential, with the development of coherent policies in health service matters.

This is the basis for designing the III Health Plan, the main reference in the strategic health plan of our Autonomous Community, which includes the aims we want to achieve and the main lines of action to be carried out during the period it is in effect.

Health Plans establish the priorities for public health at all times, and contribute to improving the health of the population. According to the most recent statistical data published the National Statistics Institute, corresponding to 2005, in Castilla y León the indicator of life expectancy at birth continues to improve: in this Community it is 78.08 years for men, 84.58 years for women and 81.28 for both sexes, bettering the data of 80.25 which was the national baseline in the same year. These data are amongst the highest in the country and higher than the many other European countries. Furthermore, our Community is one of the leaders in other indicators related to improved health, measured with the data of the so-called "Mortality Sensitive to Primary Prevention" and "Mortality Sensitive to Medical Care" indicators.

The resources and actions proposed in the previous Health Plan contribute to this improvement. Over 80% of the specific aims set out in the II Plan have been completely met and this figure exceeds 95% if we include the aims that have been partially reached.

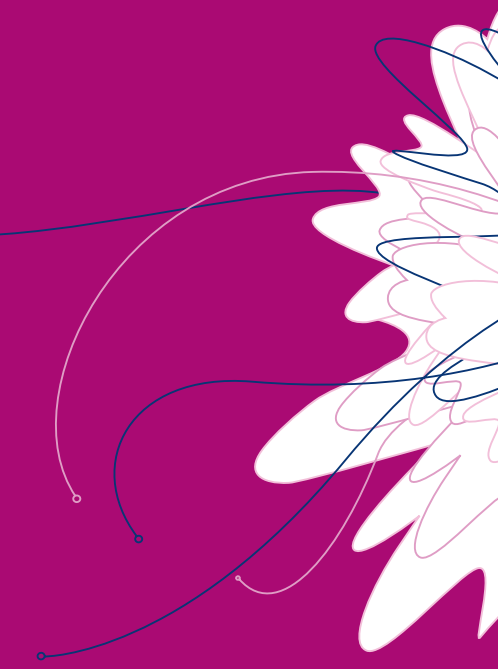
The III Castilla y León Health Plan (2008-2012), presented here, will be in effect for five years and is aimed at a limited and very prioritized number of health problems affecting the citizens of Castilla y León, with a selection of aims which should allow continuing advances to be made in the improvement of the state of the population's health.

Health promotion and disease prevention play a leading role, but there are public health problems about which evidence is lacking concerning the interventions which enable incidence rates to be improved. This means the appearance of new cases, and activities involving early detection and health attention are highlighted in the Plan.

Intervention in health risk factors is a fundamental aim of the III Plan. It is important to note that by taking measures and action aimed at reducing tobacco and alcohol consumption, encouraging physical activity and promoting healthy diets, we will greatly reduce early deaths, improve the time in which citizens live without disability, and see considerable improvements in their health. These are risk factors implicated in many of the problems considered in the III Plan and may condition the future of many citizens.

According to the Nobel Prize winner for Economics, Amartya Sen (India, 1933), health is an indicator of the wealth and freedom in a society. Health policies must efficiently establish the way to attain a lasting, healthy society. That is the aim of the Castilla y León Regional Government.

Regional Health Minister
Francisco Javier Álvarez Guisasola



General aims, specific aims, recommended measures and strategies

Between 2008 and 2012 strategies and interventions will be established to improve the population's health by reducing incidence rates, mortality, avoidable early mortality and disabilities caused by the main health problems in this Autonomous Community.

General Aims

GA-1 Reduce the incidence of cardiac insufficiency (CI) in under 65s.
GA-2 Reduce mortality from cardiac insufficiency by 1% per year.
GA-3 Reduce hospital admissions for CI by up to 15%

Specific aims

All specific aims related to the prevention and treatment of smoking, obesity, ischemic cardiopathy (IC) and diabetes, as well as the specific aims of promoting a healthy diet and physical activity are considered to be included within this health problem.

SAHP-1 Improve diagnosis and increase the number of patients diagnosed with IC with ultrasound scanning.
SAHP-2 Improve access to quality treatment and evaluate the results of new, organizational models of care for IC.

SAHP-3 Improve treatment with drugs, administering those acting upon the rennin-angiotensin system in over 90% of patients diagnosed with IC, and beta-blockers in over 50%.
SAHP-4 Improve treatment and reduce the 2007 readmission rates for IC.
SAHP-5 Improve access to cardiac rehabilitation programs, guaranteeing access in all areas.
SAHP-6 Maintain an information system integrating general information available about the health problem with that obtained more specifically.

Measures and strategies

All the measures and strategies related to the prevention and treatment of smoking, obesity, ischemic cardiopathy (IC) and diabetes, as well as the specific aims of promoting a healthy diet and physical activity are considered to be included within this health problem.

1. Review of the organizational circuits and procedures in primary and specialist care to increase the capacity to perform ecocardiograms, and increase primary care professionals' access to diagnostic tests.
2. Evaluate the results obtained in areas with Cardiac Insufficiency Units.
3. Begin to create working groups with "expert patients" in the areas with a Cardiac Insufficiency Unit.
4. Monitoring the suitability of treatments (according to the latest guides), evaluating drugs acting on the renin-angiotensin system and beta-blockers.
5. Establish coordination protocols between healthcare levels.
6. Promote the use of telecardiology in patients with IC.
7. Development and implementation of protocols for cardiac rehabilitation and access to this service in all areas, through organizational models adapted to each situation. This service is common to other heart problems.
8. Preparation and distribution of reports about this health problem.
9. Offer of ongoing training in dealing with patients with cardiac insufficiency.
10. Promote research into IC at the two healthcare levels.

General aims

GA-4 Modify the current upward tendency in the incidence of ischemic cardiopathy (ACS).
GA-5 Stabilize mortality due to ACS in under 65s near to national reference figures.
GA-6 Maintain the downward tendency in Potential Lost Years of Life (YPLL) due to ACS.
GA-7 Reduce the average length of temporary disability caused by ACS to under 190 days.

Specific aims

All specific aims related to the prevention and treatment of smoking, obesity, diabetes, hypertension and hyperlipemia, as well as the specific aims of promoting healthy diets and physical activity are considered to be included within this health problem.

SAHP-7 Improve outpatient treatment, increasing the total number of semi-automatic defibrillators installed and optimizing the quality of their use in the Autonomous Community (in all care centres, in all Advanced Life Support and Basic Life Support ambulances and in non-healthcare installations).
SAHP-8 Improve emergency extra-hospital care of ACS, keeping average response times after the call to the emergency services (112) below 30 minutes in 90% of the calls.
SAHP-9 Improve emergency care, implementing the triage process for acute thoracic pain in hospital emergencies and optimizing the time for this to be carried out to average times of 10 minutes with a 12-lead ECG in all hospitals.

SAHP-10 Improve emergency treatment of patients diagnosed with ACS, increasing reperfusion therapies - chemical and mechanic - in patients needing it, and increasing pre-hospital use of fibrinolysis.
SAHP-11 Improve emergency treatment of patients diagnosed with ACS, reducing reperfusion times to below 120 minutes if this treatment is given.
SAHP-12 Increase the total number of ACS patients attended in hospital to reduce the difference with the theoretical incidence of ACS cases.
SAHP-13 Improve emergency treatment of ACS patients, reducing door to needle times to 30 minutes and door to balloon times to 90 minutes.
SAHP-14 Improve the treatment of ACS patients, increasing the number of patients with unknown coronary anatomy undergoing risk stratification before discharge.
SAHP-15 Improve the treatment of complications in ACS patients, setting an agreed protocol for the use of ventricular assistance devices in cases of acute cardiac insufficiency after myocardial infarction.
SAHP-16 Improve access to rehabilitation for ACS patients, increasing the percentage of patients treated in rehabilitation programs, extending cardiac rehabilitation to all areas.
SAHP-17 Optimize the results of secondary prevention in patients after myocardial infarction, increasing the percentage of patients whose risk factors are controlled.
SAHP-18 Maintain an information system integrating general information available about the health problem with that obtained more specifically.
SAHP-19 Promote research into ischemic cardiopathy in the population.

Measures and strategies

All measures and strategies related to the prevention and treatment of smoking, obesity, diabetes, hypertension and hyperlipemias, as well as the measures related to promoting a healthy diet and physical activity are considered to be included within this health problem.

11. Annual monitoring of the data in registers of the semi-automatic defribillators installed and their use in the Autonomous Community (in healthcare centres and units, and non-healthcare locations).
12. Define quality criteria for the use and handling of defibrillators in hospitals, health centres and ambulances and establish suitable training to improve their use by all healthcare personnel.
13. Analysis and optimization of travel times of health transport units on the healthcare resource map. Specific analysis of the travel times in rural areas and action plans for improvement.
14. Develop, with the Emergency Coordination Centre, the information system to locate the clinical data of a patient who has previously suffered from ACS and who may be suffering a new episode, in order to accelerate the care given in the new process.
15. Ongoing training in primary care, in the emergency rooms and in emergency healthcare. Retraining in the diagnosis and handling of acute thoracic pain (ATP).
16. Development of the clinical management process, "Acute Thoracic Pain".

17. Review of the triage protocol for ATP in all hospitals and preparation of an ongoing improvement plan - action taken prior to implementing the clinical process for ATP.
18. Development and implementation of an information system to register and monitor acute coronary syndrome in hospitals and healthcare emergencies, enabling the establishment, among other things, of: a register of cases treated, partial treatment times after the initial call, techniques used from the time of the call, result of interventions, etc.
19. Development of actions aimed at the families and care-givers of patients with ischemic cardiopathy.
20. Preparation of the map of travel times to referral services for mechanic reperfusion in Castilla y León.
21. Preparation of a consenus protocol for the use of ventricular assistance devices in acute cardiac insufficiency after AMI, with the participation of the healtcare centres involved.
22. Define and implement a cardiac rehabilitation and secondary prevention service in all areas, ensuring coordination between all levels. Define actions to be taken by the nursing staff in cardiac rehabilitation and secondary prevention.
23. Promote the study of the results of secondary prevention in primary care.
24. Preparation and distribution of reports about the health problem.
25. Study the existence of gender-related differences with ACS and its risk factors and propose specific action.
26. Creation of referral centres to study and investigate cardiovascular pathologies in Castilla y León.
27. Creation of the Castilla y León Cardiovascular Pathology Advisory Board.
28. Continue with periodic research and keep epidemiological information about ACS and its risk factors in Castilla y León.
29. Publication of articles about cardiovascular research in which health professionals in centres in Castilla y León have participated.
30. Promote research into ischemic cardiopathy at the two healthcare levels and the allocate resources for this research.
31. Offer of ongoing training on dealing with ischemic cardiopathy patients.

General aims

GA-8 Reduce the overall incidence of strokes by 10%.
GA-9 Reduce the incidence of stroke in under 65s by 20%.
GA-10 Reduce the Potential Lost Years of Life (YPLL) due to stroke to a rate of 1/1,000.
GA-11 Reduce total and serious disability due to stroke from 22% to 15%.

Specific aims

All the specific aims related to the prevention and treatment of the smoking, alcoholism, drug use (cocaine), obesity, diabetes, hypertension and hyperlipemia, as well as the specific aims for promoting a healthy diet and physical activity are considered to be included within this health problem. Likewise, the specific aim from ACS about the reduction of times after the call to the emergency services (112) is considered to be included.

SAHP-20 Improve the recognition of stroke's alarm symptoms, increasing awareness above 80% in moderate- or high-risk patients and their relatives.
SAHP-21 Improve access to specific stroke care units or teams, increasing the number of Basic Health Zones with stroke referral teams/units.
SAHP-22 Implement the "Stroke Code"/emergency thrombolysis in health areas.
SAHP-23 Increase the number of patients given fibronolytic treatment in under 3 hours from the onset of symptoms.
SAHP-24 Improve stroke patient rehabilitation, increasing the number of patients undergoing early

rehabilitation, started during hospital admission and continued after discharge.
SAHP-25 Improve secondary prevention, reducing the number of recurrent episodes of stroke by 5%.
SAHP-26 Maintain an information system integrating general information available about the health problem with that obtained more specifically.

Measures and strategies

All measures and strategies related to the prevention and treatment of smoking, alcoholism, drug abuse (cocaine), obesity, diabetes, hypertension and hyperlipemias, as well as the measures related to promoting a healthy diet and physical activity are considered to be included within this health problem.

32. Increase home care and personalised care plans aimed at the patient and care-giver.
33. Define and apply monitoring protocols in cases of transitory ischemic accidents (TIA).
34. Develop health education activities at discharge aimed at relatives and care-givers.
35. Distribute information enabling relatives to identify alarm signals in patients at risk.
36. Promote the formation of mutual help groups amongst patients and relatives.
37. Create informative material aimed at patients and relatives about technical help and adapted ortho-prosthetic material.
38. Celebrate "Stroke Day"
39. Review and re-define healthcare circuits, process flows, referrals and referral services/units for stroke.
40. Define the location, development time, and the working and treatment protocols (including emergency thrombolysis) of the Multidisciplinary Stroke Referral Units in Castilla y León.
41. Begin to apply the "Stroke Code" in one area of Castilla y León and plan its extension to all hospitals after evaluating the results.
42. Creation of clinical guidelines and promotion of their use amongst healthcare professionals.
43. Re-design emergency action protocols for stroke to speed up the application of fibrinolytic treatment.
44. Promote day centres and increase occupational therapy activities.
45. Plan and begin the rehabilitation of patients who have suffered a stroke, during hospital admission.

46. Study the development and evaluation of rehabilitation activities in collaboration with physiotherapists, including the opportunity to do the activities in the patient's home.
47. Reduce waiting times for the first neurology consultation.
48. Evaluate secondary prevention measures in cardiopathy and vasculopathy.
49. Establish agreed anti-aggregation and anti-coagulation protocols.
50. Review and improve the clinical-epidemiological information system about strokes and associated risk factors.
51. Prepare and spread reports about the health problem.
52. Prepare a discharge report with specific instructions regarding the coordination necessary between the healthcare and social resources in each case.
53. Look into the need for beds for hospital stays for these pathologies.

Breast Cancer

General aims

GA-12 Reduce annual mortality from breast cancer in women between 45 and 69 by 1.4%.
GA-13 Increase 5-year survival rates to over 78% in women who have suffered from breast cancer.
GA-14 Reduce the impact due to disability of breast cancer in women's working lives.

Specific aims

All the aims related to the prevention and treatment of obesity and lifestyle are considered to be included with this health problem.

SAHP-27 Improve breast cancer screening (BCS), exceeding participation rates of 70% in the program in all areas.

SAHP-28 Improve BCS, increasing the percentage of breast cancer cases diagnosed in early stages: T<1 cm, above 26.5%.
SAHP-29 Improve specific monitoring of women with a personal or family history of breast cancer, increasing the number of people examined in the Cancer Genetic Counselling Units.
SAHP-30 Improve diagnosis, reducing the time from suspicion to radiological and anatomical-pathological confirmation to a maximum of 15 days.
SAHP-31 Improve treatment by reducing access times to a maximum of 2 weeks for surgery, 1 week for chemotherapy and 4 weeks for radiotherapy.
SAHP-32 Improve the quality of the diagnosis and treatment, implementing the breast cancer onco-guide in all areas.
SAHP-33 Improve the quality of surgical treatment, increasing the rates of effective conservative surgery.
SAHP-34 Improve access to breast reconstruction techniques in all health areas.
SAHP-35 Improve the prevention and treatment of lymphedima, offering physiotherapy for lymphatic drainage in all areas.
SAHP-36 Improve the quality of surgical treatment, extending the use of the sentinel ganglion technique.
SAHP-37 Improve psycho-social support for patients and relatives, offering it in all hospitals.
SAHP-38 Design and implement an information system for cancer, an aim common to other types of cancer.

Measures and strategies

All the aims related to the prevention and treatment of obesity and lifestyle are considered to be included within this health problem.

54. Establish a plan for improving the system for appointments and follow-up calls for women who do not go to the first appointment of the Breast Cancer Screening Program (BCS).
55. Development of regular action giving general and personalized information about the BCS, with leaflets and campaigns in the media (consider big publicity events involving well-known members of society), in the public health Internet portal and the workplace.
56. Analysis and development of action aimed at reducing possible inequalities in access to preventative services due to place of residence or social standing.
57. Review and improve protocols and monitoring guidelines for women with risk factors.
58. Give primary care professionals periodic information about the possibility of genetic counselling for breast cancer and the indications and criteria for women at risk.

59. Develop the necessary action to reduce waiting times for diagnosis.
60. Study establishing high resolution diagnosis and treatment units for breast cancer, working in parallel with the BCS.
61. Evaluate the capacity of oncology and radiotherapy teams and resources and whether they are sufficient, and improve access to them if necessary.
62. Implementation and review of the clinical process "Oncoguides: breast cancer", which establishes criteria and intervention times.
63. Extend the use of conservative surgery, evaluating existing protocols regarding surgical treatment of breast cancer. Promote a multi-centred study.
64. Adequately staff all centres with Nuclear Medicine to enable a protocol to be established for the study of the "sentinel ganglion", reducing the number of unnecessary lymphadenectomies.
65. Improve the offer of rehabilitation treatment after surgery. Improve training in prevention measures for lymphadema.
66. Provide psychological support for patients or relatives in need throughout the health care process.
67. Promote breast cancer surgery without hospital admission.
68. Promote the use of a unique coding system in the Anatomical Pathology Services in the health network (common to other types of tumours).
69. Develop hospital registers of tumours in all centres (common to other types of tumours).
70. Extend the Cancer Population Register to all the provinces of Castilla y León (common to other types of tumours).
71. Prepare and spread reports about the health problem.
72. Promote the development of coordinated research projects into breast cancer.
73. Promote, through protocols, suitable clinical information about the diagnosis, prognosis and therapeutic options for patients and relatives.
74. Develop the Castilla y León Cancer Advisory Board.
75. Include the actions in a Comprehensive Women's Healthcare Plan.
76. Include formative activities about breast cancer in the Ongoing Training Plans of health areas.
77. Promote research into breast cancer at the two healthcare levels.

General aims

GA-15 Check the upward tendency in the incidence of lung cancer.
GA-16 Improve 5-year survival rates to above 14%.
GA-17 Check the upward tendency in mortality from lung cancer.
GA-18 Check the upward tendency in Potential Lost Years of Life (YPLL) due to lung cancer.

Specific aims

All the aims related to the prevention and treatment of smoking are considered to be included within this health problem.

SAHP-39 Improve treatment, increasing the number of patients undergoing specific surgical assessment.
SAHP-40 Improve lung cancer treatment, implementing the Oncoguide in all healthcare areas.
SAHP-41 Improve treatment, increasing the percentage of operated patients who receive chemotherapy.
SAHP-42 Improve treatment, increasing the use of chemotherapy in patients with metastases.
SAHP-43 Improve treatment, increasing the use of radiotherapy in locally advanced cases.
SAHP-44 Improve treatment, increasing the use of palliative radiotherapy in patients with metastases.
SAHP-45 Reduce the risk of developing lung cancer due to exposure to asbestos.
SAHP-46 Increase the percentage of patients attended in specific palliative care units.

SAHP-47 Design and implement an information system for cancer, common to other types of tumours.

Measures and strategies

All the measures and strategies related to the prevention and stop smoking are considered to be included within this health problem.

78. Promote inter-area tumour committees, using videoconferences and digitalized images of diagnostic examinations.
79. Review and implement the Oncoguide about lung cancer.
80. Review oncology staffing and radiotherapy equipment on a regular basis to improve access to the services related to cancer treatment, taking the current standards as a reference.
81. Promote vigilance and compliance with the measures of the Royal Decree 396/2006 to minimize occupational exposure to asbestos.
82. Through the Register related to occupational exposure to asbestos, promote anti-tobacco counselling and direct these patients to specialist anti-smoking units, if necessary.
83. Study the possibility of piloting support measures in one healthcare area to facilitate stays in cases where patients travel long distances to receive regular treatment (a measure common to other types of tumours).
84. Implement a home health unit and hospital palliative care unit in each Healthcare Area (linked with the development of the Regional Palliative Care Plan (a measure common to other types of tumours).
85. Develop the Regional Palliative Care Plan.
86. Promote the use of a unique coding system in the Pathological Anatomy Services in the health network.
87. Develop hospital registers of tumours in all centres.
88. Extend the Cancer Population Register to all the provinces of Castilla y León.
89. Prepare and spread reports about the health problem.
90. Include formative activities about lung cancer in the Health Areas' Ongoing Training Plan.
91. Promote research into lung cancer at the two healthcare levels.

General aims

GA-19 Reduce the incidence of colorectal cancer.
GA-20 Stabilize mortality from colorectal cancer, in accordance with national references.
GA-21 Increase 5-year survival rates for colorectal cancer.

Specific aims

All the specific aims related to the prevention and treatment of smoking, alcohol consumption and obesity, as well as the promoting a healthy diet and physical activity are considered to be included within this health problem.

SAHP-48 Improve early diagnosis, implementing a pilot screening program for colorectal cancer in one health area, extending it progressively to other areas.
SAHP-49 Improve early detection in intermediate-risk populations, guaranteeing monitoring of at least 80% of this population through the corresponding protocol.
SAHP-50 Improve early detection in high-risk populations, increasing the cases who attend the genetic counselling program for colorectal cancer in Castilla y León by 30%.
SAHP-51 Improve diagnosis, reducing to a maximum of 15 days the time from suspicion to diagnostic confirmation.
SAHP-52 Improve treatment, reducing to a maximum of 30 days the time taken from diagnostic confirmation until stratification and the therapeutic decision.
SAHP-53 Evaluate the quality of treatment, studying the results.

SAHP-54 Improve the quality of cancer treatment by implementing the Oncoguide, reducing to a maximum of 8 weeks the period between surgical treatment and the onset of chemotherapy and adjuvant radiotherapy, when indicated.
SAHP-55 Improve the quality of treatment by means of tumour committees in all hospitals/healthcare facilities, and by launching new organizational models such as multidisciplinary teams for colorectal care.
SAHP-56 Guarantee psycho-social support for patients and their relatives.
SAHP-57 Design and implement an information system about cancer, common to other types of cancer.

Measures and strategies

All the measures and strategies related to the prevention and treatment smoking, alcohol consumption and obesity as well as the promoting a healthy diet and physical activity are considered to be included within this health problem.

92. Design of a colorectal cancer screening program (CRC program).
93. Launch of a pilot project for colorectal cancer screening and the design for extending it to the rest of the Autonomous Community.
94. Define and spread amongst healthcare professionals the intermediate-risk criteria and the selection and referral procedure in all areas.
95. Establish referral professionals in all healthcare areas for the referral and monitoring of at-risk patients who are admitted to Genetic Cancer Counselling Units (GCCU).
96. Analyse the future development of the GCCUs.
97. Plan and review endoscopy staffing in the Autonomous Community.
98. Review and implement the Oncoguide for colorectal cancer surgery.
99. Study the inclusion of a stomotherapist as part of the multidisciplinary team for colorectal cancer treatment.
100. Establish specialized referral units for necessary cases, for creating healthcare protocols and for coordinating investigation.
101. Provide psychological support for patients or relatives in need throughout the healthcare process.

102. Promote the use of a unique coding system in the Pathological Anatomy Services in the health network.
103. Develop hospital registers of tumours in all centres.
104. Extend the Cancer Population Register to all the provinces of Castilla y León.
105. Prepare and spread reports about the health problem.
106. Specific training for nursing staff in the prevention of colorectal cancer.
107. Provide hospitals with multidisciplinary care teams for colorectal cancer.
108. Establish a recruitment protocol, linked with colorectal cancer screening, with Occupational Hazard Prevention Services.
109. Establish a consensus protocol concerning common recommendations for patients for preparing for and undergoing a colonoscopy and pseudoanalgesia.
110. Standardize the anatomopathological reports in colorectal cancer.
111. Establish a direct colonoscopy application circuit from primary care in health centres in the Autonomous Community.
112. Establish a system of preferential access to diagnostic confirmation tests and surgery in all hospitals in cases with positive results after undergoing a colonoscopy.
113. Guarantee comfort and intimacy in the cancer day hospital and implement the program for those accompanying the patient.
114. Include formative activities about colorectal cancer in the Health Areas' Ongoing Training Plan.
115. Promote research into colorectal cancer at the two healthcare levels.

General aims

GA-22 Reduce the incidence of type 2 DM to below 1.7/1,000 inhabitants.
GA-23 Reduce early mortality from diabetes below 1.44/100,000 inhabitants in under 65s and below 5.2/100,000 inhabitants in people under 75.
GA-24 Reduce hospital admissions with a main diagnosis of diabetes mellitus below 0.9/1,000 inhabitants.

Specific aims

All the specific aims related to the prevention and treatment of obesity, promoting physical activity and a healthy diet and controlling hyperlipemia are considered to be included within this health problem.

SAHP-58 Improve the quality of health care for people with diabetes, developing a Regional Strategy to deal with the disease.
SAHP-59 Improve early detection, increasing the number of patients with risk factors whose glycemia is measured following the Clinical Practice Guidelines.
SAHP-60 Improve the control of patients diagnosed with diabetes, reaching HbA1c (glycosilated hemoglobin) levels below 7% in 50% of cases.
SAHP-61 Improve the prevention, treatment and monitoring of diabetic retinopathy.
SAHP-62 Improve the prevention and treatment of cardiovascular complications.
SAHP-63 Improve diabetic foot check-up activities, also involving patients in self-care in order to achieve a reduction in the incidence of non-trauma amputations in diabetes.

SAHP-64 Improve prevention and stabilize the progression of diabetic nephropathy.
SAHP-65 Maintain an information system integrating general information available about the health problem with that obtained more specifically.

Measures and strategies

All the measures and strategies related to the prevention and treatment of obesity, promoting physical activity and a healthy diet and controlling hyperlipemia are considered to be included within this health problem.

116. Identification of people with risk factors and establishing basal glycemia, following the Clinical Practice Guidelines.
117. Establish the conditions for undertaking screening in risk groups.
118. Develop a line of communication aimed at healthcare professionals to include the detection of diabetes mellitus in the prevention activities in primary care and occupational health.
119. Perform screening of alterations in the metabolism of carbohydrates in all pregnant women, and in positive cases, give health care within one week.
120. Activities aimed at controlling all the risk factors in diabetic patients.
121. Waist circumference measurement at consultation.
122. Review, establish and spread criteria and normal standards.
123. Measures to improve coordination between hospital and primary care for diabetics.
124. Enhance individual and group education about diabetes to achieve the greatest patient self-sufficiency and self-care and a better quality of life by controlling the illness. Define the role of nurses in this activity.
125. Define, through consensus, the Clinical Practice Guidelines (CPG) to use for type 1 and type 2 diabetes, and implement them in the Autonomous Community.
126. Define and implement the screening extension plan for diabetic retinopathy through in-depth study of the eye with midriatic retinography in all healthcare areas (or in specific consultations).
127. Divulge and implement the Castilla y León Cardiovascular Risk Guide in order to reduce the risks of complications and to delay the evolution of diabetic microangiopathy in these patients.
128. Promote foot examinations for diabetic patients by using the monofilament and vascular doppler tests, being sure to give advice about self-care to the patients.
129. Set a protocol for periodically establishing the albumin/creatine quotient, or for using the analytic test that is considered most suitable at each moment as a screening method for diabetic nephropathy in patients under 70 without a history of proteinuria.

130. Prepare and spread reports about the health problem.

131. With the consensus CPG, include in the computerized clinical history in primary care the most necessary or suitable action to be taken with patients with diabetes and also those with risk factors.

132. Set specific aims related to diabetes mellitus in the ongoing training of healthcare professionals.

133. Following regulations, develop the Castilla y León Diabetes Advisory Commission.

134. Promote research into diabetes mellitus at the two healthcare levels.

Chronic Obstructive Pulmonary Disease (COPD)

General aims

GA-25 Reduce hospital admissions for COPD below 2.2/1,000 inhabitants.
GA-26 Reduce mortality from COPD below 0.38/1,000 inhabitants.
GA-27 Reduce premature mortality from COPD in males to below 0.3/1,000 inhabitants.
GA-28 Reduce disability caused by COPD by 25%.

Specific aims

All the specific aims related to the smoking prevention and treatment are considered to be included within this health problem.

SAHP-66 Maintain environmental pollution levels within the parameters established in European regulations.
SAHP-67 Launch measures to reduce air pollution in the workplace.

SAHP-68 Know exposure levels of the different receptors of air pollution, i.e. the population, crops and natural ecosystems, and thus be able to react in the event of possibly harmful incidents. (Aim of the air quality control strategy (2001-2010) of the Department of the Environment of Castilla y León)
SAHP-69 Improve the results of secondary prevention, reducing the percentage of patients with COPD who smoke to at least 30%.
SAHP-70 Improve the prevention and early treatment of exacerbations and reduce hospital admissions.
SAHP-71 Improve monitoring of patients with COPD, to achieve an increase in the application of care plans of up to 90%.
SAHP-72 Improve access to respiratory rehabilitation treatment performed in specialist care and ensure its use in serious cases.
SAHP-73 Improve the quality of healthcare for patients with COPD, implementing the consensus Clinical Practive Guidelines.
SAHP-74 Improve the diagnosis of respiratory insufficiency and ensure that oxygenotherapy indications in COPD are met.
SAHP-75 Improve early diagnosis of patients with COPD and alpha-1 deficiency (non-smokers and smokers under 40)
SAHP-76 Maintain an information system integrating general information available about the health problem with that obtained more specifically.

Measures and strategies

All the measures and strategies related to the smoking prevention and treatment are considered to be included within this health problem.

135. Monitoring air quality.
136. Equip all health centres with a pulsioximetre.
137. Extend the use of hospital at home services.
138. Include in the care plan one-to-one nurses at discharge.
139. Establish and implement standardized care plans following the Clinical Practice Guidelines (CPG).
140. Spread and training in the CPG.
141. Include oxygenotherapy and espirometry in the ongoing training of primary care professionals.
142. Improve the criteria for the use of oxygenotherapy, carrying out monitoring in all areas.
143. Check working conditions of patients with COPD.
144. Study the creation of a Regional Register of patients with alpha-1 deficiency and the criteria that could be established to develop screening of risk groups in primary care.
145. Promote research into COPD.
146. Prepare and spread reports about the health problem.

General aims

GA-29 Maintain the downward tendency in suicide rates.
GA-30 Maintain the downward tendency in the number of hospital admissions for depression.
GA-31 Reduce disability due to depression.

Specific aims

SAHP-77 Improve early diagnosis of depression in the following groups: terminal patients, teenagers, the aged, family caregivers, people deprived of freedom, women in stages of pregnancy, puerperium and the menopause.
SAHP-78 Improve the quality of the diagnosis, increasing the number of people diagnosed with depression who receive treatment (to 3.6/1,000 inhabitants).
SAHP-79 Improve the quality of health care for depression, developing a new Mental Health Strategy which takes into account this health problem.
SAHP-80 Improve the quality of care in all areas, applying case management methodology in the clinical depressions leading to the most disability.
SAHP-81 Improve the quality of treatments with options such as psychotherapy for those patients with clinical depressions leading to the most disability
SAHP-82 Improve prevention of suicides, increasing the percentage of prevention plans for risk situations.

SAHP-83 Increase the detection in primary care of suicide plans.
SAHP-84 Improve secondary prevention, evaluating individual risk at discharge and checking it in the first week after discharge from hospital.
SAHP-85 Improve the quality of the diagnosis and treatment of depression in primary health care, developing and applying a healthcare process.
SAHP-86 Develop and implement information systems related to this problem.

Measures and strategies

147. Improve services in primary care for adolescents, women, the aged, immobile patients, terminal patients and care-givers.
148. Include this type of pathology in the analyses of the Sentinal Network in Castilla y León and the periodic analyses of the drugs prescribed.
149. Development of the clinical process "Depression".
150. Development and implementation of a new Regional Mental Health Strategy considering, amongst other pathologies, depression, and developed with the participation of health professionals and patient associations, amongst others.
151. Improve collaboration and co-ordination in medical consultations, where depression is identified as a comorbid pathology.
152. Use case management methodology, in the clinical depressions leading to the most disability.
153. Include a care service for affective disorders in the portfolio of services in primary care.
154. Agree on and implement a protocol with criteria for the early detection of suicide risk, to be applied in primary care, outpatient departments, hospitals and accident and emergency departments, and create a telephone helpline to give help in potential suicide cases, giving training to those attending the calls.
155. Develop a monitoring program for people who have attempted to commit suicide.
156. Establish care plans and monitoring of patients under treatment.
157. Increase the number of cases of depression treated in primary care.
158. Agree on early detection criteria in primary care.
159. Improve information systems, installing computers and applications that facilitate consultations in mental health care, and ensure their continuity at the primary care level.
160. Increase the number of places at day centres for the aged.
161. Collaborate in the development of training programs in depression for staff in homes for the aged.
162. Collaborate in training prison staff and facilitate consultations of these cases.

163. Creation of the Castilla y León Advisory Board for monitoring mental health.
164. Include training activities for depression in the Health Areas' Ongoing Training Plans.
165. Promote research into depression at the two healthcare levels.

Sepsis, serious infection and nosocomial infection

General aims

GA-32 Reduce the incidence of sepsis as the main diagnosis below 0.2 per 1,000 inhabitants, maintaining hospital discharge rates for this cause.
Ga-33 Reduce mortality from sepsis by 25%.
Ga-34 Reduce vertical transmission infections.
GA-35 Stabilize the tendency in the prevalence of nosocomial infection, keeping it below 9% in hospitals with over 200 beds and reducing it to under 7% in hospitals with less than 200 beds.

Specific aims for sepsis and serious infection

SAHP-87 Reduce the risk of infection, achieving high percentages of vaccinations for those pathologies that can most frequently cause sepsis or serious infection (meningococcus, pneumococcus, Hib, influenza).
SAHP-88 Reduce the risk of infection, increasing the vaccination coverage for influenza to 75% in high-risk patients.
SAHP-89 Detect and reduce risks of infection in all women during pregnancy and childbirth.
SAHP-90 Reduce resistance to antibiotics.
SAHP-91 Improve early diagnosis of serious infection in all hospitals.

SAHP-92 Improve early treatment of serious infection and sepsis, applying treatment protocols.

Specific aims of nosocomial infection

SAHP-93 Reduce the risk of infection associated with the use of hospital devices - probes, catheters and mechanic ventilation.
SAHP-94 Reduce the risk of surgical infection, increasing the appropriate use of antibiotic prophylaxis, when indicated.
SAHP-95 Reduce the risk of nosocomial cross-infection.
SAHP-96 Minimise the risk of nosocomial infection associated with infrastructures, equipment and products.
SAHP-97 Reduce the incidence of nosocomial infection caused by multiresistant micro-organisms.
SAHP-98 Design the "Regional Strategy for the Surveillance, Prevention and Control of Nosocomial Infection" with the help of a Technical Advisory Commission and other healthcare professionals.
SAHP-99 Implement a corporative information system enabling monitoring of the incidence of nosocomial infection in critical areas and processes (indicator of the quality of care given).

Measures and strategies

166. Creation of a Technical Advisory Commission for surveillance, prevention and control of nosocomial infection.
167. Implementation of the "Regional Strategy for the Surveillance, Prevention and Control of Nosocomial Infection", adapted to each hospital.
168. Interventions to maintain the high coverage of vaccinations in children and adults, with activities to actively capture groups and populations with the lower coverage.
169. Implement a centralized information system for vaccinations.
170. Increase activities to achieve a higher vaccination rate amongst healthcare staff.
171. Extend vaccination programs of high-risk patients, including better strategies to capture patients with chronic illnesses at the two healthcare levels.
172. Updating of action guidelines for the prevention of congenital and perinatal infection in Castilla y León, before, during and after pregnancy.
173. Regular promotional interventions aimed at citizens regarding the responsible use of antibiotics in the home.
174. Inclusion in ongoing training in the use of antimicrobial drugs and the early treatment of serious infection.
175. Improve the availability of an urgent early diagnosis.
176. Agree on diagnostic methods and referral laboratories.
177. Implement paediatric triage in the emergency room.
178. Preparation of technical guidelines for serious infection, adapted for primary care, continuous care coints, the emergency room, paediatric services, ICU, etc.
179. Define control policies for the use of antimicrobial drugs in all hospitals and primary care centres, and elaborate and distribute resistance maps on a regular basis in each health area.
180. Development of strategies aimed at the general public about hygiene habits to stop germs at home, the workplace and school, with others departments.
181. Creation of a laboratory network for surveillance and investigation.
182. Promote information systems for epidemio ogical surveillance enabling the active identification and detection of outbreaks.
183. Design immediate communication channels permitting the necessary measures to be adopted in cases of nosocomial infection needing urgent control.
184. Suitable equipping of isolation rooms.
185. Inclusion in all ongoing training programs of tested and proven preventive measures against NI.
186. Evaluation of the deployment and efficacy of programs involving the controlled introduction of alcohol solutions implemented in hospitals.
187. Preparation of graphic materials which facilitate taking effective measures in the prevention of NI.
188. Preparation of a guide with recommendations for the prevention of nosocomial infection in primary care.
189. Assess the updates in the Technical Guidelines aimed at reducing the risk of NI associated with infrastructures.
190. Preparation of Technical Guidelines with

recommendations for managing the sterilization process in hospitals and for introducing traceability systems in the processes involving sterilized surgical material.

191. Preparation of a Guide with recommendations for managing multi-resistant micro-organisms in health centres.

192. Preparation and spread of reports about the health problem.

193. Design and implementation of a corporate information system for microbiology permitting the monitoring of both the micro-biological incidence of germs of interest to public health and anti-microbial resistances in the Autonomous Community.

194. Promotion and development of lines of research at the two healthcare levels.

195. Include formative activities about sepsis and NI in the health areas' ongoing training plans.

Pain osteoarticular pathology

General aims

GA-36 Maintain the prevalence of pain caused by osteoarticular pathologies at national reference levels.

GA-37 Improve the quality of life perceived by people with osteoarticular pain.

GA-38 Reduce disability associated with osteoarthrosis.

Specific aims

All the specific aims related to the smoking prevention and treatment and obesity, as well as the promoting physical activity are considered to be included within this health problem.

SAHP-100 Improve the prevention of osteoarticular pathologies in schools by teaching correct posture.

SAHP-101 Improve the diagnosis and treatment of pathology of the locomotor apparatus in primary and specialist care, applying clinical action protocols and training activities.

SAHP-102 Improve treatment, facilitating access to rehabilitation in specialist and primary care (physio-

therapy) and back schools, if necessary, for patients with osteoarticular pain.
SAHP-103 Improve care of patients with chronic pain, implementing care plans in all healthcare areas.
SAHP-104 Reduce waiting times between the diagnosis and treatment of osteoarticular pathologies.
SAHP-105 Reduce waiting times for surgery on the locomotor apparatus.
SAHP-106 Reduce waiting times for receiving rehabilitation treatment in primary care below 20 days.
SAHP-107 Improve the quality of integral care for pain, implementing referral "pain consultations" in all health areas.
SAHP-108 Reduce the average number of days of temporary disability to under 42.7 days for lumbalgia, under 59.5 days for cervicalgia and under 129 days for osteoathritis.
SAHP-109 Maintain an information system integrating general information available about the health problem with that obtained more specifically.

Measures and strategies

All the measures and strategies related to the smoking prevention and treatment and obesity, and those related to promoting physical activity are considered to be included within this health problem.

196. Promote exercise and physical activity for all ages (an activity also connected with other health problems).
197. Establish a protocol for the early detection and care of problems in childhood and the detection and diagnosis of chronic injuries in adults.
198. Include the handling of osteoarticular pain in ongoing training in primary care.
199. Develop sessions for reviewing and circulating the therapeutic pain control strategies detailed in the main Clinical Practice Guidelines.
200. Select and implement consensus Clinical Practice Guidelines in health centres.
201. Periodic analysis of the use of analgesic drugs, NSAIDs and opioid drugs by means of the prescription information system, to establish indicators of the use and quality of prescriptions.
202. Facilitate access to a greater number of specific diagnostic tests in primary care.
203. Promote prevention activities in physiotherapy units.
204. Review geographical distributions to improve access to physiotherapy units.
205. Extend the offer of functional devices to all healthcare areas in response to common problems with the locomotor apparatus (back schools in physiotherapy units).
206. Prepare nursing care plans aimed at improving the quality of life of patients with chronic pain.
207. Promote the role of rheumatology specialists in the prevention, diagnosis and treatment of osteoarticular pain. Extend the role of nursing staff in the care of this pathology.
208. Agree on the protocol for specific referral and early treatment of patients with rheumatoid arthritis, reducing waiting times until diagnosis and the onset of treatment.

209. Study specialist staffing related to osteoarticular pain care in the Autonomous Community, in particular rheumatology specialists.
210. Improve access times to rheumatology services and specialist and primary care rehabilitation services (physiotherapy), depending on the indications of each pathology.
211. Provide the Autonomous Community with two Resident Medical Intern rheumatology training units.
212. Extend the use of home physiotherapists to guide patient care.
213. Establish a pain unit or referral specialist in all health areas, as well as in multi-disciplinary referral units in the Autonomous Community.
214. Preparation and distribution of reports about this health problem.
215. Include training activities in osteoarticular pain in the Health Areas' Ongoing Training Plans.
216. Promote research into osteoarticular pain at the two healthcare levels.

Road traffic accidents

General aims

GA-39 Reduce the number of traffic accidents by 5%.
GA-40 Maintain the downward tendency in the last 5 years in mortality from traffic accidents.
GA-41 Break the current upward tendency in Potential Lost Years of Life (YPLL) due to traffic accidents.

Specific aims

All the specific aims related to alcohol and other drugs are considered to be included within this health problem.

SAHP-110 Improve emergency care and achieve median arrival times of no more than 15 minutes for the first healthcare resource at an accident.
SAHP-111 Reduce the incidence of accidents due to violations of laws, inappropriate speeds, distraction/fatigue, alcohol and drug consumption and not using safety measures.

SAHP-112 Improve the quality of pre-hospital care.
SAHP-113 Improve the quality of emergency room care.
SAHP-114 Improve the quality of hospital care during admission.
SAHP-115 Improve the quality of rehabilitation from the effects of traffic accidents and reduce access times for victims in need of rehabilitation programs (time and quality of services).
SAHP-116 Establish an information system about the health care given to patients after traffic accidents, including transport between hospitals.
SAHP-117 Contribute to the training of young drivers about matters related to the prevention of traffic accidents. Reduce accidents involving young people related to alcohol and other drugs. (V Regional Drug Plan).
SAHP-118 Enhance specific knowledge for implementing conducts for safe driving.
SAHP-119 Optimize the physical condition of young people when driving.
SAHP-120 Inform drivers about the technical characteristics of their vehicle.
(The three previous aims are taken from the "Young Persons Road Safety Campaign", of the Family and Equal Opportunities Department).
SAHP-121 Promote driving and road safety conditions that produce a reduction in traffic accidents.
(Aim taken from the Castilla y León Regional Roads Plan, of the Development Department).

Measures and strategies

All the measures related to alcohol and other drugs are considered to be included within this health problem.

217. Spread and extend offers of first aid course aimed at the first person to arrive at a traffic accident.
218. Training of more people to obtain medical transport qualifications.
219. Ongoing training of primary care professionals in emergency care in traffic accidents.
220. Training for the general public in first aid.
221. Review travel times of ambulance teams and healthcare resources available in order to deal with traffic accidents in the shortest possible time.
222. Agree on the communication of information in the register systems and from the monitoring of traffic accidents, in order to know the progress made regarding the different causes of traffic accidents: violations of laws, inappropriate speeds, distraction or fatigue, alcohol or drug consumption, not using safety measures, technical faults in vehicles, road conditions, etc.
223. Development of protocols for transfer between emergency care in the site of the accident and treatment in the emergency room and intensive care units.
224. Application of clinical guidelines in all the emergency services regarding the care of victims of traffic accidents.

225. Monitoring and action regarding rehabilitation on offer for patients with injuries and after-effects caused by traffic accidents.
226. Develop accident prevention activities in schools.
227. Monitoring aimed at avoiding a patients' medical equipment being changed when transferred.
228. Inclusion of activities to prevent traffic accidents within the responsibilities of primary care.
229. Define and maintain strategies aimed at age groups with the highest accident rates: under 18s, people between 18 and 34, and over 75s. Develop activities related to education for children.
230. Preparation and circulation of reports about this health problem.
231. Increase control in centres examining medical aptitude to drive and refuse certificates in cases considered in the legislation, looking out, in particular, for the consumption of psychotropic drugs.

Health in the workplace

General aims

GA-42 Reduce the incidence of occupational accidents by over 5%.
GA-43 Reduce the incidence of professional illnesses to below the average national level.
GA-44 Modify the upward tendency in fatal accidents reducing them to below the national average.
GA-45 Reduce the number of days of temporary disability due to occupational accidents and professional illnesses.
GA-46 Reduce the duration of temporary disability for common contingencies.

Specific aims

All the specific aims related to the prevention and treatment of arterial hypertension, smoking and the consumption of alcohol or drugs are considered to be included within this health problem.

SAHP-122 Improve the training of workers in occupational health and safety (OHS) departments, increasing both the percentage of workers who have received training in OHS during the last 12 months and also the percentage of workplaces where someone has taken courses or received a talk about OHS.
SAHP-123 Improve the information given to workers by the companies about their own risks in the workplace.
SAHP-124 Improve the prevention of osteoarticular pathologies in the workplace, with the health and safety services evaluating ergonomics, adjustments, protection and adaptations in the workplace.
SAHP-125 Improve the provision and maintenance of protection equipment and increase the number of companies that have acquired, substituted and modified both collective and individual protection equipment (EPI).
SAHP-126 Improve the prevention culture amongst employers, increasing the number of companies which have improved their organization of prevention during the last 12 months to 45%.
SAHP-127 Improve the coverage of risk evaluations.
SAHP-128 Increase the coverage of the surveillance of workers' health.
SAHP-129 Reduce the percentage of workers who smoke to less than 30%.
SAHP-130 Improve the procedure for declaring contingencies.
SAHP-131 Increase awareness of primary health professionals of dealing with temporary disability (TD) and reduce: the number of TD cases per month in relation to the number of active workers in their quota; TD prevalence and its average duration; and the average length of TD related to the number of active workers.
SAHP-132 Maintain an information system integrating general information available about this health problem with that obtained more specifically.
SAHP-133 Incorporate systematic vaccinations for adults in the context of monitoring workers' health.
SAHP-134 Reduce the prevalence of workers at risk from alcohol and those who abuse alcohol.
SAHP-135 Reduce the harm associated with the consumption of alcohol, tobacco and illegal drugs (the two previous aims are taken from the V Castilla y León Regional Drugs Plan, 2005-2008. These two aims are common to the problems related to drinking alcohol).
SAHP-136 Reduce the incidence of deficiencies caused by traffic or workplace accidents, and others taking place during everyday activities. (This aim is taken from the Sectorial Care Plan for the Disabled, of the Family and Equal Opportunities Department and is common to traffic accidents).

Measures and strategies

All the measures related to the prevention and treatment of arterial hypertension, smoking and the consumption of alcohol or drugs are considered to be included within this health problem.

232. Preparation and application of proposals to improve training for workers in occupational health.
233. Before granting any subsidy, ensure that the company complies with occupational health and safety regulations.
234. Increase the number of inspections to guarantee that regulations are fulfilled: Evaluation of risks, prevention plans and health monitoring.
235. Prepare and implement a "Good Practice Guide" aimed at occupational health and safety services.
236. Prepare and implement "Guidelines for Vaccinations in the Workplace" aimed at occupation health and safety services.
237. Extend the drugs plan to health and safety services, including anti-tobacco counselling in the periodic monitoring of the workers' health.
238. Include courses about the duration and control of TD processes in the ongoing training of primary care professionals in all healthcare areas.
239. Establish an information system about occupational health for the healthcare system and implement a pilot trial.
240. Prepare and spread reports about this health problem.
241. Training in occupational health for the highest number of healthcare professionals.
242. Provide staff for all occupational health posts in the Regional Services.
243. Include work history in clinical histories.

Food safety

General aim

GA-47 Improve food safety in Castilla y León.

Specific aims

SAHP-137 Improve official control through the use of information and communication technologies (ICT).
SAHP-138 Optimize the training of personnel involved in official control in the framework of a

Strategic Training Plan of the Regional Health Department.
SAHP-139 Implement a specific quality program for official control, including audits.
SAHP-140 Promote the preparation by food sectors of guidelines for good hygiene practice and for applying hazard analysis and critical control points, from here on "Guidelines for food sector hygiene". These will be supervised by the Health Department.

Measures and strategies

244. Installation during 2008 of structured cabling for computers in the main buildings where official control workers are found, including abattoirs.
245. Equipping all districts, and 70% of abattoirs, with computers during 2008.
246. Development and implementation during 2008 of a computer application, based on documented procedures for official control in food safety, to which all districts and the main abattoirs can connect. This application should be fully operational by 2010.
247. Design the specific training model for professionals performing initial, generic and specific (materials, risks, sectors, new technologies) official control, including online training options, in the framework of the Strategic Training Plan.
248. Development of systems for performing official control audits, as a means of improving the quality of control procedures.
249. Implementation of specific training in quality systems in the Regional Health Services and in the districts, aimed at people obtaining credentials in these systems.
250. Preparation of "Guidelines for food sector hygiene" by the different private sectors involved.
251. Supervision and promotion of the Guidelines in the previous section by the Health Department.

General aim

GA-48 Improve health monitoring of water for human consumption in Castilla y León.

Specific aims

SAHP-141 Improve the information systems and the monitoring register of water for human consumption through the use of ICT.
SAHP-142 Improve training for the people performing health monitoring of water for human consumption.
SAHP-143 Modernize supply zones of water for human consumption.
SAHP-144 Design risk maps for parameters related to geological conditions.
SAHP-145 Implement a specific quality control program of health monitoring of water for human consumption.

Measures and strategies

252. The installation, during 2008, of structured cabling for computers in the main buildings for professionals responsible for the health monitoring of water for human consumption.
253. Providing all administrative units having workers responsible for health monitoring of water for human consumption with computers during 2008.
254. Implement, during 2008, a regional software application permitting data collection and processing, to be available in all the health districts.

255. Design a specialized training model for the people who perform health monitoring of water for human consumption. Include an online training option in the framework of the Strategic Training Plan.
256. Develop specific training in quality systems in the Regional Health Services and the Districts.
257. Define the criteria which permit a new definition of supply zones to be created, with the collaboration of the supply managers.
258. Georeference at least 90% of underground water deposits, including the most important of these.
259. Create risk maps related to certain parametric values of water for human consumption linked with geological conditions which could have special implications for health.
260. Develop systems for performing audits and supervising official control as a means of improving the quality of the health monitoring of water.

Dependence syndrome

General aims

GA-49 Reduce the incidence of dependency associated with abandoning treatment in people with serious and chronic mental illness.
GA-50 Reduce the incidence of dependency associated with fractured hips in over 79s.
GA-51 Reduce the incidence of the dependency associated with the crisis or discompensation phases of dementia.
GA-52 Define the need, depending on the processes in need of them, for medium and long-term pla-

ces in healthcare centres, improving equity and access to them in all the Autonomous Community.

Specific aims

SAHP-146 Define the criteria for the use of medium and long-term places in healthcare centres: profile of the users, access system, type of care to be provided, length of stay, financing and provision system.
SAHP-147 Develop and implement a new Geriatric Healthcare Strategy in 2008/2009.
SAHP-148 Develop the case management program in serious and chronic mental illness, and include 80% of patients with this pathology in the program.
SAHP-149 Improve treatment by performing early surgery (first 48 hours) in patients with a fractured hip.
SAHP-150 Improve the prevention of complications in patients with a fractured hip.
SAHP-151 Improve rehabilitation, achieving continuity in the care and rehabilitation of patients having had a hip operation, in order to recover the ability to walk.
SAHP-152 Offer coordinated care services for dementia at the two healthcare levels and the social services.
SAHP-153 Establish hospital care procedures, with different circuits for dementia care.
SAHP-154 Develop a healthcare strategy aimed at non-professional care-givers.
SAHP-155 Enable old people with a need for temporary care due to convalescence, rehabilitation, etc, to keep their usual home, through the use of temporary stays in residential centres.
SAHP-156 Facilitate the adaption of the homes of old people, giving them the technical aids to enable them to have an autonomous life.
SAHP-157 Ensure the continuity of the care in the patient's own surroundings, optimizing the coordination between the social and healthcare services.
(The three previous aims are taken from the "Regional Sectorial Plan for the Care of Old People" of the Family and Equal Opportunities Department.
SAHP-158 Promote the reinforcement of health care for people with a disability, improving the coordination between social and healthcare areas.
SAHP-159 Promote increased knowledge and exchanges of experiences regarding disability between workers in the healthcare and social sectors.
SAHP-160 Boost the adaptation of healthcare services to the needs of people with a disability, in accordance with each specific situation.
SAHP-161 Give technical, rehabilitation and healthcare services to day centres to meet the needs of their users; both the centre's own users and those coming from collaboration with other bodies.
SAHP-162 Programs will be provided, in coordination with the health system, for caring for people with alterations in behaviour or dual disorder showing special social integration or adjustment problems in the day centre.
SAHP-163 Establish referral protocols between social and mental health resources, enabling care to be given to those with serious behavioural disorders or dual disorder which is suitable to each case and to the stage of the process.
SAHP-164 Help people with a disability and their relatives with access to healthcare services and provisions, with equal opportunities to the rest of the population.
SAHP-165 Develop coordination mechanisms between the healthcare system and social services, permitting short-stay treatment in healthcare resources for people with a disability suffering from a crisis.

SAHP-166 Develop regional resources, in a different environment to those of the referral services, for services requiring a capacitating and therapeutic approach, to treat people with a disability and with serious cohabitation or adaptation problems.
(The nine previous aims are taken from the "Regional Sectorial Plan for the Care of People with a Disability" of the Family and Equal Opportunities Department.

Measures and strategies

261. Protocols to reduce hospital stay times as much as possible in order to avoid the loss of cognitive capacity and functions often caused by hospital admissions, and to continue treatment on discharge in coordination with Primary Care.
262. Organization of the management of serious and chronic mental health cases in all mental health teams (MHT), developed by nurses and social workers.
263. Define the valuation and intervention guidelines and protocols for managing cases in terms of the patients, their family and their surroundings.
264. Promote treatment at home and care plans for these patients.
265. Implement integral action protocols in hospitals for treating hip fractures (HF) with early surgery, early mobilization after surgery and a reduction in the length of hospital stays.
266. Include in the discharge report of HF patients a care plan to ensure the continuity of the treatment by the social and healthcare services.
267. Preparation and implementation of action guidelines and protocols for coordination between primary and specialist care, for dealing with dementia syndromes (DS).
268. Define action protocols between mental health and primary care teams for how to act in crisis situations.
269. Shared management of DS cases through base coordination teams.
270. Establish stable collaboration agreements with patient and relative associations, including giving support to care-givers.
271. Review the programs aimed at care-givers in the services offered in primary care.
272. Include in the care service the main care-giver the people who carry out this function in hospitals.
273. Depending on the pathology, develop specific training programs and information protocols for care-givers.
274. Know the conditions of the health care given to care-givers, and establish measures to improve them if necessary.
275. Agree measures between sectors enabling care-givers to take breaks.
276. Development and implementation of the specific information system for describing and monitoring cases.
277. The integration of protocols between the social and healthcare mechanisms involving convalescence or short-term stays, aimed at patients recovering functionality and returning to their own surroundings.

Aims related to tobacco

Specific aims

SAHP-167 Specifically reduce the prevalence of female smokers declared in 2007.
SAHP-168 Delay the age at which adolescents start smoking tobacco.
SAHP-169 Avoid the exposure of the population to air contaminated with tobacco smoke in closed places.
SAHP-170 Reduce the prevalence of habitual tobacco use.
SAHP-171 Reduce the damage associated with tobacco use (The four previous aims are taken from the V Castilla y León Regional Drug Plan, 2005-2008, of the Family and Equal Opportunities Department).

Measures and strategies

278. Intensify the activities of the Anti-tobacco Advisory Board in all healthcare centres.
279. Develop specific anti-tobacco programs aimed at: 1) parents of children, 2) pregnant women, 3) adolescents, 4) healthcare professionals, 5) education professionals.
280. Make dishabituation units or specialist anti-tobacco consultations available in all healthcare areas.
281. Create a "healthcare educator" in health areas and pilot the activity in a basic health zone.
282. Promote leisure activities, especially in the open air, amongst children and young adults (sports, tobac-

co- and alcohol-free parties, extending library opening hours, etc).

283. Distribute "Best Practice Codes" amongst local businesses for combating tobacco.

284. Equip all health centres with more co-oximetres.

285. Use spaces available in the media to include initiatives of interest and diffuse best practices.

286. Study the creation of a weekly institutional television programme about promoting health and a healthy lifestyle.

287. Use recognised tobacco-prevention programs in schools.

288. Control tobacco outlets near to schools.

289. Increase the catchment and coverage of the medical council regarding tobacco use within the care program for young people.

290. Increase inspections in institutions, establishments and closed premises into compliance with tobacco regulations.

291. Development of training activities about anti-tobacco counselling techniques aimed at primary care professionals.

292. Maintain anti-tobacco counselling as a priority in primary care and make a register of it in clinical histories.

Aims related to physical activity

Specific aims

SAHP-172 Increase the total percentage of the population doing physical activity in their free time by 10%.

SAHP-173 Increase, specifically, the percentage of women doing physical activity in their free time.

SAHP-174 Reduce the time spent by children under 16 using information and communication technology.
SAHP-175 Promote physical activity amongst schoolchildren in Castilla y León.
SAHP-176 Promote moving around on foot, with non-motor vehicles and collective vehicles.
SAHP-177 Promote permanent activities connected with sustainable mobility. (The two previous aims are taken from the program "The city without my car" of the Environment Department.
SAHP-178 Promote participation in sports as a habit for a healthy life.
SAHP-179 Provide education in developing habits for a healthy life. (The two previous aims are taken from the Sports Programs of the Department of Culture and Tourism).
SAHP-180 Promote accessible routes and destinations and distribute information about them.
SAHP-181 Finance town councils to promote accessible routes on public highways. (The two previous aims are taken from the "Program for Improving of the Quality of Tourist Resources" of the Dept. of Culture and Tourism).

Measures and strategies

293. Unify all efforts and institutional offers aimed at promoting regular participation in exercise and physical activity.
294. Promote participation in daily physical activities, encouraging travelling to work on foot or by bicycle and reserving parking spaces for bicycles in workplaces.
295. Preparation and broadcasting of messages and campaigns in publicity or promotional spots in the written press, radio and television aimed at the adult population, with the message that it is necessary to walk for at least 30 minutes every day.
296. Develop initiatives to increase awareness amongst healthcare professionals, with the collaboration of Scientific Societies for defining new activities.
297. Spread information for parents about the maximum daily and weekly times recommended for the use of information and communication technology by children.

298. Promote a wide range of regular sporting activities in schools available to all pupils.
299. Study proposals to extend the time allotted to physical education in primary and secondary education.
300. Development of agreements with Town and Provincial Councils to organize physical activities for large groups of people of a wide age range, promoting options that can be practised in public spaces and in the open air.
301. Promote participation in physical activities by the whole family.
302. Reflect in all hospital discharge reports the recommendations for the exercise and physical activity indicated in each case.
303. Implement individual health counselling in physical activity in primary care.

Aims related to high blood pressure (HBP)

Specific aims

SAHP-182 Reduce the prevalence of hypertension by 10%.
SAHP-183 Improve the early detection of HBP in health system users over 20 years of age.
SAHP-184 Improve the suitable control of patients with HBP.

Measures and strategies

304. Measure the prevalence of HBP and other risk factors in the population using examinations, health surveys and other monitoring systems.

305. Create a food and drink information program for the population about HBP, dealing in particular with the amount of sodium in foods, and with specific recommendations about daily intakes of salt.
306. Develop opportunist screening measures for HBP in primary care for people over 20.
307. Perform systematic screening, following protocols, of anyone showing any cardiovascular risk factor.
308. Develop measures for monitoring renal complications in uncontrolled cases of HBP.
309. Spread the HBP screening protocol among workers in occupational health services.
310. Develop strategies for the active search for cases, with re-call measures for patients who do not go to the consultation.
311. Assess and improve the technical norms regarding early detection and measuring of (high) arterial pressure defined in the services of primary care.
312. Increase the coverage and the quality standards of the "HBP Patient Care Service", in the list of services of primary care.
313. Equipping health centres with holter pressure monitors or outpatient monitoring of arterial pressure.
314. Preparation of guidelines for HBP prevention aimed at the population.
315. Calculation of cardiovascular risk in all patients diagnosed with HBP, with information for the patients about the results, and with relevant recommendations.
316. Promote self-care measures and adherence to the treatment by the patients.
317. Implement the Clinical Practice Guidelines.

Aims related to hyperlipemia

Specific aims

SAHP-185 Reduce the prevalence of hyperlipemia by 5%.
SAHP-186 Reduce the population unaware that they suffer hyperlipemia.
SAHP-187 Improve the permanent monitoring of patients diagnosed with hyperlipemia (to at least 75%).
SAHP-188 Improve the prevention of hyperlipemia, implementing the family hypercholesterolemia screening program in target populations with a family history of this problem.

SAHP-189 Improve the prevention of hyperlipemia, implementing screening in men over 35 and women over 45, following the criteria in the Cardiovascular Risk Guide.

Measures and strategies

318. School meals to be checked by nutrition experts.
319. Menus of collective canteens to be checked by nutrition experts.
320. Measures aimed at identifying and monitoring food producing hyperlipemia in eating establishments.
321. Monitoring that labelling regulations are followed.
322. Define common criteria for performing the basal analysis.
323. Specific checking, following protocols, of patients who have suffered from a previous coronary event.
324. Early detection of cases of family hypercholesterolemia. Active search for cases and first-degree relatives of the patients affected.
325. Calculation of cardiovascular risk in patients diagnosed with hypercholesterolemia, giving the relevant information and recommendations.
326. Define the protocol to initiate the opportunist screening of hyperlipemia in patients over 20 or with risk factors (universal screening is not recommended).

Specific aims

SAHP-190 Check the upward tendency in obesity in adults.
SAHP-191 Check the upward tendency in obesity in children under 16.

Measures and strategies

327. Promote exercise and physical activity at all ages.
328. Design the obesity care plan in primary care and monitor the results.
329. Diverse interventions concerning parents' knowledge and ability to improve education in healthy eating in the heart of the family.
330. Action and recommendations directed at the media involving social leaders to promote healthy eating.
331. Establish alliances between institutions: with the agroalimentary sector, Town and Provincial Councils, professional associations, community and patient associations, etc.
332. Improve the coverage and results of the "Obesity Service" in primary care.
333. Promote associations organising activities in the open air.
334. Promote healthy menus (contents and preparation) in eating establishments and in centres with collective canteens.
335. Development of the referral network for the surgical treatment of obesity.
336. Study taking action involving the regulations related to the publicity and sale of hypercaloric products in educational centres.

337. Increase the number of unorganized/free activities, and offer extra-curricular educational activities related to in nutrition and the identification and preparation of tasty, healthy food.
338. Systematic screening of overweight and obese children in primary care centres.

Aims related to alcohol and other drugs

Specific aims

SAHP-192 Reduce the prevalence of habitual drinkers, binge drinkers and people at risk from drinking alcohol.
SAHP-193 Reduce the harm associated with the consumption of alcohol and illegal drugs.
SAHP-194 Reduce binge drinking of alcohol amongst young people.
SAHP-195 Delay the age of onset of alcohol consumption in adolescents. (The four previous aims are taken from the V Castilla y León Regional Drug Plan, 2005-2008, of the Family and Equal Opportunities Department).

Measures and strategies

339. Continuous development of information and prevention campaigns aimed at target groups.
340. Use recognised prevention programs in schools and the family.
341. The inclusion of prevention activities in the care service for young people in primary care in coordination with other prevention programs endorsed by the Regional Drug Plan.
342. Inspections of alcohol retail outlets.

343. Intensify care activities for at-risk drinkers in primary care.
344. Development of training activities about counselling techniques aimed at Primary Care professionals.

Aims related to food

Specific aims

SAHP-196 Increase the daily intake of fruit and vegetables.
SAHP-197 Improve the general public's ability to identify a balanced and healthy daily diet, and encourage them to eat one.
SAHP-198 Reduce the regular intake of hypercaloric, fatty and salty foods.

Measures and strategies

345. Creation and distribution of intersectorial campaigns about healthy eating, directed at the whole population.
346. Measures giving institutional support to eating establishments applying effective measures in healthy eating.
347. Organize healthy eating programs which include preparing healthy meals in schools, and with the participation of parents.
348. Offer courses on institutional web pages and portals showing how to prepare healthy food easily.
349. Promote physical activities together with healthy eating programs.
350. Limit the selection of hypercaloric products in educational centres.

Intersectorial plans and programs of the Castilla y León regional government

Strategic line: the integration of the aims in the III Health Plan requiring coordination between different Administrations and the incorporation of plans and programs related to health determinants from other Departments of the Castilla y León Regional Government, as well as impact actions to be evaluated during the III Health Plan.

This section is a collection of the Plans and Programs of the Castilla y León Regional Government, whose development includes aims involving sectors working together to improve the health of the citizens of the Autonomous Community.

Interior and Justice Department

Integral Immigration Plan of Castilla y León, 2005-2009.

Environment Department

Strategy for the Control of Air Quality of Castilla y León, 2001-2010.
Regional Sectorial Plan for Industrial Waste of Castilla y León, 2006-2010.
Regional Sectorial Plan for Urban and Packaging Waste of Castilla y León, 2006-2010.
"The City without my Car" program. Promotion of the network of sustainable localities.

Family and Equal Opportunities Department

Strategy for the conciliation of personal, family and professional life, 2008-2011.
Help network for women who are victims of gender violence.
Regional Sectorial Plan for the Care and Protection of Infants.
III Young People's Health Plan of Castilla y León.
Regional Sectorial Plan for the Care of the Aged.

Young People's Road Safety Campaign.
Living Together Campaign. Young people for Tolerance, 2008.
V Regional Drug Plan of Castilla y León (2005-2008).
Regional Sectorial Plan for the Care of people with Disability.
Strategic support lines for families.

Education Department

Priority Educational Zones Project.
Care Plan for Pupils with Special Educational Needs.
Framework Plan for Educational Attention to Diversity for Castilla y León.
Care Plan for Foreign Pupils or those from Minority Groups.
Plan for the Prevention and Control of Truancy.

Department of Culture and Tourism

School Sports Program
Program of Social, Water and Winter Sports
University Sports Program.

Department of Economy and Employment

Creation of the Health and Safety at Work Institute of Castilla y León and the Regional Observatory of Occupational Hazards.
Promotion of energy saving and renewable energy.

Department of Agriculture and Cattle

Traceability in the primary production of food and animal feed.
Program for monitoring, control and eradication of transmissible spongiform encephalopathies.
Program for the eradication of bovine tuberculosis.
Control program for salmonella affecting public health in farms with egg-laying hens in Castilla y León. Study of the prevalence of Salmonella spp in farms with chickens or pigs.
Program for the eradication of bovine and ovine/caprine brucellosis.
Monitoring plan for avian influenza in Castilla y León.
Plan of control of certain substances in live animals.
Program for quality milk in primary production.
Program for control and surveillance of tularemia in wild rodents and lagomorphs.

Department of Development

Regional Road Safety Strategy, 2004-2008.
Transport on Demand Project.
Regional Highways Plan of Castilla y León.
Programs of rural housing and housing for young people.
"Get Started" Program; Network of digital localities.
Broadband program. "Get Connected" Program.
Regional network of cybercentres.

Development of new plans and strategies derived from the III Health Plan:

- REGIONAL MENTAL HEALTH STRATEGY
- REGIONAL DIABETES STRATEGY
- REGIONAL CANCER STRATEGY
- REGIONAL PALLIATIVE CARE STRATEGY
- REGIONAL STRATEGY FOR ISCHEMIC CARDIOPATHY AND STROKE (CARDIOVASCULAR HEALTH)
- III SOCIAL HEALTH PLAN
- REGIONAL STRATEGY FOR THE SURVEILLANCE, PREVENTION AND CONTROL OF NOSOCOMIAL INFECTION
- INTEGRAL REGIONAL PLAN FOR WOMEN'S HEALTH CARE Includes gender violence from a healthcare perspective.
- REGIONAL PLAN FOR GERIATRIC HEALTH CARE
- REGIONAL STRATEGY FOR RESEARCH IN BIOMEDICINE

Evaluation of the III Health Plan of Castilla y León

Evaluation of the III Health Plan

The III Castilla y León Health Plan incorporates the evaluation of its aims as an instrument for its management, from which the level of fulfilment will be deduced. It enables the monitoring of the measures and strategies initiated, and also the adaptations that become necessary while it is in force.

Evaluation will be performed using the measurements and the estimations of the indicators set for the aims, using the data sources generating the most up-to-date information.

In the case of the aims which have not generated information, the indicators, mechanisms and procedures for obtaining it will be reviewed.

Each aim has been assigned to the directive units with the greatest involvement in its development. These units will be responsible for providing the evaluation system with the information available.

There will also be monitoring of the operational measures and the process adopted to reach the aims.

Evaluation will be carried out on an annual basis and will be prepared in the first three months of the year. Every year the "Progress Report" will be written, which will give a picture of the evolution of the achievements obtained as the Plan develops, the degree to which it has been carried out and the results of the different measures adopted. Quality control strategies will be defined for the evaluation. The "Final Evaluation Report" will be presented once the III Plan is no longer in force.

The Progress Reports will include an assessment of the progress of each of the specific aims and of the measures considered, and it will be essential to incorporate in each case any useful recommendations that ensure that the aim is reached.

To perform the evaluation process an information system will be developed with details distributed on how to complete it, in order to speed up the transfer and communication of data. Monitoring of the III Plan will take place both at local and central levels, which will coordinate to apply the measures that arise from the evaluation and feedback process.

As a result of developments in the measures in the III Health Plan, interventions will be triggered on many occasions that cannot initially be considered in the Plan, but can be considered essential for achieving the aims. The evaluation process will also include monitoring of all these new measures.

The results of the studies, analyses and surveys related to the III Health Plan will also become part of its evaluation, as well as the results of questionnaires that may be prepared by professionals and managers concerning awareness of the Plan.

The analyses of the evaluation will be performed for each health area and the results for the Autonomous Community will be reached by adding up those of each Area. The management of the health areas and the Regional Health Service will be involved in evaluating the results that correspond to them, and thus will play an active role in the process.

To evaluate the reduction in inequalities in health, equity and the inclusion of the gender perspective considered in the III Plan, the data will be used which facilitates the analysis from these viewpoints.

While in force, the III Health Plan directs healthcare policies in order to improve results in healthcare in the Autonomous Community. For it to become operative, the management instruments of the Regional Health Management will be used, amongst others, with the Annual Management Plan (AMP) considered to be fundamental; It will distribute the aims assigned to each unit within the time framework of the Health Plan. The feedback procedures will also be reflected in the AMPs.

The Department of Health could form specific groups to help with the monitoring of certain aims in the III Health Plan.

For the intersectorial aims and strategies considered in the III Health Plan and agreed within the frame-

work of the Intersectorial Coordination Commission, the previously described evaluation mechanisms will be used and the Department of Health will be informed on a regular basis.

The Strategies developed from the III Health Plan will have individual evaluation procedures which, whenever corresponding, will be in line with the aims of the III Plan.

The results of the evaluation of the III Plan will also be an opportunity to reconsider management procedures, and if necessary to assess the needs regarding the location and distribution of resources.

	AIM	INDICATOR	SOURCE INFORMATION
CARDIAC INSUFFICIENCY	GA 1	IC incidence rate in under 65s	PC Register
	GA 2	IC mortality rate	National Statistics Institute (NSI)
	GA 3	Hospital discharge rates for IC	Basic Min. collection Data (BMCD)
	SA 1	% of patients diagnosed with IC undergoing an echocardiogram	PC and Areas
	SA 2	Intrahospital mortality rate in patients with IC	BMCD
		Evaluation report about new forms of organization and coordination of IC	AREAS
	SA 3	% of patients diagnosed with IC in treatment with renin angiotensin drugs	AREAS
		% of patients diagnosed with IC in treatment with beta-blockers	AREAS
	SA 4	Re-admission rates for IC	BMCD
	SA 5	% of patients with IC treated in Cardiac Rehabilitation Unit	Health Areas
	SA 6	Active information system N° of areas providing data	Health Areas
ISCHEMIC CARDIOPATHY. ACUTE CORONARY SYNDROME	GA 4	ACS incidence rate	Specific system
	GA 5	Mortality rate for ACS in under 65s	National Statistics Institute (NSI)
	GA 6	YPLL rate for ACS	NSI
	GA 7	Rate, average duration of TD and permanent disability due to ACS	National Social Security Institute (NSSI)-RHM
	SA 7	N° SADE installed	SADE register and Centres
		Minutes until defibrillation after call	Healthcare Emergency Management -HEM
	SA 8	Distribution of emergency arrival times in ACS cases	HEM
	SA 9	Centres with consensus triage protocol for ATP	RHM
		N° of patients treated with protocol	Specific system / Areas

	AIM	INDICATOR	SOURCE INFORMATION
ISCHEMIC CARDIOPATHY. ACUTE CORONARY SYNDROME	SA 10	% of patients with IC receiving reperfusion	Specific system / Areas
	SA 11	Average time until reperfusion treatment	Specific system / Areas
	SA 12	Admission rate for AMI	BMCD
		Intrahospital mortality rate after coronary angioplasty	
		% emergency re-admissions after MI	
		N° ACS cases per Area	
	SA 13	Average door-needle/door-balloon time by areas	Specific system
	SA 14	N° of coronariographies per area	Specialist Care Info. system
	SA 15	Consensus protocol for using ventricular assistance devices in IC after MI	Specific system
	SA 16	% of patients in rehabilitation after ACS	AREAS
	SA 17	Survey of cardiovascular risk factors in patients with ACS	PC register and Sentinel Network
		Assessment of cardiovascular risk in over 34s	PC register
	SA 18	Active information system N° of areas providing data	Specific system
	SA 19	List of research projects	Specific system
		Survey of cardiovascular risk factors in patients with ACS	PC register and Sentinel Network
STROKE	GA 8	Incidence rate for stroke	BMCD
	GA 9	Incidence rate for stroke in over 65s	BMCD
	GA 10	PYLL rate for stroke	NSI
	GA 11	Rate, average duration of TD and permanent disability due to ACS	Medical inspection / NISS
	SA 20	Information prepared and distributed about stroke	RHM
	SA 21	N° of areas with stroke units	RHM
	SA 22	N° of cases in which stroke code was applied	AREAS
	SA 23	% of patients with thrombolysis	
		Average application time of thrombolysis	Specific System
	SA 24	% of patients with stroke in rehabilitation during admission	Specific system
		% of patients with stroke in rehabilitation after discharge	(areas)

	AIM	INDICATOR	SOURCE INFORMATION
STROKE	SA 25	% of hospital re-admissions due to stroke	BMCD
	SA 26	Active information system. Nº of areas providing data	RHM-Dept. Health
BREAST CANCER	GA 12	Mortality rate due to breast cancer between45 and 69	NSI
	GA 13	5-year survival rates of patients with breast cancer	Tumour register / specific system
	GA 14	Rate of permanent disability due to breast cancer	NSSI
	SA 27	% of women with mammography in last cycle between 45 and 69	Results of Breast Cancer Early Detection Program (BCEDP) & National Health Strategy
	SA 28	% of breast cancer detected in stage I	BCEDP & tumour register
	SA 29	Nº of women with family history of breast cancer studied in the GCCUs	GCCU
	SA 30	Average and maximum diagnosis and treatment times of breast cancer by areas	Specific system
	SA 31		Specific system
	SA 32	List of areas with the implementation of breast cancer oncoguide	PAG
	SA 33	% of conservative surgery in breast cancer	BMCD and specific system
	SA 34	List of reconstruction techniques % of reconstructions in women with radical mastectomy by area	BMCD and specific system
	SA 35	% of patients treated for breast cancer who develop lymphedema % of women with lymphedema in rehabilitation	BMCD and Specific system RHM
	SA 36	List of hospital using the sentinel ganglion technique and its results	RHM/Specific system
	SA 37	List of hospitals using the sentinel ganglion technique which systematically offer psycho-social support to breast cancer patients and relatives, and results	RHM/Specific system
	SA 38	Active information system. Nº of areas providing data	RHM-Dept. Health

	AIM	INDICATOR	SOURCE INFORMATION
MALIGNANT TUMOUR OF THE LUNG, TRACHEA AND BRONCHIAL	GA 15	Incidence rate of cancer of the lung, trachea and bronchial tubes	Tumour register/ Specific system
	GA 16	5-year survival rates after cancer of the lung, trachea and bronchial tubes	Tumour register/ Specific system
	GA 17	Mortality rate due to cancer of the lung, trachea and bronchial tubes	NSI
	GA 18	Rate of YPLL due to cancer of lung, trachea and bronchial tubes	NSI
	SA 39	% of patients diagnosed having surgical treatment	BMCD
	SA 40	Oncoguide Areas	PAG
	SA 41	% of patients treated with chemotherapy	Specific system
	SA 42	% of patients with metastases treated with chemotherapy	Specific System
	SA 43	Patients with locally advance tumours treated with radiotherapy	BMCD and Specific system
	SA 44	% of patients with metastasis treated with palliative radiotherapy	BMCD and Specific system
	SA 45	Register related to exposure to asbestos in the workplace Jobs with asbestos in which exposure assessment is performed	Gen. Directorate Work / Gen. Dir. Promotion of Research, development and Innovation (GDPRDI)
	SA 46	% of patients with lung cancer who receive palliative care	RHM
	SA 47	Active information system Nº of areas providing data	RHM-Dept. Health
COLORECTAL CANCER	GA 19	Incidence rate of colorectal cancer	Tumour register
	GA 20	Mortality rate due to colorectal cancer	NSI
	GA 21	5-year survival rates for colorectal cancer	Tumour register / specific system
	SA 48	Coverage of screening program and results	Specific system
	SA 49	Detection in intermediate-risk populations	Specific system
	SA 50	Evolution of Nº of cases attended by GCCU due to family history of colorectal cancer	GDPRDI-GCCU

	AIM	INDICATOR	SOURCE INFORMATION
COLORECTAL CANCER	SA 51 SA 52	Average times of diagnosis, statification and treatment with surgery, chemotherapy and radiotherapy for colorectal cancer	Specific system
	SA 53	Evaluation of quality results in surgical interventions	BMCD/Specific system
	SA 54	List of areas with implementation of oncoguide	PAG
	SA 55	N° of hospitals with tumour committee	RHM/Specific system
	SA 56	N° of hospitals with psycho-social support; N° of hospitals with multi-disciplinary care teams for colorectal cancer	 RHM
	SA 57	Active information system. N° of areas providing data	RHM-Dept. Health
DIABETES MELLITUS	GA 22	Incidence rate of Type 2 DM	PC register
	GA 23	Mortality rate of DM in people between 65-75	NSI
	GA 24	Hospital Discharge Rates for DM	BMCD
	SA 58	Regional Diabetes Strategy	Castilla y León Official Bulletin
	SA 59	% of patients with glycemia measurements in PC	PC registers
	SA 60	% of diabetic patients with HbA1c <7%	PC registers
	SA 61	% of diabetic patients over 14 having had in-depth eye examination in last two years	PC registers
	SA 62	% of diabetic patients with cardiovascular complications requiring hospital admission	BMCD/Specific system
	SA 63	Amputation rates of lower limbs in diabetics	BMCD
	SA 64	% of diabetic patients on dialysis	PC register / dialysis register
	SA 65	Active information system N° of areas supplying data	RHM-Dept. of Health
COPD	GA 25	Hospital Discharge Rates for COPD	BMCD
	GA 26	Mortality rate for COPD	NSI
	GA 27	Premature death rate in males due to COPD	NSI
	GA 28	Permanent Disability Rate N° days TD due to COPD	NSSI-RHM
	SA 66 SA 67 SA 68	Air pollution indicators of the Air Control Strategy	Air Quality Control Strategy

	AIM	INDICATOR	SOURCE INFORMATION
COPD	SA 69	% COPD patients who smoke	PC register
	SA 70	N° and rate of hospital admissions due to exacerbation in COPD	BMCD
	SA 71	% COPD patients in care plans in PC	PC registers and specific system
	SA 72	% of COPD patients in rehabilitation	PC registers and specific system
	SA 73	Approval of Clinical Practice Guidelines	RHM
	SA 74	Progress of COPD population treated with oxygenotherapy	PC registers and Inspection
	SA 75	Study of need for and viability of populational register of patients with alpha-1 deficit	RHM
	SA 76	Active information system N° of areas providing data	RHM-Dept. Health
DEPRESSION	GA 29	Mortality Rate due to suicide	NSI
	GA 30	Hospital admission rates due to depression	BMCD
	GA 31	Permanent Disability Rate: rate, days and average duration of TD	NSSI-RHM
	SA 77	Specific action protocols to deal with potential risk situations	
	SA 78	N° of people diagnosed with depression in treatment	Specific system
		First consultation rates and hospital admissions due to affective disorders	BMCD
	SA 79	Mental Health Strategy	C & L Official Bulletin
	SA 80	Evolution and N° of patients included in case management	PC registers-Mental Health registers
	SA 81	% of patients in psycho-therapy treatment	Mental Health Registers
	SA 82	N° of areas implementing prevention plans in risk situations	PC registers/Registers of Mental Health
	SA 83	N° and rate of suicides	NSI
		Register of comorbidity in depression in PC	PC registers-Mental Health registers
	SA 84	% patients admitted due to attempted suicide re-examined afte1 week	Specific systems
		Re-admission rate of psychiatric patients	BMCD

	AIM	INDICATOR	SOURCE INFORMATION
DEPRESSION	SA 85	N° of areas with a defined care process N° of patients attended in PC	PC registers-Mental Health registers
	SA 86	Mental Health Information system	RHM/Gen. Directorate of Social Care
SEPSIS, SERIOUS INFECTION AND NOSOCOMIAL INFECTION	GA 32	Hospital admission rate due to septicaemia	BMCD
	GA 33	Mortality rate for sepsis	NSI
	GA 34	Incidence rate of teratogenic transmissible diseases	BMCD and Specific system
	GA 35	Prevalence of hospital-acquired infection	Study of Prevalence of NI in Spain
	SA 87	% of vaccination coverage	Mandatory reporting of diseases / Vaccination Information system
	SA 88	% coverage of influenza vaccination in high risk patients	
	SA 89	Incidence rate of teratogenic transmissible diseases Prevalence of HIV and syphilis in pregnancy Treatment of perinatal congenital infection	BMCD and Specific system
	SA 90	% prescribed antibiotics as first choice in PC	Drug consumption Information system
	SA 91	Areas implementing emergency microbiological diagnosis	RHM
	SA 92	Consensus action protocols for sepsis	RHM
	SA 93	Incidence rate of bacteraemia associated with catheters and pneumonia associated with mechanical ventilation	ENVIN-HELICS program and specific system
	SA 94	Aggregate incidence of surgery-acquired infection in selected surgical processes % suitable prophylaxis in selected surgical processes	Specific system
	SA 95 SA 96	Actions developed to avoid the risk of nosocomial cross-infection or infection associated with products equipment of infrastructures	Technical assessment committee for surveillance, prevention and control of NI
	SA 97	Incidence of NI due to multi-resistant micro-organisms	Specific system and area microbiology services
	SA 98	Design of the Regional Strategy for the surveillance, prevention and control of NI	Castilla y León Official Bulletin
	SA 99	N° of areas providing data	RHM

	AIM	INDICATOR	SOURCE INFORMATION
PAIN: OSTEOARTICULAR PATHOLOGY	GA 36	Prevalence of pain due to osteoarticular pathologies	National Health Survey
	GA 37	Perceived quality of life in people with osteoarticular pain	National Health Survey / Specific system
	GA 38	Permanent Disability Rate and days, average duration and rate of TD associated with pain due to osteoarticular pathologies	NSSI-RHM
	SA 100	Activities taking place in schools	
	SA 101	Referral rate from PC for osteooarticular pain	PC-RHM
		Training activities developed in primary and s specialist care aimed at osteoarticular pain	RHM
		% of Health Centres with access to specific diagnostic tests	RHM
	SA 102	Visitations and activities in multidisciplinary units and consultations for pain in painful osteoarticular pathologies	Areas and RHM
		Visitations / activities in back schools	Areas and RHM
	SA 103	Rate of patients with osteoarticular pain in PC healthcare plans	PC registers
	SA 104	Access times to first specialist consultation related with osteoarticular pain and access times to rehabilitation and physiotherapy	PC registers and RHM
	SA 105	Delays for surgery on hips, knees and back	RHM
	SA 106	Visits and rehabilitation activities in PC (physiotherapy)	PC register
	SA 107	N° of Areas with a functioning Pain Referral Unit	RHM
	SA 108	Average duration of TD due to lumbalgia, cervicalgia and osteoathrosis	RHM/NSSI
	SA 109	Active information system. N° of areas providing data	RHM
ROAD TRAFFIC ACCIDENTS	GA 39	N° traffic accidents	Gen.Directorate for Traffic (GDT)
	GA 40	Fatal victims of traffic accidents	GDT/NSI
	GA 41	Rate of YPLL due to traffic accidents	NSI
	SA 110	Average arrival times of emergency healthcare units	Emergency healthcare Management (EHM)
	SA 111	Evolution in n° of traffic accident according to causes	GDT

	AIM	INDICATOR	SOURCE INFORMATION
ROAD TRAFFIC ACCIDENTS	SA 112	N° of (pre-hospital) deaths in traffic accidents	EHM
	SA 113	N° of deaths in emergency room from traffic accidents	RHM
	SA 114	N° of (intrahospital) deaths due to traffic accidents	BMCD-Areas
	SA 115	Access time to rehabilitation after traffic accidents	
		% of discharges without disability after rehabilitation	Specific system
	SA 116	Hospital admission rates due to traffic accidents	BMCD
		Active information system	
		N° emergency cases due to traffic accidents	RHM
		% traffic accidents with inter-hospital transfer	
	SA 117 SA 118 SA 119 SA 120	Evaluation indicators of the "Young persons Road Safety Campaign"	Dept. Family and Equal Opportunities
	SA 121	Modernization of highways and investment in	C&L Regional
		Infrastructures	Highways Plan
WORKPLACE	GA 42	Incidence rate of occupational accidents	C&L occupational
		Health and Safety Centre (OHSC)	
	GA 43	Incidence rate of occupational illnesses	OHSC
	GA 44	Mortality rate for occupational accidents	OHSC
	GA 45	Average duration of TD in occupational accidents	RHM/NSSI
	GA 46	Average duration of common contingency TD	RHM/NSSI
	SA 122	% workers with training in Prevention of Occupational Risks/year	Survey of company working condition sin C&L
		% workplaces giving training in Occupational Health	Information systems Health surveillance services
	SA 123	N° workers receiving information about own occupational risks	Information system Health Surveillance Services

	AIM	INDICATOR	SOURCE INFORMATION
WORKPLACE	SA 124	% assessment considering a post's risks of developing osteo-articular pathologies	Survey of company working conditions in C&L (SCWC)
	SA 125	% companies having acquired, substituted or modified IPE	SCWC
	SA 126	% of companies having improved organization of prevention	SCWC
	SA 127	% of companies having evaluated risks of post	SCWC
	SA 128	N° workers / coverage of health surveillance	SCWC
	SA 129	% of workers who smoke	SCWC
	SA 130	N° of contingency decisions / N° of professional contingency processes	Medical Inspection Service
	SA 131	Incidence of TD Prevalence of TD Average duration TD Average Duration TD/worker	RHM/NSSI
	SA 132	Active information system	Dept. Economy and Employment
	SA 133	Vaccination protocols	
	SA 134 SA 135	Indicators of V C&L Regional Drug Plan	V C&L Regional Drug Plan
	SA 136	Sectorial Plan for the Care of people with disability	
FOOD SAFETY	GA 47	List of improvement activities	
	SA 137	Existence of official control information system	
	SA 138	% of professionals having received training in official control	
	SA 139	N° of audits of official control systems N° of administrative units responsible for official control in accreditation process by quality system	
	SA 140	N° of hygiene guides for supervised food sectors	

	AIM	INDICATOR	SOURCE INFORMATION
ENVIRONMENTAL HEALTH	GA 48	List of improvement activities	
	SA 141	Existence of an information system for surveillance of water for human consumption	
	SA 142	% of professionals having received training	
	SA 143	Testing the re-designing of supply zones of water for human consumption	
	SA 144	Risk maps prepared	
	SA 145	Quantity of audits and supervision of administrative units responsible for health surveillance of water for human consumption	
DEPENDENCE SYNDROME	GA 49	Incidence rate for dependency associated with patients with chronic serious mental illness abandoning treatment Social Health Plan	
	GA 50	Incidence rate for dependency associated with fractured hips in over 79s	Social Health Plan
	GA 51	Incidence rate for dependency associated with dementia crises or discompensations	Social Health Plan
	GA 52	Study of needs for medium and long-stay places in care facilities	Social Health Plan
	SA 146	Approved protocol with use criteria for medium/long-stay places	Social Health Plan
	SA 147	Date to approve the Geriatric healthcare strategy Rate of day hospitalization in geriatric patients	Castilla y León Official Bulletin RHM
	SA 148	Coverage of case manager in chronic serious mental illness	Primary and specialist care registers
	SA 149	Time until surgery after fractured hip and existence of protocol	BMCD and areas
	SA 150	Mobilisation time after treatment for fractured hip and existence of protocol	Areas
	SA 151	% patients with fractured hip who continue rehabilitation after hospital discharge	Areas
	SA 152	Existence of protocols between the two healthcare levels and social services: nº of cases dealt with by Social Health Coordination Commission	Gen. Dir. Planning Quality Ordinance and Training

	AIM	INDICATOR	SOURCE INFORMATION
DEPENDENCY SYNDROME	SA 153	N° of areas with hospital care protocols with different circuits for dementia	Mental Health
	SA 154	Coverage of care aimed at non-professional care-givers	PC register
	SA 155-157	Regional Sectorial Plan for the care of the Aged	Dept. Family and Equal Opportunities
	SA 158-166	Regional Sectorial Plan for the care people with a disability	Dept. Family and Equal Opportunities
TOBACCO	SA 167	Prevalence of smokers	Health surveys
	SA 168	Age for start of tobacco use in adolescents	V C&L Regional Drug Plan / health surveys
	SA 169	Application of new measures to protect non-smokers N° of reports and claims about not respecting tobacco regulations	V C&L Regional Drug Plan
	SA 170	Prevalence of regular smokers in school and general populations	V C&L Regional Drug Plan
	SA 171	Proportion of hospital discharges due to cancer of Esophagus, oropharyngeal cavity, larynx, and lung, COPD and others	V C&L Regional Drug Plan
PHYSICAL ACTIVITY	SA 172	% population who do physical activity in free time	Health survey
	SA 173	Prevalence of sedentary lifestyle in women	Health survey
	SA 174	Prevalence of sedentary lifestyle in under 16s	Health survey
	SA 175	Prevalence of sedentary lifestyle in schoolchildren	Health survey
	SA 176	Indicators of "The City without my Car" program	"The City without my Car" program
	SA 177	Indicators of "The City without my Car" program	"The City without my Car" program
	SA 178	Indicators of the "Sport Programs" program	Sport Programs
	SA 179	Indicators of the "Sport Programs" program	Sport Programs
	SA 180	Indicators of the "Tourist Resources Quality Improvement Plan"	Tourist resources quality improvement plan
	SA 181	Indicators of the "Tourist Resources Quality Improvement Plan"	Tourist resources quality improvement plan

	AIM	INDICATOR	SOURCE INFORMATION
ARTERIAL HYPERTENSION	SA 182	Overall prevalence of AHT	PC register / specific studies
	SA 183	% people unaware of having AHT	Health examinations in PC Health surveys
	SA 184	% patients with hypertension with adequate control	PC register / specific studies
HYPERLIPEMIA	SA 185	Prevalence of hyperlipemia	Health examinations in PC Health surveys
	SA 186	% people unaware of having hyperlipemia	Health examinations in PC Health surveys
	SA 187	% hypertension patients being suitably controlled	PC register
	SA 188	N° people screened for family HC	SPIDI
	SA 189	N° people screened for HC with cardiovascular risk factor, men > 35 and women > 45	PC register
OBE-SITY	SA 190 SA 191	Prevalence of obesity according to sex and age groups	Health Survey
ALCOHOL AND OTHER DRUGS	SA 192	Overall prevalence of alcohol consumption	V C&L Regional Drug Plan
	SA 193	N° of emergency cases of alcoholic coma by age group	V C&L Regional Drug Plan
	SA 194	Prevalence of excessive alcohol use in young people	Health survey
	SA 195	Average age to start alcohol use in adolescents	V C&L Regional Drug Plan
FOOD AND DRINK	SA 196	% people eating fruit and vegetables daily	Health survey / health examinations
	SA 197	% people declaring healthy, balanced diet	Health survey / health examinations
	SA 198	Prevalence of people regularly consuming hypercaloric and salty food	Health survey / health examinations

III Health Plan

Castilla y León

Junta de Castilla y León