Local Delivery Plan 2011-12

Written by

Performance & Corporate Reporting

NHS Greater Glasgow and Clyde

November 2011

NHS
Greater Glasgow and Clyde

Annex 1

The Quality Ambitions and wider outcomes-based approach

The Quality Ambitions and the Wider Outcomes-Based Approach

An outcomes-based approach encourages us all to focus on the difference that we make to people using the service, their families, carers, staff and all who work with NHSScotland in delivering the vision of world-leading healthcare quality. It is about far more than just the inputs or processes over which we have control. Success is about **impact** and should be judged by tangible improvements in the things that matter to the people of Scotland. Our Health Board has been working in partnership across NHSScotland, with Community Planning Partners and with the Scottish Government to embed an outcomes-based approach by identifying key priority areas. This has enabled Health Boards to:

i. Align activity to explicitly contribute to the Government's over-arching purpose of sustainable economic growth through the National Performance framework.
ii. Better integrate activities with local government, with other Public Bodies, and in partnership with the Third and private sectors to address the Government's Purpose Targets and National Outcomes through Single Outcome Agreements (SOAs).
iii. Focus activity and spend on achieving real and lasting benefits for people and as such minimise the time and expense on associated tasks which do not support the national outcomes and purpose.
iv. Create the conditions to release innovation and creativity in delivering better outcomes.

NHSGGC planning approach is now characterised by a shift to outcomes based planning, where we establish clear outcomes to be delivered over the three year planning cycle.

NHSGGC's Planning and Policy Frameworks set out the actions required in key areas of activity to meet the overall outcomes set out above. Each of the frameworks has clear arrangements for future development and oversight of progress, including a range of performance indicators, including HEAT targets.
The frameworks cover the following areas.

Planning Frameworks	**Policy Frameworks**
Acute	Tacking Inequality
Adult Mental Health	Sustainability
Alcohol and Drugs	Employability, Financial Inclusion and responding to the recession
Cancer	Health Improvement
Child and Maternal Health	Quality
Long Term Conditions, Older People and Disability	Unpaid Care
Primary Care	End of Life and Palliative Care
Sexual Health	

Implementation and local planning is driven by the annual Development Plans which set out what each part of the organisation will do to achieve the outcomes. Each action is linked to a range of key performance indicators which are used to measure progress. An example of this is shown overleaf.

The Development Plans are a core part of the organisational performance process and their effective implementation will be assessed through the Organisational Performance Review (OPR) process. The structure of the OPRs focuses on consideration of progress against each Planning and Policy framework, ensuring a continuous alignment between activity, progress and outcomes.

OPRs have been timed to engage with and inform the forward planning process. The planning and performance cycle is continuous and so it is expected that the conclusions from the November 2011 OPRs will be translated into actions within Development Plan updates and these updates will be the main source document in the spring 2012 round of OPRs.

In 2008, the Scottish Government introduced a National Performance Framework, which set out, for the first time, an ultimate purpose of Government, supported by 7 high-level targets, and 15 National Outcomes. Of these, 6 are particularly relevant to the work of the NHS:

- We have tackled the significant inequalities in Scottish society
- Our children have the best start in life and are ready to succeed
- We have improved the life chances for children, young people and families at risk
- We live longer, healthier lives
- Our public services are high quality, continually improving, efficient and responsive to local people's needs
- We reduce the local and global environmental impact of our consumption and production

In 2010, the Healthcare Quality Strategy for NHSScotland set out the overarching aim of achieving world-leading quality healthcare services across Scotland, underpinned by the 3 **Healthcare Quality Ambitions**.

Healthcare Quality Ambitions

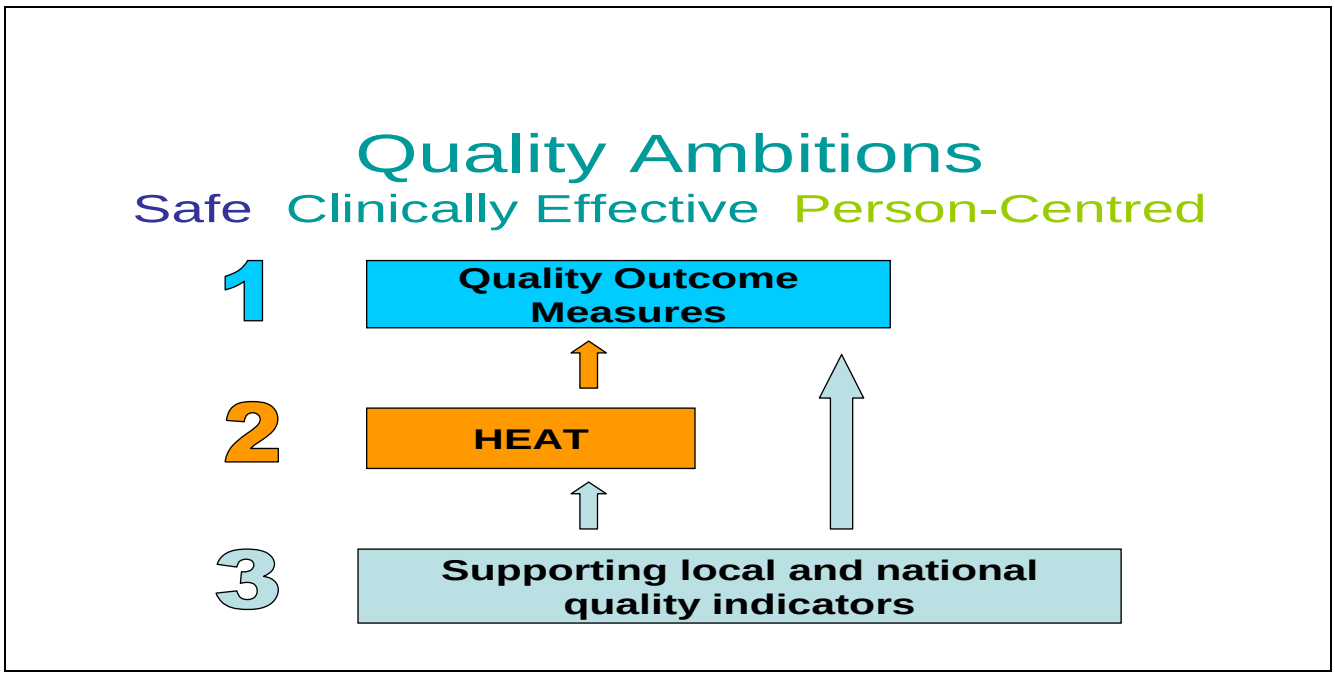
Person-centred - Mutually beneficial partnerships between patients, their families and those delivering healthcare services which respect individual needs and values and which demonstrate compassion, continuity, clear communication and shared decision-making.

Safe - There will be no avoidable injury or harm to people from healthcare they receive, and an appropriate, clean and safe environment will be provided for the delivery of healthcare services at all times.

Clinically Effective - The most appropriate treatments, interventions, support and services will be provided at the right time to everyone who will benefit, and wasteful or harmful variation will be eradicated.

The Quality Strategy included a commitment to develop a Quality Measurement Framework to support our shared vision of healthcare quality. It was proposed that progress towards the three Quality Ambitions would be assessed by reference to a number of Quality Outcome Measures, and that these measures would be based on a combination of patient and staff perspectives, alongside measures of safety and effectiveness. These measures would be used to assess direction of travel, and would not be set as targets.

As part of the proposal for the Quality Measurement Framework, the Quality Strategy made a commitment that the HEAT targets would be aligned to the Quality Ambitions. The HEAT targets would therefore reflect the agreed areas for specific accelerated improvement each year, contributing to progress towards the Quality Ambitions.



The QAB agreed the need for alignment within the Quality Measurement Framework, with HEAT targets demonstrating how they positively support the Quality Ambitions

A small number of high-level Quality Outcomes (probably 5-6) will describe our priority objectives in language which is inclusive across NHSScotland and with our delivery partners. These will be based on the current provisional set:

- People have a positive experience of healthcare
- Staff feel supported and engaged
- Healthcare is safe
- People are supported to live well at home or in the community with access to appropriate treatment when they need it
- People live longer healthier lives
- *There is no inappropriate variation* (further work required to confirm this outcome, and related measures)

- A set of Quality Outcome Measures are being established which we will use as proxy measures to reflect the Quality Outcomes, and to track progress towards achieving our Quality Ambitions.

- As the Quality Outcomes/measures are further developed over the year ahead, we will work with SGHD and partners to ensure that the set of HEAT targets are aligned with and underpin progress towards our Quality Ambitions. In addition, we will work to ensure that all our measurement at local or national level, for improvement activity, monitoring or reporting purposes, becomes aligned with the Quality Ambitions, as envisaged in Level 3 of the Quality Measurement Framework.

Through our Local Delivery Plan, we set out how we will be judged in terms of performance on our operational targets, which have been agreed with Government and across NHSScotland to support delivery of the outcomes and Quality Ambitions.

In addition, through CPPs, we have worked with Local Authorities and other public bodies to agree the priority local outcomes and related indicators. With our partners, we are also

developing our outcomes-based approach, individually and together. This will require each organisation to be clear about their relative contributions. Each organisation will be responsible for ensuring that they have appropriate local performance management systems in place to ensure the delivery of their particular responsibilities – this local delivery plan is an important aspect of our performance management system.

Progress has been made in reviewing the HEAT targets so that they reflect the NHS contribution to the National Outcomes, and this process continues each year. In addition, we can demonstrate how the HEAT targets positively support the 3 Quality Ambitions.

We have also made a range of contributions towards the delivery of the local single outcome agreement over and above the HEAT targets and these are set out in our Local Delivery Plan. This focuses on our Board's contributions to the 4 national priority areas:

- Health inequalities
- Early years
- Tackling poverty
- Economic recovery

These areas have been identified as requiring major contributions from a range of partners, but are also areas where there is the potential for significant collaborative gain.

HEAT TARGETS CONTRIBUTING TOWARD SCOTTISH GOVERNMENT'S NATIONAL OUTCOMES	We have tackled the significant inequalities in Scottish society	Our children have the best start in life and are ready to succeed AND We have improved the life chances for children, young people and families at risk	We live longer, healthier lives	Our public services are high quality, continually improving, efficient and responsive to local people's needs	We reduce the local and global environmental impact of our consumption and production	We have strong, resilient and supportive communities where people take responsibility for their own actions and how they affect others.
Alcohol brief interventions						
Targeted Health Checks						
Suicide reduction						
Child healthy weight interventions						
SIMD Smoking cessation						
SIMD Child Fluoride Varnishing						
Financial balance						
Efficiency savings						
Carbon Emissions & Energy Consumption						
62-day & 31-day Cancer Waiting Times						
18 weeks referral to treatment						
Drug & Alcohol misuse treatment						
Faster access to mental health services						
Emergency bed days for over 75s						
Stroke services						
Healthcare associated Infection						
Reduce A&E attendances						

clear line of sight in supporting short term

indirect or longer term contribution

Healthcare Quality Ambitions
Person-centred - Mutually beneficial partnerships between patients, their families and those delivering healthcare services which respect individual needs and values and which demonstrate compassion, continuity, clear communication and shared decision-making.

Safe - There will be no avoidable injury or harm to people from healthcare they receive, and an appropriate, clean and safe environment will be provided for the delivery of healthcare services at all times.

Clinically Effective - The most appropriate treatments, interventions, support and services will be provided at the right time to everyone who will benefit, and wasteful or harmful variation will be eradicated.

HEAT TARGETS CONTRIBUTING TOWARD SCOTTISH GOVERNMENT'S NHS QUALITY AMBITIONS	**People live longer healthier lives**	**People supported to live at home / community with access to treatment**	**Healthcare is safe**	**People have a positive experience of healthcare**	**Staff feel supported and engaged**	***There is no inappropriate variation***
Alcohol brief interventions						
Targeted Health Checks						
Suicide reduction						
Child healthy weight interventions						
SIMD Smoking cessation						
SIMD Child Fluoride Varnishing						
Financial balance						
Efficiency savings						
Carbon Emissions & Energy Consumption						
62-day & 31-day Cancer Waiting Times						
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Faster access to mental health services						
Emergency bed days for over 75s						
Stroke services						
Healthcare associated Infection						
Reduce A&E attendances						

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Annex 2

Risk Management Plan

LDP Final Risk Management Plan

Health Board: NHS GREATER GLASGOW AND CLYDE

Use of Risk Management Plan

Please insert Health Board name in the space provided above.

Please insert in the space provided for each target, the Health Board Lead responsible for the target.

Boards should, as in previous years, use the LDP Risk Management Plan to provide contextual information on key risks to delivery of each target and how risks are being managed. Within the template, the description of the key risk should be provided in the first column and detail on how the risk is being managed should be provided in the second column. Cross-reference to local plans should be made where necessary.

- **Delivery**: briefly highlight local issues and risks that may impact on the achievement of targets and/or the planned performance trajectories towards targets and **how these risks will be managed**.

- **Workforce**: brief narrative on the workforce implications of each of the HEAT targets **where appropriate and relevant**. This should include an assessment of staff availability to deliver the target, the need for any training and development to ensure staff have the competency levels required, and consideration of affordability cross referenced to the Financial Plan.

- **Finance**: **Where applicable** boards should identify and explain any specific issues, e.g. cost pressures or financial dependencies specifically related to achieving the target. There is **no need to repeat generic financial risks** that apply to all targets.

- **Improvement**: **Where applicable**, boards should outline any risks to sustainable improvement, particularly in respect of their national improvement programmes and implementation of lean methodology, required to deliver and sustain targets and how these are being managed.

- **Equalities: Where applicable**, boards should outline any risks that the delivery of the target could create unequal health outcomes for the six equalities groups, and/or for people living in socio-economic disadvantage; and how these risks are being managed.

Health Improvement for the People of Scotland

Health Improvement

Achieve agreed number of screenings using the setting-appropriate screening tool and appropriate alcohol brief intervention, in line with SIGN 74 guidelines during 202011/12.

Achieve agreed number of inequalities targeted cardiovascular Health Checks during 202011/12.

Reduce suicide rate between 2002 and 2013 by 20%

Achieve agreed completion rates for child healthy weight intervention programme over the three years ending March 2014.

NHSScotland to deliver universal smoking cessation services to achieve at least 80,000 successful quits (at one month post quit) including 48,000 in the 40% most deprived within Board SIMD areas over the three years ending March 2014.

At least 60% of three and four year olds in each SIMD quintile to have fluoride varnishing twice a year by March 2014.

Achieve agreed number of screenings using the setting-appropriate screening tool and appropriate alcohol brief intervention; in line with SIGN 74 guidelines during 202011/12.

NHS BOARD LEAD:	Catriona Renfrew – Director of Corporate Planning and Policy

Delivery

Risk	**Management of Risk**
Insufficient sign up from GPs to deliver screening and brief intervention in primary care settings.	This risk has been managed with 191 practices now signed up to the ABI LES, out of a total of 270 practices. We will continue to expect our local leads, however, to use the local forums to encourage other GPs to sign up. We will be targeting those GPs with low levels of activity to ascertain if they are having local issues and to identify any further support requirements. This will be done in April/May once all 2010/11 returns are submitted. Sufficient numbers of CH(C)P staff have completed the ABI trainer's course. Future risks need to be managed in terms of ongoing Training for Trainers Course to take into account staff turnover. Additionally, it will be important to engage other practices to sign up to the LES in 2011/12.
Insufficient capacity to deliver brief interventions in some high volume settings.	This risk is being managed to a large extent with the expansion of the Addictions Acute Liaison team to deliver staff training and delivery of ABI in acute settings. Further work is ongoing regarding training and delivery of ABI from other acute staff groups.

Workforce

Risk	**Management of Risk**
Insufficient delivery capacity in non GP practice settings.	1,451 CHP staff have now been trained to deliver ABI. The risk remains that capacity in non GP settings to deliver ABI is a problem. The focus for 2011/12 will be to embed the delivery in the everyday work of all staff. This will require central support, coordination and prioritisation from the Board and CHP Directors. Monitoring of activity remains a challenge.
Insufficient training and competency in CHCP/CHP settings.	Risk has been managed. There is a focussed delivery of the national training framework in place. Trained trainers are geographically proportionate and are supported by delivery/implementation team to address local capacity issues. The issue of ongoing training due to staff turnover will require ongoing management.

Local measurement systems do not reflect real levels of activity.	IM&T development post being established as part of the implementation and support team. GP reporting is now routine. Reporting in non practice settings remains a challenge, and is the focus of continued work.

Finance

Risk	**Management of Risk**
SESP finance discontinued.	LES will be continued until April 2012.
Demand outstrips available budget.	Currently, demand has not outstripped available budget. Should the need arise, we would reprioritise programme and cap activities within available resources.

Improvement

Risk	**Management of Risk**
Improvement cannot be demonstrated via existing IM&T systems.	IM&T development post being established as part of the implementation and support team. Reporting in non practice settings remains a challenge.
Improvements cannot be demonstrated via activity alone.	Evaluation and research programme was costed within overall delivery framework. External GP evaluation completed in 2010. Funding issues likely to make a non heat external evaluation difficult.

Achieve agreed number of inequalities targeted cardiovascular Health Checks during 202011/12.

NHS BOARD LEAD:	Heather Jarvie – Keep Well Planning Manager

Delivery

Risk	**Management of Risk**
• Delays in concluding GP contract negotiations due to confirmation of funding may impact on commencement of activity. • Failure to achieve desired number of health checks as composition of target population becomes increasingly weighted towards the "hard to engage." • Range of difficulties associated with developing exact profiles of non-attenders.	Provisional funding agreed with Scottish Government therefore contact negotiations have commenced with Local Medical Committee. Contract will reflect a start date of 1st April 2010. Extend role of community outreach workers to all participating practices to attempt to engage with patients where practice efforts have been unsuccessful. Ensure learning associated with targeting less motivated/equipped is maximised across programme and resources are allocated to this aspect of development. Increased primary prevention activity through involvement of new practices will increase numbers of "new population". NHSGGC denominator will include new patients identified aged 40-64 years of age.
• System does not capture impact of patient choosing to refuse health check.	Patients who have "opted-out", i.e. those who have been contacted and refused/declined a health check will have been coded a "refusal."
• Failure to capture accurate numerator and denominator data in real time.	Practices will be required to run regular searches/update tracking to reflect those patients turning 40 years, deceased, moved away, terminally ill or other grounds for exclusion.
• Managing impact of Keepwell on existing infrastructure and wider primary care programmes e.g. CDM or IT.	Keepwell governance arrangements implemented in tandem with linked Primary Care arrangements
• Variations in levels of service/ success across practices and between participating CH(C)Ps.	Local ownership of target needs to reflect this and CH(C)P performance monitoring of practice activity is in place.

• Early findings from wave 1 revealed considerable number of incorrect patient contact details (address and telephone numbers) therefore "un-contactable". This has been a consistent finding in many similar initiatives (e.g. “Have A Heart Paisley”).	Outreach worker will aim to visit addresses of those who have not yet had a "successful contact" to establish if correspondence details are correct. However, experience shows that this approach frequently fails to fully resolve these issues.
• Ensuring accurate data collection.	Local involvement in Keepwell IT and Data Group to flag up data issues.

Workforce

Risk	**Management of Risk**
• Workforce requires continued development to build skills /competencies associated with health checks; motivational interviewing; onward referral and complex needs.	Additional workforce training and project learning events scheduled.
• Ongoing turnover of staff associated with delivery and impact on available number of appointments.	Ongoing training and mentoring programmes in place.
• Practice delivery models vary - some have dedicated staff delivering Keep Well health check - staff absences/leave will affect number of available appointments therefore number of health checks completed that month. Even if maximum appointments are provided and attended the % will still fluctuate due to changes in denominator.	Local performance management arrangements in place to monitor any detrimental impact on programme delivery.

Finance

Risk	**Management of Risk**
• Difficult to establish sustainable practice due to short term nature of funding.	• Ongoing negotiation with practices and services regarding funding allocation. • Establishment of Anticipatory Care Executive group to determine mainstream Keep Well programme model by 2012.

	• Regular review of programme activity to ensure practice lessons are mainstreamed through LTC strategy and Primary Care strategy development.
• Timescales vary within project - continued availability of health checks requires to be balanced with continued access to onward services.	• Management of budget in conjunction with local funding streams and anticipated levels of demand for services.

Equalities

Risk	**Management of Risk**
Potential to increase health inequalities: • Failure to reach the most vulnerable population through the health check and potential for increased subsequent marginalisation from services as the result of persistent approach. • Limited capacity for new practices to see all eligible patients within 12 months resulting in those most likely to attend being "seen". • "Equality profiling" of those not engaging limited by availability of data from practice lists.	• Evidence-informed local approaches to facilitate attendance through buddying and advocacy. • Development of modified health checks/dedicated efforts for subgroups with additional needs e.g. learning difficulties and BME populations. • Ongoing monitoring of service user profiles. • Targeted approach to the unengaged. • Opportunities to integrate with wider initiatives targeting vulnerable groups. • Inequalities Sensitive Practice post in place to offer greater support in this area.

Reduce suicide rate between 2002 and 2013 by 20%

NHS BOARD LEAD:	Trevor Lakey, Health Improvement and Inequalities Manager

Delivery

Risk	**Management of Risk**
Potential risk of a fragmented approach to suicide prevention.	Coordination work will be undertaken to ensure close liaison between NHS and other statutory sector activity to prevent suicide and the wider, community based prevention programmes overseen by Choose Life work in each community planning partnership area; suicide prevention is featured as an integral element of the 'No Health Without Mental Health' strategic framework for mental health improvement in Greater Glasgow and Clyde. One specific area of priority development for the Health Board and its partners during 2011-12 is child and youth, with a review of mental health improvement and early intervention for children and young people (including suicide prevention) underway.

Workforce

Risk	**Management of Risk**
A risk of loss of momentum around suicide prevention training following achievement of the H5 training target.	A revised training plan will be devised that ensures continuity of training and focuses on ensuring key frontline staff groups continue to receive relevant training. A more flexible, affordable and locally responsive approach will be adopted in terms of appropriate courses and modules offered.

Finance

Risk	**Management of Risk**
There is a diminished overall pool of finance, generally, and more specifically budget reductions to a number of the local authority based Choose Life programmes.	With an increased pool of internally based trainers for a range of suicide prevention courses, the unit cost for running courses is now much lower than at start of H5 work - our planning will seek to utilise in-house trainers and minimise use of externally commissioned trainers wherever possible.

Improvement

Risk	Management of Risk
Potential risk of lack of focus on suicide prevention in planning and service delivery.	A range of approaches will be utilised to ensure that suicide prevention remains a priority within clinical and allied services, including use of care governance systems, and consideration within a number of service reviews, including primary care mental health and child and youth mental health.

Equalities

Risk	Management of Risk
Risk that equalities and inequalities considerations are not given direct attention in the suicide prevention work.	Active planning of inequalities and equalities dimensions will be undertaken, drawing on wider equalities mental health approaches and programmes; this includes drawing on findings of commissioned research into addictions and suicide risk, due to report March 2011. The programme of suicide prevention and inequalities work in North and East Glasgow continues, in partnership with NHS Health Scotland, including youth suicide prevention work utilising film making and social networking

Achieve agreed completion rates for child healthy weight intervention programme over the three years ending March 2014.

NHS BOARD LEAD:	Anna Baxendale – Head of Health Improvement

Delivery

Risk	**Management of Risk**
Extension of service to include school based service delivery model: • Autonomy of education departments/individual schools. • Data collection requires to be consented.	New service model developed in conjunction with Local authority colleagues. Range of delivery approaches adopted to 'fit' with current operating arrangements. Interested schools targeted to secure delivery within timelines. Existing local authority coaching staff briefed and aligned to school delivery programme. Flexibility secured with coaches to work across other areas. New data collection system required to collect data for school based delivery of intervention. Letter supporting informed consent piloted to promote participation.
Managing delivery through multiple Local Authority Partnership Models.	Internal audit undertaken - actions from report addressed by steering group. Performance monitored within the Board's performance review process. Each local authority area implementation group established to identify and address local problems. Each area is represented at steering group and provides regular status reports. Performance management templates have been developed to support reporting and follow up by steering group on a monthly basis.
Expansion of service to include school base delivery may compromise potential impact	Maintained investment in our community model which is targeting more overweight for more intensive intervention. In addition we are using the school based model to identify individuals who would benefit from also participating in the community.
Adequate Administration and IT system are not in place to support the programme including. Potential issues include: • Integrating with Child Health Surveillance Programme. • Ensuring routine remote	Work is underway to scope and cost the impact of the integration with CHSP locally Improved protocol to support local data input in

collection data. • Ensuring strong communication and administration process are underpinning the programme. • Maintaining compliance with data protection regulations while working with a remote data collection system.	place and additional time has been allocated per practitioner/coach. Ongoing dedicated IT development support identified We have established an ongoing review of the protocol in relation to administration Dedicated post established to carry out the administration function on behalf of all local authorities We have put in place a remote IT system to store data in compliance with regulations. In addition a detailed protocol to support compliance is in place.
Recruitment of sufficient numbers of children below >98th centile.	School based model encompasses children below 98th centile, which is aimed to increase numbers of completers. All areas have developed local communication plans identifying setting, modes and benefits of the intervention. Routinely monitored by steering group.

Workforce

Risk	**Management of Risk**
Difficulties in recruiting + and retaining of coaches.	Availability of coaches has varied across the system; current solutions include use of staff flexibly across other local authority areas and adapted training programmes. Support from Local Authority partners secured for flexible working.
Training gaps in “new” workforce.	A number of coaches have undergone an extensive training programme. Additional training is developed as the programme evolves and new training needs emerge. Additional training on “How to raise the issue of obesity” has been offered to an extended workforce with the aim to capitalise opportunities to encourage referrals in wider settings such as education.

Finance

Risk	**Management of Risk**
Service creates an increase expectation for tertiary services.	Allocated budget for programme does not include further tertiary intervention but links have been made with the existing specialist service to minimise requirement for tertiary support, as we have identified that there are only very few occasions where referral to tertiary service is required.

Sustainability of service.	The delivery of this comprehensive programme is only possibly if embedded in existing services and structures. It will require continued finance for delivery beyond 2011. This source has yet to be confirmed, although a new target has been set to 2014.
Devolved funding/service context with Local Authorities	Management of service contracts with Local Authorities partners and CH(C)Ps requires ongoing financial monitoring arrangements.

Improvement

Risk	**Management of Risk**
Failure to align with future direction briefing paper on target from 2011/12 outlines increased emphasis on school based delivery model.	NHSGGC response to outline submitted with concerns/challenges identified. Advance negotiations with Education. Continued support for community ACES service to ensure evaluation/impact fully assessed before diversion to alternative service delivery model.
Insufficient number of completers.	Continued focus on best practice to ensure recruitment, attendance and follow up within ACES programme.
Incompleteness of evaluation.	Data input at local level to be supported for full entry by March 2011. Evaluation report scheduled in advance of new service model implementation for new target.

Equalities

Risk	**Management of Risk**
Service meeting the needs of Different ages bands, gender ethnicity and deprivation.	Demographics are monitored through the data collection. Current level of delivery in areas of deprivation well above the expectation in the new guidelines of 40%. Community programme is currently being adapted in one area for children and parents in a special need school with aim to be a model, which can be delivered across health board area. Community programme has successfully incorporated children with special needs in main stream classes. Identification of any additional needs are identified at initial point of contact as well as initial 1:1 appointment with coach. School based programme is currently delivered in autism unit and experience will inform suitability for delivery to some other units.

	Service arrangements agreed with Yorkhill/GCWMS to support children outwith target age bands.

NHSScotland to deliver universal smoking cessation services to achieve at least 80,000 successful quits (at one month post quit) including 48,000 in the 40% most-deprived within-Board SIMD areas over the three years ending March 2014.

NHS BOARD LEAD:	Agnes McGowan/Fiona Dunlop – HI Leads (Tobacco)

Delivery

Risk	**Management of Risk**
Smokefree Pregnancy Service (SPS) not able to provide adequate support to pregnant women.	Management of Service transferred to Core HI team for two year period from January 2011. Service model and staffing support currently under review. Recruitment process in place to posts currently vacant. Women & Children's Directorate will provide ongoing senior management support to the service and ongoing "hosting" of SCA posts within directorate accommodation. SPS management steering group established.
Fluctuation and delays in data returns from service providers causes problems in relation to data entry and subsequent reporting.	In partnership with CH(C)Ps and pharmacy advisers, pharmacy service providers regularly monitored to improve timely reporting. Tobacco Planning and Implementation Group (PIG) identified and reallocated finance for data team including increasing staff hours and outsourcing follow up calls to ensure all quits are recorded. Formula developed for projected quits (ISD aware as this is a national issue).
Decrease in smoking population and in smokers wanting to quit therefore fewer referrals to the service.	Tobacco PIG and subgroups focusing on action to improve local stop smoking service delivery through sharing good practice. Meetings held between PIG chair and those CH(C)Ps with a shortfall in their local HEAT trajectory and local action plans agreed. A letter and prescribing pathway sent to GPs reminding them of importance of referring for behavioural support from specialist services for all quit attempts.

Workforce

Risk	**Management of Risk**
Loss of skilled advisors due to fixed term funding. Potential impact that efficiency savings may have on tobacco	Ongoing training and mentoring programme to support newly appointed staff. Working with partners to broaden staff portfolio of work and to ensure joint working/shared

workforce across NHS GGC.	responsibility on tobacco issues i.e. training and zero hours contracted staff.

Finance

Risk	Management of Risk
Meeting requirement of ISD reporting of three and 12 month quits.	Telephone calls outsourced to improve reach to clients out of office hours. Request made to ISD and SG for review of this requirement across NHS Boards.
Late allocation of finance to Stop Smoking Services.	Tobacco PIG continued to maintain cessation services and achieving the target has remained a high priority for partners. Local finance systems supported expenditure at anticipated funding levels. Given the financial climate, this will prove more challenging going forward.
Prescribing costs increased for NHSGGC.	Tobacco PIG agreed additional enhancements to Nicotine Replacement Therapy (NRT) through core cessation services for the last quarter of HEAT in an attempt to increase quit rates. Protocol developed to ensure appropriate prescribing and this is being implemented across Board so that smokers that have relapsed can be provided with two NRT products and where appropriate, offered varenicline.

Improvement

Risk	Management of Risk
Reorganisation of Glasgow City CH(C)Ps from five to one.	Retaining focus on continuity of provision of Smokefree Services through reorganisation process. Ongoing communication via Tobacco PIG and subgroup structure to ensure cessation resources best utilised in new operating structure.

Equalities

Risk	Management of Risk
Ability to attract particular equality strands, for examples individuals with learning difficulties.	Needs assessment carried out in partnership with wider HI team on client and carers needs for people with learning difficulties regarding smoking cessation. Awareness Training held for smoking cessation advisers and client information resource developed.

At least 60% of 3 and 4 year olds in each SIMD quintile to have fluoride varnishing twice a year by March 2014.

NHS BOARD LEAD:	Karen Murray

Delivery

Risk	**Management of Risk**
Not every GDP in NHSGGC agrees to offer fluoride varnish application as a routine caries prevention treatment for children.	• Inclusion of FVA in National Statement of Dental Remuneration is essential. • GDPs will be made aware again that Extended Duty Dental Nurses (EDDNs) are not the exclusive providers of FVA in GDS. • Lead Childsmile GDPs are employed in NHS GGC to promote Childsmile in GDS practices.
Oral Health Directorate continues to be financed for Childsmile Nursery to offer FVA to only 20% of most deprived Nursery population.	• Childsmile Nursery is planned to commence in March 2011. • OHD will seek additional funding to allow a greater number of children to be offered FVA in nurseries. Given the current financial climate, no additional local funding is available.
Consent rates for FVA are low in Childsmile Nursery & GDS.	• The consenting processes in Childsmile Nursery will be audited to identify additional methods to improve parental consent rates. Alternative methods of promoting parental consent for FVA for three to four year olds will be trialled and implemented as appropriate. GDS will be made aware of HEAT target.

Workforce

Risk	**Management of Risk**
GDS will not release Dental Nurses (DN) to undertake EDDN training.	• GDPs/Hygienists will deliver FVA in GDS.

Finance

Risk	**Management of Risk**
Insufficient funds to extend current Childsmile Nursery activity.	• NHSGGC to request additional funding from SGHD. Delivery of target will not be possible without extension of Childsmile Nursery activity.

Improvement

Risk	Management of Risk
The children at greatest risk of developing dental decay may not attend GDS and consent rates for FVA in this group in Nursery setting may be low.	• Nursery Toothbrushing Programme will continue to be supported and promoted. • 'Smile Too' will continue to be supported in Nurseries. • Increase opportunities for this age group to access FVA. • CSDS to promote FVA. • Health Visitors to promote FVA to parents of children on their caseload.

Equalities

Risk	Management of Risk
Inequalities may be increased as the more affluent children may be more likely to attend GDS regularly and consent rates for children in lowest deprivation quintiles may mean that a high percentage of these children will not access FVA either through GDS or through Childsmile Nursery.	• Dental Health Support Workers (DHSW) will assist in Oral Health Improvement activities/promotion of FVA. • Childsmile will become integral to Health Visitors' routine activities. • Dental Health Support Workers to facilitate dental attendance for FVA for this group. • Ante-natal input to promote improved diet and use of fluoride toothpaste especially by less affluent families.
Consent/Literacy.	• Childsmile consent material is available in 13 different languages. • Interpreting services will be made available to families if required.

Efficiency and Governance

Efficiency and Governance
NHS Boards to operate within their agreed revenue resource limit; operate within their capital resource limit; meet their cash requirement. NHS Boards to deliver a 3% efficiency saving to reinvest in frontline services NHSScotland to reduce energy-based carbon emissions and to continue a reduction in energy consumption to contribute to the greenhouse gas emissions reduction targets set in the Climate Change (Scotland) Act 2009.

NHS Boards to operate within their agreed revenue resource limit; operate within their capital resource limit; meet their cash requirement.

NHS BOARD LEAD:	Douglas Griffin – Director of Finance

Delivery

Risk	Management of Risk
[Insert extra rows for extra risks as required]	

Workforce

Risk	Management of Risk
[Insert extra rows for extra risks as required]	

Finance

Risk	Management of Risk
[Insert extra rows for extra risks as required]	

Improvement

Risk	Management of Risk
[Insert extra rows for extra risks as required]	

Equalities

Risk	Management of Risk
[Insert extra rows for extra risks as required]	

NHS Boards to deliver a 3% efficiency saving to reinvest in frontline services

NHS BOARD LEAD:	Douglas Griffin – Director of Finance

Delivery

Risk	**Management of Risk**
[Insert extra rows for extra risks as required]	

Workforce

Risk	**Management of Risk**
[Insert extra rows for extra risks as required]	

Finance

Risk	**Management of Risk**
[Insert extra rows for extra risks as required]	

Improvement

Risk	**Management of Risk**
[Insert extra rows for extra risks as required]	

Equalities

Risk	**Management of Risk**
[Insert extra rows for extra risks as required]	

NHSScotland to reduce energy-based carbon emissions and to continue a reduction in energy consumption to contribute to the greenhouse gas emissions reduction targets set in the Climate Change (Scotland) Act 2009.

NHS BOARD LEAD:	Alex McIntyre – Director of Facilities

Delivery

Risk	**Management of Risk**
Impact of the evolving physical estate as a result of the major developments within the Board will increase the total emissions for the Board.	National management reporting specifications must incorporate system/methods of reporting which will allow for the cost impact of double running not to misrepresent the basic energy improvements e.g. report on unit consumption per square metre or tonnes of CO_2 per square metre.
Increase in the utilities consumption as the estate expands and additional equipment is brought into service.	Ensure that procurement process for supplies and equipment takes account of the utility consumption, subject to clinical or service needs.

Workforce

Risk	**Management of Risk**
Workforce loses sight of overall need to maintain and indeed improve energy utilisation.	Ensure workforce are empowered and motivated to strive for improvement in standards and possibly seek to introduce a “competitive” element between sites. In March 2011 we will launch our Environmental Energy Awareness Campaign for staff, in line with Climate Change week.

Finance

Risk	**Management of Risk**
Securing significant additional finance at a time of commitment to major estate developments.	Clear, concise and accurate costing plans embracing all aspects of proposals e.g. running costs, utility costs, maintenance costs and the impact of the proposed schemes on the board’s overall development plans.

Improvement

Risk	**Management of Risk**

Access to Services

Access to Services

From the quarter ending December 2011, 95 per cent of all patients diagnosed with cancer to begin treatment within 31 days of decision to treat, and 95 per cent of those referred urgently with a suspicion of cancer to begin treatment within 62 days of receipt of referral.

Deliver 18 weeks referral to treatment from 31 December 2011.

By March 2013, 90% of clients will wait no longer than three weeks from referral received to appropriate drug or alcohol treatment that supports their recovery.

Deliver faster access to mental health services by delivering 26 weeks referral to treatment for specialist Child and Adolescent Mental Health Services (CAMHS) services from March 2013; and 18 weeks referral to treatment for Psychological Therapies from December 2014.

From the quarter ending December 2011, 95 per cent of all patients diagnosed with cancer to begin treatment within 31 days of decision to treat, and 95 per cent of those referred urgently with a suspicion of cancer to begin treatment within 62 days of receipt of referral.

NHS BOARD LEAD:	Jonathan Best – Director of Regional Services

Delivery

Risk	**Management of Risk**
Insufficient radiotherapy treatment capacity	The Beatson West of Scotland Cancer Centre operates at between 90-95% of its current available resourced Radiotherapy capacity. A national review, commissioned by the Scottish Radiotherapy Advisory Group (SRAG), was undertaken to assess the overall capacity issues for Radiotherapy across Scotland. This review identified that the main challenge for capacity is in the West of Scotland. The other Cancer Centres across Scotland currently operate at 65-80% capacity. The risk to the West of Scotland is that there is a delay in investing in additional linear accelerator capacity given that overall Scotland could still make significant increases in productivity. A local solution for the West, such as extending the working days at the Beatson, or weekend working, may have to be considered in the near future. However there is no additional resource available locally to deliver this.
Insufficient chemotherapy treatment capacity	Demand for Chemotherapy day case treatments within the Beatson West of Scotland Cancer Centre continues to rise at an approximate rate 9% per year. This will ultimately bring physical capacity challenges on the available treatment space. The building was originally designed to accommodate 15,000 chemotherapy day case treatments in 2008/09. The predication for 2010/11 is that 26,500 pulses of chemotherapy will have been delivered on a day case basis. Conversely, there has been a slight drop in the number of inpatient chemotherapy treatments by 2-3% year on year. It is likely that one of the inpatient areas will be converted to accommodate the increasing demand for day case chemotherapy treatments. This will require additional resource which is not currently available.

The National Bowel Screening Programme will have been running for two years in April 2011. This presents a risk in that not only will the 'new' cases of over 50 years be invited for screening, but the original cohort of patients will start to be recalled again as the screening cycle runs every two years.	Depending on the predicted increase in numbers, and any considerable increase in uptake on the screening programme, there could be a significant risk to both scoping and treatment capacity. We do not have additional resources available to cope with increased demand.
Extending Tumour Groups under Guarantee	Currently Breast, Lung, Colorectal, Cervical, Ovarian, Melanoma, Urological, Lymphoma, Head & Neck and Upper GI tumour groups are covered by the above noted performance guarantees (Leukaemia is also subject to the 31 day guarantee). These tumour groups collectively account for circa 86% of cancers across Scotland. Discussion is ongoing around extending the range of tumour groups to include some of the less common cancers types within the 62 and 31 day performance guarantees. Any such proposals will need to be scoped through in significant detail to allow NHS Boards to understand the financial and delivery implications of this possible change. A sudden introduction of new tumour groups would have the potential to destabilise the Boards current performance. There is no resource available locally to deliver capacity for additional tumour groups.

Workforce

Risk	**Management of Risk**
There is still a significant element of tracking resources within NHSGG&C employed on non recurring revenue from the Centre. These posts are essential for the ongoing tracking and escalations of patients under guarantee.	Each year an allocation is generally forthcoming to allow continuation of these posts. Thus far, there has not been any confirmation that an allocation will be made for 2011/12.

Finance

Risk	**Management of Risk**
As above	As above

Improvement

Risk	Management of Risk
National Radiotherapy Treatment Protocols There is currently variation in some of the clinical radiotherapy treatment protocols across Scotland.	A specific piece of work has just been commissioned via the SRAG to look at where variation exists and to make recommendations around standardising, where possible, the treatment protocols
Acute Oncology Development In line with both National and Regional Direction, there will be a requirement to develop a model of Acute Oncology with Glasgow and the wider West of Scotland Oncology service.	The configuration of this model has not yet been determined; there are many different examples in operation in England. It is likely that a Short Life Working Group will be formed to consider the optimal model for Acute Oncology across Glasgow and West of Scotland.
Monitoring of Referral Outcomes A recent audit was undertaken to determine the volume of confirmed cancers diagnosed from urgent with suspicion of cancer referrals, against general urgent referrals. This audit identified that there are still a proportion of cases diagnosed via the general urgent channel. A review of these cases was undertaken.	The audit will be repeated throughout the course of the year to establish if further referral education and guidance is required.

Deliver 18 weeks referral to treatment from 31 December 2011.

NHS BOARD LEAD:	Jim Crombie – Director of Surgery

Delivery

Risk	**Management of Risk**
Ability to accurately monitor and report on progress due to IT systems.	The roll out of PMS will mitigate this risk; however this is a two year rolling programme. The further development of the data warehouse will support our efforts to accurately monitor and report on 18 week progress

Workforce

Risk	**Management of Risk**
Some challenges highlighted in ability to recruit to sub-specialties posts which are embedded within the pathways	Review workforce options and identify alternative options to fulfil requirements

Finance

Risk	**Management of Risk**
Funding has still to be confirmed regarding waiting times support	

Improvement

Risk	**Management of Risk**
Need to ensure that improvements that are implemented are sustainable	Use sustainability model to ensure that as pathways are developed they are tested using the model for their sustainability.

Equalities

Risk	**Management of Risk**
Systems are not designed to have a negative impact on equalities however this may take place	Look to mitigate any inequalities where possible
Capacity not currently aligned to demand for the locality	Establish process to realign capacity on sites where demand profile requires increased capacity.

By March 2013, 90% of clients will wait no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery.

EAST RENFREWSHIRE ADP

East Renfrewshire Lead:	Safaa Baxter – Chair East Renfrewshire ADP

Delivery

Risk	**Management of Risk**
Capacity – increase in demand challenging ability to deliver service.	Managed through existing service redesign, service user pathway, and process for managing waiting times through routine monitoring of activity and feedback loop.
Data - implementation of new waiting times system.	Establish baseline and trajectory. New reporting procedures improve ability to performance manage at both service and ADP level.

Workforce

Risk	**Management of Risk**
High caseloads and workforce saturation	Redesign of service provision to improve service delivery and reduce caseloads within the CAT team. Improve access to services and provide pathway from Tier 3 to Tier 2 service through the implementation of a new recovery service.
Implementation of new waiting times system.	Delivery of waiting times training to all appropriate staff. Development of local process and mechanism to collate and collect data.

Finance

Risk	**Management of Risk**
The overall public service budget is expected to reduce in real terms over the next three years.	Cost savings will be managed to protect front line services.

Improvement

Risk	**Management of Risk**
Maintain high level of performance.	New reporting procedures improve ability to performance manage waiting times at both service and ADP level.

Equalities

Risk	**Management of Risk**
Differential outcomes for equalities group in terms of access to services and treatment.	An equalities impact assessment will be completed on the alcohol and drug strategy. New waiting times system enables ongoing equalities data collection and analysis.

GLASGOW CITY ADP

NHS BOARD LEAD:	Eric Steel

Delivery

Risk	Management of Risk
Performance on drug misuse waiting times is not improved from current levels.	ADP focus on measures of improved performance for every CHP and purchased services.
Glasgow City services (purchased and provided) failing to collect waiting times (compliance).	Ongoing support to purchased and provided services from Performance support team.
Waiting times increase for services due to increase in demands.	Routine monitoring of activity, alert systems for increases in demand, reprioritise at risk and vulnerable groups.
Technical capability of Glasgow City ADP ensuring electronic data return.	Glasgow City ADP will return using New waiting times database with a view to possible development of file upload facility from mainframe systems.
Newly established ADP and structures across GG&CHB area – five separate reporting structures.	GAS will now report waiting times on behalf of Glasgow City ADP only. Other ADP's will report separately.

Workforce

Risk	Management of Risk
High caseloads and workforce saturation.	Ensure clear learning and development programme, resource flow to reduce caseloads, reprioritisation of services.
Lack of essential services for recovery in place.	Ensure clear commissioning plans are in place via each Locality Planning Group, overseen by ADP and proper balance of care.
Delay to implementation of new waiting times database (beyond April 2011) due to staffing constraints.	Continued support to services and staff with regard to training. Roll out of training to staff and identify service champions within each service to ensure ongoing training on new system with available staff.
Decrease in Performance within services due to staffing constraints.	Continued support to services and staff with regard to training. Ongoing performance management support and training in locality based reporting (available from new system).
Decrease in numbers of staff in support team (GAS) responsible for training, collating and monitoring performance of Citywide services.	Where possible identifying and training other staff members in the support process.

Finance

Risk	Management of Risk
Escalating costs of some recovery services – particularly residential care.	Individual review with providers based on principles of best value. Re-tender where required and where better value can be demonstrated.
Demand increases for drug misuse treatment and care services.	Routine monitoring of activity, alert systems for increases in demand, reprioritise at risk and vulnerable groups.

Improvement

Risk	Management of Risk
Some areas working to existing high levels of performance.	Maintain existing performance whilst prioritising services/ areas of poor performance.
Inequity of performance across substance (alcohol/drug) area exists.	Use existing ADP performance management approach, with CHP's and individual services via to review and improve performance where required.

Equalities

Risk	Management of Risk
Differential outcomes for equalities group in terms of access to services and treatment which do not take differential needs into account.	Further development of services which are inequalities sensitive using the following tools: • Ongoing data collection and analysis from an equalities perspective (ethnicity, race, disability and gender). Available in part via new waiting times database. • Research with addiction BME clients and addiction staff underway to identify, inform and improve access and care pathways. Outcome of study due April 2011. • Equalities working group operational currently considering undertaking an EQIA of referral system (timescales still to be agreed).

INVERCLYDE ADP

NHS BOARD LEAD:	Susanna McCorry – Rice, Bob McLean

Delivery

Risk	Management of Risk
That processes are not responsive enough to produce outcomes.	Currently examining delays in the referral process which can be overcome by changing system, including simplifying group referral process, examining duty assessment process.

Workforce

Risk	Management of Risk
Loss of key worker through long term illness/leaving post.	Currently working on policy of balancing out caseloads in a way which will give greater possibilities in terms of our ability to absorb additional work.
Loss of medical time.	More difficult issue. Loss of prescribers impacts greatly on waiting times. Some new treatment programs and greater focus on recovery have the aim of reducing overall numbers in treatment.
15 separate services, performed by 40 workers and three clerical support staff. Nine of these services contribute to the waiting times programme. This puts significant pressure on clerical staff.	The clerical team being strengthened by one additional worker will alleviate any such pressures.
Reduction in workforce due to financial pressures in particular not filling posts left vacant.	Close tracking of waiting times. Getting better at discharge. Using other community facilities services to support clients.
Having to take time to retrain staff who are redeployed into alcohol posts who require training.	Ensure intensive support and training is given from other staff.

Finance

Risk	Management of Risk
Some short term funded aspects of the service, which have a recovery focus, have funding ended.	Funding decisions partly based on outcomes and success. Maximum effort going into achieving best outcomes.
Insufficient funding of medical time.	Development of prioritisation of spend through Alcohol and Drug Partnership, Community Health and Care Partnership, Single Outcome Agreement.

Improvement

Risk	Management of Risk
That the service becomes static, and unchanging due to pressures of demand.	A range of new initiatives already planned to move service forward and reduce demand including recovery service funding bids, introduction of new shorter term treatment program.
Need to continually Identifying service improvement	Regular monitoring and audit.
Need to better involve service users' views.	Develop feedback forms for all service users in particular completers. Integrated alcohol and drug services in Inverclyde have committed to implementing the Scottish Drugs Forum National Quality Development Programme which provides a focus on service user feedback on service quality and outcomes.

Equalities

Risk	Management of Risk
Gender based unequal provision due to childcare responsibilities being predominantly carried by female clients	Regular review of system impact on single parents with child care responsibilities. Development of policy and practice which minimises this.
Exclusion due to financial limitations regarding travel costs to service	Development of greater outreach capacity, targeted financial support as part of recovery care plan.

RENFREWSHIRE ADP

NHS BOARD LEAD:	Fiona Mc Neill

Delivery

Risk	Management of Risk
Alcohol and drug services unable to submit data (compliance)	Training is ongoing in the new data collection system which will ensure service compliance.
New waiting times database will be implemented on 1st April 2011 - which could lead to issues with data quality	As above
Waiting times increase for services due to increased demand	Routine monitoring of activity, systems in place to reprioritise at risk and vulnerable groups.
Insufficient capacity within 'Specialist Treatment Providers'	Service review about to be undertaken which will ensure enhanced access to treatment within the target timescales. This will include the Local Enhanced Scheme with GPs.
Lack of understanding that the HEAT target is a partnership target	Drug and Alcohol Strategy is currently being reviewed which will include the development of a Performance Framework (will include a variety of targets including waiting times) will seek approval from all partners.

Workforce

Risk	Management of Risk
Additional training required for new and existing staff to ensure Recovery focussed service provision	Workforce Development Plan is currently being developed which will include a training needs analysis – recommendations will be fed into ADP structures.
High caseloads and workforce saturation	Workload management processes implemented. Monitoring systems are in place overseen by the ADP.
Limited capacity due to staff sickness	Robust application of sickness/absence management policies.

Finance

Risk	Management of Risk
Current financial climate may impact on current funding levels	ADP Financial Framework/Commissioning Strategy are currently being developed which will include systems to monitor activity and pressures on service capacity/delivery. This information will be reported routinely within ADP structures.

Improvement

Risk	Management of Risk
Sustaining current high levels of performance across all services	Waiting Times are closely monitored within ADP structures via Performance Framework

Equalities

Risk	Management of Risk
Differential outcomes for equalities group in terms of access to services which do not take into account differential needs	Implement EQIA within all services in Renfrewshire. Will be included within ADP Performance Framework.

WEST DUNBARTONSHIRE ADP

NHS BOARD LEAD:	Helen Weir

Delivery

Risk	Management of Risk
Data inputting difficulties skew numbers	• Proforma will be used to enable nursing, social care and third sector staff to pass appropriate information to administration staff for inputting on to the system. • Proactive review of system and data in place to allow "hic ups" to be addressed prior to system going live on 1st April 2011. • Ongoing monitoring of data quality will ensure systems are working and appropriate data is being submitted. • Additional training on the use of the proforma has been delivered within statutory service provision areas, could also be rolled out to third sector providers if required.
Staff unable to use the new Waiting Times Database	• All administrative staff have received training/ follow up training on the use of the system. • All other members of staff participated in briefing sessions to allow them to understand how the system works, what information is being collated. The importance of completing the abovementioned proforma was also reiterated during these sessions.
ADP unable to extrapolate specific reports	• ISD are compiling a list of readily available reports which will be shared with all ADP's. • ADP Lead, Head of Service and Information Analyst working to identify other reports which may be of interest locally, these will be run to confirm feasibility and to iron out any potential problems.

Workforce

Risk	Management of Risk
Staff sickness/Annual Leave	• Maximising attendance procedures followed within all statutory sector service provision areas. Regular review and monitoring of absence will be used to manage work load appropriately. • Duty system in place to enable patients/clients

	to access statutory services directly/or be signposted to other services as necessary. • All statutory and third sector service providers operate self referral systems.
Reduction in staffing allocation as a direct result cost saving exercises	• Current, direct service provision staffing levels have not been reduced as a result of cost saving exercises. This situation will be reviewed in line with future such exercises and where possible staffing levels will remain unchanged.

Finance

Risk	**Management of Risk**
Reduction in WDC budget as a result of cost cutting exercises.	• Within current cost cutting exercises the WDC Addictions budget has been protected.
NHS Addictions Budgets has had a substantial cut	• Mitigation of any adverse affects needs to be considered as part of the ongoing development and review of the Commissioning Strategy.

Improvement

Risk	**Management of Risk**
NHS Addictions Budgets cut year on year for the next two – three years	• West Dun current delivery on waiting times has been held up as an example of good practice, particularly in relation to the development of the new HEAT A11 Target. Nearly all i.e. (90%+) clients are currently accessing first appointment and first treatment within 14 and 21days respectively. • However, ability to maintain current high levels of success in these areas may be adversely affected once the result of the cut to budgets becomes clearer. Work to mitigate any adverse affects needs to be considered as part of the ongoing development and review of the Commissioning Strategy.

Equalities

Risk	**Management of Risk**
Clients/patients perceive that there is an imbalance in the access to and types of services available to them.	• Integrated care pathways are followed to ensure that clients and, where appropriate their families, are at the centre of the development and monitoring of individual care packages. • Regular client satisfaction surveys are undertaken by all services, this survey explores, amongst other things, perceptions of services;

	whether clients feel they are treated as individuals. Views as to whether or not they feel respected and if their individual needs are being met. • These surveys are carried out annually and have, in the past led the development of a new out of hour's service. • The Future of Addiction Services Team (FAST) the local client led structure has representation on the ADP to ensure that the views of clients are an integral element in the future development of local services.
Staff unable to input date as relevant passwords have not been received.	• Liaison with ISD to ensure that all relevant SLA's have been completed and that all staff have or will receive their individual passwords. • Ensure that ADP Lead, Information Analyst and Head of Service also have access to passwords.

Deliver faster access to mental health services by delivering 26 weeks referral to treatment for specialist Child and Adolescent Mental Health Services (CAMHS) services from March 2013

NHS BOARD LEAD:	Mark Feinnman – Sector Director, Glasgow City CHP

Delivery

Risk	**Management of Risk**
• Dedicated Functional teams at Stage 3 and 4 have increased access to services for specific vulnerable care groups. This improvement in access to services for vulnerable children and young people risks overwhelming locality services in terms of increase in numbers referred. • Inconsistency of referral processes. • Triage and ICP provision insufficient and historic. • Plans for more integrated working in children's services.	• Maximising activity at Stage 3 by increasing levels of staff and ensuring staffing of each team is consistent and provides the best evidenced mix of skills and competencies. • We will review and agree best evidence criteria for managing demand. • We are currently reviewing case management processes within locality CAMHS and developing single patient management system to share with other CAMHS teams across GG&C. • We are implementing CAPA demand and capacity model across all Health Board wide CAMHS services to maximise delivery at Stage 3 and supporting this with specific expertise at Stage 4. • We will use the seven helpful habits of effective CAMHS programme. • We are reviewing and developing monthly data collection and activity processes, and reviewing triage and referral criteria to form proposals for the implementation of an agreed methodology. • We will use the IAF assessment to create integrated multi-agency assessments.

Workforce

Risk	**Management of Risk**
• Workforce is primarily made up of part time, female staff of child bearing age. • Uptake of family friendly policies.	We are currently planning our workforce on the basis that that is likely to be part time and with career breaks and we are skill mixing workforce where possible to provide maximum flexibility.

Finance

Risk	Management of Risk
The current financial climate nationally, and within NHSGGC and the impact of Agenda for Change and its inflationary pressure.	We are developing our workforce within our current resource where possible. Additional CAMHS funding has been secured through the National Delivery Plan for Specialist Children's Services and has been prioritised in: • Improving funding in Clyde. • Providing Out of Hours and crisis responses.

Improvement

Risk	Management of Risk
We are implementing changes in organisational culture and processes and managing a significant number of targets which can bring with it a certain amount of change fatigue.	We are ensuring significant OD support through changes and ensuring staff involvement and professional leadership in the critical stages of redesign processes. We currently have a Specialist Children's Services Professional Advisory Group which provides a forum for reflection on the professional impact of redesign.

Equalities

Risk	Management of Risk
Redesign presents a risk of not identifying areas of significant need in the population. There is a need to ensure that we redesign in a way that improves services for all groups of children and young people.	• We are implementing a programme of EQIAs on all Service Redesign. • We are creating a Single Patient Management System for Children and Young People's Specialist Services which will improve data sharing across teams in CYPSS and improve activity, outcome and equalities data collection and profiling. • We are reviewing and developing monthly data collection and activity processes, and reviewing triage and referral criteria to form proposals for the implementation of an agreed methodology. • We are developing service user involvement within CAMHS as a core element of all service redesign and planning. • We are working closely with Child and Maternal Public Health in the identification and use of relevant epidemiology in relation to specialist children's services and ensuring that all redesign is set within evidenced based practice and interventions.

Deliver faster access to mental health services by delivering 18 weeks referral to treatment for Psychological Therapies from December 2014.

NHS BOARD LEAD:	Fiona McNeill (Head of Mental Health, Renfrewshire CHP)

Delivery

Risk	**Management of Risk**
Whilst the target has been set, key definitions on (for example) assessment and modalities of delivery are still to be agreed. The risk is that these may not be closely aligned to current data gathering systems and may hinder comparison with baseline data.	• Board management and clinical leads in regular contact with national reference group to remain updated and to contribute to definition setting.
There is a risk that a service-led definition of date referral received causes misunderstanding amongst patients as referrals are not always specific for therapy but rather for general service assessment.	• As above.
There is a risk of patient expectation being heightened and then not met because there is not a clear understanding of assessment and eligibility criteria.	• Development of clear national and local communication plan for patients to explain the eligibility criteria.
There are currently different data collection systems across different services/care groups and significant variations in waiting times across settings, care groups and modalities. For example, identification of need in a MH setting may only arise in a MDT meeting many weeks after initial referral to service.	• Board lead convenes a psychological therapies stakeholder group that covers all settings/care groups and is working to gather intelligence and comparable data. This group has developed an action plan and will develop an implementation plan as the definitions work is clarified nationally.
Lack of appreciation at Board level of breadth of target, and involvement of wide range of staff.	• Engagement of Executive Director sponsor – Anne Hawkins. • Ensure Psychological Therapies Implementation Group includes representation from wide spectrum of areas. • IM&T support to target sought at Board level to increase understanding and breadth.

	• Brief being prepared for CHP/Sector Directors to increase awareness & understanding. • Communication Strategy in development.
Missing data - absence of individual or group charged with the responsibility for identifying all services in which Psychological Therapies are being delivered, leading to incomplete data. (eg capturing data from Clinical Health psychologist who may be employed in Acute Medical services)	• Ensure IM&T lead identified in relation to reporting. • Early engagement between IM&T support and local teams and operational managers to identify gaps and plans to ensure data capture requirements are clear and are progressed.
Resistance of staff to collecting data: • if data collection system is seen as too complex or time-consuming • if data collected doesn't reflect work they are doing	• Early engagement between IM&T supports and local teams and operational managers to identify and simplify data collection requirements. • Ensure the buy-in of operational managers through proactive communication & engagement. • Use of improvement methodologies to convey the importance of data collection.

Workforce

Risk	**Management of Risk**
Support for delivery thus far has been dependent on resources made available through MH Collaborative in terms of data analysis, project management and service improvement - this funding ceases March 2011.	Agreement for existing MHC funding underspend to be carried forward to support project management and service improvement work in year April 2011 – March 2012. Gathering of information to support representation for mental health inclusion in any service improvement funding
Skill mix and distribution of therapy staff across settings and care groups may mean some parts of the Board are less well resourced to meet target.	• Psychological Therapies group as above working on current data and plan in place to assess cross service capacity.

Finance

Risk	Management of Risk
Systems support in terms of IT and administration	• PT group will assess this as part of the implementation plan, and will seek IM&T support at Board level to ensure that this HEAT target has corporate support in same way as all others.
As for workforce above, there may be insufficient investment in some areas to meet the target - this will require a re-assessment of investment in a cost neutral environment for those services.	• PT group will assess and report. • Ensure links to training plan - issue may be more around skills rather than numbers. • Encourage & promote use of capacity modeling to understand what is required for efficient delivery.
Insufficient numbers of appropriately trained staff to deliver volume of interventions required	• Maximise the use of the training opportunities provided by Psychological Interventions Team and NES Psychological Therapies Programme, as well as capacity to deliver training in-house.
Insufficient numbers of trained Psychological Therapies supervisors to support both increase in training, and safe and effective ongoing service delivery	• Local mapping exercise to determine supervision capacity. • Maximise uptake of opportunities via NES development and roll-out of training for Psychological Therapies Supervisors.

Improvement

Risk	Management of Risk
Data not available to effectively manage demand and capacity and waiting lists.	• Clarity from Scottish Government on data requirements • Prioritise development and use of data systems locally to collect and analyse relevant data.
Lack of skills within Board to analyse demand and capacity and identify opportunities for improvement	• Ensure system in place to share knowledge from 18 weeks programmes in other specialities across to mental in conjunction with IM&T colleagues.

The target is focused on specific therapies and specific conditions and will exclude the higher volume of '"lower intensity" interventions - this risks creating perverse incentives in the system to redirect resource from this preventative work to deliver the target short term - for example counselling or self help services in PCMHTs and other settings.	• Representations made to national group to ensure this corollary data should also be counted to remove the incentive. • Agree what qualitative and quantitative information we wish to capture locally via PT Group.

Equalities

Risk	**Management of Risk**
Key groups will have poorer access to services – for example within areas of deprivation and poor literacy, inequalities gap could increase, with the potential for those who are more articulate to be deemed suitable for some therapies thus reinforcing existing inequalities. In addition, some care groups are less well resourced, e.g. older adults.	• Services will require to EQIA in all settings and care groups to assess and quantify this risk and put in place action plans to address this. • Services may have to actively manage numbers across various areas to ensure those in most deprived areas do not receive less therapy.
There are variations across geographical areas that are closely linked to service design - for example (as above) in relation to PCMH services There is a risk that services for patients not "covered" by the target will be re-prioritised.	• Stakeholder group will assess and monitor variation. • Ensure PCMHT service review is briefed to address this risk.

Treatment Appropriate to Patient

Treatment

Reducing the need for emergency hospital care, NHS Boards will achieve agreed reductions in emergency inpatient bed days rates for people aged 75 and over between 2009/10 and 2011/12 through improved partnership working between the acute, primary and community care sectors.

To improve stroke care, 90% of all patients admitted with a diagnosis of stroke will be admitted to a stroke unit on the day of admission, or the day following presentation by March 2013.

Further reduce healthcare associated infections so that by March 2013 NHS Boards' staphylococcus aureus bacteraemia (including MRSA) cases are 0.26 or less per 1,000 acute occupied bed days; and the rate of Clostridium difficile infections in patients aged 65 and over is 0.39 cases or less per 1,000 total occupied bed days.

To support shifting the balance of care, NHS Boards will achieve agreed reductions in the rates of attendance at A&E between 2009/10 and 2013/14.

Reducing the need for emergency hospital care, NHS Boards will achieve agreed reductions in emergency inpatient bed days rates for people aged 75 and over between 2009/10 and 202011/12 through improved partnership working between the acute, primary and community care sectors.

NHS BOARD LEAD:	Catriona Renfrew – Director of Corporate Planning and Policy

Delivery

Risk	**Management of Risk**
In response to economic pressure, Councils reduce resources for Older People's services, causing significant increase in delayed discharges. This is already occurring in Glasgow City. Lack of clear evidence regarding actions that can significantly and consistently impact on admissions. Changes in demography are not uniform across the Board area so differential solutions are required.	Regular monitoring of delayed discharges over and nearing six weeks. Regular communication with Councils. Financial implications being negotiated. Change Fund Plans will seek to mitigate impact. We are unable to provide a trajectory for this target until Change Plans are finalised and their impact is understood. Implementation of High Impact Changes identified in LTC plan, participation in national projects re shifting the balance of care. Older People's Planning group established to ensure consistency. New approach to prevention in development linking LTC, Keep Well and older people. Change plans in development with each local authority to address demographic and service pressures including bed days occupied by older people with a particular focus on those ready for discharge.
People over 75 are the biggest users of bed days, target not adjusted for this nor for affects of deprivation on need for acute services.	Continued discussion with Scottish government re equalities aspects of HEAT.
Background of increasing A & E and emergency admissions since 2004/5.	Development of assessment units to provide rapid assessment and treatment without admission - final site goes live in March 2010 following closure of stobhill casualty.

Finance

Risk	**Management of Risk**
Financial pressures in health and social services lead to reduction in services that foster enablement and reduce dependency.	Change fund offers opportunity to generate new service options and will include joint financial frameworks for older peoples services. West Dunbartonshire and Inverclyde now integrated CHCPS giving themselves greater opportunities to explore flexible solutions.

Improvement

Risk	Management of Risk
Highly complex area of work with multifactorial causes and solutions.	Joint planning in place with each partner local authority linked to change fund. New community rehab and enablement service in place from 2nd May. Carers – we will also continue to look at the most effective use of Carers Information strategy funding to support carers alongside our emerging plans for the Change Fund. Dementia – AHP consultant developing action plan with particular focus on patients in acute hospitals. Living and Dying Well Plan including care homes to promote anticipatory care planning and preferred place of care showing initial good results.

Equalities

Risk	Management of Risk
Premature discharge for people experiencing multiple disadvantage may have negative impact on repeat attendance and widen the health inequalities gap.	Development of inequalities sensitive practice and assessment to identify barriers to effective discharge.

To improve stroke care, 90% of all patients admitted with a diagnosis of stroke will be admitted to a stroke unit on the day of admission, or the day following presentation by March 2013.

NHS BOARD LEAD:	Anne Harkness/Christine McAlpine

Delivery

Risk	**Management of Risk**
Ensuring imaging available to confirm diagnosis of stroke to ensure rapid patient movement.	Agreement of pathways and capacity plans with diagnostics.
In most sites patients first assessed in acute medical receiving area prior to admission to a stroke unit.	Agreement of assessment and admission pathways with acute receiving colleagues.
Impact of increasing regional referrals on GGC hospitals.	Discussions with regional planning group.
Implementation of ASR in Greater Glasgow will shift pattern of referrals and require changes in service models for thrombolysis.	Agreement of pathways and associated workforce model to allow relevant skills to be acquired.

Workforce

Risk	**Management of Risk**
Current consultant vacancies at GRI and IRH which have already been advertised unsuccessfully, large number of stroke consultant posts across WOS.	Re-advertise and review job plans of current postholders and vacant posts to consider balance of stroke/other specialty interests.
Sites with single handed practitioners pose difficulties in sustaining specialist review all year.	Review of working arrangements and pathways.
Stroke specialist nurses and AHPs do not work at weekends.	Review of working arrangements and pathways.

Finance

Risk	**Management of Risk**
Impact of regional referrals.	Discussions with regional planning group.
Impact of increased out of hours work for consultants.	Review of pathways and working arrangements across Board area. No additional resource available locally.

Equalities

Risk	**Management of Risk**
Incidence of stroke linked to deprivation so high numbers of admissions across GGC.	Clear capacity plan.

Maintaining stroke units on all sites may not be possible so referrals may require to be directed to fewer sites impacting on carers.	Transport Needs Assessment.

Further reduce healthcare associated infections so that by March 2013 NHS Boards' staphylococcus aureus bacteraemia (including MRSA) cases are 0.26 or less per 1,000 acute occupied bed days; and the rate of Clostridium difficile infections in patients aged 65 and over is 0.39 cases or less per 1,000 total occupied bed days.

NHS BOARD LEAD:	Tom Walsh – Infection Control Manager

Delivery

Risk	Management of Risk
Failure to engage Directorates.	Develop, with Directors, robust achievable targets for each directorate.
Failure to sustain current improvements in antimicrobial prescribing.	Work with AMT to ensure a strategy to maintain optimal prescribing continues in the long term and AMT resources are deployed in support of achieving the targets.
Maintaining robust Infection Control Practice across the Board.	Progress and monitor detailed Infection Control Programme which is targeted through local surveillance outcomes and underpinned by education and training**.** Assurance against objectives and outcomes provided to NHS Board in bi-monthly reports.

Workforce

Risk	Management of Risk
As Resources.	

Finance

Risk	Management of Risk
Failure of delivery due to insufficient resource to deliver both targets.	Undertake workload analysis examining recent changes in C. diff and MRSA epidemiology.

Improvement

Risk	Management of Risk
SPSP and IC targets not harmonised.	Work with SPSP to ensure care bundles are targeted to maximise benefit.

Equalities

Risk	Management of Risk
None specific to target. Where infection control involves communication with patients, there is a risk that communication needs will not be fully assessed.	All IC policies are tested for equality and diversity. Compliance with Accessible Information Policy.

T10: To support shifting the balance of care, NHS Boards will achieve agreed reductions in the rates of attendance at A&E

NHS BOARD LEAD:	Catriona Renfrew, Director of Corporate Policy and Planning

Note – Following guidance from Scottish Government, the trajectory now excludes GP direct referrals and Minor Injuries Units' attendances.

Delivery

Risk	**Management of Risk**
A review of attendance rates at A&E indicates that after a period of relatively low growth in the 1990s, there has been a significant increase in A&E attendances over recent years. We have a concern that this trend could continue and there is a lack of evidence about what interventions the NHS can make that can effectively reduce A&E attendances.	A&E Steering Group established and has formulated and oversees implementation of an action plan relating to this target; co-ordinating activity across the system aimed at understanding patterns of A&E attendances; and identifying connections with other activity which might impact on A&E attendances, for example work relating to long term conditions. A range of workstreams are in place, including the following: • A&E attenders: – Analysis of A&E attenders who are experiencing disadvantage. – Analysis of numbers flowing from A&E to OOH unscheduled care. – A focus on Suicide Preventation, with significant numbers of front line staff trained in recognising and responding to suicide risk. • Information – development of monthly reports, shared with all key partners, detailing A&E attendances at CH(C)P and GP practice level (including reasons for attending, admissions, readmissions, length of stay and SPARRA data). • Piloting OOH GP telephone support to Scottish Ambulance Service – positive feedback received to date. • Mental Health and Addictions – co-location of Crisis Intervention Teams with NHS24, GP OOH services and SAS, providing NHS24 and GPs with access to the service for advice which will potentially avoid attendance at

Risk	Management of Risk
	A&E. • Development of ENP Minor Injury Services: – Opening of two nurse-led MIUs in 2009 at new ACHs in the North and South of the City. – Further development of ENP provision through the creation of dedicated minor injury areas in A&Es. – moving forward with an assessment model of care across all acute sites, to be complete by end March 2011. The move of services from Stobhill hospital will see a transfer of A&E activity to other sites, including MIUs. NHS 24 is committed to working closely with territorial Boards in exploring and agreeing specific actions that will support reductions in rates of attendance at A&E. NHS 24 already carries out a range of activities to help reduce the A&E attendance rate, such as the delivery of self care information, and plans to increase the amount of Category C calls taken from the Scottish Ambulance service, converting the majority of these to Primary Care Outcomes. In addition, we and NHS 24 will work proactively to identify and resolve any issues with our A&E referrals, and respond to any feedback by clinicians including appropriate thresholds for referral to A&E and provision of free mobile phone calls.

Workforce

Risk	Management of Risk

Equalities

Risk	Management of Risk
Action to reduce A&E attendances could potentially impact disproportionately on people who are experiencing disadvantage, restricting their access to health services.	Analysis of A&E attenders who are experiencing disadvantage has been carried out. A work programme is now being established to create a more holistic and whole system response to the needs of attenders at A&E. This will ensure patients get a more effective response from the NHS and may result in a decrease in repeat attenders

FURTHER INFORMATION

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NHS
Greater Glasgow and Clyde

Annex 3

All Single Outcome Agreements

NHS Board Local Delivery Plan 2010/11
Contributions to Single Outcome Agreements

1.	**NHS Board:**	NHS Greater Glasgow and Clyde
2.	**Community Planning Partnership:**	Inverclyde Alliance/Inverclyde Community Health and Care Partnership
3.	**Summary of critical issue:**	Health Inequalities. Our local Health & Wellbeing Survey undertaken in 2008 showed marked inequalities in health outcomes in Inverclyde, compared to many other parts of NHS Greater Glasgow & Clyde Health Board area. While some improvements have been made in reducing the health inequalities that exist between the more and less affluent areas within Inverclyde, the differences in some key areas remain significantly large. The latest Community Health and Wellbeing Profiles produced by ScotPHO in late 2010 highlight these differences, and comparisons between the 2010 and 2008 Profiles indicate levels of change. Some of the main points from the Profile are highlighted as follows. <u>Life Expectancy</u> Male life expectancy in Inverclyde is almost three years less than the Scottish average of 75.4 years, and within Inverclyde, ranges from 79.0 years in our more affluent areas to 65.2 years in more deprived areas. This represents a difference of almost 14 years. In the 2008 Profile, overall male life expectancy has increased by 0.7 years, in line with Scottish improvement; however the gap between the most and least affluent areas at that time was 11.4 years meaning that the male life expectancy gap has increased by approximately two and a half years. Female life expectancy in Inverclyde has increased slightly, from 77.8 years in 2008 to 78.1 years in 2010. The 2010 rate is marginally below the national average of 79.5 years; however the gap in female life expectancy within Inverclyde localities has increased from the 12.3 years observed in 2008 to 12.6 years in 2010.

		Early Deaths from Coronary Heart Disease (<75 years) In 2008 the Inverclyde rate was 106.9 per 100,000 population, which was 40% above the Scottish average. Just two years later in 2010, the rate is 68.8. Although the whole of Scotland has seen a drop in early CHD deaths, that gap has narrowed and Inverclyde now sits at a vastly improved 11.5% above the Scottish average. Within Inverclyde however, variations in this rate range from 10.6 to 125.1. Early Deaths from Cancer (<75 years) In 2008 the Inverclyde rate was 164.7 per 100,000 population, which was 12% above the Scottish average. In 2010, the rate is 134.9, which is very close to the Scottish average of 134.7. Within Inverclyde, variations in the early deaths from cancer rate range from 83.7 to 221.9. Early Deaths from Cerebrovascular Disease (<75 years) In 2008 the Inverclyde rate was 34.4 per 100,000 population, which was 42% above the Scottish average. In 2010, the rate is 24.8, which is still 32% higher than the Scottish average. Within Inverclyde, variations in the early deaths from cerebrovascular disease rate range from 9.7 to 60.3. Smoking Prevalence In 2008 the Inverclyde rate was 30.6% of the adult population against the Scottish average of 27.3%. In 2010, the Inverclyde rate is 25%, which is the same as the Scottish average. The data do not provide figures at locality level within Inverclyde, however our own local intelligence suggests that the SIMD areas have higher rates of smokers. Alcohol-Related Hospital Admissions In 2008 the Inverclyde rate of admission to hospital for alcohol attributable reasons was 1,236.6 per 100,000 population, which was 61% above the Scottish average. In 2010, the rate has risen to 1,414.0. The whole of Scotland has seen an increase in admissions to hospital for alcohol attributable reasons, as despite this local rise, our rate has reduced to 30% above the Scottish average. Within Inverclyde, variations in this rate range from 609 to 2,458. Alcohol Related Deaths In 2008 the Inverclyde rate for alcohol-related deaths was 47.6 per 100,000 population, which was 75% above the Scottish average. In 2010, the rate has risen by over a third to 64.8, although this is now at 36% above the Scottish average, which itself has risen even more dramatically. The data

		do not provide figures at locality level within Inverclyde. <u>Income Deprivation</u> In 2008, 19.3% of Inverclyde's population were classified as Income Deprived, which was 39% above the Scottish average. In 2010, the Inverclyde rate has risen to 20.6%, which is 36% above the Scottish average. Within Inverclyde, variations in this rate range from 5.3 to 35.9.
4.	**Community Planning Partnership Outputs:**	The Inverclyde Alliance has recognised that the communities that are subject to these inequalities of health outcome are often the same communities that experience inequalities in terms of social, economic and educational outcomes. The Partnership has therefore undertaken an extensive learning programme to help understand the connections between inequalities as well as their complex and multiple roots. This has included: • Inviting a number of key speakers to the Health Inequalities Outcome Delivery Group meetings to help formulate thinking and increase knowledge and awareness of health inequalities. These have included Dr Carol Craig from the Centre for Confidence and Wellbeing in Scotland and Professor George Morris from Scottish Government, and the Chief Medical Officer for Scotland, Dr. Harry Burns, will be addressing the Inverclyde Alliance early in the New Year • A workshop facilitated by Professor George Morris on the Scottish Government's Better Health Better Places Strategy was held to focus thinking amongst the partners on the linkages between health and health inequalities, the environment and social regeneration. This event helped to raise awareness of tools and approaches to measuring health impact/outcome and has helped to develop an application from Inverclyde, in conjunction with Glasgow Caledonian University, to the Public Health Research Institute. In addition, a successful bid for £10,000 from the Scottish Government Equally Well Unit has enabled a literature review to be undertaken to help support this application; • An Active Living Strategy is currently being developed for Inverclyde which will encompass all aspects of active living rather than conventional physical activity and sports strategies; and • Key partners (Inverclyde Community Health Partnership, Inverclyde Council and Strathclyde Passenger Transport) have developed a partnership approach to the new Greenock Bus Station to develop it as a "smoke free zone".
5.	**Local Outcome(s):**	The health of local people is improved, combating health inequality and promoting healthy lifestyles.

6.	**National Outcome(s):**	National Outcome 6 - We live longer, healthier lives
7.	**Please detail the specific contribution of the NHS Board in tackling this critical issue?**	The NHS has facilitated the outputs highlighted, and supported the partnership by providing key information to demonstrate the links between health inequalities and the other seven SOA local outcomes, which has led to agreement across the partnership that health inequalities are a symptom of wider ingrained cultural and social inequalities that are often perpetuated across generations. We have identified deficits in community resilience and are working with our partners to develop a radical small-area "wrap around" approach to try to build resilience and ultimately reduce the whole spectrum of inequalities experienced in that area.
8.	**Please illustrate the ways in which the NHS Board is working in collaboration with Community Planning Partners to tackle the critical issue?**	Our project - Developing Resilient Communities - utilises a longitudinal study approach to more fully understand the long term impacts of a range of interventions currently being delivered which improve both the physical and social environment within our deprived communities in Inverclyde and to ensure we impact on reducing health inequalities. Inverclyde has a high proportion of deprived areas with 42% of the Inverclyde population living in areas which are defined as the most deprived 20% across Scotland. In these most deprived and disadvantaged areas people face multiple problems such as high levels of worklessness, ill health, fear of crime, poor educational achievement, low aspirations, low levels of confidence, low income, poor housing and environment. Youth crime, violence and disorder have consistently been linked to issues of social deprivation, poor housing, low educational attainment, drug and alcohol abuse and poor employment prospects. However explaining these relationships Oldfield et al (2009) point out, have been constrained by an over reliance on quantitative research which inadequately explores any causal relations and all too frequently high crime communities are perceived to be full of “problem people” and not people who have problems. (Foster 2002) Inverclyde Alliance partners have developed mainstream services and a number of initiatives to address the effects of poverty and deprivation in the area particularly in relation to young people. These were designed to promote multiagency working in line with the current Community Planning Partnership and Single Outcome Agreement outcomes to address health and wellbeing as well as crime, violence and antisocial behaviour in order to develop attractive and secure communities. There is a real desire to improve both the physical and social environment within our deprived

		communities in Inverclyde and to ensure we impact on reducing health inequalities. Within Inverclyde there is a commitment to working with children and young people using early interventions and providing alternative life choices and support to reduce youth offending; promoting child protection and increasing life chances for young people; in particular focussing on and addressing the problems of groups of youths deemed to be at risk and the associated issues of child protection. This is in line with the Scottish Government's campaign; Safe Streets (2008) and Getting it Right for Every Child (2008). The first phase of this project is almost complete with a successful bid for £10,000 from the Scottish Government Equally Well Unit being secured which has enabled a literature review to be undertaken. The second stage will be completed in early 2011 with the development of an application from Inverclyde SOA Health Inequalities Outcome Delivery Group, in conjunction with Glasgow Caledonian University, to the Public Health Research Institute for funding to undertake this longitudinal study and identify the high impact variables that can be actioned to increase community resilience. On a practical level we have identified that there are 19 families in one locality that have particularly high levels of contact with specialist drug and alcohol services; mental health services, and criminal justice and antisocial behaviour teams. Of these 19 families, 7 also have regular contact with either social work standby services, child protection arrangements or Youth Justice services. We are hoping to extend our intelligence on these families to include usage patterns for health services with a view to better co-ordination of supports and inputs to generate better outcomes for the families, by considering the totality of their engagement with services and how this can be improved.
9.	**Please explain how the NHS Board is performance managing its contribution to tackling this critical issue?**	We are regularly monitoring some Key Performance Indicators in relation to this work. Some examples of these are: • The percentage of people 65+ with intensive needs receiving care at home was 40.3% in 2008 and this fell to 38% in 2010. Our aim is to increase the percentage to 41.5% by 2010/11; • The number of people presenting to Inverclyde Homeless Service that accessed a nurse-based health check or facilitated GP appointment increased. In 2009 14% accessed a health check and this rose to 58% in 2010; and

		• The percentage of the Learning Disabled population known to GP practices to have had a comprehensive health assessment has shown a slight improvement from 25% in 2009 to 27% in 2010.
10.	**Please explain how the NHS Board will demonstrate continuous improvement in the course of tackling this critical issue?**	Areas we will focus on in 2010/11: • Continue to support Inverclyde Alliance organisations to embrace their roles in improving health and tackling inequalities; • Research, consider and support the use of health inequalities planning tools and health impact assessment models to build capacity in agencies; supporting a partnership-wide approach to minimising negative impact on health. Specifically undertake a health impact assessment of the Inverclyde Tallships Event in 2011; • Continue to maximise capacity in communities to ensure resident level leadership to tackle health inequalities and poor health outcomes; • Continue to utilise the Single Outcome Agreement and Alliance Partnership as vehicles to consider local expansion of the current tobacco legislation (Smoking Health and Social Care (Scotland) Act); • Develop and implement the Active Living Strategy and action plan for Inverclyde; and • Continue to develop actions to support the bringing together of disparate workstreams focussing on vulnerable groups at risk of the greatest health inequalities (e.g. offenders, people with a learning disability and people experiencing homelessness).

1.	**NHS Board:**	NHS Greater Glasgow and Clyde
2.	**Community Planning Partnership:**	Renfrewshire Community Planning Partnership
3.	**Summary of critical issue:**	Childhood obesity - There is continued concern over the levels of obesity among children in Scotland. Obesity during childhood is a health concern in itself, but can also lead to physical and mental health problems in later life, such as heart disease, diabetes, osteoarthritis, back pain, increased risk of cancer, low self-esteem and depression. In Renfrewshire the percentage of children in Primary 1 that are classed as obese and severely obese has reduced from 7.8% in 2006/07 to 6.6% in 2009/10. Rates in Renfrewshire are below the Scottish average.
4.	**Community Planning Partnership Outputs:**	Active schools, school nurses, Eat Well to do Well. Good practice example is implementation of healthy child weight intervention.
5.	**Local Outcome(s):**	Our residents have improved levels of health.
6.	**National Outcome(s):**	We live longer, healthier lives.
7.	**Please detail the specific**	NHS developed model of intervention, management time and resources.

	contribution of the NHS Board in tackling this critical issue?	
8.	**Please illustrate the ways in which the NHS Board is working in collaboration with Community Planning Partners to tackle the critical issue?**	CHP worked with Council Education Services and Renfrewshire Leisure Ltd to recruit and train coaches, publicise the service and link with existing initiatives. This is an example of all partners signing up to and helping deliver a HEAT target. The next step is to review the model for use in schools. Success in Renfrewshire is due to partnership approach.
9.	**Please explain how the NHS Board is performance managing its contribution to tackling this critical issue?**	We monitor numbers coming into the service, completers, and achievements.
10.	**Please explain how the NHS Board will demonstrate continuous improvement in the course of tackling this critical issue?**	

1.	**NHS Board:**	NHS Greater Glasgow and Clyde
2.	**Community Planning Partnership:**	Renfrewshire Community Planning Partnership
3.	**Summary of critical issue:**	Alcohol - Alcohol consumption and its damaging effects have increased greatly in the Greater Glasgow and Clyde area since the 1990s. Over 1,650 patients from Renfrewshire are admitted to hospital annually for alcohol related or attributable causes (12% above Scottish average). Renfrewshire has the fourth highest number of alcohol related deaths in the UK (336 in the last five years – 35% above Scottish average).
4.	**Community Planning Partnership Outputs:**	Joint Alcohol Team (health and social work). Good practice example is pooling of information to influence the Licensing Forum.
5.	**Local Outcome(s):**	Our residents have improved levels of health.
6.	**National Outcome(s):**	We live longer, healthier lives.
7.	**Please detail the specific contribution of the**	NHS provided management time to review and collect information.

	NHS Board in tackling this critical issue?	
8.	**Please illustrate the ways in which the NHS Board is working in collaboration with Community Planning Partners to tackle the critical issue?**	CHP worked with Police and Social Work to collect relevant data and link it geographically – specifically linking density of licensed premises with deprivation and health and social outcomes. These include alcohol related hospital admission, domestic violence, incidence of serious assault etc. The next step is to present this to the Licensing Forum to persuade them to add detail to the current over provision statement.
9.	**Please explain how the NHS Board is performance managing its contribution to tackling this critical issue?**	In progress.
10.	**Please explain how the NHS Board will demonstrate continuous improvement in the course of tackling this critical issue?**	

1.	**NHS Board:**	NHS Greater Glasgow and Clyde
2.	**Community Planning Partnership:**	East Renfrewshire Community Planning Partnership
3.	**Summary of critical issue:**	Critical issues were identified as part of an assessment of need in the development of the SOA for years 1 and 2 in particular. This assessment of need highlighted demographic and social changes which indicated a need for a change in approach. Broadly these are summarised under the headings: • Children in their early years and vulnerable children; • Health improvement and tackling health inequalities; and • Vulnerable people being supported in their rehabilitation, recovery and enablement.
4.	**Community Planning Partnership Outputs:**	NHS Greater Glasgow and Clyde contributes directly to Community Planning Partnership Outputs through the theme lead role of the integrated CHCP in the CPP on community care and health. Implementation of activity supporting key outcomes is driven by Outcome Delivery Groups (ODGs). Key ODGs are Integrated Children's Services, Health and Community Care, and Improving Health. Linked CPP outputs relate to the Employability Partnership and Alcohol and Drugs Partnerships. ODGs have terms of reference which link their activity to high level SOA Outcomes, related Intermediate Outcomes and Key Performance Measures. ODGs have each delivered outcome-focused strategies based on logic models, often drawing on the healthscotland models.
5.	**Local Outcome(s):**	There are 11 local outcomes. These are as follows: • SOA 1 Our economy is strong with a more competitive, more diverse business base;

		• SOA 2 More of our residents have the skills needed for employment; • SOA 3 Our learners are successful, confident individuals, effective contributors and responsible citizens; • SOA 4 More of our children have a better start in life and are ready to succeed; • SOA 5 Our local people are healthier, more active and inequalities in health are reduced; • SOA 6 Our most vulnerable residents enjoy a better quality of life and live as independently as possible; • SOA 7 Our residents are safer in their neighbourhoods and their homes; • SOA 8 East Renfrewshire residents have easier access to key services via sustainable modes of transport; • SOA 9 Our local people live in an attractive natural and built environment that is sustainable and enhanced for future generations; • SOA 10 There are high quality and affordable housing opportunities for our residents; and • SOA 11 Our communities are more active and have influence over service design and delivery.
6.	**National Outcome(s):**	Local outcomes align with all five of the National Outcomes: Healthier; Wealthier and Fairer; Smarter; Safer and Stronger; and Greener.
7.	**Please detail the specific contribution of the NHS Board in tackling this critical issue?**	Through the CHCP, NHS Greater Glasgow and Clyde contribute through: • Evidence-based smoking cessation services delivered through the health improvement team; • Aligning health visiting resources with indicators of need in particular through the What About Me? (WAM) service for children affected by parental substance misuse; • The Active Children Eating Smart (ACES) programme of healthy weight interventions; • Triple P parenting programme; • Oral health programme; • Delivery of alcohol brief interventions; • Physical activity programmes; • Co-ordinating local training on suicide intervention across staff groups and across sectors; • UNICEF baby friendly accreditation and targeted peer support; • Specialist support to mainstream management of long-term conditions in the community, e.g., specialist nurses, pharmacy support. Evidence shows a closing of the gap between SIMD

		deprived areas and East Renfrewshire as a whole with exclusive breastfeeding rising from 6 per cent to 23 percent in the three years to 2010; and • Integrated health and community care teams and management in community addictions, learning disability, older people and mental health services – impacting on improvements in admissions for long-term conditions, achieving zero six week plus delayed discharge HEAT standard, the proportion of people with learning disability in 'open employment', bed days for older people admitted on two of more occasions, mental-health related hospital admission rates, and alcohol admission rates.
8.	**Please illustrate the ways in which the NHS Board is working in collaboration with Community Planning Partners to tackle the critical issue?**	The critical issues require to be addressed in partnership. They are cross-cutting issues with contributions from different CPP partners. The delivery of activities supporting these outcomes is driven through the Outcome Delivery Groups and supporting structures. These groups have a cross-sectoral membership including key partners and stakeholders across the CPP. The NHS collaborates with key partners in the voluntary and community sector through East Renfrewshire Voluntary Action, the Public Partnership Forum, education, housing, community and leisure, and primary care.
9.	**Please explain how the NHS Board is performance managing it's contribution to tackling this critical issue?**	The CPP has a Performance Accountability and Review (PAR) process at which lead contributors are held to account for performance on SOA themes. Alongside this the NHS and East Renfrewshire Council have in place a joint Organisational Performance and Review (OPR) process through which NHS and Council Chief Executives interrogate the performance of the CHCP. A Performance Management Framework is in place with key measures of performance disaggregated to partnership areas. Quarterly performance reports are presented to the CHCP Committee. A set of Planning Frameworks is in place which structure the CHCP Development Plan. The CHCP Development Plan is a three-year plan with an annual up-date and review cycle. The Development Plan aligns with the Council's Outcome Delivery Plan (ODP) and SOA outcomes. Progress on the delivery of key actions and performance measures is the major focus of the joint OPR. Several of the HEAT measures which CHCP staff are responsible for delivering link to the SOA outcomes. Targets and trajectories are set. Performance against these is monitored and managed regularly at a local and corporate level.

10.	**Please explain how the NHS Board will demonstrate continuous improvement in the course of tackling this critical issue?**	Quarterly performance reports, joint OPRs, PARs, the Development Plan and Outcome Delivery Plan feed into the SOA annual update.

1.	**NHS Board:**	NHS Greater Glasgow and Clyde
2.	**Community Planning Partnership:**	East Dunbartonshire Community Health Partnership
3.	**Summary of critical issue:**	The CHP is currently experiencing a significant demographic change, with the proportion of older people expected to increase by 30% over the next 10 years. This change will mean that services for older people in particular will face an unprecedented increase in demand. The 2001 census identified 16.6% of the population of East Dunbartonshire as having a long term condition. During the year 2006/07 – 2007/08, the prevalence of COPD rose by 3.1%, the biggest rise in GG&C and there has been gradual upward trend to the length of stay for patients with a significant diagnosis of CHD. The CHP has recognised the need to reduce the number of unscheduled emergency admissions, reduce the number of acute bed days for patients with a long term condition and **prevent delayed discharges** through supporting people at home.
4.	**Community Planning Partnership Outputs:**	• Single Outcome Agreement National Outcome [11a] – Strong resilient and supportive communities where people take responsibility for their own actions and how the effect others.
5.	**Local Outcome(s):**	• Older people and other vulnerable adults benefit from a comprehensive and joined up care structure.
6.	**National Outcome(s):**	• National Performance HEAT Standard – **Achieve zero delayed discharge target.** • Community Care Outcomes Framework [A1a] – **Delayed discharges.**

7.	**Please detail the specific contribution of the NHS Board in tackling this critical issue?**	The CHP contributes to the East Dunbartonshire Integrated Discharge Group which is a six weekly forum where the Local Authority, NHS Acute and CHP review reports generated from the EDISON system in order to **predict and take action to prevent potential delayed discharges.**
8.	**Please illustrate the ways in which the NHS Board is working in collaboration with Community Planning Partners to tackle the critical issue?**	A Community Care & Health Partnership has been established to plan and develop jointly agreed services/interventions for the population of East Dunbartonshire. This multi agency forum provides an infrastructure to address Mental Health, Drug & Alcohol, Disabilities, Older People and Health Improvement. A suite of priorities and key performance indicators have been agreed and included within East Dunbartonshire SOA. The Delayed Discharge HEAT standard forms an integral part of the East Dunbartonshire SOA. The CHP, East Dunbartonshire Council and the Acute sector work together to deliver on prevention of admission to hospital, reduction in bed days, and meeting the delayed discharge targets. The CHP is working with acute and local authority services, GPs, community pharmacists and voluntary organisations to implement LTC High Impact Changes, including health improvement, self management and support for carers. To achieve this goal, there will be a redesign of the rehabilitation and enablement services across the CHP.
9.	**Please explain how the NHS Board is performance managing its contribution to tackling this critical issue?**	Performance is reported through the Community Care and Health Partnership which is the strategic community planning group responsible for the delivery and performance management of jointly agreed health and social care outcomes. The CHP continues to deliver good performance against this standard through the robust systems described above.

10.	**Please explain how the NHS Board will demonstrate continuous improvement in the course of tackling this critical issue?**	The CHP, in partnership with East Dunbartonshire Council, is developing a joint vision and action plan for older people's services. This work sets out the direction of travel for future service planning and development and describes key workstreams to achieve change. The predicted demographic shift on the older people's population and limited resource for older people in SW services in particular, will however continue to present a significant challenge.

1.	**NHS Board:**	NHS Greater Glasgow and Clyde
2.	**Community Planning Partnership:**	Glasgow City
3.	**Summary of critical issue:**	Child Poverty is a complex cross-cutting issue and a critical issue for Glasgow where it affects six out of 10 families (Leading with Impact Report 2009). The challenge for Glasgow is how we can effectively tackle these issues at a City level. Uniquely in Scotland, Glasgow's Single Outcome Agreement gives a commitment to tackle child poverty. This gives an opportunity to develop a joined up approach at a City level. The main ways to tackle child poverty are to increase incomes, reduce outgoings, mitigate the impact and reduce inequality and discrimination. The UK Child Poverty Act 2010 has enshrined the commitment to tackle child poverty in law and the Scottish Government recently consulted on how this will be implemented in Scotland. The challenge locally is to take a joined up approach across a range of interventions e.g. employability, financial inclusion, health improvement, housing, children's services, education, childcare etc.
4.	**Community Planning Partnership Outputs:**	The Children's Services Sub Group on Child Poverty has been building on the work of a Leading With Impact group on Child Poverty. The Sub Group has brought together partners from the GGC, NHSGGC and the Voluntary Sector to develop a city wide response. The Director of Public health chairs the group jointly with The Depute Director of Development and Regeneration Services. Other related work being deliver by partners includes: • The Health Commission Report (http://www.glasgow.gov.uk/NR/rdonlyres/019795D2-E4B9-431B-8027-406DB3F12019/0/GlasgowHealthCommissionFinalReport.pdf) made a recommendation to create a child friendly City and this has been taken forward by the Health

		Policy Team in GGC linked to work on child poverty within a rights based approach; and • NHSGGC, GCC and Glasgow Centre for Population Health received Scottish Government funding for Healthier Wealthier Children to deliver income maximisation services to children and families in contact with health services, linked to CEL36. The project will offer income maximisation advice for families experiencing child poverty and will aim to prevent families from falling into child poverty by working with health and early years services to identify families at risk at an early stage. There are a range of other programmes being delivered by partners to children and families throughout the City which will also contribute to reducing child poverty through mainstream services (e.g. children's services, education etc) and partnerships (e.g. Glasgow Works).
5.	**Local Outcome(s):**	• Local Outcome 7: Increase the number of jobs in Glasgow; • Local Outcome 8: Increase the proportion of better paid and more productive jobs; • Local Outcome 9: Increase the proportion of Glasgow residents in work; • Local Outcome 17: Reduce the proportion of children in poverty; • Local Outcome 20: Improve Literacy and Numeracy of the population; • Local Outcome 22: Improve skills for employment; and • Local Outcome 23: Improve residents' aspirations, confidence, decision making capacity and involvement in community life.
6.	**National Outcome(s):**	• National Outcome 5: Our children have the best start in life and are ready to succeed; • National Outcome 7: We have tackled the significant inequalities in Scottish society; • National Outcome 8: We have improved the life chances for children, young people and families at risk; • National Outcome 11: We have strong, resilient and supportive communities where people take responsibility for their own actions and how they affect others; and • National Outcome 15: Our public services are high quality, continually improving, efficient and responsive to local people's needs.
7.	**Please detail the specific contribution of the**	NHSGGC has taken a leadership role on the issue of Child Poverty through the Director of Public Health with support from the Public Health Team, Health Improvement and the Corporate Inequalities Team. The Director of Public Health co-chairs the Child Poverty Sub Group.

	NHS Board in tackling this critical issue?	In order to deliver Healthier Wealthier Children, NHSGGC has employed development workers in each CH(C)P and commissioned income maximisers from local providers using the funding from the Scottish Government. A range of local and corporate NHS staff support the development and delivery of the project.
8.	**Please illustrate the ways in which the NHS Board is working in collaboration with Community Planning Partners to tackle the critical issue?**	**See also No. 4.** NHSGGC is involved in: • Championing and supporting the Child Poverty Sub Group; • Delivering Healthier Wealthier Children; • As a member of the Glasgow Works Partnership; [1] and • Through health specific health programmes such as the Parenting Strategy [2] Healthy Children, Infant and Maternal Nutrition, GIFEC and Children's' Services.
9.	**Please explain how the NHS Board is performance managing its contribution to tackling this critical issue?**	NHSGGC has Planning and Policy Frameworks which relate to this critical issue including: • Children's Services Planning Framework; • Tackling Inequality Policy Framework; • Employability, Financial Inclusion and Responding to the Recession Policy Framework; • Mental Health Planning Framework; • Acute Planning Framework; • Health Improvement Policy Framework; and • Quality Policy Framework. These frameworks are performance managed through the Organisational Performance Review Framework.

[1] School Gates Employability Project being delivered by Glasgow Works and other partners.
[2] A joint NHSGGC and Glasgow City Council Parenting Support Framework was launched in June 2009 with the aim of improving outcomes for children through co-ordinated support for parents.

10.	**Please explain how the NHS Board will demonstrate continuous improvement in the course of tackling this critical issue?**	The Child Poverty Sub group are developing indicators and targets based on the Scottish Government proposals to meet the requirement of the Child Poverty Act 2010. The Sub Group will propose that the targets and indicators are adopted in the new SOA, alongside a range of proxy indicators already included. Glasgow Centre for Population Health is developing Child Health and Wellbeing indicators which will also be used. Healthier, Wealthier Children is being fully evaluated by Glasgow Centre for Population Health to give local and national guidance on mainstreaming any learning form the pilot.

1.	**NHS Board:**	NHS Greater Glasgow and Clyde
2.	**Community Planning Partnership:**	West Dunbartonshire Community Planning Partnership
3.	**Summary of critical issue:**	Smoking is still the biggest cause of premature death in Scotland, especially in disadvantaged communities[3]. Smoking accounts for about 24% of all deaths in Scotland, rising to as much as 34% in some areas. In addition, the life expectancy gap between smokers and those who have never smoked is greater than that between higher and lower social classes. This means that the scope for reducing health inequalities is limited unless more deprived people stop smoking. Adult smoking rates increase with increasing deprivation. In Scotland in 2005-06, smoking rates ranged from 11% in the least deprived 10% of areas to 44% in the most deprived 10%.
4.	**Community Planning Partnership Outputs:**	Local outputs reflect a range of Tobacco Control Programmes/Interventions delivered by WD CH(C)P, WDC (particularly Educational Services and Regulatory Services) and Strathclyde Fire and Rescue. This also includes the Scottish Government's Equally Well National Tobacco Test Site in Whitecrook which focuses on tobacco related health inequalities and that is locally led by WD CH(C)P Programme. The Local Implementation Group for this test site has been developed to be the overall CPP tobacco control programme group.
5.	**Local Outcome(s):**	• Increased proportion of people (65+) needing care or support who are able to sustain an independent quality of life as part of the community; • Increased life-expectancy within 15% most deprived SIMD areas; and • To reduce harm from tobacco consumption in the lowest 15% SIMD areas in West Dunbartonshire.

[3] *Equally Well: Report of the Ministerial Task Force on Health Inequalities - Volume 2*. Edinburgh: Scottish Government; 2008

6.	**National Outcome(s):**	NO-06 We live longer and healthier lives.
7.	**Please detail the specific contribution of the NHS Board in tackling this critical issue?**	WD CH(C)P leads the over-arching "health" thematic partnership of the WD CPP, as well as the specific multi-agency local tobacco control programme group. The CH(C)P leads local work in relation to the Scottish Government's Equally Well Tobacco Test Site which is focused on Whitecrook (within Clydebank), ensuring its specific focus on tobacco related health inequalities. Through the work of the test site, the CH(C)P has overseen and supported specific programmes relating to: • Lowering availability of tobacco products to those under 18; • Lowering exposure to second hand smoke; • Education and prevention activities on tobacco; and • Delivering an inequalities sensitive smoking cessation service. Lessons learned through this work have been and continue to be disseminated through both Scottish Government and NHSGGC networks. Locally the NHS also provides a full range of smoking cessation service (e.g. community-based groups, pharmacy service, Stop Smoking Pregnancy Service, Hospital Stop Smoking Service and Smokefree Youth Services) that contribute to the delivery of the relevant HEAT target.
8.	**Please illustrate the ways in which the NHS Board is working in collaboration with Community Planning Partners to tackle the critical issue?**	WD CH(C)P leads the over-arching "health" thematic partnership of the WD CPP, as well as the specific multi-agency local tobacco control programme group. In addition to a range of NHSGGC and WD CH(C)P staff, key stakeholders involved include: • Local councillors; • Community organisations; • WDC Education/Trading standards/Environmental Staff; and • Health Scotland and Scottish Government staff.

		Membership of this group is ongoing, reflecting the wide range of tobacco control issues.
9.	**Please explain how the NHS Board is performance managing its contribution to tackling this critical issue?**	As a national test site, issues relating to performance management are being monitored and reported as part of the national programme evaluation. The CPP tobacco control programme was developed through use of the Scottish Government Tobacco logic models, with performance indicators and outcomes reflecting this model and monitored through the local implementation group. Local performance management is managed through the CPP thematic reporting structures, with the health thematic partnership chaired by the WD CH(C)P Head of Strategy, Planning & Health Improvement, the CH(C)P Director, a member of the CPP Executive Group and CPP Strategic Board. The NHS smoking cessation services component of this work is performance managed through the current smoking HEAT mechanisms at both a CH(C)P level and NHSGGC level.
10.	**Please explain how the NHS Board will demonstrate continuous improvement in the course of tackling this critical issue?**	As part of the national evaluation of the Equally Well test sites, lessons learned from this programme will be incorporated into the national evaluation report. Locally learning notes from this programme have been shared and are being developed for distribution at both CH(C)P and NHSGGC level with learning from the test-site already having directly informed initiatives across the NHSGGC area more widely through the mechanism of the DPH-led NHSGGC Tobacco Control Planning and Implementation Group.

NHS
Greater Glasgow and Clyde

Annex 4

Trajectories

2011/12 LDP HEAT DELIVERY TRAJECTORIES

Final Version

This document is to be used by NHS Boards to complete 2011/12 LDP Trajectories.

Colour Coding Key:

	Colour
Performance required to achieve target	
Baseline position	
Requested trajectories from April 2011 to achieve target delivery (Boards to complete)	

NHS Scotland Performance and Business Management Team
Health Delivery Directorate
Scottish Government

LDP Delivery Trajectories

1. Boards are asked to enter the planned levels of performance for each key performance measure.

2. The format of the LDP Trajectory is very similar to the template issued last year. A Methods and Sources reference document, to explain the specification of each of the key measures, has been provided and Boards are invited to refer to this when completing trajectories.

3. There is a single sheet in LDP HEAT Delivery Trajectories for each performance measure, which shows either the baseline or the latest available actual performance. **Boards are requested to complete the 'blank white cells' from April 2011 through to agreed target delivery.** Boards are already engaging with policy leads on trajectories. **It is *essential* that Boards return the completed Annex 3 excel workbook as a stand-alone document and not embedded within 2010/11 NHSScotland LDP Guidance. It is also essential that Boards do not alter the format of the workbook (for example, by adding rows, or changing dates).** Completing the excel workbook to these standards will help minimise the number of avoidable queries. Workbooks not adhering to these standards will be returned to Boards for re-submission.

4. Updates:

   Version 1.1 (21/12/2010)

   Stroke unit trajectory changed to quarterly.
   Baseline data added to A&E table
   Baseline and target data updates in CO2 table

Alcohol brief interventions

Cumulative Total	Ayrshire & Arran	Borders	Dumfries & Galloway	Fife	Forth Valley	Grampian	Greater Glasgow & Clyde	Highland	Lanarkshire	Lothian	Orkney	Shetland	Tayside	Western Isles
Apr-Jun 2011							3,517							
Apr-Sep 2011							7,033							
Apr-Dec 2011							10,550							
2011/12							14,066							

Notes:
1. The exact number of interventions will be agreed through the LDP process. Indicative target numbers will be provided to Boards by the end of the calendar year.

Inequalities Targeted Cardiovascular Health Checks

Cumulative Total	Ayrshire & Arran	Borders	Dumfries & Galloway	Fife	Forth Valley	Grampian	Greater Glasgow & Clyde	Highland	Lanarkshire	Lothian	Orkney	Shetland	Tayside	Western Isles
Apr-Jun 2011							1300							
Apr-Sep 2011							3800							
Apr-Dec 2011							5800							
2011/12							7050							

Notes:
1. Cumulative total number of checks to be agreed as part of the LDP process.
2. As a guidline target numbers will be similar to last year.

Child Healthy Weight Interventions

Cumulative Total	Ayrshire & Arran	Borders	Dumfries & Galloway	Fife	Forth Valley	Grampian	Greater Glasgow & Clyde	Highland	Lanarkshire	Lothian	Orkney	Shetland	Tayside	Western Isles
Apr-Jun 2011							272							
Apr-Sep 2011							353							
Apr-Dec 2011							855							
Apr 11 - Mar 12							1,131							
Apr 11 - Jun 12							1,403							
Apr 11 - Sep 12							1,484							
Apr 11 - Dec 12							1,985							
Apr 11 - Mar 13							2,261							
Apr 11 - Jun 13							2,533							
Apr 11 - Sep 13							2,616							
Apr 11 - Dec 13							3,115							
Apr 11 - Mar 14							3,389							

Notes:
1. The exact number of interventions will be agreed through the LDP process.

Glasgow, West Dun, East Dun, East Ren summer courses 8 areas x 5 completers = 40
Each school quarter = 250 completers
Reporting period between September and December will display double numbers of completers due to classes starting in separate periods but finishing in same reporting period

Smoking cessation (SIMD)

Cumulative Total	Ayrshire & Arran	Borders	Dumfries & Galloway	Fife	Forth Valley	Grampian	Greater Glasgow & Clyde	Highland	Lanarkshire	Lothian	Orkney	Shetland	Tayside	Western Isles
Apr-Jun 2011							810							
Apr-Sep 2011							1,620							
Apr-Dec 2011							2,430							
Apr 11 - Mar 12							4,054							
Apr 11 - Jun 12							4,864							
Apr 11 - Sep 12							5,674							
Apr 11 - Dec 12							6,484							
Apr 11 - Mar 13							8,108							
Apr 11 - Jun 13							8,918							
Apr 11 - Sep 13							9,728							
Apr 11 - Dec 13							10,538							
Apr 11 - Mar 14	3,544	838	1,373	3,550	3,002	4,648	12,182	2,358	5,929	7,011	105	104	3,628	175

Notes:
1. Number of successful quits at one month after the quit in 40% most-deprived areas within each NHS Board (i.e the bottom two local SIMD quintiles).

Child Fluoride Varnish Applications (SIMD)

Period ending	Ayrshire & Arran	Borders	Dumfries & Galloway	Fife	Forth Valley	Grampian	Greater Glasgow & Clyde	Highland	Lanarkshire	Lothian	Orkney	Shetland	Tayside	Western Isles
Jun-11							0.0%							
Sep-11							0.0%							
Dec-11							3.0%							
Mar-12							3.0%							
Jun-12							10.0%							
Sep-12							15.0%							
Dec-12							15.0%							
Mar-13							15.0%							
Jun-13							25.0%							
Sep-13							30.0%							
Dec-13							35.0%							
Mar-14	60%	60%	60%	60%	60%	60%	60%	60%	60%	60%	60%	60%	60%	60%

Notes:
1. Data for period ending June 2010 against the final performance measure will be distributed to boards by the end of 2010.

Financial Performance

Month	Ayrshire & Arran	Borders	Dumfries & Galloway	Fife	Forth Valley	Grampian	Greater Glasgow & Clyde	Highland	Lanarkshire	Lothian	Orkney	Shetland	Tayside	Western Isles	NHS24	NHS Education	NHS Health Scotland	NHS National Services	NHS QIS	National Waiting-Times Centre	Scottish Ambulance Service	State Hospital
Jun-11																						
Jul-11																						
Aug-11																						
Sep-11																						
Oct-11																						
Nov-11																						
Dec-11																						
Jan-12																						
Feb-12																						
Mar-12	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Jun-12																						
Jul-12																						
Aug-12																						
Sep-12																						
Oct-12																						
Nov-12																						
Dec-12																						
Jan-13																						
Feb-13																						
Mar-13	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Jun-13																						
Jul-13																						
Aug-13																						
Sep-13																						
Oct-13																						
Nov-13																						
Dec-13																						
Jan-14																						
Feb-14																						
Mar-14	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Notes:
1. Positive values are underspends.
2. Values are in thousands of pounds

Cash Efficiencies

Monthly Cumulative	Ayrshire & Arran	Borders	Dumfries & Galloway	Fife	Forth Valley	Grampian	Greater Glasgow & Clyde	Highland	Lanarkshire	Lothian	Orkney	Shetland	Tayside	Western Isles	NHS24	NHS Education	NHS Health Scotland	NHS National Services	NHS QIS	National Waiting-Times Centre	Scottish Ambulance Service	State Hospital
Apr-Jun 2011																						
Apr-Jul 2011																						
Apr-Aug 2011																						
Apr-Sep 2011																						
Apr-Oct 2011																						
Apr-Nov 2011																						
Apr-Dec 2011																						
Apr 2011 - Jan 2012																						
Apr 2011 - Feb 2012																						
2011/12																						

Notes:
1. Values are given in thousands of pounds.

Reduce carbon emissions

Year	Ayrshire & Arran	Borders	Dumfries & Galloway	Fife	Forth Valley	Grampian	Greater Glasgow & Clyde	Highland	Lanarkshire	Lothian	Orkney	Shetland	Tayside	Western Isles	NHS24	NHS Education	NHS Health Scotland	NHS National Services	NHS QIS	National Waiting-Times Centre	Scottish Ambulance Service	State Hospital
2009/10	10,373	3,358	6,823	11,608	8,205	23,916	59,506	16,192	13,453	31,286	807	535	22,934	1,977						4,400		2,448
2011/12	9,760	3,159	6,420	10,922	7,720	22,502	55,989	15,235	12,658	29,437	759	504	21,578	1,860						4,140		2,304
2012/13	9,467	3,065	6,228	10,594	7,488	21,827	54,309	14,778	12,278	28,554	737	488	20,931	1,804						4,016		2,234
2013/14	9,183	2,973	6,041	10,276	7,264	21,172	52,680	14,334	11,910	27,697	714	474	20,303	1,750						3,895		2,167
2014/15	8,908	2,883	5,860	9,968	7,046	20,537	51,100	13,904	11,553	26,867	693	460	19,694	1,698						3,778		2,102

1. Values are in tonnes of CO2

Reduce Energy Consumption

Year	Ayrshire & Arran	Borders	Dumfries & Galloway	Fife	Forth Valley	Grampian	Greater Glasgow & Clyde	Highland	Lanarkshire	Lothian	Orkney	Shetland	Tayside	Western Isles	NHS 24	NHS Education	NHS Health Scotland	NHS National Services	NHS QIS	National Waiting-Times Centre	Scottish Ambulance Service	State Hospital
2009/10	282,072	95,061	183,151	304,591	217,323	600,454	1,676,465	309,061	378,095	914,447	15,264	18,013	635,762	36,595						136,943		46,426
2011/12	276,459	93,169	179,506	298,530	212,998	588,505	1,643,103	302,911	370,571	896,249	14,960	17,655	623,111	35,867						134,218		45,503
2012/13	273,695	92,237	177,711	295,544	210,868	582,620	1,626,672	299,881	366,865	887,287	14,811	17,478	616,879	35,509						132,876		45,048
2013/14	270,958	91,315	175,934	292,589	208,760	576,794	1,610,405	296,883	363,196	878,414	14,663	17,303	610,711	35,153						131,547		44,597
2014/15	268,248	90,402	174,175	289,663	206,672	571,026	1,594,301	293,914	359,564	869,630	14,516	17,130	604,604	34,802						130,232		44,151

1. Values are in GJ.
2. The baseline has not been climatically adjusted. Data against this measure will be climatically adjusted to 2009/10.

Suspicion-of-cancer referrals (62 days)

Quarter of Treatment	Ayrshire & Arran	Borders	Dumfries & Galloway	Fife	Forth Valley	Grampian	Greater Glasgow & Clyde	Highland	Lanarkshire	Lothian	Orkney	Shetland	Tayside	Western Isles
Apr-Jun 2011							95.0%							
Jul-Sep 2011							95.0%							
Oct-Dec 2011	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%

All Cancer Treatment (31 days)

Quarter of Treatment	Ayrshire & Arran	Borders	Dumfries & Galloway	Fife	Forth Valley	Grampian	Greater Glasgow & Clyde	Highland	Lanarkshire	Lothian	Orkney	Shetland	Tayside	Western Isles	National Waiting-Times Centre
Apr-Jun 2011							95.0%								
Jul-Sep 2011							95.0%								
Oct-Dec 2011	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%

Notes:
1. Decision-to-treat until treatment for all referral types.

18 weeks Referral To Treatment

Month of Treatment	Ayrshire & Arran	Borders	Dumfries & Galloway	Fife	Forth Valley	Grampian	Greater Glasgow & Clyde	Highland	Lanarkshire	Lothian	Orkney	Shetland	Tayside	Western Isles	National Waiting-Times Centre
Apr-11							80%								
May-11							80%								
Jun-11							81%								
Jul-11							83%								
Aug-11							84%								
Sep-11							86%								
Oct-11							88%								
Nov-11							90%								
Dec-11	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%

Notes:
1. Trajectories will be agreed as part of the LDP process
2. Percentages relate to combined admitted and non-admitted performance

Drug and Alcohol Treatment: Referral to Treatment

Quarter of Treatment	Ayrshire & Arran	Borders	Dumfries & Galloway	Fife	Forth Valley	Grampian	Greater Glasgow & Clyde	Highland	Lanarkshire	Lothian	Orkney	Shetland	Tayside	Western Isles
Oct-Dec 2011														
Jan-Mar 2012														
Apr-Jun 2012														
Jul-Sep 2012														
Oct-Dec 2012														
Jan-Mar 2013	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%

Notes:
1. Performance Management Information available from April 2011
2. Trajectories to be agreed by September 2011.
3. Percentage of clients referred for drug or alcohol combined treatment are to be treated within 3 weeks from date referral received.

Faster access to CAMHS

Month of Treatment	Ayrshire & Arran	Borders	Dumfries & Galloway	Fife	Forth Valley	Grampian	Greater Glasgow & Clyde	Highland	Lanarkshire	Lothian	Orkney	Shetland	Tayside	Western Isles
Sep-11														
Oct-11														
Nov-11														
Dec-11														
Jan-12														
Feb-12														
Mar-12														
Apr-12														
May-12														
Jun-12														
Jul-12														
Aug-12														
Sep-12														
Oct-12														
Nov-12														
Dec-12														
Jan-13														
Feb-13														
Mar-13	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Notes:
1. Performance Management Information available from April 2011
2. Trajectories to be agreed by September 2011.
3. Number of patients who waited over 26 weeks from referral to treatment

Reduction in emergency bed-days for patients aged 75+

We are unable to provide a trajectory until Change Plans are completed and their impact is understood

Year ending	Ayrshire & Arran	Borders	Dumfries & Galloway	Fife	Forth Valley	Grampian	Greater Glasgow & Clyde	Highland	Lanarkshire	Lothian	Orkney	Shetland	Tayside	Western Isles
Mar-09	5339	6608	5205	4306	4503	5831	6273	5454	4598	6036	4890	4053	5080	6882
Mar-10	5091	6100	5259	4011	4046	5023	6244	5422	5066	5716	4711	3892	4927	7033
Apr-11														
May-11														
Jun-11														
Jul-11														
Aug-11														
Sep-11														
Oct-11														
Nov-11														
Dec-11														
Jan-12														
Feb-12														
Mar-12														
Mar-13														
Mar-14														
Mar-15														

Notes:

1. Year ending March 2010 data is provisional.
2. Although the target delivery date is 2011/12, the policy aim this relates to is concerned with a longer time period. Therefore boards are invited to provide
3. The data are the number of emergency bed days in a year per 1000 population.

Stroke unit

Quarter of admission	Ayrshire & Arran	Borders	Dumfries & Galloway	Fife	Forth Valley	Grampian	Greater Glasgow & Clyde	Highland	Lanarkshire	Lothian	Orkney	Shetland	Tayside	Western Isles
2009	75.5%	47.9%	63.1%	65.1%	51.5%	65.3%	63.6%	34.2%	77.5%	54.5%	37.5%	0.0%	45.3%	35.0%
Apr-Jun 2011							65%							
Jul-Sep 2011							70%							
Oct-Dec 2011							75%							
Jan-Mar 2012	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%
Apr-Jun 2012							83%							
Jul-Sep 2012							86%							
Oct-Dec 2012							88%							
Jan-Mar 2013	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%

Notes:
1. Percentage of stroke patients admitted to stroke unit on day of or day following, admission to hospital.
2. Patients are assigned to the board of original hospital admission.
3. Monthly management information is available to NHS Boards.
4. All hospitals admitting acute stroke patients are included in the target.
5. 2009 data is taken from the Scottish Stroke Care Audit website

MRSA/MSSA bacterium

Year ending	Ayrshire & Arran	Borders	Dumfries & Galloway	Fife	Forth Valley	Grampian	Greater Glasgow & Clyde	Highland	Lanarkshire	Lothian	Orkney	Shetland	Tayside	Western Isles	National Waiting-Times Centre
Mar-10	0.38	0.28	0.38	0.56	0.50	0.33	0.37	0.26	0.34	0.44	0.06	0.40	0.37	0.19	0.55
Jun-11							0.35								
Sep-11							0.33								
Dec-11							0.31								
Mar-12							0.30								
Jun-12							0.29								
Sep-12							0.28								
Dec-12							0.27								
Mar-13							0.26								

Notes:

1. Boards are expected to achieve a rate of 0.26 cases per 1000 acute occupied bed days or lower by year ending March 2013. Boards currently with a rate of less than 0.26 are expected to at least maintain this, as reflected in their trajectories.

2. Boards will be held to account against the 0.26 rate.

3. The rate of 0.26 cases or less per 1000 acute occupied bed days is based on the best performing board as measured in year ending March 2010. Should it be demonstrated that a lower rate is sustainable then the target may be revised.

4. It is acknowledged that there are particular issues with island board targets given that very small changes in case numbers will have a disproportionate impact on rates. This will be taken into account when assessing whether these boards have effectively delivered their target; but the expectation of zero tolerance of preventable infections will continue to apply.

Clostridium difficile infections

Year ending	Ayrshire & Arran	Borders	Dumfries & Galloway	Fife	Forth Valley	Grampian	Greater Glasgow & Clyde	Highland	Lanarkshire	Lothian	Orkney	Shetland	Tayside	Western Isles	National Waiting-Times Centre
Mar-10	1.03	0.39	1.03	0.39	0.33	0.99	0.39	0.49	0.58	0.66	0.79	0.00	0.86	0.40	
Jun-11							0.39								
Sep-11							0.39								
Dec-11							0.39								
Mar-12							0.39								
Jun-12							0.39								
Sep-12							0.39								
Dec-12							0.39								
Mar-13							0.39								

Notes:

1. Boards are expected to achieve a rate of 0.39 cases per 1000 acute occupied bed days or lower by year ending March 2013. Boards currently with a rate of less than 0.39 are expected to at least maintain this, as reflected in their trajectories.

2. Boards will be held to account against the 0.39 rate.

3. The rate of 0.39 cases or less per 1000 acute occupied bed days is based on the best performing board as measured in year ending March 2010. Should it be demonstrated that a lower rate is sustainable then the target may be revised.

4. It is acknowledged that there are particular issues with island board targets given that very small changes in case numbers will have a disproportionate impact on rates. This will be taken into account when assessing whether these boards have effectively delivered their target; but the expectation of zero tolerance of preventable infections will continue to apply.

Rate of attendance at Accident and Emergency

Note - projections exclude attendances at MIUs and GP Direct Referrals

Year ending	Ayrshire & Arran	Borders	Dumfries & Galloway	Fife	Forth Valley	Grampian	Greater Glasgow & Clyde[2]	Highland	Lanarkshire	Lothian	Orkney	Shetland	Tayside	Western Isles
Mar-10	2,471	1,647	2,703	1,856	1,529	1,550	3,034	1,369	2,855	1,950		3,216	1,522	2,186
Jun-11							3,023							
Sep-11							3,012							
Dec-11							3,001							
Mar-12							2,990							
Jun-12							2,985							
Sep-12							2,974							
Dec-12							2,961							
Mar-13							2,949							
Jun-13							2,937							
Sep-13							2,925							
Dec-13							2,920							
Mar-14							2,888							

Notes:

1. Figures are rates per 100,000 population per month based on attendances at A&E as reported by ISD from EDIS and GRO 2009 mid-year population estimates
2. The baseline value for Greater Glasgow and Clyde is under development.

NHS
Greater Glasgow and Clyde

Annex 5

Financial Plans

NHS Greater Glasgow and Clyde

EFFICIENCY SAVINGS

Line no	Saving Scheme Details	2011-12 Rec £000s	2011-12 Non-Rec £000s	2011-12 Total £000s	Risk rating 2011-12 High %	Med %	Low %	2012-13 Rec £000s	2012-13 Non-Rec £000s	2012-13 Total £000s	Risk rating 2012-13 High %	Med %	Low %	2013-14 Rec £000s	2013-14 Non-Rec £000s	2013-14 Total £000s	Risk rating 2013-14 High %	Med %	Low %	2014-15 Rec £000s	2014-15 Non-Rec £000s	2014-15 Total £000s	Risk rating 2014-15 High %	Med %	Low %	2015-16 Rec £000s	2015-16 Non-Rec £000s	2015-16 Total £000s	Risk rating 2015-16 High %	Med %	Low %
3.01	**Prior Years' Recurring Savings Carry-forward**							56,900		**56,900**				114,400		**114,400**				172,500		**172,500**				231,100		**231,100**			
	Efficiency & Productivity Workstreams:																														
3.02	Clinical Productivity	6,600		**6,600**						**0**						**0**						**0**						**0**			
3.03	Workforce	15,200		**15,200**						**0**						**0**						**0**						**0**			
3.04	Drugs and Prescribing	9,000		**9,000**						**0**						**0**						**0**						**0**			
3.05	Procurement	2,500		**2,500**						**0**						**0**						**0**						**0**			
3.06	Support Services	2,650		**2,650**						**0**						**0**						**0**						**0**			
3.07	Estates and Facilities	3,350		**3,350**						**0**						**0**						**0**						**0**			
3.08	Unidentified Savings	17,600	1,700	**19,300**				57,500		**57,500**				58,100		**58,100**				58,600		**58,600**				59,200		**59,200**			
3.09	**Total In-Year Savings**	56,900	1,700	**58,600**	**0**	**0**	**0**	57,500	0	**57,500**	**0**	**0**	**0**	58,100	0	**58,100**	**0**	**0**	**0**	58,600	0	**58,600**	**0**	**0**	**0**	59,200	0	**59,200**	**0**	**0**	**0**
3.10	***Total Cumulative Savings***	*56,900*						*114,400*						*172,500*						231,100						290,300					

NHS Greater Glasgow and Clyde

REVENUE OUTTURN STATEMENT

Line no	2010-11 Total £000s		2011-12 Rec £000s	2011-12 Non-Rec £000s	2011-12 TOTAL	2012-13 Rec £000s	2012-13 Non-Rec £000s	2012-13 TOTAL	2013-14 Rec £000s	2013-14 Non-Rec £000s	2013-14 TOTAL	2014-15 Rec £000s	2014-15 Non-Rec £000s	2014-15 TOTAL	2015-16 Rec £000s	2015-16 Non-Rec £000s	2015-16 TOTAL
1.01	1,366,243	Clinical Service - Pay	1,372,600	0	**1,372,600**	1,379,200	0	**1,379,200**	1,380,700	0	**1,380,700**	1,384,000	0	**1,384,000**	1,387,100	0	**1,387,100**
1.02	1,410,466	Clinical Service - Non Pay	1,416,000	0	**1,416,000**	1,431,500	0	**1,431,500**	1,452,200	0	**1,452,200**	1,471,300	0	**1,471,300**	1,490,700	0	**1,490,700**
1.03	41,100	Non-Clinical Service - Pay	41,100		**41,100**	41,600		**41,600**	42,000		**42,000**	42,500		**42,500**	42,900		**42,900**
1.04	14,500	Non-Clinical Service - Non Pay	14,500		**14,500**	14,600		**14,600**	14,800		**14,800**	14,900		**14,900**	15,100		**15,100**
1.05	*2,832,309*	*Total Gross Expenditure*	*2,844,200*	*0*	*2,844,200*	*2,866,900*	*0*	*2,866,900*	*2,889,700*	*0*	*2,889,700*	*2,912,700*	*0*	*2,912,700*	*2,935,800*	*0*	*2,935,800*
1.06	510,063	Less Operating Income	518,700		**518,700**	522,400		**522,400**	526,100		**526,100**	529,800		**529,800**	533,400		**533,400**
1.07	*2,322,246*	*Core RRL Expenditure*	*2,325,500*	*0*	***2,325,500***	*2,344,500*	*0*	***2,344,500***	*2,363,600*	*0*	***2,363,600***	*2,382,900*	*0*	***2,382,900***	*2,402,400*	*0*	***2,402,400***
1.08	*1,056*	Capital Grants			**0**			**0**			**0**			**0**			**0**
1.09	154,500	Net FHS Non-discretionary costs	*154,500*		**154,500**	*154,500*		**154,500**	*154,500*		**154,500**	*154,500*		**154,500**	*154,500*		**154,500**
1.10	*70,337*	Other Non-cash Expenditure	*70,300*		**70,300**	*70,300*		**70,300**	*80,300*		**80,300**	*80,300*		**80,300**	*112,300*		**112,300**
		Non-Core:															
1.11	*36,810*	Annually Managed Impairments			**0**			**0**			**0**			**0**			**0**
1.12	*9,450*	Annually Managed Provisions			**0**			**0**			**0**			**0**			**0**
1.13			*0*	*0*	***0***	*0*	*0*	***0***	*0*	*0*	***0***	*0*	*0*	***0***	*0*	*0*	***0***
1.14	*31,066*	IFRS PFI Expenditure	31,100		**31,100**	31,100		**31,100**	31,100		**31,100**	31,100		**31,100**	31,100		**31,100**
1.15	*303,219*	*Costs not charged to RRL*	*255,900*	*0*	***255,900***	*255,900*	*0*	***255,900***	*265,900*	*0*	***265,900***	*265,900*	*0*	***265,900***	*297,900*	*0*	***297,900***
1.16	2,019,027	Revenue Resource Outturn	2,069,600	0	**2,069,600**	2,088,600	0	**2,088,600**	2,097,700	0	**2,097,700**	2,117,000	0	**2,117,000**	2,104,500	0	**2,104,500**
1.17	2,019,027	Revenue Resource Limit (RRL)	2,069,600	0	**2,069,600**	2,088,600	0	**2,088,600**	2,097,700	0	**2,097,700**	2,117,000	0	**2,117,000**	2,104,500	0	**2,104,500**
1.18	0	**Saving/(Excess) against RRL**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

main contact name: Andrew Daly
email address: andrew.daly@ggc.scot.nhs.uk
contact telephone number: 0141 201 4701

version number: 1
date of submission: ######### dd/mm/yyyy
time: 11:00 hh:mm Please use 24 hour clock

NHS Greater Glasgow and Clyde

RECURRING AND NON-RECURRING REVENUE PROJECTION

Line no	Revenue Resource Limit (RRL)	2011-12 Rec £000s	2011-12 Non-Rec £000s	2011-12 TOTAL	2012-13 Rec £000s	2012-13 Non-Rec £000s	2012-13 TOTAL	2013-14 Rec £000s	2013-14 Non-Rec £000s	2013-14 TOTAL	2014-15 Rec £000s	2014-15 Non-Rec £000s	2014-15 TOTAL	2015-16 Rec £000s	2015-16 Non-Rec £000s	2015-16 TOTAL
2.01	Initial / Base Allocation	1,895,600		**1,895,600**	1,914,600		**1,914,600**	1,933,700		**1,933,700**	1,953,000		**1,953,000**	1,972,500		**1,972,500**
2.02	*Anticipated Allocations (list below):*															
2.03	Assumed parity uplift to funding			**0**			**0**			**0**			**0**			**0**
2.04	Carry forward			**0**			**0**			**0**			**0**			**0**
2.05	Transfer of Other Non-cash Expenditure	(70,300)	0	**(70,300)**	(70,300)	0	**(70,300)**	(80,300)	0	**(80,300)**	(80,300)	0	**(80,300)**	########	0	########
2.06	National programmes funding deduction			**0**			**0**			**0**			**0**			**0**
2.07	Revenue Transferred to Capital *(negative)*			**0**			**0**			**0**			**0**			**0**
2.08	**Further Allocations***	244,300	0	**244,300**	244,300	0	**244,300**	244,300	0	**244,300**	244,300	0	**244,300**	244,300	0	**244,300**
2.09	**Anticipated Allocations**	174,000	0	174,000	174,000	0	174,000	164,000	0	164,000	164,000	0	164,000	132,000	0	132,000
2.10	**TOTAL Revenue Resource Limit (RRL)**	**2,069,600**	**0**	**2,069,600**	**2,088,600**	**0**	**2,088,600**	**2,097,700**	**0**	**2,097,700**	**2,117,000**	**0**	**2,117,000**	**2,104,500**	**0**	**2,104,500**

*Please list anticipated allocations on the "Form 6 - Allocations" sheet. (Totals should feed through automatically)

NHS Greater Glasgow and Clyde

INFRASTRUCTURE INVESTMENT PROGRAMME

Line No	2010-11 £000s	Capital Expenditure	2011-12 £000s	2012-13 £000s	2013-14 £000s	2014-15 £000s	2015-16 £000s
4.01		**a) Property (list below)**					
4.02	9,046	Rolling Programmes	15,420	15,000	15,000	15,000	15,000
4.03	60,975	New South Glasgow Hospitals	152,250	280,213	234,607	94,204	3,824
4.04	1,016	Obstetrics Strategy	1,928				
4.05	150	GRI Tower	17,322	70			
4.06	7,981	Renfrew & Barrhead HCs	1,793				
4.07	300	Alexandria HC	9,500	7,510			
4.08	950	Possilpark HC	7,842	1,606			
4.09	4,381	Primary Care Modernisation Schemes	9,165				
4.10	12,584	ASR Enabling Schemes	600	1,500	14,000	21,100	11,100
4.11	26,548	ASR Redesign Schemes	3,900				
4.12	1,945	Mental Health Schemes	14,390	3,500	1,000		
4.13	(2,842)	Anticipated Slippage	(51,156)	44,651	(1,474)	(3,874)	
4.14							
4.15							
4.16							
4.17							
4.18							
4.19							
4.20							
4.21							
4.22	15,365	Other	34,232	24,559	7,457	5,457	4,457
4.23	138,399	*Total Property Expenditure*	217,186	378,609	270,590	131,887	34,381
4.24		**b) Equipment (list below)**					
4.25	7,011	Rolling Programmes	8,836	7,874	7,874	7,874	7,874
4.26	347	ACH Equipment and Post Opening Reqts	70				
4.27	401	NSD Related Equipment					
4.28		PET Scanner	2,100				
4.29		Radiotherapy Equipment Replacement	3,608				
4.30							
4.31							
4.32							
4.33							
4.34							
4.35							
4.36							
4.37							
4.38							
4.39		Other					
4.40	7,759	*Total Equipment Expenditure*	14,614	7,874	7,874	7,874	7,874
4.41		c) IM&T (list below)					
4.42	1,810	Rolling Programmes	2,000	2,000	2,000	2,000	2,000
4.43	2,415	IT PMS	1,330				
4.44	2,000	IT Scanning	1,500				
4.45	1,830	IT GP Replacement System	2,170				
4.46	1,000	IT Hosting & Virtualisation					
4.47	1,488	Harmonisation and Desk Top Services					
4.48	1,185	ICT WoS Infrastructure	200				
4.49	108	ICT WoS Infrastructure (Ph 2)					
4.50	102	Prison Healthcare Transfer (GPASS Rep System)					
4.51							
4.52							
4.53							
4.54		Other					
4.55	11,938	*Total Property Expenditure*	7,200	2,000	2,000	2,000	2,000
4.56		d) Intangible Assets					
4.57	400	Carbon Emissions	400	400	400	400	400
4.58							
4.59							
4.60							
4.61							
4.62							
4.63							
4.64							
4.65		Other					
4.66	400	*Total Intangible Asset Expenditure*	400	400	400	400	400
4.67	158,496	**Total Capital Expenditure**	**239,400**	**388,883**	**280,864**	**142,161**	**44,655**
		Capital Resource Limit (CRL)					
4.68	83,887	SGHD Formula Allocation	27,000	27,000	27,000	27,000	27,000
4.69	73,813	Project Specific Funding	199,392	339,675	253,864	115,161	19,781
4.70		Radiotherapy Funding	3,608				
4.71		PCCMP Funding					
4.72	1,852	Other Centrally Provided Capital Funding	9,000	22,208			
4.73	(1,056)	Capital Grant Funding	0	0	0	0	0
4.74		Revenue to Capital Transfers	0	0	0	0	0
4.75	*158,496*	**Total Capital Resource Limit**	**239,000**	**388,883**	**280,864**	**142,161**	**46,781**
4.76	0	**Saving/(Excess) against CRL**	**(400)**	**0**	**0**	**0**	**2,126**
4.77		**Donated Assets**					
		Asset Additions					
4.78		Stobhill Hospital Extension - 60 Bed Unit	15,800				
4.79							
4.80							
4.81							
4.82							
4.83							
4.84							
4.85	*0*	**Total Asset Additions**	**15,800**	**0**	**0**	**0**	**0**
4.86	(378)	**Capital Income**	(400)				

External Funding Commitments

	2010-11 £000s	Payments	2011-12 £000s	2012-13 £000s	2013-14 £000s	2014-15 £000s	2015-16 £000s
4.87	28,496	Existing PPP Unitary Charges	28,927	28,298	28,775	29,260	29,651
4.88	0	Proposed PPP Unitary Charges	1,962	1,988	2,015	2,043	2,071
4.89	138	Finance Leases	138	138	138	138	138
4.90	10,183	Operating Leases	10,183	10,183	10,183	10,183	10,183
4.91	38,817	*Total*	41,210	40,607	41,111	41,624	42,043

Memorandum

	2010-11 £000s	Capital Grants	2011-12 £000s	2012-13 £000s	2013-14 £000s	2014-15 £000s	2015-16 £000s
4.92	965	GDP Dental Decontamination					
4.93	91	Bariatric Equipment/ Other					
4.94							
4.95							
4.96							
4.97							
4.98							
4.99							
5.00							
5.01							
5.02	1,056	*Total*	0	0	0	0	0

NHS Greater Glasgow and Clyde

FINANCIAL PLANNING ASSUMPTIONS

Line no	2010-11	Assumptions - uplift (%)	2011-12	2012-13	2013-14	2014-15	2015-16
5.01	2.15%	Resources	2.70%	1.00%	1.00%	1.00%	1.00%
5.02	2.50%	Pay	1.20%	1.00%	1.00%	1.00%	1.00%
5.03	1.00%	Prices	1.00%	1.00%	1.00%	1.00%	1.00%
5.04	6.00%	GP prescribing	6.00%	6.00%	6.00%	6.00%	6.00%
5.05	6.00%	Hospital Drugs	8.00%	8.00%	8.00%	8.00%	8.00%
5.06	0.00%	Other FHS uplift	0.00%	0.00%	0.00%	0.00%	0.00%

RISK ASSESSMENT

Key Assumptions/Risks	Risk rating	Impact/ £
	Select from Drop-down list: H / M / L	

Extra rows can be inserted in this sheet if needed.

NHS Greater Glasgow and Clyde

RECURRING AND NON-RECURRING REVENUE PROJECTION

	Directorate	SG Contact Name	2011-12 Rec £000s	2011-12 Non-Rec £000s	2011-12 TOTAL	2012-13 Rec £000s	2012-13 Non-Rec £000s	2012-13 TOTAL	2013-14 Rec £000s	2013-14 Non-Rec £000s	2013-14 TOTAL	2014-15 Rec £000s	2014-15 Non-Rec £000s	2014-15 TOTAL	2015-16 Rec £000s	2015-16 Non-Rec £000s	2015-16 TOTAL
Anticipated Allocations (list below)	**Please select from drop-down**																
Gender Based Violence Delivery Plan	Chief Nursing Officer				0	0		0	0		0	0		0	0		0
HAI - National MRSA screening programme	Chief Nursing Officer				0	0		0	0		0	0		0	0		0
HAI Funding	Chief Nursing Officer	Christine Brocklehu	246		246	246		246	246		246	246		246	246		246
Healthcare Support Workers CEL23(2010)	Chief Nursing Officer				0	0		0	0		0	0		0	0		0
HNC Continuing Students	Chief Nursing Officer				0	0		0	0		0	0		0	0		0
HNC Nursing students	Chief Nursing Officer				0	0		0	0		0	0		0	0		0
One Year Job Guarantee	Chief Nursing Officer	Christine Brocklehu	66		66	66		66	66		66	66		66	66		66
Open University payments	Chief Nursing Officer				0	0		0	0		0	0		0	0		0
Rehabilitation Co-ordinator appointments	Chief Nursing Officer	Christine Brocklehu	55		55	55		55	55		55	55		55	55		55
Alcohol funding	CMO, Public Health & Sport	Alison Douglas	9,059		9,059	9,059		9,059	9,059		9,059	9,059		9,059	9,059		9,059
BBV Prevention	CMO, Public Health & Sport	Felicity Naughton	2,268		2,268	2,268		2,268	2,268		2,268	2,268		2,268	2,268		2,268
Child Healthy Weight Intervention Programmes	CMO, Public Health & Sport	Gill Scott	400		400	400		400	400		400	400		400	400		400
Drug Treatment funding	CMO, Public Health & Sport	Sarah Forster	9,559		9,559	9,559		9,559	9,559		9,559	9,559		9,559	9,559		9,559
Equally Well test sites	CMO, Public Health & Sport				0	0		0	0		0	0		0	0		0
Funding to support Alcohol and Drug Partnerships	CMO, Public Health & Sport	Sarah Dillon	744		744	744		744	744		744	744		744	744		744
HAI - Funding for Additional Cleaners	Chief Nursing Officer	Christine Brocklehu	1,265		1,265	1,265		1,265	1,265		1,265	1,265		1,265	1,265		1,265
Hepatitis C Action Plan	CMO, Public Health & Sport	Robin Bate	5,238		5,238	5,238		5,238	5,238		5,238	5,238		5,238	5,238		5,238
Implementation of smoking prevention action plan	CMO, Public Health & Sport	John Glen	344		344	344		344	344		344	344		344	344		344
Keep Well / Well North	CMO, Public Health & Sport	Tim Warren	3,057		3,057	3,057		3,057	3,057		3,057	3,057		3,057	3,057		3,057
Research Support and UKCRC Budget	CMO, Public Health & Sport	Malcolm Pringle	16,011		16,011	16,011		16,011	16,011		16,011	16,011		16,011	16,011		16,011
Sexual Health Funding	CMO, Public Health & Sport	Felicity Naughton	1,127		1,127	1,127		1,127	1,127		1,127	1,127		1,127	1,127		1,127
Smoking Cessation activity	CMO, Public Health & Sport	Mark O'Donnell	2,569		2,569	2,569		2,569	2,569		2,569	2,569		2,569	2,569		2,569
CYP specialist services National Delivery Plan (NDP	Health & Healthcare Improvement	Lucy Colquhoun	3,307		3,307	3,307		3,307	3,307		3,307	3,307		3,307	3,307		3,307
Diabetes	Health & Healthcare Improvement				0	0		0	0		0	0		0	0		0
Genetic Services Review	Health & Healthcare Improvement	Callum Percy	1,222		1,222	1,222		1,222	1,222		1,222	1,222		1,222	1,222		1,222
Health care capacity in schools	Health & Healthcare Improvement				0	0		0	0		0	0		0	0		0
Maternal and Infant Nutrition (CEL 36)	Health & Healthcare Improvement				0	0		0	0		0	0		0	0		0
Wheelchair and Seating Services (WSS) Modernisation	Health & Healthcare Improvement	Janet Garcia	2,098		2,098	2,098		2,098	2,098		2,098	2,098		2,098	2,098		2,098
CAMHS Psychology Workforce Development	Health & Social Care Integration				0	0		0	0		0	0		0	0		0
Childsmile	Health & Social Care Integration	Elizabeth Mclean	2,343		2,343	2,343		2,343	2,343		2,343	2,343		2,343	2,343		2,343
Clinical academic staff	Health & Social Care Integration				0	0		0	0		0	0		0	0		0
Dental clinical and special waste	Health & Social Care Integration	Lynne Morrison	180		180	180		180	180		180	180		180	180		180
Emergency Dental Services (EDS)	Health & Social Care Integration	Neil Fergus	150		150	150		150	150		150	150		150	150		150
Integrated Resource Framework (IRF	Health & Social Care Integration				0	0		0	0		0	0		0	0		0
Learning Disability Health Inequalities Change Programm	Health & Social Care Integration	Peter Kelly	37		37	37		37	37		37	37		37	37		37
Mental health delivery and partnershi	Health & Social Care Integration	Ewen Cameron	948		948	948		948	948		948	948		948	948		948
NHS Carer Information Strategies	Health & Social Care Integration				0	0		0	0		0	0		0	0		0
Primary Medical Services	Health & Social Care Integration	Gary MacDonald	155,368		155,368	155,368		155,368	155,368		155,368	155,368		155,368	155,368		155,368
Priority Group Funding	Health & Social Care Integration	Elizabeth Mclean	120		120	120		120	120		120	120		120	120		120
Scottish Dental Access Initiative (SDAI	Health & Social Care Integration				0	0		0	0		0	0		0	0		0
Scottish Enhanced Services Programme (SESP)	Health & Social Care Integration	Peter Allan	3,455		3,455	3,455		3,455	3,455		3,455	3,455		3,455	3,455		3,455
Specialist CAMHS	Health & Social Care Integration	Tom Hogg	501		501	501		501	501		501	501		501	501		501
Stracathro regional treatment centre	Health & Social Care Integration				0	0		0	0		0	0		0	0		0
WISH pilot	Health & Social Care Integration				0	0		0	0		0	0		0	0		0
Distant Islands Allowance	Health Finance & Information				0	0		0	0		0	0		0	0		0
eHealth support	Health Finance & Information				0	0		0	0		0	0		0	0		0
Highland and Islands Travel Scheme	Health Finance & Information				0	0		0	0		0	0		0	0		0
Island Boards - Partnership Working	Health Finance & Information				0	0		0	0		0	0		0	0		0
18 Weeks allocations	Health Workforce & Performance	Andrew Dewar	1,819		1,819	1,819		1,819	1,819		1,819	1,819		1,819	1,819		1,819
Distinction Awards for NHS Consultants	Health Workforce & Performance	Sandra Neill	9,060		9,060	9,060		9,060	9,060		9,060	9,060		9,060	9,060		9,060
LTCC NHS Boards	Health Workforce & Performance	Fraser McJannett	419		419	419		419	419		419	419		419	419		419
Waiting Times - AST allocation	Health Workforce & Performance	Pauline Hunter	20,744		20,744	20,744		20,744	20,744		20,744	20,744		20,744	20,744		20,744
					0			0			0			0			0
Please list further items and their associated Directorate not included in the list abov					0			0			0			0			0
	Please select from drop-down				0			0			0			0			0
Community Pharmacy Practitioner Champions	Primary & Community Care	Elaine Muirhead	73		73	73		73	73		73	73		73	73		73
Community Pharmacy Palliative Care Model Schemes	Primary & Community Care	Elaine Muirhead	97		97	97		97	97		97	97		97	97		97
HEAT T10 Action Plan Resources	Unknown	Graeme Aitken	190		190	190		190	190		190	190		190	190		190
QMAS	Finance	Alan Morrison	(151)		(151)	(151)		(151)	(151)		(151)	(151)		(151)	(151)		(151)
HFS Subscriptions	Finance	Alan Morrison	(103)		(103)	(103)		(103)	(103)		(103)	(103)		(103)	(103)		(103)
PMSPS	Finance	Alan Morrison	(176)		(176)	(176)		(176)	(176)		(176)	(176)		(176)	(176)		(176)
Prisms	Finance	Alan Morrison	(283)		(283)	(283)		(283)	(283)		(283)	(283)		(283)	(283)		(283)
Recombinant Factor VIIa, VIII & IX Riskshare	Finance	Alan Morrison	(6,718)		(6,718)	(6,718)		(6,718)	(6,718)		(6,718)	(6,718)		(6,718)	(6,718)		(6,718)
Orphan Drugs Riskshare	Finance	Alan Morrison	(377)		(377)	(377)		(377)	(377)		(377)	(377)		(377)	(377)		(377)
Golden Jubilee - Hospital Activity 90% Marginal Cost	Finance	Robert Peterson	(1,766)		(1,766)	(1,766)		(1,766)	(1,766)		(1,766)	(1,766)		(1,766)	(1,766)		(1,766)
Community Pharmacy Pre-Registration Training	Primary & Community Care	Elaine Muirhead	(652)		(652)	(652)		(652)	(652)		(652)	(652)		(652)	(652)		(652)
Experimental Cancer Medicine Centre	Unknown	Alan McNair	139		139	139		139	139		139	139		139	139		139
Equipping & Technical Phase 1	Finance	Alan Morrison	(230)		(230)	(230)		(230)	(230)		(230)	(230)		(230)	(230)		(230)
Community Pharmacy Walk-In Service pilots	Primary & Community Care	Allison Strath	30		30	30		30	30		30	30		30	30		30
PET Scanning Costs	Finance	Alan Morrison	2,271		2,271	2,271		2,271	2,271		2,271	2,271		2,271	2,271		2,271
PET Scanning Adjustment	Finance	Alan Morrison	(971)		(971)	(971)		(971)	(971)		(971)	(971)		(971)	(971)		(971)
Cytogenetics	Finance	Alan Morrison	(1,177)		(1,177)	(1,177)		(1,177)	(1,177)		(1,177)	(1,177)		(1,177)	(1,177)		(1,177)
Childsmile - Lorna Macpherson EPA	Primary & Community Care	Elizabeth Mclean	12		12	12		12	12		12	12		12	12		12
Neurological MCN Pump Priming	Unknown	Craig Bell	45		45	45		45	45		45	45		45	45		45
NSD - Islet Cell Transplantation	Finance	Alan Morrison	(208)		(208)	(208)		(208)	(208)		(208)	(208)		(208)	(208)		(208)
Balance due for the 09/10 DESs	Primary & Community Care	Gary MacDonald	(5)		(5)	(5)		(5)	(5)		(5)	(5)		(5)	(5)		(5)
NHS Superannuation Scheme - Inc in Employers' 09/10	Finance	Lin Ferguson	94		94	94		94	94		94	94		94	94		94
Mental Health Collaborative	Unknown	Ruth Glassborow	370		370	370		370	370		370	370		370	370		370
					0			0			0			0			0
Other Funding	Unknown			0	0			0			0			0			0
Rounding	Unknown		17		17	17		17	17		17	17		17	17		17
					0			0			0			0			0
					0			0			0			0			0
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					0			0			0			0			0
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					0			0			0			0			0
Total Additional Allocations			244,300	0	244,300	244,300	0	244,300	244,300	0	244,300	244,300	0	244,300	244,300	0	244,300

NHS
Greater Glasgow and Clyde

Annex 6

Summary of Workforce Issues Facing NHS Boards

Summary of Main Workforce Issues Facing NHS Boards 2011/12

Skill Mix Changes

Nursing & Midwifery

As part of our 2010/11 Workforce Plan NHSGGC is reviewing the Skill Mix in Nursing and Midwifery. The aim is to ensure that the professionally qualified workforce at Levels 5 and 6 and above are fully supported by well trained support workers and freed to focus on the clinical work for which their experience and qualifications have prepared them.

The first phase of the skill mix changes are being piloted this year with the establishment of ten demonstration sites across the Acute Division. The aim of these sites is to test the new skill mix changes with the introduction of trained support workers and assistant practitioners at levels 3 and 4 of the NHS career framework.

Advanced Practitioner roles in Nursing and Midwifery have also increased significantly in the last five years with an 8% rise in these roles over the last three years. It is anticipated that advanced practice roles will continue to increase across 2011/12.

Medical & Dental

Reshaping the Medical Workforce CEL28 (2009) required all NHS Scotland Boards to make workforce planning assumptions of reductions of 40% in the middle grade medical workforce and of 25% in junior grade medical staff (although it was recognised that final number would vary depending on specialty, and Board).

Over the next 5 years NHSGGC anticipates that the middle grade medical workforce will reduce by 37% and that junior doctors numbers will fall by approximately 29%. These reductions will be offset by increases in Consultant (6.5%) and Speciality Doctors (63%) numbers as the Board moves towards the trained doctor service model outlined in CEL28.

During 2010/11 NHSGGC expect that the changes in the special workforce will be relatively small with an overall reduction of 13 WTE across the workforce. The bulk of the changes to the medical workforce will take place over the next 3 to 5 years.

Allied Health Profession

In line with our vision of “a professionally-qualified workforce adequately supported at appropriate levels” NHSGGC are looking at the potential to redesign the current Allied Health Professions workforce to replace some posts on Levels 5/6 of the NHS Career Framework with new “support workforce” posts on Levels 3 and 4.

Administrative & Clerical

It is anticipated that across NHSGGC resource savings based on service redesign and improved levels of productivity will secure efficiencies of 5% across the Administrative and Clerical Workforce as a whole. The projected leaver’s rate of 7.47% for the Administrative and Clerical Job Family suggests that this level of change is achievable providing an appropriate system of vacancy management is in place. Over the next few years it is likely that improvements in Information Technology, particularly in relation to voice recognition and electronic data transfer will present significant opportunities to secure efficiencies. Initial scoping work within Health Information & Technology commenced during 2010/11.

Senior Managers

In line with the Scottish Government's target of reducing Senior Management posts NHSGGC will continue to review organisational management structure with a view to further reducing number of senior management post beyond the 35 wte reduction secured during 2010.

Changes to Services

NHSGGC's Acute Services Review will resulted in many significant changes to the current configuration of the Acute Services Division, including

- The closure of Stobhill Hospital and a review of services in North Glasgow by February 2011.
- A new centralised laboratory building on site of existing Southern General Hospital.
- Changes to inpatient rehabilitation services in East Glasgow.

The redesign of services for the north-east of Glasgow with the transfer of inpatient services from Stobhill to Glasgow Royal Infirmary has been progressing with the capital programme well underway. This project, like the new hospitals project for South Glasgow, will be a key project to be progressed during 2010 / 2011. The centralisation of Vascular and Renal Services on two sites are expected to be completed during 2011.

In August 2010 NHSGGC agreed to establish a single NHS CHP for Glasgow City with a three sector structure to replace the existing 5 Community Health and Care partnership Model. An important objective in addition to establishing effective management arrangements is to ensure that management costs are reduced wherever possible. The new senior management structure should reduce costs by around £500K on current expenditure.

In addition to the staff in management posts affected by the transition to a CHP there will be a number of other staff affected by the changes. These include staff in functions which are replicated in all five CHCPs and will be reduced to match the single CHP or three sector structure; examples include human resources, organisational development and community engagement. There are also a number of specialist teams organised on a five sector basis and the team leaders for these services are likely to be affected by the restructure.

NHSGGC anticipate that further changes to the structure to reflect a shift from three to five areas will generate additional cost reductions e.g. a review of AHP services and of the organisation of Elderly Mental Illness beds will yield a further savings, the order of which are still being assessed.

The major workforce challenges in achieving the service changes set out in the Workforce Plan include

- Developing response which are sustainable following the impact of Reshaping the Medical Workforce and the European Union Working Time Directives.
- Redeployment and capacity development of the workforce to deliver changed roles in the context of the overall reduction in staffing levels and the shifting the balance of care from inpatient to community services.
- Delivery of financial savings while :
- Maintaining care and the capacity of community services to sustain lower levels of inpatient bed use
- Ensuring that the balance of care shifts across the Primary/Secondary Care boundary

How is Workforce Contributing to Efficiency Savings

NHSGGC currently has an operating budget of £2.79 billion. Approximately 50% of the budget (£1.4 billion) is the salary cost of the workforce. The cost savings plan for NHSGGC has identified a need for savings of £56.9 million during financial year 2010/11. It is too early to predict with certainty the likely savings which will be required in future years.

At present efficiency savings are being secured through a number of routes however it is clear that from the information known about current and future cost saving requirements that NHSGGC will require to deliver services in an increasingly constrained financial environment. Given that 50% of current budget costs are salary related securing productivity improvement efficiencies from the redesign of services will be the main component of the NHSGGC approach.