EMBARGOED UNTIL MEETING

Greater Glasgow NHS Board

Board Meeting

Tuesday 20th April 2004 **Board Paper No. 2004/22**

Director of Planning and Community Care
Director of Finance

Local Health Plan and Financial Strategy

Recommendations:

The Board is asked to:

- **Approve this update to the 2002/05 Local Health Plan.**
- **Confirm the proposals for the use of new monies available in 2004/05 as set out in both the Local Health Plan and in fuller detail in the annexed Director of Finance Report, which thereby define the 2004/05 Startpoint Revenue Allocations;**
- **Confirm the follow through into the 5 Year Financial Plan as set out in the Director of Finance Report.**
- **Receive a further detailed report on the 2004/05 recovery plan at the May Board meeting, that will set out how the Board will return to financial breakeven over the next 2 years.**

A. BACKGROUND AND CONTEXT

1.1 The Board approved the five year Local Health Plan (LHP) and financial strategy which underpinned it in May 2002. The purpose of the LHP is to:

- enable the Greater Glasgow NHS Board to set a clear direction and priorities to deliver our three key objectives which are to:
  - improve health;
  - improve health services;
  - tackle inequalities;
- provide clear accountability from the Board to the Scottish Executive for the performance of the NHS in Greater Glasgow;
- provide clear information on what we are trying to achieve and our performance;
- draw together a wide range of planning and implementation activity within a single document.

The Plan sets a strategic direction for the next 5 years and its content is a product of a whole range of different planning processes which include Local Authorities, NHS staff and other stakeholders. The full document provides an overview and signposting to detailed plans.

1.2 This paper is focused on 2004/05 and provides a short summary of our key local priorities for this year, how we intend to deliver the requirements of national priorities and, finally, sets out the financial plan for 2004/05.

1.3 The 2002/2005 Local Health Plan reflects a number of key strategies:

- implementing the Primary Care Strategy and associated new investment;
- priority developments in acute services and, in later years, the revenue costs of capital investment to deliver the Acute Services Strategy;
- substantial expansion of drug and alcohol services;
- joint investment, with Local Authorities, in the development of community care services;
- investment in community children's services, including mental health;
- implementing the Modernising Mental Health strategy.

1.4 The financial plan which underpins the LHP had five main pillars of financial policy:

- to ensure, over a five year period, that there was adequate and assured capacity to invest strategically in measures aimed to improve health and tackle inequalities;
- to provide better cover for financial risk, particularly around pay inflation, which has in the past undermined the financial stability of Divisions;
- the requirement to make adequate financial provision to cover the increased costs of replacing old hospital facilities;
- relieving the pressures on Acute Divisions to enable underlying deficits to be addressed and Division staff to focus on qualitative and quantitative improvement to services for patients, within fair budgetary allocations and without constant financial retrenchment;
- resolving longstanding shortfalls in income from other West of Scotland NHS Boards.

The Plan therefore included details of how growth monies for four spending programmes, acute hospital services, adult mental health, child and maternal health and primary and community services, would be allocated.

In reviewing the plan for 2004/05 we have had to recognise a number of very significant financial issues which have left us with a major gap in making realistic provision for inflation and other pressures while continuing to honour all of our forward commitments. At headline levels those financial issues are:

- the impact of our decisions to address Trust deficits and honour LHP commitments in 2003/04
- actual levels of inflation for salaries and supplies which are above the uplift in our allocation
- meeting national priorities.

The rest of this paper describes:

- the approach we have taken to review and revise those forward commitments;
- how we are responding to the National priorities set by the Scottish Executive;
- our proposed financial plan for 2004/05 including an outline of the measures we need to take to meet our commitments and get back into financial balance.

It is particularly important to highlight that we need to finalise our plans for 2005/06, when we have further forward commitments that are no longer affordable in order to put proposals to the Board for decisions as early in this financial year as possible. It

will be particularly important that those proposals are fully discussed with Local Authorities with whom we increasingly align budgets.

B. LOCAL HEALTH PLAN PRIORITIES

2.1 The financial context summarised briefly above and set out in more detail in section D has meant we have to review all of the plans and priorities for 2004/05 which were set out in our 2002/2005 Local Health Plan. This section summarises, in narrative form, the outcome of that review for each spending programme. Further detail on the financial impact is set out in Section C and in the tables at Attachment 1, which show in tabular form the detail of all changes to each of the four spending programmes.

2.2 Mental Health (Detailed presentation Table 1 Attachment 1)

The key planks of the Mental Health Strategy, which we have been implementing since 2000, are:

- reduced acute and continuing care beds;
- new community services;
- significant expansion to social care services;
- additional specialist services;
- improved facilities;
- a strategy for forensic services, including the medium secure unit.

In reviewing the programme to reflect the present financial context we have reduced or deleted the following significant service developments:

- a new service for people with alcohol related brain damage of whom there are significant numbers in Greater Glasgow. These people are often living in inappropriate accommodation without specialist health services which would improve their conditions;
- a substantial expansion of day services - which was intended to ensure that people with severe and enduring mental health problems could access more meaningful daytime activity - potentially as a route into employment or training;
- additional investment in social care services - failing to achieve our aim of better community infrastructure to support people with mental health problems;
- expansion of the liaison psychiatry service which would have offered additional input to patients in psychological distress in acute hospitals. Access to the service will be limited and not meet demand.

There are substantial further investments planned for mental health services in 2005/06 which will be subject to further review with the rest of future commitments in the Local Health Plan. Those commitments include a new provision for inflationary pressures on later investments in the programme which was set at a 2000/01 financial base.
In addition, we are undertaking a detailed look at all present mental health spending to identify any further opportunities to reduce costs and contribute to the corporate recovery plan.

2.3 Child and Maternal Health (Detailed presentation Table 2 Attachment 1)

In revising this programme to reflect the current financial content we have reduced or deleted the following lines:

- a provision for the expansion of the West of Scotland adolescent inpatient unit - to which we are committed with other Boards but which has been rephased into 2005/06;
- additional speech and language therapy for children with autism - a deficit identified by the Autism Taskforce which we will not be able to address;
- a reserve to fund new services for eating disorders in children, with the detailed service model presently being planned;
- a new specialist mental health service for children with addiction problems - these children will continue to be treated in the mainstream service which already has substantial waiting time and demand pressures;
- additional funding for the family bereavement service at Yorkhill, which will not be able to expand as planned;
- funding to expand innovation fund projects to other parts of the city.

The LHP includes additional commitments to meet high costs, low volume specialist services to fund the transfer of ENT and plastic surgery for children into Yorkhill. In later years the most substantial planned investment was the rollout of the Starting Well project, which provides additional support to vulnerable families and is presently available, funded by the Scottish Executive, to only two areas in Glasgow. The future of this initiative will be included in our consideration of plans for 2005/06

2.4 Primary Care and Other Community Services (detailed presentation Table 3 Attachment 1)

This programme covers a wide range of different services which have historically not attracted investment but are significant priorities: We propose the deletion or reduction of the following planned investments.

- investment to further improve multiple sclerosis services, recognising that there is significant unmet need in terms of therapy and other specialist services for people with multiple sclerosis, we will not be able to expand services as planned;
- we planned to expand the service for high blood pressure and complete a network of rehabilitation services for people with heart problems discharged from hospital;
- our review of physical disability services has highlighted significant deficits in head injury and other disability services - we will not now be in a position to make the planned investments to address these deficits which may result in people remaining for lengthy periods in acute hospitals and having limited access to community based services after discharge;
- further development funding for clinical governance in primary care which would have enabled GP practices to have more protected time to review their clinical activity and quality;
- the completion of the new primary care mental health service which is aiming to treat effectively the 30% of patients seeing their GPs with mental health problems - this reduction will mean this new service is not provided across Greater Glasgow;

- we have reduced the planned additional spending on addiction services. This means we will not be able to:
  - fund psychology input to the community addiction teams which will reduce their ability to treat effectively the underlying causes of substance misuse;
  - fund new specialist addiction services including inpatient beds to provide effective interventions for patients who currently are treated in general mental health facilities without specialist input;
  - new rehabilitation services to meet the significant unmet need identified in our joint purchased addition service review with Glasgow City Council- this will mean that we continue not to be able to provide comprehensive treatment services to people with addiction problems.

Future years of these plans also highlighted substantial further improvement in addiction services - reflecting the above priorities and particularly beginning to develop a much more substantial range of treatment services for people with alcohol problems.

2.5 Acute Services (detailed presentation Table 4 Attachment 1)

In addition to reflecting the future revenue costs of implementing the Acute Services review the programme includes a number of investments to address the outcomes of services reviews and address bottlenecks and quality issues. The investments we have reduced or deleted are:

- investment to improve nurse staffing levels, which will now remain at current levels and will be subject to further review as part of the manpower benchmarking review of all staff groups to identify the potential for reducing costs.
- investment in the pain management programme to provide effective treatment for people with intractable pain who presently are dealt with in a range of inappropriate services or, after very long waits, in the limited specialist services.

We have had to find revenue in 2004/05 for a range of new and unavoidable costs including our share of investment to address immediate pressures in neurosciences, and the costs of improved decontamination to meet national requirements, a number of deductions by the Scottish Executive to meet cost pressures in national specialist services and reduced income from out of area treatment agreements.

2.6 Other Spending Programmes

In addition to the changes to the LHP outlined above, there are four additional spending programmes for 2004/05, which reflect further earmarked allocations by the Scottish Executive. Our proposals for spending on these ring-fenced programmes are shown in tables 5, 6, 7, and 8 within Attachment 1

2.7 Finally, the SEHD have made additional allocations to three NHS Boards which are intended to reflect the additional demands on health services made by deprived populations. The "unmet need" adjustment is being made pending a more detailed review of the national funding formula and gives us an additional allocation in each of the next two years. The detailed financial tables for each spending programme at Attachment 1 set out our proposals to use this allocation - which will be subject to

approval by the SEHD. Our approach has been to allocate resources to services which require development and expansion to meet the needs of deprived populations and which would otherwise have been reduced or constrained because of our financial position and to invest in additional activity to tackle health inequalities.

Spending areas will include:

- addiction services;
- primary care mental health;
- sexual health;
- improving oral health;.
- reducing smoking.

C. NATIONAL PRIORITIES

3.1 We are required by the Scottish Executive to include in this update to the Local Health Plan a position statement about progress, on the Executive's national priorities. These are:

- To improve the health of everyone in Scotland and to reduce the gap between the health status of people living in affluent and more deprived communities.
- To modernise NHS services to better meet the needs of patients by promoting service redesign.
- To actively involve the people of Scotland, including communities, patients and carers, in planning and delivering NHS services.
- To ensure patients receive healthcare at the right time in the right place and in the right way by:
  - ensuring that everyone contacting their GP surgery has guaranteed access to a GP, nurse or other healthcare professional within 48 hours;
  - reducing waiting times for inpatient, day case and outpatient treatment;
  - ensuring that patients who no longer need hospital treatment are discharged as soon as possible into appropriate care;
  - reducing healthcare associated infections and providing a clean, hygienic healthcare environment;
- Tackling:
  - cancer;
  - heart disease;
  - mental illness.

The rest of this section describes our proposals to address each of these priorities in 2004/05.

3.2 Improving Health

The full Local Health Plan 2002/2005 sets out in detail a series of major programmes which fully reflect the extent of our efforts to improve the health of our population. We have briefly highlighted below key points.

- **Health Improvement - The Challenge:** In March 2003, the Scottish Executive issued *Improving Health in Scotland: The Challenge*, as a strategic framework for the delivery of a more rapid rate of health improvement in Scotland.

  The health challenge for Scotland has been identified as:

  - "to improve the health of all the people in Scotland; and,
  - to narrow the opportunity gap and improve the health of our most disadvantaged communities at a faster rate, thereby narrowing the health gap."

  Greater Glasgow, as the NHS Board area with the largest population of Scotland's population and the greatest concentration of deprivation, has a pivotal role to play in the overall success of Scotland in meeting this challenge.

- **National and local health priorities/translating the challenge to meet local circumstances:** While work should continue on tackling all determinants of ill health, the challenge has taken a focussed approach with an expectation that priority should be given to work in four areas:

  - early years;
  - teenage transition;
  - workplace (working-age people);
  - communities;

  and on the following five key risk factors affecting health:

  - tobacco;
  - alcohol;
  - low fruit and vegetable intake;
  - physical activity levels;
  - obesity.

  Health improvement work in Greater Glasgow will therefore support these national priorities - but must also be sensitive to local circumstances and local health priorities (as identified through community planning, joint health improvement planning and work with local communities).

- **Health and social inclusion:** Our overarching priority for improving health is tackling health inequalities in Greater Glasgow. The Board's health improvement efforts are set firmly within the social inclusion framework. Work to promote healthier lifestyles must be allied to work to improve circumstances - and, in particular, to tackle the detrimental health effects of poverty and deprivation.

  A key area of development for health improvement will be supporting people into employment - through support for community learning and the intermediate labour market, providing employment within NHS Greater Glasgow for socially excluded people and measures targeted at those currently unable to work through ill health.

The results of the Health and Wellbeing survey of the Greater Glasgow population 2002 have identified that people living in Social Inclusion Partnership (SIP) areas have significantly worse status on a range of measures than the rest of the population. However, there are signs of improvements since the baseline was carried out in 1999, suggesting that the policy of targeting effort and resources to these areas is achieving positive results.

- **Community Health Partnerships:** The advent of Community Health Partnerships provides the potential for better coordination of health improvement work at local level, with a continued focus on the need for the NHS to contribute to social and economic regeneration for health.

- **Supporting the wider public health workforce:** There is growing recognition of the expansion of the wider public health workforce to include not only a wide range of health professionals, but also those with roles in the public, private and voluntary sector who in the course of their work can contribute to the health improvement effort. There is a need for the Board to work with all of these groups and provide them with the knowledge, expertise and support to help maximise the positive impact that their activities have on health.

- **Working in partnership:** The challenge document has reinforced the principle (previously set out in *Towards a Healthier Scotland* and reiterated in *Our National Health: A Plan for Action a Plan for Change*) that improving health is not solely the business of the NHS. All of the Board's health improvement work is founded on the principle of the NHS working in partnership with others - eg, local authorities, other public sector agencies, the voluntary sector, employers and communities. Our participation in community planning and particularly the joint health improvement plan (JHIP) process are key mechanisms for health improvement planning in each local authority area in Greater Glasgow, which are complemented by other joint planning arrangements such as children's services planning, community safety partnerships and SIP plans and strategies for health. This section briefly highlights a few areas of work from the detailed Health Improvement Programmes we have in place with each Authority.

- **Employment:** Improving Scotland's Health - the challenge has identified the workplace as one of 4 key areas for health improvement. Recognising that being in employment is a key positive factor for health, in Greater Glasgow, an area of high unemployment, health promotion efforts have extended beyond initiatives to promote health at work to include a focus on the NHS engaging in partnership with others to help people into employment.

  Examples of such initiatives in 2003:

  - Training local people as coaches for Kool Kids – a children's physical activity club operating in 40 Glasgow primary schools.

  - Entering into partnership with Job Centre Plus to train long term unemployed people for employment in NHS hospitals.

- A pilot project with Primary Care to support people on incapacity benefit back into employment.

- ***Tackling poverty – primary care as a channel for welfare benefits***

  LHCCs have been allocated health promotion funds to employ local voluntary organisations to provide welfare benefit advice to patients.

  GGNHSB currently funds the sessional provision of money advice services through 10 of our 16 LHCC's that cover our poorest communities. We commit £120K per annum to this programme. Attendance Allowance claimants account for the majority of income generated for patient users of the primary care services. In one LHCC, with £20K NHS investment £213K income was generated for 74 awards with another 71 pending an outcome in the current financial year. Therefore from £120K investment the NHS will have "levered" over £1.5 million of income for NHS primary care patients, particularly around attendance allowance.

- ***Smoking cessation***

  a) ***community pharmacy***

  Over 120 community pharmacies in Greater Glasgow participate in Starting Fresh – the community pharmacy smoking cessation scheme that is available in all areas in Greater Glasgow.

  Clients self refer or are referred by any health professional. They receive NRT (for prescription cost or free) together with one-to-one support by a trained adviser for up to 12 weeks. In the first 6 months of 2003 almost 1000 smokers have accessed the services. This is one of the most extensive schemes in Scotland and has provided a model of good practice for others to follow.

  b) ***LHCC based group interventions***

  Those more addicted smokers can access a group intervention which has been shown to be the most effective support for them as they quit smoking. Clients can access NRT (for prescription cost or free) through their local pharmacy with ongoing support over 12 weeks through the locally based groups, led by trained local health workers.

- ***"Text 4 u" - Sexual Health – using new technology for health education***

  A pilot project involving a local youth health project, and local health services provides young people in the East End of Glasgow with the opportunity to gain information about sexual health issues and services through a text messaging service. This initiative has been worked up in partnership with all the relevant agencies (including the introduction of protocols to cover child protection concerns).

We continue to give significant focus to health improvement activity although our financial position substantially constrains our ability to continue the four year pattern of investing in health improvement and tackling inequalities which has been at the heart of the current Local Health Plan.

3.3 Service Redesign and Modernisation

This short section briefly describes a number of the initiatives we are taking to deliver change and innovation. It takes the approach that this work should be at the core of the strategies and change programmes developed through the Local Health Plan process rather than separating change and innovation from the mainstream of our work. A number of the changes we are implementing to deliver other national priorities are reflected in the other contents of this section covering, waiting, cancer, heart disease, mental health and health improvement.

- **Older people:** We consulted on a comprehensive joint strategy for Older Peoples Services with Glasgow City Council during 2003 and in 2004 the focus will be on implementation of a series of changes to services to reflect the outcome of that consultation and the final service strategy. These changes will include:

  - further community service developments;
  - reassessing and revising long stay care commissioning;
  - extending and improving rehabilitation.

- **Emergency admissions:** The Emergency Admissions Review Team has completed its first year of work. Three major elements of work have been finalised:

  - Emergency Care Complex: detailed proposals for 'front end' hospital services have been produced and approved. The next phase is to develop short, medium and long-term implementation plans and to produce modelling of patient numbers, workforce and physical requirements for each hospital site.

  - Capacity Planning: a detailed review of capacity has been produced and will be followed up with two major programmes of work. One will focus on how to tackle long lengths of stay and one will focus on analysing care pathways in the post 48 hour phase of hospital care. Both will produce proposals for change.

  - Short Term Changes: Divisions have established implementation groups to deliver the more immediate changes which have been identified to improve patient care. There will be a detailed review of progress in achieving change in March 2004.

- **Maternity services:** We have completed consultation on the outcome of our review of maternity services. During 2004 we will be developing and implementing detailed change proposals including the closure of a delivery service and the further extension of community based services. A key aim will be to have a consistent service across NHSGG and better integration between maternity services and primary care.

- **Managed Clinical Networks:** At the end of 2003 we launched our managed clinical networks for CHD and stroke and during the early part of 2004 the Diabetes Advisory Group will migrate into an MCN. Each of these networks will develop and implement proposals for change during 2004, building on existing strategies and plans. They have already prioritised issues for funding from monies to support the National Strategy for CHD and Stroke

- **Homelessness:** Improving the health of homeless people and their health status remain high priorities as we continue the implementation of our Health and Homelessness action plan.

  A continuing focus of that plan is to change mainstream NHS services to respond more appropriately and flexibly to the needs of homeless people. In addition to that programme of change across Greater Glasgow we are primary partner with Glasgow City Council, in delivering the closure of the long stay hostels. During 2004/05 a major programme of joint commissioning will deliver new and extended health services for homeless people.

- **Primary Care:** Implementation of the new GMS contract consolidates our primary care strategy with its key planks of:

  - improving chronic disease management;
  - providing new services for addictions, mental health and older people;
  - Improving premises and IT.

  In addition to these continuing programmes we are developing proposals to provide GP out of hours services which will consolidate current arrangements, as an initial step, but thereafter provide a platform for innovative approaches to a broader range of out of hours services.

- **Acute Services Review:** The implementation of the ASR requires a major programme of change and innovation. The Programme Board, which oversees implementation, has a number of sub groups, driving the required changes. These cover a range of activities including the redesign of services associated with the Ambulatory Care Hospitals; planning for the new inpatient services, with detailed review of care pathways, service models and performance; and transport and access.

3.4 Patient Focus Public Involvement

As part of its obligation to modernise its approach to Patient Focus and Public Involvement (PFPI), since April 2003 NHS Greater Glasgow has been implementing an action plan which contains a wide range of initiatives. A sub-committee of the NHS Board, the Involving People Group, is charged with delivering the action plan which will lead to:

- an Involving People Network - linking patient, public and voluntary interests and encouraging the spread of best practice among NHS teams;
- a unified strategy for patient and public involvement, developed in an inclusive way, which will set out objectives and standards common to all organisations within NHS Greater Glasgow;

- integration of PFPI principles and practice across the planning, advisory and decision-making structures which serve NHS Greater Glasgow;
- programmes for organisational development and training that will enable front-line staff to take forward effective public/patient involvement.

The Involving People Group met for the first time in May 2003 and since then has been working to put in place the basic infrastructure that will support wider initiatives. One of the principal philosophies of the group is to recognise that there is considerable, existing good practice within NHS Greater Glasgow's services and that this should be developed through a wider strategy and infrastructure that promotes local creativity and encourages the spread of best practice. Early work has included:

- qualitative research among patient and other stakeholders to determine local preferences for engagement with NHS Greater Glasgow;
- a pilot programme to 'de-jargon' patient information, services and directional signage in the context of Glasgow's two new ambulatory care hospitals;
- input to establishing alternative formats for public meetings, including the use of open space techniques at the NHS Board's 2003 Annual General Meeting and two major consultation events on the future of maternity services staged in January 2004;
- creating a wide, representative database of local individuals and organisations who wish to engage with NHS Greater Glasgow;
- completion of an audit of patient/public involvement activity across the local healthcare system.

Over the next few months, the Involving People Group will be involved in:

- a major event designed to begin the process of developing a unified PFPI strategy for Greater Glasgow;
- a response to the requirements of the NHS Reform Bill and the introduction of the new Scottish Health Council;
- development of PFPI structures for Community Health Partnerships;
- launch of a dedicated 'microsite' on the NHSGG website that will incorporate the means to offer opinion, debate with NHS staff, learn from the work of others and obtain specific information

In addition to this comprehensive programme of work there are a number of other initiatives which should be highlighted:

- the extensive programme of preconsultation and consultation carried out as part of the Maternity Services Review;
- the further development of the community involvement team supporting the implementation of the Acute Services Review;
- the development and funding of a user network of homeless people as part of the Homeless Partnership's commitment to involve service users.

It is important to highlight that in the context of this overall programme to which we are fully committed, the requirement to deliver changes to services to remain within our revenue plan will inevitably create tensions between the need to deliver rapid change and to fully involve all stakeholders from the earliest possible stage. An important point of this paper is to begin to highlight services for which change may be required in order to begin the engagement process.

3.5 48 Hour Access to Primary Care

The national target is for access to primary care services within 48hrs. The target is defined as face-to-face, telephone or email contact with an appropriate member of the primary care team which could be a GP, practice nurse or other healthcare professional such as a physiotherapist. The 48hrs target does not apply to urgent cases as these are dealt with on the same day or within twenty-four hours, nor does it apply to access to a specific named member of the primary care team. NHS Greater Glasgow has developed a comprehensive strategy to address access issues across a range of services as part of its wider plans to improve and develop primary care services through the implementation of the Primary Care Strategy. Set out below is our current performance against the national criteria and outlines plans for further action.

- **Results against national performance criteria:** The Scottish Executive has set the criteria outlined below for measuring performance against the 48hr target. In order to meet the target the local NHS system must demonstrate that practices have in place one or more of the following:

- **Open access:** This method of organising access to appointment systems through 'drop ins' is not widely used in Glasgow and although suitable in some circumstances it is not a major part of the access strategy. However those practices that operate these systems meet the performance target. Currently 14 practices provide this type of service to their patient population.

- **Advanced access:** This practice redesign programme continues to be progressively rolled out across Glasgow. The Scottish Primary Care Collaborative aims to improve access and quality of services and will be rolled out across Greater Glasgow over the next 3 years. Involvement in the programme does not necessarily indicate compliance with the performance target but is considered an excellent practice based action to both improve quality of service and improve access times.

- **RCGP or training practice accreditation:** is similar to Advanced Access above, achievement of these criteria does not necessarily indicate compliance with the target but is an indicator of achieving a standard of practice organisation required to maximise access for patients. The Division target is for all practices to have achieved accreditation by the end of 2004 with a target of 180 by 31 March 2004.

- **Nurse or doctor triage/advice:** The operation of a professional triage service meets the criteria of 48hrs access by providing immediate advice and assessment of a patient's needs. 14 practices are operating these arrangements at present. A training programme for nurse triage is already underway and will be rolled out across the city over the next 2 years.

- **Appointments:** The appointment surveys have continued to be developed with a marked improvement in the return of information through an electronic format. The January 2004 survey showed A total of 188 (88.3%) met the access target of a nurse or doctor appointment within 48hrs. When including those practices that meet the target on some of the days, the access criteria were met 93.5% of the time.

In addition to the comprehensive action plan outlined above which addresses the long term issues of primary care capacity and demand management, a series of the shorter term actions are being taken including:-

- Advanced access roll out:
- Practice Accreditation:
- Triage training and rollout:
- LHCC Plans: each LHCC has prepared an action plan based on an analysis of each practice based on their individual performance.

- **Conclusion:** Good progress has been made in taking forward a wide range of initiatives to improve quality and access within primary care. These include practice redesign, triage training and practice accreditation. As a result around 92% of all practices currently meet the access target or have strategies in place to improve access and the Division has produced an action plan to ensure that the remaining 17 practices (8%) develop plans to improve access over the coming year. While the results of the recent appointment survey are very encouraging it is important to remember that these only reflect availability at a single point in time and will obviously vary, depending on local demand and circumstances. It is also acknowledged that the most effective way of assessing performance will be through the experience of individual patients and feedback will therefore be directed to the individual practices and LHCCs to help identify and resolve any specific access problems. It is also important to note that there is currently no contractual obligation upon practices to meet the access criteria and, though there is a small incentive in terms of quality points the NHS relies on the co-operation of practices and independent contractors to meet this goal.

3.6 Waiting Times for Inpatient Day Care and Outpatient Treatment

This section describes the scale of the challenge confronting NHS Glasgow Acute Services to achieve and sustain the six month maximum waiting time target by December 2005.

Speciality Capacity Plans have been established by South and North Glasgow Operating Divisions to determine the scale of activity and related costs required to provide the additional capacity to deliver the targets for inpatient, day case and outpatient services by December 2005, and to sustain them thereafter. Yorkhill are now finalising their capacity planning processes and do not expect any major difficulties in achieving the six month waiting time target by December 2005.

This paper describes the process we have worked through to develop plans. It summarises the activity and costs (recurrent and non recurrent) required to achieve the six month wait target and outlines issues to be addressed to achieve this target in Glasgow.

- **Capacity Plans produced:** Divisions have now produced plans for all major specialties.

- **Activity and cost analysis:** At headline level, in the period to March 2006, there is a total investment requirement of £48.6 million. This is identified separately as recurrent, non recurrent and capital investment.

Investment Required

	Recurrent £000	Non Recurrent £000	Total £000
2004/05	9.1	16.3	25.4
2005/06	13.9	9.3	23.2

The activity that must be delivered to achieve the waiting time target in each year is significant - in 2004/05 almost 14000 additional inpatient/day cases and in 2005/06 a further 15000 cases. Thereafter, almost 9300 additional cases per year will be undertaken to sustain this waiting time target.

In addition, there is a major challenge to be addressed to deliver the 26 week wait for outpatients by December 2005. NHS Divisions are now refining an analysis of new and return outpatients by specialty that must be seen to deliver this new target.

As expected, the challenge is most significant in particular specialties - orthopaedics, ophthalmology, plastics and ENT At March 2004, Glasgow NHS was treating 77% of all outpatients within 26 weeks.

A mixed economy approach to deliver the waiting time target will be required. Activity will be undertaken within NHS Divisions, at the Golden Jubilee National Hospital and externally to the NHS. We are working together to finalise the balance of activity and in doing so to ensure that Glasgow has the required capacity available at the Golden Jubilee National Hospital.

Where it is possible, GGNHS will invest to expand local NHS capacity on a recurring basis. It is agreed that expanding NHS service infrastructure now is critical if GGNHS is to achieve this target - the lead-in time to recruit staff particularly can be several months.

The Corporate Management Team has established a group specifically to look at service performance issues across GGNHS services using the benchmarking analysis commissioned from the external consultants, CHKS. It is therefore proposed that we continue to refine our understanding of the issues raised in capacity plans and monitor waiting list dynamics closely as we move forward with new investment towards delivering the December 2005 targets.

There is also a capital requirement to support this capacity growth of £3.14 million. This is assumed to fall entirely in 2004/05 and is mainly required to purchase surgical instrumentation/equipment. This is shown within the non-recurrent funding line in the above table.

To sustain the six month waiting time target from April 2006 onwards, the recurring investment level is £14.6 million.

All of these costs are inclusive of the non-Glasgow residents that are to be treated on Glasgow's waiting lists. We are proposing to recover 27% of the costs which relate to other West of Scotland Boards.

- **Availability Status Codes (ASCs):** These figures exclude patients with ASCs. A decision by SEHD to set waiting time targets for patients with an ASC will present a significant and additional challenge, both in activity and further investment terms. There is a clinical and administrative review of the ASC lists underway by Divisions.

3.7 Delayed Discharges

2003/04 has seen the development and implementation of the second round of delayed discharge action plans with our six Local Authority partners. This programme further developed initiatives introduced during 2002/03 including rapid response teams, additional care home capacity for enhanced/comprehensive and overnight homecare. This year's plan sees the development of new integrated hospital discharge teams, improved access to equipment and adaptations, improved health supports to care homes, a falls prevention programme, including access to hip protectors for those in long term care, and further enhancement of rehabilitation services.

This year has seen a further improvement in partnerships delayed discharge performance with improvements against all the main "headline" indicators (see table below). The PAF indicators demonstrate that Greater Glasgow continues to perform significantly better than the Scottish average. The partnership has focused on delivering sustainable improvement against a backdrop of increased activity, including hospital admissions. Further improvement is predicted in the first quarter of 2004 resulting from further capacity planning developments, the full impact of the integrated hospital discharge teams and other 2003/04 action plan initiatives.

The next financial year will see the trend continuing as the full year effect of the 2003/04 delayed discharge plan impacts, an in-depth reassessment of our institutional care commissioning strategy delivers further capacity improvements, and the system improvements accrued from the implementation of joint health and social care strategies for older people and adults with physical disability. However, the challenge for 2004/05 will be significant to maintain the successful holistic working of the local system, the change programmes being proposed, application of shared performance frameworks and the successful implementation of the recently issued guidance on Choice of Accommodation: Discharge from Hospital.

Performance Indicators

	Jan 2002	**Jan 2003**	**Jan 2004**
Patients ready for discharge	464	418	344
Patients delayed six weeks or more	295	285	195
PAF Indicator 2.08.01(*)			
Greater Glasgow	63.6	67.1	56.7
Scotland	66.6	65.6	
PAF Indicator 2.08.02(**)			
Greater Glasgow	8.8	8.0	7.6
Scotland	12.1	10.2	

* Delayed discharge - % of patients experiencing a delay in discharge where the delay was six weeks or more.

** Delayed discharge - patients ready for discharge as a percentage of occupied beds.

Our proposals for the national funding streams are set out in Table 5 Attachment 1.

3.8 Healthcare Associated Infection

- **Infection control infrastructure:** The infection control infrastructure in Glasgow has been streamlined with the Greater Glasgow-wide Infection Control Committee with membership from all Division Infection Control Committees. A unified, new infection control policy manual has been in progress. All infection control teams within Greater Glasgow will comply with this manual and all policy recommended by the CSBS standard will be in place by end of March 2004. To improve the current infection control infrastructure in Greater Glasgow, additional funding has been made available in the current financial year to appoint four additional nursing staff.

- **Education:** All Divisions within NHS Greater Glasgow have implemented teaching programmes on hand-hygiene and principles of infection control. This is an ongoing programme, including a mandatory induction programme for all new clinical staff. Currently, there is also a programme of putting through the first cohort of cleanliness champions and so far about 80 champions have been identified to take them through the appropriate training.

- **Policies:** All Divisions agreed to follow a unified policy on infection control throughout the Greater Glasgow area, compiled under the auspices of the greater Glasgow infection control committee. All policies recommended by the CSBS standard will be in place by the end of March 2004. Every policy in the manual now comes with a standard Self-Directed Learning unit and also an audit tool, so that these policies can be audited on a regular basis.

- **Audits:** All Divisions agreed on an ongoing audit programme. Priorities for audits are given to specific areas, including environmental audits, clinical waste audits, kitchen audits and hand-washing audits.

- **Surveillance:** All Divisions are currently taking part in national surveillance programmes coordinated by the Scottish Centre for Infection and Environmental Health (SCIEH) to comply with the HDL on surveillance.

- **Cleanliness:** Scotmeg standards are the minimum level of service agreement and clinical managers now have clear information on agreed standards and how to tackle any failure to meet them.

- **NHS HDL (2002) Ministerial Plan on Watt Report:** We have a detailed local action plan to comprehensively respond to the Watt Report requirements.

This plan includes financial provision for a new decontamination facility, to meet the revised National Standards in full, which will be operational in 2006.

3.9 Cancer

Improvement in cancer services remains an important priority. The Greater Glasgow cancer planning group is currently consulting locally and regionally on a draft cancer plan. This has been produced collaboratively with all Glasgow healthcare providers with the intention of identifying an effective strategic vision for cancer services that

identifies the key priorities, responsibilities and timescales. Once adopted this will form the basis for the development of cancer services across Greater Glasgow.

Current key priorities being progressed include:

- **The achievement of National Waiting Times targets by December 2005:** To achieve these targets a number of specific actions are being undertaken including:

  - the implementation of improved referral and triage protocols and practice across Glasgow for suspected colorectal cancer;
  - the further development of radiology services to ensure best possible diagnosis and treatment;
  - the use of process redesign in colorectal, lung and breast cancer specialties to streamline services, increase capacity and improve response. This is a collaborative approach with staff from Quality Improvement Scotland.

- **The delivery of the new West of Scotland Cancer Centre:** Particular milestones in the achievement of this priority include:

  - the appointment of a new Medical Director for the Beatson Oncology Centre;
  - improvements in the staffing levels at the Beatson;
  - approval has been obtained for Phase II of the new West of Scotland Cancer Centre on the Gartnavel site and a principal contractor has been appointed with construction intended to start in summer 2004.

- **Integration of Managed Clinical Networks:** the MCN Managers and Clinical Leads are fully involved in the planning process and contributed to the production of the draft plan;

  - incorporating delivery of MCN standards into the cancer planning process;
  - supporting the implementation of MCN accreditation.

- **The delivery of IM&T solutions to improve productivity and communication:** The Beatson Oncology Centre is participating as an early implementer in trials of the new electronic portal for a number of cancer specialties which will deliver easily accessible electronic records for all healthcare providers.

  Glasgow is leading the national procurement process for picture archive and communication systems which will greatly improve radiology services.

- **Current progress against targets**

Breast Cancer:

Urgent treatment within one month of diagnosis.

	Current	Previous
North Glasgow	91%	79%
South Glasgow	80%	56%
West of Scotland	86%	80%

70% of referrals to be seen within four weeks.

	Current
North Glasgow	91%
South Glasgow	93%
West of Scotland	93%

80% with diagnosis within 2 weeks of first clinical visit.

	Current	Previous
North Glasgow	95%	94%
South Glasgow	99%	95%
West of Scotland	93%	91%

Colorectal Cancer:

Time between diagnosis and first definitive treatment not more than four weeks.

	Current
North Glasgow	75%
South Glasgow	56%
West of Scotland	61%

By 2005 the maximum wait from urgent referral to treatment for all cancers will be two months.

	Current
North Glasgow	55%
South Glasgow	41%
West of Scotland	45%

This Local Health Plan does not include any new investment in cancer services therefore our aim is to progress these national targets and wider service improvement within current resources. That will be a major challenge particularly in the context of substantial pressures on existing services through new treatments and more intensive drug regimes.

3.10 Coronary Heart Disease and Stroke

In December 2003 we launched the MCNs for heart disease and stroke, and revised strategies for both diseases are being developed led by the MCN teams. Each will

work through a small executive group to co-ordinate and progress activity; and through sub-groups for specific work areas defined by the MCN and reporting to it. They have a wide representative membership ensuring wide buy in of the various constituencies and good communication in both directions between all involved in heart disease and stroke and the two MCNs.

Our proposals to use the new national funding are set out in Tables 6 and 7 of Attachment 1.

Important points to highlight are:

- **Stroke:**

  - The local chronic disease management programme will be wrapped into the implementation of the GMS contract ensuring we continue to strengthen primary care services.
  - The primary and secondary care interface is being addressed through joined up discharge arrangements.
  - New Opportunities Funding (NOF) is enabling the provision of new services including smoking cessation, transport and a discharge team.
  - A series of prevention initiatives, covering smoking, physical activity and diet are in place (contribute to heart disease and stroke).
  - Psychology services are being put in place

  There remain a number of areas where services could be improved, particularly strengthening medical and therapy staffing and timely imaging. We are not able to plan further investment in these priorities at present.

- **Heart Disease:**

  - The successful chronic disease management programme will be consolidated into the new GMS contract.
  - NOF funding will support a number of new initiatives including weight management, pharmacy service for heart failure patients, tackling issues relating to ethnicity and deafness. In addition, a direct access service for those with palpitations is being developed to ensure the correct investigation pathway is followed and those who require cardiologist review receive it timeously.
  - A single care pathway has been developed for patients with chest pain.
  - We are reviewing the utilisation of catheter laboratories to deliver urgent access in a consistent way and identify opportunities to reduce waiting times.

  We are not planning further investment in heart disease and are working to manage the costs of primary care prescribing and to reduce waiting times within current resources. However, it will be difficult to make progress on improving acute chest pain services and heart failure services and address competing national and local priorities within available resources. We have not been able to allocate additional resources for drug eluting stents recommended by the National Institute for Clinical Excellence (NICE) or for resynchronisation therapy

3.11 Mental Health

We continue to implement our comprehensive, joint Mental Health Strategy. The strategy includes significant investment, a major shift from institutional to community based services and extensions of social care. During 2004/5 specific changes will include:-

- a move to fully integrated health and social care community mental health teams;
- preparing for the implementation of the new Mental Health Act;
- developing innovative work with people who have personality disorders;
- increasing the therapeutic input on inpatient wards;
- new supported accommodation provision.

3.12 Financial Breakeven

A final requirement set by the SEHD is the requirement to achieve financial breakeven. We have highlighted the scale of the challenge meeting that requirement presents - not least given our obligations to meet the national priorities outlined in the earlier part of this section. Our Plan is underpinned by a financial strategy which aims to return to recurrent financial balance over a maximum period of the next two years. The next section illustrates in detail that challenge and the measures to reduce costs which we will need to deliver in order to meet it.

D. 2004/05 FINANCIAL PLAN

4.1 There are a number of key points of context to set out ahead of the rest of this section which describes the 2004/05 financial plan under four headings:

- **income:** describes our available resources for 2004/05;
- **inflation and other pressures and allocations to operating divisions:** describes how we have assessed the need for additional resources in 2004/05;
- **revising the Local Health Plan and national priorities:** describes our planned spending on local and national priorities;
- **closing the gap** - corporate recovery plan: sets out our plans to close the financial gap.

4.2 The four key points of context are:

- reduced allocation due to population changes;
- substantial additional inflationary pressures particularly in terms of pay;
- significant additional costs for national priorities, particularly delivering the waiting times targets;
- the 2004/05 impact of Board decisions to over commit resources in 2003/04 in order to honour Health Plan commitments and provide additional funding for the pressure on the then Trusts (now Divisions).

4.3 The net effect of these points is to produce a financial challenge of around £50/60 million which we must address over a maximum of two years - paragraph 4.7 onwards sets out our plans to reduce costs. Recognising we are now working as a unified system these proposals bring together measures to ensure operating divisions can live within their allocations - a critical challenge for 2004/05, and corporate plans to close the remaining financial gap.

4.4 Income

The income available to us in 2004/05 is as follows:

	£m
Income base	1,011.6
General uplift	65.3
Modernisation fund	4.8
Unmet need	4.0
Earmarked funds	15.7
Devolvement of bridging finance	3.2
Total	1,104.6

It is important to emphasise that due to population changes our Arbuthnott uplift is less than we expected and the minimum for any NHS Board.

4.5 Inflation and Other Pressures and Operating Division Allocations

This section summarises the demands on these additional resources.

- Firstly there is the deficit carried forward from 2003/04 with two elements:-
  - Local Health Plan commitments
  - Trust deficits

- Secondly there is provision for inflation with the following key components:

  - New Consultant contract
  - Agenda for Change
  - Basic pay inflation
  - Non pay inflation
  - GP prescribing inflation
  - Hospital prescribing inflation
  - Junior medical staff costs
  - Increases in capital charges

This assessment of inflation and other pressures generates 2004/05 allocations to Operating Divisions. Two important points of context:

- the North and South Glasgow and Yorkhill Operating Divisions all had significant deficits in 2003/04, partly addressed by non recurring measures;
- there are a number of new pressures on clinical services, including emergency admissions and new treatments.

The allocations made to Operating Divisions do not fully take account of these points and we are working as a corporate team to agree savings plans to enable Divisions to live within these allocations.

In concluding this section it is important to highlight potential areas of risk in our assessment of inflation and other pressures. These include:

- pay awards are not yet finalised and the costs of the new consultant contract and Agenda for Change may exceed the sums identified;
- there are substantial pressures on prescribing costs in hospitals and in primary care;

4.6 Revising the Local Health Plan and National Priorities

Section B of this paper described how we have reviewed the commitments made in the Local Health Plan in the light of our changed financial circumstances. Shown below are the financial outcomes of those reviews:

Additional spend for 2004/05

	£m
Acute services	8.0
Mental health	3.4
Maternal and child health	0.9
Primary care and other community services	6.1
Earmarked national funding	15.7
Additional 2004/05 costs	**34.1**

In addition to these commitments a further recurring sum of £2 million is required (net of West of Scotland caseload) in 2004/05 to meet the first phase of investment to ensure we can deliver the national waiting times targets.

In summary, at this point our 2004/05 financial plan can be presented as follows:

	£m	**£m**
Total available additional resources		**93.1**
Inflation and other pressures: divisional allocations	115.8	
Reviewing the Local Health Plan Waiting times national target	34.1 2.0	
Total additional costs		**151.9**
Shortfall in funding		**58.8**

Set against the income we have available this would leave a deficit of £58.8 million. The next section outlines our plans to address that potential deficit.

4.7 Corporate Recovery Plan

The preceding parts of this Section have summarised the factors which have led to the financial challenge which the Board faces over the 2 financial years, 2004/05 and 2005/06. Set out below are the actions we have proposed thus far to address this position within the Corporate Recovery Plan which the Corporate Management Team (CMT) is developing. The detailed actions within this plan will be expanded during the next month with the objective of ensuring that the Board has a deliverable set of

proposals which will return the NHS within Greater Glasgow to a position of financial balance two years hence.

The importance of achieving a return to financial balance in two years cannot be over-emphasised. The current arrangements governing resource allocation within NHS Scotland prescribe that any year-end overspend carries with it a double financial jeopardy: the forward financial plan needs to reflect both the year-on-year recurrent over-commitment and a non-recurrent allocation reduction which matches the level of the previous year-end deficit. The impact of our agreed 2003/04 overcommitment on our opening position clearly illustrates this point.

The plan recognises we are working in a single system and brings together the measures which Operating Divisions will need to take to remain within their allocations, with a series of actions which will require effort across the whole NHS system.

It is particularly important to recognise that a managed and fair reduction in staffing is essential to reduce costs - focussed as far as possible on non frontline posts.

Set out below are the main themes from the plan, still subject to further work. A number of the potential proposals may require consultation - our aim will be to conclude the necessary work to enable detailed proposals to be brought to the May Board.

The focus of the plan has been to reduce costs with the minimum possible impact on patient services recognising it will not be possible to achieve the scale of cost reduction without any effect on services.

	RECOVERY PLAN PROPOSALS	2004/05 £'000 Target
1	**Benchmarking Acute Services and Identifying Potential to Reduce Capacity**	3,150
	Review:	
	– Day care only homoeopathic service	
	– All "stand alone" rehabilitation hospitals	
	– Dermatology in-patient beds	
	– Conversions to 5 day wards	
2	**Acute Services: Potential ASR Acceleration**	**tbc**
3	**Review Care Services for Older People**	
	– Reduce continuing care beds	1,500
	– Close beds to reflect reduced cross boundary flow	1,000
4	**Improve Prescribing**	
	– Restrict introduction of new drugs	7,200
	– Aggressive cost reduction programme	
5	**Introduction of pan Glasgow Working in:**	
	– Finance and supplies	3,915
	– Human Resources	
	– Pharmacy	
	– Catering	
	– Medical illustration	
6	**Pay Modernisation**	
	– Manage introduction of Agenda for Change within funding available	
7	**West of Scotland Income**	
	– Recover full costs of services in Glasgow hospitals or reduce activity	10,000
8	**Cancer and Heart Disease**	
	– Review of current service costs	0
9	**Benchmark Workforce**	
	– Range of initiatives including:	2,150
	o Reduce agency costs	
	o Identify potential for reduced and reshaped workforce	
	o Scrutinise all vacancies	
	o Move from on call to shift systems	
10	**Review Estates**	
	– Identify potential for workforce and facility changes	500
11	**Review Non Acute Capacity**	1,000
	– Identify potential to reduce mental health beds	
	– Identify potential to reduce Children's Hospital beds	
12	**Reduce Management costs**	500
13	**Clinical Workforce Design**	
	– Range of initiatives including:	
	o Reduce costs of junior doctors	1,000
14	**Document Management**	
	– Replace paper records	tbc
	TOTAL	**31,915**

Shown as: recurrent savings available to offset deficit	21,915
Non recurrent income	10,000
	31,915

2004/05 Revenue Startpoints

To summarise and bring the preceding paragraphs together, the Local Health Plan proposals as set out in this Report leave deficit of £58.8m as set out in Paragraph 4.6.

The Corporate Recovery Plan proposals to date, as set out in Paragraph 4.7, reduce the recurrent deficit to £36.8m in 2004/05.

Clearly, as already stated, the focus of attention now needs to shift to ensure that further savings are identified to deliver financial breakeven over the next 2 years.

The attached report from the Director of Finance, "2004/05 Revenue Startpoints and 5 Year Financial Plan" sets out, in greater detail, the overall financial position together with a clear statements of the associated risks. The proposals for 2004/05 are then set into context of a 5 Year Financial Plan.

GREATER GLASGOW NHS BOARD | **PROGRAMME MENTAL HEALTH** | **ATTACHMENT 1 TABLE 1**

	A	B	C	D	E	F	G	H	L
1		2003/04		2004/05					
3		Original £'000	Revised £'000	Unavoid-able £'000	Actual Commit-ment £'000	Deferred Actual £'000	Planned Commit-ment £'000	Total £'000	2005/2006 £'000
6	**Existing Investment Plans**								
7	Mentally Disordered Offenders		(100)		(100)			(100)	1,455
8	EPPIC (**Unmet Need**)								750
9	Employment	200	200	120	80	100		300	300
10	ARBD	937	300	500		500		1,000	1,000
11	Mental Health in Prisons								
12	Increased Medical Workforce Plan								750
13	People with Severe Personality Disorder								300
14	Psychological Therapy								300
15	Social Care (Adults) GCC								
16	Support to Resource Centre	145	145	145				145	145
17	Services for Younger People with Dementia	100	100	100				100	100
18	Enhanced Day Services					300		300	375
19	Home Based Respite	150	128	150				150	150
20	Home Support & Day Care	144	59	144				144	188
21	Adult Accommodation Assumptions	1,948	1,948	2,175				2,175	2,073
22	Social Care (Older People) GCC								
23	Home Based Respite	100	50		150			150	150
24	Home Support & Day Care	150	100		350			350	600
25	Services for Older People with Dementia	150	100	200				200	290
26	Older People Accommodation Assumptions	793	793	1,288				1,288	1,288
27	Social Care - Other LA's								
28	East Dunbartonshire	195	98	98	49	49		196	392
29	East Renfrewshire	106	54	54	27	27		108	216
30	North Lanarkshire	38	19	19	10	9		38	76
31	South Lanarkshire	149	75	75	38	37		150	300
32	West Dunbartonshire	130	66	66	33	33		132	264
33	Assumptions: Blawarthill P'ship Beds (West)	500	500	500		490		990	990
34	Assumptions: Greenfield Park P'ship Beds (East)								
35	Specialist In-Patient Addiction Beds (Whole Area)	200	200	400				400	400
36	Eating Disorders	400	270	400				400	400
37	Counselling Services - Centre for Women's Health	50	50	50				50	50
38	Integrated Pathway Project (Perinatal)	80	80	80				80	80
39	Perinatal Inpatients	250	250	250				250	250
40	Perinatal Community	160	160	380				380	380
41	Liaison Psychiatry	500	500	555		195		750	1,000
42	Training Bid	70	70	100				100	180
43	Tackling Stigma	100	100	130		50		180	180
44	Managed Network / System Managers	100	20			100		100	100
45	Antipsychotic Drugs		500	1,000				1,000	1,500
46	Mental Health Act Implementation		50	1,000				1,000	1,400
47	Ward Closure Savings		(430)	(790)				(790)	(1,456)
48	Included in Base (2001/02 - 2003/04)			(6,455)					
50	**Existing Investment Plans Cumulative**	7,845	6,455	2,734	637	1,890		11,716	16,916
56	**New Unavoidables**								
57	Forensic Unit Inflation / Capital Charge Pressure								685
59	**New Unavoidables Cumulative**								685
74	**Investments Cumulative**	7,845	6,455	2,734	637	1,890		11,716	17,601
77	**Investments Incremental**	7,845	6,455	2,734	637	1,890		11,716	5,885

2004/05 REVENUE STARTPOINTS AND 5 YEAR FINANCIAL PLAN

Report of the Director of Finance
Board meeting 20th April 2004

RECOMMENDATIONS:

The Board is asked to:

- **Confirm the proposals for the use of new monies available in 2004/05 as proposed in the Local Health Plan and as set out in this report which thereby define the 2004/05 Startpoint Revenue Allocations.**

- **Confirm the follow through into 5 Year Financial Plan as set out in this Director of Finance Report.**

- **Receive a further report on Recovery Plan proposals that will set out how the Board will return to financial breakeven over the next 2 years.**

SUMMARY

This paper sets out the Board's financial prospects for 2004/05 within the context of 5 year financial plan for the period 2004/05 to 2006/07.

The analysis gives full details of both the additional funding available and proposals for the use of that funding as follows for 2004/05:

	£m	£m
INCOME		
2003/04 Base Brought Forward		1,011.6
2004/05 General 'Uplift	68.5	
Modernisation Fund	4.8	
Unmet Need	4.0	
Earmarked Funds	15.7	
		1,104.6
EXPENDITURE		
2003/04 Base Brought Forward		1,011.6
Overcommitment from 2003/04	38.2	
2004/05 Inflation Uplift	77.6	
Service Developments, Including Wait Times	36.1	
		1,163.5
OVERCOMMITMENT		58.8
Offset by Recovery Plan Savings		22.0
REMAINING DEFICIT		36.8

The Board has set itself a target of achieving financial balance over the next 2 years: this assumption underpins the affordability of Phase I of the ASR.

If this is not achieved, the financial plan for the next 5 years needs to model both:

- The year-on-year recurrent over commitment; and
- A non recurrent allocation reduction to correspond with any year end deficit.

On this basis, and with no step up in the Recovery Plan savings, financial prospects are as follows:

	2004/05	**2005/06**	**2006/07**	**2007/08**	**2008/09**
	£m	**£m**	**£m**	**£m**	**£m**
Recurrent deficit	(36.8)	(57.3)	(57.8)	(54.0)	(50.4)

This financial deficit can only be closed by a more radical approach to service design and delivery locally.

RISK MANAGEMENT

Even at this figure, there are significant risks associated with the overall assessment as follows:

- Pay awards may exceed the funding available. There remains major uncertainty around the final cost of the new Consultants' Contract and funding for the new GP's Contract. The detail of proposals contained in Agenda for Change will similarly need to be clarified in 2004/05.

- Prescribing costs may increase beyond the funding available, particularly as a result of drugs approvals.

- Capital charges and/or revenue may be required as a result of the reduction in "capital to revenue" transfers.

- The basis on which Trusts have assessed their underlying deficits varies and so far only £11m (£13m over 2 years) of operational savings have been identified to offset the estimated £18m total deficit.

- There are major risks associated with curtailing new service developments: equally, the sums identified for wait list improvements are assumed to be adequate to meet the required targets. Brokerage against future land sales will need to be agreed with SEHD to fund the additional non recurrent funding required (approx £10m in each of 2004/05 and 2005/06).

- West of Scotland income targets may not be achieved.

- Most crucially, the main focus now needs to shift to the Recovery Plan. Current proposals leave an unfunded "gap" of £36.8m, and any slippage on proposals will increase the deficit further in 2004/05.

STRATEGIC CONTEXT AND RISK MANAGEMENT

The financial challenge facing the Board is major: there are risks associated with both the assessment of new funding requirements and the release of monies against the Recovery Plan proposals.

The following sections highlight key issues.

NEW MONIES AVAILABLE:

The SEHD have advised the following uplift to Glasgow's 2004/05 Revenue Allocations:

	£m	
General Uplift	65.3	Equivalent to 6.75%
Devolved funds previously centrally held	3.4	
Modernisation fund	4.8	
Unmet need	4.0	Non recurrent fund in 2004/05 and 2005/06 only
	77.5	

As a result of changes in Glasgow's population estimates, the annual general uplift has been reduced to the minimum available, 6.75%.

However, in recognition of the degree of ill health and deprivation, specific, non recurrent, funding has been made available to address this "unmet need". £4m is available in 2004/05, rising to £8m in 2005/06. Uncertainty remains as to whether this funding will eventually be incorporated into baseline allocations.

In addition, specific allocations for investment in National priority services is anticipated in 2004/05 equivalent to that received in prior years as follows:

	£m
Cancer	8.912
Stroke	0.600
CHD	0.600
Delayed Discharge	5.543
	15.677

PAY AWARDS

The new monies available each year has to fund annual pay and prices increases.

2004/05 will see the implementation of major pay arrangements in the NHS as set out in the new Consultants' Contract, the new GPs' contract, Agenda for Change (from October 2004) together with commitments made to other aspects of Staff Partnership working.

Most staff groups have now been advised of a 'cost of living' increase of +3.225% in 2004/05. The further impact of Agenda for Change is difficult to estimate and may now be delayed to October 2004.

The proposal is uplift all pay budgets by 5.5% @ £26.0m. If Agenda for Change is delayed this could release up to £4.0m, in 2004/05 only: if there is no backdating of the award.

Senior Medical Staff:

The Board are familiar with the complexities of the New Consultants' Contract: For the purposes of this analysis, the estimated costs have been modelled @ £17.2m and assumes that all Senior Medical Staff agree work plans giving on average an additional 1.4 sessions plus 0.8 Out-of-Hours sessions.

The estimated cost of £17.2m will be funded as follows:

	£m
2003/04 Uplift not yet committed	3.0
2004/05 Uplift @ 5.5%	3.1
West of Scotland contribution	3.2
Glasgow additional cost	7.6
Board staff	0.3
TOTAL	**17.2**

Work plans have yet to be agreed with individual Consultants and the total cost of the new contract may yet further increase.

Junior Medical Staff:

A further investment of £6.1m to achieve rota compliance is proposed. After this point, there should be scope for some rationalisation.

SUPPLIES INFLATION:

Equally complicated is the assessment of the impact of inflation and other related factors on the non pay (ie supplies) budgets. General inflation has been assumed at 2%, but particular items attract the need for additional funds as follows:

Prescribing

An 8% uplift, equivalent to £12.4m, is proposed for GP prescribing. This is a reduction from the previously proposed 10% increase: seen in conjunction with the £5m target for reductions in medicines spend, this may present a degree of risk in-year. In particular, there needs to be absolute clarity that savings have not been "double counted".

Hospital prescribing budgets are similarly under pressure, particularly from new drugs approvals and for cancer treatment.

A further uplift of 5% on those budgets, equivalent to £2m, is proposed for allocation across all Trusts.

Capital Charges

Following a detailed review, the impact of indexation on existing capital charges budgets requires additional funding of £12.6m; £10.2 net of West of Scotland contributions.

At this figure, all Trusts will have funding to match existing capital charges.

Capital to Revenue Transfers

SEHD have advised all Health Boards to anticipate "a significant reduction" in approvals for capital to revenue transfers. Annually, NHS Greater Glasgow requests approximately a £20m transfer to match expenditure on minor capital items, such as backlog maintenance, medical and computer equipment up to £5,000 and so on.

For the purposes of this report, the potential impact, which is unclear, has been handled as a non recurrent issue. Over time, however, if as a consequence all capital spend attracts capital charges, there will be a need to adjust revenue budgets accordingly.

Overall Inflation Requirements

To summarise, new funds available for 'general uplift' in 2004/05 are £68.5m: the cost of inflation as described above equates to £77.6m. Immediately, the Board requires savings to "stand still". This factor in combination with continuing uncertainty about aspects of pay awards presents considerable risk.

Again, for the purposes of this analysis, all inflation uplifts have been shown net of West of Scotland contributions, on the assumption that these will be met in full.

TRUST DEFICITS

Trusts were then asked to test whether, with the addition of the proposed inflation uplifts to startpoint allocations, they would be able to breakeven. All Trusts reported, that to varying extents, they still had unmet cost pressures, totalling to an underlying recurrent deficit of £18.2m.

This figure is in addition to the recurrent over commitment of £20.2m agreed by the Board in setting budgets for 2003/04. Non recurrent funds were available in 2003/04 (essentially from "profit" on land sales) to offset this amount last year.

All of the factors referred to in the narrative thus far, can be summarised as follows:

	£m	£m
2004/05 New monies available		
General uplift	65.3	
Bridging finance	3.4	
Modernisation fund	4.8	
Unmet Need	4.0	
SUB TOTAL		**77.5**
2004/05 Commitments:		
Over-commitment from 2003/04	20.2	
Trusts underlying deficits	18.0	
Pay inflation including Consultants' Contract	39.7	
Supplies inflation including prescribing	27.7	
Capital Charges	10.2	
SUB TOTAL		115.8
OVERCOMMITMENT		**38.3**

BALANCING THE NEED FOR NEW SERVICES DEVELOPMENTS AGAINST RECOVERY PLAN SAVINGS

As the table above demonstrates, such is the cost of inflation, together with other underlying cost pressures, that new monies available for new service developments can only be "generated" by equivalent savings/cost recovery plans.

At this point, it is arguably unreasonable to assume that no forward plans can be honoured: the challenge becomes how to balance demands for service investments against proposals for equivalent recovery proposals so that, over a similar time period, financial savings can be made available to fund new developments.

Two processes, therefore, need to run in parallel:

- A re-assessment of the Local Health Plan (LHP) spending programmes to minimise the 2004/05 deficit by limiting new service developments; and
- A rigorous cost recovery plan that will generate savings over the same time period.

A separate report updates the Board on LHP proposals: the recurrent revenue requirement for "unavoidable" service developments totals £36.1m, including £15.7m investment of earmarked funds for Cancer, Heart Disease, stroke and Delayed Discharges.

For the purposes of the 5 Year Financial Plan, any deferred plans not confirmed as "unavoidable", in 2004/05 have been shown as requiring funding in 2005/06, together with the relevant pre-existing LHP proposals for that year and beyond.

Acute Service Review

Beyond these pre-existing LHP proposals, the Board has additionally approved revenue funding to support the ASR Phase I to be available by 2007/08. This has been shown as a recurrent commitment from 2005/06.

Unmet Need

Proposals for the use of the additional £4m funding available to address Glasgow's 'unmet needs' have been included in the relevant healthcare programme.

Waiting Time Targets

To achieve the National targets by December 2005, additional recurrent investment of £2m is required, together with the uncommitted £4m available in the existing baseline allocation. A further £4m is required from West of Scotland Boards to achieve these targets for cases undertaken in Glasgow.

In addition, there is a significant requirement for non recurrent funding (approximately £10m in each of 2004/05 and 2005/06) to deal with the "backlog" of patients.

Brokerage against future land sales is sought from the SEHD to provide the necessary non recurrent funding.

WEST OF SCOTLAND INCOME

As ever, there are significant risks associated with assumptions about income from other West of Scotland Health Boards.

To assist the analysis, monies due have been separated into:

- Inflation and related uplifts to existing service level agreements with Glasgow Trusts.
- Additional income due as a result of cross-subsidisation of current services by Glasgow and the need to underpin regional services with explicit agreements to reflect case mix complexity.

Inflation Related Uplifts

West of Scotland Health Boards have been asked to confirm that they will meet their respective shares of the following inflation and related costs, specifically:

- Pay and prices including Consultants' Contract
- Capital charges
- Wait Times
- Neurosciences

As already stated, the revenue plan consequently shows the net cost to NHS Greater Glasgow for these factors.

Case Mix Complexity and Cross Subsidisation

Discussions of these aspects are tied into proposals for the Regional Planning Framework.

Desktop analysis indicates substantial sums are due to reflect particularly case mix complexity. Consequently, the Glasgow-wide Recovery Plan assumes £10m additional income in 2004/05. It is, however, unlikely, even if agreement is reached, that the funding will be released in a single year.

RECOVERY PLAN PROPOSALS

Trusts have indicated that recurrent deficits will be carried forward into 2004/05: savings proposals have been identified that, in part, offset those deficits as follows:

[All figures £m]	Deficit	Savings		Net Position
	2004/05	2004/05	2005/06	2004/05
North	(8.500)	4.400	5.400	(4.100)
South	(3.966)	1.665	2.784	(2.301)
PCT	(3.800)	3.850	3.850	0.050
Yorkhill	(1.906)	1.000	1.000	(0.906)
TOTAL (Table 20)	**(18.172)**	**10.915**	**13.034**	**(7.257)**

Trust-specific savings plans identified above have been incorporated into fuller pan-Glasgow Recovery Plan as follows:

		2004/05 £'000 Target
1	**Benchmarking Acute Services and Identifying Potential to Reduce Capacity** Review: – Day care only homoeopathic service – All "stand alone" rehabilitation hospitals – Dermatology in-patient beds – Conversions to 5 day wards	3,150
2	**Acute Services: Potential ASR Acceleration**	**tbc**
3	**Review Care Services for Older People**	
	– Reduce continuing care beds	1,500
	– Close beds to reflect reduced cross boundary flow	1,000
4	**Improve Prescribing**	
	– Restrict introduction of new drugs	7,200
	– Aggressive cost reduction programme	
5	**Introduction of pan Glasgow Working in:**	
	– Finance and supplies	3,915
	– HR	
	– Pharmacy	
	– Catering	
	– Medical illustration	
6	**Pay Modernisation**	
	– Manage introduction of Agenda for Change within funding available	
7	**West of Scotland Income**	
	– Recover full costs of services in Glasgow hospitals or reduce activity	10,000
8	**Cancer and Heart Disease**	
	– Review of current service costs	0
9	**Benchmark Workforce**	
	– Range of initiatives including:	2,150
	o Reduce agency costs	
	o Identify potential for reduced and reshaped workforce	
	o Scrutinise all vacancies	
	o Move from on call to shift systems	
10	**Review Estates**	
	– Identify potential for workforce and facility changes	500
11	**Review Non Acute Capacity**	1,000
	– Identify potential to reduce mental health beds	
	– Identify potential to reduce Children's Hospital beds	
12	**Reduce Management costs**	500
13	**Clinical Workforce Design**	
	– Range of initiatives including:	
	o Reduce costs of junior doctors	1,000
14	Document Management	
	– Replace paper records	tbc
	TOTAL	**31,915**

Shown as: recurrent savings available to offset deficit	21,915
Non recurrent income	10,000
	31,915

SUMMARY AND RECOMMENDATIONS:

As this report sets out, 2004/05 will start with a financial deficit: modelling the implications over the next 5 years produces the following profile:

	2004/05 £m	**2005/06 £m**	**2006/07 £m**	**2007/08 £m**	**2008/09 £m**
Income					
New Monies Available	77.4	79.4	66.9	71.0	75.2
Earmarked Funding	15.7				
Income	**93.1**	**79.4**	**66.9**	**71.0**	**75.2**
Uses					
Trust Deficits	20.2	36.8	57.3	57.8	54.0
	18.0				
Pay	39.7	35.0	22.1	23.4	24.7
Supplies	27.8	32.7	35.0	37.3	39.9
Capital Charges	10.2				
New Service Investments	20.4	36.9	4.5		
Acute Services Review		7.3	6.0	6.4	6.9
Earmarked Expenditure	15.7				
Uses	**151.9**	**148.7**	**124.8**	**125.0**	**125.6**
Gap	**(58.8)**	**(69.3)**	**(57.8)**	**(54.0)**	**(50.4)**
Recovery Plan	(22.0)	(12.0)			
Recurring Surplus/(Deficit)	**(36.8)**	**(57.3)**	**(57.8)**	**(54.0)**	**(50.4)**

As the requirements for funding are well established, the focus of attention now needs to shift to ensuring that the Corporate Recovery Plan delivers the required savings over next 2 years.

Consequently, the following recommendations are made:

- Confirm the proposals for the use of new monies available in 2004/05 as set out in this report and thereby define the 2004/05 Startpoint Revenue Allocations.

- Confirm the follow through into 5 Year Financial Plan as set out in this Report.

- Receive a further report on Recovery Plan proposals that will set out how the Board will return to financial breakeven over the next 2 years, 2004/05 and 2005/06.