**NHS GREATER GLASGOW AND CLYDE**

**NHS Board Meeting**
**20th January 2015** **Paper No 15/01**

**Director of Corporate Planning and Policy**

# Approval of Schemes of Integration – Introductory Paper

## Recommendation

The Board is asked to approve the attached Integration Schemes:-

- Subject to resolution of the final points of discussion indicated in this paper including chairing and arrangements for the Board to ensure targets and measures are established as described in this paper, directly drawn from the regulations;
- With authorisation to the interim Chief Officers and Director of Corporate Planning and Policy to work together with Council colleagues to revise schemes based on the Board discussion and to engage with Scottish Government to progress the Schemes approval;
- Should that approval process raise issues which cannot be resolved to report back to the Board for further direction.
- Confirmation in that approval process that the Board's Scheme of delegation can frame the operational responsibilities so that the Board can be assured its governance and accountability requirements and responsibilities can be met.

## 1. Introduction and Purpose

The Public Bodies (Joint Working)(Scotland) Act 2014 (the Act) requires Health Boards and Local Authorities to integrate defined Adult Health and Social Care Services. They can also choose to integrate additional Adult Health and Social Care Services beyond the minimum prescribed by Ministers, and Children's Health and Social Care Services. The Act requires the Council and the NHS Board to prepare jointly an Integration Scheme setting out how this Integration is to be achieved.

This paper brings to the Board for approval the proposed Integration Schemes which have been developed through processes led by Interim Chief Officers for:-

- East Renfrewshire
- West Dunbartonshire
- Inverclyde
- Glasgow City

The Integration Joint Boards, which the full approval of the Schemes will establish, are required to be responsible for the strategic planning of the functions set put in the legislation, including planning for elements of Acute Services, and for directing the delivery of those functions through the locally

agreed operational arrangements.

We have agreed with these four Councils that responsibility for a wider range of services than those prescribed by the legislation and regulations will sit with the Integration Joint Boards and their Chief Officers. Each Scheme sets out the detail of those agreements.

## 2. Process

Each Integration Scheme has been developed and drafted through a local process led by the Chief Officers Interim or Designate and fully engaging local CH(C)P Committees and the emerging shadow IJB's. There has been appropriate consultation on each draft Scheme.

## 3. Operational Arrangements

We set out to the November Quality and Performance Committee the proposed approach to operational delegation which is now reflected in these Integration Schemes. The essence of the approach is that the Chief Officer will be responsible for the operational delivery of an agreed range of services with oversight and direction provided by the IJB. That range of services as set out within the legislation and regulations:-

- With the exception of Acute Services where the operational responsibility remains with the Board.
- With the addition of Children's Services where Councils and the Board have agreed an integrated delivery approach.

The November Quality and Performance Committee also considered a draft Scheme of Delegation intended to provide the Board with a clear basis for delegation and assurance about the lines of sight back to the Board's statutory responsibilities for governance across clinical quality and safety, staff and employment, equalities and finance. A final draft of that Scheme is **appendix 1** of this paper. The Scheme will be finalised for consideration by IJB's by Board and Chief Officers.

Operational management of additional defined specialist services, which do not lie within the scope of the legislation, may be the responsibility of a Chief Officer but the oversight will remain directly with the Board through the Chief Executive, including agreement on changes to resourcing or organisation of services. These services include forensic and prison health care, sexual health, and specialist children's services. The final versions of the Integration Schemes will need to reflect this.

## 4. Staff Governance

The Board has had an Integration Development Group to coordinate where required the development of our approach to integration. That Group has included extensive staff side representation and has developed a singular narrative on staff governance which is included within each draft Scheme.

## 5. Chairing

The Board made proposals about Chairing arrangements to achieve an NHS and Council balance across Partnerships which were not accepted by all Councils. Following a report on this outcome the November Quality and Performance Committee asked the Board Chief Executive to seek an agreed way forward to deliver that balanced approach. Responses have not yet been received from all Councils to the subsequent further correspondence. The draft Schemes reflect the Council positions and in considering the draft Schemes it is proposed that the Board formally notes chairing arrangements need to be agreed before Schemes can be submitted. That correspondence is **appendix 2** of this paper.

## 6. Outcomes

The Council and the NHS Board have two responsibilities with regard to performance which need to be addressed in Integration Schemes, these are to:-

- **set out a process** by which a list of targets, measures and arrangements that relate to any operational functions will be developed, and the extent to which responsibility will lie with the Integration Joint Board.
- **Set out a process** for those targets, measures and arrangements that the Integration Joint Board must take account of in their Strategic Plan as the provision of integrated services will impact upon the delivery of the targets.

The Council and the NHS Board will work together to develop proposals on these targets, measures and arrangements to meet these requirements to put to the first meeting of the Integration Joint Board for agreement based on Council Strategic Plans and SOAs and local NHS strategic direction and national NHS LDP and related requirements. A draft of the NHS proposals is included as **appendix 3** to this paper. This wording, which is drawn directly from the regulations, is not consistently included in all schemes. It is important for the discharge of the Board's accountability to Scottish Government and related governance that revised drafts are clear on this point.

## 7. Financial Issues

The Board needs to have confidence in establishing IJBs that the funding allocated to them is appropriate to the responsibilities which the IJB will discharge. The relevant national guidance states:-

***Financial assurance and risk assessment***

*In order to assess whether the resources delegated to the Integration Joint Board are adequate for it to carry out its functions, the shadow Chief Officer and shadow Chief Finance Officer must review the provisions in the Integration Scheme that set out the method of determining the payments and amounts to be made available to the IJB; this should include both the method for setting the initial sums and that to be followed in subsequent years.*

*Assurance for the Initial sums*

*It is recommended that the initial sums should be determined on the basis of existing Health Board and Local Authority budgets, actual spend and financial plans for the delegated services. It is important that the plans are tested against recent actual expenditure and that the assumptions used in developing the plans and the associated risks are fully transparent.*

*To assist in this it is recommended that:*

- *The budget in the financial plan is assessed against actual expenditure reported in the management accounts for the most recent two/three years. Ideally, the roll forward of the budget for the delegated services and the actual expenditure over this period should be understood;*

- *Material non-recurrent funding and expenditure budgets for the delegated services and the associated risks are identified and assessed;*

- *The medium term financial forecast for the delegated services and associated assumptions and risks is reviewed;*

- *Savings and efficiency targets and any schemes identified are clearly identified and the assumptions and risks are understood by all partners. This is a key part of the assurance process and the experience from Highland partners is that it is a potential source of future disagreement it is advised that partners devote sufficient time to understand the targets, efficiency schemes and associated assumptions and risks;*

- *All risks should be quantified where possible and measures to mitigate risk identified. Risks could be classified as delivery of efficiency savings; on-going risks; emerging risks;*

- *The amount set aside for the IJB consumption of large hospital services is consistent with the methods recommended in the IRAG guidance on the set aside resource and that the assumptions and risks are assessed.*

*Partners should be aware that the financial regimes, cultures and terminology differ between Health Boards and Local Authorities with the potential for confusion when reviewing the budget-particularly in the definition of what represents a recurrently balanced budget. It is recommended that partners are clear about the definitions of the terms used in their assurance work.*

*In line with normal budget monitoring practice, it is advised that a review be carried out during the post integration period to compare actual performance against the assumptions in the plan.*

*A key lesson from the experience of Highland partnership is that partners may find it useful to consider treating the first year as a transitional year and agree to a risk sharing arrangement with adjustments being made through subsequent year's allocations; if partners adopt this approach, it is recommended that it is*

*incorporated in the Integration Scheme.*

**This work has not yet been fully completed due to the NHS and Local Authority budgetary cycles. The rest of this section gives a headline view of the financial position.**

## 7.1 NHS Allocations

The Board will not finalise 2015/16 allocations until February 2015 (subject to final Board approval in May/June 2015). However it is important approval of these Schemes is underpinned by an appraisal of financial viability, particularly in relation to the outcomes described above.

The NHS budgets of all four Partnerships are in recurring balance going into 2015/16. For 2015/16 the Board will make additional allocations to cover identified cost pressures in staff costs/pensions and other inflationary pressures. Individual Partnerships will be expected to contribute to the Board savings target, currently assessed as around £45 million of which Partnerships share is currently estimated to be £15m. Financial planning work to date led by Chief Officers has indicated that savings at this level could be delivered in 2015/16. It is important to link the financial position to delivery requirements; **appendix 3** to this paper outlines the Board's approach to delivery requirements of IJB's establishing must do areas of performance and areas where there is more flexibility although targets remain in place. **Most fundamentally given the pressures on Emergency Acute Services we need Partnerships to ensure patients are discharged on time.**

From the Board's perspective it is important to recognise this commitment would require the remaining savings target to be delivered through the Board's Corporate and Acute Services. Particularly important in this regard is that IJB's deliver on delayed discharge targets within their allocations.

## 7.2 Social Care Allocations

Councils will not finalise their budget allocations until February or March 2015 but draft proposals are currently available. The likely opening position for each of the four Councils Social Work budgets is described below.

**Inverclyde** – The current year projection for Social Work is a small overspend of £0.27 million which will be eliminated by the year end from one off monies. The Council will address this in 2015/16 by additional demographic pressures funding. The Social Work budget for 2015/16 is £48.15 million (net), which was agreed as part of the 2013-2016 multi-year budget and includes £1.03 million of agreed savings, although this target will be reduced by the agreed uplifts for pay and other inflation and by £0.75 million of additional funding for demographic pressures with Older Peoples Services (with a subsequent further £0.5 million in 2016/17) and £0.2m for Learning Disabilities, subject to ratification by Council in February. As a result the Council considers that a balanced position can be achieved for 2015/16.

**Glasgow City** – The current projected out-turn for Glasgow's social work budget for 2014/15 is an overspend of £3.9m which will be managed in year as part of the Council's overall out-turn. At this stage we have not seen detailed plans on how the Council proposes to close this gap in 2015/16 following the establishment of the IJB although in overall terms this is a relatively small deficit (less than 1%) when taken as a proportion of the overall net expenditure social work budget of approximately £430 million.

**West Dunbartonshire** - West Dunbartonshire Council will not finalise 2015/16 allocations until February 2015. The current budget submission by the Social Work department identifies a budget of £63.2m which takes account of increased service pressures (before deduction of 2015/16 savings targets). Local Authority funding is expected to be allocated to cover financial pressures existing in 2014/15, however a pressure of approximately £0.4m within care home staffing costs will require to be met through local management control.

**East Renfrewshire** - The indicative 2015/16 opening budget for the social work services to be included within the IJB is £46.9 million. This includes an inflationary uplift of £2.2 million and a deduction of £1.2 million for agreed savings targets. The year to date position for 2014/15 is a small surplus with a forecast out-turn of an overspend of £0.4 million which will be managed within the Council's overall out-turn. The Council believes a balanced position is achievable in 2015/16 subject to achievement of planned savings.

## 8. Acute Services Planning

The Integration Joint Boards have statutory responsibility for strategic planning, including for a range of Acute Hospital Services, for which the operational delivery responsibility will remain with the Board. National guidance sets out how the financial values are to be developed for strategic planning and confirms that:-

- In Boards with more than one Partnership there should be a single coordinating plan held by the Health Board.
- There should be a jointly agreed approach to managing the financial impacts of changes in Acute activity;
- There should be a carefully planned and managed move from historic to fair share allocations;

The Board is establishing joint planning arrangements with Chief Officers to develop Acute Planning and the financial arrangements which underpin it.

## 9. Next Steps

The recommendations to the Board provide a clear basis to move the draft integration schemes into the next phase of process which is submission to Scottish Ministers for their approval. Once that approval is granted Integration Joint Boards can be established by Order of Scottish Ministers.

Our aim is that the timing of that establishment is synchronised with the abolition of Community Health Partnerships which takes effect from April 1st 2015. The timescale set out by the Government in earlier correspondence suggest a lengthy

period for their consideration of Schemes, in our view our Schemes should be able to be scrutinised and laid before Parliament to enable us to meet that timescale. If that is not the case we will establish interim arrangements as required and report to the Board accordingly.

If the Board does not at this stage approve any Scheme that would trigger further negotiations with the relevant Local Authority with the aim of meeting the Government deadline to submit schemes for approval by April 1st 2015. The recommendations to this paper suggest a degree of flexibility for redrafting within the next stage of process but with the facility to return to the Board for further guidance.

**Appendix 1**

## Scheme of Delegation to Integration Joint Boards

### 1. Introduction and Purpose

This short paper sets out the basis on which the Board will delegate responsibility for service delivery to each of the Chief Officers with oversight and direction to be provided by each Integration Joint Board.

IJBs are responsible on a statutory basis for:

- Strategic planning for their population a responsibility created by statute;
- Working jointly with the Board to plan the delivery of Acute Services to their population;

The creation of IJBs as operational entities managing on an integrated basis the delivery of services is the clear intention of the legislation. Those operational responsibilities for Health Services need to be agreed between the Board, the Council and the IJB.

Chief Officer will be responsible for the operational delivery of the agreed services with the IJB providing oversight and direction. The proposed services covered by this Scheme are as set out within the legislation and regulations, with the exception of:-

- Acute Services where the operational responsibility remains with the Board.
- Services where the Board agrees with IJBs and Chief Officers that delegation will be to a single IJB and Chief Officer to manage services on behalf of the others, for which oversight arrangements will be agreed.
- Children's Services where the four Councils and the Board have agreed an approach which goes beyond the requirements of the legislation.

This Scheme of Delegation sets out a clear basis for delegation and provides assurance about the lines of sight back to the Board's statutory responsibilities for governance across clinical quality and safety, staff and employment, equalities and finance.

### 2. Operational Responsibilities

The principle of this Scheme of Delegation is that IJB's and their Chief Officers have a high degree of autonomy for service delivery but that this Scheme provides an essentially clear basis for the relationship to the Board which ensures the Board can exercise its responsibilities.

Delivery of specialist, regional and national services may be delegated directly by the Board to individual Chief Officers. Delegation arrangements for these services, which will continue to be governed by the Board, are not included in this Scheme of Delegation.

## 3. Governance

Governance for the operational services specified is carried out by the Integration Joint Board. In carrying out that role there are a number of obligations placed on the NHS Board by statute and Scottish Government direction to which the IJB needs to have regard:-

- **Staff:** The NHS Board remains the employer for all staff within HSCPs and therefore the IJB needs to scrutinise compliance with Staff Governance and related requirements. The Board Staff Governance Committee will meet a small number of times each year to take a system wide overview. Partnership arrangements within IJBs will need to meet the required national standards and Area Partnership Forum will retain its role in final decisions on HR policy for all the Board's employees. As the Board remains employer there will be reporting arrangements in place for HR issues which Partnerships will need to fulfil including in relation to the Equality Act.

- **Financial:** In relation to delegated operations compliance will be required to comply with the Boards Standing Financial Instructions and related scrutiny arrangements.

- **Clinical:** the Board Chief Executive is responsible for clinical governance, quality, patient safety and engagement, supported by the Board's professional advisers. This responsibility is delegated to each Chief Officer. COs and their IJBs need to establish appropriate arrangements to discharge and scrutinise those responsibilities and to link to Board wide support and reporting arrangements including the systems for reporting of serious clinical incidents. The Board Medical Director is responsible for the systems which support the delivery of clinical governance and medicines governance, those arrangements including the clinical governance unit and the processes which underpin it remain unchanged.
  In respect of services for which the Board retains responsibility the Board Clinical Governance Forum is responsible for demonstrating compliance with statutory requirements in relation to clinical governance, authorising an accurate and honest annual clinical governance statement and responding to scrutiny and improvement reports by external bodies such as Healthcare Improvement Scotland. To achieve this, the Committee oversees a governance framework including a strategy, annual work programme, infrastructure of governance groups and an annual report. For services which the IJBs are responsible, they will be required to demonstrate through their partnership Clinical Governance committees/groups that they are compliant and provide demonstrable assurance to the Board Clinical Governance Forum. The Board wide patient safety programme needs to be operationally delivered by COs and scrutinised by IJBs with assurance provided to the Board Clinical Governance Committee.

  A single medicines governance policy framework, within existing corporate professional advisory structures, provides assurance of safe, effective and cost effective prescribing practice across acute services, mental health and primary care. This spans the activities of the Scottish Medicines Consortium, Regional Prescribing Advisory Groups and the Board Area Drug and Therapeutics

Committee, for example in relation to antimicrobial prescribing. In addition, the Board Head of Pharmacy & Prescribing Support (PPSU) is the Controlled Drugs Accountable Officer and is required by regulation to establish and operate systems for the safe management and use of controlled drugs.

- **Complaints:** Partnerships will deal with complaints about the NHS services for which they are responsible within the NHS policy framework and will need to comply with the reporting arrangements which enable the Board to fulfil its responsibilities.

- **Equalities:** IJBs will be responsible for the Public Sector General Equality Duty (PSGD) Equality Act 2010 in relation to staff and patients. The Board will continue to be responsible for the Equality Act 2010 PSDG and the Specific Duties which will require it to report on mainstreaming, equality outcomes, equality impact assessment, employee information, equal pay and procurement which will jointly set with the Board and the IJBs including joint equality outcomes.

- **Child Protection:** there will be a review with each Chief Officer with the Nurse Director as the Boards Lead for child protection on the arrangements which underpin responsibilities for child protection including Chief Officers Groups.

- **Patient Experience:** IJBs will be responsible for ensuring the requirements of the Patients Right Act are fulfilled by ensuring feedback and comments and suggestions from patient are adopted to demonstrate improvements. The Board will continue to be responsible for the production of the annual report on Feedback comments and suggestions unless this arrangement is revised by Scottish Government.

## 4. Legislation and Policies

There are a number of Board policies which the HSCP is required to comply with, these policies are those where there a legislative requirement or Government direction and relate to the statutory functions which remain with the Board The IJB will need a means to scrutinise that compliance. The areas covered by those policies are:-

- Patient Safety and Clinical Quality
- Infection control
- Complaints
- HR including Health and Safety
- Equalities
- Patients Rights including engagement
- Information and data protection
- Safe use of medicines
- Nursing and Midwifery National Framework
- Child and Adult Protection Policies
- Care and Assurance Accreditation Framework

The detailed list of the policies within these areas will be agreed with Chief Officers.

## 5. Professional Leadership

The Public Bodies (Joint Working) (Scotland) Act 2014 does not change the professional regulatory framework or established professional accountabilities currently in place.

Each IJB and CO will have identified professional leads as an integral part of the management team. These leads will have defined additional roles formally set out. They will have professional accountability to the Boards professional advisers through formal arrangements set out in more detail in the Board's management processes. The Board's professional leads will also be able to offer advice to Chief Officers and to IJB's. Professional leads work as an integral part of general management teams but have a particular professional responsibility to ensure they express their advice assertively in the interests of patients with an absolute responsibility to escalate concerns if their advice is not being taken, through professional, managerial or Board member routes.

## 6. The Responsible Officer

The Board Medical Director role includes the following areas:

- The Board Medical Director is the Responsible Officer within the terms of the Medical Profession (Responsible Officers) Regulations 2010 including the statutory role in making recommendations about the revalidation of doctors with a prescribed connection to NHS Greater Glasgow and Clyde. Chief Officers are required to cooperate with the Board's Medical Director to enable her to fulfil that role.
- The Board Medical Director is responsible for under and post graduate education and teaching of medical students and this will continue to be discharged through the Director of Medical Education.
- The Board Medical Director is responsible for single system pharmaceutical service provision including contractual arrangements with community pharmacies. This will continue to be discharged through delegated responsibility to the Head of PPSU. Chief Officers are required to co-operate with the Head of PPSU to enable fulfilment of this role.

## 7. Professional Nurse Regulation and Governance

The Board Nurse Director is responsible for all under graduate and post graduate nurse and midwifery education and evaluation of student nurse clinical placements. for all Board services.

The Board Nurse Director is responsible for the roll out of Revalidation for Nurses and Midwives which will be introduced during 2015 by the Nursing and Midwifery Council. Chief Officers are required to cooperate with the Board's Nurse Director to enable her to fulfil that role.

## 8. Relationship to the NHS Board

Each Partnership will have a number of relationships with the NHS Board:-

- **IJB members:** are Board Non Executives and remain members of the full Board and it's processes of governance and scrutiny as well as those of the IJB;
- **Strategic direction:** A board strategic direction will be developed with the IJBs setting out, at a high level, an agreed direction for health services.
- **Acute services:** The Board and IJB teams will work together to plan the delivery of acute services and the Board will reallocate resources in the light of changes and redesign delivered through that planning process.
- **Board Chief Executive:** shares a line management relationship with the Council Chief Executive to the HSCP Chief Officers.
- **Corporate Team:** the Board Chief Executive will have a structured routine of meetings with the Chief Officers as a group with Board Directors with system wide responsibilities including the Nurse, Medical, HR, Finance Planning and Public Health Directors. This group is the formal forum to identify and address any issues in the operation of this scheme of delegation
- **Financial allocations:** there will be a whole system financial planning process which will engage IJBs and Chief Officers leading to annual allocations to IJBs.
- **Support functions:** a number of whole system functions will continue to support Chief Officers in the discharge of their responsibilities. These include, capital planning, facilities; child protection; inequalities; clinical governance and prescribing.
- **Research and development:** This will continue to be led by the Board's medical Director on a whole system basis.

## 9. Supporting Scrutiny

To support these governance arrangements a single set of performance information for NHS services and responsibilities is being developed and will be signed off by the Board; IJBs and their Chief Officers. This will enable scrutiny by the Chief Officer and within the IJB, scrutiny by the Board Chief Executive in his line management capacity and aggregation to enable the full Board to have the overview of governance required to discharge its responsibilities.

**Appendix 2**

# NHS Greater Glasgow and Clyde

# Memorandum

**To:** Joyce White, CEO West Dumbartonshire Council
John Mundell, CEO Inverclyde Council
Lorraine McMillan, CEO East Renfrewshire Council
Sandra Black, CEO Renfrewshire Council
Annemarie O'Donnell, CEO, Glasgow City Council
Gerry Cornes, CEO East Dunbartonshire Council

**From:** Robert Calderwood, Chief Executive NHS Greater Glasgow and Clyde

**Date:** 22nd December 2014

**Subject:** **Chairing and Membership Arrangements – Integration Joint Boards**

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Thanks for responses to my note about chairing and membership arrangements for the Integration Joint Boards. We took the opportunity to discuss this at our November Quality and Performance Committee, below is the extract of the relevant section of that paper.

***Chairing and Membership:*** *The September Committee approved a proposal for discussion with Councils covering the arrangements for the first Chair of the Integration Joint Boards and the numbers of voting members as follows:-*

- *National guidance does not provide any direction on how the first IJB Chairs should be elected or their term of office be decided. From the Board perspective we need to ensure there is a balanced approach across the six Partnerships we will be establishing which builds confidence for the Board and our staff that there is genuine shared leadership across our new Partnerships. To achieve this it is proposed that where the Chief Officer is from a Local Authority background the Chair should be drawn from the NHS IJB members and vice versa. It is also proposed that the initial term of office for all Chairs should be two years, a balance between the two short term of a single year and the maximum of three years.*

*Responses from Local Authorities as set out below:-*

- ***West Dumbarton:*** *agrees approach to chairing so first Chair will be Council's.*
- ***Inverclyde:*** *accept the principle of the Board's proposed approach to chairing but wish to retain current Chair, Councillor Joe McIlwee who will be a Council nominee for the IJB, in the interests of continuity.*

- ***East Renfrewshire:*** *Accept the Board's proposal on chairing which would see first Chair from the NHS.*
- ***Renfrewshire:*** *want Council to have first Chair regardless of background of Chief Officer when appointed.*
- ***Glasgow City:*** *want Council to have first Chair although Chief Officer is a Council employee.*
- ***East Dunbartonshire:*** *Agree Board Chair approach, first Chair will be Council.*

Board members noted that these Council responses would see only one IJB chair come from the NHS members, with East Renfrewshire the only Council accepting our proposed approach where that resulted in an NHS Chair. Our members are of the view that this is not an appropriately balanced position and asked me to return to Council's to seek movement on the following basis:-

- To obtain collective agreement to our proposed approach so that there would be a more balanced split of chairs;

- To ask each Council for thoughts on a fair alternative approach which does not simply see an inflexible proposition that the Council has the first Chair;

If neither of these options is agreeable the proposal from our members is that we seek the agreement of Scottish Government to a joint Chairing arrangement for all Partnerships rather than register a failure to agree chairing.

I am conscious that we are working to finalise schemes of establishment for approval in the next few weeks and therefore would be grateful for your thoughts on these points as soon as possible. I am happy to discuss this with individual councils if that would be helpful.

**Appendix 3**

## DRAFT INTEGRATION SCHEME INDICATORS

Outlined below is a list of NHSGG&C indicators to be put to the Integration Joint Boards. The draft indicators have been grouped under the 5 strategic priorities outlined in NHSGG&C's 2015-16 Draft Strategic Direction. Within these groupings the indicators have been categorised as either essential or flexible. Those categorised as essential must be delivered against target and those categorised as flexible will be viewed as best endeavours within the context of continuing challenges.

The list of NHSGGC indicators originate from the Scottish Governments Local Delivery Plan Guidance, the Strategic Commissioning Plan Guidance and NHSGG&C's 2015-16 Draft Strategic Direction. It should be noted that performance against all of the Strategic Commissioning Plan outcome indicators are still draft with targets to be agreed. The list of indicators reflect a combination of each alongside some key indicators from NHSGG&Cs 2015-1 6 Draft Strategic Direction.

**Strategic Priority 1: Early Intervention and Preventing Ill Health**

| Ref | *Essential* Indicators | Local Delivery Plan Standards | Strategic Commissioning Plan Draft Outcome Indicators | Draft NHSGGC Indicators | 2015/16 Target |
|---|---|---|---|---|---|
| 1 | Primary Care Mental Health Team Waits | | | | |
| | % of patients referred to 1st appointment offered > 4 weeks | | | √ | 100% |
| | % of patients referred to 1st treatment appointment offered > 9 weeks | | | √ | 100% |
| 2 | Access Psychological Therapies - % of patients who started treatment within 18 weeks of referral | √ | | √ | 95% |
| 3 | Child and Adolescents Mental Health (CAMHS) - % of patients seen within 18 weeks | √ | | √ | 90% |
| 4 | Drugs and alcohol Referral To Treatment - % of patients seen < 3 weeks | √ | | √ | 91.5% |
| 5 | Smoking in Pregnancy | | | √ | 20% |
| 6 | % of children receiving their 30 month assessment | | | √ | tbc |

| | | | | | |
|---|---|---|---|---|---|
| | % of children reaching their 27 - 30 month assessment milestones | | | √ | tbc |

| Ref | *Flexible* Indicators | Local Delivery Plan Standards | Strategic Commissioning Plan Draft Outcome Indicators | Draft NHSGGC Indicators | 2015/16 Target |
|---|---|---|---|---|---|
| 7 | Cancer Screening: | | | | |
| | % uptake of Bowel screening | | | √ | 60% |
| | % uptake of Breast screening | | | √ | 70% |
| | % uptake of Cervical screening | | | √ | 80% |
| 8 | Smoking Cessation (quits at 3 months) | √ | | √ | 2,823 (14/15 target 15/16 target tbc) |
| 9 | Alcohol Brief Interventions | √ | | √ | 14,595 |
| 10 | Breastfeeding exclusive 6-8 weeks | | | √ | 24.4% |

**Strategic Priority 2: Shifting The Balance Of Care**

| Ref | *Essential* Indicators | Local Delivery Plan Standards | Strategic Commissioning Plan Draft Outcome Indicators | Draft NHSGGC Indicators | 2015/16 Target |
|---|---|---|---|---|---|
| 1 | Rate of emergency admissions for adults (including proposals to look at rate of emergency bed days for adults) | | √ | √ | tbc |
| 2 | Delayed Discharge | | | | |
| | > 14 days | | √ | √ | 0 |
| | > 72 hours(% of people leaving hospital within 72 hours of being ready for discharge) | | √ | √ | tbc |
| | Bed days lost to delayed discharge | | √ | √ | 75% reduction on 2009/10 baseline |

| | | | | | |
|---|---|---|---|---|---|
| 3 | Readmissions to hospital within 28 days | | √ | | |
| 4 | Deaths in acute hospitals: | | | | |
| | % patients aged 65 years+ | | | √ | 48% |
| | % patients aged 75 years+ | | | √ | 48% |

| Ref | *Flexible* Indicators | Local Delivery Plan Standards | Strategic Commissioning Plan Draft Outcome Indicators | Draft NHSGGC Indicators | 2015/16 Target |
|---|---|---|---|---|---|
| 5 | % of carers with a carers assessment | | √ | | |
| 6 | % of carers who feel supported to continue in their caring role | | √ | | |
| 7 | % of adults able to look after their health very well or quite well | | √ | | |
| 8 | % of adults supported at home who agree that they are supported to live as independently as possible | | √ | | |
| 9 | % of adults supported at home who agree that they had a say in how their help, care or support was provided | | √ | | |
| 10 | Proportion of last 6 months of life spent at home or in community setting | | √ | | |

**Strategic Priority 3: Reshaping Care for Older People**

| Ref | *Essential* Indicators | Local Delivery Plan Standards | Strategic Commissioning Plan Draft Outcome Indicators | Draft NHSGGC Indicators | 2015/16 Target |
|---|---|---|---|---|---|
| 1 | People newly diagnosed with dementia will have a minimum of 1 years post diagnostic support | √ | | √ | 100% |
| 2 | Falls rate per 1,000 population 65 years+ | | √ | | |

| Ref | *Flexible* Indicators | Local Delivery Plan Standards | Strategic Commissioning Plan Draft Outcome Indicators | Draft NHSGGC Indicators | 2015/16 Target |
|---|---|---|---|---|---|
| 3 | Number of people aged 65 years+ with an anticipatory care plan in place | | | √ | tbc |

| Ref | *Essential* Indicators | Local Delivery Plan Standards | Strategic Commissioning Plan Draft Outcome Indicators | Draft NHSGGC Indicators | 2015/16 Target |
|---|---|---|---|---|---|
| 1 | GP Access | | | | |
| | GP 48 hour access | √ | | √ | 90% |
| | GP advance booking | √ | | √ | 90% |
| 2 | % of complaints responded to within 20 days | | | √ | 70% |
| 3 | Staff sickness absence rate | √ | | √ | 4% |
| 4 | % of staff with completed e-KSF/PDP | | | √ | 80% |
| 5 | Induction Completion rates | | | | |
| | % of Health Care Support Worker staff with mandatory induction completed within the deadline | | | √ | 100% |
| | % of Health Care Support Worker staff with standard induction completed within the deadline | | | √ | 100% |
| 6 | Community Nursing Standards Compliance: | | | | |
| | Record Keeping | | | √ | 100% |
| | Medication | | | √ | 100% |
| | Hand Hygiene | | | √ | 100% |
| 7 | Financial balance | √ | | √ | (breakeven) |

**Strategic Priority 4: Improving Quality, Efficiency and effectiveness**

| Ref | *Flexible* Indicators | Local Delivery Plan Standards | Strategic Commissioning Plan Draft Outcome Indicators | Draft NHSGGC Indicators | 2015/16 Target |
|---|---|---|---|---|---|
| 11 | % of people with positive experience of their GP practice | | √ | | |
| 12 | % of adults supported at home who agree that their health and care services seemed to be well co-ordinated | | √ | | |
| 13 | % of adults receiving any care or support who rate it as excellent or good | | √ | | |
| 14 | % of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life | | √ | | |
| 15 | % of adults supported at home who agree they felt safe | | √ | | |
| 16 | % of staff who say they would recommend their workplace as a good place to work | | √ | | |
| 17 | Proportion of care and care at home services rated 3 or above in Care Inspectorate Inspections | | √ | | |

**Strategic Priority 5: Tackling Inequalities**

The indicators relating to tackling inequality will require further discussion.

| Ref | *Essential* Indicators | Local Delivery Plan Standards | Strategic Commissioning Plan Draft Outcome Indicators | Draft NHSGGC Indicators | 2015/16 Target |
|---|---|---|---|---|---|
| 1 | Number of Routine Sensitive Inquiry's carried out | | | √ | tbc |
| | Number of referrals made as a result of the routine sensitive inquiry being carried out | | | √ | tbc |

| | | | | | |
|---|---|---|---|---|---|
| 2 | % of staff trained in Gender Based Violence | | | √ | tbc |
| 3 | % of staff trained in Equality and Diversity Training | | | √ | tbc |
| 4 | Number of quality assured EQIAs carried out | | | √ | tbc |
| 5 | Number of referrals to financial inclusion and employability services | | | √ | tbc |
| 6 | Premature mortality | | √ | | |