Local Delivery Plan 2012-13

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Performance & Corporate Reporting

NHS Greater Glasgow and Clyde

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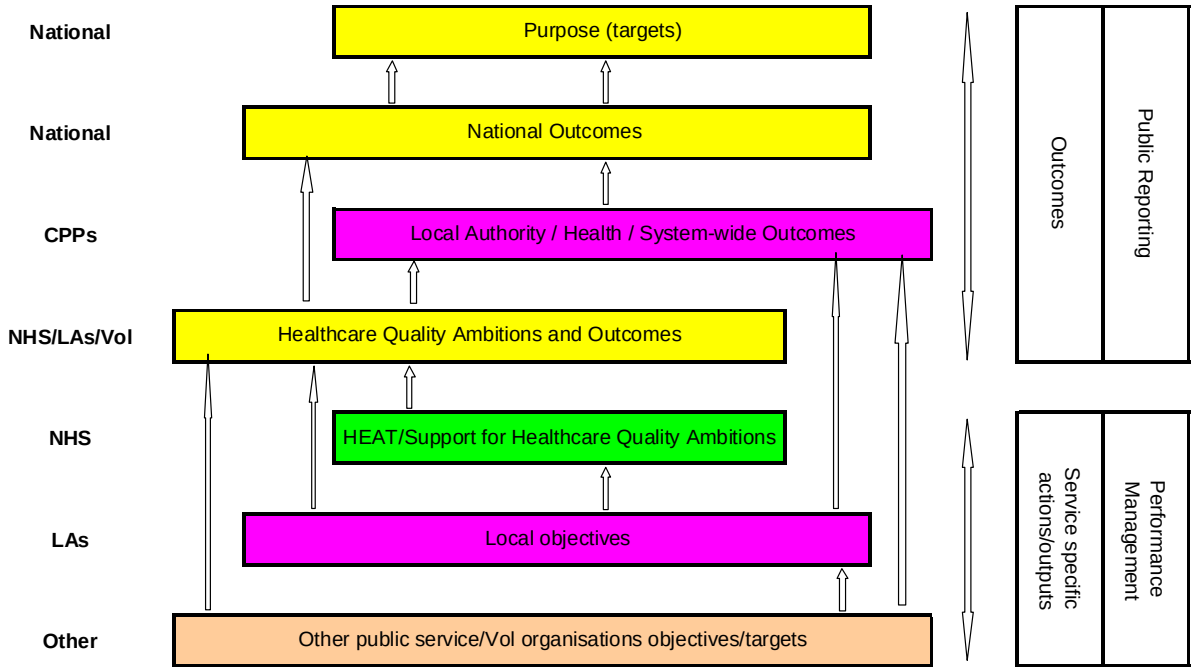
NHS
Greater Glasgow and Clyde

Annex 1

The Quality Ambitions and wider outcomes-based approach

Scottish Government and NHSScotland's Outcomes Approach

Over the last four years NHSScotland has developed its outcome approach.



NHS Greater Glasgow and Clyde's (NHSGG&C's) planning approach has been characterised by a shift to outcome based planning, where we have established clear outcomes to be delivered over the three year planning cycle.

Our Planning and Policy Frameworks outline the actions required in key areas of activity to meet the overall outcomes. Each framework has arrangements for future development and oversight of progress, with a range of performance indicators, including HEAT targets and standards.

The Planning and Policy Frameworks cover the following areas:

Planning Frameworks	**Policy Frameworks**
- Acute - Adult Mental Health - Alcohol and Drugs - Cancer - Child and Maternal Health - Long Term Conditions, Older People and Disability - Primary Care - Sexual Health	- Employability, Financial Inclusion and Responding to the Recession - Health Improvement - Sustainability - Unpaid Care - Tacking Inequality - Quality

Local planning and implementation is driven by the annual Development Plans which set out what each part of the organisation will do to achieve the outcomes identified in each of the Planning and Policy Frameworks. Each action is linked to a range of key performance

indicators which are used to measure progress against. An example of this can be seen below.

Example of Implementation and Accountability of Development Plans

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

OPRs have been timed to engage with and inform the forward planning process in addition to ensuring improvement in performance. The planning and performance cycle is an ongoing process and therefore it is expected that the conclusions from the November/ December 2011 OPRs will be translated into actions within Development Plan reviews. These reviewed plans are subsequently used as the main source document in the 2012/13 round of OPRs.

The Quality Strategy sets out NHSScotland's vision to be a world leader in healthcare quality, described through three quality ambitions: effective, person centred and safe. These ambitions are articulated through the **six Quality Outcomes** that NHSScotland is striving towards:

- Everyone gets the best start in life, and is able to live a longer, healthier life;
- People are able to live at home or in the community;
- Healthcare is safe for every person, every time;
- Everyone has a positive experience of healthcare;
- Staff feel supported and engaged; and
- The best use is made of available resources.

Twelve 'direction of travel' Quality Indicators help demonstrate progress towards the six outcomes (these are not targets). Every year a small number of **HEAT targets** are agreed with NHSScotland and partners. These set out the accelerated improvements that will be delivered across Scotland in support of progress towards the Healthcare Quality Ambitions and Outcomes. The latest statistics can be accessed through *Scotland Performs*.

The Scottish Government and NHSScotland are supporting frontline clinicians to adopt international best practice through improvement programmes including the Joint Improvement Team, the Quality Efficiency Support Team, and Scottish Patient Safety Programme. These programmes support delivery of system-wide improvement.

NHSScotland is a publicly funded and publicly delivered service. The services are planned in partnership on a national, regional and local basis. The principles underpinning the approach to performance management are set out in the Local Delivery Planning guidance.

The key ambitions and outcomes identified in the National Quality Strategy have been incorporated within NHSGG&C's Quality Policy Framework and reflected in Local Development Plans. Progress is reported to the Board's Quality and Performance

Committee at regular eight weekly intervals. In addition, the implementation of the National Quality Strategy is an integral part of the Board's organisational and development approach 'Facing The Future Together' which clearly sets the message to all staff that providing a 'quality' patient centred, safe and effective service to patients and their families and carers is everyone's responsibility.

The Government is fully committed to ensuring that patients, carers and communities are fully involved in the design and delivery of healthcare services and for them to be genuine partners in their own health care. We now have a Participation Standard, which builds on the Patient Focus and Public Involvement agenda that's been progressed in recent years. The Standard gives the assurance that progress is being made and identifies areas for improvement. As of 2010-11 all NHS Boards have conducted self-assessments against the Standard (using the Framework issued by the Scottish Health Council in its letter of 20 August 2010) and all have received feedback in the form of written reports from the Scottish Health Council and agreed improvement plans, for implementation throughout 2011-12.

During 2011-12 we submitted our Participation Standards self assessment to the Scottish Health Council. The self assessment highlighted the Board's progress in engaging with patients and the public in the planning and provision of our health services. Following the feedback received from the Scottish Health Council Improvement Plans have been developed in order to improve attainment levels in relation to each of the standards and a short report will be prepared for the Annual Review with the Scottish Government.

Through Community Planning Partnerships, we have worked with Local Authorities and other public bodies to agree the priority local outcomes and related indicators. With our partners, we have developed and agreed local outcomes and the approach for their delivery through Single Outcome Agreements. The Scottish Government's three social frameworks (Equally Well, Early Years Framework and Achieving Our Potential) provide the strategic direction for action to contribution towards delivery on national outcomes.

NHSGG&C is committed to Community Planning and tackling the identified Local Outcomes within the Single Outcome Agreement. This is demonstrated through this Local Delivery Plan which describes our contribution to a specific critical issue, derived from an identified Local Outcome, and which relates to the three interconnected social frameworks, or to economic recovery.

The importance of technology to underpin delivery of outcomes and drive efficiency is recognised. The National eHealth Strategy 2011-2017 sets out five strategic aims and the requirement for NHS Boards to provide outcomes based eHealth Plans aligned to these aims. These plans should be signed off locally by the senior management Board and progress against the Plan reported to Scottish Government eHealth Division.

The National eHealth Strategy can be found at:

http://www.scotland.gov.uk/Publications/2011/09/09103110/0

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Annex 2

Risk Management Plan

Final LDP Risk Management Plan 2012-13

Health Board: NHS Greater Glasgow and Clyde

Use of Risk Management Plan

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

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

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

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

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

HEATS TARGETS FOR 2012/13

To increase the proportion of people diagnosed and treated in the first stage of breast, colorectal and lung caner by 25%, by 2014/15.

At least 80% of pregnant women in each SIMD quintile will have booked for antenatal care by the twelfth week of gestation by March 2015 so as to ensure improvements in breast feeding rates and other important health behaviours.

Reduce suicide rate between 2002 and 2013 by 20%.

To achieve 14,910 completed child health weight interventions over the three years ending March 2014.

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

At least 60% of three and four year old children in each SIMD quintile to receive at least two applications of fluoride varnish (FV) per year by March 2014.

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

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

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

Reduce the rate of emergency inpatient bed days for people aged 75 and over per 1,000 population, by at least 12% between 2009/10 and 2014/15.

No people will wait more than 28 days to be discharged from hospital into a more appropriate care setting, once treatment is complete from April 2013, followed by a 14 day maximum wait from April 2015.

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

Further reduce healthcare associated infections so that by 2012/13 NHS Boards' *staphylococcus aureus* bacteriamia (including MRSA) cases are 0.26 or less per 1,000 acute occupied bed days; and the rate of *Clostridium difficile* infections in patients aged 65 and over is 0.39 cases or less per 1,000 total occupied bed days.

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

To increase the proportion of people diagnosed and treated in the first stage of breast, colorectal and lung cancer by 25%, by 2014/15

NHS BOARD LEAD:	Jonathan Best, Director, Regional Services

Note: this is an early draft of known issues. It will be considerably enhanced following the national Detecting Cancer early event in 22 March and the subsequent first meeting of the GGC Implementation group

Delivery and Improvement

Risk	Management of Risk
Secondary care is responsible for measuring target at time of presentation, but actions required to increase early presentation need to be taken in primary care or at individual patient level.	Detecting Cancer Early has been established as a workstream of the single system GGC Cancer Services Steering Group. The Steering Group contains primary, secondary and tertiary care representation, as well as public health, third sector and patient reps.
Poor awareness among population of signs and symptoms	NHSGGC Cancer Health Improvement Strategy, launched in 2012 with a three year timescale will tackle the public health messages required. A variety of advertising, social media and Health Improvement campaigns are included within the strategy.
Increased number of incidental findings, leading to additional activity within non-cancer services.	Monitor activity through existing methods to ascertain impact.
Challenges with collecting data, specifically in relation to the staging information.	Accelerate roll out of MDT system in order to ensure that data is collected from the MDT. Involvement of Clinical Audit staff to ensure the necessary fields are collated, and verified prior to data submissions. Address the issue of MDT coordination to ensure that one named individual is responsible for data collection.
Data and definitions interpretation.	Develop a National Manual, similar to that for Cancer Waiting Times, to ensure that data fields and definitions are correctly applied thus maintaining overall national consistency.
Clarification required over 'responsible NHS Board'.	Need to ensure there is a mechanism in place which allows reporting by patients' postcode, rather than Board of Diagnosis. Without this, NHS Boards may not be sighted on the true volume of cases related to their individual geographical area.

Workforce

Risk	Management of Risk
Primary care and diagnostic services cannot meet increases in presentation rates.	Need to move to more flexible and extended day working within all diagnostic and treatment settings is constantly under review. Detecting Cancer Early Implementation Group to consider further.

Finance

Risk	Management of Risk
Unplanned demand surges in referrals for diagnostic testing.	To be reviewed by Detecting Cancer Early Implementation Group.
Increased number of incidental findings, leading to additional activity within non-cancer services.	To be reviewed by Detecting Cancer early Implementation Group.

Equalities

Risk	Management of Risk
Increased awareness of signs and symptoms leads to higher presentation rate among 'worried well' and the message does not reach more socially deprived population.	NHSGGC Cancer Health Improvement Strategy has workstreams for targeting those most at risk and for reducing secondary cancers. NHSGGC Cancer Plan includes specific targets for improving cancer detection rates within socially deprived areas.

At least 80% of pregnant women in each SIMD quintile will have booked for antenatal care by the 12th week of gestation by March 2015 so as to ensure improvements in breast feeding rates and other important health behaviours

NHS BOARD LEAD:	Kevin Hill, Director of Women and Children's Services

Delivery and Improvement

Risk	Management of Risk
Women don't know who to contact when they have a positive pregnancy test.	Social marketing strategy needs to be considered, potentially as part of national telehealth project work (see below) to ensure women aware of how to make first contact with health services. Discussion will take place between acute and primary care/GP colleagues to ensure robust channels of communication are established and maintained.
Requirement for central electronic booking point to facilitate midwife as first point of contact.	Discussions ongoing linked to the national telehealth project to consider NHS24 providing this service across GGC. Appointment system will be changed to provide booking visit split into two to enable women to have first appointment by 10 weeks, including full booking and screening and second appointment between 11 – 13+6 weeks for ultrasound.
Women presenting close to or later than 12 weeks.	As part of a national target and in line with the KCND model, we will fully participate in national campaigning to raise awareness of the benefits of early referral. At a local level, there will be a shared role between acute and primary care in ensuring women know the benefits of early contact, particularly women who will be high risk for clinical or social reasons. Joint working will be planned and monitored between acute and CH(C)Ps through the Child and Maternal Health Strategy Group. CH(C)Ps will use local community planning partnerships to raise awareness of early contact and initiatives such as Solus screens in GP surgeries/Health Centres and other social media. We will also work with a range of third sector networks, such as the Glasgow Council for Voluntary Services and the Social Care Ideas Factory to seek support in

	promoting awareness.

Workforce

Risk	Management of Risk
Resource to staff central booking point.	Discussions with NHS24 as above – resource requirements for GGC as yet unknown. Work currently underway on vulnerable families pathway in pregnancy.
Midwife required at all antenatal visits, including those only for US, as referral may be required.	Workforce requirements being assessed as part of RIE work. Proposals underway to reduce the number of community spokes across GGC. This work will involve workforce planning across the ante and postnatal pathways and will take into account the requirements of the HEAT Target. It is anticipated that reduced travel time will increase the opportunity for face to face contact time.
Availability of Health Improvement staff to provide necessary interventions.	Work underway as part of Rapid Improvement Event action plan and SLWG established by Health Improvement Team to understand requirements of redesigned hub and spoke pathway to enhance joint provision of care. This work will take account of HEAT target. Fewer spokes will help to improve the efficiency of overall contact time across all members of the multidisciplinary team.

Finance

Risk	Management of Risk
Costs of providing central electronic booking point – NHS24.	Discussions with NHS24 as above - cost implications for GGC as yet unknown.

Equalities

Risk	Management of Risk
Inequitable access across NHSGG&C.	Implementation of central booking required to enable Greater Glasgow roll-out. If not possible or not financially viable, inequitable access to services < 12 weeks for Greater Glasgow versus Clyde women will continue.

Reduce suicide rate between 2002 and 2013 by 20%

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

Delivery and Improvement

Risk	Management of Risk
Wider economic and social factors exert an upward pressure on suicide rates, which is likely to have a disproportionate effect in Greater Glasgow and Clyde given demographic profile of Board area.	Such wider societal factors are likely to have an influence on suicide rates within the Health Board, so we must ensure our suicide prevention efforts remain focused in order to have maximum impact; we will ensure that suicide prevention programmes develop active linkages to allied work on risk factors, including economic aspects, wider mental health improvement and resilience work, including emerging approaches on community assets.
Challenge of coordination of suicide prevention overall approach across multiple planning structures.	A re-established suicide prevention group for NHSGGC will work to create a coordination of activity and to assist in prioritising activity both within clinical settings (including adult mental health services, CAMHS, A&E, primary care and addictions) and with wider partners, including local authority led Choose Life programmes; this group will give active consideration to development of guidance on referral pathways and support systems for those at risk of suicide and serious self harm, and to maximise responses within clinical services. Support will also be provided to each of the local authority based Choose Life programmes, with an emphasis on supporting evidence-based approaches in community settings.

Workforce

Risk	Management of Risk
Potential loss of momentum in terms of suicide prevention training and allied activity following achievement of H5 Suicide Prevention Training target by December 2010.	Continued emphasis on implementation of a detailed staff training plan, with detailed staffing projections prepared for each relevant part of the system and with monitoring and reporting arrangements in place; development of additional flexible support systems to engage with staff groups who have been able to make limited contact with training opportunities to date; continued leadership work to ensure profile of suicide prevention and allied work on self harm support receives attention and action required.

Finance

Risk	Management of Risk
With overall finances under pressure, there may be lack of resource to ensure sufficient on-going training and allied activity to support allied suicide prevention work.	Developing closer partnership working arrangements, particularly in Glasgow City, to ensure limited financial and staffing resources are utilised to best effect; this will include development of joint arrangements for organisation and delivery of staff training, including shared resourcing of this with key departments in City Council, with effort made to ensure similar arrangements remain in other local authority areas, or are updated where necessary; maximising use of in-house trainers and venues will be part of this strategy.

Equalities

Risk	Management of Risk
Risk that equalities and inequalities considerations are not given sufficient attention in the overall suicide prevention work programmes.	Ensure a strong focus on inequalities issues, both in the new NHSGGC group, in the multi-agency Choose Life programmes and in planning within CH(C)Ps and other structures. A new approach to simplifying and clarifying higher risk groups for attention will be developed, drawing on a range of pre-existing work, such as the North and East Glasgow Suicide Prevention Partnership (approaches in deprived communities); addition high risk groups that will warrant attention include: criminal justice system, people with borderline personality disorder, joint work in addictions sphere, including a focus on alcohol harm prevention work and drug death prevention work), homelessness and care leavers.

To achieve 14,910 completed child health weight interventions over the three years ending March 2014

NHS BOARD LEAD:	Anna Baxendale – Head of Health Improvement

Delivery and Improvement

Risk	Management of Risk
Delay in data being transferred to new system (CHSS) due to new ways of handling data.	Ensure current way of working is adjusted to meet the need for data transfer to CHSS.
Increased risk of error due to handling of data by non NHS/ multiple users.	• Identify the different stages of data collection and data handling ensuring correct information is collated in accordance with national requirements; • Data handling protocol developed; and • Accuracy of recorded data monitored and inaccuracies shared with local areas. Local areas to address recording quality issues locally.
School based programme is unsuitable to target audience	School based programme evaluated, ensuring suitability and quality assurance of programme. • Opinions sought from pupils, parents and teachers; • Amendments carried out based on findings; • Findings shared with local implementation groups; and • Additional opportunities explored to deliver programme to hard to reach groups such as teenagers.
Continued participation of education departments (x6) in the delivery of School based programme due to consent.	• Event organised with Directors of Education to ensure ongoing commitment to participation. Findings from evaluation to be disseminated; and • Local implementation groups identify local schools and secure participation.
Inadequate data collection and/ or measurement consent achieved within School based programme	• Parental packs including description of programme, supporting resources from Health Scotland and the importance of parental support is provided to teachers and parents before programme start; • Levels of consent for data and measurements are monitored. Amendments to letters seeking consent, avoiding confusion; and • Local areas to consider 'opt out' consent proposals and agreement to be secured with

	local Education Directors.
Maintaining delivery levels across multiple CH(C)P and Local Authority Partnership arrangements	• CH(C)P delivery monitored within the Organisational Performance Review process; • Each local authority area implementation group identify and address local problems. Each area is represented at steering group and provides regular status reports; • Quarterly reports provided to steering group with up-dates on progress; and • Additional localised data provided to local implementation groups.
Recruitment of sufficient numbers of children >91st centile based on average class size and centile distribution.	Number of classes modelled to deliver target children with a BMI >91st centile based on average centile distribution. Delivery arrangements in place to support required number of classes.
Recruitment of sufficient numbers of children >91th centile to intensive community based programme.	• Individualised letters sent out to each child identified with a BMI >91st centile in the school based programme, encouraging contacting more intense community based programme; • Local implementation groups reviews communication plans and focus efforts, based on localised referral information provided e.g. GP Practices, School Nurses; • Research conducted identifying critical points of engagement into programmes and additional understanding of motivation/lack of motivation to engage; • One area identified for further improvement is transition between school based and community based programmes; and • Additional training on 'How to Raise the Issue of Obesity' has been offered to an extended workforce with the aim to capitalise opportunities to encourage referrals in wider settings such as education.

Workforce

Risk	**Management of Risk**
Difficulties in recruitment and retention of coaches due to short term funding arrangements and increased market value of workforce.	• Supply and training of coaches has been extended and incorporates local play leaders; • Additional advertisement locally has increased recruitment but coach supply continue to be a challenge; • Availability of coaches has varied across the system, solutions includes use of staff flexibly across other local authority areas;

	• Current coach model is revisited, exploring additional opportunities for coach sharing across local authority areas; • Additional training is delivered as new training needs emerge; and • Areas of pressure/opportunity to accelerate activity are routinely identified and discussed with Local Authority partners.

Finance

Risk	**Management of Risk**
Allocated budget for H3 does not include tertiary intervention for children >99.6th centile who therefore are at risk of not receiving appropriate treatment.	• Those suitable for tertiary intervention at GP Practice level are and currently referred to ACES via specialist service; and • Specialist service is currently exploring other financial avenues for funding an additional component for those in line with national guidelines, which is extra and beyond what is currently delivered in ACES.
Development of a school based service model which is sustainable with limited funding.	• Steering group has commissioned local implementation groups to explore how the school based programme can be delivered by teachers; and • Evidence of how the active choices programme meets health and well being outcomes in the school curriculum is currently being identified.
Development of a community based service model which is sustainable with limited funding.	Model for community based programme is currently being explored with aim to secure future delivery for intensive level intervention.
Multiple service level agreements with Local Authorities requires ongoing financial monitoring arrangements.	Management of service contracts is undertaken by CH(C)Ps and exception reports to Steering Group.

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

NHS BOARD LEAD:	Fiona Dunlop, Health Improvement Lead (Tobacco)

Delivery and Improvement

Risk	Management of Risk
The delay in the return of cessation data from service providers affecting the accuracy of quarterly reports.	• The use of projected quits, based on data from previous years to allow identification of any potential issues in terms of performance; • The new integrated data system will be in place this year allowing more effective and streamlined data inputting, thus reducing the backlog and improving reporting. The transition to the new data base and associated training may have a short term impact on data management but steering group and training protocols in place to reduce any negative impact; and • The on going monitoring through the Tobacco Planning & Implementation Group (PIG), allowing for reallocation of staff and funds as required to address any potential backlog of data.
Variations in performance (quit rates) across areas and across different service strands.	Ongoing monitoring of performance on a quarterly basis by the Tobacco PIG and appropriate action taken as needed (one to one meetings with relevant areas, best practice sharing workshops, mentoring and additional support).
Decrease in smoking population and in smokers wanting to quit therefore fewer referrals to the service.	Ongoing focus on maintaining level and quality of referrals to the service through: • Focused promotional and marketing activity based on evidence; • Implementation of a Communications and Marketing Action Plan overseen by a sub-group of the Tobacco PIG; • Scrutiny of performance against trajectory; and • Provision of targeting support if issues identified.

Workforce

Risk	Management of Risk
Insufficient capacity within CH(C)Ps to delivery cessation services at certain times (in relation to sickness/maternity cover), particularly in small CH(C)Ps with limited staff.	• Addressing issue through Tobacco PIG structures; • Investigating possibility of twinning cessation services in small CHPs with those of other larger areas; and • Using staff on zero hours contracts to provide cover where needed as a short term measure.
Issues with release of key staff to attend tobacco related Brief Intervention training due to workload and competing demands for training – subsequent impact on referrals.	• Amending training to reduce duration of courses and therefore make them more accessible to staff; • Increasing the use of e-learning; • Reviewing Health Improvement training offered to staff to avoid competition and to reduce duplication; and • Promoting the benefits of tobacco brief intervention training overall.

Finance

Risk	Management of Risk
Annual allocation of budget affecting longer term planning in terms of staff and programmes.	Circulation of Health Improvement Funding allocation letter from Scottish Government to local Heads of Finance to help to ensure the continued funding of fixed term posts and ongoing commitment to programmes of work.
Impact of the bundling of cessation funds with alcohol funding for the first time.	As this is a new development the risk is unknown. Ongoing commitment through Tobacco PIG structures to maintaining level of financial support for tobacco programmes.
Impact of ongoing increase in Nicotine Replacement Therapy (NRT) prescribing costs.	• Re-tendering of the contract to provide NRT across NHSGGC, with a view to improving the level of NRT rebate provided and additional support offered (promotion and training); and • Regular review of prescribing data to ensure services are adhering to the protocol, address inappropriate prescribing of NRT.

Equalities

Risk	Management of Risk
Service not meeting the needs of equality strands.	• Demographics of service users monitored and analysed, specifically monitoring use of services by ethnic minority, gender, age, socio economic group across CH(C)P areas

	and different service strands; • Update sessions for staff to address any issues identified and to ensure evidence based approaches are in place; • Supporting pilot initiatives within local areas addressing equality issues; and • Best practice sharing sessions through the Tobacco PIG.
Failing to meet the inequalities element of the smoking cessation target.	• Quarterly scrutiny of data to ensure local areas achieve trajectory set for inequalities element and to allow early identification of potential issues/areas for concern; and • Update sessions to share best practice.

At least 60% of 3 and 4 year old children in each SIMD quintile to receive at least two applications of Fluoride Varnish (FVA) per year by March 2014

NHS BOARD LEAD:	Karen Murray, Director East Dunbartonshire CHP

Delivery and Improvement

Risk	Management of Risk
Not every General Dental Practitioner (GDP) in NHSGGC will offer Fluoride Varnish Application (FVA) as a routine caries prevention treatment for children. Childsmile Operational Team provide information on the Childsmile Programme	• There is 691 GDPs in NHSGGC working out of 259 practices; • FVAs were incorporated into the National Statement of Dental Remuneration on 1 October 2011; • GDPs continue to be made aware that Extended Duty Dental Nurses (EDDNs) are not the exclusive providers of FVA in General Dental Services (GDS); and • Childsmile Operational Team provide regular communication to parents/GDP's/CH(C)Ps and pre school establishments to promote Childsmile Programmes.
Oral Health Directorate continues to be financed for Childsmile Nursery to offer FVA to only 20% of most deprived nursery population.	• Childsmile Nursery commenced in March 2011 and the Childsmile Team visit twice yearly for FVA for consenting children. 87 nurseries are targeted; • To review the proportion of children receiving FVAs in school and nursery populations; • Consent rates for nurseries is 70%. Oral Health Directorate are working in partnership with parents/CH(C)Ps/pre school establishments to promote increased consent for the Programme; and • Plans to introduce a new consent procedure at national level which will eliminate the need for individual consent for return FVAs is hoped to improve consent rates.
Consent rates for FVA are low in Childsmile Nursery & GDS.	• The consenting processes in Childsmile Nursery will be audited to identify additional methods to improve parental consent rates; • Work with parents/GDP's/CH(C)Ps and pre school establishments to promote increase in consents to the Programme; • NHSGGC have four Childsmile Vans, which assist in promoting the Programme; • GDS have been made aware of HEAT target since Childsmile was incorporated into SDR and prior to this. They are encouraged to

	promote the Programme; • Since Childsmile was incorporated into the SDR, GDS has been sent booklets/information by NHS Scotland: - *'Childsmile Incorporation into SDR* *'Using new codes on the GP17 form'; and* • Childsmile Team provide regular communication to GDS via email, visits to practice and events.
The children at greatest risk of developing dental decay may not attend GDS and consent rates for FVA in this group in Nursery setting may be low.	• Nursery Toothbrushing Programmes will continue to be supported and promoted; • 'Smile Too' nursery programme is presently being updated; • Childsmile is now a mandatory field at 6-8 week Health Visitor assessments and is reported through Child Health Surveillance system. Health Visitors will follow Childsmile Early Years Pathway for all children; and • Community and Salaried Dental Service will promote FVA.

Workforce

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

Finance

Risk	Management of Risk
Childsmile Nursery Programme budget insufficient to deliver programme.	• Oral Health Directorate will plan, prioritise, implement and evaluate all Childsmile Programmes within Scottish Government Childsmile budget.

Equalities

Risk	Management of Risk
Inequalities may be increased as the more affluent children may be more likely to attend GDS regularly and consent rates for children in lowest deprivation quintiles may mean that a high percentage of these children will not access FVA either through GDS or Childsmile Nursery.	• Dental Health Support Workers (DHSW) will assist in Oral Health Improvement activities/promotion of FVA; • Childsmile referrals are recorded at Childs six-eight week assessment by Health Visitors; • DHSW to facilitate dental attendance for FVA for this group; and • Ante-natal input into maternity booking clinics to promote improved diet, use of fluoride toothpaste especially by less affluent families

	and to arrange registration with a dentist.
Consent/Literacy.	• Childsmile consent material is available in 13 different languages; and • Interpreting services will be made available to families if required.

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

NHS BOARD LEAD:	Alex McIntyre – Director of Facilities

Delivery and Improvement

Risk	Management of Risk
Impact of the evolving physical estate and double running of new/old properties, continues to be a pressure, resulting from the major developments under way within the Board. Resulting in a short to medium term short fall on national carbon emissions targets.	This trend is expected to reverse once site closure programme in delivered 2016/17. In the mean time one off energy efficiency and two off carbon neutral (Biomass) project proposals have been submitted to the NHSScotland Carbon Reduction Programme for funding. Work is also under way for completion of our Carbon Management Plan in partnership with the Carbon Trusts, Carbon Management Revisited programme. Mapping our energy and carbon management aims, targets and priorities for the next three years.

Workforce

Risk	Management of Risk
Workforce loses sight of overall need to maintain and indeed improve energy utilisation.	Staff Engagement via our Ecosmart initiative, launched March 2011. This will be expanded and enhanced from our partnership work with the Carbon Trust on their public sector energy awareness programme during 2012/13.

Finance

Risk	Management of Risk
• Increasing cost of utilities; • CRCEES Carbon Tax Burden (Circa £1.6m); and • Impact of austerity measures on investment opportunities.	Investigate investment options from ESCO service providers, to develop opportunities to minimise the impact of rising utility costs and CRCEES tax burden.

Equalities

Risk	Management of Risk
Climate change resulting from carbon and greenhouse gas emissions poses potential risks to human health and threatens to widen health inequalities between rich and poor populations in the UK as well as	Maintain and adapt NHSGG&C exemplar Sustainable Development Action Plan to minimise the impact of our activity on both the local and national environment via our exemplar sustainability governance structure, leading by example in our partnership working arrangements with: • The Carbon Trust;

the rest of the world.	• Good Corporate citizenship programme; and • Glasgow Climate Change Partnership. Further information on how NHSGGC is committed to tackling inequalities at: http://www.equalitiesinhealth.org/

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

NHS BOARD LEAD:	Fiona McNeill, Renfrewshire ADP Lead

Delivery and Improvement

Risk	Management of Risk
Local services have data quality issues.	• Training continues to be ongoing; • New proforma developed to aid process; and • Ongoing monitoring of data quality will ensure systems are working and appropriate data is being submitted.
Waiting Times increase due to increased demand.	• Routine monitoring of activity, systems in place to reprioritise at those at risk and most vulnerable; and • Recommendations will be implemented as part of the Service Review which will ensure enhanced access to treatment within the target timescales. This will include the Local Enhanced Scheme with GPs.
Insufficient time for staff to support data recording	• Process and systems are continually reviewed within Alcohol & Drug Partnerships (ADP) structures.
Sustaining high levels of performance across all services	• Waiting Times are closely monitored within ADP structures via Performance Framework.

Workforce

Risk	Management of Risk
Additional training required for new and existing staff to ensure recovery focussed service provision.	Working Group is currently being set up to consider recommendations from the Training Needs Analysis recently carried out which will also inform the Workforce Development Plan.
High caseloads and workforce saturation.	Workload management process implemented. Monitoring systems in place overseen by the ADP.
Limited capacity due to staff sickness.	Robust application of sickness/absence management policies.

Finance

Risk	Management of Risk
Current financial climate may impact on current funding levels.	ADP Financial Framework has been developed together with a Joint Finance Group which has systems in place to monitor activity and pressures on service capacity/delivery. Information is reported routinely within ADP structures.

Equalities

Risk	Management of Risk
Differential outcomes for equalities group in terms of access to services which do not take into account differential needs. Service users may perceive unequal balance in access to and types of services available to them.	Implement EQIA within all services. • Regular service user satisfaction surveys are undertaken and findings reported within ADP structures; • Service user involvement network currently being developed; and • Regular service user input to the ADP.

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

NHS BOARD LEAD:	Eric Steel (City Wide Lead – Addictions) Glasgow City

Delivery and Improvement

Risk	Management of Risk
Performance on drug and alcohol misuse waiting times is not improved from current levels.	ADP focus on measures of improved performance for every CHP and purchased services.
Glasgow City services (purchased and provided) failing to collect waiting times (compliance).	Ongoing support to purchased and provided services from Performance support team.
Waiting times increase for services due to increase in demands.	Routine monitoring of activity, alert systems for increases in demand, reprioritise at risk and vulnerable groups.
Technical capability of Glasgow City ADP ensuring electronic data return.	Glasgow City ADP will return using new waiting times database with a view to possible development of file upload facility from mainframe systems.
Newly established ADP and structures across GG&CHB area – five separate reporting structures.	Glasgow Addiction Services (GAS) will now report waiting times on behalf of Glasgow City ADP only. Other ADP's will report separately.
Some areas working to existing high levels of performance.	Maintain existing performance whilst prioritising services/ areas of poor performance.
Inequity of performance across substance (alcohol/drug) area exists.	Use existing ADP performance management approach, with CHP's and individual services via to review and improve performance where required.

Workforce

Risk	Management of Risk
High caseloads and workforce saturation	Ensure clear learning and development programme, resource flow to reduce caseloads, reprioritisation of services.
Lack of essential services for recovery in place	Ensure clear commissioning plans are in place via each Locality Planning Group, overseen by ADP and proper balance of care.

Decrease in Performance within services due to staffing constraints.	Continued support to services and staff with regard to training. Ongoing performance management support and training in locality based reporting (available from new system).
Decrease in numbers of staff in support team (GAS) responsible for training, collating and monitoring performance of Citywide services.	Where possible identifying and training other staff members in the support process.

Finance

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

Equalities

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

NHS BOARD LEAD:	Susanna McCorry Rice, Head of Mental Health, Addictions and Homelessness – Inverclyde CHCP

Delivery and Improvement

Risk	Management of Risk
Processes are not responsive enough to produce effective outcomes in relation to agreed trajectory re waiting times and timeously inclusion to services.	Referral processes have been streamlined for both alcohol and drug services. This will lead to effective service delivery in relation to waiting time's targets and speed of initial response to referrals.
Services lack innovation and become static.	A range of new initiatives have been implemented. Recovery funding bid successful. Persistent Offenders Partnership (POP) established.
Need to continually identify service improvement.	Continue to review, monitor and audit. Introduction of the new quarterly performance service review.
Need to better involve service users' views.	The Scottish Drugs Forum National Quality Development Programme has been implemented which provides a focus on service user feedback on service quality and outcomes. Your Voice ICCF is involved in all aspects of ADP performance and planning. National Recovery Programme input is currently being negotiated.

Workforce

Risk	Management of Risk
Loss of capacity through long term illness.	Utilised resource re temporary cover. Ensured appropriate HR and Occupation Health input as appropriate.
Loss of medical time.	New post recruited. Shared care capacity increased by 50 places (drugs – methadone programme). Intensive Recovery programme established. Pharmacy prescribing established.
The complexity and diversity of services across addictions creates significant pressure upon existing admin resources.	The clerical team has been strengthened by the addition of the ADP admin resource, additional admin capacity in the Cathcart Centre and temporary staffing as required. CHCP admin review.
Reduction in workforce due to financial pressures in particular not filling vacant posts.	More efficient use of existing resources. Utilisation of additional Scottish Government funding re: ADP development and service expansion. Using other community facilities

	services to support service users. Develop new ADP Partnership initiatives (POP, Fire Risk Assessment Policy).
Workforce skills mix is inadequate to effectively respond to complexity of task.	Ensure intensive support and training is delivered. Staff participating in NHS and Council sponsored in-house and external training courses. New Complex Needs Co-ordinator post established.

Finance

Risk	**Management of Risk**
The demands of NHS and Council target savings diminish effectiveness.	Increase service effectiveness. Utilise new and external sources of funding.

Equalities

Risk	**Management of Risk**
Risk that individuals cannot access services due to actual or perceived barriers (e.g. physical, psychological, literacy, sensory impairment, cultural).	Included as part of ongoing work by Inverclyde CHCP on equality and diversity and continue to review our Equalities Impact Assessment in relation to Addiction Services.

NHS BOARD LEAD:	Helen Weir, West Dunbartonshire ADP Lead

Delivery and Improvement

Risk	Management of Risk
Data inputting continues to be an issue, data linked to long waits continue to pose problems and skew the quality of information reported to the ADP/NHS/Scottish Government.	All appropriate staff have passwords and appropriate access to the waiting time system. An interim agreement has been reached between the ADP Support Team and ISD regarding access to service specific information. This is with the written consent of all Team Leaders and is for a short term. Regular meetings are held between front line Administration Staff, Joint Service Manager, Team Leaders and ADP Support Staff to ensure that issues are identified and resolved timeously. A waiting times 'pathway' has been developed to ensure that front line staff are aware of all relevant stages of the process. A further briefing session is being arranged for all Team Leaders to ensure they are able support to Administration Staff in inputting data and encourage Care Managers to provide updates on individual clients directly after they have been seen by a member of staff.

Workforce

Risk	Management of Risk
Staff absence/sick leave.	Maximising attendance procedures followed within all statutory sector service provision areas. Regular review and monitoring of absence will be used to manage work load appropriately. Duty system in place to enable patients/clients to access statutory services directly/or be signposted to other services as necessary. All statutory and third sector service providers operate self referral systems. Out of hours confidential telephone support service is operational five evenings per week, ensuring that clients/patients can receive additional supports at times when they feel particularly vulnerable.

Reduction in staffing allocation as a direct result cost saving exercises.	Current, direct service provision staffing levels have not been reduced as a result of cost saving exercises. This situation will continue to be reviewed in line with future such exercises and where possible staffing levels will remain unchanged.

Finance

Risk	Management of Risk
Reduction in West Dunbartonshire Council (WDC) budget as a result of cost cutting exercises.	Within current cost cutting exercises the WDC Addictions budget has been protected.
Problems in implementation of the Alcohol and Drug Services Commissioning Strategy	Process to be developed and ratified by the ADP to enable establishment of a finance subgroup. Appropriate processes for the allocation of ADP funding to be established. A process for consideration of funding applications to external funding organisations to be put in place.

Equalities

Risk	Management of Risk
Clients/patients perceive that there is an imbalance in the access to and types of services available to them.	Integrated care pathways are followed to ensure that clients and, where appropriate their families, are at the centre of the development and monitoring of individual care packages. The Alcohol and Drug Services Commissioning Strategy 2011 – 2021 indicates, as one of its longer term aims, a move from a service focussed tiered model to a person focussed tiered model, this will ensure that the clients care plan grows organically around them in order to meet their needs and to enable sustained recovery from alcohol or drug addiction. Regular client satisfaction surveys are undertaken by all services, this survey explores, amongst other things, perceptions of services; whether clients feel they are treated as individuals. Views as to whether or not they feel respected and if their individual needs are being met. These surveys are carried out annually and have, in the past led the development of a new out of hours service.

	The Future of Addiction Services Team - the local client led structure has representation on the ADP to ensure that the views of clients are an integral element in the future development of local services. The ADP have agreed that a mapping exercise is required to measure the client journey; this will be a commissioned piece of work that will require a sample number of case notes being reviewed to enable measurement of individual client experiences. Whilst historically all services have been internally reviewed in terms of equitable access for all (via the surveys and focus groups mentioned above. However a formal EQIA was completed in June 2011, no major issues were identified as part of that exercise. Endeavours to ensure the ongoing delivery of equitable and accessible services continue to be a significant priority for the CHCP/ADP.

NHS BOARD LEAD:	Safaa Baxter – Chair, East Renfrewshire ADP

Delivery and Improvement

Risk	Management of Risk
Capacity – increase in demand challenging ability to deliver service.	Managed through existing service redesign, service user pathway, and process for managing waiting times through routine monitoring of activity and feedback loop.
Data - implementation of waiting times system.	Baseline and trajectory now established. New reporting procedures improve ability to performance manage at both service and ADP level.
Sustaining high levels of performance across all services.	Waiting Times are closely monitored within ADP structure via the Performance Framework.

Workforce

Risk	Management of Risk
High caseloads and workforce saturation.	Management of risk through service redesign.
Implementation of the waiting times system.	Continued delivery of waiting times training to all appropriate staff. Development of local process and mechanism to collate and collect data which is reviewed through regular performance reporting.

Finance

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

Equalities

Risk	Management of Risk
Differential outcomes for equalities group in terms of access to services and treatment.	In East Renfrewshire an equalities impact assessment of the alcohol and drug strategy is currently being progressed. An EQIA of access to community addiction services will be completed (East Renfrewshire CHCP development plan 2012/13). New waiting times system enables ongoing equalities data collection and analysis.

NHS BOARD LEAD:	Liz Sneddon - East Dunbartonshire ADP

Delivery and Improvement

Risk	Management of Risk
Failure to meet waiting time trajectory.	This has been ameliorated through ensuring internal processes for collating and reporting waiting times performance information to ISD are fit for purpose. The local team has worked directly with ISD to ensure that this activity is being undertaken as effectively as possible. A local management review process has been established to ensure routine monitoring of waiting times on a fortnightly basis. Through a process of service redesign, improvements to service access and treatment delivery have been achieved, which will have a positive impact on achieving waiting times trajectory. Work will also be taken forward in ensuring an identified pathway through services and within the existing cohort of provided and commissioned services in East Dunbartonshire.

Workforce

Risk	Management of Risk
Insufficient workforce capacity to meet waiting times target.	Through service redesign and improvement processes a number of work streams have been completed to ensure prompt access to the service, and that staff have a shared and specialist skills set to effectively respond to treatment needs.

Finance

Risk	Management of Risk
Potential for demand for treatment within three weeks target that exceeds service capacity to deliver.	Drugs and alcohol needs assessment completed late 2011, which indicated that we have sufficient capacity to meet demand.

Equalities

Risk	Management of Risk
Risk that inequalities issues are not given full consideration in the drive to meet the three week target.	EQIA completed during 2011, with associated action plan being implemented. Good understanding of areas/communities of greatest need locally. Disaggregated patient data will be used to inform the ADP planning process.

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

NHS BOARD LEAD:	Stephen McLeod, General Manager

Delivery and Improvement

Risk	Management of Risk
Dedicated Functional teams at Stage 3 and 4 have increased access to services for specific vulnerable care groups. This improvement in access to services for vulnerable children and young people risks overwhelming locality services in terms of increase in numbers referred. Variations on waiting times across teams in GGC and consistent reporting of data to monitor demand and capacity levels.	• Maximising activity at Stage 3 by increasing levels of staff and ensuring staffing of each team is consistent and provides the best evidenced mix of skills and competencies. • We will regularly review and agree best evidence criteria for managing demand including implementing CAPA demand and capacity model across all Health Board wide CAMHS services to maximise delivery at Stage 3 and supporting this with specific expertise at Stage 4. • We have agreed monthly data collection and activity processes for monitoring demand and capacity levels. These are compared against Trajectories for Weeks Waiting and Numbers Waiting above 26 weeks with monthly interrogation of those breeching trajectory targets. • We will use the seven helpful habits of effective CAMHS programme. • We are preparing an Evidence Based Practice Specification for CAMHS which provide guidance to staff on the best evidenced therapies to be used.
Inconsistency of referral processes. Triage and ICP provision insufficient and historic.	• We are currently reviewing case management processes within locality CAMHS and developing single patient management system to share with other CAMHS teams across GG&C. • We are continually reviewing triage and referral criteria to form proposals for the implementation of an agreed methodology. • We will use the IAF assessment to create integrated multi-agency assessments.

Tier 2-Early Intervention teams currently provide pre-referral/consultation/training to other Health staff and partner agencies. Delivery of this work is not considered direct clinical care and may have an impact on the achievement of the psychological therapies target for CAMHS.	• We are preparing a Tier 2- Early Intervention Specification to clearly outline the services to be delivered by CAMHS at this level. This will need to take cognisance of the Psychological Therapies defined within the target and may require a reduction in the non-direct clinical care services provided.
We are implementing changes in organisational culture and processes and managing a significant number of targets which can bring with it a certain amount of change fatigue.	• We are ensuring significant Organisational Development support through changes and ensuring staff involvement and professional leadership in the critical stages of redesign processes. We currently have a Specialist Children's Services Professional Advisory Group which provides a forum for reflection on the professional impact of redesign.

Workforce

Risk	**Management of Risk**
Workforce is primarily made up of part time, female staff of child bearing age. Uptake of family friendly policies.	• We are currently planning our workforce on the basis that that is likely to be part time and with career breaks and we are skill mixing workforce where possible to provide maximum flexibility.
Implementation of the agreed CAMHS workforce model for GGC will take time with movement of staff geographically and filling of vacancies. This may have a short term impact on the skill mix available in the teams with some disparity across GGC.	• Movement of staff will be conducted with staff partnership and HR involvement and will be conducted with the principle of 'least disruption' in order to maintain service delivery standards across teams; and • This work will be conducted through a prompt process with vacancies filled quickly and appropriately to bring teams up to full compliment/skill mix.

Finance

Risk	**Management of Risk**
The current financial climate nationally, and within NHSGGC and the impact of Agenda for Change and its inflationary pressure.	• We have developed our workforce within our current resource where possible.
Training needs of staff may identify gaps in skills in relation to identified psychological therapies interventions.	• Identify skills and training needs; and • Identify capacity to deliver in-house training where appropriate.

Equalities

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

18 weeks referral to treatment for Psychological Therapies from December 2014

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

Delivery and Improvement

Risk	Management of Risk
There is a risk of inaccurate aggregation of activity because the defined target count points along the patient pathway do not always represent how some services care is configured to deliver (i.e. review of long-term patients in CMHT, In-Patients admission procedure, Clinical Health Psychologists in the Acute Medical services).	Steering Group to ensure liaison with national reference groups to ensure there is ongoing development of the eligibility criteria including all likely patient pathways.
Risk of staff being resistant to collect and input the required data: • If the data collection system is seen as too complex or time consuming; and • If the data collected doesn't reflect the work being done, either because the treatment provided is not on the defined list, or the intervention provided is of a low level intensity and therefore not required to be captured towards the aggregated count.	• Ensuring the buy-in of CHP/Sector Directors and Operational Managers through proactive communication and engagement; • CHP/Sectors managing their local implementation strategy with Operational Leads noting and addressing local implementation issues; • Ongoing support to staff from IT regarding data input and awareness of reporting mechanisms and to encourage closer working between IM&T and clinical staff in relation to this agenda; • Development and training for clinical and administrative staff in the use of reports to highlight erroneous data and to assist with quality assurance of information. Uptake of training is reported to the Steering Group; and • Distribution of PT FAQs across organisation to underpin knowledge of staff regarding the requirements of the target.
There is a risk of not being able to report on all related activity as a number of the data collection systems used by teams/services within the organisation are not directly managed by IM&T staff.	• Where possible teams/services are migrating the recording of their activity to PIMS – there is a detailed plan in place for this migration process; • Acute Physical Health are supplying data from their own systems which is included in the aggregated return; • We have raised the issue with, and await

	feedback from, ISD relating to how the Addiction Services web-based data collection system already in use for target A11 could also be used to collect the necessary data information for this target; • Undertake a scoping exercise of teams/services that use other (non-health) IT systems to understand whether their systems are able to capture the information required; and • Link with the Board representative regarding Joint Information agreements with other organisations and the ability and agreement to report.
Given the size and complexity of the organisation we need to ensure that all services that offer a psychological therapy have been identified.	Steering Group to ensure communication between the local Operational Leads and IT to ensure that all services are identified and that they are accurately represented on the information system; and Routine inclusion of all care groups (Adult, Older People, CAMHs, Addictions, Forensics, Acute Physical Health, Learning Disabilities) at both Steering Group and Operational Group levels.
Anticipated increase in demand as awareness of the target increases, challenging the ability of services to deliver.	Managed through system redesign, improving pathways, understanding the flow and supporting the workforce.
There is a risk around assuring the quality of the data to accurately reflect the associated activity.	• Development and training to Clinical and Administrative staff in the use of reports to highlight erroneous data and to assist with quality assurance of information. Uptake of training is reported to the Steering Group; and • New Ways counting has still to be introduced to our information systems to assist with the accurate reporting of activity.
There is a risk that the data for the target is either under or over reported • The target could drive staff to report on inappropriate activity to ensure that their clinical activity is noted; and There is the risk that low level	Ongoing support to staff from IT and management support regarding required data to input and to note the PT FAQs as a guide for what activity is and is not included in the target – also to promote that target as a catalyst for continuous service improvement. Continued representation to national groups to ensure the count of low level intervention is included in future target returns to remove any

interventions could be used as a perverse incentive to reduce the numbers waiting for a high level treatment.	incentive.
Risk that the target becomes an exercise in data collection without the associated understanding and use of the information it contains to drive and monitor continuous service improvements.	Steering Group to promote the local understanding and use of continuous improvement methodologies. QuEST funding will be allocated to local projects that promote the use of continuous service improvement methodologies that assist with the implementation of the target.
Risk that the skills to analyse demand and capacity information within the organisation are not utilised to identify opportunities for improvements.	Encouragement of staff trained in service improvements to use the skills and knowledge within their work area. Continue to promote the use of demand and capacity data to inform and monitor continuous service improvement activity. Local implementation work plans should highlight the use of increased knowledge and understanding to promote service improvement. QuEST funding will be allocated to local projects that promote the use of continuous service improvement methodologies and the implementation of the target.
Some services have significant waiting lists.	Services to highlight significant waits as part of their local implementation risk assessment and to ensure that they have a managed action plan in place and resourced.
The monitoring of clinical outcome measures is not routine across the organisation.	Steering Group and Operational Leads Group to actively promote and the routine use of clinical outcome measure through the local CHP/Sector implementation plans and through the implementation risk assessment feedback, with plans for those services where no measure is being used. Ensure there are systems in place locally for identifying which staff are delivering psychological therapies and what percentage of these are routinely using clinical outcomes data and also systems to enable recording and reporting of clinical outcomes scores. Implementing recommendations from the Primary care Mental Health Review.

Workforce

Risk	Management of Risk
Implementation and management support for the delivery of the target has been from Mental Health Collaborative funding carried forward and also by QuEST funding up to March 2013.	Programme management support post to continue using QuEST funding up to March 2013. Use of QuEST funding for some short-term service improvement work.
As demand increases there is a risk of higher caseloads and workforce saturation.	Redesign of service provision to improve service delivery and reduce caseloads. Local implementation work plans to promote local teams to further their knowledge and understanding of the demand and capacity on the services they provide.
The skill mix and distribution of therapy staff across the various settings and care groups may mean some parts of the organisation are less well resourced to deliver and supervise treatments than others.	Undertaking a Board wide workforce capacity audit relating to Psychological Therapies. Use this detail to inform the organisation of the skill mix spread across the areas and across the care groups. Outcome from the capacity workforce audit to be used to inform development of local learning and training plans. Steering Group to explore development of PT Networks to ensure a coordinated provision of services across a geographic area.
The extent of administrative support that services, who deliver Psychological Therapies, have available will be a key factor in both their ability to deliver the target and to make the significant improvements required.	Ensure that there is appropriate support from Administrative staff to support the implementation process to meet the target.

Finance

Risk	Management of Risk
Support for IT infra-structure to accommodate the collection and analysis of related activity.	Currently short-term funding for service improvement staff from IT to assist Clinical and Administrative staff regarding the accurate collection and reporting of data. Steering Group to promote support from the Mental Health IM&T Group to highlight the requirements from an IT system to meet the

	target.
The current financial climate nationally, and within NHSGGC.	We are developing our workforce within our current resource where possible. Steering Group to explore PT Networks to ensure a coordinated provision of services across an area.
Relating to the workforce there may be insufficient investment to meet the needs of a particular area or care group.	Ensure links to training plans – issues may be more around skills rather than numbers. Use detail from completed Capacity Audit to inform further service developments and the potential redistribution or sharing of staff resources.
Insufficient numbers of appropriately trained staff to deliver the volume of interventions required.	Continue to maximise the training opportunities provided by Psychological Interventions Teams and NES Psychological Therapies Programme, as well as to promote the capacity to deliver in-house training.
Insufficient numbers of trained Psychological Therapies supervisors to support increased training and safe and effective delivery.	Use detail from completed Capacity Audit to map locally and inform local area needs. Maximise roll out of in-house training for Psychological Therapies Supervisors. Maximise opportunities that arise via any NES developments.
Outcome measures may have 'copyright' and license agreements issues.	Steering Group to investigate funding streams to support the implementation and monitoring of outcome measures.

Equalities

Risk	**Management of Risk**
There is a risk of inequality in the workforce capacity skill mix across the organisation leading to an inequity of treatments being provided on a geographical basis - this may also include the potential for inequalities to arise due to deprivation or for services to be more likely offered to the more articulate – thus reinforcing existing inequalities.	Capacity audit of workforce will provide detail on the number of staff who can deliver a psychological therapy, where they are located and which therapies they can deliver. This detail will inform service developments and improvement in access to treatments in longer term. Implementing recommendations from the Primary Care Mental Health Review of services. Ensuring that local implementation plans include

	an EQIA. Steering Group recommendation to all CHP/Sectors that there should be inclusion of all relevant care groups within a local Psychological Therapy HEAT Target implementation plan.
There is a risk of unequal access to Psychological Therapies across the organisation due to a lack of suitably skilled therapists across some care groups.	The capacity workforce audit will highlight inequalities of service provision across care groups and allow the opportunity to plan and manage the position, to ensure that there is equality of access to services irrespective of the care group. Steering Group to explore PT Networks to ensure a coordinated provision of services across an area. Steering Group recommendation to all CHP/Sectors that there is inclusion of all relevant care groups within a local Psychological Therapy HEAT Target implementation plan.

Reduce the rate of emergency inpatient bed days for people aged 75 and over per 1,000 population, by at least 12% between 2009/10 and 2014/15

NHS BOARD LEAD:	Catriona Renfrew/Anne Hawkins – Director of Corporate Planning and Policy/Director of Glasgow City CHP

Delivery and Improvement

Risk	Management of Risk
Failure to improve the discharge of older people.	• Agreement with Glasgow City Council to implement new Adults With Incapacity (AWI) procedures; • Work with Scottish Government to developed a delayed discharge bed days target as part of the Integration of Health and Social Care agenda and ensure accountability for local authorities to deliver the target; • Regular monitoring delayed discharge bed days reductions across the Board; and • Implement a series of service changes and developments financed as part of the Change Fund and Joint Commissioning Plan development.
Highly complex area of work with multifactorial causes and solutions.	• Development of enablement teams in the community, changes to support to nursing homes; • implementation of one point of access across NHSGG&C; • Improved discharge arrangements; and • Develop further anticipatory care and action to reduce the impact of poly pharmacy.
Changes in demography are not uniform across the Board area so differential solutions are required.	Older People's Planning Group established to ensure consistency. Change Fund Plans developed with each local authority to address demographic and service pressures including bed days occupied by older people with a particular focus on those ready for discharge.
Background of increasing A&E and emergency admissions since 2004/5.	Introduced assessment units to provide rapid assessment and treatment without admission.
In response to economic pressure, Councils reduce resources for Older People's services, causing significant increase in delayed discharges.	Regular monitoring of delayed discharges over and nearing 28 days. Regular communication with Councils. Change Fund Plans seek to mitigate impact.

Finance

Risk	Management of Risk
Financial pressures in health and social services lead to reduction in services that foster enablement and reduce dependency.	Change Fund provides opportunity to generate new service options and includes joint financial frameworks for older people's services. West Dunbartonshire and Inverclyde are now integrated CH(C)Ps facilitating greater opportunities to explore flexible solutions.

Equalities

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

No people will wait more than 28 days to be discharged from hospital into a more appropriate care setting, once treatment is complete from April 2013, followed by a 14 day maximum wait from April 2015

NHS BOARD LEAD:	Catriona Renfrew/Anne Hawkins – Director of Corporate Planning and Policy/Director of Glasgow City CHP

Delivery and Improvement

Risk	Management of Risk
Failure to improve the discharge of older people.	• Agreement with Glasgow City Council to implement new AWI procedures; • Work with Scottish Government to develop a delayed discharge bed days target as part of the Integration of Health and Social Care agenda and ensure accountability for local authorities to deliver the target; • Regular monitoring delayed discharge bed days reductions across the Board; and • Implement a series of service changes and developments financed as part of the Change Fund and Joint Commissioning Plan development.
Changes in demography are not uniform across the Board area so differential solutions are required.	Older People's Planning Group established to ensure consistency. Change Fund Plans developed with each local authority to address demographic and service pressures including bed days occupied by older people with a particular focus on those ready for discharge.
In response to economic pressure, Councils reduce resources for Older People's services, causing significant increase in delayed discharges.	Regular monitoring of delayed discharges over and nearing 28 days. Regular communication with Councils. Change Fund Plans seek to mitigate impact.

Finance

Risk	Management of Risk
Financial pressures in health and social services lead to reduction in services that foster enablement and reduce dependency.	Change Fund provides the opportunity to generate new service options and includes joint financial frameworks for older people's services. West Dunbartonshire and Inverclyde are now integrated CH(C)Ps facilitating greater opportunities to explore flexible solutions.

Equalities

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

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

NHS BOARD LEAD:	Anne Harkness/Christine McAlpine – Director of Rehabilitation/Consultant

Delivery and Improvement

Risk	Management of Risk
Ensuring imaging available to confirm diagnosis of stroke to ensure rapid patient movement.	Comprehensive audit of admission imaging pathway to be carried out in 2012. Subsequent to this, agreement of pathways and capacity plans with diagnostics.
In most sites patients first assessed in acute medical receiving area prior to admission to a stroke unit.	Ongoing work to agree assessment and admission pathways with acute receiving colleagues. Further joint work with bed management using learning from Rapid Improvement Event at Inverclyde Royal Hospital (IRH).
Impact of increasing regional referrals on GGC hospitals.	Discussions with regional planning group.
Implementation of Acute Services Review (ASR) in Greater Glasgow will shift pattern of referrals and require changes in service models for thrombolysis.	Agreement of pathways and associated workforce model to allow relevant skills to be acquired. Further work in 2012 to link to broader ASR work.

Workforce

Risk	Management of Risk
Current consultant vacancies at Glasgow Royal Infirmary and IRH which have already been advertised unsuccessfully; large number of stroke consultant posts across West of Scotland.	Re-advertise and review job plans of current postholders and vacant posts to consider balance of stroke/other specialty interests. Royal Alexandria Hospital (RAH) post currently being advertised.
Sites with single handed practitioners pose difficulties in sustaining specialist review all year.	Review of working arrangements and pathways. Consider feasibility of some consultant posts working across different sites.
Stroke specialist nurses and Allied Health Professionals do not work at weekends.	Review of working arrangements and pathways.

Finance

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

Equalities

Risk	Management of Risk
Incidence of stroke linked to deprivation so high numbers of admissions across GGC.	Clear capacity plan and EQIA as part of service planning.
Maintaining stroke units on all sites may not be possible so referrals may require to be directed to fewer sites impacting on carers.	Transport Needs Assessment as part of routine service planning.

Further reduce healthcare associated infections so that by 2012/13 NHS Boards' *staphylococcus aureus* bacteriamia (including MRSA) cases are 0.26 or less per 1,000 acute occupied bed days; and the rate of *Clostridium difficile* infections in patients aged 65 and over is 0.39 cases or less per 1,000 total occupied bed days

NHS BOARD LEAD:	Tom Walsh – Infection Control Manager

Delivery and Improvement

Risk	Management of Risk
Failure to engage the community if strategies to reduce out of hospital infections are developed.	Work with the Public Health Protection Unit to engage with groups in the community that may have an influence on out of hospital infections.
SABs at an irreducible minimum in acute care and limited interventions available elsewhere.	Analyse information on community SABs and determine, if possible, what the irreducible minimum is.
Failure to sustain current improvements in antimicrobial prescribing.	Work with the Acute Management Team (AMT) to ensure a strategy to maintain optimal prescribing continues in the long term and AMT resources are deployed in support of this.
Failure to embed new initiatives into practice to sustain improvement; e.g. Peripheral vascular cannula care plan.	Continue to support the use of the care plan through education and assess compliance via root cause analysis of cases of SABs.

Workforce

Risk	Management of Risk
Failure to educate the workforce adequately in the principles of the prevention of Hospital Acquired Infections.	Training needs assessment to be undertaken. On line training linked to Oracle Learning Management - e:ESS system as soon as possible. Audit of infection control policies.
Failure to educate the Infection Control Nurses to diploma level.	Source funding external to NHSGGC for education courses.

Finance

Risk	Management of Risk
Failure of delivery due to resource being diverted, e.g. if recommended that infection control is changed to a seven day per week service.	• Undertake a workload analysis; and • Undertake a skill mix analysis.

Equalities

Risk	Management of Risk
None specific to targets.	N/A.

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

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

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

Delivery and Improvement

Risk	Management of Risk
A review of attendance rates at A&E indicates that after a period of relatively low growth in the 1990s, there has been a significant increase in A&E attendances over recent years. The growth in emergency activity continues and there is a lack of evidence about what interventions the NHS can make that can effectively reduce A&E attendances. Through redesign of services to redirect GP referred patients to Medical Assessment Areas and minors to dedicated Minor Injury Areas, NHSGGC has achieved a reduction in A&E attenders of just over 5%. As outlined above, emergency activity continues to grow and the trajectory for NHSGGC in 2012/13 will be to sustain current levels.	A&E Steering Group established and has formulated and oversees the implementation of an action plan relating to this target; co-ordinating activity across the system aimed at understanding patterns of A&E attendances; and identifying connections with other activity which might impact on A&E attendances, for example work relating to long term conditions. A range of workstreams are in place, including the following: • A&E attenders: – Analysis of A&E attenders who are experiencing disadvantage; – Analysis of numbers flowing from A&E to Out of Hours (OOH) unscheduled care; – Analysis of GP referred patients – new Quality Outcome Framework targets and Change Fund initiatives should support redesign which will identify alternatives to attendance at A&E; – A focus on Suicide Prevention, with significant numbers of front line staff trained in recognising and responding to suicide risk; – A focus on mental health to identify repeat A&E attenders and review care pathways to avoid further A&E attendances; and – The outcomes of the external review of Unscheduled Care have been developed into an Action Plan and these are being taken forward through the local UCC Sector Groups, the extended Board wide Winter Planning Group and HEAT T10 Steering Group. • Information – development of monthly reports, shared with all key partners, detailing A&E attendances at CH(C)P and GP practice

Risk	Management of Risk
	level (including reasons for attending, admissions, readmissions, length of stay and SPARRA data). • OOH GP telephone support to Scottish Ambulance Service (SAS) – positive feedback received to date. • Mental Health and Addictions – co-location of Crisis Intervention Teams with NHS24, GP OOH services and SAS, providing NHS24 and GPs with access to the service for advice which will potentially avoid attendance at A&E. • Development of ENP Minor Injury Services: – Opening of two nurse led MIUs in 2009 at new ACHs in the North and South of the City; – Further development of ENP provision through the creation of dedicated minor injury areas in A&Es – further redesign at RAH will see the department reconfigured to allow dedicated minor injury area to be created; and – Continue to develop assessment model of care. Closure of Stobhill Hospital has seen services transfer to a redesigned front door at GRI with dedicated assessment area where GP referred patients go directly; similar service in place at Western Infirmary. Reviewing potential to redesign front door services at RAH through the extension of a modular build adjacent to the current A&E department. NHS 24 is committed to working closely with territorial Boards in exploring and agreeing specific actions that will support reductions in rates of attendance at A&E. NHS 24 already carries out a range of activities to help reduce the A&E attendance rate, such as the delivery of self care information, and plans to increase the amount of Category C calls taken from the SAS, converting the majority of these to Primary Care Outcomes. In addition, we and NHS 24 will work proactively to identify and resolve any issues with our A&E referrals, and respond to any feedback by clinicians including appropriate

Risk	Management of Risk
	thresholds for referral to A&E and provision of free mobile phone calls.

Workforce

Risk	Management of Risk

Equalities

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

FURTHER INFORMATION

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NHS
Greater Glasgow and Clyde

Annex 3

Contributions to Single Outcome Agreements

NHS Board Local Delivery Plan 2012/13 — Contributions to Single Outcome Agreements

1.	**NHS Board:**	NHS Greater Glasgow and Clyde (NHSGG&C)
2.	**Community Planning Partnership:**	Inverclyde Alliance/Inverclyde Community Health and Care Partnership
3.	**Summary of critical issue:**	Financial Inclusion. Research carried out by the Rural Policy Centre at the Scottish Agricultural College (published in May 2011) identified that Inverclyde is the fourth most 'vulnerable' local authority in Scotland to further negative economic impacts as result of the ongoing economic downturn and reductions in the level of public sector budgets. This vulnerability was calculated using an index that took into account four indicators: • Proportion of jobs in the public sector; • Average earnings of local residents; • Proportion of the population of working age; and • Proportion of the population receiving Job Seekers Allowance (JSA). The most recent updates to the income and employment domains of the SIMD, which were published in October 2011, show that Inverclyde: • Is the fifth most income deprived local authority in Scotland (20.8%); and • Is the second most employment deprived local authority in Scotland (17.8%). These figures do not take into account the full impact of the economic downturn, ongoing reductions in public sector budgets and the likely negative impact on individuals and households of the implementation of Welfare Reform.

		These are all likely to significantly impact upon low-income and vulnerable individuals and households across Inverclyde who already experience the *poverty premium* (where individuals and households on low incomes are penalised by having to pay higher prices for basic necessities such as utilities, banking and insurance). This vulnerability will manifest itself through a number of factors including low income levels; unmanageable debt; lack of access to mainstream financial services; difficulty managing money; and reliance on expensive home credit and loan sharks. Inverclyde, with its dependence on public sector employment (according to NOMIS in October 2011, 37.3% of employment was in public sector), is particularly vulnerable to further reductions in public sector budgets, consequent job losses and further demand for financial advice and support. The most recent employment figures from NOMIS for August 2011 show that: • The unemployment rate is 8.7%, Scotland is 7.6%; • The JSA Claimant Count is 5.2% (2,692 people), Scottish Average is 4.0%; and • JSA Claimants per unfilled job vacancy are 2.2, figure for Scotland is 6.1. In addition, the most recent information from NOMIS identifies that those in work in Inverclyde continue to earn less than the national average with available employment opportunities often cyclical. In Inverclyde: • 20.5% of Inverclyde employees are paid less than £7 per hour; • In private sector households of working age it is estimated that there are in excess of 6,000 low income households where the net annual household income is less than £13,260; • 8,678 individuals have council tax arrears; and • There has been an increase of 41% from September 2010 to September 2011 in the amount of secured loan arrears. Since 2010 the UK Government has implemented a programme of Welfare Reform which has reduced the level of support for families and those with disabilities - further reductions are due to be implemented over the next few years.

		The withdrawal of some benefits completely and a reduction in others will result in collective losses in Inverclyde of at least £10 million per annum. • 6,240 working age benefit claimants claiming Incapacity Benefit/ESA - 12.1% for Inverclyde, Scottish Average is 8.1% (NOMIS October 2011); • 20.7% of Inverclyde working age households are in receipt of tax credits; • 24.2% of children within Inverclyde are in workless families, receiving benefits such as Job Seekers Allowance, Incapacity Benefit and Carers Allowance; and • There is a high level of eligibility and low take-up of the Healthy Start Scheme for low income families. All of these factors contribute to inequality of health outcomes. The needs of those who are most likely to suffer health inequalities, in particular those with LTCs or disabilities, differ from the wider population and increasing levels of disability and illness requires financial and debt advice, income maximisation and specialist employment and housing advice to be in place. In Inverclyde: • Life expectancy for men is estimated to be 70.9 years, three years lower than the Scottish Average; • Female life expectancy is estimated at 77.8 years, this is also three years lower than the Scottish Average; • 6,880 people are currently claiming Disability Living Allowance (this includes under 65s); and • Reluctance by many older people to claim benefit they are entitled to is not only depriving people of income but also results in missing out on services. Increased fuel prices and resulting fuel poverty are cited as a major concern for older people. There are estimated to be 12,500 households in Inverclyde who are either in fuel poverty or at risk of falling into fuel poverty through a combination of rising household energy costs and low and falling household income.

4.	**Community Planning Partnership Outputs:**	The Inverclyde Alliance recognises that these factors, along with many other related economic and social issues, mean that the Community Planning Partnership (CPP) as a whole must work within an extremely challenging environment if it is to effectively promote financial inclusion in Inverclyde as an important facet of our drive to reduce health inequalities. The Alliance is therefore undertaking an extensive programme of work to reconfigure and refocus our approach to financial inclusion and support services. This has included: • Working with local statutory and voluntary organisations to scope what financial advice, inclusion and support services currently exist. This has led to the need for more detailed work to clarify the different agencies' understanding of specific terminology (e.g. income maximisation; debt counselling etc). Initial scoping might have led to a conclusion that there was extensive duplication of effort, however by clarifying the range of understandings of these terms, it has become apparent that organisations use the same terms to describe different things; • Following on from this, we are developing a common vocabulary, and a "financial inclusion pipeline", whereby each of the partners from statutory as well as voluntary organisations knows and understands the various contributions each has to make to help reduce the prevalence and impacts of financial exclusion; • The new Financial Inclusion Strategy (FIS) developed by a multi-agency working group over the last year is an important first step – it will provide a framework for the Alliance to promote financial inclusion for the next five years, from 2012-17; and • Previously many of the local organisations had been working, at times, in competition with each other, the (FIS) has fostered a universal understanding that competition is not helpful to those who require support, and that there is in fact more than enough work to go round.
5.	**Local Outcome(s):**	Communities are stronger, responsible and more able to identify, articulate and take action on their needs and aspirations to bring about an improvement in the quality of community life.

6.	**National Outcome(s):**	National Outcome 7 - We have tackled the significant inequalities in Scottish society.
7.	**Please detail the specific contribution of the NHS Board in tackling this critical issue?**	The CHCP has facilitated the outputs highlighted, and has chaired the FIS Group which led the work of the Financial Inclusion Pipeline. As this work has progressed it has become increasingly apparent that much needs to be done across the CPP to help us to prepare for impending changes to welfare provisions to help us, where possible, to mitigate against some of the potential detrimental impacts to our most vulnerable communities. To this end we are working with our partners to identify issues and potential approaches to addressing them (for example, UC will require budgeting and money management skills that many prospective recipients will not have; RSLs may have to support applications for the DWP to continue to pay HB directly to RSLs to prevent rent arrears etc.). The CHCP is taking the lead role in developing this workstream.
8.	**Please explain the ways in which the NHS Board is working in collaboration with Community Planning Partners to tackle the critical issue?**	Our FIS, led by the CHCP, highlights a core vision that has now been agreed across the CPP. We will work in partnership to ensure that all residents of Inverclyde are: • Able to maximise their money; • Able to access appropriate financial services and products, enabling them to manage their money on a day to day basis; • Able to plan for the future and deal effectively with unexpected financial pressures; and • Encouraged and supported to achieve their potential and make a positive contribution to the social and economic life of the area. In order to help deliver this vision, the strategy sets out six outcomes: • Income is maximised and protected; • Problem Debt is better managed; • Access is increased to appropriate financial services; • Fuel poverty and inability to afford warmth is tackled;

		• Financial Capability is increased; and • The Financial Inclusion partnership is ready to respond to the impact of Welfare Reform.
9.	**Please explain how the NHS Board is performance managing its contribution to tackling this critical issue and how this is reported into the CPP?**	The FI Strategy & Pipeline will be underpinned by some key shared principles, such as an agreed and shared first assessment proforma, and streamlined referral-on processes and pathway. The CHCP will have lead responsibility for some points within the pathway, including: • Providing basic information with regard to financial advice and support; • Signposting customers as appropriate; • Undertaking initial assessments of customers; and • Providing specialist WRO support, e.g. for appeals and tribunals. The performance framework is still to be developed but we anticipate that we will report back to the Alliance Board on the numbers of customers we support, as well as the number of referrals on to other parts of the pipeline. We also aspire to developing a common set of measures to gauge our throughcare and aftercare performance.
10.	**Please explain how the NHS Board will demonstrate continuous improvement in the course of tackling this critical issue?**	The performance framework will be designed to reflect improvements in the key areas of financial inclusion/exclusion, and in particular, those outlined at three above. We will also continue to support the other Alliance partners to embrace their roles in tackling social inequalities (which are closely linked to health inequalities). We will ensure that our Involving People workstreams are engaged through the Alliance Community Engagement Network, to foster a greater sense of community ownership if the impact that financial exclusion can have on communities as well as individuals.

NHS Board Local Delivery Plan 2012/13 —Contributions to Single Outcome Agreements

1.	**NHS Board:**	NHS Greater Glasgow and Clyde
2.	**Community Planning Partnership:**	West Dunbartonshire Community Planning Partnership
3.	**Summary of critical issue:**	Alcohol misuse continues to be a major health problem in West Dunbartonshire which affects a significant proportion of the individuals, families and communities across the area. West Dunbartonshire has the third highest recorded level of alcohol related deaths in Scotland (based upon five year average)[1]. An estimated 6% of the West Dunbartonshire population (aged 15 – 64) live with problems associated with alcohol misuse[2] with the rate per 100,000 population for alcohol hospital admissions (averaged over three years) being 1,157 compared to the Scottish average of 1,088.[3] The process of reviewing drug deaths in West Dunbartonshire also identified that issues relating to underlying alcohol misuse was a key factor in those deaths. Regulating access and availability of alcohol has a strong evidence base[4] in reducing harm from alcohol therefore this is a priority public health concern for the West Dunbartonshire Community Health & Care Partnership (CHCP), the local Alcohol and Drug Partnership (ADP) and the Community Planning Partnership (within which the CHCP is a core partner and participant).

[1] Registrar's Office for Scotland (GRO)

[2] *Estimating the National and Local Prevalence of problem Drug Misuse in Scotland, August 2009*

[3] Health and Wellbeing Profiles, Scotpho 2010

[4] Society for the Study of Addiction Barbor et al Alcohol; No Ordinary Commodity - A Summary of the second Edition - Alcohol and Public Policy Group 2010

4.	**Community Planning Partnership Outputs:**	The development of a robust Overprovision Policy for the West Dunbartonshire Licensing Board is a key element of a Community Planning Partnership (CPP) work programme which aims to reduce the impact of alcohol and drug misuse on communities (and which is reflected within the local Single Outcome Agreement). The West Dunbartonshire ADP is a sub group of the Safe & Strong Communities arrangements of the local CPP (reflecting the national expectations that the governance of ADPs should sit within those of local CPPs). The ADP is chaired by the CHCP Director, who is also a member of the local CPP Executive Group and Strategic Board.
5.	**Local Outcome(s):**	Reduced impact of alcohol and drug misuse on communities.
6.	**National Outcome(s):**	National Outcome 9 - We live our lives safe from crime, disorder and danger. National Outcome 6 - We live longer and healthier lives.
7.	**Please detail the specific contribution of the NHS Board in tackling this critical issue?**	The West Dunbartonshire CHCP Director leads and chairs the ADP, with CHCP officers chairing and co-ordinating the work of the associated substructures. The ADP led the development of the overprovision policy in conjunction with the Local Licensing Forum as part of a work programme to address the access and availability of alcohol. Data provided by NHSGGC – including the Community Health Profiles and in particular the SIMD data relating to intermediate datazones – and analysis undertaken by the CHCP Health Improvement Team confirmed that 15 of the 18 intermediate datazones were overprovided for. The local overprovision assessment and policy led by the CHCP has been showcased at a number of national conferences; and promoted as an example of best practice by Alcohol Focus Scotland and the Scottish Government.

8.	**Please explain the ways in which the NHS Board is working in collaboration with Community Planning Partners to tackle the critical issue?**	The ADP membership and the subgroup established to address overprovision include a number of key stakeholders in addition to the CHCP (representing both NHSGGC and local authority social care) e.g. Strathclyde Fire and Rescue; Strathclyde Police; other West Dunbartonshire Council departments (Educational Services and Regulatory Services); voluntary sector organisations; Community Councils; and Licensees. These stakeholders were and continue to be involved in working groups, data collection, analysis and consultation.
9.	**Please explain how the NHS Board is performance managing its contribution to tackling this critical issue and how this is reported into the CPP?**	The review and planning processes established to monitor the effectiveness of ADPs Alcohol and Drug Strategy: 2011-2014 includes the ongoing monitoring and review of data required to support the Licensing Board's Overprovision Policy. This progress is regularly reported (quarterly) to the Safer and Stronger Thematic Group through the agreed reporting structures using the performance management system agreed by the CPP (i.e. Covalent).
10.	**Please explain how the NHS Board will demonstrate continuous improvement in the course of tackling this critical issue?**	The overprovision assessment conducted in West Dunbartonshire has been showcased at a number of national conferences and promoted as an example of best practice by Alcohol Focus Scotland and the Scottish Government. Collaborative working with and through the Community Planning Partnership to address access and availability of alcohol will continue to prioritised by the CHCP as a key element of its commitment to and leadership role on prevention. A notable element of on-going work is a comprehensive Health Impact Assessment (HIA) of the Licensing Policy Statement that is being driven buy the local ADP Expert Support Team (who are an integral part of the CHCP Strategy & Planning Section), in order to identify further areas where public health can be protected and improved in West Dunbartonshire.

NHS Board Local Delivery Plan 2012/13 —Contributions to Single Outcome Agreements

1.	**NHS Board:**	NHS Greater Glasgow and Clyde
2.	**Community Planning Partnership:**	Glasgow City Community Planning Partnership
3.	**Summary of critical issue:**	<u>Tackling Socio-Economic Inequality.</u> The latest SIMD figures (2009) estimate that over 190,000 Glaswegians, a third of the cities population, reside in the 10% most deprived areas in Scotland. Almost half of Glasgow's residents (285,000) reside in the 20% of most deprived areas in Scotland. Male life expectancy in Glasgow has increased by nearly three years over the last two decades however the improving trend in Glasgow has not kept pace with improvements in Scottish life expectancy. Within Glasgow there is now a 16 year gap in male life expectancy between the least and most deprived areas. Appallingly the gap is two years greater than it was two decades ago, reflecting that the improvements we have seen have by-passed our poorest residents and inadvertently contributed to widening the gap. Sir Michael Marmot's landmark government review in 2010 identified the key determinants of health as relating to a host of issues including employment, the welfare state and child development. The heavy reliance on welfare within Glasgow means welfare reform will bring very significant change for our residents. This alongside the changing economic landscape is expected to generate further differences in health outcomes for our population. Tackling socio economic inequality is therefore fundamental to addressing SOA local and national outcomes and indeed NHS related HEAT requirements. Building

		community and personal resilience and assets to affect change is crucial, however, structural socio-economic inequalities will remain a limiting factor in progress.
4.	**Community Planning Partnership Outputs:**	Glasgow Community Planning Partnership (GCPP) has well established partnership mechanisms developing and implementing significant programmes to address socio economic inequality. Each partnership has a set of local SOA and national outcome targets: • A refreshed 2012-15 FIS for the city www.glasgow.gov.uk *Council papers 2011/12 Print 2 page 97;* • 2011-2014 Glasgow Works Strategy, promoting employability within the city. www.glasgoworks.eu; • A newer 'One Glasgow' partnership infrastructure to achieve significant progress on three key themes; early years, reducing youth offending, and older people www.glasgowcpp.org.uk *Board papers 13 September 2011;* • Parenting Strategy Partnership. www.glasgowcpp.org.uk/.../2373E35B-2823-4DA8-B397-1AFE4245D313/0/pdfparentingstrategy.pdf; and • Persistent Poverty neighbourhood partnerships working in identified neighbourhoods currently being established. www.glasgowcpp.org.uk.
5.	**Local Outcome(s):**	Local Outcome 7 - Increase the number of jobs in Glasgow. Local Outcome 8 - Increase the proportion of better paid and more productive jobs. Local Outcome 9 - Increase the proportion of Glasgow residents in work. Local Outcome 10 - Increase performance and volume of business carried on in Glasgow. Local Outcome 11 - Improve the attractiveness of Glasgow as a place to live, invest, work and visit. Local outcome 14 - Improve children's diets. Local Outcome 15 - Reduce the difference in life expectancy between most affluent and most disadvantaged residents. Local Outcome 16 - Reduce the harm caused by drugs addiction. Local Outcome 17 - Reduce the proportion of children in poverty. Local Outcome 18 - Increase the proportion of parents who are capable, responsible and supported.

		Local Outcome 20 - Improve Literacy and Numeracy of the population. Local Outcome 21 - Improve educational attainment and achievement of all children and young people. Local Outcome 22 - Improve skills for employment. Local Outcome 23 - Improve residents' aspirations, confidence, decision making capacity and involvement in community life.
6.	**National Outcome(s):**	National Outcome 2 - We realise our full economic potential with more and better employment opportunities for our people. National Outcome 3 - We are better educated, more skilled and more successful, renowned for our research and innovation. National Outcome 4 - Our young people are successful learners, confident individuals, effective contributors and responsible citizens. National Outcome 5 - Our children have the best start in life and are ready to succeed. National Outcome 6 - We live longer, healthier lives HIGH Contribution to a range of health programmes across a diverse age. National Outcome 7 - We have tackled the significant inequalities in Scottish society. National Outcome 8 - We have improved the life chances for children, young people and families at risk. National Outcome 11 - We have strong, resilient and supportive communities where people take responsibility for their own actions and how they affect others. National Outcome 12 - We value and enjoy our built and natural environment and protect it and enhance it for future generations.
7.	**Please detail the specific contribution of the NHS Board in tackling this critical issue?**	GCHP is an active member of all the partnership structures given in section four on behalf of the NHS. This requires a variety of inputs, as a contributor to determining strategic themes and programmes, to providing the partnership capacity to implement programmes all the way through to funding, evaluating and lobbying for action to benefit the city. Examples are given below. <u>Financial Inclusion Strategy</u> GCHP has jointly commissioned financial inclusion services with Glasgow City Council and

		the Glasgow Housing Association to ensure patients and residents are able to access financial support at appropriate times. This includes mainstreaming the previous Healthier Wealthier Children service enabling midwifes and health visitors to refer families for financial advice, Keep Well referrals through primary care, referrals from Yorkhill Hospital for families affected by childhood illness and referrals to the Macmillan Financial Inclusion Service for patients with cancer and long term conditions. NHS research and evaluation staff have lead on the Social Return on Investment (SROI) assessment of the MacMillan service. <u>Glasgow Works</u> GCHP jointly commission (with Glasgow Works) from the Glasgow Regeneration Agency the Bridging Service Programme. This provides teams of employability staff to work with Primary Care, CHP and Social Work staff, raising awareness of the importance of employment within treatment and care pathways and providing a single referral point for NHS staff for employability support. Over 1,000 referrals are made annually into Bridging Services, principally from addictions, mental health, criminal justice and primary care staff. Further work is being developed in our role as an employer, particularly in relation to younger adults. <u>Parenting Strategy Partnership</u> The Director of Public Health chairs the cities parenting strategy partnership which leads on the implementation of the three year strategy agreed in 2009. The NHS contribution is to ensure our child health staff are able to identify families that may be supported by the Triple P parenting programme and to provide group and one-to-one parenting interventions. The NHS also supports partners to identify their contribution to this agenda, working with Glasgow Housing Association and Glasgow Life in particular to build capacity to deliver within these organisations. At a local level NHS staff connect the parenting programme into other relevant developments e.g. the MIDAS programme in North Glasgow supporting vulnerable youngsters now enables the families of these youngsters to engage in Triple P.

8.	**Please explain the ways in which the NHS Board is working in collaboration with Community Planning Partners to tackle the critical issue?**	See also Section 4 and 7. NHSGGC is involved in GCPP partnership and the partnership infrastructure listed in section 4. As a member in some cases and as the partnership lead in others e.g. Parenting Strategy, Healthier Wealthier Children.
9.	**Please explain how the NHS Board is performance managing its contribution to tackling this critical issue and how this is reported into the CPP?**	NHSGGC has three Policy Frameworks which relate to this critical issue. The policy frameworks cut across the discrete service planning frameworks, and should be evident in all service planning areas. Each operating section of NHSGGC are required to articulate in annual development plans action in relation to the policy frameworks both within service planning and beyond. • Tackling Inequality Policy Framework; • Employability, Financial Inclusion and Responding to the recession Policy Framework; and • Health Improvement Policy Framework.
10.	**Please explain how the NHS Board will demonstrate continuous improvement in the course of tackling this critical issue?**	The GCHP Development Plan is performance managed through NHSGGC bi annual Organisational Performance Reviews (OPRs) where activity, referrals and outcomes are considered to determine progress. The GCPP annual SOA return and progress reporting can highlight issues to the NHS. Our engagement in critical partnership structures enables us to receive early notification of the outcomes of action to address socio economic inequality which we often influence rather than solely deliver. Specific evaluations and/or performance monitoring arrangements are in place for specific programmes: • Healthier Wealthier Children Evaluation being completed by Glasgow Centre for

		Population Health, spring 2012; • Financial Inclusion Contract performance system being progressed for contract commencing April 2012. This will contain data relating to NHS referrals and related outcomes; • Glasgow Works, Bridging Service evaluation into the impact of the service on health and wellbeing is reporting early 2012; • Employability 'Staff attitudes survey' conducted in 2006 and 2009 due to be repeated later in 2012 to capture extent to which NHS staff see the importance of employability for patients and their referral activity; • Macmillan Financial Inclusion Service, SROI in progress; and • Parenting Strategy, monitoring and evaluation programmes running over the three year strategy.

NHS Board Local Delivery Plan 2012/13 —Contributions to Single Outcome Agreements

1.	**NHS Board:**	Greater Glasgow and Clyde
2.	**Community Planning Partnership:**	Renfrewshire Community Planning Partnership
3.	**Summary of critical issue:**	The most effective interventions to improve the lives and opportunities of vulnerable children will be delivered before they are three years old. As a result of our limited ability to intervene in children's lives at this early stage, responses usually occur when children have suffered developmental consequences. At that point, responses are more costly and less effective than earlier intervention would be. The consequences of limited and late intervention include educational failure, anti-social behaviour, crime and violence. Poor parenting has immediate impacts on children such as making them feel emotionally excluded, less able to learn social skills, feel stupid and incompetent, have little persistence and feel frustrated and angry. Longer term impacts include low attachment to family and school, no 'good' friends, poor confidence, low qualifications, poor work, anti-social behaviour, criminality and drug misuse.
4.	**Community Planning Partnership Outputs:**	Joint funding, implementation and delivery of an evidence based parenting programme which reaches across the Renfrewshire population, and targets parents who need additional support.
5.	**Local Outcome(s):**	• Children have positive early years experiences; • The health of our young children is improved; and

		• Our children will be well qualified and prepared for adult life.
6.	**National Outcome(s):**	• Our children have the best start in life and are ready to succeed; and • We have tackled the significant inequalities in Scottish society.
7.	**Please detail the specific contribution of the NHS Board in tackling this critical issue?**	Early work was developed between the NHS Board and Glasgow City highlighting the need for early intervention and proposing an evidence based parenting programme. This work was progressed by Renfrewshire CHP, firstly at the CHP Committee which had Council and public representation, then through the Children's Services Partnership, which is part of the Community Planning structure. Partners signed up to both the need for early intervention and the use of an evidence based programme. The CHP then led the process to develop an implementation plan and funding package for Renfrewshire.
8.	**Please explain the ways in which the NHS Board is working in collaboration with Community Planning Partners to tackle the critical issue?**	There is a joint implementation group with representatives from Social Work, Education and Health. The training programme will see 250+ local staff trained in delivering Triple P, including some from the voluntary sector. The local Further Education College has contributed in kind by providing accommodation for training. Direct funding has been sourced jointly by both the CHP and Council departments. The initiative is embedded in Achieving Step Change which is the wider piece of work in Children's Services to match activity and investment with agreed outcomes for children and young people.
9.	**Please explain how the NHS Board is performance managing its contribution to tackling this critical issue and how this is reported into the CPP?**	Renfrewshire uses the performance management system developed by the Health Board. We monitor staff training, delivery activity, feedback from parents who attend parenting seminars and pre and post intervention measures. We also monitor expenditure against budget. There is a four weekly implementation group which carries out this monitoring role.

10.	**Please explain how the NHS Board will demonstrate continuous improvement in the course of tackling this critical issue?**	The CHP uses the four weekly implementation group to ensure agreed targets are met. We have also developed peer support groups to allow staff to share good practice and participating in the Board-wide evaluation and planning.

NHS Board Local Delivery Plan 2012/13 — Contributions to Single Outcome Agreements

Please refer to the Guidance Notes prior to completing the template.

1.	**NHS Board:**	NHS Greater Glasgow & Clyde
2.	**Community Planning Partnership:**	East Renfrewshire Community Planning Partnership
3.	**Summary of critical issue:**	Demographic challenge/ageing population and co-ordinated response. At a local level the extent of demographic change and the impact on traditional service models has long been recognised. • Over the long-term the older population in East Renfrewshire has increased by 55% between the 1980 and 2010; • Within this overall increase the number of people aged 85 and over has increased by 171%; and • This trend is expected on population projections to continue into the 2020 with older people outstripping children in the early 2010s and rising to over 19,000.
4.	**Community Planning Partnership Outputs:**	East Renfrewshire Reshaping Care for Older People Change Plan resulted in a range of interventions which were developed and implemented during 2011/12. Interventions include: • Community capacity building; • Dementia post-diagnostic support; • Falls prevention;

		• Long-term conditions nursing/advanced nurse practitioner; • Alternative day opportunities; • Older adults mental health; • Responder service linked to telecare and community safety; • Homecare reablement; • End of life care; • Pharmacy support focusing on poly-pharmacy; and • Discharge liaison.
5.	**Local Outcome(s):**	Our most vulnerable residents enjoy a better quality of life and live as independently as possible.
6.	**National Outcome(s):**	Our people are able to maintain their independence as they get older and are able to access appropriate support when they need it.
7.	**Please detail the specific contribution of the NHS Board in tackling this critical issue?**	There are good examples of collaborative working in delivering on this agenda within East Renfrewshire with lessons to be learnt for working in early years. Working in partnership across Rehabilitation and Assessment Directorate acute services, GPs, community nursing, community mental health, community rehabilitation and enablement, Voluntary Action East Renfrewshire, the Public Partnership Forum and East Renfrewshire Carers' Centre to develop and deliver a range of interventions to fundamentally reshape care for older people. NHS GG&C further supporting local initiatives through a central approach developed through the Ageing Population Planning Group. On the 2009/10 baseline set for year one of the East Renfrewshire Change Plan there has been a 9% reduction in the monthly average of over 75 bed days in the April-November period of 2011/12. Over 2011/12 performance has improved in the partnership area. For example in relation to delayed discharges, from the 2009/10 baseline East Renfrewshire has in the

		April-November 2011/12 period seen a reduction from 402.4 to 331.6 days (or 17.6%) in the monthly average accumulated bed days for people experiencing delayed discharge. Over the same period the average number of bed days within this accumulated for people under Adults with Incapacity legislation has reduced from 101.6 to zero.
8.	**Please explain the ways in which the NHS Board is working in collaboration with Community Planning Partners to tackle the critical issue?**	Through the CHCP, the NHS Board is working directly with Voluntary Action East Renfrewshire in taking an assets-based approach to community capacity building, developing preventative and early intervention approaches within the CHCP, and working in different ways to prevent admission to and facilitate discharge from hospital for older people. A good example of collaborative working on community capacity from an assets base relates to work with Voluntary Action East Renfrewshire to further developing Community Transport involving the recruitment of volunteer drivers providing opportunities for 42 older people to participate in assisted shopping and socialisation, working with re-designed day service to promote variety of day opportunities, organisational 'health checks' undertaken with 97 organisations, recruitment and training of volunteers to deliver Computer Training and digital inclusion activity targeted on day services and sheltered housing complexes. Work also includes hub development and community repair volunteer services.
9.	**Please explain how the NHS Board is performance managing its contribution to tackling this critical issue and how this is reported into the CPP?**	Performance on the Reshaping Care for Older People agenda is prioritised highly with monthly reporting on key performance measures. Monthly reports are generated and distributed across all partnerships enabling progress monitoring, action planning and benchmarking to support improvement. Six monthly OPRs are held between the CHCP, NHS Greater Glasgow & Clyde and East Renfrewshire Council and key actions and performance measures figure prominently in discussions. Partners report progress and performance to the CPP's Performance and Accountability Review.

		Key performance measures include: • Delayed discharge numbers; • Beds accumulated for delayed discharges; • Emergency admission; • Unplanned admission; • Home care provision; • Re-ablement; • Carers identification and assessment; • Care home admissions and residents; and • 'Talking Points' personal outcome measures.
10.	**Please explain how the NHS Board will demonstrate continuous improvement in the course of tackling this critical issue?**	Performance management information is reviewed at a local level through the OPR process to drive improvement. At a board level, performance is analysed across partnerships within corporate performance and reporting arrangements. Performance reports, evidence-based and positive practice is considered by the Ageing Population Planning Group which enables sharing of good practice across partnerships.

NHS Board Local Delivery Plan 2012/13 — Contributions to Single Outcome Agreements

Please refer to the Guidance Notes prior to completing the template.

1.	**NHS Board:**	GGC
2.	**Community Planning Partnership:**	East Dunbartonshire CHP
3.	**Summary of critical issue:**	Community planning partners have identified the lack of a local multi-agency framework as a barrier to effective planning and delivery of coordinated and comprehensive information, advice and support for families.
4.	**Community Planning Partnership Outputs:**	• Community Planning Partners participation at a prioritisation workshop; • Community Planning Partners participation in a Logic Model workshop; • Community Planning Partners involvement in Family Support Framework development working group; • Community Planning Partners involved in a Parenting Programme Operational working Group; and • Health and Local Authority planning and performance support in developing KPIs and IT solutions.
5.	**Local Outcome(s):**	East Dunbartonshire children and young people are safe, healthy and ready to learn.
6.	**National Outcome(s):**	We live longer, healthier lives.

7.	**Please detail the specific contribution of the NHS Board in tackling this critical issue?**	NHSGGC has led in the development and contributed to the delivery of a number of evidence based policies, plans, protocols, service models and interventions including the development of the multi-agency infrastructure around family support. NHSGGC led the process of raising the profile amongst planning partners and securing their buy-in and commitment to a range of evidence based positive interventions. The Board has also shared knowledge and expertise in key areas such as logic modelling to ensure a more outcomes focussed planning approach is adopted in the development of a comprehensive family support framework. NHSGGC has sourced evidence based practice with regard to parenting support with community planning partners including Social Work Services, Fire Services, Police, Housing, Citizen's Advice Bureau and the voluntary sector in order to incorporate a wide range of interventions from universal to more specialist level support services.
8.	**Please explain the ways in which the NHS Board is working in collaboration with Community Planning Partners to tackle the critical issue?**	The CHP leads the 'Supporting Families Health Improvement Group' which is a subgroup of the community planning strategic partnership 'Delivering for Children & Young People'. This multi-agency partnership group is leading the development of an East Dunbartonshire Family Support Framework. The framework incorporates preventative approaches to obesity, smoking, sexual health, parenting, breast feeding, injury prevention, homelessness and financial inclusion. Each partner is demonstrating their level of commitment to collectively addressing these key factors that impact on the health and wellbeing of families. Some examples include jointly completing final draft sexual health policies, undertaken a wide community consultation exercise regarding mental health improvement, secured agreement with the Citizen's Advice Bureau to deliver financial inclusion services and jointly agreed the parameters for the joint Health Improvement Plan. In addition, the CHP through leading this group has responsibility for taking for taking forward the health and well being actions agreed for the implementation of the TOTAL PLACE INITIATIVE which is a targeted approach to tackling the inequalities experienced by the most deprived community in East Dunbartonshire.

		NHSGGC is leading the development of a systematic performance management system and is currently leading on the development of a robust suite of measures in which to track progress against. The CHP has secured agreement with the local authority to populate the covalent electronic performance management system to enable the partnership jointly record and report progress against agreed performance indicators to the Community Planning Board.
9.	**Please explain how the NHS Board is performance managing its contribution to tackling this critical issue and how this is reported into the CPP?**	Governance and performance management arrangements have been jointly agreed and performance will be recorded and reported via the Covalent electronic system and six monthly exception reports. Progress is reported via the DCYPP to the Community Planning Board. Progress against NHS specific indicators is reported as part of the GGC OPR process.
10.	**Please explain how the NHS Board will demonstrate continuous improvement in the course of tackling this critical issue?**	An outcome focus logic model is being developed for all agreed interventions. Key performance measures are currently being jointly developed and agreed by partners across Health, Council and the Voluntary Sector. These include all relevant HEAT and Community Care Outcome targets.

NHS
Greater Glasgow and Clyde

Annex 4

Target Trajectories

Reduction in Emergency Bed Days for Patients Aged 75+

Year Ending	Ayrshire & Arran	Borders	Dumfries & Galloway	Fife	Forth Valley	Grampian	Greater Glasgow & Clyde	Highland	Lanarkshire	Lothian	Orkney	Shetland	Tayside	Western Isles
Mar-10	5,091	6,102	5,286	4,051	4,052	5,023	6,256	5,450	5,066	5,847	4,711	3,892	4,927	7,039
Apr-12							6,016							
May-12							6,007							
Jun-12							5,997							
Jul-12							5,988							
Aug-12							5,978							
Sep-12							5,969							
Oct-12							5,959							
Nov-12							5,950							
Dec-12							5,940							
Jan-13							5,930							
Feb-13							5,921							
Mar-13							**5,911**							
Apr-13							5,900							
May-13							5,888							
Jun-13							5,876							
Jul-13							5,864							
Aug-13							5,853							
Sep-13							5,841							
Oct-13							5,829							
Nov-13							5,817							
Dec-13							5,806							
Jan-14							5,794							
Feb-14							5,782							
Mar-14							**5,711**							
Apr-14							5,759							
May-14							5,747							
Jun-14							5,735							
Jul-14							5,724							
Aug-14							5,712							
Sep-14							5,700							
Oct-14							5,688							
Nov-14							5,677							
Dec-14							5,665							
Jan-15							5,653							
Feb-15							5,642							
Mar-15							**5,630**							

Notes:
1. The data are the number of emergency bed days in a year per 1,000 population
2. Boards have been provided separately with more recent performance management information (up to year ending June 2011)

2012/13 LDP HEAT DELIVERY TRAJECTORIES

Version 1.1

This document is to be used by NHS Boards to

Colour Coding Key:

	Colour
Performance required to achieve target	
Baseline position	
Requested trajectories from April 2012 to achieve target delivery (Boards to complete)	

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

2012/13 HEAT Targets

Detect Cancer Early

Early Access to Antenatal Care (SIMD)

Child Healthy Weight Interventions

Smoking Cessation (SIMD)

Child Fluoride Varnish Applications (SIMD)

Reduce Carbon Emissions

Reduce Energy Consumption

Drug and Alcohol Treatment: Referral to Treatment

Faster Access to CAMHS

Psychological Therapies

Reduction in Emergency Bed Days for Patients Aged 75+

28 Days Delayed Discharge

Stroke Unit

MRSA/MSSA Bacterium

Clostridium difficile infections

Rate of Attendance at Accident & Emergency

Detect Cancer Early

Proportion of Colorectal, Lung and Breast Cancer Patients Diagnosed at First Stage of Disease	Ayrshire & Arran	Borders	Dumfries & Galloway	Fife	Forth Valley	Grampian	Greater Glasgow & Clyde	Highland	Lanarkshire	Lothian	Orkney	Shetland	Tayside	Western Isles
2005/2009	17.3%	18.3%	20.6%	17.6%	16.3%	12.6%	12.2%	16.8%	13.2%	16.1%	11.3%	11.6%	16.0%	15.3%
2012/2013							14.2%							
2013/2014							17.0%							
2014/2015	20.0%	20.0%	20.0%	20.0%	20.0%	20.0%	20.0%	20.0%	20.0%	20.0%	20.0%	20.0%	20.0%	20.0%

Notes:
1. Data based on calendar years.
2. 2005/2009 baseline data covers the average of the 5 calendar years from 2005 to 2009
3. Performance in 2014/2015 should be at least 20%
4. Performance Management Information for Target is currently under development

Early Access to Antenatal Care (SIMD)

Percentage of Pregnant Women Booked for Antenatal Care by 12th Week of Gestation in the worst performing quintile	Ayrshire & Arran	Borders	Dumfries & Galloway	Fife	Forth Valley	Grampian	Greater Glasgow & Clyde	Highland	Lanarkshire	Lothian	Orkney	Shetland	Tayside	Western Isles
2010	64.5%	82.4%	83.5%	60.0%	86.1%	79.4%	62.8%	80.9%	75.9%	69.0%	69.0%	63.2%	61.7%	67.4%
Apr-Jun 12							62.8%							
Jul-Sep 12							62.8%							
Oct-Dec 12							62.8%							
Jan-Mar 13							62.8%							
Apr-Jun 13							64.9%							
Jul-Sep 13							67.1%							
Oct-Dec 13							69.3%							
Jan-Mar 14							71.4%							
Apr-Jun 14							73.6%							
Jul-Sep 14							75.7%							
Oct-Dec 14							77.9%							
Jan-Mar 15							80%							

Notes:
1. Baseline data covers the calendar year of 2010
2. Performance in Jan-Mar 2015 should be at least 80%

Child Healthy Weight Interventions

Cumulative Total	Ayrshire & Arran	Borders	Dumfries & Galloway	Fife	Forth Valley	Grampian	Greater Glasgow & Clyde	Highland	Lanarkshire	Lothian	Orkney	Shetland	Tayside	Western Isles
Apr 11 - Jun 12	440	130	182	435	283	583	1,403	364	1,175	945	21	27	456	31
Apr 11 - Sep 12	528	145	215	525	283	623	1,484	396	1,175	945	24	31	476	38
Apr 11 - Dec 12	616	180	248	615	433	803	1,985	461	1,375	1,210	27	38	596	44
Apr 11 - Mar 13	704	215	281	720	583	983	2,261	563	1,525	1,475	40	45	716	50
Apr 11 - Jun 13	792	245	314	825	583	1,156	2,533	671	1,650	1,740	43	52	843	56
Apr 11 - Sep 13	880	260	347	930	583	1,196	2,616	707	1,650	1,740	46	57	868	63
Apr 11 - Dec 13	968	296	380	1,050	733	1,376	3,115	779	1,745	2,005	49	63	993	69
Apr 11 - Mar 14	1,057	331	413	1,060	883	1,556	3,389	887	1,745	2,268	58	70	1,118	75

Notes:

1. Boards submitted 3-year trajectories for number of interventions in the 2011/12 LDPs. These are provided in the table above.

Smoking Cessation (SIMD)

Cumulative Total	Ayrshire & Arran	Borders	Dumfries & Galloway	Fife	Forth Valley	Grampian	Greater Glasgow & Clyde	Highland	Lanarkshire	Lothian	Orkney	Shetland	Tayside	Western Isles
Apr 11 - Jun 12	1,500	350	525	1,480	1,251	1,940	4,864	990	2,471	3,063	30	48	1,526	73
Apr 11 - Sep 12	1,800	420	650	1,776	1,501	2,382	5,674	1,188	2,965	3,540	38	56	1,806	88
Apr 11 - Dec 12	2,100	490	775	2,072	1,751	2,770	6,484	1,386	3,459	4,005	50	64	2,041	102
Apr 11 - Mar 13	2,400	560	900	2,368	2,001	3,158	8,108	1,581	3,953	4,836	60	72	2,422	117
Apr 11 - Jun 13	2,700	630	1,025	2,664	2,252	3,546	8,918	1,776	4,447	5,361	70	80	2,737	131
Apr 11 - Sep 13	3,000	700	1,150	2,960	2,502	3,934	9,728	1,971	4,941	5,796	80	88	3,017	146
Apr 11 - Dec 13	3,300	770	1,275	3,256	2,752	4,322	10,538	2,166	5,435	6,219	95	96	3,251	160
Apr 11 - Mar 14	3,544	838	1,373	3,550	3,002	4,648	12,182	2,358	5,929	7,011	105	104	3,628	175

Notes:

1. Boards submitted 3-year trajectories for number of interventions in the 2011/12 LDPs. These are provided in the table above.
2. Number of successful quits at one month after the quit in 40% most-deprived areas within each NHS Board (i.e the bottom two local SIMD quintiles).

Child Fluoride Varnish Applications (SIMD)

Period Ending	Ayrshire & Arran	Borders	Dumfries & Galloway	Fife	Forth Valley	Grampian	Greater Glasgow & Clyde	Highland	Lanarkshire	Lothian	Orkney	Shetland	Tayside	Western Isles
Jun-12	12.0%	44.0%	22.5%	20.0%	25.0%	40.0%	10.0%	30.0%	40.0%	14.0%	40.0%	30.0%	25.0%	25.0%
Sep-12	19.0%	47.0%	27.5%	20.0%	30.0%	45.0%	15.0%	35.0%	50.0%	14.0%	40.0%	35.0%	30.0%	30.0%
Dec-12	26.0%	50.0%	32.5%	30.0%	35.0%	48.0%	15.0%	40.0%	50.0%	15.0%	40.0%	40.0%	35.0%	35.0%
Mar-13	33.0%	53.0%	37.5%	30.0%	40.0%	50.0%	15.0%	45.0%	55.0%	30.0%	50.0%	45.0%	40.0%	40.0%
Jun-13	40.0%	56.0%	42.5%	40.0%	45.0%	53.0%	25.0%	50.0%	55.0%	45.0%	50.0%	50.0%	45.0%	45.0%
Sep-13	47.0%	59.0%	47.5%	40.0%	50.0%	55.0%	30.0%	55.0%	55.0%	60.0%	50.0%	55.0%	50.0%	50.0%
Dec-13	55.0%	62.0%	52.5%	50.0%	55.0%	58.0%	35.0%	55.0%	60.0%	60.0%	50.0%	60.0%	55.0%	55.0%
Mar-14	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%

Notes:

1. Boards submitted 3-year trajectories for number of interventions in the 2011/12 LDPs. These are provided in the table above.

Reduce Carbon Emissions

Year	Ayrshire & Arran	Borders	Dumfries & Galloway	Fife	Forth Valley	Grampian	Greater Glasgow & Clyde	Highland	Lanarkshire	Lothian	Orkney	Shetland	Tayside	Western Isles	National Waiting-Times Centre	State Hospital
2009/10	10,556	3,358	5,875	11,811	8,378	23,916	59,801	14,522	13,454	29,969	807	535	22,971	1,977	4,400	2,447
2012/13	9,634	3,065	5,362	10,780	7,647	21,827	54,579	13,254	12,279	27,352	737	488	20,965	1,804	4,016	2,233
2013/14	9,345	2,973	5,201	10,456	7,417	21,172	52,941	12,856	11,910	26,531	714	474	20,336	1,750	3,895	2,166
2014/15	9,065	2,883	5,045	10,143	7,195	20,537	51,353	12,470	11,553	25,735	693	460	19,726	1,698	3,778	2,101

Notes:
1. Values are in tonnes of CO2
2. Information for 2009/10 (baseline) is included in table

Reduce Energy Consumption

Year	Ayrshire & Arran	Borders	Dumfries & Galloway	Fife	Forth Valley	Grampian	Greater Glasgow & Clyde	Highland	Lanarkshire	Lothian	Orkney	Shetland	Tayside	Western Isles	National Waiting-Times Centre	State Hospital
2009/10	289,793	95,061	183,151	309,937	222,192	600,455	1,684,283	284,576	376,467	893,802	15,264	18,013	636,551	36,595	136,943	46,140
2012/13	281,186	92,237	177,711	300,731	215,593	582,621	1,634,258	276,123	365,285	867,255	14,811	17,478	617,645	35,509	132,876	44,770
2013/14	278,374	91,315	175,934	297,724	213,437	576,795	1,617,916	273,362	361,633	858,583	14,663	17,303	611,469	35,153	131,547	44,322
2014/15	275,590	90,402	174,175	294,747	211,302	571,027	1,601,736	270,629	358,016	849,997	14,516	17,130	605,354	34,802	130,232	43,879

Notes:
1. Values are in GJ.
2. Information for 2009/10 (baseline) is included in table

Drug and Alcohol Treatment: Referral to Treatment

Quarter of Treatment	Ayrshire & Arran	Borders	Dumfries & Galloway	Fife	Forth Valley	Grampian	Greater Glasgow & Clyde	Highland	Lanarkshire	Lothian	Orkney	Shetland	Tayside	Western Isles
Apr-Jun 11	90.4%	93.8%	76.3%	72.3%	89.1%	58.4%	92.6%	80.8%	97.9%	49.3%	91.7%	95.2%	70.2%	92.6%
Apr-Jun 12	90.0%	94.0%	92.0%	82.0%	82.0%	76.2%	91.5%	60.0%	95.0%	74.1%	90.0%	90.0%	79.2%	85.6%
Jul-Sep 12	90.1%	94.0%	92.0%	85.0%	83.0%	81.1%	91.5%	70.0%	95.0%	81.1%	90.0%	90.0%	82.8%	87.2%
Oct-Dec 12	90.2%	95.0%	92.0%	87.0%	85.0%	86.0%	91.5%	80.0%	96.0%	87.1%	90.0%	90.0%	86.4%	88.8%
Jan-Mar 13	90.3%	95.0%	92.0%	90.0%	88.0%	90.9%	91.5%	90.0%	97.0%	90.0%	90.0%	90.0%	90.0%	90.4%

Notes:
1. Boards submitted trajectories during October 2011. These are provided in the table above
2. Percentage of clients referred for drug or alcohol combined treatment are to be treated within 3 weeks from date referral received.
3. Published information for Apr-Jun 2011 is included in the table

Faster Access to CAMHS

Patients who waited over 26 weeks for CAMHS treatment: Month of Treatment	Ayrshire & Arran	Borders	Dumfries & Galloway	Fife	Forth Valley	Grampian	Greater Glasgow & Clyde	Highland	Lanarkshire	Lothian	Orkney	Shetland	Tayside	Western Isles
Apr-12							72							
May-12							65							
Jun-12							56							
Jul-12							41							
Aug-12							36							
Sep-12							27							
Oct-12							12							
Nov-12							0							
Dec-12							0							
Jan-13							0							
Feb-13							0							
Mar-13	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Notes:
1. Trajectories submitted in October 2011 should be amended as appropriate with more recent performance management information
2. Number of patients who waited over 26 weeks from referral to treatment
3. Scottish Government are considering a tolerance for this target and this will be discussed with Boards during the LDP process

Faster Access to Psychological Therapies

DO NOT COMPLETE - TO BE UPDATED DURING 2012/13 LDP YEAR

Month of Treatment	Ayrshire & Arran	Borders	Dumfries & Galloway	Fife	Forth Valley	Grampian	Greater Glasgow & Clyde	Highland	Lanarkshire	Lothian	Orkney	Shetland	Tayside	Western Isles
Sep-12														
Oct-12														
Nov-12														
Dec-12														
Jan-13														
Feb-13														
Mar-13														
Apr-13														
May-13														
Jun-13														
Jul-13														
Aug-13														
Sep-13														
Oct-13														
Nov-13														
Dec-13														
Jan-14														
Feb-14														
Mar-14														
Apr-14														
May-14														
Jun-14														
Jul-14														
Aug-14														
Sep-14														
Oct-14														
Nov-14														
Dec-14	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Notes:

1. Trajectories to be agreed by October 2012.
2. Number of patients who waited over 18 weeks from referral to treatment for Psychological Therapies
3. Scottish Government are considering a tolerance for this target and this will be discussed with Boards during the LDP process

28 Days Delayed Discharge

Census Night	Ayrshire & Arran	Borders	Dumfries & Galloway	Fife	Forth Valley	Grampian	Greater Glasgow & Clyde	Highland	Lanarkshire	Lothian	Orkney	Shetland	Tayside	Western Isles
Oct-11	16	4	2	22	9	17	82	9	20	26	0	0	17	0
Apr-12							62							
Jul-12							52							
Oct-12							42							
Jan-13							22							
Apr-13	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Notes:
1. Number of NHS Delayed Discharges above 28 Days (4 Weeks)
2. Census night in October 2011 is included in the table

Stroke Unit Access

Quarter of Admission	Ayrshire & Arran	Borders	Dumfries & Galloway	Fife	Forth Valley	Grampian	Greater Glasgow & Clyde	Highland	Lanarkshire	Lothian	Orkney	Shetland	Tayside	Western Isles
2010	93.3%	64.3%	68.0%	74.8%	39.3%	64.7%	63.9%	28.9%	78.0%	71.2%	57.5%	0.0%	77.7%	81.3%
Apr-Jun 2012	83.0%	82.5%	84.0%	82.0%	82.5%	82.0%	83.0%	80.0%	85.0%	85.0%	82.0%	90.0%	85.0%	82.5%
Jul-Sep 2012	85.0%	85.0%	86.0%	85.0%	85.0%	85.0%	86.0%	85.0%	85.0%	85.0%	85.0%	90.0%	85.0%	85.0%
Oct-Dec 2012	87.0%	87.5%	88.0%	87.0%	87.5%	87.0%	88.0%	85.0%	85.0%	85.0%	87.0%	90.0%	90.0%	87.5%
Jan-Mar 2013	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%

Notes:
1. Boards submitted 2-year trajectories for Stroke Access in the 2011/12 LDPs. These are provided in the table above.
2. Percentage of stroke patients admitted to stroke unit on day of or day following, admission to hospital.
3. Patients are assigned to the board of original hospital admission.
4. Monthly management information is available to NHS Boards.
5. All hospitals admitting acute stroke patients are included in the target.
6. Baseline information for calendar year of 2010 is included in the table

MRSA/MSSA Bacterium

Year Ending	Ayrshire & Arran	Borders	Dumfries & Galloway	Fife	Forth Valley	Grampian	Greater Glasgow & Clyde	Highland	Lanarkshire	Lothian	Orkney	Shetland	Tayside	Western Isles
Jun-11	0.37	0.33	0.23	0.39	0.42	0.36	0.33	0.21	0.34	0.37	0.24	0.00	0.35	0.26
Jun-12	0.28	0.27	0.31	0.37	0.32	0.28	0.29	0.26	0.29	0.31	0.06	0.30	0.29	0.32
Sep-12	0.27	0.26	0.29	0.33	0.30	0.28	0.28	0.26	0.28	0.29	0.06	0.28	0.28	0.30
Dec-12	0.26	0.26	0.27	0.30	0.28	0.27	0.27	0.26	0.27	0.28	0.06	0.26	0.27	0.28
Mar-13	0.26	0.26	0.26	0.26	0.26	0.26	0.26	0.26	0.26	0.26	0.26	0.26	0.26	0.26

Notes:

1. Boards submitted 2-year trajectories for number for MRSA/MSSA in the 2011/12 LDPs. These are provided in the table above.
2. Boards are expected to achieve a rate of 0.26 cases per 1,000 acute occupied bed days or lower by year ending March 2013. Boards currently with a rate of less than 0.26 are expected to at least maintain this, as reflected in their trajectories.
3. Boards will be held to account against the 0.26 rate.
4. It is acknowledged that there are particular issues with island board targets given that very small changes in case numbers will have a disproportionate impact on rates. This will be taken into account when assessing whether these boards have effectively delivered their target; but the expectation of zero tolerance of preventable infections will continue to apply.
5. Information for year ending June 2011 is included in the table

Clostridium difficile infections

Year Ending	Ayrshire & Arran	Borders	Dumfries & Galloway	Fife	Forth Valley	Grampian	Greater Glasgow & Clyde	Highland	Lanarkshire	Lothian	Orkney	Shetland	Tayside	Western Isles
Jun-11	0.64	0.28	0.64	0.23	0.17	0.36	0.29	0.26	0.36	0.41	0.98	0.00	0.32	0.07
Jun-12	0.50	0.39	0.65	0.39	0.33	0.45	0.39	0.40	0.43	0.46	0.17	0.20	0.55	0.44
Sep-12	0.45	0.39	0.55	0.39	0.33	0.43	0.39	0.40	0.40	0.44	0.17	0.20	0.50	0.43
Dec-12	0.40	0.39	0.45	0.39	0.33	0.41	0.39	0.39	0.39	0.41	0.17	0.20	0.45	0.41
Mar-13	0.39	0.39	0.39	0.39	0.33	0.39	0.39	0.39	0.39	0.39	0.39	0.20	0.39	0.39

Notes:

1. Boards submitted 2-year trajectories for number for C Difficile in the 2011/12 LDPs. These are provided in the table above.
2. Boards are expected to achieve a rate of 0.39 cases per 1,000 acute occupied bed days or lower by year ending March 2013. Boards currently with a rate of less than 0.39 are expected to at least maintain this, as reflected in their trajectories.
3. Boards will be held to account against the 0.39 rate.
4. It is acknowledged that there are particular issues with island board targets given that very small changes in case numbers will have a disproportionate impact on rates. This will be taken into account when assessing whether these boards have effectively delivered their target; but the expectation of zero tolerance of preventable infections will continue to apply.
5. Information for year ending June 2011 is included in the table

Rate of Attendance at Accident & Emergency

Year Ending	Ayrshire & Arran	Borders	Dumfries & Galloway	Fife	Forth Valley	Grampian	Greater Glasgow & Clyde	Highland	Lanarkshire	Lothian	Orkney	Shetland	Tayside	Western Isles
Mar-10	2,471	1,642	2,703	1,856	1,529	1,550	3,034	1,369	2,855	1,950		3,216	1,522	2,186
Sep-11	2,570	1,736	2,558	1,865	1,623	1,570	2,836	1,390	2,765	1,990		3,115	1,530	2,108
Jun-12	2,536	1,619	2,631	1,804	1,493	1,534	2,985	1,336	2,660	1,934		3,091	1,474	2,089
Sep-12	2,528	1,614	2,623	1,798	1,486	1,532	2,974	1,329	2,654	1,931		3,086	1,469	2,078
Dec-12	2,517	1,608	2,615	1,792	1,480	1,529	2,961	1,324	2,648	1,928		3,081	1,464	2,068
Mar-13	2,503	1,603	2,607	1,786	1,488	1,526	2,949	1,318	2,642	1,924		3,076	1,460	2,057
Jun-13	2,484	1,598	2,599	1,780	1,486	1,523	2,937	1,309	2,636	1,921		3,071	1,455	2,047
Sep-13	2,461	1,593	2,591	1,774	1,485	1,520	2,925	1,300	2,631	1,918		3,066	1,451	2,037
Dec-13	2,433	1,588	2,583	1,768	1,489	1,517	2,920	1,292	2,625	1,915		3,061	1,446	2,026
Mar-14	2,401	1,582	2,575	1,763	1,500	1,515	2,888	1,285	2,619	1,911		3,055	1,442	2,016

Notes:
1. Trajectories show anticipated monthly average attendance rates per 100,000 population at specified departments for year ending in the months shown. The target will be monitored using the 12 month moving average - based on attendances at these sites as reported by ISD, and relevant NRS mid-year population estimates.
2. Baseline information for financial year of 2009/10 is included in the table

NHS
Greater Glasgow and Clyde

Annex 5

Financial Template

NHS GREATER GLASGOW & CLYDE

Revenue Outturn Statement

Line no	2011-12 Total £000s		2012-13 Rec £000s	2012-13 Non-Rec £000s	2012-13 TOTAL	2013-14 Rec £000s	2013-14 Non-Rec £000s	2013-14 TOTAL	2014-15 Rec £000s	2014-15 Non-Rec £000s	2014-15 TOTAL	2015-16 Rec £000s	2015-16 Non-Rec £000s	2015-16 TOTAL	2016-17 Rec £000s	2016-17 Non-Rec £000s	2016-17 TOTAL
		Total Expenditure															
1.01	1,399,157	Clinical Service - Pay	1,389,800		**1,389,800**	1,432,200		**1,432,200**	1,452,300		**1,452,300**	1,456,900		**1,456,900**	1,446,300		**1,446,300**
1.02	1,419,931	Clinical Service - Non-Pay	1,375,400	90,420	**1,465,820**	1,390,300	87,500	**1,477,800**	1,425,500	69,400	**1,494,900**	1,445,200	50,600	**1,495,800**	1,480,300	50,600	**1,530,900**
1.03	37,000	Non-Clinical Service - Pay	32,300		**32,300**	32,600		**32,600**	32,900		**32,900**	33,200		**33,200**	33,500		**33,500**
1.04	13,000	Non-Clinical Service - Non-Pay	11,400		**11,400**	11,500		**11,500**	11,600		**11,600**	11,700		**11,700**	11,800		**11,800**
1.05	n/a	Outgoing funds - Health & Social Care Integration			**0**			**0**			**0**			**0**			**0**
1.06	2,869,088	**Total Gross Expenditure**	2,808,900	90,420	**2,899,320**	2,866,600	87,500	**2,954,100**	2,922,300	69,400	**2,991,700**	2,947,000	50,600	**2,997,600**	2,971,900	50,600	**3,022,500**
		Less															
1.07	493,000	Operating Income	488,100		**488,100**	490,800		**490,800**	493,500		**493,500**	496,200		**496,200**	498,900		**498,900**
1.08	n/a	Incoming funds - Health & Social Care Integration			**0**			**0**			**0**			**0**			**0**
1.09	493,000	**Total Gross Income**	488,100	0	**488,100**	490,800	0	**490,800**	493,500	0	**493,500**	496,200	0	**496,200**	498,900	0	**498,900**
1.10	**2,376,088**	**Total Expenditure**	**2,320,800**	**90,420**	**2,411,220**	**2,375,800**	**87,500**	**2,463,300**	**2,428,800**	**69,400**	**2,498,200**	**2,450,800**	**50,600**	**2,501,400**	**2,473,000**	**50,600**	**2,523,600**
		Non-Core RRL Expenditure															
1.11	1,070	Capital Grants	n/a	3,460	**3,460**	n/a	0	**0**	n/a	0	**0**	n/a	0	**0**	n/a	0	**0**
1.12	72,300	Depreciation / Amortisation	n/a	71,300	**71,300**	n/a	72,300	**72,300**	n/a	83,300	**83,300**	n/a	84,300	**84,300**	n/a	117,300	**117,300**
1.13	37,147	AME - Impairments	n/a	46,360	**46,360**	n/a	46,900	**46,900**	n/a	28,800	**28,800**	n/a	10,000	**10,000**	n/a	10,000	**10,000**
1.14	8,000	AME - Creation of Provisions	n/a	8,000	**8,000**	n/a	8,000	**8,000**	n/a	8,000	**8,000**	n/a	8,000	**8,000**	n/a	8,000	**8,000**
1.15		AME - Donated Assets Depreciation	n/a		**0**	n/a		**0**	n/a		**0**	n/a		**0**	n/a		**0**
1.16	33,060	IFRS PFI Expenditure	n/a	32,600	**32,600**	n/a	32,600	**32,600**	n/a	32,600	**32,600**	n/a	32,600	**32,600**	n/a	32,600	**32,600**
1.17	**151,577**	**Total Non-Core RRL Expenditure**	**n/a**	**161,720**	**161,720**	**n/a**	**159,800**	**159,800**	**n/a**	**152,700**	**152,700**	**n/a**	**134,900**	**134,900**	**n/a**	**167,900**	**167,900**
1.18	155,260	FHS Non Discretionary Net Expenditure	155,600		**155,600**	156,400		**156,400**	157,200		**157,200**	158,000		**158,000**	158,800		**158,800**
		Core RRL Expenditure															
1.19	2,069,251	Core Revenue Resource Outturn	2,165,200	(71,300)	**2,093,900**	2,219,400	(72,300)	**2,147,100**	2,271,600	(83,300)	**2,188,300**	2,292,800	(84,300)	**2,208,500**	2,314,200	(117,300)	**2,196,900**
1.20	2,069,251	Core Revenue Resource Limit (RRL) (line 1.30)	2,165,200	(71,300)	**2,093,900**	2,219,400	(72,300)	**2,147,100**	2,271,600	(83,300)	**2,188,300**	2,292,800	(84,300)	**2,208,500**	2,314,200	(117,300)	**2,196,900**
1.21	**0**	**Saving / (Excess) against Core RRL**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Recurring and Non-Recurring Core Revenue Resource Limit Projection

Line no			2012-13 Rec £000s	2012-13 Non-Rec £000s	2012-13 TOTAL	2013-14 Rec £000s	2013-14 Non-Rec £000s	2013-14 TOTAL	2014-15 Rec £000s	2014-15 Non-Rec £000s	2014-15 TOTAL	2015-16 Rec £000s	2015-16 Non-Rec £000s	2015-16 TOTAL	2016-17 Rec £000s	2016-17 Non-Rec £000s	2016-17 TOTAL
1.22		Baseline allocation	1,937,900	n/a	**1,937,900**	1,991,300	n/a	**1,991,300**	2,042,700	n/a	**2,042,700**	2,063,100	n/a	**2,063,100**	2,083,700	n/a	**2,083,700**
1.23		Anticipated allocations - recurring (line 5.99)	0	n/a	**0**	0	n/a	**0**	0	n/a	**0**	0	n/a	**0**	0	n/a	**0**
1.24		*Updated baseline*	1,937,900	n/a	**1,937,900**	1,991,300	n/a	**1,991,300**	2,042,700	n/a	**2,042,700**	2,063,100	n/a	**2,063,100**	2,083,700	n/a	**2,083,700**
1.25		Carry forward	n/a		**0**	n/a		**0**	n/a		**0**	n/a		**0**	n/a		**0**
1.26		Transfer of depreciation / amortisation (line 1.12)	n/a	(71,300)	**(71,300)**	n/a	(72,300)	**(72,300)**	n/a	(83,300)	**(83,300)**	n/a	(84,300)	**(84,300)**	n/a	(117,300)	**(117,300)**
1.27		Revenue transferred to capital	n/a		**0**	n/a		**0**	n/a		**0**	n/a		**0**	n/a		**0**
1.28		Anticipated allocations - earmarked / non-rec (line 5.9	227,300	0	**227,300**	228,100	0	**228,100**	228,900	0	**228,900**	229,700	0	**229,700**	230,500	0	**230,500**
1.29		**Sub-total**	227,300	(71,300)	**156,000**	228,100	(72,300)	**155,800**	228,900	(83,300)	**145,600**	229,700	(84,300)	**145,400**	230,500	(117,300)	**113,200**
1.30		**Core Revenue Resource Limit (RRL)**	**2,165,200**	**(71,300)**	**2,093,900**	**2,219,400**	**(72,300)**	**2,147,100**	**2,271,600**	**(83,300)**	**2,188,300**	**2,292,800**	**(84,300)**	**2,208,500**	**2,314,200**	**(117,300)**	**2,196,900**

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NHS GREATER GLASGOW & CLYDE

Efficiency and Other Savings

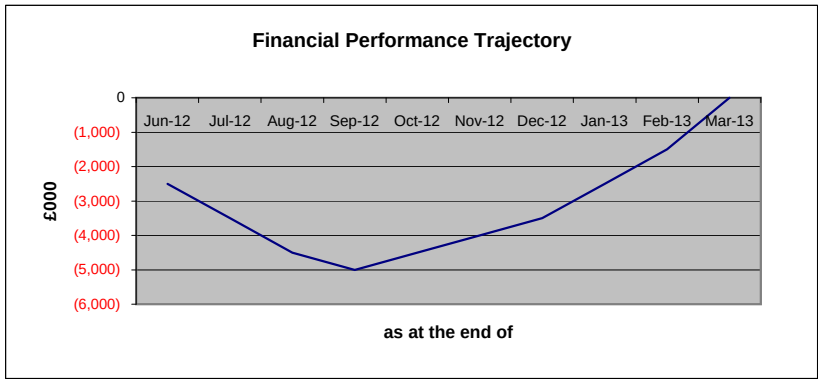
Line no	Saving Scheme Details	2012-13 Rec £000s	2012-13 Non-Rec £000s	2012-13 Total £000s	2012-13 Risk rating High %	2012-13 Risk rating Med %	2012-13 Risk rating Low %	2013-14 Rec £000s	2013-14 Non-Rec £000s	2013-14 Total £000s	2013-14 Risk rating High %	2013-14 Risk rating Med %	2013-14 Risk rating Low %	2014-15 Rec £000s	2014-15 Non-Rec £000s	2014-15 Total £000s	2014-15 Risk rating High %	2014-15 Risk rating Med %	2014-15 Risk rating Low %	2015-16 Rec £000s	2015-16 Non-Rec £000s	2015-16 Total £000s	2015-16 Risk rating High %	2015-16 Risk rating Med %	2015-16 Risk rating Low %	2016-17 Rec £000s	2016-17 Non-Rec £000s	2016-17 Total £000s	2016-17 Risk rating High %	2016-17 Risk rating Med %	2016-17 Risk rating Low %
	Efficiency & Productivity Workstreams																														
2.01	Clinical Productivity	13,797		**13,797**	21%	49%	30%			**0**			100%			**0**			100%			**0**			100%			**0**			100%
2.02	Workforce	10,504		**10,504**	14%	49%	37%			**0**			100%			**0**			100%			**0**			100%			**0**			100%
2.03	Drugs and Prescribing	8,435		**8,435**	0%	91%	9%			**0**			100%			**0**			100%			**0**			100%			**0**			100%
2.04	Procurement	3,563		**3,563**	3%	67%	30%			**0**			100%			**0**			100%			**0**			100%			**0**			100%
2.05	Support Services	2,163		**2,163**	24%	57%	19%			**0**			100%			**0**			100%			**0**			100%			**0**			100%
2.06	Estates and Facilities	4,289		**4,289**	6%	36%	58%			**0**			100%			**0**			100%			**0**			100%			**0**			100%
2.07	Unidentified Savings	7,250		**7,250**	100%	0%	0%	29,700		**29,700**	100%		0%	26,000		**26,000**	100%		0%	52,600		**52,600**	100%		0%	54,200		**54,200**	100%		0%
2.08	**Total In-Year Efficiency Savings**	**50,000**	**0**	50,000	#####	#####	#####	**29,700**	**0**	29,700	#####	**0**	**0**	**26,000**	**0**	26,000	#####	**0**	**0**	**52,600**	**0**	52,600	#####	**0**	**0**	**54,200**	**0**	54,200	#####	**0**	**0**
2.09	**Other Local Savings Schemes (excluding efficient government schemes)**			0			100%			0			100%			0			100%			0			100%			0			100%
2.10	**Total Other Local Savings Schemes**	**0**	**0**	**0**	0	0	0	**0**	**0**	**0**	0	0	0	**0**	**0**	**0**	0	0	0	**0**	**0**	**0**	0	0	0	**0**	**0**	**0**	0	0	0
2.11	**Total Savings**	**50,000**	**0**	50,000	#####	#####	#####	**29,700**	**0**	29,700	#####	**0**	**0**	**26,000**	**0**	26,000	#####	**0**	**0**	**52,600**	**0**	52,600	#####	**0**	**0**	**54,200**	**0**	54,200	#####	**0**	**0**

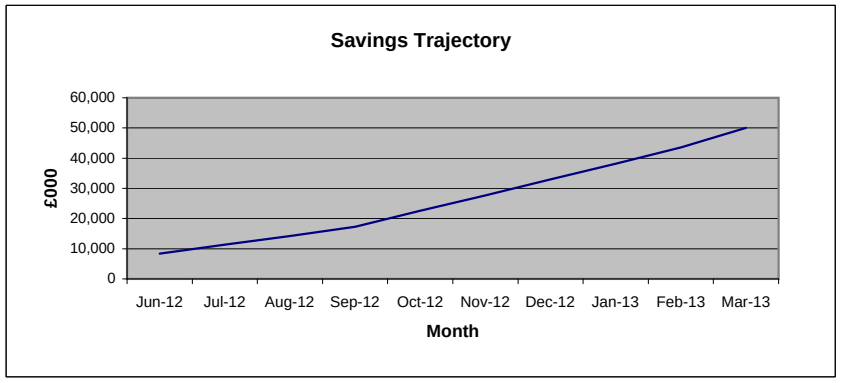
NHS GREATER GLASGOW & CLYDE

Financial Trajectories

	Saving / (Excess) against Core RRL *as at the end of*	£000s
3.01	Jun-12	(2,500)
3.02	Jul-12	(3,500)
3.03	Aug-12	(4,500)
3.04	Sep-12	(5,000)
3.05	Oct-12	(4,500)
3.06	Nov-12	(4,000)
3.07	Dec-12	(3,500)
3.08	Jan-13	(2,500)
3.09	Feb-13	(1,500)
3.10	Mar-13	0

Savings *Cumulative savings as at the end of*	Efficient government schemes £000s	Other local schemes £000s	Total Savings £000s
Jun-12	8,371		8,371
Jul-12	11,303		11,303
Aug-12	14,236		14,236
Sep-12	17,241		17,241
Oct-12	22,571		22,571
Nov-12	27,707		27,707
Dec-12	32,951		32,951
Jan-13	38,196		38,196
Feb-13	43,578		43,578
Mar-13	50,000	0	50,000





NHS GREATER GLASGOW & CLYDE

Financial Planning Assumptions

Line no	2011-12	Assumptions - uplift (%)	2012-13	2013-14	2014-15	2015-16	2016-17
4.01	2.70%	Resources	1.00%	2.76%	2.58%	1.00%	1.00%
4.02	1.40%	Pay	1.00%	2.25%	2.00%	1.00%	1.00%
4.03	1.00%	Prices	1.00%	1.00%	1.00%	1.00%	1.00%
4.04	5.90%	GP prescribing	2.97%	4.40%	6.00%	6.00%	6.00%
4.05	7.90%	Hospital drugs	13.16%	11.60%	7.50%	7.50%	7.50%
4.06	0.50%	Other FHS uplift	0.50%	0.50%	0.50%	0.50%	0.50%

Risk Assessment

	Key Assumptions / Risks	Risk rating (please select from drop-down)	Impact / £
4.07	Salaries. Assumptions have been made about pay inflation on the basis of the Chancellor's desire for modest increases in public sector pay.	M	Pay freeze assumed for 2012/13 with additional costs for effect of £250 increase for low paid staff and 0.3% net increase in employers' national insurance. As RPI remains high it will be difficult to maintain a pay freeze.
4.08	Supplies. Assumptions have been made about general price inflation in line with the Chancellor's target for inflation.	M	There is a risk that supplies inflation may be higher than estimated, particularly as the RPI is high. However, the effect of the recession mayl keep inflation low in future. Each 0.5% difference equates to £2.5m impact.
4.09	Incremental Pay Progression. Until Agenda for Change reaches equilirium there will continue to be a net increase in cost relating to incremental pay progression..	H	Until Agenda for Change reaches equilibrium there will continue to be a net increase in cost relating to incremental pay progression. For 2012/13 the net cost after taking accout of leavers is estimated at £10m, though depending on turnover, could be as high as £14m
4.10	Prescribing. Assumptions have been made about prescribing inflation based on experience of previous years including delivery of cost savings programmes.	M	The rate of introduction of Dabigabtran could push prescribing costs to a level considerably in excess of budget in 2012/13, up to £3m additional cost per annum.
4.11	Energy Costs. Energy price movements in recent years have been volatile, albeit formal purchasing arrangements have succeeded in containing expenditure growth going forward.	M	Forward purchasing will afford predictability of future costs on a year by year basis. However, longer term outlook remains uncertain. There is the potential for significant cost pressure to occur, albeit forward purchasing will allow more time to plan to mitigate this
4.12	NRAC. For 2012/13, SGHD has confirmed a funding increase of 1.0% (plus additional funding for Access Targets, Prison Healthcare & Change Fund). For 2013/14 & 2014/15, the financial plan assumes increases of 2.8% & 2.6%.	M	Our assumption is a judgement based on Scottish Government budget proposals.
4.13	Cost Savings - ASR. Planned costs savings to fund the ASR will be accumulated as planned in the run up to the opening of the new South Glasgow Hospital.	L	The time frame available to generate the cost savings allows reasonable time to plan and secure these. The challenge will be to retain them for ASR rather than to contribute to the overall balancing of funding and expenditure withio the Board's financial plan

NHS GREATER GLASGOW & CLYDE

Revenue Resource Limit - Anticipated Allocations

Line no	Anticipated Allocations	Directorate (please select from drop-down)	SG Contact Name	2012-13 Recurring £000s	2012-13 Earmarked £000s	2012-13 Non-Rec £000s	2012-13 TOTAL	2013-14 Recurring £000s	2013-14 Earmarked £000s	2013-14 Non-Rec £000s	2013-14 TOTAL	2014-15 Recurring £000s	2014-15 Earmarked £000s	2014-15 Non-Rec £000s	2014-15 TOTAL	2015-16 Recurring £000s	2015-16 Earmarked £000s	2015-16 Non-Rec £000s	2015-16 TOTAL	2016-17 Recurring £000s	2016-17 Earmarked £000s	2016-17 Non-Rec £000s	2016-17 TOTAL
5.01	Brokerage Repayments	Health Finance & Information	Robert Peterson				0				0				0				0				0
5.02	eHealth Bundle	Health Finance & Information	Lesly Donovan				0	0			0	0			0	0			0	0			0
5.03	Effective Prevention Bundle	Health & Healthcare Improvement	Mark O'Donnell		11,015		11,015	11,015			11,015	11,015			11,015	11,015			11,015	11,015			11,015
5.04	Dental Services Bundle	Health & Social Care Integration	Tom Ferris		3,016		3,016	3,016			3,016	3,016			3,016	3,016			3,016	3,016			3,016
5.05	Mental Health Bundle	Health & Social Care Integration	Geoff Huggins		2,000		2,000	2,000			2,000	2,000			2,000	2,000			2,000	2,000			2,000
5.06	Practice Education Facilitators	CNO, Patients, Public & Health Professions					0	0			0	0			0	0			0	0			0
5.07	HAI - National MRSA Screening Programme	CNO, Patients, Public & Health Professions					0	0			0	0			0	0			0	0			0
5.08	HAI Funding	CNO, Patients, Public & Health Professi	Christine Brocklehurst		82		82	82			82	82			82	82			82	82			82
5.09	MSK Rollout	CNO, Patients, Public & Health Professions					0	0			0	0			0	0			0	0			0
5.10	HNC Continuing Students	CNO, Patients, Public & Health Professions					0	0			0	0			0	0			0	0			0
5.11	HNC Nursing Students	CNO, Patients, Public & Health Professions					0	0			0	0			0	0			0	0			0
5.12	One Year Job Guarantee	CNO, Patients, Public & Health Professions					0	0			0	0			0	0			0	0			0
5.13	Open University Payments	CNO, Patients, Public & Health Professions					0	0			0	0			0	0			0	0			0
5.14	Alcohol Funding	CMO, Public Health & Sport	Alasdair Menzies		9,244		9,244	9,244			9,244	9,244			9,244	9,244			9,244	9,244			9,244
5.15	Drug Treatment Funding	CMO, Public Health & Sport	Laura Powrie		9,559		9,559	9,559			9,559	9,559			9,559	9,559			9,559	9,559			9,559
5.16	Equally Well Test Sites	CMO, Public Health & Sport					0	0			0	0			0	0			0	0			0
5.17	Funding to Support Alcohol and Drug Partnerships	CMO, Public Health & Sport	Alasdair Menzies		743		743	743			743	743			743	743			743	743			743
5.18	Keep Well / Well North	CMO, Public Health & Sport	Andy Bruce		4,670		4,670	4,670			4,670	4,670			4,670	4,670			4,670	4,670			4,670
5.19	Research Support and UKCRC Budget	CMO, Public Health & Sport	Malcolm Pringle		15,238		15,238	15,238			15,238	15,238			15,238	15,238			15,238	15,238			15,238
5.20	CYP Specialist Services National Delivery Plan (NDP	Children & Families	Fiona McKinlay		3,962		3,962	3,962			3,962	3,962			3,962	3,962			3,962	3,962			3,962
5.21	Refreshed Framework for Maternity Care Implementa	Children & Families	Christine Duncan		263		263	263			263	263			263	263			263	263			263
5.22	Diabetes	Health & Healthcare Improvement					0	0			0	0			0	0			0	0			0
5.23	Genetic Services Review	Health & Healthcare Improvement	Elizabeth Porterfield		1,222		1,222	1,222			1,222	1,222			1,222	1,222			1,222	1,222			1,222
5.24	Wheelchair and Seating Services (WSS) Modernisatio	Health & Healthcare Improvement	Elizabeth Porterfield		1,967		1,967	1,967			1,967	1,967			1,967	1,967			1,967	1,967			1,967
5.25	Positron Emission Tomography (PET) SCAN	Health & Healthcare Improvement					0	0			0	0			0	0			0	0			0
5.26	Clinical academic staff	Health & Social Care Integration					0	0			0	0			0	0			0	0			0
5.27	Integrated Resource Framework (IRF)	Health & Social Care Integration					0	0			0	0			0	0			0	0			0
5.28	Learning Disability Health Inequalities Change Progra	Health & Social Care Integration					0	0			0	0			0	0			0	0			0
5.29	NHS Carer Information Strategies	Health & Social Care Integration					0	0			0	0			0	0			0	0			0
5.30	Primary Medical Services	Health & Social Care Integration	Gary MacDonald		157,100		157,100	157,900			157,900	158,700			158,700	159,500			159,500	160,300			160,300
5.31	Scottish Dental Access Initiative (SDAI)	Health & Social Care Integration					0	0			0	0			0	0			0	0			0
5.32	Scottish Enhanced Services Programme (SESP)	Health & Social Care Integration	Gary MacDonald		3,455		3,455	3,455			3,455	3,455			3,455	3,455			3,455	3,455			3,455
5.33	Stracathro Regional Treatment Centre	Health & Social Care Integration					0	0			0	0			0	0			0	0			0
5.34	Distant Islands Allowance	Health Finance & Information					0	0			0	0			0	0			0	0			0
5.35	Highland and Islands Travel Scheme	Health Finance & Information					0	0			0	0			0	0			0	0			0
5.36	Island Boards - Partnership Working	Health Finance & Information					0	0			0	0			0	0			0	0			0
5.37	Golden Jubilee activity - 90% marginal costs	Health Finance & Information	Barbara Crowe		(1,772)		(1,772)	(1,772)			(1,772)	(1,772)			(1,772)	(1,772)			(1,772)	(1,772)			(1,772)
5.38	18 Weeks allocations	Health Workforce & Performance					0	0			0	0			0	0			0	0			0
5.39	Distinction Awards for NHS Consultants	Health Workforce & Performance	Sandra Neill		7,924		7,924	7,924			7,924	7,924			7,924	7,924			7,924	7,924			7,924
5.40	LTCC NHS Boards	Health Workforce & Performance					0	0			0	0			0	0			0	0			0
5.41	Waiting Times - AST allocation	Health Workforce & Performance					0	0			0	0			0	0			0	0			0
5.42	Early Detection of Cancer	Health Workforce & Performance					0	0			0	0			0	0			0	0			0
5.43	Supporting Delivery of Local Quality & Efficiency	Health Workforce & Performance					0	0			0	0			0	0			0	0			0
5.44	Reshaping the Medical Workforce	Health Workforce & Performance					0	0			0	0			0	0			0	0			0
5.45	NDC Top Sliced Contributions	Health Finance & Information	Alan Morrison		(2,955)		(2,955)	(2,955)			(2,955)	(2,955)			(2,955)	(2,955)			(2,955)	(2,955)			(2,955)
5.46	NSD Risk Share	Health Finance & Information	Alan Morrison		(8,054)		(8,054)	(8,054)			(8,054)	(8,054)			(8,054)	(8,054)			(8,054)	(8,054)			(8,054)
5.47	HFS Subscriptions	Health Finance & Information	Alan Morrison		(103)		(103)	(103)			(103)	(103)			(103)	(103)			(103)	(103)			(103)
5.48	QMAS	Health Finance & Information	Alan Morrison		(110)		(110)	(110)			(110)	(110)			(110)	(110)			(110)	(110)			(110)
5.49	PMSPS	Health Finance & Information	Alan Morrison		(173)		(173)	(173)			(173)	(173)			(173)	(173)			(173)	(173)			(173)
5.50	PRISMS	Health Finance & Information	Alan Morrison		(282)		(282)	(282)			(282)	(282)			(282)	(282)			(282)	(282)			(282)
5.51	Enzyme replacement / orphan drugs	Health Finance & Information	Alan Morrison				0	0			0	0			0	0			0	0			0
5.52	HFS Equipping & Technica	Health Finance & Information	Alan Morrison		(187)		(187)	(187)			(187)	(187)			(187)	(187)			(187)	(187)			(187)
5.53	Assumed parity uplift to funding (NRAC)	Health Finance & Information	Alan Morrison				0				0				0				0				0
	Please list further anticpated allocations and their associated Directorate not included in the list above																						
5.54	NHSGGC Emergency Medical Retrieval Service (EMF	Health & Healthcare Improvement	Robbie Pearson		1,886		1,886	1,886			1,886	1,886			1,886	1,886			1,886	1,886			1,886
5.55	Glasgow Centre for Population Health	CMO, Public Health & Sport	Andy Bruce		1,000		1,000	1,000			1,000	1,000			1,000	1,000			1,000	1,000			1,000
5.56	Direct Enhanced Services (DES)	Health & Social Care Integration	Gary MacDonald		3,252		3,252	3,252			3,252	3,252			3,252	3,252			3,252	3,252			3,252
5.57	Support for National Implementation of eESS	Health Workforce & Performance	Ricky Verrall		600		600	600			600	600			600	600			600	600			600
5.58	NHS Ethics Scientific Officer Support	CMO, Public Health & Sport	Malcolm Pringle		40		40	40			40	40			40	40			40	40			40
5.59	Community Pharmacy Practitioners Champions	CMO, Public Health & Sport	Shelagh Scott		73		73	73			73	73			73	73			73	73			73
5.60	HFS Decontamination	Health Finance & Information	Alan Morrison		(42)		(42)	(42)			(42)	(42)			(42)	(42)			(42)	(42)			(42)
5.61	Childsmile	Health & Social Care Integration	Elizabeth Mclear		12		12	12			12	12			12	12			12	12			12
5.62	Pharmacist Pre-Registration Training	CMO, Public Health & Sport	Shelagh Scott		(652)		(652)	(652)			(652)	(652)			(652)	(652)			(652)	(652)			(652)
5.63	Disestablished Training Posts	Health Finance & Information	Robert Peterson		247		247	247			247	247			247	247			247	247			247
5.64	Community Pharmacy Walk-In	Health & Social Care Integration	Gary MacDonald		30		30	30			30	30			30	30			30	30			30
5.65	Maternal & Infant Nutrition Framework for Action	Children & Families	Helen Yewdall		401		401	401			401	401			401	401			401	401			401
5.66	Advocacy Provision	CNO, Patients, Public & Health Professi	Sandra Falconer		122		122	122			122	122			122	122			122	122			122
5.67	Experimental Cancer Research Centre	CMO, Public Health & Sport	Alan McNair		139		139	139			139	139			139	139			139	139			139
5.68	PET Scanning - Costs	Health Finance & Information	Graham Dunn		3,622		3,622	3,622			3,622	3,622			3,622	3,622			3,622	3,622			3,622
5.69	PET Scanning - GGC Contribution	Health Finance & Information	Graham Dunn		(1,267)		(1,267)	(1,267)			(1,267)	(1,267)			(1,267)	(1,267)			(1,267)	(1,267)			(1,267)
5.70							0	0			0	0			0	0			0	0			0
5.71							0	0			0	0			0	0			0	0			0
5.72							0	0			0	0			0	0			0	0			0
5.73							0	0			0	0			0	0			0	0			0
5.74							0	0			0	0			0	0			0	0			0
5.75							0	0			0	0			0	0			0	0			0
5.76							0	0			0	0			0	0			0	0			0
5.77							0	0			0	0			0	0			0	0			0
5.78							0	0			0	0			0	0			0	0			0
5.79							0	0			0	0			0	0			0	0			0
5.80							0	0			0	0			0	0			0	0			0
5.81							0	0			0	0			0	0			0	0			0
5.82							0	0			0	0			0	0			0	0			0
5.83							0	0			0	0			0	0			0	0			0
5.84							0	0			0	0			0	0			0	0			0
5.85							0	0			0	0			0	0			0	0			0
5.86							0	0			0	0			0	0			0	0			0
5.87							0	0			0	0			0	0			0	0			0
5.88							0	0			0	0			0	0			0	0			0
5.89							0	0			0	0			0	0			0	0			0
5.90							0	0			0	0			0	0			0	0			0
5.91							0	0			0	0			0	0			0	0			0
5.92							0	0			0	0			0	0			0	0			0
5.93							0	0			0	0			0	0			0	0			0
5.94							0	0			0	0			0	0			0	0			0
5.95							0	0			0	0			0	0			0	0			0
5.96							0	0			0	0			0	0			0	0			0
5.97							0	0			0	0			0	0			0	0			0
5.98	Roundings				12	0	12	12			12	12			12	12			12	12			12
5.99	**Total Anticipated Allocations**			**0**	**227,300**	**0**	**227,300**	**0**	**228,100**	**0**	**228,100**	**0**	**228,900**	**0**	**228,900**	**0**	**229,700**	**0**	**229,700**	**0**	**230,500**	**0**	**230,500**

NHS GREATER GLASGOW & CLYDE

Infrastructure Investment Programme

Line No	2011-12 £000s		2012-13 £000s	2013-14 £000s	2014-15 £000s	2015-16 £000s	2016-17 £000s
		Capital Expenditure					
		Property					
6.001	7,082	Statutory compliance and backlog maintenance property expenditur	23,518	24,441	29,208	29,208	29,208
6.002	347	Radiotherapy equipment construction work	361	361	0	0	0
6.003	0	Enabling works for stand alone NPD projects	0	0	0	0	0
6.004	0	Enabling works for hub initiative projects	2,000	0	0	0	0
6.005	0	PFI reversionary interest for projects signed prior to 1 April 200	3,099	3,099	3,099	3,099	3,099
6.006	154,021	New South Glasgow Hospitals	245,774	252,315	102,935	3,938	1,788
6.007	1,500	GRI University Tower	14,870	0	0	0	0
6.008	1,000	Alexandria Health Centre	17,772	1,814	0	0	0
6.009	600	Possilpark Health Centre	8,895	0	0	0	0
6.010	650	SGH Relocations - Psychiatry & Perinatal MBL	8,832	0	0	0	0
6.011	250	Older Peoples Mental Health - Phase 1	6,390	0	0	0	0
6.012	0	Older Peoples Mental Health - Phase 2	5,027	2,000	0	0	0
6.013							
6.014							
6.015							
6.016							
6.017							
6.018							
6.019							
6.020							
6.021	26,012	Other	12,343	20,705	11,000	6,300	0
6.022	**191,462**	**Total Property Expenditure**	**348,881**	**304,735**	**146,242**	**42,545**	**34,095**
		Equipment					
		Medical Equipment					
6.023		Equipping costs of revenue financed projects					
6.024		Imaging (CT / Ultrasound / MRI / Gamma Cameras					
6.025		Other X ray (Angio / Dental / Fluoroscopy / General X Ray					
6.026	3,445	Radiotherapy	1,748	1,723	0	0	0
6.027	2,100	PET Replacement Programme	0	0	0	0	0
6.028		IV systems (Syringe and Volumetric Pumps					
6.029	7,172	Other medical equipment eg defibrilators, dialysis machines, endoscope	8,300	8,000	8,000	8,000	8,000
6.030	*12,717*	*Sub-total - Medical Equipment*	*10,048*	*9,723*	*8,000*	*8,000*	*8,000*
		Vehicles					
6.031		Emergency vehicles					
6.032		Patient Transport Service (PTS)					
6.033		Support services vehicles					
6.034		Other vehicles					
6.035	*0*	*Sub-total - Vehicles*	*0*	*0*	*0*	*0*	*0*
		Other Equipment					
6.036		Plant and machinery					
6.037		Other					
6.038	*0*	*Sub-total - Other Equipment*	*0*	*0*	*0*	*0*	*0*
6.039	**12,717**	**Total Equipment Expenditure**	**10,048**	**9,723**	**8,000**	**8,000**	**8,000**
		IM&T Projects					
6.040		e-Health projects					
6.041	1,624	ICT Rolling Replacement & Upgrade Programme	1,000	1,000	2,000	2,000	2,000
6.042							
6.043							
6.044							
6.045							
6.046							
6.047							
6.048							
6.049							
6.050							
6.051							
6.052	4,276	Other	1,750	1,000	0	0	0
6.053	**5,900**	**Total IM&T Expenditure**	**2,750**	**2,000**	**2,000**	**2,000**	**2,000**
		Other Capital Expenditure					
6.054	300	Intangible assets	300	300	300	300	300
6.055	1,000	Donated assets additions	1,000	1,000	1,000	1,000	1,000
6.056		Other					
6.057	**1,300**	**Total Other Expenditure**	**1,300**	**1,300**	**1,300**	**1,300**	**1,300**
6.058	**211,379**	**Total Gross Direct Capital Expenditure**	**362,979**	**317,758**	**157,542**	**53,845**	**45,395**
		Capital Receipts Applied					
6.059	(1,000)	Donations (line 6.055)	(1,000)	(1,000)	(1,000)	(1,000)	(1,000)
6.060		Other capital grants received					
6.061		Capital receipts applied locally					
6.062		Other					
6.063	**(1,000)**	**Total Capital Receipts Applied**	**(1,000)**	**(1,000)**	**(1,000)**	**(1,000)**	**(1,000)**
6.064	**210,379**	**Total Net Direct Capital Expenditure** (line 6.058 plus line 6.063)	**361,979**	**316,758**	**156,542**	**52,845**	**44,395**
		Indirect Capital Expenditure					
6.065	1,070	Capital Grants (line 6.103)	3,460	0	0	0	0
6.066							
6.067							
6.068							
6.069	**1,070**	**Total Indirect Capital Expenditure**	**3,460**	**0**	**0**	**0**	**0**
6.070	**211,449**	**Total Net Capital Expenditure** (line 6.064 plus line 6.069)	**365,439**	**316,758**	**156,542**	**52,845**	**44,395**
		Capital Resource Limit (CRL)					
6.071	24,700	SGHSCD formula allocation	30,868	34,141	38,908	38,908	38,908
6.072	182,887	Project specific funding	330,462	280,533	117,634	13,937	5,487
6.073	3,792	Radiotherapy funding	2,109	2,084	0	0	0
6.074	0	Hub enabling funding	2,000	0	0	0	0
6.075		Other Centrally Provided Capital Funding					
6.076		Revenue to capital transfers (line 1.27	0	0	0	0	0
6.077	**211,379**	**Total Capital Resource Limit**	**365,439**	**316,758**	**156,542**	**52,845**	**44,395**
6.078	**0**	**Saving / (Excess) against CRL**	**0**	**0**	**0**	**0**	**0**

Revenue Finance - NPD / hub Asset Additions

		Revenue Finance - NPD / hub Asset Addition					
6.079		Hub Schemes			60,000		
6.080							
6.081							
6.082							
6.083							
6.084							
6.085							
6.086	**0**	**Total Revenue Finance - NPD / hub Asset Addition**	**0**	**0**	**60,000**	**0**	**0**

External Funding Commitments

		Payments					
6.087	34,164	Existing PPP unitary charges	33,497	34,335	35,195	36,075	36,977
6.088		Proposed PPP unitary charges					
6.089		Proposed hub initiative unitary payment					
6.090	109	Finance leases	109	109	109	109	109
6.091	8,721	Operating leases	8,721	8,721	8,721	8,721	8,721
6.092	**42,994**	**Total**	**42,327**	**43,165**	**44,025**	**44,905**	**45,807**

Memorandum

		Capital Grants					
6.093	0	East Pollokshields	2,300	0	0	0	0
6.094	501	Dental Decontamination	160	0	0	0	0
6.095	0	Quarriers	1,000	0	0	0	0
6.096	500	Marie Curie Cancer Care	0	0	0	0	0
6.097	17	Server for St Vincent's Hospice	0	0	0	0	0
6.098	52	N3 Connections for Hospices	0	0	0	0	0
6.099							
6.100							
6.101							
6.102							
6.103	**1,070**	**Total**	**3,460**	**0**	**0**	**0**	**0**

		Capital Receipts Returned to SGHSCD					
6.104							
6.105							
6.106							
6.107							
6.108							
6.109							
6.110							
6.111							
6.112	**0**	**Total**	**0**	**0**	**0**	**0**	**0**

NHS
Greater Glasgow and Clyde

Annex 6

Workforce Plan

Summary of Main Workforce Issues Facing NHSGGC 2012/13

NHSGGC employs circa 33,000 WTE staff and as such the board is the largest employer in Scotland and the largest NHS employer in the UK.

NHSGGC is undergoing a significant clinical change programme which is supported by a capital investment programme in its facilities which will transform health care delivery in the West of Scotland.

The Acute Services Review will see services delivered on fewer sites with increased technology and greater synergy between services resulting in reduced bed numbers and reduced lengths of stay. The implementation of the Mental Health Strategy has also resulted in a reduction in long stay in-patient facilities with an increase in specialist services to support clients living in the community. In Primary Care, the development of the Community Health (and Care) Partnerships has resulted in new service delivery models and the emergence of new roles spanning health and social care.

During 2012/13 the changes in workforce numbers and in skill mix will be as a consequence of the continued implementation of redesign strategies in Acute, Community and Mental Health Services within NHSGGC.

The first phase of the boards skill mix changes were piloted last year through the establishment of ten demonstration sites across the Acute Division. The aim of these sites was to test the new skill mix changes by introducing trained support workers and assistant practitioners at levels 3 and 4 of the NHS career framework. The evaluation of the Healthcare Support Worker Level pilot in various locations within Acute Services will be available over the course of the next few months and the implications of this may result in some variation to our existing workforce models.

Within Nursing, Acute Services will continue to review the bed model and take the opportunity to rationalise service configuration in anticipation of the move to the new South Glasgow Hospital. Acute Services will continue to use the national Nursing workforce and workload planning tool to underpin any changes. In Mental Health Services there will be continued rationalisation of in-patient beds at the Parkhead, Inverclyde and Ruchill Hospital sites. There are also reviews of Mental Health Rehabilitation Services, Community Based Crisis Services, Primary Care and Mental Health Services underway. All these changes are aimed at enhancing the provision of services within Mental Health and are likely to impact on workforce composition.

During 2011/12 NHSGGC's continued review of productivity and efficiency within Administration services realised greater than expected savings from non patient facing functions without impacting on patient-care. NHSGGC also embarked on a review of administration support to Senior Managers introducing a workforce model which reduced administrative support from 1.0 WTE to a new ratio of 0.6 WTE per manager. This led to a reduction in the Administrative and Clerical Job Family.

At the same time the Board has continued to reduce the number of Senior Managers in line with its three year programme to meet the Government's target of a 25% reduction in senior posts. This programme realised a reduction of in the Executive job family and also further reduced the need for Administrative support staff.

In 2012/13 NHSGGC will continue with a programme of service redesign aimed at maximising the productivity of the Administrative and Clerical function ensuring that the priority is on activity which directly support clinical staff or patients. Further changes to the administrative and clerical workforce will take place during this year as a result of the continued introduction of the computerised patient management system, the use of new technology generally and our aim to become increasingly "paperlite".

As NHSGGC continue to rationalise the estate, particularly in areas which provide accommodation for non-direct patient care staff we anticipate continued changes within the Support Services workforce.

In summary, approximately 50% of NHSGGC's budget is the salary cost of the workforce. At present efficiency savings are being secured through a number of routes however it is clear that from the information known about current and future cost saving requirements that NHSGGC will require to deliver services in the continued constrained financial environment. Given that 50% of current budget costs are salary related securing productivity improvement efficiencies from the redesign of services will be an important focus for NHSGGC activity during 2012/13.