PLANNING FRAMEWORKS

ACUTE SERVICES

ACUTE SERVICES PLANNING FRAMEWORK

1. Introduction

The Acute Services Planning Framework describes the outcomes and changes which are required to ensure that Acute Services respond to the five priorities which are set out in NHSGG&C's Corporate Plan for 2013-16.

The key aims for the Acute Services Division are:

- To improve the health of the population of NHSGGC through the provision of timely and equality focused secondary and tertiary care services for adults, children and babies alike

- To deliver modern healthcare services in keeping with the 21st century

The Acute Services Division contributes to NHS Greater Glasgow & Clyde's (NHSGG&C's) overall aim to "deliver effective, high quality health services, to act to improve the health of our population and to do everything we can to address the wider social determinants of health which cause inequalities".

In addition, the Framework sets out the changes and developments which need to be achieved to support the delivery of the other planning and policy frameworks e.g. Older People's, Primary Care.

2. National Context

This section identifies changes to policy that have been issued in the last year and reinforces the position of existing policies which require to be considered in planning for Acute Services during 2013-16 and beyond.

- **The Patient Rights (Scotland) Act 2011 –** Sixteen of the Act's Sections came into force on 1st April 2012. There are six main aspects to the Act, Charter of Patient Rights and Responsibilities, Patients' individual needs and circumstances, Right to give feedback/comments, Patient Advice & Support Service (PASS), Contaminated Blood claims and the Treatment Time Guarantee (TTG). The TTG came into force on 1st October 2012 and Health Boards must ensure that patients will not wait longer than 12 weeks fom the date in-patient/day case treatment is agreed, to the start of their treatment.

- **The Healthcare Quality Strategy for NHS Scotland** – this continues to be an important focus of NHS Scotland policy which sets out the six dimensions of quality namely, person centred, safe, effective, efficient, equitable and timely. This strategy ensures that these six dimensions are central to patient care.

- **Detecting Cancer Early (DCE) Initiative** – this was formally launched in the autumn of 2011 and is the Scottish Government Health Department's implementation plan to raise cancer awareness and to increase by 25% the number of Scots diagnosed in the first stage of cancer, starting with the three big cancers - lung, breast and colorectal cancers.

- **Reshaping Care for Older People** - this work emphasises the SGHD focus on Older People's Care with health and local authorities working together to consider future demand and service models which recognise the trend of an increasing proportion of older people within the population. Supporting this agenda is the **Change Fund announced in 2011-12** which enables health and social care partners to work together to make better use of their combined resources for Older Peoples Services.

- The current **Consultation on the Integration of Health and Social Care** which proposes that Health and Social Care Partnerships replace CHPs and CHCPs and that integrated budgets should be in place for some (yet to be defined) acute hospital care, will also support this agenda.

- **New HEAT targets –** there is a changing emphasis on the HEAT targets and an increasing focus on achieving the quality outcomes. There are 12 additional new HEAT targets proposed for 2013-14 which will contribute to the Quality Outcomes.

- **Health Promoting Health Service: Action in Acute Settings CEL 01 (2012)–** Describes the concept that 'every healthcare contact is a health improvement opportunity' and requires Boards to implement the specific health promoting actions outlined in the CEL to support health improvement in all hospital settings.

3. NHSGGC Planning Context

The financial position continues to influence the planning context for Acute Services with the ongoing challenge affecting NHSGG&C and the NHS in general. This has brought increased focus to efficiency and productivity requirements, which will continue to drive much of the agenda in the next few years with shorter lengths of stay, more cases seen as day cases and a drive to reduce emergency admissions.

A key priority for the Acute Services Division continues to be delivering the **Acute Services Review** (ASR) and continuing to deliver the **Vision for the Vale of Leven**. This includes delivering the final stages of the extant Acute Services Strategy for Glasgow which sees the new Southern General Hospital opening in 2015, the closure of the Western Infirmary, the Victoria Infirmary, the Royal Hospital for Sick Children and the Mansionhouse Unit.

The Acute Services Division is currently planning these significant service changes through the **'On the Move' Programme.** This programme has been established to redesign clinical services prior to their transfer to the new Southern General Hospital. In addition, a Clinical Services Review **'Fit for the Future'** has been established to take a fundamental look at service design and provision from 2015 and beyond. In addition, the interface with primary and community and social care services together with opportunities to shift the balance of care, should enable the development of a more integrated strategy for the next 5 -10 years.

Ensuring that quality is at the forefront of care remains a key focus within acute services with the **Better Together – Patient Experience Inpatient programme** alongside the **Healthcare Quality Strategy** for NHS Scotland remaining a core element to consider in delivering and designing patient care.

Maintaining existing performance in relation to **HEAT** targets and standards and delivering on the new **HEAT** targets will continue to be a focus within the Acute Division in 2013-16.

4. Progress to Date

The existing Acute Services Framework has enabled a number of developments and improvements over the last three years. Some key outcomes have been:-

Delivering the Acute Services Review (ASR) and Clyde Strategies

During 2010-13, the ASR and Clyde Strategies were progressed as follows:-

- **ASR progress - New South Glasgow Hospital**

  The new hospital build programme continues to be on schedule at the Southern General campus with building and design work well underway and on target for completion by early 2015. The new Laboratory Services and Facilities building was completed in March 2012 and is now fully operational.

  The '**On the Move** ' Programme has set up six key work streams to redesign services and during 2013-15 this programme will be further progressed to develop the new service models and prepare the detailed operational plans to enable the move to the new hospital. In addition these work streams will support the work in relation to defining the transition plans from existing sites and staffing profiles to support the new service configuration.

  Underpinning the delivery of the ASR is the bed model for acute services across Glasgow and Clyde. Progress has been made towards the delivery of the first part of the bed model with bed reductions implemented across surgical and regional specialties and within care of the elderly services.

- **Vale of Leven Vision**

  The Consultant- led, GP supported model to deliver unscheduled care has been implemented and continues to progress well. Activity within the Minor Injuries Unit and the Medical Assessment Unit remains well within the expected levels. Outpatient and day case activity have both increased over the past 3-4 years with specific development in the local provision for rheumatology and urology services as well as in developing ophthalmology day surgery.

- **Laboratory Strategy** - Glasgow and Clyde position

  During 2011-12 laboratory services have been redesigned and the new South Glasgow Laboratory building has been fully operational from July 2012. Building work commenced at GRI University Tower during 2011-12 and will be completed by the end of July 2013. A Clyde Laboratory Strategy will be implemented during 2012-13.

- **Access**

  Over the past three years the Acute Services Division has continued to demonstrate good progress and strong performance in relation to the access targets, meeting, and for the most part, sustaining the targets.

- **Delivery of the 18 week RTT**

  There has been considerable success in achieving improvements in waiting times as the result of the access targets. In December 2011 the 18 week Referral to Treatment target was achieved which included an extended range of diagnostic tests covered within the waiting time guarantees.

- **98% of A&E patients treated / discharged / transferred within 4 hours**

  This target has continued to prove challenging during 2011-12, particularly over the winter period with a significant increase in demand over late December 2011 and January 2012.

- **Cancer targets**

  - 95% of all urgent referrals of patient suspected of having cancer should achieve a maximum wait of 62 days from urgent referral to first treatment
  - 95% of all patients diagnosed with cancer begin treatment within 31 days of the decision to treat

  NHS GGC has continued to demonstrate consistent achievement against these standards. However during 2012-13 a new cancer target to improve early detection by increasing the number of cancers detected at the first stage of disease by 25% by 2014-15 for breast, colorectal and lung cancer has been introduced. This will require primary care and secondary care to work together to raise awareness and encourage earlier patient presentation to the GP and primary care team.

- **Stroke**

  To improve stroke care, the target is that 80% of all patients admitted with a diagnosis of stroke are admitted to a stroke unit on the day of admission or the day following presentation. This target has been further extended to achieve 90% by March 2013.

- **Health Improvement**

  There has been further consolidation of the health improvement programme with good progress being made in a number of areas:

  '**Safe Talk' Training Programme** (Suicide Prevention

  Ongoing action to improve the health of staff including the achievement of **Healthy Working Lives** and **Healthy Living Awards** with progress started toward achieving Gold status in 2013.

  Significant progress has been made in the **standard of food, fluid and nutritional care** provided to patients with positive feedback from national reviews by Quality Improvement Scotland (QIS) and Health Facilities Scotland benchmarking NHSGGC positively against other Health Boards.

  Acute Services undertook a number of Equality Impact Assessments in frontline services and there is now a substantial evidence base of recurrent themes and issues within service areas and our focus will be to deliver actions consistently across services.

- **Involving Patients**

  The Patient Experience Inpatient survey information alongside the Healthcare Quality Strategy for NHS Scotland reinforces the requirement to consider further the patient experience and the quality of care in relation to the services we provide.

  Over the past few years there has been an increasing focus on patient engagement and patient involvement including:

  - The Community Engagement Team has built strong relationships with Public Partnership Forums (PPFs) across NHSGGC and has encouraged patient and carer involvement in service changes around the Stobhill and GRI, the Vale of Leven Vision and as part of the engagement and consultation exercise for Lightburn Hospital.
  - Better Together, Scotland's Patient Experience Programme has provided valuable information on how patients view our inpatient services and hospitals. This feedback has informed actions plans to improve the patient's experiences of the NHS.

ACUTE SERVICES	PLANNING FRAMEWORK 2013-16	
EARLY INTERVENTION AND PREVENTING ILL HEALTH		
OUTCOMES	**CHANGE/DEVELOPMENT REQUIRED**	**MEASURES**
• Patients are able to access the right care in the right setting in Acute, appropriate to their condition.	• Referral management guidelines are developed for each care pathway, agreed with the local medical committee and publicised to GP's.	• Clear process is in place to develop, update, agree and monitor referral guidelines.
	• Care pathways are developed and implemented within the Acute setting.	• Acute Care Clinicians develop care pathways
• Disadvantaged groups can use services in a way which reflects their needs.	• The national access targets e.g. 18 week Referral to Treatment, Treatment Time Guarantee and access to diagnostic tests are adhered to.	• Access targets are met
• Opportunities for Health Improvement interventions are recognised and acted upon in the Acute setting.	• Implement A&E Inequalities Work and targeted work to reduce DNAs in areas of high deprivation.	• Local target for DNA's for new appointments in SIMD areas to be developed.
• Increase the proportion of key conditions including Cancer detection at an early stage.	• Maximise health improvement opportunities in Acute by using the "teachable moment" to target smoking, obesity, alcohol, exercise and promote access to services which promote health & wellbeing and provide advice on risk factors.	• Rates of referral to smoking cessation services lifestyle advice, number of ABIs.
	• GP's are supported by secondary care to refer their patients appropriately using agreed referral guidelines.	• Referral guidelines available and published.
	• GP's receive constructive and timely feedback on referrals to Acute, electronically.	• Audit of number and content of referrals back to GP's.
	• Acute clinicians refer internally within Acute	• Audit number of internal referrals in Acute.
	• Implement the Detect Cancer Early (DCE) initiative	

	to increase the number of people diagnosed in the first stage of cancer starting with lung, breast and colorectal cancer.	• Increase the proportion of people diagnosed and treated in the first stage of the 3 cancers by 20%, by 2014-15.

SHIFTING THE BALANCE OF CARE		
OUTCOMES	**CHANGE/DEVELOPMENT REQUIRED**	**MEASURES**
• Fewer people are cared for in settings which are inappropriate to their needs and only patients who need Acute care are admitted to hospital.	• Clear care pathways are in place to ensure patients are treated appropriately. • Patients are only admitted to Acute care if it is absolutely necessary. • Boarding of patients in hospital is minimalised as far as possible.	• Number of admissions by CHCP by speciality, age, SIMD area. Number of bed days by CHCP by specialty, by age by SIMD. 18 week RTT 12 week TTG Reduce A&E attendances by 2,888 by March 2014. • Proposed new HEAT target.
• There are agreed patient pathways	• Communicate clearly to the population how to use A&E and Minor Injuries Units appropriately. • Referral pathways with clear criteria are in place for each condition and accessible to Primary Care. • Referrals are received electronically from Primary Care and triaged electronically in Acute Hospitals.	• DVD uptake, community engagement interactions, increases in MIU attendances and corresponding reduction in A&E attendances. • Primary Care utilise referral pathways • Percentage of referrals triaged electronically.
• More carers are supported to continue in their caring role.	• Acute Services are able to identify carers, including young carers. • Carers are provided with advice and information to	• Carers Information available, staff identify carers and consider and involve them where appropriate.

	support them in their role. • Carers are involved in discussing care and treatment where appropriate. • Carer arrangements are considered during Discharge Planning	
• More people are able to die at home or in their preferred place of care.	• Carers are advised of services available within their community to support them. • The Liverpool Care Pathway (LCP) is implemented, as required, across all Acute settings.	• Audit implementation of pathway and measure reduction in number of people on (LCP) dying in hospital.

RESHAPING CARE FOR OLDER PEOPLE		
OUTCOMES	**CHANGE/DEVELOPMENT REQUIRED**	**MEASURES**
• A clear pathway of care is developed and in place for Older People who use Acute Services.	• Work with MCN's to develop appropriate care pathways	• Pathway is developed and implemented
• Older people are only admitted to hospital if they require Acute care.	• Work with CHCP's re Change Fund and alternatives to admission.	• Reduction in bed days utilisation of patients aged over 65.
• Patient pathways anticipate care needs.	• Anticipatory care arrangements in place • Improve access to stroke pathway in Acute.	• 90% of all patients admitted with diagnosis of stroke are admitted to Stoke Unit on day of admission or one day after.
• We strive to improve the experience of care in Acute Hospitals for Older People.	• We consistently implement the findings of the OPEC inspections. • We examine the findings from Better Together	• Action Plans are implemented. • Changes implemented are evidenced.

	surveys and implement changes as appropriate to improve the quality of care delivered to older people. • We improve the care of patients with dementia.	• Dementia Champions trained and in place.

IMPROVING QUALITY, EFFICIENCY AND EFFECTIVENESS		
OUTCOMES	**CHANGE/DEVELOPMENT REQUIRED**	**MEASURES**
• We will reduce the rate of Healthcare Associated Infections (including MRSA/MSSA and C-Difficile).	• We will ensure staff are trained in infection control and adhere to hand washing standards. • We will ensure that staff comply with anti-microbial prescribing guidelines.	• MRSA/MSSA reduce rate by 0.26 cases per 1000 occupied bed days. • C-Difficile rate in patients over 65 is 0.39 cases or less per 1000 occupied bed days.
• We will ensure that patients are treated in the right place by the right person. • We will continue to implement to the Scottish Patient Safety Programme (SPSP) • We will deliver person centred, effective and efficient care.	• Care pathways are adhered to. • We will minimise boarding patients into different wards as far as possible. • Improve medicines reconciliation in discharge documentation • Implement Better Together inpatient programme.	• Proposed new HEAT target. • Audit discharge documentation. • Measured via use of patient questionnaire.
• Our staff are trained and supported to improve the quality of patient care and respond positively to patient feedback. • Patients can access outpatient appointments, tests and treatments	• Implement inspection recommendations. • Access to training. • Apply learning from patients' and relatives' complaints.	• Audit implementation of Action Plan. • Number of staff attending relevant training • Evidence of learning in place. • Evidence of shared learning

within the national waiting times target. • Our services are responsive to needs and there is appropriate physical access to our services.	• Learning from areas of good practice shared across the organisation. • Implement 18 week RTT • Implement 12 week TTG • We will provide information in accessible form at and in a range of languages. • Implement Access Audit Recommendations	• Access targets met • Implementation of Accessible Communications Policy • Appropriate physical access to our facilities is in place.

	TACKLING INEQUALITIES	
OUTCOMES	**CHANGE/DEVELOPMENT REQUIRED**	**MEASURES**
TACKLING INEQUALITIES • Acute Services are planned and delivered in a way which understands and responds better to individuals' wider social circumstances. • Information on how different groups access and benefit from our services is more routinely available and informs service planning. • We narrow the health gap through clearly defined programmes of action by our services and in conjunction with our partners.	• Action A&E inequalities work. Reduce DNAs from areas of high deprivation. Implement arrangements for Patient Rights Act re access and support for vulnerable people to make hospital appointments • Better data collection and recording of inequalities information to inform service design, planning & delivery • Working with partners, support the reduction of the health inequalities gap between the deprived and non deprived populations accessing secondary care services	• X% reduction in DNAs (male & female) from areas of high deprivation (target to be developed) • Inequalities data is used to routinely influence service planning and redesign. • X% Reduction of DNAs for new appointments. (target to be developed)

AMH PLANNING FRAMEWORK 2013-2016

BACKGROUND

New Planning Framework Period 2013 -16

- This Framework seeks to set out the policy, priorities and outcomes for NHS GG&C adult mental health services delivered primarily through Mental Health Services and CH(C)P's for the 3 year period 2013-2016.

- Improving the quality of life of people with mental health problems, prevention of illness and promotion of mental well being, are influenced by both access to mainstream health and local authority services and supports, and by the wider actions of a range of partners in relation to community resilience, employment, reducing the prevalence of suicide and self harm, tackling inequalities, financial & social inclusion & broader community planning.

- This Planning Framework has built on a range of previous work and in effect has distilled and summarised the significance of this work in terms of:
    - National and local policy and priorities
    - Outputs /Outcomes to be delivered
    - The contribution of the above outcomes to the GG&C NHS Corporate Themes

- The NHS GG&C Corporate Plan for 2013-16 sets out 5 strategic priorities along with the outcomes that require to be delivered for those 5 priorities. The corporate priorities are::
    - Early intervention and prevention of ill health
    - Shifting the balance of care
    - Reshaping care for older people
    - Improving quality and effectiveness
    - Tackling inequalities

- The Corporate Plan also calls for existing Planning & Policy Frameworks to be reframed to reflect the direction set out in the Plan, by setting intermediate outcomes linked to measurable indicators, in order to deliver against the strategic priorities.

- In a change from previous years, it is recognised that as the essential drivers of the 6 Policy Frameworks have been incorporated into the Corporate Plan, it would be sensible to integrate the key policy drivers within each of the Planning Frameworks, rather than having detailed separate documents

CHP Integration Timetable and Progressive Development of Joint Commissioning Strategy.

- In preparing the Planning Framework for Adult Mental Health, account has been taken of the intention of the Scottish Government to create integrated Health and Social Care Partnerships, which will be accountable for an agreed set of outcomes. It is anticipated that joint commissioning strategies will be progressively strengthened and developed from 2013 onwards.

NATIONAL CONTEXT & TARGETS

- Faster Access to Psychological Therapies – deliver faster access to MH services by delivering 18 weeks referral to treatment for Psychological Therapies from December 2014. (NHSGG&C Target to be agreed during 2012-13).

- Delayed discharges – 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 (NHSGG&C Target = 0 by April 2013)

- Suicide - reduce suicides rate between 2002 and 2013 by 20%.
  Note that a refreshed national suicide prevention programme will be launched in early 2013

NHS GG&C PLANNING CONTEXT 2013 – 2016 INCLUDING LAST THREE YEARS STOCKTAKE

Stocktake

- Balance of care shifts/ reduced levels of inpatient activity have occurred but are now plateauing out.
- Clyde Strategy implementation completed except Inverclyde long stay
- Crisis services redesign implemented
- PCMHT specification and redesign being implemented 2012/13
- Development of national and regional forensic secure services implemented
- Development of local eating disorder services implemented
- Model staffing and skill mix for inpatient services agreed and progressively being implemented

Context

- Continued public sector financial constraint seeing Board savings level of between 1-3%
- SG MH Strategy published August 2012 and further process of stock take of current position, must do's and should do's is currently work in progress. "Must do's" are reflected in National targets above. Range of wider themes for adult mental health reflected in the National Strategy include:

  <u>Mental Health of those with Physical Illness</u>
  - GPs and other partners to increase the number of people with long term conditions and a co-morbidity of depression or anxiety receiving appropriate care and treatment for their mental illness
  - Development of social prescribing and self help

  <u>First Episode Psychosis</u>
  - Early intervention services to respond to first episode psychosis

  <u>Mental Health and Alcohol</u>
  - Alcohol Brief Interventions (ABI's) are a HEAT Standard 2012/13 in primary care, A&E and antenatal. Develop delivery of ABIs to respond to depression (and other common mental health problems) with a particular focus on primary care.
  - more effectively link the work on alcohol and depression and other common mental health problems to improve identification and treatment, with a particular focus on primary care

    - Support to family and carers
    - Extension of use of peer support
    - Developing the outcomes approach to include, personal, social and clinical outcomes
    - Improved recording of ethnic monitoring

- Clinical Service Review process and summary of emerging case for change will provide the framework for further service redesign beyond extant plans
- Broadly stable population but significant risks of increased demands for service supports in context of consequences of recession, austerity policies and erosion of benefits safety net. Whilst such pressures are likely to be experienced by all services the major impact is likely to require:
    - Ensuring assessment and care planning consider employability, and money issues and facilitate access to appropriate supports
    - Increased early intervention and support through primary care mental health supports

  At this stage we are initiating work to explore the links between a wider "civic response" to the impact of the austerity measures and the specific implications for mental health supports. Additionally we have not "bottomed out" the balance between productivity gains and increased demand. During the period of the planning framework we will undertake work with a range of partners to develop a clearer framework of response in relation to both the connections between mental health services and wider supports, and additionally any potential implications for additional investment in this area which may be required.
- Requirement to ensure consistent needs based, rather than age based, access to services to comply with Equalities Act implementation from October 2012.

Local priorities

- Deliver national targets for access to psychological therapies, delayed discharges and suicide reduction
- Develop case for change and service redesign proposals through clinical services review process
- Consolidate inpatient services for Parkhead and Stobhill on the Stobhill site
- Transfer inpatient services from SGH to Leverndale to support the wider acute developments of the SGH site
- Maximise variability of service responses related to individual needs, whilst reducing the level of variability associated with local variation unrelated to individual needs
- Improve the management of people with multiple co morbidities so that service users experience a coherent response to their multiple needs
- Improve support to carers
- Improve our understanding of the health gap and specific consequences for mental health services
- Explore the scope for improved productivity and levels of patient facing time through specific work to understand the range of activity in community teams which can deflect from patient contact and reduce productivity
- Seek to mitigate the impact of the recession and benefits safety net erosion on peoples mental health, through:

  - ensuring increased activity in promotion, prevention and early intervention supports in extended primary care supports
  - Ensuring assessment and care management processes take account of support requirements relating to money, employability and appropriate engagement and support to carers
- In line with Commitment 15 of the new Scottish Mental Health Strategy, develop a range of social prescribing and related initiatives that strengthen access to wider community-based supports for mental health and resilience
- Address longstanding inequities of access to specialist service supports in the GG&C area
- Ensure appropriate levels of support to carers whose own mental health may be made more vulnerable through their caring responsibilities
- Further develop the culture of using the range of information sources and lean methodologies to inform local practice beyond the current more variable “islands of excellence”

RESPONDING TO THE CORPORATE PLAN THE FIVE PRIORTIES

1. EARLY INTERVENTION AND PREVENTION OF ILL HEALTH

Overall Position & Issues

Range of self care, self management supports and early intervention supports in place through primary care, stress centres, early intervention in psychosis

A number of key reports and policy documents have highlighted the importance of developing a strategic approach to improving population mental health. "Keeping Health in Mind", the Director of Public Health's biannual report for Greater Glasgow and Clyde, published December 2011 sets out range of prevention approaches, closely connecting with the previously published national policy, "Towards a Mentally Flourishing Scotland and our locally developed framework, "No Health Without Mental Health". The material in the planning framework below sets out a range of the priority actions required to drive improvements in population health, and to mitigate the predicted psycho-social impacts of the continuing economic recession.

MH in Focus identifies high levels of local health needs and in particular:
Current barriers to access for age appropriate responses for access to psychological therapies/crisis supports require early resolution to comply with Age Discrimination Act Implementation Oct 2013

The physical health of people with MH problems is worse than that of the general population, and this is an area of priority for service users. We have developed a Physical Health Care Policy to address this and this confers significant benefits in directing clinicians to identify physical illnesses early and address treatment. This approach will be supported by ongoing liaison with GPs and Primary Care through our Interface working group which focuses on areas of common interest with General Medical Services and MH services – for example in the early detection and treatment of depression and good practice in prescribing. Close collaboration is also focused on MH input to initiatives such as Keep Well through this liaison group.

RESPONDING TO THE CORPORATE PLAN THE FIVE PRIORTIES

1. EARLY INTERVENTION AND PREVENTION OF ILL HEALTH

OUTCOMES	CHANGE OR DEVELOPMENT REQUIRED	MEASURES
• **Outcome to be delivered in next three years** • **Narrative for HEAT Targets should be here expressed as the outcome which is intended to be achieved**	• **Brief description of change or development required to deliver this outcome to provide direction to local development plans**	• **These should be set out as a group under each of the 5 priorities not necessarily linked to each change or development**
Increase the detection of mental health problems at an early stage	• Roll out access to first onset psychosis service GG&C wide	• Increased geographic catchment for accessing ESTEEM support • Increased caseload and completed episodes for early intervention support from ESTEEM
Maintain and improve access to physical health checks	The Physical Health Care Policy (PHCP) has been completed and approved. A range of pilot sites have been identified and operation guidance produced to support this. The pilot will report in Autumn 2012 and it is anticipated full implementation and identification of measures will follow.	The PHCP details a range of health measures that are specific to conditions on a patient by patient basis. Ultimately the outcome measure will be reduced levels or morbidity and mortality in the adult MH population. Intermediate measures to be identified through the pilot work and then specified
Ensure delivery of HEAT target for waiting times for access to psychological therapies for all age groups (HEAT Target - Deliver faster access to MH	• Ensure equal access to psychological therapies regardless of age	• Compliance with HEAT target waiting times for access – 18 weeks RTT from December 2014. • Target trajectory - o 10% of patients having waited > 18 weeks RTT from March 2013 o 4% of patients having waited > 18 weeks RTT from March 2014

RESPONDING TO THE CORPORATE PLAN THE FIVE PRIORTIES

1. EARLY INTERVENTION AND PREVENTION OF ILL HEALTH

OUTCOMES	CHANGE OR DEVELOPMENT REQUIRED	MEASURES
• **Outcome to be delivered in next three years** • **Narrative for HEAT Targets should be here expressed as the outcome which is intended to be achieved**	• **Brief description of change or development required to deliver this outcome to provide direction to local development plans**	• **These should be set out as a group under each of the 5 priorities not necessarily linked to each change or development**
services by delivering 18 weeks referral to treatment for Psychological Therapies from December 2014.)		• Proportionate access to psychological therapies by SIMD
Refine care pathways to ensure access to early intervention services at the appropriate stage	• Ensure redesigned primary care teams are operating consistent with service specification and delivering access targets	• Increased numbers accessing primary care psychological therapies
HEAT Target – Suicide prevention training : reduce levels of suicide	Continuing to maintain HEAT standard for ensuring at least 50% of front line staff are trained in suicide prevention skills	Percentage of front line staff trained in suicide prevention skills, maintained above 50%, backed by enabling policies, protocols and practice guidance for staff
Suicide Prevention and Self Harm: positively impacting on trends in rates of suicide and self harm	Responding to the emerging recommendations of the GGC Suicide Prevention Planning Group (SPPG) for service improvement and multi-agency working Continued support for the multi-	Establishment of suicide prevention programmes leading to positive impact on predicted trends in suicide and serious self harm, with a particular emphasis on high risk, multiply disadvantaged groups

RESPONDING TO THE CORPORATE PLAN THE FIVE PRIORTIES

1. EARLY INTERVENTION AND PREVENTION OF ILL HEALTH

OUTCOMES	CHANGE OR DEVELOPMENT REQUIRED	MEASURES
• **Outcome to be delivered in next three years** • **Narrative for HEAT Targets should be here expressed as the outcome which is intended to be achieved**	• **Brief description of change or development required to deliver this outcome to provide direction to local development plans**	• **These should be set out as a group under each of the 5 priorities not necessarily linked to each change or development**
	agency Choose Life programmes in each area, in developing comprehensive suicide prevention programmes and specific connections to action on equalities, financial inclusion and employability agendas Ensuring all planning entities (CH(C)Ps / Sectors) working toward responsive services in development of GGC-wide systems and protocols incorporating best evidence in suicide prevention and self harm	

RESPONDING TO THE CORPORATE PLAN THE FIVE PRIORTIES

1. EARLY INTERVENTION AND PREVENTION OF ILL HEALTH

OUTCOMES	CHANGE OR DEVELOPMENT REQUIRED	MEASURES
• **Outcome to be delivered in next three years** • **Narrative for HEAT Targets should be here expressed as the outcome which is intended to be achieved**	• **Brief description of change or development required to deliver this outcome to provide direction to local development plans**	• **These should be set out as a group under each of the 5 priorities not necessarily linked to each change or development**
Improvements in key measures of population mental health and key determinants	Comprehensive Mental Health Improvement Action Plans in place and implemented in each Sector/CH(C)P, ensuring resourced, robust and strengthened partnership approaches with Local Authority / CPP areas. To include development of social prescribing approaches and community assets approaches to support above, drawing on "No Health Without Mental Health" framework Each MH improvement action plan should explicitly address key inequalities dimensions and prioritise higher need sections of the population	Improvements in key mental health indicators for whole population and for higher risk sections of the population, along with improvements in key contributory factors for poor mental health, such as excessive alcohol consumption. "Local mental health improvement action plans should be populated with measures to be selected from the National Adult Mental Health Indicators material developed by NHS Health Scotland - each indicator will have its own frequency of reporting, e.g. annually for suicide rates http://www.healthscotland.com/uploads/documents/6011-mhi_brief_2702_22008.pdf "Connecting with this national indicators package is the detailed report available from Glasgow Centre for Population Health, 'Mental Health in Focus' http://www.gcph.co.uk/publications/284_mental_health_in_focus which provides additional guidance as to indicators suitable for use at Board-wide and/or more local levels, along with relevant baseline data for multiple indicators. "Additionally the nationally published Mental Health Improvement

RESPONDING TO THE CORPORATE PLAN THE FIVE PRIORTIES

1. EARLY INTERVENTION AND PREVENTION OF ILL HEALTH

OUTCOMES	CHANGE OR DEVELOPMENT REQUIRED	MEASURES
• **Outcome to be delivered in next three years** • **Narrative for HEAT Targets should be here expressed as the outcome which is intended to be achieved**	• **Brief description of change or development required to deliver this outcome to provide direction to local development plans**	• **These should be set out as a group under each of the 5 priorities not necessarily linked to each change or development**
		Outcomes Framework for Scotland provides detailed guidance on the planning and selection of short-, medium- and long-term outcome indicators for the major domains of mental health improvement work http://www.healthscotland.com/understanding/evaluation/planning/mental-health.aspx

Finance & Workforce Issues

- Access to psychology time required for OPMH either through increase in dedicated psychology in OPMH or through access to AMH psychology time
- Enabling the development of the staffing capacity to roll out ESTEEM GG&C wide.

Overall position & issues
Achieved substantial balance of care shifts through development of community and crisis services GG&C wide with 34% reduction in inpatient activity since 2003 without prejudice to the quality measures of readmissions and boarding out
Inpatient activity now plateau'd out
Modestly reducing population probably more than offset by increases in risks associated with recession/loss of range of benefits safety nets
Benchmarking internal and external suggests some modest further scope for shifting balance of care in next 3 years but pace of change to be reviewed in context of service pressures
Constraints on feasibility and phasing of achieving balance of care shifts are in part dependant on access to capital which has to date proved problematic

Carers (and in this context MH Carers) suffer from stigma and discrimination, often through lack of awareness.

OUTCOMES	CHANGE OR DEVELOPMENT REQUIRED	MEASURES
• **Outcome to be delivered in next three years** • **Narrative for HEAT Targets should be here expressed as the outcome which is intended to be achieved**	• **Brief description of change or development required to deliver this outcome to provide direction to local development plans**	• **These should be set out as a group under each of the 5 priorities not necessarily linked to each change or development**
Fewer people cared for in settings which are inappropriate for their needs;	• Median lengths of stay discharges are based on "right length of stay"	• Delayed discharge targets achieved. (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) • Reduce the range of variability in the range of average and median lengths of stay between areas

OUTCOMES	CHANGE OR DEVELOPMENT REQUIRED	MEASURES
• **Outcome to be delivered in next three years** • **Narrative for HEAT Targets should be here expressed as the outcome which is intended to be achieved**	• **Brief description of change or development required to deliver this outcome to provide direction to local development plans**	• **These should be set out as a group under each of the 5 priorities not necessarily linked to each change or development**
Perverse incentives to contain workloads between community, crisis and inpatient services are worked through so team caseloads and activity are consistent with the most appropriate setting and interventions to meet service user needs rather than the "inverse care law"	**Undertake work on productivity of community teams to understand current activity and propose service and activity targets**	**To be determined based on outcome of work**
More carers are supported to continue in their caring role. (Resilience)	Caring Together: The Carers Strategy For Scotland 2010-2015 sets out the action that is being taken with partners to provide better support to family members and carers to enable them to offer care & support without themselves coming to harm. This includes: • Services are able to identify carers including young carers • Provide information and advice to carers to support their role • Ensure carer representation in local health partnerships and mental health system wide PFPI systems • Ensure staff are aware of the importance of involving and learning from carers expertise and experience of services • Development of carer/mental health carer training and development packages via GG&C anti stigma partnership	• Families/ carers are routinely involved in learning from Significant Incidents • Carers including young carers are identified through single shared assessments in community and inpatient settings • DH triangle of care assessment tool used within all acute inpatient areas • Carer feedback is used for service improvement • Develop training packages for NHS GG&C, 6 x GGC Local Authorities and support materials for newly identified MH carers

OUTCOMES	CHANGE OR DEVELOPMENT REQUIRED	MEASURES
• **Outcome to be delivered in next three years** • **Narrative for HEAT Targets should be here expressed as the outcome which is intended to be achieved**	• **Brief description of change or development required to deliver this outcome to provide direction to local development plans**	• **These should be set out as a group under each of the 5 priorities not necessarily linked to each change or development**
	• Utilisation of Carers Information Strategy funding to assist delivery of identified needs	
Minimising and mitigating the impact of capacity reductions in community services on the capacity to sustainably shift the balance of care	• Modest further reductions of capacity of acute inpatient beds	• Stable or reducing levels of inpatient activity (admissions/ OBD's/Boarding/Readmissions)

Finance and workforce
The financial outcomes we need to achieve in the next three years are a shift in spending from hospital services. However at a time of financial constraint it seems unlikely that savings can be reinvested in community services.

3. RESHAPING CARE FOR OLDER PEOPLE

- Not applicable to Adult MH but see references to access to age appropriate services elsewhere in this Plan.

4. IMPROVING QUALITY AND EFFECTIVENESS

Overall position & issues

- Range of environmental improvements to inpatient wards previously implemented but continue to have ward environments which are of lower quality with reliance on shared ward spaces which raise both quality issues for individual patients, can exacerbate patient safety challenges, and can constrain the flexibility of wards to meet needs due to limited single sex/single room accommodation
- HAI/patient feedback has raised issues as follows:

HAI

The standards for healthcare acquired infection continue to be implemented across all mental health in-patent areas. A point prevalence study was conducted in early 2012 which show that NHS Greater Glasgow & Clyde mental health areas remain below the national rate for HAI in these settings. Seasonal monitoring of norovirus outbreaks demonstrate relatively low activity (adult & older peoples MH wards) in comparison to RAD and other acute areas. The Healthcare environment inspectorate visits will extend to mental health in-patient areas this year and a significant area of work has been undertaken to prepare for this, there remains however significant issues in relation to the standard of some of the estate.

Patient Feedback

- A variety of mechanisms are in place for gathering patient experience within mental health services. This includes questionnaires, focus groups, PFPI structures and ‘ you said , we did’ models within in-patient areas. Service user organisations are integral to these approaches and are directly involved in eliciting feedback from patients and carers.

Service users have told us through a range of national and local work what they want from services. This includes:

- Involvement in decisions and respect for preferences
- Emotional support, empathy and respect
- Clear information and support for self care
- Fast access to reliable health advice
- Effective treatment delivered by trusted professionals
- Attention to physical, and environmental needs
- Involvement of and support for family and carers
- Continuity of care and smooth transitions

4. IMPROVING QUALITY AND EFFECTIVENESS

The majority of people are happy with their care and rate their relationship with health care staff as very good. Other themes include the importance of ensuring smooth transition between services, improved discharge planning and co-ordination of care where multiple services are involved.

- Out Of Hours redesign
- Service specification and productivity KPI's development
- Outcome framework development

OUTCOMES	CHANGE OR DEVELOPMENT REQUIRED	MEASURES
• **Outcome to be delivered in next three years** • **Narrative for HEAT Targets should be here expressed as the outcome which is intended to be achieved**	• **Brief description of change or development required to deliver this outcome to provide direction to local development plans**	• **These should be set out as a group under each of the 5 priorities not necessarily linked to each change or development**
Improving environment of inpatient wards	An agreed and costed plan to ensure that all in-patient environments are of a consistent and measurable standard.	• No of wards with improved environments
Deliver inpatient reconfigurations as per previous commitments to deliver both balance of care shifts and efficiency savings - Parkhead/Stobhill /Ruchill - SGH to Leverndale - As per Case for Change re inpatient services	• Develop and produce a coherent and co-ordinated inpatient configuration plan that reflects effective engagement and views of users, carers, staff, which is clinically and financially effective. • This may require concentration on less sites but more quality. • Energy cost implications of service redesign to be included within the plan.	• Agreed MH plan as a result of Case for Change outcome that sets the direction for future inpatient services

4. IMPROVING QUALITY AND EFFECTIVENESS

OUTCOMES	CHANGE OR DEVELOPMENT REQUIRED	MEASURES
• **Outcome to be delivered in next three years** • **Narrative for HEAT Targets should be here expressed as the outcome which is intended to be achieved**	• **Brief description of change or development required to deliver this outcome to provide direction to local development plans**	• **These should be set out as a group under each of the 5 priorities not necessarily linked to each change or development**
Making further reductions in avoidable harm and in hospital acquired infection	• Implement proposals of National MH Scottish Patient Safety Programme as a member of implementation group • Implement standard operating procedures for control of infection within hospitals. • Implement recommendations from HIS report on learning from significant clinical incidents	• Evidenced based/National approach to MH SPSP approaches • Point prevalence study on rates of infection within mental health hospital settings • Seasonal monitoring of Norovirus outbreaks • System wide learning from SCIs
Delivering care which is demonstrably person centred, effective and efficient	• Ensure mutually beneficial partnerships between patients/carer's and service providers which respect individual needs and values • Scope out utility of electronic methods of gathering routine / real time patient feedback • Implement CARE measure • Ensure no avoidable harm to people from the healthcare they receive • Provision of the most appropriate treatments, interventions, support and services at the right time to everyone who will benefit • Eradicate wasteful or harmful variation	• Readmissions and boarding : stable or reducing • Patient feedback measures inform service delivery / clinical practice • SCI's are completed within the appropriate timescale • Waiting Times targets achieved • Quality Improvement Productivity Measures (LEAN, DCAQ) implemented across community mental health teams.

4. IMPROVING QUALITY AND EFFECTIVENESS

OUTCOMES	CHANGE OR DEVELOPMENT REQUIRED	MEASURES
• **Outcome to be delivered in next three years** • **Narrative for HEAT Targets should be here expressed as the outcome which is intended to be achieved**	• **Brief description of change or development required to deliver this outcome to provide direction to local development plans**	• **These should be set out as a group under each of the 5 priorities not necessarily linked to each change or development**
Patient engagement across the quality, effectiveness and efficiency programmes	• Ensure effective engagement throughout the Case for Change process • More effective ongoing engagement with MH leadership • Service User / carer participation in service reviews, scrutiny and assurance functions	• Outcome of engagement process influences Case for Change • Routine series of focus meetings built in to MH leadership meetings • Patient participation in SPSP programme • Scottish Recovery Indicator (SRI 2) implemented across adult mental health teams
Improve appropriate access on a range of measures including waiting times, access to specialist care; physical access and needs responsive access	• Model for OOH redesign is developed and implemented	• Access to Psychological Therapies Target compliance (18 weeks referral to treatment from December 2014) • No deterioration in MH waits for A&E admissions • No increase in levels of people admitted outwith daytime services

Finance and workforce

Develop improved understanding of productivity and effectiveness of community services and develop and implement service and productivity KPI's
Release fixed cost and unit cost savings to mitigate impacts of delivering savings plan targets.

5. TACKLING INEQUALITIES

Overall position & issues

- unequal geographic access to specialist service
- access to some services (e.g. psychological therapies) for needs which are not age specific is currently differentiated on the basis of age rather than need

OUTCOMES	CHANGE OR DEVELOPMENT REQUIRED	MEASURES
• **Outcome to be delivered in next three years** • **Narrative for HEAT Targets should be here expressed as the outcome which is intended to be achieved**	• **Brief description of change or development required to deliver this outcome to provide direction to local development plans**	• **These should be set out as a group under each of the 5 priorities not necessarily linked to each change or development**
We plan and deliver health services in a way which understands and responds better to individuals' wider social circumstances; and we contribute to achieving higher levels of public awareness of mental health issues, combined with lower levels of stigma and discrimination	Services planned and delivered in a way which ensures a greater understanding of individual's wider circumstances, and which contributes to reduced levels of stigma and discrimination in the population, in line with resources of Anti Stigma Partnership and its thematic groups – e.g. LGBT communities, peri-natal MH, Mental Health Carers, Employment Consider outputs from Gender Based Violence routine enquiry pilot, to determine the implications and feasibility of a roll-out across MH services GG&C wide.	• MH Improvement and Inequalities training opportunities – increased uptake across CH(C)Ps / Sectors and within Partner agencies (Measures such as # staff trained; # agencies accessing training, etc) • Public attitudes surveys examining trends in mental health awareness, stigmatising attitudes (e.g. via See Me campaign commissioned research)
Information on how different groups access and benefit from our services is more routinely available and informs service planning	Clarify baseline recording levels and explore feasibility of improving recording levels Undertake specific piece of work to clarify implications of knowledge base re differential prevalence, utilisation, factors in experience of protected groups and their significance for the functionality and characteristics of service models as an input to the CSR process	Degree of baseline recording of protected characteristics in service utilisation activity information.
Physical health needs of mental health patients are addressed equitably as	Physical health care of patients is a significant element of this and we are addressing this through the	See Section 1 above

5. TACKLING INEQUALITIES

OUTCOMES	CHANGE OR DEVELOPMENT REQUIRED	MEASURES
• **Outcome to be delivered in next three years** • **Narrative for HEAT Targets should be here expressed as the outcome which is intended to be achieved**	• **Brief description of change or development required to deliver this outcome to provide direction to local development plans**	• **These should be set out as a group under each of the 5 priorities not necessarily linked to each change or development**
compared with the general population.	Physical Health Care Policy – see Section 1 above Further work is undertaken to identify the health gap and actions to mitigate this drawing on work on the Health needs assessment/Clinical Services Review.	 Health gap is identified Range of actions are identified based on outcome of work
Reduce inequalities gap - Financial Inclusion / Anti Poverty measures	Seen as key drivers in increasing the inequalities gap – CH(C)Ps / Sectors MH Improvement Action Plans to ensure adequate service provision targeted at high risk groups, and to incorporate financial inclusion support, employability services and other anti-poverty measures as integral elements.	• Uptake of financial inclusion services across CH(C)Ps / Sectors • Availability and access of FI services to at risk groups, including clients of MH services
Geographic access issues resolved		• Specialist services activity for areas previously without access to such services
Age discriminatory access to Psychological Therapies /liaison/crisis supports is resolved		• Increased access to psych therapies • Overall increase and compliance with HEAT target • Proportionate access by SIMD • Proportionate access by age

Finance and workforce

The financial challenge we need to meet in the next three years is to demonstrate that we have shifted our use of resources to deliver on these inequalities outcomes and have considered the inequality impact in all of our financial decisions.

ALCOHOL AND DRUGS PLANNING FRAMEWORK

1. NATIONAL CONTEXT

1.1 Scotland continues to have the highest alcohol and drug-related death rates in the UK with drug and alcohol problems particularly affecting people who are socially excluded and/or those living in deprived areas. People with drug and alcohol often have other problems such as mental health issues, housing etc. Children of parents who misuse drugs and alcohol are often at increased risk of emotional and physical abuse and in the long term may be at risk of developing substance problems themselves.

1.2 This planning framework is particularly influenced by two key national policy documents; Changing Scotland's Relationship with Alcohol: A Framework for Action (2009) and Scotland's current drug strategy, The Road to Recovery (2008).

1.3 The planning framework takes into account national targets relevant to alcohol and drugs, including:-

- No more than 18 weeks referral to treatment for Psychological Therapies by Dec 2014
- sustain and embed alcohol brief interventions
- 90% of clients to access alcohol or drug treatment within 21 days of referral (2013/ 14)
- 12 week waiting time guarantee to access day place or inpatient care.

2. NHSGGC PLANNING CONTEXT

Alcohol and drug related ill health and deaths remains an issue that is closely correlated with deprivation and inequality.

2.1 NHSGGC is an active participant in Alcohol and Partnerships (ADPS) the main partnership delivery arrangements within each local authority area. It is anticipated that outcomes and actions within this framework that are relevant to ADPs should be reflected in their delivery plans.

2.2 Addictions services have performed very well in meeting waiting times target for both referral and treatment. This is particularly noteworthy given the large caseloads that teams often carry. Drug related death rates have remained fairly static over recent years and efforts continue to reduce that trend. Across NHSGGC, alcohol brief intervention targets have been met. NHSGGC and its partners also continue to meet performance targets to successfully secure national funding to implement ADP delivery plans.

3. FINANCE

3.1 Prevalence figures estimate that there are large numbers of the population with a significant alcohol and/or drug problem who do not engage with services or, if they do, it is usually in an unplanned way. Additional resources

would therefore be required to address unmet need, from improved engagement and preventative work, through to direct addiction service provision.

3.2 The impact of the Welfare Reform Act 2012 remains to be seen. This, along with the social impact of current austerity measures and the challenging state of the economy, may place additional demands on services that require additional resources.

3.3 Efforts will continue to ensure services continue to operate within agreed budgets and contribute effectively towards efficiency programmes.

4. WORKFORCE

4.1 The continuing shift to more recovery focused services will require staff to be provided with the right training and development opportunities to deliver this care, along with levels of caseloads conducive to offering increased service user contact time with those willing and able to participate in recovery focussed care. Staff training and development plans to be put in place to meet the requirements of 'Getting Our Priorities Right'.

EARLY INTERVENTION AND PREVENTING ILL HEALTH		
OUTCOMES	**CHANGE OR DEVELOPMENT REQUIRED**	**MEASURES**
Work with ADPs to ensure there is a consistent and shared approach to delivering prevention activity across services and partners to reduce the number of people developing problems.	Fewer adults and children are drinking or using drugs at levels or patterns that are damaging to themselves or others Ensure people with addictions have access to the range of health improvement programmes, with targeted harm reduction programmes for vulnerable people.	1. Reduce alcohol-related deaths 2. Reduce drug-related deaths 3. Maintain and embed number of ABI screenings in priority settings 4. Reduce alcohol-related hospital discharges 5. Reduce harmful levels of alcohol consumption
There is a better understanding of the levels of unmet need and the barriers to accessing services	Estimate levels of unmet need and review strategies to address this, including improved engagement with difficult to reach individuals and communities. Review service profile that would be required to respond to unmet need	Increased demand for services Profiles of service users versus estimated prevalence / population estimates

SHIFTING THE BALANCE OF CARE		
OUTCOMES	**CHANGE OR DEVELOPMENT REQUIRED**	**MEASURES**
Continue to shift services towards more recovery focused care	Greater service user involvement in care planning and reviews, offering greater choice around treatment and care options. More people successfully detoxed from alcohol misuse and achieved abstinence from drugs	1. Alcohol detoxification and drug abstinence numbers 2. No. clients accessing education/ training/ employment 3. Number of people discharged 4. Care planning documentation reflects recovery focus 5. Number of clients supported into housing

	Offer appropriate recovery opportunities linked to longer term training, employment and social re-integration	or tenancies sustained 6. Service user feedback
Reduce the number of unplanned alcohol detoxifications that take place in Acute hospital settings in favour of more planned detoxifications within addiction services	Improved prevention and engagement With Acute, review reasons for admission and whether those admitted were in contact with addictions services. Strengthen access to liaison psychiatry services	Reduce the number of unplanned admissions to Acute

IMPROVING QUALITY, EFFICIENCY AND EFFECTIVENESS		
OUTCOMES	**CHANGE OR DEVELOPMENT REQUIRED**	**MEASURES**
Improve access to psychological therapy	Review current access arrangements and service changes necessary to achieve target.	No more than 18 weeks referral to treatment for Psychological Therapies by Dec 2014
Robust processes in place to engage service users and carers in care planning and service improvement.	Review current models of service user and carer engagement to maximise opportunity for participation and influence Work with GPs, HVs, schools and nurseries to identify young carers early and help them to obtain appropriate support	Service user and carer feedback Evidence of engagement processes and structures Increase in the number of young carers identified
Improve access to services	Review current access arrangements and service changes necessary to achieve target. Ensure services are inequalities sensitive and barriers to access are removed.	90% of clients to access alcohol or drug treatment within 21 days of referral (2013 – 14) HEAT target EQIAs
Develop NHSGGC 'core' community addictions service specification and	Local review and participation in NHSGGC process to develop Board-wide core	Specification and performance framework agreed and implemented

performance framework (with flexibility to suit local needs)	specification and performance framework	
Review pathway between GP Shared Care and community addiction services to ensure individuals receive effective care and support in the setting most appropriate to their needs.	Ensure service users in shared care have access to the appropriate range of primary care services; that specialist input from addiction services is targeted effectively; and that services are in line with the recovery agenda.	Increase the number of people supported in shared care Locally Enhanced Service monitoring arrangements Shared Care action plans
Improve occupancy and efficient bed usage within Tier 4 alcohol detox services, achieving 12 week waiting time guarantee	Review admission criteria and ensure that it is applied consistently Reduce variations in practice to agree optimum lengths of stay Community addictions teams to play greater role in admission and discharge planning.	Bed Occupancy Length of Stay 12 week waiting time guarantee
The needs of service users with co-morbidity are met in an integrated way	Improved pathways in place for service users with co-morbidity	Service user feedback
Implement the recommendations within 'Getting our Priorities Right'	Further develop multiagency information sharing protocols and pathways Further develop integrated assessments Ensure there is a 'whole family' approach when assessing need Ensure early identification of pregnant women using drugs and/or alcohol to ensure support is provided for mother and baby	Evidenced through integrated assessments The development of the 'Child's Plan Improve access to parenting programmes Reduced alcohol consumption or drug usage

TACKLING INEQUALITIES		
OUTCOMES	**CHANGE OR DEVELOPMENT REQUIRED**	**MEASURES**
Improved recording of equality related data within assessment and treatment plans, including sensitive inquiry	Staff are made fully aware of the importance of information recording Systems are in place to support data recording and monitoring	Audit of assessments and care plans
Improve the level and quality of addiction services provided to people in prison and effectiveness of throughcare	Implement findings of prison health needs assessment Strengthen the treatment pathway for prisoners with alcohol and drug problems so that we are delivering continuity of treatment from prison and back out into the community. Review scope for additional resources provided to people in prison	Increased service activity within prisons Evidence of continued service engagement (including with non-Addiction services) upon release from prison.

NHGC CANCER PLANNING FRAMEWORK 2013-16

NATIONAL CONTEXT & TARGETS

It is recognised nationally that over the past 20 years enormous progress has been made in both the detection and treatment of cancers. Detection, and awareness of possible cancer symptoms, has been the subject of many national health campaigns in recent years across Scotland. This, overlaid with increased public awareness of contributory and risk factors, such as smoking, diet and exercise, alcohol, sun exposure, have heightened public awareness and knowledge around many of the common cancer types.

Treating cancer early has vastly improved due in part screening programs for breast, colorectal and cervical cancers. NHS access targets have also enabled rapid diagnostic and treatment pathways allowing patients to commence specialist treatment rapidly. Advancements in surgical, medical and radiation treatments also give clinical teams considerably more options for radically treating the disease.

However, approximately 30,000 people in Scotland are told they have cancer every year and trends predict that numbers are likely to rise to almost 35,000 by 2020. This increase is largely due to the increasing population and life expectancy. Cancer remains the second most common cause of death and smoking remains the single largest preventable cause of cancers. It causes about 90% of lung cancer and is responsible for over a quarter of all cancers. Three modifiable risk factors: obesity, alcohol consumption and poor diet account for about 42% of breast cancers that might otherwise be avoided. Colorectal cancer incidence increased by about 30% between 1970s and early 1990s. Red meat increases the risk of colorectal cancer by 15% for every 50g/day consumed; every unit of alcohol increases the risk by about 9% and each extra inch of waist circumference increases risk by 5%. Malignant melanoma is caused by ultraviolet light exposure, principally from sunlight and sun beds and childhood sun exposure.

Co-morbidities, in particular those due to smoking, alcohol, poor diet, obesity and socioeconomic deprivation, are likely to influence patients' survival directly and through their fitness to receive optimal cancer treatment. In addition, patients who present with cancer at an advanced stage are less amenable to treatment, and have poorer survival outcomes, often resulting in more complex interventions with greater associated costs. More positively, over the last two decades, almost all cancers have shown improvement in survival five years after diagnosis. The key message of the national Detecting Cancer Early Programme is therefore *'the earlier the better'* cancer is detected.

The Better Cancer Care: An Action Plan, published by the Scottish Government Health Department (SGHD) 2008 underpins national and local planning and policy development. In addition, the SGHD's Detecting Cancer Early Initiative (DCE) 2011 introduces a new HEAT target '*to increase by 25% the proportion of patients diagnosed and treated when their cancer is at the earliest stage',* focussing on the stage of the disease at which treatment is provided and commencing with breast, colorectal and lung cancers.

Current around 86% of cancers are under performance guarantee across Scotland. Scoping work has been undertaken in last 18 months to look at the potential to increase these access targets to cover some of the rarer tumour groups (Sarcoma, Neurology, Mesothelioma, Endometrial, Thyroid, Squamous Cell Carcinoma of the skin, and Myeloma). A series of audit are underway looking at the performance of each tumour group in turn.

There are two further distinct programmes currently underway from a national perspective. These are the introduction of Quality Performance Indicators (QPI) across the main tumour

groups, and the Cancer Modernisation Programme. The quality performance indicators will allow services to review key element of the patients care from a standardised and defined set of quality performance criteria. The QPIs are being developed nationally and the initial indicators for renal and breast will be measured from January 2012 onwards.

The Cancer Modernisation Programme has also allocated funding to three distinct work flows: Radiotherapy Capacity, Acute Oncology and Surgical Oncology. NHS Boards have received funding allocations to take forward various initiatives under the three categories and pilot improvements over a period of 24 months.

LOCAL CONTEXT

The West of Scotland Cancer Surveillance Report (2011) highlights that cancers are the second most common cause of death among Greater Glasgow and Clyde residents. Despite the good progress made over recent years, the population continues to face significant health challenges. It has shorter life expectancy than the rest of Scotland and indeed many parts of Europe. There are however, markedly higher levels of deprivation in parts of the West of Scotland, resulting in an associated impact on health. Residents are experiencing some of the widest variations in health between the affluent and poor in society and there is a significant increase in obesity and alcohol related problems. The population is ageing, but this is happening at different rates. The inequalities and poor health in the population drive high levels of hospital admissions, GP consultations and the use of a wide range of other services, with particular pressures in emergency care services.

There are a number of factors that individually or collectively to contribute to these variances including genetics; awareness and understanding; lifestyle behaviours; screening uptake; and treatment. Evidence suggests these inequalities impact greatly on people from lower socioeconomic status; those adopting poor lifestyle behaviours; those from black and minority ethnic communities; people with learning disabilities; lesbian, gay, bisexual, transgender (LGBT) communities; and those living in remote geographical locations. Action is required if variances within NHSGGC are to be brought into line with other Northern European countries and the US.

The NHSGGC Cancer Services Steering Group (CSSG) oversees the strategic development, delivery and performance management of the whole system cancer planning. The CSSG has links to national, regional and local planning forums. It has a Quality and Improvement Sub-Group, and an interface with Primary Care ensuring a cancer planning focus across Acute and CHCP/Primary Care Boundaries. The CSSG assumes responsibility for the development and updating of the Cancer Planning Framework 2013/16, the Cancer Plan 2010/13 and the Detect Cancer Early Health Improvement Strategy 2012/15.

The NHS Greater Glasgow & Clyde DETECT CANCER EARLY HEALTH IMPROVEMENT STRATEGY (2012 to 2015) sets out NHSGGC's Strategic Objectives to deliver the vision that:

'Greater Glasgow and Clyde residents and staff adopt a healthy lifestyle to reduce the risk of developing cancer and to improve outcomes for those who live with the disease' "You can do it – We can help".

The Strategy focuses on the changeable determinants of cancer and provide clarity and co-ordinate efforts to prevent and detect cancer. This strategy applies to prevention, as well as survivorship for people living with cancer.

The Cancer Plan 2010/13 outlines the detailed priorities, actions and outcomes for NHSGGC. NHSGGC provides specialist cancer services on a national, regional and local level, which covers a population of more than 1.2 million for NHS Greater Glasgow & Clyde (NHSGGC) and extending on a West of Scotland basis to more than half of Scotland's population. These span promotion, prevention, referral to diagnosis, treatment, care and after care spectrum of services

across primary, community and secondary care settings. To ensure that our services meet the needs of that extended population joint planning arrangements are in place with our partner West of Scotland Health Boards.

Much progress has been made in the past three years, particularly around access targets. GG&C has consistently achieved 95% or above in the last two years for the current cancer performance access targets (62 and 31 days).

The Board, in conjunction with the Region and SGHD, have actively progressed future planning assumptions for radiotherapy capacity across the central belt. A business case is currently being developed to assess the viability of a satellite cancer centre in West Central Scotland.

In terms of Chemotherapy delivery, NHSGG&C has achieved compliance with HDL 27 (2005) Chemotherapy standards. Focus in the area of chemotherapy delivery is moving towards the implementation of an Acute Oncology Service, similar to the models in NHS England, taking cognisance of the NCEPOD report in 2008 reviewing the care of patients who died within 30 days of receiving systemic anti-cancer therapy.

WORKFORCE ISSUES

Work will need to be undertaken to ensure the specialist health improvement and public health workforce have the required knowledge, skills and time to work with organisations across the public, independent and voluntary sector to optimise their role in delivering the cancer health improvement and prevention agenda. Much of the cancer promotion/prevention work focusses on children, young people and families, but there remains a need to consider health promotion and prevention across the life span.

Strategies need to be developed and implemented to secure engagement of staff across NHSGGC workforce in positive lifestyle behaviours and taking up screening opportunities. Furthermore, the organisation needs to better equip staff with the necessary knowledge and skills to become cancer health improvement role models and agents of change.

Work is being progressed to examine efficiencies in services, including planned national benchmarking of services, as well as determining aspects of the patient journey which could be more efficiently managed in the primary care setting. Areas such as follow-up, community monitoring of disease progression in specific tumour groups, pre chemotherapy blood testing and referral education are currently being considered. A number of initiatives are also being progressed in relation to BWoSCC workforce modelling, including:

- the impacts of medical staffing numbers by 2015
- assessment of the role of therapist radiographers in light of the potential reduction in medical staffing time
- assessing the advantage of utilising Advanced and Consultant Radiographers
- further evaluation of general radiography to assess if the 4 tier structure could legitimately reduce staffing costs
- assessing the role of Clinical Nurse Specialists within the Centre
- Skills Mix Pilot Programme Board is taking forward training nursing auxiliary staff to take on enhanced responsibilities
- remodelling internal administration support. The implementation of the PMS may provide further opportunities for service redesign
- evaluating chemotherapy and radiotherapy capacity at the Beatson West of Scotland Cancer Centre.

FINANCE ISSUES

Over the next three year period, there are a number of infrastructure programmes that are planned and/or underway. The Capital replacement programme for Linear Accelerators across Scotland is agreed, and will ensure that state of the art technology is in place for this cancer treatment modality. Further work is currently underway to assess options for a West of Scotland Satellite Radiotherapy Centre. It is anticipated that a fully costed business will be completed by the end of financial year 2012/13. This will then go forward for further consideration by the Regional Planning Group. It is likely that it would take around 3 years for any build to be commissioned from the point at which the business case is approved.

The opening of the New South Glasgow Hospital (NSGH) marks a key milestone in the development of surgical services in general and in cancer surgery in particular. Surgical cancer services are currently offered on a number of sites and coordinated across GGC via Multi Disciplinary Teams. This mechanism mitigates against the physical dislocation by close networking but evidence shows that better outcomes are often achieved with increased volume on a fewer number of sites. The 2015 vision for surgical services in accordance with the extant Acute Services Review (CSR), sees the centralisation of Urology and ENT cancer cases in the NSGH. The opportunity for better outcomes by centralisation of these services at NSGH will enable the shared expertise, close team working and fast access to diagnostic facilities required for cutting edge cancer surgery. The final detail of the location and split of General Surgical cancer surgery will be shaped by the outcome of the Clinical Services Review (CSR) due for publication next year, however the overarching principles of centralisation to achieve better quality outcomes will be applied.

Although there is a degree of uncertainty, there are likely to be a number of emerging medicines/indications that will have significant budgetary implications. The majority of new medicines are for the treatment of cancer. Medicines are included in the plan using the information from SMC 'Forward Look' document as a starting point and then applying local intelligence. Historically there are usually around 20-30 new medicines/indications for consideration – these will range in individual patient cost, scale of anticipated uptake and overall budget impact. It is recognised that some medicines may fail to achieve marketing authorisation, slip in terms of timescale, or fail to demonstrate cost-effectiveness to SMC in which case there will be no budget impact for 2013/14. Others will come to fruition within this timescale but the initial assumptions may require revision for example, patient numbers, cost per patient, timescale for introduction, likely displaced therapies.

In addition, it may be necessary to make provision for selected medicines currently not recommended by SMC but which, if successfully resubmitted, the Board would be expected to introduce to clinical practice. There is some risk attached to this approach but it has proved prudent in previous years to include for example new medicines in melanoma that may be given such consideration for 2013/14.

There are medicines introduced during 2012/13 for which the full financial impact has yet to be experienced. This includes Abiraterone for prostate cancer, Fingolimod for MS, Fidaxomicin for C difficile infection. As some local experience will have been gained with these medicines there would be increased confidence in the accuracy of predictions for use in 2013/14.

EARLY INTERVENTION AND PREVENTING ILL-HEALTH

- A plethora of international research clearly demonstrates that much of the suffering and death from cancer could be prevented by more systematic efforts to reduce tobacco use, improve diet and physical activity, reduce obesity, and expand the use of established screening tests
- Tobacco use remains the single largest preventable cause of disease and premature death and the majority of smokers become addicted to tobacco before they are legally old enough to buy cigarettes. The opportunity to prevent diseases caused by smoking is greatest when smokers quit early and population surveys (Scotland & GGC) indicate that a significant majority of people want to quit
- Obesity, physical inactivity, and poor nutrition are major risk factors for cancer, second only to tobacco use. Maintaining a healthy weight, staying physically active throughout life, and consuming a healthy diet can substantially reduce a person's lifetime risk of developing or dying from cancer. Research indicates that interventions are required to support individual choice, as well as community action to create a supportive physical and social environment. Community action can involve employer led health promotion programmes; health and social care professionals supporting patients on effective lifestyle behaviours; community leaders creating safe, enjoyable, and accessible environments for physical activity and affordable, healthy foods in schools, communities and worksites; and local councils developing policy and regulation that impact across different settings.

Early detection of bowel, breast, and cervical cancer through screening can improve survival and decrease mortality by detecting cancer at an early stage when treatment is more effective. In addition to detecting cancer early, screening for colorectal or cervical cancers can identify and result in the removal of precancerous abnormalities, preventing cancer altogether.**EARLY INTERVENTION AND PREVENTING ILL-HEALTH**		
OUTCOMES	**CHANGE OR DEVELOPMENT REQUIRED**	**MEASURES**
Increase population awareness and uptake of cancer prevention messages, interventions and services: ▪ Promote and support positive population health and well-being and prevent and/or minimise the risk factors that contribute to	Deliver and/or support others to deliver public health campaigns relating to cancer prevention Support local councils and other organisations to develop healthy public policies and regulations that impact across different settings Commission and/or deliver a range of health improvement programmes/interventions including for smoking, alcohol physical activity,	▪ Achieve comparable cancer incidence rates with the lowest European quartile by 2015 ▪ Uptake of and outcome from behaviour change interventions across a range of settings. HEAT Targets & Standards and other targets

developing cancer ▪ Detect cancer earlier for Breast, Lung and Colorectal (more treatable), particularly reducing variation in referral patterns amongst GP practices ▪ Improve the health and well-being of the NHSGGC workforce	nutrition across acute, primary care, community and particularly focussing on deprived communities and vulnerable groups	- Smoking quit rates - Child Healthy Weight - ABI - Breast feeding rates - Screening targets (Bowel, Breast, cervical) - DCE HEAT Targets for breast, colorectal and lung cancers - Hepatitis C screening uptake - HPV uptake rates - RTT targets - Variance in uptake by social class and protected characteristics ▪ Healthy Working Lives accreditation ▪ Uptake of and outcomes achieved from financial inclusion and employability interventions/services ▪ Referral pathway guidance to diagnostics, treatment and care produced and disseminated to primary care workforce (Not sure this is the right outcome, think the outcome should be that use of referral pathway guidance demonstrates referral best practice to ensure early diagnosis/detection?) ▪ Voluntary Sector contracts in place incorporating service specifications, expected outcomes and performance measures
	Support those in greatest need though improving the uptake of services to address life circumstances including income maximisation and employability opportunities	
	Build community capacity to support communities to become more empowered, resilient and engaged in health improvement	
	Utilise social marketing opportunities and deliver targeted interventions to increase awareness and understanding of early symptoms of cancer among the general population and target groups and communities	
	Increased awareness and understanding in primary care of early tests and referral pathways through liaising with primary care staff to share care pathways information	
	Develop relationships and/or contracts with relevant voluntary sector organisations to deliver key messages and services relating to cancer prevention, treatment and care	
	Increase NHSGGC Staff awareness of the impact of lifestyle factors on cancer risk and understanding of early symptoms of cancer	
	Implement and continue to monitor Bowel, Breast (including two-View digital mammography service) and Cervical Screening	
	Increase the numbers of NHSGGC staff engaged in positive lifestyle activities, participating in workplace health improvement	

	programmes and attending screening services	
	Increased numbers of NHSGGC staff feel empowered to be Cancer HI role models and to act as agents of change	▪ Brief interventions and prompts to screening at Occupational Health re cancer risk factors ▪ Uptake by staff of 'Raising the Issue' and other Health Improvement training programmes ▪ Network of Health Champions established ▪ Health Improvement Strategies & action plans developed and implemented

IMPROVING QUALITY EFFICIENCY AND EFFECTIVENESS

- NHSGGC makes a significant investment every year in the delivery of cancer care across primary, community, acute and tertiary services. As demand continues to expand and new opportunities emerge, it is incumbent on the Board to deliver the range and quality of services required to meet the needs of their local populations and to make best possible use of the available resources.
- To achieve quality assurance, cancer services need to keep abreast of clinical and technological developments; understand and address variations in clinical practice; apply the learning from clinical audit; and comply with agreed clinical protocols and Scottish Intercollegiate Guidelines Network (SIGN) clinical guidelines for specific tumour types.
- The Cancer Networks have proved extremely valuable in implementing the actions set out in *Cancer in Scotland: Action for Change*, clarifying the complexities of clinical pathways and service delivery and supporting continuing qualitative improvements in the delivery of care
- The views and experiences of carers informs service changes and developments as part of the "Better Together" programme. Patient experiences provides a better understanding of the barriers that prevent cancer services from delivering the most effective and appropriate care for communities.
- NHSGGC Cancer Services also take account of the Scottish Health Council Participation Standard (published in 2009), the Healthcare Strategy for NHS Scotland (2010) and the work of the National Quality Steering Group set up under the auspices of the Scottish Cancer Task Force

Improving quality efficiency and effectiveness		
OUTCOMES	**CHANGE OR DEVELOPMENT REQUIRED**	**MEASURES**
Patients with cancer experience high quality services which are safe, effective and efficient: ▪ Effective planning systems in place ▪ Clinical audits undertaken and findings acted upon	Embed CPORT – (Chemotherapy Planning Online Tool) Embed CEPAS (RCAG) Embed R-Port Glasgow and Edinburgh to pilot this year	▪ Project Commissioning/Implementation Plan ▪ Outcome of pilots
	Continue to develop joint planning arrangements across NHSGGC and robust links at national and regional levels.	▪ RCAG, WOSCAN, SCT: frameworks and joint work plans in place ▪ Equity of standardised care
	Continue to develop the Cancer Steering	▪ Cancer Plan Developed

▪ Service sustainability plans in place	Group and its sub-groups in order to improve cancer planning, communications/joint working between primary and secondary care and share best practice.	▪ Cancer Plan Action Plan ▪ Quality Action Plan ▪ Clinical Lead Action Plan
	Put in place single system protocols Work to develop integrated, streamlined care pathways Continue to make progress pathways for acute specialty services: Breast, Head & Neck, ENT, Haematology, Lung Cancer, Upper GI, Urology etc.	▪ Pathways developed subject to EQIA ▪ Infection Control Standards ▪ Equity of pathways ▪ QIS Standards for endoscopy ▪ Carry out a national survey of the patient experience of their cancer care
	Continue to implement the recommendations from the RCAG FRMC report (October 2008): Review: Phase 1 – Gap analysis, Phase 2 – Review of Strategy, Phase 3 – Review of MDTs, Phase 4 – Follow-up, Phase 5 – Radiotherapy	Monitored against FRMC Recommendations RCAG
	Develop IT systems, fit for purpose across the system to support the delivery of cancer services.	QIS Cancer Core Standards
	Take forward agreed service specialty developments within the GGC Cancer Plan	▪ Cancer Plan performance process/action plan ▪ Monitor capacity and demand ▪ Patient views
	Deliver and review Patient Experience Programme	National evaluation and Patient views
	Provide information and advice to carers and where appropriate involve older people and their carers in care planning and delivery	▪ Patient and carers experience audits ▪ Patients/carers participating in service planning groups
	Review and refine NHSGGC internal cancer audit reporting schedule, with clearly defined data items to be reported on for each tumour sites, including improved data quality and consistency; and ensure robust risk management and governance arrangements developed.	▪ Evaluation of service ▪ Clinical staff views ▪ QIS Standards – Governance ▪ CSG Quality Improvement Group Work Plan

	Increase skills and capacity of workforce to undertake clinical audit	Clinical Effectiveness Action Plans
Patients with cancer have improved access to palliative care at the right time and in the right setting, and that meet or surpass the national standards	Deliver better end of life care through Liverpool Care in all care settings and roll out through established NHSGGC plan	Demonstrate through Audit LCP in place and being used appropriately in all care settings
	Track development in Communication, Advanced Care Planning and DNACPR for implementation in all care settings and implement agreed approaches across NHSGG	Audit use of SPAR, DNACPR and ACP over time in all care settings Further review of living and dying well
	Improve access to Psychological, social, emotional and spiritual needs across all care settings with partners in providing palliative care	▪ Audit of DES and LCP ▪ Each CHCP/CHP has palliative care plan
	Ensure 24 hour support through Community nursing, Home care and other services such as equipment to support people as near to home for as long as possible	▪ Part of ongoing audit ▪ Each CHCP/CHP has palliative care Implementation plan
	Support all staff through appropriate training to support patients who are dying and their carers through communication and competency in providing good quality care including pain management in all care settings	▪ Monitor uptake of training through PDPs against sector plans, Acute, Community and Care Home ▪ Patient/family feedback ▪ Complaints feedback

TACKLING INEQUALITIES

- The overall picture with regard to cancer morbidity and mortality is positive. Death rates are falling and survival rates have improved for almost all of the twenty most commonly diagnosed cancers
- Cancer Research UK advises there are considerable inequalities in cancer incidence and outcomes still exist between different social groups across the UK and Scotland specifically with the harder to reach groups having unmet need relating to information, support and cancer services. Evidence suggests there are inequalities at each stage of the patient pathway, from information and advice through to end of life care.
- Evidence suggests there are specific groups of people experiencing cancer inequalities:-
  - Socioeconomic status – incidence, mortality and survival is poorest in lower socioeconomic groups and the gap is widening. GG&C has some of the greatest levels of deprivation in Scotland
  - Black and minority ethnic communities - differences in lifestyle, language, culture resulting in poor uptake of prevention services
  - People with learning disabilities –experience higher incidence of particular cancer types and have poor access to preventative services
  - Geographical location – as a regional service, GGC serve people living in rural communities and research suggests these communities attend health services late which effects their treatment options and survival rates
  - Lesbian, gay, bisexual, transgender (LGBT) communities – Lifestyle is a significant contributing factor including higher than average levels of smoking, alcohol consumption and overweight. Although the evidence is limited, it is estimated that around half of all cancers could be prevented by changes to lifestyle and there appear to exist unmet need within this group for information, support and health services.
- People from deprived communities are less likely to access preventive care, including timely cancer screening and are more likely to be diagnosed at an advanced stage of cancer, when survival rates are much lower and treatment is more extensive and costly. These circumstances often result in poorer outcomes for these patients.
- Multi-agency multifaceted approaches to cancer prevention, treatment and care are required to address some of the complex wider determinants of health that contribute to widening health inequalities.

Tackling inequalities		
OUTCOMES	**CHANGE OR DEVELOPMENT REQUIRED**	**MEASURES**
Cancer health inequalities between deprived and non-deprived population are identified and action taken to reduce variances	Address financial inclusion across all settings, including access to Welfare Benefits for cancer sufferers and carers	Uptake of and outcomes achieved from financial inclusion and employability interventions/services Patient views
	Identify and address differential access issues to support planning, and to facilitate prioritisation of resources for the most deprived populations	Benchmark health variances within and across CHCPs
	Identify and address differential access issues to support planning, and to facilitate prioritisation of resources for the most deprived populations	Number determined for each service area
Patients with cancer have equity of access and improved access to services in the right place at the right time: • For local and WoS - regional services, with timely information, diagnosis, treatment and • For rehabilitation services	Continue to use electronic systems to support service delivery/local and regional services: SCI Gateway to improve vetting of referrals, e.g. E-Triage, E-Tertiary referrals and Inter-hospital referrals	▪ HEAT E7 ▪ Referral management Group action Plan ▪ Undertake referral audits
	Develop relationships with voluntary and charitable organisations, e.g. Cancer Charities, support Groups, Cancer Coalition to deliver support to patients and families/carers	Voluntary Sector contracts in place incorporating service specifications, expected outcomes and performance measures
	Delivery of cancer access targets. NHSGGC retrospective analysis of cancer types.	HEAT Standard: A9 and A10 National review for expansion of additional cancer types subject to performance review
	Implement the role of community pharmacy as lead care manager	Determine benchmark target numbers Through Macmillan Pharmacy PC Demonstrator Project

	Increase the availability of locally delivered day case/OP chemotherapy treatments on a regional basis	Monitor Day case/OP activity vs. IP activity
	Repatriate patient management/treatments to appropriate local services as close to the patients home as possible including FRMC chemotherapy repatriation	As above
	Implement Scottish Referral Guidelines - Cancer Pathways (2007/ 2009) across primary, community and secondary care, including streamlining cancer journey and review of Patient Pathways/System to remove bottlenecks.	Referral Management Group Action Plan: Reduction and consolidation of pathways developed and implemented HEAT A9 – radiotherapy pathway

CHILD AND MATERNAL HEALTH

1. NATIONAL CONTEXT AND TARGETS

1.1 The child and maternal health policy and practice environment is undergoing substantial change. In summary the major themes arising from this wide ranging and complex policy context are:

- Focus on early intervention and prevention, especially but not exclusively, in the early years.
- Placing the child and family at the centre of all that we do.
- Reducing health inequalities.
- More effective leadership and co-ordination of care and interventions, both in health but also in partnership with a range of public and third sector agencies.
- Clear and seamless pathways from assessment into care and support.
- Use of evidence based and clinically effective care and support.
- Move towards "progressive universalism" in meeting the needs of children.
- Strong emphasis on holistic assessments and outcome based planning to meet children's needs based on the GIRFEC national practice model.
- Assets based approaches which build the resilience and capacity of children and their families to develop and thrive.
- Improving productivity and efficiency of service delivery.

1.2 Over the past year a number of national policy changes have been announced:

- **The Early Years' Taskforce -** will take forward a significant change programme to help deliver the joint commitment to prioritising the early years of children's lives and to early intervention. As part of the Government's support for the delivery of the taskforce's an **Early Years' Collaborative** is being established which will use improvement techniques to facilitate change.

- **Children and Young People's Bill** – proposes the introduction of legislation covering children's rights, early years' education, implementing elements of GIRFEC and changes to the care system.

- **Legislation to integrate health and social care -** whilst this legislation will cover initially only adult services (with a priority given to older people's services), there is an ongoing debate about whether or not this should be extended to include children's services.

- **Future scrutiny and improvement of services for children, young people and families –** the government has set out a revised framework for the scrutiny of children's services and views the responsibility of planning and delivering integrated children's services as lying with community planning partnerships. Each inspection will report publicly on the question: How well are the lives of the most vulnerable children improving?

- **Getting our Priorities Right (Updated Good Practice Guidance for use by all practitioners working with children, young people and families affected by substance use) -** this guidance is intended to support the wider Recovery Agenda for families facing substance use issues, ensuring that child protection, recovery and wider family support concerns are brought together as part of a

coordinated approach to giving children, young people and families the best support possible.

- **Mental Health Strategy for Scotland** – has a section on Child and Adolescent Mental Health and gave a number of commitments to infant and early years mental health, responding better to conduct disorders, responding better to attachment issues, looked after children, learning disability and CAMHS, access to specialist CAMHS, CAMHS admissions to adult beds and mental health indicators.

1.3 Over the past year the Government has announced a number of new initiatives including the following:

- The introduction of an ealry years' Change Fund of £50m over four years with additional contributions expected from the NHS and local authorities.
- Its intention to publish a **National Parenting Strategy.**
- A programme to develop **Children and Family Centres** across Scotland funded from the Change Fund.
- The roll out of the **Family Nurse Partnership** approach funded from the Change Fund.

2. LOCAL CONTEXT AND PROGRESS

2.1 The planning framework for 2010 to 2013 set out a range of priorities for action and many of these have been either achieved or have seen significant progress. These include:

- Establishment of the maternity hub and spoke model of care
- Roll out of SNIPS Board wide.
- Planning for the new Children's Hospital.
- Focus on inequalities with the success of the Healthier Wealthier Children programme and the training of staff in Routine Sensitive Enquiry.
- Implementation of whole population approach to parenting.
- Re-design of the locality CAMHS.
- Implementation of the Speech and Language Therapy framework
- Implementation of the Integrated Assessment Framework with local authorities.
- Implementation of a range of health improvement programmes in respect of oral health (Childsmile), sexual health education, breastfeeding (including obtaining UNICEF Baby Friendly Accreditations).
- Developed and piloted a new 30 month assessment
- Developing and implementing a financial plan for Children's Services.

3. FINANCIAL ISSUES

3.1 The re-design of Specialist Children's Services has created a consistent model of CAMHS and Community Paediatric Services for Greater Glasgow and Clyde, which will release efficiency savings over the next three years. The implementation of Releasing Time to Care and CAPA, the focus on evidence based practice and the introduction of the new IM&T system will promote further efficiencies and increased productivity.

3.2 The implementation of the Healthy Children Programme will reconfigure children and family locality teams to ensure a robust early years' programme that defines the health visitor's role in relation to the delivery of assessments, care planning and evidenced based interventions which will be required for the universal and vulnerable

care pathways. Critical factors in defining the size of the future workforce and the finance required to support it will be through establishing agreed caseload sizes across teams (which take into account a balance of universal and vulnerable children), the focus on each child having a named person and the establishment of skill-mixed teams across all of GG&C.

3.3 Our workforce planning would indicate that the resources available from the re-design would need to be re-invested in locality children and family teams, if the desired outcomes included in this planning framework are to be achieved.

3.4 The review of school health will create a sharper focus on the role of school nursing as part of the overall children and family locality teams as well as improving the interface between school nursing, community and acute paediatric nursing. Benchmarking of School Nursing has found that additional resources are required to ensure a consistent service across GG&C.

3.5 There will be a need to ensure the affordability of the New South Glasgow Hospital and the New Children's Hospital. Furthermore, in the Women and Children's Directorate, there are a number of areas under consideration to enhance the quality of services, whilst improving efficiency, including the future of paediatric inpatient facilities at Royal Alexandra Hospital and the Community Maternity Units at Inverclyde and the Vale of Leven Hospitals.

4. WORKFORCE ISSUES

4.1 There have been a number of workforce change and re-design programmes across maternal and child health services in the past few years, which will require to be implemented during the 2013-15 planning cycle. These will be encapsulated in the workforce plans for locality children and family teams in CHCPs/CHPs and Specialist Children's Services. Issues considered as part of the workforce planning processes include:

- Optimum band and skill mix for teams.
- Caseload sizes and ensuring that they are manageable and reflect the needs and health inequalities experienced by the children across the Board's area.
- The roles, functions and competencies required by children and families staff to deliver the universal and vulnerable children's pathways.
- The content of a learning and development programme for staff to support them in delivering on the emerging policy and practice agenda.

4.2 A joint workforce plan for general medical posts in acute and community paediatrics has been agreed and will be implemented during this planning period. It will improve the co-ordination of recruitment and deployment of medical staff across the system.

EARLY INTERVENTION AND PREVENTING ILL-HEALTH

Overall Position and Issues

- The evidence from research tells us that interventions in the early years represent the most cost-effective solution for tackling the intergenerational effects of poverty within vulnerable families. The analysis demonstrates that the impact of failing to intervene is profound: significantly increasing costs throughout childhood and adult life and a high risk of the next generation having the same problems.

- The Scottish Government's Early Years' Framework and Equally Well recognise that inequalities in the early years must be addressed to achieve a better quality of life for children in the short term and to reduce inequalities in the longer term.

- In Early Interventions: The Next Steps, Graham Allen sites the findings of the California Adverse Childhood Experience Study. This research looked at outcomes for 17,000 people and found that adults who had adverse childhoods showed higher levels of violence, anti-social behaviour, mental health problems, school under-achievement and poor physical health.

- Our overarching strategy for early years and early intervention is set out in "Mind the Gaps: Improving services for vulnerable children", which aims to achieve a step change improvement over the long term in the health, attainment and well-being of children and their families.

- The Board has taken forward a wide range of early intervention programmes and projects as part of health improvement (breastfeeding, smoking cessation etc) as well as in children and families services (Triple P, PACT, SNIPS etc). Furthermore, CHCPs/CHPs have well developed partnerships with schools to deliver health improvement programmes as part of the curriculum.

- Challenges will be to sustain the momentum of these programmes, support the development of new programmes (such as Family Nurse Partnership) and to shift resources to support our children and family teams to focus on the early years and early intervention but at the same time continue to deliver an effective service. Achieving the ante natal HEAT target will be challenging given that many vulnerable women tend to present late for booking.

<table>
<tr><th colspan="3">EARLY INTERVENTION AND PREVENTING ILL-HEALTH</th></tr>
<tr><th>OUTCOMES</th><th>CHANGE OR DEVELOPMENT REQUIRED</th><th>MEASURES</th></tr>
<tr>
<td rowspan="4">Increase in healthy pregnancies:

• Women access ante natal care as early as possible in their pregnancy early

• Reduction in smoking in pregnancy

• Improve maternity services for vulnerable women

• Abstinence from alcohol, or reduced alcohol consumption during pregnancy</td>
<td>Specific actions for NHSGG&C are outlined in the risk assessment and include actions in relation to:

• Establishing the local governance structure
• Improving data collections and performance information
• Raising public awareness of early booking.
• Engagement with primary care services.
• Whole system workforce engagement.
• Establish a central booking system.

Actions for CHCPs/CHPs include relate to promoting awareness of early booking through local primary care and community planning structures.</td>
<td rowspan="4"><u>Ante natal care HEAT Target</u>
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.

No of smoking quits/quit rate for pregnant women.

Demonstrable improvements in our knowledge of vulnerable pregnant women and in the quality of support and care we can provide for them.

No. of ABIs delivered through maternity services

Breastfeeding targets achieved.

Measures in relation to healthy maternal weight being developed

<u>Scottish Dental Action Plan Targets</u>:
• 60% of 5yr olds will have no obvious dental decay – currently 58.2%, (to be maintained & improved).
• 60% of 11yr olds to have no obvious dental decay. Currently 62.6% (to be</td>
</tr>
<tr><td>Continue to develop the Smokefree Pregnancy Service and measure against agreed KPIs.</td></tr>
<tr><td>Progress the work of the sub group on vulnerable women in pregnancy</td></tr>
<tr><td>Continue acute Alcohol Brief Intervention Programme and through specific pregnancy services, such as SNIPs</td></tr>
</table>

EARLY INTERVENTION AND PREVENTING ILL-HEALTH		
OUTCOMES	**CHANGE OR DEVELOPMENT REQUIRED**	**MEASURES**
Improve maternal and infant nutrition	Implement actions arising from the Maternal and Infant Nutrition Action Plan and, in particular, improving: • Breastfeeding rates • Infant nutrition • Maternal weight	maintained & improved). <u>HEAT Target:</u> • 60% of 3 & 4 yr olds in each SIMD quintile to receive 2 applications of fluoride varnish by Mar 2014 – work in progress to improve. <u>Childsmile:</u> • 20% of nursery popn (that are feeders to the most deprived primary schools), & P1 – P4 children to have 2 applications of fluoride varnish per year. 100% of nurseries and 20% of P1 & 2 in the most deprived schools to participate in tooth brushing programme. To achieve 14,910 completed child healthy weight interventions over the three years ending March 2014. Smoking rates for secondary school children. Measures for injury prevention still to agreed. No./% of children reaching 30 months receive an assessment. No./% of children with revised HPI at the
Continued improvements in dental health	Implement the Oral Health Action Plan in relation to children and young people.	
Reduction in obesity	Implement measures to increase numbers participating in ACES and Active Choices programme (healthy weight support programme);	
Reduce the harm to children caused by smoking	Implement actions from the Tobacco Strategy Reduce children's exposure to second-hand smoke Reduce the number of young people smoking Creation of pathways from acute care to smoking cessation and smokefree homes servifes in the community	
Reduce injuries to children	Implement the injury prevention strategy and reduce numbers of children who incur an avoidable injury.	

EARLY INTERVENTION AND PREVENTING ILL-HEALTH		
OUTCOMES	**CHANGE OR DEVELOPMENT REQUIRED**	**MEASURES**
Improve identification and support to vulnerable children and families.	Fully implement 30 month assessment across all CHCPs/CHPs.	appropriate age. No/% of LAAC who have received a health assessment. No. (200 to 400) first time teenage mothers participating in Family Nurse Partnership. No. of Triple P interventions
	Fully implement revised HPI across all CHCPs/CHPs.	
	Fully implement the Health Support Team model once this has been piloted.	
	Ensure requirements of CEL 16 (2009) are implemented to ensure that all looked after children receive a physical and mental health assessment.	
	Implement the Family Nurse Partnership programme and use learning from programme to shape future service delivery. • First cohort in Glasgow City, West Dunbartonshire and East Dunbartonshire. • Second cohort in Inverclyde, Renfrewshire and East Renfrewshire.	
	Implementation of the parenting education programme using Triple P.	

SHIFTING THE BALANCE OF CARE

Overall Position and Issues

- **Improving community based services for children and young people who experience mental health problems**: Between 2000 and 2009 in NHSGG&C 290 young people (aged 0 to 24) committed suicide per 100,000 people. The Director of Public health's report emphasised the wide range of actions outwith the specialist and clinical settings which should be taken forward to reduce the incidence of poor mental health in children and young people. Examples, given were working with education services to develop whole school approaches to promoting resilience and well being of pupils, training staff on suicide prevention techniques and using social media and other methods to reduce stigma and discrimination against people with mental health problems. One of the main challenges with this approach is that we will rely on strong partnership working with our 6 local authorities and third sector organisations to achieve these aspirations.

- **Enable more paediatric services to be delivered from community/locality settings**: The data shows us that there are high and rising numbers of outpatient referrals, high and rising A&E rates and high DNA rates. Delivering more paediatric services in primary and community care will, therefore become increasingly a major focus of the joint work between Women and Children's Directorate and partnerships as we work towards the completion of the New Children's Hospital. Challenges will be the capacity of primary and community care to support this shift, the availability of suitable accommodation and the willingness of parents to use services locally rather than attend hospital.

- **Improving care pathways**: Scottish Government guidance on the Pathway of Care for Vulnerable Children (0 – 3 years) outlines a continuum of support from **universal provision** (the **universal pathway**) through to specialist targeted provision to meet the needs of children and families at different ages and stages across the life course. A variety of different services and interventions are required to address the different needs of families and the multiple risk factors that impact on children's outcomes. The aim for services is to support children and families to remain within the universal pathway whenever possible**,** bringing in targeted or specialist provision where appropriate. This will be a major focus of development work as it will be used to define the services we will provide in maternity and in partnerships.

- **Young carers and carers of disabled children:** carers are equal partners in care and are vital in achieving this objective. The government has published a young carers' strategy (**Getting it Right for Young Carers: The Young Carers Strategy for Scotland 2010-201**. The last census identified almost 17,000 young people in Scotland who were providing care. Key issues are how we identify and support young carers.

SHIFTING THE BALANCE OF CARE		
OUTCOMES	**CHANGE OR DEVELOPMENT REQUIRED**	**MEASURES**
Improve mental health of children and young people	Implement actions arising from the work on Mental Health Improvement and Early Intervention for Children and Young People. In particular: • Create communication and engagement strategy • Provide multi-agency investment to create and sustain a network of resilience and early intervention services. • Upgrade staff skills, strengthen policies and protocols in relation to distress, self harm and suicide prevention: • Map the range of services, build professional connections, and promote public understanding of services and how to access them. • Create a GGC-wide forum to draw together on priorities for practice development and staff development.	Reduced demand on CAMHS Tier 3 and 4 services. Reduction in young people committing suicide. Increase in young carers known by services and receiving support. No. of referrals to hospital based paediatric services. No of children accessing paediatric services in community/locality settings
More outpatient paediatric services will be delivered locally	Ensure the effective joint planning for the new children's hospital	

SHIFTING THE BALANCE OF CARE		
OUTCOMES	**CHANGE OR DEVELOPMENT REQUIRED**	**MEASURES**
	Develop locality peadiatric services.	
There are agreed patient pathways across the system, with roles and capacity clearly defined including new ways of working for primary and community care.	Implement the universal and vulnerable care pathways across and within maternity and primary/community services.	
More carers are supported	Ensure arrangements are in place both in partnerships and Women and Children's Directorate to identify and support • Young carers, including those children affected by parental substance misuse • Carers of children with significant health needs and/or disabilities. Ensure use of Carers' Information Strategy funding takes into account the needs of young carers and carers of children with health needs and/or disabilities..	

IMPROVING QUALITY EFFICIENCY AND EFFECTIVENESS

Overall Position and Issues

- Since 2010 all partnerships in NHSGG&C have received child inspection reports and have been responding to the areas which have been identified for improvement. Key areas include: early sharing of information, quality of chronologies, risk assessment, assessment and care planning, access to therapeutic services, recognising and responding to child neglect and self evaluation.

- A Listening to Children and Young People's framework has been developed based on the Participation Standards. This will be used to capture information on the scale and nature of patient engagement across the Board, as we know that significant activity takes place in involving children and young people in discussions about their own care and about wider service change proposals, but we are not able to obtain a comprehensive picture.

- Releasing Time to Care started to be rolled out during 2012 with Children and Families' Teams and will continue over the next few years. Through Releasing Time to Care and the introduction of the new IM&T system we would anticipate that patient facing time should be increased, through changes to the way the workplace is arranged, reducing travel time and reducing time spent by clinical staff on non clinical administration.

- The average longest wait for access to CAMHS is 40 weeks against a Board trajectory target of 33 weeks (May 2012). However, there is a wide variation across partnerships of between 11 and 40 weeks.

- There is good evidence that Getting it Right for Every Child is being embedded in the day to day work of staff and in service change programmes. However, similar to other parts of Scotland, there is a wide variation in the implementation of GIRFEC across the constituent parts of our organisation. The implementation of the GIRFEC elements of the Children's and Young People's Bill will, therefore, present us with challenges. Partly this is to do with the nature of the programme which has been delivered through local arrangements with local authorities and other partners and partly to do with its wide scope. There is a strengthening focus on the rights of the child and the Children and Young People's Bill will introduce a number of measures to ensure that public bodies take account of these rights in the planning and delivery of services.

IMPROVING QUALITY EFFICIENCY AND EFFECTIVENESS		
OUTCOMES	**CHANGE OR DEVELOPMENT REQUIRED**	**MEASURES**
Improve our arrangements for child protection	Implement recommendations from inspections of children's services and ensure action plans are implemented and monitored by both partnerships and acute. • Implement the under 1 year olds' policy. • Developing and implementing a self evaluation framework. • Review the vulnerable pregnancy protocol and implement across NHSGG&C. • Ensure that staff are equipped to identify and respond to neglect. • Implement the child protection training programme 2013-16.	Actions plans to address concerns raised by inspections are implemented. No. of referrals made under the under 1 year olds' policy All children in their pre-school years have an NHS (midwife/health visitor) named person. All children who require multi-agency support have a single child's plan. Length of stay in hospital after birth. Releasing Time To Care • Number of clusters participating. • Increase in direct patient facing time (current estimate of 5% increase) • 100% clinical supervision in place All staff in children and family teams have regular clinical and caseload supervision sessions. Implementation of a new model and core specification for nursing in schools which is evidence based where possible, which meets the health needs of children and young people aged 5–19 years, has a clear focus on vulnerability and neglect, delivered in
Women, children, young people and their families are at the centre of all that we do	Ensure that Getting it Right for Every Child and the National Practice Model are implemented, including those elements related to • Named person, • Lead professional, • Single and Joint assessments • Single child plan, • Promoting effective inter agency working. Implement measures to improve interfaces between midwives, health visitors and GPs,	

IMPROVING QUALITY EFFICIENCY AND EFFECTIVENESS		
OUTCOMES	**CHANGE OR DEVELOPMENT REQUIRED**	**MEASURES**
	especially in relation to sharing information on women and the child during pregnancy and at handover. Maternity care staff are actively supported to deliver person centred care through effective learning and development and supervision processes.	accordance with Quality Strategy aims to ensure the best quality of care is delivered. Evidence that children, young people and families have contributed to care plans Evidence that maternity care is influenced by women's experience and public involvement feedback. Service re-design programmes demonstrate engagement with children, young people and their families. 26 weeks referral to treatment for specialist Child and Adolescent Mental Health Services (CAMHS) services from March 2013, reducing to 18 weeks by December 2014; and 18 weeks referral to treatment for Psychological Therapies from December 2014. Implementation of EMIS Web in line with agreed programme of roll out Satisfaction of young people with transition process taken from patient experience survey.
Increase the time spent by staff in supporting children, young people and their families	Continuing the implementation of Releasing Time to Care and Leading Better Care	
Improve supervision arrangements	Full implementation of clinical and caseload supervision model for health visiting teams	
Improve maternity services	Complete and implement the review of the hub and spoke model in maternity services . Implement the timely discharge process for women who have given birth without complications. Review the findings from the work on the delivery and organisation of post natal care, such as the pilot in Rutherglen Health Centre and pilot a similar approach in Glasgow.	
Improve school health services	Implement the School Health Review	
Children, young people and their families are fully involved in assessments and care	Implement the Listening to Children and Young People Framework.	

IMPROVING QUALITY EFFICIENCY AND EFFECTIVENESS		
OUTCOMES	**CHANGE OR DEVELOPMENT REQUIRED**	**MEASURES**
planning and in influencing service change and re-design.	Patient experience feedback tools and patient and public involvement processes are integral to maternity care service improvement. Maternity care services utilise the Scottish Health Council's 'Good Practice in service user involvement in maternity services'	
Improve transition between children's and adults' services	Complete and implement transition policy	
Improve access to specialist care for children and young people	Deliver faster access to Child and Adolescent Mental Health Services.	
Improve collation, analysis and sharing of information across children's services	Complete development and then implement the EMIS Web patient management system across maternity and children and families' services.	

TACKLING INEQUALITIES

Overall Position and Issues

There are significant health inequalities between communities in the NHSGG&C area:

- Only 13.7% of women in the 15% most deprived neighbourhoods breastfeed their babies at 6 to 8 weeks compared to 22.9% for the Board as a whole.
- 25% of women in the 10% most deprived communities smoke during pregnancy compared to 15.9% for the Board as a whole.
- The percentage of babies who have a low birth weight varies across CHCPs from only 2.8% to 8.1% of live births.
- In 2008 52.2% of children in NHSGG&C were living in families where there was a reliance on out of work benefits/child tax credits. This was significantly higher than the national figure of 46.6%.
- Highest incidences of domestic abuse in Scotland were recorded for West Dunbartonshire and Glasgow City (1,800 and 1,580 per 100,000 population respectively). Renfrewshire and Inverclyde were amongst the ten council areas in Scotland with the highest rates.
- In Glasgow alone there could be up to 20,000 children affected by parental substance misuse.
- Although the gap is reducing children living in the poorest areas have higher levels of tooth decay than those in the least deprived.

NHSGGC&C has delivered a number of programmes in children and families over the past few years aimed at reducing the inequalities gap. Examples include the specialist midwives, SNIPS, Triple P targeted at specific groups (such as prisoners, ethnic minority families and other vulnerable groups), the Healthier Wealthier Children's Programme and training staff in how to ask women if they have experienced domestic abuse (routine sensitive enquiry).

There are a number of issues still to be addressed:

- The inequalities persist and may widen as a result of the economic recession, changes to welfare reform and demographic changes.
- We can only tackle many of the problems in partnership with other agencies in the public, voluntary and private sectors.
- Until the new IM&T systems are in place Board-wide we will not be able to have a comprehensive picture about barriers to access our services as we do not possess comprehensive equalities' data for child and maternal health services.

TACKLING INEQUALITIES		
OUTCOMES	**CHANGE OR DEVELOPMENT REQUIRED**	**MEASURES**
We plan and deliver health services in a way which understands and responds better to the wider social circumstances of children and their families	Implement measures to improve the quality of assessment and care planning for vulnerable children.	Improvements in the quality of assessments and care planning identified as part of the core and local audit programmes. Increase in the number of vulnerable children (as defined in the review) who receive a service from community paediatric services. Increase in number of families identified who are at risk of poverty and referred for financial inclusion advice. No. of young people offered training placements/ modern apprenticeships Improvement in the support for pregnant women by increased disclosure of their experience of gender based violence based on the evidence that there is an increased risk of domestic abuse in pregnancy. Reduction in teenage pregnancies. Provision of secure and intensive
Improve our community paediatric service for vulnerable children	Implement the Community Paediatric Review.	
We make a contribution to reducing child poverty	Implement measures aimed at reducing child and family poverty. Contribute to national targets for raising attainment and employment amongst young adults as a public sector partner.	
We narrow the health inequalities gap through clearly defined programmes of action by our services and in conjunction with our partners.	In conjunction with partners implement programmes that reduce teenage pregnancy Implement inequalities sensitive practice in maternal and child health.	
Improve care for children and young people who require secure and intensive psychiatric care	To ensure planning for this provision is taken forward at a national level with other health boards and the Scottish Government.	

Information on how different groups access and benefit from our services is more routinely available and informs service planning.	Use of data from EMIS system (as it is rollled out over the next 18 months) is analysed and circulated to key managers to inform their service planning. Use of Equality Impact Assessments to shape the re-design and service change programmes.	psychiatric care is developed in Scotland All service re-design and change programmes subject to EQIA.

Disability Planning Framework 2013-16

Introduction

The term disability covers a broad range of conditions including physical impairment, learning disability, acquired brain injury, sensory impairment and autism spectrum disorder. There are many common issues across these groups but also many differences, this presents a challenge to joining up the planning approach to disability.

Within NHSGG&C a specific learning disability forum is now in place which will take forward the strategy for adult learning disability services across the board area. There a range of planning arrangements in place across local authority areas for wider disability groups.

The National Context

The Same as You Evaluation 2012

This is a report which looks at impact of the national review of learning disability from 2000. Key message is that while much has been done to integrate people with a disability in communities, there remains much more to do to achieve the aims set out in the original document.

Strengthen the Commitment

This report aims to ensure that people of all ages have access to expert learning disability nurses and their families and carers get the support and care they need. It also seeks to make best use of learning disability nurses through the entire NHS and Social Care system.

Personalisation and Self Directed Support

The personalisation agenda and Self Directed Support (SDS) are key drivers which will shape future development of care services in Scotland. SDS and personalisation put service users at the centre of their own planning with support from the people who care for them and about them.

HEAT Target for Psychological Therapies

This will ensure that people with disabilities have access to psychological therapies within 18 weeks of referral. This is a particular issue for people with a learning disability.

The Local Context

Adult Support and Protection

There is an ongoing commitment to ensure NHSGG&C staff are appropriately trained and are confident to act as required to protect and support adults with disabilities.

Health Needs Assessment for People with Learning Disabilities

This review of the health of people with learning disabilities across NHSGG&C was carried out in 2010/11 and made 28 recommendations. These recommendations will be carried forward by the learning disability forum.

The LD Strategy

This strategy is in place to establish a clear position on the function and purpose of specialist adult learning disability service and a strong sense of the unique contribution of specialist practitioners in helping people with learning disabilities achieve a good quality of life.

Welfare Reform

Glasgow has a high number of recipients of welfare benefits. This reform will change the assessment process for disability benefits and will potentially have a significant impact in Glasgow.

Outcomes	Change of development required	Measures
Early intervention/prevention		
The recommendations of the Health Needs Assessment are progressed	Implement the recommendations regarding increasing the uptake of screening among people with LD	Increase in screening uptake
People with disability are included in HI activity	HI programmes of activity take account of needs of people with a disability Routine identification of needs of people with a disability and referral to relevant HI services	Evidence of inclusive provision for HI within development plan
CIS funding is used to ensure carers are better supported in their caring role	Work with GPs and other services to identify carers and refer them to local services for support Provide training for carers to increase their confidence in helping the patient to self-manage their care Link with local carer services/advocacy services to support carers in the SDS process	Increase in referrals to carers services Increase in carers assessments Training provided
Shifting the balance of care		
More people with a disability live independently/ less people in hospital or institutional care	Reduce long term beds and shift to a social care model with enhanced support Influence local housing associations to increase the availability of accessible housing	Reduction in use of long term beds/ care home placements Reduction in average no. of days delayed in hospital /discharges of individuals with complex physical disability

Outcomes	Change of development required	Measures
Improving quality and efficiency		
More effective use of specialist services Mainstream services are better able to meet needs of patients with a disability. Patients with a disability have an improved experience of mainstream health services (acute and primary care)	Take forward programme of work set out in the LD strategy to develop clear pathways identifying the roles and contribution of mainstream and specialist services. Train staff in mainstream services to increase their confidence and capacity to work with patients with LD. Acute care staff access the better together programme patient stories; e learning tool and training DVD Development of agreed acute liaison roles within acute care Carers are supported through the acute care journey The LD LES is commissioned and supporting IT screens changes implemented Accessible information for all services Maximise opportunities to improve accommodation and make facilities DDA compliant	 Numbers and types of staff accessing Disability Awareness training. General health liaison service roles developed and implemented Carers steering group established and care pathway developed IT reporting framework Use of local capital funds to improve access for people with a disability
Staff understand their role in relation to adult support and protection	Provide training in adult support and protection to all relevant staff	Numbers and types of staff receiving ASP training Increase in ASP referrals
Better transition from children's to adult services	Improve the transition from children's disability services to adult services	Reduction in numbers of young adults receiving services from children's services
Improved performance information	Develop an effective information system to	Relevant data

	support performance amendment and service improvement	
Tackling inequality		
Gender based violence experienced by people with a disability is better recognised and support provided	Implement the sensitive enquiry protocol for all patients, including those with a disability	GBV referrals
LD among prisoners is better recognised and support provided	Prison health services to diagnose LD among prisoners	Numbers of prisoners identified with LD.
People with a disability are supported to maintain employment and/or engage with employability /financial inclusion services	Services to support patients with a disability to engage with employability/ training/ financial inclusion services	Referrals made and levels of uptake
Services are inclusive for all disabilities	The needs of people with different disabilities (e.g. sensory impairment, physical disability, frailty and LD) are taken into account by mainstream services	EQIA of service change when necessary Evidence of improvements in access to people with range of disabilities

LONG TERM CONDITIONS

INTRODUCTION

Around 2 million people in Scotland have at least one LTC, and one in four adults over 16 reported some form of long term illness, health problem or disability The human costs and the economic burden of long term conditions for health and social care are profound. Sixty per cent of all deaths are attributable to long term conditions and they account for 80% of all GP consultations. People with long term conditions are twice as likely to be admitted to hospital, will stay in hospital disproportionately longer and account for over 60% of hospital bed days used. Most people who need long term residential care have complex needs from multiple long term conditions

1. NATIONAL CONTEXT

2.1 National policy highlights the need to improve prevention, identification and the treatment of long term conditions, and the major contribution this has to reducing inequalities. There is a national commitment to ensuring that patient experience drives change and improvements in care.

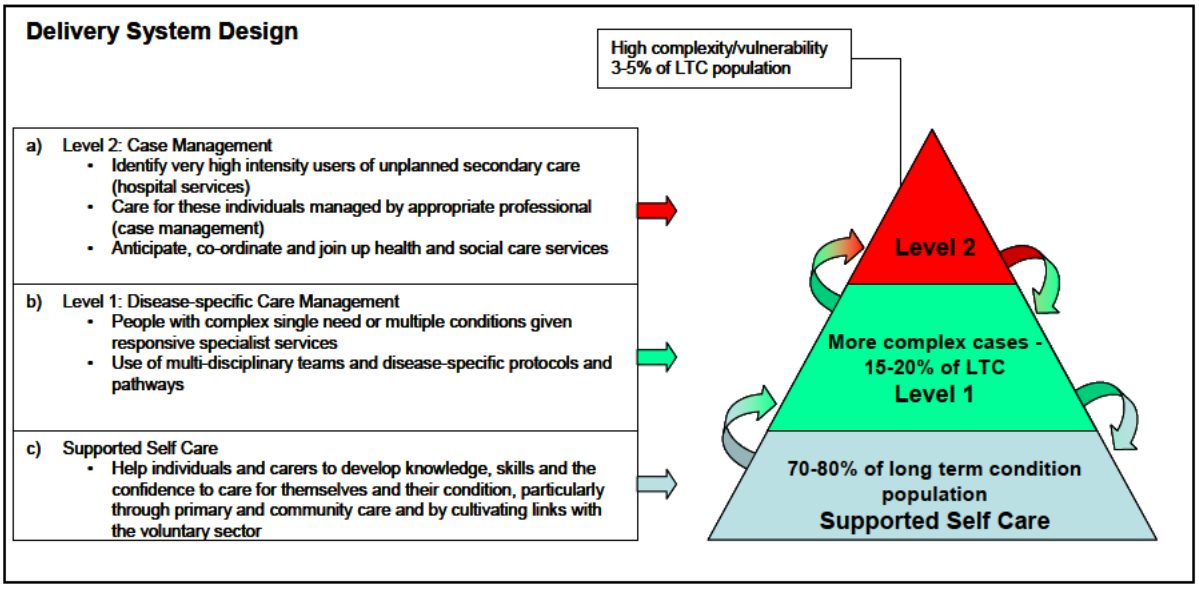
National policy also promotes the continued development of anticipatory care, supported self care and the development of community services to underpin shifting the balance of care. Underpinning this direction is the Quality Strategy, with the three central ambitions that care should be person centred, safe and effective

3 LOCAL CONTEXT AND PROGRESS

3.1 NHSGGC's long term strategic framework for LTCs sets out the direction of travel to 2015, in respect of how we propose to deal with the challenge of responding to the needs of people with LTCs

3.2 The LTC framework provides a model with which to support the stratification of LTC into levels of need, promoting anticipatory care approaches, supported self care and self management and the central role of CH(C)Ps in developing community services and shifting the balance of care. It aims to make integrated care management approaches mainstream and more consistent. It highlights the importance of effective patterns of consultation in primary care for those with one or more LTCs, and the further development and use of tools to identify and support those at highest risk of admission to hospital.

LTCs Model of Care



4. LOCAL CONTEXT, SERVICE AND PERFORMANCE

4.1 The extent to which individuals report the debilitating effect of living with a long term condition and coverage by CHP area is shown in Table 2 below, an extract from the Health & Wellbeing survey of 2011.

Table 2 Adults aged 16 plus

CHCP	Sample	% LTLI
Glasgow City NE sector	811	21.0%
Glasgow City NW sector	913	17.0%
Glasgow City South sector	1074	20.5%
Glasgow City CHCP	*2798*	*19.5%*
East Dunbartonshire	537	17.9%
East Renfrewshire	463	12.3%
Renfrewshire	898	12.0%
Inverclyde	450	23.1%
West Dunbartonshire	584	22.3%
NHSGGC *	6094	18.8%

** includes part of South & North Lanarkshire not shown above (sample sizes not robust)*

4.2 A major challenge facing LTC care is the nature and extent of multimorbidity and the fact that traditionally our health systems are focussed on delivering single disease specific models of care. Around a quarter of people with an LTC have three or more problems. 42% of people with three or more chronic diseases have activity limitation. The number of chronic diseases in people

with LTCs increases with age. In 65-74 age groups the average number of chronic conditions is 1.7. The scale of this challenge is highlighted below in Table 3 which shows the number of individual's with a concurrent diagnosis of up to 5 long term conditions.

Table 3: Concurrent diagnoses within GGC Enhanced Services Programme 2010/11

No of Patients	*CHD*	*Stroke*	*HF*	*Diabetes*	*COPD*	*No of Patients*
5	Δ	Δ	Δ	Δ	Δ	125
4	Δ	Δ	Δ	Δ		380
4	Δ	Δ	Δ		Δ	206
4	Δ	Δ		Δ	Δ	207
4	Δ		Δ	Δ	Δ	263
4		Δ	Δ	Δ	Δ	23
3	Δ	Δ	Δ			920
3	Δ	Δ		Δ		1215
3	Δ	Δ			Δ	763
3	Δ		Δ	Δ		1530
3	Δ		Δ		Δ	900
3	Δ			Δ	Δ	744
3		Δ	Δ	Δ		130
3		Δ	Δ		Δ	110
3		Δ		Δ	Δ	238
2			Δ	Δ	Δ	104
2	Δ	Δ				4150
2	Δ		Δ			4661
2	Δ			Δ		7291
2	Δ				Δ	3942
2		Δ	Δ			535
2		Δ		Δ		2816
2		Δ			Δ	1561
2			Δ	Δ		701
2			Δ		Δ	616
2				Δ	Δ	1707
1	Δ					31325
1		Δ				14758
1			Δ			3041
1				Δ		32992
1					Δ	20232
Total Patients						**138186**

4.3 Progress in last 3 years of the Framework

Progress has been made in improving LTC care, in particular in the areas highlighted below,

- **Systematic Delivery of Best Practice Care** – Protocols and guideline development is well embedded within each specialty area, with a corresponding scrutiny on uptake and application across the system

  There is more work to be done on demonstrating and performance managing adherence to guidelines by measuring the impact on health outcomes for patients.

- **Reducing Demand** – Early supported discharge teams, specialist nurse and AHP support are in now more widely in place place to deliver early discharge and support closer to home or in the community. However delivery of a shift in the balance of care is not yet visible.

- **Primary care**: we have a comprehensive programme of locally enhanced services covering individual diseases.

- **Complex care/anticipatory care** interventions designed to avoid exacerbation/slow disease progression and the need for admission are in place but we do not yet have a comprehensive approach to anticipatory care and discharge planning

- **Supported Self Care** A supported self care framework has been developed. We need to do more to enhance the contribution of voluntary sector organisations to support self management and also represent the views of people with long term conditions and their unpaid carers

- **Psychological Support for people with LTCs** Overall, around 30% of people with LTCs experience poor mental health, compared with only 9% of other adults; We need to do more to engage with patients around psychological support and respond to what they are telling us they need.

5. LTC FRAMEWORK IN SUPPORT OF NHSGG&C CORPORATE PRIORITIES

5.1 Early Intervention , Preventing Ill-Health; and Anticipatory Care

- Developing preventative approaches is critical to the future sustainability of health and social care system. The need for early intervention and prevention of ill health is a major driver for NHSGG&C. and critical to reducing the demands placed on health care resources. Over the next three years we need to deliver an increase in prevention and early intervention. We will promote an integrated spectrum of prevention activities woven

throughout all clinical care and encourage prioritisation of activities which offer the strongest evidence of effectiveness.

Better knowledge of and awareness of their long term condition helps people understand their symptoms and experiences and helps improve their long term health and wellbeing. The role of the care professional is to encourage self confidence and the capacity for self management and to support people to have more control of their conditions and their lives and promote their efforts to enhance their health and wellbeing. This means having a shared approach to setting goals and problem solving, and signposting people to the type of support and information they need. A supported self management framework has been developed to facilitate the systematic implementation of this approach. A supported self management action plan is core to MCN business and includes a disease specific, tailored approach to the framework. The existing emphasis on promoting and maintaining good health sits alongside the need for wider programmes around healthy weight, alcohol, tobacco use at a population level. Lifestyle factors are placing a huge and increasing burden on NHSGGC. Investing in effective measures to improve lifestyle and even modest improvements in lifestyle (particularly smoking) are likely to yield savings in resources for NHSGGC.

The NSGGC Anticipatory Care Planning Group is developing a framework to guide the planning and prioritisation of the different elements of preventive healthcare.

The framework is based on three principles:

- Focus on the factors that make the biggest contribution to our total burden of disease and to inequalities in health.
- Promote an integrated spectrum of prevention activities woven throughout all clinical care.
- Encourage prioritisation of activities which offer the strongest evidence of effectiveness.

EARLY INTERVENTION AND PREVENTING ILL HEALTH/ ANTICIPATORY CARE		
Outcomes	**Change/Development Required**	**Measures**
Individuals will have a clearer understanding about their condition and their role in managing it with a resulting increased capacity to look after themselves.	The supported self care framework will be systematically applied within each LTC Each MCN will develop a programme to further develop and support the key components of the SSC framework – education and support, access to health and wellbeing services, voluntary sector	No of LTC patients participating in LTC LES

	support , support for carers Existing LES's will be reviewed and an LTC LES will be developed based on common risk factors in order to improved the management of co-morbidities and co-ordination of care for those with more than one condition As part of the LES review, each MCN will support the identification of the evidence for effective interventions at primary, secondary and tertiary level and influence any necessary change in practice as a result	
Care will be needs led and person centred	A screening programme to routinely identify LTC patients at risk of admission will be implemented in each CHP We will develop programmes to allow us to intervene earlier for more patients An integrated care management programme will be applied to avoid deterioration and the need for hospital stay Existing pathways and protocols will be reviewed to ensure that there are clearly defined stages and measures delineated at appropriate stages in the pathway to help people avoid complications or slow down the progression of their condition. Through application of the Supported self care framework, individuals will be provided with the rights skills, knowledge and understanding of their condition to recognise and better cope with a flare-up or exacerbation "Engagement" lesson/best practices learned from "Keep Well" will be shared and taken forward into the CDM./ LTC programmes	Monthly 'Sparra' (or similar risk identification tool) lists of patients at high risk to admission will be reviewed at CHP level and appropriate action identified Increase in number of individuals with a care management plan

5.2 Shifting the Balance of Care

Delivery of the LTC Framework is based upon systematic, planned and coordinated care across sectors where delivery of care is person centred and based around the needs of the individual. Our aim is to identify how we deliver more care for people with long term conditions outwith the acute settings and by so doing, reduce the need for admission and ensure early discharge.

A key challenge continues to be the integration of our services to ensure a seamless transition from primary to secondary care to facilitate a more holistic approach to the management of LTC care by all partners. Communication with the range of stakeholders is critical to informing the improvement of this process, including the need to forge effective relationships with 3rd Sector organisations

We need to implement an integrated system of care across primary care, hospitals, social work, community and voluntary sectors, facilitated by information systems that support sharing of data;

For those with particularly complex needs who require a more intensive level of care, or 'care management', a co-ordinated and proactive approach will contribute to improved quality of care for the individual with the potential to lead to a reduction in hospital admission. Our LTC aim is to maximise flexible and responsive care at home incorporating support for carers.

SHIFTING THE BALANCE OF CARE		
Outcomes	**Change/Development Required**	**Measures**
Improved access to care and treatment through changes in the location of services	Maximise flexible and responsive care at home, with support for carers	A reduction in acute bed days consumed by each LTC
Improved experience for individuals and carers who want to remain at home	LTC pathways will be systematically reviewed to identify the most appropriate care setting and care provider	
	Earlier identification of individuals who might benefit from interventions to sustain independence and avoid or delay deterioration or exacerbation of illness	
	Extension of the scope of services	Increase in 'specialist'

	provided by non medical practitioners outside the acute hospital setting	interactions in community previously delivered only in acute setting
	Increase care planning to increase anticipatory care and reduce the number of falls and health crises at home	Increase in number of iIndiviudalised care plans
	Continue to explore the potential for Telecare to positively impact both on maintaining health for the individual together with positive effect on healthcare resources	Increase in number of individuals able to interact with their healthcare provider via remote monitoring of their health symptoms and aspects of daily living
	Development of support programmes aimed specifically at unpaid carers so that the role of the carer is identified and supported	Each LTC will have a carer's framework incorporating key disease facts and information to be tailored to individual in conjunction with supported self management needs

5.3 Reshaping Care for Older People

Our population is ageing. Over 50's are predicted to increase from 30% to 38% of

population between 2008 and 2033. Dependency ratio's will increase to 2040. These are predicted to vary from 44% in Glasgow City to 91% in East Dunbartonshire. Older singer person households are predicted to rise and will account for 54% of households by 2031. Long term conditions become more common with age. Drivers of demand for our older population are chronic disease and frailty (including cognitive impairment) and projected significant growth in the numbers of people with dementia – (estimated 25% increase per decade). By the age of 65, nearly two-thirds of people will have developed a long term condition. Older people are also more likely to have more than one long term condition: 27% of people aged 75-84 have two or more such conditions. Older people are most at risk of fragmented care and are often in touch with multiple services – GPs, community health services, mental health services, social care, housing.

There is also significant variation in life expectancy and healthy ageing, as demonstrated in the table below . We need to ensure that effective management of ltcs is an intergral part of the way we plan and care for older people

The systematic delivery of an integrated care management approach is the LTC model of care response to the complex care needs of the frail and elderly

Healthy Life Expectancy (female)

	Life Expectancy	**Health Life Expectancy**	**Expected period 'not healthy'**
East Renfrewshire	**80.9**	**73.9**	**7.0**
East Dunbartonshire	**80.2**	**72.9**	**7.3**
Inverclyde	**77.5**	**68.7**	**8.8**
East Glasgow	**75.5**	**61.5**	**14.0**
North Glasgow	**74.7**	**61.6**	**13.1**

Reshaping Care for Older People		
Outcomes	**Change/Development Required**	**Measures**
A systematic and integrated multi-agency care management approach is in place across CHPs Improved experience for individuals and carers	We will implement proactive integrated care management Systematic delivery of anticipatory care planning - with care packages that can respond quickly to changing circumstances	Increase in number of iIndiviudalised and integrated care plans in place
	Rapid and easy access to community services	
	Increase care planning to increase anticipatory care and reduce the number of falls and health crises at home	

5.4 Improving Quality Efficiency and Effectiveness;

There are major challenges in delivering improved quality efficiency and effectiveness. In order to deliver the most effective and efficient care we need to ensure systems of care reflect multimorbidity as the norm and move away from single disease specific focus. This is a major driver in the shift to shape services and support around the needs and wishes of the patient. Services are currently organised around single disease pathways. Increasingly patients present with multiple morbidities and problems that do not fit a single pathway. Patients are frequently attending multiple appointments and services in hospital and community with care often provided in a fragmented manner. Care and setting for care, acute hospital or community, should be based around patient need not only what suits the service. Achieving the LTC priorities highlighted in the preceding sections will enable the more effective use of resources and support the addressing of demand pressures.

IMPROVING QUALITY, EFFICIENCY AND EFFECTIVENESS		
Outcomes	**Change/Development Required**	**Measures**
LTC pathways and care delivery systems redesigned to reflect the need for a comorbid as opposed to single disease specific approach to better meet the needs of the patient	We will deliver our LTC LES programme based on best value principles and maximum health outcome A streamlined comorbidity LTC LES will be developed and delivered in primary care with a frequency determined by the identification of an individual's risk factors We will identify the evidence for effective interventions as part of the LES delivery review Use the LES data for effectiveness enquiry and to assess compliance with disease specific pathways Secondary care LTC systems and processes will reflect revised primary care LES arrangements	Reduction in number of patient visits required for LES review – in primary care Key disease specific pathway indicators will be routinely reported to the MCNs on quarterly basis to facilitate dialogue with primary care and identify need for targeted approaches where outcomes are not optimal

	Follow-up appointments to secondary care clinics will be based on need Patients will be supported to better manage their own medicines, whether in the community or in hospital Community Care Team (PPSU) will collaborate with CHCPs to support achievement and measurement of these outcomes and changes	Reduction in primary and secondary care review appointments All pharmacies will deliver CMS – 50% patients ***** receiving CMS 80% of practices participating in electronic repeat prescription transfer No of people with >6 medicines receiving medication reviews and polypharmacy reconciliation (*****Estimate based on historical trends - subject to national financial negotiations)
Individuals feel more supported to deal with the psychological impact of dealing with a LTC	We will produce guidance and resources to support the adoption of models and approaches which offer a range of emotional and psychological support to people living with a long term condition at different stages of their condition	Reduction in no of patients referred to GP for depression/anxiety via the LES
We will reduce hospital admissions and bed days of patients with primary diagnosis of COPD, Asthma, Diabetes and CHD	There will be clear pathways between primary, acute and social care There will be services, systems and processes in place to allow rapid response and re-entry to secondary care from the primary care pathway in case of need A comprehensive review programme will be developed for	Target 2% reduction each year of Framework. Continued referral to pulmonary rehabilitation with record of completion rates for the programme - Referrals, availability, location (COPD). Proportion of COPD admissions followed up by the Early Supported

	each LTC disease specialty to focus on hospital admission, discharge and bed day usage	Discharge Service. Increase in Provision of Inhaler Technique advice/information (Asthma). Cardiac Rehab - Reduction in the percentage of patients referred for but decline or fail to complete the full cardiac rehab program. . Community Heart Failure Clinical Nurse Specialist service - A rise in the percentage of newly diagnosed stable heart failure patients signing up for and completing the new community based structured education program Reduction in admissions with Ketoacidosis and Hypoglycaemia e.g. acute diabetic emergencies a minimum of 75% of patients with diabetes have a foot risk score 90% active foot ulcers to be reviewed at multi-disciplinary clinics (Diabetes) A % increase in attendance at structured patient education in each CHCP area (Diabetes and Pulmonary Rehab)

5.5 Tackling Inequalities

Determinants of health. The impact of health inequalities on LTCs closely follows the pattern of the effects on general health. There are stark differences in health and health outcomes across different social groups, which challenge the way we organise our services to close the health gap with significant differences in healthy lfe expectancy. Higher prevalence rates for coronary heart disease, stroke, diabetes and COPD are recorded in areas of deprivation than in more affluent areas. In 2005,

it was recorded that those living in the most deprived parts of Greater Glasgow (Deprivation Category 6/7) were almost twice as likely to report that they have a long-term limiting illness (26%) than those living in the least deprived parts (DEPCAT1/ 2: 14%).

Poverty and vulnerability continue to be significant drivers of ill health and the way people access services in GG&C. 35.5% of our population live in the most deprived quintile. This may rise with the recession and welfare changes. The onset of multi-morbidity occurs 10-15 years earlier in people living in the most deprived areas compared with the least deprived areas.

Ethnicity also has a direct effect on health inequalities. The incidence of Type 2 Diabetes has been shown to be as high as 8% in South Asian population of Glasgow compared to 3% in the indigenous population. This figure rises to as high as 40% in the South Asian 70+ age group**.** Over the next three years we need to identify action to ensure that tackle these inequalities.

TACKLING INEQUALITIES		
Outcomes	**Change/Development Required**	**Measures**
We will narrow the health inequalities gap through a clearly defined programme of action agreed by each MCN	We will ensure that the consideration of inequality impacts are embedded in all appropriate workstreams	Increase in attendance of patients from the BMW community
	The design of tailored and targetted interventions aimed at specific groups known to be difficult to engage/hard to reach Identify populations at risk of unmet need.	Reduction in number of young males failing to attend follow up appointments Increased access for asylum seeker community
	Identify and address key failure points in the pathway of care which mitigate against vulnerable individuals accessing healthcare	Reduction in DNA rate
	Each MCN will support and be advocates for an increased knowledge and understanding of the inequalities and discrimination facing our population by collecting and using available data and research We will work towards routinely collecting and scrutinising data reflecting inequlaties and unmet need, establishing new data systems where necessary	Development of a standardised Inequality sensitive practice report which is routinely collected within each MCN

	Each MCN will incorporate into pathways where appropriate opportunities for referral for financial/welfare advice and support the spread of awareness of inclusion services in clinical practicel	Increase in number of financial/welfare advice referrals

6. WORKFORCE & RESOURCE IMPLICATIONS

There are a range of challenges facing our workforce which largely mirror our LTC challenges. We have an ageing workforce which impacts on a range of professions in both acute and community, as well as on carers.

There are recruitment challenges with some hard to recruit professions.

Access to medical care is rapidly a 24/7 requirement and medical workforce increasingly required for 24 hour cover.

There are reductions in junior staffing with increasing need for senor staff/senior doctors hours to provide 24/7 care – this is challenging for current service models.

We need to support our workforce to meet future changes and balance specialist and generalist; acute and community workforce teams.

Workforce re- modelling is increasingly necessary to define the changing roles required to meet both the resource demands on the service, and the challenge arising from a new LTC polyclinic approach.

Detailed work is required to define the specialist and subspecialist input required.

FINANCE IMPLICATIONS

Ageing population; rise in emergency admissions and growth in chronic disease attendances and admissions with resultant rise in prescribing costs are various drivers highlighted within this LTC planning framework that contribute to an increased demand on resource allocation and demand a multi-faceted response.

The MCN financial framework has been developed identifying a range of potential areas worthy of further exploration to identify ways of maximising service efficiency and productivity. This programme will be developed further within each MCN.

A programme budgeting and marginal analysis approach has also been developed to provide a basis to scrutinise LTC spend in different sectors. This has not significantly progressed due to difficulty in accessing GP LTC base data. The new

data sharing agreement with primary care which is currently being concluded will support and enable ramping up this work allowing progress to be made.

Patient Experience

There is a strong commitment within LTC and MCN programmes to seek patient views on current and proposed service developments. We will continue to try and improve communication and shared decision making in order to support good patient care.

OLDER PEOPLE'S PLANNING FRAMEWORK 2013-16

1. NATIONAL CONTEXT AND TARGETS

1.1 Reshaping Care for Older People is a major national priority for the NHS and partner agencies. The key national drivers to this programme are:

- **Reshaping Care for Older People: A Programme For Change 2011 – 2021;**
- Allocation of the **Change Fund;**
- Consultation on **integration of adult health and social care services**, the outcome of which should be known later this year**.**

1.2 This framework requires to deliver the following HEAT targets:

- 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. (**NHSGGC target 5,630 by March 2015**);
- 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. (**NHSGGC target 0 by April 2013**)

2. NHSGGC CONTEXT

2.1 A review of progress against previous planning framework outcomes indicates that the following require further action over the course of this planning cycle:

- development of effective approaches to early intervention and anticipatory care including with other partners to ensure older people who need support have their needs identified as early as possible and that appropriate multi speciality and agency arrangements are in place;
- further development of community capacity and support to carers, clearly linked to delivery of outcomes;
- a shift in the balance of care so that people are cared for in settings appropriate to their needs;
- actions to meet targets for discharging patients from hospital as soon as they are clinically ready;
- implementation of the national dementia strategy; and,
- further development of effective end of life care.

OLDER PEOPLE'S PLANNING FRAMEWORK 2013-16
OUTCOMES AND ACTIONS
Preventing ill-health and early intervention

Preventing ill health and early intervention are vital if we are to reshape older people's services and support more people to live independent lives in community settings, including those with dementia. Prevention and early intervention are also crucial in improving the health of older people, tackling inequalities and reducing demand. A key focus for us over the next three year planning cycle will be to put in place programmes to support active ageing and older people staying healthy, more anticipatory care plans.

OUTCOMES	CHANGE / DEVELOPMENT REQUIRED	PERFORMANCE MEASURES
1) Effective joint plans with other partners, including housing and the third sector to prevent ill health amongst older people.	- Develop local programmes to support active ageing, with a focus on preventing depression, anxiety, social isolation, and promoting positive physical and mental health and well being, including actions on smoking, alcohol and obesity as well as health impacts of poverty and welfare reform. - Take forward actions from the Community Food, Fluids and Nutritional Care group to implement nutritional screening and intervention. - Review local falls prevention programme in light of national recommendations.	- Number of older people participating in active ageing programmes, including carers - Completion of MUST and related care pathways within community settings - Levels of participation in physical activity/falls prevention programmes - Rates of 65+ conveyed to A&E with principal diagnosis of a fall (SAS data)
2) Promote early intervention by improving identification of, and response, to vulnerable older people, particularly those at risk of admission to hospital.	- Maximise use of SPARRA amongst GP practices to support early intervention approaches and assist in managing demand - Introduce GP practice based registers of vulnerable older people utilising QOF/QP data on COPD, falls and SPARRA.	- Reduced rate of emergency inpatient bed days for over 75s - Number of people with anticipatory care plans. - Evidence of carers needs included in anticipatory care plans

OUTCOMES	CHANGE / DEVELOPMENT REQUIRED	PERFORMANCE MEASURES
	- Ensure anticipatory care plans are in place for those at risk of admission to hospital. - Introduce anticipatory prescribing to enhance patient care and aid the prevention of unnecessary crises and unscheduled hospital admissions. - Ensure carers needs and support are an integral part of anticipatory care planning. - Investigate ways to secure more integrated working between GP practices, community health services, social work services and third sector organisations	

Shifting the balance of care

We need to shift the balance of care if we are to support more people to live in community settings, and to respond to the demographic changes. Progress will be needed over the course of this three year planning cycle to change key pathways of care, and deliver services closer to where people live, if we are to make a significant shift in the balance of care by 2016.

OUTCOMES	CHANGE / DEVELOPMENT REQUIRED	PERFORMANCE MEASURES
3) Ensure patients, including people with dementia, are cared for in appropriate settings, and able to stay in their own homes, including care homes, as long as possible.	- Implement local provision of specialist medical assessment where appropriate. - Deliver Board-wide specification on support to care homes. - Take action with Acute and Social Work to improve and maintain the efficient	- Reduction in number of acute bed days lost to delayed discharge (inc AWIs) – 65+ - Emergency admissions 75+ Rate /1,000 pop - Delayed Discharges: zero delays longer than 4 weeks by April 2013 and zero

OUTCOMES	CHANGE / DEVELOPMENT REQUIRED	PERFORMANCE MEASURES
	management of discharge planning. - Take action via locality unscheduled care groups to analyse patterns of admission and design appropriate effective interventions. - Assess need for intermediate care to inform commissioning plans and identify issues requiring consistent Board-wide approach. - Reach agreement with SAS and GEMS on actions to improve OOH response including District Nursing. - Implement actions from polypharmacy strategy and associated guidelines.	delays longer than 2 weeks by April 2015
4) More carers are supported to continue in their caring role.	- Put in place arrangements with GPs to identify and support carers in primary care settings - Assess the implications and unpaid care requirements of reshaping care for older people plans - Assess how carers will be identified and supported - Align Change Fund carers support with Carers Information Strategy implementation plans	- Number of carers recorded on GP registers
5) Increase the number of people dying in the	- Implement recognised tools or triggers for	- % of time in last 6 months of life spent at

OUTCOMES	CHANGE / DEVELOPMENT REQUIRED	PERFORMANCE MEASURES
place of their choosing.	palliative and end of life care needs. - Implement processes for assessment and review of patients with palliative care and end of life care needs using recognised tools. - Ensure that timely, holistic and effective care planning takes place at appropriate stages of the patient journey.	home or in community setting (national guidance to be issued) - Number of advanced care plans.

Reshaping Care for Older People

Reshaping care is a key strategic priority for NHS GG&C and our partners, and a national priority. Reshaping the way we delivery care for older people is important if we are the meet the demographic and resource challenges set out in the Corporate Plan. Over the course of this three year planning cycle fundamental changes are planned that will be taken forward in partnership to radically change how we respond to the needs of older people, including those with dementia. These will be articulated in Joint Strategic Commissioning Plans that set out a ten year strategy to change the way we support older people.

OUTCOMES	CHANGE / DEVELOPMENT REQUIRED	PERFORMANCE MEASURES
6) Clearly defined models of care and patient pathways that meet the needs of people with dementia, including increased levels of post diagnosis support.	- Establish specialist liaison services with adult mental health and OPMH - Improve liaison arrangements between GPs, psychiatrists, nurses, community pharmacy, care homes, and community services in prescribing and medicines	- Reduction in average length of hospital stay - Number of people diagnosed with dementia on QoF - Number of people with post diagnostic support packages

OUTCOMES	CHANGE / DEVELOPMENT REQUIRED	PERFORMANCE MEASURES
	management. - Encourage GPs to identify dementia at an early stage in the disease process. - Implement protocols for post diagnosis support in conjunction with social work services and the voluntary sector - Prepare local action plan to implement new HEAT target by March 2014.	
7) Improved partnership working to redesign and enhance support to older people to remain at home.	- Develop joint strategic commissioning with partner agencies, including users and cares, that reduce delays and emergency admissions, shifts the balance of care towards early intervention and prevention, including arrangements for integrated multi-agency approach to care. - Use Integrated Resource Framework to inform agreed joint financial and workforce plans to shift balance of care. - Establish effective shared performance management framework that informs service plans.	- One year action plan, three year plan and ten year strategies in place by March 2013 - Shared joint financial framework that shifts balance of care. - Shared performance framework.

<u>Improving Quality, Efficiency and Effectiveness</u>

The NHS Board has a programme in place to improve the quality of care for older people in all care settings. It is a key priority to improve patient's experience of the NHS and the quality and effectiveness of the care we provide. At a time of considerable change in older people people's services it is vital that service quality is maintained and patient's experience of care in NHSGG&C continues to improve.

OUTCOMES	CHANGE / DEVELOPMENT REQUIRED	PERFORMANCE MEASURES
8) Improved experience of care for older people in all care settings.	- Implement single point of contact model. - Take forward the Board's quality improvement programme for older people to improve patients' experience of NHS care - Establish engagement with older people and their carers and use feedback to improve service redesign and delivery - Take forward actions and recommendations arising from National Hospital Inspection reports	- Number of people accessing services via single point of contact model - Evidence of improved patient experience reported annually - regular feedback mechanisms in place and evidence of follow up - Agreed action plans in place following each inspection visit.
9) Modernise District Nursing services to provide a safe, effective and patient centred service.	- Implement actions from the District Nursing service review, including specific actions on agile working, Releasing Time to Care, leading better care, local workforce plans, and DN Out of Hours service.	- improved clinical quality indicators - improved prevention of pressure ulcers - Increased patient facing time - Increased patient activity - Improved staff satisfaction rates - Improved patient experience - Improved efficiencies in stock control and staff travel costs.
10) People with dementia and their carers receive the treatment, care and support that enable them to live as well as possible regardless of setting.	- Raise awareness and understanding of dementia and promote early identification and improved response. - Improve the recognition and management of	- Achievement of Dementia Standard. - Number of patients receiving an annual review.

	dementia across all staff groups in acute care settings. - Review standards of service delivery for people with dementia with the aim of improving quality of care. - Review dementia training for staff, ensuring there is appropriate access to training as per the recommendations in Promoting Excellence (Scottish Government 2011).	

Tackling Inequalities

The challenge to meet inequalities among our older population and protect people from the adverse effects of early ageing and deprivation in particular were outlined in the Director of Public Health's report. Partnerships in developing local plans need to ensure that measures are put in place to mitigate against the potential for widening the health gap among older people, as well as responding to equalities legislation.

OUTCOMES	**CHANGE / DEVELOPMENT REQUIRED**	**PERFORMANCE MEASURES**
11) Plans in place that respond to older people's wider social circumstances.	- EQIA change fund plans and joint commissioning strategies. - Impact of welfare reforms assessed as part of proposals for local service change, including Change Fund plans.	- EQIAs complete - Equalities plans in place - Evidence of plans taking into account impact of welfare reform and deprivation and other factors.

3. FINANCE AND WORKFORCE

Workforce

3.1 Partnership Change Fund plans include a significant number of new NHS posts appointed to support implementation of a range of projects/initiatives across CHP/CHCPs and Acute Services. Workforce plans will need to be in place to manage these changes when Change Fund funding ceases in March 2015, together with other planned changes such as those arising out of the District Nursing review.

Finance

3.2 The estimate of current NHS spend on older people's services in NHS Greater Glasgow and Clyde is approximately £650m. The financial challenge relating to older people's services comprises:

- Achieving year on year efficiency savings.
- Meeting the anticipated growth in demand for primary care, community services in particular District Nursing services, and acute hospital services due to increases in the number of people aged over 75...
- Managing the impact of Change Fund ceasing in March 2015.

3.3 During this three year planning cycle we will make a shift in resources from hospital/institutional care to support community based anticipatory care/early intervention, meet the demographic challenge and enable older people to remain within their own homes or other community settings. The projected reduction in acute hospital bed days lost due to delays in discharges will support Partnerships in implementing this shift in the balance of care. Partnership's joint strategic commissioning plans for reshaping care for older people, to be developed towards the end of 2012, will need to be robust enough to ensure this requirement is capable of being met.

PRIMARY CARE PLANNING FRAMEWORK

1. INTRODUCTION

1.1 The delivery and development of primary care is fundamental to progressing the five strategic priorities identified in the Corporate Plan. It builds on our Greater Glasgow and Clyde Primary Care Strategy established in 2010 which has been driving a range of local work to develop primary care based services and work. In addition, we are working with the Scottish Government to play our full part in shaping changes to the general medical services and other national primary care contracts. Our review of clinical services beyond 2015 (Fit for the Future) looks at developing clinical services across primary, community and acute care, including mental health. This framework will inform this emerging work.

1.2 The Primary Care Planning Framework describes how primary care (general medical services, community pharmacy, optometry and dental services) will develop to respond to the five priorities. It also describes the changes required in primary care to support the delivery of other frameworks eg Long Term Conditions, Older People and Acute Services.

2. NATIONAL CONTEXT

2.1 The Corporate Plan notes that the biggest drivers of demand for primary care services are age and deprivation. Demographic changes are one of the biggest challenges currently facing Scotland. The response to this challenge has been set out in "Reshaping Care: A programme for Change 2011-2021". The aspiration that people will live longer, healthier lives at home will have significant implications for primary care. In 2012, the Scottish Government published an Intermediate Care Framework for Scotland: Maximising Recovery, Promoting Independence. Intermediate care aims to enable individuals to live independent lives with meaning and purpose, within their own community and to avoid dependency on health and social care. Primary care has a key role, with hospital services, Council Social Work and housing services and the voluntary sector in leading the development of intermediate care.

2.2 Other national policy and context which directly impacts on primary care includes:

- Delivering Quality in Primary Care.
- Quality and Outcomes Framework development.
- Plans to develop a Scottish GP contract to focus on patients, strengthen links between hospital and community and improve integration.
- General practice in Scotland: They Way Ahead (February 2010) (progress report March 2012).
- National Oral Health Improvement Strategy for Priority Groups (July 2012).
- Plans to improve patient pathways between General Optometry Services (GOS) and secondary care.

2.3 The Primary Care Framework covers our responses to primary care policy and our response in primary care to other policy areas.

2.4 Primary care services impact both directly and indirectly on the following HEAT targets:

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

- To increase the proportion of people diagnosed and treated in the first stage of breast, colorectal and lung cancer by 25% by 2014/15 (NHSGGC target 20%).

- 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 breastfeeding rates and other important health behaviours.

- Reduce the rate of emergency inpatient bed days for people aged 75 and over per 1000 population by at least 12% between 2009/10 and 2014/15 (5,630 in NHSGGC).

- 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.

2.5 Primary care also has a signposting role in supporting the HEAT targets for smoking cessation and child healthy weight intervention.

3. LOCAL CONTEXT AND PROGRESS

3.1 The existing primary care framework has driven forward a number of changes and development in the last three years, particularly in general medical services. CH(C)Ps have developed locality groups to bring practitioners together to develop local solutions to problems and deliver service improvements. We have also invested in developing primary care premises. New Heath Centres have been opened in Renfrew and Barrhead and a wide programme of improvements of other GP premises has been implemented.

3.2 Targets for achieving cardiovascular health checks have been achieved, and the lessons learned from Keep Well are now being widely applied across Greater Glasgow and Clyde. The OPR process has driven a focus on primary care prescribing which will impact on how resources are managed and used Access to GP services has been a priority for CH(C)Ps and systems to improve and measure access are being implemented across Greater Glasgow and Clyde.

3.3 The Primary Care Deprivation Group, building on the work of the “Deep End” GPs, has brought together a range of professionals, practitioners and patients to address the needs of our most deprived populations. We will use this work to inform our thinking on the Scottish GP contract.

3.4 The QOF process is now beginning to address demand management. We have focused on orthopaedics, geriatrics, gastroenterology and neurology and the disaggregation of referral data in these areas.

3.5 Progress at the interface between primary and secondary care has been slower ,but change fund work and the QOF programme in 2011 and 2012 work have focused attention on the key areas and a number of improvement actions are now progressing.

4. FINANCE AND WORKFORCE

4.1 Most of our expenditure on primary care is set by national contract and our key areas of influence for 2013-16 are:

- Prescribing budgets.
- Local enhanced services.
- Local contract variations eg 17(c) contracts.

Activity in primary care also drives costs throughout the NHS system and our focus on appropriate secondary care referrals and patient pathways will reduce costs in the acute sector.

4.2 We will continue to develop the primary care team, working in localities with community services and, where appropriate, social care and voluntary services.

EARLY INTERVENTION AND PREVENTING ILL HEALTH

Early intervention and preventing ill health in primary care are critical to reducing the demand for acute care. We will focus on anticipatory care (including Keep Well) and chronic disease management in the next three years.

Outcomes	**Change/Development Required**	**Measures**
There will be consistency and a systematic approach to anticipatory care planning across Greater Glasgow and Clyde → The learning from the first phases of Keep Well will be rolled out across GGC	Keep Well to be implemented across the Board area. Learning from Community oriented primary care pilot in Drumchapel to be disseminated Anticipatory care plans to be developed A new approach to enhanced services is developed to support comprehensive chronic disease management	Increasing breastfeeding rates No. of FAST screens and ABIs % 11 year olds with no DMFT % 3-5 year olds registered with a dentist No. of Keep Well checks v target % of people ready to change who are referred Increased use of social prescribing Sustaining/improving levels of immunisation rates Number of carers' assessments Reduced COPD bed days and morbidity
There will be increased identification and a reduction of key risk factors (smoking, obesity, alcohol use) → Primary care practitioners will be aware of key risk factors and onward referral routes	Alcohol Screening and Brief Interventions to be promoted in primary care CHPs to maximise existing effort and resource to reduce the COPD burden	
Disadvantaged groups will be enabled to use services in a way which reflects their needs → Health improvement for vulnerable groups will be prioritised	The work and findings of the deprivation group will inform practice in primary care and will influence practice in other services A range of early interventions (including oral health) for priority groups will be progressed Routine systems established to identify carers in primary care and refer on for assessment	

SHIFTING THE BALANCE OF CARE

Primary Care has a key role to play in supporting the shift in the balance of care. We will use the opportunities offered by the proposed health and social care integration, joint service planning and by ongoing service review and redesigns to ensure that people are cared for in a setting appropriate for their needs.

Outcomes	**Change/Development Required**	**Measures**
The interface between acute and primary care is much better, with the acute sector only dealing with acute issues → Clear referral pathways into secondary care will be established → Patient pathways will be streamlined → Better understanding of variations in primary care referral behaviour → Diagnostics pathways will be improved for patients	Jointly agreed implementation plan to be developed to transfer radiology services to secondary care Referral guidance for high volume conditions will be developed and implemented Explore direct referral from primary care to endoscopy Establish clarity around access to CT scans Secondary care onward referrals are not returned to primary care Key areas identified through the QOF process will be targeted (orthopaedics, gastroenterology and neurology) by ensuring only electronic referrals, using demand profiles and QOF reports and developing/improving referral guidelines Explore opportunities for direct access to a wider range of diagnostic services	Rollout of Liverpool Care Pathway LARC provision Development of locality level indicators Implement planned new referral guidance across all NHSGGC

Outcomes	Change/Development Required	Measures
Care will be provided in the most appropriate place by the most appropriate professional → Service redesigns will focus on workforce and interface issues → People are supported to stay at home in their own community for as long as possible → Non urgent/avoidable use of emergency care services will be minimised	Audit/review if better access to emergency outpatient appointments could reduce admissions ATOS work will be developed into a comprehensive plan to reduce A&E attendances. A&E staff will be supported to work with vulnerable frequent attenders. Optometry/2^{o} interface improved Develop indicators of demand and activity in primary care to model the impact of service change	
There are agreed patient pathways across the system with roles and responsibilities clearly defined including new ways of working for primary and community care	Locality groups to continue to develop and provide evidence of added value Primary Care team toolkit to be tested in localities Develop a plan to match practice lists with geographical localities. Development of Scottish contract to address current limitations re vulnerable children and adults with complex needs	
More people are able to die at home or in their preferred place of care	CHPs to demonstrate through use of SPAR and LCP that more people can end their life at home	

RE-SHAPING CARE FOR OLDER PEOPLE

Primary Care is an important part of the complex system of care required for our growing older population. We will use the Change Fund and our work with Social Work departments to reduce dependency on hospital care for older people.

Outcomes	**Change/Development Required**	**Measures**
Older people will have their health and social care needs met in an integrated way → Older people will only receive secondary care services when they have a need for Acute care	Demonstrate the involvement of GPs and other primary care practitioners in Change Fund plan actions/improvements to services Develop plans to provide consistent GP support to care homes Review and enhance Out of Hours access to Community Services	Change Fund KPIs
Older people have improved experience of care in all our services	CHPs to develop improvement plans to address older people's experience of services	

IMPROVING QUALITY, EFFICIENCY AND EFFECTIVENESS

Improved access to primary care services and better communication and information sharing between primary care and other services are our priorities to improve quality, efficiency and effectiveness.

Outcomes	**Change/Development Required**	**Measures**
We can demonstrate that patients have improved access to general medical services	Robust access measures and reporting arrangements to be established in all CH(C)Ps	Evidence that advance booking and 48 hour access is available Accommodation/premises strategy deliver planned improvements Evidence of use of patient feedback at practice level and through other routes such as PPF, Locality Groups, Patient Opinion GP prescribing budgets and cost/population
Patients are engaged in developing primary care services	We have better understanding of patient experience in primary care, linking practice patient groups with local PPFs. Patients have influence in changing primary care services Independent contractors are fully involved in quality programmes Patient information/leaflets for endoscopy and knees to be reviewed	
Better communication and information sharing to improve patient care	Roll out of SPSP in primary care. Improved information flows between primary and secondary care, including information sharing.	
We make the best use of available resources	Primary care prescribing budgets are met and measures are put in place to reduce non-formulary prescribing in secondary care affecting primary care. Chronic Medication Service (CMS) is rolled out	

Outcomes	**Change/Development Required**	**Measures**
	Each CH(C)P to develop an accommodation strategy for primary care services. Strategies should address sustainability and environmental concerns	

TACKLING INEQUALITIES

Our primary care practitioners are well placed to identify and respond to the inequalities faced by patients. Recent work by the Deprivation Group has resulted in a series of proposals for primary care and other services to narrow the inequalities gap caused by deprivation.

Outcomes	**Change/Development Required**	**Measures**
We plan and deliver health services in a way which understands and responds better to individuals' wider social circumstances → Employment, financial inclusion and literacy pathways will be clear to primary care practitioners	Information sharing policies developed to respond to the gaps identified by the Deprivation Group Improve communication between GPs and Social Work Agree an approach for primary care practitioners to respond to Gender Based Violence Develop clear pathways for primary care practitioners into literacy, employment and financial inclusion services	Fluoride varnishing rate No. of Keep Well checks by SIMD DNA rates/SIMD Number of referrals into literacy, employment and financial inclusion services
We narrow the health inequalities gap through clearly defined programmes of action by our services → Improved concordance with treatment protocols as a result of communication needs being met	Keep Well targeting Reduce the inequalities gap in DNAs Childsmile programmes to be consistently supported. Further develop the GP Docman system to audit the outcomes of DNA letters sent to patients	

SEXUAL HEALTH AND BLOOD BORNE VIRUS PLANNING FRAMEWORK 2013-16

1. NATIONAL CONTEXT

1.1 In August 2011 the Scottish Government issued the new Sexual Health and Blood Borne Virus Framework 2011-1015. The new national framework places emphasis on blood borne virus prevention and treatment and the inter-relationship between sexual health, BBV and addictions issues.

The strategic objectives of the national plans and policies continue to be to: promote positive sexual wellbeing; to reduce adverse consequences of sexual activity; to prevent new STIs and blood-borne virus infections and to ensure effective service delivery.

1.2 The National Framework outcomes are;

- Fewer newly acquired blood borne virus and sexually transmitted infections: fewer unintended pregnancies
- A reduction in the health inequalities gap in sexual health and blood borne viruses
- People affected by blood borne viruses lead longer, healthier lives
- Sexual relationships are free from coercion and harm
- A society where the attitudes of individuals, the public, professionals and the media in Scotland towards sexual health and blood borne viruses are positive, non-stigmatising and supportive.

1.3 The Framework also takes account of national documents in relation to HIV and BBV:

1. Healthcare Improvement Scotland published a set of standards for HIV Services in July 2011. These standards aim to improve the quality and co-ordination of HIV Care for HIV infected individuals and those at high risk of acquiring infection.
2. The Quality Indicators for Hepatitis C Services (Healthcare Improvement Scotland, April 2012) specify a minimum set of high-level measures for hepatitis C services in Scotland. These indicators cover aspects of prevention, testing and assessment, treatment and support, and service organisation.
3. CEL 29 (2012) entitled Managed Clinical Networks: Supporting and Delivering the Healthcare Quality Strategy which reiterated the Government's commitment to the role of MCN's
4. NICE Guidelines on Management of Chronic Hepatitis B Infection (currently in draft and expected to be issued in April 2013)

2. NHSGGC PLANNING CONTEXT

2.1 The local context for the development sexual health and BBV services includes:

- A review of terminations to support equitable access across NHSGG&C
- Developing primary care responses to achieve a shift in the balance of routine sexual health care from Sandyford specialist services to primary care
- Carrying out and implementing a comprehensive review of Sandyford services
- Responding locally to the focus in the national framework on
  - The linkages between sexual health and parenting programmes
  - The role of addictions services in promoting better sexual health and addressing BBVs
  - The need for sensitive enquiry and work to address gender based violence

2.2 The responsibility for achieving the objectives set out in this framework is shared across the NHS system. This framework therefore includes activity where

- Sandyford specialist health services have prime responsibility (Sandyford Central and Hubs)
- Acute hospital services have direct responsibility or a key role in supporting sexual health, BBV services
- CHPs/CHCPs have direct responsibility (through the activity carried out by their staff e.g. health improvement and staff training)
- CHPs/CHCPs do not have direct control but are expected to exert influence (through working in partnership with primary care, local authorities and other community planning partners)
- Areas of work that depend on all parts of the system fulfilling their responsibilities.

2.3 Prisoners tend to come from populations that are at increased risk of sexual ill-health and blood-borne viruses. The transfer of prison healthcare to NHSGG&C will present a significant challenge for the delivery of sexual health and blood-borne virus services. There should however be opportunities for better coordination of patient care (e.g. transfer of patient data) between prisons and other parts of NHSGG&C system, with better outcomes for prisoners' health

2.4 This planning framework takes account of the revised NHSGG&C policy frameworks, particularly in relation to health improvement and tacking inequalities.

2.5 The responsibility for reviewing and updating this Planning Framework lies with the Lead Director (Director of Corporate Policy and Planning), supported by a Lead Planner (Head of Planning and Performance, North West Sector) and the Public Health lead for Blood-Borne Viruses (Clinical Director, Public Health Protection Unit), subject to approval by the NHSGG&C Sexual Health Planning and Implementation Group which comprises representatives of key stakeholders.

Sexual Health and BBV

Outcomes	Change of development required	Measures
Early intervention/prevention		
Reduce unintended pregnancy	Ensure that community planning has a focus on coordinated activity to reduce teenage pregnancies	Local SOAs/ local teenage pregnancy plan agreed with partners
	Increase provision of LARC in primary care	LARC LES uptake
	Maternity services provide advice and support to mothers and promote LARC (especially to vulnerable women)	Percentage (n.) of all women admitted to maternity and termination services who have contraceptive method recorded Percentage of women offered effective contraceptive methods prior to discharge from maternity and Termination Services.
	Have in place a network of condom distribution centres that are easy to access and in the right geographic locations	Numbers and locations of condom distribution centres, with particular focus on condom distribution in areas of deprivation/ areas with higher teenage pregnancy rates
	Termination service review completed and implemented so there are consistent and equitable TOP services across NHSGG&C	Proportion of reproductive age women using LARC (sourced from KCIs note: ISD record age 15-49) Reported through The Sexual Health and BBV Framework 2011-2015 SH1.3 The rate of terminations of pregnancy SH1.4 The rate of repeat terminations of pregnancy

Sexual Health and BBV

Outcomes	Change of development required	Measures
Reduce STIs and BBV infection	Increase number of Addictions clients receiving Hep B vaccination Reduce drug injecting episodes that involve sharing or re-use of equipment.	Lab info re HIV testing *(national data no longer recorded re HIV testing, so less accurate monitoring data will be available – however still considered important measure for NHSGG&C)* Hep B vaccinations Estimates and reports of injecting episodes and equipment-sharing. The number of people diagnosed with HCV whose infection was acquired in the previous six months.
Promote positive sexual health by improving access to and quality of sexual health advice and information for young people	Work with local authority partners to develop effective Sexual Health and Relationship Education, including support to parents	Effective SHRE programme in place TALK2 or equivalent in place / numbers participating? / Numbers of schools supported?
Shifting the balance of care		
Earlier diagnosis of HIV/Hep B and Hep C	Increase HIV testing (in acute services and primary care)	Lab info re HIV testing *(national data no longer recorded re HIV testing, so less accurate monitoring data will be available – however still considered important measure for NHSGG&C)* Reduction in numbers of late and very late diagnosis

Sexual Health and BBV

Outcomes	Change of development required	Measures
	Implement the BBV testing policy	Numbers of BBV tests
Improving quality and efficiency		
More effective sexual health services with clearer definition of roles of Sandyford, acute, primary care services	Review of Sandyford services Implement the consequences of the review in all parts of NSHGG&C Work with GP practices to ensure that sexual health services are provided in primary care using an inequalities sensitive approach	HIV testing Rates of LARC
More appropriate use of lab diagnostic services	Work with GPs to reduce number of inappropriate high vaginal swabs	Numbers/ rate of HV swabs
Tackling inequality		
Increase number of Addictions clients receiving Hep B vaccinations and accessing sexual health services	Addictions Services to take a proactive approach to BBV prevention/vaccination Addictions Services to promote positive sexual health as part of a holistic approach to supporting clients'' health	Hep B vaccinations Hep B/ Hep C/ HIV testing Condoms distributed via Addictions services
Improve the coordination of health care re sexual heath and BBV for prisoners	Agree a development plan for prison health care which includes better coordination of patient records between prison and other parts of NHS (e.g. Hep B vaccination/BBV testing)	Services in place and appropriate referrals

Sexual Health and BBV		
Sustainable support services for women, men and young people who are victims of sexual assault	Secure the future of Archway and other associated services	Services in place
Outcomes	**Change or development required**	**Measures**
A culture that promotes positive sexual health and non-stigmatises people living with BBV.	Develop ways of working that treat patients with HIV/Hep B and Hep C as people living with a LTC Provide information and support for carers of people living with HIV, Hep B and Hep C	Increase in Hep B vaccinations Evidence of support provided