

NHS GREATER GLASGOW AND CLYDE

NHS Board Meeting
17th February 2015

Paper No 15/07

Director of Corporate Planning and Policy

Draft Strategic Direction and Local Development Plan 2015/16

Recommendation

The Board discuss work in progress to finalise the Strategic Direction and Local Development 201/16 for submission to Scottish Government by the end of March.

1. Introduction and Purpose

The Board submits a Local Development Plan (LDP) each year to outline how it will deliver against the annual planning guidance issued by Scottish Government. Our approach is to develop the LDP as an integral part of finalising our Strategic Direction for 2015/16. This covering paper reports on progress in developing this work. The paper has two attachments:-

- the Draft Strategic Direction and LDP
- a draft of the current financial plan which has been submitted to Health Directorates

2. Completing the Plan and Direction

To complete the combined Strategic Direction and LDP (draft attachment1) we need to:-

- Set out the actions which we need to take to move us towards delivering the national 2020 Vision;
- Describe our plans for 2015/16 to implement the Clinical Service Strategy and ensure that we deliver high quality, sustainable services within the resources available to the Board.
- Agree with IJBs the contribution they can make to reducing pressure on acute hospital services including substantial reductions in delayed discharges, we currently have over 300 patients assessed as ready for discharge to social care occupying NHS funded beds;

These areas of activity need to drive the decisions which will be required to deliver a balanced financial plan.

3. Financial Position

Attachment 2 to this paper sets out the detail of our current appraisal of the financial position which has been submitted to Scottish Government.

The gap between our 2015/16 income and known costs has been assessed at £48 million. Across our Acute, Partnerships and Corporate services we have so far identified around £32 million of savings establishing a gap of around £16 million. Work is underway to identify further cost savings for 2015/16 and there may also be further cost pressures to cover for example, additional costs for new drugs and for out of hours services.

The key points to note in terms of the draft LDP are as follows:-

- Substantial elements of the additional uplift either:-
 - relate to additional costs, for example drugs, where the additional allocation is substantially less than the known cost increases.
 - require to be passed to Integration Joint Boards and are not available for the additional costs which the NHS Board faces, for example resources for the integrated care fund and delayed discharges.
- The figure for savings identified is a full year effect figure which will not be able to be fully delivered in 2015/16.
- The previous section described the approach to establishing in principle budgets for IJBs to achieve at least non recurring balance. If part of our approach to deliver additional savings is to seek further savings from IJBs will create further financial instability for the new Partnerships.
- These savings proposals include a number of bed closures founded on delivering care more efficiently and shifting the balance of care from acute to other services in line with National and local Strategy.

4. Integration Joint Boards

Integration Joint Boards will be in place from early in the new financial year with their new responsibilities for strategic planning of local services and substantial elements of unscheduled care. This has a range of implications for this LDP process:

- The Board is responsible for allocations to the new Partnerships. In approving Integration Schemes the Board agreed in principle to allocations which reflected Partnerships financial and savings plans for 2015/16 with the likelihood of enabling financial balance to be achieved in 2015/16 and the IJBs to be established on a financially viable basis, although a number of the savings are non recurrent posing real challenges for the IJBs to deliver recurrent balance in 2016/17. It is also important to underline the substantial pressures on social care budgets

which will flow through to Council allocations to IJBs from 2015/16 onwards.

- A number of the LDP and related requirements will become the responsibility of the IJBs these will need to be reflected in early agreements with the new Boards.
- As this paper restates the Board has agreed to use the final year of the Corporate Plan as the basis for a Strategic Direction covering 2015/16 and to work with the IJBs during this year to establish a longer term direction.
- IJBs service delivery responsibilities are fundamental to enabling achievement of critical priorities outlined in the strategic direction and LDP and highlighted in this paper.
- The Board has now signed off a Clinical Services Strategy which provides a comprehensive framework for changing the way we deliver clinical care. We will seek early discussion with IJBs on the Strategy and developing plans together to implement the service changes which it requires.

5. Specific LDP Requirements

Set out below are specific LDP requirements with a brief indication of our current position. At headline level a major issue is our ability to deliver the targets and standards set within available resources.

5.1 Health Inequalities and Prevention

The LDP should set out local priorities for addressing health inequalities and improving prevention work based on the needs of the local population. Plans should focus on those communities where deprivation is greatest. The plan should outline how these will be achieved setting out improvement aims, levels of activity, and demonstrating how the activity is embedded in to routine practice. The plan will also include information about how the NHS Board and its partners priorities action and monitor progress. We have a wide range activity in this regard but for 2015/16 substantial elements of this will be the responsibility of IJBs.

5.2 Antenatal and Early Years

The LDP should set out the local actions to be taken to ensure that the relevant parts of the workforce will have the capacity, training and relevant protocols to carry out these duties under the Act by 1 August 2016. **Work in progress.**

5.3 Person Centred Care

The LDP should set out how services will support a positive care experience delivered in accordance with the “five must do’s with me”. It should also outline the key local action being taken to transform the culture to support staff and the public to be open and confident in giving and receiving feedback; widely publicise the information people need to give feedback and make complaints, and the support available for them to do so; and with a focus on learning from feedback, implementing the changes, and telling people what improvements were made as a result of their feedback. The plan will include information on how progress will be measured locally. **We have extensive activity which meets this requirement.**

5.4 Safe Care

The LDP should set out the priority actions the NHS Board is taking across these programmes of work, the plans for spread and sustainability and the impact they are having on patient care and should include an example from each SPS programme of how safety of care has improved in the last 12 months. This should include plans to ensure that governance and leadership across managerial and clinical staff is in place for each programme and that robust data collection methods are in place to demonstrate improvement. Boards will work towards implementing the recommendations set out in the Vale of Leven Inquiry Report. **We have extensive activity which meets this requirement.**

5.5 Primary Care

The LDP should set out the prioritised local actions that are being pursued to increase capacity in primary care and the resources identified to achieve this. The plan should also identify where national action would help local delivery. **We have very limited capacity to address this issue, we will set out the process by which we will develop, with IJBs, whose lead this is, a shared analysis of action which is required to feed into the new national contract negotiations. We will also be able to assess from the Paisley development programme whether there are self financing changes which can be made and we will continue the development of the 17c programme with new practices joining in 2015/16.**

5.6 Integration

The LDP should set out the key local actions that are being pursued to ensure effective involvement of clinical and care professionals in the strategic planning group. The LDP should also set out the redesign priorities emerging for the integrated care pathways delivered in the community. Strategic planning groups are the responsibility of each IJB. Redesign priorities for integrated care are well established in the Boards Clinical Strategy.

5.7 Workforce

NHS Boards should provide a short outline of their local implementation plans for 2015-16 to deliver the 5 priorities in the Everyone Matters: 2020 Workforce Vision Implementation Plan 2015-16. The 5 priorities are: Healthy

Organisational Culture, Sustainable Workforce, Capable Workforce, Integrated Workforce and Effective Leadership and Management. NHS Boards should indicate any workforce areas where there is a risk to delivering service. We have extensive activity which meets this requirement.

5.8 Community Planning Partnership Contribution

In this LDP we are asking NHS Boards to indicate how they will continue to strengthen their approach to community planning during 2015/16, through both their direct contributions and how they demonstrate leadership within the CPP. This should focus on how the CPPs act to improve local priority outcomes which relate to health and wellbeing, and how they shift activity and spend towards tackling inequalities, prevention and community empowerment. The Scottish Government will discuss progress against these commitments with NHS Boards. This will be a lead role for IJBs.

6. Targets

The Appendix to attachment sets out the **Local Delivery Plan Standards** The Board will need to assess in financial planning whether all of these targets can be delivered.

7. Next Steps

The final LDP including our financial plan for 2015/16 is due for submission on 20th March 2015. The early March time out session with Board members needs to agree the action to reduce costs to enable a balanced budget as a required integral part of that plan.

NHS GREATER GLASGOW AND CLYDE STRATEGIC DIRECTION 2015-16

1. INTRODUCTION

1.1 The strategic planning landscape is changing. The new Health and Social Care Partnerships will be responsible for strategic planning from April 2015. The Health Board will be responsible for working with the Partnerships, Community Planning Partners and wider stakeholders to establish a shared strategic direction; allocating resources within that strategic direction; ensuring effective governance arrangements are in place for services delegated to the Partnerships; planning acute services with the Partnerships and delivering acute services in line with those plans.

1.2 In the current transition process, where Partnerships are being established in shadow form, it would not be appropriate for the Board to establish a medium term strategic direction but we need to set a direction for 2015/16. The final year of the Board's Corporate Plan is 2015/16. That Plan was subject to wide consultation and engagement and it therefore appropriate to use the existing Corporate Plan to provide a strategic direction for 2015/16. This document is extracted from the Corporate Plan and has been developed to incorporate the 2015-16 Local Delivery Plan (LDP) requirements in Partnership with our shadow Integration Joint Board's.

1.3 NHS Greater Glasgow and Clyde's purpose is to:

“Deliver effective and 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 health inequalities.”

1.4 The Board has five strategic priorities to move us towards achieving that purpose. The strategic priorities The Government's LDP guidance sets six improvement priorities.

NHSGGC's five priorities are:

- early intervention and preventing ill-health;
- shifting the balance of care;
- reshaping care for older people;
- improving quality, efficiency and effectiveness;
- Tackling inequalities.

1.5 The 2015-6 SG Local Delivery Plan six improvement priorities are:

- health inequalities and prevention;
- antenatal and early years;
- person-centred care;
- safe care;
- primary care;
- integration.

1.6 There are real challenges and tensions to deliver on these priorities. As just one example, there are pressures to introduce new treatments which, with limited resources, need to compete against increasing spending on prevention or early intervention. **The Board has**

not yet identified a financial plan which will cover the cost of existing and known new commitments in 2015/16. The decisions which will be required to establish a balanced budget will be the most significant influence on the final version of this Direction and the LDP.

- 1.7 This Strategic Direction establishes how we will progress these five priorities alongside the LDPs six improvement priorities in 2015/16. We will work with Health and Social Care Partnerships to establish a shared longer term direction during this year. The Direction provides a framework for the overall planning system including the initial strategic plans which are being developed by the Integrated Health and Social Care Partnerships.
- 1.8 The next four sections of this paper set out the information which we have used to develop the five strategic priorities and the outcomes, these are:
- the national policy context;
 - our population;
 - our organisation and services;
 - our resources

2. NATIONAL POLICY CONTEXT

- 2.1 The Scottish Government has set out its vision for the NHS in Scotland in the strategic narrative for 2020.

Our vision is that by 2020 everyone is able to live longer healthier lives at home, or in a homely setting.

We will have a healthcare system where we have integrated health and social care, a focus on prevention, anticipation and supported self management. When hospital treatment is required, and cannot be provided in a community setting, day case treatment will be the norm. Whatever the setting, care will be provided to the highest standards of quality and safety, with the person at the centre of all decisions. There will be a focus on ensuring that people get back into their home or community environment as soon as appropriate, with minimal risk of readmission.

Achieving Sustainable Quality in Scotland's Healthcare: A 20:20 Vision

- 2.2 Underpinning the narrative is the Quality Strategy, with the three central ambitions that care should be person centred, safe and effective. The quality outcomes and 2020 vision are the major national drivers of NHS targets and strategic direction including the LDP Standards.
- 2.3 The vision and outcomes for the NHS are set in the context of a significant budget challenge. The NHS budget faces major pressure from the ageing population, new technologies and the cost of drugs.
- 2.4 The successful development of the new integrated partnerships alongside working with our Community Planning Partners will be key to the achievement of all of the strategic priorities set out in this Direction most particularly in shifting the balance of care and reshaping older people's care. **We will include in the final version of this direction the steps which we are required to deliver this vision.**

3. NHS GREATER GLASGOW AND CLYDE ORGANISATION AND SERVICES

- 3.1 NHS Greater Glasgow and Clyde is the largest NHS Board in Scotland and covers a population of 1.2 million people. Our annual budget is £3 billion and we employ over 40,000 staff.
- 3.2 Services are currently planned and provided through the Acute Division and six Community Health (and Care) Partnerships, working with our six partner Local Authorities. We have many hundreds of independent primary care contractors who deliver the vast majority of NHS activity.
- 3.3 The Acute Division delivers planned care and emergency services in nine major hospital sites and provides specialist regional services to a much wider population. This includes medicine and emergency services; surgery; maternity services; children's services; cancer treatment; tests and investigations; older people and rehabilitation services. In our hospitals in 2010/11 there were 467,051 A&E attendances; 407,030 new outpatient attendances; 169,827 day cases; 286,403 inpatient stays and over 15,000 births. During 2015/16 the Division will radically reshape services as the new Southern General Hospital opens. **[Update these numbers]**
- 3.4 The six new Partnerships will be responsible strategic planning for their population and for the full range of community based health services delivered in homes, health centres, clinics and schools. These include health visiting, district nursing, speech and language therapy, physiotherapy, podiatry, mental health and addictions. The Partnerships will also work in partnership to improve the health of their local populations and reduce health inequalities. The Partnerships will work with the full range of primary care contractors, dentists, optometrist, pharmacists and GPs. Each year over 1 million patients are seen by GPs and practice staff and there are over 1.5 million visits to patients by Health Visitors and Community Nurses.
- 3.5 This Strategic Direction sets out the priorities, outcomes and LDP requirements which all of these parts of our system will have to work together to achieve.

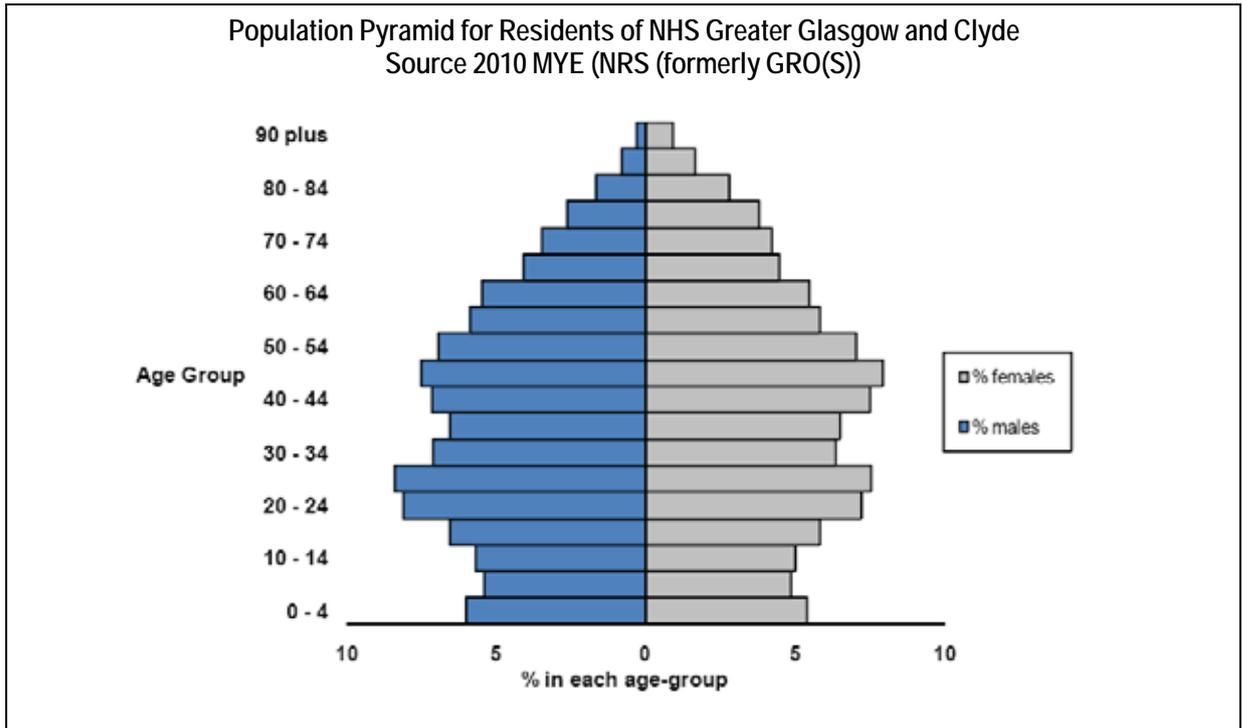
4. THE POPULATION OF NHS GREATER GLASGOW AND CLYDE

4.1 Population Health

The biennial Director of Public Health reports set out in detail the changing health profile of people living in Greater Glasgow and Clyde and the factors which influence it¹.

These reports highlight some significant improvements in recent years. Overall life expectancy has risen; rates of premature mortality have fallen, with particular improvements for Coronary Heart Disease. Cancer survival has improved significantly across a range of cancers. However, there remain many significant health challenges and marked inequality across NHS Greater Glasgow and Clyde.

Our population is relatively young compared to other parts of Scotland, although this varies significantly between local authority areas. Women predominate in the older age groups. The current age profile is shown below.



It is a population with high levels of deprivation compared to the rest of Scotland. 30.4% of people in NHS Greater Glasgow and Clyde live in the 15% most deprived data zones (Scottish Index of Multiple Deprivation). This ranges from 3.1% in East Dunbartonshire, to over 50% North and East Glasgow.

Overall, average life expectancy in NHS Greater Glasgow and Clyde is well below the Scottish average (see below). Again, there is considerable variation between different parts of NHS Greater Glasgow and Clyde.

¹ All reports available at www.nhsggc.org.uk/dphreport/

Healthy life expectancy in NHS Greater Glasgow and Clyde is even lower compared to the Scottish average. People in NHS Greater Glasgow and Clyde live for many years in ill health, with the consequent impact on quality of life, economic and societal contribution and need for services. Over the past 10 years, the gap in healthy life expectancy between the 20% most deprived and the 20% least deprived areas has increased from 8 to 13 years.

Life Expectancy at Birth by Gender 2007 - 2009
Source: NRS (formerly GRO(S))

CH(C)P	Male	Female
Glasgow City	71.1	77.5
East Dunbartonshire	78.3	83.1
East Renfrewshire	77.8	82
Renfrewshire	73.7	79.2
Inverclyde	73.1	79
West Dunbartonshire	72.5	78.4
NHSGGC	73.1	78.9
Scotland	75.4	80.1

The Director of Public Health reports highlight a number of major health and health behaviour challenges in NHS Greater Glasgow and Clyde. In almost every indicator, the same marked inequalities in health outcomes can be seen between the most affluent and most deprived areas. Factors which contribute to this include:

- high levels of alcohol consumption and alcohol related health problems;
- high rates of drug dependency;
- growing rates of obesity;
- growing numbers of people with long term conditions, including those with multiple long term conditions;
- despite significant success in supporting people to stop smoking, smoking rates remain high particularly in deprived areas and in some particularly vulnerable groups such as pregnant women;
- rising levels of dementia and depression.

The reports also highlight the interdependence between these issues, and the rising numbers of people with multiple health and social concerns. We must recognise how people's life circumstances can affect the health choices they make. Many of these issues have a long term impact and high disease burden, affecting employment, mental health, social participation and ability to benefit from existing health services.

As well as direct measures of health and health behaviour, NHS Greater Glasgow and Clyde faces challenges in a number of key determinants of health. Most significantly:

- children and families living in poverty;
- high levels of unemployment, including youth unemployment;
- impact of the recession and tax and benefit changes, particularly disability benefits;
- Isolation and loneliness with high numbers of people living on their own.

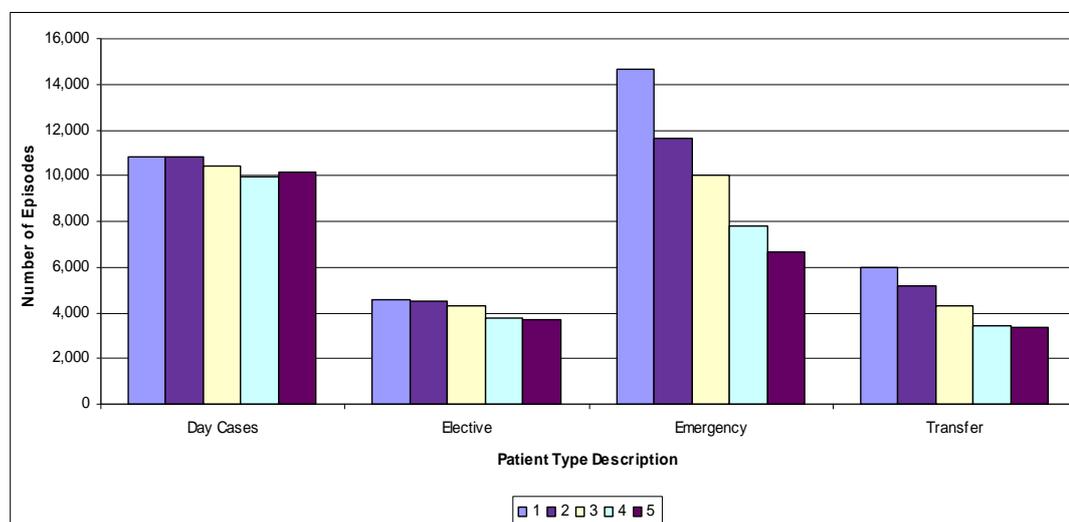
Each of these has major short and long term implications for individual and population health.

4.2 How our Population Uses and Benefits from Services

The inequalities and poor health in our population drive high levels of hospital admissions, GP consultations and use of a wide range of other services.

NHS Greater Glasgow and Clyde's rates of emergency admissions are significantly higher than the Scottish average, and this has a very clear social gradient.

**NHS Greater Glasgow and Clyde Residents
Rate of Episodes per 100,000 Head of Population by Patient Type and SIMD Quintile
Discharged in 2009/2010**



NB: high crude rates of admission in Greater Glasgow and Clyde (1.142 compared to national average)

In primary care, the biggest drivers of demand for services are age and deprivation². Age is a major driver of service use across a range of services, with the majority of contact with the NHS in the last few years of life.

We have made huge improvements in health outcomes and treatment for many people. For example, the massive reductions in waiting times and shift to day case surgery for the vast majority of cases, and our improvements in cancer survival rates. We see many more patients more quickly and with better outcomes. But we also know that not everyone has benefitted from these improvements: one of the key challenges in meeting our aspirations will be how we address unmet need and differential uptake of services which lead to the health gap and premature mortality for people in equality groups or living in persistent poverty.

4.3 Projections and Trends for 2013-16

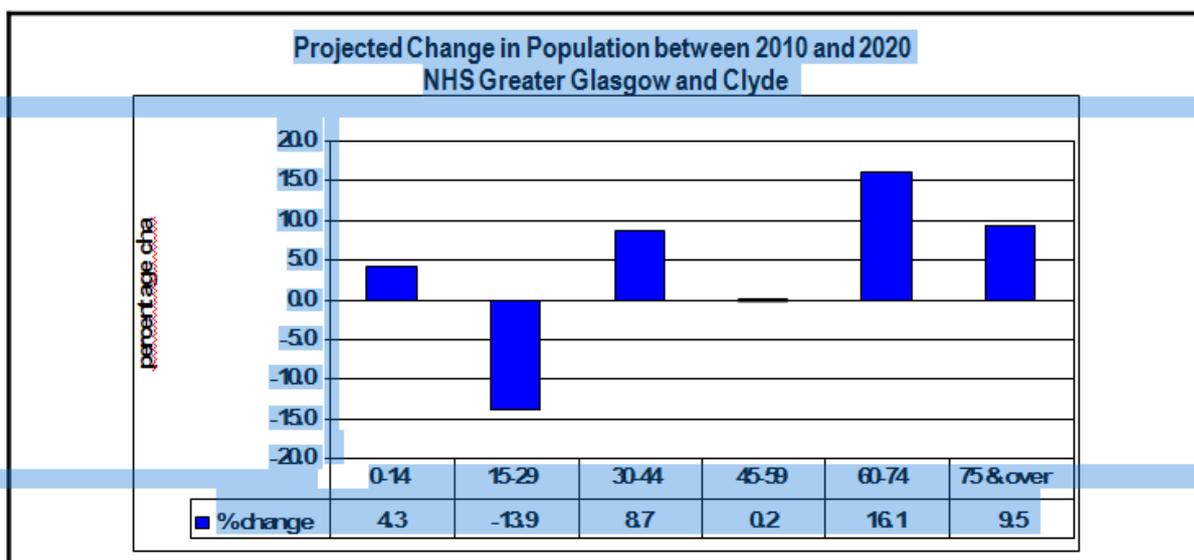
Greater Glasgow and Clyde's population is expected to continue to rise from 1,194,675 in 2008 to a peak of 1,198,174 in 2013 at which point it is expected to start a *modest* long-term decline, to reach 1,196,943 in 2016³.

² Tomlinson et al, *The Shape of Primary Care in NHS Greater Glasgow and Clyde*, GCPH 2008

³ Source NRS (formerly GRO(S))

During this time, the age profile of the population will continue to change. In common with much of Scotland, in most areas there will be a steep rise in the numbers and proportion of older people. This will impact differently across Greater Glasgow and Clyde with areas like East Dunbartonshire and East Renfrewshire already experiencing significant rises in numbers of older people, whilst Glasgow City is projected to see a short term decline in the numbers of older people, before following the same longer term trends. The number of

children across NHS Greater Glasgow and Clyde is also expected to rise, although this is primarily limited to Glasgow City.



The growth in numbers of older people represents a success story with many people living longer and healthier lives. Active older people make a substantial social and economic contribution. However, as people get older they are also more likely to need health services. Women predominate in the older age groups and many experience poverty which aggravates poor health and multi-morbidity. If we carry on with current rates of service use, with a larger population of older people, there is likely to be a substantial rise in emergency admissions and demand for care home placements and home care.

A significant rise in the numbers of people with dementia is also expected, with consequent challenges both directly for dementia services and for the way in which all services for older people are delivered. At the same time, NHS Greater Glasgow and Clyde will see a growth in the number of single person households. New legal duties to ensure age equality in public services will also shape the way we respond to these changes.

The small growth in the numbers of children also demonstrates that this is not a simple or consistent population change across NHS Greater Glasgow and Clyde, and there will be continuing demand for universal and specialist children’s services as well as services to support the many vulnerable children and families in our population.

As well as the demographic changes, our work on the impact of the recession in Glasgow suggests there is likely to be a short and long term impact on health, with rising unemployment linked to poorer mental health and lower income, both of which are in turn linked to longer term ill health. The changes to the welfare system and benefits will also impact on a significant proportion of our population and may have particular consequences for those who are disabled or in poor health.

Whilst we will not see the full impact of these trends during 2015-16, they are all issues we are currently beginning to face and next year will be a critical period in reshaping services to meet these pressures and the expected long term demographic changes.

5. OUR RESOURCES

This section will be developed further to reflect the financial planning discussion

5.1 Overview

Reshaping how we use our resources is fundamental to delivering the changes this Direction sets out. We need to:-

- use technology to further drive forward flexible and agile working to further reduce our office and support costs;
- encourage and support our staff to generate and deliver ideas which make better use of resources;
- develop our benchmarking activity to understand where there may be potential for change or improvement;
- more clearly link financial allocations to Partnerships to population health needs, taking account of expected change;
- rationalise the number of sites which we occupy;
- deliver a number of whole system redesigns which reduce costs and increase efficiency and effectiveness including for district nursing and mental health;
- develop fair share starting budgets and robust financial governance arrangements for the new Health and Social Care Partnerships;
- continue our focus to deliver effective and efficient services, based on best practice and value for money including reducing the use of hospital services
- increase capacity in primary care;
- ensure we fully recover the costs for the services that we provide to other NHS Boards;
- continue to promote our view that the national resource allocation formula does not fully reflect the impacts of deprivation or our population.

5.2 Allocations: material including:

- allocations to IJBs already signed of in principle;
- material on resource equalization for between Partnerships;
- material on due diligence during 2015/16 for IJBs;
- material on acute service notional budgets, related activity targets and handling activity shifts in year.

6. STRATEGIC PRIORITIES

6.1 Overview

Within the resources which are available to us in 2015/16 our aim is to meet national targets, achieve existing commitments, move towards the national 2020 vision improvement priorities identified for 2015/16 and deliver on NHS Greater Glasgow and Clyde's purpose, all in the context of the health needs of the population we serve. We must make significant progress on the five interlinked strategic priorities.

- preventing ill-health and early intervention;
- shifting the balance of care;
- reshaping care for older people;
- improving quality, efficiency and effectiveness;
- tackling inequality.

The delivery and development of primary care is fundamental to progressing all of these priorities. In addition to a full range of local work to develop primary care we will engage with Scottish Government to play our full part in shaping changes to the general medical services and other national primary care contracts. **We will include here material drawn from the primary care discussion paper we are about to launch and an assessment of the resource and workload challenges in Primary Care.**

Also critical to all of the strategic priorities is delivering change in hospital services. The approval of the Board's Clinical Strategy in January provides a detailed framework for redeveloping programmes of change for acute services and mental health. During 2015/16 we will:-

- complete a number of critical parts of the existing acute services strategy with the opening of the new South Glasgow University Hospital, the move to a new Children's hospital on the new South Glasgow University Hospitals campus, and the implementation of existing plans to reduce the number of sites for key specialties;
- deliver the services a series of service changes in line with the clinical services strategy (CSS); **we will list these here**
- develop plans for further service changes which progress the CSS.

Finally, in this overview of our strategic priorities it is important to restate our commitment is to tackle these priorities with a cross cutting focus on reducing the health gap which is such a major issue for our population.

6.2 Preventing Ill-health and Early Intervention

Prevention and early intervention have always been priorities for NHS Greater Glasgow and Clyde, demonstrated by our focus on parenting, development of Keep Well, chronic disease management in primary care and extensive health improvement activities particularly focused on smoking, breast feeding, alcohol and drugs, sexual health and obesity. Despite our focus we know that:

- high numbers of vulnerable children and families in Greater Glasgow and Clyde have poor outcomes and high risks across a range of indicators, as described in Mind the Gaps our analysis of the issues for children and families;
- an increasing number of individuals and families will be affected by poverty, debt, fuel poverty and potentially homelessness;
- poor healthy life expectancy for our population means that many people in Greater Glasgow and Clyde need health services at a younger age and for longer than in other areas of Scotland;
- budget pressures are impacting on the ability of all agencies to focus on early intervention and prevention and exacerbating the problem of high thresholds for intervention.

Effective prevention and early intervention are critical to improving the health of our population, delivering better outcomes, narrowing the equalities gap and reducing the demand for services, particularly acute care.

Outcomes we need to deliver in 2015-16 are:

- improve identification and support to vulnerable children and families;
- enable disadvantaged groups to use services in a way which reflects their needs;
- increase identification of and reduce key risk factors (smoking, obesity, alcohol use);
- increase the use of anticipatory care planning;

- increase the proportion of key conditions including cancer and dementia detected at an early stage;
- Enable older people to stay healthy.

LDP section on Antenatal Care and Early Years requirements

6.3 Shifting the Balance of Care

The national strategic narrative and the imperatives of the expected growth in demand mean that it is essential that we deliver a move away from high cost hospital care. Shifting the balance of care cannot just be about doing the same things in a different place or with different people, but has to be about changing pathways of care and critically reviewing the following:

- responsibility: who is managing or co-coordinating the pathway of care;
- focus: an emphasis on prevention, identifying risk and responding early, focusing on outcomes at each stage;
- location of services;
- use of technology to support different ways of working;
- The role of patients, carers and the third sector.

These issues were at the core of the clinical services review. The creation of integrated Health and Social Care Partnerships will be an opportunity to ensure that patients are supported more effectively in the community.

Outcomes we need to move forward during 2015/16 are:

- fewer people cared for in settings which are inappropriate for their needs and only patients who really need acute care are admitted to hospital;
- there are agreed patient pathways across the system, with roles and capacity clearly defined including new ways of working for primary and community care developed from the Paisley Programme;
- we offer increased support for self care and self management which reduces demand for other services;
- more carers are supported to continue in their caring role;
- more people are able to die at home or in their preferred place of care.

6.4 Reshaping Care for Older People

Older people are the biggest users of health services. Reshaping care for older people is a central element of the national strategic narrative and our success in changing the way we care for older people and planning for the changing demographics will be critical to the future sustainability of services in NHS Greater Glasgow and Clyde. Older people are supported by a complex system of care, and we need to understand and change how that system works. The experience of older people is also a key marker of the quality of care we provide to all of our patients.

There are a series of major issues for us, including:

- the substantial growth in the numbers and proportion of older people across Greater Glasgow and Clyde, coupled with relatively poor healthy life expectancy and wider social changes including the growth in single person households;

- the growth in numbers of people with dementia across all our services;
- the challenge of funding constraints in other agencies working with older people, and the impact on the third sector;
- challenges around older people's experience of care in all settings;
- a range of issues around end of life care, respite and high cost community care;
- the need to more effectively influence housing developments for older people;

Many older people require support from both health and social care services, and the creation of integrated Health and Social Care Partnerships across the Board area is a critical opportunity to reshape care. We need to ensure that this structural change delivers greater quality for individual patients and more effective and efficient use of resources.

Outcomes we need to move forward in 2015/16 are:

- clearly defined, sustainable models of care for older people;
- more services in the community to support older people at home and to provide alternatives to admission where appropriate;
- increased use of anticipatory care planning which takes account of health and care needs, and home circumstances and support;
- carers are supported in their caring role;
- improved partnership working with the third sector to support older people;
- improved experience of care for older people in all our services.

6.5 Improving Quality, Efficiency and Effectiveness

The national Quality Strategy and our local quality improvement programmes are a major strategic priority. Our focus will continue to be on ensuring that care is person centred, safe and clinically and cost effective. A key part of this is ensuring all patients, carers and staff have the opportunity and confidence to share their experience and that we listen, learn and report back the changes implemented as a result. We need to continue our shift towards defining clear quality outcomes and to embed this in our performance management systems; focusing on caring and experience of care as well as treatment.

Outcomes we need to deliver during 2015/16 are:

- making further reductions in avoidable harm and in hospital acquired infection;
- delivering care which is demonstrably more person centred, effective and efficient;
- patient engagement across the quality, effectiveness and efficiency programmes;
- developing the Facing the Future Together programme to support our staff to improve quality, hear and respond to patient feedback;

In achieving the above outcomes we will embed the "five must do's with me" principles in mainstream patient care. We plan to roll out our universal feedback initiatives in in-patient care to ensure total coverage by December 2016 and develop plans to use feedback initiatives in all of our outpatient and day case settings.

Feedback will be measured locally through a range of feedback mechanisms currently in place. Appendix 2 provides examples of local feedback initiatives currently in place. We have revised how electronic feedback is handled including Patient Opinion and aligned this function within the wider Patient Experience agenda, to ensure a high quality response is made to every posting and to back up both this and NHSGGC's own form of electronic feedback with robust monitoring systems that track actions to ensure that patient feedback, where appropriate, leads to improvements in services. This also ensures that issues raised or themes that emerge from patient or carers feedback are seen by directors of Services as well as senior managers.

We remain committed to providing the highest quality care to our patients and will build upon some of the successes achieved to date through the implementation of the Scottish Patient Safety programme (*Clinical Governance Committee will provide a 2015-16 plan for the spread and sustainability of SPSP*). We plan to continue to work with the National Measurement Support Team to develop a plan for each of the 4 SPSP programme areas and maintain an appropriate trajectory. Key examples of improvements in the safety of care during the past 12 months can be seen in Appendix 3. We will also continue to learn from those occasions where care does not proceed as planned and use this knowledge to improve patient safety. A key example of this will be the implementation of 65 recommendations outlined in the Vale of Leven Hospital Inquiry Report.

6.6 Tackling Inequalities

Our statement of purpose includes a commitment to addressing the determinants and consequences of inequality. Inequalities are created by a complex set of economic, social and personal factors which the NHS cannot address alone, but there are significant steps we can take to understand and respond to the inequalities faced by patients. By focusing on providing NHS services in a way which understands and responds to inequalities through the Inequalities Sensitive Health Service programme, we will deliver benefit to individuals and improve the outcomes of our services, for example by reducing non-attendance, poor concordance with treatment, misdiagnosis and unnecessary repeat attendance.

This Direction describes the longstanding and worsening health gap between the most and least deprived in our population. There are significant differences in health, access, experience and outcomes of health care between different groups depending on their age, gender, race, disability, sexual orientation, income and social class. Equality legislation requires us to set clear outcomes for improvement to protected characteristics.

We will also continue to strengthen our approach to community planning and work with partners to influence the wider determinants of health and inequalities, including in our roles as a major employer, local investor, and supporter of local communities and as a key Community Planning partner.

Outcomes we need to continue to work towards during 2015/16 are:

- we plan and deliver health services 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 inequalities gap through clearly defined programmes of action by our services and in conjunction with our partners.

2015-16 Local Delivery Plan deliverables include:

NHSGGC has high levels of activity to address health inequalities and early intervention as evidence in our Equality Outcomes Update 2014-15 in Appendix 4. During 2015-16 our priorities will be to:

- Reduce barriers for groups who face discrimination to improve access and ensure people's human rights in all our services (people with protected characteristics covered by the Equality Act 2010)

- Improve health outcomes for people experiencing poverty and inequality which results in poorer health outcomes
- Address the health needs of people who face marginalisation and significantly poorer health including homelessness, gypsy travellers, prisoners, asylum seekers and refugees, ex-service personnel
- Early intervention and prevention for children and young people and older people to improve health

Equality impact assessment will be used to consider the needs of people at greatest risk when planning services, using disaggregated data and population health data to understand need. Robust engagement with people from equality groups or with people experiencing poverty will inform service improvements.

Person centred care and inequalities sensitive practice has been implemented in priority areas to ensure that all opportunities for prevention and early intervention are maximised in clinical consultations.

From April 2015 the NHS Board will work with the Health and Social Care Partnerships to develop equality outcomes which reflect the needs of their local populations. Many SOAs already reflect priorities in relation to health inequality and this process will be continued to strengthen pathways for patients through all community services, including primary care and acute.

7. WORKING WITH OUR PEOPLE

- 7.1 Our people are our most important resource and this section has two purposes. Firstly to confirm our commitment to the continuing development of the Facing the Future Together programme to ensure that we engage better with our whole workforce. That engagement will drive improvements in quality, efficiency and effectiveness as our staff face the real challenges of delivering our strategic priorities.
- 7.2 The second purpose is to signal the changes we expect to occur to our workforce in 2015/16. There will continue to be changes to:-
- numbers and skill mix across all professions to reflect different ways of working which our five strategic priorities require;
 - reflect the impact of current service redesign and changes to the configuration of services, which will mean that many people will be working in different roles and locations;
 - deliver increased efficiency which will mean we need to support staff to work differently in many areas, and recognise the impact of this on staff;
 - support staff to develop and maintain skills and practice with effective supervision and governance arrangements

We will need to give more detail to workforce change in this section to reflect our emerging financial narrative

- 7.3 Our people are our most important resource and this section has two purposes. Firstly to confirm our commitment to the continuing development of the Facing the Future Together programme to ensure that we engage better with our whole workforce. That engagement will drive improvements in quality, efficiency and effectiveness as our staff face the real challenges of delivering our strategic priorities.

7.4 The second purpose is to signal the changes we expect to occur to our workforce in 2015/16 in line with the 5 priorities outlined in the Everyone Matters: 2020 Workforce Vision (see NHSGGC's Workforce Action Plan for 2015-16). There will continue to be changes to:

- numbers and skill mix across all professions to reflect different ways of working which our five strategic priorities require;
- reflect the impact of current service redesign and changes to the configuration of services, which will mean that many people will be working in different roles and locations;
- deliver increased efficiency which will mean we need to support staff to work differently in many areas, and recognise the impact of this on staff;
- support staff to develop and maintain skills and practice with effective supervision and governance arrangements.

Our staff partnership arrangements will be crucial to designing and delivering these changes.

7.5 2015-16 Local Delivery Plan deliverables include:

- We will continue to utilise nationally validated nursing workforce planning tools were available for undertaking any planning workforce activities. In addition, we have also developed a senior professional judgement model which takes account of the local context. This model uses specialty staff to bed ratios developed with reference to nationally approved Adult Inpatient Tools and being applied across NHSGGC on a programmed basis and outcomes are used to inform nursing workforce planning.
- Partnerships have been reviewing community services during the last 2 years including Health Visiting, District Nursing and Specialist Children's Services. These reviews have concentrated on improving efficiency, making services fit for the future and improving quality and governance structures.
- The review of district nursing proposes changes to the workforce, sets out a governance and quality framework, maximises the benefits of agile working and defines an equitable and uniform service model that will support the move to Health and Social Care Partnerships in 2015.
- The health and deprivation demographics of NHSGGC are currently having an effect on recruitment to certain Health Visitor posts, particularly North Glasgow and resulting in inequitable caseloads for health visitor posts across CHP areas. In addressing this, we have established a Health Visitor Recruitment and Retention Group to monitor escalate and implement remedial action in relation to identified health visiting staff issues and a number of actions have been agreed to mitigate existing difficulties.

ACUTE SECTION STILL TO BE COMPLETED

7.6 Key areas of service development that have specific implications for NHS workforce include:

- The new South Glasgow University Hospital and the new Royal Hospital for Sick children will open in 2015-16. As part of the development of the new hospitals investment has been made in additional Emergency Nurse Practitioners for the new Minor Injury unit and additional Paediatric Advanced Burse Practitioners to support the extended age range of paediatric patients to include those up to and including

15 years old. Recruitment for these posts had been pre-planned and expected to be complete with no shortfall.

- The implementation of Getting It Right for Every Child (GIRFEC) national practice model requires school nurses to have a health visitor qualification. This has resulted in the implementation of a revised HV education programme developed in partnership with Glasgow Caledonian University.

7.7 Key demographic information influencing sustainability or otherwise of services:

7.8 The workforce age demography for NHSGGC presents no immediate concerns for service delivery in 2015-16. However, there are areas within the workforce where the current age profile may begin to cause concern in the next 3 – 5 years.

- 38% of the current nursing workforce is over 50 years. The age profile within District nursing service indicates the potential for increased levels of retirement across the next 5 years, although this may be mitigated by service redesign activities currently underway.
- The nursing workforce within Mental Health and Learning Disability Services is likely to be affected by increased retrial rates associated with high numbers of staff with Mental Health Officer pension status reaching 55 years old. It is estimated that approximately 18% of this component of the nursing workforce will be eligible to retire in the next 5 year period.
- There is an ageing workforce profile in both Facilities and Estates functions and action is in place as part of the NHSGGC Youth Employment Strategy and the Education Partnership work stream which will create new, flexible career pathways into both professions including Modern Apprenticeships.
- A similar age profile has been noted within the Healthcare Science workforce (37% over 50 years) although the Medical & Dental, Psychology and Pharmacy workforce display a younger profile

8. DELIVERING THE DIRECTION

8.1 This section will need to sets out how agreed deliverables for 2015/16, including the material required for the LDP, National Standards and national outcomes covering the areas below to be drawn from narrative in section 6.

APPENDIX 1 – 2015-16 Local Delivery Plan Standards

Preventing Ill Health and Early Intervention

- Cancer - 31 days from decision to treat (95%)
- People diagnosed and treated in the first stage of breast, colorectal and lung cancer (25%)
- 62 days from urgent referral with suspicion of cancer (95%)
- Sustain and embed alcohol brief interventions in 3 priority settings (primary care, A&E, Antenatal) and broaden delivery in wider setting

Improving Quality, Efficiency and Effectiveness

- Eligible patients commence IVF treatment within 12 months (90%)
- 18 weeks referral to treatment for Psychological Therapies (90%)
- 18 weeks referral to treatment for specialist Child and Adolescent Mental Health Services (90%)
- 12 weeks Treatment Time Guarantee (TTG 100%)
- 18 weeks Referral to Treatment (RTT 90%)
- 12 weeks for first patient outpatient appointment (95% with stretch 100%)
- Clients will wait no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery (90%)
- SABs Infections per 1,000 acute occupied bed days (0.24)
- Clostridium difficile infections per 1000 total occupied bed days (0.32)
- Sickness Absence (4%)
- Operate within agreed revenue resource limit; capital resource limit; and meet cash requirement.

Shifting the Balance of Care and Reshaping Care for Older People

- 4 hours from arrival to admission, discharge or transfer for A&E treatment (95% with stretch 98%)
- People newly diagnosed with dementia will have a minimum of 1 years post diagnostic support
- 48 hour access or advance booking to an appropriate member of the GP team (90%)

Tackling Inequalities

- At least 80% of pregnant women in each SIMD quintile will have booked for antenatal care by the 12th week gestation
- Sustain and embed successful quits, at 12 weeks post quit, in the 40% SIMD areas

APPENDIX 2 - 2015-16 LOCAL DELIVERY PLAN DELIVERABLES – PERSON CENTRED CARE

LDP requirements - set out how services will support positive care experience delivered in accordance with the “five must do’s with me”. It should also outline the key local action being taken to transform the culture to support staff and the public to be open and confident in giving and receiving feedback; widely publicise the information people need to give feedback and make complaints, and the support available for them to do so; and with a focus on learning from feedback, implementing the changes, and telling people what improvements were made as a result of their feedback. The plan will include information on how progress will be measured locally

We now have established a number of ways for patients, staff, carers and relatives to provide feedback about their experience whilst in our care. These are supported by clearly defined processes to gather, assess and respond to this feedback and to take appropriate action to improve.

Our commitment to supporting positive care experience is clearly outlined in our Person Centred Health and Care Framework. The values underpinning this Framework are set out in our Facing the Future Together programme which has the purpose of ensuring we deliver better care for patients and recognises that this must be underpinned by better engagement and support for our staff.

The overall aim of FTFT is:

“To improve how we support each other to do our jobs, provide an even better service to patients and communities and improve how we all feel about NHSGGC as a place to work.”

Key examples of local feedback initiatives around person – centred care for 2015-16 include:

- The person-centred health and care (PCHC) collaborative programme team have developed a “themed conversation” methodology to listen and gather feedback from patients, relatives and carers. This is used as the basis for driving change and improvement. Feedback is gathered from patients, family members and carers on their health and care experience whilst still in hospital, at out-patient clinics and after discharge from community services or hospital. The feedback is themed into eight domains, admission experience; consistency and coordination; respect and dignity; communication and involvement; safety; meal time experience; environment and facilities and overall care experience. Feedback is also gathered on one additional domain of enablement and support where this is relevant. The feedback is shared with the clinical team and used to endorse and enhance elements of the health and care experience which are viewed to be positive as well as identifying the opportunities for learning, change and improvement. The clinical teams are then supported and mentored by the PCHC Collaborative programme team to identify and test interventions and actions which will result in an improvement in the care experience of patients, relatives and carers.
- The five ‘must do with me’ principles are embedded into the improvement work of the 33 pilot clinical improvement teams being supported by the person-centred health and care collaborative team. These are a few examples of what is currently being tested and implemented:
 - **What matters to you?** – The things that are most important to an individual are incorporated into the care planning and delivery process. A “what matters to me” at a glance bedside board to display what is important to the patient as well as other key pieces of information is being implemented in all the Specialist Dementia Care teams as well as some of the more general areas of practice we are working with. The information displayed is with the consent of the patient and family. This has helped to personalise care giving, provide quick prompts to relieve distress for some patients and acts as an aid for non-permanent members of the care team on important issues

to facilitate communication with patients. Information is updated as and when changes occur for the individual.

- **Who matters to you?** Patients are asked who the most important people are to them and who they wish to be involved in their care while in hospital. A number of the pilot clinical improvement teams are implementing proactive relative and carer rounds during visiting times to engage with them and update on the clinical status of their relative and address their needs and requirements for information and support.
- **What information do you need?** Patients are being asked during ward rounds and when information is exchanged what information they want to know; if there is anything that has been missed or if they have any questions. The clinical improvement teams are being encouraged for this to be an ALWAYS event.
- **Nothing about me without me.** Patients are being invited to be a partner in decisions taken about their treatment and care planning during consultations, ward rounds and care planning discussion and goal setting meetings.
- **Personalised Contact** All staff involved with a patient introduce themselves using the 'Hello My Name is...' ethos. The patient can identify the nurse who is looking after them on each shift and relatives and carers are able to identify who to speak to when they visit. Staff check-in with patients on a mutually agreed timeframe and respond quickly to calls for assistance when required.
- Continue to roll out the **Universal Patient Feedback system** – this allows patients to provide feedback on the experience they have had on our wards. Patients are given a feedback card on the day of their discharge which asks the question: "How likely are you to recommend our ward to friends and family if they needed similar care or treatment?" There is also a comments box for patients to tell us more about their experience. Once a month completed cards are analysed, providing a 'Percentage Positive' Score and prominently displayed in wards.
- The ongoing implementation of "**Patient Conversations**" model within all Mental Health in-patient wards. The conversations model provides direct feedback from service users and carers in relation to their in-patient experience in terms of what has gone well and what could be improved upon. Visitors are also involved in the conversations; this is particularly useful within our dementia wards. The model allows local services to become more proactive in shaping care delivery which meets identified patient and carers needs. The sessions also signal to service users that we are interested in and willing to act on their views. A "You said, we did" poster is produced and prominently displayed in each ward. Between conversations, any necessary actions are undertaken and reviewed at the next visit to the ward. During 2015-16 we will review the model and develop conversations within community services in order to better capture feedback on the patient journey within our community teams and at points of transition between services.
- Ongoing implementation of the **On-line Patient Feedback System** that aims to further improve the patient experience and patient pathway which has always been a recognised and valued way of ensuring continued improvement and efficiency of NHS Services. Comments received go directly to appropriate frontline service providers and used to inform service improvements and drive up standards of care and compassion.
- There are plans to encourage **staff to feedback their comments** about the care they themselves (or relatives or friends) have experienced. This will be developed and implemented during 2015-16.

- The continued participation in the **Better Together** initiative where questionnaires are sent to patients based on a randomised sample of overnight stay patients and also questionnaires handed out and gathered back in the wards. Better Together audits are monitored and appropriate action taken at ward level.
- The implementation of the revised **Dignity At Work** policy. The revised policy promotes actions that will help develop and maintain a more positive workplace culture. Delivering that culture is one of the most important objectives of our *Facing The Future Together* programme. We want to achieve a culture where showing dignity and respect is the norm and members of staff feel comfortable and confident to deal with disrespectful behaviour if it occurs. The policy defines disrespectful behaviour separately from more serious allegations of bullying and harassment and therefore allows such issues to be dealt with in a more appropriate and immediate way.
- We will continue to embed **Inequalities Sensitive Practice (ISP)** as a way of working which responds to the life circumstances that affect people's health. Evidence shows that if these issues are not taken into account by the health service, opportunities are missed to improve health and to reduce health inequalities. NHSGGC has a number of programmes of work which aim to ensure that our services understand how to recognise and respond to the life circumstances that are affecting someone's health e.g. healthier wealthier children's programme or gender based violence programme.

APPENDIX 3 - 2015-16 LOCAL DELIVERY PLAN DELIVERABLES – SCOTTISH PATIENT SAFETY PROGRAMME EXAMPLES

LDP requirements - set out the priority actions the NHS Board is taking across these programmes of work, the plans for spread and sustainability and the impact they are having on patient care and should include an example from each SPS programme of how safety of care has improved in the last 12 months. This should include plans to ensure that governance and leadership across managerial and clinical staff is in place for each programme and that robust data collection methods are in place to demonstrate improvement. Boards will work towards implementing the recommendations set out in the Vale of Level Inquiry Report.

Below are some examples from each of the 4 Scottish Patient Safety Programmes on how safety of care has improved or improving. These examples are accompanied by more detailed reports which also highlight the governance and leadership arrangements across managerial and clinical staff alongside the data collection methods in place for each of the programmes. Examples include:

- **Acute Care – Falls and Pressure Ulcers Workstream** - the existing approach to both falls prevention and pressure ulcers are based on the clinical standards for each. The positive impact of work in both workstreams can be seen in the reduction in falls and the gradual but downward trajectory in pressure ulcers
- **Primary Care – Polypharmacy LES Workstream** - in NHSGGC 252 practices participated in the Polypharmacy LES during 2013/14 of which the national SPSP-PC medicines reconciliation formed part of the LES. This work demonstrated improvements in care bundle compliance from 80% at the beginning of the work to 90% by March 2014 and resulted in 30,894 patients receiving a face to face Polypharmacy medication review. Compliance with the care bundle to date for 2014/2015 is 92%. Analysis of 217 practice reflection sheets showed practices have viewed the medicines reconciliation workstream very positively with 82% reporting they felt it improved patient safety and 80% reporting it had improved practice processes.
- In building upon the positive work with GP practices around medicines reconciliation (Care Bundle Compliance) NHSGGC is one of the 4 health boards who were successful in bidding to become part of the new Pharmacy in Primary Care Collaborative which has been created and will run for the next 2 years. The aims of this collaborative are to:
 - Improve patient safety by strengthening the contributions of pharmacists to:
 - Deliver reliable processes for the safe dispensing, monitoring and administering of high risk medications;
 - Improve the reliability medication reconciliation when patients are discharged from hospital; and
 - Improve the safety culture of pharmacy teams.

NHSGGC will work with 8 community pharmacists and 2 GP practices to take this work forward.

- **Adult Mental Health Scottish Patient Safety Programme** aims to systematically reduce harm experienced by people receiving care from mental health services in Scotland, by supporting clinical staff to test, gather real-time data and reliably implement interventions, before spreading across the NHS board area. The work is being delivered through a four year programme, running from September 2012 to September 2016.
- The leadership and culture work stream applies to all wards involved in the programme. The elements of the leadership and culture work stream are:

- Staff Safety Climate Tool
- Patient Safety Climate Tool
- Leadership Walk rounds

- **Staff Safety Climate Tool**

Organisations working to develop or improve a culture of safety need a reliable measure to monitor the success of their initiative. The Institute for Healthcare Improvement (IHI) Safety Climate Survey is being used for this purpose in this Programme. The climate tool is repeated after a year to establish whether there are changes in perceptions of staff. Most participating wards have now completed the survey with over 300 surveys completed, collated and analysed in NHS GG&C. Wards use the collated results to discuss perceptions of safety in the ward and identify areas for improvement.

- **Patient Safety Climate Tool**

A Patient Safety Climate Tool has been developed by mental health service users and carers, and the SPSP Mental Health Teams across NHS Boards have supported the implementation and delivery of the Patient Safety Climate Tool (PSCT). The tool is designed to enquire about environmental, relational, medical and personal safety. As part of the programme all boards are expected to use the PSCT to ask patients what they feel about the safety of the ward they are in.

In NHS GG&C, Glasgow Mental Health Network has been working with ward staff and Clinical Governance Support Unit staff to administer the tool and collate the results. To date over 110 surveys have been completed in NHS GG&C. Results of the surveys are fed back to the ward staff in order to identify areas where improvements can be made. In addition themes are being identified in order to share learning throughout the service.

- **Leadership Walk Rounds**

Using learning from Leadership Walk rounds in Acute SPSP Programmes, Leadership Walk rounds have been adapted for use in Mental Health Services. In an attempt to assure staff of the 'two way' nature of the walk rounds, these have been named Safety Conversations in NHS GG&C. To date two of these Safety Conversations have taken place and these were found to be extremely useful for all concerned. Safety Conversations for all the other SPSP wards are now being planned.

- **Input at National Level**

In addition to all the work taking place within NHSGG&C, many staff have played key roles in the development of the Programme at a national level. This has included membership of the National Delivery Group; piloting and developing the Patient Safety Climate Tool; presenting and facilitating at National Learning Events and leading on developing guidance for Mental Health Safety Walk rounds. NHSGG&C are represented on all five Workstream Development Delivery Subgroups.

APPENDIX 4 – EQUALITY OUTCOMES UPDATE AVAILABLE AT END OF FEBRUARY 2015.

SGHSCD Supporting Narrative – 13 February 2015

Progress Report on Development of 2015/16 Financial Plans

Attachment 2

Purpose

The purpose of this paper is to provide SGHSCD with an update on progress with the development of the financial plan for 2015/16. At this stage all plans shown must be viewed as draft and there remains significant work before a final plan will be submitted.

Summary

In late 2014 the Chief Executive approved a draft cash-releasing savings target of £48.1m for 2015/16. Of this total, £30.0m was given to the Acute division, £15.0m was given to Partnerships and £3.1m to Corporate. In addition, the net uplift for prescribing assumes that £10.0m of savings will be delivered. The Chief Executive recognised that non cash releasing schemes would also be developed to meet SGHD's target for 3% efficiency savings.

Work continues to identify schemes to identify and deliver the allocated savings targets for 2015/16. Assuming all schemes identified to date can be implemented and that the local partnership targets are achieved the remaining in year gap for 2015/16 is currently estimated at between £15m and £20m due to uncertainty around the timing of implementation of a number of proposals. This gap would require to be covered by either identifying additional in year savings or by generating non recurring cover from other expenditure budgets. The Board's ability to generate non recurring funding in 2015/16 to bridge any savings gap will be more limited than usual as it is likely that most non recurring sources will be required to cover transitional costs following the move to the new hospitals. As a result 2015/16 will be an extremely challenging year for the Board to deliver a breakeven out-turn. Savings will be discussed in more detail at the Board Awayday on 9 March 2015.

It is important for SGHD to note that whilst the current plan has been produced on a prudent basis, recognising pressures that still require more detailed evaluation, the final plan may be modified to reflect the outcome of further evaluation.

SGHSCD Supporting Narrative – 13 February 2015

Progress Report on Development of 2015/16 Financial Plans

Update on inflation, cost pressures & investments

An updated estimate of the level of financial challenge faced by the Board in 2015/16 has recently been prepared. This draft, together with the previous projection which was presented to Board members, is set out below and required no change to the original challenge. Detailed notes are attached.

	Jun 2014 £m	Feb 2015 £m	Notes
<u>Carry Forward from 2014/15</u>			
Forecast recurring over-commitment	(0.0)	(0.0)	1
<u>2015/16 Funding Uplift</u>			
Minimum Uplift	41.1	39.8	2
Integrated Care Fund		8.9	3
Additional Drugs Uplift		8.2	4
Delayed Discharges		7.1	5
	41.1	64.0	
<u>Cost Drivers</u>			
Pay Cost Growth	(42.0)	(35.8)	6
Prescribing Cost Growth	(27.2)	(24.5)	7
Energy Cost Growth	(3.0)		8
Capital Charges Indexation	(2.0)	(2.0)	9
Other Cost Inflation	(10.7)	(10.3)	10
	(84.9)	(72.6)	
<u>New Service Commitments</u>			
South Glasgow University Hospitals	(13.0)	(11.9)	11
Other	(12.6)	(27.6)	12
Board Contingency			13
	(25.6)	(39.5)	
Financial Challenge	(69.4)	(48.1)	
CRES requirement	3.5%	2.4%	

SGHSCD Supporting Narrative – 13 February 2015

Progress Report on Development of 2015/16 Financial Plans

2015/16 Projections – Explanatory Notes

1. As per the 2014/15 Financial Plan, the Board is in recurring financial balance, so the recurring over-commitment carried forward from 2014/15 is £0.0m.
2. Actual funding uplift for 2015/16 is subject to parliamentary approval of the 2015/16 budget. We expect that we will receive the indicative minimum uplift of 1.8%. The uplift includes additional income from SLAs with other Boards and NSD.
3. The Change Fund, funding for which had been in the Board's baseline, has now been discontinued. That funding, together with additional investment from SG, will now support the new Integrated Care Fund. The net impact for NHSGGC is an increase of £8.9m, as shown below.

	£m
Withdrawal of Change Fund	(14.8)
Integrated Care Fund	23.7
Net Uplift	8.9

4. As part of the Barnett consequentials funding in 2015/16, SG has provided £32.2m as a contribution to drugs pressures. NHSGGC's share of this funding is £8.2m.
5. As part of the Barnett consequentials funding in 2015/16, SG has provided £30.0m as a contribution to delayed discharges. NHSGGC's share of this funding is £7.1m.
6. Pay cost growth comprises:

	£m
Provision for 1% uplift	14.2
Provision for additional low pay costs	1.8
Provision for additional Superannuation	17.0
Provision for discretionary points	1.0
Provision for incremental pay progression - AfC	0.0
Provision for incremental pay progression - Consultants	1.5
Total Pay Cost Growth	35.8

Pay provision: Current indications are that a provision of 1.0% for pay uplift in 2015/16 is reasonable. On top of the 1.0%, provision has been made for additional the additional costs of a £300 increase for staff earning up to £21,000.

Superannuation: A provision of £17.0m has been made for the recurring implications of the increase of 1.4% to 14.9% in employers' superannuation contributions.

Incremental pay progression - AfC: The experience of monitoring AfC related pay trends has helped the Board develop a detailed understanding of the effect of incremental pay progression. This has enabled us to carry out a detailed forecast of pay growth for 2015/16, using current staff turnover ratios by staff category. The pay modelling has indicated that incremental pay progression for AfC will not be a cost pressure in 2015/16, so no provision has been made for additional costs.

SGHSCD Supporting Narrative – 13 February 2015

Progress Report on Development of 2015/16 Financial Plans

Incremental pay progression – Consultants: Although this has not featured as a pressure in the last few years, there has been an increase in average seniority, and hence costs, of consultants recently. This is because of a fall in turnover. A provision of £1.5m has been made for the forecast additional cost in 2015/16.

7. Prescribing cost growth projection for 2015/16, based on initial indications from the Board's Prescribing Advisers:

	£m
Primary Care	16.3
Acute	19.1
PPRS Receipts (Estimated offset to Acute pressures)	(9.5)
Hepatitis C	8.6
Gross Uplift	34.5
Primary Care Savings	(7.0)
Acute Savings	(3.0)
Net Uplift	24.5

This includes provision for likely cost increases related to growth in new and existing drug treatments within Acute Sector, including new drugs approved by SMC, and makes a realistic level of provision for likely growth in volume / prices, based on current trends, related to drug treatments prescribed within Primary Care. Cost growth projections will continue to be refined and updated.

The PPRS receipts figure is an estimate of the possible funding that NHSGGC might receive, to offset costs incurred within the £19.1m gross increase.

Current estimate of Hepatitis C costs for 2015/16 is £17.0m. This is based on 400 patients at £40k each for the new drugs regime, plus £1.0m for conventional treatments. The existing recurring budget is £8.4m, so an additional £8.6m is required.

8. Current estimates are, given the recent oil price decline, that no additional provision is required for 2015/16.
9. Indexation of asset values is anticipated to add £2.0m to capital charges.
10. Other costs inflation: 1.0% general provision has been set aside for inflation on non-pay costs excluding prescribing costs, energy costs, and capital charges costs. In line with the allocation uplift, 1.8% has been set aside for inflation on Resource Transfer, legal / contractual cost commitments and inflation on amounts payable to other NHS Boards and Voluntary Organisations, related to SLAs agreements.
11. South Glasgow University Hospitals: £4.4m was set aside recurrently in 2014/15 as an initial contribution to the additional capital charges for the new hospital and was used non-recurrently in that year. An additional £11.9m has been provided for the additional step-up to the full capital charges. It should be noted, however, that the Acute Division has generated savings over the past few years to fund, in full, the additional costs of the new hospitals.

SGHSCD Supporting Narrative – 13 February 2015

Progress Report on Development of 2015/16 Financial Plans

12. FYE of existing service commitments entered into in previous years plus new recurring pressures identified have been evaluated in draft form only to date and include:

	£m
Integrated Care Step Up	8.9
Delayed Discharges	7.1
Boundary Changes Gap	3.0
CNORIS	2.8
Consultants' Pay Progression 2014/15	1.5
National Services	1.4
Brain Injuries	1.3
Satellite Radiotherapy	0.8
R&D Loss of Income	0.6
Immunisation Schemes	0.2
Total Other Service Commitments	27.6

13. The current recurring contingency fund is £5.0m. It is not appropriate to decide at this stage how that fund will be used but it is clearly prudent to retain some central flexibility in a plan that has £3.0bn of expenditure, potential unexpected pressures and a number of areas of significant financial risk. Some possible applications, as yet unquantified, include:

- Additional prescribing pressure that cannot be funded within divisions;
- Winter pressures that cannot be funded within divisions;
- Spend to save schemes, such as the demolition of buildings on surplus sites;
- Additional orphan drugs costs;
- Additional transitional costs for South Glasgow University Hospitals.

As these risks are quantified, this draft plan will be amended as necessary.

SGHSCD Supporting Narrative – 13 February 2015

Progress Report on Development of 2015/16 Financial Plans

2015/16 Savings – Initial Proposals

The following savings targets have been proposed:

	£m
Acute	30.0
Partnerships	15.0
Corporate	3.1
	48.1
Financial Challenge identified above	48.1
Funding Flexibility	0.0

In addition, the net uplift for prescribing assumes that £10.0m of savings will be delivered.

We recognise that, in addition the cash releasing schemes above, we will develop non cash releasing schemes to meet SGHD's target for us to generate 3% efficiency savings.

Examples of areas identified for savings at this stage are:

Corporate Savings:

- Financial and management accounts - £0.4m
- Recruitment advertising - £0.1m
- Reductions in vaccine costs - £0.4m
- Implementation of Electronic Patient Record / Other HI&T schemes - £0.7m
- Office supplies savings - £0.1m

Partnership Savings:

- Workforce Planning efficiencies from re-profiling of pay budgets - £2.0m
- Local prescribing savings - £1.0m
- Clyde mental health strategy - £0.4m
- Redesign of children's services – £1.2m
- Sexual Health / Oral Health / Physiotherapy - £0.5m
- Local partnership schemes - £5.2m
- Redesign of addictions inpatient services - £0.9m

Acute Services Savings:

- Bed Model / ASR - £2.9m
- Procurement / Supply Savings - £1.4m
- Service Redesign - £0.6m
- Prescribing - £1.6m
- Workforce Change - £0.4m
- Workforce Planning New SGH - £6.6m
- Other (including Capital Charges) - £4.8m

SGHSCD Supporting Narrative – 13 February 2015

Progress Report on Development of 2015/16 Financial Plans

Next Steps – 2015/16

To ensure that the savings target remains realistic, we will continue to refine our assessment of funding uplifts and budget changes required for:

- Pay inflation;
- Non-pay inflation;
- Energy costs;
- Capital charges;
- Prescribing;
- Reductions in R&D funding;
- IT expenditure;
- Procurement;
- Investments;
- Orphan drugs;
- Nurse staffing ratios;
- Other cost pressures and risks.

Next Steps – 2016/17 & Beyond

In addition to the above list there are a number of other issues which we will have to consider for longer term financial planning. These include:

- Cross Boundary Flow – we need to ensure that the methodology is continually refined to ensure it remains fit for purpose;
- Benchmarking, areas of focus and performance measurement – we have to continue the work on benchmarking and areas of focus in order to establish how they influence our thinking about longer term budget setting;
- Integrating health and social care – we have to monitor the development of proposals and establish the impact on our longer term financial strategy;
- Employers' National Insurance – we have to refine our calculation of the additional cost arising from the abolition in 2016/17 of the contracted-out rebate.