NHS Greater Glasgow & Clyde

Board paper

21 April 2015

**Report of the Director of Corporate
Planning and Policy, Catriona Renfrew**

Paper No: 15/15

Strategic Direction and Local Development Plan

Recommendation

Board note submission of the Strategic Direction and Local development Plan

1.   Purpose of Paper

The attached final draft Local Development Plan (LDP) was submitted on 20th March 2015 to outline how the Board will deliver against the annual planning guidance issued by Scottish Government. The LDP for 2015/16 was developed as an integral part of finalising our Strategic Direction for the coming year.

2.   Risks and Issues

The It is important to note the risks and outstanding issues which are highlighted in the Plan and will be subject to further discussion with Scottish Government.

Financial issues: There are a number of risks within the financial plan:-

- A number of non recurring sources have been used to deliver the financial position for 2015/16 outlined above.
- Work is underway to finalise a plan for the prescribing of new hepatitis C drugs.
- Further costs are likely to emerge for nursing skill mix and GP out of hours the assumption is these will be covered non recurrently
- Per the current financial plan the assumption is that additional winter costs are covered non recurrently;
- A requirement for further investment into unscheduled care which would add a further £4 million to the financial gap.
- Additional transitional costs for the new hospital.

Targets and standards: Given the financial and service pressures across the system, there will be significant challenges to deliver all of the required targets in 2015/16. At the timeout the Board heard the detail of work in progress to try to address the service issues for unscheduled care. There are also a series of cost pressures related to delivering elective targets, most particularly workforce costs.

Delayed discharges: the plan requires a major reduction in the current level of delayed discharges, including consistent delivery of the national targets to enable the acute sector to achieve the bed reductions included in the savings plan and improve unscheduled care.

Service change proposals: the plan includes a number of service change proposals which need to be delivered during 2015/16 to achieve in year balance and also proposals to be delivered from the start of 2016/17 to ensure that recurring balance is restored. If any of these changes are not able to be delivered then balance in 2015/16 is at risk and the

financial challenge of 2016/17 increases

3. Integration Joint Boards

In considering finalising the LDP it is important to note that the 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;
- IJBs service delivery responsibilities are fundamental to enabling achievement of critical priorities outlined in the strategic direction and LDP.
- 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.

4. Next Stages

Scottish Government have provided initial feedback on the draft plan and discussion will continue over the next few weeks, with a particular focus on the issues and risks outlined in the previous section of this paper.

Catriona Renfrew
Director Corporate Planning and Policy
14th April 2015

**NHS GREATER GLASGOW AND CLYDE
STRATEGIC DIRECTION AND LOCAL DELIVERY PLAN 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 NHS 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 current Corporate Plan covers 2015-16. That Plan was subject to wide consultation and engagement and it is 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 Boards.

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 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 2015-16 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 This Strategic Direction establishes how we will progress these five priorities alongside the LDPs six improvement priorities over the next 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.

1.7   It is important to highlight in the introduction to this Direction and Plan the risks which we face in delivering it. These include:

- **Financial Risks:** the resources section of this paper sets out the approach we have taken to develop the financial plan and the related risks including:

  - we do not yet have a plan which delivers financial balance in 2015-16;
  - work is still in progress on a number of areas of pressure and additional costs;
  - non-recurring resources are a significant feature of the plan.

- **Targets and standards:** given the financial and service pressures across the system, there will be significant challenges to deliver all of the required targets in 2015-16. There are a series of cost pressures related to delivering elective targets, most particularly workforce costs and to the delivery of the unscheduled acre targets.

- **Delayed discharges:** the plan requires a substantial reduction in the current level of delayed discharges to enable the acute sector to achieve the bed reductions included in the savings plan.

- **Service change proposals:** the plan includes a number of service change proposals which need to be delivered during 2015-16 to achieve in year balance and also proposals to be delivered from the start of 2016-17 to ensure that recurring balance is restored. If any of these changes are not able to be delivered then balance in 2015-16 is at risk and the financial challenge of 2016-17 increases

- **Demand pressures:** there are a number of demand pressures across the system.

- **Workforce challenges:** there are a number of areas of pressure on our workforce.

- **Opening new South Glasgow University Hospital:** the programme to close a number of existing sites and move to the new hospital is challenging and complex.

1.8   A further important point of context is that 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 Strategic Direction and 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.

- IJBs service delivery responsibilities are fundamental to enabling achievement of critical priorities outlined in the strategic direction and LDP.

- 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.

1.9   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. 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.

2.4   To reshape care and deliver this vision we need to spend less on acute services and change the delivery of those services. Our Clinical Services Strategy provides the framework for us to make those changes.

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 2013/14 there were 451,545 A&E attendances; 393,493 new outpatient attendances; 155,023 day cases; 348,135 inpatient stays; and over 13,000 births. During 2015/16 the Division will radically reshape services as the new South Glasgow University Hospital opens.

3.4   The six new Partnerships will be responsible for 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, optometrists, 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.
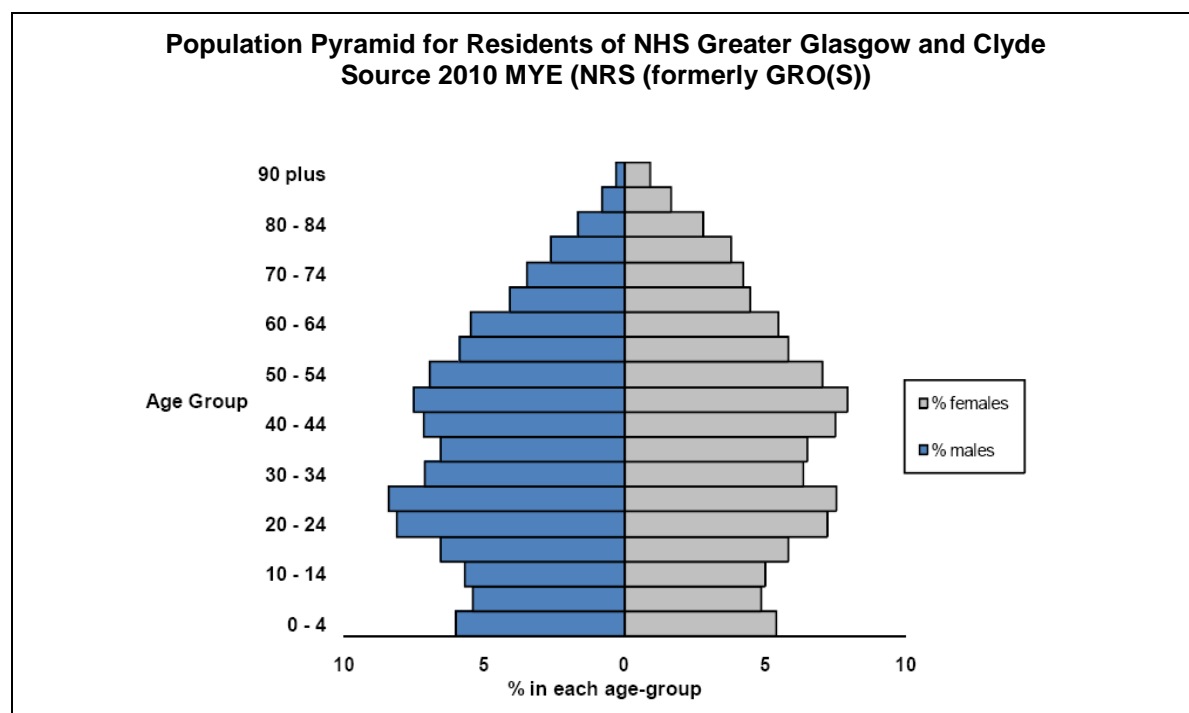
4.   THE POPULATION OF NHS GREATER GLASGOW AND CLYDE

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 it[1].

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.

Population Pyramid for Residents of NHS Greater Glasgow and Clyde Source 2010 MYE (NRS (formerly GRO(S))

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

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.

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;
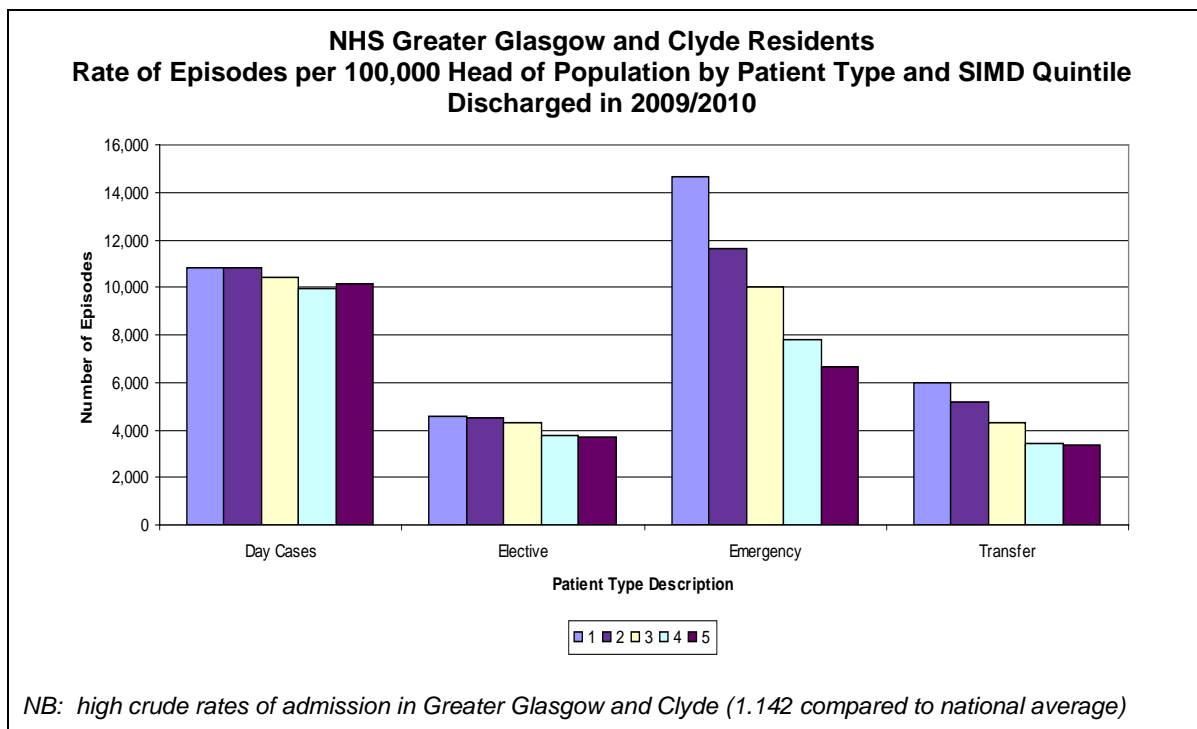- high levels of unemployment, including youth unemployment;

- 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 deprivation[2]. 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.
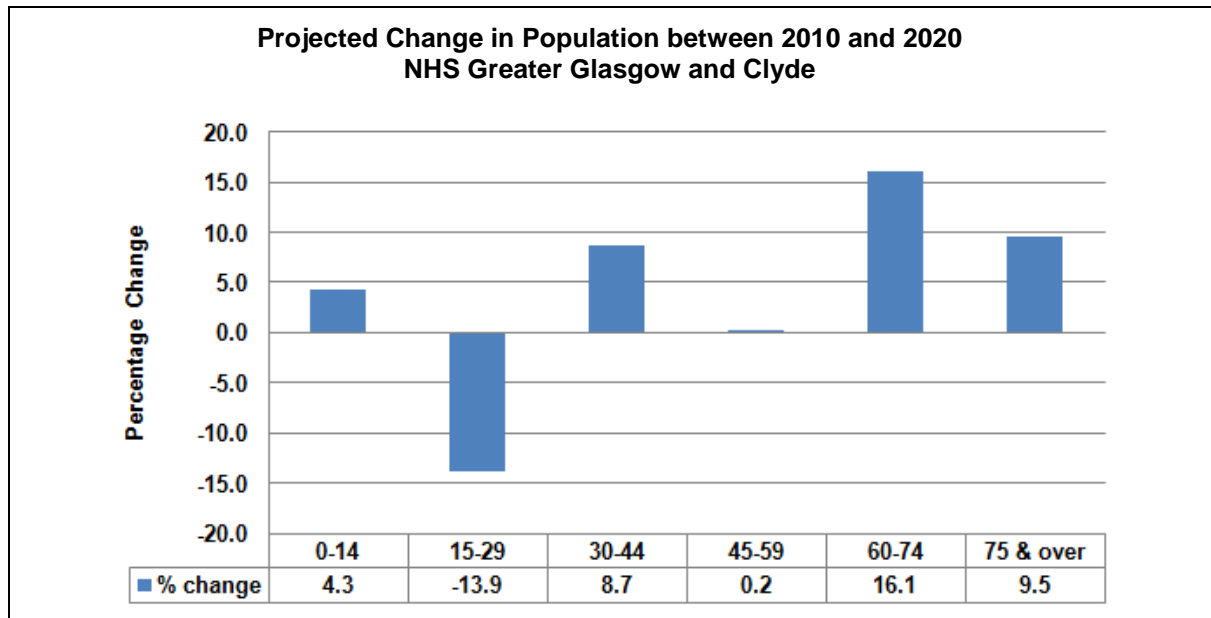
4.3 Projections and Trends for 2013-16

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 2016[3].

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[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.

Projected Change in Population between 2010 and 2020 NHS Greater Glasgow and Clyde

	0-14	15-29	30-44	45-59	60-74	75 & over
■ % change	4.3	-13.9	8.7	0.2	16.1	9.5

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

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   At this stage all plans shown must be viewed as draft and there remains significant work before a final plan will be submitted. In late 2014 we 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. We recognised that non cash releasing schemes would also be developed to meet SGHD's target for 3% efficiency savings. At the Board Away Day on 9 March 2015, we reframed the likely cash-releasing savings target to between £39m and £43m for 2015/16. The current expected target is £40.9m. The reasons for the change from the original £48.1m are shown below:

	£m
Financial Challenge at February 2015	(48.1)
Additional Income from NHS Highland	2.0
Additional Income from other Boards	0.9
Additional Expected PPRS Receipts	7.7
Capital Charge Savings from Site Closures	8.0
Reduction in Acute Prescribing Savings	(0.8)
Increase in CNORIS Provision	(0.9)
Increase in Hepatitis C Provision	(3.0)
Local Ivacaftor Costs	(2.7)
Provision for Unscheduled Care Costs	(4.0)
Financial Challenge at March 2015	40.9

5.3 At present, of the £40.9m target, £6.7m remains to be identified and a further £5.7m is high risk. Work continues to identify further schemes to deliver the allocated savings targets for 2015/16. Any remaining gap would require to be covered by either identifying additional in year savings during the year 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. 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.The detailed draft 2015-16 Financial Plan is set out in the attached proforma

5.4 Update on Inflation, Cost Pressures and 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.

	Jun 2014	Feb 2015	Mar 2015
	£m	£m	£m
Carry Forward from 2014/15:			
Forecast recurring over-commitment	(0.0)	(0.0)	(0.0)
2015/16 Funding Uplift:			
Minimum Uplift	41.1	39.8	42.7
Integrated Care Fund		8.9	8.9
Additional Drugs Uplift		8.2	8.2
Delayed Discharges		7.1	7.1
	41.1	64.0	66.9
Cost Drivers:			
Pay Cost Growth	(42.0)	(35.8)	(35.8)
Prescribing Cost Growth	(27.2)	(24.5)	(23.3)
Energy Cost Growth	(3.0)		
Capital Charges Indexation	(2.0)	(2.0)	(2.0)
Other Cost Inflation	(10.7)	(10.3)	(10.3)
	(84.9)	(72.6)	(71.4)
New Service Commitments:			
South Glasgow University Hospitals	(13.0)	(11.9)	(3.9)
Other	(12.6)	(27.6)	(32.5)
Board Contingency			
	(25.6)	(39.5)	(36.4)
Financial Challenge	**(69.4)**	**(48.1)**	**(40.9)**
CRES Requirement	**3.5%**	**2.4%**	**2.1%**

5.5   2015/16 Projections - Explanatory Notes

- 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.

- 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.

- 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**

- 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.

- 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.

- Pay cost growth comprises:

	£m
Provision for 1% uplift	14.2
Provision for Additional Low Pay Costs	1.8
Provision for Additional Superannuation	17.3
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 £17.3m 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.

- 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.

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

	£m
Primary Care	16.3
Acute	21.8
PPRS Receipts (Estimated offset to Acute pressures)	(17.2)
Hepatitis C	11.6
Gross Uplift	32.5
Primary Care Savings	(7.0)
Acute Savings	(2.2)
Net Uplift	**23.3**

- 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 additional funding that NHSGGC might receive, to offset costs incurred within the £21.8m gross increase. This is in addition to £2.9m which had been assumed recurringly in the 2014/15 plan.

- Current estimate of Hepatitis C costs for 2015/16 is £20.0m. This is based on £19.0m for the new drugs regime, plus £1.0m for conventional treatments. The existing recurring budget is £8.4m, so an additional £11.6m is required.

- Current estimates are, given the recent oil price decline, that no additional provision is required for 2015/16.

- Indexation of asset values is anticipated to add £2.0m to capital charges.

- 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.

- South Glasgow University Hospitals: The total capital charge per the business case is £18.7m. £2.4m was made available in 2013/14 for capital charges on the Laboratory Block and Car Park 1. £4.4m was set aside recurringly in 2014/15 as an initial contribution to the additional capital charges for the new hospital and was used non-recurringly in that year. In addition, £8.0m of capital charge savings arising from site closures has been identified, leaving an additional £3.9m to be 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.

	£m
Total Capital Charge	18.7
less	
Labs and Car Park 1 Already Funded	(2.4)
Funding Set Aside in 2014/15	(4.4)
Savings from Site Closures	(8.0)
Net Additional Capital Charges	**3.9**

- 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
Unscheduled Care	4.0
CNORIS	3.7
Boundary Changes Gap	3.0
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	**32.5**

5.6   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.

5.7   2015/16 Savings - Initial Proposals

The following savings targets have been proposed:

	£m
Acute	22.8
Partnerships	15.0
Corporate	3.1
	40.9
Financial Challenge identified above	40.9
Funding Flexibility	0.0

5.8   In addition, the net uplift for prescribing assumes that £9.2m of savings will be delivered and net additional capital charges assumes that £8.0m of savings from site closures will also 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 - £2.9m;
- Workforce Change - £0.8m;
- Workforce Planning New SGH - £4.6m

5.9   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.

5.10   Next Steps - 2016/17 and 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.

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.

6.2   Primary Care

The delivery and development of primary care is fundamental to progressing all of these priorities. Successful primary care is integral to the 2020 vision and integrated health and social care. The overwhelming majority of healthcare interactions are at primary care level, both in-hours and out-of-hours. There are major pressures on primary care driven by the aging population, deprivation and with more people living with complex long term conditions. Last year NHS Boards developed strategic assessments of primary care (NHSGGC Strategic Assessment of Primary Care.). These identified four key themes: leadership and workforce; planning and interfaces; technology and data; contracts and resources. 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 are planning a major engagement exercise about GP services enable us to develop a shared direction for these services with the new Partnerships. Actions already in place include:-

-         an Interface Group to improve working between acute and primary care;
-         a programme of 17c contracting;
-         work to develop a shared record
-         continuing substantial investment in locally enhanced services;
-         developing HIT across health system;
-         through the Paisley Programme testing new models of community service and primary care delivery;
-         premises investment
-         additional funding for practices to deliver services to Nursing Homes;
-         continuing support for the Deep End and primary care inequalities programmes;
-         extending community services:
  -    rehabilitation teams;
  -    single point of access;
  -    IRF investments;
  -    additional children's resources.

6.3   Clincal Service Strategy

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);
- develop plans for further service changes which progress the CSS.

6.4 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 including associated the health inequalities (smoking, healthy weight, drug and alcohol use);
- embed the principles of the Health Promoting Health Service across care settings;
- 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.

2015-16 Local Delivery Plan deliverables include:

- **Early Years**

    As part of the revised structure and architecture of the Healthy Children's Programme a Getting It Right For Every Child (GIRFEC) Group has been established to take forward the responsibilities in relation to the requirements of the Children and Young People (Scotland) Act 2014.

    The GIRFEC group is currently developing a work plan based around the relevant Touchpoints including the allocation of the Named Person; allocation of the Lead

Professional; Single Childs Plan; Information management, sharing and transfer; request for assistance; training requirements; Communication Strategy; and a complaints process.

Representatives from the Healthy Mums Healthy Babies Programme Board are part of the GIRFEC group to influence the work plan in relation to information management, sharing and transfer.

The work plan will scope out what is required with a timeline for completion by April 2016 and full implementation by August 2016.

Each of the six Partnership areas are also working locally on key aspects of GIRFEC and will be monitored through the Healthy Children Programme Local Implementation Groups. The governance arrangements for the GIRFEC group will be through the Healthy Children's Planning and Implementation Group.

Work in Maternity Services with regard to introducing an antenatal GIRFEC assessment is being taken forward via the Healthy Mums Healthy Babies Programme Board in support of a work plan which will see full implementation by August 2016.

- **Antenatal Care**

Earlier access to ante natal care is being encouraged and facilitated via the establishment of the central booking system which allows women to call and directly make appointments for booking and scan appointments. The use of IT allows for timely review of capacity which can be increased as and when required to facilitate early appointments. The monitoring of impact across SIMD quartiles is ongoing.

- **Young Persons Framework**

The development of a Prevention and Early Intervention Framework for young people with a focus on more vulnerable young people.

6.5 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.

Primary care is the bedrock on which the delivery of the NHS relies during 2015/16 we plan a major engagement programme across primary.

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.

6.6 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.

6.7 Improving Quality, Efficiency and Effectiveness

The national Quality Strategy and our local quality improvement programes 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;
- Continuing to focus on unscheduled care through delivery of our Local Unscheduled Care Action Plan.

2015-16 Local Delivery Plan deliverables include:

- 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 aligned electronic patient feedback including Patient Opinion to the wider Patient Experience agenda, to ensure a high quality response is made to every posting backed up with robust monitoring systems that track actions to ensure that patient feedback, where appropriate, leads to improvements in services.

- 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 (SPSP). During 2015-16 we will 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. The 2015-16 SPSP priorities are as follows:

  - **Acute Adult Programme:**

    - accelerated roll out of Deteriorating Patient workstream ensuring it becomes active on all acute sites and in all ward teams in one hospital (RAH);
    - continued development of electronic support to medicines reconciliation process whilst building larger scale of spread of reliability across the patient's journey.

  - **Mental Health Programme:**

    - implementing an "as required" medication bundle;
    - developing "ward safety profiles" using Patient and Staff Climate Surveys and other information;
    - standardising our approach to safety briefs.

  - **Primary Care Programme:**

    - implementing the community pharmacy programme as part of national pilot;
    - improving medicine reconciliation and the monitoring of DMARDS in General Practices;
    - improving prevention and care of Pressure Ulcers and Catheter associated UTIs with Community Nursing teams.

- **Maternity and Children Quality Improvement Collaborative:**

  - redeveloping programme support infrastructure when national support funding for midwifery champions ends;
  - develop pilot work on reliable process for deteriorating patient and SEPSIS in paediatric settings.

Examples of key 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. Our response to and implementation of the 65 recommendations in the Vale of Level Hospital Inquiry Report is a key example of this. We will also to be involved in the work with the National Vale of Leven Implementation Group and Reference Group.

6.8   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;
- we will deliver social and community benefits that support wider environmental, employment and economic well-being as part of our local investor role (Public Sector Reform (Scotland) Bill;
- 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; and
- we will consider the role of place based approaches within our community planning and locality development work.

2015-16 Local Delivery Plan deliverables include:

- NHSGGC has high levels of activity to address health inequalities and early intervention as outlined in our Equality Outcomes Framework 2013-16 and evidenced in our Equality Outcomes Monitoring Report 2014. (The 2014-15 monitoring report is currently being drafted). 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.

7.3   Our 2020 Workforce Vision Action Plan 2015-16 outlines our 2015-16 local priorities to deliver the 5 priorities in Everyone Matters: 2020 Workforce Vision Implementation Plan.

7.4   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.

2015-16 Local Delivery Plan deliverables include:

- We will continue to work to address the short medium and long term workforce challenges facing our medical workforce in Acute including:

  - the sustainability of services across all specialties reflecting the expectations of 7 day working and particularly for NHSGGC, the challenges of doing so across a large number of sites with a finite availability of the medical trainee and trained workforce;
  - the supply and demand challenges in relation to the Consultant workforce. Although there are different challenges in different areas, notable challenges exist across Radiology, Dermatology, Neurology, Psychiatry and Acute Medicine. We need to understand and address the barriers to successful recruitment at individual specialty level and give consideration to solutions involving non medical and regional roles;
  - the issues relating to trainee experience and working arrangements including changes to Junior Doctors hours and Junior Doctor rota compliance;
  - the impact of Greenaway implementation will be significant in NHSGGC particularly in respect of training and the potential emergence of skills gaps.

- 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.

- In addressing the workforce challenges in Partnerships - a review of community services has been carried out 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. In response to projected age retrials and identified difficulties in external recruitment (particularly with band 6 staff) we have dedicated resources to fund additional post graduate training which will allow staff to practice as District Nurses. 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.

7.5   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 Nurse 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.

7.6   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 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 retiral rates associated with high numbers of Mental Health Officer staff with pension status reaching 55 years of age. It is estimated that approximately 18% of this component of the nursing workforce will be eligible to retire in the next 5 year period;
-       within Facilities and Estates there is an ageing workforce profile and action is in place as part of the NHSGGC Youth Employment Strategy and the Education Partnership work stream to 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);
-       in diagnostics key workforce factors are being dealt with as part of the action being taken to address services under stress. A key example includes the £1.1 million invested during 2013-14 in Diagnostic Imaging to address increases in patient demand and activity. This investment resulted in an increase in the Radiographer workforce and associated Healthcare Support Worker and Administrative workforce. This funding also provided additional radiologist reporting medical staff resulting in extending the availability of MR scanners, at some hospitals, into the evening and at weekends. NHSGGC continues to have challenges with recruiting and retaining radiography staff at both Band 6 and Band 5 level. Nationally there appears to be a low-level of supply and opportunities within other Healthcare providers across the UK have made it difficult to retain staff.

2015-16 LOCAL DELIVERY PLAN STANDARDS AND REQUIREMENTS OF JOINT COMMISSIONING GUIDANCE FOR INTEGRATION JOINT BOARDS

Progress against each of the Local Delivery Plan Standards and IJB standards will be monitored by the NHS Board or appropriate Committee. In establishing Integration Joint Boards the Board will set out the elements of these standards which are required to be delivered by the IJB, as is required in the regulations, and the focus on performance delivery will be through the IJB.

Draft Indicators for Integration of Health and Social Care

- Percentage of adults able to look after their health very well or quite well.
- Percentage of adults supported at home who agree that they are supported to live as independently as possible.
- Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided.
- Percentage of adults supported at how who agree that their health and care services seemed to be well co-ordinated.
- Percentage of adults receiving any care or support who rate it as excellent or good.
- Percentage of people with positive experience of their GP practice.
- Percentage of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life.
- Percentage of carers who feel supported to continue in their caring role.
- Percentage of adults supported at home who agree they felt safe.
- Percentage of staff who say they would recommend their workplace as a good place to work.
- Premature mortality.
- Rage of emergency admissions for adults (inc proposal to also look at rate of emergency bed days for adults).
- Readmissions to hospital within 28 days.
- Proportion of last 6 months of life spent at home or in community setting.
- Falls rate per 1,000 population in over 65s.
- Proportion of care and care at home services rated 3 or above in Care Inspectorate Inspections.
- Delayed discharge - 14 days, 72 hours, bed days lost.
- Percentage of adults with intensive needs receiving care at home.

Local Delivery Plan Standards

- <u>Preventing Ill Health and Early Intervention</u>

    - 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.

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

    - 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.

- <u>Shifting the Balance of Care and Reshaping Care for Older People</u>

    - 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%).

- <u>Tackling Inequalities</u>

    - 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.

2015-16 LOCAL DELIVERY PLAN DELIVERABLES - PERSON CENTRED CARE

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 what 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

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.

- **Maternity and Children Quality Improvement Collaborative** - (Paediatrics and Neonatal Workstream) - within paediatric wards the areas of work are hand hygiene, CEWS, Safety Briefs, SBAR, PVC and CVC maintenance which is being spread from PICU. Success can be seen in the level of spread and reliability in that all teams have shown reliability in all elements with a further 3 teams identified as having sustained reliability in all applicable elements. For the few who have not yet achieved the sustained reliability the Clinical Improvement Co-ordinator continues to link to provide support and maintain focus. The CVC maintenance has spread to two areas with reliability established in one, a third area commenced testing in December 2014. The plan for spread is currently being reviewed alongside the migration plan to ensure spread to all high risk areas.

- **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;
    - 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.