

Board Meeting: 28 June 2016

Report of the Director of Planning &  
Policy, Catriona Renfrew

## LOCAL DELIVERY PLAN: DRAFT FOR APPROVAL

### Recommendation

The Board agree submission of the Local Delivery Plan.

#### 1. Purpose of Paper

The attached final draft Local Delivery Plan (LDP) outlines how the Board will deliver against the annual planning guidance issued by Scottish Government. Much of the format of the Plan is prescribed and our approach has been to ensure the plan links to the wide range of other critical documents. The next section of this short covering paper briefly draws out in the key issues from the plan.

#### 2. Points to Highlight

This section briefly highlights key issues which have been highlighted during the planning process as follows:

- A series of **financial issues** and risks which are described in more detail in the financial plan.
- Challenges to deliver **targets and standards** the Board has committed to a major review of unscheduled care to improve our performance, for scheduled care the LDP includes information on deliverable performance within the available recurring resources.
- Continuing reduction in the **level of delayed discharges**.

In addition to these issues, during development of the plan members sought reassurance on a number of points:

- Decisions on **over the counter medication and access to gluten free products** will be taken in national processes not by NHSGG&C.
- The proposals in the **service change** section will be considered in detail at the August Board meeting.
- The changes to **GP out of hours services** reflected in the financial plan relate to increased efficiency and reduced support costs not to reductions in clinical services.

#### 3. Next Stages

The plan will be submitted to Scottish Government, much of the implementation is already underway and the Board will be regularly updated.

# LOCAL DELIVERY PLAN

## 1. INTRODUCTION

This Local Delivery Plan (LDP) brings together:

- An appraisal of our strategic position and context.
- Principles established to frame the development of our plans for 2016/17 to ensure that we make decisions which are coherent with our strategic direction and priorities.
- An appraisal of the detailed service and financial planning we have underway to deliver this plan and an outline of service and financial risks and challenges which we face for 2016/17.

**1.1** This LDP, including the financial planning, has been developed in concert with the Integrated Joint Boards (IJBs). The Board now shares responsibility for strategic planning with the IJBs but retains responsibility for the allocation of the NHS budget between the services for which we retain direct operational responsibility and those managed by IJBs. IJBs need to develop and approve integrated service and financial plans for the NHS and Council services which are legally delegated to them. IJBs also have a central role in working with the NHS Board on the planning and financing of the acute sector and our Plan cross references to Partnerships Strategic Plans.

**1.2** This plan highlights a number of areas of risk reflecting the fact that we do not yet have a fully balanced financial plan across NHSGG&C, a substantial programme of work continues to identify the required level of savings, and to put in place the necessary actions, to achieve financial balance in 2016/17.

## 2. STRATEGIC POSITION AND CONTEXT

**2.1** The Board has a detailed strategic direction which sets our purpose as 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.”***

**2.2** That purpose is amplified with five strategic priorities to move us towards achieving that purpose, these are:

- Early intervention and preventing ill-health
- Shifting the balance of care
- Reshaping care for older people
- Improving quality, efficiency and effectiveness
- Tackling inequalities.

**2.3** A key purpose of this LDP is to set out the detailed service change plans which we have developed to deliver that purpose and those priorities. Those plans will deliver better services for patients and will progress the delivery of:

- The mental health strategy progressed through the final capital development to deliver modern mental health services.
- The clinical service strategy, which maps out a clear direction for acute services, updated to reflect the National Clinical Strategy and translated into detailed service change plans. Implementing service change is critical to our ability to meet unscheduled and scheduled care targets and to deliver high quality care.

- Continuing the pattern of change in community services which has improved the range and efficiency of those services but not yet the more radical developments to enable us to reshape the acute sector.
- The development of primary care in line with the national direction, local priorities identified through our recent engagement exercise and work being developed in each HSCP.

**2.4** The aim of the approach set out in this LDP is to make changes which align with our strategic direction, priorities and clinical strategies and enable us to deliver financial balance.

**2.5** In addition to this LDP we are working on a delivery plan for our Acute Division, which alongside the implementation plans which IJB's are deriving from their strategic plans, will provide more details of the challenges we need to address and the changes we need to deliver in 2016/17.

**2.6** It is also our intention to use the platform of the publication of the National Clinical Strategy to establish a planning process - **why “establish”, the June Board paper does this** during the autumn of 2016 to deliver a change plan for acute services for the period 2017/20 and a longer term acute services plan which can drive capital investment.

**2.7** The financial position is summarised in section six of this LDP.

### **3. PRINCIPLES FOR PLANNING**

**3.1** In order to ensure our planning and financial decisions align with our strategic direction the Board established the principles set out in this section. These have shaped our approach to developing this LDP.

**Our overriding principle is to give absolute priority to patient facing services and ensuring these are always high quality and safe.**

Our further principles are to:

- Make financial decisions for 2016/17 which are in line with and enable us to move in coherence with our purpose, strategic direction and related strategies all of which are focussed on ensuring our services are focussed on the needs of patients.
- Continue to play our part in trying to reduce the inequalities which affect our population and have a strong focus on equality impacts in making our decisions.
- Ensure that our decisions do not have unintended consequences such as unplanned transfers of pressures, responsibilities or costs to other parts of the system.
- Aim to continue to deliver the key Scottish Government targets.
- Focus first on changes which make clinical and service sense and increase efficiency and productivity and reduce our unit costs.
- Ensure that where we propose to restrict access to services or stop planned developments we will have a clear framework for prioritisation of patient care linked to clinical benefit.
- Shift the balance of care and resources but also recognise the pressures on acute services.
- Test all new national initiatives and proposals which have financial implications against our strategy and report to Board for decision.
- Underpin our decision making with evidence about what delivers the safest, highest quality and most cost effective healthcare.
- Explicitly consider risks and benefits in making decisions.
- Remain committed to the importance of innovation and research to shape changes in the way we deliver care.

- Work across boundaries with other Health Boards and public bodies to identify ways in which we can deliver services more efficiently.
- Take a whole system approach not localised savings targets, that approach driven by:
  - cost scrutiny in every part of the organisation, led by the local teams
  - a whole system programme of change to deliver cost reduction.

We recognise that the scale of the challenge we face means that we are entering a period of significant change. Fundamental principles of our decision making are:

- A commitment to engagement with patients and the wider public.
- A commitment to fully engage with our staff and their representatives in shaping, planning and delivering the changes to services which will be required.

#### 4. SERVICE CHANGES

This section gives a brief summary of service changes which will require public engagement. The changes outlined move forward the Board's Clinical Service Strategy. The strategy provides the basis for future service planning and the development of detailed service change proposals. The strategy sets out the high level service models to shape the service provision and identifies the key approaches to underpin the future service planning for the populations served by NHSGG&C:

- Improving health and prevention of ill health; empowering patients and carers through the development of supported self care.
- Developing primary care and community service models; simplification of community models; focus on anticipatory care and risk stratification to prevent crisis.
- Improving the interface between the community and hospital to ensure care is provided at the right time in the right place; Community and primary care services inward facing and hospital services outward facing; focused on patient and carers needs.
- Developing the ambulatory approach to hospital care, with inpatient hospital care focused on those with greatest need ensuring equitable access to specialist care.
- Redesign of specialist pathways to establish a consistent service model delivering the agreed clinical standards and good practice guidelines.
- Developing the rehabilitation model based on need not age; working across the service within primary and secondary care and with partner organisations to provide rehabilitation in the home setting where clinically appropriate.
- Changing how care is delivered - patient centred care; shifting the paradigm to deliver care differently for patients particularly for patients who have multiple conditions; helping patients and the public to develop and understand the new approaches to care.
- Care which is patient focused with clinical expertise focused on providing care in the most effective way at the earliest opportunity within the care pathway.
- Services and facilities have the capacity and capability to deliver modern healthcare with the flexibility to adapt to future requirements.
- Sustainable and affordable clinical services can be delivered across NHSGG&C.

Proposals setting out the detail of the service changes outlined below will be brought to the August Board meeting to enable the required public engagement to be approved.

**Review of RAH paediatric services:** proposal to retain the current full range of general and specialist outpatient children's services at the RAH, with inpatient care to be provided at the new children's hospital.

**Review of Clyde Birthing Services:** proposal to retain all ambulatory services at the CMUs with deliveries offered in our midwife led units in RAH, PRMH and the QEUH or at home; finalising proposals on these services will include work with the CMO to look at

midwifery delivery services across NHSGG&C and decisions will be made in the light of the outcome of the national review of maternity services.

**Review of CIC Inpatient Services:** proposing to deliver the full current range of CIC services on an ambulatory care basis, this reflects the fact that the vast majority of patients are now local to Greater Glasgow and Clyde.

**Review of inpatient rehabilitation services:** proposing to transfer inpatient rehabilitation from Lightburn to the new centre of excellence at Gartnavel General Hospital with ambulatory care continuing to be delivered in the East End as part of developing plans with the new Health and Social Care Partnership for new community facilities. The current Parkinson's service will continue to be delivered in the East End.

## 5. LOCAL DELIVERY PLAN REQUIRED CONTENT

This section sets out *in italics* the LDP guidance requirements with links to each of the documents used to support the delivery of the specific areas identified.

### 5.1 Health Inequalities and Prevention

*The LDP should set out local priorities for how they will address health inequalities and improving prevention work based on the needs of their local population and own workforce. 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 into routine practice. The plan will also include information about how the Board and its partners prioritise action and monitor progress. Plans should set out what is being done to tackle the preventable causes of the costs to the NHS and society of preventable disease. Alongside the public health themes addressed by the existing LDP standards, Boards are asked to provide details of their priorities for actions to address the unsustainability of the burdens arising from poor diet and weight management.*

#### **Our Approach**

- Early Intervention and Prevention is an established strategic priority across NHSGG&C. Our priorities in addressing health inequalities and prevention across NHSGG&C are outlined on our [2015-16 Equality Monitoring Report](#) alongside our [2016-20 A Fairer NHS Greater Glasgow & Clyde – Equality Outcomes Framework](#). In addition, our [Strategic Direction for Health Improvement](#) details the extensive programme of Health Improvement Activity aimed at delivering this strategic priority. This priority is also the focus of the Joint Strategic Commissioning Plans for each of the six Health and Social Care Partnerships (HSCPs) detailing the actions in place to tackle Health Inequalities and Prevention for the Partnership areas ([Renfrewshire HSCP:draft](#)); [Inverclyde HSCP](#); [Glasgow City HSCP](#); [East Renfrewshire HSCP](#); [East Dunbartonshire HSCP](#); and [West Dunbartonshire HSCP](#)). In addition, these priority areas will also be the primary focus for the development of the IJB Equality Outcome Plans currently under development ([Renfrewshire Equality Outcomes](#); [Inverclyde Equality Outcomes](#); [Glasgow City Equality Outcomes](#); [East Renfrewshire Equality Outcomes](#); [East Dunbartonshire Equality Outcomes](#) and [West Dunbartonshire Equality Outcomes](#)).
- In finalising our financial plan we are assessing the impact of the reduced national allocation for prevention and health improvement and reductions in national funding for services which are critical to tackling inequalities, including those for people with drug and alcohol problems.

## 5.2 Antenatal Care 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 August 2016. The LDP should also set out plans for health visitors including baselines and additional numbers being recruited through to 2018.*

### **Our Approach**

- HSCPs are currently working together to deliver the GIRFEC work plan and the major challenges to be overcome to deliver the new pathways.
- Maternity services have progressed preparations and joint arrangements with health visiting services to ensure readiness to deliver GIRFEC commitments.
- Our programme of service reviews also includes considering the deliverability of the national policy to increase health visitor numbers and to continue the Family Nurse Partnership programme. Details of this are outlined in our [Health Visitors Investment Plan](#).

## 5.3 Safe Care

*The LDP should set out how the Board is taking forward one of the three points of care where data submission is supplementary. These are:*

- Venous Thromboembolism (VTE)
- Heart Failure
- Surgical Site Infection (SSI).

*Detail should include plans for spread and sustainability, the impact this area is having, and will have on patient care and how Boards are collecting data to drive local improvement. This should include an example from each Scottish Patient Safety Programme of how safety of care has improved in the last 12 months. In recognition of the contribution which NHS Boards can make to wider quality improvement across the integrated health and social care landscape, Boards are asked to provide detail on how they are engaging with Local Authorities and care providers to achieve the aim of achieving a 50% reduction in grade 2 - 4 pressure ulcers acquired in hospital or care home by end of 2017.*

### **Our Approach**

- NHSGG&C is committed to providing safe high quality care that our staff and patients can be proud of. Over recent years the Scottish Patient Safety Programme has provided a shared platform through which our clinical services have collaborated and developed improvement in the safety of care. Over the next few years we wish to develop an NHSGG&C Clinical Safety Programme, which will build on our experience and the support of the national programme, but allow us to integrate other useful developments such as our clinicians work in reviewing quality of care through morbidity and mortality meetings. The [Safe Care Plan](#) details our plans for spread and sustainability, the progress we are making and the next steps.

## 5.4 Person Centred

*The LDP should set out how services will deliver person-centred care. This may be done with reference either to:*

- *How Boards will deliver a positive care experience in accordance with the five “must do with me” principles of care: What matters to you? Who matters to you? What information do you need? Nothing about me without me, and service flexibility or*
- *The Strategic Framework for Action on Palliative and End of Life Care.*

*The LDP should also outline the action that will be taken locally to support staff and the public to be open and confident in giving and receiving feedback, comments, concerns and complaints, with a particular focus on how the Board will involve people meaningfully in reviewing how themes emerging from feedback and complaints can be used to improve healthcare services, and how it will demonstrate the improvements made as a result of feedback.*

### **Our Approach**

- We have developed a [Person Centred Care Action Plan](#) to take forward the Strategic Framework for Person Centred Care with an extensive programme of activity underpinning the delivery of this.
- We are developing an action plan to take forward the Strategic Framework for End of Life Care with Partnerships.

## **5.5 Primary Care**

*The LDP should provide progress on those priority actions identified in 2015-16 LDP alongside any new actions being pursued to manage as much care ‘out of hospital’ as possible, including the resources identified to achieve this aim. This should include action taken to support the introduction of the post QOF (Transitional Quality Arrangements) revisions to the GMS contract in 2016-17 and the implementation of Sir Lewis Ritchie’s review of out of hours primary care services. The plan should also identify where national action would help local delivery.*

### **Our Approach**

- In September 2015, we launched a programme of engagement for a wide range of interests to [develop a direction for GP Services](#) across NHS G&C. The [output](#) from these engagement events clearly identified the pressures within Primary Care GP services. We are working with IJBs to develop an action plan to address the issues identified.
- In January 2015 a major project to test new ways of structuring primary care services was launched in Inverclyde. The [pilot](#) will look at how the role of the GP can be refocused, reducing the time they spend on tasks that could be more appropriately done by other health professionals and examining how these staff can support patients in the community.
- We have a programme of work to implement the 2016/17 GMS contract and we are integrating into that our proposals for the primary care transformation fund. Our approach is to begin to mitigate pressures on GPs while we develop longer term plans for primary care. Our approach will aim to develop strong relationships between IJBs and GPs and to reduce workload and improve morale.
- Out of hours: IJBs are considering how the national review will be reflected in their forward plans and we are working on a number of changes to GP OOH in 2016/17 to continue to provide a safe and sustainable service.
- IJB plans include proposals to develop and reshape primary care and community services.
- There are significant risks in relation to primary care and community services including:
  - the extent to which the immediate demand pressure on GPs can be mitigated to secure services to enable a more transformational programme of change.
  - the pressures and focus on acute services continue to create real challenges to shift the balance of care.

- the financial pressures which we have set out in this plan require us to generate savings in community services.
- there are significant pressures on social care services which have the potential to directly impact on NHS services.
- the primary care transformation fund is a welcome additional resource but much more major investment in primary care is required.

## 5.6 Integration

*The LDP should set out a summary of how the delivery of national and local standards/targets will be aligned between the local planning and operational structures.*

### **Our Approach**

- Work is currently underway with each of the six HSCPs to ensure the [delivery of key national and local standards/targets](#) that they have lead responsibility for delivering. There is agreement that these standards will also be embedded within each of the six Strategic Commissioning Plans and reported routinely to their respective IJBs and internal reporting arrangements and links will be made to each. Our need to continue to build and strengthen our joint working and operational structures with each of the partnerships will be reflected to ensure the delivery key targets including delayed discharges. Included is a risk narrative in relation to the [Smoking Cessation](#) and [Alcohol Brief Intervention](#) Local Delivery Plan Standards.
- We have whole system planning arrangements with our IJBs, including to develop the financial plan.
- We have not yet finalised allocations to IJBs, therefore there are financial risks for the IJB strategic plans and their operational service delivery responsibilities.

## 5.7 Scheduled Care and Unscheduled Care

*The LDP should set out a summary of the local work that will be carried out during 2016-17 under the National Scheduled Care Programme (sustainability). The LDP will provide a clear summary of actions being taken forward through the local six Essential Actions programme in 2016-17. This will include references to local plans including six Essential Actions, Winter and Joint Strategic Commissioning plans.*

### **Our Approach:**

For both scheduled and unscheduled care our new pattern of hospital services has been established during 2015/16 and we are now taking stock of capacity and performance issues which have emerged. Given the financial position and demand pressures there are significant risks to meeting performance standards in 2016/17.

- We are continuing to review and assess capacity requirements in the light of the increasing pressure on scheduled care, sustaining current levels of activity will prove challenging in the light of the pressures on unscheduled care and the financial position.
- We will work closely with the Scottish Government's Access Support Team that has been established as part of the 'Getting Ahead' – sustainable whole systems management for elective services' programme. Our submission to the programme is on link here, these levels of activity have been underpinned by substantial non recurrent resources which will not be available in 2016/17 given the Board's financial position.
- During 2015/16 we had significant challenges in meeting the unscheduled care target. We have worked closely with Scottish Government colleagues to improve our performance and we have a process underway to review the delivery of our unscheduled care plan and assess areas for improvement, with Partnerships. The additional levels of non recurring funding in currently in play for unscheduled care are not included in this plan on a recurring basis.

## 5.8 Mental Health

*Performance on the mental health access standards continues to show a considerable rise in the number of people starting treatment. A Mental Health Improvement Programme to support NHS Boards to improve access to services and meet the waiting times standard sustainably has been announced. The programme will be delivered by Healthcare Improvement Scotland which will establish a Mental Health Access Improvement Support Team (MHAIST). MHAIST will work in partnership with NHS Boards to identify enablers and barriers to the Board being able to deliver improved access and meet the waiting times standard, and support Boards to review their mental health access improvement plans in light of that joint consideration of local enablers and barriers to delivery. In advance of the MHAIST starting its work in 2016-17, the LDP should provide information focusing on reducing waiting times and on improving access to mental health services in line with local need. The plans should include an assessment of the level of access currently provided by the Board and with the anticipated level of need locally – including benchmarking with other boards in Scotland. We expect the plans to include a workforce development plan with evidence of the current workforce capacity in Child & Adolescent Mental Health Services (CAMHS) and psychological therapies and how that will be developed.*

### **Our Approach**

- NHSGG&C currently performs better than most areas of Scotland in relation to access targets for psychological therapies and CAMHS community services. The [CAMHS Report](#) outlines the performance and improvements made during the past two years alongside the detail of how this will be maintained or further improved with access to the new Scottish Government funds and initiatives once the detail of these have been made available. The [Psychological Therapies Report](#) highlights actual performance during the past four years and how we will manage the risks associated with the delivery of this target. Linked to the ongoing delivery of these targets will be our work with the MHAIST during 2016-17.
- To date the achievement of the targets have been linked to agreed funding, however, if there is an overall shortfall in the funding of mainstream services, including the consequences of 'bundled' funding reductions, then these services cannot be ring fenced or excluded from the consequences of financial challenges with potential to affect the current good performance in delivering the access targets.

## 5.9 Community Planning

*Boards must indicate how they will continue to strengthen their approach to community planning during 2016-17, through both their contribution to integration and how they demonstrate leadership within the broader CPP. This should focus on playing a strong and leading contribution within the CPPs 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.*

### **Our Approach**

- Health related activity around Community Planning will be led by Partnerships where close links have already been established to ensure the delivery of local priority outcomes relating to health and well being. NHSGG&C's contribution is evident through the activity identified in each of the Single Outcomes Agreements ) in each of the partnership areas ([Renfrewshire SOA](#); [Inverclyde SOA](#); [Glasgow City SOA](#); [East Renfrewshire SOA](#); [East Dunbartonshire SOA](#); and [West Dunbartonshire SOA](#)) alongside the Strategic Commissioning Plans.
- The Board is also engaging with Councils to establish wider relationships for community planning across the NHS system.

## 5.10 Workforce Planning

*Boards are required to provide information on two key workforce areas in the LDP this year.*

- *Delivering Everyone Matters: 2020 Workforce Vision: NHS Boards should provide a short outline of their local implementation plans for 2016-17 to deliver the five priorities in the Everyone Matters: 2020 Workforce Vision Implementation Plan 2016/17. The five priorities are: Healthy Organisational Culture, Sustainable Workforce, Capable Workforce, Workforce to Deliver Integrated Services and Effective Leadership and Management.*
- *NHS Boards should indicate any workforce areas where there is a risk to delivering service. Specifically Boards are asked to make clear reference to:*
  - *the use of Nursing and Midwifery Workload and Workforce Planning tools, recruitment issues, vacancy rates or concerns - professions or groups of professions affected, services affected - steps being taken or national approach required.*
  - *areas in which services are being developed which may have specific implications for the NHS workforce, or for individual professions as appropriate, and steps taken to manage these locally e.g. Health Visitors, School Nurses, Advance Nurse Practitioners and Health Care Support Workers.*
  - *demographic information i.e. age of workforce impacting on service delivery, local pressures, staff numbers, other workforce factors influencing the sustainability or otherwise of services.*
  - *how workforce factors are being dealt with as part of action being taken to address services which are under stress e.g. A&E, Oncology and Radiology.*

*The Board will continue to be required to publish their wider workforce plan during 2016 and are reminded that the application of the Nursing and Midwifery Workload and Workforce Planning Tools are mandatory and should be used and documented in the development of Workforce Plans and workforce projections.*

### **Our Approach**

- We face a series of workforce issues these include junior and senior medical workforce recruitment issues; clinical sickness absence levels and the age profile of key parts of our workforce, including GPs.
- Delivering a sustainable financial plan will require significant workforce redesign as will progressing regional and national initiatives to share services.
- The [Workforce Planning Report](#) outlines how we continue to realise the 2020 Workforce Vision through our 2016-17 Workforce Vision Implementation Plan alongside identifying those workforce areas where there could be a risk to delivering services.

## **6. FINANCIAL PLAN**

- 6.1** The Scottish Government set out its budget to the Scottish Parliament in December 2015. This set out an up lift of £511 million or 5.3 % to the Health budget.
- 6.2** For NHSGGC, this resulted in a funding up lift of £92.8m. However, as £59.1m of this was Social Care Funding and was “passed straight through” to our 6 IJBs, the uplift to the Board was £33.7m (1.7%).
- 6.3** The Board also faced reductions in “bundled funding” and the New Medicines Fund. When offset against 2016/17 cost pressures of £96m, the majority constituted of pay cost growth (£50m) and prescribing cost growth (£25m), the Board is facing the significant challenge of requiring to save £69m of recurrent savings in order to break even.
- 6.4** The Board also continues to face severe financial challenges and financial risks, including the cost of new medicines, including those for Hepatitis C, and orphan / ultra-orphan and end of life medicines.
- 6.5** The Acute division continues to experience significant cost pressures in Medical pay where significant expenditure on agency and locum cover has been incurred to support activity levels. Actual non elective and elective inpatient activity continues to increase significantly, together with long-term vacancies, difficulties recruiting and the requirement for waiting list initiatives to achieve TTG targets. Nursing pay also continues to be a significant cost pressure, with excess bank and agency spend driven by activity levels and accentuated by higher than average sickness/absence rates.
- 6.6** As outlined above, a comprehensive planning process involving all Directors and a wide range of managers, and in concert with the IJBs, commenced in the Autumn 2015. This involved identifying savings schemes to address the financial gap, and various presentations and discussions at Board Seminars and away days through October 2015 to April 2016. A process of engagement was also conducted with staff side and with the Scottish Government Health Directorate.
- 6.7** At the time of drafting this document, “green and amber” savings totalling £43.5m full year effect (£34.5m part year effect) have been identified. In addition, a range of “red rated” schemes have been identified, including some service redesign propositions outlined elsewhere in this document that require further work and consultation, totalling £11.5m full year effect (£8m part year effect).
- 6.8** In addition, Acute Division Management implemented a £10m cost containment programme in December 2015 to take effect before the 31st March 2016 in order to start the new financial year at, or close to, balance. However, this has proved extremely challenging, not least through the continual use of winter beds which have remained open to help manage demand and capacity. As such, £7.5m of non-recurring coverage will be required through 2016/17. In addition, the Acute Division underachieved projected 2015/16 recurrent savings by £3m and HSCPs underachieved by £7m. These were covered non-recurrently in-year by each Division. However, further work and discussions are currently on-going to establish if these can be covered internally again in 2016/17.
- 6.9** The table below is a summary of the current position;

**TABLE 1: The overall savings position 2016/17**

NHSGCC	CYE	FYE
<b>Savings Summary</b>	<b>16/17</b>	<b>16/17</b>
	<b>£m</b>	<b>£m</b>
<b>2016/17 Savings Target</b>	<b>69.00</b>	<b>69.00</b>
<b>Savings summary achievability</b>		
Green	20.08	20.35
Green/Amber	9.40	12.85
Amber	5.50	11.63
<b>Total Green and Amber</b>	<b>34.98</b>	<b>44.83</b>
Red	8.63	11.73
<b>Total savings identified to date</b>	<b>43.61</b>	<b>56.56</b>
<b>Remaining gap - further savings required</b>	<b>25.39</b>	<b>12.44</b>
Revisions to initial assumptions/investments	-3.30	-3.30
	22.09	9.14
Acute Division - cost containment cover	7.50	0.00
<b>Cash requirement in-year</b>	<b>29.59</b>	<b>9.14</b>

- 6.10** It is clear from the above table that in addition to £11.7m of complex and challenging “red risk” rated schemes, on a full-year effect for 2016/17, the Board still has a savings gap of £9.1m (rounded up to £10m). It is proposed at this stage that these savings maybe realised through the National Workstreams.

*National Workstreams*

- 6.11** Through the joint work of the Chief Executives, Directors of Finance and Scottish Government colleagues a number of workstreams have been developed both to support Boards in their local delivery of savings plans, and to examine whether a national approach to certain propositions can be agreed and delivered. Work is on-going to determine whether these national initiatives will have a further positive impact locally.
- 6.12** A number of these workstreams are already incorporated in our local schemes (and 2016/17 cost containment programme) but a small number could deliver savings to NHSGGC. This includes a review of effective prescribing medicines and Shared Services for both corporate and clinical support functions.
- 6.13** However, until the outcome of these national workstreams become clear and for the purposes of achieving financial balance, the £10m will be allocated proportionately, and the three parts of the business are therefore required to identify additional schemes to close the gap – and present these to the October 2016 Board meeting. Should the national workstreams subsequently deliver the projected savings in-year, these additional local savings schemes will be deferred into 2017/18.

### Managing in-year

- 6.14** As outlined above, Directors and Managers continue to work to address the remaining savings gap and finalise a balanced Plan. Due to the timing of the implementation and impact of these schemes in-year, the Board have again recognised the need to cash manage the business towards the realisation of these savings.
- 6.15** This will be achieved through the further utilisation of non-recurring provisions and reserves. For 2016/17, this will include a timing benefit repayable in future years through the reversal of historic provisions totalling £32.5m for NHSGGC. This was identified as part of the national Balance Sheet Flexibility Group and involves reclassifying the funding source of pre-2010 provisions, particularly in relation to Pension and Injury Benefit provisions. This does not impact on the actual level of provision, just the funding source, and will involve a charge to the RRL as the liabilities crystallise over a number of future years.

### Managing the Risk

- 6.16** It is clear from the above detail there is a real risk the Board will not achieve financial break-even in 2016/17. To have a chance of break-even, all these risks must be managed. In addition, definitive management action and tangible results must be achieved around the following key risks;
- Achievement of the Acute cost containment programme, locum agency spend and sickness absence rates driving nurse bank and agency spend;
  - Continued support from the Scottish Government around the achievement of key waiting times targets, particularly in the winter period;
  - Managing any changes to the unscheduled care model within the current financial envelope;
  - Achievement of all savings schemes outlined above, including service redesign propositions;
  - Continued work to finalise, consult, approve and deliver the “red” rated schemes; and
  - Achievement of £10m savings from the National Workstreams and/or identification, presentation and delivery to the October 2016 Board meeting of additional schemes equal to that sum from the three key areas of the business.
- 6.17** In terms of quantifying risk inherent in achieving break-even, and in addition to the £10m FYE gap outlined above, it is estimated the Plan carries financial risk of between £20m to £25m. Should this risk crystallise, there are insufficient reserves to provide cover. It would require receipts from projected land sales to ensure financial balance. However, the complexity and uncertainty over the timing and level of receipt of land sales must also be highlighted.
- 6.18** Whilst the Board at this point continues to work toward a balanced budget for 2016/17, it is apparent that again in 2016/17 the Board will be reliant on non-recurring sources of funding and reserves to achieve in-year balance. This position is clearly not sustainable. The continued use of non-recurring funds and reserves in 2016/17 to fund day-to-day business will create a significant risk to the sustainability of the Board into 2017/18 and beyond. There is a real risk the Board enters 2017/18 with minimal reserves.

### Financial Planning 2017/18 and Beyond

- 6.19** There is a need for a change in financial planning for 2017/18 and beyond. This will require the development and embedding of a more collegiate, continuous improvement environment that delivers savings on a more consistent basis. The Board has an excellent track record of achieving savings and improving efficiency. However, due to the scale of the financial challenge and underlying recurring financial imbalance, a transformation programme will be required to deliver a step change in the size and scale of recurring savings and efficiencies needed in 2007/18 and beyond.