

## GREATER GLASGOW AND CLYDE NHS BOARD

Board Meeting  
Thursday 15<sup>th</sup> June 2017

Board Paper No: 17/17

Director of Planning and Policy

### LOCAL DELIVERY PLAN 2017/18: DRAFT FOR APPROVAL

#### Recommendation:

- **The Board agree submission of the Local Delivery Plan.**

#### 1. PURPOSE OF PAPER

- 1.1 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

- 2.1 Key issues which have been highlighted during the planning process are 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 completed a major review of unscheduled care to improve our performance, for scheduled care the LDP sets out our approach to maximise performance within the available resources, driving efficiency and productivity.
  - Continuing reduction in the **level of delayed discharges.**
  - focusing with our HSCPs on **reducing the demand for acute care** and shifting the balance of care, developing primary care and community services;
  - continuing to focus on the Board's **public health** responsibilities;

#### 3. NEXT STAGES

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

## GREATER GLASGOW AND CLYDE LOCAL DELIVERY PLAN: 2017-18

### 1. SUMMARY

1.1 This draft Local Delivery Plan (LDP) sets the strategic context, describes our plans for 2017/18, including the current position with the financial plan, and also sets out our position on the areas required by the LDP guidance. Key areas of risk to this plan are as follows:

- We have been challenged to meet the scheduled and unscheduled care targets in 2016/17. This plan describes our extensive programs of work to address those challenges.
- The plan describes a substantial financial challenge, particularly for acute services, and discussions continue with our six Integration Joint Boards (IJBs) to finalise their allocations. Further information on the current position is included in the financial section. This plan sets out the work underway to achieve financial balance with the aim of reaching a more concluded position for the year ahead for submission to the Scottish Government at the end of June.
- The plan describes a number of service changes which will improve the quality of care for patients and deliver our shared objective, with the Health and Social Care Partnerships (HSCPs), to shift the balance of care.
- This plan is founded on working in partnership with our IJBs to reduce demand for acute care and ensure that patients who no longer require acute care are discharged home or move into HSCP services in a timely manner; and that HSCPs develop services to deliver care for more patients which can avoid an acute hospital intervention. Making rapid progress in each of these areas is essential to enable the Acute Division to reach a stable service and financial position.

### 2. STRATEGIC POSITION AND CONTEXT

2.1 The Board has a 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 This final draft LDP sets out, for the requirements of the LDP guidance, how we are working to deliver these strategic priorities in concert with our HSCPs.

## 2.4 Working with HSCPs

The content of this draft LDP covers the Board's responsibilities and has been developed with the HSCPs, reflecting our joint responsibility for strategic planning and for service delivery. IJBs develop and approve their own strategic plans and 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 we have substantially developed this work during 2016/17, particularly in relation to unscheduled care.

Links to each of our six HSCPs' Strategic Plans are at: [East Dunbartonshire HSCP](#), [East Renfrewshire HSCP](#), [Glasgow City HSCP](#), [Inverclyde HSCP](#), [Renfrewshire HSCP](#) and [West Dunbartonshire HSCP](#). Each of the plans and the related commissioning intentions outlines the HSCP approach to improving population health and developing their services including the critical focus on reducing demand for acute services.

## 2.5 Transforming Acute Services

During 2016/17 a process was established to develop a framework for the transformation of acute services, reflecting the direction set out in the Scottish Government's National Clinical Services Strategy, reinforced in the Health and Social Care Delivery Plan. The objective is to ensure we make the changes required to continue to deliver the highest quality of care to patients over the next few years, within the available resources. That framework for acute services integrates with the planning and delivery of community health and social care services. This is now being developed into a programme of service reviews to enable detailed plans to be completed. The Transforming Framework will be developed into a fully comprehensive plan during 2017/18 and will see a number of key issues for the medium and longer term. These include:

- Delivering acute care with less inpatient bed days.
- Providing services currently in inpatient beds in ambulatory care settings.
- Local HSCP services providing beds for patients who would previously have been cared for in acute services.
- Shifting the balance of care to HSCP services and reduce the demand for acute care.
- Increasing the utilisation of our modern ambulatory care hospitals.
- More care for older people delivered by HSCPs with acute services focused only on patients who require full acute care; acute specialists will have a bigger role in supporting HSCP services.
- Most rehabilitation, for all ages, will be delivered by HSCPs, including elements of specialist care which does not require acute services.
- Identifying how we reshape acute capacity from 2017/18 onwards and plan the future of our acute estate.

## 2.6 Regional Planning

NHS Greater Glasgow and Clyde has been an active participant in regional planning and will play a key role in the development of the new processes to develop a more comprehensive Regional Delivery Plan which will be drafted by the end of September 2017. We know that we will be delivering higher volumes of specialist care, for example, major trauma, laboratory and imaging services, for the rest of the region and that we will also have an important role in planning a different approach to general secondary care services across the region.

### 3. SCHEDULED AND CANCER CARE

3.1 This section describes our approach to meet the challenges we face in meeting the targets for scheduled and cancer care.

#### 3.2 Scheduled Care

The LDP guidance confirms that until the National Review of targets and scheduled care access standards reports, the current LDP standards will remain in place although clinical priority will be given to patients - including unscheduled care, cancer and other patients, referred with an urgent status. The guidance includes a requirement to develop local improvement plans for the delivery of agreed standards against a background of appropriate risk assessment. In finalising LDPs, NHS Boards have been asked to take account of what can be done to make scheduled care services more sustainable. The pressures in the system which were apparent in 2016/17 are continuing in the current financial year and are reflected in waiting times performance. For inpatients and day cases, the pressures have mainly been in the specialties of orthopaedics and trauma, urology and general surgery. In outpatients, the pressures are in orthopaedics and trauma, general surgery, gastroenterology and ophthalmology.

- We are completing work to enable us to assess how improved efficiency, including reducing length of stay; improving day case rates and theatre utilisation; improvements to booking and DNA systems can achieve maximum throughput with the available resources.
- We are also planning the implementation of a major programme of outpatient redesign in line with the national approach.
- This work will be underpinned by a programme to transform patient administration which is now underway.

More details of these programmes are set out in the rest of this below.

- **Modernising Outpatient Programme.** Linked to the above and in response to the Scottish Governments Modernising Outpatient Programme, NHSGGC have set up a Modern Outpatient Programme (MOP) Board. The aim of the MOP Board is to reduce outpatient activity and provide practical examples of change, which if adopted at scale, could have a significant impact in addressing pressures on outpatient services and improve productivity. Implementation proposals to date include:
  - Agreeing and implementing core principles of the Modern Outpatients agenda as the norm for all specialties.
  - Agreeing and implementing a Patient Focused Booking roll out programme to all services currently working within the waiting time standards.
  - Establishing a Short Life Working Group tasked with developing a specification of the administrative infrastructure and IM&T necessary to support the 'Modern Outpatient' agenda.
  - All of the above will be implemented at specialty level either as part of existing service reviews or as part of a programme of change and supported by a dedicated project team.
- **Demand and Capacity Gap Assessment and Improvement Programme.** Also linked to the above is the programme of demand and capacity gap assessment and the improvements currently underway. The aims for the programme are to:
  - Examine the current gap with and without the use of additional sessions funded through Waiting List Initiatives.

- Develop a series of productivity actions for each specialty at the Division and Sector level that will increase the available capacity without additional funding.
- Reassess the potential gap between demand and the improved capacity after actions have been put in place to identify priority areas for any additional funds.

The programme has four phases:

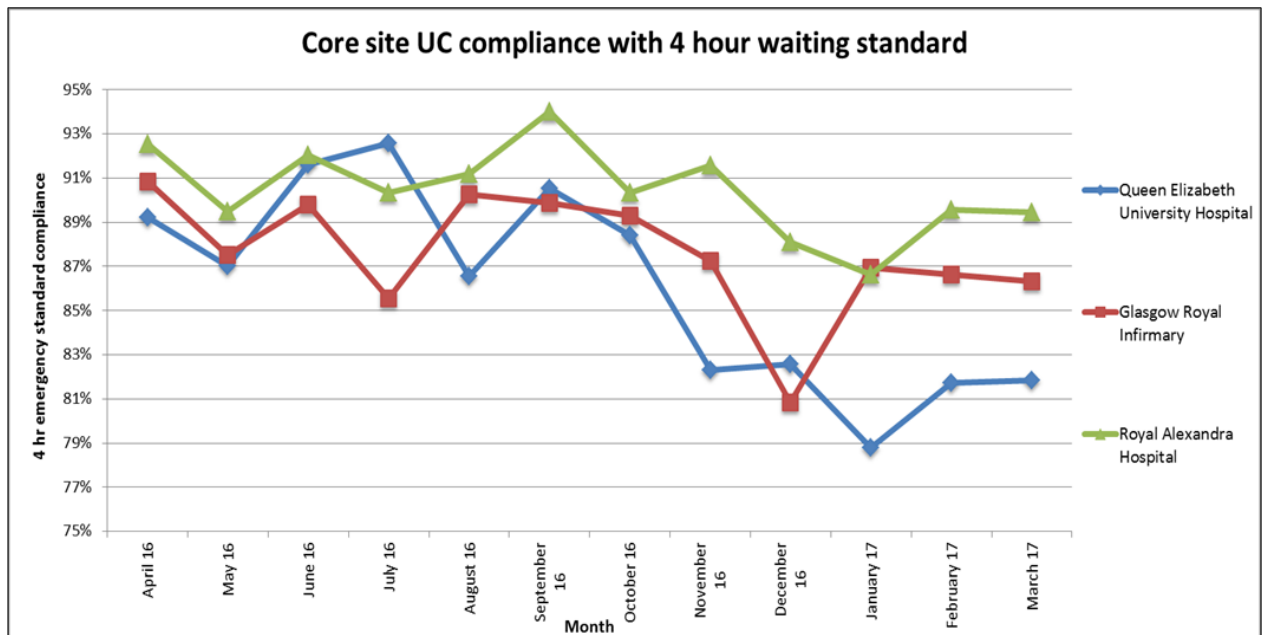
- Phase 1: Analysis of the elective activity and utilisation across all elective specialties during the year 2016-17.
- Phase 2: Estimate the additional capacity that could be gained if efficiency metrics were achieved.
- Phase 3: Develop a sector level specialty action plan, agreed through a series of sector workshops.
- Phase 4: Implementation of the agreed actions and the ongoing tracking of those actions and their impact on the delivery of access targets through the Acute Director's Access meeting.

The Scottish Government have confirmed the levels of central funding that will be available to support performance recovery and the national access team remain in close dialogue with the Board to explore all the viable options to stabilise, improve and maintain performance.

- 3.3 **Cancer Waiting Times.** The Division has had major issues in performance against the 31-day and 62-day cancer standards achieving one instance of >95% performance (against the 31-day standard) in the last five reported quarters. Considerable work has gone into achieving the 31-day standard and we expect to deliver recovery to >95% performance as soon as possible. Pressures in particular specialties, such as urology, have contributed to the more challenging position on 62-day performance. New appointments and ways of working will help as part of the Board's redesign programme for cancer services to sustainably improve performance; the new approach will be outlined in the Board's updated cancer plan. We are committed to sustaining and improving cancer tracking services are critical to improving and maintaining performance.

#### 4. **UNSCHEDULED CARE**

- 4.1 Delivery of unscheduled care within the national target has been one of our major challenges and we have completed a comprehensive review of unscheduled care to identify the actions required to improve performance.
- 4.2 A performance summary for the GGC sites for April 2016 to March 2017 is shown below. GGC continues to underperform against the 95% standard, delivering 92.1% at Board level with the three largest acute inpatient sites particularly challenged.



4.3 The full review is now completed and recommends extensive changes to the delivery of care which will enable us to improve performance and reshape resources within the Acute Division and HSCPs.

4.4 A number of these changes and improvements are already being made and we are working with HSCPs to bring the review and their planning together into a single implementation programme, which clearly delineates the required action within the Acute Division, and by each HSCP. HSCP commissioning intentions broadly commit, in the short term, to the existing level of resources for unscheduled care, focusing on the changes which can be delivered by the review, and looking for shifts in resources in future years beyond 2017/18 with further development

4.5 The **main recommendations** can be summarised as:

- **Alternatives to Admission by providing Condition Specific Pathway Alternatives:**
  - Achieve targeted reduction of short stay (Zero/1 Day) Inpatient episodes to reduce bottlenecks. We currently report 18,038 zero/1 day Emergency Inpatient Admissions at GRI, QEUH and RAH (excluding AU same day discharges); this represents approximately 15% of total annual admissions.
  - Introduce joint ambulatory care clinical pathways to provide consistent care and alternatives to admission for both GP-referred and ED patients.
  - Develop ambulatory care pathways for high volume conditions initially targeting Acute Abdominal Pain, Chest Pain, Cellulitis, Self-Harm, Falls and Seizure.
  - Introduce a dedicated emergency pathway for frail elderly patients utilising early Frailty Screening, Comprehensive Geriatric Assessment and appropriate resources to achieve early discharge.
- **Emergency Department Processes:**
  - Improve Minors flow by providing a protected pathway and options to ensure efficient service delivery. This will maintain compliance for 52% (220,526) of all ED activity including the dedicated MIUs.
  - Enact early senior clinical input and diagnostic screening to support decision making and improve the effectiveness of streaming patients into the most appropriate clinical pathway ('Triage Plus').

- Ensure that all GGC Hospitals adopt the same triage category coding system so that patients are effectively streamed to the most appropriate clinical area for treatment. This will also provide more consistent and transparent metrics to support Sector and Board escalation plans through standard reporting.
- Ensure that ambulatory care pathways are consistently implemented across Emergency Departments and Assessment Units.
- **Management of Current Inpatient Capacity:**
  - Embed efficient inpatient management processes as embodied in the 'Exemplar Ward' concept in all ward areas (this will incorporate Daily Dynamic Discharge).
  - Develop Criteria Led Discharge processes and ensure they are consistently applied to improve weekend discharge rates and increase numbers of planned discharges during the week days.
  - Facilitate enhanced co-operation between the Discharge Lounge, Transport and Pharmacy services to improve both the discharge process and discharge rates (this will include the development of the 'transport hub' concept).
  - Undertake 'Day of care' audits across all major acute sites to provide a snap shot of bed utilisation and inform the development of both in and out of hospital solutions to minimise in-patient delays.
- **Escalation:**
  - Build on current Sector Escalation plans to develop a Board wide Escalation Policy. This will include the development of standard metrics to be applied across all sites and ensure that escalation decisions are clear, transparent and effectively communicated to stakeholders including the Scottish Ambulance Service.
- **eHealth/IT:**
  - Introduce Microstrategy dashboard for Assessment Units to improve patient safety and provide better flow analysis on the stages of the patient journey.
  - Develop 'Live Bed State' dashboard to provide electronic data to support flow coordination and bed management processes and reduce manual system dependencies ('hub' concept).
  - Develop TrakCare solutions to improve patient safety and escalation of care starting with NEWS/GAPS recording systems and the development of 'senior clinical assessment Icon'.

4.6 **Impact on Acute Beds.** A critical element of the final report is assessing the issues around beds, the rest of this section includes assessment of how these changes will enable us to improve our performance.

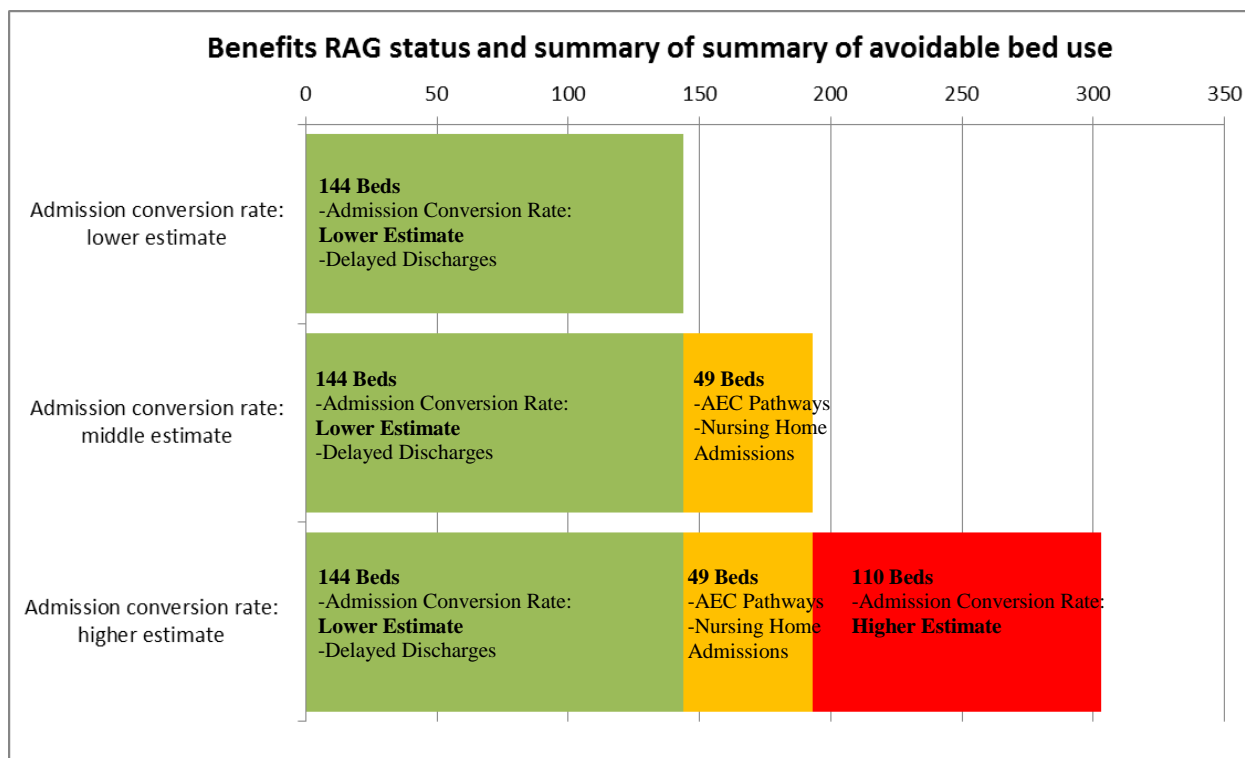
- **Demand/Supply Imbalance:**
  - The bed occupancy comparison calculated using bed days demonstrates that occupancy levels for emergency medical activity are at a high level. Based on current ways of working, current demand drives increased inpatient activity. We believe that better patient experience and outcomes can be achieved through service redesign to provide more care in an outpatient setting or away from hospitals entirely. The components of this approach are outlined in the following points.

- **Admission Conversion Rate Reduction:**
  - Analysis of the Board's emergency attendance admission conversion rate was completed and compared with other large acute sites in Lothian and Tayside. We have made two assumptions for the admission reduction calculation:
    - the target to reduce the admission conversion rate between GGC and Lothian should, in the first instance, be halved: the gap between Boards is between 5.4% and 10.9% therefore we have set a target to deliver between 2.7% and 5.4%;
    - the LOS associated with these admissions has been estimated as 3.7 days using the planning assumptions derived for the Acute Sector reconfiguration.
  - **The target number of reduced admissions is between 8,589 and 23,580. Applying the assumptions above would generate savings of between 58 and 159 beds worth of activity.**
- **Ambulatory Emergency Care Pathway Development:**
  - An important mechanism to deliver the reduction in admissions described above is the better use of Ambulatory Emergency Care (AEC) treatment pathways. Analysis of admissions **showed the potential to reduce admissions by up to 8,228 patients.** In addition we analysed the number of admitted patients with zero or 1 day LOS. Excluding same day discharges there are 18,038 such patients representing 15% of total admissions. **Our target would be to reduce this by 50% to 9,019.**
- **Delayed Discharge:**
  - One of the key elements of HSCPs' commissioning intentions is to reduce demand for acute care. This is based on work framed by collective agreement in a range of areas where changes in community and primary care services could be expected to reduce or reshape demand for acute care. This includes a target to eliminate Delayed Discharges across HSCPs **The aim is to eliminate Delayed Discharges across HSCPs. This will avoid 35,701 bed days generating 96 beds worth of activity.**
- **Nursing Home Admissions:**
  - From the analysis of nursing/care homes in NHSGGC, we have highlighted those with highest hospital admission to bed ratio. Of the 149 nursing homes, 20 are responsible for 30% of all hospital admissions and 49 are responsible for 60% of all admissions. We have also identified high volume conditions related to these hospital admissions which will allow HSCP's to progress targeted support and pathway development. **The aim is to reduce nursing/care home bed day usage by 30% from 29,280 to 14,640 to generate 24 inpatient hospital beds worth of activity.**
- **Associated Process/Flow Improvements:**
  - **ED >4 hour wait reduction:** the introduction of a combined AEC service where patients are streamed post triage and assessment from both ED and AUs is likely to result in a reduced number of delays. There are currently 7,005 patients who may be suitable for AEC pathway management across GRI, QEUH and RAH. **The aim is to reduce > 4 hour waits for AEC conditions by 50% to 3,503 patients which equates to 11.3% of the annual total.**



- **Pre noon discharges:** the purpose of the exemplar ward project is to improve the quality and efficiency of patient management at ward level, and as a result increase the number of patient discharges earlier in the day. Work will continue to embed this across all inpatient wards.
- **The aim is to increase AM discharges by 5% to improve patient flow.**

4.7 The following table reflects our assessment of the degree of difficulty in realising the benefits.



The above describes opportunities to improve the demand / supply imbalance through the introduction of pathway and process change that would **result in between 144 and 303 beds worth of current inpatient activity being released**. This illustrates that within our existing service provision there is scope to improve compliance with the 4 hour standard by adapting existing good practice and developing more efficient pathways for patients.

4.8 **Primary Care/HSPCs.** There is significant potential for primary care/HSPCs to contribute by reducing demand on hospital-based services. HSCP's have been developing their commissioning intentions and associated plans across a range of services with the aim of reducing demand for acute care. This work was framed by collective agreement in several areas where changes in community and primary care. The intention is to bring those strands of work together as an important component of the delivery of improvements to unscheduled care. This will be a major focus of the next phase of work.

4.9 **Performance Metrics.** The journey towards achieving an improved unscheduled care performance will be closely monitored via a new performance metrics dashboard. The dashboard, which is in the final stages of development, will reflect board wide and site specific progress in achieving the unscheduled care performance aims associated with the above recommendations and will be updated on a monthly/yearly basis.

The high level metrics the performance dashboard will monitor are outlined below:

- Hospital LOS.
- Unscheduled care attendances/admissions.
- AEC discharges.
- Frail and elderly admissions.
- Hospital boarding.
- Other key metrics.

## 5. DELIVERING MORE EFFECTIVE AND EFFICIENT CARE IN 2017/18: SERVICE REVIEWS

5.1 This section sets out the current position with a number of service change proposals and reviews including our planning to cover the required LDP headings of:

- **Maximise efficiency, productivity and sustainability.**
- **Progress the key outcomes of the National Health and Social Care Delivery Plan and National Clinical Strategy including Shifting the Balance of Care.**

5.2 The focus is on services which are the direct responsibility of the NHS Board, and therefore covered by the LDP process, while also highlighting the critical interfaces with HSCPs, including joint work on service planning and change and the directions from HSCP commissioning intentions.

5.3 We have a number of service changes in public engagement processes:

- **Review of Clyde Birthing Services:** consultation has paused on the proposal to transfer birthing services from the IRH and Vale CMUs while the Board considers the implications of the national review of maternity services.
- **Review of NE Rehabilitation Services:** consultation is concluded on the proposal to modernise rehabilitation services in NE Glasgow; and the Board will consider the outcome of consultation and whether to submit the changes to Scottish Government in mid June 2017.
- **Review of RAH Paediatric Services:** the proposal to transfer acute children's services from the RAH to the RHC were submitted to the Scottish Government for consideration in March 2017.

5.4 A number of reviews focused on delivering improved quality, effectiveness and efficiency are in progress, at various stages, these are summarised in the rest of this section.

5.5 **Frail Older Peoples Care.** Frail older people are the major part of the workload for acute services, across clinical specialities. As part of the Acute Division Delivery Plan we agreed to review the systems and resources with which we care for older people. The overall objective of this work is to agree and implement changes which enable high quality and efficient acute care for the older people who require it. The focus is on the design of acute specialist elderly care; the interface between general acute services and acute specialist elderly care and the interface from acute specialist elderly care with services in HSCPs.

- There is significant variation in care pathways between sectors, including what assessment tools are used, where assessments take place and who undertakes them.
- There is significant variation in resources between sectors including nursing and AHP roles and capacity and beds.
- There is a major driver to ensure only patients who require acute care are in acute services.

Three short life working groups have been established to review and report on front door care; the interface with HSCPs and the inpatient services for older people focussing on the following areas:

- **Systems of care:**
  - Assessment processes, tools and timing.
  - Consistency in and out of hours.
  - Links with EMI.
  - Process in ED and four hour target.
  - Processes in non specialist acute services.
  - HSCP care system connections to acute services.
  - Access to clinical records across the system.
  - Anticipatory care planning.
  
- **Services:**
  - Defining essential specialist acute hospital care.
  - Defining the non acute services needed in HSCPs to support that acute model:
    - general care home support;
    - services accessible by hospital to avoid or shorten admissions;
    - services accessible by GPs as alternative to hospital;
    - single point of access;
    - rehabilitation teams;
    - end of life care.
  - Acute specialist inputs to HSCP services.
  - Care for AWI patients.

This work has already identified a new model of frailty assessment and service delivery at the front door and a set of essential requirements to enable effective interfacing between acute care and HSCPs. During 2017/18 this work will be implemented and developed with HSCPs to provide better care, reduce demand for acute care and shift the balance of care. A review of the ortho geriatric service is also underway to consider the model of acute care and the balance of rehabilitation between acute services and the HSCPs.

5.6 **Breast Surgery Service.** The service has seen a 30% increase in referrals in recent years but no appreciable difference in the incidence of cancer or the need for treatment resulting from the increase in referrals. The breast service waiting time has been maintained by the use of a high number of waiting list initiatives, the review aims to deliver a high quality and sustainable service within available resources.

- Work with patient focus groups has highlighted that speed and quality of treatment and continuity of care from a team they trusted outweighed any preference for a particular hospital site.
- The breast team in Clyde cover 3 sites and in the South the breast team operate as 2 sub teams split across GGH and the Victoria ACH. This covering across or split between sites leads to difficulty in delivering continuity of care on each site, the ability to cross cover during leave or absence and minimises the time during which the team are together on a single site which hampers team building and knowledge sharing.
- A one stop high risk clinic requires the sustainable coordination of the breast team and diagnostic support. There is a national shortage of breast radiologists and a high proportion of those in post are approaching retirement. Recruitment into vacant breast radiology posts is challenging we are moving to extend the role of radiographers but there is a serious shortfall of the available skilled workforce in the short to medium term.
- The breast service has been supported by the use of specialty doctors. There is now a real challenge in filling these posts which is driving a need to look at alternative and enhanced roles for nurses.

- Equipment is not of a consistent standard and is under utilised on some sites.

There are a number of proposals emerging from the review, which has included option appraisal and a patient's panel, including:

- A review of the referral criteria for breast services was conducted and new guidelines developed supported by increased education for primary care regarding these criteria and improved processes for the compliance with these criteria. The new criteria have been piloted in Clyde where there has already been a 9% decrease in referrals in 2016 and the full effect of the change is estimated at up to 30%, which would enable us to deliver waiting times within available resources.
- Stratification of breast referrals into high risk one stop shop and low risk clinics.
- Improving the interface with plastic surgery to deliver coordinated breast reconstruction.

The proposals are in line with the National Clinical strategy consolidating complex, specialist care and maximising delivery of ambulatory care as locally as possible, making the most efficient use of workforce and resources.

5.7 **Minor Injuries Service.** The minor injuries service in West Glasgow was temporarily closed because of under utilisation and the opportunity to re-profile the resources to alleviate pressure on the QEUH. The Glasgow City HSCP will consider report at its June meeting recommending establishment of a review of the service, working with the Board, to:

- Analyse the service delivery, financial and access issues outlined below.
- Establish an option appraisal process to set out potential options and criteria to consider those options.
- Develop a proportionate approach to gather patient and public views, including a means of ensuring there is a patient perspective in the option appraisal process.
- Establish the views of other key stakeholders including local GPs.
- Report on the conclusions and recommendations from the review to enable early decision making on the future of the service.

5.8 **Gynaecology.** We have variable arrangements for delivery of gynaecology across the Board area and as interventions have moved from inpatient delivered to day service and outpatient based we have a pattern of delivery which does not make best use of resources. We are completing a review of gynaecology which will deliver proposals to achieve:

- Consistent and improved access to ambulatory, one stop gynaecology across Greater Glasgow and Clyde and improved utilisation of ACAD facilities moving appropriate procedures from inpatient facilities.
- Concentration of the expertise to deliver complex surgery, concentrating skills and equipment to improve clinical outcomes and efficiency.
- Reduce variation in clinical practice between services.
- Further develop the Sandyford termination service and delivering rapid access for women across the area to the least Medicalised environment.

5.9 **Acute Stroke Services.** Strokes are one of the major causes of death and disability for the population of NHS Greater Glasgow and Clyde. Around 80% of people will survive their stroke, but half of stroke survivors are left with long term disability and require help for everyday activities. The effective identification, specialist assessment and treatment of patients who are at risk of stroke, or who have had strokes, can substantially reduce that burden of death and disability. There is a strong evidence base and clinical consensus on the requirements to deliver the most effective prevention and treatment services for stroke. The key points to assess a high quality clinical service are:

- The Scottish stroke service bundle of early access to imaging, assessment of swallow function; speed to thrombolysis; early prescription of aspirin; admission to a specialist stroke unit.
- Delivering full assessment to TIA patients triaged as high risk within 24 hours.
- Delivering rehabilitation without delay and on 7 days of the week.
- Delivering community services which enable early supported discharge.
- Across the care pathway delivering timely imaging of the right modality.

There is strong clinical and economic evidence that failing to meet these standards in delivering stroke care will result in excess deaths and disability and direct excess cost to the NHS and social care services. NHSGGC has major issues in delivering the national stroke targets. A comprehensive review of stroke services across the Acute Division has been completed during 2016/17 making detailed recommendations to improve the quality of care. A detailed implementation programme including public engagement is being finalised. The implementation programme will benefit from the contribution of the Stroke Association and other charitable bodies with expertise in public engagement and strong connection with patients and their carers. The key elements of service change are to ensure patients across Greater Glasgow and Clyde have access to:

- Hyper acute stroke care without delay before returning to their local hospital stroke service.
- Urgent specialist assessment and investigation if they experience a “mini stroke” or TIA.
- Optimal rehabilitation in hospital and in the community to maximise their return to functioning.

5.10 **Hospital Based Complex Care.** We are completing the transition from NHS continuing care these changes are reshaping care outside acute hospitals, transferring responsibility for all beds not on acute sites to HSCPs. These changes have reduced acute bed numbers and shifted the balance of care to enable the delivery of new models of HSCP care.

5.11 **Imaging and Laboratory Services.** The opening section of this draft plan highlighted issues of excess demand and use, this includes for imaging and laboratory services and a programme of benchmarking and demand management is underway to address this.

5.12 **Surgical Services.** We are developing reviews of urology and orthopaedics across the Division which will bring forward proposals for service redesign during 2017/18.

5.13 **GP OOH.** HSCPs are conducting an overall review of OOH services and, as a priority within that, reviewing the future delivery of GP OOH service. This service is under pressure due to GP availability and excess demand for the service; regular contingency arrangements are often required. In addition to the workforce driver we also need to contain costs within the HSCP direction. In the short term the Acute Division, which is responsible for operational delivery of the service, is reviewing the potential service redesign across the OOH service.

5.14 **Complex rehabilitation.** A major review is considering how we:

- Improve the delivery of specialist rehabilitation within the Acute Division.
- Better manage the care of patients with complex needs who continue to require acute care.
- Delineate clearer responsibilities between the Board and HSCP responsibilities for the commissioning of specialist rehabilitation.
- Reshape the former continuing care resources.
- Consider the consolidation of inpatient services around the specialist service at the QEUH considering the future of beds provided in at the IRH with the HSCP.

- 5.15 **Acute Beds.** We have completed a detailed benchmarking of acute beds which has identified a number of areas where we could improve efficiency and reduce bed numbers, detailed plans to deliver this are currently being developed. In the short term, bed changes will be within the existing estate but beyond 2017/18 there is a need to consider more fundamental reshaping to achieve maximum service and financial efficiency. Our HSCPs have worked hard to reduce the level of patients delayed waiting for HSCP services but we still have around 120 beds each day occupied by such patients. We are implementing new arrangements ensure these patients are accommodated in beds which have less direct impact in the flow from ED and assessment units while continuing to work with HSCPs to achieve on time discharge.
- 5.16 More detail on the work summarised in this section is available in the 2016/17 **Acute Division Delivery plan** which also described the challenges and issues facing our Acute Division. That plan is being updated and developed for 2017/18. We have begun to develop the wider programme of reviews which need to be completed to enable us to translate the Transforming Acute Services Framework into the detailed site and service plans which are essential to inform capital investment, patient and public engagement and achieving sustainable and financially viable acute services.
- 5.17 A critical thread which runs through the work outlined in this section is to reduce the **demand for acute care and shift the balance of care.** Developments of the Framework to transform acute services and our service reviews have identified higher use of acute care by our population. In order to deliver new models of care of care which improve services to patients, to shift the balance of care and address our financial position we need to reduce demand across a wide range of acute services. HSCP commissioning intentions consistently focus on this issue and make a number of proposals on how HSCPs will reduce demand and the contribution the Acute Division can make to this endeavour, which is also essential to shifting the balance of care. HSCPs are working on the development of their services, GP and wider primary care and community services to link with acute sector service changes.

## 6. FINANCIAL PLANNING

- 6.1 The Scottish Government draft budget was announced on 15<sup>th</sup> December 2016. This announcement revised the baseline uplift to 1.5% for territorial boards, of which 1.1% will form a transfer to Social Care.
- 6.2 This draft LDP financial plan focuses on year one (2017-18) however, financial plans for revenue, including efficiency savings, will cover a period of three years 2017-18 to 2019-20. The capital infrastructure investment programme/CRL outturn forecast also covers a three year period.
- 6.3 Of the Board's £31.1m uplift, £23.7m (76%) has been passed through to IJBs, leaving the Board £7.4m to cover in-year cost increases and brought forward unachieved savings. This assumes that National PPRS receipts which are used to support the New Medicine Fund are estimated to reduce from £60m to £30m in 2017/18. This corresponds to a reduction of £7.9m in the NHSGGC allocation.
- 6.4 A summary of the projected savings carry forward, inflation and financial pressures is highlighted in the table below.
- 6.5 The Board is anticipating a recurring deficit of £29.6m carried forward from 2016/17.

### 2017/18 Carried Forwards, Pressures and Investments

	<b>£m</b>
<b>Carry Forward from 2016/17</b>	
Forecast recurring over/under commitment	(29.6)
<b>Cost Drivers</b>	
Pay Cost Growth	(20.0)
Costs for Other Boards Services	(6.0)
Prescribing Cost Growth	(29.5)
Rates Revaluation	(11.0)
Apprenticeships Levy	(8.0)
Pension Costs - Recurring effect of 2016/17 AME	(3.5)
Capital Charges Growth	(1.0)
Cost Inflation and Contractual Uplifts	(6.0)
Commitments Funded Non-recurrently	(9.7)
<b>Cash Releasing Financial Challenge</b>	<b>(122.4)</b>
<b>Cash Releasing Financial Challenge</b>	<b>5.6%</b>

- 6.6 IJBs were given an indicative budget settlement in line with the Scottish Government instruction - *“NHS contributions must be maintained at least at 2016/17 levels”*. This offer was made formally in January 2017 and equates to £23.7m. The Board remain in discussions with our six IJB partners to finalise the 2017/18 budget allocation.
- 6.7 The Boards financial planning assumptions have taken account of the IJB settlement position, and assumed the IJBs will achieve financial break even in-year. As such, the Boards financial savings challenge is £97m, allocated based on brought forward pressures, and proportionate shares of in-year pressures to be £60m (5.6%) for the Acute Division and £ 37.0m (10%) for our corporate services.

### **Meeting the Challenge**

- 6.8 The 2017/18 financial position presents a significant challenge to NHSGGC. It is critical the Board identifies and actions the removal of costs early in 2017/18. The Boards entered 2017/18 with minimal reserves or funds and as such, savings must be made in the early part of the financial year.
- 6.9 The 2017/18 Financial Planning process began mid way through 2016/17. The Corporate and Acute Directors continue to identify and quantify savings schemes, and the Board is fully engaged in national initiatives.
- 6.10 In the previous draft LDP, submitted in March 2017, the Board had identified a financial gap, after identified savings, of £50m. Since 1st April 2017, the new Chief Executive has increased the focus and drive around the identification of additional savings initiatives.
- 6.11 As a result, the updated and current financial position and projection for 2017/18 is shown below.

## 2017/18 Savings Identified to Date

	<b>£m FYE</b>
Corporate Budgets	23.0
Acute Budgets	21.0
Additional Organisational Initiatives	12.5
Productivity and Efficiency	5.0
Additional Income and Accounting Adjustments	<u>19.0</u>
<b>TOTAL</b>	<b>80.5</b>
<b>Remaining Gap</b>	<b><u>18.5</u></b>

- 6.12 Whilst significant progress had been made to identify the full savings required, there remains a financial gap of £18.5m (FYE).
- 6.13 The above savings schemes have been risk rated based on achievability, timing and estimate of saving. A number of the schemes identified have been classed as "red risk". In addition, many of these schemes will not be realised until the later part of the financial year, creating additional pressure in the early part of the financial year. Therefore, the Board is still currently unable to predict a break-even position for 2017/18.
- 6.14 The Board are continuing work to;
- Identify additional savings schemes (both locally and nationally).
  - Bring savings schemes forward into the earlier part of the financial year.
  - Focus on the delivery of currently identified schemes and reduce the risk rating.
  - Identify additional sources of income and balance sheet management.
  - Manage our capital allocation to ensure an optimal out-turn for the Board.
- 6.15 The Board are also in continuing dialogue with the Scottish Government around our financial position, and the possibilities of additional in-year support.

## Capital Plan and Investment

- 6.16 The Board has developed a Capital Plan which responds to our clinical strategy and prioritises out investment plans over the term of the LDP. For minor works, the Board will commit capital investment that will target asset condition improvement, backlog maintenance and statutory compliance and the PAMS documentation is used to determine the priority spend across the Acute Division and the six Health and Social Care Partnerships.
- 6.17 The Board has allocated capital funding for both e Health projects and the procurement of medical and diagnostic equipment. A high level summary of the Board's Capital Plan is tabulated below:

	2017/18	2018/19	2019/20
	£m	£m	£m
Committed & In Progress	£47.015	£27.691	£20.798
Committed in Principle	£5.308	£24.160	£20.200
Under Review	£7.222	£5.555	£3.092
Total	£59.545	£57.406	£44.090



## **7. LOCAL DELIVERY PLAN FURTHER REQUIRED CONTENT**

7.1 This section sets out the LDP guidance requirements (in italics), which have not been covered in other sections, and our intended actions.

### **7.2 Increasing Healthy Life Expectancy**

*The LDP should set out the actions to increase Healthy Life Expectancy.*

Healthy life expectancy in NHSGGC is low compared to the Scottish average. People in live for many years in ill health (10.5 years), 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 have increased from eight to 13 years. We recognise the need to do more to prevent disease through addressing the determinants of health and supporting healthy lifestyles. We also need to better support people to manage their own health and prevent crisis. Inadequate focus on prevention and support for people at an early stage in their illness can lead to poorer health outcomes, and to people accessing services and support at crisis points or at later stages in their illness. The Global Burden of Disease Study indicates that the main immediate causes of loss of health in the UK in rank order are Musculoskeletal pain, Ischaemic Heart Disease, Depression, Type 2 Diabetes, Injury, COPD, Stroke and Lung Cancer. The main underlying determinants of these are tobacco and alcohol consumption, poor diet, lack of exercise and fundamentally socioeconomic inequality. Our approach will be focused on prioritising the development of resources for preventative and anticipatory care and for primary care and community services to address these issues.

Life expectancy and healthy life expectancy are lower in areas of deprivation and disadvantage. NHS Greater Glasgow and Clyde has a responsibility and role to reduce these inequalities as an employer, procurer and service provider. We will continue to monitor health inequalities and use this information to advocate for and develop policies with community planning partners to reduce child poverty, improve housing, reduce unemployment and ensure access to fair welfare benefits.

During 2017-18 we will continue to work with HSCPs and Community Planning Partnerships to:

- Integrate financial inclusion services with health services, to understand the needs of homeless people with severe and complex morbidity, to mitigate the effects of cost of the school day and school holidays and to work with health visitors, primary care and education on key issues such as Adverse Childhood Experiences (ACES). We will also develop initiatives to reduce inequalities in uptake of preventative interventions such as screening and child health surveillance.
- Improve population health and to prevent ill health through community based interventions. Tackling lifestyles that increase the risk of diabetes, stroke, cardiac problems, obesity and cancer is a top priority. The causes of ill health are preventable by not smoking, being physically active, being a healthy weight, drinking alcohol within recommended levels and maintaining a healthy diet. Tackling these issues is a major part of our public health challenge that will continue during 2017-18. We are already seeing reductions in tobacco smoking and alcohol consumption. We will continue to drive forward these initiatives and re-energise our efforts to tackle obesity and encourage more active and healthier lifestyles to ensure that people live longer and healthier lives;

Programmes of work which will support these approaches include our financial inclusion strategy, Healthier, Wealthier Children, Health and Employment team advocacy for high quality employment opportunities, The Healthy Minds Strategy, the actions of our six

Alcohol and Drug Partnerships including efforts to reduce the availability of alcohol, the provision of Smoke-free Services and promotion of tobacco control actions, GGC's community cooking network, Physical Activity Programmes, such as Live Active and Vitality, our weight management service, etc - see [links](#) for more detail and our most recent [DPH report](#).

*Prevention should feature strongly in LDPs with specific links to Health Visitors and family Nurse Partnership expansion in the context of 'Getting It Right for Every Child'.*

The detail and lead responsibility for this lies with HSCPs and incorporated as part of their Strategic Plans: [East Dunbartonshire HSCP](#), [East Renfrewshire HSCP](#), [Glasgow City HSCP](#), [Inverclyde HSCP](#), [Renfrewshire HSCP](#) and [West Dunbartonshire HSCP](#). The HSCPs have detailed plans to deliver the nationally directed changes on health visiting and are engaging with Government on the future of FNP.

### 7.3 Regional Planning

*LDPs should set out practical early steps underway to ensure we are prepared to co-operate fully in regional planning and delivery of services during 2017-18. Final LDP submitted in September the Scottish Government will look for Regional Planning and delivery aspects to be more fully developed and Scottish Government will work closely with Boards to develop their approach to regional planning and delivery.*

We are fully engaged in the existing programme of regional service reviews and the ongoing process to develop a new regional planning approach. In addition to this work on clinical services we have also established agreement with other Boards to move forward the shared services agenda by:

- Working with other Boards to consider the development of shared approaches to eHealth across the region.
- Developing proposals for a shared public health function.
- Exploring the potential to consolidate laboratory services.

### 7.4 2020 Vision of Safety and Person Centredness

*LDPs should continue to set improvement aims in relation to the 2020 vision of safety and person centeredness.*

NHSGGC is committed to providing safe high quality care, 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 will develop an NHSGGC Clinical Safety Programme, which will build on our experience and the support of the national programme, but allow us to integrate other useful developments for example, our clinicians work in reviewing quality of care through morbidity and mortality meetings.

During 2017-18 we also plan to:

- Extend the Acute Adult Deteriorating Patient work-stream by increasing the number of acute care wards who can demonstrate a reliable process for frequency of observation, complete the development of the local structured response model and ensure it is being rolled out in each hospital.
- Support an efficient medicines reconciliation process by making an electronic form available to clinical teams.
- Continue to roll out dynamic clinical risk assessment in the mental health programme.

- Build on the primary care programme by focusing on support to early identification of sepsis project and continued roll out of the disease-modifying anti-rheumatic drugs toolkit.
- Implement the locally developed deteriorating patient bundle in paediatric wards.

## 7.5 Workforce Planning

*The LDP should provide a short outline of their Everyone Matters: 2020 Workforce Vision Implementation Plans for 2017-18 to deliver the five priorities. A national Health and Social Care Workforce Plan is planned for publication in Spring 2017. The plan will present an opportunity to refresh guidance for the production of NHS workforce plans and introduce workforce planning which provides an overall picture for health and social care staff. The Scottish Government intends to circulate a National Discussion Document in early 2017 which will look at the practical issues involved, seeking input from NHS Boards and others. NHS Boards will also be required to publish their wider workforce plan during 2017 and recommend 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.*

A short outline of our Everyone Matters: 2020 Workforce Vision Implementation Plans for 2017-18 is set out below:

- NHSGGC is currently drafting a response to the proposed National Discussion Document and will publish our wider Workforce Plan during 2017.
- 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 the workforce, including GPs.
- Delivering a sustainable financial plan will require significant workforce redesign as well as progressing regional and national initiatives to shared services.
- The [Workforce Planning Interim Report](#) provides a brief outline of how we continue to realise the Everyone Matters: 2020 Workforce Vision Implementation Plans for 2017-18 to deliver the five priorities.
- Our final Workforce Plan containing more detail on the Medical, Nursing and Midwifery and Allied Health Professions workforce as a result of the need to support the developing acute plans is scheduled for completion later in 2017. Overseeing the development of the Workforce Plan and projections is the Strategic Workforce Plan Performance Group also established to support the emerging Regional and National Workforce Plans.

## 8. SUSTAINABILITY AND VALUE

8.1 The drive for sustainability and value is a critical programme of work; this section describes elements of our work programme which have not been covered elsewhere in this draft plan.

### 8.2 Sustainability and Best Value

As part of the Local Delivery Plan process, NHSGGC have been asked to produce detailed plans to minimise waste, reduce unwarranted variation, standardise and share best practice. In addition, a number of other potential productive improvement opportunities have been identified including the cost of outpatient appointments, theatres cancellations, procedures of limited value and infrastructure costs.

Following an initial meeting with the Scottish Government Quest Team, to explore in more detail the potential opportunities, NHSGGC have agreed to establish a Sustainability and Value Multi-Disciplinary Team to focus effort in areas in need of improvement and identify

potential opportunities to access resources from the Innovation Fund to implement Tests of Change and roll-out areas of good practice identified across the organisation.

### **8.3 Reduction in Medical and Nursing Agency and Locum Spend**

*LDPs should set out how a 25% reduction in medical and nursing agency spend will be achieved.*

The Cost Containment Programme was launched in October 2015 to eradicate the operational overspends within the Acute Division that had emerged following the Acute Restructure in early 2015. All the key drivers rested on the major pays drivers - locum and agency spend, bank and agency nursing etc.

A range of work-streams and initiatives have been undertaken to support the Programme. These are summarised in the following paragraphs:

- Agency nursing spend amounted to circa £3.7m in 2016/17. A number of actions, both nationally and locally, to reduce and ultimately eradicate premium rate agency nursing, have been, and are being, implemented. Local schemes include the following:
  - education and leadership to ensure maximum use made of current staffing and bank use ensuring patient safety;
  - centralised recruitment of nurses and those who are not slotted into posts are employed by the bank, have their induction and then into posts as they arise;
  - a concerted multi-team effort to re-locate patients with high levels of 1:1 enhanced observation and supervision from Acute into a more appropriate setting;
  - a review of the procedure and controls around staff engaging with premium rate agency nurses, to ensure authorisation levels at chief nurse and executive management;
  - a joint project with neighbouring boards to agree how we stop premium rate agency.

The Board spent circa £17m on medical agency in 2016/17. Actions taken to reduce this can be summarised as follows:

- A Medical Locum Steering Group was established within the Board, with membership including the Director of Finance, the Medical Director, the Director of Nursing, the HR Director and the Head of Procurement. Actions centred on a number of initiatives both local and national.

Medical agency and locum spend has remained constant throughout 2016/17. However, it remains a major area of focus for the Board, with recently permanently recruited posts and the commencement of the external managed service provider expected to reduce costs into 2017/18. The specified 25% reduction will be difficult to achieve but this work programme is a top priority.

### **8.4 Effective Prescribing**

We provide input and support to EPP for the development of prescribing quality improvement initiatives and have a process through existing medicines governance structures to consider and implement EPP initiatives as part of ongoing prescribing quality improvement. EPP initiatives included in prescribing plans for this year include:

- Diabetes strategy.
- Respiratory strategy.
- Biosimilar switches.

## 8.5 **Shared Services**

The section on Regional Planning described a number of areas where we are working with other West of Scotland Boards to drive efficiency through developing plans to share services and functions across the Region. In addition to that work we are working as part of the national shared services structures to reach agreement on a number of proposals which will move this important agenda forward.

## 2017-18 LOCAL DELIVERY PLAN (LDP) STANDARDS

Those LDP Standards where HSCPs have direct responsibility for delivering are highlighted in italics.

Ref No	2017-18 Local Delivery Plan Standard	2017-18 Target
1.	Cancer - 31 days from decision to treat	95%
2.	Cancer - 62 days from urgent referral with suspicion of cancer	95%
3.	Detect Cancer Early - people diagnosed and treated in the first stage of breast, colorectal and lung cancer	25%
4.	<i>Sustain and embed alcohol brief interventions in 3 priority settings (primary care, A&amp;E, Antenatal) and broaden delivery in wider setting</i>	13,086
5.	Eligible patients commence IVF treatment within 12 months	90%
6.	<i>18 weeks referral to treatment for Psychological Therapies</i>	90%
7.	<i>18 weeks referral to treatment for specialist Child and Adolescent Mental Health Services</i>	90%
8.	18 weeks Referral to Treatment (RTT)	90%
9.	12 weeks for first patient outpatient appointment	95%
10.	<i>Clients will wait no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery</i>	91.5%
11.	SABs Infections per 1,000 acute occupied bed days	0.24
12.	Clostridium difficile infections per 1000 total occupied bed days (0.32)	0.32
13.	4 hours from arrival to admission, discharge or transfer for A&E treatment	95%
14.	Operate within agreed revenue resource limit; capital resource limit; and meet cash requirement	Breakeven
15.	<i>People newly diagnosed with dementia will have a minimum of 1 years post diagnostic support</i>	
16.	<i>48 hour access or advance booking to an appropriate member of the GP team</i>	90%
17.	<i>At least 80% of pregnant women in each SIMD quintile will have booked for antenatal care by the 12th week gestation</i>	80%
18.	<i>Sustain and embed successful quits, at 12 weeks post quit, in the 40% SIMD area</i>	2,254
19.	Sickness Absence	4%