

Greater Glasgow & Clyde Health Board

Board Meeting

Tuesday 26 June 2012

Board Paper No. 12/26

Director of Corporate Planning and Policy

NHSGG&C CORPORATE PLAN 2013-16

Recommendation:

The NHS Board is asked to approve the Corporate Plan for the period 2013-16.

1. Background and Purpose

- 1.1. The final draft NHS Greater Glasgow and Clyde Corporate Plan 2013-16 is attached. The plan sets out the strategic priorities for the Board for the next three years, and the outcomes we aim to deliver in that period. The purpose of the Corporate Plan is to set a clear and consistent direction for the period 2013-16. The Plan will drive the overall planning system including planning and policy frameworks, the development plans produced by each part of the organisation, and our performance systems to measure progress. The Corporate Plan will also provide the basis our work with partner organisations over this period, particularly with Local Authorities.
- 1.2. The Plan establishes five strategic priorities:-
 - early intervention and preventing ill-health;
 - shifting the balance of care;
 - reshaping care for older people;
 - improving quality efficiency and effectiveness;
 - tackling inequalities.
- 1.3. For each of these priorities outcomes which we need to achieve are set out in the Plan including financial outcomes.

2. Development and Engagement

- 2.1. The plan is the product of wide engagement initiated by a discussion paper, produced following a development sessions with the Board and the Corporate Planning Group. That paper set out the planning context, proposed strategic priorities, and a set of questions for wide debate and consideration.

EMBARGOED UNTIL DATE OF MEETING

2.2. Engagement took place through the discussion paper being:-

- made available on Staffnet through the Facing the Future Together page;
- issued to Directors for debate with their management teams;
- highlighted in the February Team Brief encouraging all staff to read the discussion paper and respond to the questions.
- discussed at the Area Partnership Forum and Area Clinical Forum, and sent to each of the professional advisory forums.
- a core part of the corporate event held in February for the whole management team.

2.3. The table below sets out the major issues raised and how these have influenced the final version of the Corporate Plan.

Issue	Response
Context	
The impact of the recession and welfare reform on inequalities, poverty and mental health will be significant.	Expected impact reflected in final version.
Ageing population impact differently in different areas. Need to be mindful of current and growing numbers of children in some areas.	Updated projections used, including rise in younger people.
The ageing population should not just be presented as a 'problem'.	Positive aspects included.
The plan should more explicitly acknowledge and address the inverse care law and how this might be addressed and any improvement measures.	More explicitly included in inequalities section, and further detail to be picked up within primary care framework.
Strategic Priorities	
Overlap between shifting the balance of care, older people and 'acute' section.	Sections amended and overlaps explicitly acknowledged.
Acute needs to be described in context of overall pathway.	Priorities amended to cover whole system.
Supporting development of required community services.	Primary and community services development more explicitly included.
Safety is one aspect of quality so shouldn't be separated out - need to make progress on all six dimensions.' Trade off' suggests cost might be chose above quality. Training, skills development and maintenance, supervision and governance arrangements are more important than service review and redesign.	Quality and safety section changed to 'quality, efficiency and effectiveness' to cover all 6 aspects of quality and relationship between savings and quality.
Reshaping care for older people: <ul style="list-style-type: none"> • Don't over simplify – about whole system of care, not just 'change fund' • Long term care of very dependent patients in community needs specialist skills and support • Integration has to focus on service improvements and not structures 	Detail will be picked up in the older people's planning framework. Integration, carers and development of community services more explicitly included in final version.

EMBARGOED UNTIL DATE OF MEETING

Issue	Response
<ul style="list-style-type: none"> • More emphasis on carers. 	
End of life care should be more explicitly mentioned and is a major area for change.	Included explicitly in shifting the balance of care and quality.
Shifting the balance of care: <ul style="list-style-type: none"> • Agree focus on supported self management • More explicit inclusion of work with third sector. 	
Needs more explicit mention of mental health and addictions.	Statement included in the plan that the five priorities apply across all services including mental health. Planning frameworks for mental health and addictions will include detail on how the strategic priorities related to these specific areas.
Delivery	
<ul style="list-style-type: none"> • Workforce issues critical – need to get language and implementation right; engage with staff. • Acknowledge changes already made and existing pressure on staff. • Include clinical and professional leadership • Greater clarity on how we will work with GPs to deliver targets which don't directly apply to them. 	Workforce section amended to emphasise the importance of engagement and effective involvement of staff. Primary care emphasised as central to each of the strategic priorities. Primary Care framework will pick up specific delivery issues.
Targets and Indicators	
Need to include all HEAT targets.	Included in appendix to final plan.

REVISED DRAFT - 19TH JUNE 2012



FINAL DRAFT CORPORATE PLAN 2013-16

JUNE 2012

**NHS GREATER GLASGOW AND CLYDE
CORPORATE PLAN 2013-16**

CONTENTS

1. Introduction.....	2
2. National Policy Context.....	3
3. NHS Greater Glasgow and Clyde Organisation and Services.....	4
4. The Population of NHS Greater Glasgow and Clyde.....	5
5. Our Resources.....	10
6. Strategic Priorities.....	13
7. Working With Our People.....	18
8. Delivering the Plan and Measuring Progress: How the Process Works.....	19
Appendix 1 - Heat Targets 2013-16.....	20

NHS GREATER GLASGOW AND CLYDE CORPORATE PLAN 2013-16

1. INTRODUCTION

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

“Deliver effective and high quality health services, to act to improve the health of our population and to do everything we can to address the wider social determinants of health which cause health inequalities.”

1.2 This Corporate Plan for 2013-16 sets out the five strategic priorities to move us towards achieving that purpose over the next three years, and also sets out the outcomes we will deliver for those five priorities.

The five priorities are:

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

1.3 The Corporate Plan sets a clear and consistent direction for our activity for the period 2013-16. The Plan will drive the overall planning system including more robust and streamlined systems to enable change across the whole system and a clearer line of sight between agreed corporate priorities and assessment of overall performance and progress across NHS Greater Glasgow and Clyde. It is important to be clear there are real challenges and tensions to deliver on this group of priorities. As just one example, there are pressures to introduce new treatments which, with limited resources, need to compete against increasing spending on prevention or early intervention. The direction set in this Plan aims to help us to resolve those challenges and tensions.

1.4 We have engaged widely on the content of the Plan to ensure that it is meaningful and credible and that it begins to have a profile across the organisation. The publication of the Plan is a further opportunity to engage internally and across our diverse populations.

1.5 The next four sections of this paper set out the information which we have used to develop the five strategic priorities and the outcomes, these are:

- the national policy context;
- our population;
- our organisation and services;
- our resources.

2. NATIONAL POLICY CONTEXT

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

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

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

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

- 2.2 Underpinning the narrative is the Quality Strategy, with the three central ambitions that care should be person centred, safe and effective. The quality outcomes and 2020 vision will be the major national drivers of NHS targets and strategic direction for the period 2013-16 and beyond, including the HEAT targets for which the Board will be held to account each year.
- 2.3 The vision and outcomes for the NHS are set in the context of a significant budget challenge for Scotland. While the health budget is set to increase slightly over the next three years, the wider challenge for Scotland of a real terms spending reduction of over 11% between 2010/11 and 2014/15 will impact across the public sector. The NHS budget will face additional pressure from the ageing population, new technologies and the cost of drugs. These pressures mean that the NHS across Scotland will be required to focus on increased efficiency, while sustaining and improving the quality of care.
- 2.4 During the period of this Corporate Plan, integrated Health and Social Care Partnerships will be created across Scotland, accountable for an agreed set of outcomes. This will represent a major change and opportunity for the Board and existing partnerships. Successful development of the new integrated partnerships will be key to the achievement of all of the strategic priorities the Plan establishes, most particularly in shifting the balance of care and reshaping older people's care.

3. NHS GREATER GLASGOW AND CLYDE ORGANISATION AND SERVICES

- 3.1 NHS Greater Glasgow and Clyde is the largest NHS Board in Scotland and covers a population of 1.2 million people. Our annual budget is £2.8 billion and we employ over 40,000 staff.
- 3.2 Services are planned and provided through the Acute Division and six Community Health (and Care) Partnerships, working with our six partner Local Authorities. We have many hundreds of independent primary care contractors who deliver the vast majority of NHS activity.
- 3.3 The Acute Division delivers planned care and emergency services in nine major hospital sites and provides specialist regional services to a much wider population. This includes medicine and emergency services; surgery; maternity services; children's services; cancer treatment; tests and investigations; older people and rehabilitation services. In our hospitals in 2010/11 there were 467,051 A&E attendances; 407,030 new outpatient attendances; 169,827 day cases; 286,403 inpatient stays and over 15,000 births.
- 3.4 The six Community Health (and Care) Partnerships are responsible for the full range of community based health services delivered in homes, health centres, clinics and schools. These include health visiting, district nursing, speech and language therapy, physiotherapy, podiatry, mental health and addictions. The Community Health (and Care) Partnerships also work in partnership to improve the health of their local populations and reduce health inequalities.
- 3.5 The Partnerships work with the full range of primary care contractors, dentists, optometrist, pharmacists and GPs. Each year over 1 million patients are seen by GPs and practice staff and there are over 1.5 million visits to patients by Health Visitors and Community Nurses.
- 3.6 This Corporate Plan sets out the strategic priorities and outcomes which all of these parts of our system will have to work together to achieve.

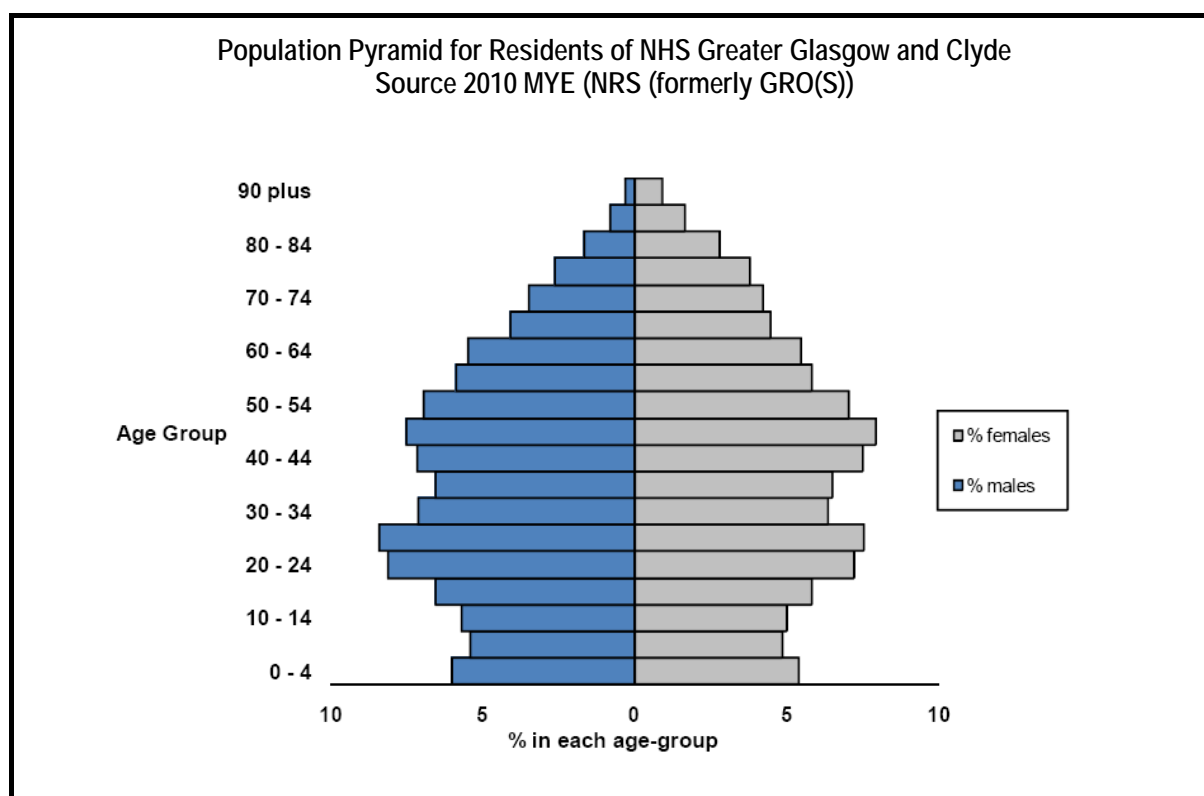
4. THE POPULATION OF NHS GREATER GLASGOW AND CLYDE

4.1 Population Health

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

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

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



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

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

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

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

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

GRO(S))

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

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

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

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

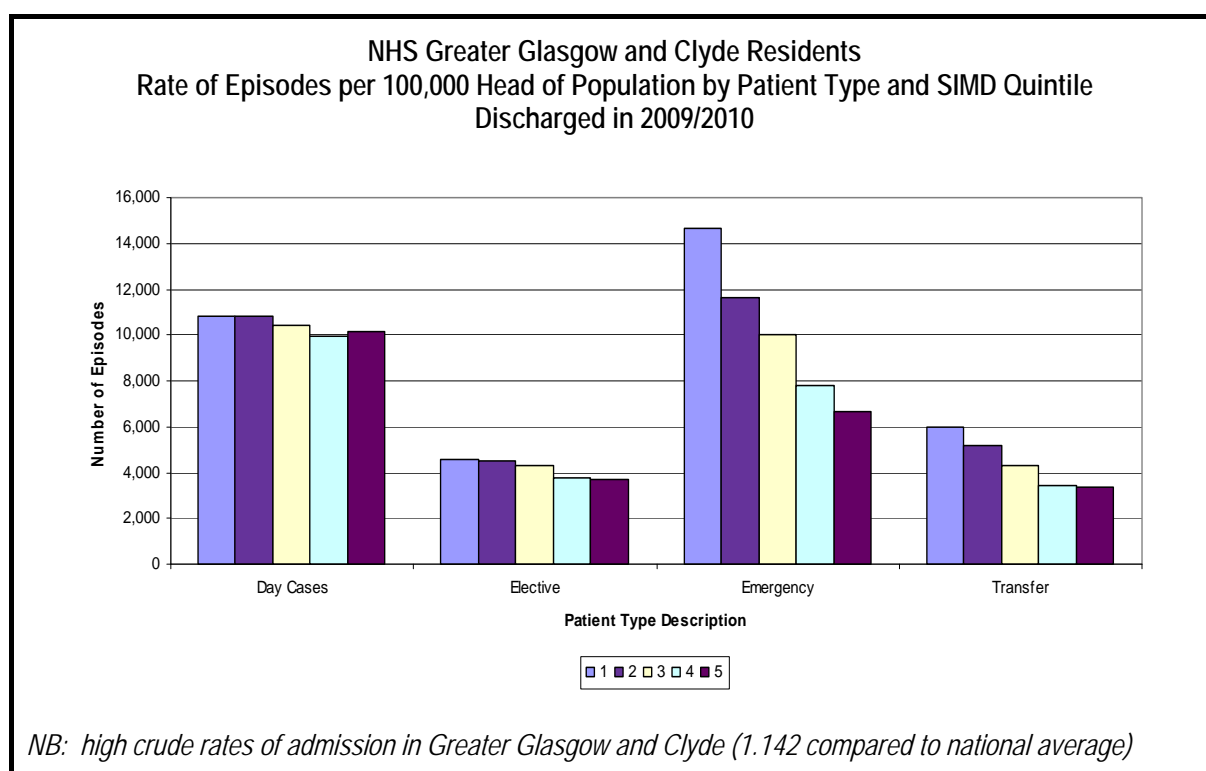
- children and families living in poverty;
- high levels of unemployment, including youth unemployment;
- impact of the recession and tax and benefit changes, particularly disability benefits;
- isolation and loneliness with high numbers of people living on their own.

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

4.2 How our Population Uses and Benefits from Services

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

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



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

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

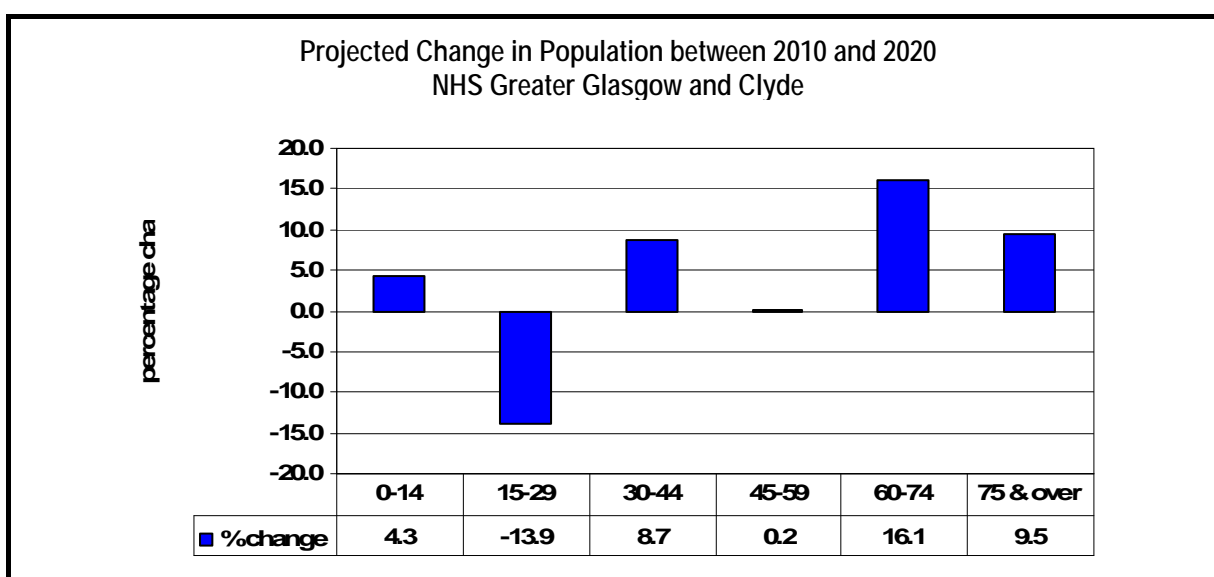
4.3 Projections and Trends for 2013-16

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

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

³ Source NRS (formerly GRO(S))

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



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

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

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

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

In the wider social and political context, there will be some significant events during 2013-16. The Glasgow Commonwealth Games will take place in 2014 and is focusing heavily on the 'Games legacy' including the impact on physical activity, health and wellbeing and wider economic and infrastructure benefits. A referendum on Scottish independence is currently being planned for 2014. Health and Social Care represent over 50% of current Scottish Government spend and are likely to be major issues for debate, and this will affect the political dynamic within which the NHS operates.

Whilst we will not see the full impact of these trends during 2013-16, they are all issues we are currently beginning to face and 2013-16 will be a critical period in reshaping services to meet these pressures and the expected long term demographic changes.

5. OUR RESOURCES

5.1 Overview

Reshaping how we use our £2.9 billion of resources is fundamental to delivering the changes this Corporate Plan sets out. We expect the period 2013-16 to be a time of continued major financial challenge across the public sector in Scotland. At present, health spend is protected, but there are substantial underlying pressures which mean that further savings and efficiencies will be required. These include finding funding to meet the costs of:

- Inflation, especially pay and energy costs;
- funding needed for planned service developments including nationally set priorities for access improvements and new services;
- continuing development of new drugs and treatments;
- changing services to deal with demand pressures or to address gaps in provision;
- addressing service pressures associated with changing need and demographics;
- the effects on the NHS of pressures and budget reductions for partner agencies, including Local Authorities and third sector organisations.

The next sections on each of the five strategic priorities identify the key financial challenges and questions which we need to address in developing our detailed service and financial plans for the next three years. In addition to addressing those issues we will also:

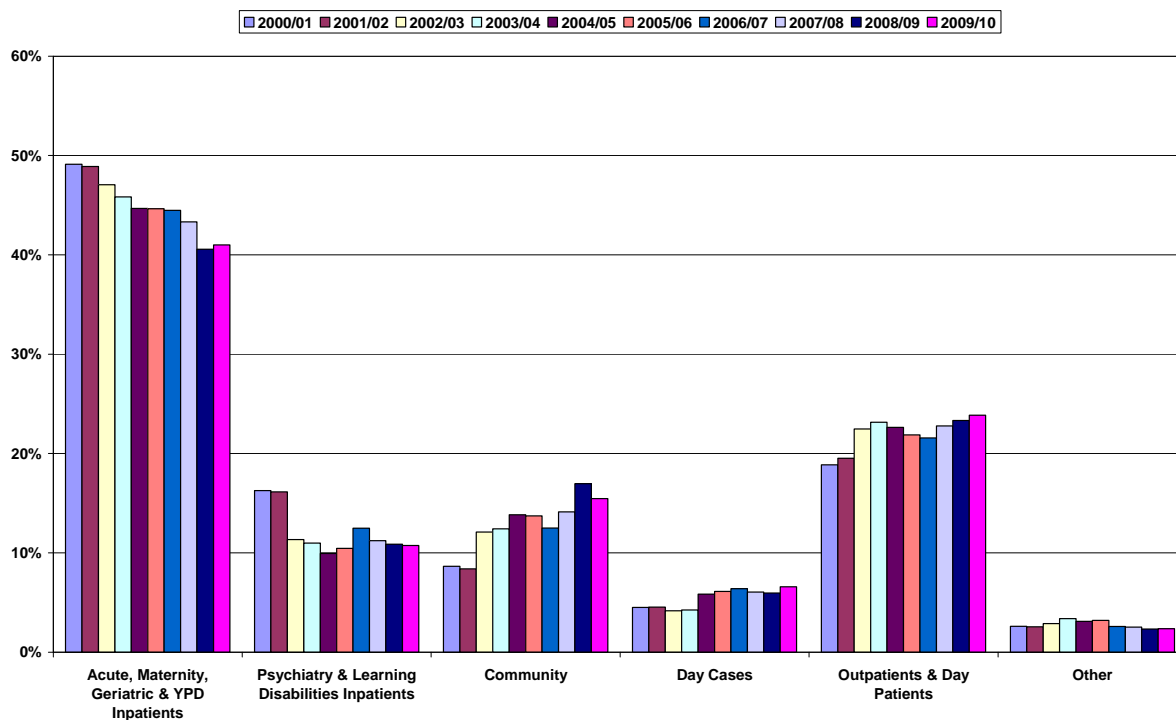
- use technology to further drive forward flexible and agile working to further reduce our office and support costs;
- encourage and support our staff to generate and deliver ideas which make better use of resources;
- develop our benchmarking activity to understand where there may be potential for change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

5.2 Current Spending Profile

NHS Greater Glasgow and Clyde has an annual budget of £2.9 billion which is broken down as follows:

Service area	£m
Acute	1,489
ICT, HR, Medical Records	91
Partnerships	466
Prescribing	244
GMS / FHS	344
Resource Transfer to Councils	119
External Healthcare Purchases	79
Other including Unallocated	63
TOTAL	2,895

Over the last 10 years the balance of spend has shifted away from inpatient care towards more community, day case and outpatient care. The table below illustrates this change.



Acute expenditure includes the costs of services provided on a regional or national basis. The costs which can be broken down by CH(C)P to show how our population uses our services in each area is show below, and is taken from the Integrated Resource Framework modelling which is still under development.

	Hospital Based Care £m	Community Based Care £m	Total £m
CH(C)P			
Glasgow City	595	561	1,156
East Renfrewshire	63	63	126
Renfrewshire	134	144	278
East Dunbartonshire	92	78	170
West Dunbartonshire	80	77	157
Inverclyde	69	73	142
CH(C)P Sub Total	1,033	996	2,029
Other			
CH(C)P Funding not yet mapped			124
GGC Residents of other GPs			176
NSD Income & Other Boards' Residents			420
Other			146
Other Sub Total			866
Total			2,895

6. STRATEGIC PRIORITIES

6.1 Overview

Over the period 2013-16 our aim is to meet national targets, achieve existing commitments, move towards the national 2020 vision and deliver on NHS Greater Glasgow and Clyde's purpose, all in the context of the health needs of the population we serve. In order to do this we must make significant progress on the five major interlinked strategic priorities set out below. These do not cover all of the business of NHS Greater Glasgow and Clyde, but attempt to set out the critical issues where a clear and consistent strategic direction is required to guide change across the whole organisation and applying across all care groups.

The five strategic priorities are:

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

The delivery and development of primary care is fundamental to progressing all of these priorities. In addition to a full range of local work to develop primary care we will engage with Scottish Government to play our full part in shaping changes to the general medical services and other national primary care contracts.

Also critical to all of the strategic priorities is delivering change in hospital services. During the period of this Corporate Plan, we will complete a number of critical parts of the existing acute services strategy with the opening of the new Southern General Hospital in 2015, the move to a new Children's hospital on the Southern General site, and the implementation of existing plans to reduce the number of sites for key specialties and to reflect the impact of the change fund. A wider review of clinical services has begun to look beyond our existing plans to the next stage of development for clinical services across primary, community and acute care, including mental health. The emerging conclusions of that review support the delivery of the wider strategic priorities set out in this Plan.

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

6.2 Preventing Ill-health and Early Intervention

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

- high numbers of vulnerable children and families in Greater Glasgow and Clyde have poor outcomes and high risks across a range of indicators, as described in Mind the Gaps our analysis of the issues for children and families;
- an increasing number of individuals and families will be affected by poverty, debt, fuel poverty and potentially homelessness;

- poor healthy life expectancy for our population means that many people in Greater Glasgow and Clyde need health services at a younger age and for longer than in other areas of Scotland;
- budget pressures are impacting on the ability of all agencies to focus on early intervention and prevention and exacerbating the problem of high thresholds for intervention.

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

Key outcomes we need to deliver in this area during 2013-16 are:

- improve identification and support to vulnerable children and families;
- enable disadvantaged groups to use services in a way which reflects their needs;
- increase identification of and reduce key risk factors (smoking, obesity, alcohol use);
- increase the use of anticipatory care planning;
- increase the proportion of key conditions including cancer and dementia detected at an early stage;
- enable more older people to stay healthy.

The financial outcome we need to achieve in the next three years is a shift in spending to prevention and early intervention, including from hospital care; being able to evidence that shift and its financial effectiveness; focussing on interventions which are effective and reduce demand. In some areas this poses particular challenges where the savings from upstream activities are not released from NHS costs.

6.3 Shifting the Balance of Care

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

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

The work described above to develop the clinical service strategy needs to focus on shifting the balance of care. The creation of integrated Health and Social Care Partnerships will be an opportunity to ensure that patients are supported more effectively in the community. Key outcomes we need to deliver in this area during 2013-16 are:

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

- more people are able to die at home or in their preferred place of care.

The financial outcome we need to achieve in the next three years is a shift in spending from hospital to community services; this will require creation of levers and incentives for our existing and new Partnerships to change patterns of demand. We also need to reshape spending on community and primary care services, including controlling growth in prescribing, to free up resources to invest in local services.

6.4 Reshaping Care for Older People

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

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

- the substantial growth in the numbers and proportion of older people across Greater Glasgow and Clyde, coupled with relatively poor healthy life expectancy and wider social changes including the growth in single person households;
- the growth in numbers of people with dementia across all our services;
- the challenge of funding constraints in other agencies working with older people, and the impact on the third sector;
- challenges around older people's experience of care in all settings;
- a range of issues around end of life care, respite and high cost community care;
- the need to more effectively influence housing developments for older people;
- the opportunity of the Change Fund to act as a catalyst for service redesign.

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

Key outcomes we need to deliver in this area during 2013-16 are:

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

The financial outcomes we need to achieve in the next three years are demonstrating the value for money of the change fund and other community service investments, directing our resources to support primary care to do more for older people and reducing spending on hospital care for older people

6.5 Improving Quality, Efficiency and Effectiveness

The national Quality Strategy and our local quality improvement programmes are a major strategic priority for this Corporate Plan. Our focus will be on ensuring that care is person centred, safe and clinically and cost effective. There is a huge range of activity which could come under the banner of 'quality', and a consequent need to focus on a clear set of commitments and priorities. We need to continue our shift towards defining clear quality outcomes and to embed this in our performance management systems; focusing on caring and experience of care as well as treatment.

Key outcomes we need to deliver in this area during 2013-16 are:

- making further reductions in avoidable harm and in hospital acquired infection;
- delivering care which is demonstrably more person centred, effective and efficient;
- patient engagement across the quality, effectiveness and efficiency programmes;
- developing the Facing the Future Together programme to support our staff to improve quality, hear and respond to patient feedback;
- improve appropriate access on a range of measures including waiting times, access to specialist care; physical access and needs responsive access.

The financial outcomes we need to achieve in the next three years are that investments in current and new services are rigorously scrutinised for effectiveness and efficiency, our decisions are informed by that scrutiny and resources shift accordingly. We need to influence the development of national plans and policies to reflect our service priorities and deliver changes which sustain or improve quality and reduce cost.

6.6 Tackling Inequalities

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

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

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

Key outcomes we need to deliver in this area during 2013-16 are:

- we plan and deliver health services in a way which understands and responds better to individuals' wider social circumstances;
- information on how different groups access and benefit from our services is more routinely available and informs service planning;
- we narrow the health inequalities gap through clearly defined programmes of action by our services and in conjunction with our partners.

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

7. WORKING WITH OUR PEOPLE

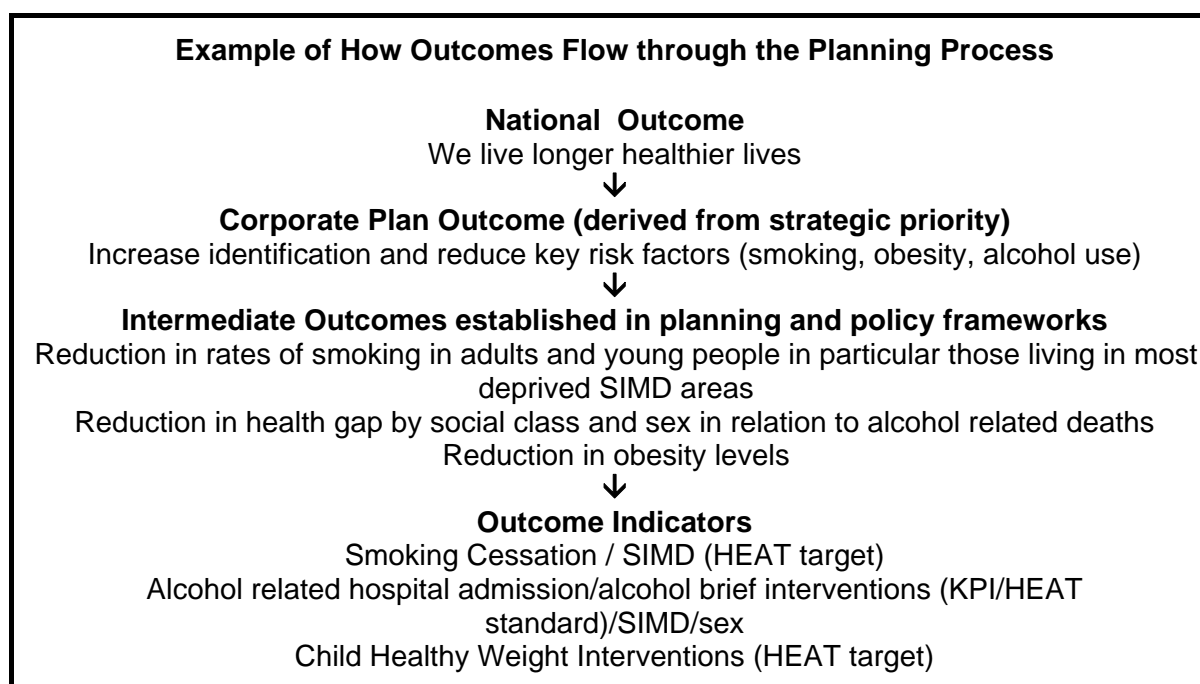
- 7.1 Our people are our most important resource and this section has two purposes. Firstly to confirm our commitment to the continuing development of the Facing the Future Together programme to ensure that we engage better with our whole workforce. That engagement will drive improvements in quality, efficiency and effectiveness as our staff face the real challenges of delivering our strategic priorities.
- 7.2 The second purpose is to signal the changes we expect to occur to our workforce over the period 2013 to 2016. There will continue to be changes to:-
- numbers and skill mix across all professions to reflect different ways of working which our five strategic priorities require;
 - reflect the impact of current service redesign and changes to the configuration of services, which will mean that many people will be working in different roles and locations;
 - deliver increased efficiency which will mean we need to support staff to work differently in many areas, and recognise the impact of this on staff;
 - support staff to develop and maintain skills and practice with effective supervision and governance arrangements
- 7.3 Our staff partnership arrangements will be crucial to designing and delivering these changes.

8. DELIVERING THE PLAN AND MEASURING PROGRESS: HOW THE PROCESS WORKS

- 8.1 This section sets out how the strategic priorities and outcomes we have outlined in this Corporate Plan will be delivered and measured.
- 8.2 Our Policy and Planning Frameworks covering the areas set out in the table below will be reframed over the next four months to reflect the direction set in this Plan.

Acute Services	Primary Care	Cancer	Inequalities
Older People	Long Term Conditions	Disability	Quality
Sexual Health	Alcohol and Drugs	Unpaid Care	Sustainability
Children and Maternity	Mental Health	Health Improvement	Financial Inclusion

- 8.3 Each of these planning and policy frameworks will set intermediate outcomes linked to measureable indicators to meet the commitments we are establishing. The table below illustrates this approach and how it links to national outcomes



- 8.4 The Planning and Policy Frameworks provide the basis for each part of the organisation to develop a 2013/16 development plan describing how they will deliver the changes required and measure their progress. These plans in turn form the basis of the corporate performance process. The HEAT targets which we are required to deliver are set out in Appendix 1, aligned to our strategic priorities.

//

APPENDIX 1 - HEAT TARGETS 2013-16

(includes those to be delivered by March 2013)

Preventing Ill Health and Early Intervention

1. To increase the proportion of people diagnosed and treated in the first stage of breast, colorectal and lung cancer by 25% **by 2014/2015**.
(NHSGGC target 20% by 2014/15)
2. At least 80% of pregnant women in each SIMD quintile will have booked for antenatal care by the 12th week of gestation **by March 2015** so as to ensure improvements in breast feeding rates and other important health behaviours.
(NHSGGC target 80% March 2015)
3. At least 60% of 3 and 4 year olds in each SIMD quintile to have fluoride varnishing twice a year **by March 2014**.
(NHSGGC target 60% by March 214)
4. To achieve 14,910 completed child healthy weight interventions over the three years ending **March 2014**.
(NHSGGC target 3,389 by March 14)
5. NHS Scotland to deliver universal smoking cessation services to achieve at least 80,000 successful quits (at one month post quit) including 48,000 in the 40% most-deprived within-Board SIMD areas over the three years **ending March 2014**.
(NHSGGC target 12,182 March 2014)
6. Reduce suicide rate between 2002 and **2013** by 20%.

Improving Quality, Efficiency and Effectiveness

7. NHS Boards to operate within their agreed revenue resource limit; operate within their capital resource limit; meet their cash requirement.
8. NHS Scotland to reduce energy-based carbon emissions and to continue a reduction in energy consumption to contribute to the greenhouse gas emissions reduction targets set in the Climate Change (Scotland) Act 2009.
(NHSGGC target 51,353 tonnes of CO² by 2014/15 and 1,601,736 GJ energy consumption by 2014/15)
9. Deliver faster access to mental health services by delivering 26 weeks referral to treatment for specialist Child and Adolescent Mental Health Services (CAMHS) services from March 2013, reducing to 18 weeks **by December 2014**; and 18 weeks referral to treatment for Psychological Therapies from **December 2014**.
(NHSGGC target 0 patients waiting >26 weeks for CAMHS by March 2013 reducing to >18 weeks by December 2014 and target for psychological services to be agreed during 2012-13)
10. **By March 2013**, 90% of clients will wait no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery.
(NHSGGC target 91.5% by March 2013)

11. To improve stroke care, 90% of all patients admitted with a diagnosis of stroke will be admitted to a stroke unit on the day of admission, or the day following presentation **by March 2013**.
(NHSGGC target 90% by March 2013)
12. Further reduce healthcare associated infections so that **by March 2013** NHS Boards' staphylococcus aureus bacteraemia (including MRSA) cases are 0.26 or less per 1000 acute occupied bed days; and the rate of Clostridium difficile infections in patients aged 65 and over is 0.39 cases or less per 1000 total occupied bed days.
(NHSGGC target MRSA/MSSA 0.26 by March 2013 and CDiff Infection 0.39 by March 2013)

Shifting the Balance of Care and Reshaping Care for Older People

13. Reduce the rate of emergency inpatient bed days for people aged 75 and over per 1,000 population, by at least 12% between 2009/10 and **2014/15**.
(NHSGGC target 5,630 by March 2015)
14. No people will wait more than 28 days to be discharged from hospital into a more appropriate care setting, once treatment is complete from April 2013; followed by a 14 day maximum wait **from April 2015**.
(NHSGGC target 0 by April 2013)
15. To support shifting the balance of care, NHS Boards will achieve agreed reductions in the rates of attendance at A&E between 2009/10 and **2013/14**.
(NHSGGC target 2,888 by March 2014)