NHS Greater Glasgow and Clyde

Annual Delivery Plan 2022/23

July 2022

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Executive Summary

1. Current Position

The impacts of the pandemic continue to be felt in NHS Greater Glasgow and Clyde (NHSGGC). We are still dealing with high and fluctuating levels of COVID in our hospital beds and there remains significant pressure on our community and mental health services. In addition, we have maintained a level of elective activity, prioritising cancer and, urgent cases. We are working through the options for delivering the recent targets for people waiting for 18/24 months for treatment. Our staff have worked very hard to treat these high numbers of patients but the continued uncertainty makes plans for remobilisation, recovery and redesign very challenging. We have focused significant effort in meeting the requirements of the Public Inquiry and these demands are expected to continue over the next 12 months. Our plan for 2022/23 demonstrates the considerable achievements to date, and sets ambitious but realistic plans for the year ahead. It highlights and builds on the innovative practice which has emerged over the last 12 months.

2. Approach

Our approach to developing this plan has been cross system, including primary care, secondary care, mental health and health and care services in the community. We used the Health & Social Care Partnership (HSCP) and Acute Tactical Groups, the Recovery Tactical Group (RTG) and the Strategic Executive Group (SEG) to test the plans and priorities as they were developing. This inclusive process has been supplemented by more formal engagement with a number of the Board's governance groups. Our plan focuses on the priorities noted in the commissioning letter, with two local priorities:

- Staff Wellbeing
- Recruitment and Retention of our Health and Social Care Workforce
- Recovering Planned Care
- Urgent and Unscheduled Care
- Supporting and Improving Social Care
- Sustainability and Value
- Public Health (local)
- Mental Health (local)

3. Strategic Direction

Moving Forward Together (MFT) remains our key strategic document, describing the medium term vision for clinical services in NHS Greater Glasgow and Clyde. Implementation of some MFT recommendations has been accelerated by the need to respond rapidly to the demands of COVID. In the twelve months ahead, we will build on this transformational change and embed the innovative practice recently established.

4. Key Priorities

The detail of the plan builds on the key priorities detailed below, and identifies specific actions to be progressed during 2022/23:

Workforce

We will continue our commitment to staff mental health and wellbeing and deliver the NHSGGC action plan. We will focus on anticipatory workforce planning to respond to the changing demands of services which is detailed in our 3 year workforce plan. In particular our recruitment teams are focused on increasing and maintaining capacity as staff numbers are impacted by COVID levels and increased activity. We will continue to support the return to office working as appropriate and in line with our hybrid working guidance.

Planned Care

We aim to step up activity in our elective programme when COVID levels allow. We will focus on cancer and urgent cases, balancing this with specific actions to treat patients who have been waiting over 18 and over 24 months. We will continue to increase our use of virtual patient management (Near Me) and day case procedures, and we will enhance pre op assessment and pre admission management of patients. We will focus on radiology and endoscopy to reduce waiting times, and will work with other providers to deliver additional activity. We will progress our transformation programme to begin to establish surgical hubs and redesign care pathways.

Unscheduled Care

The Scottish Government relaunched the Urgent and Unscheduled Care Collaborative in June 2022. Across the NHSGGC system, we have identified three areas of high impact change to focus our efforts during 2022/23. These were informed by a cross system self-assessment process and include Virtual Capacity, Rapid Assessment and Discharge and Community Focused Integrated Care. During 2022/23, we will maximise the use of our Flow Navigation Centre and associated pathways, implement consistent signposting and redirection supported by a strong communications message and optimise cross system working with the Ambulance Service, NHS 24, GP Out of Hours and our Urgent Care Resource Hubs. We will further develop effective interfaces to support older people to stay in their own community and further increase the use of Hospital @ Home.

Social Care and Primary Care

Key priorities to progress with HSCPs include support for care homes and the care at home service. This will be underpinned by a focus on developing a resilient workforce. We recognise the need to reduce delayed discharges and to maximise independence for our population, supporting older people to live safely in their own community. Digital and telecare solutions will support this work.

Throughout the course of the pandemic Primary Care has supported and managed the significant impact on the health of needs of patients and the consequential demands due to delays in treatment during this period which has resulted in a sustained increase in demand for services. All independent contractors and services continue to work in a flexible way to offer a mixture of consultations through telephone, virtual and face to face consultations and will continue to offer a choice of consultation methods to support new ways of working. As well as continued implementation of the GP contract we will work to develop a NHSGGC Primary Care Strategy during 2022/23 which supports the wider NHSGGC and HSCPs priorities.

Public Health

We recognise the existing health inequalities exacerbated by the pandemic and will seek to address them with specific actions. We will continue to support the development of the vaccination programme. We will also support the wider health improvement agenda with a focus on child health, minimising Type 2 diabetes and preventing drug related deaths and harms.

Mental Health

We will continue to implement our Mental Health Strategy, including services for older adults, recognising the additional impact the pandemic has had on the mental health of the population. A focus on digital will increase virtual patient management and support new psychological services. Mental Health services will support the wider unscheduled care agenda, building on the Mental Health Assessment Units model and developing Consultant Connect. In particular, our recruitment

teams are focused on increasing and maintaining capacity as staff numbers are impacted by COVID levels. We will work with partners to reduce social isolation and loneliness. We will focus on the delivery of waiting list improvement in Child and Adolescent Mental Health Services and for Psychological Therapies.

5. Finance

Our plan will be underpinned and intrinsically linked to the Board's Financial Plan which will demonstrate how we will manage within the financial resources available to us. We have highlighted areas of risk, where delivery of priorities is dependent on receipt of funding which has not yet been agreed. Capital planning will continue to be linked to service planning, and will inform the work being progressed to develop a Board-wide Infrastructure Strategy.

6. Summary

Our plan attempts to describe the difficult balance facing us in 2022/23 as we continue to see high levels of COVID in our communities and our hospitals, unscheduled and urgent care demands remain high and we try to protect the planned care programme. It will also be essential to ensure our financial challenges are afforded a high level of priority. The challenges facing our staff over the last 30 months have been immense and show no signs of reducing. The achievements delivered over that period cannot be underestimated.

1. Introduction

1.1 Background and Context

The Annual Delivery Plan (ADP) has been developed to respond to the commissioning letter from Caroline Lamb on 27th April and the subsequent planning guidance which was circulated shortly thereafter. It covers the period 1st April 2022 to 31st March 2023 and build on previous Remobilisation Plans. The plan focusses on the limited set of priorities highlighted in the commissioning letter:

- Staff wellbeing
- Recruitment and retention of our health and social care workforce
- Recovering planned care
- Urgent and unscheduled care
- Supporting and improving social care
- Sustainability and value

We have added a focus on two local priorities:

- Public Health priorities of maintaining the ability to respond to COVID waves, Child Health, Type 2 Diabetes, reducing drug related deaths and harms
- Mental Health to recognise the increased demand placed on these services as a consequence of the pandemic, and the impact that mental ill health has on health outcomes and inequalities

Finally, we have described our plans for the cross-portfolio priorities noted in the commissioning letter:

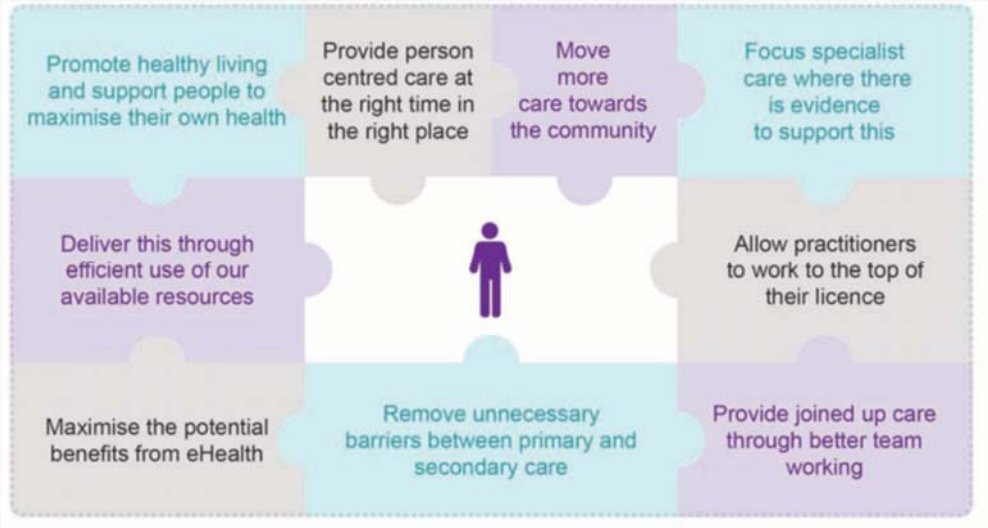
- Child poverty
- Communities
- Fair work
- Reducing drug deaths
- Climate change

The Scottish Government Delivery Planning Template has been completed to enable monitoring of this programme of work, and monthly reports will be reviewed by Directors and Chief Officers.

1.2 Strategic Direction

The Annual Delivery Plan focusses on the next 12 months, referred to as Horizon 1 in the commissioning letter. This is a period of stabilisation, following the fluctuating demand driven by the pandemic. Moving Forward Together (MFT) remains the strategic document which describes the strategic vision for future clinical and care services in NHS GGC. Progressing this long term vision, which encompasses horizons 2 and 3 (reform and transformation), has continued throughout the pandemic. The principles are summarised in figure 1.

Figure 1: Moving Forward Together (MFT) Principles



Over the last 2 years, we have taken a portfolio approach, focussing on some key projects and applying a rigorous project management approach to implementing change. The portfolio includes the redesign of urgent care, reprovision of the Institute of Neurological Sciences, implementation of the trauma network, development of a thrombectomy service, development of the North East hub, mental health strategy implementation and Best Start.

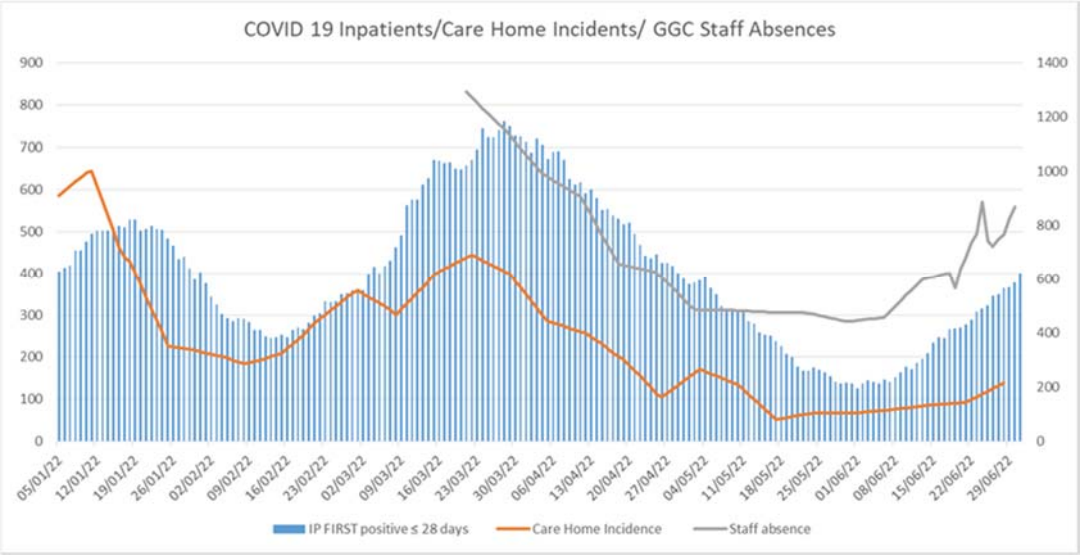
As we move on from this stabilisation horizon, we are revisiting the transformational aspirations described in MFT. The MFT blueprint sets out our vision for transformational service change by creating a tiered model of care with less dependency on hospital care, delivering more services in the community or within patients' homes, through cross-system working and by embracing digital technologies. The blueprint is underpinned by the need for good quality and high performing NHS estate and infrastructure and the use of digital technology to ensure the needs of our staff, patients and the public are met now and in the future.

We are beginning work across the health and care system in GGC to develop a clinically led Infrastructure Strategy. This work is supported by the Scottish Government and will be carried out in collaboration with facilities and healthcare planning experts. It will identify a programme of short, medium and long-term redesign and investment requirements designed to gradually transform the GG&C infrastructure arrangements so that they better meet the challenges faced and support the transformation of clinical services. This will include the investment required to retain the existing estate in a safe, effective, and fit for purpose manner over an extended period. The output from this work will inform our Three Year Delivery Plan.

2. Current Position – Recovery & Continued Pandemic Response in 2022/23

The one year delivery plan has been developed within the context of continued uncertainty of planning, with ongoing and fluctuating levels of COVID demand on health and social care services. This has a significant impact on the Board's ability to deliver planned care and meet unscheduled care targets, with ongoing staffing challenges as a result of continued and fluctuating levels of community transmission of COVID. **Figure 2** illustrates the number of COVID inpatients, Care Home COVID incident rate and the Board staff absence rates between January 2022 and June 2022.

Figure 2: COVID inpatient numbers, Care Home Incidents & Staff Absence Jan to June 2022



Throughout the pandemic period, the NHSGGC response has been led by a Gold and Silver Command Structure, with meeting frequency being informed by the level of challenge in the system. Currently, the Strategic Executive Group (SEG) meets twice a week with a dedicated focus on recovery at one of those meetings, and this is supported by weekly meetings of the HSCP, Acute and Recovery Tactical Groups.

The SEG continues to undertake a weekly review and forecast of hospital activity – both COVID, non-COVID and planned activity. Throughout the pandemic the SEG has regularly used community positive rates to forecast hospital activity and provide activity projections to SG. As this data is no longer available, we now use experience of last 2 years and care home testing with ONS data to inform decisions to support activity levels.

Given the current challenges, and looking ahead over the next few months, a range of mitigations are being used to ease the expected pressure on beds. This is constantly being reviewed. Key challenges remain as follows:

- **Staffing and availability of workforce -** is a key limiting factor in our ability to provide care and is the key factor in our ability to increase levels of planned care activity

- **Bed availability** - availability of acute and care home beds as a result of COVID ward / care home closures in line with Infection Control guidance continues to be challenging. We continually review occupancy in beds across our estate, ensuring flexible use, and reprofiling wards and beds as necessary

- **Specialist Assessment and Treatment areas (SATAs)** - set up as additional clinical areas to support pathways for patients with actual/suspected COVID remain in place

- **Delayed discharges** remain a major factor affecting hospital flow impacting across the patient pathway. HSCP colleagues continue to focus on care packages and care home places for hospital patients requiring discharge. Caring for patients in acute wards under AWI guidelines is challenging, with continued pressure on these beds.

- **Planned Care Activity Levels-** planned care activity levels are reviewed weekly in line with available capacity (after assessment by Chief of Medicine), cancer and urgent services are maintained as priority

Vaccination Programme

The Board has offered the second booster to those eligible and has promoted uptake to the younger age groups to maximise protection before the summer holidays.

5 to 11 year olds have been offered their second dose as have young people turning 16 who are newly eligible for a booster.

The contact centre is calling people in the most vulnerable groups who have not had a second booster to maximise uptake.

The summer programme in July and August will be minimal with the mobile vaccination unit being used in areas of lower uptake. Other adult vaccinations will be delivered over the summer months and Occupational Health will support staff vaccination

It is now less than 12 weeks to the proposed start of the Autumn Winter campaign for which we await final JCVI advice.

Figure 3: Percentage of patient aged over 75 eligible for a 2nd Booster who have received it (as at end June 2022)

Area	% of those over 75 eligible for a 2nd booster who have received it
Scotland	90.3
GGC	90
East Dun	94.2
East Ren	94
Glasgow	84.4
Inverclyde	93.5
Renfrew	94
West Dun	91.9

Glasgow City still has a number of older people to be vaccinated at home and this work is continuing

94% of eligible care homes residents in GGC have had a second booster compared to 92% nationally.

3. Staff Wellbeing

NHSGGC anticipated the pandemic would impact on the health and wellbeing of the workforce, and established a Workforce Mental Health and Wellbeing Group (WMHWG) to prepare a 3 year Mental Health and Wellbeing Action plan. This plan is aligned to NHSGGC principles, supported by NHSGGC Staff Health Strategy, NHSGGC Workforce Strategy and NHS Scotland Staff Governance Standards whilst reflecting our six HSCP approaches to sustaining and improving staff

wellbeing. The WMHWG includes sub groups focusing on Peer Support and Medical Staff Wellbeing. All activity is discussed and agreed in partnership with the Area Partnership Forum.

NHSGGC has delivered three phases of the Staff Mental Health Check-In survey and set up a Staff Support Helpline (support by a Clinical Psychologist) all as additional support to the Occupation Health counselling service.

The Board's Peer Support programme will encourage all staff to complete a LearnPro module 'Introduction to Psychological Wellbeing' and will offer training for those who are keen to be trained as peer supporters. The peer support network will be further supported by the establishment of a 'train the trainer' programme.

We will continue to provide all existing support resources and have an agreed action plan for 2022-23 which is detailed in full within the Three Year Workforce Plan.

4. Recruitment & Retention of our Health and Social Care Workforce

4.1 Current Staffing Profile

NHS Greater Glasgow and Clyde (NHSGGC) has a Whole Time Equivalent (WTE) workforce of 35,750 including 16,365 within the Nursing and Midwifery job family, 3,629 Medical and Dental staff and 2,758 Allied Health Professionals. The WTE of each job family, by area, service, sector and partnership is provided in the Board's Three Year Workforce Plan. The breakdown of WTE by job family, by pay band is also provided.

4.2 Establishment Gap

The most challenging establishment gap between service demand and current staffing profile is with Band 5 registered nurses. This cohort is at 87% of establishment in both Acute areas and Health and Social Care partnerships (HSCPs). The existing vacancies will be largely addressed through the annual recruitment of Newly Qualified Nurses and Midwifes who are planned to commence their careers with us in September and October this year. Nurses and Midwives at Band 6 and above are reasonably well established, with fewer than 3% of roles being vacant.

4.3 Attract – Recruitment Strategy

NHSGGC is developing a Recruitment and Marketing Strategy which sets out objectives and describes how we will address our resource challenges until 2025. The strategy is aligned to the workforce as well as local and national workforce strategies. In recent years it has become increasingly challenging to recruit and retain the right people with the right skills, upon which the ability to deliver high quality, person centred care depends.

The following programmes of work will address our key issues by improving our planning, our reputation, how we recruit and the type of roles we recruit.

4. **Recruitment Effectiveness** – being innovative in the way that we recruit and the role to which we recruit, both domestically and internationally
5. **Recruitment Experience** – ensuring a socially inclusive approach, with improved use of technology and candidate feedback
6. **Brand and Reputation** – supporting NHSGGC as an employer of choice with a focus on benefits and incentives packages

- **Employee Retention** – hiring the right person, first time with improved on-boarding processes and approaches to flexible working but also analysing why people leave and actions which can minimise turnover

NHSGGC is a welcoming and inclusive employer, where all staff are valued. We have successfully and ethically recruited internationally trained nurses this year and will offer more opportunities moving forward. NHSGGC has maintained a strong presence in apprenticeships throughout the pandemic and continues to build on these opportunities as well as work experience, careers insight and the Young Person Guarantee. We are focused on increasing opportunities for people within our communities who are furthest from employment, including the long term unemployed, refugees and asylum seekers. NHSGCC is also committed to being a Forces Friendly Employer.

4.4 Workforce Drivers

NHSGGC recognises that effective planning of staffing and resource is critical to maintaining service delivery. Clinical pathways have changed, and services have been re-designed across all service areas. Capacity has been flexed and expanded in key areas. Our staff continue to respond flexibly, undertaking new roles and adapting to new ways of working in extremely challenging circumstances.

Staff availability is a key consideration throughout the summer and into the winter of 2022/23. Sickness levels were higher than usual during Winter 2021/22, more recently COVID related absences have fluctuated with the waves of infection. Currently (10th to 14th July 2022), there are on average 820 COVID related staff absences each day.

The importance of staff having the opportunity to fully utilise their annual leave allowance is recognised and encouraged.

Staff turnover (the percentage of staff leaving NHSGGC within a year) has been at 10.9% for the previous 12 months. This is not forecast to significantly increase in the period to March 23, although some anecdotal changes to behaviours have been observed. This, alongside retirement risk and succession planning is being monitored closely and is fully detailed within the workforce plan.

4.5 New Roles

The opportunity to introduce new roles to NHSGGC is currently being explored across several areas and this is detailed in the workforce plan. There are a number of opportunities within Nursing & Midwifery to consider changes to skill mix to build multi-disciplinary teams in order to best support service delivery.

5. Recovery and Protection of Planned Care

5.1 The Context for Planned Care

Planned care service provision across NHSGGC in 2022/23 will build on the experiences gained over the last two years, and using this solid foundation NHSGGC will continue to generate further capacity for the longer term.

NHSGGC recognises the need to balance the risks across both unscheduled care and planned care that supports access to inpatient elective beds and optimises use of ambulatory sites and short stay provision. We will aim to implement a consistent approach across Sectors and specialties which will help to ensure efficient use of all available resources, and support this through clear clinical leadership within an individual specialty.

A significant challenge for planned care recovery is ensuring the workforce is in place to deliver the scale of elective activity over the coming years; for example, sufficient theatre nursing workforce for the number of surgical procedures. Some elective services are continuing to experience high levels of sickness absence and staff turnover, this combined with the impending opening of the National Treatment Centres places additional risk for staff recruitment and retention.

Over the longer term there is further challenge to ensure the broader infrastructure is in place across all sites to efficiently deliver the wider priorities and objectives for elective service delivery over the next 3/5 years.

The sections below provide an overview of the work which will be progressed during 2022/23 to support the elective programme in NHSGGC and mitigate against rising waiting lists. Through this work we will continue to work closely with the Centre for Sustainable Delivery, using their wide network to ensure we are learning from the experiences Scotland.

In setting out this plan NHSGGC has committed to delivering the following levels of activity in 2022/23:

- **Outpatients:** in quarter 1 and 2 we delivered 85% of 2019/20 base activity, rising to 90% in quarter 3 and 4
- **TTG:** in quarter 1 and 2 we delivered 65% of 2019/20 base activity, this will rise to 75% in quarter 3 and 4, subject to winter pressures and existing pressures on acute beds as a result of the high number of delayed discharges
- **Endoscopy:** in quarter 1 and 2 we delivered 85% of 2019/20 base activity, rising to 90% in quarter 3 and 4

This capacity will be utilised to deliver the management of urgent patients, clinically prioritised patients, and accommodation of long waiting patients for the new maximum waiting times targets announced by the Scottish Government in July 2022. Significant work has been undertaken to set out plans for the delivery of these new maximum waiting time targets.

Outpatients: we will offer appointments to our longest waiting patients to ensure that no outpatient waits longer than 24 months by the end of Aug-22. The further targets of 18 months by Dec-22 and 12 months by Mar-23 are challenging. We are continuing to model the capacity required for these targets, and make assessment of the level of additional capacity that will be required to meet the March 2023 target.

TTG: we will work to address long waits for inpatients and day cases, the targets of reducing waits to within 24 months by the end of Sep-22, 18 months by Sep-23 and 12 months by Sep-24 in the majority of clinical specialties are significantly challenging. At present without significant further additional external support the September 2022 target will not be met for the following services:

- Orthopaedic Surgery, Neurosurgery (spinal), ENT, and Surgical Paediatrics

The GGC senior team have regular dialogue with Scottish Government through the Chief Executive meetings and the Weekly Operational and Performance Delivery Board. Further modelling work has been undertaken to identify the capacity required to deliver the September 2023 target.

A separate planned care funding template has been provided to support achievement of the waiting time targets.

5.2 Cancer Waiting Time Performance

Recovering performance against the national cancer waiting time standards is a key objective for the Board. NHSGGC aims to continue to achieve 95% performance for the 31 day decision to treat until first treatment target.

Performance against the 62 day referral to first treatment target has been challenging across the pandemic period. A package of recovery and improvement actions is being implemented with a strategic focus on high volume and challenged patient pathways.

We recognise the 95% target for the 62 day pathway will continue to be challenging for NHSGGC to deliver, currently we are aiming to achieve sustained performance above 80% and improve on this position in the coming year as longer term improvement plans are embedded.

We will review our SACT strategy for the post-Covid period with the aim of moving more chemotherapy closer to patients' homes as part of a tiered model of care.

5.3 Maximising Activity: Outpatients and Inpatients/Day Cases

Levels of elective activity in both outpatients and inpatient services have been significantly constrained over the last two years. We will maximise opportunities for further increasing activity.

5.4 Balancing of Priorities

NHSGGC will continue to focus on the most urgent elective patients in tandem with a prioritised and phased reduction in patients experiencing the longest waiting times. This will be informed by the clinical validation process already embedded across NHSGGC balanced with the requirement to reduce waits for our longest waiting inpatients, daycases and outpatients in line with the new minimum waiting times targets. In addition, it is essential this is informed by modelling of demand and capacity to facilitate decisions on the balance of provision. Our approach to modelling demand and capacity will be developed further throughout 2022/23 and will support a continued focus on returning specialties to full base capacity.

5.5 Efficient Processes

Services are gradually returning to some of the pre-COVID processes that help efficient use of resources (for example Patient Focussed Booking). We have completed a review of all processes supporting efficient service delivery and waiting list management; a detailed action plan has been drawn up and all actions are being implemented at the earliest opportunity. Robust processes for monitoring activity and efficiency measures are well established, including activity against our remobilisation plan targets.

5.6 Additional Capacity

In common with previous years NHSGGC will make proactive use of proleptic appointments and flexible arrangements within our workforce, by 'Retire to Return' opportunities or extended hours for part-time staff. This is particularly important with the current challenges in recruitment and helps to build a more stable workforce. In addition, where local capacity is particularly challenged to meet the local demand, NHSGGC will continue to use waiting list initiatives out of hours for specific specialties throughout the year (subject to staff availability), and facilitate targeted insourcing for defined specialties with lengthy waiting times (for example, Gastroenterology). Increase in elective activity may impact on other parts of our organisation, such as on capacity and staffing for the decontamination service.

5.7 External Surgical Capacity

The activity delivered through our Service Level Agreement with the Golden Jubilee National Hospital (GJNH) is essential to supporting reduction of waiting lists; we will continue to pro-actively engage with the GJNH to maximise all available capacity. Our focus on reducing maximum waits for inpatients and daycases will be subject to additional capacity being available at the Golden Jubilee National Hospital for key specialties such as orthopaedics.

Furthermore NHSGGC will use opportunities to link with all external partners to explore any other options for additional capacity, for example current arrangements with an Independent sector provider for a small volume of Spinal activity, or any opportunities offered by the emerging opening of National Treatment Centres (NTCs).

5.8 Transforming Delivery of Services

5.8.1 Pathway Redesign

Transformation of service delivery is an integral part of our approach in NHSGGC. In 2022/23 we will examine the successes of recent pathway redesign in areas such as Pain Management and Gastroenterology and seek to apply these principles more widely across other specialties. We will continue to establish relevant specialty programmes with senior clinical leadership to review and redesign patient pathways with the aim of ensuring patients receive the most appropriate support at the earliest opportunity. This will be implemented in a consistent approach across all Sectors helping to improve equity of access for all.

5.8.2 Surgical Hubs

NHSGGC has recently outlined its plans for the progression of elective surgical hubs that would provide protection and support for elective care. These plans describe surgical provision in key locations across NHSGGC offering streamlined care that maximises daycase and short stay surgery, and where possible insulates planned care from the fluctuations in emergency and trauma demand.

A particular emphasis will be placed on generating Orthopaedic capacity recognising the particular challenges of high numbers of patients waiting in this specialty; 63% of the current Orthopaedic waiting list is priority 4 patients and Orthopaedics make up almost 20% of all Priority 2 patients waiting. We are working towards increasing throughput in some ophthalmology theatre sessions, working with the national group for cataract surgery.

In addition we will seek to expand models for ambulatory care, such as Urology Diagnostic Hubs and Office Gynaecology, transferring activity out of theatres and into an ambulatory care setting. These plans are now being taken forward in a phased approach and will outline the investment required in supporting infrastructure to build additional capacity over following years.

5.8.3 Supporting Patients Pre-operatively

Additional transformation is underway in essential support areas such as pre-operative patient management to streamline provision and better support the most complex patients. This work aims to deliver improved support to patients pre-operatively and address issues at an early stage, including pharmacy support for medications management and early phases of prehabilitation.

5.9 Improving Diagnostic Access

5.9.1 Endoscopy

Diagnostic pathways remain a key focus to reduce overall patient waiting times, particularly for cancer pathways. Plans are in place within NHSGGC in line with the national strategy for Endoscopy. For Endoscopy we will add to our existing capacity over the next year using the commissioned capacity of a two-room mobile unit at Gartnavel General Hospital.

We recognise the need to strengthen our Endoscopy workforce and develop new roles that will create a strong career framework and greater flexibility within the workforce. Over the longer term we aim to increase our internal capacity through increasing the number of Nurse Endoscopists.

The new developments of CCE, TNE and Cytosponge are now well established in NHSGGC. In 2022/23 we will maintain current levels of activity for CCE and TNE, and aim to expand provision of Cytosponge, including wider application to different patient groups. This will be further supported by integration of the Cytosponge digital platform into NHSGGC e-health clinical systems.

Some Endoscopy capacity is currently delivered for NHSGGC by the GJNH; NHSGGC will continue this partnership approach and seek to make use if further external capacity becomes available in 2022/23.

5.9.2 Radiology

Radiology Services continue to experience higher demand than the capacity available, however NHSGGC has made some progress in reducing the imbalance between inpatient and outpatient demand.

A key deliverable for 2022/23 is to reduce the current waiting times for all radiology modalities. This will require NHSGGC to increase the core scanning base for both CT and MRI. Specific plans will be developed aiming to put in place longer term sustainable solutions to these issues, for example any opportunities for additional ACH based. We will explore options in conjunction with the Scottish Government for investment in capital and staffing solutions.

NHSGGC will also build on its commitment to direct GP access to diagnostic testing, which remains an important tool in streamlining patient cancer pathways. The success of these initiatives to date will be reviewed and options for potential expansion set out.

Facilitating faster access to PETCT is also a recognised priority. The pilot scheme for rapid PETCT scanning in selected lung cancer patients has demonstrated patient benefits and a positive impact on waiting times; NHSGGC will explore options for rapid access to PETCT over the longer term.

5.10 Workforce Development

Critical to the success of our plans will be to put in place a stable and sustainable workforce and to develop new roles to support new pathways. We recognise a proactive approach to recruitment and retention is essential to create greater flexibility and skills within all grades, including investment and support for training. Investment will be prioritised towards theatre workforce roles and Nurse/AHP practitioner roles supporting outpatients, including Pharmacy roles supporting pre-operative care.

Planned care services will link with NHSGGC workforce development to ensure the workforce plan for NHSGGC reflects the particular challenges for planned care, including the staffing requirements to support the Surgical Hub expansion programme and the potential risks from the impending opening of the National Treatment Centres. This will include flexible approaches to staff development that capitalise on the wealth of experience and expertise available within NHSGGC and helps make NHSGGC an attractive place to work.

5.11 Digital Developments

Key to our developments in 2022/23 and beyond is a strong emphasis on using digital technology to best advantage, recognising that some of our patients will need additional or alternative support for this.

NHSGGC is supporting a significant programme of work with our e-health teams working closely with clinical teams to identify priorities that will give greatest impact for patients. Examples include:

- Commence implementation of Citizen Access to test results, patient questionnaires and digital letters including appointments
- Using infrastructure implemented during the pandemic and maximising the investment in technology to further scale up support to ACRT, including a focus on Patient Initiated Review and advice referrals
- Implementation of remote management tools and other telecare systems to support care at home
- Implementation of the Ophthalmology electronic patient record (Open Eyes) for the Glaucoma pathway
- Further digitisation of the acute dental service through use of EHCR and dental charting system
- Pilot of the iRefer Radiology Clinical Decision Support Programme
- Digital tools for Dermatology outpatient referral
- Testing use of the Right Decision Platform providing information on acute pathways to support GPs in managing their patients

5.12 Supporting our Patients

5.12.1 Communication and Information

In our plans for planned care in 2022/23 we have outlined a number of ways in which we aim to streamline patient pathways and better support all patients to access information and advice at an early stage; for example, putting in place routine processes across outpatient services for Patient Initiated Review and Patient Initiated Follow Up. This will improve communication with our patients and help patients to be better involved in decisions about their own care. In addition we are continuing to explore patient opt-in approaches for appropriate pathways. This is a new approach for some specialties and we are committed to engaging with patients to understand the experience of different patient groups and in particular understand the impact for those who may find it hardest to access services. A digital patient hub has also been implemented and is being piloted for patient questionnaires and access to some test results.

5.12.2 Single Point of Contact: Cancer Pathways

Having a main point of contact enables patients on a cancer pathway to discuss questions related to their clinical care, receive advice on their appointments, investigations and results, and feel empowered to input into their own care. The Board aims to ensure all cancer patients are supported

by a Clinical Nurse Specialist throughout their cancer pathway to act as a key contact for cancer patients.

Over the longer term we will continue to expand the Clinical Nurse Specialist roles and in 2022/23 the single point of contact agenda will be further supported with new CT Navigator posts. These individuals will provide an easy contact point for patients and play a key role in ensuring patient pathways from diagnosis to treatment are managed efficiently.

5.12.3 Prehabilitation

NHSGGC recognises the benefits of prehabilitation encompassing physical activity, nutritional support and psychological support for our patients. Prehabilitation programmes are already well established in NHSGGC for the most complex patients with specialist AHPs and psychology staff providing this specialist intervention to optimise treatment outcomes and support people to better cope with cancer and non-cancer treatment. This approach to prehabilitation is part of our broader, well established ERAS programme

A key element of our approach to improving cancer waiting times in 2022/23 will be to set out a programme to expand patient access to prehabilitation support as part of a patient's cancer pathway, ensuring this important support is available to more cancer patients. In addition we will explore whether there are any other patient groups where a similar approach could be applied to aid patient management.

5.13 Summary of Key Milestones

Figure 4 provides a summary of the key milestones to support the recovery of planned care in 2022/23. The key deliverables for each milestone are set out within the Delivery Planning Template in **Appendix 1.**

Figure 4: Recovering Planned Care – Summary of Key Milestones in 2022/23

Maintaining Cancer Services as a priority – continue to ensure cancer services are prioritised, implement CT Navigator posts and set out proposals for the expansion of a multidisciplinary, targeted and highly specialist Prehabilitation model.

Improving access to outpatient services – maximise outpatient capacity through the promotion of patient focussed booking to reduce DNA rates, review of clinic templates and clinic slot utilisation. Examine successes of new outpatient pathway redesign and apply to other specialities.

Improving access to inpatient and daycase activity:

- Establish a new 'Surgical Hub' model, implementing the initial model in GGH and IRH and set out infrastructure requirements for the further development of the 'Surgical Hub' model
- Reduce maximum waits for inpatients, daycases and outpatients
- Embed short stay orthopaedic arthroplasty within all 3 sectors
- Outline the model for Urology Diagnostic Hubs in NHSGGC and the model for Office Gynaecology in Clyde and prepare a business plan and proposed implementation plan
- Model capacity & Demand - test approaches to modelling of capacity and demand at a specialty level to review and inform service planning in a minimum of 3 priority specialties
- Augment local capacity through use of proleptic appointments, WLIs and Insourcing in priority specialties. Whilst also ensuring all external surgical capacity is fully utilised, including working collaboratively with NHS Golden Jubilee

Increasing Endoscopy capacity

- Continue clinical validation of surveillance patients and escalate prioritised cat 1 and 2 patients into endoscopy clinics
- Expand Cytosponge activity including wider application
- Undertake a Nurse Endoscopy recruitment programme throughout 2022/23 to support the expansion of Endoscopy and explore alternative capacity through different models of provision

Improving access to Radiology

- Set out options to increase MRI and CT capacity, and review staffing across GGC
- Review the balance of outpatient vs. inpatient scanning and make recommendations that will increase capacity for the outpatient waiting list

Developing Digital Programmes

- Commence implementation of Citizen Access to test results, patient questionnaires and digital letters including appointments
- Use infrastructure implemented during the pandemic and maximising the investment in technology to further scale up support to ACRT, including a focus on Patient Initiated Review and advice referrals
- Test use of the Right Decision Platform providing information on acute pathways to support GPs in managing their patients
- Continue engagement with the CfSD and use their Heat Map process to inform our planned care priorities

6. Building Resilience and Recovery in Urgent and Unscheduled Care

6.1 Overview

This section of the Annual Delivery Plan sets out:

- A summary of the key achievements to date in the redesign of urgent and unscheduled care
- The Board's vision for the future delivery of urgent and unscheduled care
- The key areas of focus for further improvement and redesign in 2022/23 and the key milestones associated with the planned changes

This section of the Annual Delivery Plan describes the work that will be undertaken to deliver each of the key work streams.

6.2 Working with HSCPs and other NHS Partners to develop a more Integrated Approach to Urgent and Unscheduled Care Services

We continue to work collaboratively with the six HSCPs to deliver a number of improved pathways for urgent and unscheduled care. The work has been innovative and delivered at pace, moving away from existing ways of working and adopting a 'virtual approach' to service delivery. Patient feedback has been very positive and the responsiveness and flexibility of the FNC model has been highlighted by patients as hugely positive when accessing virtual care. **Figure 4** provides a summary of the key achievements to date.

During 2022/23 NHSGGC will review the current governance structure for urgent and unscheduled care to ensure an integrated approach to bring together teams across Health & Social Care, to deliver the single common aim: **'Right Care Right Place for Every Person Every Time'.**

Figure 5: Summary of Achievements to date

We have undertaken significant redesign of urgent and unscheduled care pathways, including developing a number of virtual urgent care pathways and new services at pace including:

- establishing the Flow Navigation Centre in Dec 20 with paediatrics included in June 21
- opening two acute mental health assessment units
- opening eight out of hours community hubs
- establishing interface and accelerated interface care pathways, including remote monitoring pathways
- developing the integrated primary and secondary care frailty programme to support provision of care closer to home and avoid hospital admissions
- developing a new pilot falls pathway for care homes- providing virtual assessment and treatment plans to avoid hospital admission
- establishment of the hospital at home service
- introducing signposting and redirection
- delivering a positive patient experience – through provision of a responsive and flexible service
- developing OPAT pathways and services
- developing interface pathways for patients with heart failure

In addition significant planning of new services and pathways has been undertaken including:

- refreshing the current community falls response pathway
- development of the home first response service to support increased discharge home or to a homely setting.

Improvement in Primary Care and GP Out of Hours services including:

- The establishment of an appointment system within GP out of hours centres (with no walk ins)
- The increase in GP advice calls which has led to a significant decrease in the need for centre visits
- Maintaining the well utilised and efficient home visiting and patient transport service
- Establishment of revised workforce planning, clinical governance and organisational management arrangement to ensure the service is more sustainable
- Positive patient feedback through a patient survey.

We are committed to the continued development of the virtual urgent and unscheduled care services and pathways. In 2022/23 we will continue to work with NHS 24 and SAS partners to maximise the use of virtual care pathways, to ensure patients receive the right care in the right place.

6.2 Scottish Government Urgent & Unscheduled Care Self-Assessment

As a whole systems team, we have undertaken the Scottish Government Urgent and Unscheduled Care Self-Assessment, which has identified the three most productive opportunities in 2022/23 as:

- Virtual Capacity
- Rapid Acute Assessment and Discharge

- Community Focused Integrated Care

These priorities (together with the three fixed anchor points of responsive operational management, Discharge without Delay (DwD), continuing local and national redesign of Flow Navigation Centres to meet evolving system priorities, supported with digital technologies, will be the focus of the detailed work plan for 2022/23.

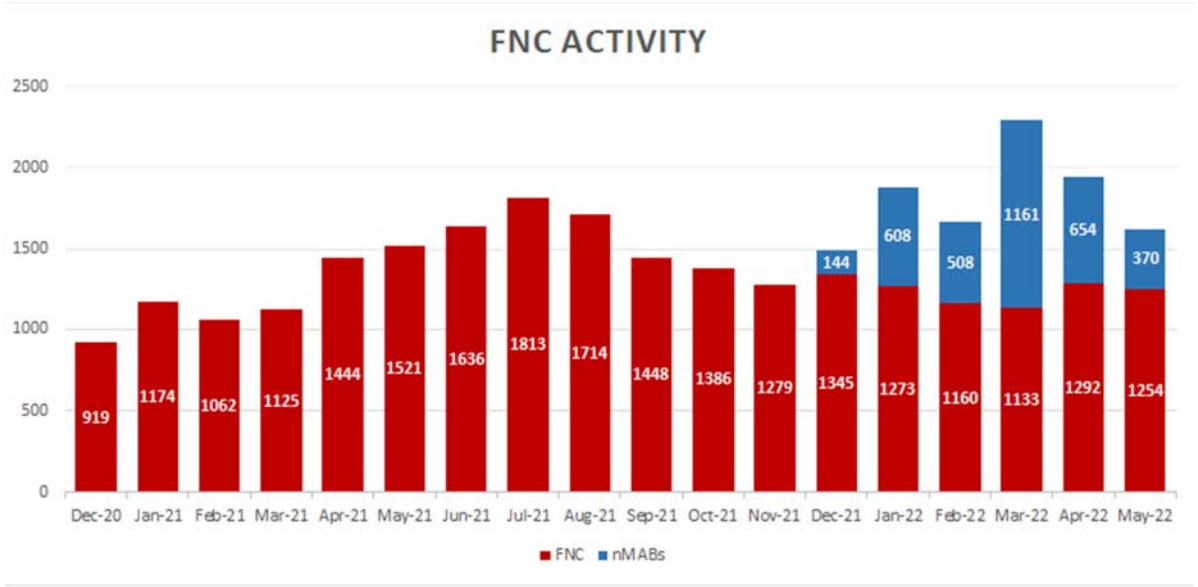
6.3 Vision for Urgent & Unscheduled Care within NHS GGC

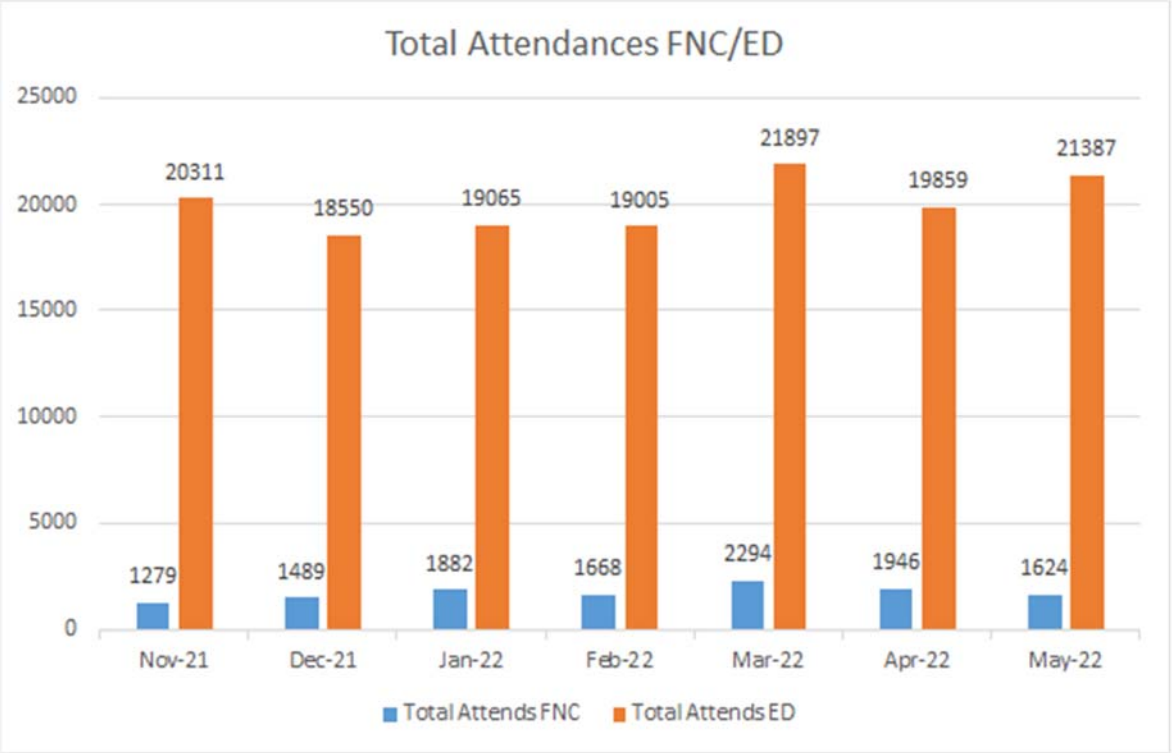
Our vision is to work with partners and implement the redesign of whole system pathways for urgent care across primary, secondary, and social care. The vision includes:

- Maximising the virtual unscheduled care service for patients, linking with the GP out of hours service, NHS 24 and SAS to increase virtual unscheduled care activity. Utilising eight unscheduled care hubs and the flow navigation centre to improve the patient experience and reduce presentation & conveyancing to hospitals. Implementation of the new virtual falls pathway with our SAS partners will provide an exemplar patient pathway and experience.
- Implement signposting and redirection at Emergency Departments linking with community services and supporting patient self-care

We will continue work towards shifting the balance from ED self-presenters to ED attendances using the virtual first approach delivering the single common aim: **'Right Care Right Place for Every Person Every Time'.** The current FNC and ED attendances (activity includes prescribing of neutralising monoclonal antibodies (nMABs) for non-hospitalised patients with COVID) are illustrated in in **Figure 5.** The Board's medium to long-term aim is to reverse the balance.

Figure 6: FNC Activity and Total attendances FNC/ED





6.4 Continuing the development of the Flow Navigation Centre

The Flow Navigation Centre (FNC) was established in December 2020. The FNC serves as a virtual triage service for both adult and paediatric patients and currently operates from 10am – 10pm, 7 days a week. The FNC works in collaboration with GGC Primary & Secondary Care, NHS24, SAS, GCU, GU, Child Protection, Police Scotland and Social Work.

A positive evaluation of the FNC was conducted by the Scottish Government in 2021, the FNC staff and management continue to work closely with the GGC Patient Experience Team to regularly gather feedback from patients.

Since its inception in December 2020 to end May 2022 there have been **27,423** attendances, this includes **23,978** FNC attendances NHS 24 pathway (Dec 2020 - May 2022) and **3,445** FNC attendances nMabs pathway (Dec 2021 - May 2022).

In 2022/23 we will:

- Continue to further develop the FNC and maximise its impact by improving and embedding the pathways already in place, introducing additional patient pathways and identifying opportunities to test changes in ways of working to optimise FNC performance
- In line with SG recommendations the Board will identify the options for delivering a 24/7 FNC service and identify the resource requirements of the preferred way forward

Key to the success of the FNC will be further strengthening relationships with NHS 24, GPOOHS,HSCP resource hubs and SAS to support increasing triage rates to FNC and reduce both hospital conveyancing and patient self-presentation rates.

Key milestones in 2022/23 are set out in **Figure 7.**

Figure 7: Further Development of the FNC - Key Milestones in 2022/23

Pathways:

- Further improve data, reporting and performance of the 12 active pathways
- Maximise the pharmacy pathway and improve communication between pharmacy and ED including improved data analysis
- Improve GP calls pathway, increase uptake and instil consistency
- Falls & Frailty: Work closely with HSCPs and SAS to refine, expand and embed Falls and Frailty pathway
- Establish clear service to service pathways with GPOOHS and HSCP Resource Hubs in the first instance
- Expand the use of digital tools to support the pathways

NHS 24:

- Regularly review and further develop pathways from NHS24 111 into FNC

SAS:

- Regularly review and further develop pathways from SAS into FNC
- Maximise the role of Advanced Paramedic services in FNC

Operational Model:

- Maximise utilisation of the current capacity of the FNC
- Identify the options for a 24/7 service in line with Scot Government recommendations and assess the resource requirements to support a 24/7 service
- Progress opportunities for FNC co-location (SAS/NHS24)
- Identify opportunities to test changes in ways of working to optimise FNC performance
- Improve and expand the ability to schedule unscheduled care into ED, MIU or alternative pathways
- Maximise Professional to Professional communications and decision making

6.5 Communication, Public Messaging & Sign Posting and Redirection

We will continue to develop a positive and consistent communication/public messaging to ensure patients are fully informed about how to access the right care in the right place. In addition we will continue to seek patient feedback about their experience in order to inform further improvements to the service.

Redirection & signposting is also a vital element of the redesign of urgent and unscheduled care and the consistent implementation of redirection policy across all GGC sites will support the development of the FNC. Responding to current pressures and access to appropriate space, Redirection is, at present, being introduced across sites. To support the introduction of redirection & signposting, GGC has updated our website to reflect the new National Redirection Policy. The focus for redirection & signposting in 22/23 will be:

- continued focus to support the adoption and implementation of redirection & signposting on all sites
- ensuring consistency in application of the redirection policy across all sites

6.6 Discharge without Delay (DwD)

There are currently appropriately 300 acute delayed discharges across NHSGGC. Admission avoidance work continues to build including frailty at the front door and hospital at home.

The leading reason for delays across acute sites remains Code 9 Complex Needs (AWI patients) with the majority of patients delayed for that reason. This is followed by patients delayed from discharge under care home codes. The current key issues include:

- 'Adults with Incapacity' (AWIs) remains the largest challenge for discharging patients. AWI's account for the majority of all acute hospital delays in NHSGGC and a far higher percentage of total bed days lost to delayed discharges.
- Challenges with discharges to Care Homes account for approximately 25% of delays. This is due to staffing shortages and recruitment challenges, staggered admissions, home closures and market volatility all contributing to delays in discharges.
- Delays related to COVID complexities such as ward closures and care/nursing home closure is reducing in line with COVID community case prevalence.

Where the patient, family or legal guardians preferred care home is not available or there isn't support to return home available in a timely manner, the clinical teams will work with the patient/ family or legal guardian to identify an interim care home placement option. To achieve this the team will seek both interim funding and agreement from the patient / family or legal guardian. The Board continues to work with patients, families and legal guardian to avoid unnecessary and lengthy delays in moving a patient to a care home setting. To support this process the Board has formalised a medically led escalation process.

The first principle of the new discharge without delay programme will be to ensure patients are discharged to, supported and cared for in a homely setting at the earliest opportunity. The programme will focus on reducing length of stay, reduce the percentage of patients who become delayed discharges and reduce the number of bed days lost when patients are medically fit.

The DwD programme will inform the development of localised work plans. To support this, GGC has recently undertaken a number of acute sector & HSCP engagement/self-assessment sessions with key stakeholders including Scottish Government representatives and sector based (i.e. localised) work plans are in development following the self-assessment process.

The key areas of focus for the DwD programme in 22/23 are set out in **Figure 8.**

Figure 8: Key Areas of Focus for the DwD programme in 2022/23

Key areas of focus within the work plan will include:

- Home as the default position for all discharges- delivered through further developing intermediate care services and care at home services that support rapid discharge and enablement.
- All parties work towards an agreed Planned Date of Discharge (PDD) by ensuring discharge planning starts on admission, supported by a whole team approach across acute and community, early referral to social work and home care teams with a designated senior lead managing performance. Patients will not be assessed for long-term support needs in an acute environment- supported by adopting a discharge to assess ethos, access to equipment to support complex and ongoing need is simplified, and development of a transition team that support the first 72 hours at home.
- Decisions are made and discharges occur across seven days – the aim is to deliver this through dynamic daily discharge planning, rapid daily huddles to finalise plans and development of criteria lead discharge. Additionally robust data will identify areas for improvement within this work stream
- Timely and realistic conversations between professionals and with the patient, family, and carers will manage expectations and perceptions around discharge. Stream lining referral processes and integrated documentation across acute and community will expedite early discharge and minimise risk and readmission.
- Ensuring robust accurate data and developing a digital dashboard will allow local ownership and identify opportunities to improve performance and isolate concerns.

6.8 Urgent Care Resource Hubs

HSCPs launched their Urgent Care Resource Hubs in January 2021. They were established to bring together OOHs services in the community, enhancing integration and the co-ordination of care. The hub provides direct professional to professional access across the health and social care OOHs system and delivers a whole system approach to unscheduled and/ or emergency care via NHS 24. This model has not been as successful as initially anticipated as the service model continued to evolve during COVID with the introduction of Mental Health Assessment Units (MHAUs), FNCs etc. where some of the predicted demand is now accommodated. Alternative virtual connections aligned to the changed service landscape are being considered. This includes:

- Identifying opportunities for professional to professional services focused on optimising digital systems and processes with the aim of developing a virtually connected professional network for OOHs. This approach is intended to remove any unnecessary steps and facilitate direct connections into exist services wherever possible. Initial areas being reviewed during 22/23 include:
    - falls team responses including SAS
    - H@H optimisation
    - district nursing pathways and how they link to the FNC

6.9 Mental Health Assessment Units

Two MHAUs were established in 2020 in response to the COVID pandemic and consolidated through the winter period with a full redesign of the urgent care pathways and access routes. These units have continued to reduce demand on secondary care services by reducing footfall through Emergency Departments. The referral pathway provides an immediate route out of ED for those who present directly, with vulnerable patients largely being managed away from the stressful ED

environment. The MHAUs also provide an alternative to patients who would otherwise have been conveyed to ED by SAS or Police Scotland. Between December 2020 and March 2021 there were a total of 4,400 patients seen through our MHAUs. The MHAUs are now well established and are integral parts of the whole system urgent care service in GGC.

Further information about the Mental Health Assessment Units and our 2022/23 plans are within Section 10 the Mental Health of this plan.

6.10 Interface Care (IC) and Accelerated Interface Care (AIC) Pathways

As part of the national response to developing virtual capacity for resilience and recovery, Interface Care is being developed for implementation in GGC. Heart Failure and Out-Patient Parenteral Antimicrobial Therapy (OPAT), have been prioritised, as high volume, high impact services, for redesign of services in the first instance.

The Interface Care programme sits within the Redesign of Urgent Care governance structure and incorporates the Accelerated Interface Care programme (AIC), to include respiratory monitoring and community response. Collaboration between Acute Services and HSCPs is a key priority to enable planning assumptions to be agreed, and governance arrangements established to support delivery of the Respiratory Ambulatory Service model.

6.10.1 OPAT

The OPAT model provides opportunities to achieve further reductions in length of stay in suitable patients including earlier and wider identification of those patients who remain in hospital. There is an increasing need for early supported discharge alongside improving time from referral to review, patient training and discharge capacity. This will be supported through delivery of the following:

- Medication review prior to discharge improving time to discharge
- Increased consultant capacity for outpatient review
- Utilise digital prescribing to support the pathway

It is anticipated that the pathway once fully rolled out across NHS GGC in the next 2 years will:

- Deliver further efficiencies by releasing bed days – a minimum of ~12 beds
- Avoidance of circa 250-350 IAU attendances in the first full year
- Direct antibiotic cost savings of at least £50,000

The number of bed days saved may be increased further as the model becomes fully embedded and established at each site.

Impact of the model will be measured applying the following performance indicators:

- Number of patients referred
- Date from referral to discharge
- Length of OPAT and antibiotic utilisation/drug costs

Data collected will inform future service provision and developments. Savings are anticipated to be cumulative following recruitment to the workforce model and completion of staff training.

6.10.2 Heart Failure

The Heart Failure service model seeks to efficiently improve the management and outcomes of people with heart failure (HF) and will be replicated in each sector. The key aim is to redesign the current Heart Failure Service to deliver an optimised and sustainable service by delivering the following:

- Reduction in waiting times for HF diagnostics, and earlier initiation of life-saving HF treatment
- Delivery of nurse led 'one' stop diagnostic clinics across all 3 sectors providing equitable and standardised HF care with parity
- Digitally supported remote consultant clinical management plans for 100% of patients, reducing subsequent referrals to general cardiology clinics.
- Digitally supported remote patient follow-up care incl. self-management support for approx. 1000 patients per year
- Increased OP HF clinic capacity releasing new capacity to support recovery planning and future sustainability of the HF nurse and HF pharmacist services
- Access to HF early supported discharge clinic service
- Reduced HF 30-day readmission rate.
- Access to HF ambulatory care for all people who meet pre-specified criteria
- Urgent/responsive outpatient care ('hot clinic')
- Improved accessibility to HF data in order deliver a data driven approach to cardiac care, and facilitate sharing of patient information with primary care.

Impact of the Heart Failure model will be measured applying the following performance indicators:

- Referral to treatment time for community HF diagnostic service
- No. of clinical contacts avoided by digital remote follow-up service
- Proportion of patients discharged from hospital with diagnosis of HF who receive outpatient care from Heart Failure MDT within 14 days
- No. of people referred to HF ambulatory care service
- Estimated no. of bed days avoided by HF ambulatory care service
- Average length of stay for all patients discharged and 30 day and 1 year readmission rates
- Total and adjusted hospitalisation rates and bed days for heart failure
- Mortality rate within 30 days and within 1 year following discharge

6.10.3 Ambulatory Respiratory Services

The ambulatory respiratory model seeks to promote community based management for patients with respiratory conditions presenting to emergency services, avoiding hospital admissions, and promoting early discharge and reduction in bed days. The following actions will be prioritised for 2022/23:

- Develop and implement a Test of Change for a virtual ward model by December 2022
- Implement home monitoring and supported self-management by March 2023 (incremental process of adoption across HSCPs).

Impact will be measured applying performance indicators such as:

- Number of new patients referred in the community for hospital admission avoidance
- Number of new patients identified for supported discharge from hospital
- Total patient contacts per week

6.10.4 Interface Care Pathway Resources

The Interface Care non-recurring funding allocations for 2021/22 and 2022/23 (currently indicative for 22/23) were bundled together to create an overall funding envelope (£2.440m) which has been allocated across Heart Failure and OPAT. The Ambulatory Respiratory Interface Care pathway has not yet been funded.

6.10.5 Key Milestones for Accelerated Interface Care and Interface Care Pathways

The key milestones in 2022/23 are set out in **Figure 9.**

Figure 9: Interface Care Pathways - Key Milestones in 2022/23

Outpatient Parenteral Antimicrobial Therapy (OPAT):

- Develop OPAT Hub and Spoke model by initially expanding current service within QEUH (Hub) to deliver a 7 day per week cellulitis service
- Develop cellulitis and other ambulatory infection management pathways across all acute sites (spokes) in GGC
- Maximise early/same day identification and discharge of suitable patients across GGC.
- Recruit to workforce model

Heart Failure:

- HF Diagnostics - embed Digital platform HF service model into using the digital platform in placeand procure AI enhanced equipment
- Digitally Supported Remote HF Management - undertake evaluation of Test of Change Pilot in Clyde Sector to develop more widely
- HF Nurse Inpatient & Early Supported Discharge Service - recruit to workforce model of HF Nurse Specialists, Advanced Nurse Practitioners, and MDT support from Medicine for the Elderly
- Ambulatory Care - work with site operational teams to identify outpatient real estate to enable ambulatory care clinics

Respiratory Pathway Development:

- Community Respiratory Team Services – within Glasgow City HSCP there are multidisciplinary teams based in the community to enable Primary and Secondary Care teams to refer COPD patients, as an alternative to hospital admission. Within the Clyde area a test of change will be established to focus specifically on a 'virtual ward' model for patients at risk of hospital admission. The test of change will enable time to develop the skill base requirements to support spread of service across the remainder of GGC and build an evidence base on the impact on acute beds
- Home Monitoring and Supported Self-Management – implement use of electronic devices, smart phones and oximeters to supply community-based support and early introduction of therapy to prevent / treat exacerbations. The aim is to level up best practice use across GGC.

6.11 Care Closer to Home

Work is being taken forward as part of the Greater Glasgow & Clyde Falls and Frailty Programme designed to support a GG&C whole system approach to the assessment and management of frailty in line with an integrated primary and secondary care frailty pathway. The premise is that frailty is mainly managed in the community with attendance and / or admittance to hospital, only for patients with more acute needs. Activity underway during 2021/22 includes:

- Nursing/Care Home Falls Pathway
- Community Falls Response Pathway
- Home First Response Service
- Hospital@Home

6.12 Nursing/Care Home Falls Pathway

Following successful conclusion of a 12 week pilot working with 7 Care Homes, the new falls pathway is being implemented for all Nursing/Care Homes for older people across NHSGGC by the end of summer 2022. The pathway provides an enhanced service to care homes with professional advice to care home staff for patients who have sustained an injury by fall within the care home. Accessed via the Flow Navigation Centre and utilising video assessment, treatment plans are formulated and in many cases hospital admission averted.

All six HSCPs will adopt this pathway, utilising their close relationships with Care Homes to deliver and support the training needs required, acknowledging the dynamic and complex conditions in this sector.

6.13 Community Falls Response Pathway

The numbers of patients sustaining a community fall with conveyance to a GGC acute site is consistently higher than the national average at 80%, presenting a clear opportunity to reduce pressure on our hospital system. To address this, the current pathway will be refreshed and integrated with the Flow Navigation Centre to centralise triage and signposting. A Standard Operating Procedure will be agreed across NHSGGC supported by a data dashboard to track improvement.

Culture, confidence and communication are barriers to improving the pathway. A priority will be to develop a communication and engagement strategy to reach across the organisations, and in particular SAS stations/crews. Further risks include:

- Data translation and system functionality across the cornerstone 3 organisations. Work is underway to understand this and to develop a dashboard to support data transfer and sharing
- Current Hours of FNC service 10am – 10pm aligned to peak activity, the call volume would need to be considered and potential test of 24 hour cover dependent on the emerging data.
- Confidence and assurance to support culture change within the SAS crews. A strong communication and engagement strategy will seek to mitigate some of this risk.

6.14 Home First Response Service

Launching in August 2022, this new service will introduce an augmented multi-disciplinary team approach bringing together primary and secondary care professionals to expedite turnaround of frailty presentations at the acute front door. Utilising digital solutions to facilitate peer to peer advanced practitioner triage the service will support patient flow to the most appropriate setting – planned or otherwise. Integration with the Flow Navigation Centre will enable triage to take place prior to conveyance to hospital.

The new model is expected to:

- to increase discharge home or to a homely setting from unscheduled care in frail older adults from 15% to 25%;
- to reduce the LoS for our frail population
- to ensure all individuals >75 years and those >65 years from care homes undergo frailty assessment
- to increase the number of frailty management plans developed to support patients back in the community setting
- to reduce conveyance to the front door as a result of our pathway utilising the Flow Navigation Centre

6.15 Hospital at Home

Launched in January 2022, a test of change is operating in the Glasgow South locality to prevent admission of acutely unwell patients, undertaking procedures which would normally be undertaken within the hospital setting. This is a nurse led model with clinical oversight from Consultant staff, a Consultant Nurse and Specialist GP with supporting MDT and strong links to Home Care services. Starting initially with 10 virtual beds operating over 7 days, 8am – 8pm, it will progressively increase to a maximum capacity of 25 beds. The key actions and milestones in 2022/23 are set out in **Figure 10.**

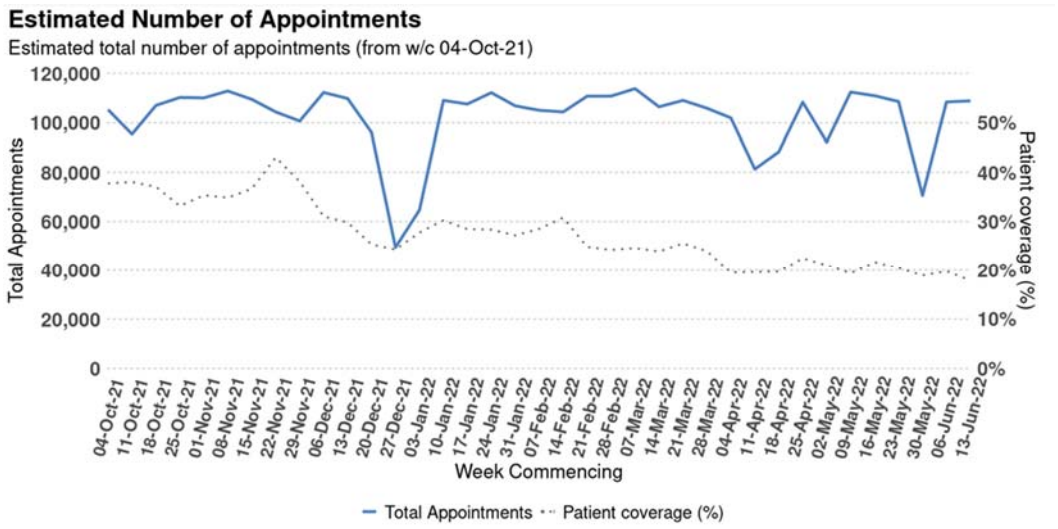
Figure 10: Hospital at Home - Key Milestones in 2022/23

- The range of interventions conducted will be steadily progressed, linking in to the 'Interface Pathway' developments described above (OPAT, Heart Failure), in addition we are seeking funding to support the implementation of the ambulatory respiratory pathway
- Infrastructure such as the use of Trakcare/Microstrategy tools to manage patient administration will be developed as generic platforms capable of supporting broader community interface initiatives through the provision of remote printing and mobile access to data.
- Continued quality improvement cycles will refine professional practice to ensure effective use of skill mix
- Evaluation is in place to ensure quantitative, qualitative data review, with existing reporting to Scottish Government
- Economic evaluation will be undertaken to underpin planning for extension of service beyond the current 25 beds across other HSCPs and localities

6.16 Supporting General Practice & General Practice Out of Hours Service

General Practice maintained a high level of access to appointments throughout the pandemic, both face to face and by switching to alternative methods of communication. GPs have embedded triage processes to help to differentiate and manage demand appropriately. Weekly survey material of GP access indicate in excess of 100,000 appointments offered every week across NHSGGC. Whilst 'near me' video is utilised, telephone consultations continue to be favoured by patients and GPs alike as the more acceptable alternative to face to face appointments, accounting for around 2/3 of all consultations.

Figure 11: Total GP Appointments Oct 2021 to Jun 2022



Robust data on demand is limited but the perception from all quarters is that it is heightened compared to pre pandemic levels. Concerns about late presentation and increased acuity of need are being experienced across all areas of healthcare. The relationship that General Practice has with its patients mean that pressures in other parts of the system present as additional demand such as supporting patients waiting for planned hospital care. Increased use of all forms of digital and virtual working facilitate efficiency but add to the overall workload pressures as patient demand grows. This is impacting on the wellbeing of the General Practice workforce.

We are addressing public confidence anxieties about access to healthcare through a campaign of public messaging aimed at building public awareness of the range of healthcare options available including development of the range of urgent care responses in the community, mental health and acute care. For Primary Care, a central message is that face to face appointments continue to be core to General Practice alongside the added flexibility of digital and telephone consultations. Continued communications relaying the levels of demand alongside the wider service offer of care has an added importance, countering some of the negative publicity which frontline practitioners experience and supporting our workforce.

The GP OOHs service has gone through considerable change following the redesign of delivery necessary as part of business continuity measures. It is now in a much more resilient status following review and redesign of process. The service operates from 3 sites: a central service serving the majority of NHSGGC and two localised services focusing on the particular needs of the Lomond and Inverclyde localities. It has ceased accepting ‘walk-ins’, with patients contacting the service through NHS24 and if a face to face consultation is required, being directed to attend a physical centre. Further consideration of the service model will continue over the next year focusing on alignment of pathways with the Flow Navigation Centre as well as further enhancing a broader multi-disciplinary approach to reduce reliance on GPs.

Continued implementation of our Primary Care Improvement Plans is part of our overall response to demand, creating capacity through multi-disciplinary teams and disaggregating routine monitoring activities from active care management that needs the attention of our most experienced practitioners. Investment in Pharmacists and Link Workers has reached levels of accessibility that will add capacity across General Practice, diverting activities to appropriate professionals and services. Development of Clinical Treatment and Care Services have now reached the level

whereby activities such as phlebotomy, suture removal, management of minor injury and dressings services can be provided to around 90% of General Practices. A priority for the next year will be continued consolidation of these services and focusing on the localities where the constraint has been availability of suitable accommodation.

A further priority in addressing the access challenges for Primary Care will be to develop a strategic outlook that takes into consideration pre pandemic challenges such as demography and workforce as well as Primary Care's broader role with other parts of health and social care in the context of backlogs of demand. It will be necessary to prioritise how to target resource most effectively and in collaboration with other planned and unscheduled care services.

6.17 Dental Services Recovery

Access to General Dental Services was considerably restricted during COVID and placed additional strain on Public Dental Service provision. With the lifting of restrictions, a return to pre pandemic access is progressing but concerns continue with respect to dental practices withdrawing from NHS provision.

Access to surgical treatment pathways for Dental Services is our priority area for paediatric and adult treatment pathways with theatre access being the primary constraint. It is part of the broader recovery trajectory for Planned Care. Specific Dental actions include:

- Clinical review leading to substitution of General Anaesthetic by anaesthetic led sedation would divert around 50% of the adult backlog to open up options for treatment capacity
- Cohorting of shorter, less complex procedures to maximise theatre efficiency.
- Flexible & responsive take up of theatre capacity when released.

A broader review of Public Dental Service paediatric assessment pathways has led to improvements in service utilisation including screening protocols directing to alternatives to General Anaesthetic pathways and enabling sharing of patient records through the extension of Egton Medical Information Systems (EMIS) to Public Dental Services (PDS). This latter development is supporting a pilot to strengthen support to vulnerable children drawing from the broader primary care team, including health visiting teams as well as PDS consultants.

Dental health improvement teams have remobilised and from August, are expected to be delivering the 'Child Smile' programme to all pschools.

During 2022/23 we will engage with the National Reform Programme for NHS General Dentistry to support the national review in delivering a more administratively simpler and more clinically focussed system.

6.18 Addressing Health Inequalities

NHSGGC is committed to listening to and learning from all our communities through collaborative and inclusive engagement. Tools such as the Equality Impact Assessments embed engagement with communities at the heart of service change and design.

The Equality and Human Rights Team (EHRT) engage with those protected by the Equality Act and with those living in poverty to inform the action in the Fairer NHSGGC Equality Scheme.

The EHRT have worked closely with the Board's Patient Experience Public Involvement (PEPI) Team to assess the acceptability of the Near Me virtual patient appointment programme to a range of our patients. Learning from this joint working has informed the work of the PEPI team and was adopted for the GP Out of Hours service evaluation interviews.

Learning from these engagement opportunities will continue during the evaluation of NHSGGC's Flow Navigation Centre to capture the experiences of patients who do not have English as a first language.

Feedback from our BME communities highlighted a lack of access to unscheduled care exacerbated by the COVID pandemic whereby they could not access many health services as they could not call as they do not speak English and they were no longer able to drop in to make an appointment or ask advice. The EHRT and the Interpreting Service developed a patient interpreting code to ensure direct access to any NHSGGC service as the patient can now call up an interpreter and ask them to call any service including NHS24 and better access unscheduled care as well as discuss or change out-patient appointments, call pharmacist or make a GP appointment.

The EHRT and PEPI Team have secured funding for a Peer Co-ordinator post to recruit and support a group of peers from seldom heard groups to act as a bridge between NHSGGC and these communities. These peers will take out information related to initially vaccination and poverty and bring back intelligence of what barriers these communities face. Unscheduled care will be part of the planned work programme.

6.19 Summary of the Key Areas of Focus in 2022/23

Figure 12 provides a summary of the key areas of focus across urgent and unscheduled care during 2022/23.

Figure 12: Summary of the Key Areas of Focus in Urgent and Unscheduled Care 2022/23

- Working with HSCPs and other NHS Partners to develop a more integrated and whole systems approach
- Maximising the capacity of continuing the development of the FNC, identifying options for delivery of a 24/7 service
- Continued focus on the adoption and implementation of redirection & signposting
- Develop the DwD programme to reduce delayed discharges and improve patient and staff experience
- Review the urgent care resource hubs to support the virtual out of hours urgent care service
- Roll out the OPAT interface care pathway across NHS GGC, Implement the Heart Failure interface care pathway, develop the Respiratory interface care pathway
- Implement the full rollout of the Nursing Care / Home falls pathway
- Further develop the community falls response pathway and the home first response pathway
- Evaluate the newly piloted Hospital at Home service
- Continue to develop the primary care improvement plans to support the creation of capacity through multidisciplinary team working
- Develop a Primary Care Strategy to support both pre pandemic and pandemic challenges within general practice
- Support the recovery of dental services and improve dental service access
- Ensure new services and service change is evaluated in terms of health inequality and patient access

7. Supporting Social Care

7.1 Introduction & Strategic Overview

Social Care operates across society as a whole, supporting the needs of communities and individuals across a network of interfaces. Whilst the ADP guidance is weighted towards supporting acute secondary care, our response reflects the strategic message common across IJB Strategic Plans that developing resilience and support throughout the community is necessary to ensure acute interventions are effective.

Operationalising the 'Framework for Community Health and Social Care Integrated Services' relies on a whole system approach overcoming organisational and sectorial boundaries. Social Care works best when capacity delivered by Local Authority and independent sector providers is supported in partnership with third sector services and unpaid carers within community networks.

Our priorities in supporting social care over the next year intrinsically acknowledge these principles, building on a direction of travel that has been in place over several years and articulated through IJB Strategic Plans. All HSCPs have progressed models of service that draw together the strengths of professional teams with multi-disciplinary responses in critical areas of need, particularly in relation to Urgent & Unscheduled Care.

This work is progressing as a collaborative approach within the remit of the NHSGGC Joint Commissioning Strategy for Unscheduled Care. The emphasis of this approach is the "right person at the right time and in the right place" ethos. It has three broad themes reflecting stages in the patient journey:

- Prevention & early intervention
- Improving the primary & secondary care interface
- Improving hospital discharge

7.2 Business Continuity and Workforce Planning

A key message from across our HSCPs is that workforce challenges were a critical cause of service pressure when in extremis. Staff absence impacted on statutory and other providers alike, necessitating a range of responses that wouldn't have arisen normally. A further concern is the contribution of unpaid carers, whose resilience is relied upon but who have had limited respite and may find their caring role undermined by pressures of cost-of-living difficulties.

Workforce planning in its wider sense is a priority moving forwards. This extends to supporting and involving third and independent sector colleagues with practical measures such as wellbeing support as well as maximising recruitment and retention opportunities:

- Support to volunteers (East Renfrewshire/Voluntary Action 'Kindness Collaboration')
- Buddying support and recruitment work with local provider for targeted advertising for sessional staff in Care at Home services (Renfrewshire)
- Addressing underlying issues impinging on retention such as out of hours transport (investment in electric vehicles in East Dunbartonshire)
- Potential for redeployment of HSCP and Council staff at periods of escalation
- Utilisation of winter monies to underpin and maintain recruitment

HSCPs are reshaping business continuity plans to reflect pressures all year round. Involvement of third and independent sector colleagues is central to this. Escalation plans are being jointly developed to recognise operational priorities of respective partners. Scenario planning workshops include contingencies for high risks such as internal and external staffing challenges and other

supply chain issues. Responsive governance arrangements add to preparations ensuring management oversight to engage escalation steps as circumstances develop.

7.3 Care at Home and Care Homes

The close partnership of primary and community nursing services with Care at Home Services, is critical to supporting people to remain safely at home. Collaboration across the six HSCPs acts to support stability across the wider NHSGGC system. It co-ordinates understanding and resolution of issues, progression of developments and provides a focal point for action around admission avoidance and hospital discharge. The pan NHSGGC collaborative action in relation to day care services is a specific example, recognising their importance in providing respite and support particularly to unpaid carers.

The targeted support to Care Homes is being extended with contingency planning for staffing pressures and support that may be offered through the NHS. HSCP leadership works closely with the Care Home Collaborative. This has 3 hubs across NHSGGC to strengthen the professional and practical support, with oversight offering a range of additional support in key areas including (but not limited to) Infection Prevention and Control, person centeredness, food fluid and nutrition, Tissue Viability, quality improvement, and education support. Involvement in whole system planning is changing perspectives and leading to initiatives such as Care Homes offering day support within community networks.

Delays in community assessment continue to be a feature in some HSCPs but not all. Alongside actions building workforce resilience, single point of referral mechanisms are steadily being consolidated to co-ordinate demand for Care at Home and other services. These mechanisms employ the ‘first point of contact’ ethos to ensure individuals are directed effectively. They provide robust signposting, information provision and redirection by utilising 3rd sector/ commissioned or community supports and promote prevention and early intervention approaches that promote independence, reablement and rehabilitation. Continued development will see inclusion of community and district nursing as well as primary care mental health services as implementation of primary care improvement plans progress.

This ethos is also applicable in the actions to support acute hospital services and are referred to in the Building Resilience and Recovery in Urgent and Unscheduled Care section. They include the ‘Home First’ test of change to be launched in August with services working closely with the QEUH and RAH. They build on a deepening understanding of the needs of patients at the ‘front door’ to inform service responsiveness and add to the approaches to supporting early discharge. Over recent years HSCPs have progressively developed and consolidated multi-disciplinary teams with increasing in-reach provision working with ward staff to minimise delays in assessment and mobilise service provision.

7.4 Self Directed Support

The vision for social care for the future sees more people taking direct control of how their support is provided using budgets allocated to them. People who require services can choose to receive a budget and arrange that support themselves, have services from a specific provider arranged for them by the HSCP, or receive services directly from the HSCP. Embedding Self Directed Support as a routine option for patients discharged with intermediate care requirements and its introduction to patients and their carers at very early stage of an admission pathway offers opportunity to minimise hospital stays. This is being piloted in East Renfrewshire with the alignment of an experienced Self Directed Support Forum worker into the Home from Hospital team. The aim is to build awareness and confidence in the direct payment option which can allow families to tailor packages to meet needs.

With transformational change programmes such as Glasgow City’s ‘Maximising Independence’, the six IJBs aim to deliver meaningful improvements in health and wellbeing aligned to early intervention

and prevention. This common intent to deliver care through capacity built on strengthening community networks and the resilience of local partners and third sector organisations recognises that the best health and care outcomes are associated with the highest possible levels of self-management and independence. Change of this nature requires significant whole system commitment to shift the culture from more traditional deficit based practice towards strengths based practice. Alternative models of community care promoting independent living, shaped to meet local needs will complement and offering alternatives to more prescribed solutions currently available within statutory health and social care systems.

7.5 Supporting Telecare

Extension and embedding of telecare and utilisation of digital monitoring tools is continuing at pace. The SG TEC Pathfinder Programme has a number of developments within NHSGGC. TEC Peer Mentor is being employed at the front door as part of overall redesign, integrated into the single assessment process. The Connecting Neighbourhoods programme in Shettleston and Castlemilk is progressing into its 2nd year of operation, employing technology support for overnight care. Further expansion will see this develop into NW Glasgow. Similar initiatives are in place in other HSCPs utilised for overnight support and supported living where we commission core-and-cluster supported tenancies for people with learning disabilities. All HSCPs will continue to work with the Analogue to Digital switchover which is core to strategic plans enabling greater utility of remote support, providing proactive outbound call based systems, support self-management and assist with expansion of the single point of access.

7.6 Summary of Key Milestones for 2022/23

The pandemic stretched capacity across all sectors, impacting on workforce whether in statutory, independent or third sector providers. Learning from this context will inform planning across the 6 HSCPs over next year, the key milestones are set out in **Figure 13**.

Figure 13: Social Care – Key Milestones in 2022/23

- Build resilience in workforce through collaborative capacity planning with third sector partners
- Strengthen Business Continuity plans, building in escalation contingencies and responsive governance with community partners
- Continue to broaden and embed collaborative actions to strengthen Care Home resilience
- Continued extension of “First Point of contact” ethos and ‘Single point of Referral’ mechanisms throughout integrated teams
- Pilot opportunity for application of Self Directed Support at early stages of admission pathways
- Continued implementation of Digital and Telecare solutions.

8. Sustainability and Value

8.1 Financial Sustainability & Value

The Financial Plan for 2022/23 was submitted to Scottish Government in March 2022. However, the outturn for 2022/23 remains uncertain, both in terms of costs, income and Scottish Government funding streams. The costs of managing COVID are, very much, still part of that uncertainty, due to the uncertainty of funding.

The forecast for 2022/23 has been updated based on the Q1 review, adjusting the overall financial challenge to £78.4m. This is an increase of £26.9m against the previous forecast of £51.5m, which is as a result of funding not being available to cover all the expected costs of COVID.

	Original Forecast 2022/23 £m	**Revised Forecast 2022/23 £m**
Recurring Deficit forecast	(172.7)	(174.5)
Forecast savings achievable	50.0	50.0
Non-Recurring savings	41.2	42.1
	91.2	92.1
Revised in year deficit after savings	(81.5)	(82.4)
Additional Non-Recurring Funding	30.0	30.0
Non-Recurring COVID		(26.0)
Revised in year deficit	**(51.5)**	**(78.4)**

As outlined above, the forecast remains subject to amendments based on the impact of COVID on service delivery and the funding to support the remobilisation to the end of March 2023. The key messages on the indicative numbers above can be summarised as;

The deficit of £78.4m is as a consequence of the impact of COVID both in 20/21 and 21/22 which resulted in an increase in the underlying recurring deficit brought forward combated with a number of additional pressures due to increased energy and inflation costs and ongoing COVID costs.

The cost of COVID 22/23 has been estimated at a total of £133.4m, these costs will be subject to change dependant on the impact of COVID, the exit planning and the finalisation of the plans for the vaccination programmes. This is made up of Board costs (£87.7m) and IJB costs (£45.8m). This covers the following key areas which are detailed in the Quarter 1 return.

- Workforce and Capacity £57.2m
- PPE, Equipment and IPC £12.1m
- The estimated cost of the COVID & Flu Vaccination programme of £31m
- Social Care costs and community £28.4m
- Primary Care £0.1m
- Other £4.6m

There is no provision for unachieved savings in 2022/23 unlike in previous years when non-recurring funding was made available to cover the impact of COVID on achieving savings.

The revised financial plan reflects the COVID funding envelope of £61.6m allocated by Scottish Government. Work continues to review the COVID costs in order to reduce them where possible.

8.2 Key Financial Risks

There have been a number of risks identified in 2022/23 and these are detailed in **Figure 14.**

Figure 14: Key Financial Risks

COVID costs	The funding envelope allocated by Scottish Government of £61.6m does currently leave a gap for the Board of £26m. The Board is currently working on an exit plan however some costs are unavoidable given the current patient numbers and other costs are waiting on policy decisions. A stringent review is being carried out on all costs in order to reduce the risk. There is also the added complication of the recurring costs associated with Vaccinations, Test and Protect and Public Health Measures that need to be addressed.
Winter	In addition to additional COVID costs there is also the additional costs associated with winter. The Board's winter plan, which identifies a range of initiatives including opening additional beds and supporting the flow within the Acute Division, is normally supported by the funding allocation received from Scottish Government, has still to be confirmed. However historically there has always been a gap between the funding received and the plan which adds to the financial challenge detailed above.
Planned Care	RMP5 had identified for 22/23 a funding requirement of £36m in year to support the planned care improvement programme. Funding had been verbally confirmed to be c£22.5m from Scottish Government, which is based on an NRAC share of available funds. However based on the changes to the planned care targets, funding remains uncertain. It should be noted that NHS GGC activity profile is c30% of Scotland significantly higher than the NHS GGC NRAC share at 22.1%. This funding allocation excludes Diagnostics and elements of Endoscopy, both of which have still to be confirmed. Further work is underway looking at specific specialty needs in line with the new targets, and funding requirements will be updated.
Unscheduled Care	There is a risk of insufficient funding to deal with unscheduled care, we are still awaiting confirmation of the funding in relation to flow hubs, redirection monies and the step up of the ICU capacity. There is also the impact that the increased level of Delayed Discharges is currently having on unscheduled care.
Confirmation of funding levels	Conformation of funding levels for 2022/23 from Scottish Government remains outstanding. Given the current financial climate and in the context of the recently announced spending review there remains considerable risk to the levels and recurring nature of funding across a range of expected allocations.

	The HSCPs have previously received funding from Scottish Government to deliver on a range of initiatives including Mental Health Recovery and renewal, Adult Support Winter Planning, Drugs Taskforce monies, Action 15 Mental Health and Primary Care Improvement funding. Funding confirmation is awaited.
Break-Even position	Detail above the Board still has a financial gap of £78.4m and will endeavour to do everything possible to close this gap, however there are still a number of risks associated with achieving financial balance and also achieving the recurring savings target of £50m.

8.3 Resource Requirements

The Annual Delivery Plan identifies a number of funding requirements either recurring(R) or non-recurring (R) to support delivery, these are set out in **Figure 15**.

Figure 15: Funding Requirements to Support Delivery of the ADP

Key Areas	Detail	NR Funding received 21/22 £M	Additional Funding required 22/23 £M	Total 22/23 Funding required £M
Planned Care	Cancer Services	2.2	0	2.2
	Elective capacity – GJNH, Additional staffing, WLI, Endoscopy mobile Unit , proleptic staff	22.5	0	22.5 (R 5.2 & NR 17.3)
	Diagnostic funding	1.6	1.3	2.9 (R 1.3 & NR 1.6)
	Surgical Hubs		13.6 (7.5 R & 6.2 NR)	13.6 (7.5R & NR 6.2)
Unscheduled Care	Flow Navigation Centre 21/22 12/7 and looking to move to 24/7	2.2	1	3.2 (R)
	Sign posting & redirection	0.6 (part year)	0.7	1.3 (R)
	Interface Care- for Heart Failure and OPAT. This is a two year project.	1.55 (21/22)	0.9 (2 22/23)	0.9 (NR)
	Winter. Funding received is a set amount based on an NRAC share. Actual cost is usually c£6m	2.2		2.2 (NR)
	DwD.	1.1(NR)	0.5(NR)	0.5(NR)
	GP OOH (non-recurring funding received annually over a number of years)	1.1(NR)		1.1(NR)
Mental Health	Mental Health Assessment Units- Funded from COVID monies	1.27		1.27 (R)

8.4 Financial Improvement Programme (FIP)

Our well established Financial Improvement Programme (FIP) will seek to continue to deliver savings from a diverse range of projects in order to assist the Board in meeting the significant fiscal challenge for the coming year.

We have set a FIP target of £50m on a recurring basis for the year FY 22-23 with the balance of the financial challenge being met on a non-recurring basis.

This year's programme will continue to drive and evolve the Workstream driven approach that will seek to identify and leverage best practice, benchmarking and wider service efficiency and productivity initiatives.

Specific savings schemes that will contribute to this target are:

1. Drugs: Savings from contractual price changes, changes in clinical practice and reduction in waste.
2. Procurement: Savings from contractual changes, commercial reviews, standardisation and rationalisation of products used.
3. Infrastructure: Savings from the effective use of the estate, income from rental, consolidation of asset base and savings from energy efficiency.
4. Sustainability: range of measures to generates savings through reduction in waste, logistics and wider sustainability measures.
5. Service Redesign: Savings driven from the consolidation of services and the implementation of new ways of working post the pandemic.

As with recent years the programme will be required to be agile in line with the challenging operational environment as the Board looks to recover and remobilise from the COVID pandemic. We are also an active participant in the National Financial Improvement network where Scotland wide approaches and best practice are shared.

The alignment of the FIP with the Board wide strategic priorities will be a key area of focus such as;

- Recovery plan – service efficiency opportunities and best practice sharing
- Infrastructure strategy - Consolidation of assets and effective use of assets
- Sustainability Plan - leveraging the move to net zero, through the reduction in waste streams, energy efficiency, green travel and other sustainability measures.

The well-established FIP governance and reporting processes will ensure that visibility and progress of the programme is maintained throughout the year, with assurance being provided through monthly meetings with the Chief Executive and Director of Finance as part of the governance process.

8.5 Capital Plan

The Board's updated Capital plan for 2022/23 has £76.4m of forecast Capital resources available for investment in the year.

This figure comprises a general "formula allocation" of £37.4m from SG in respect of our core items of capital expenditure, additional ring-fenced "scheme specific" SG funding of £39.2m, estimated retained capital receipts of £1.7m from planned property disposals, and £1.1m from locally generated, revenue funded schemes. A transfer of £3m has also been made from Capital to Revenue funding to assist with expenditure that has historically been included within the capital plan but is revenue in nature.

The additionally funded scheme specific projects of £39.2m referred to above, include £24.5m on the commencement of building contract work on our new Health Centre in the North East of Glasgow, £0.5m on initial work required to progress the relocation of our Radionuclide Dispensary service, £6.3m on the installation of two new Bi-Planar machines and a CT Scanner for the West of Scotland Thrombectomy Service and a further £7.9m of Radiotherapy equipment for the routine replacement of high value single items such as Linear Accelerators and CT simulators.

We are in ongoing dialogue with SG colleagues to revise our projected spend and funding requirements as these schemes progress and to confirm funding support for capital schemes classed as "anticipated allocations" on our SG returns. We are also in routine discussion with SG colleagues regarding the release of any additional in year capital funding that may become available, to support emerging initiatives that can be completed within the current financial year.

8.6 Realistic Medicine

The driver for Realistic Medicine is to promote person-centred care, value and safety. It's particularly relevant as our organisation remobilises in a climate of high demand and expectation, balanced with finite resources. To date the Realistic Medicine (RM) programme in NHSGGC has successfully elevated the profile of RM across NHSGGC creating the capability to effectively practice RM by establishing an effective framework of processes, training and resources. Ongoing work continues to improve awareness of RM and provide practical advice for staff, by building on the successful RM awareness campaign including the high profile and well attended awareness week in March 2022, the launch of the RM Toolkit and associated App and the creation of the RM Champions Network will all further embed RM in practice across GGC.

The implementation of RM is led by the Clinical Lead for RM, supported by a part-time RM Project Manager and the RM Network Group. The governance of RM is managed through the GGC Healthcare Quality Strategy Group along with bi-annual reports to the Scottish Government and quarterly national meetings. Regular updates are taken to CMT.

The benefits of realistic medicine principles are recognised and being applied within the Planned Care agenda in NHSGGC. Approaches such as ACRT and PIR support clinicians to provide a personalised approach to care with patients actively supported to manage their own condition. Implementation within NHSGGC is being progressed through pathways that are standardised across NHSGGC, thereby reducing unwarranted variation and making best use of our resources.

There are three phases to embedding Realistic Medicine in our remobilisation planning

1) Increasing awareness of RM

2) Increasing ability and capacity off staff to practice RM

3) Increasing public awareness

Figure 16 summarises the key milestones in 2022/23.

Figure 16: Key Realistic Medicine Milestones in 2022/23

Treatment Escalation Plans (TEP)

- Continue TEP quality improvement work by updating documentation based on user feedback and collaboration with the recently re-instated 'Deteriorating patient' programme. Wide dissemination is planned after HQSOG review

Awareness Campaign:

- Relaunch and re-invigorate awareness of the ISD Scottish Atlas of Variation and Demand Optimisation programme, which was paused due to the pandemic
- Continuous improvement of RM website content including regularly published 'RM in Action' articles in-line with our communications strategy. GGC website content is also being used, with permission, by other NHS boards in Scotland
- Our patient information leaflets have been redesigned to incorporate 'It's okay to ask' questions – what are the benefits, risks, alternatives and what if I do nothing?

Training:

- Work will continue to train staff through the provision and facilitation of monthly Realistic Conversations Communication Skills Training
- In conjunction with NES support national roll out of RM Resource Pack

Value Improvement Fund: facilitate submission of Value Improvement Fund bids across GGC

Addressing Health Inequalities: planning with the Patient Experience Public Involvement team towards increased public awareness of the ethos and practice of Realistic Medicine from a patient and carer perspective

Champions Network: finalise recruitment of RM Champions and creation of GGC wide RM Champions Network

Toolkit: build on successful launch of RM Toolkit App in GGC by working with NES to share App at National Level

Recruitment: recruitment is now complete for Acute and Primary Care RM Leads and is in process for a Project Manager

8.7 Climate Change

NHS Greater Glasgow & Clyde's Sustainable Development and Net Zero transformation is driven by the Scottish Government's targets, driven by the climate emergency, mandating the public sector to achieve Net Zero by 2045 to combat the climate change threat we currently face. NHS Scotland has gone one step further and tasked territorial health boards to become net zero by 2040 across all our scoped emissions and Net Zero in how we heat and power our buildings by 2038. This is validated by mandatory reporting in the form of: The Climate Change (Duties of Public Bodies: Reporting Requirements) (Scotland) which covers Scope 1, 2 & 3 reporting, adaptation & resource planning and the National Sustainability Assessment Tool (NSAT), which aligns Board operations to the UN Sustainable Development Goals.

The UN Sustainable Development Goals (UN SDG's) are incorporated into the National Performance Framework which focuses on economic, social and environmental indicators. The 17 goals are aligned to NHS Scotland's National Sustainability Assessment Tool. NHS GG&C has based its governance framework for sustainability on this national approach, as set out in **Figure 17.**

Figure 17: NHS GGC Governance Framework for Sustainability

Our NHS	Our People	Our Planet
Governance & Policy		
- Capital Projects - Active Travel - Transport - Greenspace - Nature & Biodiversity	- Awareness - Welfare - Ethical Issues - Communities - Sustainable Care	- Environmental Management - Procurement & Supply Chain - Waste - Adaptation - Greenhouse Gases

NHS GGC's response to the climate emergency is the establishment of the Sustainability Governance Group that will oversee the agenda by developing and coordinating work streams that support NHS Scotland's and NHS GGC's Sustainable Development Policy & Strategy to ensure its corporate and operational activities are carried out in a compliant manner, while promoting sustainable development as the driver to achieve net zero by improving processes and technology, where practicable.

NHS GGC's goal is to improve the environmental, financial and social performance of its assets and services for our patients, staff and visitors through continuous improvement, in turn achieving carbon reduction targets. The Group is chaired by the Deputy Director of Facilities and Corporate Services and it has recently appointed Executive and Board champions, as mandated in NHS Scotland's Climate Change & Sustainable Development Policy – DL (2021) 38. Output from the group will go through the Corporate Management Team (CMT) and Financial Performance and Planning (FPP) before reporting to the Board.

The Sustainability Governance Group will ensure the delivery of national policy and align its spending plans and use of resources to contribute to reducing emissions and delivering its emissions reduction targets, as mandated.

The Sustainability Governance Group coordinates all facets of the UN SDG development areas by overseeing strategic working groups. The groups will develop policy and strategy for their respective topic area and report accordingly on progress, projects, initiatives, training and communications. This in turn will be streamlined into the Board's objectives, reporting and progressing NHS GGC's Sustainable Development Strategy.

Key objectives in 2022/23 are set out in **Figure 18.**

Figure 18: Sustainable Development Strategy – Key Milestones in 22/23

- Production and launch of NHS GGC's Sustainable Development Strategy
- Implementation of the Environmental Management System
- Benchmarking and target setting for key work streams to reduce scope 1, 2 & 3 emissions
- Climate Change and Sustainability E-Learning Module Launch
- Increase staff engagement through new website, social media and focused communications strategy

Beyond this year the Sustainability Governance Group endeavours to ensure the achievement of the following objectives:

- Promote compliance within NHSGG&C through an effective Environmental Management System
- Promote the strategic goals of NHSGG&C in order to offer safe, reliable and high-quality services that are respectful of the environment
- Improve the productivity and efficiency of NHSGG&C through improved management practices based on innovation, productivity, resource efficiency and sustainability
- Effectively manage the environmental risks and opportunities deriving from changes in legislation and operations to maximise the positive impacts of activities and minimise the negative impacts
- Become an anchor organisation by encouraging a culture of ethical behaviour that increases transparency in order to generate credibility and trust within the NHSGG&C stakeholders, which includes society as a whole
- Contribute to the recognition of NHSGG&C achievements and the improvement of its reputation through interactive communications with staff, patients, visitors and the communities we serve

9. Public Health

9.1 Public Health Strategy – "Turning the Tide through Prevention"

In August 2018, the Health Board agreed the Public Health Strategy "Turning the Tide through Prevention". This 10-year strategy has 3 aims:

- to accelerate the improvement in both healthy life expectancy and life expectancy
- to narrow the gap between these within Greater Glasgow and Clyde
- to narrow the gap between these in Greater Glasgow and Clyde and the rest of Scotland for both men and women by 2028

Turning the Tide is an ambitious strategy with long term aims which will only be achieved by development of local networks, relationships, and joint working with stakeholders across services and partner agencies in order to influence and inform their actions. By working across Greater Glasgow and Clyde as a whole system we are committing to becoming an exemplar public health anchor organisation. We will work closely with our Local Authority and Community Planning partners to support them in addressing the drivers of child poverty and improving the health and wellbeing outcomes for our communities. This work will contribute to the cross cutting priorities of Child Poverty, Communities and Fair Work (section 9.3.3).

A broad range of public health work will continue across all three domains, health protection, health improvement and health services public health, such as screening and immunisation in line with local and national strategies. But the framework for our annual priorities has been the emerging evidence of the adverse impact of the pandemic on individuals and communities.

Thus the priorities for Public Health for the annual delivery plan for 2022/23 are to balance the response to further waves of COVID-19 as we move to 'living with COVID', and re-focussing on prevention and early intervention in line with the Public Health Strategy 'Turning the Tide through prevention'. This encompasses:

- Maintaining the ability to respond to COVID waves (and other new and emerging infections).
- Focussing on Child Health; the Universal Pathway, CAMHS and Dental Health Services
- Developing an Action Plan to minimise Type 2 Diabetes; prevention and early intervention
- Preventing drug related deaths and harms; delivering a comprehensive set of evidence based interventions

In addition we will review 'Turning the Tide' in light of the COVID pandemic to ensure it reflects the additional challenges that the pandemic has brought. The Health and Wellbeing Survey undertaken in 2022/23 will help assess the impact of the pandemic on our local communities and inform this review.

Section 9.2 provides further details on the local GGC Public Health priorities for the annual delivery plan 2022/23. Reducing the number of drug related deaths has also been highlighted as a cross cutting priority for the Annual Delivery Plan working with our local stakeholders, and recognising the lead role of the Alcohol and Drug Partnerships.

9.2 Public Health Local priorities for 2022/23

9.2.1 Maintain ability to respond to COVID waves

Recent events (e.g. monkey pox, non A-E hepatitis) have re-emphasised the continued uncertainty and unpredictability of new and emerging infections, with respect to timing as well as their implications for health and social care and public health which also applies to next COVID wave/or new variant.

Actions on COVID

Support transition to 'living with COVID', particularly for care homes and other higher risk settings, maintain high awareness of COVID as restrictions are lifted

Maintain ability to respond to waves, including planning and implementation of national vaccination campaigns (COVID and seasonal influenza)

9.2.2 Child Health

The pandemic has magnified many of the issues facing children and young people in terms of developmental concerns, mental health issues including eating disorders, obesity and worsening poverty.

Early years have a profound influence on future health, development and attainment. Action on health and influences in childhood thus also impact on adult mental and physical health. The revised universal pathway was brought in to provide extended universal support to families and children with the aim of improving health during this particularly influential life stage and narrowing the gap seen on entry to school. The full pathway has now been implemented in NHS GGC, and maximising the outcomes from this investment in child health is important, particularly as NHSGGC has a high level of developmental concern at 27-30 months.

Child and adolescent mental health was a concern from pre-COVID, and there is evidence of the adverse impact of the pandemic. Referrals to CAMHS and presentations with distress have increased. This increase in demand for mental health support is being highlighted within Tier 1 and 2 services as well.

Dental cavities remains the most common reason for a child to be admitted to hospital for a General Anaesthetic (GA) across the UK. There is evidence of a drop in registration with dentists for young children compared to before the pandemic. The priorities are the continued recovery of dental services to increase service capacity, with a renewed focus on identifying and supporting the most vulnerable children and families. Quality Improvement work undertaken during COVID provided alternative treatment pathways when theatre lists were restricted, diverting significant numbers away from GA, with better patient outcomes, and we aim to progress and expand on this work.

Actions on Child Health:

- **The Universal Pathway** - to increase the number of child development assessments completed within the assessment window
- **Child and Adolescent Mental Health** - to increase referrals of children to early intervention mental health services

- **Dental Health Services -** *to* increase the percentage of children registered with an NHS dentist *a*nd to reduce the number of children who need a General Anaesthetic for dental treatment.

9.2.3 Type 2 Diabetes (T2DM)

The prevalence of T2DM has steadily increased in Scotland by 37.7% over the past decade (from 199,264 in 2009 to 274,442 in 2019). Within NHSGGC an estimated 59,619 people are currently diagnosed, around 5.5% of the population. Diabetes is closely related to deprivation and ethnic background.

Obesity is the biggest driver of T2DM in Scotland with 87.1% (GGC 85%) of those diagnosed with T2DM classed as overweight or obese at the end of 2019. Around a third of children in 2018 were at risk of being overweight or obese by Primary 1 highlighting the need to develop a life course approach to healthy weight.

With the right support and guidance, individuals can be empowered to maintain a healthy weight, mitigate their risk of developing type 2 diabetes and, for those diagnosed with type 2 diabetes, to improve management of their condition to delay and avoid complications.

Actions on T2DM:

- **Prevention** - *to* increase the proportion of the overweight and obese population who achieve a healthy weight or achieve 5% weight loss
- **Early Intervention** - *to* develop targeted interventions with 'at risk' groups such as those from our BAME communities and pregnant women
- **Pro Active Intervention** - *to* ensure all those newly diagnosed with Diabetes complete a structured education and weight management programme

9.2.4 Reduce Drug Related Deaths and Harms

Drug related deaths (DRD) are increasing within Scotland. In 2018, 1187 individuals died a drug related death increasing to 1339 in 2020. There were 444 deaths within NHS Greater Glasgow and Clyde in 2020, an increase of 9.9% on 2019. Greater Glasgow and Clyde has seen the greatest increase in drug-related death rates over time, rising from a rate of 8.9 per 100,000 population in the period 2000-2004 to 30.8 per 100,000 population in 2016-2020. After adjusting for age, Greater Glasgow and Clyde had the highest drug-related death rate of all health board areas for the 5- year period 2016-2020 (30.8 per 100,000 population).

The 6 local ADPs within the Board each have a three year strategic delivery plan covering the period of 2020 to 2023, which sets out both the national and specific local strategic priorities and objectives aligned with the Drug Death Task Force Actions and the National Mission, with clear detailed actions and identified responsible leads for delivery.

The Alcohol and Drugs Partnerships report directly to Scottish Government on their contribution to national priorities and outcomes. GGC partners from Renfrewshire HSCP, Glasgow City ADP and Public Health are supporting the Scottish Government development of a Partnership Delivery Framework and ADP performance framework that will allow consistent reporting on progress against the national priorities

Public Health will work in partnership with the ADPs to coordinate actions and develop a strategy to identify areas of focus which can be supported on a Board-wide basis in order to prevent drug-

related deaths and reduce harms. The work will consider evidence based interventions and local needs alongside the national priorities to inform a person centred approach which enables Board-wide delivery of a comprehensive set of population prevention and harm reduction activities.

Our specific focus will be to:

- Increase the number of take home Naloxone kits issued in GGC
- Increase the proportion of people referred to assertive outreach following non-fatal overdose (NFO) who are seen within two days of referral

9.3 GGC as a Public Health anchor organisation – cross cutting priorities of Child Poverty, Communities and Fair Work

9.3.1 Child Poverty

NHSGGC has established partnership working with our 6 Local Authority partners to undertake the joint preparation of Local Child Poverty Action Reports (LCPAR) in line with the duty outlined in the Child Poverty Act (CPA, 2017) requiring all Health Boards and Local Authorities in Scotland to work together to mitigate and report on actions to reduce child poverty. The local authority and the relevant Health Board must "jointly prepare and publish a report".

Child poverty is associated with poorer early years' outcomes, educational and employment prospects, and major health problems in adulthood. Child poverty in NHS GGC ranged from 15.8% in East Renfrewshire to 32.2% in Glasgow City; in excess of 50,000 children. Scottish Government targets are for less than 10% of children to live in relative poverty by 2030 with an interim target of less than 18% by 2023/24. With evidence that child poverty is increasing and that targets will not be met a national strategy is in development.

NHSGGC will continue to work with partners and communities to address the drivers of child poverty (which include income from social security, income from employment, costs of living); undertake action to mitigate the impact of poverty within the health service setting through supporting access to financial inclusion services, and assess and respond to local needs including those needs identified by lived experience. The particular needs of the priority groups will be considered within the LCPAR partnerships including; lone-parent families, a household where someone is disabled, families with three or more children, minority ethnic families, families with a child under one year old, families where the mother is under 25 years of age.

9.3.2 Working with our Community Planning Partners

The Public Health Strategy: Turning the Tide will continue to drive our focus on communities. Working closely with our 6 Community Planning Partnership (CPP) partners to deliver existing priorities set out in the Local Outcome Improvement Plans and COVID Recovery Plan. NHSGGC will seek to strengthen health and wellbeing outcomes for communities as part of the remobilisation of Public Health and alignment with the Scottish Government's Place and Wellbeing Programme and World Class Public Health System developments. GGC's Population Health and Wellbeing Survey will be undertaken in 2022 to provide robust data at Local Authority area to inform future priorities and service planning within the CPP with information on the impact of the pandemic.

Health Improvement teams will continue to improve health outcomes through the development of Locality Plans and undertake Place Making and models of Whole System Working to ensure the most deprived communities are supported and engaged in local planning and development activities such as Thriving Places or Shaping Places for Wellbeing.

Community led Health Improvement will continue to be supported by Health Improvement teams working closely with Third Sector Partners and community organisations to ensure a focus on capacity building and resilience support.

Traditional Public Health data will be enhanced with an additional focus on lived experience and community engagement for key programmes and vulnerable groups.

9.3.3 Fair Work

NHSGGC continues to make good progress across the 5 Fair Work Dimensions with a benchmarking exercise completed in April 2021; Fair Work employer self-assessment tool completed in January 2022 and the ongoing development of the associated action plan incorporating additional SG Fair Work First elements. The Fair Work action plan is routinely considered as part of the Staff Health Strategy and Workforce Strategy and has been mapped to related Staff Governance Standards and Governance Groups within NHSGGC.

This Fair Work action plan will drive our activity over the next 12 months with a focus on incorporating Fair Work principles throughout GGC Anchors /Community Wealth Building programme; Procurement policy and practice; Internal Communication and Employee Engagement and Workforce Strategy.

9.4 Summary of Key Milestones in 2022/23

The key public health milestones in 2022/23 are set out in **Figure 19.**

Figure 19: Public Health Key Milestones in 2022/23

- To maintain the ability to respond to waves of COVID
- To increase the number child development assessments completed within the assessment window
- To increase the proportion of the overweight and obese population who achieve a healthy weight or achieve 5% weight loss
- To reduce the number of drug related deaths

10. Mental Health

10.1 Context

The year 2021/2022 has seen an increase in contacts with people by specialist community mental health teams and an increase in occupancy for acute inpatient care. Across all services, there has been continued reliance on additional hours, bank, agency and recently retired clinicians across all professional groups.

Front line services reported increasing acuity, attributed to delays in seeking support and illness becoming more apparent as lifestyles returned to pre pandemic normality. Services and workforce have been subject to similar pressures as other parts of healthcare with COVID related constraints on operating and levels of absence. Mental health need is being experienced across health and social care services including General Practice and Acute services.

Consequently a range of operational contingencies have been employed to mitigate difficulties and meet demand including staff working with increasing flexibility across different locations responding to need in a peripatetic manner. Weekly contingency meetings ensure there is constant review of priorities in accordance with individual patient escalation plans with clarity of process and communication to enable timely intervention. These meetings will continue for the foreseeable future in response to levels of demand, ideally deescalating from weekly to monthly meetings.

Inpatient services have similarly experienced continuing pressures with very high levels of occupancy and longer than normal lengths of stay. Specific pressures are Intensive psychiatric care units and adult acute assessment wards.

Planning therefore continues to align existing refresh of extant and developing mental health plans utilising new recurring and non-recurring funding.

10.2 Prevention and Early Intervention, General practice and Primary Care

At a population level, the priority is promotion and support of the conditions for good mental health, suicide prevention and wellbeing. Action is focused on providing accessible signposting to help, advice and support, with provision of a rapid and easily accessible response to those in distress with safe, effective treatment for people living with mental illness. Third Sector Interfaces are enabling HSCPs to align with developments led by local Third Sector services with directly allocated funding.

Progress with the implementation of the Primary Care Improvement plans is delivering increased levels of support with link workers and will continue to contribute to develop new approaches responding to localised need at a cluster/GP practice level.

A range of Mental Health and Wellbeing services will be developed in Primary Care with General Practice. This includes developing three pilot hubs focussing on support to adults with stress, distress or low intensity mental health issues alongside life / experiential stressors and with needs below secondary and specialist mental health thresholds

These developments will interface with the multi-disciplinary Community based Mental Health teams building capacity for lower intensity specialist secondary care responses delivered to patients experiencing periods of distress.

10.3 Mental Health Assessment Units

Our MHAUs became operational at the beginning of the pandemic as part of our strategy for supporting unscheduled care in Mental Health. They are a critical ‘anchor’ development within our broader urgent and unscheduled care service response, aligned with Flow Navigation services to direct demand to appropriately specialist response. Systems have been developed to provide primary care GPs access to MHAUs, through the use of digital tools, e.g. SCI Gateway and

Consultant Connect. Triage has been developed in conjunction with the Scottish Ambulance Services to ensure consistency in pathways and urgent referral responses.

Activity levels have increased significantly during their second year of operation and exceed the levels that informed planning assumptions, indicating that the Units have become established and core parts of service. The clinical workforce model has been hampered by difficulties in recruiting to a Consultant Psychiatry position necessitating a rethink of arrangements.

Funding and long term accommodation issues remain outstanding. The service was initially introduced via a combination of realignment of existing resource (c. £2m pa.) with COVID funding covering a further £1.27m, in agreement with SG. Accommodation has been adapted to meet the developing requirements but is no longer sufficient as a long-term option.

Over the forthcoming year the priority actions will be:

- Extension to include and embed access to Social Work
- Resolve clinical workforce model
- Resolution of recurrent funding
- Develop solutions for accommodation requirements

10.4 Adult Inpatient Services

High bed occupancy rates are common across the 'family' of mental health services but more acute in specific areas such as Intensive psychiatric care and adult acute assessment wards. Our strategic direction recognises that inpatient provision can reduce the ability to enhance the community setting which can have greater flexibility and reach for patients. The challenge is to engineer shifts in provision that deliver high quality and safe care in a community setting whilst allowing realignment of bed capacity to meet pressures in specialist services.

Opportunities to realign bed capacity will be identified and supported by tests of change to ensure safe and appropriate service changes.

Forensic inpatient services are provided by the Acute Division. As part of a national programme to reduce delays in high and medium secure, a capital development to provide an additional 15 new beds is being progressed. Forensic services are now included in the multi-agency accommodation oversight arrangements to enable progression of discharge from low secure to supported community accommodation as part of this development.

10.5 Psychological Therapies

We are committed to increasing clinical capacity to support the development of psychological therapy skills in the wider mental health workforce, this plan includes more nurses and occupational therapists being trained to deliver these.

The capacity of the dedicated Psychological Therapies Groups Service will increase which will also increase provision of treatment programmes and the number of secondary specialist mental health services that can refer. The capacity of the peripatetic team will also be increased to support individual areas and services to achieve psychological therapies targets.

10.6 Perinatal and Maternal Mental Health

As part of designing more effective services we will increase staffing in both Community and Mother and Baby Unit inpatient service in line with the recommendations of the national taskforce.

10.7 CAMHs

The publication of the National Service Specification for CAMHs in 2020 is the backdrop for a 2 stage programme of work to address challenges of access and to restructure and strengthen areas

of service need. The subsequent publication of the National Neuro Developmental Service Specification is aligned to and further informs the direction of travel. National funding allocations will support development of capacity to achieve the deliverables of the specifications. Central to this is investment is the development of the workforce with the challenge to recruit a further 123 wte to various roles across the six HSCPs. This workforce expansion will be necessary to implement the new service specification and also contribute to addressing the backlog of demand and reducing waiting times. An interim milestone for this year would be to ensure the 18 week treatment time guarantee is achieved for 80% by December. An important principle in building this programme of work will be engagement and co-production with children and young people.

Phase 1 relates to Tier 3 services delivered at HSCP/Board level. The programme of work will include:

- Capacity building to reduce waiting times
- Extension of transition services to cover patients from 18 to 25 years of age
- Review of out of hours and unscheduled care
- Neurodevelopmental service planning and increased capacity to deliver specialist assessments
- Communications programme to support children, young people and families to understand what and how services can help them.

Phase 2 relates to Tier 4 services which are specialist care to be developed and delivered on a Regional basis. It will include:

- Development of clinical capacity
- Creation of 1 of 3 Regional Intensive Psychiatric Care Units on the Stobhill site
- Regional delivery of service for those with learning disabilities, forensic needs or in secure care & prison
- Home & intensive treatment services
- Expansion of Unscheduled Care pathways

The current management arrangements for the service will also be reviewed to maximise the potential for a Board wide approach.

Figure 20: Mental Health - Summary of Key Milestones in 2022/23

Prevention & Early Intervention:

- Establish 3 new Wellbeing Hubs covering a combined population in excess of 100,000 patients

Mental Health Assessment Units:

- Extension to include and embed access to Social Work
- Resolve clinical workforce model
- Resolution of recurrent funding
- Develop solutions for accommodation requirements

Adult Inpatient Services:

- Develop options for realignment of bed capacity supported by tests of change to ensure safe and appropriate service changes
- Progress accommodation solutions for Low Secure Forensic Services and Community pathways

Psychological Therapies:

- Increased clinical capacity to increase service provision & access

Perinatal and Maternal Mental Health:

- As part of designing more effective services, review the staffing in both community and mother and baby unit inpatient service in line with the national taskforce recommendations

CAMHs:

- Implementation of the National Service Specification for CAMHS and National Neuro Developmental Service Specification
- Develop workforce plan to support the above
- Meet 80% delivery of the 18 week treatment time guarantee by December
- Review current management arrangements

Digital Development:

Rollout of HEPMA is now underway in inpatient mental health sites. The implementation will include Leverndale, Dykebar, RAH mental health wards, Gartnavel Royal, Netherton, Stobhill and Rowanbank

11. Key Risks

The key high level risks in delivering the plan are set out in the **Figure 21** below, the detailed risk assessment for each priority and associated deliverables is contained within the Delivery Planning Template.

Figure 21: Key High Level Risks Associated with Delivering the Plan

Risk	Impact Description
Continuing and fluctuating COVID demand on Healthcare Services	Urgent and Emergency care services across primary and secondary care continue to manage fluctuating numbers of COVID related activity.
Accumulative impact of COVID-19 stresses the interfaces between Health & Social Care	Services at the interface of Health & Social Care, where interdependencies need to be at their most resilient are weakened, compounding disruption to delivery of care.
Continued High Non COVID related demand	Resurgence of other chronic respiratory and seasonal related conditions stretch existing capacity. Delays in treatment for routine conditions results in increasing acuity requirements.
Planned care services disrupted by demand for Unscheduled Care	Routine care in primary and secondary care is halted due to urgency of additional unscheduled care. Remobilisation trajectories for recovery of planned care disrupted leading to further extension of waiting times and unmet need.
Unable to access sufficient external capacity to support delivery of Long Wait Targets	Significant demand nationally limits available access to additional surgical capacity.
COVID related absence impacts on staffing levels	Service capacity disrupted by challenges maintaining staffing levels for COVID related reasons.
Reduced resilience of workforce	Ongoing impact of working through pandemic impacts on staff wellbeing leading to burnout, absence and reduced flexibility for extended hours/overtime.
Reliance on non-recurring COVID funding & shortfall of non-recurring funding in 2022/23	Projects and improvements funded non-recurringly may not be able to continue if there is no funding to support the work to continue. Continuing reliance on non-recurring COVID related funding – we are is currently undertaking a 'COVID Exit Exercise' to support a reduction in COVID related costs. (See also section 8 for more detailed assessment of the Board's key financial risks in 2022/23)

12. Conclusion

Our Annual Delivery Plan describes the challenging year we face in 2022/23. We continue to face high and fluctuating levels of COVID in our community, which impacts on unscheduled care demand and the availability of our workforce. The need to deliver and protect planned care compounds the challenges we face, and we are progressing the modelling work to maximise our capacity to respond to new waiting times targets. We are indebted to our staff across the health and care system, including those in support services, as they continue to strive to deliver patient centred care.

Appendix 1: Delivery Planning Template

For each priority the revised Delivery Planning Template has been completed and is contained within Appendix 1. The revised Delivery Planning Templates will be used to track progress and provide a robust monitoring framework.

In line with the Annual Delivery Plan Guidance the small number of ongoing RMP4/5 actions are included within the Annual Delivery Planning Template.

Appendix 2: National and Local Priorities for Alcohol and Drugs Partnerships

National Priorities

Significant focus has been placed on rapidly progressing the implementation of the ten Medication Assisted Treatment (MAT) Standards for Scotland published by the Drug Deaths Task Force in May 2021. Implementation of the MAT Standards is the responsibility of the Integrated Joint Board's and plays a significant role in relation to the health and wellbeing of the Greater Glasgow and Clyde population.

Implementing the MAT Standards will ensure that people have immediate access to the treatment they need with a range of options and the right to make informed choices. It will reinforce a rights-based approach by ensuring people have choice and are empowered to access the right support for where they are in their recovery journey. Implementation of the Standards has a significant part to play in helping vulnerable people affected by substance use.

The ADPs strategic delivery plan is focussed on the national strategic priorities, specifically the Drug Deaths Task Force (DDTF) Emergency Response Strategies as set out in Jan 2020:

1. Targeted distribution of naloxone
2. Implement immediate response pathway for non-fatal overdose
3. Optimise the use of Medication-Assisted Treatment
4. Target the people most at risk
5. Optimise Public Health Surveillance
6. Ensure equivalence of support for people in the Criminal Justice System

Additional Local Priorities

Each HSCP's ADP Strategy 2020-2023 also describes additional, cross cutting priorities that will help each HSPC achieve their aims for their populations and contribute towards their strategic vision.

The key local priorities are as follows:

Figure 22: Summary of the Key Local Priorities within ADPs

Glasgow City
• Enhanced Drug Treatment Service providing heroin assisted treatment to those at significant risk of drd with multiple and complex needs • Crisis Outreach Service, providing daily and rapid out of hours outreach support to those identified as having had a near fatal overdose and /or at significant risk of drd • Successful pilot of the WAND initiative in the City Centre, providing incentivised wound care, assessment of injecting risk, naloxone and BBV testing to people who inject drugs. Planned roll out across Glasgow City, East Dun and East Renfrewshire • Safer Drug Consumption Facilities-work continues with Police Scotland and Scottish Government to consider the possibilities of developing an SDCF within the current legal framework
Renfrewshire
• The Harm Reduction Response Team (HaRRT) has been established and will be available out of hours. This will provide crucial healthcare and harm reduction services

including the provision of Naloxone. HaRRT will assertively outreach areas in Renfrewshire in a custom built van to increase engagement with difficult to reach communities

- CIRCLE (Recovery Hub) has been established which provides enhanced support to individuals who are on a recovery journey.
- A dedicated Drug Deaths Prevention Lead Officer in post which has resulted in the development of a clear structure and work plan to reduce the number of drug related deaths in Renfrewshire
- Individuals affected by alcohol and drugs have access to an out of hours telephone helpline as part of the enhancement of a local Crisis Support Service

Inverclyde

Drug Death Taskforce funding has been used in appointing various posts as tests of change. This has included:

- the Overdose Response Team ensures assertive outreach within 48 hours to anyone who has had a non-fatal overdose. This work is now being continued using MAT funding
- A Naloxone Link Worker to support Third Sector partners in supply and administration of Naloxone and develop peer mentors who can provide training on Naloxone
- A Peer Support role has created an employment pathway
- the development of Early Help in Police Custody, using a model of Peer Navigators
- the expansion of the Nurse Liaison service supporting those most at risk into treatment
- the development of a new residential rehabilitation pathway
- family support services commissioned by SFAD

East Renfrewshire

- Developing arrangements for lived experience involvement and influence in services and the Alcohol and Drugs Partnership, including peer research programme and Lived Experience Panel
  - Working with lived experience volunteers on developing and enhancing community based recovery opportunities and supports
  - Developing peer services including peer support for recovery and peer navigators services to support people with multiple complex needs and drug harms
- Increasing distribution and uptake of Naloxone through the Community Addictions Team and outreach work through Peer Naloxone Champion post, employed by RCA Trust
- Working with Turning Point Scotland on rollout of the WAND initiative in the City Centre, providing incentivised wound care, assessment of injecting risk, naloxone and BBV testing to people who inject drugs

West Dunbartonshire

- Implementing the Recovery Orientated Systems of Care approach

- Enhancing out of hours provision with the implementation of a Harm Reduction mobile treatment unit, operational by the beginning of July
- Dedicated Family support work for Addiction Services, this is currently progressing through the procurement process
- Custody to community pilot – this is a 2 year pilot where staff members attend the custody suite to attempt engaging people in to treatment services where problematic substance misuse is highlighted as an issue
- Implementation of 2 dedicated Advocacy workers within Addiction Services, over 300 people within West Dun stat and non-stat services plus community attended a full day workshop to raise awareness of the human right approach

East Dunbartonshire

- Continue to extend the reach of naloxone – postal service was developed and local promotional resources & training provided to other local services
- Partnership working between Turning Point Scotland and West Dunbartonshire for the Overdose Response Team need to look at longer-term sustainable support
- Increase capacity within ADRS to support the implementation of MAT standards and the increase in referrals/caseloads
    - Extend medical cover over the week to ensure same day prescribing is possible when clinically appropriate – 5 days available but need to cover any contingencies
    - Continue to develop the DTTO nursing post – situated within Justice 2 days per week and ADRS 3 days per week
- Develop and implement rehab pathways to ensure transparency and equity of support
- Implement the WAND initiative in partnership with Glasgow City/TPS/East Ren – will be in East Dunbartonshire once a fortnight

Monitoring Progress to deliver the National and Local Strategic Priorities:

Each ADP has a detailed strategic delivery plan which monitors the delivery of the key priorities in the form of a detailed action plan. The successful implementation of the strategic delivery plan is monitored through each Integration Joint Board who are responsible for overseeing the delivery of the plan. In addition to this an NHS GG&C group has been established to support and monitor the implementation of the new MAT standards across the Board.

Alcohol and Drug Recovery Services and other relevant services across GGC are coordinating actions required to meet the Standards, this work includes:

- Working with the Scottish Government MAT Standards Implementation Support Team for project management and analytics support, workforce resource, monitoring of progress and sharing of best practice is ongoing
- A Planning and Implementation Structure has been established. An action/implementation plan has also been developed and is monitored against further progress, and will be reported locally through relevant ADPs and HSCPs, and to NHS GGC

- Engaging with key local and national partners, including; people with lived and living experience of receiving services/problem drug use and their families; Prison Healthcare and Police Custody Health Care; Acute Services and Primary Care; relevant Royal Colleges and; Lead Psychologists in Addiction Services and National Pharmacy Organisations. All ADPs are currently reviewing financial plans for new service developments and capacity building, in order to meet the MAT Standards

Scottish Government has confirmed additional national funding to Health Boards to expand access to Buvidal (long-acting buprenorphine): and also to ADPs for expanding effective and assertive outreach; expanding and improving near-fatal overdose pathways; improving the reach of the voices of those with lived and living experience; supporting the priorities of the National Mission; supporting access to residential Rehab; and supporting implementation of the Whole Family Approach.

The Alcohol and Drugs Partnerships also continue to report directly to Scottish Government on their contribution to national priorities and outcomes. GGC partners from Renfrewshire HSCP, Glasgow City ADP and Public Health are supporting the Scottish Government development of a Partnership Delivery Framework and ADP performance Framework that will allow consistent reporting on progress against the national priorities.