

Greater Glasgow and Clyde NHS Board

JB Russell House
Gartnavel Royal Hospital
1055 Great Western Road
GLASGOW
G12 0XH
Tel. 0141-201-4444
Fax. 0141-201-4601
Textphone: 0141-201-4479
www.nhsggc.org.uk



Mr Lewis Macdonald
Convener
Health and Sport Committee
T3.60
The Scottish Parliament
EDINBURGH
EH99 1SP

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Our Ref: JB/GD

Enquiries to: John Brown
Direct Line: 0141-201-4410



Dear Mr Macdonald

Thank you for your letter of 6th June 2018 requesting some additional information further to our attendance at the Health and Sport Committee on 8th May 2018. I would like to thank you and Committee members for affording us the opportunity to attend.

You indicated that the Committee required some elaboration on points from my opening statement. I trust the detail below will assist.

In respect of the issuing and tracking of prescriptions and analysis of any data available, I can confirm 24 million prescription 'items' were dispensed at community pharmacies for NHS Greater Glasgow and Clyde (NHSGGC) patients in the last financial year. NHS National Services Scotland process these prescriptions and make available a range of data for use by NHS Boards. This includes details on the GP issuing the prescription, the patient, the pharmacy who dispensed it and the product that has been prescribed. The Board has access to a range of tools to analyse and report this data and undertake detailed local analysis to review prescribing and inform a programme of work to support safe, effective and efficient prescribing. More information on the national system is available at:

<http://www.isdscotland.org/Health-topics/Prescribing-and-Medicines/>.

I talked about the significant number of research studies within NHSGGC, circa 900. With regard to the financial arrangements, there are two different streams. For our non-commercial trials all grants are costed according to a nationally agreed costing template (AcoRD*) and paid to the relevant departments for the use of NHS resources and research nurses for the research trial. For commercial trials, direct costs are again reimbursed to relevant departments, the Board is reimbursed for overhead costs, and the balance is transferred to discretionary investigator funds to support further research and reinvested in research infrastructure. (*AcoRD attributing the costs of health and social care research).

In terms of Board influence over the movement of resources from acute to primary and community care, the Board remain fully committed to shifting the balance of care into primary and community care, and this remains a key feature of our current joint working with our Partnership colleagues and our medium to longer term strategic plans. The approach within the GGC area of one of whole system working with colleagues in the NHS Board, IJBs and Councils, as well as a number of other stakeholders to deliver transformational change across the system.

To expand on my comments about how the Board is ensuring that the Integration Joint Boards (IJBs) are supporting the delivery of the Health and Social Care Delivery Plan, I would highlight our overall approach to transformation. To deliver against the Plan, and realise the aspirations of integration, we must transform on a whole system basis across all six local Partnerships as well as the six other Partnerships that are adjacent to GGC, and this is what our Moving Forward Together programme is about. Our direction is entirely in line with the Health and Social Care Delivery Plan and consistent with the Partnerships' Strategic Plans and we will continue to work closely with our IJBs and HSCPs to get the balance of care right.

To answer your question around percentage efficiency savings, I can confirm that in the 2017/18 budget, the target was 3% of the total budget of £3.1bn or 5.6% of the baseline allocation from which savings can be made - £2.1bn. For 2018/19 the figure is 3% of the total budget of £3.2bn or 5% of the baseline allocation from which £2.2bn savings can be made – circa £87.9m.

As far as 'getting our public on board' with our transformation programme, we involved the public and our staff from the outset to help shape and develop this strategy. We established a Stakeholder Reference Group which has been involved throughout the process, giving opinion and valuable insight into the views of the patient, service users and carers who benefit from our care services and guiding us in how we engage with, and inform, our public.

Feedback from the Stakeholder Reference Group was that traditional methods of engagement that relied on printed materials and public meetings often failed to engage communities. Their advice led to the development of a range of digital materials and alternative methods to communicate the Moving Forward Together programme and its benefits, including a dedicated website, the creation of videos and an animation for use of social media and TV screens.

We used our established and trusted communications channels to engage with the public about the programme:

- Health News - our digital magazine with a reach of 60,000.
- Social media video clips with a current reach of 40,000.

We have also engaged extensively with, and learned from, the knowledge and experience of our staff from across health and social care services. More than 1000 clinicians and non-clinical staff have contributed to the vision and have supported the direction of travel that we have taken.

I will now deal with the other specific issues you have raised on key topics.

Waiting Times

In response to our comments about establishing our baseline capacity, the Committee have asked for clarification on the benefits of making improvements. The programme of demand and capacity planning for both outpatient and inpatient Services was initiated last year and aimed to establish the predicted service demand against NHSGGC baseline capacity. A number of productivity metrics were analysed to identify areas for improvement and potential capacity gain.

The productivity recommendations from the programme will ensure all outpatient clinic and theatre capacity is fully utilised. This includes reducing cancellations, DNA rates and, where appropriate, the number of return appointments in order to increase patient throughput. The resulting outcome of this work will be to shorten patient waiting times and reduce the number of patients waiting over 12 weeks for an appointment/treatment.

The programme remains in place and various specialties are at different stages in the process. In tandem to this work, the Annual Operational Plan was submitted to the Scottish Government in April 2018. The Plan included a series of milestones to bring the number of patients waiting over 12 weeks for both outpatient, inpatient and daycase services back to the same performance level achieved in March 2017 as requested by the Scottish Government. Performance against these

milestones is monitored at a number of internal management meetings as well as the bi-monthly Acute Services Committee and the NHS Board Meeting.

A number of specialties within NHSGGC continue to meet the 12 week target for outpatients including Gynaecology, Plastic Surgery and various Paediatric specialties. Additionally, the Board anticipates that further specialties will meet the 12 week guarantee by March 2019. However, capacity pressures remain present for many specialties and productivity gains are being worked towards to ensure patient waits are reduced in the coming year. This is also the case for inpatient and Diagnostic services whereby work is ongoing to meet local milestones for reducing waiting times. In addition, a number of redesign initiatives are being progressed to review current service models and build on good practice.

In relation to work around cancer delays and 'flexing capacity', NHSGGC aims to offer patients with an 'Urgent Suspicion of Cancer priority' an outpatient/diagnostic appointment within 14 days of referral. In order to meet these robust timelines, capacity across the Board is managed to ensure urgent slots are ring-fenced for specific cancer demand.

Capacity is also flexed, where possible, as demand fluctuates; for example, return clinic slots may be converted to urgent new slots when required. Diagnostic scope slots are also converted to accommodate specific demand pressures, for example Bowel Screening. Additionally, when required, sessions are run at weekends and evenings to address peaks in demand.

However, this can have a consequential impact on other parts of the organisation, for example routine and return capacity can be displaced in order to prioritise cancer demand. To mitigate against this, clinic capacity is maximised and work on patient pathways is ongoing to ensure the Board makes best use of all clinical resources including Nurse and AHP led services.

Telehealth

We discussed the benefits of Telehealth and highlighted our ongoing commitment to development. In terms of calculating projected savings, this is a challenging area with evaluation of all pilots and planned developments critical to this. The NHS Board is committed to exploiting technology to support effective and efficient delivery of patient care. NHSGGC has a track record of maximising the use of technology on a number of fronts, such as the creation of the West of Scotland electronic health record ensuring that appropriate clinical information is accessible to those providing care thus removing any perceived barriers due to NHS Board boundaries.

In addition the Board's Corporate Management Team have recently considered the Board's "Digital as Usual Strategy" where Telehealth and use of the "Attend Anywhere" system is a key component for delivery to support further efficiencies around capacity and service redesign opportunities. The Board has an ambition to implement Attend Anywhere across 10% of outpatient attendances by the end of 2018/19 as agreed at our Modern Outpatient Group.

Attend Anywhere is a software system that has been piloted in a number of NHS Boards to support remote clinics using videoconference (VC) facilities. The Attend Anywhere system utilises VC technology, allowing the patient to connect securely over the internet to the clinician in a pre-arranged clinic slot.

Three NHSGGC services participated in pilots of the Attend Anywhere system this year:

- Dermatology (patch testing).
- Diabetes outpatients.
- Neurology (epilepsy).

The pilots were evaluated within NHSGGC and the evaluation group recommended that the pilot had achieved its objectives and that the system should be rolled out further. Further implementation is now underway.

Delayed Discharge

We described a number of activities designed to reduce the bed days lost to delays in discharge. As part of the approach to setting trajectories for the Ministerial Strategic Group targets, each HSCP has outlined reductions for delayed discharges which, on average, equate to a 10% reduction of bed days lost in 2017/18. We will continue to work with the Partnerships to ensure an ongoing improvement in performance.

Health Improvement

You highlight the potential time lag for health improvements to emerge and ask how effectiveness will be measured. This is recognised and we will measure this through a range of indicators including quality of health care experience, mental well-being and risk behaviours. We plan to use data from the Scottish Health Survey as well as our local Health and Well-being Survey which enables comparisons amongst local areas. We also have a series of measures that are being considered across the Board area and within each HSCP. In addition, we are contributing to the wider work within Community Planning Partnership which have set their own local measures.

Financial Savings

In respect of your question about unachieved savings and liability in accounts, in 2016/17 the Board had a savings target of £87m. Against this, £57.4m of recurring savings were achieved. In order to break-even, non recurring funds were used in-year to cash manage the gap. However, this then left a £29.6m underlying recurring deficit, which had to be added to the financial challenge in 2017/18 and for the Board to try and address. The use of non-recurring funds to achieve in-year financial balance is an increasing situation across almost all Boards in Scotland, as outlined in the Audit Scotland NHS Overview Report. However, we are focusing in 2018/19 on increasing the level of recurring savings achieved during the year.

The Committee wish to understand the issue of savings 'materialising later in the year'. As outlined, financial balance was achieved in the last quarter through a number of measures - greater financial control and "grip"; managing winter pressures within the financial envelope; further identification of non-recurring sources of funding, including an additional allocation from the Scottish Government; and the realisation of the late crystallisation of savings. Typically, these savings would be identified over the summer months, delivered over the autumn/winter, with the cash release being realised in the last quarter. Savings are realised all through the year - in 2017/18 there was a higher proportion in the last quarter. This rebasing was anticipated and reported throughout the financial year.

In terms of governance, it is worthy of note that we established the Finance and Planning Committee during the latter part of 2016. This is chaired by myself and has provided an opportunity for deeper scrutiny of finance in addition to the role of the NHS Board. This ensured the Board had ongoing visibility of the financial position as the year progressed.

A&E Attendance

As you describe, there was lengthy discussion on the issue of A&E attendance. In terms of action to address patients who frequently attend the Emergency Department (ED), we have recently undertaken a review of all NHSGGC ED activity over a 12 month period to identify patients with a profile of repeat attendance and/or repeat admission. This analysis has been further stratified to include detailed information by HSCP and GP Practice. Each HSCP is planning to complete a review of patients and GP practices where there is evidence of disproportionate rates of attendance and will facilitate local discussions with GPs and MDTs to identify whether alternatives to ED can be appropriately provided. In addition, there is an HSCP "Public Information" work stream underway that has been tasked with enabling communities to choose the right services or self-help, if appropriate. This work will focus on how to provide more effective methods of targeted information and an improved approach to public communication.

In respect of opening hours of GP Practices we are focusing on enabling timely access during existing core hours through the development of the multi-disciplinary team as set out in the Primary Care Improvement Plans, and also taking forward our out of hours response in line with the recommendations of the Sir Lewis Ritchie review. The majority of practices across GGC continue to participate in the Extended Hours enhanced service to offer additional appointments outwith core hours in the early morning and / or evening.

Access to Records

There are a number of activities underway to move this agenda forward. As described, there have previously been issues around data protection of patient information and who was ultimately responsible for that information. However, with the new GP contract, there is the opportunity to progress the sharing of patient data to ensure that the best and most informed decisions can be made, ensuring the patients wellbeing, in whatever healthcare environment the patient finds themselves. Some recent activities are detailed below:

- NHSGGC progressed a pilot within the Inverclyde area which shared Immediate Discharge Letters for patients who had registered with pharmacies around Chronic Medication. This had positive results.
- We are also discussing wider access to data including the Emergency Care Summary (allergy and prescribing data from general practice), and hope to progress this once GP contract discussions with the Scottish General Practice Committee are concluded.
- After a successful pilot, where a selected number of community pharmacies had access to the clinical portal, the difference that community pharmacies can play can be clearly seen, when information is made available to them to assist in managing patient care. Under our transformational change programme, work is being initiated to establish what can be put in place for all pharmacies to gain access to the clinical portal.

The Board is now looking to progress all opportunities, in conjunction with the Scottish Government, to extend our data sharing initiatives more widely to support patient care and as part of our local clinical strategy developments.

I trust this information provides sufficient detail, however, please let me know if there is anything further required.

Yours sincerely

A handwritten signature in black ink, appearing to read 'John Brown', written over a large, light-colored oval shape.

JOHN BROWN CBE
Chairman