

**Health and Sport Committee
NHS Board Accounts 2013-14
Questionnaire Response from NHS Greater Glasgow and Clyde**

Covering note

We attach the Board's response to the committee's questionnaire for 2013/14. Please note that we have based our responses on the Board's draft budget submission. Our final budget may contain further revisions and is yet to be approved by our Board.

Paul James
Director of Finance

Service developments

1 (a) Three examples of local service developments that we have been able to fund in 2013-14 are

- Consultants
- Patient management systems
- Elderly mental health

The Board has invested significantly in recruiting additional Consultants and in doing so has redesigned the delivery of services most immediately impacted by changes in Junior Doctor availability. A significant proportion of the overall investment has gone to recruiting additional Consultants in Emergency Medicine, Anaesthetics and Obstetrics & Gynaecology in 2012 -13 and this will be carried forward into 2013 -14 with the recruitment of additional Paediatric Consultants.

The Board will complete the roll out of the new Patient Management System (known as TrakCare) in 13/14. This will provide a 21st century IT system for use by all of our clinical staff, with patient activity and demand reports available in real time. In addition, the Board is investing in an ambitious programme to deliver Electronic Patient Records on a sector by sector basis in 13/14. We are also rolling out a previous trial of a new electronic prescribing system that assists GPs in making cost effective and clinically effective prescribing decisions.

We are refurbishing the elderly mental health inpatient wards at Stobhill Hospital.

1 b Services we would like to develop if we had additional funding include

- Improvements in our estate
- Adult mental health

NHS GG&C has made significant progress in rationalising the estate, either by refurbishing existing buildings, or by providing new facilities. We have a large estate, some of which requires investment and this is reported in our property and asset management strategy. In some cases the investment shown in our strategy relates to parts of our estate that are unused and difficult to sell due

to market conditions. In addition the delivery of our major new hospital and laboratories will replace some of our existing operational estate and will therefore reduce the older estate that requires investment. Nevertheless additional funding to allow backlog maintenance to be accelerated would be afforded a high priority.

We would like to make further investment at Stobhill Hospital to build new adult mental health inpatient wards. This would provide much better quality accommodation for patients as well as reducing the cost of services. We have submitted an Initial Agreement to the Scottish Government and are awaiting a decision on the proposals.

1 c We have not withdrawn any services in 2013-14.

Preventative spending

In relation to preventative spending we have set out our answers under three sections. The first section covers general preventative spending. The second covers healthy weight in adults and the third addresses tobacco initiatives. Since the committee's questions 2, 3 and 4 are all inter-related we have answered them separately under each of the three sections.

Preventative spending – General

Q2. There are a range of preventative health programmes in budget plans for 2013-14 including AAA (Abdominal Aortic Aneurysm) screening, Bowel screening, Breastfeeding, Smoking cessation (In Patient / Maternity / staff settings), and Alcohol Brief Interventions

We invested £9.9m in health improvement in Glasgow CHP in 2012/13, 28% of which is direct Scottish Government prevention programme funding e.g. smoking prevention and Keep Well. This resource is specifically targeted at preventative health programmes and represents 1.6% of the Glasgow CHP annual budget. It does not include resources aligned through clinical staff time in preventative activity.

Q3. We have had a process of developing a refreshed strategic direction for health improvement within the city and are reviewing investment as a consequence of this. Spending areas that clearly fit the strategic direction, contribute to HEAT performance, limit redeployment and limit the impact on critical third sector contracts are being protected.

Q4. Health Improvement is part of our financial planning process and considered both as a component part of our organisational plans and through specific reporting to our senior management team.

Preventative spending – Healthy Weight (Adults)

Q2. Development of tiered weight management service across NHSGGC including introduction of new Tier 2 service and redesign of Tier 3 / 4 services will be undertaken during 2013/14. Work is underway to redirect current expenditure within local budgets and national funding

streams to establish a new Tier of service. Specific expenditure is currently being modelled.

- Q3.** Preliminary activity modelling undertaken based on:
- review of referral criteria from existing services to new service and associated activity redirection to new service
 - provision for unmet need associated with LTCs
- Q4.** Anticipated activity levels within each Tier are reflected by anticipated disinvestment / reinvestment across all Tiers. (approx 25% current expenditure will be reallocated). Estimated increased activity levels are linked to SG investment for Tier 2 and bariatric surgery.

Preventative spending – Tobacco

- Q2.** In addition to continued delivery of smoking cessation targets, the new national tobacco strategy requires an increased focus in relation to Tobacco control activities in conjunction with Community Planning Partners to achieve reductions in smoking prevalence. In particular Boards are required to deliver smoke free grounds and increase prevention work with young people.

The Board's tobacco framework has been reviewed to increase investment in smoke free grounds, staff smoking cessation, youth tobacco programmes and capacity for local tobacco alliance activity through Community Health Partnerships and Community Planning Partners. Expenditure will be redirected within the existing Tobacco financial framework to address the focus in these areas.

- Q3.** A review of cost effectiveness of smoking cessation services has been undertaken leading to areas of service improvement across NHSGGC. This will drive both effectiveness and efficiencies to support the local CHP redirection of investment in to new priority areas within the tobacco programme. In addition, national cost effectiveness studies on tobacco control programmes were considered by the Board and have informed the development of key programme.
- Q4.** Work is currently underway to develop local financial plans within the tobacco framework. The overarching Tobacco Financial framework and planned 2013/14 investment has been reviewed accordingly.

Q5. Access to new medicines

Our forward planning for new medicines is a sophisticated process, involving local clinicians and local pharmacists, prescribing data and forecasts of expected use. Our finance department is fully engaged in that process.

It is important to note that the spend on “new medicines” sometimes includes spend on existing medicines for which new indications have been approved. It is also important to note that some existing medicines have grown significantly in terms of the usage we have experienced. In addition the substitution of

newer for older medicines can have effects that reduce, or increase, medicines expenditure. These factors complicate the planning process.

In relation to spending on newly-licensed medicines we have been able to provide the planned spend for both 12-13 and 13-14. We have also added commentary in this section of our response in order to add further information. We trust that this helps the committee to get a better understanding of the extent to which forward planning for new medicines is incorporated in financial planning.

We recognise that the committee has also requested information on actual spend on new medicines in 12/13. We do not keep this information in a format that is comparable with the planned spend shown so we have not included it. Our acute prescribing systems, for example, are not linked to what a medicine was actually used for on a patient by patient basis. We would therefore be providing misleading comparative information because, in many cases, the planned investment in a particular medicine is for a single indication whereas our reporting of actual spend encompasses all indications.

The planned additional investment for NHS GGC for medicines anticipated to be licensed in the time period of 2012/13, and 2013/14 is shown below. The committee should note that this is far less than the total uplift being allocated to medicines, as explained by our notes.

	GP prescribing	Hospital prescribing	Total
2012-13 (planned)	£1.3m	£4.5m	£5.8m
2012-13 (actual)			
2013-14 (planned)	£2.0m	£3.6m	£5.6m

In relation to actual expenditure it may assist the committee to note that

- The uptake for the new oral anticoagulant medicines in clinical practice during 2012/13 was slower than expected for a variety of reasons, including caution around the safety aspects (lack of reversibility). The anticipated cost pressure did not materialise during 2012/13. The 3rd agent in class, apixaban, accepted by SMC in February 2013, is anticipated to have an improved safety and efficacy profile and more acceptable to prescribers and therefore greater financial impact. Our 2013/14 financial plan therefore contains a significant planned investment for these new agents.
- Several medicines in the 2012/13 list were delayed in, or failed, the licensing process, and some were not recommended by SMC and therefore we would not anticipate expenditure on these medicines/indications

In relation to planned expenditure it may assist the committee to note that the figures include resource allocated for:

- Medicines that were previously not recommended by SMC but that are anticipated as likely to have a successful resubmission in the relevant year, causing a significant cost pressure
- Medicines that were introduced late in the previous financial year and so the impact does not start until the relevant year.

It may also assist the committee to note that the figures exclude resource allocated for:

- New medicines accepted during the previous financial year that had still to reach full year effect in the relevant year.
- New medicines introduced in the last few years, accepted by SMC, and that continue to grow year-on-year e.g. biologic medicines, medicines for HIV infection, multiple sclerosis, age-related macular degeneration and similar ophthalmological conditions requiring ongoing medical treatment. These medicines contribute the majority of the cost pressure for expenditure on medicines in the acute sector.

As the financial year progresses it may become apparent that certain new developments will no longer be expected to impact or have reduced / increased financial impact. In these circumstances the planned additional investment may no longer accurately reflect the in-year expectation. Strong links are in place between the Pharmacy and Prescribing Support Unit (PPSU) and Finance to communicate and manage these in-year changes. For example:

- a medicine may fail to achieve marketing authorisation, or be delayed through the licensing process. Acceleration through the licensing process is less frequent but possible.
- a medicine may be not recommended by SMC and therefore not be available for routine use in the Boards.
- a new medicine may be accepted by SMC for a restricted population in which case the patient numbers may be lower than initially forecast.
- a new medicine (or a newly licensed indication for an existing medicine) may be accepted by SMC on the basis of a Patient Access Scheme which provides a discount on the anticipated or listed purchase price.
- prices or patient numbers may be higher than originally forecast or timescales advanced such that the allocation may be underestimated.

Q6. Individual patient treatment requests

For each individual patient request agreed in 2012-13, relating to newly-licensed medicines not recommended by the SMC, NHS GGC IPTRs are shown below

Medicine	Indication	Average cost per course per annum	Number of patients	Comment
Abiraterone	Prostate cancer	£28k	7	
Bendamustine	Blood cancer	£7k	<5	
Bevacizumab	Colon cancer	£30k	<5	
Bortezomib	Myeloma	£32k	<5	
Canakinumab	CAPS	£72k	<5	
Denosumab	Protection from skeletal events in cancer	£5k	<5	
Golimumab	Psoriatic arthritis	£9k	<5	homecare supply
Lenalidomide	Myeloma	£70k	<5	
Ofatumumab	Blood cancer	£49k	<5	
Ranibizumab	Branch retinal vein occlusion	£5k - £7k	9	assumes 6 - 8 injections
Total		Total potential cost of £0.75m	35 patients	

The total cost incurred will be influenced by a wide range of factors including patient response to treatment, adverse effects/tolerability. In order to determine the actual cost per IPTR approved the individual case notes would require to be reviewed. Instead we have presented an average cost for a course of treatment or per annum as appropriate. Costs also exclude any confidential discounts achieved through implementation of patient access schemes.

Where numbers of IPTRs are between one and four patients then in order to guard against potential patient identification, this is represented as <5. IPTRs included in this response are

- approved in 2012/13 for GGC residents
- classified as “new” if the medicine was introduced in last two financial years. This list therefore excludes a number of IPTRs that involve older medicines

The committee may wish to note that

- IPTRs reported above were raised at a point in time when the medicine was not recommended by SMC. That recommendation can change.
- Expenditure may impact across more than one financial year but we have not attempted to reflect the impact over multiple time periods

Q7 Inequalities

We have answered question 7 in sections. The first section refers to health improvement and includes Keep Well. The second addresses Child Poverty and the third addresses the need to reduce barriers to services.

Reducing inequalities – Health Improvement

Q7a

A progressive programme of increasing access and outcomes for inequality groups in all Health Improvement programmes is under development including;

- Alcohol Brief intervention
- Smoking Cessation
- Healthy Weight Interventions (Child)
- Keep Well Health Checks

Q7b

The level of spending on our Keep Well Programme is £4.2m in 2012/13 and £4.2 m in 2013/14

Q7c

Stage 1 outcomes for tobacco – Increased service uptake by group e.g. 40% most deprived SIMD / BME etc

Stage 2 outcomes for tobacco – Increased positive outcomes by group e.g. Quits by 40% most deprived SIMD

Keep Well

- Increase number of practices participating in keep well programme
- Deliver target number of eligible patients (total and defined sub-populations) attending keep well health checks

Q7d

Stage 1 outcomes:

The focus on narrowing the gap in health inequalities is addressed within the Health Improvement framework where specific service areas have adopted a targeted approach. Improvements have been made in relation to smoking cessation service uptake with over 4000 quits being made consistently over the last 2 years by the most deprived communities (37% above target). Detailed analysis of low service uptake by BME groups is now being followed up by targeted work in the South Asian community. Analysis by age demonstrates the contribution of the Smoke Free Hospital service in supporting smoking cessation in older people and tailored services are in place for young people.

Nearly 50% of healthy weight interventions were completed by children in SIMD 1 which suggests a positive targeting of services based on the distribution of obesity across the population.

The majority of ABIs (43%) undertaken within Acute settings is with most deprived communities and 41% are carried out with younger adults (<40yrs) and 19% with older adults (> 60yrs)

This approach will be extended to other service areas including primary care ABIs, screening programmes, breastfeeding, Live Active (exercise referral) and adult weight management programmes from 2013/14

Keep Well

- NHS GG&C continues to prioritise delivery of Keep Well from GP practice based settings as its principal delivery method, via Local Enhanced Service (LES) contract arrangements, to ensure sustainable coverage of our most deprived neighbourhoods. From 1st April 2013, 150 NHS GG&C GP practices continue to participate within the Keep Well LES
- NHSGGC delivered total of 14,943 Keep Well health checks during 2012/13, of which over 70% (10,508) were completed with eligible patients residing in our most deprived neighbourhoods.
- Work will continue during 2013/14 to target and improve uptake within defined target populations including South Asian and Black & Afro-Caribbean ethnic subgroups, offenders, gypsy/travellers, homeless individuals, those affected by substance misuse and carers
- Approx 45% of Keep Well checks are carried out with men, this is comparable with previous year and men continue to be targeted within the programme.
- Uptake for patients with known sensory impairment will continue to be monitored, with focused activity to improve uptake for people with known visual impairment

	Number of Eligible patients	Number attended health checks to date	% attended health check
Registered Deaf	3,451	2,758	79.9%
Registered Blind	731	167	22.8%
Registered Deaf & Blind	30	22	73.3%

- Additional activity will be progressed during 2013/14 to integrate learning from Keep well within existing health check programmes targeting patients with learning difficulties and also patients with severe & enduring mental health.
- A substantial amount of development and redesign activity is also underway within the NHSGGC Chronic Disease Management Enhanced Services programme, to ensure that the programme is fully aligned to need. The deployment of 'Intelligent Templates' in April 2013 (an electronic consultation support template allowing a patient-centred dialogue that can be customised to the patient's individual needs and priorities) has replaced previous 'one size fits all' clinical template; this

development will strengthen patient-centred consultations for patients with co-morbidity and will also support more evidence based motivational interviewing and inequalities sensitive practice. More concerted action will also be undertaken to respond to the needs of patients who do not engage in the CDM Enhanced Services programme, using learning and operational systems from Keep Well and the needs assessment on housebound patients.

Reducing inequalities – Tackling Child Poverty

Q7a

The Healthier Wealthier Children programme involved developing new approaches to providing money and welfare advice to pregnant women and families with children at risk of, or experiencing, child poverty across NHS Greater Glasgow and Clyde (NHSGGC). It involved a range of partners including NHSGGC, Glasgow City Council, other council partners, and the voluntary sector.

By creating information and referral pathways between the NHS early years workforce and money/welfare advice services, it was envisaged that staff, such as midwives and health visitors, would strengthen the identification of need for advice among pregnant women and families, thereby mitigating the impact of child poverty.

Operating within the ten Community Health and Care Partnership (CH(C)P) areas that existed across NHS GGC in 2010, the project development and subsequent delivery was primarily coordinated by health improvement staff and commissioned HWC advice staff. It was supported by local planning groups operating in each CH(C)P area between October 2010 and March 2012. The programme continued in 2012-13 with particular emphasis on mainstreaming support to children and families and targeting particular at-risk groups such as children in acute services and homeless families.

Q7b

In 2012-13 £350,000 was invested in financial inclusion services. In 2013-14 financial inclusion investment is mainstreamed in two local areas or provided by existing services.

Q7c

The financial inclusion provider organisations record the number of referrals and financial gain as shown below

Referrals Oct-Dec2012 (55% HV referrals, 55% HV referrals)

Area	Referrals	Total gain
NE Glasgow	176	£97,195
NW Glasgow	62	£38,331
South Glasgow	45	£52,112
East Dunbartonshire	20	£26,374
East Renfrewshire	21	£40,237
Renfrewshire	102	£195,613

Area	Referrals	Total gain
Total	385	£449,832

A range of other outcomes include reduced debt, essential goods such as cookers/ buggies and referrals on to other support organisations. A full evaluation of 2012-13 will be available in June 2013.

Q7d

An evaluation carried out by Glasgow Centre for Population Health on the first phase of the programme identified the following impacts-

- Between October 2010 and January 2012, the project achieved an overall financial gain of £2,256,722 for pregnant women and families accessing HWC advice services
- Of the 2,516 referrals, 1,347 (54%) accessed some type of advice. Almost one in two (663) people receiving advice were entitled to some type of financial gain, with an average annual client gain of £3,404.
- Other gains from accessing advice included help with childcare and housing, support with charitable applications, advocacy, switching to cheaper utility options and an increased uptake of Healthy Start vouchers. One in twenty people receiving some type of gain were awarded Healthy Start vouchers to exchange for milk and vitamins for children.
- Eight percent (110) of people accessing advice were referred onwards for additional help. The four most frequent reasons were other financial support, immigration issues, social work support and accessing voluntary organisations.
- Follow-up interviews with clients accessing advice revealed that a number reported reduced stress, improved mood and increased sense of self-worth and security. Some also saw an improvement in relationships with families and friends.
- The gains (financial and non-financial) achieved for pregnant women and families with children are important determinants of health that can contribute to improving overall family wellbeing.
- The majority (77%) of people accessing advice had a monthly household income of less than £1,399 which is slightly above the £1,349 eligibility threshold for Healthy Start vouchers, primarily offered to low income groups on certain types of benefits and tax credits.
- Among those receiving gain, one in five families were awarded a Disability Living Allowance payment

Reducing inequalities – Reducing Barriers to Services

Q7a

NHSGGC has an Interpreting Service to reduce the barriers to access to health services by those whose first language is not English. The service was brought in house in October 2011 and we now have 236 spoken language interpreters and 2 British Sign Language Interpreters as sessional interpreters. We cover approximately 76 spoken languages, although this also varies with the population. We appoint on average 350 spoken language interpreter-supported appointments per day and 17 British Sign Language

interpreter- supported appointments per day. We now provide an interpreting service that covers Lanarkshire Health Board too (they are not indicated in this spend).

As an adjunct to the Interpreting Service we provide accessible information to patients. Our Accessible Information Policy states that we will provide all new and reviewed information in our top 5 community languages and accessible formats such as audio, large print, BSL and words and pictures, as well as responding to patient requests for any language or accessible format to meet their needs

Q7b

Interpreting

2012 – 13 £2.6m

2013 – 14 £2.8m

This is a centrally funded demand led budget. It may increase due to increased demand, rationalisation of how we spend the interpreting budget means we have increased value for money for each interpreting appointment.

Accessible Information

2012 – 13 £30k

2013 – 14 £38k

Q7c

Our outcome measure is to provide a competence based interpreting service for all patients who express need.

Q7d

Increasing patient demand upon the interpreting service.

Focus groups with specific language groups indicate an increasingly honed service to meet the needs of our patient groups.

Resource transfer

Q8a

We will transfer around £126m in 2013/14. The funding will contribute to alternative services to support people who were previously hospitalised. Local authorities would be better placed to describe in more detail the services that are supported.

Q8b

There are a very small number of specific posts supported by local authority funding, but the total value is very low.

Equalities

Q9

The Interpreting Service referred to above was recognised as being underfunded to meet the substantial communication needs of the diverse population in NHSGGC and the budget has been protected and enhanced. It will continue to be enhanced if required to ensure that no communication need goes unmet and which in turn will improve diagnosis and treatment outcomes.

NHSGGC has adopted a Fair Financial Decision making process in line with the Equality and Human Rights Commission guidance to ensure that cost savings are equality impact assessed (EQIA). Where these have led to services redesigns the EQIA process has protected equality groups from differential or adverse impact.

Sustainable development

Q10

In relation to sustainability initiatives, the Board has a Sustainability Action Plan which covers a range of local and national sustainability aspirations both in terms of reducing the Boards carbon footprint and reducing costs. The undernoted initiatives are provided as examples of the initiatives being taken forward which have influenced budget decisions.

Energy – the Board benefits from contributing to National Energy Procurement Contracts (covering Electricity and Gas) and coupled with reductions in local usage, through a range of EcoSmart initiatives, this has a significant budget impact of maximising cost avoidance.

Energy – the Board has approval in principle (and is finalising Business Cases and working with Procurement) to proceed with a Biomass initiative in 2 of our Hospitals in 2013/14 to reduce waste and carbon emissions.

Property and Asset Management – our estate is continually being assessed on an invest-to-save basis to ensure that buildings are sustainable, fit for purpose and energy efficient facilities.

Agile Working – the Board has in pace an ambitious programme, and infrastructure support, to enable staff to work in an agile manner, through IT solutions and hot desk arrangements across many of our sites.

Electric / Low Emission Vehicles – there are a number of trials being undertaken of Electric Vehicles in order to reduce environmental impacts and assess the overall costs savings that can be achieved. These trials are taking place with suppliers of a range of electric and low emission vehicles covering pool cars, vehicles for community midwives, and the Board's commercial fleet. In order to increase the availability of plug in points, the Board is working closely with the Energy Savings Trust to install public access charge-points new build Health Centres.

Carbon Tax – has however had a negative impact and provides an increasing cost pressure.