

## Greater Glasgow NHS Board

### Board Meeting

Tuesday 19 November 2002

Board Paper No. 2002/76

Director of Planning and Community Care

## UPDATING THE LOCAL HEALTH PLAN

### Recommendation:

Members are asked to:

- Consider the proposed approach to update the Local Health Plan.

### 1 BACKGROUND

The Board approved the first Local Health Plan, Attachment 1 to this paper, in May 2002. The Plan covers 5 years, however, we are required to update it annually.

The purpose of this paper is to provide an opportunity for the Board to influence the content of the draft update to the Plan, which will come to the Board for approval in December 2002 and the process thereafter.

The content of this paper is based on:

- Revised National guidance.
- Feedback from stakeholders, including Local Authorities and Trusts.

Our proposition is that the Plan should be updated to reflect progress and change rather than completely rewritten.

### 2 PROPOSED CHANGES AND UPDATING

This section provides information on National Guidance and proposals for changes to the Local Health Plan (LHP).

#### 2.1 National Guidance

The main thrust of the revised planning guidance restates the key purposes of a Local Health Plan as:

- **NHS Boards and Staff:**
  - Enables a Board to be clear about its overall **strategic** direction and financial planning;
  - Enables a Board to be specific and detailed about its implementation plans for NHS National Priorities and local priorities for the next year;
  - Allows a Board to set out how the NHS will implement its plans for its own services and services provided in partnership with other bodies;
  - Allows a Board to communicate with its staff about its overall **strategic** direction;
  - Ensures a Board has an integrated and comprehensive planning process.

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- **Local Community:**
  - Enables the local community to be clearly informed about and engaged with local health improvement and NHS service issues;
  - Allows two-way communication between a Board and the local community;
  - Allows Community Planning partnerships, including Joint Health Improvement Plans, to feed into the Local Health Plan.
  
- **Scottish Executive:**
  - Enables assessment of progress towards meeting the agreed plans for the implementation of NHS National Priorities;
  - Provides a basis for accountability to Ministers and Parliament.

In considering the current Plan and the proposals for change outlined below, it is useful to test our position against these purposes.

The guidance also requires us to produce a detailed report on our activity to deliver National priorities – it is proposed that this is an annexe to the main Plan. More detail on how this might be presented is shown in a later section.

### 2.2 Key Objectives

The current Local Health Plan sets 4 key strategic objectives:

- Improving health.
- Reducing inequalities
- Improving health services.
- Developing patient centred services.

It has been suggested that an expansion of these headline objectives would enable more clarity on how all of the activity detailed later in the Plan connects to a clear strategic direction, for example, the improving health services banner could be underpinned by a number of more specific statements:

- Integrating services – with Local Authorities and between primary and secondary care.
- Increasing capacity to meet demand and reduce waiting.
- Improving the quality of clinical care.

If the Board agree, we will adopt this approach in the December 2002 draft.

### 2.3 Acute Services

The current LHP was criticised for lacking detail on acute services. The approval of the Acute Services Strategy enables the updated Plan to focus on the programme of implementation and provide more detail on the key issues and priorities for 2003/04.

### 2.4 Local Authority Health Improvement Plans

Health improvement planning with Local Authorities is gathering momentum. It is important to try and ensure synchronisation between the Greater Glasgow-wide Health Improvement agenda and these locally rooted priorities. We should use the period between December 2002 and March 2003 to ensure that our updated Greater Glasgow Local Health Plan reflects the emerging local priorities and issues. We also need to ensure that Health Improvement Plans are addressing the critical health issues we have identified.

## 2.5 Consultation and Involvement

The full Local Health Plan is not an appropriate vehicle for generalised public consultation. However, the LHP process should generate a range of material summarising its content, and with clear linkages to the large number of different planning processes, enabling a wide range of interests to access information and connect to planning groups. Our objective is that a wide range of public involvement activity, both on a continual basis, and on particular issues or services, is an integral part of what we do. It is proposed that the updated Plan highlights major areas of activity – for example, around the Acute Services Strategy and that we set ourselves further 2 objectives for engagement on the updated Local Health Plan:

- To enable our main partners to exert greater influence over the shape and content of the Plan.
- To make the Plan and processes around it more engaging of NHS staff.

The first objective can be met by producing a draft update of the Plan in December 2002 and ensuring it is widely trawled through all of our planning mechanisms, including those evolving from community planning structures.

If we accept the second objective as a priority we should consider how this can be achieved and reflect specific proposals in the December 2002 Board report.

## 2.6 Performance Indicators

The updated Plan should include a report on progress against the Performance Assessment Framework and should show progress in the development of local key indicators, demonstrating the extent to which the Local Health Plan priorities and commitments set out in 2002/03 are being delivered.

## 2.7 Trust Contributions

The current plan has short sections for each of our partner Local Authorities and there is a view this increases the sense of their connection as key partners to the Local Health Plan.

It is proposed that the Plan includes a short statement setting out how each NHS Trust will contribute to the key objectives of the Plan. This will enable a more explicit connection between planning and delivery and should increase ownership of the Plan across the NHS in Greater Glasgow.

## 2.8 Progress Update

Each section should have a short update on progress in 2002/03, key outcome indicators, investment plans and new issues and priorities.

## 2.9 Staff Governance

The current Plan has a relatively short section on staff governance, but the establishment of the Staff Governance Committee of the Board to monitor, in conjunction with the Area and Local Partnership fora, gives us an opportunity to set out, in more detail, progress on the National Staff Governance standard.

We will also be able to present the action taken as a result of the annual staff survey which is designed to measure our progress against the 5 key Staff Governance Standards, achieving a workforce which is:

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- Well informed.
- Appropriately trained.
- Involved in decisions which affect them.
- Treated fairly and consistently.
- Provided with an improved and safe working environment.

### 3 NATIONAL PRIORITIES

As outlined in Section 2, we are required to include specific and detailed implementation plans for the National priorities listed below, covering:

- our local position in relation to the target:
- current services,
- new/improved services and investment,
- outcomes from current services
- anticipated/planned outcomes from proposed new improved services.

This proposition is that this material will form the basis of an agreement between the SEHD and the NHS Board, an aggregation of which will form a NHS National Priorities Implementation Agreement. The identified National Priorities are:

- Health Improvement: Achieving Step change in Scotland's Health Strategy
- Delayed Discharge
- 48 Hour Access to Primary Care
- Cancer
- CHD/Stroke
- Mental Health
- Healthcare Acquired Infection
- Waiting Times
- Public Involvement
- Workforce Development and Staff Governance
- Financial Breakeven
- Service Redesign:

A first attempt to set our position in relation to these priorities in the prescribed form will be included in the draft LHP. It will be important to reflect the balance between these National and our local priorities in the final Plan and ensure our resource allocation is in line with the implementation plans we set out.

## 4 UPDATING THE FINANCIAL STRATEGY

4.1 The financial assumptions underpinning the current 5 year strategy are under detailed review. This section highlights a number of key issues on which there will need to be final decisions to update the financial section of the Local Health Plan and ensure our service and health improvement priorities are aligned with financial allocations.

### 4.2 Sources

In April 2001, the Scottish Executive gave details of expected uplifts to Boards. Our uplift was expected to be £74.4 million for 2003/04. In April 2002 the Chancellor confirmed significant new money for health, but we do not yet know if that will be reflected in an increased general uplift for next year. In addition to our general uplift, we received earmarked, recurring uplifts in 2002/03 for cancer, waiting times and delayed discharges, as well as a non-recurring allocation for winter. We have also been notified of a further delayed discharge allocation. In 2003/04 we will receive an additional £2 million to deliver new health services for homeless people.

4.3 Two significant issues about our Arbutnott position: the SEHD have advised us that our share of the National total will reduce from 19.61% to 19.02% to reflect latest population and deprivation estimates. The financial effect in 2005/06 would be a £17 million reduction in funding sources. That is a worst case assumption and we continue discussion with SEHD about the calculation and the timing of its effect. A potential fall in our share of the over 85 population may result in a further allocation reduction.

4.4 With a more immediate effect, from 2003/04 we had assumed, on the basis of SEHD advice, that general medical services funding would begin to be subject to the formula – if this is not the case an alternative funding source for our primary care strategy of £1.5 million in 2003/04 and £4 million in 2004/05, is required.

### 4.5 Applications

The current financial framework assumes that new resources which remain after funding pay, non pay and prescribing inflation are distributed between 4 programmes of expenditure:

– Acute services	49.10%
– Mental health	13.41%
– Primary care and other community services	24.12%
– Child and maternal health.	13.37%

4.6 In 2002/03, recognising the pressure on acute services, and our key objective to achieve financial balance, an additional, recurring allocation of £6.5 million was made to the North and South Trusts as well as extra non recurring support. The flow through of these decisions to 2003/04 require an additional £1.5 million funding, above the acute programme share. If the non-recurring support made to acute Trusts in 2002/03 is also made recurring that requires a further £3.7 million.

4.7 We have a programme of Health Improvement activities underpinned by a specific stream of funding. This funding is non-recurring and ends at the start of 2004/05. We will need a process to consider these spending areas and decide what should be recurrently financed and how. In addition, the tapering down of SIP and New Opportunities Funding will create pressures on us to find additional resources for those activities, although there may be specific allocations to new community planning partnerships to resource a number of these programmes.

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4.8 The level of provision for inflation is a critical factor in the financial framework. The current financial strategy assumes:

Pay	4%
Non Pay	2%
Prescribing	8%

4.9 There are upward pressures on pay settlements, including the new consultant contract. For non pay the hospital prices index has been consistently low but there is a continuing debate about its durability in relation to real hospital costs, particularly drugs. For primary care prescribing, inflation in 2002/03 is running at 12%, in line with increased pressures across Scotland. Work is underway with the PCNHST to consider what measures are appropriate to manage costs. In addition to these inflation issues, changes to National Insurance and Superannuation contributions by employers will increase costs for which we need to make provision.

Various scenarios around inflation are currently being modelled.

4.10 In 2002/03, Acute Trust Chief Executives proposed further consideration of financial factors in addition to inflation to be top sliced from available resources in advance of programme allocations this reduces resources available for programme pressures and investments and such an approach would need to be judged in the context of an overview of spending priorities.

4.11 The current programme shares for mental health and primary care and other community services are fully committed. At the end point of the Mental Health Strategy there is a shortfall of around £3 million to fund full implementation and there are a number of unfunded priorities in community services. The Child and Maternal Health programme has a detailed set of investment plans and priorities for acute and community services and for health improvement.

4.12 Other significant financial issues include new priorities and proposals emerging for health improvement planning with Local Authorities, joint planning for community care services and from service planning activity, including the cancer and oral health strategy groups. There are also a number of potentially high cost pressures including implementing the risk sharing policy for Beta Interferon and new drug developments. In addition, major pressures on addiction services, particularly the methadone programme, have significant financial costs. A further critical factor which needs to be reflected in the draft LHP is the potential costs of the national priorities outlined in section 3. In particular delivering shorter waiting lists may require resources beyond our current plans.

4.13 This short section has set out the financial context, in broad terms. There are a number of key financial decisions to be made in updating the financial strategy which underpins the Health Plan:

- the level of pay, non pay and prescribing inflation which is funded.
- The inclusion of any further 'inflation' provision.
- The level of funding allocated to acute services and, therefore, what is available for other programmes.
- The balance of pressures and new developments funding.
- How to make provision for changes to the health improvement fund.

Work is in progress with Trust Chief Executives, planning leads and partners to enable these issues to be reflected in the draft LHP.

## **5 CONCLUSION**

5.1 This paper makes a number of proposals which should enable an updated LHP to:

- Give a clear track of progress.
- Meet National requirements.
- Align financial decisions with LHP priorities.

The draft update will be presented to the Board in December 2002 – reflecting the outcome of discussion on this paper and the opportunity for development through Board Seminars. Thereafter a final LHP will be presented to the March 2003 Board.



# **LOCAL HEALTH PLAN**

**2002/2007**



## 1 INTRODUCTION

1.1 This Local Health Plan is the main strategic document for NHS Greater Glasgow. It replaces the Health Improvement Programme but has a similar focus on our key objectives of improving health, reducing inequalities and improving health services. This Plan has a number of purposes:

- It enables the Greater Glasgow NHS Board to set a clear direction and priorities to deliver our 3 key objectives.
- It provides clear accountability from the Board to the Scottish Executive for the performance of the NHS in Greater Glasgow.
- It provides the public with clear information on what we are trying to achieve and our performance. A more accessible summarised version will be widely distributed.
- It draws together a wide range of planning and implementation activity within a single document.

The Plan sets a strategic direction for the next 5 years but focuses in detail on 2002/03. This is the first Local Health Plan and our aim is to develop the planning process and content during the coming year.

The content of the Plan is a product of a whole range of different planning processes which include Local Authorities, NHS staff and other stakeholders. Much of that detailed planning, briefly outlined here, has also included significant public engagement. We intend this document to provide an overview and signposting to those detailed plans. We are developing links into a comprehensive, electronic database and a summary, directed at more general readers, will be produced for wide distribution.

1.2 **The Plan is set out in 7 sections:**

- 2 Population Health Status**
- 3 Strategic Health Issues**
- 4 Working with Local Authorities**
- 5 Plans and Priorities**
- 6 Integrating Service and Financial Planning**
- 7 Change and Development Plan**
- 8 Implementation and Accountability**

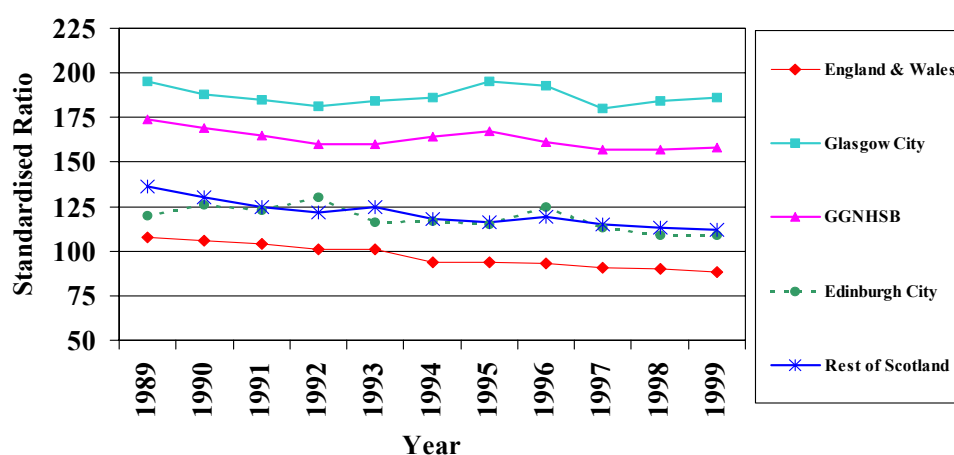
## 2 POPULATION HEALTH STATUS

2.1 This section briefly describes the health of our population, which is so important in deciding on strategies, detailed plans and priorities for action. The rest of this Plan sets out a series of actions to address the health issues this section describes.

- **Mortality compared to elsewhere.**
- **The shape and change of the population.**
- **NHS Greater Glasgow performance against key health indicators.**
- **Measures of health and well-being.**

- 2.2 The health of Glaswegians is improving. Fewer people in the West of Scotland die before the age of 65 from heart disease than was the case 20 years ago. However, health in our area is not improving as rapidly as elsewhere in Scotland and in the UK more generally. In most English cities there has been a steady fall in risk of premature death over the last decade while the risk of death from all causes in Greater Glasgow has remained fairly static. Glaswegian males are now twice as likely to die before the age of 65 as males in England and Wales and they are significantly more likely to die prematurely than males living in most English cities.

Standardised Mortality Ratios 1989-1999. All causes, persons aged 15-64. Glasgow City compared to England & Wales and English Health Authorities. (E&W in 1993 = 100)



- 2.3 The principal underlying problems remain the social and economic conditions of the West of Scotland. High levels of death from respiratory disease and lung cancer point to the importance of smoking in determining health. The variation in a number of other indicators of ill-health by socio-economic status reinforces the importance of collaborative working between health, housing, education and employment agencies to improve the fabric of society in the West of Scotland. The necessary partnership structures are now in place. Our collective challenge is to ensure that they make a real difference to the health of the people of Greater Glasgow.

The following table shows how our population is changing.

**Projected change in the GGNHSB population 1998-2016**

Age Group	BASE YEAR		% change			
	1998	2001	2006	2011	2016	
0-14	168,324	-3.2	-8.7	-12.7	-13.4	
15-24	122,944	0.9	1.8	-0.3	-6.9	
25-34	155,989	-7.5	-18.2	-19.5	-18.7	
35-44	134,765	6.8	9.7	-1.8	-14.0	
45-54	103,320	4.8	15.6	31.2	35.0	
55-64	88,519	-2.4	2.3	9.4	22.0	
65-74	77,575	-3.8	-8.6	-11.9	-6.1	
75-84	45,831	-1.3	-1.8	-2.6	-3.7	
85+	13,933	-2.1	-4.3	1.4	8.0	
<b>TOTAL</b>	<b>911,200</b>	<b>-0.9</b>	<b>-1.9</b>	<b>-2.7</b>	<b>-3.2</b>	

This information is taken from the previous census. We expect data from the new census to be available later this year. The table highlights a number of issues:

- The population of Glasgow City is expected to reduce over the next few years. The greatest reduction will be amongst children and young people while the proportion of the population in the 45-64 age group will increase. People in this age range are significant users of health services. They are also a group for which health promotion opportunities are important. If those in middle age can be persuaded to stop smoking, take exercise and reduce weight, they will be far fitter as they near retirement age. This is also the age group for which preventive medicine is important. Tackling hypertension, high cholesterol and ensuring appropriate screening opportunities are taken up will also prevent further ill health in later life.
- A critical issue for further analysis is how these population changes will impact on our share of the Scottish Health funding ‘cake’, for which population is a significant driver.
- Although a significant reduction in the number of school age children is expected over the next 15 years, we remain convinced that the key to Greater Glasgow’s future health improvements lies in changing the health experience of children.
- The growth in the numbers of very elderly people, who are high users of health and social services, gives particular priority to strategic planning for older people.

Set out below are a number of key health indicators which the plans described in later sections are intended to begin to improve. **Where references are to SMR figures the Scottish benchmark is 100 – above that is worse health and below that is better health.**

#### 2.4 **Coronary Heart Disease**

Coronary heart disease is falling in incidence in the Greater Glasgow NHS Board area. The WHO Monica Project has confirmed that NHS Greater Glasgow risk factor prevalence has fallen greatly over the past decade. We have started from a high base, however, and the improvements set for us are still challenging. Enormous improvements in risk factor prevalence are necessary if we are to achieve the target in deprived areas. The table below shows the Greater Glasgow position. **Planned action 5.10.**

<b>AREA</b>	<b>SMR RATES</b>
Scotland	100
Glasgow	148
Glasgow Men	206
Glasgow Women	96
Glasgow SIPs	170
Glasgow Non SIPs	140

#### 2.5 **Cancer**

Cancer mortality is relatively static in the area. We could achieve our target if smoking and diet changed in the population. The smoking prevalence among women will lead to a serious and substantial increase in lung cancer rates in Greater Glasgow women over the next 2 decades. Those women in their 30s and 40s currently smoking will have significant risks of death from lung cancer when they reach their later years. For Greater Glasgow, Registrar General 1995-1997 data indicate for our

residents aged 0-74 years, standardised mortality rates per 100,000 population of 211 (236 for males and 189 for females). This represents a Standardised Mortality Ratio of 115 (118 for males and 113 for females. Scotland = 100). For the population living in Social Inclusion Partnership areas, the standardised rate is 214 per 100,000; and the ratio, 116. This compares with a rate of 210 per 100,000, and a ratio of 114 in non Social Inclusion Partnership areas. **Planned action 5.3.**

## 2.6 **Smoking**

Smoking is a major addiction problem. 36% of men and 37% of women in our population smoke while the Scottish averages are 34% and 32% respectively. In addition to causing a variety of cancers, smoking in pregnancy has specific effects on the developing foetus, causing low birth weight and increasing the risk of ill health in later life. Maternal smoking also increases the risk of lung disease in children living in the house and is clearly an area we wish to target. For Greater Glasgow, best estimate is health visitor data which indicates that, during 1999 NHS in Greater Glasgow, 26.9% of mothers reported being smokers at the time of their first health visitor visit (10 days). In the Social Inclusion Partnership areas, the rate was 47.5%; in non Social Inclusion Partnership areas it was 19%. **Planned action 3.14.**

## 2.7 **Alcohol and Drug Misuse**

Greater Glasgow's problem with alcohol-related ill health is well known. The direct, toxic effects of alcohol consumption are, perhaps, better known than the considerable burden of mental ill health caused by excess consumption. Domestic violence and depression are major problems in the area and many such cases are exacerbated by alcohol. We have one of the highest death rates from trauma in Scotland and, again, inappropriate alcohol consumption lies at the root of many deaths. Alcohol related death and emergency admission numbers and rates provide a useful indicator for alcohol-related problems are about 10 times greater for people from the most deprived areas compared with the most affluent.

For Greater Glasgow, latest data for NHS Greater Glasgow's area (1999) indicated that 20.3% of the population are exceeding recommended weekly limits of alcohol consumption, this represents 28.1% of males and 12.8% of females. Greater Glasgow's problem with drug misusers is also well known. Like alcohol, drug deaths and emergency hospital admissions are good indicators of an area's problem and in Glasgow they are high, especially in the most deprived areas. The age profile is changing with clients presenting for help younger. The latest prevalence study indicates that Greater Glasgow is the Health Board area with the highest prevalence of problem drug use estimated at 3.1% of the 15-54 age range. We also have the highest prevalence of injecting at 1.4% of the 15 – 54 age range. 95% of problem drug users live in the most deprived areas. Drug use is particularly common among socially excluded groups, for example prisoners, homeless people and prostitutes, young people in care and young offenders.

There is a recognised problem of under-reporting in relation to alcohol consumption. Further work will be carried out, linked to the NHS Board's developing alcohol strategy, to test these reported levels in relation to other NHS data. **Planned action 3.14.**

## 2.8 **Teenage Pregnancy**

Baseline rate for teenage pregnancy in NHS Greater Glasgow's area (13-15 year olds) as at 31 March 1998, is 10.3 per 1,000. This compares with the Scottish figure of 8.7 per 1,000. **Planned action 5.5.**

## 2.9 **Dental Health**

In 1999, 66% of 5 year old children had already experienced dental disease in their first teeth. In 2000, 64% of 12 year olds had experience of decay in their adult teeth. For children in this older age group, the prevalence of dental disease ranged from 39% in the most affluent communities to 79% in the least affluent communities. At 31 May 2001, 33% of children (0-17 years) and 50% of adults (18 years and over) were not registered with a NHS dentist.

Dental caries is the commonest reason for children requiring a general anaesthetic in Greater Glasgow. Although general anaesthesia is a safe procedure, recent tragedies underline the non-trivial nature of such treatment. We await National advice on fluoridation of water supplies. In the interim, we have demonstrated that it is possible to improve children's dental health through targeted health promotion activity in the community. This is clearly an area where improvements can be made. **Planned action 5.9.**

## 2.10 **Measures of Health and Well-Being**

National indicators and targets have not yet been agreed for measures of health and well-being. Such measures are, however, useful 'summary' measures of health and quality of life in our population and communities. Therefore, our local survey of 2,000 residents in 1999, included a range of health and well-being measures. Some headline results are outlined below, and relate to the total sample aged 16 and over.

- 22% of the population report having a condition or illness that interferes with their daily living. Among residents of Social Inclusion Partnership areas, the proportion is 30%.
- 41% of the population are currently receiving treatment for at least one condition/illness.
- On the Hospital Anxiety and Depression Scale (HADS), 7% of respondents' answers indicated 'caseness' in relation to depression. This measure of depression is strongly associated with all of our indicators of deprivation. Levels ranged from 1.5% within Social Class A to 17.4% in Social Class E; 2.1% in Deprivation Category 1 to 9.6% in Deprivation Category 7; and 5.3% in non-Social Inclusion Partnership areas to 10.4% in SIP areas.
- Overall, 84% (70% in Social Inclusion Partnership areas; 88% in non-Social Inclusion Partnership areas) have a positive perception of their quality of life. 79% (70% in Social Inclusion Partnerships; 82% in non-Social Inclusion Partnerships) have a positive perception of their general physical well-being; and 85% (79% in Social Inclusion Partnerships; 87% in non-Social Inclusion Partnerships) have a positive perception of their general mental/emotional well-being.

- 2.11 Once again these data highlight the striking associations between deprivation and ill-health within the Greater Glasgow population. They reinforce the fact that if we are to improve health within the NHS Greater Glasgow area and contribute to the meeting of the National Health Targets, we need to improve health within our most deprived communities. In line with the framework set out in *Towards a Healthier Scotland*, this will require action to improve people's life circumstances, as well as to support lifestyle change and to impact on health outcomes. **Planned action 3.4 – 3.10.**

The rest of this Plan describes how we will tackle these health issues. We have also highlighted a number of key indicators from the Performance Assessment Framework – set by the Scottish Executive – alongside our plans to improve our performance.

### 3 STRATEGIC HEALTH ISSUES

3.1 This section provides information on a number of key strategic themes and priorities for the NHS in Greater Glasgow, including:

- **Modernising the facilities and organisation of acute and mental health services.**
- **Promoting health and tackling inequalities.**
- **Improving the health of children.**
- **Developing and reshaping primary care.**
- **Integrating community services with Local Authorities.**
- **Implementing comprehensive strategies to tackle addictions.**
- **Developing collective planning arrangements with other West of Scotland Boards.**

These strategic themes are also reflected in our work with Local Authorities (Section 4), plans and priorities (Section 5) and financial planning (Section 6).

#### 3.2 **Modernising the Facilities and Organisation of Acute and Mental Health Services**

The NHS Board has concluded a major consultation exercise on the future strategy for acute services with the aim of delivering:

- Locally accessible services.
- The benefits of advanced technologies and specialist skills.
- More rapid access to treatment.
- 21<sup>st</sup> century facilities.
- High quality teaching and research.

In January 2002, we approved a number of important strategic proposals to deliver these objectives:

- 3 in-patient sites for Greater Glasgow.
- Major ambulatory care hospitals in South-East and North-East Glasgow.
- The siting of the in-patient hospital for South Glasgow.
- The disposition of clinical specialties across sites.

A final decision will be taken in the early part of this summer on the configuration of accident and emergency and orthopaedic services.



Implementation arrangements will include further work on bed numbers, and a joint planning team to ensure in-patient services are sustained at Stobhill, during the period prior to transfer. In addition, we are working with 4 communities, for which hospital services are less accessible, to identify how local services might be extended and transport issues addressed.

The strategic framework will enable the production of a detailed clinical strategy and implementation plan – during the early part of 2002/03. The delivery of our strategy is critical to achieving these objectives outlined above.

The Acute Services Review will take several years to implement. During that period we will also have to deal with a number of major pressures on, and challenges to, acute services in Greater Glasgow. These include:

- Significant financial issues relating to National policy changes, for example junior doctors hours, standards of decontamination, developing clinical governance and reducing waiting times.
- Human resources issues, including shortages of medical, nursing and paramedical staff, the implications of European legislation on working hours and improving the conditions of ancillary staff.
- The drive to improve standards of care, including the requirements of the Clinical Standards Board.

Our programme approach enables a degree of investment in addressing the financial aspects of these issues, but there remain major pressures on services which we are working with Acute Trusts to try to address. The critical challenge is to find a balance between new National and local aspirations and developments and ensuring the core of acute care is in financial and clinical equilibrium. For the next year our approach to these pressures already includes reshaping services, for example concentrating orthopaedic and gynaecology in-patient care and rationalising laboratory services. Further changes are likely to be proposed during the next 12 months.

**3.3 For mental health services**   – a detailed strategy for modernising mental health services and facilities was approved by the NHS Board in May 2000. The strategy will deliver:

- Modern mental health facilities on 3 general hospital sites.
- Enhanced community services.
- Improved staffing levels for in-patient services.
- The development of specialist mental health services.
- New social care services replacing NHS continuing care.
- Better local access to modern NHS continuing care facilities.
- Improved mental health promotion.

Implementation of detailed service changes is underway and final capital proposals should be approved during 2002. Our financial strategy reflects significant new investment in mental health. Linked to the Mental Health Service Strategy is our Strategy for Mentally Disordered Offenders, approved in 1997. The final element of the service developments the strategy described is the Secure Unit. A site has now been approved and implementation is underway. The opening of the Unit will see a comprehensive range of local forensic services in place.

**3.4 Promoting Health and Tackling Inequalities** 

Greater Glasgow NHS Board has a clear strategic framework to promote health and reduce inequalities, including:

- A model of health which has physical, mental and social dimensions. Our aim is not only to reduce levels of ill-health and premature death within the population, but also to enhance quality of life.
- Working principles which guide our activities: partnership with agencies in the public, private and voluntary sectors to tackle the fundamental determinants of health; empowerment of local people by providing opportunities for them to have greater control over the decisions which affect their health; and

accountability through increased levels of communication with the Greater Glasgow population.

- Emphasising that social and economic factors are the overriding determinants of health in modern society.
- Highlighting the importance of *relative circumstance*, and the fact that in order to improve the population's health we need to concentrate more on narrowing the gaps that exist between different subgroups and communities.
- A commitment that action to reduce health inequalities would guide all components of health planning. This commitment is also reflected in our financial framework and investment priorities.

3.5 In translating this direction into programmes of action to reduce inequalities in health, we have established a four-level approach comprising initiatives designed to:

- strengthen individuals
- strengthen communities
- improve access to services and facilities
- encourage macro-economic and cultural change.

3.6 Each of these levels of action is applied to the three broad foci for action set out in *Towards a Healthier Scotland*. These three foci are life circumstances, lifestyles, and direct work on priority health topics. Year-on-year the NHS in Greater Glasgow is working more and more closely with other agencies and local people to ensure a shift in focus increasingly towards improving the basic life circumstances in which people live. This is a fundamental plank of all of our health improvement activity, but is particularly strong in our work with the Social Inclusion Partnerships.

3.7 In addition, we recognise the need to develop a different approach to health care which recognises the medical consequences of inequalities in society and discrimination relating to poverty, gender, race, sexuality and disability. A social model of health care – where assessment of the presenting health problem and its management reflects its social origins – is being implemented at the Sandyford Initiative, in our response to survivors of gender based violence and in our maternity services. It is our intention to extend this work to mental health services, building on existing good practice.

3.8 The major strategic developments which have had a significant influence on our priorities and action programmes, include the Glasgow Alliance Strategy, the establishment of Social Inclusion Partnerships, the introduction of New Community Schools, the national vision for achieving social justice in Scotland and the various strategies to support lifelong learning.

3.9 The Scottish Health Plan includes a large number of initiatives which are reflected in this Plan, which seek to achieve:

- services and communities planning and working together;
- individuals taking a shared responsibility for their own health;
- working in partnership, across organisations and traditional boundaries;
- tackling inequalities and effecting social justice;
- making the NHS a national health service, not a national illness service.



3.10 The Health Improvement Fund was created in Scotland from the monies released through the hypothecated tobacco tax. Priorities identified for the allocations given to NHS Boards were:

- implementation of the public health review of nursing (including a public health practitioner for every Local Health Care Co-operative);
- development of child Health Services and services for adolescents;
- children’s health, including a focus on vulnerable families and a particular emphasis on children’s diets;
- strengthening of work to improve sexual health and lifestyles.

Our detailed 3 year investments reflect these priorities.

3.11 Detailed plans to promote health and reduce inequalities cover our contribution to:



- Tackling economic issues, maximising family income and reducing the costs of achieving better health – for example through allocating funding to Social Inclusion Partnerships and Community Health Projects.
- Improving employment opportunities.
- Developing the skills base within Greater Glasgow.
- Reducing barriers to accessing health services and to develop a social model of health care.
- Making healthy living easier.
- Improving the physical and social environment.
- Improving emotional well-being.

Extending and developing action on these themes will be a key feature of our Health Improvement Plans with each Local Authority. **Tackles issues 2.10.**

### 3.12 **Improving the Health of Children**

Section 2 of this Plan outlined the importance of focussing our efforts, particularly in partnership with Local Authorities, on improving the health of Greater Glasgow’s children. This section briefly summaries the key elements of that work.

We have 2 linked sets of planning arrangements:

- A Child and Maternal Health Strategy Group – including the full range of NHS interests with Health Improvement and Health Service perspectives. 
- Children services planning arrangements with each Local Authority. 

The Child Health Team we established in April 2000, brings together public health, planning and health promotion to generate a comprehensive approach to children’s health across these planning processes. There is an identified programme budget for child and maternal health which includes a balanced programme of investment between the acute services, provided by Yorkhill, community and mental health service development and tackling the health improvement agenda. Section 5.20 gives more details.


An important focus of work with Local Authorities is:

- Integrating planning and service delivery
- Agreeing investment plans for the ‘Children’s Change Fund’.
- Developing action plans to deliver the recommendations of ‘For Scotland’s Children’.

**Key performance Indicators:**

	<u>Glasgow</u>	<u>Scotland</u>
Percentage low birth weight babies	6.4	5.7
Percentage women breastfeeding	33.6	35.2

**3.13 Developing and Reshaping Primary Care**

The development of primary care is a key strategic objective as a way of tackling inequalities and improving health as well as modernising services. The Primary Care Strategy  – developed in a highly inclusive way, with a wide range of stakeholder involvement, sets a clear direction for primary care, with 3 strands for development:

- Improving existing services and expanding capacity, including creating better links between primary and secondary care.
- Developing new services for minority groups, including people with mental health problems, homeless people and vulnerable older people.
- Developing Local Health Care Co-ops for co-ordination and delivery of primary care.

The Strategy is supported by investment and implementation plans.

**Key performance Indicators:**





	<u>Glasgow</u>	<u>Scotland</u>
Number of district nurses/'000 population	0.643	0.688
Number of community pharmacists/'000 population	0.221	0.267
Percentage of generic prescriptions	68.2	70.4


**3.14 Integrating Community Services with Local Authorities**



The health service in Greater Glasgow has been pursuing an agenda to deliver community services better co-ordinated and integrated with Local Authorities for a number of years. The National 'Joint Futures' requirements provided additional impetus. We have processes in place with each Local Authority to deliver local partnership agreements covering joint resourcing and management, shared governance and accountability and developing information systems.

**3.15 Implementing Comprehensive Strategies to Tackle Addictions**

Greater Glasgow has a massive problem of smoking, drug and alcohol misuse, with the highest prevalence of drug misuse in Scotland. There are estimated to be around 16,000 people who have a serious drug misuse problem and 33,000 people who drink more than safe limits. The human, social and physical impact of addiction, including on demand for acute hospital services, is immense. Our strategic approach has 6 important strands:

- Implementing, over the next 3 years, our alcohol strategy which tackles prevention as well as treatment and care.  
- Developing alcohol action plans with each Local Authority – in line with the new National Strategy.
- Implementing the Drug Action Team Strategy which is fully comprehensive and includes prevention and treatment, in the broadest sense – including employment, training and rehabilitation.  
- Implementing the outcome of the review of the Methadone Programme which develops services in an integrated and comprehensive way, including the

delivery of local addiction teams, bringing together NHS and Local Authority staff. 

- Reviewing the services we finance in partnership with Local Authorities.
- Developing a tobacco strategy with Glasgow City Council as a first step to a similar approach with each Local Authority.  

These elements of our overall approach to addictions include significant new investment but the scale of the problem in our population means there remains a significant gap between the resources available and those required to provide the comprehensive services which people with addiction problems need. **Tackles issues 2.6 – 2.7.**

### 3.16 **Developing Collective Planning Arrangements With Other West of Scotland Boards**

NHS Greater Glasgow provides a number of services to other West of Scotland Boards and a number of planning arrangements are already in place to ensure strategic planning decisions are made in a collective way. These arrangements include West of Scotland groups dealing with the planning and financing of:

- Neurosciences services.
- Paediatric services provided by Yorkhill.
- Mobility services provided by WESTMARC.
- Adolescent psychiatric services.
- Renal services.
- Cancer services.
- Cardiac services.

The West of Scotland Chief Executives have also sponsored collective work on plastic surgery, severe allergy services and child protection.

There remains a real challenge for NHS Boards, in different financial positions and with different, competing Board priorities, in following through collective processes with financial commitment. The current Scottish Executive Health Department Review of Regional Planning will provide an opportunity to revisit, strengthen and extend the current arrangements.

## **4 WORKING WITH LOCAL AUTHORITIES**

4.1 Local Authorities are our most important planning partners. They have the potential to make a major contribution to improving the health of their populations, they provide services and care with the NHS to large numbers of vulnerable people and their responsibilities for community planning enable the drawing together of multiple interests to improve people's lives.

4.2 We work with 6 Local Authorities:

**Glasgow City, with a population of 609,370**

**East Dunbartonshire, with a population of 110,760**

**West Dunbartonshire, the Clydebank population of 46,350**

**South Lanarkshire, the Rutherglen and Cambuslang population of 56,560**

**East Renfrewshire, the Eastwood population of 64,900**

**North Lanarkshire, the Stepps and Moodiesburn corridor population of 16,460**

This section provides a short summary of our key areas of activity with Local Authorities, including health improvement and service issues. Our Health Promotion staff work closely with Local Authorities and their Social Inclusion Partnerships and health is a prominent feature in community planning processes. The appointment of public health practitioners and capacity builders in Local Health Care Co-operatives and Local Authorities, will enable us to develop fully comprehensive health improvement plans with Local Authorities. Outlined for each Authority is this work in progress.

We have arrangements with each Authority to deliver:

- The Joint Futures agenda, integrating planning and service delivery.
- Children’s services plans including the use of Children’s Change Fund resources.
- Joint Community Care Plans, for key client groups, including older people and people with mental health problems.
- Homelessness Action Plans for health and a health contribution to homelessness strategy development.



The following sections focus on progress on:

- Developing Health Improvement and Health Promotion agendas.
- Community planning.
- Addictions planning and service development.
- Primary care change and development.

The first Health Improvement Plans with each Authority will be finalised during March 2002.

#### 4.3 **Glasgow City Council**

##### **Community Plan and Health Improvement**

Glasgow City Council has managed the community planning through the Glasgow Alliance, developing their process further is currently under discussion. More detail on the Glasgow Alliance strategy is set out below. There are two complementary city-wide partnerships to promote health improvement in Glasgow – the Glasgow Alliance and the Glasgow Healthy City Partnership. **The Glasgow Alliance**, established in 1998, comprises all the major public sector agencies involved in the regeneration of the city. The Alliance has agreed a 10-year strategy  , which has the following 5 key themes: a vibrant Glasgow, a learning Glasgow, a working Glasgow, a safe Glasgow and **a healthy Glasgow**.

The strategic aim for a healthy Glasgow is that **by 2010, Glasgow will be a city where all citizens have the knowledge, services and support to live a safe, active and healthy life**. The achievement of this objective implies:

- A population which is educated about the causes of good and ill health
- A population which has easy access to information about health and about the range of services and facilities in the city which help to promote good health or provide health care
- A range of good quality health, education, leisure, housing, transport and social services, accessible to all
- A safe, hygienic and clean environment across the city
- Communities with a strong sense of neighbourliness and well-established community infrastructures



- Opportunities for local people to contribute to and shape decisions which affect their health and that of their families
- Effective action to tackle poverty
- All Alliance partners therefore recognise that achieving a healthy Glasgow is dependent upon the successful delivery of the other 4 themes.
- For each theme the Alliance has agreed key strategic objectives, which form a 5-year plan.

The strategic objectives for a Healthy Glasgow are:

- **To reduce the proportion of families with young children who find it a problem to meet an unexpected cost of £20 by 20% by 2004**
- **To reduce the difference in the level of clinical depression between Social Inclusion Partnership and non-Social Inclusion Partnership areas in Glasgow by 25% by 2004**
- **By 2004 reduce premature death (from heart disease, lung and breast cancer) by 20% over and above current trends.**

These objectives have been based, not only on national health priorities and information on the causes of ill health and death in Glasgow, but also on the findings of a survey of the health and well-being of the population carried out in 1999. This survey identified poverty as a key determinant of ill health and the major differentials in health (especially mental health and well being) between people living in Social Inclusion Partnership and non-Social Inclusion Partnership areas.

Each year an action plan is developed that identifies actions that the Alliance will undertake to progress the strategic objectives for each of the 5 themes. It should be noted that these actions have been chosen because they represent areas where co-ordinated action by Alliance partners will make a difference. They are additional to activity carried out by partner organisations as part of their individual remits. The Glasgow Alliance planning process and strategy deliver community planning for Glasgow City Council.

**The Glasgow Healthy City Partnership**   is a partnership jointly funded by Glasgow City Council and Greater Glasgow NHS Board, with a specific remit to develop health in Glasgow. Since its members are also partners in the Alliance, its plans and those of the Alliance are congruent and there is a strong focus on tackling health inequalities.

The Glasgow Health Development Plan, launched in November 2001, sets out a detailed plan of short, mid and long-term activity that will contribute to the development of a healthy Glasgow.



City-wide action for health by the main public sector agencies is complemented by work with and in communities to develop health at a local level. Improving health and well being is a key objective for all Social Inclusion Partnerships in Glasgow (both Social Inclusion Partnerships that cover geographical areas and those Social Inclusion Partnerships which serve communities of interest in the city). Funding and support from health promotion staff is provided to each Social Inclusion Partnership to assist them in achieving this.

A key feature of the Healthy City Partnership's work in partnership with Greater Glasgow NHS Board is the provision of support for a network of community health projects throughout the city and for the network of healthy living centres due to be established, (subject to successful applications to New Opportunities Fund), in the coming year.



Detailed actions are agreed each year to contribute to meeting the objectives set by the Glasgow Alliance and Healthy City Partnership. Current examples include:

- Financial and operational support for the network of new Healthy Living Centres and work in partnership with Scottish Enterprise Glasgow and local further education colleges to prepare local people for the new job opportunities these centres offer.
- Roll-out of Fruitplus in all primary and nursery schools (with every child receiving fresh fruit 3 times per week in conjunction with curriculum activities and a motivation reward scheme).
- Production of a draft Physical Activity Strategy for Glasgow and work with Glasgow City Council to capitalise on the potential New Opportunities Fund funding for physical activity in schools.
- The development and implementation of a Tobacco Strategy.

### **Primary Care and Service Integration**

We have integrated planning arrangements in place with Glasgow City Council for mental health, learning disability and homelessness. A programme of work is in hand to deliver comprehensive integration under a Joint Community Care Committee.   At locality level, locality planning and implementation groups, bringing together primary care, social work and housing interests, will be in place early in 2002/03 – with the objective of delivering the key objectives for older people as per Joint Futures and providing a vehicle for further integration and devolution of decision-making. A core element of these arrangements will be community development and public involvement.

### **Addictions**

The misuse of drugs and alcohol are major problems in Glasgow City. A programme of changes, including developing an integrated drugs service, are being jointly implemented.  

## **4.4 East Dunbartonshire Council**

East Dunbartonshire is a relatively prosperous area made up of a series of communities, with some small pockets of disadvantage, and an increasing elderly population.

### **Community Plan**

The first community plan was launched in the summer of 2001 around the main themes of safe and health communities, education and employment, and effective partnership. The planning process has recently been restructured, including the recruitment of a Community Planning Officer, to develop and implement the key issues identified. Local fora have been established to ensure regular community engagement.

### **Health Improvement and Health Promotion**

The NHS Board is working with the Local Authority to develop a comprehensive health promotion agenda. Existing activity includes developing community involvement, creative and educational programmes and promoting physical activity. The creation of a Social Inclusion Committee will give added impetus and cohesiveness to the work programme. The community planning partners have established a small core group to develop an initial Health Improvement Plan and a process to develop the agenda with other community planning partners. However, actions from the community plan can serve as an embryonic health improvement agenda. Some specific actions include:

- Promoting the use of exercise counsellors including briefing General Practitioners and issuing promotional material.
- A structured programme, including alcohol awareness events, to address drug and alcohol misuse.
- Developing community involvement capacity.
- Developing measures to enhance access for the disabled.

### **Primary Care**

Anniesland, Bearsden and Milngavie Local Health Care Co-op and Strathkelvin Local Health Care Co-op represent primary care services in locality joint working. They are also responsible for implementing the Primary Care Strategy within the authority. Priority areas of work include:

- Secondary prevention of Ischaemic Heart disease and Stroke.
- Development of primary care mental health services.
- The care of diabetic patients.
- Support of other priority groups including frail elderly, addictions and people with a learning disability.

## 4.5 **West Dunbartonshire Council**

Clydebank is a densely populated area with concentrations of severe deprivation alongside pockets of affluence. The area has suffered because of a sharp fall in traditional industries, but is now experiencing significant regeneration.

### **Community Plan**

The Community Planning Core Group are currently reviewing the remit and direction of community planning. The process to date has proved successful and involved active partner participation.

### **Health Improvement and Health Promotion**


A number of existing initiatives include:

- The appointment of 3 Health Education Co-ordinators providing support, guidance and expertise to support teaching staff in all primary and secondary schools.
- Working with the Social Inclusion Partnership, the planning partners have developed a bid to the New Opportunities Fund for the establishment of a Healthy Living Centre.
- Children and Young Activities, both as health promoting in themselves and as a preventative measure against the misuse of drugs and alcohol.
- Using the Children's Change Fund to establish a children and families support team in line with Action in Partnership priorities.

### **Addictions**

The multi agency forum has operationalised addiction work through sub groups for alcohol and drugs which develop the workplan contained within the Drug Action Team Corporate Action Plan. The planning structure is currently under review. However, current priorities for the locality include the implementation of the Greater Glasgow NHS Board methadone review and the introduction of community addiction teams.

### **Primary Care**

The Clydebank Local Health Care Co-op are active and full partners in developing locality working within the area  , in particular joint developments in services for older people and primary care mental health services. Other priorities for the Local Health Care Co-op include:

- Secondary prevention of Ischaemic heart disease.
- Community anticoagulation clinic.
- Young people and health services project.
- Smoking cessation.

#### 4.6 **South Lanarkshire Council**

Cambuslang/Rutherglen has a population of 58,000, representing 6% of Greater Glasgow and 18% of South Lanarkshire. By comparison with the rest of South Lanarkshire, Cambuslang/Rutherglen has experienced population decline in the past decade, lost significant numbers of jobs and has higher levels of poverty, unemployment and ill health.

##### **Community Plan**



A progress plan encompassing new and existing activity on the Community Plan was produced in March 2002 for the Annual Community Planning conference.

##### **Joint Health Improvement and Health Promotion**

An initial Joint Health Improvement plan was prepared in March 2002 based on the strong building block provided by the Community Plan. A Health and Care Partnership Group consisting of the key planning partners with an influence on health will take forward work to strengthen health improvement and to lead the production of a longer term and more comprehensive action plan with more robust outcome measures for 2003. Current activity includes:

- Working with Camglen Local Health Care Co-op to ensure that their contribution into the SIP agenda is maximised.
- Tackling poverty-related issues by developing a welfare benefits advice service in primary care settings.
- Developing health promotion initiatives targeting the elderly population, linking into existing local structures and initiatives where appropriate.
- Continuing to provide health promotion support to the recently established Child & Family Centre.
- Bid for Cambuslang and Rutherglen Healthy Living Initiative (outcome should be known by summer of 2002).
- Supporting the introduction of the New Leaf Regeneration Strategy for the area.

##### **Addictions**

The Rutherglen/Cambuslang Substance Misuse Planning Group  continues to lead action on addressing addiction issues at local level. There is also a very active Drug Forum, chaired by a volunteer. The Planning Group is producing a substance misuse action plan. Priorities for 2002/03 include: 

- Establishing an integrated social work and health care Community Addiction Team with additional nursing staff being appointed from money identified in the Health Improvement Programme.
- Implementing actions set out in the Alcohol Strategy Implementation Plan.

##### **Camglen Local Health Care Co-operative**

Priorities for 2002/3 include:

- Completion and development of the Rutherglen Primary Care Centre, which is the first project of its type in Scotland, linking a traditional Health Centre to three other Practices within one complex. The Centre offers a wide range of Community Services with a Maternity Care Centre managed by the North Glasgow University Hospitals NHS Trust.



- Developing and implementing the initial Primary Care Strategy priority project selected for Camglen Local Health Care Co-op around the treatment of type 2 diabetes within the General Practitioner surgery and Community setting.


### **Social Inclusion Partnership**

Following a review by the Scottish Executive, Cambuslang Social Inclusion Partnership will lose its status in 2004. In recognition of the continuing relative deprivation and poor health of Cambuslang and Rutherglen, the Board has supported South Lanarkshire Council and other partners in taking a holistic approach towards regeneration in the area. The New Leaf Strategy aims to achieve significant physical, social and economic improvement in the area over the next 10 years. Action on issues such as health inequalities represent a critical part of the strategy. Implementation of the strategy will build on recent health developments and current plans in the area including better integrated care services, a new health centre and child clinic, a healthy living network and the new ACAD at the Victoria.

## 4.7 **East Renfrewshire Council**

Eastwood has a population of 64,000 representing 7% of Greater Glasgow and 72% of East Renfrewshire. Relative to other areas across Scotland, Eastwood is a prosperous area with high levels of home and car ownership, low unemployment and generally good health.

### **Community Plan**

The planning structure in East Renfrewshire is under review. Four policy groups will be set up under the community planning structure, with the Caring and Healthy Communities Policy Group having a strategic overview of community care, Joint Futures and health improvement. 

East Renfrewshire has recently completed its sixth survey of its Citizens' Panel. The survey provides information for the East Renfrewshire Community Planning Partnership on residents' priorities and other related issues.

### **Joint Health Improvement and Health Promotion**

A Joint Health Improvement Plan for 2002/3 will be developed by March 2002 within the context of the community plan. A Health Improvement Action Team co-ordinated by the joint funded Public Health Capacity Building post will develop this during the year. Currently agreed areas of work between Greater Glasgow NHS Board, the Local Health Care Co-op and East Renfrewshire Council include exercise, safety and smoking cessation will be continued and the programme of health promotion activity includes:

- Active membership of the New Community Schools Steering Committee, assisting in the development of the health promoting school model.
- Creation of a parents' room in the Glen Nursery (Health Improvement Funds 2001/2). Establishment of development worker post offering support to parents.
- Awareness raising activity (2002/3) focussing on the links between mental well being and domestic abuse.
- Support to Local Health Care Co-op Public Health Facilitator (appointed 2001) in undertaking needs assessment.
- Working with the school meals service to promote healthy eating.

### **Addictions**

The East Renfrewshire Substance Misuse Forum continues to lead action on addressing addiction issues at local level. Priorities for 2002/03 include:

- Extend and collocate the Substance Misuse Team, including an additional part-time nurse to be appointed from money identified in the HIP.
- Complete a substance misuse Action Plan based on priorities set out in the Drug Action Team Strategy 1999-2003; Greater Glasgow NHS Board's Alcohol Strategy; the Methadone Review document; and local needs and gaps in services.

#### **Eastwood Local Health Care Co-operative**

Following the establishment of the Community Older People's Team the future work for Eastwood Local Health Care Co-op includes:

- Planning the roll-out of other Primary Care Strategy projects eg. Mental health, community involvement and child health;
- Roll-out of chronic disease management programmes eg rheumatoid arthritis, epilepsy, coronary heart disease and stroke;
- Work on clinical governance including generic standards for community services and Royal College of General Practitioners accreditation for all practices.

### 4.9 **North Lanarkshire Council**

The Steps-Moodiesburn corridor, which also includes the villages of Chryston, Gartcosh and Auchintloch, has a population of 16,410. It represents 5% of the population of North Lanarkshire Council and less than 2% of the population of NHS Greater Glasgow. The area has lower unemployment than other areas in North Lanarkshire and it is characterised by rural and isolated villages, which has implications for service provision.

#### **Community Plan**

The North Lanarkshire Partnership has established a strong base to take corporate action to improve the economy, the environment and the health of the citizens of North Lanarkshire.

#### **Health Improvement and Health Promotion**

Health priorities for the area reflect those found in most deprived areas: high levels of smoking, alcohol and substance misuse, high levels of unemployment and poor housing. This is reflected in the Health, Wellbeing and Care theme within the Community Plan. The Eastern Glasgow Local Health Care Co-op will be appointing 2 Public Health practitioners to assist with identification of priority areas and development of service provision for the population of the area. The health promotion department and the Local Health Care Co-op have developed a number of local initiatives in the following areas:

- Cholesterol, smoking cessation, exercise referral.
- Healthy eating initiatives, breast feeding, infant massage and a young people's sexual health group.

#### **Addictions**

Plans are in place to develop and introduce a new community addiction team for the area. The new team will be in place by early summer of 2002.

#### **Primary Care**

The Eastern Local Health Care Co-op is an active and full partner in developing locality working within the area in particular joint services for the elderly, primary care mental health services, young people's services smoking cessation and the development of triage nursing. New monthly structured fora have been set up to identify specialist interests and to create a current directory of services locally.

## 5 PLANS AND PRIORITIES

5.1 The purpose of this document is not to replicate every plan. This section provides signposts into the areas for which we have detailed plans and briefly describes how those plans will deliver National and local policies and priorities. The range of the plans, which cover the service change, health improvement and inequalities dimensions of our activities, reflect the priorities we have set to improve the health of our population.

### 5.2 **Elderly Services:**

We are developing a strategic framework for elderly services, in partnership with Local Authorities and in parallel to developing local plans to integrate services and improve community care. The strategic framework will include services and care in:

- Hospital settings
- Care homes
- People’s homes

covering acute, rehabilitation, primary and community services. This strategic work is underpinned by a comprehensive financial framework which sees additional investment in a range of services. For delayed discharges we have a relatively low proportion of hospital beds inappropriately occupied by patients awaiting community care, but we are continuing to work with Local Authorities to try and reduce delayed discharges further through additional investment in community services, specialist support to nursing homes and ensuring long stay capacity matches demand.

#### **Key performance Indicators:**

	<u>Glasgow</u>	<u>Scotland</u>
<b>Percentage patients experiencing delayed discharge</b>	<b>39.4</b>	<b>68.3</b>
<b>Percentage beds occupied by delayed discharge</b>	<b>6.3</b>	<b>11.3</b>

### 5.3 **Cancer:**

Improving cancer services is a major local and National priority. Cancer planning groups for the West of Scotland and Greater Glasgow are now in place. The West of Scotland Group will focus on the implementation and further development of the agreed Cancer Plan, including its major programme of investment. The Glasgow Group will develop a comprehensive overview of service issues and priorities and change and financial plans required to get cancer services right. A number of improvements are already being implemented and we are beginning to measure performance against National Health Plan and Clinical Standards Board targets to identify and address any issues. **Tackles issue 2.5.**

### 5.4 **Maternity Services:**

The Maternity Services Liaison Committee is overseeing the implementation of the National Maternity Services Strategy and its aim is to support the consistent development of maternity and neonatal services from a public health perspective in order to ensure that women and their families using services in Glasgow receive the highest possible quality of maternity care. An inclusive process is underway to implement our agreed strategy to reduce the number of delivery units from 3 to 2, in the light of the declining birth rate. The Committee are also engaged in the planning and investment decisions for the Child and Maternal Health Programme (paragraph 3.11).

### 5.5 Sexual Health:

The multi-agency Sexual Health Planning and Implementation Group is pursuing the implementation of our Sexual Health Strategy, a programme of service change and development to promote the sexual health of our population and deliver effective and accessible sexual health services which contribute to reducing sexual ill health and reduce teenage pregnancy. **Tackles issue 2.8.**

#### Key performance Indicators:

	<u>Glasgow</u>	<u>Scotland</u>
Incidence of sexually transmitted diseases	703.1	637.8

### 5.6 Chronic Disease:

The Primary Care Strategy includes a significant programme of investment in developing chronic disease management in primary care. A NHS Greater Glasgow wide group is steering development and implementation coverage includes heart disease, stroke, Chronic Obstructive Pulmonary Disease, diabetes, rheumatoid arthritis, multiple sclerosis and epilepsy. All these diseases have their own planning and implementation groups. **Tackles issue 2.2.**

### 5.7 Palliative Care:

In parallel to an inclusive process to review the palliative care strategy – a number of actions are being implemented to improve service. Major issues include the future services and funding for hospices and palliative care expertise for acute services.

### 5.8 Community Care Planning:

We have a range of planning and implementation arrangements with the 6 Local Authorities with which we work. These planning arrangements cover older people, mental health, learning disability, sensory impairment, physical disability and head injury – their proposals are reflected in the Joint Community Care Plans we produce in partnership with each Authority, more detail is provided in Section 4.

### 5.9 Oral Health:

The overall impact on health and well-being of Greater Glasgow's poor dental health record is significant. In addition to the pain and discomfort caused to children by dental caries, there are other more significant consequences of poor dental health. The bacteria associated with poor oral hygiene may be implicated in a range of other serious conditions. Poor dental hygiene leads to loss of confidence and low self-esteem in adult life. Oral Health Action Teams have been established, enabling health professionals to work with local communities. An Oral Health Planning and Implementation Group has been formed to provide a fresh and comprehensive impetus to our efforts to tackle the poor dental health of our population. The group will focus on prevention and service issues. **Tackles issue 2.9.**

### 5.10 Heart Disease:

The Board has a comprehensive coronary heart disease (CHD) strategy which covers prevention, primary care, secondary and tertiary services, Programme spending plans reflect a range of investments to develop and redesign services. A multi-disciplinary group is driving implementation. **Tackles issue 2.4.**

5.11 **Stroke:**  

The priorities for stroke are to improve a number of aspects of acute services, including early specialist advice and investigation and acute care in South Glasgow. The Planning Group considers acute care, rehabilitation, primary and secondary prevention, longer term care and psychosocial aspects.

**Key performance Indicators:**

	<u>Glasgow</u>	<u>Scotland</u>
Mortality rate stroke <75	34.5	29.1

5.12 **Gender and Health:**  

We have planning structures in place for men's and women's health reflecting gender related differences in health status and use of health services. The Women's Health Policy Group steers a wide ranging programme of change across health services, including mental health, maternity services and acute care. A strategic framework for men's health is in development.

5.13 **Gender Based Violence:**  

A cross NHS planning group leads the strategic development of health responses to the spectrum of abuse. This includes survivors of childhood abuse, domestic violence and sexual assault. A detailed programme of training and service change is being implemented linked to the Women's Health Policy work programme. We are contributing to the development of Local Authority led multi-agency strategies.

5.14 **Ethnic Minority Health:**  

In line with the recommendations of the Scottish Executive's 'Fair for All' and Race Equality Advisory Forum reports, NHS Greater Glasgow will develop and implement action plans covering the themes of access to health services and employment. In particular, action will take place around further developing the multi-agency Interpreting Partnership, training for NHS staff to ensure their cultural competence, and exploring ways of listening to the minority ethnic communities and engaging them in the health service planning processes, including asylum seekers and refugees. NHS Greater Glasgow has signed up to the Commission for Racial Equalities Leadership Challenge.

5.15 **Asylum Seekers:** 

Glasgow City Council provides accommodation for 8,000 asylum seekers and West Dunbartonshire Council is about to contract with the Home Office. The Primary Care NHS Trust has developed a range of health services to meet the needs of asylum seekers.

5.16 **Homelessness:**  

Health and Homeless Action Plans have been developed with each Local Authority. We are partners in the Glasgow City integrated planning arrangements to tackle homelessness and we have invested in a number of new health services for homeless people. **Tackles issue 2.10.**

### 5.17 **Learning Disability:** ☞

Our joint Learning Disability Strategy will exceed the targets set in 'The Same as You', including closing all long stay NHS provision by the end of 2002.

### 5.18 **Waiting Times and Standards:** ☞

Delivering reduced waiting times is a critical National and local priority. This section, which is underpinned by a more detailed plan, sets out the key targets we are aiming to achieve. In-patient and day case waiting times are important, but we also know that patients and their general practitioners are unhappy with long out-patient waiting times and bottlenecks for investigations. Our targets aim to address those priorities:

#### **National Targets:**

The new National Waiting Times Unit has set a number of targets:

- A maximum waiting time for in-patients and day cases of 9 months, to be achieved by December 2003. 4% of patients waiting, or 1,500 people, currently wait longer than this target. ☹
- 75% of out-patients to be seen within 3 months. Currently 73% of our residents are seen within this timescale. ☹
- Demonstrating plans to meet the National Plan Cancer standards:
  - for breast cancer, childhood malignancy and leukaemia a one month maximum to commence treatment from diagnosis. We currently meet this target. ☺
  - from 2005, a 2 month maximum to commence treatment from diagnosis. The West of Scotland and Glasgow Cancer Planning Groups are developing staged proposals to ensure this target is met. ☹
- A maximum 12 week wait for angiography and achieving a 6 month maximum wait for intervention to cardiac surgery or angioplasty. We currently meet this target for most patients. ☺
- Patients will be able to see the 'right' primary care professional within 48 hours by October 2002. We await further guidance on the measurement and definition of this standard. The significant investment in primary care which underpins our Primary Care Strategy is already improving access for patients.

#### **Local Targets:**

Our local targets include:


- Maximum 6 month wait for cataract and joint surgery – met in 90% and 62% of cases, respectively.
- Reducing waiting times for investigations.
- Working towards a maximum out-patient waiting time of 15 weeks.

We intend to give highest priority to achieving:

- The National targets, including the very challenging 9 month maximum waiting time requirement.
- Addressing bottlenecks in imaging services and other investigations.
- Tackling the longest, over 26 weeks, out-patient waiting times.

We will continue to work towards our targets for ‘health gain’ procedures and maximum out-patient waiting times.

Reflecting the importance of reducing waiting times and our commitment to take a whole system approach, we intend to establish a Greater Glasgow patient access team to ensure that we deliver these targets and that service redesign to improve patient experience is at the heart of our approach.

We will regularly report on these standards and targets and joint performance against them. 

#### Key performance Indicators:

	<u>Glasgow</u>	<u>Scotland</u>
<b>Mean wait in days</b>	<b>55.6</b>	<b>61.4</b>
<b>9 month guarantee not met</b>	<b>7%</b>	<b>4%</b>
<b>Surgery rates:</b>		
– <b>Hips</b>	<b>253.9</b>	<b>358.5</b>
– <b>Knees</b>	<b>281.6</b>	<b>293.8</b>
– <b>Cataracts</b>	<b>1,846</b>	<b>1,961</b>
– <b>CABG</b>	<b>677.3</b>	<b>633.0</b>
<b>Out-patients &gt; 12 weeks</b>	<b>73%</b>	<b>75%</b>

#### 5.19 Physical Disability:

A comprehensive strategy to improve services and an explicit financial framework will be developed and implementation begun during 2002. A series of service improvements for epilepsy, Parkinson’s disease, head injury and multiple sclerosis are already being implemented.

#### 5.20 Child Health:

Our detailed programme of work on child health includes:

- Work with Local Authorities to:
  - Implement the recommendations of ‘For Scotland’s Children’.
  - Finalise and implement plans for children’s services and the Children’s Change Fund.
  - innovation in New Community Schools, school health services and family support.
- We are implementing strategies for:
  - Mental health services.
  - Children with disability.
  - Breastfeeding.
- Change programmes include:
  - Developing and extending the Starting Well Programme.
  - Improving child protection.
  - Reducing waiting times.
  - Centralising children’s accident and emergency services.
  - Improving relationships between primary and secondary care.

### Tackles issue 2.3.

#### 5.21 **Pharmaceutical Care Strategy:**

Local pharmacists have developed the strapline ‘Making the Most of Medicines’ to cover a series of initiatives being led, collectively, to improve the quality, safety and effectiveness of pharmacy services.

## **6 INTEGRATING SERVICE AND FINANCIAL PLANNING**

This chapter sets out the financial framework which underpins the service plans and priorities described in the rest of this document. The framework for 2002/03 has been developed from the 5 year financial plan which the Board approved in the 2001 – 2006 Health Improvement Plan (HIP).

### 6.1 **The Health Improvement Plan Framework**

The HIP stated 5 main pillars of financial policy:

- To ensure, over a 5 year period, that there was adequate and assured capacity to invest strategically in measures aimed to improve health and tackle inequalities.
- To provide better cover for financial risk, particularly around pay inflation, which has in the past undermined the financial stability of Trusts.
- The requirement to make adequate financial provision to cover the increased costs of replacing old hospital facilities.
- Relieving the pressures on Acute Trusts to enable underlying deficits to be addressed and Trust staff to focus on qualitative and quantitative improvement to services for patients, within fair budgetary allocations and without constant financial retrenchment.
- Resolving longstanding shortfalls in income from other West of Scotland NHS Boards.

### 6.2 To deliver these imperatives, the Board approved a 5 year allocation template which:

- Made provision for 2.5% non pay inflation, 4% pay inflation and for the increasing costs of employers’ contributions to NHS superannuation.
- Provided for 10% General Practitioner prescribing inflation per year – but with a marker that further policy development required to balance the very substantial opportunity costs of provision at that level, incentives and good practice in prescribing.
- Growth monies were earmarked for 4 spending programmes:
  - Acute Hospital services
  - Adult mental health
  - Child and maternal health
  - Other Hospital and community health services

### 6.3 It was explicit that these programme areas should be protected from erosion caused by pressure in other areas. Three reasons underpinned that position.

- A commitment to move away from the history of acute services sucking in resources at the expense of community services.
- Determination that the NHS should make a meaningful impact on long term health improvement for our population through meaningful investment into



child and maternal health, social inclusion, chronic disease, addictions and community care.

- The desire to give greater clarity about future funding to enable better change planning – avoiding short-termism and ‘stop-go’ turbulence.

6.4 The allocation model was also underpinned by a policy agreed with Trusts that, in exchange for the Board foregoing the traditional approach to efficiency savings reducing funding allocations, Trusts would manage cost pressures by improving their efficiency and retaining the financial room for manoeuvre increased efficiency generated.

For programmes other than acute services, detailed commitments were made for future years, generally reflecting agreed and explicit strategies and plans developed in partnership with Local Authorities. These plans are part way through implementation.

#### 6.5 Sources of Funds and Inflation

- The 2001/02 plan assumed that £19.4 million was available for investment in 2002/03, after funding pay and non pay inflation.
- In fact £22.7 million is available for investment, reflecting a reduced inflation on prescribing and an improved uplift reflecting Greater Glasgow’s Arbutnott position.
- In addition further, new, allocations have been made:

	<u>£ Million</u>
Cancer services	3.5
Delayed discharges	3.8
Waiting times	2.7

The section below outlines our thinking on resource allocation.

#### 6.6 Resource Allocations

In reaching decisions on the allocation of these resources, we considered a number of issues:

- The increasing costs of junior doctors’ hours and other staff-related financial pressures, including the European Working Time Directive.
- Trusts had identified significant pressures during 2001/02 and breakeven was only achieved with non-recurrent funding.
- National policy changes on hospital infection control and decontamination add significant new costs.
- The new allocations for cancer, delayed discharges and waiting times should be ring fenced to enable us to meet national targets in these three areas.

In the light of the financial pressures on acute services, the likelihood of in-year slippage and the expectation of significant further increases in NHS spending reflecting the Chancellor’s April 2002 budget announcement we have allocated a further £10 million of non recurrent resources for acute services in 2002/03 with commitment from Trusts to:

- Manage within their allocations in 2002/03.
- Work with us to ensure we deliver recurrent financial balance prior to April 2004.

Reflecting these issues, new resources, after dealing with inflation, at 4.5% for pay and 2% for non pay, and dealing with increased superannuation costs, have been allocated as follows:

#### Financial Plan 2002-2004

	<b>£ Million</b>	
	<b>2002/2003</b>	<b>2003/2004</b>
	<b>£m</b>	<b>£m</b>
<b>Sources of Funds</b>		
Recurring Income Base	1,014.1	1,084.0
Family Health Services Uplift	5.4	5.7
General Uplift	61.8	74.4
<b>Additional Allocations</b>		
Waiting Times	2.7	
Cancer Services	3.5	
Delayed Discharges	3.8	
<b>Total Income</b>	<b>1,091.3</b>	<b>1,164.1</b>
<b>Applications of Funds</b>		
Expenditure Base	1,014.1	1,084.0
Family Health Services	5.4	5.7
General Inflation	23.8	35.4
Superannuation Increase	4.9	
Prescribing Inflation @ 8.0% in 2003/04	10.3	11.5
Agreed Investments	0.1	
<b>Additional Allocations</b>		
Waiting Times	2.7	
Cancer Services	3.5	
Delayed Discharges	3.8	
Available for <b>Recurring</b> Investment	22.7	27.5
<b>Total Expenditure</b>	<b>1,091.3</b>	<b>1,164.1</b>
Available for <b>Recurring</b> Investment	22.7	27.7
<b>Non-Recurring</b> Investment	10.6	
<b>Total Funding Available</b>	<b>33.3</b>	<b>27.7</b>
<b>Expenditure Approved</b>		
Mental Health	3.1	3.7
Primary Care & Other	5.2	6.2
Child and Maternal Health Services	3.1	3.3
Acute – Programme Share	8.3	10.2
Acute – Additional Recurring	3.0	3.0
Acute – Non Recurring	10.6	
Unallocated Resources		1.1
<b>Total Expenditure Approved</b>	<b>33.3</b>	<b>27.5</b>

Detailed spending schedules underpin these programmes allocations with indicative commitments for 2003/04 to enable Trusts to plan ahead service changes and developments.

For non acute programmes, figures for 2003/04 reflect the programme spending set out in the HIP financial framework. We need to review future years' allocations to reflect:

- Pressures and priorities on non acute programmes.
- The profile of acute services spending which underpins the Acute Services Review.
- A further appraisal of the definition of inflation which is allocated in advance of programme shares.

This process needs to be anchored in clarity of the principals which underpin the allocation of resources – our current principles are confirmed in paragraph 6.1.

## 6.7 Risks

There are a number of risks associated with this financial strategy which we will need to manage during 2002/03 and beyond:

- Adverse changes to our Arbutnott position.
- The table above illustrates that on the basis of current information we have a gap between expected resources in 2003/04 and programme expenditure plans.
- There are significant pressures on emergency admissions – we are carrying out a comprehensive review of how these can be addressed, but it is likely that new resources will be required.
- There are a number of potential pressures relating to new drugs – for example, we do not yet have final information on the costs of the introduction of the UK wide scheme for the risk sharing provision of beta interferon to patients with Multiple Sclerosis.
- There are significant pressures on the methadone programme and although our allocations include additional resources for these services it is not yet clear whether these can meet demand.
- Primary care prescribing needs to remain within budget.
- We need to ensure other West of Scotland NHS Boards adopt a similar approach to annual uplifts as Glasgow and managing the consequences of Regional Service Planning changes.
- That the additional, earmarked allocation for cancer, waiting times and delayed discharges are sufficient to fund what is required.

The key assumption, agreed with Trusts, is that they achieve breakeven position within the agreed allocation.

Overall, the 2002/03 start point carries a degree of risk which we will seek to mitigate and reduce as the year progresses.

## 7 CHANGE AND DEVELOPMENT PLAN

- 7.1 It is important to demonstrate how the NHS in Greater Glasgow will develop the capacity and capability to achieve the outcomes set out in this Plan. This section briefly outlines how this will be developed to deliver the ambitions this Plan sets out.

## 7.2 **NHS Board Development**

The new NHS Board, established in October 2001, has had a series of development events and seminars which will continue during 2002/03. The unified arrangements at Board level produce a platform for the development of a more collective approach throughout NHS Greater Glasgow and with Local Authority partners.

## 7.3 **Staff Governance**

Greater Glasgow NHS Board will adopt and extend the principles and policies of the National work developed for staff governance including the establishment of a Staff Governance Committee. We will use the outcomes of the staff surveys to help us set local priorities to achieve staff who are:

- Well informed
- Appropriately trained
- Provided with improved and safe working environments
- Involved in decisions which effect them
- Treated fairly and consistently

## 7.4 **Partnership Working**

The Greater Glasgow Partnership Forum is currently working through, with the NHS Board Executive team, how it can develop its role to best influence strategy, the Local Health Plan, financial planning and, in particular, influence the direction of ‘people management’ issues. Of particular significance is developing a collective approach around pay and conditions and managing the change agenda associated with joint futures.


## 7.5 **Local Health Plan Steering Group**

An important part of the process of developing this Plan has been the formation of a Steering Group, including Local Authorities, Partnership representatives and the Local Health Council joining Directors of the NHS in Greater Glasgow. The purpose of this group is to provide a forum for collective discussion on the development of the Plan ensuring our partners can influence key areas of policy. Our aim is to further develop this process during 2002/03.

## 7.6 **Workforce Planning**

One of the biggest challenges facing the NHS in Scotland is the recruitment and retention of staff – this impacts on health services, but is also true of social care and other critical Local Authority services. Shortages of staff are already impacting in a number of areas including nursing, radiology and paramedical staff. We have established a unified workforce planning process to enable us to address these issues and the change agenda described later in this section.

## 7.7 **Organisation Development Plans**

In addition to the pan Greater Glasgow issues described above – each of the organisations which form NHS Greater Glasgow have their own organisational development and training plans,  for the Primary Care NHS Trust this included the critical area of development of Local Health Care Co-operatives.

An important challenge for the next year is to unify these separate plans to underpin and enhance new ways of collective working.

The Local Development Team is developing a pan-Glasgow organisational development plan which will include a number of specific interventions, including:

- Glasgow-wide open learning which will attract Scottish University for Industry funding.
- A development plan for members of Partnership Fora.

## 7.8 **Information Management and Technology**

An important contribution to our ability to deliver the objectives set out in this Plan is the development of information management and technology. Good progress has been made in using technology in clinical settings, but the approach has not been fully co-ordinated across the whole system. We have produced a unified information and communication strategy with the following objectives:

- Improve clinical decisions by making the right supporting information more readily available.
- Speed up patient ‘throughput’, reduce waiting and thereby improve the patient’s experience.
- Make better use of doctors’ and nurses’ time by eliminating form filling and using telemedicine to send images digitally to the doctor rather than asking the doctor to relocate to where the image is captured.
- Make the day-to-day tasks of clinical staff easier by providing electronic access to protocols, directories, test requesting and so on.
- Help avoid mistakes, particularly in medicines management.
- Improve patient care by capturing patient details and sharing treatment details across the extended care team.
- Improve patient and carer access to information about their condition and treatment.
- Provide the wider public with access to information about services and other healthcare issues.

We are also working with our Local Authorities to develop ways of sharing information in support of delivering Joint Futures.

## 7.9 **Managing Change**

As well as the general themes outlined above a number of the policies and plans within this Plan present significant challenges to organisations and staff:

- The acute services review requires very different ways of working and a massive change agenda for frontline staff.
- The mental health and learning disability strategies mean significant changes for staff.
- The Joint Futures agenda – moving to integrated teams serving patients, with staff from social care and health background – working together, mean changes for many NHS and Local Authority staff.

To meet the challenges outlined above we will develop a comprehensive approach to:

- Shared partnership arrangements with Local Authorities.
- Organisational development focussed on real issues.
- Training plans which enable staff to meet the challenge of change.
- Workforce planning and development.
- Effective communication strategies.

We want to manage change well and fully engage staff at all levels in that process, as well as in the development of our policies and plans.

#### 7.10 Education and Training

Education and training are critical to the NHS in Greater Glasgow, both in terms of the retention and development of our current workforce, but also in relation to ensuring we are able to recruit trained and skilled staff. The key strands of our approach are:

- To support and encourage life long learning and development of all NHS staff with access to flexible learning methods.
- Thinking through the educational and training dimensions of our key strategies and addressing issues identified in planning and implementation.
- We have liaison arrangements with each of the 3 Glasgow Universities and are working with them to put in place a fully collective approach to develop a comprehensive strategy to exploit Glasgow's potential as a place for education and employment.
- We need to develop a wider network of relationships with educational institutions.

## 8 IMPLEMENTATION AND ACCOUNTABILITY

8.1 This section covers:

- **Delivering the Plan**
- **Public involvement and patient focus**
- **Measuring progress – key indicators.**

#### 8.2 Delivering the Plan

This Plan sets a strategic direction and provides summarised signposts to detailed planning and implementation activity within the NHS, and in partnership with a range of other organisations. It is those activities and relationships which will set and deliver the detailed changes and outcomes for which the Plan describes a framework. We are working to develop a system of performance management which:

- Delivers the requirements of the National Performance Assessment Framework.
- Ensures that planning activity includes a focus on implementation and outcomes – linking planning groups into performance management routines.
- Moves towards shared accountability arrangements with Local Authorities for collective activity.
- Enables the NHS Board to have confidence that the commitments and objectives of this Plan are delivered.

In addition to performance management, we will put in place, during 2002/03, arrangements to ensure that detailed planning and implementation activity is visible to the range of organisations and individuals who have interests in particular areas, where possible, we have used an initial set of key indicators in the body of the Plan.

### 8.3 **Public Involvement and Patient Focus**

The issues of accountability with the NHS system are addressed above. A critical, further element of accountability is the way in which we involve the public and achieve a patient focus.

Our approach to public involvement has a number of dimensions:

- Major consultation exercises on strategic plans.
- Representatives involved in ongoing planning and implementation.
- Comprehensive engagement with the Local Health Council.
- Engagement with local and National elected representatives on specific plans and issues as a matter of routine.
- Engagement with communities through Social Inclusion Partnerships, community care planning and health improvement.

The rest of this section gives an indication, for major areas of strategy, on how these arrangements have operated.


- **Maternity Services**  
A major consultation exercise on the maternity services strategy has been followed by significant representative involvement in the implementation phase.
- **Mental Health**  
As well as the major consultation exercise on modernising mental health, we finance a users network which contributes to strategic and operational planning across Greater Glasgow and at a local level, for example in the East End.
- **Acute Services**  
In addition to the huge consultation exercise on the Acute Services Strategy, we have community involvement at local hospitals, patient involvement in planning for particular care groups and community involvement in planning activity in 4 areas to consider how local access can be improved in implementing the Strategy.
- **Community Care and Community Planning**  
Joint Community Care Plans and community plans have been a major focus of public consultation and user and carer involvement in their development.
- **Forensic Services**  
A major effort to engage local communities and interests in the decision on the siting of the Secure Care Unit.

During the first year of this Local Health Plan we need to consider, with the Health Council and others, how we can further develop a comprehensive approach to patient focus and public involvement.

#### 8.4 **Measuring Progress**

We are putting in place a comprehensive approach to performance management which will enable us:

- To describe our performance against National indicators and what we are doing to address any issues.
- Measure whether the plans and priorities we have set out are being implemented and delivering the outcomes we have set.

Regular reports on key indicators will be considered by the Board. Our Annual Report will include similar information. 



## LOCAL HEALTH PLAN

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Indicates link to further detail.



Indicates planning process.



Indicates waiting time target achieved.



Indicates work in hand to meet waiting time target.



Indicates waiting time target not achieved.