EMBARGOED UNTIL MEETING

Greater Glasgow NHS Board

Board Meeting

Tuesday 17 December 2002 **Board Paper No. 2002/83**

Director of Planning and Community Care

DRAFT LOCAL HEALTH PLAN (LHP) UPDATE

Recommendation:

Members are asked to:

- Discuss and endorse the draft LHP update for wider circulation and debate.

A BACKGROUND

The Board approved the first Local Health Plan in May 2002, the purpose of which is to:

- Enable the Greater Glasgow NHS Board to set a clear direction and priorities to deliver our 3 key objectives.
- Provide clear accountability from the Board to the Scottish Executive for the performance of the NHS in Greater Glasgow.
- Provide clear information on what we are trying to achieve and our performance.
- Draw together a wide range of planning and implementation activity within a single document.

The Plan set a strategic direction for the next 5 years but focused in detail on 2002/03. This updated Plan retains a similar strategic direction, but includes more detailed plans and priorities for 2003/04 and an indication of progress in the past 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 has also included significant public engagement. We intend the document to provide an overview and signposting to detailed plans. A summary for general readers will be produced.

B PURPOSE

The purpose of developing and agreeing this draft update is to enable full engagement of our key partners in finalising the Local Health Plan for consideration by the Board at its March 2003 meeting.

C CONTENT

Our focus in updating the Plan has not been to rewrite the primary objectives the Board approved 6 months ago, nor to change the strategic direction agreed at that point.

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The updated Plan reflects:

- Changes to National guidance and policy including the requirement to show more detailed plans for 12 prescribed National priorities.
- Substantial progress in developing Health Improvement Plans with each Local Authority.
- With the approval of the Acute Services Strategy, an outline of the implementation process and priorities.
- The further implementation of the Joint Futures agenda and integration of services.
- Progress in developing staff governance and partnership working.
- Progress in implementing the plans and priorities we set out in May 2002.
- A further iteration of the key indicators set in the National Performance Assessment Framework.

In considering the shape of the update, at its November 2002 meeting, the Board agreed that:

- We should include a section for each NHS Trust, summarising their contribution to the key objectives. This will enable a more explicit connection between planning and implementation.
- There should be a particular focus on ensuring NHS staff are aware of the LHP, its direction and priorities and how they can contribute to it.

These will be reflected as the update is developed.

D KEY ISSUES

The draft update highlights a number of important issues for debate during this next phase of development. These include:

- Ensuring the GGNHSB-wide health improvement activity fully reflects and influences local priorities.
- New policy issues and priorities where action needs to be finalised.
- The balance between focussing on the limited range of National priorities and our own local strategies and priorities.
- Our performance over the past year in delivering the commitments set out in the first LHP.
- Identifying areas and issues where further action is required to achieve our objectives.
- Developing a financial plan which ensures we deliver our objectives, including achieving financial balance.
- The final version needs to include more information on capital planning – which is also critical to achieving our objectives.

E CONCLUSION

Generating this early update will enable a substantial programme of work over the early part of 2003 to ensure the final version, addresses the issues outlined in the previous section and properly reflects detailed discussions with our key partners.

NHS
Greater
Glasgow

LOCAL HEALTH PLAN
2002/2005

2003 UPDATE

DECEMBER 2002

LOCAL HEALTH PLAN

I N D E X

📖 Indicates link to further detail.

Indicates planning process.

✪ National Priority

☺ Indicates waiting time target achieved.

😐 Indicates work in hand to meet waiting time target.

☹ Indicates waiting time target not achieved.

£ Indicates financial implication

LOCAL HEALTH PLAN 2002 – 2005
2003 UPDATE

NHS Greater Glasgow

1 INTRODUCTION

1.1 This Local Health Plan is the main strategic document for NHS Greater Glasgow. The focus of the plan remains 3 overarching objectives:

- **Improving Health:**
  - Focusing our health improvement capacity on delivering change with Local Authorities and LHCCs through stronger local health improvement plans.
  - Increase resources available for health improvement.
  - Increase the exploration of the potential of health services to contribute to health improvement.

- **Reducing Inequalities:**
  - Recognising the extent of health and social inequalities in our population and directing our energy, resources and influence to reduce them.
  - Ensuring the delivery of health services reflects the health consequences of social inequalities.
  - Committing ourselves to a wide range of partnerships which can multiply the impact of our own actions and resources.

- **Improving Health Services:**
  - Integrating services with Local Authorities and between primary and secondary care.
  - Increasing capacity to meet demand and reduce waiting.
  - Modernising services by improving the quality of clinical care, the physical environment and developing patient centred care.

1.2 This Plan has a number of purposes, these are:

- **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.

- **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.

1.3 Our first Local Health Plan, covering the period 2002 to 2005, set out a clear strategic direction. This updated Plan reports on progress in 2002/03 and provides further detail on our plans for 2003/04.

In addition, we have ensured Section 5 on Plans and Priorities has covered the Scottish Executive requirement to clearly indicate our local position, current services, future plans, and their anticipated outcomes, for the 12 National priorities which include:

- Health Improvement
- Delayed Discharge
- 48 Hour Access to Primary Care
- Mental Health
- Waiting Times
- Workforce Development and Staff Governance
- Cancer
- Heart Disease and Stroke
- Public Involvement
- Hospital Acquired Infection
- Financial Breakdown
- Service Design

1.4 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 have developed links into a comprehensive, electronic database and a summary, directed at more general readers, will be produced for wide distribution.

1.5 **The Plan is set out in 6 further 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 Delivering the Plan

2 POPULATION HEALTH STATUS 🕮

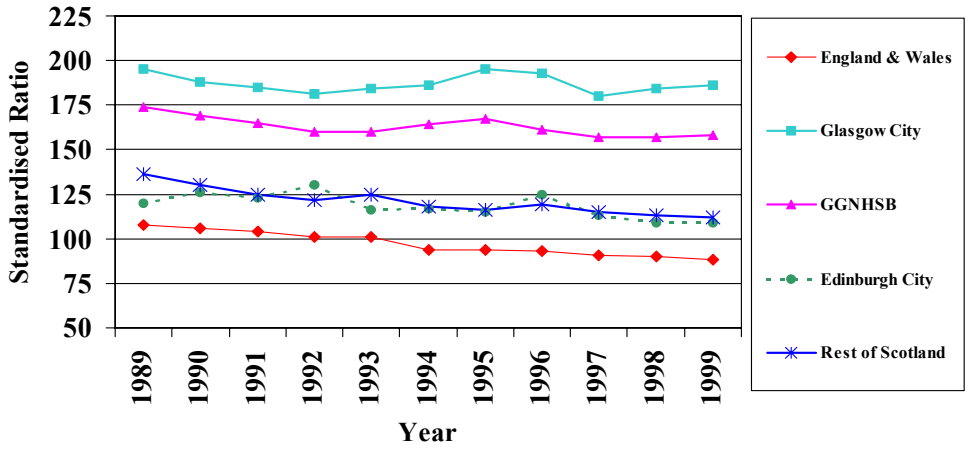
2.1 This section briefly describes the health of our population, which is so important in deciding on strategies, detailed plans and priorities for action. It covers:

- **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.**

The rest of this Plan sets out a series of actions to address the health issues this section describes

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. **[This will be updated when new Census data is available].**

Projected change in the GGNHSB population 1998-2016

	BASE YEAR	*% change*			
Age Group	***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
TOTAL	**911,200**	**-0.9**	**-1.9**	**-2.7**	**-3.2**

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.**

AREA	SMR RATES
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, 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.

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.

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. **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.

This survey was repeated in 2002 to track progress and investigate some further factors that influence health. The results, once they become available in 2003 will help inform future planning.

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, with our baseline and updated position.

3 STRATEGIC HEALTH ISSUES

3.1 The first Local Health Plan set out 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). The themes have remained as before, but this section is updated to reflect progress during 2002/03.

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

In August 2002, the Minister for Health approved our Acute Services Strategy which will enable the full modernisation of hospital services to deliver:

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

Our proposals to deliver these objectives include:

- 3 in-patient sites for Greater Glasgow.
- Major ambulatory care hospitals in South-East and North-East Glasgow.
- Two major Accident and Trauma services, at the GRI and Southern General, with GP emergencies at Gartnavel and Minor Injury Units on 5 sites.

3.3 Implementation of the Strategy is now underway:

- An Executive Steering Group has been established with a number of subgroups covering finance, workforce, service redesign and transport.
- A single Project Director will be in place early in 2003.
- Legal and financial advisers have been procured.
- A Community Engagement Team has been appointed.
- A cycle of regular reporting to the Unified Board has been established with annual reviews to be published and external scrutiny by Audit Scotland.
- A macro transport analysis has been completed and published as a basis for more detailed work during implementation.
- Capital procurement for the 2 ACADs and the new Beatson will be underway early in 2003.
- Proposals for a Monitoring Group of community and political interests are being finalised.
- A joint planning team, focused on sustaining Stobhill services, is in place.

3.4 The Acute Services Review will take several years to implement. The 2002 Local Health Plan highlighted the fact that 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:

- Increasing pressures on emergency admissions.
- 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.

3.5 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. During 2002/03 our approach to these pressures has included reshaping services, for example concentrating orthopaedic and gynaecology in-patient care and rationalising laboratory services. We have a significant programme of service change, modernisation and improvement for acute services – this is described in greater detail in Section 5.

3.6 **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 have been approved during 2003 to deliver modern in-patient services. 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. We now have planning permission for the Stobhill site and building should commence early in 2004.

During 2003/04 we will deliver:

- Completion of the rollout of community services for older people.
- Services for those with Alcohol Related Brain Damage (ARBD), including assessment beds, long stay nursing home provision, supported accommodation and joint assessment and treatment teams.
- Specialist community and day services for those with eating disorders.
- Specialist perinatal in-patient and community services.
- A range of social care services, including home support, day care, respite and dementia services.

- The continued expansion of supported accommodation places.
- The continued rollout of primary care services to those with mild to moderate mental health problems.

These developments in 2003/04 are part of the 5 year programme of developments in order to meet the National requirements to deliver fully developed community and crisis services, full implementation plans for our forensic strategy, a rebalancing between long stay health and social care and modern in-patient facilities.

3.7 **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.

3.8 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.

3.9 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.

The Scottish Executive is about to issue a new document, which will inform our more detailed health improvement work. The strategic direction of our work will remain, but the increased national emphasis on the 4 priority areas of 'early years, transition, workplace and community' will be reflected in our local work programmes.

3.10 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.

3.11 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.

3.12 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.

3.13 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. We recognise the need to plan for future funding of these important initiatives. **£**

3.14 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 is a key feature of our Health Improvement Plans with each Local Authority. Emerging work which is outlined in Section 4. **Tackles issues 2.10.**

We also need to review financial provision for these activities. **£**

3.15 **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
– Implementing investment plans for the 'Children's Change Fund'.
– Developing action plans to deliver the recommendations of 'For Scotland's Children'.

Key performance Indicators:

	Glasgow		Scotland	
	Baseline	**Current**	**Baseline**	**Current**
Percentage low birth weight babies	**6.4**	**6.3**	**5.7**	**5.6**
Percentage women breastfeeding	**33.6**	**34.3**	**35.2**	**35.7**

3.16 **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.

3.17 During 2002/03 a further 2 major events were held to take stock of progress on implementation over the last 2 years and focus on emerging issues for the next phase of the strategy. An updated strategy will be available early in 2003 and will inform the final version of this Plan. More specific detail on primary care services is included in Section 5.

The implementation of the new GP contract and increasing service integration at locality level provide further opportunities to develop and reshape primary care. A particular issue for 2003/04 will be developing better whole system working between primary and secondary care.

Key performance Indicators:

	Glasgow		Scotland	
	Baseline	**Current**	**Baseline**	**Current**
Community nurses/'000 population	**0.84**	**0.89**	**0.87**	**0.90**
Community pharmacists/'000 population	**0.22**	**0.23**	**0.27**	**0.27**
% of generic prescriptions	**68.2**	**74.9**	**70.4**	**75.6**

3.18 **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 Local Partnership Agreements covering joint resourcing and management, shared governance and accountability and developing information systems in place with each Local Authority. Section 4 outlines, in more detail, progress on integrating services.

3.19 **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, these will be reflected in the final version of this Plan.
- 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. 🕮 During 2002/03 we have implemented integrated community addiction teams in East Glasgow, East and West Dunbartonshire and South Lanarkshire. An additional 1,000 people are on the methadone programme with increased numbers in shared care and more GPs participating in the scheme.
- 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. £**

3.20 **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. In 2002/03, the Scottish Executive Health Department published guidance on Regional Planning and West of Scotland Chief Executives undertook development work to begin to map out how Regional Planning would be implemented. During 2003/04 we expect:

- A Regional Planning co-ordinator to be appointed.
- A consistent approach to funding inflation to be agreed and delivered.
- A financial framework to set out arrangements for development funding for Regional services to be put in place.
- Other Health Boards to be involved in the implementation process for the Acute Services Review.
- A Regional approach to maternity services provision to be agreed.

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:

- Health Improvement planning.
- Joint Futures.

4.3 Glasgow City Council 🕮

4.3.1 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**.

4.3.2 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.

4.3.3 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.**

4.3.4 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.

4.3.5 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.

4.3.6 **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.

4.3.7 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.

4.3.8 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.

4.3.9 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 healthy living centres.

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

- The rollout of breakfast provision to all primary schools in Glasgow augmented by additional staff and resource for full breakfast clubs in areas of greatest need.
- Continuing work to improve access to affordable healthy food and promoting healthy choices in schools and the community.
- Maximising the health impact of new community schools.
- The establishment of a multi-agency City centre youth information and support facility.
- The development of detailed action plans to support the Tobacco Strategy and the extension of community pharmacy smoking cessation support services.
- The further development of the GP exercise referral programme.

4.3.11 **Primary Care and Service Integration**

A Joint Community Care Committee has been established with wide ranging responsibilities, including a focus to oversee the further development and integration of health, social care and housing services, both in terms of planning and service delivery.

At locality level, we have seen the establishment of 9 Local Planning and Implementation Groups (LPIGs) bring together primary care, social work and housing with the initial objective of delivering the key objectives for older people as per Joint Future.

Service integration is being developed on a number of fronts. We have integrated planning arrangements in place for mental health, learning disability and homelessness. This year has also seen the establishment of a joint equipment store. The development of an integration infrastructure is also being undertaken in the filed of information, human resources, finance and performance management. The current work programme will see further integration of locality services, older people's service planning and delivery, addictions services and children's services.

4.3.12 **Addictions**

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

4.4 East Dunbartonshire Council

4.4.1 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.

4.4.2 **Community Planning**

The Community Planning Partnership Board, supported by a Secretariat, developed a Development plan as a result of a Partnership by Design review. Issues around ownership of the community plan and communications appeared to be the most pressing. Developments have included:

- The development and implementation of a communications strategy and action plan.
- The establishment of a sub-group to review and develop roles and responsibilities of individuals and partners agencies.
- The further development of the Kirkintilloch Initiative.
- A review of partnerships to establish and share good practice and the development of effective communications issues.

4.4.3 **Joint Future**

The Joint Planning Forum has recently approved recommendations from the Senior Officers Group to formally consult on proposals to develop a fully integrated health and social care service for East Dunbartonshire. The proposals also include for the establishment of a Joint Committee.

4.4.4 Ongoing work has seen the establishment of a joint trade union partnership forum, a community older persons team, introduction of intermediate mental health services, the development of a joint equipment store with Glasgow City and the Primary Care Trust and further development of joint OT services.

4.4.5 The immediate future sees the need to develop joint financial frameworks to support integrated planning and service delivery, the refinement and implementation of single shared assessment and participation in a consortium to develop an IT solution to support SSA and information sharing.

4.4.6 **Health Improvement**

A Health Improvement Strategy Group has recently been established to co-ordinate and facilitate the delivery of Community Planning health objectives and to produce an annual Joint health Improvement Plan and associated action plan. Initial focus of the group will include:

- To establish a network of health promoting practitioners to co-ordinate health improvement activity within East Dunbartonshire.
- To establish the extent of health promoting activity currently ongoing.
- Through improved data and research develop a greater understanding of the needs within the locality.
- To raise awareness of health issues amongst community planning partners.

Later versions of the health plan will be able to include initial priorities developed by the group.

4.5 West Dunbartonshire Council 🕮

4.5.1 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.

4.5.2 **Joint Future**

A Health Improvement and Social Justice Sub-Committee has been established to oversee the development of health, social care and housing services across West Dunbartonshire. The committee has already made significant progress in developing joint solutions for the locality:

- The introduction of a fully integrated health and social care learning disability service within the authority.
- A joint commissioning programme for the re-provisioning of long-term care services for older people.
- The establishment of integration capacity posts to support the integration agenda and development of aligned financial frameworks.

4.5.3 The Joint Strategy Group is currently exploring options that will further integrate health and social care services.

4.5.4 The work programme within the Clydebank locality has seen the development and implementation of a community older people's team, the piloting and roll out of single shared assessment for older people, the development of intermediate mental health services at Goldenhill, community addiction team and the implementation of the national drug and alcohol strategies. The development of financial frameworks and joint performance management arrangements are amongst current priorities.

4.5.5 **Health Improvement**

Partners in West Dunbartonshire convened a multi-agency group to develop a Joint Health Improvement Plan for the area. The plan details mechanisms for addressing the wider determinants of health, using a 3-tiered approach: individual, community and structural. The plan will also take account of the new priorities of the Scottish Executive.

4.5.6 Initially the plan takes a 'process' approach but will also offer an opportunity to deliver new initiatives. Initial work has identified the theme of positive mental health and well being as a priority for partner agencies.

4.6 South Lanarkshire Council 🕮

4.6.1 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.

4.6.2 **Community Planning** 🕮 🗣

An updated community plan 2002/4 was launched in October 2002. Health services are involved in most of the 7 theme partnerships, with the main emphasis on the new Health and Care Partnership. This partnership leads on all health planning activity including the joint health improvement plan, joint community care plan and the Local Partnership Agreement. In addition it will oversee the implementation of the New Leaf Regeneration Strategy – a document setting out a health, social and economic vision for the local area.

4.6.3 Cambuslang/Rutherglen is also to be one of the Scottish Executives 12 pilot sites for Community Budgeting. This places emphasis on identifying financial frameworks at a local level to enable the best use of resources and improve service delivery.

4.6.4 Some current actions being addressed by all theme partnerships include:

- Identifying cross cutting issues to streamline activity.
- Developing user involvement.
- Identifying training needs for partnership working.

4.6.5 **Joint Futures**

Building on the recent Local Partnership Agreement, health and social care colleagues are working to develop single shared assessments. A tool for Older People will be introduced in early 2003, with assessments for Mental Health and Addiction services following on in 2003/4.

4.6.6 There are currently two integrated health and social care teams being developed in Cambuslang/Rutherglen, - a Community Older People's team and a Community Addiction Team. Both are expected to become operational in early 2003 taking forward jointly managed and resourced services. Further consideration is being given to joint management across all adult and older people community care services.

4.6.7 **Health Improvement** 🕮 🗣

The Cambuslang/Rutherglen Healthy Living Initiative has been successful in its bid for funding. This project is now being taken forward by the local community providing the main vehicle for the promotion of healthy living activity locally.

4.6.8 The priorities identified in the Health Improvement Plan are also being taken forward across South Lanarkshire. These include:

- An audit of health promotion activity.
- Developing LHCC area needs profiles to include population, health, housing, education, employment statistics.
- Developing initiatives to provide opportunity for physical activity
- Support to the health improvement agenda for children and young people.

There is a requirement for a GGNHSB investment of around £70K to support this range of work and secure user involvement. **£**

4.7 East Renfrewshire Council

4.7.1 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.

4.7.2 **Community Planning**

East Renfrewshire Council has created 4 policy groups in line with the 4 themes of the Community Plan these include:

- Caring and Healthy Communities.
- Opportunities for Lifelong Learning.
- Safer Communities.
- A Sustainable and High Quality Environment.

4.7.3 Each policy group is chaired by a senior politician, and includes a number of elected members. Work plans outlining actions and priorities have been produced for each of the groups. The approach to community planning is currently being re-assessed in light of the most recent guidance.

4.7.4 The remit of the caring and healthy communities group includes:

- Tackling health inequalities.
- Promoting health awareness.
- Modernising health and social care services in the community

4.7.5 **Joint Future**

Joint Future is an integral part of the community planning process. The Caring and Healthy Communities Policy Group is driving forward this agenda. The overall approach has been shaped by the configuration of the Local Authority across 2 Health Board areas. East Renfrewshire wide structures on joint strategy, joint resourcing and performance are complimented at locality level by the Eastwood Joint Planning Steering Group with assorted care group strategy groups.

4.7.6 Attention has concentrated on implementing the main actions from the initial local partnership agreement.

- A single shared assessment model has been modified in practice with the Eastwood community older people's team (COPT) to make it more streamlined and workable.
- Future joint management arrangements under discussion are likely to proceed in evolutionary stages building on the positive experience of the COPT to generate a sustainable solution across all of East Renfrewshire. We are actively seeking agreement with Argyll and Clyde NHS Board on a coherent NHS approach.
- On joint resourcing work is underway to examine the practicalities and implications of aligned budgets built on improved understanding of individual financial processes and structures.
- Work on developing a shared performance framework has recently commenced.
- A single older people's strategy has been drafted which will provide the basis for agreements on overall priorities and targets.

4.7.7 **Health Improvement**

The Health Improvement Action Team is focusing on:

- Implementation and monitoring of the Joint health Improvement Plan.
- Mapping existing health related policy and activity across East Renfrewshire in order to identify gaps, overlaps and priorities.
- Devising a core heath data set.
- Influencing the strategies, plans and services of all agencies in order to maximise their public health impact and ensure they are health sensitive.
- Developing a strategy for involving the community via existing structures.

4.7.8 There is a requirement for a GGNHSB investment of around £80K to support this range of work and secure improved public involvement. **£**

4.8 **North Lanarkshire Council** 🕮

4.8.1 The Stepps-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.

4.8.2 **Health and Care Partnership**

The Health and Care Partnership, brings together health and Local Authority partners across North Lanarkshire, has agreed a revised planning structure to progress the community care Joint future agenda. The Joint Future Implementation Group has been established to implement the aims and actions of the Local Partnership Agreement. The initial partnership agreement received a favourable response from the Scottish Executive. Significant progress has been made in delivering the joint future requirements including the development of single shared assessment processes including information sharing, intensive support and care schemes, early supported discharge teams and the creation of a joint equipment store. The work plan currently focuses on delivering joint management arrangements, joint resourcing and developing a joint performance framework.

4.8.3 The third tier of planning is Local Care Partnerships, multi-agency groups charged with the responsibility of implementing Joint Future in localities. The Eastern LHCC are active members of the Cumbernauld Partnership. Early work has focused on training for single shared assessment, improving hospital discharge arrangements and community older peoples services.

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**: 🕮

A strategic framework for services for frail older people and older people with dementia/mental illness has been developed and is currently subject to consultation. The framework is structured around a hierarchy of need ranging from the lowest level where services are required to promote good health and well being, encourage independence, and prevent disability. At the other end of the scale complex packages of care are required to respond to intensive care needs.

The current year has seen significant service development:

- The introduction of an enhanced model of GP support to residents on nursing homes funded from the PMS initiative.
- The development in each locality of multi disciplinary community older peoples teams.
- Acute hospital based teams to support discharge, prevent inappropriate admission and nursing home liaison.

The strategic framework has identified a number of services and investment priorities:

- The need to further develop and invest in rehabilitation services in both hospital and community settings
- The development of a health promotion agenda for older people
- A falls prevention programme for residents of care homes and in domiciliary settings
- The need to develop fully integrated health and social care models for service delivery and planning
  Locality structures that improve care pathways and make services more responsive to client need.

5.3 Delayed Discharges

During the last calendar year, the number of people experiencing delayed discharge showed a small increase across Greater Glasgow due to an increase in admissions and pressure on the availability of care home places. This year, to date, has witnessed a fairly consistent position.

We have a detailed Action Plan for Delayed Discharges ✪ with the aim of reducing delayed discharges from 258 to 190 by the new financial year, with further reductions thereafter. Our programme already includes new long stay capacity, additional community infrastructure, rehabilitation, dementia community services, care packages for very long waiters and overnight care capacity. We will be discussing with planning partnerships the use of additional resources allocated by the SEHD in 2002/04. These may include the developments outlined in the strategic framework.

Key performance Indicators:

	Glasgow		Scotland	
	Baseline	**Current**	**Baseline**	**Current**
Percentage patients experiencing delayed discharge	**59.3**	**67.3**	**68.3**	**66.3**
Percentage beds occupied by delayed discharge	**6.3**	**8.0**	**11.3**	**11.2**

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 which has already begun to strengthen services and staffing at the Beatson Oncology Centre – which will be led by a new Medical Director taking up post during 2003. The Glasgow Group has already identified its key priorities:

- Meeting CSBS standards.
- Implementing multidisciplinary team working by investing, ensuring Glasgow patients have the best possible diagnosis and treatment.
- Working closely with Primary Care. **[meaning?]**
- Smoothing out bottlenecks in diagnostic procedures to ensure that care is delivered as quickly as possible.
- Investing in tertiary services such as surgical, medical and clinical oncology.
- Achieving the new Beatson Oncology Centre.

A detailed plan to address these will be published in early 2003 and incorporated into the final version of the Local Health Plan, including an update on our current position on National standards and plans to improve performance.

Among measures already taken are:

- Investing in the Beatson Oncology Centre
- Establishing Managed Clinical Networks to ensure high standards of care across the West of Scotland.
- Measures to improve communication between Primary and Secondary Care services
- Improving the provision of Palliative Care
- Improving our diagnostic services

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. Our agreed strategy required a reduction in delivery units from 3 to 2 and our expectation is that a process will be in place to enable the Board to take a decision in the early summer of 2003. This process will include linking to other Health Boards. Priorities identified for additional resources include foetal anomaly screening and antenatal HIV screening.

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.**

For 2003/04, priorities will include – establishing a teenage pregnancy co-ordinator with Glasgow City Council, additional resources for the Sandyford Initiative reflecting significant growth in attendances, extending sexual health screening, developing services for asylum seekers and improving sexual health services in primary care. **£**

Key performance Indicators:

	Glasgow		**Scotland**	
	Baseline	**Current**	**Baseline**	**Current**
Incidence of sexually transmitted diseases	**703.1**	**No updated**	**637.8**	**Not updated**

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.**

Patients with a variety of chronic diseases – CHD, stroke, diabetes, COPD, rheumatoid arthritis, MS and epilepsy – will have systematic management in primary care to standards set by expert working groups or MCNs for each disease. Seventy practices are undertaking a preparatory year for either CHD or stroke during 2002/03 and will implement the programme during 2003/04. This incremental approach will deliver all practices (or the LHCC on their behalf) delivering the programme in each disease area by 2005/06. Training and subsequent updates for each disease is being put in place, as well as Glasgow specific patient literature. The IT infrastructure, both in terms of networks and at a practice level, is being upgraded to support these programmes.

Other work in chronic disease management includes pain management, and during 2003-04 work to commission a pan Greater Glasgow NHS pain management programme will go forward.

For diabetes, a new service will be implemented across Greater Glasgow in 2003-04, transferring to GPs of many patients, improving specialist services, comprehensive retinal screening and a comprehensive diabetes register.

For MS, the chronic disease management programme is in development, for implementation in 2003/04, likely to require a register of people with MS and annual review.

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. The Oral Health Planning and Implementation Group, formed in 2002, to provide a fresh and comprehensive impetus to our efforts to tackle the poor dental health of our population, is preparing a full Oral Health Strategy. This will require new investment to strengthen community dental health teams, complete the roll out of oral health action teams; provide target interventions for vulnerable children, develop special needs services and modernise the general anaesthetic and sedation services **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.**

In 2002/03, we have further developed the heart failure liaison nurse service, guidelines have been agreed for a number of key clinical decisions and service redesign is underway.

For 2003/04, we will implement the review of catheter laboratory services, begin to implement a comprehensive IT strategy and put in place culturally sensitive rehabilitation services.

The CHD and Stroke Strategy for Scotland, published in November 2002, sets a number of priorities, including a requirement to establish a managed clinical network for cardiac services. ✪

We believe our current planning and implementation group for heart disease – bringing together primary, secondary and tertiary care as well as health promotion and prevention meets these requirements. A final version of the Plan will describe those arrangements in more detail and how we will address the specific issues outlined in the strategy.

Shown below is our performance against the National waiting times targets which include a maximum 12 week wait for angiography and achieving a 24 week maximum wait for intervention to cardiac surgery or angioplasty – 100% delivery by December 2002.

October 2002 – All NHS Board Residents – Waits Over Target

CHD	Target	Total
Angiography	12 week maximum	64
Angioplasty	12 week maximum	18
CABG	24 week maximum	3

Initiatives are in place to clear the current longer waiters and the review of the use of the catheter laboratories has been undertaken and that, along with additional review of clinical procedures, will ensure that the longer term situation is kept within the guarantees.

5.11 **Stroke:** 🕮 🐑

We have a planned programme of change for stroke services which have already improved a number of aspects of acute services, including early specialist advice and investigation and acute care in South Glasgow.

The CHD and Stroke Strategy for Scotland, published in November 2002, sets a number of priorities, including a requirement to establish a managed clinical network for stroke services. ✪

We believe our current planning and implementation group for stroke – bringing together primary, secondary and tertiary care as well as health promotion and prevention meets these requirements. A final version of the Plan will describe those arrangements in more details and how we will address the specific issues outlined in the strategy. As well as the critical need to achieve stroke units on every acute site, particular challenges also likely to require new investment include waiting times and imaging capacity. Our review of SIGN guideline requirements has highlighted a number of service and staffing deficits – our aim in 2003/04 is to develop firm proposals to address these issues and seek substantial new investment in 2004/05. **£**

Key performance Indicators:

	Glasgow	**Scotland**
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.

For 2003/04, priorities are: implementing the review of termination services, ensuring primary care and specialist mental health services are implemented with a gender perspective, addressing variations in cervical and breast screening uptake, evaluating sexual abuse services and identifying ways of including women's views into service and practice developments**. £**

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. Small financial allocations enable a direct service response and development work in frontline health services, including primary care, maternity and accident departments. During 2003/04 we will develop a comprehensive implementation plan for Scottish Executive guidance for healthcare workers. **£**

5.14 **Ethnic Minority Health:** 🕮 🐑

A pan NHS Greater Glasgow group will be established to co-ordinate the response to the Race Relations (Amendment) Act 2000, the Scottish Executive's 'Fair for All' guidance on developing culturally competent services, and NHS Greater Glasgow's Race Equality Policy. Substantial work has gone into developing Race Equality Schemes and action plans will be developed and implemented to mainstream race equality into the planning and delivery of health services and employment.

In particular, action will take place around further developing the multi-agency Interpreting Partnership, training of NHS staff in race equality and cultural competence, and exploring ways of listening to minority ethnic communities and engaging them in health service planning and review processes. **£**

5.15 **Asylum Seekers:** 🕮

We provide services to around 10,000 asylum seekers and refugees who have been dispersed to Greater Glasgow. Around 80% of our applicants are getting positive decisions and the vast majority are staying in Glasgow.

The main profile of this population is family groups with high levels of physical health and some mental health needs. The cost of providing care will rise to around £3 million, including interpreting services, during 2003/04 – we have not received any additional funding from the Scottish Executive Health Department, but as asylum is granted the people become part of indigenous population and should positively influence our Arbuthnott allocation. **£**

5.16 **Homelessness:** 🕮

We are working with each Local Authority in the development of homelessness strategies which will incorporate the health and homeless action plans already in place. We are partners in the Glasgow City integrated planning arrangements to tackle homelessness. During 2002/03 services for addictions, physical and mental health were extended and a primary care practice for homeless people was implemented. Substantial new resources allocated to close Glasgow City's large hostels will enable further health service development. **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. There are financial pressures on these services as numbers of people with learning disabilities are increasing**. £**

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:

5.18.1 **National Targets**:

- 12 month guarantee consistently delivered.
- Maximum 9 month wait by December 2003.
- Maximum 6 month wait by December 2005.

We have had significant pressures to consistently deliver the 12 month guarantee, particularly for orthopaedics. For the 9 month target our aim is to achieve a 50% reduction by March 2003 and detailed plans are in place to achieve that, including significant private sector and National Waiting Times Centre activity.

We are developing plans with Trusts to achieve the final reduction between March and December 2003 and to achieve a sustainable position at a 9 month maximum, shifting to a 6 month maximum to meet the end 2005 target. Achieving and sustaining these positions may require significant capacity increases, particularly for orthopaedics and probably plastic surgery. The final version of this Plan will reflect our detailed proposals.

5.18.2
- 75% of out-patients seen within 3 months.
- 6 month maximum wait for out-patients by 2006.

Our performance on the 75% target has slipped from 73% 9 months ago to a current 61%. We are trying to understand and address this deterioration.

5.18.3 **Local Targets**:

Our 2001 Health Improvement Plan set 3 local targets:

- Maximum 6 month wait for cataract and joint surgery.
  Achieved in 90% and 62% of cases respectively.

- Working towards a maximum out-patient waiting time of 15 weeks.
  Achieved in 75% of cases.

- Reducing waiting times for imaging.

5.18.4 Reflecting the importance of reducing waiting times and our commitment to take a whole system approach, we will have established a Greater Glasgow patient access team by the start of 2003/04 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:

	Glasgow		Scotland	
	Baseline	**Current**	**Baseline**	**Current**
Mean wait in days	**55.6**	**56.7**	**61.4**	**64.2**
9 month guarantee not met	**7%**	**6.8%**	**4%**	**4.9%**
Surgery rates:				
– **Hips**	**254**	**247**	**359**	**351**
– **Knees**	**282**	**295**	**294**	**309**
– **Cataracts**	**1,846**	**2,098**	**1,961**	**2,100**
– **CABG**	**677.3**	**225**	**633.0**	**234**
Out-patients > 12 weeks	**73%**		**75%**	

5.19 **Physical Disability:** 📖 🗣

A strategic framework document has been developed in conjunction with Glasgow City Council to set the direction of future planning for health, social care and voluntary agencies. The document focuses on developing a whole systems approach to service delivery across primary, secondary and social care organisations. It is intended this will be achieved through collaborative working between agencies and encouraging the best use of professional skills that move outside traditional ways of working. Key recommendations include:

- The development of a number of facilities across Glasgow providing integrated health, social care and voluntary sector provision linked together to form a comprehensive network of support.
- Provision of a single, jointly, managed accessible information service.
- Expansion of home care services.
- Investment in joint training to support changes in working practice.

This strategic work is underpinned by a comprehensive financial framework that identifies significant investment needed in a range of services. As part of the development of this strategic approach, discussions will be initiated with all Local Authority partners to agree a comprehensive future planning programme across all Greater Glasgow. **£**

For head injury – the new community link service is now open. The service will include data collection to assess the effectiveness of different interventions. New resources are needed for acute care to achieve appropriate specialist observation and assessment. **£**

5.20 **Child Health:** 🕮 

Our detailed programme of work on child health includes:
Work with Local Authorities to take forward the recommendations of For Scotland's Children by:

- Developing flexible family support services for vulnerable families which can be accessed by all professionals.
- Strengthening the planning and delivery of services at a local level, learning from the Joint Futures model and including learning communities.
- Supporting the roll out of the new community school approach, with additional investment in health development officers and the school health service.
- Monitoring and evaluating the use of the Changing Children's Services Fund.

Ongoing implementation of strategies for:

- Child and adolescent mental health, concentrating on recruitment to community teams and specialist city-wide teams for looked after, learning disabilities and forensic services.
- Ensuring a good start in life, which is taking forward the family support model and the development of family learning centres.
- Breastfeeding.

The change programme includes:

- Developing and extending the Starting Well programme.
- Implementing the recommendations of the report of the Child Protection Audit and Review.
- Reducing waiting times, focusing on out- patient paediatric surgery.
- Agreeing a capital programme for acute and community paediatric services within an affordable revenue framework.
- Redesigning services at the interface of primary and secondary care through the Clinical Forum.

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.

5.22 **Reviewing Emergency Admissions**

The work to finalise the Acute Services Strategy highlighted the major problem in the present acute receiving services, including coping with rising demand.

This issue cuts across our capacity to deliver elective services, undermines the quality care for patients and puts enormous pressure on staff. We have established a comprehensive review of emergency admissions with the aim of:

- Produce an accurate forecast of future activity.
- Identify and implement systems and process changes to improve management of acute medical admissions in the short-term.
- Identify and implement systems and process changes to support the long-term reduction of acute receiving sites.
- Confirm the capacity and infrastructure required to accommodate acute admissions and investment needed.
- Develop and implement a change management plan to support the development of new service models.

We will consider an interim report in the early part of next year, with short-term action to be in place during 2003.

5.23 **Hospital Acquired Infections**

Hospital Acquired Infections (HAIs) are detrimental, not only to patients acquiring them, but to the health system as a whole. HAIs close wards and can prevent new patients receiving key treatments.

To combat HAIs, GGNHS has:

- Begun working on new standards for HAIs, to be published by summer 2003.
- Invested in the implementation of National guidelines.
- Strengthened the Area Control of Infection Committee.
- Provided more support for frontline control of infection nursing teams.
- Re-emphasised the importance of this issue by building HAIs into Clinical Governance for GGNHS. **£**

5.24 **Critical Care**

Pan Glasgow work on critical care services has highlighted a umber of pressure points – during 2002/03 we expanded ITU capacity at Stobhill Hospital. For 2003/04 we expect capital work to expand the GRI ITU service – we also need to take stock of pressures on the Southern General ITU and a pan Glasgow audit of medical HDU. **£**

5.25 **Primary Care**

The key strands of the Primary Care Strategy – investing in older people's services, mental health, addictions and chronic disease management, are highlighted elsewhere in this section. Achieving the key National priority of achieving 48 hour access will be a function of all of those different strands of activity.

The target is defined by SEHD as:

"access to an appropriate member of the primary care team by direct contact (telephone or face-to-face) between the patient and the professional in line with the practice's consultation arrangements where:

- Professional, clinical advice is sound and given within 2 working days in accordance with the clinical needs of the patients; and
- A professional, clinical opinion and/or diagnosis is required in order to determine a further course of action, eg to treat, to refer or to provide professional advice."

Defining Professional and the Primary Care Team

- Professional means a doctor, nurse or health visitor in the practise within which the patient is registered, who is competent to deal with patient's clinical needs.

Our baseline audit in June 2002 suggested:

A total of 179 (83%) practices were surveyed and the results showed that 74% of practices were able to meet the target. The remaining 26% were unable to offer a routine appointment within 48 hours.

Our specific action plan to achieve this target, which has been submitted to the SEHD highlights new services included in the Strategy which will contribute to:

- Chronic disease management
- PMS for homeless people and nursing home residents
- Primary care mental health
- Improved IT
- Community older people's services
- Community addiction teams.

Further initiatives include:

- Self referral to paramedical services
- Practise redesign
- Over the counter medication trials
- Introducing assessment and triage
- Ophthalmology redesign
- Improved data collection and monitoring

The additional cost implications, beyond planned investment, need to be included in the financial planning process our aim is to achieve the target by April 2004. **£**

5.26 **Neuroscience**s

We are committed to the development plan agreed with West of Scotland Boards which will improve access to intensive care, tackle bottlenecks for investigations and reduce out-patient waiting time – as soon as agreement is reached on funding.

We have implemented the National risk sharing guidelines to provide beta interferon for people with Multiple Sclerosis who meet the clinical criteria. This was not an investment priorities which was set by our MS Planning Group. Finding the resources for the drug cost will be a major financial issue and we have not expanded capacity to assess these patients as a higher priority than other people waiting for a neurology service.

6 INTEGRATING SERVICE AND FINANCIAL PLANNING 🕮

This chapter sets out the financial framework which underpins the current Health Plan and describes issues for 2003/04 financial planning

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
  - Primary care and other community services.

6.3 It was explicit that these non-acute 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 that 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. For acute services the Acute Services Review sets a macro financial framework.

6.5 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.

6.5.1 **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. In 2003/04 we will receive an additional £2 million to deliver new health services for homeless people.

6.5.2 Two significant issues about our Arbuthnott 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.

6.5.3 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.

6.5.4 **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%

6.5.5 As well as the above streams of expenditure, we have a programme of Health Improvement activities underpinned by a specific stream of funding. This funding is non-recurring and was due to end at the start of 2004/05, although there is now a reasonable likelihood of continuation for further years. 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 priorities.

Paragraph 6.5.7 and 6.5.8 describe the pressures on inflation against the framework assumptions.

6.5.6 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 requires an additional £3.35 million funding, above the acute programme share. Similarly, additional funding with recurring consequences of £0.5 million was made available to Yorkhill.

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

Pay	4%
Non Pay	2%
Prescribing	10%

6.5.8 There are upward pressures on pay settlements, including the new consultant contract and 'Agenda for Change'. For non pay the hospital prices index has been consistently low but there is a continuing debate about IT 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.

6.5.9 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. Such an approach may undermine existing investment commitments on other programmes and certainly reduces resources available for new pressures and development priorities and should be judged in the context of an overview of spending priorities. In addition, many of our resources are now tied into formal partnerships, for example through joint community care committees.

6.5.10 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, but has been required to meet excess capital costs of £1.2 million until a delivery unit is closed.

6.5.11 Planning work to inform this Local Health Plan update has generated an initial sense of a number of pressures and investment priorities beyond current financial plans which the Board will need to consider in reaching final financial decisions in March 2003. Many of these points are covered in more detail in the text in Section 5, they are summarised below. These issues are products of our structured and sponsored planning activity and it is important that we respond to them in that way to retain the credibility these planning processes.

6.5.12 Acute Services

Pressures:
- Junior Doctors
- Drug Costs, including Beta Interferon
- Recurring 2002/03 commitments

Priorities:
- Emergency admissions
- Cancer
- Waiting times
- CSBS standards
- Head injury services
- Stroke services

6.5.13 Primary Care and Other Community Services

Pressures:
- Prescribing costs
- Methadone programme
- Asylum seekers and interpreters
- SIP funding changes
- Sexual health

Priorities:
- Oral Health Improvement
- Local Authority Health Improvement
- Smoking cessation
- Extending chronic disease management
- Rehabilitation
- Domestic violence

6.5.14 Mental Health

Pressures:
- Drugs Costs
- Junior doctors
- Capital indexation

Priorities:
- Eating disorders and perinatal services
- Challenging behaviour services

6.5.15 Child and Maternal Health

Pressures
- Recurring 2002/03 commitments
- Excess maternity costs.

Priorities
- School Health services
- Forensic team
- Antenatal HIV screening

6.5.16 Financial issues which do not relate to a particular programme include:

- Development funds required to support National services.
- Cervical screening changes.
- Pharmacy Strategy.

6.5.17 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 in advance of programme shares.
- How the flow through of 2002/03 decisions, beyond programme shares is addressed.
- Which assumptions we make about further funding for National priorities.
- What are the priorities for further investments?

7 DELIVERING THE 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, covering:

- Unified Board development.
- Staff governance and partnership working.
- Communication.
- Workforce planning.
- Information management and technology.
- Modernisation and service redesign.
- Education and training.
- Trust contributions
- Public involvement

7.2 **Unified Board Development**

During 2002/03 the Unified arrangements at Board level began to come together – an indication of progress so far and our plans for 2003/04 are described below:

- Development of corporate and executive directors objectives.
- Cross Glasgow acute services implementation.
- Local health plan steering group.
- Extending seminar programme to include other key interests.
- Unified communication structure.

7.3 **Staff Governance and Partnership Working** 🕮

Our approach in 2003/04 will focus on a number of issues continuing to address the issues in the March 2002 Staff Survey – the key results of which included:

- The majority of staff enjoy working in NHS Greater Glasgow.
- Staff are generally happy with communications and the information provided to them but there is concern about the timeliness.
- Staff are uncertain as to how to ensure their views and suggestions are fed into the system and are wary about speaking up and challenging the ways services are organised.
- Staff are not very aware as to what goes on in other departments and services.
- The majority of staff have access to some form of training and personal development but there was some frustration that their needs were not being properly assessed.
- There was low awareness of the Partnership Fora.
- Most staff feel their workplace provides a safe and secure environment but those working with patients have concerns about violence and aggressive behaviour.
- 1 in 10 of those staff who replied to the survey felt they had experienced some level of harassment – shouting, threatening – from managers or colleagues – very few ever report these incidents.
- 3 in 5 staff who responded to the survey feel stressed due to increasing workload.

A number of actions throughout this Plan contribute to tackling these issues – for example, the review of emergency admissions will focus on reviewing the pressures on staff.

We will develop the roles of Area and Local Partnership Fora to provide genuine input to the Local Health Plan. A key element of our corporate communications development is to focus on staff most particularly on ensuring that staff are fully aware of the Local Health Plan and how they can link to it.

Nationally the launch of 'Agenda for Change' is a major opportunity too. On the Joint Futures agenda we have in place a number of Joint Partnership Fora with our Local Authorities to give a forum in each area to debate emerging issues to concerns. A staff governance committee, co-chaired by the Board Chair and Employee Director, is in place to develop its work programme to:

- Create a culture for delivering the highest possible standard of management to support all staff.
- Address the need to agree a personal development plan for all staff working in NHS Greater Glasgow.
- Approve action plans for improvement based on the Area Partnership Forum's review of local partnership fora responses to issues highlighted in staff surveys.
- Develop, by March 2003, an agreed approach to self assessment audit to be conducted by each local partnership forum.
- Ensure that, by February 2003, an agreed action plan is finalised which prioritises areas for improving the occupational health and safety of staff across NHS Greater Glasgow.
- Creating a more inclusive approach to the development of the Local Health Plan and ensuring that any resource implications of implementing improvements in the staff governance arrangements recommended by the Staff Governance Committee are considered by the NHS Board when considering competing priorities across the fields of the Health Plan.

To support the work of the ICT Strategy Group in responding to the energy, enthusiasm and commitment of clinical staff to improve services to patients and carers through the effective use of Information Technology.

7.4 Communication

The current Local Health Plan committed us to develop effective and comprehensive communication strategies. The implementation of the Unified communication structure, described above, will enable GGNHS to deliver information, engage with the public, our staff and partner organisations, and allow involvement in decision making to all.

Early in 2003 and through into 2004 and maintained beyond, the GGNHS system will deliver a comprehensive mass communication strategy underlined by strong public involvement actions to engage and inform the widest possible audience of the planned modernisation of Greater Glasgow's acute hospital and service provision.

This will focus on traditional print media publications, distributed freely through newspaper dispensers throughout Glasgow's pharmacies, libraries, supermarkets, hospitals dental and optical outlets. The GGNHS News will also feature key areas of development such as NHS 24, health improvement and education campaigns. It will promote awareness of a new one-stop GGNHS website portal.

This will compliment a more proactive NHS programme of activity in the mainstream local, regional and National print and broadcast media circulating in Greater Glasgow, directed at both media feature and new releases and in advertising campaigns.

The GGNHS website portal will show the vision for future acute hospital provision offering the chance to take a 'virtual tour' of new acute facilities and the reasons behind the need for change. CD-Rom presentation and information packs – detailing, in clear, unambiguous language, will be issued to groups identified in the Public Involvement Network and to any other individual or group who contacts GGNHS Board, or any Trust, via the newspaper communication or GGNHS web link. NHS staff will deliver such presentations, as and when required, to community and professional organisation groupings.

Web based information kiosks, planned city-wide, will carry detailed information on the modernisation programme, the Local Health Plan and health improvement campaigns. These kiosks will also provide key messages in various language options.

Close tie-ups with NHS 24 will provide a key opportunity for GGNHS mass communications to promote NHS 24 services, directing the population of Greater Glasgow to their 24 hour on-call service to provide health information specific to individual needs in their specific locality.

The key elements of our communication plan for the coming year will include:

- Health plan involvement and engagement on an ongoing basis.
- Acute hospital modernisation strategy.
- Maternity services consultation.
- NHS staff communication.
- Communications with the staff of partner organisations in Local Authorities and other associated bodies.
- Support for voluntary sector organisations to use NHS mass communications vehicles to the common good.
- Health improvement and ease of access to all NHS services and links to those provided by partner organisations.
- Promotion of public health issues such as immunisation programmes.

7.5 Local Health Plan Steering Group 🕮

[text to follow]

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 our first workforce plan will be in place for the final Local Health Plan.

7.7 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.

Insert material from progress report.

7.8 Modernisation and Service Redesign

Text to follow.

7.9 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.

7.10 Trust Contributions

This section will briefly describes the contribution each NHS Trust will make to delivering the overarching objectives set out in Section 1 and to the strategic health issues outlined in Section 3.

7.11 **Public Involvement** ✪

The Plan reflects a wide range of public involvement:

- In consultation on specific proposals
- Routine engagement of users and patient interests in a range of service planning and in Trust structures.
- With Local Authorities engaging local interests in community care and community planning structures.

The draft interim National guidance was issued for consultation in May 2002. The Board approved a detailed response and final National guidance is awaited.

Earlier in 2002, the Board approved proposals to establish a process to build the infrastructure for public and patient involvement in the development and delivery of service. Two open events led to the formation of a Steering Group, with a wide range of representation, to lead the establishment of a public involvement network (PIN) which would provide:

- Leadership and co-ordination to mainstream public involvement into service delivery operating at strategic and frontline levels.
- Support and facilitation to frontline NHS staff in taking forward public involvement activity.
- Knowledge management – a readily accessible database of activity and practise.
- Resources – both locally carved to and drawn down from National initiatives.

A proposal is before the Board to finalise management arrangements for the network and approve a detailed action plan for its function. The PIN will lead the establishment of an overall public involvement strategy as an overarching framework for the wide range of local activity already in place and for emerging National Strategy and Policy.