

## Greater Glasgow NHS Board

### Board Meeting

Tuesday 17<sup>th</sup> May 2005

Board Paper No. 2005/40

Director of Planning and Community Care  
Acting Director of Finance

## Local Health Plan and Financial Strategy - 2005/06 Update

### Recommendation:

The Board is asked to:

- **approve this update to the 2002/2007 Local Health Plan;**
- **confirm the proposed financial proposals for 2005/06 as set out in Section N of the Local Health Plan**

### A. BACKGROUND AND CONTEXT

1.1 The Board approved the five year Local Health Plan (LHP) and financial strategy which underpinned it in May 2002. The purpose of the LHP is to:

- enable the Greater Glasgow NHS Board to set a clear direction and priorities to deliver our three key objectives which are to:
  - improve health;
  - improve health services;
  - tackle inequalities;
- 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 five years to 2007 and its content was a product of a whole range of different planning processes which include Local Authorities, NHS staff and other stakeholders. The full document provides an overview and signposting to detailed plans.

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- 1.2 This update is focused on 2005/06 and provides a short summary of our key local priorities for this year, how we intend to deliver the requirements of national priorities and, finally, sets out the financial plan for 2005/06.
- 1.3 The 2002/2007 Local Health Plan reflects a number of key strategies:
- implementing the Primary Care Strategy and associated new investment;
  - priority developments in acute services and, in later years, the revenue costs of capital investment to deliver the Acute Services Strategy;
  - substantial expansion of drug and alcohol services;
  - joint investment, with Local Authorities, in the development of community care services;
  - investment in community children's services, including mental health;
  - implementing the Modernising Mental Health strategy.
- 1.4 The financial plan which underpins the LHP had five main pillars of financial policy:
- to ensure, over a five 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 Divisions;
  - the requirement to make adequate financial provision to cover the increased costs of replacing old hospital facilities;
  - relieving the pressures on Acute Divisions to enable underlying deficits to be addressed and Division 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.

The Plan therefore included details of how growth monies for four spending programmes, acute hospital services, adult mental health, child and maternal health and primary and community services, would be allocated.

In approving the plan for 2004/05 we had to recognise a number of very significant financial issues which left us with a major gap in making realistic provision for inflation and other pressures while continuing to honour all of our forward commitments. Therefore the Plan for last year included substantial review of financial commitments and a major corporate recovery plan to ensure a return to financial balance. The finance section of this 2005/06 Plan reflects further review of forward programmes and development of that recovery plan as pressures on pay inflation and funding requirements to meet national priorities continue. The finance section also highlights a further requirement to close a remaining small gap between available resources and commitments and the major area of potential risk relating to the costs of the new, nationally negotiated, general medical services contract, over the costs of which the Board has no direct control.

- 1.5 A further critical point of context is that 2005/06 is a transitional year as we move from our present organisational arrangements into the reformed Greater Glasgow NHS with a new planning and performance system linking the Community and

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Mental Health Partnerships and our Acute Division into a single NHS system. It has therefore been important in updating the Local Health Plan to ensure a continued focus on delivery against our key priorities and a robust financial plan.

### **B. HEALTH PLAN PRIORITIES**

2.1 The Local Health Plan identifies a number of priorities and subsequent sections of this update set out our priorities for 2005/06 for those priority areas which are:

- C. **Mental Health** (also a national priority)
- D. **Child and Maternal Health**
- E. **Developing Addiction Services**
- F. **Modernising Acute Services**
- G. **Stroke** (also a national priority)
- H. **CHD** (also a national priority)
- I. **Cancer** (also a national priority)

2.2 In addition to the local priorities this update reports on further national priorities. These are:

- J. **To improve the health of everyone in Scotland and to reduce the gap between the health status of people living in affluent and more deprived communities.**
- K. **To modernise NHS services to better meet the needs of patients by promoting service redesign.**
- L. **To actively involve the people of Scotland, including communities, patients and carers, in planning and delivering NHS services.**
- M. **To ensure patients receive healthcare at the right time in the right place and in the right way by:**
  - **ensuring that everyone contacting their GP surgery has guaranteed access to a GP, nurse or other healthcare professional within 48 hours;**
  - **reducing waiting times for inpatient, day case and outpatient treatment;**
  - **ensuring that patients who no longer need hospital treatment are discharged as soon as possible into appropriate care;**
  - **reducing healthcare associated infections and providing a clean, hygienic healthcare environment.**

### **C. MENTAL HEALTH**

3.1 For mental health services a detailed strategy for modernising mental health services and facilities was approved by the NHS Board in May 2000. Over a seven to ten year period 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;

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- new social care services replacing NHS continuing care;
- better local access to modern NHS continuing care facilities;
- improved mental health promotion.

3.2 Subsequently the forthcoming Mental Health Act, to be implemented in Oct 2005, fundamentally revises the legal framework for compulsory treatment in community settings balanced by a number of checks and balances and service rights for users. The Act will require:

- provision of a range of age appropriate service responses to meet needs at the lowest level of restriction;
- access to 24/7 community services infrastructure to meet such requirements;
- arrangements to support the operation of appeals tribunals in which service users can challenge the application of compulsory treatment.

3.3 These requirements are broadly consistent with those anticipated in the Mental Health Strategy. However the additional broad local priorities to encompass the further requirements of the Act will be:

- ensuring consistent access to all components of the core community service range throughout the GGNHSB area;
- strengthening the capacity of crisis services to provide 24/7 assessment and treatment response and development of assertive outreach services;
- strengthening the health promotion and community development mental health focus of CHPs to promote the broader social inclusion requirements of the Act;
- ensuring the continued sustainability of the recently developed perinatal inpatient unit funded and provided on a West of Scotland basis through confirming the commitment of all West of Scotland Boards to these arrangements

3.4 The requirement to deliver integrated mental; health services within the context of the development of CHPs will require fundamental organisational and service reconfiguration to support the structural and geographic changes associated with such developments.

We have agreed detailed arrangements for the development of integrated community mental health services managed by CHPs. These will be underpinned by the development of a CHP Mental Health Partnership to ensure the coherence of service delivery between Community and inpatient services, and for services necessarily managed and delivered on a pan CHP or GGNHSB wide service.

3.5 The National Programme for Improving Mental Health and Well-being provides a framework for the organisation and delivery of mental health promotion. The four key aims being to:

- reduce stigma;
- improve public knowledge of mental health;
- reduce suicide;
- promote and support recovery.

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The programme then sets out 6 priority areas for delivering these aims. Locally these areas have been addressed by:

- Starting Well roll out;
- ten projects funded for work with schools and informal sector to promote emotional resilience;
- roll out of work development teams and support to employers on Healthy Workplace initiative;
- suicide awareness training and funding services for groups vulnerable to suicide;
- development of mental health literacy and anti stigma work.

3.6 During 2005/06 we will deliver:

- local implementation of the Mental Health Act consistent with its new legal obligations;
- expansion of crisis resolution capacity to assess and treat on a 24/7 basis;
- expansion of assertive outreach programmes of care;
- services for those with Alcohol Related Brain Damage, 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 inpatient 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;
- establishment of integrated mental health services in the context of CHPs and the CHP Mental Health Partnership;
- roll out of work development teams which support the transition of service users into employment;
- development and implementation of a framework for more structured local implementation of the National Mental Health and Well being strategy.

3.7 These developments in 2005/06 are part of the sustained 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 inpatient facilities.

## **D. CHILD AND MATERNAL HEALTH**

### **4.1 Integrated Children's Services Plan**

Guidance issued to Chief Executives of Local Authorities and NHS Boards on 11<sup>th</sup> November 2004 outlined revised planning requirements for children's services planning. It asked agencies to draw together their existing separate plans for school education, children's social work, child health and youth justice into an integrated Children's Services Plan from April 2005. Many developments in children's services

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are taken forward jointly with local authorities, but we have had to ensure that health issues in acute secondary and tertiary services are included, and that a similar set of information is given to each local authority that we are involved with. The specific service issues to be prioritised over the next three years are set out in the rest of this section.

### **4.2 Starting Well**

The National Demonstration Projects were invited to bid for further Scottish Executive funding at the end of the initial three-year period. The evidence from the first phase of Starting Well was used to develop a service model, which could be rolled out across the City, providing an intensive support service for the most vulnerable children and their families. The existing staff will work with Social Work colleagues across all Glasgow CHPs, providing a time limited intervention, which can be accessed by any agency. Teams in each CHP will comprise health visitors, nursery nurses, health support workers and social work staff. There will be a single management structure agreed by health and social work. The cost in 2005/06 is covered by the financial plan but as Scottish Executive money reduces in later years there are significant additional costs to be included in our forward financial plan.

### **4.3 Additional Support for Learning Act**

The Education (Additional Support for Learning) (Scotland) Act 2004 (the ASL Act) comes into force in September 2005. The Act updates the thinking about special educational needs, introducing the much wider concept of Additional Support Needs. Additional support needs can arise from any factor which causes a barrier to learning, eg, when a child is being bullied, has behavioural difficulties, has learning difficulties, is a parent, has a sensory or mobility impairment, is at risk or is bereaved. The Act places duties on Education and other services to meet the needs of children and young people with additional support needs. The current Record of Needs and Future Needs Assessment process will cease and new dispute resolution processes will be introduced. The Scottish Executive has allocated funding to local authorities and NHS Boards to address the duties of the Act. The table below describes our implementation plan for addressing the issues raised in the Act. It highlights the need for continued local funding of £277k per annum from 2008/09 when central support ceases.

### **4.4 New Learning Communities**

New Learning Communities are Glasgow City's vehicle for the roll-out of the integrated community school model. A New Learning Community is made up of a secondary school, its feeder primaries and the associated nurseries. It is denominational and excludes the SEN sector. There are 29 NLCs in Glasgow, and a similar model exists in other local authorities, supporting 52 secondary schools in total in the GGNHSB area. NLCs are charged with two primary responsibilities: increasing social inclusion and raising attainment. They are required to work towards becoming health promoting schools. A New Learning Community Principal supports each NLC, and the citywide NLC Joint planning Group gives direction. Work will begin in the next few weeks to look at how planning at school level can be part planning for children's services in CHPs.

#### **4.5 Community Health Partnerships**

Agreement has been reached with Glasgow City and East Dunbartonshire Council to move towards an integrated model of planning and delivering children's services within CHPs. This model of service considers organising children's services as a single system while recognising the continuing responsibilities of Local Authorities and NHS Boards, both as separate employees but also with different statutory responsibilities. The model avoids multiple assessments and provides a single route into services for families and referrers, ensuring there is clear responsibility for vulnerable families. The proposal is that, behind a front line advice and screening function, children and families who require specialist services would be directed to a joint health and social care assessment team.

It is proposed that the joint assessment and care management team would:

- provide an assessment and care management service to children and families;
- identify a care manager to provide an ongoing service following assessment to children and young people who are assessed as vulnerable due to a number of factors;
- provide intervention directly or arrange required interventions from the range of health and social care professionals within the team;
- the care managers within this joint team would have access to a range of health and social work teams offering specialist interventions and services;
- manage the transfer of the care management function to the specialist joint health and social care teams, where there is a single dominant issue.

Planning for this model has now begun, with a view to migrating towards it over the next 12 months.

#### **4.6 Changing Children's Services Fund**

This joint fund, allocated through local authorities resources a number of developments across health. Social work. Education, Culture and Leisure and the voluntary sector. Its continuation beyond the original temporary period (to March 2006) was confirmed in the spending review. However, it will move into local authorities' Grant Aided Expenditure over the next few years, and children's services planners have expressed concern that councils will be under pressure to use the funding in other areas. The Glasgow City Change Fund supported developments totalling £1.498million in 2004/05, most of which are recurring. This includes contributions to developments such as direct access psychology in schools, health staff in SEN schools and the homeless families healthcare team. Funding was allocated to support existing joint strategies and was agreed on an inter-agency basis.

#### **4.7 Health For All Children (Hall 4)**

The recommendations in Hall 4 reflect a move away from a wholly medical model of screening for disorders, towards greater emphasis on health promotion, primary prevention and targeting effort on active intervention for children and families at risk. Hall 4 is based on the principle of universal access to NHS services, leading to service delivery tied closely to identified need. All families will be offered the core screening and surveillance programme, including immunisation, information and

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advice on services. In addition, some families will be offered additional structured support and others will be offered intensive support. Hall 4 also recommends orthoptist vision screening for pre-school children and universal newborn hearing screening (UNHS). No additional funding has been identified to implement Hall 4, and the Child Health team is working closely with the health visiting service and the school nursing service to develop an implementation plan. UNHS will be implemented in the early part of 2005/06 at a cost of £300k that year and £213k recurrently.

### 4.8 Mental Health

In the autumn of 2000, the Scottish Executive commissioned a needs assessment of the mental health of Scotland's children and young people. The resulting Scottish Needs Assessment Programme (SNAP) report on Child and Adolescent Mental Health was published in 2003 and made 10 broad recommendations. Some have implications at a national level; some for local strategic planning; and others for local practice. The National CAMH Development Group agreed to develop a framework to assist local health, education and social services in planning and delivering integrated approaches to children and young people's mental health across the continuum of promotion, prevention and care. This Framework for Promotion, Prevention & Care is the result, and is intended to be used by local agencies to identify goals and milestones to secure continuous improvement in the delivery of services and approaches to support and improve the mental health of children and young people in Scotland. It is currently out for consultation. Much that is described within this Service Framework is already happening somewhere in Scotland, and in the final document, we hope to include examples of activity drawn from contributions provided by those who respond to the consultation. All of the elements outlined in the Service Framework are expected to exist within local services within 5 years.

Over the same period of development as the Framework for Promotion, Prevention & Care, a separate working group has been giving detailed consideration to the size, configuration and commissioning arrangements for psychiatric inpatient services for children and young people in Scotland. The Inpatient Working Group has presented a report which recommends that Scotland has one nationally commissioned psychiatric inpatient unit for children and 3 regionally commissioned psychiatric inpatient units for adolescents. The West of Scotland Adolescent Consortium has agreed the outline business case for a 24 bed adolescent psychiatric inpatient facility at Stobhill which aims to be open in September 2007. The annual revenue costs for Greater Glasgow will be £998k from 2007/08.

A pilot Adolescent Eating Disorder Day Service has been developed over the last 2 years and has had a significant impact on the provision of treatment for low weight anorexia.

Other priorities for the Joint Commissioning Group for CAMH in the next 3 years include:

- developing a Mental Health Act adolescent resource to support young people in adult psychiatric wards (£150k from JLIP);
- rolling out School Based Counselling to all schools in East Dunbartonshire and phased roll out in Glasgow City (£150k - already in base);



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- jointly commissioning Notre Dame child guidance centre with GCC social work and education, providing an agreed service level for joint agency priorities;
- commissioning a Young People's Advocacy Service to meet our requirements under the Mental Health Act. (£65k from JLIP);
- redesigning the Autism service for children and young people, combining tiers 2, 3 and 4 to reduce waiting times, improve early detection and improve joint treatment programmes.

### 4.9 **Breastfeeding**

The aim of Glasgow's Breastfeeding Strategy is to encourage and support more women to breastfeed. The Strategy objectives are grouped in three areas:

- adopting breastfeeding best practice for professionals;
- promoting social and attitude change so that breastfeeding becomes accepted as the normal feeding choice;
- monitoring changes in breastfeeding rates and targeting areas with low breastfeeding rates.

Infant Feeding Policy and Guidelines have been developed within NHS Greater Glasgow to help ensure consistent, evidence-based practice throughout the area. This inclusive document, covers care for formula feeding mothers and the introduction of complementary (weaning) foods, as well as breastfeeding. Two priority areas for the promotion of breastfeeding in Glasgow include the rollout of both the Breastfeeding Friendly Nursery Programme and the Breastfeeding Welcome Award Scheme.

### 4.10 **Acute Children's Services**

The major development in the next few years will be the planning and designing of a new children's hospital co-located with adult and maternity services. In the meantime we will work with the Ministerial Group to address immediate service issues. Other acute developments and initiatives include:

- the opening of a new, purpose-built Paediatric Intensive Care and High Dependency Unit to improve the quality of care for acutely ill children. Revenue funding for the HDU has not yet been identified;
- the national waiting time guarantees of no one waiting more than 26 weeks for an outpatient appointment and no more than six months for inpatient treatment by the end of December 2005 will be met;
- planning is also underway to meet the improved guarantees of 18 weeks for outpatient appointments and 18 weeks for inpatient treatment due to come into effect at the end of 2007, within the lifetime of this plan;
- assessing the options and feasibility of centralising Glasgow's paediatric A&E services;
- we are exploring options to improve the quality of the environment for adolescents and young people who suffer from cancer related diseases and require to be admitted to hospital;
- there is currently a review of the NHS in Scotland (National Framework for Service Change). Child Health Services form part of the review, which spans primary, secondary and tertiary care. The Action Framework will set out

actions, milestones and timescales to implement strategy and policies for child health services. Young people's services are being considered and one recommendation is that the age range of admissions to paediatric hospitals should rise to 16 years and that those aged 16-18 years should be offered the choice of admission to adult or paediatric facilities;

- dental services will be consolidated at Yorkhill for all children aged up to 14 who require a general anaesthetic. The pre-operative assessment work will continue at the Glasgow Dental Hospital;
- Scotland's first consultant paediatric audiological physician has been appointed to modernise hospital and community audiology services. This will involve the creation of a multi-disciplinary hearing impairment team;
- the ongoing programme of service redesign for children with complex needs will include increased support for the provision of home ventilation services.

#### **4.11 Young People's Health Services**

The Scottish Executive's 'Walk the Talk' (2000) document created national and local momentum to ensure that young people had better access to health services that were more youth friendly, partnership-based, rooted in consultation with users and barrier-free. In Greater Glasgow NHS Board area this work has addressed issues relating to access to mainstream services, led to the employment of youth health workers, the development of discreet youth health services and the development of initiatives designed to improve young people's awareness and knowledge of these services. Specific initiatives include:

- further developing access to the full sexual health services linked to Sandyford Initiative and in particular, its young people's service -The Place. This will include consolidating existing Place satellites and developing new young people targeted provision within the context of renewed local Sandyford services and within community pharmacy provision;
- maximising the pivotal role that the School Health Service can provide at an early intervention stage within a school context. For example the provision of school-based School Nurse –led Drop-in provision will be extended. This will allow young people to have easier access to confidential health guidance, information and support on a whole range of issues. In 2005, school nurses will transfer from Yorkhill to primary care as Community Health Partnerships are established. This will allow school nurses to become integral part of local services for young people;
- young people using acute health services have the right to be able to influence and shape their provision. One important programme that has been piloted in Greater Glasgow has been Youth Voices - a partnership project developed in collaboration between the NHS and Voluntary Sector targeting young people who have experience as inpatients or regular outpatients and aiming to help them gain the self-confidence and self-awareness to express their views on health services that affect them;
- a focus on the transition into adult services. Some good practice guidelines have been developed at Yorkhill for young people with chronic conditions whose care management is passing from Yorkhill to acute adult hospitals. In areas such as cystic fibrosis, clinicians already work well together to ensure that young peoples educational, social and emotional needs are considered when medical care moves. In addition, a joint protocol with Social Work is

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being developed to improve the transition for young people with learning disabilities moving into adult services.

### **4.12 Health Promotion - Oral Health, Nutrition, Safety, Physical Activity, Smoking**

The Oral Health Strategy has been supported by Glasgow City Council, and has several implications for children and for children's services:

- commitment to Nursery Tooth Brushing Programmes - facilitation of delivery network, support staff training and role, curriculum activity around smile nursery programme;
- development of School Health Service to establish links with General Dental Service and proposed Children's dental service in areas of service gaps. (proposal within strategy - not fully explored);
- support for Development of models for Oral Health within ICS programmes linked to OHATs;
- support for Development of pathway for special needs children in Child Health Development Centres.

Within nutrition, specific initiatives affecting children include:

- education policy to support food & Health Framework Hungry for Success implementation in Primary and secondary schools by 2006;
- continued commitment to Fruit in Schools/Refresh initiatives;
- continued commitment to Breakfast Clubs;
- nutritional guidelines for pre-five establishments – imminent from SEHD;
- support for First foods community weaning initiative (rolling out across SIP areas in partnership with Child Development Centres, LHCCs & Community Health Projects).

Other health promotion priorities for children are safety, physical activity and tobacco policies.

### **4.13 Child Protection**

This has been identified by the Corporate Management Team as a key priority for the NHS in Glasgow. This is demonstrated by the creation of a Child Protection Forum chaired by an Executive Director and attended by senior managers from adult and children's services. The Forum has drawn up an action plan in response to the recent reviews on child deaths and the Scottish Audit. It has taken forward some work on training, case conferences and notification systems, and has prioritised some work on maternity and A and E services. The Forum has also agreed to create and resource a Child Protection Unit to support the process in the NHS. The Unit will provide support to all parts of the NHS including mental health and addictions.

### **4.14 Planning Paediatrics on a Regional Basis**

A West of Scotland Paediatric Planning Group was set up in 2000 to plan tertiary children's services with Yorkhill. The group addressed cross subsidisation and high cost / low volume issues in the first few years and has acted as a mechanism to discuss future tertiary developments. Priorities identified for the group in the next

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year are the High Dependency Unit, revenue funding for the 7<sup>th</sup> theatre at Yorkhill and cystic fibrosis.

### **E. DEVELOPING ADDICTION SERVICES**

5.1 During 2004/05 we made significant progress on a number of priorities for addiction services. These include:

- increased health resources were put into the methadone programme in 2004/05 to develop the alternative model of medical sessions in CATs and meet the implications of the GP contract which started in September 2004;
- rolled out the Community Addiction Team (CAT) programme in 2004/05. Developments were made possible through new drugs funding in 2004/05 and new funding to the Board. Will further roll out in 2006/06 across the 6 local authorities in the GGNHSB area;
- developed a service model linking the acute sector and addiction treatment services including community services;
- reviewed purchased community and residential facilities for alcohol and drugs with Glasgow Addiction Partnership colleagues. The commissioning process is almost complete and the final services will be commissioned in 2006/06. Review tied in with the closure of hostels for homeless people in Glasgow;
- consultation on specialist services concluded and there was some service redesign. A fifteen bed addiction unit serving north Glasgow opened in 2004/05. The NHS Board allocated additional funding to enhance psychology input to CATs . Further redesign of specialist services is planned in 2005/06;
- New NHS Board funding has been set aside to meet costs for expanding the needle exchange programme. More will be required in future as needle exchange outlets are expanded.

5.2 In setting priorities for 2005/06 there are a number of emerging policy issues:

- the Lord Advocate's guidance on needle exchange is awaited and will have financial implications;
- amendment to section 9(a) of the Misuse of Drugs Act gives doctors, pharmacists and drug workers the authority to supply drug injecting paraphernalia. Will have cost implications;
- increasing prevalence of Hepatitis C;
- continuing link between deprivation and addiction problems;
- future of short-term funded alcohol and drug projects is uncertain;
- how we best look after people with a dual diagnosis of addictions and mental health problems in the light of Mind the Gap and other reports. Alcohol related brain damage requires more development and investment;
- helping children who use substances themselves or live with carers who do.

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5.3 We are required to meet a number of national targets:

- reduce the proportion of drug users who inject and the proportion of injecting users sharing needles and syringes. Target 20% reduction by 2005;
- increase the number of drug users in contact with services in the community by at least 10% every year until 2005;
- reduce the number of men and women aged 16-64 exceeding weekly sensible drinking levels (exact targets set out in the Corporate Action Plan). Measured via health and wellbeing study;
- reduce the frequency and level of drinking from 20% of 12-15 year olds to 18% between 1995 and 2005 and to 16% by 2010 ( measured via the SALSUS survey);
- reduce the proportion of under 25s reporting use of illegal drugs in the last month and previous year, and heroin use by 25% by 2005;
- reduce waiting times for drug treatment and rehabilitation services. All services submit monthly waiting times returns to the GGDAT and AAT;
- increase the number of drug users successfully completing treatment. Measured by the number of planned discharges recorded in the monthly waiting times returns to the GGAAT and DAT;
- reduce the number of drug related deaths by at least 25% by 2005. Monitored via the GGDATs Drug Deaths Group and recorded in the CAP.

5.4 Detailed action plans for drugs and alcohol are in place through the Drug and Alcohol Action Teams. For 2005/06 the priorities for the NHS will be:

- further expanding the methadone programme continues to be stretched, particularly by pressures faced in implementing the new GP contract;
- increasing needle exchange provision;
- planning the establishment of a dedicated inpatient unit in South Glasgow;
- Hepatitis A and B immunisation needs to be part of mainstream provision if we are to tackle the spread of bloodborne viruses;
- developing the full range of services to ensure rapid access and reduced waiting times;
- consolidating the full integration of services.

### 5.5 Other Priority Service Areas

We have established a number of other priorities.

- **Primary Care.** Over the last five years the development and implementation of the Primary Care Strategy has been a major priority with substantial additional investment. The focus in 2005/06 will be to:
  - conclude the implementation of primary care mental health teams;
  - continue the development of services linked to the new GMS;
  - ensure the transition to CHPs provides a platform for further primary care development.

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- **Asylum Seekers.** In partnership with GCC, Strathclyde Police and voluntary organisations GGNHS continues to provide a range of health services to 8-10,000 asylum seekers and refugees dispersed to the city under the government's national programme. The current estimated annual cost of service provision for GGNHS is £3.5M. A further bid to have these supported was made to the Scottish Executive in November 2004 as part of a joint deputation co-ordinated by CoSLA. We continue to pursue national funding costs as indicated in the financial plan.

Scope for tapering boosted primary care costs over time is under examination, to reflect the relatively high proportion of asylum seekers who are choosing to settle in the city when given leave to remain. Other health issues include young unaccompanied asylum seekers and level of untreated chronic disease while further cost pressures for GGNHS may accrue with introduction of new process for induction with associated health screening.

The present contract is due to terminate on 31 March and GCC is presently considering a 15 month contract extension from NASS for 2000 units for families only subject to resolution of the issue of outstanding costs. A full utilisation of the new contract would maintain and for some NHS services may increase the present level of demand. A further contract extension beyond June 2006 is uncertain due to position of GHA, future availability of housing stock and possible introduction of regional quotas.

- **Falls Prevention.** The Osteoporosis and Falls Steering Group has been established to develop a strategic approach to planning and developing falls prevention and management. A strategy, which will be subject to wider consultation, proposes a multi-factorial approach providing comprehensive coverage from general population based prevention programmes to targeted responses for those who have fallen and at risk of falling again. There is good evidence that risk assessment and management programmes can achieve a substantial (between 15 and 30%) reduction in the incidence of falls among older people. The draft implementation plan proposes a series of service developments.
  - the roll out of the home falls prevention programme (funded from the Delayed Discharge Action Plan);
  - the development of an agreed set of protocols and procedures for outpatient fall clinics;
  - the establishment of a standardised tiered exercise programme;
  - work with the health supports to care homes initiative to manage falls risk in care homes including development of falls risk management protocols, exercise for care home residents, training for care home staff and osteoporosis prevention initiatives;
  - a number of service developments aimed at preventing falls in hospital including, the establishment of falls co-ordinators on all acute sites, exercise programmes, review of CANARD as a falls risk predictor;
  - preventing individuals sustaining further injury from falls including further refinement of the hip protector service and the development

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- of a local protocol for the use of equipment and restraints to reduce the risk of falling;
- action to reduce the risk of fractures and in particular osteoporosis treatment including the development of standardised referral pathways, extension of DXA/DADS, pharmacological interventions, patient education and consideration of a vertebroplasty service;
- a number of underpinning process issues including transport, training research and audit, and other resources including publications.

### **F. MODERNISING ACUTE SERVICES**

- 6.1 A detailed programme of work to implement the Acute Services Strategy is in place and routinely reported. In 2005/06 key points are:
- concluding option appraisal on the potential to accelerate the Acute Services Review;
  - completing work on the disposition of specialties;
  - publishing detailed analysis of the bed numbers required for the new inpatient facilities;
  - launching the procurement process for the new Southern General Hospital;
  - continuing the delivery of the ambulatory care proposals.
- 6.2 In addition to the macro strategic picture there are a substantial range of other initiatives to improve acute services including those sponsored by the Centre for Change and Innovation, the Glasgow Patient Access Team, in relation to improving waiting times and through the efforts of the Managed Clinical Networks.

### **G. STROKE**

- 7.1 The Managed Clinical Network is pushing forward an ambitious programme of development for stroke. A brief summary is included in the rest of this section

#### **7.2 Acute Stroke Units**

These now exist in Stobhill, Western Infirmary, Glasgow Royal and the Southern General with rehabilitation available either on or off site:

- Western Infirmary. Work is currently underway to move the unit into its new premises with anticipated completion April 1st 2005.
- Stobhill. Building work is now complete;
- the Southside Stroke Service was launched last month with all acute stroke beds now being situated at the Southern General along with rehabilitation and HDU. The Mansionhouse Unit completes the Southside service with its 20 beds for stroke rehabilitation.

**7.3 Supported Discharge Services**

Stroke IRIS (Northside) and Stroke DART (Southside) that have been funded for 3 years by New Opportunities Fund monies were launched in April 04 and June 04, respectively and are stroke specific arms of the already established IRIS and DART services. The staff involved have specific stroke care skills and liaise closely with the Stroke Nurse Specialist, Liaison nurses and Allied Health Professionals in secondary care pre and post discharge.

**7.4 Stroke Educational Audit.**

This audit of stroke care professionals training history and need is now underway through the University of Glasgow. It is anticipated that the initial outcomes of this project will be available by September 05 following analysis of data gathered by questionnaire.

**7.5 Chronic Disease Management - Stroke Therapy Team**

This team was officially launched in the summer of last year and forms part of the CDM programme for Stroke. With an initial complement of Physiotherapy, Occupational Therapy and Clinical Psychology this team is now being expanded to include Speech Therapy. The team has been well received by practice nurses and covers the whole of Glasgow. With around 95% uptake of practices the demand on this team is great and is currently expanding its post numbers.

**7.6 Electronic Health Record**

This project is forging ahead with the unit at Stobhill serving as the pilot site for the new electronic version from early summer. An enormous amount of work has gone into the development of this Electronic Health Record including a pilot of the paper version. All clinicians affected have been consulted and have had the opportunity to contribute. PCs and/or mobile devices are being rolled out using National Strategy monies prioritised through the MCN and training needs are being taken into consideration.

**7.7 NHS QIS Standards**

Self-Assessments have taken place in the north and south of the city in Jan/Feb of this year. These both went well on the whole, with no major surprises in the outcomes. Imaging remains an ongoing difficulty, with some sites more poorly served than others. The effect on both in-patient and out-patient services is currently being addressed by the MCN through the outpatient-working group and links with the imaging group at GGNHSB.

**7.8 Scottish Stroke Care Audit System**

The Scottish Stroke Care Audit System data has been gathered for the past year. We will be able to extract some findings from the data in summer 05. Staff training and equipment issues which have caused some difficulties with data collection, have been dealt with. Work is currently underway to catch up with the backlog and will be back on track within the next 2 months.



**7.9 Acute Admissions**

New guidelines for acute admissions and thrombolysis were developed and launched in October 04 through the MCN Acute Care working group. The guidelines were developed with involvement from stroke physicians, Accident and Emergency, NHS24 and GEMS and launched for primary care staff. Early reports show an increase in appropriate referral rate to the 2 sites that administer thrombolysis (Western Infirmary and Southern General).

**7.10 Psychology**

MCN funding has now provided 2x0.5wte clinical psychology posts for stroke in-patients on 2 sites with plans to extend this to all sites in the next financial year. A Portacabin has also funded to be used as the administrative base for these posts.

**7.11 Website**

The Glasgow Heart, Stroke and Diabetes website is currently being developed to provide professionals, patients and the general public with information, advice and support across the 3 disease areas. This site will link with the GGNHS site and have an MCN component where all papers, publications and developments of the MCN can be accessed.

**7.12 Glasgow Anticoagulant Service**

All patients on warfarin across Greater Glasgow are now having warfarin monitoring delivered as part of the service which is also delivered to the housebound. The numbers of patients on warfarin is increasing, and this should translate into better stroke prevention – atrial fibrillation (AF - an irregular heart rhythm) is a major risk factor for stroke and the risk is reduced for those with AF if they take either warfarin or aspirin.

**H. HEART DISEASE**

8.1 The Managed Clinical Network is now functioning effectively through its executive group and various sub-groups reporting back to the larger steering group with wide representation. IN 2005 work will be undertaken to ensure representation from CHPs in the MCN and continued representation of GPs.

8.2 The Chronic Disease Management programme is now established as Local Enhanced Scheme (part of nGMS). First audit information for 2004-05 will be available in April 2005. In 2005 we will work to deliver continuing support and training for practice nurses to deliver the programme.

8.3 The potential to change cardiac surgery and cardiology services utilising the Golden Jubilee National Hospital is out for consultation. Meanwhile various measures have been put in place to increase staff recruitment and retention in Glasgow's catheter laboratories. Drug eluting stents are now available as per the NICE guidelines (first stage). The national waiting time targets are being delivered.

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8.4 Other issues to be pursued during 2005/06 are:

- completing an updated strategy for heart disease,
- moving forward with an electronic health record as part of Greater Glasgow's IT strategy, and delivering electronic ECGs stored on a single service and viewable wherever required,
- collaborating with the National Heart Failure Centre to build on existing services to deliver even better care for heart failure patients,
- identifying the need for, and resource to deliver various devices such as ICDs and CRT. This will be taken forward through the regional planning group,
- delivering a re-design of myocardial perfusion services,
- contributing to improving regional planning,
- contributing to a robust bed-model for the Acute Services review, including defining possible service re-design and piloting as appropriate and possible,
- delivering improved pathways of care to support the ACAD development,
- ensuring the continuation of the annual reviews for CHD patients and moving forward on delivery of care to those who are housebound.

### **I. CANCER**

**TO BE COMPLETED - PERFORMANCE INFORMATION AWAITED.**

### **J. IMPROVING HEALTH**

10.1 The full Local Health Plan 2002/2007 sets out in detail a series of major programmes which fully reflect the extent of our efforts to improve the health of our population. This section highlights the key points.

10.2 In March 2003, the Scottish Executive issued Improving Health in Scotland: The Challenge, as a strategic framework for the delivery of a more rapid rate of health improvement in Scotland.

The health challenge for Scotland has been identified as:

- “to improve the health of all the people in Scotland; and,
- to narrow the opportunity gap and improve the health of our most disadvantaged communities at a faster rate, thereby narrowing the health gap.”

10.3 While work should continue on tackling all determinants of ill health, the Challenge has taken a focussed approach with an expectation that priority should be given to work in four areas deemed to be the “pillars” for health improvement:

- early years;
- teenage transition;
- workplace (working-age people);
- communities;

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- 10.4 Greater Glasgow, as the NHS Board area with the largest proportion of Scotland's population and the greatest concentration of deprivation, has a pivotal role to play in the overall success of Scotland in meeting The Challenge. Given the context within which the Board is working (eg, with over 80% of Glasgow City population in Deprat 6 and 7) priority is given to tackling health inequalities, with work to improve healthier lifestyles underpinned by work to improve life circumstances.
- 10.5 All of the Board's health improvement work is therefore founded on the principle of the NHS working in partnership with others - Local Authorities and their community planning partners, the voluntary sector, employers and communities. GGNHSB's participation in community planning and other joint planning and strategic partnerships, such as children's services planning, community safety, and SIP area strategies, provides the opportunity to put health on the shared agenda, with share responsibility for delivering progress.
- 10.6 In all such work the involvement of GGNHSB is crucial in achieving the right balance between contributing to national health improvement priorities and targets and responding to local health needs (in effect, translating national policy and strategy into locally relevant shared objectives, linking improved health with physical, economic and social regeneration). For example, the table below illustrates how this strategic Healthy Glasgow theme of the Glasgow City community plan contributes to each of the four key target areas and to the individual priority topics in The Challenge.

<b>Community Plan Objective</b>	<b>Early Years</b>	<b>Teenage</b>	<b>Working Age</b>	<b>Communities</b>	<b>Priority Topics</b>
Tackling effects of poverty on children's health	x	x	x	x	Oral health, nutrition, sexual health
A city where non-smoking is the norm	x (maternal smoking)	x	x	x	Smoking
Positive mental health		x		x	Mental health
Drug and alcohol misuse	x (hidden harm)	x		x	Alcohol
Services to promote health of young people			x	x	All
Promote health of carers			x	x	
Safe and healthy working lives	x (support to parents)		x	x	All

- 10.7 These same strategic health objectives underpin the Regeneration Outcome Agreement with each Local Authority and provide the framework for improving the health of the most deprived communities in Greater Glasgow. Looking to the future, CHPs will provide further opportunities for integrated action for health at a local level. Each of the following sections describes activity in 2004/05 and forward looks to 2005/06 under a series of key headings.

10.8 **Early Years**

- Implementation of Hall 4 and continued support for SureStart.
- Work to promote breastfeeding, healthy weaning, oral health.
- Further development of pregnancy smoking cessation service in each maternity hospital and smoke free homes pilot in Easterhouse.
- Parenting projects.
- Employment initiatives to support parents into employment.
- Multi-agency Teenage Pregnancy Steering Group.

10.9 **Teenage Transition**

Throughout 2005/04 evidence was reviewed on effective interventions for teenage transition, with focus on identifying factors that put young people at risk/protect young people from damaging health behaviours. A mapping exercise was carried out to identify how work to protect all young people in what can be a vulnerable stage in their lives complements specific work to support particularly vulnerable young people (eg, care leavers). Recognition also needs to be given to the value of work with younger children in preparing them for teenage years (and later transitions in life).

Some examples of key areas of work include:

- use of school as a means of provision protective factors:
  - health promoting schools and integrated schools (with network of full-time School Health Development Officers employed jointly by Local Authorities and GGNHSB);
  - active schools programme and network of after school clubs;
  - hungry for success - support in menu planning and promotion of healthy choices;
- potential school nurse drop-in service;
- survey of parents on sexual health (to inform future action);
- new C-Card distribution service for condoms;
- sexual health social marketing campaign aimed at young people planned for 2005/06;
- network of eleven youth mental health projects (in partnership with voluntary and community groups);
- involvement through community safety in restorative justice services and outreach project with young “street drinkers” to involve them in diversionary activity;
- development of physical activity programme targeting teenage girls (Girls with Attitude);
- planned input to Glasgow anti-violence strategy, with shared recognition of need to tackle problems “upstream” (including emphasis on pre-five and early school years);
- continued development of LHCC youth health services by CHPs.

**10.10 Working Age**

Support to those in employment through dedicated Health at Work team to support employers in promoting health through Scotland's Health At Work, Safe and Healthy Working Lives, Healthy Returns, etc. Team provides an extensive training programme on various aspects of workplace health.

GGNHSB also recognises that employment is a determinant of health and therefore supports a range of initiatives to assist people into training and employment - eg, Compass, Equal Access to Employment, Working for Health, and GP referral scheme for arts (in partnership with Scottish Arts Council) and literacy and learning (as part of Glasgow City Council community learning plan).

Reducing rates of adults smoking through the implementation of NHS smoking policy and expansion of smoking cessation services throughout NHS and in the community (with approximately 200 of total 220 community pharmacists participating in the GGNHSB scheme). Acute hospital smoking cessation pilot will expand to include all hospital sites.

Increasing rates of physical activity through physical activity strategy (previously described) and continued enhancement of GP exercise referral scheme

**10.11 Smoking Cessation in Glasgow**

Comprehensive smoking cessation services have now been established across Greater Glasgow with Nicotine replacement therapy (NRT) and cessation support being available to adults for up to twelve weeks. Over 160 pharmacies citywide provide 1:1 support through the "Starting Fresh" programme and intensive group support continues to be provided locally in LHCCs. In secondary care a 'developmental' service has been established within two wards in the Southern General hospital, and on completion of the test period will roll out to other hospitals in autumn 2005. In-patients who want to give up smoking are provided with NRT with support and onward referral to primary care for continued support and NRT on discharge. Within Glasgow's three maternity hospitals the Breath project now offers 1:1 smoking cessation support to pregnant women at the time of booking in. This includes a risk benefit analysis and the provision of nicotine replacement therapy if appropriate.

**10.12 Older Peoples Health Improvement**

Work is ongoing to develop a strategic framework for improving the health, security and inclusion of older people within Glasgow City. The Framework will provide recommendations on the structure and partnership arrangements for the management and implementation of the older peoples health improvement strategy, scope the resources and timescales for the development and implementation. The document will make recommendations on the ongoing engagement of older residents in implementation and generating the shared ownership for this agenda. Work is due to be complete by June 2005.

An initial piece of work informed directly by older people themselves will be complete in April. Key issues identified are:

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- timely and culturally sensitive service information for older people to allow them to prepare for the aging process;
- training for all staff to support older people appropriately in terms of their personal value, dignity and privacy;
- proactive health and social care services with continuity, perhaps through a key worker, for the older person;
- ensuring equity of access to appropriate and culturally sensitive physical activity, day care and befriending for older people;
- ongoing support for transport to allow access to all quality of life issues.

### **10.13 Sexual Health**

We have an annual planning and implementation process for sexual health improvement and services. Our proposals for the additional national funding include the further expansion of the extended local services. By September 2005 we will submit the required plans within the framework established by the National Sexual Health Strategy, in partnership with Local Authorities. A particular focus for us is reducing teenage pregnancy.

### **10.14 Teenage Pregnancy**

The teenage pregnancy rate for Greater Glasgow in 2002/3 was 44 per 100 women. This is the third highest rate of all the Scottish NHS Boards. Numbers however are relatively small with the total number of teenage pregnancies for 13-19 years being 1739 of which 1624 are amongst 16-19 year olds and 115 amongst 13-15 year olds. Just over 50% of teenage pregnancies proceeded to live births.

Greater Glasgow NHS Board funds a range of activities designed to have an impact on teenage pregnancy. These include the provision of sexual and reproductive services for young people in the Sandyford Initiative (The Place) and in local communities. In 2004/5 a joint appointment between the Board and Glasgow City Council was established to add value to the current work. In 2005/6, the focus of the work will be on addressing the needs of young parents and supporting initiatives aimed at prevention. City wide surveys of young peoples' experiences and parents views will be undertaken.

### **10.15 Oral Health**

Our recently launched Oral Health Strategy creates a clear vision for oral health in Greater Glasgow which is that:

- healthy mouths matter in Greater Glasgow;
- good oral health will be valued as part of healthy living;
- everyone will have healthy mouths and be able to maintain them. Improving oral health is everyone's business.

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To deliver the vision, our strategy is built on the following core principles:

- reducing inequalities;
- integrated working and pathways;
- evidence-based practice;
- making oral health everybody's business;
- making oral health integral to holistic health.

Summarising the aims of the Oral Health Strategy which will be translated into an implementation plan in 2005/06:

- To improve oral health:
  - strengthen public health leadership;
  - change attitudes and culture;
  - target priority groups.
- To enhance dental services:
  - tackle inequalities in access;
  - emphasise prevention;
  - create a mixed economy of service provision;
  - improve quality;
  - develop specialist services.

### **10.16 Prevention and Protection**

- Contribute to Glasgow City Anti-violence strategy ensuring enough emphasis placed on upstream activity with children and young people.
- Continued work on HIV and HEP C prevention in light of increasing prevalence.
- Increase immunisation rates.
- Expand tooth brushing programme in breakfast clubs.
- Assessing the BBV prevention service needs of asylum seeking group and target resources to redesign services.
- Provide ongoing support to Primary Care staff to maintain and improve immunisation uptake rates.

### **10.17 Strengthening Local Health Systems**

- Complete the review of community health projects in Glasgow.
- Continued development of Working for Health in Greater Glasgow.
- Support for Pathways to Work and consideration of evaluation of Compass
- Establish robust community engagement for health and potentially linking CHP with CPP infrastructures (depends on CPP decisions)
- Complete development programme for HI in CHPs.
- Develop HI priorities for 2005/06.
- and action plan in each CHP for 2006/07.
- Prepare report on public health workforce development.

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- Redesign HP training programme in light of review findings.
- Develop new formula for resource allocation for HI to CHPs based on SIMD.
- Develop capacity to deliver HI role of health services as part of MCN in CHD.
- Establish GGNHSB HI sub-committee in line with governance arrangements for new board structures.

10.18 We continue to give significant focus to health improvement activity although our financial position substantially constrains our ability to continue the four year pattern of investing in health improvement and tackling inequalities which has been at the heart of the current LHP.

### **K. SERVICE REDESIGN AND MODERNISATION**

11.1 This short section briefly describes a number of the initiatives we are taking to deliver change and innovation. It takes the approach that this work should be at the core of the strategies and change programmes developed through the Local Health Plan process rather than separating change and innovation from the mainstream of our work. A number of the changes we are implementing to deliver other national priorities are reflected in the other contents of this section covering, waiting, cancer, heart disease, mental health and health improvement.

#### **11.2 Older people**

We consulted on a comprehensive joint strategy for Older Peoples Services with Glasgow City Council during 2003 and in 2004 and the focus now is on implementing a series of changes to services to reflect the outcome of that consultation and the final service strategy. These changes include:

- further community service developments;
- reassessing and revising long stay care commissioning;
- extending and improving rehabilitation.

#### **11.3 Managed Clinical Networks**

At the end of 2003 we launched our managed clinical networks for CHD and stroke and during the early part of 2004 the Diabetes Advisory Group will migrate into an MCN. Each of these networks will develop and implement proposals for change during 2004, building on existing strategies and plans. They have already prioritised issues for funding from monies to support the National Strategy for CHD and Stroke

#### **11.4 Homelessness**

Improving the health of homeless people and their health status remain high priorities as we continue the implementation of our Health and Homelessness action plan. A continuing focus of that plan is to change mainstream NHS services to respond more appropriately and flexibly to the needs of homeless people. In addition to that programme of change across Greater Glasgow we are working with Glasgow City Council, in delivering the closure of the long stay hostels. During 2005/06 a further series of health developments will deliver new and extended health services for



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homeless people, including a trauma service and a new service for people with personality disorders.

### 11.5 Primary Care

Implementation of the new GMS contract consolidates our primary care strategy with its key planks of:

- improving chronic disease management;
- providing new services for addictions, mental health and older people;
- Improving premises and IT.

### 11.6 Acute Services Review

The implementation of the ASR requires a major programme of change and innovation. The Programme Board, which oversees implementation, has a number of sub groups, driving the required changes. These cover a range of activities including the redesign of services associated with the Ambulatory Care Hospitals; planning for the new inpatient services, with detailed review of care pathways, service models and performance; and transport and access.

## L. PATIENT FOCUS PUBLIC INVOLVEMENT

12.1 NHS Greater Glasgow has been making strenuous efforts to improve the way patients and communities 'voices' are heard and fed into the processes of developing and modernising healthcare. This is being done against the national backdrop of the 'Patient Focus and Public Involvement' (PFPI) strategy published by the Scottish Executive in December 2001.

12.2 In meeting its obligations, NHSGG has begun over the last two years to put in place arrangements to sustain effective involvement of patients, the public and partners in the future.

These have included:

- establishing a Committee of Non-Executive Board Members to co-ordinate and monitor the involving people agenda across all of NHSGG's different services;
- setting up a database of individuals and organisations with an interest in being involved in NHSGG and contacting them regularly as part of formal consultations and to receive feedback;
- setting up of a Community Engagement Team to ensure local involvement in the £750 million hospitals modernisation programme;
- launch of the Our Health series of events which provide public and patients' representatives and voluntary organisations with a chance to join Board Members and other decision-makers in debate around key health issues. The first event took place in September 2004 and the second, which focused on Community Health Partnerships, in February 2005;
- an audit of involving people initiatives already underway in NHSGG;

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- an action plan to improve support for NHS staff who want to try out new ways of involving people in improving services - including a website with access to a list of involving people projects and contacts;
- a research project to find out how patients the public and partners would like to be involved in NHSGG;
- the launch of Health News, distributed via the Daily Record, to improve public access to factual information about healthcare;
- introduction of new style consultation and public meeting arrangements, including an 'open space' style Annual General Meetings in 2003 and 2004;
- revamping and 'unification' of the NHSGG website in order to base navigation and content on the requirements of patients and the public rather than organisation boundaries;
- introduction of new projects, including a long-term attempt to remove medical jargon from public information and signage.

12.3 The entire direction and environment around PFPI from 2005 will be subject to enormous changes. NHSGG will need to respond to these changes at a time when the organisation itself will be significantly restructured. Key objectives will include ensuring that the interests of patients and communities are not obscured during this period of change and that existing examples of best practice in PFPI are preserved. Examples of the most significant changes are described below.

### 12.4 Scottish Health Council

Local health councils, including Greater Glasgow Health Council, have been abolished and replaced by the new Scottish Health Council as of 1 April 2005.

The Scottish Health Council (SHC) is a national body but also supports a network of local offices, of which one serves the West of Scotland. The role and remit of the new body differs substantially from the previous local health councils.

The SHC will be an 'autonomous component' of NHS Quality Improvement Scotland and will not be directly linked to NHS Boards as was the case with the predecessor councils. The new body's purpose is to promote improvements in the quality and extent of patient focus and public involvement in health services. Its Statutory Functions will be based on:

- **Assessment.** Carrying out independent assessments of and publishing reports on the performance of NHS Boards in achieving patient focus and public involvement.
- **Development.** Providing a critical mass of expertise and experience, available to NHS Boards and organisations representing the interests of patients and the public, to help develop and spread good practice in public involvement in health services.
- **Feedback.** Making sure that patients and their carers are able to provide feedback to the NHS and others about their experiences of health services and that action is taken as a result.

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The SHC will not directly represent the 'patient's (or the community's) voice' within the NHS or the NHS complaints system - in other words, the role of patient/public advocacy does not fall to the SHC.

Instead, the NHS Reform Bill passes this responsibility to NHS Boards. NHSGG must make sure that local networks and arrangements are in place to ensure that patients' and the public's views are represented within service development and decision-making. Under the National Health Service Reform (Scotland) Act 2004, NHS Greater Glasgow now has a duty to ensure that people for whom services are being provided, or who may receive services in the future, are involved and consulted in the planning and development of those services, or upon any decisions which may affect delivery of those services.

### **12.5 Single System Working**

NHS Trusts were abolished in April 2004 – NHS Greater Glasgow is now operating a single organisation and further changes to its structure are to be implemented to consolidate this. In turn, this will lead to changes in the way healthcare is managed and the introduction of common policies and practices for involving people.

### **12.6 Community Health Partnerships**

CHPs became operational on 1 April 2005. Each CHP is to establish a Public Partnership Forum to input to decision-making. These for a will become a fundamental part of the structure that will deliver better involvement and engagement of patients and communities in NHS services in the future. For many people, CHPs may well become the part of the NHS with which they have most contact and familiarity.

To date emphasis has been put on the basic establishment of CHPs. Now that they are in place, the operational readiness and development of the new organisations will be advanced. Establishment of the PPFs will be instrumental in the process, particularly as management teams seek to build dialogue with local communities. A start was made to this at the 24 February 2005 Our Health event, which put CHP teams in contact with people and organisations willing to be involved in developing CHPs.

### **12.7 Ongoing Service Modernisation**

Delivery of the hospitals modernisation will reach a critical phase in the course of the year when long-awaited elements, like the new ambulatory care hospitals, begin to physically take shape. A campaign of communications and community engagement will be required to support delivery of the new hospitals. Additionally, ongoing pressures on services allied to preparation for forthcoming modernisation and building will require short-term changes to the location and pattern of some acute services. Delivery of clear information and engagement with the affected patients, carers and relatives – and staff - will be critical.

**12.8 Major Service Change**

Early into 2005/06, two sets of processes around major service change will begin. Consultation carries on to May 2005 around proposals to create a West of Scotland centre for Cardiothoracic Surgery at the Golden Jubilee National Hospital in Clydebank. Also, Professor Andrew Calder of the University of Edinburgh, will be chairing an advisory group which will oversee the selection of a site for a new Children's Hospital in Glasgow to replace the Royal Hospital for Sick Children. Once this process is complete, arrangements will have to be put in place to support wide engagement and input around the design of the new hospitals and the services to be housed within it.

12.9 A major PFPI framework for NHSGG with key actions for 2005/06 is in place. Of particular importance is the community engagement programme for acute services modernisation.

12.10 The programme to modernise Glasgow's Hospitals and acute services, is one of the largest of its' kind in the UK. NHS Greater Glasgow's commitment to informing, involving and engaging with its' communities on this programme of work is demonstrated by the establishment of the Community Engagement Team. The team is comprised of experienced staff with a community development or patient involvement background. Working with members of the public, patient and carers groups and community organisations, the Community Engagement Team has two main functions.

The first is to provide face-to-face, accessible and accurate information to any member of the public, patient or carer in the Greater Glasgow area. This is important, not only in overcoming misunderstandings about the Hospital Modernisation Programme, but in creating a safe and accessible way for members of the public and community groups to find out what is being proposed and to raise any issue important to that individual, their partner or family member. It is also important in feeding back to NHS Greater Glasgow the actual views and concerns of members of the public and ensuring this informs the wider agenda of hospital modernisation.

The second function of the Community Engagement Team is to engage with patients and carers and community members to ensure that the physical fabric of the new hospitals best meets the needs of all patients, to assist the process of service redesign by supporting patient and carer involvement and to enhance the patient experience by facilitating the patient voice.

12.11 Key initiatives which will be undertaken in 2005/06 by the Community Engagement Team:

- **Information.** The Community Engagement Team will continue to meet with any patient, carer or community group which requests information on the programme to modernise Glasgow's Hospitals and its services. This ongoing commitment provides a degree of reassurance to community groups and continuity of communication.

In this way, members of the Community Engagement Team met with over 5,000 members of the public in 2004/05. A common theme which emerged

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from this interaction was a desire from the public to find out more about forthcoming changes to emergency care. Many members of the public are unaware of the existence of the pilot Minor Injury Units and the role they will play in future provision as well as the changes being introduced across Scotland with the introduction of a paramedic led “999” ambulance service. The Team has, therefore, organised a roadshow event involving the Scottish Ambulance Service and the Emergency Nurse Practitioners, who lead on the Minor Injuries Unit, which will travel to each CHP area. Members of the team will also be providing information to the public on the new Hospitals at Stobhill, the Beatson and the Victoria. It is hoped that this roadshow approach will act as a pilot for systematic acute sector/CHP engagement activities in the future.

Past engagement has also indicated a thirst for information resources on the Hospital Modernisation Programme. The Team has worked closely with NHS Greater Glasgow’s Communications Team to develop a variety of resources for use in 2005/06. These include realistic representations of new developments, a video on blue light “999” ambulance services and further information contained in Health News and the Community Engagement Newsletter.

- **Engagement.** The Community Engagement Team and the ACAD project team established an advisory group of people living with disabilities to inform and add value to the process of designing new hospitals in Glasgow. Unfortunately, it is not a given that new buildings are fully inclusive in their design and build and it was, therefore, felt to be extremely important that NHS Greater Glasgow makes every effort to ensure that the new hospitals not only exceed the requirements of the Disability Discrimination Act but provide an environment which is fully inclusive for patients and staff. In 2005/2006, the Inclusive Access Group will be working with the ACAD Project Team, the Hospital Architects and the Community Engagement Team in the process of detailed design.

The Team will continue to support the engagement of patients and carers in the process of service redesign. Currently, the team has supported the Managed Clinical Networks to develop a framework to support the involvement of patients in their work. The team will also be working with a variety of patient groups in specific service developments. For example, the team is supporting the development of a West of Scotland cancer patients network based around the developments at the Beatson or assisting with the patient appraisal of the pilot foot and ankle orthopaedic triage scheme.

However, the issue which most affects patients and carers in relation to the provision of acute services is access and transport. The team is undertaking a variety of initiatives to improve transport - for example, piloting evening door to door transport provision for hospital visitors or the provision of systematic information on public transport in each acute hospital. The main focus in 2005/06 will be researching the needs of the elderly, those with restricted mobility or disability and those living in marginalized communities in relation to transport. Listening to patients and community members, it became apparent that current transport planning and provision was not fully

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meeting the needs of these groups. The Community Engagement Team working with a variety of partners – Glasgow City Council, SPT, Glasgow Disability Alliance, the PIGs, the West of Scotland Seniors Forum, Arthritis Care etc is undertaking a major piece of community generated research. This work will be presented at a conference next autumn and will hopefully inform the public discourse on transport provision.

### **M. ENSURING PATIENTS ACCESS SERVICES**

13.1 This section covers the national priorities in relation to access to primary care, waiting times, delayed discharges and hospital acquired infection.

#### **13.2 48 Hour Access to Primary Care**

The Scottish Executive introduced a national target for access to primary care services within 48hrs. The target is defined as face-to-face, telephone or email contact with an appropriate member of the primary care team which could be a GP, practice nurse or other healthcare professional. The 48hrs target does not apply to urgent cases as these are dealt with on the same day or within twenty-four hours, nor does it apply to access to a specific named member of the primary care team. NHS Greater Glasgow has developed a comprehensive strategy to address access issues across a range of services as part of its wider plans to improve and develop primary care services through the implementation of the Primary Care Strategy.

A systematic approach to auditing appointment availability within practices has been established with reporting on a quarterly basis. The survey measures third available appointment at a fixed time each day for five days.

<b>GP Practice Appointment Stock take Results 2004 /2005</b>					
<b>Month</b>	<b>Jan 04</b>	<b>April 04</b>	<b>Aug 04</b>	<b>Oct 04</b>	<b>Jan 05</b>
Returns as % of total number of practices	98.6 %	95.8%	95.3%	98.6 %	97.6%
Met 48 hour Target as % days of returns	96.5%	94.9%	98%	96.3%	98.4%
Met 48 hour target as % days of all (including non returns and 2 practices with restricted lists)	88.3%	90.9%	93.4%	95.4%	96%

Initiatives supporting access in Primary Care:

- **Advanced Access.** This practice redesign programme continues to be progressively rolled out across Glasgow. The Scottish Primary Care Collaborative ( SPCC) aims to improve access and quality of services. As of January 2005, 7 LHCCs are participating in the programme , namely ; Eastern, Maryhill/ Woodside and South West, Drumchapel, North, Westone and Bridgeton LHCCs. This involves a total of 100 practices as part of wave 1 and 2 of the SPCC programme. Involvement in the programme does not necessarily indicate compliance with the performance target but is considered

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an excellent practice based action to both improve quality of service and improve access times. The SPCC programme has recently issued guidance on phase 2 of the programme with a view to seeking applications from practices not already involved – this will be taken forward on a CHP basis.

- **RCGP or Training Practice Accreditation.** Achievement of these criteria does not necessarily indicate compliance with the target but is an indicator of achieving a standard of practice organisation required to maximise access for patients. The status as of October 2004 shows that 188 (87%) practices have achieved RCGP or QPA Accreditation. Plans and support are in place to help the remaining practices achieve accreditation and also support those practices due for revalidation.
- **Nurse or Doctor Triage/Advice.** The operation of a professional triage service meets the criteria of 48hrs access by providing immediate advice and assessment of a patient's needs. 14 practices are operating these arrangements at present. Over the last 18 months around 60 Practice Nurses have undertaken an accredited training programme. Evaluation of the both the training programme and implementation of triage at practice level is underway.

Each LHCC has prepared an action plan based on an analysis of each practice based on their individual performance. It is important to achieve this level of detailed planning as the reasons for being unable to meet the criteria are often a combination of unique circumstances such as staff illness or additional demand on a single day.

### 13.3 Waiting Times for Inpatient, Day Care and Outpatient Treatment

Waiting times remain a major national and local priority. We need to ensure that waiting times for outpatient and inpatient services do not exceed 26 weeks by December 2005 and ensure that cancer and CHD guarantees are delivered. In 2004/05 we exceeded our target reductions and reduced inpatients waiting over these targets by more than 1000 and outpatients by around 10,500.

In 2005/06 we need to clear another 531 inpatients and 9,000 outpatients. Detailed plans and substantial investment are being finalised to meet and sustain these targets. Milestones have been agreed with the National Waiting Times Unit. The new targets established in "Fair to all Personal to each" come into play in December 2007 and we have begun to plan for their achievement. These are:

- No patient will wait more than eighteen weeks from GP referral to an outpatient appointment (there is no current maximum wait standard set; there is, however, a commitment to achieve a maximum wait of twenty-six weeks by December 2005).
- No patient will wait more than eighteen weeks from a decision to undertake treatment to the start of that treatment (the current maximum wait guarantee stands at nine months, with a commitment to reduce this to six months by December 2005).

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- Shorter maximum waiting times are being introduced for specific conditions:
  - eighteen weeks from referral to completion of treatment for cardiac surgery;
  - four hours from arrival to admission, discharge or transfer for Accident and Emergency treatment;
  - twenty-four hours from admission to a specialist unit for hip surgery following fracture;
  - sixteen weeks from GP referral through a rapid access chest pain clinic or equivalent to cardiac intervention.
- There will also be new waiting time standards for key diagnostic tests and availability status codes will be abolished.

### 13.4 **Delayed Discharges**

During the current year there has been further improvement in the Greater Glasgow Partnership's delayed discharge performance with improvements against all the main 'headline' indicators (see table below). Like all areas in Scotland the partnership has been set annual targets equating to an in-year improvement of 20% against a number of agreed performance measures. In a number of cases the annual target has been delivered at the October ISD Census date. The position at January 2005 saw a deterioration but we can expect some further improvement by the end of the financial year. Greater Glasgow, historically, has been one of the best performing partnerships in Scotland in this area. There is no single reason for the improvement this year, however, the development of Integrated Hospital Discharge Teams and the further development the care home commissioning strategies have impacted favourably.

Performance in respect of patients who have been delayed in excess of one year remains problematic. Detailed work is underway to design and commission packages of care for patients with complex care packages, including people with acquired brain injury and severe mental health problems ,that should impact on this position.

For 2005/06 the Scottish Executive have set new targets requiring partnerships to make a further 20% improvement in delayed discharge performance. We will continue to take a holistic approach to reducing delays in discharge by further developing the health and social care system to prevent inappropriate/unnecessary hospital admission, ensure efficient arrangements are in place to manage patient transfers and discharges from hospital and that the appropriate community infrastructure is in place to facilitate timeous discharge.



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### Performance Indicators.

	Jan 2002	Jan 2003	Jan 2004	Jan 2005
<b>Patients ready for discharge</b>	<b>464</b>	<b>418</b>	<b>344</b>	<b>257</b>
Patients delayed 6 weeks or more	295	285	195	154
Patients delayed in excess of one year	17	22	11	10
PAF Indicator 2.08.01 (*)				
Greater Glasgow	63.6	67.1	56.7	60.0
Scotland	66.6	65.6		
PAF Indicator 2.08.02 (**)				
Greater Glasgow	8.8	8.0	7.6	5.7 #
Scotland	12.1	10.2		

(\*) Delayed discharge - % of patients experiencing a delay in discharge where the delay was 6 weeks or more

(\*\*) Delayed discharge – patients ready for discharge as a percentage of occupied beds

# Indicative

### **13.5 Healthcare Associated Infection**

Tackling Healthcare Associated Infection is a major national and local priority. This section briefly describes our actions and priorities.

- **Infection Control Infrastructure.** The infection control infrastructure in Glasgow has been streamlined with the Greater Glasgow-wide Infection Control Committee with membership from all Trust Infection Control Committees. A unified, new infection control policy manual has been in progress. All infection control teams within Greater Glasgow will comply with this manual and all policy recommended by the CSBS standard is in place.
- **Education.** All Divisions within NHS Greater Glasgow have implemented teaching programmes on hand-hygiene and principals of infection control. This is an ongoing programme, including a mandatory induction programme for all new clinical staff. Currently, there is also a programme of putting through the first cohort of cleanliness champions and so far about 80 champions have been identified to take them through the appropriate training.
- **Policies.** All Divisions have agreed to follow a unified policy on infection control throughout the Greater Glasgow area, compiled under the auspices of the Greater Glasgow infection control committee. All policies recommended by the CSBS standard will be in place by the end of March 2004. Every policy in the manual now comes with a standard Self-Directed Learning unit and also an audit tool, so that these policies can be audited on a regular basis.

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- **Audits.** All Divisions agreed on an ongoing audit programme. Priorities for audits are given to specific areas including environmental audits, clinical waste audits, kitchen audits and hand-washing audits.
- **Surveillance.** Following the appointment of surveillance nurses, and additional ICNs, all Divisions are currently taking part in national surveillance programmes co-ordinated by the Scottish Centre for Infection and Environmental Health (SCIEH) to comply with the HDL on surveillance.

### N. FINANCIAL PLAN

14.1 The key points of the 2005/06 Financial Plan are described in the four sections which follow. These are:

- **Funding** - describes available resources for 2005/06.
- **Cost Inflation and Other Expenditure Pressures** - describes how the need for additional resources in 2005/06, has been assessed.
- **Revising the Local Health Plan and National Priorities** - describes planned spending on local and National priorities.
- **Cost Savings Plan (Corporate Recovery Plan)** - describes plans to achieve cost savings in 2005/06.

The background to the 2005/06 Financial Plan is:

- increase in available general funding of 6.5%;
- non recurring funding of £12.6 million provided by SEHD in 2004/05 no longer available in 2005/06;
- substantial additional inflationary pressures, particularly pay pressures associated with implementation of Agenda for Change;
- significant additional costs to meet National priorities, particularly the achievement of waiting times targets;
- major unavoidable additional cost commitments of £12.2 million on new GMS contract, with availability of matching funds still to be confirmed by SEHD; and
- ongoing development and implementation of cost savings plan to offset gap between funding and expenditure.

14.2 The net outcome of these factors is a financial challenge of around £10 million in 2005/06. It is the Board's intention to address this during 2005/06 by developing further proposals to contain costs within available funds. This is before additional costs of £12.2 million on GMS contract, where confirmation of funding is awaited from SEHD.

**14.3 Funding**

Funding available in 2005/06 is as follows:

	<b>£ million</b>
Funding base	1,100.7
General uplift	70.0
Unmet need	4.0
<b>Total</b>	<b>1,174.7</b>

The Financial Plan assumes that this will be supplemented by:

- increasing recurrent funding received from other West of Scotland Boards in respect of cross boundary patient flow from £2.2 million in 2004/05 to £8.2 million in 2005/06;
- securing profit on future planned land sales of £7.5 million in 2005/06; and
- securing additional funding of £1.5 million to offset the additional costs which the Board has incurred in providing services to Asylum Seekers living within the Greater Glasgow area.

**14.4 Cost Inflation and Other Expenditure Pressures**

This section summarises the demands on available resources in 2005/06:

- During 2004/05, the Board managed to absorb the deficit which was carried forward from 2003/04 and by implementing its Corporate Recovery Plan, ended the year in a position which was close to financial breakeven. Funding carried forward into 2005/06 should be sufficient to match expenditure commitments carried forward, however, the loss of the full amount of non recurrent funding relief of £12.6 million provided by SEHD in 2004/05, means that the Board is unable to maintain this financial breakeven position going into the new financial year, and enters the year with a deficit of approximately £12.5 million.
- Additionally, there is a requirement to provide for inflationary costs related to the following key items:
  - Basic pay inflation
  - Agenda for Change Implementation – impact on pay inflation
  - Non pay uplifts
  - GP Prescribing Inflation
  - Hospital Prescribing Inflation
  - Increases in Capital Charges
- The assessment of inflation is based on detailed work carried out with each of the Operating Divisions: it is worth highlighting two key points:

**GP and Hospital Prescribing Inflation.** Provision for additional expenditure on primary and secondary care prescribing is based on detailed cost projections prepared by NHSGG Prescribing Advisors and Pharmacists. These have been reviewed by the Board’s Prescribing Management Group

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which has approved an overall allocation of £8.5 million as being a realistic provision for expenditure growth in 2005/06.

**Agenda for Change Implementation – Impact on Pay Inflation.** The cost of implementing Agenda for Change accounts for a significant proportion of an overall provision for pay inflation of £39 million in 2005/06. A key assumption is that regarding the potential cost of backfilling those additional holidays taken by staff due to an increase annual holiday entitlement. An overall backfill rate of 50% is assumed at this stage as a realistic basis for calculating potential additional costs. This will be kept under close review in the light of further information as this becomes available during the course of the year.

Notwithstanding the detailed work which has been carried out to assess the costs of inflation, it is important to recognise the potential risk of additional expenditure in each of these areas, in particular prescribing within primary and secondary care. In addition, there is a likelihood of an increase in capital charges. This increase is dependent on the outcome of the current revaluation of assets at 31 March 2005.

### 14.5 Revising the Local Health Plan and National Priorities

We have reviewed the commitments made in the Local Health Plan in the light of NHSGG's financial circumstances. The outcomes of these reviews are shown below:

	<b>£ million</b>
Acute Services (excluding waiting times targets)	4.6
Mental Health	5.0
Maternal and Child Health	1.1
Primary Care and Other Community Services (excluding new GMS contract)	1.1
Unmet Need	4.0
<b>TOTAL</b>	<b>15.8</b>

In addition to these commitments, a further sum of £10.9 million (ie £4 million recurrent, £6.9 million non recurrent) is set aside as a provision to cover those additional costs which will require to be covered in 2005/06 relating to the achievement of National Waiting Times Targets.

### 14.6 Cost Savings Plan (Corporate Recovery Plan)

The Board's Cost Savings Plan has been further developed and extended to embrace a wider range of projects. The forecast level of additional cost savings planned for 2005/06 is summarised below:

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	<b>£ million</b>
a Full year cost savings from current projects	3.9
b Extension/reappraisal of current projects	2.5
c New projects starting 2005/06	
– Utilisation of estates/estates valuation	0.8
– Shared laboratories services - reagents procurement arrangements	0.65
– Shared catering services	0.65
– Agency/Bank Nursing	1.0
– Estates – implementation of best practice arrangements	0.3
	<b>9.8</b>
<b>Less</b>	
Non recurring savings from 2004/05 Corporate Recovery Plan	(3.8)
<b>Additional Planned Cost Savings in 2005/06</b>	<b>6.0</b>

**14.7 Overall Summary**

In summary, at this point the Board's 2005/06 Financial Plan can be presented as follows:

	<b>£ Million</b>	<b>£ Million</b>
<b>Total Available Additional Resources</b>		
SEHD funding recurring	74.0	
Additional WOS funding	6.0	
Profit on land sales	7.5	
Funding for services provided to Asylum Seekers	1.5	89.0
<u>Total Additional Expenditure</u>		
<b>Inflation and Other Pressures</b>	78.7	
<b>Local Health Plan</b>	26.7	
<b>Cost Savings Plan</b>	(6.0)	99.4
Shortfall in Funding		<b>10.4</b>

The Board's intention is to address this shortfall by developing further proposals to contain costs within available funding in 2005/06. This is before additional costs of £12.2 million on GMS contract where confirmation of funding is awaited from SEHD.

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