GREATER GLASGOW NHS BOARD

ANNUAL REVIEW 2005

CHAIRMAN’S SELF-ASSESSMENT FOR MEETING WITH SCOTTISH EXECUTIVE HEALTH DEPARTMENT ON 31 AUGUST 2005
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1. **INTRODUCTION**

I welcome the opportunity to present the main features of GGNHS performance in the period 2004-05 and to look forward over 2005-06.

Greater Glasgow’s health needs are dominated by two overlapping issues; the urgent requirement to reduce the inequalities gap alongside improving overall population health and the provision of sustainable high quality medical services.

In terms of ill health the drive for improvement has gained momentum from four developments; Board level prioritisation, the implementation of clearly targeted delivery of health improvement strategies, and the creation of CHPs and from the setting up of the Centre for Population Health.

Modernisation of Greater Glasgow NHS services through implementation of the first stages of the acute services plan is progressing apace. Key milestones are the construction of the new cancer hospital, finalisation of plans for the new diagnostic and treatment hospitals (ACADs) and the initiation of planning for the new children’s hospital in conjunction with Professor Calder. The Board has redoubled its efforts on patient focus and public involvement to ensure a much higher awareness of these developments.

Service redesign of major in-patient services in preparation for the later stages of the acute services review is being undertaken with a clear commitment to provide the highest quality of sustainable patient care.

PROFESSOR SIR JOHN ARBUTHNOTT  
CHAIRMAN  
NHS GREATER GLASGOW
2.1 The following lists the actions agreed as the outcome of last year’s Accountability Review and in italics the progress made.

2.2 Area Clinical Forum: Board will work with the ACF to develop a clear strategic role. 
*Paper by Chief Executive presented to ACF in a meeting attended by the Chairman in January with suggestions on role development; presently being developed.*

2.3 Area Partnership Forum: Board will ensure the engagement of staff at all levels of the organisation. 
*Agree implementation plans for PIN Guidelines on a pan Glasgow basis. The Managing Change Policy has been agreed in partnership and there are plans for further work on harmonisation of all policies in the light of NHSGG restructuring. The parental leave policy remains an issue. Staffside believe the PIN Guideline requires the employer to offer paid leave. The pan Glasgow policy was implemented last year to offer unpaid leave. The issue is to be discussed at the Staff Governance Committee again.*

2.4 Regional Planning: Agree on costs of cross border flows with other West of Scotland Boards. 
*Agreed with West of Scotland Directors of Finance on 28 March with agreement and implementation arrangements concluded in April with Health Department Director of Finance and Chief Executives of West of Scotland Boards. See also Section 5A.*

2.5 Improving Health: Senior level meeting on Unmet Needs Proposals to take place between the Scottish Executive Health Department and NHS Greater Glasgow. 
*Unmet Needs allocations for both 2004-05 and 2005-06 now being finalised.*

2.6 Improving Health: Focus work on tackling the inequality ratio. 
*Glasgow Centre for Population Health now well established. See also Section 3.*

2.7 Improving Health: Provide an update on the initial outcomes of work in Oral Health. 
*In March 2005 following extensive consultation the Board approved its 5 year oral health strategy. The strategy was launched by the Chairman and Chief Executive and copies were sent to the Scottish Executive. The strategy is presently being implemented aided in part by the new national funding. Progress on achievement including against national targets will be reported to the Board during 2005-06. See also Section 3.*

2.8 Financial Plan: Ensure accurate and timeous financial forecasts. 
*Achieved; now part of routine reporting. See also Section 8.*

2.9 Financial Plan: Revised Financial plan to be submitted to Scottish Executive by 31 August. 
*Completed by 31 August 2004. Follow up meetings held on 10 December 2004 and August 2005 (scheduled) with Health Department Director of Finance. See also Section 8.*

2.10 Access and Waiting: Achieve and maintain the 6 month out-patient and in-patient/day case standards from December 2005. 
*On course to achieve targets. See also Section 4.*
2.11 Access and Waiting: In the period to March 2005, achieve a 35% reduction in out-patients waiting over 6 months and a 53% reduction in in-patients/day cases waiting over 6 months (for patients covered by national waiting time standards). Surpassed targets. See also Section 4.

2.12 Access and Waiting: Review the position on orthopaedic outpatient waits by 31 October 2004. “See and Treat” initiative commissioned in private sector assessed 1000 extra patients by March 2005 with consequent in-patient treatment due to be completed by September. See also Section 4.

2.13 Accelerating Implementation of the Acute Services Review: Demonstrate affordability of your proposals. Reports confirming ACAD procurement, value for money and affordability presented to March and May meetings of Performance Review Group. See also Section 9.


2.15 Child Protection: Deliver on action plan submitted to the Minister. Implementation well underway. NHS Child Protection Forum including all medical and nursing directors established and child protection unit with head of service set up. Detailed report to Board in September 2004 and April, 2005.

2.16 Healthcare Associated Infection: Review MRSA bacteraemia rates in North Glasgow and consider comparisons with similar organizations. Review complete. Board Chairman launched major HAI campaign on 2 March. See also Section 6.

2.17 Diversity: Ensure progress on diversity issues. Major stocktake reported to Board in December. Race Equality annual report to Board in April 2005. Report on gender to Board in December 2004 and planned Board participation in EOC national pilot on gender equality. Inequalities Unit to be created as part of new restructured organization.

SCOTTISH EXECUTIVE HEALTH DEPARTMENT RESPONSE

We are pleased to note progress on each of the action points identified at the 2004 AR.

We recognise that work is being taking forward on developing a clear strategic role for the ACF and it is important that the Board continues to progress this. In relation to the APF, it is noted that the harmonisation of HR policy on a Glasgow wide basis is a complex and time consuming task. As directed in the action points from last years review we would expect that plans for harmonisation have been agreed in partnership and are now in place.

We welcome the developments in child protection particularly the development of the central unit with a dedicated head of service. We also recognise the work taken forward on Diversity and welcome the establishment of an Inequalities Unit.
Specific feedback on Regional Planning, Health Improvement, Finance, Waiting, HAI, and NHS Greater Glasgow’s ASR are covered under their respective substantive agenda items.
3. HEALTH IMPROVEMENT STRATEGY

3.1 General

3.1.1 The Executive has commented favourably on the Performance Assessment Framework (PAF) return re health improvement activity in NHS Greater Glasgow that was submitted earlier this year. Recognition has been given to the high level of cohesion and effective partnership working for health improvement, with our work on employment initiatives for health having been highlighted as exemplar practice. Areas of particular note in the past year include the following.

3.1.2 Integration of Health and Social Justice Issues

The Community Planning Partnership (CPP) for Glasgow was established in 2004 – with the first community plan being developed throughout the year. Improving health and reducing health inequalities are integral to both the overall community plan and the regeneration outcome agreements - with explicit health objectives and targets in both, shared by all community planning partners. In addition to the Closing the Opportunity Gap targets, the Regeneration Outcome Agreement (ROA) for Glasgow city specifically focuses on aspects of health where the Glasgow Health and Well-being Survey identified a potential inequality gap. The following strategic health objectives (included in both the community plan and the ROA) were identified through an extensive programme of stakeholder workshops (including specific community events):

- take action to reduce the impact of poverty on child health;
- support Glaswegians to lead active healthy lives;
- make Glasgow a city where non-smoking becomes the norm;
- promote positive mental health for all and reduce stigma associated with mental illness;
- reduce the harm associated with drug and alcohol misuse;
- provide services that promote the health of young people;
- take action to support the health of carers;
- provide the opportunities, culture and environment to support safe and healthy working lives.

A community engagement strategy for community planning in Glasgow has been commissioned, with the avowed aim of integrating community engagement processes of all the community planning partners.

GGNHSB has similarly contributed to the ongoing development of the health aspects of community planning in East Renfrewshire, East and West Dunbartonshire, and South Lanarkshire.

SCOTTISH EXECUTIVE HEALTH DEPARTMENT RESPONSE

We welcome NHS Greater Glasgow’s continuing progress in integrating health and social justice issues, reflected by the integral place of improving health and reducing health inequalities within the overall community plan and local regeneration outcome agreements. We note the Community Planning Partnership’s strategic health objectives,
identified through an extensive programme of stakeholder workshops, and the Board’s key objectives for 2005/06, which include supporting CHPs’ health improving role, continued expansion of smoking cessation services, implementation of the oral health strategy and sexual health objectives.

The Board’s report makes brief reference to the extensive work on improving mental health and well-being. The Board’s mental health improvement work is amongst some of the best in Scotland, particularly on stigma, mental health promotion for children and young people, mental health promotion in primary care, employment and mental health and suicide prevention work, and should be widely shared.

In relation to addressing drugs misuse, NHS Greater Glasgow demonstrates extensive partnership working and an impressive range of ‘whole system’ services and initiatives are in place. Considerable efforts have been made to secure maximum community input to planning future developments.

3.1.3 Reducing Health Inequalities through Employment

The Glasgow City CPP has identified worklessness as a priority (with a particular focus on the 100,000 people who are economically inactive, many through ill-health). The first Glasgow Health and Well-being Survey in 1999 identified being in employment as a key determinant of good health – and NHS Greater Glasgow has therefore actively engaged as a partner in a range of initiatives to support people into employment including:

- **Working for Health in Greater Glasgow** - a partnership with Jobcentre Plus to provide a 6-week in-house training programme to prepare participants for employment in the NHS. This was initiated as a pilot by the Health Promotion Department and has now become part of GGNHSB mainstream workforce development activity.

- **The Compass Project** – a pilot within GP practices in Pollok to support patients (many of whom have been on incapacity benefit for many years) to take up training or employment opportunities. Early findings are encouraging with a high proportion of eligible patients engaging in the project, resulting in a reported increase in perceptions of well-being, reductions in GP visits and drugs prescribed.

- **Building a Bridge** - a programme to recruit and train health facilitators from black and ethnic minority (BME) communities, involving BME communities in promoting health and engaging with NHS services, while at same time helping to increase BME representation in our workforce. This initiative has been awarded European funding and will be extended to operate in other NHS Boards in the West of Scotland.

- **Pathways to Work** - GGNHSB will be an active partner in this initiative in the coming year.

- **Employment and Health Group** for the Easterhouse area which has ensured that local socially excluded people benefit from the employment opportunities created by the new Glasgow Fort shopping centre and that all employers adopt healthy working policies.

**SCOTTISH EXECUTIVE HEALTH DEPARTMENT RESPONSE**

We commend NHS Greater Glasgow on the range of initiatives they are involved in.
3.1.4 Promoting Racial Equality

Recognising that the methodology used for the 3 yearly Health and Well-being Survey of the Greater Glasgow population did not provide a sufficiently large or robust sample of BME people to allow us to analyse the results by race, we commissioned a separate health and well-being survey of people from Pakistani, Indian, African and Caribbean backgrounds in Greater Glasgow in 2004. The results are currently being analysed and a report on the findings will be available in the next few months. This complements the Health and Well-being Survey of the Chinese community carried out last year in connection with the establishment of a Chinese Healthy Living Centre and together these will allow us to make comparisons of the health of the main minority ethnic groups with the general population and identify health inequalities resulting from race.

3.1.5 Smoking - Prevention and Cessation

Action to reduce smoking rates has been a particular focus in the past year – with the additional investment from the Scottish Executive being used to expand smoking cessation services. Greater Glasgow provides one of the most comprehensive smoking cessation services in the UK, meeting the needs of different types of smokers in an integrated package which is evidence-based. 2004/5 has seen:

- continued expansion of smoking cessation groups, using the Maudsley model for heavily addicted smokers, with provision in all Local Health Care Cooperatives (LHCCs) in Greater Glasgow;
- continued expansion of Starting Fresh – the community pharmacy scheme suitable for less heavily addicted smokers to which all can self-refer;
- the development of a service in each maternity hospital specially tailored to meet the needs of pregnant women;
- the development of a pilot smoking cessation service for patients in an acute hospital (Southern General), with follow-up on discharge from primary care, linking with the services provided in the community. In the coming year the acute hospital service will be expanded to include all main hospital sites in Greater Glasgow.

These services are being evaluated by Glasgow University and the Glasgow Centre for Population Health.

Investment in smoking cessation services has been complemented by continued work to prevent young people smoking and promote smoke-free public places. A new policy with the aim of making Greater Glasgow NHS smoke free has been developed and is currently out for consultation. Glasgow City Council has agreed to allocate an additional £250k each year for the next three years to support the implementation of the Glasgow Tobacco Strategy, which was approved in 2004.

3.1.6 Physical Activity, Healthy Eating, Oral Health and Sexual Health

The Glasgow Physical Activity Strategy (let’s make Glasgow more active) was produced in 2004/5 and is currently out for consultation. The actual process of developing the strategy has helped to broaden understanding of key officers in the council of physical activity and the
various ways in which the problems of inactivity can be tackled. This has resulted in a high level of ownership and commitment by the Council, who will now lead on the strategy’s implementation.

Linked with the strategy, a range of services has been developed in the community as part of an integrated weight management programme to tackle obesity. The GP exercise referral scheme has been expanded to include East Renfrewshire and East and West Dunbartonshire, with additional specifically tailored activity sessions being provided for participants.

**SCOTTISH EXECUTIVE HEALTH DEPARTMENT RESPONSE**

We welcome the development of the Glasgow Physical Activity Strategy, currently out for consultation.

Recent analysis of the National Dental Inspection Programme (NDIP) data for 2004/05 (unpublished) indicates that significant improvements in oral health within five year olds have been made at local and Greater Glasgow levels. These improvements are associated with the roll-out of the OHAT programme and relate to the first time period at which any impact of this initiative can be measured on a Greater Glasgow basis. A significant improvement in the dental health of five year olds living in areas of deprivation has been achieved in 2003/04 and sustained in 2004/05. Dental health inequalities between the most deprived and least deprived areas have reduced and more children in deprived areas are showing zero caries experience.

Whilst GGNHSB is making significant progress towards the 2010 target for five year olds the rate of change is slower than anticipated and the size of change required continues to be significant. During 2004/5 the Oral Health Strategy was developed and will be implemented over the next five years.

**SCOTTISH EXECUTIVE HEALTH DEPARTMENT RESPONSE**

The Board has worked hard to address very high levels of poor oral health and the impact of very high levels of deprivation in some communities; this is recognised in the Board’s 5 year oral health strategy which was approved earlier this year and is being implemented in 2005/06. The roll-out of the Oral Health Action Team and the Board’s proactive approach to oral cancer through involvement in the West of Scotland Cancer Awareness Project are particular strengths.

On sexual health Greater Glasgow NHS:

- has built an advanced sexual health improvement programme underpinned by use of evidence and research, a focus on inequalities, strong multiagency, cross-sectoral partnerships, significant financial investment and an annual review process;
- has developed jointly with Glasgow City Council a Teenage Pregnancy Prevention Strategy to improve partnership responses to meet the public health target of reducing teenage pregnancy in the 13-15 year old age group;
- is currently developing a Glasgow sexual health strategy with Local Authority and voluntary sector partners;
- has already developed and manages policies in HIV prevention amongst gay and bisexual men, young people and adults with learning disabilities;
• has a Sexual Health Promotion Team taking forward work around four key areas of information, access to services, training and education and working with at risk groups;
• through the Sandyford Initiative offers high quality integrated and targeted sexual health services from a city centre base and progressively through community based “Hubs”;
• initiated discussions six months ago with neighbouring Boards to explore planning for regional sexual health services;
• with Glasgow City Council has undertaken a survey of parents’ attitudes on sex education and plans a survey on attitudes and behaviours of young people to inform the development and delivery of education and services to promote sexual health and well-being;
• spends about £9 million on sexual health including funding of the Sandyford Initiative.

SCOTTISH EXECUTIVE HEALTH DEPARTMENT RESPONSE

Sexual health plans are well developed across NHS Greater Glasgow and partnership working with non-NHS partners is being developed. We note and welcome that the Board has initiated discussions with neighbouring NHS Boards to explore planning for regional sexual health services. We note that a key objective in 2005/06 is continued implementation of the Teenage Pregnancy Prevention Strategy and the further development of sexual health education and services in light of local survey results.

3.1.7 Looking to the Future

An underlying principle of the reorganisation of GGNHSB has been that health improvement is part of the core business of every part of the organisation. Specialist public health and health promotion staff will therefore be devolved to CHPs and the remaining divisions of the Board. The challenge will be to gain the benefits of greater local ownership for health improvement without diminishing the cohesion, quality and ability to innovate and contribute to evidence-based practice.

A public health network will be established to support the development of the specialist public health workforce, which will be complemented by a series of networks, led by specialist health improvement managers in each part of the system. A new sub-committee of the NHS Board will be established to oversee developments in health improvement. A small team with the specific remit to lead on health improvement and inequalities will develop policy and performance management for the rest of the system.

Key objectives for 2005/6 include:

• establishing new robust organisational arrangements at Board level for the delivery of health improvement, including the establishment of a Health Improvement Sub-committee of the Board;
• using the current development programme for health improvement in CHPs (funded by the Scottish Executive) to identify common issues/ needs to inform future training and development programmes to be delivered by the Public Health network;
• all CHPs to develop Health Improvement action plans;
• continued expansion of smoking cessation services to support the introduction of smoke-free legislation, with additional specialist staff and financial resources being provided to each CHP and to the development of the new acute hospital services;
• implementation of new NHS Greater Glasgow no smoking policy;
• implementation of the oral health strategy;
• continued implementation of the Teenage Pregnancy Prevention Strategy and the further development of sexual health education and services in light of survey results.

SCOTTISH EXECUTIVE HEALTH DEPARTMENT RESPONSE

NHS Greater Glasgow continues to be one of the more developed Public Health Organisations in Scotland. Health improvement is clearly identified as part of the core business of every part of the organisation and local multi-agency partnership working is a key strength. The Board’s assessment notes that efforts to drive health improvement have gained momentum following Board level prioritisation, targeted delivery of health improvement strategies, the creation of CHPs and the establishment of the Glasgow Centre for Population Health. It highlights proposals to devolve specialist public health and health promotion staff to CHPs and the remaining divisions of the Board in order to gain greater local ownership for health improvement. A key challenge will be to ensure that this does not undermine established strengths and diminish cohesion, quality and ability to innovate and contribute to evidence-based practice.

While the Board demonstrates a clear commitment to reducing the inequalities gap rates of CHD, cancer and stroke mortality (under 75s), adult smoking and smoking during pregnancy remain significantly higher than the national average. However, rates are declining and Glasgow is generally on track to meet target reductions. There has been no change in the percentage of 5 year olds free of dental caries in Greater Glasgow between 1997/98 and 2002/03; in 2002/03, the proportion of 5 year olds free from dental caries was 21% lower in Greater Glasgow than in Scotland overall. There have been improvements in the most deprived areas for all 5 indicators of health inequalities; inequality ratios have widened for dental caries and CHD mortality and narrowed for smoking during pregnancy and adult smoking. Life expectancy has improved in deprived and affluent areas at around the same rate meaning there has been no change in the inequality ratio. It is important that the Board sustain recent progress and address continuing areas of concern, given Glasgow’s relatively poor health status compared to the rest of Scotland.

3.2 Supporting the implementation of the Smoking, Health and Social Care (Scotland) Act 2005

3.2.1 With the Parliamentary approval of the smoke free legislation the Minister wrote to the Board on 6th July 2005 indicating that he wished to discuss at the Annual Review the Board’s plans for local cessation services.

3.2.2 Strategic

The Glasgow Tobacco Strategy was approved by the Glasgow Community Planning Partnership in 2004 and is supported collectively and individually by all partner agencies.
The strategy seeks to make Glasgow a city where non-smoking is the norm, to prevent young people taking up smoking and support current smokers to quit. Glasgow City Council has allocated an additional £250,000 per annum for the next 3 years to support the implementation of the strategy. This investment includes:

- additional training and staff resources in Environmental Health to support smoke free public places;
- expansion of the Smoke Free class and Smoke Free Me prevention programmes in primary and secondary schools;
- resources to support the smoke free homes initiative currently being piloted in Easterhouse;
- a public awareness raising no-smoking week.

### 3.2.3 Smoking Cessation

Greater Glasgow NHS has developed one of the most extensive and comprehensive smoking cessation services in the UK. The different strands of the service together provide an integrated evidence-based package that meets the needs of different types of smokers, with participants being referred between the different strands as appropriate.

The service comprises the following elements:

- integration of cessation services;
- service quality standards in place;
- a consistent approach – the Maudsley model, access to Nicotine Replacement Therapy (NRT);
- fully trained staff with annual updating of skills;
- mentoring system for smoking cessation practitioners;
- evidence based service independent research carried out by Glasgow University.

The different strands within the integrated service are as follows:

**Starting Fresh Community Pharmacy Scheme**

Launched in 2003, with over 180 pharmacies (83%) participating. Pharmacists prescribe NRT and provide support and advice to participants for an 8 - 12 week period. A key strength of this service is ease of access as smokers can self-refer and receive NRT (free or at prescription cost) without the need to visit a GP. This service therefore deals with the majority of smokers wanting to quit (with over 20,000 patients having registered since June 2003) and the community pharmacy service also provides the NRT for patients referred from the other elements of the cessation service.

All participating pharmacists and pharmacy assistants undertake a one-day training course on ‘brief negotiation interventions’ and complete a distance learning pack on NRT. To date over 200 pharmacists and 360 pharmacy assistants have completed the training. Training is provided on a regular basis to take account of staff changes etc.

The project is supported by a network of 7 Community Pharmacy Health Promotion Facilitators (soon to be increased to 11), working on a sessional basis, to ensure effective...
communication between the Board, PCD and local practitioners. The project has been 
highlighted as an innovative example of good practice in the Chief Medical Officer’s report.

**Intensive Group Support provided by LHCCs**

Evidence suggests that more heavily addicted smokers require the more intensive support 
provided through smoking cessation groups (7 weekly group sessions with NRT/Zyban). 
Group cessation support is provided by every LHCC. Participants are generally referred by 
their GP, Practice Nurse or other health professional (or are referred from the community 
pharmacy scheme). Considerable resources have been committed to training health staff to 
provide group cessation with 100 facilitators currently practising (using the Maudsley model). 
There are logistical difficulties in organising sufficient group sessions to provide as extensive 
a service as is required for the numbers of heavily addicted smokers in Greater Glasgow. 
However the additional investment from the Scottish Executive will be used to provide each 
CHP with dedicated smoking cessation coordinators and this will greatly increase capacity to 
run group courses at regular intervals.

**Support to Pregnant Women**

Launched in 2004, this service, supported by a link midwife in each maternity hospital in 
Glasgow, provides a service specifically tailored to the needs of pregnant women. As part 
of routine antenatal care all women have a carbon monoxide recording and where appropriate 
are then offered assistance to stop smoking by a specialist midwife.

**Secondary Care In-Patient Services**

This service will provide all hospital in-patients who are smoking with the opportunity to 
access help and support to stop smoking while in hospital. It will include access to NRT and 
continued support from the hospital specialist smoking cessation advisor for the duration of 
the hospital stay. Patients will be discharged with 2 weeks NRT and linked into the existing 
smoking cessation services in the community where they will continue to be supported and 
receive NRT for up to 12 weeks. A protocol for the service is currently being tested and 
piloted in the Southern General hospital in Glasgow, reporting in September 2005, following 
which it will be implemented in all 5 main hospital sites, with a smoking cessation coordinator 
employed in each hospital to lead the development of the service.

**Additional Services to Support Smoking Cessation**

Research has shown that smokers in more deprived areas require more support than smokers 
from more affluent areas in order to quit successfully

A pilot befriending project has been set up within a local community stress centre to support 
clients thinking about stopping to the stage they are ready to set a date to quit smoking, and 
then refer them into the NHS intensive group support in their local area. This project is 
unique because of the close collaborative working with specialist cessation services and 
volunteer services. If successful this approach would be rolled to other stress centres across 
Glasgow.
Monitoring and Evaluation

A comprehensive database has been established, which records numbers of patients, and quit rates at 4 weeks, 6 months and 12 months. The evaluation is being conducted by Glasgow University and the Glasgow Centre for Population Health, with a report due in September 2005 on progress to date.

Responding to Anticipated Increased Demand

All the services outlined above will together provide the means of supporting those who may be encouraged to quit as a result of the ban on smoking in public places. Additional investment is being made in the numbers of smoking cessation coordinators and pharmacy facilitators to support the service. The community pharmacy service has proven its ability to cope with large numbers of participants. (A key benefit of the Starting Fresh service, has been the reduction of costs and the prevention of wastage as NRT is prescribed on a weekly basis only to those who continue to attend for advice and support. A preferred supplier contract for NRT has also helped ensure best value for GGNHSB.) A pool of smoking group leaders will be on standby to provide additional group sessions in any areas where demand exceeds existing capacity.

GGNHSB has actively linked with NHS Health Scotland ‘Smokeline’ to triage all calls requesting cessation services through one dedicated telephone number. A system is in place for routing people to local cessation services based on their postcode area. It is anticipated that national publicity will be supplemented by local media, where local services available in Greater Glasgow can be promoted.

Our Health@Work team is promoting awareness of the new legislation through employer and employee seminars and arrangements are in hand to provide specific workplace smoking cessation groups for those who require this level of support (with other employees able to access services through their local community pharmacy).

3.2.4 NHS No Smoking Policy

The Board has developed a new no smoking policy, with the aim of making Greater Glasgow NHS smoke free. The policy is currently out for consultation, with the draft policy due to be reviewed by the Board in September, in the light of comments received.

SCOTTISH EXECUTIVE HEALTH DEPARTMENT RESPONSE

NHS Greater Glasgow acknowledges the significance of the proposed legislative controls in smoking in public places. Given the importance of Boards being ready to meet implementation issues surrounding the ban, it is welcoming to note the proactive and innovative approach taken by the Board to develop a comprehensive smoking cessation service.

Excellent pathways into care are being established in both primary and secondary care. Of particular note is the ‘Starting Fresh Community Pharmacy Scheme’ which has seen 20,000 patients register since June 2003. We welcome the fact that the increased
investment from the Scottish Executive will be used to provide each CHP with dedicated smoking cessation coordinators, and increase the number of pharmacy facilitators in order to gear up for the anticipated increase in demand for smoking cessation services in advance of the smoke-free legislation.

Workplace based support promoting awareness of the legislation and providing cessation support is being undertaken by Health@Work team. A good example of joint working with health improvement partners is the Glasgow Tobacco Strategy, approved by the Glasgow Community Planning Partnership with additional funding coming from the City of Glasgow Council of £250K per year for the next 3 years. Overall some excellent work being taken forward on smoking cessation, for which the Board should be commended.
4. **WAITING TIMES**

4.1 **2004/05 - Plans and Performance Review**

4.1.1 Delivering and Sustaining the 9 month Inpatient/Day Case Guarantee in 2004/05

- The national guarantee has been delivered consistently since the target date of December 31st 2003.

4.1.2 Improvements in Inpatient/Day Case Waiting Times Towards a 26 Week Maximum Wait

- We planned that inpatients/day cases waiting over 26 weeks would reduce by 53% to 795 by March 2005.
- We achieved an actual performance improvement of 69% and reduced the numbers waiting >26 weeks to 531 at March 2005.
- This also surpassed an improved planning milestone of 700 that we subsequently agreed with the NWTU, in year, to be achieved by March 2005.

4.1.3 Improvements in Outpatient Waiting Times Towards a 26 Week Maximum Wait

- We planned that outpatients waiting over 26 weeks would reduce by 35% by March 2005.
- We subsequently agreed (with the NWTU) and surpassed an improved planning milestone to be achieved by March 2005.
- The number of outpatients waiting over 26 weeks was 9,029 at March 2005 compared to a revised plan of 11,923 - an improvement of 2,894 or 24% on plan.
- To put this in context further, we achieved this against a high point in the list of 20,692 waiting over 26 weeks at September 2004 - an improvement of 11,663 or 56% - 6 months further on.
- We also promised to reduce the number of outpatients waiting the longest - over 52 weeks - we reduced this from 6,756 at August 2004 to 2,891 at March 2005 - a reduction of 3,865 or 57%.

4.1.4 Investment in Improving Waiting Times - 2004/05:

The additional cost of improving waiting times in 2004/05 was £17.7m - broken down by the following funding sources:

<table>
<thead>
<tr>
<th>Funding Source</th>
<th>£’000s</th>
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<tr>
<td>GGNHSB - Local Health Plan</td>
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<tr>
<td>GGNHSB - Other</td>
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<td>GGNHSB - Capital</td>
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<td>NWTU - Arbuthnott funding</td>
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<td>West of Scotland Boards</td>
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</tr>
<tr>
<td><strong>Total</strong></td>
<td>17,690</td>
</tr>
</tbody>
</table>
4.1.5 CHD - New Standards in 2004/05:

The maximum waiting times guarantee for cardiac revascularisation following angiography was set at 18 weeks (reducing from 24 weeks) with effect from 1 July 2004 (CABG and angioplasty); also, the guarantee for patients waiting for angiography reduced from 12 to 8 weeks effective from 1 January 2005.

All of the above standards were delivered consistently in 2004/05.

4.1.6 Access to Golden Jubilee National Hospital (GJNH) Capacity

We initially planned for 2,392 inpatients and day cases plus an additional 2,320 for scopes and imaging - totalling 4,712 episodes at a planned cost of £3.2m, to assist in delivering our capacity plans for improving waiting times in 2004/05. The out-turn against this was 6,843 total patient episodes costing £3.8m. GGNHSB certainly played their part in fully utilising the additional capacity made available at the GJNH.

4.1.7 Orthopaedic Surgery

Three proposed initiatives have been developed.

a) To make significant impact to the backlog of orthopaedic patients waiting longer than 26 weeks, NHSGG invested around £2m in a private hospital initiative. The contract will see 1,000 patients being assessed (as outpatients) and treated (as necessary as inpatients/day cases) by consultants at both the Nuffield and Ross Hall Hospitals in Glasgow. The outpatients were seen within the first three months of 2005 and will receive any subsequent orthopaedic surgery before September 2005. As a regional centre for these services and faced with recruitment difficulties, which are being experienced elsewhere in the UK and Europe, we have decided to use spare private capacity in Scotland to help accelerate our progress to meeting waiting time targets.

b) Significant new investment in NHS Greater Glasgow’s orthopaedic services, which is creating extra capacity with the recruitment of additional orthopaedic consultants along with additional anaesthetic and theatre staff and a range of other clinical specialists.

c) We are also introducing innovative ways of improving waiting times at the GRI through the use of extended scope practitioners - physiotherapists, nurses and podiatrists who are able to diagnose and refer patients for the appropriate treatment enabling surgeons to spend more time in theatre. The results have been very impressive with a 200% increase in the number of new referrals seen at orthopaedic outpatient clinics (249 to 788 from September to May) and an equivalent increase in the number of knee and hip replacements performed (rising from 25 per month in January 2003 to 80 per month in June).
4.1.8 **Availability Status Codes (ASCs):**

We routinely reported on the position with ASCs to each Board meeting during 2004/05. Between March 2004 and 2005, the total numbers of ASCs increased by 4% in NHSGG compared to a 20% increase for Scotland as a whole. The main driver of increases in ASCs in NHSGG is by the increased coding of “patient driven” ASCs - which we have little or no real influence over. “Service driven” ASCs, which we can directly influence, have in fact, reduced steadily across Glasgow over the last 2 years - from 1,648 in July 2003 (peak of 1,800 in January 2004) to 1,351 in June 2005. (See also 4.2.8)

4.2 **2005/06 - Plans**

4.2.1 **Planning Milestones - Inpatients/Day Cases**

Our waiting times milestones and investment priorities for 2005/06 were submitted to the NWTU at the beginning of May 2005.

The planned improvement for inpatients and day cases is summarised in table 1. At this stage, we are not specifically targeting improvements in >18 week waits - the milestones as presented are our assessment of the likely position at each point in time.

**Table 1 - Inpatient/Day Case waiting Time milestones 2005/06**

<table>
<thead>
<tr>
<th>Waiting Band</th>
<th>ACTUAL - 2004/05</th>
<th>PLANS - 2005/06</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Dec-04</td>
<td>Mar-05</td>
</tr>
<tr>
<td>&gt;26 weeks</td>
<td>1,275</td>
<td>531</td>
</tr>
<tr>
<td>Planned Variance from Mar-05 Baseline</td>
<td>+29 (+5%)</td>
<td>-173 (-33%)</td>
</tr>
<tr>
<td>&gt;26 weeks actual at Jun-05</td>
<td>282</td>
<td></td>
</tr>
<tr>
<td>&gt;18 weeks plan</td>
<td>2,953</td>
<td>3,945</td>
</tr>
<tr>
<td>&gt;18 weeks actual at Jun-05</td>
<td>1,882</td>
<td></td>
</tr>
</tbody>
</table>

4.2.2 **Planning Milestones - Outpatients**

The planned improvement for outpatients, excluding the dental specialties, is summarised in table 2. The inpatient/day case comment on >18 week waits is equally applicable to outpatients.
<table>
<thead>
<tr>
<th>Waiting Band</th>
<th>ACTUAL - 2004/05</th>
<th>PLANS - 2005/06</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Dec-04</td>
<td>Mar-05</td>
</tr>
<tr>
<td>&gt;26 weeks</td>
<td>13,390</td>
<td>9,029</td>
</tr>
<tr>
<td>Plan Variance from Mar-05 Baseline</td>
<td>-2,429 (27%)</td>
<td>-5,351 (-59%)</td>
</tr>
<tr>
<td>&gt;26 weeks actual at Jun-05</td>
<td>tbc</td>
<td></td>
</tr>
<tr>
<td>&gt;18 weeks plan</td>
<td>15,550</td>
<td>11,883</td>
</tr>
<tr>
<td>&gt;18 weeks actual at Jun-05</td>
<td>tbc</td>
<td></td>
</tr>
</tbody>
</table>

4.2.3 Planning Milestones - Outpatient Dental Specialties

The planned improvement for outpatient dental specialties is summarised in table 3. Dental specialty waiting times were not explicitly monitored in 2004/05 due to a lack of robust recording and reporting systems - this applied across Scotland.

<table>
<thead>
<tr>
<th>Waiting Band</th>
<th>ACTUAL - 2004/05</th>
<th>PLANS - 2005/06</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Dec-04</td>
<td>Mar-05</td>
</tr>
<tr>
<td>&gt;26 weeks</td>
<td>3,936</td>
<td>2,593</td>
</tr>
<tr>
<td>Plan Variance from Mar-05 Baseline</td>
<td>-442 (-17%)</td>
<td>-1,201 (-46%)</td>
</tr>
<tr>
<td>&gt;26 weeks actual at Jun-05</td>
<td>tbc</td>
<td></td>
</tr>
<tr>
<td>&gt;18 weeks plan</td>
<td>3,727</td>
<td>3,225</td>
</tr>
<tr>
<td>&gt;18 weeks actual at Jun-05</td>
<td>tbc</td>
<td></td>
</tr>
</tbody>
</table>

4.2.4 Investment in Improving Waiting Times - 2005/06

Original activity and cost profiles are being updated with latest estimates of projected cost now at £32 million. Investment plan due to be completed during August, 2005.

4.2.5 Access to GJNH Capacity - 2005/06

We agreed to increase our level of activity to just over 10,000 episodes (including scopes and imaging) in 2005/06, at an estimated cost of £5.7m. This compares to an out-turn of 6,843 episodes costing £3.8m in 2004/05.
4.2.6 Cancer

See section 4.4.

4.2.7 Agenda for Change

We have followed national policy with regard to the implications for improving waiting times.

4.2.8 Plans for Abolition of ASCs

Guidance was issued by the SEHD in March 2005 with regard to new ways of defining and measuring waiting times. This specifically addressed the issue of phasing out ASCs by December 2007. We submitted an action plan to the SEHD in May 2005 for implementing the new approach, beginning with tackling ASCs. We have subsequently begun to agree and develop processes that will enable us to comply with the new guidelines.

The key issue for NHS Scotland is set out below.

The key fact for senior management is that ASC codes will not exist from 31 December 2007 and all patients on the lists (outpatient and inpatient) at that date will have a guaranteed maximum wait of 18 weeks and so will need to be treated by 6 May 2008 at the latest, unless appropriate reasons have been identified and recorded in accordance with the New Ways definitions.

There are two main issues for NHSGG:

- We will need to create additional capacity for patients who are currently waiting with “service driven” ASCs - mainly in the specialties of orthopaedic and plastic surgery and for highly complex cases that need to be delivered over time. Our initial assessment is that there are likely to be manpower issues that we will need to resolve. Our Operating Divisions are currently working on this.

- Secondly, the biggest proportion - 85% of ASC patients - are waiting with “patient driven” ASCs and pose a different problem whereby their waiting time requires to be managed differently. To resolve this we are adapting the existing NHSGG waiting times policy that was put in place last year and have reconvened and expanded the group that drafted this in order to ensure that any changes are agreed and implemented on a pan Glasgow basis. This group will co-ordinate the communication throughout NHSGG of the guidelines and ensure full involvement of all relevant groups in the work being done to ensure compliance with the new guidelines. Also, we are setting up a specific group - predominantly clinicians, from both primary and secondary care - that will address the management of the medically unfit/clinically inappropriate patients.
4.2.9 In Year Developments - 18 Week Maximum Inpatient/Day Case Wait

The NWTU have taken the opportunity to discuss with GGNHSB the earlier delivery of the 18 week inpatient and day case wait by December 2006 as against December 2007. Further funds are now available (tranche 2) to help deliver this key target one year earlier. Some of these funds could be made on a recurring basis and can be used both in the NHS and the private sector. Boards have been requested to submit initial proposals on this, as monies will be released against satisfactory delivery of agreed milestones. We have also been requested to re-submit our 2005/06 milestones showing a significant reduction in the planned numbers of inpatients/day cases waiting >18 weeks.

We have agreed to respond to the NWTU by 1 August 2005.

4.3 2006/07 - Forward Look

4.3.1 The New Standards to be Achieved by December 2007

In December 2004, the Health Minister announced a new set of waiting time targets:

a) No patient will wait more than 18 weeks from GP referral to an outpatient appointment.
b) No patient will wait more than 18 weeks from a decision to undertake treatment to the start of that treatment - down from the current 9 month maximum wait guarantee.

Patients will be able to rely on shorter maximum waits for specific conditions:

c) 18 weeks from referral to completion of treatment for cataract surgery
d) 4 hours from arrival to discharge or transfer for accident and emergency treatment
e) 24 hours from admission to a specialist unit for hip surgery following fracture
f) 16 weeks from GP referral through a rapid access chest pain clinic or equivalent, to cardiac intervention.

In addition, for the first time new standards have been set for patients waiting for diagnostic tests and procedures, these were announced in June by the Minister. This means patients will wait no longer than 18 weeks - including diagnostic tests - as outpatients or inpatient/day cases by the end of 2007. The new standards apply to CT, MRI, ultrasound and barium scans as well as four procedures using an endoscope or micro camera to look inside the body: upper endoscopy, cystoscopy, sigmoidoscopy and colonoscopy.

The new 9 week diagnostic standards are included in the 18 week targets indicated at a) and b) above.

4.3.2 Planning for the New National Targets - Constraints and Limiting Factors

We carried out an initial assessment of the implications of the new targets following the Ministerial announcement in December last year.

Subsequently, in June of this year, in response to a request by the NWTU, we reassessed our ability to deliver the 18 week target for outpatients, daycases and inpatients by December
2007, one year ahead of schedule. The assessment, which is to be returned to the NWTU by 1\textsuperscript{st} August, will be based on a review of in year development, take account of constraints and limiting factors and include further modelling of outpatient and diagnostic services and ASCs.

4.4 Cancer

4.4.1 Background

Delivering the two-month waiting time target for cancer waiting times presents a major and complex challenge. GGNHS has agreed with NWTU that in the first instance, we will target our efforts around four main cancer pathways. These are being tackled both with a Greater Glasgow focus and within a West of Scotland coordinated approach:

- **Colorectal cancer** - ensuring capacity and demand for diagnostic services, particularly endoscopy services, is managed effectively
- **Lung cancer** - reducing radiotherapy and thoracic surgery waiting times.
- **Ovarian cancer** - improving data capture to allow more accurate assessment of additional actions that are required to ensure that current performance is maintained and continues to improve.
- **Breast cancer** - as a minimum, we need to ensure that current levels of performance are maintained and are sustainable.

This targeted approach is allowing us to focus in detail on areas where there are known delays and to work through, develop and implement actions that will lead to sustainable improvements in care delivery in the longer term.

4.4.2 Current Performance

Current waiting time performance is detailed below for the 4 cancers for which data is available. These data, with the expected performance position for December 2005, have been shared with the NWTU in late June 2005.

**Current Performance & Projected Position Against 2005 Target**

Number of patients referred urgently, number treated within 2 month target and % compliance with target.

N.B Due to number of cases reported care must taken when interpreting this information
With regard to other cancers, many of the actions detailed above will have a wider benefit. Performance data for other cancers (Quarter 3 2005) will be submitted in line with National reporting timetable.

**GGNHS Actions to Deliver Waiting Times 2005/6**

The tables below (extracted from analysis submitted to NWTU in late June 2005) detail the specific actions that GGNHS will be taking during 2005/06 to progress delivery of waiting time targets, against agreed actions in the National Delivery Plan.

It is clear that the progress being made by GGNHS is significantly linked to the work of other Boards in the West of Scotland. Each Board has attempted to provide what they believe are realistic projections of anticipated performance by the end of December 2005 taking account of local factors, planned actions, the anticipated level of impact and timescales for delivery.

<table>
<thead>
<tr>
<th></th>
<th>Glasgow North</th>
<th>Glasgow South</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Q3 04</td>
<td>Q4 04</td>
</tr>
<tr>
<td><strong>Breast</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urgent referrals</td>
<td>62</td>
<td>70</td>
</tr>
<tr>
<td>received</td>
<td></td>
<td></td>
</tr>
<tr>
<td>N° treated within</td>
<td>54</td>
<td>60</td>
</tr>
<tr>
<td>target</td>
<td></td>
<td></td>
</tr>
<tr>
<td>% compliance</td>
<td>87.1%</td>
<td>85.7%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Colorectal</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urgent referrals</td>
<td>20</td>
<td>18</td>
</tr>
<tr>
<td>received</td>
<td></td>
<td></td>
</tr>
<tr>
<td>N° treated within</td>
<td>13</td>
<td>11</td>
</tr>
<tr>
<td>target</td>
<td></td>
<td></td>
</tr>
<tr>
<td>% compliance</td>
<td>65%</td>
<td>61.1%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Ovarian</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urgent referrals</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>received</td>
<td></td>
<td></td>
</tr>
<tr>
<td>N° treated within</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>target</td>
<td></td>
<td></td>
</tr>
<tr>
<td>% compliance</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Lung</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urgent referrals</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>received</td>
<td></td>
<td></td>
</tr>
<tr>
<td>N° treated within</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>target</td>
<td></td>
<td></td>
</tr>
<tr>
<td>% compliance</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Key**

# combined data North and South Glasgow

* data not available on mode/urgency of referral – being resolved & Q1 05 data will be available for national reporting Dec 05 projected position
<table>
<thead>
<tr>
<th>Component</th>
<th>National Delivery Plan - Agreed Actions</th>
<th>GGNHS Planned Actions /Timescales</th>
</tr>
</thead>
</table>
| Urgent Referral| Ensure protocols for all urgent referrals agreed based on Scottish Referral Guidance for Suspected Cancers and in place across NHS Scotland. | Implementation of colorectal protocol in North Glasgow scheduled for beginning of July 2005  
Electronic referral via protocol for colorectal imminent in both North and South Glasgow (July 2005)  
Protocol under development for macroscopic haematuria (urology)  
Planned development of protocols for all other cancers is commenced. (July – Sept 2005)  
Ensure urgent referrals are processed appropriately and with minimum delay when received in secondary care  
Primary Care to be strongly encouraged to make all urgent referrals electronically (July 2005).  
Single point of receipt per site for all electronic referrals with the potential for fewer points being explored  
Electronic referrals accessible by clinical staff to enable ease of triage and allocation of appointment – passed on to SCI Gateway team to seek user annotation facilitation for SCI referrals. In the meantime paper vetting will continue.  
Ensure systems in place across NHS Scotland to identify all urgent referrals received – start of tracking system (see also information)  
Trackers to be introduced for lung, colorectal and urology  
Drive and support electronic transmission of all urgent referrals  
Practices with GPASS unable to access SCI Gateway to be upgraded.  
Practices without access to GPASS to identify alternate interim measures, i.e., fax referral  
Primary Care to be strongly encouraged to make all urgent referrals electronically.  
Colorectal referral protocol to be available electronically.  
Standard electronic urgent referral document to be used whilst specific protocols are under development. |
<table>
<thead>
<tr>
<th>Component</th>
<th>National Delivery Plan - Agreed Actions</th>
<th>GGNHS Planned Actions /Timescales</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rapid Assessment and diagnosis</td>
<td>Ensure mechanisms established to process urgent referrals within appropriate timescales</td>
<td>Baseline performance measures being identified and benchmark for specific cancers being formulated.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Introduction of prioritising process within pathology for specimens with a primary diagnosis of malignancy.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Exploring potential to expedite the reporting process and minimise time lapse.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Identifying capacity planning issues, etc., in parallel with other waiting time and quality standards.</td>
</tr>
<tr>
<td>MDT</td>
<td>Ensure Multidisciplinary Team Meetings (MDT) in place for all cancers to support clinical management decision making and data capture</td>
<td>Ensure Audit support at MDT</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Trackers to support MDT to facilitate data capture</td>
</tr>
<tr>
<td>First Treatment</td>
<td>Reduce delays in first treatment for all urgent referrals through optimal capacity, demand management and scheduling</td>
<td>Baseline performance measures being identified and benchmark for specific cancers being formulated.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Confirmed 1st Treatment Definitions to be recirculated and reinforced</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Reasons for Delay codings to be improved, expanded and communicated (regionally)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Exploring potential to reduce wait for radiotherapy to 21 days maximum by December 2005.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Capacity planning for cancer 1st treatment to be aligned with planning for all wait time targets.</td>
</tr>
<tr>
<td>Across total care pathway</td>
<td>Ensure systems in place across NHS Scotland to track all urgent referrals through diagnosis to treatment and produce monthly monitoring information</td>
<td>Tertiary Referral process and baseline to be identified.</td>
</tr>
<tr>
<td>Information</td>
<td></td>
<td>IM&amp;T system changes for data capture to be identified and facilitated (where possible) to enable data capture.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Daily Urgent Referral reports to named individuals for actions to be implemented.</td>
</tr>
<tr>
<td>Component</td>
<td>National Delivery Plan - Agreed Actions</td>
<td>GGNHS Planned Actions /Timescales</td>
</tr>
<tr>
<td>-----------</td>
<td>----------------------------------------</td>
<td>----------------------------------</td>
</tr>
<tr>
<td>Redesign</td>
<td>Ensure changes are implemented to address bottlenecks, reducing time for each step of the pathway within overall target</td>
<td>Cancer Process baseline measures to be recorded enabling process delays and bottlenecks to be identified, examined and rectified including, for example; Referral from imaging to specialist lung clinic following suspicious X-Ray planned (without need for additional GP referral) One stop haematuria service planned incorporating CT Scan and Flexible Cystoscopy.</td>
</tr>
</tbody>
</table>
SCOTTISH EXECUTIVE HEALTH DEPARTMENT RESPONSE

Inpatient and Day Case Targets

The table below shows the position for Greater Glasgow NHS Board over the course of the last year. The Board have maintained the 9-months maximum wait guarantee as at 31 March 2005 and successfully reduced the numbers waiting over 6 months to 527 as at 31 March 2005.

### NHS Greater Glasgow

<table>
<thead>
<tr>
<th>Specialty</th>
<th>31 Mar 2003</th>
<th>31 Mar 2004</th>
<th>31 Mar 2005</th>
<th>Change Over Last Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>ENT</td>
<td>243</td>
<td>126</td>
<td>29</td>
<td>-97</td>
</tr>
<tr>
<td>General Surgery</td>
<td>734</td>
<td>300</td>
<td>68</td>
<td>-232</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>161</td>
<td>88</td>
<td>48</td>
<td>-40</td>
</tr>
<tr>
<td>Orthopaedics</td>
<td>950</td>
<td>408</td>
<td>175</td>
<td>-233</td>
</tr>
<tr>
<td>Plastic Surgery</td>
<td>150</td>
<td>143</td>
<td>9</td>
<td>-134</td>
</tr>
<tr>
<td>Urology</td>
<td>314</td>
<td>285</td>
<td>89</td>
<td>-196</td>
</tr>
<tr>
<td>Others</td>
<td>283</td>
<td>291</td>
<td>109</td>
<td>-182</td>
</tr>
<tr>
<td>Total</td>
<td>2835</td>
<td>1641</td>
<td>527</td>
<td>-1114</td>
</tr>
</tbody>
</table>

Source Data: SMR 3 Inpatient/ Daycase Waiting List

Outpatient Waiting Performance

NHS Greater Glasgow recorded a 49% reduction between September 2004 and March 2005 for outpatients. From December 2004 the Glasgow Dental Hospital has been able to report the numbers waiting over 26 weeks and to successfully achieve a 34% reduction from the last quarter.

### NHS Greater Glasgow

<table>
<thead>
<tr>
<th>New Outpatients Waiting Over 26 Weeks</th>
<th>Sept 04</th>
<th>Dec 04</th>
<th>Mar-05</th>
<th>Sept 04 to March 05 %change</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Medicine</td>
<td>69</td>
<td>55</td>
<td>17</td>
<td>-75%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>225</td>
<td>205</td>
<td>17</td>
<td>-92%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>701</td>
<td>267</td>
<td>37</td>
<td>-95%</td>
</tr>
<tr>
<td>General Surgery</td>
<td>1033</td>
<td>853</td>
<td>357</td>
<td>-65%</td>
</tr>
<tr>
<td>ENT</td>
<td>1892</td>
<td>770</td>
<td>590</td>
<td>-69%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>1688</td>
<td>942</td>
<td>935</td>
<td>-45%</td>
</tr>
<tr>
<td>Orthopaedics</td>
<td>6232</td>
<td>6129</td>
<td>4392</td>
<td>-30%</td>
</tr>
<tr>
<td>Plastic Surgery</td>
<td>2316</td>
<td>2182</td>
<td>1559</td>
<td>-33%</td>
</tr>
<tr>
<td>Oral Surgery</td>
<td>37</td>
<td>43</td>
<td>64</td>
<td>73%</td>
</tr>
<tr>
<td>Neurology*</td>
<td>6</td>
<td>262</td>
<td>229</td>
<td></td>
</tr>
<tr>
<td>Urology</td>
<td>618</td>
<td>387</td>
<td>331</td>
<td>-46%</td>
</tr>
<tr>
<td>Other</td>
<td>2922</td>
<td>1604</td>
<td>601</td>
<td>-79%</td>
</tr>
<tr>
<td>Total</td>
<td>17739</td>
<td>13699</td>
<td>9129</td>
<td>-49%</td>
</tr>
</tbody>
</table>

Source Data: New Outpatient Waiting List Census Data.

* No data for Neurology from South Glasgow for Sept 04
Availability Status Codes

In the past year, NGS Greater Glasgow’s use of Availability Status Codes (ASCs) has risen by 4.3%, and patients with ASCs now account for 37.1% of its inpatient/day case waiting list. On 31 March 2004, patients with ASCs accounted for 33.9% of its inpatient/day case waiting list. The following table shows the change between 31 March 2004 and 31 March 2005.

<table>
<thead>
<tr>
<th>Codes</th>
<th>31 March 2004</th>
<th>31 March 2005</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Code 2 – Could Not Attend</td>
<td>4,535</td>
<td>4,792</td>
<td>+5.7%</td>
</tr>
<tr>
<td>Code 3 – Low Clinical Priority</td>
<td>180</td>
<td>281</td>
<td>+56%</td>
</tr>
<tr>
<td>Code 4 – Highly Specialised Treatment</td>
<td>1,382</td>
<td>1,114</td>
<td>-19.4%</td>
</tr>
<tr>
<td>Code 8 – Did Not Attend</td>
<td>1,974</td>
<td>2,106</td>
<td>+6.7%</td>
</tr>
<tr>
<td>Code 9 – Exceptional Strain On NHS</td>
<td>101</td>
<td>NONE</td>
<td>-</td>
</tr>
<tr>
<td>Code A – Medical Constraints</td>
<td>2,122</td>
<td>2,446</td>
<td>+15.3%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>10,294</td>
<td>10,739</td>
<td>+4.3%</td>
</tr>
</tbody>
</table>

Plans for meeting December 2005 Inpatient /Day Case and New Outpatient Targets

NHS Greater Glasgow plans to steadily reduce per quarter and achieve their Inpatients/Day Case and New Outpatients targets by December 2005.

NHS Greater Glasgow

Inpatients / Day Cases Waiting Over 6 Months

<table>
<thead>
<tr>
<th>Plan to December 2006</th>
<th>Mar-05</th>
<th>Jun-05</th>
<th>Sep-05</th>
<th>Dec-05</th>
</tr>
</thead>
<tbody>
<tr>
<td>ENT</td>
<td>29</td>
<td>20</td>
<td>11</td>
<td>0</td>
</tr>
<tr>
<td>General Surgery</td>
<td>68</td>
<td>60</td>
<td>47</td>
<td>0</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>26</td>
<td>20</td>
<td>10</td>
<td>0</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>48</td>
<td>49</td>
<td>33</td>
<td>0</td>
</tr>
<tr>
<td>Orthopaedics</td>
<td>175</td>
<td>248</td>
<td>143</td>
<td>0</td>
</tr>
<tr>
<td>Plastic Surgery</td>
<td>0</td>
<td>21</td>
<td>27</td>
<td>0</td>
</tr>
<tr>
<td>Urology</td>
<td>89</td>
<td>75</td>
<td>49</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>92</td>
<td>67</td>
<td>38</td>
<td>0</td>
</tr>
<tr>
<td>TOTAL</td>
<td>527</td>
<td>560</td>
<td>358</td>
<td>0</td>
</tr>
</tbody>
</table>
## Outpatients Waiting Over 6 Months

<table>
<thead>
<tr>
<th>Plan to December 2006</th>
<th>Mar-05</th>
<th>Jun-05</th>
<th>Sep-05</th>
<th>Dec-05</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiology</td>
<td>17</td>
<td>23</td>
<td>11</td>
<td>0</td>
</tr>
<tr>
<td>Dermatology</td>
<td>31</td>
<td>32</td>
<td>20</td>
<td>0</td>
</tr>
<tr>
<td>ENT</td>
<td>238</td>
<td>386</td>
<td>271</td>
<td>0</td>
</tr>
<tr>
<td>General Medicine</td>
<td>17</td>
<td>11</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td>General Surgery</td>
<td>357</td>
<td>226</td>
<td>133</td>
<td>0</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>21</td>
<td>22</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>893</td>
<td>647</td>
<td>358</td>
<td>0</td>
</tr>
<tr>
<td>Oral Surgery</td>
<td>64</td>
<td>27</td>
<td>14</td>
<td>0</td>
</tr>
<tr>
<td>Orthopaedics</td>
<td>4388</td>
<td>3090</td>
<td>1755</td>
<td>0</td>
</tr>
<tr>
<td>Plastic Surgery</td>
<td>1559</td>
<td>1026</td>
<td>513</td>
<td>0</td>
</tr>
<tr>
<td>Urology</td>
<td>331</td>
<td>252</td>
<td>143</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>1213</td>
<td>858</td>
<td>448</td>
<td>0</td>
</tr>
<tr>
<td><strong>Sub-total</strong></td>
<td><strong>9129</strong></td>
<td><strong>6600</strong></td>
<td><strong>3678</strong></td>
<td><strong>0</strong></td>
</tr>
<tr>
<td>Dental</td>
<td>2593</td>
<td>2151</td>
<td>1392</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>11722</strong></td>
<td><strong>8751</strong></td>
<td><strong>5070</strong></td>
<td><strong>0</strong></td>
</tr>
</tbody>
</table>

### Breast Cancer

The 2001 Breast Cancer target stated:

*By October 2001, women who have breast cancer and are referred for urgent treatment will begin that treatment within one month of diagnosis where clinically appropriate.*


<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>North Glasgow</td>
<td>82%</td>
<td>84%</td>
<td>82%</td>
<td>88%</td>
<td>83%</td>
</tr>
<tr>
<td>South Glasgow</td>
<td>87%</td>
<td>86%</td>
<td>81%</td>
<td>82%</td>
<td>86%</td>
</tr>
</tbody>
</table>

By December 2005, maximum wait from urgent referral to treatment for all cancers will be two months.

The tables below show how the Board is working towards this target.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast</td>
<td>88%</td>
<td>86%</td>
<td>87%</td>
<td>86%</td>
<td>94%</td>
</tr>
<tr>
<td>Colorectal</td>
<td>29%</td>
<td>56%</td>
<td>65%</td>
<td>61%</td>
<td>48%</td>
</tr>
<tr>
<td>Ovarian</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lung</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
---|---|---|---|---|---
93% | 98% | 94% | 100% | 100%

Colorectal | 33% | 34% | 67% | 40% | 0%

Ovarian | - | - | - | - | -

Lung | 56% | 69% | 69% | 69% | 69%

1 Performance is for all referrals as at this point were not able to identify urgent referrals only
2 Data not available on urgent referrals
3 No urgent referrals in this period
4 North Glasgow was unable to provide 'comparable data' for inclusion in this report

Points to Note:

- For breast cancer 2001 performance has remained within 80’s% but could be improved. Performance for breast cancer against overarching 2005 target is good and would wish to see consistent performance maintained.
- Performance for colorectal cancer against 2005 performance needs to be improved particularly in South Glasgow
- Issues of comparable data for lung cancer in North Glasgow have been resolved and information should be available in next report for Jan-Mar 2005

48 Hour Access

NHS Greater Glasgow continues to perform effectively and is actively engaging with practices to develop access arrangements. They are currently reporting 96% compliance against target.

Coronary Heart Disease Waiting Time Standards

Greater Glasgow achieved the maximum waiting times for Angiography (8 weeks), Angioplasty and CABG (18 weeks) on 31 December 2004. They have maintained this target on 31 March 2005.
5. **PARTNERSHIP WORKING**

5.1 **With Other Territorial and Special NHS Boards**

GGNHS is an active participant in regional planning. In 2004/05 we resolved, with the input of the SEHD, longstanding cross boundary financial flow issues which provide a better platform for developmental regional work.

We have worked closely with the GJNH over the last year to plan for cardiothoracic and related services and similarly closely with NHS24 to provide any possible support through the challenges they have faced. In order to ensure robust out of hours arrangements are in place for the coming winter, we will initiate a planning process with NHS 24 to be completed by November 2005.

5.2 **With Local Authorities**

5.2.1 **Joint Working**

The Board has over many years developed a mature working relationship with its Local Authorities focused around the agendas of health improvement and inequalities, community care, children’s services, health service provision, regeneration, asylum seekers and more generally community planning. Satisfactory assessments have been made by the Executive of our joint work in most of these areas with each Local Authority. The latest Joint Performance and Inspection Assessment Framework evaluation of implementing Joint Future reports good progress in four Local Authority areas with the Executive reappraising their initial assessment in the two other areas. Sections 3 and 5.3 in this paper provide further evidence of the close working relationship with Local Authorities.

5.2.2 **Community Health Partnerships**

The major initiative with Local Authorities in 2004-05 has been around the development of Community Health Partnerships particularly in the form of integrated organisations of health and social care. These bodies aim to maximise devolved responsibility for health and social care services, budgets and staff coming under the control of a single local joint board with a single director, management and clinical/professional structure, to offer more streamlined access and service delivery to secure greater local engagement and accountability and to exert greater influence on strategy and provision of non-local services. In Greater Glasgow this model represents the natural progression from our earlier integration work with many Local Authorities.

To date:

- Integrated CHPs (CHSCP s or CHCPs) have been agreed with:
  - Glasgow City Council (5)
  - East Renfrewshire Council (1) with Argyll and Clyde NHS

- Health only CHPs have been agreed for
  - West Dunbartonshire (1) with Argyll and Clyde NHS
  - East Dunbartonshire (1)
• CHP arrangements (health only) for Cambuslang/Rutherglen and the Northern Corridor are under negotiation with Lanarkshire NHS and are due to reported to the Minister in September.

Final Schemes of Establishment for all areas bar Cambuslang/Rutherglen were submitted to the Scottish Executive in April following our submission of draft schemes in December 2004 and were approved in July.

Appointments of CHP Directors are due to be announced in late July with shadow Boards likely to become active in the lead into October when CHPs are expected to begin to become fully operational.

5.2.3 Local Health Plan

All six Local Authorities in Greater Glasgow are members of the Local Health Plan Steering Group which meets on a regular basis to discuss and advise on Local Health Plan issues.

5.3 Delayed Discharges

5.3.1 2004/05 In-Year Performance

Tables 1 and 2, below, outline at a high level the movement in the Greater Glasgow ISD census numbers for patients assessed as ready for discharge, patients delayed in hospital for more than six weeks and patients delayed in hospital for more than twelve months. The trend for the first two performance indicators shows significant progress during the first 6 months and as a result by the October census the annual improvement target for the year had been met (that is a 20% reduction from the April 2004 census levels). However, from this point performance has deteriorated to the extent that the partnership has failed to deliver the target performance levels at the April 05 census date.

In relation to Table 3, these patients have been discharged, one has had a change of clinical circumstances, one has been coded to 51X - Adults with Incapacity, and one has a provisional discharge date.

Table 1 - Patients Assessed as Ready for Discharge

<table>
<thead>
<tr>
<th></th>
<th>April 04</th>
<th>July 04</th>
<th>Oct 04</th>
<th>Jan 05</th>
<th>April 05</th>
</tr>
</thead>
<tbody>
<tr>
<td>Actual</td>
<td>293</td>
<td>272</td>
<td>235</td>
<td>263</td>
<td>270*</td>
</tr>
<tr>
<td>Target</td>
<td></td>
<td>275</td>
<td>265</td>
<td>255</td>
<td>234</td>
</tr>
<tr>
<td>Variation from Target</td>
<td>-3</td>
<td>-30</td>
<td>8</td>
<td>36</td>
<td></td>
</tr>
</tbody>
</table>

Table 2 - Patients Delayed by more than 6 weeks

<table>
<thead>
<tr>
<th></th>
<th>April 04</th>
<th>July 04</th>
<th>Oct 04</th>
<th>Jan 05</th>
<th>April 05</th>
</tr>
</thead>
<tbody>
<tr>
<td>Actual</td>
<td>142</td>
<td>155</td>
<td>114</td>
<td>124</td>
<td>135*</td>
</tr>
<tr>
<td>Target</td>
<td></td>
<td></td>
<td></td>
<td>114</td>
<td></td>
</tr>
<tr>
<td>Variation from Target</td>
<td></td>
<td></td>
<td></td>
<td>21</td>
<td></td>
</tr>
</tbody>
</table>
**Table 3 - Patients Outwith Discharge Partnership Agreement One Year +**

<table>
<thead>
<tr>
<th></th>
<th>April 04</th>
<th>July 04</th>
<th>Oct 04</th>
<th>Jan 05</th>
<th>April 05</th>
</tr>
</thead>
<tbody>
<tr>
<td>Actual</td>
<td>15</td>
<td>16</td>
<td>13</td>
<td>8</td>
<td>6*</td>
</tr>
<tr>
<td>Target</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Variation from Target</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>6</td>
</tr>
</tbody>
</table>

* unvalidated census returns

Significant performance improvements have been made during the year across a range of fronts and in particular improved assessment process within integrated hospital discharge teams, implementation on the guidance on choice, and further development of joint capacity and commissioning strategies. However, the numbers of patients experiencing delay and coded to 51X - Adults with Incapacity, has increased dramatically in-year and is the primary reason why the partnership has failed to deliver the annual delayed discharge targets.

5.3.2 **Adults with Incapacity**

The deterioration in performance, from October 2004, coincided with an increasing number of patients remaining in the system because of interventions arising from the Adults with Incapacity (Scotland) Act 2000. See Table 4. The increase is most marked in the South of the city. The partnership is undertaking an audit to identify the principal factors in leading to delays associated with AWI and also an examination of the timescales involved in securing AWI resolutions. We are also developing and implementing a guidance note and for local practitioners in an attempt to deal with the issues identified, and have recently been in contact with the Justice Department at the Scottish Executive seeking clarification on the following points:

1. An indication of likely time-scales for the Scottish Executive to issue legal guidance in respect of the Bournewood ruling for AWI and the more recent judgement by Sheriff Baird, Glasgow Sheriff Court.

2. The status of current Scottish Executive and Mental Welfare Commission guidance and an indicator of best practice to be followed by Local Authorities in fulfilling their statutory obligations under the AWI Act.

**Table 4 - Adults With Incapacity (Code 51X)**

<table>
<thead>
<tr>
<th></th>
<th>April 04</th>
<th>July 04</th>
<th>Oct 04</th>
<th>Jan 05</th>
<th>April 05</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients ready for Discharge</td>
<td>13</td>
<td>12</td>
<td>19</td>
<td>38</td>
<td></td>
</tr>
<tr>
<td>Patients Delayed by more than 6 weeks</td>
<td>13</td>
<td>11</td>
<td>18</td>
<td>29</td>
<td></td>
</tr>
</tbody>
</table>

5.3.3 **Targets for 2005/06**

For 2005/06 the Scottish Executive is to apply a further 20% reduction in delayed discharges across Scotland on top of the target for 2004/05. For GGNHS this will mean a reduction of 55 to 177, and for over 6 weeks of 19 to 80. The method of national target setting continues not
to be equitable (a feature commented upon in a recent Audit Scotland report) and Greater Glasgow has consistently had one of the better performances on delayed discharges in Scotland (a view endorsed by the equivalent PAF indicators).

The Executive has also decided in 2005/06 to remove patients delayed due to Adults with Incapacity legislation from future target monitoring. This takes effect in the July, 2005 census. If this had applied at April then Greater Glasgow would have achieved its targets at April 2005.

**SCOTTISH EXECUTIVE HEALTH DEPARTMENT RESPONSE**

**Performance**

<table>
<thead>
<tr>
<th>Jan 02</th>
<th>Apr 02</th>
<th>Jul 02</th>
<th>Oct 02</th>
<th>Jan 03</th>
<th>Apr 03</th>
<th>Jul 03</th>
<th>Oct 03</th>
<th>Jan 04</th>
<th>Apr 04</th>
<th>Jul 04</th>
<th>Oct 04</th>
<th>Jan 05</th>
<th>Apr 05</th>
</tr>
</thead>
<tbody>
<tr>
<td>464</td>
<td>431</td>
<td>441</td>
<td>437</td>
<td>416</td>
<td>339</td>
<td>332</td>
<td>344</td>
<td>293</td>
<td>264</td>
<td>235</td>
<td>263</td>
<td>270</td>
<td></td>
</tr>
</tbody>
</table>

**April Census Statistics**

- Principal reasons for delay:
  1.Awaiting community care assessment (89)
  2.Awaiting place availability (57)
  3. Legal / financial issues (44)
- 124 patients are delayed outwith the 6 week discharge planning period
- 6 patients have been delayed for more than 12 months
- 5.3% of occupied beds occupied by delayed discharges (Scotland – 6%)

**Comments**

Greater Glasgow showed a significant improvement in the six months to October 2004. The Board are taking a long-term whole systems approach to resolving delayed discharges and we would look for reductions to the target level. Specific attention is required to ensure earlier effective intervention to prevent excessive long-term delays.

Greater Glasgow has been worst affected by the Adults with Incapacity Act (AwI). Previously the practice for patients (mainly dementia/mental health) was to move them to a care home while the proceedings on the guardianship order to allow the Local Authority, or other, to take responsibility to direct the patient’s affairs progressed through the courts. Recent judgements in ECHR mean that patients cannot now be moved until the process, which can be lengthy, has completed. This has led to increasing numbers being delayed in hospital for some time.

It has now been agreed that patients delayed by the application of AwI will be disaggregated from further censuses. Although data on these patients will continue
to be collected the information will be reported in a separate supplement. For April 2005, Greater Glasgow has agreed a target of 177, which is a reduction of 23.7%. The partnership still faces a challenging task to reduce the number of patients inappropriately delayed in hospital.

5.4 With Staff

5.4.1 During the past year, there have been three main areas of priority in the work of the Area Partnership Forum. These were:

- progressing the Board’s Corporate Recovery Plan;
- developing the new organisational arrangements for NHS Greater Glasgow;
- implementing “Agenda for Change”.

5.4.2 Excellent progress has been made in implementing the Board’s Corporate Recovery Plan, as a two-year plan designed to ensure a return to recurrent, financial balance. By the end of March, 2005, the first year’s targets had been delivered in full, with the Board having met its three financial targets for 2004/05. At the outset of the year, a series of monthly meetings was put in place with the Area Partnership Forum in order to ensure full engagement in the development of the Recovery Plan. In the course of the year, as both partners became more comfortable with the monitoring arrangements and the progress which was being delivered, it was agreed that the frequency of meetings could be relaxed.

5.4.3 The work involved in shaping the Board’s new organisational arrangements, following the dissolution of NHS Trusts and including the creation of Community Health Partnerships, posed some significant challenges to partnership working. Although staff partners had been involved from the outset in the work of the CHP Steering Group (which first met in September, 2003), the staff partners within the Area Partnership Forum concluded in January, 2005 that they wished to have more focused input into the development of the new organisational arrangements. With pressure on the Board’s senior officers to submit Schemes of Establishment as soon after December, 2004 (the original date set for their submission) as was possible, two draft Schemes of Establishment were presented to the NHS Board before they had formally be discussed with the sub-group. The staff partners registered their unhappiness with these arrangements in a letter to the Minister for Health and Community Care.

5.4.4 Section 7 of this paper describes in more detail the implementation arrangements for all three strands of pay modernisation. The implementation of “Agenda for Change” has been developed within NHS Greater Glasgow with full partnership involvement, both in the design of the implementation arrangements and in their execution. While progress in the early months in successfully matching individuals to post was slower than in many other parts of NHS Scotland, particular care was taken to ensure that the process was properly anchored, thereby aiming to reduce the likelihood of appeals at subsequent stages of implementation. With the numbers of matching panels increased significantly over the months of July, August and September, it is expected that Greater Glasgow’s position on implementation will be brought into line with the average position across NHS Scotland.
5.5 **With the Universities and Colleges**

5.5.1 The relationship between NHS Greater Glasgow and the Universities and Colleges within the City is one of major inter-dependence. Reflecting that position, the NHS Board has developed a strategic alliance with Universities and Colleges as a key plank of its local workforce plan for the next decade. Two major workforce conventions have been held during the past year in order to build an Action Plan on key developments which will be taken forward with the educational sectors in the years ahead.

5.5.2 The NHS Board and the University of Glasgow have worked hard also during the past year in order to strengthen their linkages in respect of teaching, research and the enhancement of specialist care. A Joint Strategy Group, Co-chaired by the University Principal and the NHS Board Chair, has now set in train a number of key strands of work, including working groups on medical manpower, finance and estates. The brand “Medicine in Glasgow” was launched also during the year as a signal of the closer relationship which the Joint Strategy Group wishes to foster. In addition, the Board and the University are working closely to strengthen clinical research capacity within the city, not least in endeavouring to draw together a Clinical Research Centre for Glasgow.

5.6 **With Patients and Public**

2004 - 2005 has been a pivotal year for the way Patient Focus and Public Involvement (PFPI) is delivered across NHS Greater Glasgow.

This is a time of major change and redesign across NHS Greater Glasgow and it is crucial that our stakeholders are kept informed and involved in these changes. Much work is underway that genuinely involves and engages with local communities and patients.

The following highlights just some of our major successes in this area.

- The establishment of the Involving People Committee – a formal sub-committee of the NHS Board to monitor the delivery of PFPI across the NHS Greater Glasgow area.

- During 2004 two Our Health events were staged at the Royal Concert Hall in Glasgow. The purpose of these events was to allow representatives of patients, the public and partner organisations to come together with NHS Greater Glasgow Board members to discuss the challenges and choices ahead, for example, CHPs. Evaluation has revealed that these have been very well received and have improved understanding. A further event is planned for 31st August 2005 and the focus will be on the implementation of the overall Acute Services Modernisation implementation plan in particular and will highlight the new Victoria and Stobhill hospitals and west of Scotland Cancer Centre developments.

- [www.nhsogg.org.uk](http://www.nhsogg.org.uk) - the single web portal for all of NHSGG is now up and running. Former divisional and Board website addresses all lead to the new site. The new city-wide site has been given new navigational systems, search engines, re-populated with up-to-date user friendly information and developed using the feedback of users from scoping PFPI groups in the city. The site now attracts 1,500 visitors a day.
• Patients and the public have been involved in decision making through a range of consultations including; CHPs, car parking on NHS Greater Glasgow sites, cardiothoracic services proposals, the oral health strategy, the sexual health strategy, dental services for children in the East End, the redesign of community services for sexual health and smoking on NHS Greater Glasgow sites and premises.

• Four editions of Health News, NHS Greater Glasgow’s 16-page full colour tabloid style newspaper for patients and the public were produced. 280,000 editions are inserted into the Daily Record with a further 280,000 distributed throughout hospitals, health centres, council offices, pharmacies and supermarkets.

• Continued expansion of the Involving People Database has been a priority. Now more than 2,000 names and patient group contacts have been identified and regularly receive information from NHS Greater Glasgow on the changes and plans that may affect them plus consultation details and advice on how to get involved.

• Community Engagement Team staff have met with more than 5,000 people and undertaken a range of activities to promote a wider community engagement in the Acute Services Review implementation arrangements. Activities include the production of a newsletter distributed to over 1,000 community groups, working with over 20 different faith groups and working with Disability Groups and Glasgow City Council to ensure that the design of the new Stobhill and Victoria Hospitals fully meets the needs of those who are disabled.

• The Yorkhill Family Council has been established so the public can give their views and be involved in all aspects of Yorkhill’s services

• The establishment of service-user networks, such as PEAK - People Speak group - set up to influence the Primary Care PFPI Steering Group, the Mental Health Network Greater Glasgow and the Maternity Services staff and users’ network – MATNET.
6. **INFECTION CONTROL**

6.1 This section comments on progress on:

- Future Infection Control Structure in Glasgow
- QIS standards;
- Code of Practice for the Local Management of Hygiene and Healthcare Associated Infection;
- Mandatory HAI Surveillance.
- Cleanliness Champions
- Additional Activities

6.2 **Future Infection Control Structure in Glasgow**

NHS Greater Glasgow is currently composed of four Divisions with individual infection control teams working to Annual Infection Control Programmes as required by NHS CSBS/QIS Standards. The plan is to have a single infection control programme and report from 2006/7. This programme will be focused on the production of data to inform and improve practice. NHS Greater Glasgow has just appointed an Infection Control Manager as recommended by the HDL (2005) 8. One of the key roles of this post will be to coordinate the prevention and control of Hospital Acquired Infection (HAI) throughout the Board area.

Work on Glasgow wide objectives is well advanced for infection control in NHS Greater Glasgow. The publication and launch of the NHS Greater Glasgow Infection Prevention and Control Manual ([www.nhsgg.org/icpmanual](http://www.nhsgg.org/icpmanual)) facilitates not only unified pan-Glasgow working practices amongst healthcare workers but also by working closely with higher education facilities the training of healthcare professionals in common policies and practices. All of the policies in the NHS Greater Glasgow Infection Prevention and Control Manual will have accompanying education packages.

6.3 **QIS Standards**

The CSBS/QIS standards have a total of 69 criteria in 15 standards. In the 2005 report all Divisions demonstrated significant improvements from the initial review (2002) across Scotland and throughout NHS Greater Glasgow. NHS QIS in their introduction describes the overall findings throughout Scotland as “significant improvement”. This can be seen throughout NHS Greater Glasgow with all Divisions demonstrating significant improvement in the number of criteria met.

<table>
<thead>
<tr>
<th></th>
<th>2002</th>
<th>2005</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yorkhill</td>
<td>67</td>
<td>88</td>
</tr>
<tr>
<td>Primary Care</td>
<td>52</td>
<td>88</td>
</tr>
<tr>
<td>North</td>
<td>42</td>
<td>72</td>
</tr>
<tr>
<td>South</td>
<td>47</td>
<td>90</td>
</tr>
</tbody>
</table>

At the end of each standard review, CSBS/QIS gives examples of local initiatives. All Divisions in NHS Greater Glasgow were cited as having examples worthy of note – an abridged version of these is given below.
6.3.1 Yorkhill Division

The Division has produced a prevention and control of infection strategy. This document clearly outlines the responsibility and accountability of healthcare staff, HDL 2001(10) lead, Infection Control Team (ICT), control of infection committee, clinical risk management committee and clinical governance committee. The supporting organisation structure demonstrates the links between the relevant committees.

6.3.2 Primary Care Division

The organisation has taken a high level and proactive approach to the management of medical equipment and has established a medical equipment committee.

6.3.3 North Glasgow Division (NGD)

Members of the ICT have written a programme for environmental audit which is used in conjunction with palmtop computers. Considerable time is now saved when doing environmental audits.

6.3.4 South Glasgow Division

It is standard practice for all audit results to be fed back to stakeholders. The Division’s ICT has established good communication links with senior nurses and general managers regarding audit work. Wards receive action plans highlighting areas requiring work.

6.3.5 Progress with the QIS (formerly CSBS) Standards

The 2005 final report from QIS statements is made following reviews done in 2004. Further since many of the statements relate to work of annual reports / programmes, the 2005 report contains commentary of some activities that took place in 2003. NHS Greater Glasgow’s infection control teams have made considerable progress on the findings of the 2005 report and these are detailed along with the assessed score and the comparison score for 2003. Since the publication of the report, action plans have been implemented to meet the remaining standards. The latest report from the North Glasgow Division (NGD) indicates that 12 of the 19 ‘not mets’ had been attained. Work was ongoing on the remaining 7. Similar action plans have been implemented in other Divisions to meet the “not met” standards.

All Divisions in NHS Greater Glasgow were mentioned as providing excellent practice that could be transferred to other areas. Work on harmonisation of services and spreading of good practice is well advanced. It is a priority for NHS Greater Glasgow to ensure that all patients and healthcare workers are cared for in environments that minimise all risks. All examples of good practice will be shared in all areas throughout Glasgow NHS services.

The new single NHS Greater Glasgow structure will require the building of new structures and compliance mechanisms to meet the NHS QIS Standards. The new Infection Control Manager will be responsible for ensuring that NHS Greater Glasgow is fully compliant with the NHS QIS Standards for HAI.
SCOTTISH EXECUTIVE HEALTH DEPARTMENT RESPONSE

NHS Greater Glasgow outline a number of areas in which they are working to tackle Healthcare Associated Infection (HAI). Compliance with NHS QIS standards has increased since the 2002 review, but compliance in North Glasgow Division (NGD) remains low at 72%. We note that since the publication of the report, action plans have been implemented to meet the remaining standards across all Divisions and that the Board is confident that 12 of the 19 ‘unmet’ standards in NGD have now been attained. It is important that the Board continue to progress in this area, with the Infection Control Manager playing a key role.

6.4 Code of Practice

The Code of Practice (CoP) produced by the HAI Task Force was published in 2004. The CoP contains details of 104 criteria under 5 sections: Staff Education, Standard Healthcare Equipment, Prevention and Control of Infection Guidance, Cleaning Services and Compliance Management. Although the CoP may share some common themes with some of the CSBS/QIS documents, the criteria are different and require the Divisions to produce separate action plans against all of the criteria. There is no separate national body which will regularly review progress against the CoP. However internal auditors for NHS Greater Glasgow Divisions have been auditing against CoP criteria and their reports are awaited. Information on progress with the CoP is detailed below:

6.4.1 Staff Education

It has been agreed that there will be a single education strategy for NHS Greater Glasgow. A good deal of work on e-learning tools based on the NHS Greater Glasgow Infection Prevention and Control Manual has already been achieved. An automated electronic recording mechanism on infection control e-learning for all NHS Greater Glasgow employees is being considered and an alcohol hand-washing programme has been launched in a high profile campaign. Such developments will help achieve the criteria in this section.

An education strategy for NHS Greater Glasgow is in an advanced stage of preparation. This follows the framework for the Delivery of HAI Education for NHS Scotland, produced by NHS Education for Scotland.

6.4.2 Service User & Public Information

ICTs in NHS Greater Glasgow working together have already produced a series of 5 leaflets on MRSA (Methicillin Resistant Staphylococcus Aureus) and HAI prevention. Further leaflets are already planned to meet these criteria.

6.4.3 Standard Healthcare Equipment

The criteria which require to be met in this section include continuous documented evidence that decontamination is effective – a person must sign that key equipment has been inspected and is visibly clean. Some equipment must be signed as clean daily, other equipment needs to
be inspected and signed weekly and monthly. Sample pro-formas are being tested currently. Several criteria are yet to be met in all Divisions in this section.

The Cowlairs Project is a pan Glasgow project that will provide healthcare institutions throughout Glasgow with a purpose built facility, specifically designed to provide an optimal service for the decontamination of medical devices.

Stobhill Sterile Services Department (SSD) will be the first to move into the new facility in 2005. Cowlairs will also provide engineering and technical support to the proposed ACADs and the soon to be constructed SSD within the Dental Hospital.

6.4.4 Cleaning

Each individual Division is assessing how cleaning standards measured against the National Cleaning Services Specification. Cleaning frequencies are regularly reviewed to ensure continual improvement and focus on priority areas and an action plan across all our healthcare sites is in place promoting and monitoring continuous levels of hospital cleanliness.

6.4.5 Compliance Management

Compliance management is perhaps the most difficult area to make progress on with so many structures currently under review. There were and are existing accountability arrangements which met some of the criteria, others require to be formalised in the new organisation structures.

The infection control manager will be charged with ensuring compliance with the CoP. Work on strategies and options for implementation of compliance management framework is in advance stages of preparation.

6.4.6 Conclusion

In short although a great deal of work is in progress to achieve the CoP a good deal of work remains to be achieved. Working as a single entity within NHS Greater Glasgow will enable this work to be undertaken more efficiently.

SCOTTISH EXECUTIVE HEALTH DEPARTMENT RESPONSE

NHS Greater Glasgow has made progress towards compliance with the Code of Practice (CoP) standards and we welcome that internal auditors have been auditing against the Code criteria. We acknowledge that difficulties in implementing the Compliance Management issues and note that the recently appointed Infection Control Manager, as recommended by HDL(2005)8, will be charged with ensuring compliance with CoP.

We recognise NHS Greater Glasgow’s investment in the Cowlairs Project which will provide Glasgow with a purpose built facility for decontamination of medical devices. We welcome this development.
6.5 Mandatory HAI Surveillance

Surveillance of specific HAIs are mandated in HDL (2001)57. This HDL states that there must be:

- surveillance and reporting of 2 surgical site infections of which one must be an orthopaedic procedure;
- surveillance and reporting of neurosurgical procedures where they are performed;
- surveillance and reporting of all MRSA bacteraemias.

All Divisions comply with the requirements of mandatory surveillance.

6.5.1 MRSA Bacteraemia Surveillance

The NGD position (HPS report 2005) is in control and showing natural variation following the out of statistical control episode detected in Jan-March 2003. The rate for the first quarter in 2005 is lower than for the same quarters in 2004 and 2003 respectfully. This division provides specialist renal services for Glasgow and some of the neighbouring NHS Boards. Renal patients account for 3% of beds in this unit and 30% of all MRSA bacteraemias. Enhanced surveillance programmes are ongoing in the unit and analysis of the past 3 years in total shows that data to June is again lower than for 2004. A continuous quality improvement programme is also ongoing in the renal unit. Analysis of NGD data excluding the renal patients indicates an annual rate of 0.21 per 1000 occupied bed days. This is comparable with other Scottish units that do not have renal patients.

NGD provides a number of specialist services in the West of Scotland. Rates of MRSA bacteraemia in England for similar ‘specialist trusts’ indicate comparable rates. MRSA bacteraemia in England for the same time period and for similar type hospitals have rates up to 0.46 per 1000 OBDs. Dept of Health Mandatory MRSA Bacteraemia Surveillance Scheme 2001-5 Report indicates that 15 specialist trusts in England have rates above the rate for NGD in 2004.

The above analysis suggests that national data is too crude for comparisons and that specialist inter unit comparisons would be more objective, as is the case in England and Wales.

The weekly rates for NGD are declining. The bacteraemia data for NGD show evidence that the rate for 2005 is less than both 2004 and 2003. Rates before this were subject to errors in reporting and are low.

SCOTTISH EXECUTIVE HEALTH DEPARTMENT RESPONSE

It is pleasing to note that all Divisions comply with the requirements of the national mandatory HAI surveillance programme. MRSA rates within NGD were raised as an area of concern at last year’s AR: we note that these are said to be declining and would wish to see these rates decrease significantly. We welcome the analysis of MRSA rates amongst renal patients and that the Board is undertaking a ‘continuous quality improvement programme’. The Board will want to develop this work further and we would be interested to know how the Board plans to reduce MRSA infection specifically amongst renal patients.
6.5.2 SSI Surveillance

Data was requested on a sample programme. The data provided is for NGD presented where possible as Statistical Process Control (p charts). The data reports indicate stability and control and possible reduction in variation which will necessitate lowering of means. This data is analysed and fed back monthly.

6.6 Cleanliness Champions

<table>
<thead>
<tr>
<th>Champions</th>
<th>In Training</th>
<th>G Grades Trained</th>
<th>G Grades in Training</th>
</tr>
</thead>
<tbody>
<tr>
<td>101</td>
<td>472</td>
<td>21*</td>
<td>137*</td>
</tr>
</tbody>
</table>

*Not in addition to the first 2 columns

The target for March 2005 suggests that there should be 413 trained champions. Although this has not been achieved there are almost 500 in training which will exceed this target.

The reasons for the delay in reaching the target include:

- a number of teething problems with the introduction of an unpiloted programme.
- the course takes more time for the individuals to complete than it was anticipated;
- some of the trainees undertaking the course had not undertaken online course before and required additional time and support to familiarise themselves with the basics of computers.

SCOTTISH EXECUTIVE HEALTH DEPARTMENT RESPONSE

The Board’s self-assessment describes the delays in achieving the targets for Cleanliness Champions and it is important that the Board progress this. We welcome that almost 500 are in training which would exceed the target of 413 for March 2005.

6.7 Additional Activities

In addition to the work described above the infection control teams in NHS Greater Glasgow are identifying novel mechanisms for reducing HAI and monitoring compliance with good practice. NGD staff had produced alcohol hand gel (AHG) usage over time from pharmacy data. This work indicates that there has been a 100% sustained increase in AHG usage since its bedside introduction in November 2004. Further work has broken the data down to individual units and this is now being fed back to ward managers as part of their regular feedback of performance. It will be used to identify systems changes which will bring about sustained improvements in practice across all wards.
Quality Improvement Programmes

Analysis of MRSA and C. difficile acquisitions is fed back monthly throughout the North Division. This data is used as a proxy for infection control practices. Trigger analysis programmes commence if ever a unit has an out of statistical control episode or if set warning limits are reached. This work has been published, is mentioned in the new draft UK guidelines on the control of MRSA and is the subject of a randomised control trial throughout the UK, the CHART project. Other examples of quality improvement programmes are available.

6.8 The Future

NHS Greater Glasgow’s move to a single system working will necessitate the devising of new structures to ensure compliance with the key policy initiatives. The newly appointed Infection Control Manager will ensure that these structures are in place and that there is harmonisation and dissemination of good practice. In addition NHS Greater Glasgow is committed to providing national, service and local data which will inform and improve practice on all aspects of infection prevention and control.

SCOTTISH EXECUTIVE HEALTH DEPARTMENT RESPONSE

There are clearly a number of initiatives in development and it is important that the Board continue to progress in this area. The single system structure will require the building of new structures and we recognise that the Board plans to have a single infection control programme and report in place from 2006/07. We welcome the appointment of an Infection Control Manager to oversee this and co-ordinate efforts in tackling HAI throughout the Board area across primary care and acute sectors.
7. **NHS EMPLOYMENT CONTRACTS AND PAY MODERNISATION**

7.1 **Background**

NHS Greater Glasgow has been active as with other health systems in implementing the General Medical Services (GMS) and Consultant Contract and is in the implementation phase of Agenda for Change. The activity is overseen by a Pay Modernisation Board, chaired by the Chief Executive; other members are the Project Leads for the three strands (Medical Director - Primary Care Division/Chair, LMC for GMS, Medical Director, NHS Board/BMA representative for Consultant Contract, Chief Executive, Yorkhill/Staffside representative nominated by the Area Partnership Forum), Employee Director and Director of Human Resources.

7.2 **Progress**

7.2.1 **GMS**

Two areas within the nGMS contract have primarily assisted in the delivery of health improvement. These are Enhanced Services and the Quality and Outcomes Framework.

- New contracts were agreed with all 220 Practices as at 1st April 2004. The new GMS contract has enabled NHS Greater Glasgow to build on the work to develop primary care in Glasgow, particularly linking clinical teams across care pathways and ensuring a full range of primary care services are available.
- The use of the Quality and Outcomes Framework to manage chronic disease in an integrated way: the mean practice achievement level is 94.7% (994.2 points), with over 78% of practices achieving more than 850 points, and less than 10% of practices achieving less than 500 points.
- A total of 17 enhanced services are being delivered within the NHSGG Area. Five directed, four national and eight local. Three of these have contributed to a shift of workload from a secondary to a primary care setting (near patient testing, pre-chemotherapy blood monitoring and multiple sclerosis services). In each case a service has been developed within the local community/GP setting which decreases hospital activity and is quicker and more convenient for patients.
- A further three local enhanced services have been developed and implemented across general practice that substantially add to the management of chronic diseases in a community/GP setting (diabetes, CHD and stroke LES). This has resulted in a reduced need for routine diabetes, CHD and stroke outpatient clinic appointments as almost all continuing chronic disease management is now carried out in a general practice setting.
- Out of Hours (OOH) unscheduled care - minor illness service: The overall aim is to provide a clinically and cost effective service by delivering high quality healthcare which complements existing OOH services and frees up GP time by ensuring that patients are seen in the right place, at the right time by the person with the most appropriate skills.
- 10 nurse practitioners have recently completed the Minor Illness Management Programme at Glasgow Caledonian University. As of the 1st August 2005 they commence their consolidation period within the Glasgow Emergency Medical Service (GEMS) which is estimated at 6 months. During this time they will begin to assess...
and undertake differential diagnosis and management of patients presenting with minor illness, working towards being autonomous nurse practitioners. Initially the Nurse Practitioners will work across four of the Primary Care Emergency Centres (PCECs) in the city with the plan being for co-location with other out of hours services within the ACADs when built in 2007-08. The service will operate in the out of hours period which covers evenings weekends and public holidays.

- GMS contract is largely being delivered within the financial envelope.

**SCOTTISH EXECUTIVE HEALTH DEPARTMENT RESPONSE**

NHS Glasgow is an active member of the new GMS network, with a high level of participation and attendance at national meetings. Glasgow has engaged well with new GMS contract and members of NHS Greater Glasgow staff have made a good contribution to national work.

It is commendable that Greater Glasgow has successfully introduced the contract across the large number of practices in the city, building on existing good relationships. They were able to deliver the Out of Hours changes in the summer of 2004, building on the previous good Out of Hours GP co-operative arrangements.

Building on this strong foundation, it is important that the Board:

- use pay modernisation in line HDL (2005) 28;
- identify how GMS can support local action in line with the Kerr Report;
- identify direction and actions regarding chronic disease management on the foundation of Quality and Outcomes Framework achievement;
- identify direction and actions regarding the development of Out Of Hours’s services especially in the context of unscheduled care.

7.2.2 **Consultant Contract**

98% of all Consultants are now on the new Consultant Contract with job plans agreed. The second phase of job planning has just begun. Consultants were assimilated onto the new pay arrangements, with a pan-Glasgow Steering Group, ensuring that agreements on Extra Programmed Activities (EPAs) had consistency across specialties, across Glasgow.

All consultants now have objectives linked to the job plan which confirm a minimum of 42 weeks of direct clinical care activity. In addition a stricter leave policy was introduced to further maximise on activity so that staffed sessions are used more effectively and there is greater flexibility in teams. The on call provisions of the new contract have assisted the rationalisation of ENT and the bringing together of dermatology services (see para 9.8.).

To help tackle waiting times in dental services, extra programmed activities have been allocated to three dental consultants. This will remove 30 new referrals per week from the dental waiting list, within normal hours, helping to improve patient access to care. This also has the financial benefit of avoiding paying for waiting list initiatives.

In radiology in South Glasgow, the team based approach to job planning introduced by the new consultant contract has allowed greater cover between consultants during annual leave,
ensuring no clinical sessions are cancelled. This increased efficiency benefits patients by making sure waiting times for radiology are not lengthened unnecessarily.

Following an initial delay, there is now agreement with the BMA on the final content of the contract documentation.

Audit Scotland are now progressing their review of the Consultant Contract implementation.

**SCOTTISH EXECUTIVE HEALTH DEPARTMENT RESPONSE**

**Key Figures**

<table>
<thead>
<tr>
<th>Board</th>
<th>Actual Board</th>
<th>NHS Scotland</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prediction March 04</td>
<td>figure</td>
<td></td>
</tr>
<tr>
<td>(a) Percentage of consultants being paid on new contract as at 31st March 2005 <em>(Source: March Board return to PMT)</em></td>
<td>-</td>
<td>91%</td>
</tr>
<tr>
<td>(b) Average number of Extra Programmed Activities (EPAs) as at 31st October 2004 <em>(Source ISD(M)53)</em> [Range 0.0 – 2.0] The core is 10 Programmed Activities = 40 hours</td>
<td>1.3 Acute 0.1 Primary Care</td>
<td>1.4</td>
</tr>
<tr>
<td>(c) Average level of on-call per Whole-Time Equivalent at 31st October 2004 <em>(Source ISD(M)53)</em> [3% = low: 8% = high] Doctors receive a supplement on top of basic salary in respect of on call the average for the boards is-</td>
<td>n/a*</td>
<td>4.71%</td>
</tr>
<tr>
<td>(d) Average number of Out Of Hours Programmed Activities per Whole Time Equivalent at 31 October 2004 <em>(Source ISD(M)53)</em> [Max 1.0] Average number of hours worked outside of the core working day (e.g. typical emergency working) which attracts a premium rate.</td>
<td>n/a*</td>
<td>0.6</td>
</tr>
<tr>
<td>(e) Percentage increase in consultant paybill 03/04 excl inflation <em>(Source ASD)</em></td>
<td>16%</td>
<td>19.8%</td>
</tr>
<tr>
<td>(f) Percentage increase in consultant paybill 04/05 excl inflation <em>(Source ASD)</em></td>
<td>n/a*</td>
<td>10.3%</td>
</tr>
</tbody>
</table>

*n/a* = Not available
NHS Greater Glasgow has implemented the consultant contract successfully and in line with the terms and conditions of service. The average number of Extra Programmed Activities' and average level of on-call are below the national averages which is a positive position.

The Board’s March 2004 predictions of the financial implications for implementation were lower for 03/04 than ultimately was the case and lower than the Scotland average which should be commended. The Boards figure for 04/05 is significantly higher than the NHS average. However this is, in part, due to the inability to exclude new consultant appointments made during 04/05 from the costing process.

7.2.3 Agenda for Change

As at 30th June 2005, 14.2% of the workforce in Glasgow had been successfully matched. Two specific measures have been put in place to increase progress:

- job matching capacity will increase with 3 to 6 matching panels per day during July and 8 per day scheduled in August and September; this is being supported by additional resources to backfill where necessary.
- job descriptions are being clustered to ensure that the number of staff behind a job description is increased.

By the end of July, the proportion of the workforce successfully matched had increased to 24%. We are still aiming to meet the national timetable recognising that this will be challenging.

Other key points include:

- An assimilation database has been developed and is being adopted by other Boards in NHS Scotland. This will:
  - decrease the amount of time spent on assimilation; and,
  - generate an electronic assimilation letter for each employee.
- Assimilation testing in conjunction with payroll department is scheduled for August 2005
- A manager's guide to the Knowledge and Skills Framework (KSF) has been produced and training of facilitators is underway.
- The use of the eKSF tool is being investigated for introduction in Greater Glasgow.

SCOTTISH EXECUTIVE HEALTH DEPARTMENT RESPONSE

Information on progress with matching is collected by SPRIG on a monthly basis. SPRIG estimate that around 15% of posts in NHS Scotland do not match national profiles. They are of the view that using 85% of the total workforce to assess progress presents of truer reflection of that progress. The most recent returns from Boards cover the period up to the end of July and using the SPRIG 85% rationale, 45% of staff in NHS Scotland have been matched. In terms of total workforce, 37% had been matched. By the end of July, Glasgow had matched 28% of its staff (using 85% workforce). In terms of total workforce, 23% had been matched.
We do note that whilst progress in the short term has been slow, NHS Greater Glasgow has taken forward matching at a cautious pace in order to avoid longer terms problems. The Board has now built up levels of expertise which will allow movement at a faster pace. In addition, the Board has completed the bulk of the nursing staff, many of whom had complex jobs which lead to matching difficulties. The Board is of the view that ancillary staff should be more straightforward, facilitating a pick up of pace in terms of matching generally.

It is encouraging to note the Board’s commitment to the process in establishing a full time project team to oversee the work of the 170 matching staff, and this is viewed as being successful. In order to improve progress towards assimilation, NHS Greater Glasgow has increased matching panels to between 3 and 6 per day in July, increasing to 8 in August and September. A database has also been developed which will decrease the amount of time spent on assimilation. It will also generate notification letters for staff.

7.3 Benefits Realisation

The benefits realisation delivery plan is being prepared. This will focus on three main areas:

- strengthening the role of primary care;
- demonstrating improved activity with a number of acute specialities; and.
- use of Agenda for Change job evaluation and knowledge and skills framework to support new role.
8. **FINANCE**

8.1 A draft Five Year Financial Plan has been submitted to Scottish Executive Health Department (SEHD), as required, at the end of June 2005. The key elements of the Financial Plan and the main underlying assumptions are explained below:

8.2 **Overall Financial Position**

<table>
<thead>
<tr>
<th></th>
<th>2005/06</th>
<th>2006/07</th>
<th>2007/08</th>
<th>2008/09</th>
<th>2009/10</th>
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</thead>
<tbody>
<tr>
<td><strong>£m</strong></td>
<td>£m</td>
<td>£m</td>
<td>£m</td>
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<tr>
<td>Revenue Funding</td>
<td>1,802.4</td>
<td>1,864.3</td>
<td>1,963.5</td>
<td>2,057.2</td>
<td>2,151.6</td>
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<tr>
<td>Expenditure Commitments</td>
<td>1,802.4</td>
<td>1,864.3</td>
<td>1,963.5</td>
<td>2,057.2</td>
<td>2,151.6</td>
</tr>
<tr>
<td>In year surplus/(deficit)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

Key points are:

- It is planned to present an updated financial plan to the Board at the mid year point. This will explain the actions which will be taken to secure the achievement of the Board’s financial targets for 2005/06.
- Beyond 2005/06, revenue funding is sufficient to cover all currently identified service commitments, with some scope for new service commitments to be made thereafter. If the Board’s efforts to contain costs in 2005/06 prove successful, this could provide scope for entering into new service commitments commencing in 2006/07.

8.3 **Recurring and Non Recurring Funding of Planned Expenditure**

A summary highlighting the extent to which the Board’s recurrent expenditure commitments are underpinned by non-recurrent funding is provided below:
<table>
<thead>
<tr>
<th></th>
<th>2004/05 £m</th>
<th>2005/06 £m</th>
<th>2006/07 £m</th>
<th>2007/08 £m</th>
<th>2008/09 £m</th>
<th>2009/2010 £m</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recurring funding less recurring expenditure</td>
<td>(9.8)</td>
<td>(6.4)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Non recurring items</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Surplus/(deficit) carried forward from previous year</td>
<td>-</td>
<td>11.9</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Land Sales</td>
<td>1.2</td>
<td>7.5</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>SEHD Funding</td>
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<td>-</td>
<td>-</td>
<td>-</td>
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<td>-</td>
</tr>
<tr>
<td>Service Commitments - ring fenced funding</td>
<td>7.9</td>
<td>(7.9)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Service Commitments - Waiting Lists</td>
<td>-</td>
<td>(6.9)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Service Commitments - Other</td>
<td>-</td>
<td>(8.6)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Additional Cost Savings/ Cost Containment Measures</td>
<td>-</td>
<td>10.4</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>In year surplus/(deficit)</td>
<td>21.7</td>
<td>6.4</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

The above table shows a progressively reducing dependence on non-recurrent funding to cover recurrent expenditure commitments in the period up to 2006/07.

It is anticipated that total receipts from land sales over the 5 year period covered by the Financial Plan will exceed £7.5 million. A firm forecast will be finalised during 2005/06 which will enable the Plan to be updated in due course. Again, this may provide scope for entering into new service commitments at an earlier stage than 2008/09.

8.4 **Revenue Resource Summary**

A summarised picture of the 2005/06 Financial Plan is set out below for information. This shows the main funding sources which the Board draws together to cover its expenditure commitments, together with a broad overview of expenditure commitments by main expenditure heading.
<table>
<thead>
<tr>
<th>Funding</th>
<th>£m</th>
<th>Expenditure Commitments</th>
<th>£m</th>
</tr>
</thead>
<tbody>
<tr>
<td>General funding allocation from SEHD</td>
<td>1,343.2</td>
<td>Hospital and Community Services</td>
<td>1,414.0</td>
</tr>
<tr>
<td>Funding received from other NHS Boards, NES, NSD etc</td>
<td>373.8</td>
<td>Family Health Services (including non cash limited of £69m)</td>
<td>370.4</td>
</tr>
<tr>
<td>Family Health Services funding from SEHD (non cash limited)</td>
<td>69.0</td>
<td>Other</td>
<td>28.4</td>
</tr>
<tr>
<td>Other</td>
<td>16.4</td>
<td>Cost Improvement Plan to be identified</td>
<td>(10.4)</td>
</tr>
<tr>
<td></td>
<td>1,802.4</td>
<td></td>
<td>1,802.4</td>
</tr>
</tbody>
</table>

A more detailed analysis of the above funding and expenditure headings will be used to report financial outturn during 2005/06 as NHSGG moves through the transitional period leading up to the introduction of new organisational arrangements for managing the provision of its Acute and Community based services. At this stage, new financial reporting templates will be introduced which will report financial outturn for each new Acute Service directorate and CHSCPs.

The above table provides a simple picture of how the Board funds its activities on an annual basis.

### 8.5 Planned Use of New Revenue Resources

The 2005/06 Financial Plan has already been approved by the Board. This section provides an overview of the forward Financial Plan to 2009/2010, showing how new revenue resources which become available to NHSGG in 2006/07 and beyond, might prospectively be allocated. The key figures from the 2005/06 financial plan are presented for completeness.
<table>
<thead>
<tr>
<th>New revenue resources</th>
<th>2005/06 £m</th>
<th>2006/07 £m</th>
<th>2007/08 £m</th>
<th>2008/09 £m</th>
<th>2009/2010 £m</th>
</tr>
</thead>
<tbody>
<tr>
<td>SEHD General Funding Uplift</td>
<td>74.0</td>
<td>76.8</td>
<td>72.9</td>
<td>77.3</td>
<td>81.9</td>
</tr>
<tr>
<td>Additional WOS Funding</td>
<td>6.0</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Asylum Seekers Services</td>
<td>1.5</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>81.5</strong></td>
<td><strong>76.8</strong></td>
<td><strong>72.9</strong></td>
<td><strong>77.3</strong></td>
<td><strong>81.9</strong></td>
</tr>
</tbody>
</table>

**Expenditure Plan**

<table>
<thead>
<tr>
<th>Inflation and other pressures</th>
<th>2005/06 £m</th>
<th>2006/07 £m</th>
<th>2007/08 £m</th>
<th>2008/09 £m</th>
<th>2009/2010 £m</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local Health Plan</td>
<td>60.1</td>
<td>55.7</td>
<td>58.7</td>
<td>61.9</td>
<td>64.4</td>
</tr>
<tr>
<td>Prior year commitments brought forward</td>
<td>21.8</td>
<td>17.1</td>
<td>9.0</td>
<td>6.0</td>
<td>3.0</td>
</tr>
<tr>
<td>New Commitments:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute</td>
<td>15.5</td>
<td>3.3</td>
<td>16.7</td>
<td>6.9</td>
<td>7.4</td>
</tr>
<tr>
<td>Mental Health</td>
<td>5.0</td>
<td>3.8</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Child &amp; Maternal</td>
<td>1.1</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Primary Care and Other</td>
<td>5.1</td>
<td>2.6</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>TBA</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>5.5</td>
<td>12.1</td>
</tr>
<tr>
<td>Forecast commitments carried forward</td>
<td>(9.0)</td>
<td>(9.0)</td>
<td>(6.0)</td>
<td>(3.0)</td>
<td>(5.0)</td>
</tr>
<tr>
<td>Total – Local Health Plan</td>
<td>39.5</td>
<td>17.8</td>
<td>19.7</td>
<td>15.4</td>
<td>17.5</td>
</tr>
</tbody>
</table>

**Other Initiatives**

<table>
<thead>
<tr>
<th>Cost savings plan</th>
<th>2005/06 £m</th>
<th>2006/07 £m</th>
<th>2007/08 £m</th>
<th>2008/09 £m</th>
<th>2009/2010 £m</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost Improvement Plan to be identified</td>
<td>10.4</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Profit from land sales</td>
<td>7.5</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>(27.9)</td>
<td>(7.1)</td>
<td>(5.5)</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>In year surplus/(deficit)</td>
<td>(9.8)</td>
<td>10.4</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Opening surplus/(deficit)</td>
<td>(9.8)</td>
<td>(10.4)</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Forecast surplus/(deficit)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

### 8.6 Key Points and Assumptions

- SEHD general funding uplift assumed to be held at minimum level of general increase, ie
  - 2006/07 6.75%
  - 2007/08 and thereafter 6.00%
• Inflation and Other Pressures

An analysis of the total provision for inflation and other pressures is provided below:

<table>
<thead>
<tr>
<th></th>
<th>2005/06</th>
<th></th>
<th>2006/07</th>
<th></th>
<th>2007/08</th>
<th></th>
<th>2008/09</th>
<th></th>
<th>2009/10</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>% Inc.</td>
<td>Cost £m</td>
<td>% Inc.</td>
<td>Cost £m</td>
<td>% Inc.</td>
<td>Cost £m</td>
<td>% Inc.</td>
<td>Cost £m</td>
<td>% Inc.</td>
<td>Cost £m</td>
</tr>
<tr>
<td>Pay</td>
<td>7.0</td>
<td>39.0</td>
<td>4.0</td>
<td>25.9</td>
<td>4.0</td>
<td>27.3</td>
<td>4.0</td>
<td>28.8</td>
<td>4.0</td>
<td>30.4</td>
</tr>
<tr>
<td>Supplies</td>
<td>1.5</td>
<td>3.0</td>
<td>2.0</td>
<td>4.2</td>
<td>2.0</td>
<td>4.3</td>
<td>2.0</td>
<td>4.4</td>
<td>2.0</td>
<td>4.6</td>
</tr>
<tr>
<td>Prescribing</td>
<td>3.8</td>
<td>8.5</td>
<td>8.0</td>
<td>15.6</td>
<td>8.0</td>
<td>16.7</td>
<td>8.0</td>
<td>17.9</td>
<td>8.0</td>
<td>19.2</td>
</tr>
<tr>
<td>Non Glasgow cost inflation</td>
<td>-</td>
<td>9.6</td>
<td>-</td>
<td>10.0</td>
<td>-</td>
<td>10.4</td>
<td>-</td>
<td>10.8</td>
<td>-</td>
<td>10.2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>60.1</td>
<td></td>
<td>55.7</td>
<td></td>
<td>58.7</td>
<td></td>
<td>61.9</td>
<td></td>
<td>64.4</td>
</tr>
</tbody>
</table>

The summary shows a spike in pay costs associated with implementation of Agenda for Change in 2005/06. It also shows a reduced rate of growth in prescribing expenditure in 2005/06 related to the impact of reduced prices for generic and branded drug products. It is assumed that a more “normal” pattern of growth in prescribing expenditure will occur from 2006/07 onwards. This remains to be tested. A 2% uplift growth in non-pay costs is also assumed for 2006/07 onwards. This also remains to be tested.

• Local Health Plan

Provision is made for all current commitments. Expenditure on the Acute Services Review Programme has been rescheduled to reflect the current programme for commencing the ACADs.

Management of the timing of implementation of service commitments will remain key to maintaining NHSGG’s overall financial plan in balance over the 5 year period.

The potential requirement to make provision for further commitments to secure achievement of waiting time targets, and to fund new priorities for investment across all programmes from 2006/07 onwards will present a real financial challenge to the Board in the light of the forecast of available new resources, and will demand continued close scrutiny of how existing resources are deployed to identify further opportunities which might potentially release further resource for re-investment.

• Cost Savings Plan

Forecast cost savings reflect the agreed cost savings plan for 2005/06 and the further extrapolation of this into 2006/07 and 2007/08 as agreed by CMT. Detailed plans remain to be worked up to secure delivery of savings in 2006/07 and 2007/08.
Subject to audit, NHS Greater Glasgow has achieved all three financial targets in 2004-05.

2004-05 OUTTURN

NHS Greater Glasgow had a Revenue Resource Limit (RRL) of £1,280.160m in 2004-05. This represented an increase of 6.75% over the comparable 2003-04 unified budget.

Subject to audit, a surplus of £11.8m is expected to be reported against the RRL in the 04-05 annual accounts. This consists of the 2003-04 brought forward surplus of £5m and the in year surplus of £6.8m. The surplus achieved reflects the successful delivery of £32m of savings and is supplemented by various budget underspends and slippage (which will require to be reprovided in 2005-06).

During the course of the year, the board experienced a number of pressure areas including the GMS contract (overspent by £5.4m) and Agenda for Change. Nursing budgets also represented a significant pressure area within the acute setting due to the reliance on agency staff to cope with service pressures and vacancies. However, this was offset by underspends in other areas.

It should be noted that the board originally identified a £58m gap against income and expenditure at the start of the financial year. This was reduced to a £4.6m forecast deficit following the implementation of range of cost improvement programmes. It also assumed receipt of £8.2m additional income from West of Scotland boards in relation to cross subsidisation/casemix complexity. (Note that the year end surplus reduced the need for this level of funding in 2004-05 and as a result it was agreed that the boards involved would contribute reduced amounts - approx £2.2m was recovered at the year end).

5 YEAR FINANCIAL PLANS

5 year financial plans submitted by NHS Greater Glasgow indicate that breakeven will be achieved.

RISKS

There are a number of risk areas which may impact on the 5 year plans, namely:

- Agenda for Change: A provision of £39m is available for pay uplifts in 2005-06. The key risk area relates to the potential cost of backfilling for any additional holidays taken as a result of the increased leave entitlement.

- The GMS contract: This will result in an additional £12.2m cost during 2005-06. This is currently being assessed against the GMS allocations to determine an accurate forecast outturn.
• Restrictions on capital to revenue transfers: From 2006-07 boards can no longer transfer an element of their capital allocation to revenue to support non-value added projects. This will represent an additional pressure in relation to any refurbishment/maintenance programmes that are classed as revenue expenditure in accounting terms.

• Receipt of income from West of Scotland boards re casemix complexity/cross subsidisation

CAPITAL

NHS Greater Glasgow had a Capital Resource Limit (CRL) of £66.213m in 2004-05. This was utilised as follows:

• Hospital Infrastructure - £60.813m
• Community Infrastructure - £5.163m
• IM&T - £237,000

In addition, a number of major capital projects are currently underway:

• ACADs: this project is progressing well with the board aiming for financial close by early 2006. It’s anticipated that construction will be complete by late 2007.

• West of Scotland Oncology Centre (Beatson) is the largest value publicly funded health facility at £86.7m. Project commenced on site on 2nd August 2004 and is due for completion on 31st July 2006. The Centre is due to open in early 2007.

• West of Scotland Adolescent Psychiatry Services: the Outline Business Case (OBC) for this project was approved in June 2005 and the Board was invited to proceed to Full Business Case (FBC). It is anticipated that the FBC will be submitted to the Capital Investment Group (CIG) for consideration in November 2005.

• Local Forensic Psychiatric Unit (Stobhill) – The FBC for this project was approved in February 2005 and Financial Close was reached in July 2005. Work is due to start on site in October.

• West Sector Reprovision of Mental Health Services (Gartnavel) – the FBC for this project was considered by CIG in March 2005. However as planning permission was outstanding, it was not formally approved by the group. (The FBC will be reconsidered using expedited procedures as soon as the relevant planning permission is granted). Approval was given early in August 2005. Financial Close is being aimed for mid to late September 2005.
8.7 Efficient Government

The Board has submitted a detailed plan to SEHD which explains the actions which it intends to take to secure the achievement of an annual cost savings target of 1% over the three year period to 2007/8. This is been deliberately skewed towards the earlier part of the three period reflecting the measures already taken by the Board to maintain a balanced financial position in 2004/05 and 2005/06.

SCOTTISH EXECUTIVE HEALTH DEPARTMENT RESPONSE

In line with Building A Better Scotland all boards have been asked to prepare efficiency plans for the 3 year period to 2007/08. At present, NHS Greater Glasgow has submitted a return identifying recurring savings of £26.9m, £33.9m and £39.5m for 2005/06, 2006/07 and 2007/08 respectively. These amounts significantly exceed the 1% recurring target based on the boards RRL, i.e. £11.4m, £23.5m and £36.4m respectively, due to 2004-05 recurring savings have been included in these targets.

<table>
<thead>
<tr>
<th></th>
<th>Day Case rates % (as a percentage of electives)</th>
<th>Return/new ratio of consultant outpatient attendances</th>
<th>Cancelled admissions (as a percentage of electives)</th>
<th>Unit Costs Ratio (Scotland=100) 2003/4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Inpatients</td>
<td>Daycases</td>
</tr>
<tr>
<td>Scotland</td>
<td>64.4%</td>
<td>2.23</td>
<td>2.7%</td>
<td>100</td>
</tr>
<tr>
<td>Greater Glasgow</td>
<td>63.0%</td>
<td>2.49</td>
<td>1.9%</td>
<td>98</td>
</tr>
</tbody>
</table>

Notes: 1. All figures are based on quarterly health board of treatment data
2. Table compares unit costs against the Scottish average for inpatients and daycases. A ratio value over 100 indicates that the Health Board has higher costs than the Scottish average.
3. Costs have not been adjusted for case-mix complexity; taking complexity of cases into account may change the relative cost ratio of the Board.

DAY SURGERY RATES

The more elective surgery that can be dealt with as day cases, the better in terms of patients outcomes, patient convenience, bed availability, and costs. NHS Greater Glasgow is slightly lower than the Scottish average suggesting room for improvement.

RETURN/NEW OUTPATIENT RATIO

NHS Greater Glasgow’s ratio is slightly higher than the Scottish average. In general, the lower the ratio, the better since fewer returns free up consultants’ time to see new patients and reduce outpatient waiting. These figures suggest that there is scope for further improvement.
CANCELLED ADMISSIONS

NHS Greater Glasgow’s rate is lower than Scotland’s indicating good experience for patients and probably less pressure on beds in the region’s hospitals.

UNIT COSTS

NHS Greater Glasgow’s costs for inpatients and daycases are lower than the Scottish average for all types of hospitals undertaking this activity (including major teaching, district general, community, maternity and dental hospitals). NHS Greater Glasgow has best national performance in terms of daycases - 75 against national average of 100.
9. **MATTERS SPECIFIC TO THE BOARD**

9.1 **Modernising Hospital Services**

The Board’s hospital modernisation plan was approved by the Minister in 2002. There are four phases to the implementation plan.

9.1.1 **Phase 1**

Phase 1 to develop a new Beatson West of Scotland Cancer Centre at Gartnavel General Hospital is well underway. Construction is on time and within budget with scheduled opening in early 2007.

Plans for new Ambulatory Care Hospitals at the Victoria and Stobhill are well on track. The Board’s Performance Review Group approved in May a report on procurement, affordability and value for money. Preferred bidders for both the construction phase and domestic and portering services have been identified. Both bids have satisfied the Executive’s Key Stage Review process. Negotiations with Glasgow City Council for the acquisition of Queens Park Recreation ground are advanced, missives are being exchanged and the Council has approved a planning application for the new road required. The project is due on site in June 2006 but there may be scope to bring this forward. Completion is due in late 2007.

9.1.2 **Phase 2**

A refreshed clinical strategy is due to be submitted to the Executive by the end of the year including updated bed modelling and financial plans.

The Board received a paper on the disposition of clinical services and on bed-modelling and capacity at its July meeting. This work on service-modelling which has been developed through fourteen clinically-led sub-groups will now be debated across the broader clinical community so that this stage of the modelling can be concluded by the end of September, 2005. Achieving this timetable will allow the conclusions to be fed into Phase 2 of the acute services modernisation plan, the re-development of the Southern General Hospital’s site.

Professional and technical advisers to support the procurement and construction programme has been appointed.

9.1.3 **Phases 3 and 4**

The third phase of the implementation plan will comprise provision of one further in-patient block at Glasgow Royal Infirmary: this is scheduled for completion in 2010\11. The fourth and final phase brings together in a single site at Gartnavel General Hospital a range of specialist services (including Clinical Oncology) alongside GP assessed acute receiving for west and north-west Glasgow. The timescale for this final phase sits between 2012 and 2014.
9.1.4 Patient and Public Engagement

The Board has been fully committed to the participation of patients and public alike in the planning and implementation phases to modernise Glasgow’s hospitals. A community engagement team has been appointed to work with communities, patients and carer groups across the city to ensure that people of Glasgow are informed about and involved in these changes.

9.1.5 Transport

Within the new service pattern transport arrangements are of critical importance. A transport and access group with wide representation including full engagement with regional and national transport operators has been set up to consider transport arrangements to hospitals in the short and longer term and to agree on the development of public services and alternative transport arrangements to support the modernisation plans. Early priorities include creation of transport information points in hospitals, extension of dial a ride schemes and development of car parking policy.

9.1.6 Accident and Emergency Services

In response to the Minister’s request to review the appropriateness and robustness of the original assumptions for these services the Board has undertaken a public review over seven months of provision of ambulance services, assessment and admission of patients, future inpatient numbers, the impact of hospital reforms in Argyll and Clyde and the proposed acute receiving model. After careful consideration of the evidence from the review the Board re-affirmed its original decisions.

9.1.7 Progress on Service Changes

Since 2002, we have completed a number of early in-patient service moves including:

- **ENT** (Ear, Nose and Throat) Surgery, formerly on four sites, was concentrated on two sites with the transfer of the service from the Victoria Infirmary to the Southern General in 2002, and the transfer of the Stobhill service to Gartnavel in 2003.
- **Ophthalmology** (treatment for eye conditions) inpatient services in the city reduced from three to two sites when the Stobhill unit transferred to Gartnavel General Hospital in 2003
- **Gynaecology** inpatient services for the north & east of the city were centralised at Glasgow Royal Infirmary in 2003 and for the south/west of the city at the Southern General in 2004.
- Inpatient **dermatology** (treatment of skin conditions) services for the city were centralised at the Southern General in January 2005.

Further changes are planned, for example:
Heart and lung surgery (cardiothoracic) Following public consultation the Board will take a final decision in September, 2005 on a proposal to create a West of Scotland Centre at the Golden Jubilee National Hospital for Cardiac and Thoracic Surgical Services, currently provided in the Glasgow Royal and Western Infirmaries and in Hairmyres Hospital in East Kilbride. Appropriate interventional cardiology services will be provided alongside.

In each of these services, we now have created larger teams of specialists meaning that patients attending hospital are assured of getting the best care and attention from the experts in their particular field.

In view of the rising pressures to sustain inpatient services on six acute sites the Board is committed to continue this process of exploring how services might be re-organised on to fewer sites to improve patient care in advance of the completion of the building programme.

SCOTTISH EXECUTIVE HEALTH DEPARTMENT RESPONSE

The Executive welcomes and supports this ambitious programme for the much needed modernisation of health services across Glasgow.

9.2 Maternity Services

The Minister announced the detail of the establishment of the Calder group at the end of June. We have established a process with Professor Calder to begin review of the sustainability issues in September and a similar timeframe for his group to consider our proposed option appraisal process which we aim to conclude by the end of October. Based on clinical opinion, we continue to have major concerns that three maternity sites cannot be sustained beyond the short term.

SCOTTISH EXECUTIVE HEALTH DEPARTMENT RESPONSE

In September 2004, the Executive recognised the case for two maternity units in Glasgow and announced £100 million investment for a new children’s hospital in Glasgow to replace Yorkhill – on top of the £750 million already earmarked for a new hospital building programme in Glasgow to make modern acute services available across the city.

The announcement followed an extensive public consultation and debate on whether maternity services should be co-located with paediatric (children’s) services or adult acute services. The Executive offered additional financial support to enable Greater Glasgow NHS Board to bring forward triple co-location - all three kinds of hospital services on a single site – which has been referred to as the “gold standard” of care.

The Executive is pleased that Professor Andrew Calder is chairing the Advisory Group to help drive forward the planning of the hospital.
9.3 **Impact of Argyll and Clyde Dissolution**

A dissolution project board and supporting team have been established as a partnership between Argyll and Clyde, Highland and Greater Glasgow. These arrangements and a series of joint subgroups will take forward a detailed plan for dissolution and integration to ensure that when the Minister decides on boundaries following the consultation progress to integration can be rapid. GGNHS have made initial proposals about organisational arrangements for elements of Argyll and Clyde services we may inherit.

**SCOTTISH EXECUTIVE HEALTH DEPARTMENT RESPONSE**

The Executive acknowledges that the issues facing NHS Greater Glasgow to progress smooth integration are challenging. We support the approaches of NHS Greater Glasgow, NHS Argyll and Clyde and NHS Highland. We agree that it is sensible to make as much progress as is practicable on integration issues over the coming months.