



ANNUAL REVIEW 2006

**CHAIRMAN'S SELF ASSESSMENT FOR MEETING WITH
SCOTTISH EXECUTIVE HEALTH DEPARTMENT
ON 22ND AUGUST 2006**

NHS GREATER GLASGOW AND CLYDE ANNUAL REVIEW 2006

CONTENTS

	<u>Page</u>
1. Introduction	1
2. Progress on Main Actions from 2005 Annual Review	2
3. Health Improvement and Tackling Inequalities	5
4. Shifting the Balance of Care to the Community	12
5. Service Redesign	25
6. Resource: Finance and Workforce	32
7. Clyde	40

1. **INTRODUCTION**

2005-06 has seen a continuation of the extensive and rapid pace of change affecting health services across Greater Glasgow. Overall we are making good progress on many fronts to transform health and health services in ways that will bring many benefits to local citizens.

Our plans to modernise our hospital and community infrastructure remain on track with new buildings beginning to appear across the city. Alongside this many of our services are being re-designed to fit with the aims of Delivering for Health, placing more emphasis on local delivery closer to people and their communities whilst strengthening our specialist services and are reliant on closer working between different parts of the health system and with our partners notably the Local Authorities. Our services continue to perform well but I recognise that more is expected from them.

We have also made significant strides forward in our approach to communications and in our engagement with patients and local populations which helps ensure that our plans and services are better understood and that they reflect better people's needs and preferences.

Two further momentous changes have occurred in the past year. 1st April saw the merging with Clyde with the consequence that the Board now has responsibility for over a quarter of Scotland's population. We face a testing challenge to deliver equitable services within a balanced budget. Second we have implemented a major reorganisation, which has reformed and revitalised our management and operations enabling us to be more efficient and effective to a uniformly high standard throughout Greater Glasgow and Clyde.

Finally may I take this opportunity to say thank you to all of the Board's staff for their continued dedication and commitment through these changing and challenging times. Without them none of this would be possible.

Professor Sir John Arbuthnott
Chairman
NHS Greater Glasgow and Clyde

2. PROGRESS ON MAIN ACTIONS FROM 2005 ANNUAL REVIEW

2.1 Partnership Working

- 2.1.1 A development event for the Area Partnership Forum (APF) held on 23rd January agreed a new membership and remit. The remit will in future focus on involvement with the development of the Board's strategy and associated delivery plans as well as oversee the development and implementation of system wide human resources policies and matters. The membership will be based on the national model proposed by the Scottish Workforce and Governance Group. APF meetings will be chaired jointly by the Employee Director with Chief Executive or Human Resources Director.
- 2.1.2 The first meeting under the new arrangements took place on 9th March to consider the Kerr Report, health inequalities and the revised constitution. The APF is now supported by a formal secretariat of two senior managers and two senior trades union representatives.
- 2.1.3 Within NHSGGC the Acute Division, all Community Health (and Care) Partnerships (CH(C)Ps) and the Mental Health Partnership are now revising their arrangements in light of the reconstituted APF and new organisational structures.

2.2 Modernising Hospital Services

- 2.2.1 The Queens Park recreation area has now been purchased as the site for the new Victoria hospital and work on new roads there will commence this month.
- 2.2.2 A positive planning decision on both the Victoria and Stobhill hospital developments has now been confirmed. A summary of the final business case was presented to the Board's Performance Review Group on 21st March prior to submission to the Executive for the key review stage. Financial close should be achieved by mid-August. Construction for both hospitals is estimated to be 27 months with a further three-month commissioning period.

2.3 Smoking Cessation

- 2.3.1 Both initiatives referred to at the Annual Review are progressing satisfactorily.
- 2.3.2 Starting Fresh, the community pharmacy scheme, continues to operate in over 100 pharmacies across the city. The present success rate is just 6% but this compares with 1-2% for people trying to stop smoking on their own. While smoking cessation classes have a better success rate at 12% they are used by many less people. Taken together 738 people out of a total of 12,000 successfully gave up smoking after 12 months.

- 2.3.4 The Smoke Free Homes pilot commenced in Easterhouse in November 2005 in conjunction with local nurseries. It has begun initially in a small number of homes and will be evaluated before being rolled out further.
- 2.3.5 One further initiative since August has been the appointment by NHS Greater Glasgow to each CHP in Greater Glasgow of a full time smoking cessation co-ordinator.

2.4 Waiting Times

- 2.4.1 NHSGGC successfully achieved its national targets by December 2005 with the exception of one breach, the circumstances of which have been fully explained to the Department and Minister.
- 2.4.2 In terms of the 2007 targets, NHSGGC has confirmed with the Scottish Executive that it will be able to bring forward achievement of the 18 week maximum target for inpatients/daycases minus Availability Status Codes (ASCs) from December 2007 to December 2006. The other targets relating to outpatients, heart conditions, cataracts, hip surgery, A&E and diagnostics as well as the cessation of the use ASCs will all be achieved by December 2007.

2.5 Winter Planning

- 2.5.1 Winter plans were successfully delivered over November, December and January including the festive period in close co-operation with NHS 24.
- 2.5.2 Weekly exception reporting confirmed no delays in elective procedures due to lack of capacity and no significant increase in demand as a result of severe weather.

2.6 Infection Control

- 2.6.1 At the Annual Review the Minister expressed concern at the high MRSA rates in North Division which at that time were the second highest in the country. The most recent results show some signs of improvement. While rates are within control limits some caution is advisable as numbers are small and can fluctuate from quarter to quarter. The performance also needs to be considered in the context that North Division is the principal centre of high risk specialities e.g. adult renal services and tertiary referrals, in Greater Glasgow. Within North for example renal patients occupy 3% of the beds but account for 30% of the bacteraemia.

2.7 NHS Employment Contracts

2.7.1 NHSGGC is steadily working through the implementation of Agenda for Change. The dedicated project teams are working with over 150 job matchers to process around 10,000 job descriptions, which are now resulting in the assimilation of staff on to the new pay arrangements. By the end of July, around 15,000 staff will have been assimilated to Agenda for Change across NHSGGC and the project plan is in place to assimilate the remainder of staff in posts where there are job descriptions and national profiles.

2.8 Efficiency

2.8.1 Revised Efficient Government (EG) targets for 2006-07 were submitted to the Executive on 16 November. These were accepted and it was agreed that the EG target for 2007-08 be reviewed in the coming financial year in light of the assumption of responsibility by NHS Greater Glasgow from 1st April 2006 for part of NHS Argyll and Clyde.

3. HEALTH IMPROVEMENT AND TACKLING HEALTH INEQUALITIES

3.1 Introduction

3.1.1 NHSGGC recognises the intractability of a range of key health problems within its area and that most of these problems are signified by the size of the health gap between communities and individuals of more or less affluence. Certain health problems such as problem alcohol use and obesity have increased across all social classes but the greatest impact still occurs amongst the poorest population groups. The nature of the reorganisation of the Board is designed to maximise the Board's contribution to improving health and addressing the variations in health outcomes across different population groups.

3.1.2 Key Developments Aimed at Improving the Health of Those in Greatest Need 2005/6

The following reflect Local Delivery Plan target areas as well as local priorities. The activity reported on has been selected in order to showcase work being carried out in areas of greatest need:

- smoking;
- Alcohol consumption;
- teenage pregnancy;
- obesity;
- community wellbeing activities in deprived communities;
- employability.

Smoking. NHSGGC has the most comprehensive evidence-based smoking cessation service in Scotland and is currently working on improving success rates for people in the most deprived areas. This is managed by the Smoking Concerns programme. There is also an exploration into the different reasons for smoking amongst women and men and their differential success rates. "Breathe Easy" Smoke Free Homes pilot has been launched in the East End of Glasgow to discourage visible smoking in front of children and to protect them from second hand smoke.

An evaluation of our smoking cessation services has been conducted under the auspices of the Glasgow Centre for Population Health. The Smoking Planning and Implementation Group is using the evaluation to improve the services, to increase targeting of smokers in the most deprived areas and to attempt to make sure people are directed to the most appropriate service for them. Prevention 2010 provides an opportunity both to extend different approaches such as buddying schemes and also to work closely with staff in primary care in supporting smokers to access the most effective service depending on their needs.

Alcohol Consumption. There are currently five alcohol prevention teams located in former Social Inclusion Partnership areas. These teams aim to reduce alcohol related harm and risk of harm in their local communities by working to change the culture of alcohol use. This includes awareness work with identified target groups to challenge attitudes, increase knowledge and improve skills, training for local staff, information and advice, communications campaigns and work with the licensed trade. The impact of the pilot funding for unmet needs from the Scottish Executive (£2.8m over two years) in Glasgow City Council's North and North West Community Addiction Teams (CATs), is being evaluated by tracking trends in new client numbers by deprivation category groupings to see whether deprived clients:

- are increasing as a proportion of overall case load in each of the two CATs;
- are increasing in comparison with two other CATs outside GCC;
- comprise at least the same proportion of the CAT caseload as they do in the catchment population.

3.1.3 Sexual Health

We welcomed the publication of the national Sexual Health Strategy and the associated additional resources reinforced the programme of change and development driven by our local strategy. The emphasis on the role of Local Authorities in improving sexual health was particularly important to enable us to establish shared action plans with each of our partner authorities. A continuing national focus on driving that wider sexual health agenda will be critical to achieving real progress.

Positive developments during the year include:

- beginning to roll out the Sandyford hub and spoke model to improve access to services in local areas;
- further improving HIV services reflecting the increased prevalence in our population;
- a range of initiatives to tackle health inequalities including establishing assertiveness programmes for young women and work with young men on masculinity;
- establishing a programme of work to address the issue of female genital mutilation;
- action with each Local Authority to address issues about access to information and sex education.

The focus of the work of the Teenage Pregnancy Steering Group, a partnership arrangement between NHSGGC and Glasgow City Council, has focussed on obtaining detailed information from young people and their parents on sexual behaviour, access and perceptions of sex education and knowledge and access to services. The "C" Card scheme, Pharmacy Pilot and

Text4U have improved access to condoms and emergency contraception to teenagers as well as provided user friendly information on sexual health services. A Midwifery Development post has been established to ensure that young parents get the best levels of support and referral as early as possible.

3.1.4 Breastfeeding

Within NHSGGC breastfeeding rates have improved. Rates have shown steady increases from 33.7% in 2001 to 38% in 2005 towards the national target of 50% of mothers to be breastfeeding at 6 weeks.

NHS Greater Glasgow has had a breastfeeding strategy since 1998, with representation from maternity services, primary care, health promotion, dietetics, paediatrics, general practitioners, peer support and the voluntary sector.

We are now establishing an Infant Feeding Strategy Group that will have responsibility across NHSGGC. Its aims are:

- to help every woman to make a fully informed choice about how she feeds her baby;
- to provide every woman with skilled help with infant feeding;
- to ensure that the information offered is accurate and evidence based;
- to encourage more women to initiate breastfeeding

We have recently appointed an Infant Feeding Coordinator operating at a strategic level leading a team of four Infant Feeding Advisers. The main focus of the team is addressing inequalities in health through improving infant nutrition practices for 0-2 years for all mothers, breastfeeding, formula feeding and when introducing complementary foods. This will be done across sectors and by multi agency working, linking in with health promoting schools, smoking cessation programs, teenage pregnancy, reduction in child obesity initiatives and the oral health action teams.

3.1.5 Obesity and Weight Management.

The Glasgow Weight Management Service (GWMS), which was introduced in November 2004, was further developed during 2005-2006. This reflects a strategic approach to obesity from prevention through to the treatment of morbid obesity. GWMS is a dedicated service for patients who meet particular criteria (according to their Body Mass Index (BMI)) and is provided by dietetic, psychology and physiotherapy staff. The service was extended during 2005-2006 to include referrals from East, South West and North CHCPs in Glasgow City. It will be rolled out to the remaining CHCPs and CHPs (West Glasgow, South East Glasgow, East Dunbartonshire, West Dunbartonshire, East Renfrewshire, Renfrewshire and Inverclyde by February 2007. Thus far approximately 1500 patients have been referred to the service. Those who do not fulfil the criteria in terms of degree of overweight are supported to access

recognised weight management programmes in the community such as Glasgow City Council's Shape Up programme, developed in conjunction with GWMS.

3.1.6 Community Wellbeing

As well as having positive impacts on health, community wellbeing leads to a more inclusive society and greater active citizenship. As part of the National Programme and in partnership with the Scottish Development Centre for Mental Health and others, a successful programme called "Steps to Health" has been established in the East End of Glasgow. Initial events in the area identified the processes underpinning community mental health and wellbeing. This led to a pilot aimed at young people to address low levels of self-esteem and aspirations, high levels of territorialism and poor perceptions of safety, financial poverty and poor health. The interventions involved the young people themselves, their families, local organisations and their communities.

3.1.7 Employability

Work is one of the main routes out of poverty and many people are excluded from the labour market due to a range of health and social issues and by different forms of discrimination. Cross agency partnerships, including NHSGGC involvement, have been successful in linking people to employment opportunities. There are a range of activities underway at a community level including volunteering projects, financial advice in health centres, sign-posting to employment advice, placements and careers in health for excluded groups and engagement with the social economy sector. A good example is "Working for Health in Greater Glasgow" which links with Job Centre Plus to train and support people into jobs within the NHS. Work on employability, its causes and consequences, is being coordinated through a range of strategic groups tackling financial inclusion, employability and healthy working lives. NHSGGC plays a key role on these groups and will continue to participate in developments in this area, for instance, through measures in the Green Paper on Welfare Reform and the Pathways to Work Condition Management Programme.

3.1.8 The Nature and Significance of Reorganisation in Relation to Health Improvement and Health Inequalities

There has been a major redesign of the planning, public health and health promotion functions to ensure that expertise and management of health improvement and health inequalities is effectively dispersed throughout the new single system.

A headquarters Corporate Inequalities Team (CIT), managed by a Head of Inequalities and Health Improvement has been established to work alongside the Directors of Public Health and Corporate Planning and Policy to facilitate

the integration of health improvement and health inequalities into the responsibilities of the entire management team and beyond. The work of the CIT includes the development of policy, managing the legal requirements of public sector duties, developing a monitoring and performance framework and supporting the development of new, effective methodologies for changing practice.

Within CH(C)Ps, Heads of Planning and Health Improvement have responsibility to ensure that an understanding of health improvement and health inequalities informs the decision making and resource allocation within their respective partnerships. To this end they are supported by Health Improvement and Inequalities Managers who manage teams of health improvement and community development staff and oversee key developments such as community health projects, health living centres and healthy eating initiatives.

Health Improvement and Inequalities Managers have also been established within the Acute Planning Directorate and the Mental Health Partnership to build capacity of frontline services to support health improvement activities with patients. Within mental health this also comprises facilitation of community support structures in deprived areas.

The final piece of the jigsaw is the creation of a Public Health Programme Manager and a Public Health Resource Unit (PHRU), under the leadership the Director of Public Health. The aim of the PHRU is to strengthen the corporate functions of the Board to improve health and address inequalities and provide support and resources to the public health workforce across NHS GGC. A key component will be the establishment and development of Public Health Networks based on the needs of the public health workforce in NHS GGC.

3.1.9 Corporate Objectives and Planning Guidance for Health Improvement and Health Inequalities

The culmination of those aspects of reorganisation aimed at improving the effectiveness and efficiency in improving health and addressing health inequalities has culminated in corporate objectives for both, inter-related, issues as well as relevant planning guidance. These will be enacted during 2006/7.

3.2 Flu Pandemic Planning

3.2.1 NHS GGC has established a comprehensive planning structure for pandemic flu. We submitted our most recent plan to the Scottish Executive in early 2006 as required and have received feedback that we are using to adapt our plan. Our pandemic flu coordinator has attended the Scottish Executive

seminars and recently met with Scottish Executive representatives to discuss our clinical response.

3.2.2 The planning sub-groups are making good progress and we plan to merge a number of them once the next draft of our plan is completed. It is expected that a robust and functional NHSGGC Pandemic Influenza Contingency Plan will be submitted to the Board by the 31st October and that it will contain or refer to related plans and sub-plans as appendices.

3.2.3 The main body of the plan will describe how NHSGGC will respond to the varying phases and alert levels of pandemic at a strategic (Board level) and tactical level (Acute Division and Community Partnership levels). The appendices will include the various plans at operational level and can be referred to as stand-alone documents as required. The former will include the command and control structures both within NHSGGC and between NHSGGC and its many partner agencies including its relationship with the Strathclyde Coordinating Group, the Police-led coalition that would lead the multi-agency response to a severe pandemic causing major societal disruption. It will also include the membership and essential functions of the various Pandemic Influenza Control Teams convened at the various levels from hospital and general practice to Board level. Finally, it will outline the essential components of the overall response by NHSGGC.

3.2.4 Our planning processes are developing plans on:

- generic business continuity planning;
- infection control in the various settings (including cleaning guidance and the use of personal protective equipment, isolation, quarantine and cohort nursing, etc);
- the distribution of antiviral agents and other pharmacological agents;
- vaccination of priority groups;
- communications (including the relationship between the SECG helpline, NHS24, NHSGGC Board communications department, and the SE communications strategy);
- supporting staff in care homes;
- social services and how their response needs to work seamlessly with that of the NHS;
- the use of beds at the Golden Jubilee National Hospital and in independent sector hospitals;
- the interface between other local authority departments, including their emergency planning departments), the bluelight services and the NHS;
- how the voluntary sector organisations can support NHSGGC;
- how the 16 universities and colleges in NHSGGC will respond to a pandemic.

3.2.5 The essential components of the proposed model of overall clinical response for NHSGGC include:

- convening Pandemic Influenza Control Teams (PICTs) at appropriate levels (strategic, tactical and operational);
- emphasis on ameliorating the effects of a pandemic and/or flattening the temporal profile of the pandemic wave as opposed to trying to prevent the pandemic. Less emphasis on segregation of flu and non-flu patients given that half of infected patients are sub-clinical;
- strong communication strategy working with SEHD and SECG, discouraging self-referral to A&E, promoting SECG helpline for info and advice and publicising availability of GP-led primary care service;
- augmented general practice service extended until 10 pm offering a walk-in (evening) and/or appointment based (daytime) service every day (including weekends) during the 3 weeks at the peak of the pandemic wave;
- emphasis on careful triage and keeping accurate records of prescriptions of tamiflu, which enables national surveillance mechanisms to quantify the effectiveness of tamiflu during a pandemic (versus policy of distributing tamiflu “on demand” until tamiflu runs out);
- cancellation of most elective procedures in the NHS when required supported by enhancement of elective lists in the private sector and Golden Jubilee. This frees up the types of beds that could be used for respiratory patients (including intensive care beds that are normally used for cardiac surgery patients);
- supporting care homes to enable staff to care for elderly patients dying in the community, including by training care home assistants to insert subcutaneous lines and carry out nebulisation and by setting up a care home emergency support centre. Supporting social services staff to ensure business continuity in related services in the community.

4. SHIFTING THE BALANCE OF CARE TO THE COMMUNITY

4.1 During 2005 the Board continued its strategy of shifting the balance of care towards the community, improving access and treatment and supporting independence at home. Two areas, which exemplify this, are primary care and long term conditions.

4.2 Primary Care Developments

4.2.1 Within primary care there are a number of developments, which are serving to shift the balance of care towards the community.

4.2.2 nGMS

The new General Medical Services (nGMS) contract will make a significant difference and builds on the previous development work in primary care undertaken by NHSGGC, in particular the Chronic Disease Management programme (CDM) through Local Enhanced Schemes (LES) offering annual review for all those with CHD, stroke, TIA, diabetes and MS. This programme has also developed all the supporting services required, many community based, to support these enhanced reviews which include symptom review, functional status, compliance and a wide ranging health related behaviours review. The support services, signposted on the LES data collection screens, include smoking cessation, our "Live Active" exercise referral programme, various alcohol projects, including local drug and addiction teams, the "Hearty Eating Programme", the Glasgow Weight Management Programme and the programme offered by our Local Authority partners with our collaboration.

In the national self-assessment strategic test of primary medical services for 2005-06 NHSGGC scored 74% overall and 87% in the redesign of services including demonstrating significant progress in shifting services from secondary to primary care. There is, for instance, clear agreement that all those with type 2 diabetes are cared for by general practice except in certain agreed circumstances, which require more expert input from a consultant led service.

4.2.3 Referral Information Services/Referral Management

Phase 1: Referral Information Service

The aim of this project is to develop the Referral Management model within NHSGGC in a phased way. The planned phasing would see the project going from a Referral Information Service (RIS) which collects, collates and analyses data on referrals and waiting times and produces reports on the

data, moving on to develop Referral Management within all clinical specialties, ie, the active management of referrals within agreed protocols.

This is the first phase of the programme: the development of a Referral Information Service, which collects, collates and analyses data on referrals and waiting times and produces reports. Currently, the quality of information captured on referrals does not, broadly speaking, capture much more than demographic details. Clinical information on referrals has never been widely captured within NHSGGC in a robust systematic way.

This higher quality of information will lead to a single data set and involvement of clinicians and patients to underpin future service development. This is a precursor to developing effective referral management processes and to provide an information tool to inform the development of new services.

Phase 2: Referral Management

Referral Management is the transition from the analysis and feedback of referral information to a more active management of demand and referrals. This will support the planning of appropriate, streamlined referral pathways via redesigned services and by supplying this information to referrers, providers, planners and patients the end-point will be that the patient is more likely to see the most appropriate person in the most appropriate place in the shortest possible time.

NHSGGC is piloting Referral Management through two projects previously sponsored by the Centre for Change and Innovation.

- The community based Foot & Ankle Triage Service in the East CHP and the South East and South West CHCPs sees patients who would traditionally have been referred to a hospital orthopaedic department for treatment. However, many of these patients do not need to see an orthopaedic surgeon and treatment pathways such as community-based podiatry will provide patients access to the most appropriate professional in the shortest possible time.
- Similarly, the Physiotherapy Knee project, operating in Clydebank and north Glasgow, enables referrals to be made directly to the service by GPs or Physiotherapists obviating the need for patients to be referred to a hospital orthopaedic department. Two Extended Scope Practitioner physiotherapists lead this project, trained to carry out orthopaedic knee assessments and to initiate, interpret and discuss further investigations, eg, MRI.

There are also direct referral systems already in place with the development of the Back Pain Service and direct referral to Dermatology.

4.2.4 CHCPs

Within NHSGGC six integrated CHCPs (five in Glasgow City and one in East Renfrewshire) have been created to drive a programme of change and improvement in population health and the delivery of health and care services. Single management of some community care services was already well established and under CHCPs is being extended with specific examples including integrated OT services, shared assessment process and appointment of rehabilitation and enablement managers.

4.2.5 Children

A key purpose of establishing integrated CHCPs was to achieve the management of locally delivered health and social care children's services under a single structure to provide the opportunity to deliver a real step change in service delivery to vulnerable children and their families and a coherent focus on tackling the inequalities which, if established in early life, blight the whole future of children.

We have succeeded in delivering this model for more than half of the Board's population, have begun to implement integrated assessment processes and set out detailed proposals to drive change and improvement.

Alongside this approach we have delivered the migration of specialist NHS children's community services out of the Yorkhill Division to be managed within CHCPs - already enabling us to focus change in these services much more closely on the needs of children in communities and achieve cohesion with other services at a local level.

Some examples of integrated working in children's services already exist such as PACT (Parents and Children Together) which exists in the form of a number of local projects across the city bringing together as an integrated colocated team health visitors, social work staff, health support workers, nursery nurses and the voluntary agency, One Plus. In this way, the team is able to offer one-stop access to a wide range of services to support vulnerable families requiring early intervention and intensive input.

4.2.6 Health Improvement

In NHSGGC CH(C)Ps have major responsibilities for improving the health of their populations and reducing health inequalities. There is an impact on the balance of care through the implementation and development of a wide array of health improvement strategies including nutrition, tobacco, physical activity, worklessness, men's health, community safety and injury prevention and strengthening their linkages for referral with GP practices as part of the QOF/LES.

4.2.7 Working with Acute

A principal objective of the Board is to reduce the barriers between primary and secondary care with better outcomes for patients. Examples of progress already exist:

- on delayed discharges where the Board met its 2006 target and has maintained its relative high performance due to the strong joint working and holistic approach established between primary and secondary care;
- retinal screening with the introduction of two mobile units to provide easier access to local services for patients with diabetes including homeless people as an alternative to attending a hospital;
- the setting up of a paediatric clinic in the east end of the city for child urinary tract infections and enuresis as an alternative to travelling to Yorkhill.

The newly formed CH(C)Ps and Acute Operating Division are charged with finding further ways of improving service links and pathways between community and hospital services and in particular of reducing patient waiting times for inpatient and outpatient treatment and sustaining guarantees:

- continuing to develop mechanisms for understanding and managing demand for primary and secondary care;
- developing and getting agreement to the use of patient pathways that increase local access and referral to ensure that patients see the most appropriate health care professional and supporting the redesign required to deliver these. This work will include referral protocols for those patients who fit “standard” investigation and treatment pathways;
- establishing forums and mechanisms for collaborative working that are built around common agendas;
- bringing a CH(C)P perspective and input to the development of capacity plans;
- reducing unplanned admissions with prevention and intervention;
- development of joint arrangements and action plans by March 2007;
- taking an active part in MCNs and other multidisciplinary planning groups by appointing a lead CH(C)P for each area, eg, heart disease or chronic pain;
- lead CH(C)Ps taking an active part in developing and getting agreement for care guidelines, including the pharmaceutical aspects.

4.2.8 Primary Care Mental Health

95% of all mental health activity takes place in primary care but nationally this is the least developed area of mental health service with few areas having consistent access to the stepped care model of support throughout a Board area. The stepped model of care ranges from population based mental health

through to self-help and self care through to one to one therapeutic interventions.

The Primary Care strategy has been progressively rolling out this model of support through a £3M programme of developments, which ensures access to specialist primary care teams and associated social care supports in all areas of Greater Glasgow. This activity has incorporated the Doing Well by People with Depression initiative, which has now been mainstreamed within the primary care teams.

The Board now has a full range of NHS and social care service supports embedded within the arrangements for management and service delivery for all mental health services in which services are responsible for the full range of mental health needs, rather than the more traditional model of secondary care supports with patchy access to primary care mental health supports.

4.2.9 Prevention 2010

Two Prevention 2010 pilots have been established in the Glasgow North and East CHCP areas. Following identification of the most deprived practice population's nineteen GP practices have agreed to take part in the project. Patients aged 45-64 are to be targeted and invited for cardiovascular screening and assessment of lifestyle risk factors with onward referral to relevant services including smoking cessation and befriending services, physical activity, eating habits and weight management programmes, local stress centres and community pharmacy services and benefits review. The programme will include strategies to ensure that traditionally "hard to engage" groups, including but certainly not exclusively, the mentally ill and homeless will also agree to take part.

4.3 Long Term Conditions

4.3.1 Strategy

The Board is shortly to develop a long term conditions strategy with the aim of shifting the balance of care to the most appropriate setting, managing appropriate activity in the community rather than hospital, redesign services to improve LTC management closer to the patients home, reduce unplanned admissions, develop appropriate links between hospital services, general practices and community services improve patient pathways and incorporate best practice modelled on multi professional working.

Diabetes

4.3.2 Local Enhanced Service

The Glasgow Diabetes project shifted care of type 2 patients into the community in 2002. This has now evolved into the Local Enhanced Service. The primary and secondary care interface group developed guidelines for the transfer of patients across primary and secondary care ensuring that patients with complex needs and type 1 diabetes would be seen in secondary care and uncomplicated patients and type 2 diabetes were managed in general practice. This guideline is currently under review to deal with an increased confidence with uncomplicated type 1 patients within primary care. The impact will be closely monitored and measured during 2006. Action for this year is to review current patient pathways across primary and secondary care, look at DNA rates across both, assess the scope to deal with uncomplicated type 1 patients in primary care and develop an improvement strategy by December 2006.

4.3.3 Microalbuminurea

The primary and secondary care subgroup has also developed guidelines for the secondary prevention of renal disease. The guideline provides advice on lab testing consistent with nGMS, and agreement about management of patients with diabetes and renal impairment including patients needing referral to secondary care. The anticipated impact is reduced but more appropriate GP referrals to secondary care and a long term reduction in the numbers of end stage renal failure.

4.3.4 Insulin Transfer Referral Pathway

An Insulin Transfer Referral Pathway across primary and secondary care has been drafted to ensure the smooth transition of a patient on multiple therapies onto insulin therapy. The aim of this guideline is to retain the overall responsibility of transferring patients onto insulin with the diabetologist but offering care as local as possible to the patient in the community. The diabetes framework action plan has tasked each MCN with the development of an insulin strategy by March 2007.

4.3.5 Retinal Screening

Previously there was no retinal screening service in secondary care. A comprehensive screening service for all patients with diabetes (including mobile units to provide local access) has been developed which will be QIS compliant by March 2007 providing an eye screening service to 80% of known patients. This project was funded as a result of the shift of type 2 patients with diabetes into general practices.

Heart Disease

4.3.6 Rapid Access Chest Pain Pilot

Rapid Access Chest Pain clinics are hospital based nurse led clinics at adult acute sites. They are designed to offer rapid assessment of patients with worsening or new chest pain. They allow rapid diagnosis and onward referral to expert services or back to general practice for further symptom management or investigation of other symptoms) and secondary prevention of CHD as required.

4.3.7 Palpitations Service (PALS)

PALS is a new technician led service allowing GPs direct access to appropriate investigation pathway for patients reporting palpitations. It promotes early re-assurance for patients, control of management by GPs, swift onward referral to expert management for the small (around 5%) of patients with relevant abnormality on initial tests. It has had a substantial effect on numbers of new patients at general cardiology clinics reducing waiting times. GP questionnaire shows high levels of satisfaction.

4.3.8 Heart Failure Liaison Nurse Service (HFLNS)

Those who have had an admission because of worsening heart failure are those most likely to have a further admission. Having identified and contacted them during admission the HFLNS follows up these patients at home and then at clinics if the patient is able. There are close links with general practice with discharge to GP care once the patient is stable and re-referral to service if there is deterioration, or for advice. Service offers patients less chance of re-admission (40% reduction or so), as well as early re-referral without hospital admission for patients who deteriorate. This includes palliative care outside hospital despite serious symptoms.

There has been a reduction in the number of readmissions to hospital for heart failure patients. Outreach clinics for this service will be trialled in local areas late in 2006.

Robust discharge criteria with a revolving door system for re- entry to the service have been set up. Investment agreed for LES for better care of more stable heart failure patients – being designed for implementation in 2007 – should delay/prevent deterioration and early admission for many patients.

4.3.9 Direct Access Echo Service

GPs have access to echo imaging for their patients for specified problems. This allows GPs to provide a diagnosis and management for patients with

heart failure in their practice rather than requiring referral to a hospital clinic. The service not only offers the results of the scan but also some advice about management and refers the GP to the local heart failure guidelines.

The service has had an impact on the number of patients with accurate diagnosis of heart failure and has contributed to raised awareness in general practice of the best management of those with heart failure as described and recommended in the guideline.

4.3.10 Outreach Cardiac Rehabilitation

Services providing group classes for education and physical activity offer local access on three off-hospital sites and the potential to increase exercise perseverance post rehab by linking with the local leisure services.

Respiratory Services

4.3.11 Outreach Spirometry Service

The Outreach Spirometry Service provides an assessment of spirometry, flow volume loop and reversibility to primary care physicians throughout Greater Glasgow. During 2005 the service performed spirometry in 4554 patients at 20 sites across the area. A significant increase in waiting times for spirometry was as a result of the introduction of the GMS contract for primary care and the BTS/NICE Chronic Obstructive Pulmonary Disease (COPD) Guidelines.

All results are reviewed and reported centrally before being returned to the referring GP together with advice and management options. The service is part of an integrated approach to the management of these patients to include smoking cessation advice, direct access pulmonary rehabilitation, disease education classes and advice on medication.

Activity has stabilized and waiting times have been reduced to a maximum of 6 weeks at all outreach sites where the service is performed by three trained clinical respiratory physiologists and has helped optimise the management of patients with obstructive disorders.

4.3.12 Early Supported Discharge for COPD

Scotland has more cases of COPD per head of population than England and Wales and the highest rate in Europe. There are an estimated 13,000 people in Greater Glasgow living with COPD related to high current and historical prevalence of smoking in both sexes.

This scheme has been introduced, in collaboration with the British Lung Foundation (BLF). COPD patients with an uncomplicated hospital admission for exacerbation will be discharged early from acute care following baseline

assessment and treatment. BLF nurses will organise quick, safe discharge for COPD patients according to set protocols and will visit them at home to monitor continuing treatment as their symptoms settle. The early supported discharge service has been set up to see patients discharged earlier from hospital (up to 3 days) and treated in the comfort of their own homes. Packages of care are tailored to meet individual patients needs with rapid access to consultant advice or re-admission if required.

4.3.13 Specialist Respiratory Physiotherapy Input to the Problem Asthma Clinic

Specialist respiratory physiotherapists offer valuable input into Problem Asthma Clinics and onward referral of patients with bronchiectasis, Allergic Bronchopulmonary Aspergillosis (ABPA) and COPD. Principal inputs include teaching of airway clearance techniques, breathing control techniques, preventing recurrent infections and advice on the benefits of controlled exercise in motivated asthmatic patients. The service has reduced referral pathway and provided a one stop service for the patient.

Stroke

4.3.14 Early Supported Discharge for Stroke Patients

An early supported discharge service for stroke patients has been developed for the north and south of the city. Pre discharge assessment and follow up into the community is carried out by a range of health professionals from OT, Physiotherapy, speech and language therapy and nursing staff as well as from social work.

Pain

4.3.15 Pain Management Programme

Funding has been made available to establish a Glasgow-wide psychology based Pain Management Programme in the community for those patients whose pain is irresolvable. The aim is to prevent the onset of chronic pain and to ensure the most efficient use of resources in both primary and secondary care with fewer GP consultations with a reduced number of sub-optimal referrals to other secondary care specialties.

Work is also ongoing to establish clear patient pathways for chronic pain patients making most appropriate use of community interventions.

4.4 Partnership Working

4.4.1 Partnership working has again been at the heart of the full range of our work during 2005/06. Particular highlights include the agreement of fully integrated

Community Health and Care Partnerships with East Renfrewshire and Glasgow City Councils; the development of a major “Pathfinder” initiative with the City; the positive development of Regional planning; collaboration with NHS Lanarkshire in the development of their acute services plans and the continuing development of an effective and visible Greater Glasgow NHS role in the evolution of Community Planning arrangements with each of our Partner Local Authorities.

4.4.2 In terms of partnership with our staff, 2005/06 was a time of major organisational change as we reformed NHS Greater Glasgow into a coherent single system organisation, established the Community Health and Care Partnerships and set out to create a stronger drive on health improvement and tackling inequalities. We maintained full engagement with staff during this process, with a particular emphasis on effective communication as we developed our new organisational arrangements. We now have a strong platform, with a newly constituted Area Partnership Forum

4.5 Mental Health

4.5.1 The Kerr report identified the four themed areas, which equally apply to mental health:

- promotion of population well being;
- prevention/ early intervention in illness;
- improved management of long-term conditions;
- manage acute care and unplanned admissions more effectively.

4.5.2 The Mental Health Act 2005 required the development of both an infrastructure to implement the processes of the Act and to manage people in the least restrictive settings consistent with need and has enabled shifting the balance of care.

4.5.3 Promotion of Population Health and Wellbeing

Proposed developments to improve the mental health and wellbeing of the population are:

- CH(C)P arrangements designed to reinforce management of service delivery in context of generic focussed local community partnership based organisational arrangements in which part of CH(C)P brief is health inequalities and well being. Over time links between service delivery and population wellbeing will be strengthened under these arrangements;
- establishment of comprehensive multi-agency development programme tackling the stigma of mental health problems, building on previous pilot work, and incorporating workplace training approaches and user involvement dimensions;

- development of innovative approaches to exploring mental health issues among black and ethnic minority communities, in conjunction with local community partners;
- active development of local Choose Life programmes and action plans, including via multi-agency steering groups and via training initiatives such as ASIST (Applied Suicide Intervention Skills Training) courses;
- ensuring local uptake of Mental Health Improvement evaluation skills and identification of local resource network;
- development of Child and Youth Mental Health Improvement Action Plan for NHSGGC, in line with the national guidance provided by ‘Heads Up’ framework;
- extension funding arranged for network of nine youth mental health promotion projects, in conjunction with local delivery partners;
- continued development of diverse community mental health improvement initiatives, including stress centre developments and Steps to Health initiative;
- development of a wide range of initiatives to promote physical health of mental health service users, including health checks, links with Culture and Leisure Services, including healthy walking initiatives and Passport to Recreation, preparatory work in relation to new smoking legislation, such as cessation support.

4.5.4 Prevention/Early Intervention

A primary care model of mental health is being rolled out NHSGGC-wide based on stepped care model ranging from population based approaches, education and group work, guided self management and one to one therapeutic interventions.

Plans are in place to develop further community development support to capacity build community organisations for use by people with mental distress. NHSGGC is probably the only primary care mental health system in the UK covering all elements of the stepped care model in all geographic areas.

There is a roll out NHSGGC wide of work development teams to support job retention and develop employment opportunities. Social care supports to primary care are also being expanded.

4.5.5 Improved Management of Long term Conditions

There is a focus on implementing the Mental Health Act by ensuring consistent access to core components of comprehensive mental health service in all areas of NHSGGC. This has been supported by a substantial service redesign and investment in strengthening of community services within this expansion of CMHTs, crisis/assertive outreach functions and associated social care supports and reworking arrangements for out of hours

support. Redesign will achieve 24/7 access to crisis and urgent out of hours supports while assertive outreach support retains engagement with services and therefore anticipates or prevents relapse and unplanned admissions.

Management of long term conditions is being improved by:

- integration of health and social care service delivery arrangements under single management within CHCPs in Glasgow City and East Renfrewshire;
- establishment of CH(C)P Mental Health Partnership to ensure coherent management of long term conditions across the pathway of primary care, social care and secondary care with integrated arrangements above managing the full range of specialist services within a single management structure;
- review and further reduction of continuing care requirements freeing up funds for other community developments/contribute to Board achieving financial balance without detriment to planned mental health developments.

A full geographic rollout of first onset psychosis early intervention service (currently in North East Glasgow only) has commenced which will achieve reduced loss of functioning and earlier management of illness. More effective management of community service capacity is being developed to manage eating disorders based on a tiered model of support to operate in conjunction with commissioned inpatient service.

4.5.6 Manage Acute Care and Unplanned Admissions More Effectively

Acute mental health problems may be managed in both inpatient and community settings. Where feasible it is preferable to manage such acute care episodes in community crisis resolution services rather than inpatient care; albeit it is not feasible to manage all acute care in community settings as some requires a level of containment or monitoring which is not feasible without inpatient admission. Similarly assertive outreach services anticipate or prevent relapse and therefore reduce unplanned admissions. Both of these services are currently in place in some areas but are now being strengthened to ensure access in all areas and to provide extended day cover from local teams and intensive out of hours support from a NHSGGC-wide team. To date these services have seen a shift in the balance of care towards community management of about 8% of acute episodes and 25 beds closed with funds redirected to such community services. The further strengthening of these functions should see a further shift in such activity after which the position will be further reviewed.

Bed management arrangements have long been established and the reliance on out of area treatments is comparatively low.

Roll out of early intervention first onset psychosis services will again provide more effective management at an early stage and has again demonstrated success in shifting the balance of management of such people in community settings with reduced reliance on unplanned admissions.

The redevelopment of the Gartnavel hospital site will see the introduction of a higher quality environment of care for inpatient services.

The development of forensic services with the Rowanbank Unit at Stobhill will see the more effective management of the pathway of care enabling transfer of care from the State Hospital into the least restrictive setting of care consistent with need. This year has seen an acceleration of this trend albeit full implementation will only occur when the Rowanbank Unit opens in May 2007.

5. SERVICE REDESIGN

5.1 Regional Planning - General

5.1.1 Regional planning in the West of Scotland has developed considerably over the past year. Examples of areas where NHSGGC has contributed significantly are provided below:

- major and explicit prioritisation process for the West of Scotland with full involvement of all Boards and a host of clinicians. This process will be further developed in coming years, but provided a transparent process for the first time around arrangements for funding cost pressures for regional specialist services;
- review of needs assessment underpinning Medium Secure Unit;
- joint planning of cardiothoracic services across the West of Scotland including development of plans to provide cardiothoracic services from the Golden Jubilee National Hospital (GJNH);
- development of agreed clinical protocols for a range of service developments in cardiology and cancer services ensuring a consistency of approach- some also developed across Scotland;
- detailed analysis of West of Scotland populations and the provision of various levels of unscheduled care across a range of planning scenarios;
- establishment of group to act as a purchasing consortium (with a view to minimising cost and risk) across the West for Level 4 inpatient care for eating disorders within the private sector.

5.2 Progress on Regional Review of Emergency Receiving Service as required by “Delivering for Health”

5.2.1 NHSGGC has actively participated in the “unscheduled care” work that has been undertaken within the West of Scotland. Local Board populations and catchment areas have all been defined and included in the analysis of potential reconfiguration of emergency care centres, including Community Casualty Facilities. All Boards have participated in detailed scenario modelling for West of Scotland populations. Population flows have been modelled for the existing configuration of level 3 unscheduled care services and also for the revised configuration following Ministerially agreed changes. Boards have all actively participated in the exploration of different levels of care in different centres and settings. All current NHS Board plans have taken full account of the broader West of Scotland context both in relation to the current provision and also in relation to plans for future configuration of services. Existing and proposed level 2 community casualty services have also been profiled across the region to show population flows.

5.2.2 NHSGGC has been engaged in three major areas of work on unscheduled care:

- with NHS Lanarkshire and NHS Forth Valley to explore the implications of the options for acute hospital services within “A Picture of Health” consultation paper;
- a major review of unscheduled care arrangements in relation to both Inverclyde Royal and Vale of Leven hospitals;
- in delivering its own plans for unscheduled care with streaming of A&E at Glasgow Royal Infirmary and the Southern General from GP referral at Gartnavel Hospital and from minor injuries at Stobhill Hospital and the Victoria Infirmary. The most recent edition of “Health News” has sought to increase public awareness of these changes.

5.3 Progress on Proposals for Regional Planned Care Centres, separated from Unscheduled Activity

5.3.1 With respect to planned care, there has been significant effort regionally around the development of cardiothoracic services at the Golden Jubilee National Hospital. Boards are working together to achieve the ASC code target for December 2007 and this is likely to involve streaming of this activity into one or more regional planned care centres. The Regional Planning Group is also developing a proposal to develop a planned care centre for inpatient oral maxillofacial services at the Southern in Glasgow. Several Boards are also engaged in cross Board discussions around specific specialities, eg, NHS Forth Valley and NHS Lanarkshire are discussing the potential to establish a vascular services centre and in NHS Ayrshire and Arran proposals for planned and rehabilitative care have been and will continue to be reviewed regionally, and this includes discussion with NHS Dumfries and Galloway.

5.3.2 NHSGGC has made extensive use of the GJNH in the past year for planned care referring 12,792 patients at a net cost of £4.9M (excluding Clyde).

5.3.3 Within the city, NHSGGC is due shortly to sign contracts for two large planned care centres at Stobhill Hospital and the Victoria Infirmary which will result in a huge programme of service and workforce modernisation being taken forward to maximise the benefits for patients of the £200M capital investment.

5.4 Waiting Times

5.4.1 New Ways of Monitoring and Reporting

The Board has recognized that given the range and scope of the new targets, that new ways of monitoring and reporting are needed.

From the final quarter of 2005/06, we revised our reporting for inpatients and day cases from waits over 26 weeks to waits over 18 weeks. The reporting of ASCs did not change. This is set out in tables 1a and 2a. Similarly, for outpatients, we revised our reporting from waits over 26 weeks to waits over 18 weeks. This is set out in table 3a.

Although we will not formally report on sustaining the 26 week guarantee, our existing monitoring arrangements will closely scrutinise performance in this area.

We have also now changed the contents of tables 1a to 3a to reflect the:

- new single system way of working;
- integration of Clyde.

We are still defining how we will report on the other new targets and also how this will be reported on in the new single system way of working.

This paper therefore represents the new reporting format of waiting times for the new NHS Greater Glasgow and Clyde Board.

5.4.2 Current Waiting Time for Patients and Day Cases

The number of patients waiting over 18 weeks at 31 May 2006 is presented in table 1a for patients waiting without availability status codes (ASCs). Table 2a presents the numbers of patients with ASCs, eg, where a patient has asked to defer admission.

Table 1a - Current IP/DC waiting >18 weeks - All NHS Board residents without ASCs

Acute Directorate	Apr 2006	May 2006	Apr-May Variance	% Variance
Emergency Care and Medical	156	67	-89	-57%
Oral Health	14	16	+2	+14%
Regional Services	69	56	-13	-19%
Surgery and Anaesthetics	738	524	-214	-29%
Women and Children's Services	144	129	-15	-10%
Sub-total	1121	792	-329	-29%
Clyde Acute Services	353	231	-122	-35%
Total	1474	1023	-451	-31%

The number of inpatients and day cases waiting over 18 weeks reduced by 451 or 31%, between April and May.

Quarter 1 Performance Review

As an update to Table 1a, we now have the high-level performance position at June 30 against our LDP trajectory (planned milestone). This is set out in Table 1b.

Table 1b - IP/DC waiting >18 weeks - All NHS Board residents without ASCs Performance against LDP June 2006 Trajectory (Planned Milestone)

Area	Actual	Plan	Variance from Plan	% Variance
GG	696	845	-149	-18%
A&C	243	368	-125	-34%
Total	939	1,213	-274	-23%

The number of inpatients and day cases waiting over 18 weeks is 274 or 23% better than the planned position at the end of June 2006. The next joint planning milestone for NHSGGC in September is 823.

5.4.3 Availability Status Codes (ASCs)

As at 31st May 2006 there were 11,921 patients waiting with ASCs across Greater Glasgow and Clyde. Of these, 88% were patient driven ASCs and 12% service driven ASCs.

Table 2a - Current total IP/DC waiting - All NHS Board residents with ASCs

Acute Directorate	Apr 2006	May 2006	Apr-May Variance	% Variance
Emergency Care and Medical	993	1021	+28	+3%
Oral Health	237	249	+12	+5%
Regional Services	1357	1282	-75	-6%
Surgery and Anaesthetics	6392	6427	+35	+1%
Women and Children's Services	994	922	-72	-7%
Sub-total	9973	9901	-72	-1%
Clyde Acute Services	2264	2020	-244	-11%
Total	12237	11921	-316	-3%

The total number of inpatients and day cases waiting with ASC codes decreased by 316 or 3% between April and May 2006.

Local Delivery Plan (LDP) - ASCs

When our plan was submitted to the SEHD it was highlighted that it was presented on an interim basis (see section 5.4.6). The ASC plan is currently being updated.

5.4.4 Current Waiting Times for New Outpatients

Table 3a - Current outpatients waiting >18 weeks - All NHS Board residents - All Referrals

Acute Directorate	Apr-06	May-06	Apr - May Variance	% Variance
Emergency Care and Medical	659	544	115	-17%
Oral Health	5	0	-5	na
Regional Services	259	173	-86	-33%
Surgery and Anaesthetics	1361	1036	-325	-24%
Women and Children's Services	249	167	-82	-33%
Rehabilitation and Assessment	5	3	-2	-40%
Diagnostics	19	11	-8	-42%
Sub-total	2557	1934	-623	-24%
Clyde Acute Services	578	473	-105	-18%
Total	3135	2407	-728	-23%

The number of outpatients waiting over 18 weeks reduced by 728 or 23%, between April and May.

Quarter 1 Performance Review

As an update to Table 3a, we now have the high-level performance position at June 30 against our LDP trajectory (planned milestone). This is set out in table 3b.

Table 3b - OP2 waiting >18 weeks - All NHS Board residents without ASCs Performance against LDP June 2006 Trajectory (Planned Milestone)

Area	Actual	Plan	Variance from Plan	% Variance
GG	2,355	3,099	-744	-24%
A&C	430	608	-178	-29%
Total	2,785	3,707	-922	-25%

The number of outpatients waiting over 18 weeks is 922 or 25% better than the planned position at the end of June 2006. The next joint planning milestone for NHSGGC in September is 3,585.

5.4.5 2005/06 Achievements

Our plans for 2005-06 were:

- to achieve and sustain delivery of all national standards (guarantees) - this was delivered;
- to deliver a maximum of 1,000 inpatient/day cases (non-ASC) waiting longer than 18 weeks by 31 March 2006 - we delivered a position of 795

patients waiting over 18 weeks at the end of March which is 205 or 21% better than the planned position.

5.4.6 2006/07 Waiting Time Plans and Local Delivery Plans (LDP)

We submitted our plans for delivery of all of the other new waiting time targets via the Local Delivery Plan submission to the SEHD.

We have highlighted in our submission that the plans for some of the targets are presented on an interim basis (see ASC reference at 5.4.3) and are currently subject to review.

For 2006-07 separate plans have been submitted for NHS Greater Glasgow and NHS Argyll and Clyde as previously constituted and as requested by the Scottish Executive.

A unified NHS Greater Glasgow and Clyde Local Delivery Plan will be produced and operate from 2007/08.

5.4.7 Weekly Reporting of Waiting Times

At a recent meeting with the SEHD it was intimated that the Minister is about to ask when Boards will be ready to move to weekly reporting on acute waiting times. The Scottish Executive's National Waiting Times Unit (NWTU) currently ask Boards to produce weekly waiting times for inpatients/day cases waiting over 18 weeks. We have not formally agreed to this process and there has not been any specific feedback on our non-compliance. It is considered that there is no added value in producing weekly waiting times reports for inpatients/day cases waiting over 18 weeks, for a number of reasons:

- weekly reporting places an additional administrative burden on the service to produce data that is not actually robust;
- if we know e.g. that we need to achieve zero patients waiting >18 weeks by December 2006 - then all the planning processes are based on monthly trajectories which are more than adequate for monitoring purposes;
- from experience, we know that weekly monitoring varies significantly *in month* because at the end of each month all the data is "cleaned" to ensure accuracy. Also, we are aware that the patients who are referred to the GJNH are counted more accurately on a monthly basis;
- cancelled clinics/theatre sessions and consultants' annual leave would all impact on this - monthly reporting evens this out.

For the last two years, in the run up to achieving national target waiting time target deadlines, we have reported on a weekly basis - but for a limited period only (10 to 12 weeks in duration) - and the commentary that is provided above applies equally to this 10 to 12 week period.

For outpatients, the problems are compounded - and the administrative burden is considered substantial on the service - particularly given that we do not have a bespoke national recording and monitoring system for outpatients.

5.4.8 Cancer Waiting Times

June 2006

Tumour Type	No of Patients Treated within the Current Month (1)	No of Patients Treated within the Target within the Current Month (2)	% Compliance with target for Patients treated within the Current Month (3)
Breast	21	21	100%
Ovarian	5	5	100%
Lung	36	36	66.7%
Colorectal	16	12	75%
Head and Neck	18	13	72%
Skin	4	4	100%
Leukaemia	2	2	100%
Lymphoma	3	3	100%

- (1) *This is the total number of patients with a cancer diagnosis who were urgently referred and received their first treatment within the current month.*
- (2) *This is the number of patients with a cancer diagnosis who were urgently referred and received their first treatment within the current month and that treatment was within the 62 day target (from urgent referral to treatment).*
- (3) *This is the percentage based on the information in columns (1) and (2).*

The persistent variance in performance on cancer waiting times is colorectal cancer. While there have been improvements it continues to fall short of the national target. To address this the Board is currently implementing a colorectal cancer action plan, the main elements of which are:

- increase % use of electronic referrals and use of specific colorectal referral form to reduce time from date of referral to initial appointment;
- direct booking for colonoscopy for lower risk patients who require colonoscopy following outpatient review;
- reduce DNA rate for colonoscopy by contacting patients in advance;
- establish single waiting list for diagnostic colonoscopy;
- colonoscopy capacity being increased to allow faster access;
- utilisation of trackers.

6. RESOURCE: FINANCE AND WORKFORCE

6.1 Workforce Modernisation

6.1.1 Organisational Development

NHSGGC is the largest NHS Board in Scotland employing over 40,000 staff and the largest public sector employer in Scotland. The general health of the people of the West of Scotland is the poorest in Scotland and therefore the workforce of NHSGGC, while delivering services to patients, has to concentrate on tackling health inequalities and health improvement. Therefore, the strategy to modernise the workforce is set against this context, ensuring that we have highly specialised staff delivering specialised services, but equally we have a range of health professional and care staff who can provide support to individuals in their own homes and in their communities.

In 2006/07, we embarked on an ambitious programme of organisational development to transform the organisation and its workforce based on the following nine transformational themes:

- achieving an organisation in which the component parts work together to shared aspirations and objectives, not competing ones, and managers and clinical leaders work in teams with shared values and priorities;
- the whole top team and organisation contribute to leadership on health improvement and tackling inequalities;
- focusing on service improvement and equipping and supporting frontline staff and first line managers to help us deliver it;
- moving away from functional systems of management to general management with managers at all levels responsible for the quality of service delivered to patients and professional staff developed into management and leadership roles;
- an organisation where people take responsibility for their area of work and for the wider performance of the organisation;
- an organisation focused on learning and development, as individuals and collectively, to improve our performance;
- a culture of clear objectives, accountability and performance management at all levels;
- driving integration of acute and community and health and social care services to improve the experience of patients;
- leaders and managers who have a value base of public services, acting in the interests of patients and the communities we service and behave in a collaborative not competitive way but constructively challenge each other.

These themes have been the foundation of our move to create a single system across NHSGGC based on eight Acute Directorates, the five CHCPs established with Glasgow City Council, the integrated CHCP with East

Renfrewshire Council, and the Community Health Partnerships established in West Dunbartonshire, East Dunbartonshire and Renfrewshire and soon to be established in Inverclyde. Our mental health services are now provided in an integrated partnership, as are learning disability, homelessness and addictions services.

In 2006/07 we appointed around 400 staff to the key posts in the new structure on the basis of a competency profile, using an assessment centre, the output of which is now driving our performance management and personal and team development process to ensure that the transformational themes are leading to service improvements in a consistent and coherent way across NHSGGC.

6.1.2 Pay Modernisation

NHSGGC is steadily working through the implementation of Agenda for Change. The dedicated project teams are working with over 150 job matchers to process around 10,000 job descriptions, which are now resulting in the assimilation of staff on to the new pay arrangements. By the end of July, around 15,000 staff will have been assimilated to Agenda for Change across NHSGGC and the project plan is in place to assimilate the remainder of staff in posts where there are job descriptions and national profiles. This process is then followed by the creation of knowledge and skills profiles, which will further underpin the development of our staff to ensure they have the appropriate competencies for the roles they undertake. These will be reviewed regularly to ensure that they are fit for purpose in relation to new or amended roles which staff is required to undertake as services change. The impact of the Acute Services Strategy implementation with the development of the new hospitals in the city will require further redesign of the workforce, which Agenda for Change will support through job evaluation and the knowledge and skills framework.

The Consultant Contract has been implemented throughout the organisation and the second round of job planning is underway to ensure that Consultant medical staff is appropriately deployed in each setting. Together with the GMS contract, the impact of Agenda for Change, and the Consultant Contract are reflected in the Pay Modernisation Benefits Realisation Plan submitted to the Scottish Executive in March 2006.

6.1.3 Workforce Planning

The Board Workforce Plan sets out the number of staff which we will require in the future, but more importantly, sets out the direction of the way in which the workforce will be structured in the future. It recognises that we will require more skilled and specialised staff but that these will increasingly be supported by more skilled and better qualified support staff.

To underpin this, we have in place a care worker development process, which, in line with the career framework being consulted upon within NHS Scotland, aims to enhance the capability and capacity of care workers who will not have come through a professional education route. This is supported by the Strategic Alliance with higher and further education established within NHS GGC, which ensures that we harness the capacity of the education sector in order to deliver the workforce, which we require. This ensures we have the infrastructure both within the organisation and outwith the organisation to deliver the qualification framework necessary to ensure we have appropriately skilled and qualified staff at all levels.

As part of our activity to improve health and reduce inequalities working in partnership with other agencies in the city, the Working for Health in Greater Glasgow programme supports those who might not normally access health employment to have supported training in order to join our workforce. In 2006/07, this is being extended to Clyde. This programme is part of our ongoing activity in relation to Welfare to Work, is aligned to our work with Glasgow City Council on the Equal Access Strategy and with Jobcentre Plus where we provide the Condition Management Programme to support the Pathways to Work initiative.

6.1.4 Staff Governance

The Board's Staff Governance Committee oversees the implementation of the Staff Governance Standard and on an annual basis produces a Staff Governance Action Plan, which is then implemented and monitored throughout the year. The key themes of the Staff Governance Action Plan are:

- That staff are well informed. The communications strategy in place has been enhanced in 2005/06 through the re-launch of the Staff News and the introduction of regular briefings – Core Brief which covers the Board's main strategies and related activities, the Partnership Brief which covers the activities of the Area Partnership Forum and associated structures, and with the integration of Clyde, the Transition Brief which kept staff informed of progress on issues leading to the creation of the new organisation on 1 April 2006.
- That staff are appropriately trained. In 2005, the former NHS Argyll and Clyde published its Learning Strategy which set out its activity around statutory and mandatory training, support for change and service modernisation, generic training, focussed or discipline specific training, and generally supporting and developing staff and services. The strategy will be updated to reflect the Greater Glasgow component which will form the basis of our learning and development activity across NHS Greater Glasgow and Clyde;

- *That staff are involved in decisions that affect them.* During 2005/06, the Area Partnership Forum was reconstituted to reflect the new single system and its business better co-ordinated to ensure a focus on both the change issues affecting the service generally and also the HR consequences of these changes, ensuring that appropriate debate, discussion and involvement takes place. The partnership structures within the Acute Directorates and the CHCPs/CHPs are now being put in place. The Chair of the Staff Partnership Forum within the CH(C)Ps is a member of the CH(C)P Committee. The results of the national staff survey are being reviewed and will lead to an update of the Staff Governance Action plan, ensuring that the feedback we have received from staff will influence and direct the future HR policies which we will take forward across the organisation.
- *That staff are treated fairly and consistently.* Early in 2005, the Managing Workforce Change Policy was agreed in partnership with the trade unions and this will underpin the service change, which will occur. This is based on the principles of the national Organisational Change Policy and was the first policy to be harmonised in the new single system. With the integration of NHS Argyll and Clyde, a programme to review and harmonise all HR policies across the organisation has begun and will be completed by Christmas 2006.
- *Provided with an improved and safe working environment.* In 2005, we launched the zero tolerance to violence and aggression campaign and are now seeking to rationalise our Occupational Health and Health and Safety resources across the organisation to ensure that we have a consistent and systematic approach to the health and safety of our workforce.

6.1.5 Productivity

The Board's line managers are respectively responsible for implementing our strategies to improve attendance at work and consultant productivity. In relation to attendance management, the current rate of absence within NHSGGC is 5.8%, our aim is to reduce this to 4.7% by March 2007 and to the national target of 4% by March 2008. This involves a revised policy and procedure to deal with absenteeism and a standard approach by line managers across the organisation, effective monitoring and reporting of absence to ensure that at a corporate level and line management level, there is accurate data to allow line managers to effectively monitor the progress towards the target.

6.1.6 Workforce Performance Indicators

Work has now begun with our internal auditors to establish a set of workforce performance indicators, which will inform the way in which we develop and take forward our Workforce Strategy in the future. These indicators will be

regularly reported to the Staff Governance Committee, the Area Partnership Forum and throughout the organisation to demonstrate that the impact of our approach to workforce modernisation is having an impact on the effect and efficient delivery of these services.

6.2 Financial Performance

6.2.1 Financial Performance – Outturn 2005/06

The Board has managed within its Revenue Resource Limit (RRL) for 2005/06 of £1,370.3M, generating a surplus of £12.3M. This was equivalent to 0.9% of RRL.

The reported surplus is wholly attributable to the timing of expenditure plans relative to funding allocations, and had been anticipated in finalising the Board's financial plan for 2006/07. "Surplus" funds carried forward are fully committed within the 2006/07 financial plan.

For example, £4.7M of funding for the achievement of waiting times targets was made available to the Board late on in 2005/06. This has been carried forward into 2006/07 and has already been deployed in full.

The residue of £7.6M relates to capital receipts (£3.5M), together with a number of ring-fenced funding commitments (£4.1M). Expenditure of these funds is already underway in the first quarter of 2006/07.

The Board managed within its Capital Resource Limit (CRL) of £69.4M in 2005/06. The Board's CRL was revised to £69.4M in December 2005 when £4M of capital funding was deferred into 2006/07, with agreement of SEHD. The Board has managed capital expenditure in line with its revised CRL as agreed at December 2005. Expenditure on the Beatson project, which is managed outwith the Board's general CRL, was also in line with available funds at March 2006.

6.2.2 Financial Performance – Financial Plan 2006/07

The Board is forecasting financial breakeven in 2006/07, with recurring expenditure commitments matched by recurring funding, and non-recurring expenditure and funding also in balance.

The financial plan for 2006/07 provides for the estimated net additional costs associated with accelerating the achievement of an 18 week waiting time target for inpatients and day cases to December 2006. It also provides for the estimated costs of pay inflation, including the implementation of Agenda for Change and MMC and other cost pressures. Specific provision is made for increased expenditure on energy in the light of recent significant price

increases experienced in 2005/06. In addition, provision is made for the anticipated growth in prescribing costs, based on detailed projections made by the Board's prescribing advisors within both acute and primary care services. Provision is made for the impact of the facility to vire capital funds to revenue being withdrawn with effect from 2006/07. The Board had historically used this facility to finance expenditure of a one off nature, on building repairs and minor equipment. As accounting rules do not permit such expenditure to be capitalised, the Board had no alternative but to set aside £7.5M of revenue funding to cover this expenditure in 2006/07, thereby restricting its scope to use this funding for service development within its Local Health Plan.

Specific risks identified within the financial plan in terms of potential for generating cost pressures in 2006/07 include prescribing cost growth exceeding projected rate(s), energy prices increasing beyond forecast levels due to market forces, and the requirement to set aside additional funds to support the achievement of waiting times targets, particularly for cancer treatment.

6.2.3. Efficiency

The Board's efficiency savings target for 2005/06, under the "efficient government initiative" was £12.468M. This was achieved in full, with recurrent savings of £12.4M secured in year. Savings were achieved from a wide range of initiatives embracing primary care prescribing, (prescribing practice and procurement), acute hospital prescribing (prescribing practice and procurement), service reengineering (including ward reconfigurations within the acute hospital sector), reviewing the use of junior doctors, general procurement, estates utilisation and maintenance, introduction of shared financial services, introduction of shared catering arrangements and other schemes.

6.3 Productivity

6.3.1 The Board has established a Consultant Productivity Working Group, comprising the directors of clinical services and members of the Board's performance team (chaired by the Board Medical Director). This group is tackling the issue of productivity in the following ways:

- examining NHSGGC's performance in detail to identify areas where specific action is required to tackle low or static productivity;
- working to improve parameters such as theatre occupancy and cancellation rates linking this to a review of the implementation of absence and leave policies;
- service redesign and implement in areas where this will increase productivity, but also review existing redesign to ensure that activity

performed by the upskilling of nursing and AHP staff previously performed by consultant staff is now being identified;

- benchmarking our activity in specific specialties and sub-specialties with those elsewhere in the NHS. Once identified, significant differences will be analysed and action taken if appropriate.

6.3.2 Progress on the productivity target will be monitored at regular Performance Review meetings within the Acute Division.

6.4 Maintaining Services with Modernising Medical Careers (MMC) Implementation

6.4.1 The implementation of Foundation Year (FY) 1 in August last year has proceeded without incident.

6.4.2 Three years ago, NHSGG established a working group linking the Deanery, management and clinicians to examine each stage of the implementation of MMC and to ensure that both its organisation and resourcing proceeded smoothly. The group has considered two main issues around FY2:

- the organisation of programmes and the identification of training slots. This process completed some time ago;
- the identification of potential service losses resulting from the implementation of FY2 and formulating plans to meet these.

6.4.3 Working with the Deanery guidance was developed which gave Directors and Associate Medical Directors the ability to assess as accurately as possible the potential service loss. Directorates then formulated plans to fill these gaps and these plans have been assessed and an investment programme totalling £2.3m has been approved by the Board.

6.4.4 The plans include a mixture of service redesign, transferring work previously done by SHOs to AHPs, for example optometrists in ophthalmology clinics, and to nursing staff in general surgery and to AHPs and nursing staff in orthopaedic clinics.

6.4.5 The other element of the plan is to utilise some of the extra SHO posts offered by NES to fill gaps, which can only be filled by medical staff, but to have clear plans to substitute these posts in the next four to six years. Supplementary posts were developed in Accident & Emergency (these posts will disappear when the new minor injury units are open in the Ambulatory Hospitals in 2009) and in general medicine and maternity.

6.4.6 We are now working on plans to meet the challenge of run-through implementation, which occurs in August 2007, and Associate Medical Directors are involved in some of the Specialty Transition Boards, which are

working across Scotland to devise implementation plans for a number of key specialties.

7. CLYDE

7.1 Integration

7.1.1 The integration with Clyde presented us with an unexpected and significant management challenge in 2005/06. The project management arrangements we established in partnership with NHS Highland and NHS Argyll and Clyde ensured that the massive programme of work to deliver the smooth transition of staff and functions was effective. The NHS Greater Glasgow top team put in significant effort to establish relationships with key parties and to ensure a visible and credible presence in key public events. All of this enabled us to take on our new responsibilities with momentum established in a number of critical areas including relationships with political interests, clinical engagement in the Acute Strategy Review, the establishment of CH(C)Ps and dealing with immediate planning and service challenges in relation to the capital programme, integrated care pilot and paediatrics at Inverclyde.

7.2 Acute Services

7.2.1 In April 2006, NHSGGC agreed to undertake a review of the clinical strategy across Clyde in the wider organisational context of Greater Glasgow and Clyde and the opportunities the bigger organisation brings, particularly in relation to medical workforce deployment and the potential for solutions to sustainable services in future.

7.2.2 This indepth work started initially at the Inverclyde Royal Hospital. Work to progress the integrated model of care pilot at the Vale of Leven is ongoing through a series of meetings with clinical staff to fully understand all aspects of the pilot.

7.2.3 Detailed work in relation to the Royal Alexandra Hospital in Paisley is commencing in August 2006. The aim is to have agreed a clinical strategy for Clyde by the end of the calendar year.

7.2.4 From an operational perspective, the Clyde Acute Directorate was established in April 2006 and a Director of Clyde Acute post created, as part of the Acute Operating Division for Greater Glasgow and Clyde.

7.2.5 An underlying challenge and key priority from both a strategic and operational perspective is to secure a safe, sustainable model of acute care within the overall context of affordability.

7.3 Community Health Partnerships

7.3.1 Community Health Partnerships (CHPs) are being established in Renfrewshire and Inverclyde. The Renfrewshire Scheme of Establishment has now been approved and the Scheme of Establishment for Inverclyde will be submitted in September.

7.3.2 A CHP for West Dunbartonshire (including Dumbarton and Vale of Leven) and a CHCP for East Renfrewshire (including Barrhead) had already been established following collaboration with the former NHS Argyll and Clyde.

7.4 Mental Health Services

7.4.1 The Board took over formal responsibility for these services from April 06.

7.4.2 The Clyde strategy process has placed its major emphasis on the development of comprehensive community services by shifting the balance of investment between inpatient and community services from the current c80:20 to nearer 50:50. The development process is still work in progress but has started to set out the requirements for sustainable substantially rebalanced services towards far higher levels of care in community settings and reduced reliance on inpatient care as “default care option”.

7.4.3 In terms of learning disability the planned closure of Merchiston Hospital by July 2007 is on schedule and financial reinvestment plans are to be reviewed.

7.5 Finance

7.5.1 We were able to effectively review the particularly critical issue of financial planning and establish with the SEHD an effective way to deal with the challenge of an underlying resource position.

7.5.2 Financial Performance 2005/06

The Board managed within its Revenue Resource Limit (RRL) for 2005/06. This was set at £616.1M and included £82.3M to clear a cumulative deficit of £81.7M at 31st March 2006.

The Board posted an in year operating deficit of £22.2M, a slight improvement on its target deficit of £23.0M. The recurrent deficit underlying this was £28.4M. This rolls forward into 2006/07 and represents the financial

challenge, which NHSGGC is expected to address through the development of a cost savings plan during the course of the 2006 calendar year.

The Board managed within its Capital Resource Limit (CRL) for 2005/06. Actual expenditure was £10.3M compared to a CRL of £11.5M. The CRL for 2005/06 had already been reduced with SEHD agreement to allow £8.5M of capital funding to be carried forward for deployment in 2006/07.

7.5.3 Financial Plan 2006/07

The Board is forecasting an operating deficit of £19.6M in 2006/07. The underlying recurring deficit of £28.4M is mitigated in part by a forecast £8.8M of non-recurring funds, arising principally from capital receipts. SEHD have already made arrangements to cover a significant proportion of this, leaving a residual balance of £4.9M - £7.4M to be covered by further SEHD funding support and/or early cost savings opportunities which are identified by local management during 2006/07. Progress towards covering this residual balance will be subject to a process of joint monitoring involving SEHD and the Board, during the remainder of 2006/07.

The financial plan has been constructed on an equivalent basis to the financial plan for Greater Glasgow, and incorporates provision for the costs of pays and other inflationary cost pressures, on the same basis as the Greater Glasgow financial plan.

Specific risks identified in terms of potential for generating additional cost pressures in 2006/07 are the same as for Greater Glasgow, and include prescribing cost growth, rising energy prices, and the adequacy of funding provisions set aside for the achievement of waiting times targets.

7.5.4 Efficiency

In arriving at an operating deficit of £22.2M in 2005/06, the Board achieved £14.4M of savings of which £9.3M were on a recurring basis. This level of savings was closely in line with expectations.

7.5.5 Cost Savings Plan

The development of a comprehensive savings plan to address the recurring deficit of £28.4M which exists between funding and current expenditure budgets on an ongoing basis, will be a key task for NHSGGC management during 2006. It is anticipated that during the remainder of 2006, a comprehensive in depth review of all service areas will be carried out, particularly looking at opportunities for achieving synergies through integrating service provision across the expanded geographical area. This process is now underway with a view to finalising a plan to be agreed with SEHD by end December 2006.

All enquiries regarding this document should be made to:

David Walker
Head of Performance & Corporate Reporting
Corporate Planning & Policy
Greater Glasgow & Clyde Health Board
350 St Vincent Street
GLASGOW
G3 8YZ

Tel: 0141 201 4522
Fax: 0141 201 4700
Email: david.walker@ggc.scot.nhs.uk