



ANNUAL REVIEW 2008

CHAIRMAN'S SELF ASSESSMENT

18TH AUGUST 2008

**NHS GREATER GLASGOW AND CLYDE
ANNUAL REVIEW 2008**

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1. INTRODUCTION

Statement from Chairman

Our purpose, as Greater Glasgow and Clyde NHS, is to deliver effective and high quality services to act to improve the health of our population and to do everything we can to reduce inequalities.

Throughout 2007/08 we have seen good progress on many fronts, including on improving health, patient care and on reducing the impact of inequalities on health in our society.

On health improvement, we have further expanded our smoking cessation services, with 13,700 people committing to quit in 2007. Alcohol remains a key priority, and a growing challenge, for NHSGGC and our work as an employer, as a service provider and as a partner are all crucial elements of our strategy. The joint alcohol policies that we have established with a number of Local Authorities indicate the shared commitment between ourselves and partner organisations to make an impact on alcohol misuse. Tackling obesity has also been a major theme for 2007 and continues to be this year. A range of initiatives are underway, from opportunistic referral to exercise programmes to services targeted at specific groups, such as the therapeutic exercise programmes for older adults living with long-term conditions.

On patient care and treatment, we are delighted to have made significant progress this year, achieving the 18 week maximum wait target by December 2007 for all new outpatients, inpatients and daycases and ensuring that 98% of patients attending A&E are seen, treated, discharge or referred within 4 hours. This has been an excellent achievement.

We have also been participating fully in the Scottish Patient Safety Programme and see this as a real opportunity to bring about improvements in patient safety.

Understanding patients' needs and empowering them to affect change at the heart of NHS treatment, planning and delivery is a guiding principle of the Scottish Government's "Better Together" patient experience programme. We are keen to engage in this work and have already started to develop plans in cancer care, mental health and surgery. We look forward to the benefits of this work in 2008.

Reducing the inequalities within our population remains a key priority and improving access to training and employment opportunities has been a major shared objective through our Community Planning Partnerships over the past year. The ten goals to an inequalities health service have helped to set out the progress already made, and the work still required in how we engage with patients, how we develop our workforce and our wider role in society.

It has been an extremely busy year and much has been achieved. I would like to take this opportunity so say thank you to all of the Board's staff for their continued dedication and commitment.

Andrew Robertson OBE LLB
Chairman, NHS Greater Glasgow and Clyde

2. PROGRESS ON MAIN ACTIONS FROM 2007 ANNUAL REVIEW

Action	Lead	Timescale	Progress
<p>1. The Board should keep the Health Directorates informed of emerging evidence of improvements in reducing health inequalities.</p>	<p>Director of Public Health</p>	<p>Ongoing</p>	<p>NHSGGC has been keeping the Health Directorate informed of progress on work on inequalities, in relation to anticipatory care and inequalities sensitive practice through existing groups such as the Keep Well Project Board, the Keep Well Advisory Group, the Have A Heart Paisley Steering Group and the Have a Heart Paisley evaluation advisory group.</p> <p>We also feed in emerging evidence through the regular meetings between the Scottish Government and NHS Chief Executives and through Tom Divers and Carol Tannahill (Glasgow Centre for Population Health) we contributed to the work of the Ministerial Task Force on Inequalities in Health, and have shared our work on 10 Goals for an Inequalities Sensitive Health Service. The Board is also represented on the Early Years Framework Programme Board and task groups bringing local experience into the discussions. We make efforts to include local experience in our responses to national consultation documents to provide context and evidence to points raised.</p> <p>Board Officers are involved in specialist groups, eg, around the ASSIGN score and contribute our experience of primary and secondary prevention at local level. We have also shared our expertise in addressing inequalities through contributions to joint meetings organised by the CMO.</p>
<p>2. Keep the Health Directorates informed of progress in developing your primary care strategy.</p>	<p>Director of Corporate Planning</p>	<p>Ongoing</p>	<p>Work continues internally to review the future strategic direction of primary care and linking where possible to other health strategies such as Rehabilitation, Health Visiting and Long Term Conditions. We have been working closely with SGHD on addressing inequalities through primary care and have undertaken a joint workshop in June with two of our CH(C)Ps.</p> <p>In addition we included key issues relating to primary care in our response on Better Health Better Care. We recognise the need for an overall strategy for primary care development</p>

Action	Lead	Timescale	Progress
			<p>which brings together common themes and makes best use of all the levers and drivers for change at our disposal. Specifically during 2007/8 we have:</p> <ul style="list-style-type: none"> • developed CH(C)P profiles which give a comprehensive assessment of population needs and health; • published a report on the Shape of Primary care in NHSGGC which sets out current services and activity in primary care, setting us a series of challenges and informing future planning; • reviewed the resource allocation to CH(C)Ps and begun to implement changes to our children's services and older people's budgets to more explicitly reflect need, for example deprivation; • continued to use the flexibilities of the contracts for pharmacists, opticians and dentists to improve access and choice for patients, particularly in deprived areas. <p>We will continue this work in 2008/9 with a view to having an updated NHSGGC wide primary care strategy in early 2009.</p>
<p>3. Continue to work with your planning partners to take forward appropriate action to tackle alcohol misuse and to build on smoking cessation activities.</p>	<p>Director of Corporate Planning/Director of Public Health</p>	<p>Ongoing</p>	<p>We have established an implementation group for our Joint Alcohol Policy with Glasgow City and Strathclyde Police and have joint policies in other local authority areas including Renfrewshire and East Renfrewshire</p> <p>We are planning a summit on alcohol with our four Local Authorities with the highest death rates from alcohol related harm, Glasgow City, Inverclyde, West Dunbartonshire and Renfrewshire, to ensure political leadership for actions within the policies. Alcohol has been agreed as a priority for community planning and within the Single Outcome Agreement with Glasgow City. Building on the recent Director of Public Health's report, joint meetings with the Glasgow Centre for Population Health (GCPH) have been held in each Community Health (and Care) Partnership area with local community planning partnerships and also at some full Council meetings with a major focus on reducing alcohol related harm.</p>

Action	Lead	Timescale	Progress
			<p>Through the Alcohol Action Team, we are finalising planning on training and implementation of brief interventions to make best use of new funding.</p> <p>We had a productive meeting with the Glasgow City Licensing Committee and agreed joint actions including further work on a local definition of overprovision. Other local authority areas have expressed interest in this work.</p> <p>We are finalising a revised tobacco strategy and action plan with each of our Local Authorities and using learning from Keep Well and from the evaluation of smoking cessation services being carried out through GCPH to further develop and improve targeting of smoking cessation services. Initial results from the evaluation shows that we have successfully taken on board recommendations from the previous evaluation and are delivering cost-effective services engaging the most disadvantaged groups. We have recently rebranded all of our work on tobacco control to give a consistent message throughout Greater Glasgow and Clyde and make it as easy as possible for people to access support to stop smoking.</p>
4. Continue to meet financial targets in 2007-08.	Director of Finance	Ongoing	Achieved
5. Maintain close contact with the Health Finance and Delivery Directorates as the Board develops its OBC for the South Glasgow Hospital and the new Children's Hospital for submission early next year and as it takes forward its wider planning process to modernise Glasgow's hospitals.	Director of Acute Planning	Ongoing	We have continued to work very closely with the Scottish Government and we have developed a successful OBC in partnership.

Action	Lead	Timescale	Progress
6. Continue to work towards achieving financial balance in Clyde by March 2010 and keep the Health Finance Directorate informed of your progress.	Director of Finance	Ongoing	We continue to liaise with SGHD colleagues as part of our ongoing financial planning processes.
7. Completion staff projections for all staff as soon as possible in order to meet the requirements of HDL (2005) 52 and the National Workforce Plan 2006.	Director of Human Resources		The projections were completed following the review, with the exception of medical workforce projections, which were subject to finalising the number of posts associated with the implementation of MMC. This information has been passed to the Scottish Government Health Directorate Workforce Department.
8. You undertook to reassess timescales for the <i>Agenda for Change</i> review process as a matter of urgency.	Director of Human Resources		The implementation of Agenda for Change is nearing completion with over 33,000 staff having been assimilated and fewer than 2,500 staff remaining to be assimilated. This involves considerable work in Payroll given that the staff remaining to be assimilated have had a number of posts or changes to their circumstances since October 2004. Additional capacity has been established in payroll to deal with this, and the task should be completed in September 2008.
9. Keep the Health Directorates informed of your progress in implementing the Knowledge and Skills Framework.	Director of Human Resources	Ongoing	The implementation of the Knowledge and Skills Framework (KSF) continues and by the end of March 2008 30% of staff had KSF based personal development plans, on route to achieving the target of 100% by March 2009.
10. Continue to work towards compliance with national targets for sickness absence	Chief Operating Officer - Acute, Directors of CH(C)Ps and MHP	Ongoing	<p>The SWISS sickness absence rate at 31st May 2008 was 4.97%. Absence reduction continues as part of all Directors and senior managers objectives. Within Directorates and CH(C)Ps, action plans are in place. A harmonised Attendance Management Policy is now agreed. We are also looking at more innovative ways of controlling sickness absence as part of a senior managers workshop, which was held this month.</p> <p>A review of the effectiveness of the Occupational Health Service is underway. An audit of attendance management within the Acute Division is being undertaken by our internal auditors, PWC.</p>

Action	Lead	Timescale	Progress
11. Continue progress to enable achievement of all national waiting times targets for 2007, paying specific attention to risk areas such as outpatient, A&E and cardiac treatment waits.	Chief Operating Officer - Acute	By December 2007	<p>The 18 week targets for new outpatients and inpatients/daycases were achieved by December 2007 in all specialties</p> <p>The 98% A&E target was achieved in NHS Greater Glasgow and Clyde in December 2007 and this level of performance has been sustained in each of the subsequent months.</p>
12. Continue to improve performance towards securing 62-day target for cancer treatment by end of the year paying particular attention to risk areas such as urology, colorectal and upper GI.	Chief Operating Officer - Acute	By December 2007	<p>Since last year steady progress has been seen in performance in cancer services with the exception of quarter 4 of 2007. The first quarter of 2008 has seen this progress maintained and further work toward the target of 95% is underway.</p> <p>There have been improvements in performance in prostate, colorectal, lymphoma and melanoma.</p>
13. The Board must continue to work with local communities and its planning partners to reduce Delayed Discharges, emergency and multiple re-admissions to hospital and to shift the balance of care closer to patients' homes.	Chief Operating Officer - Acute, Directors of CH(C)Ps	Ongoing	<p>The Board and its partners successfully ensured that no patients were waiting for more than six weeks for discharge in April 2008, there had been 71 patients the previous April. This was a significant achievement and required close working with our partner Local Authorities.</p> <p>The Board has continued to plan with Local Authority partners for the continuing shift in the balance of care and for the improved management of frail older people at risk of admission to hospital. Much of this work is led by the CH(C)Ps and is based on the local needs of their population - all CH(C)Ps are working with the SPARRA data set including beta testing SPARRA II. CH(C)Ps are also discussing with ISD the possibility of being "demonstrator" projects of an enhanced data set to inform this work. Key strategic pieces of work that have also been undertaken that will contribute to this agenda are:</p> <ul style="list-style-type: none"> • launch of long term conditions framework • consultation regarding a new model of community rehabilitation for older people, older people with mental health problems and adults with a physical disability • review of the demand for frail elderly continuing care

Action	Lead	Timescale	Progress
14. Ensure robust arrangements are in place to comply NHS QIS Clinical Governance and Risk Management Standards.	Medical Director	Ongoing	<p>NHSGGC performance against the national standards for Clinical Governance and Risk Management (NHS QIS) were internally reviewed and, given our progress against standard one on risk management, deemed to be in line with the HEAT target.</p> <p>NHSGGC is also participating in the Scottish Patient Safety Programme, which commenced in October 2007. This led initially to the setting up of nine pilot locations in January 2008 that are taking forward implementation of reliable designs for safety critical clinical and communication processes.</p>
15. Continue to ensure effective public engagement and information strategies are in place as the Board moves forward with its hospital modernisation programme.	Director of Acute Planning	Ongoing	<p>A revised Patient Focus Public Involvement Framework which ensures that there is consistency and thoroughness in the planning and delivery of PFPI activity is in preparation. This accords priority status to actions linked to the hospital modernisation programme.</p> <p>The Acute Services Community Engagement Team has established arrangements for ongoing stakeholder input to the design and layout of the New Stobhill and Victoria Hospitals, the new children's hospital and the new South Glasgow Hospital. This input will continue through the design and build process.</p> <p>Communications staff have recently worked with local media to reveal the latest design images and scale of the new South Glasgow Hospital - this has attracted significant favourable public comment.</p>
16. Complete Public Partnership Forum arrangements as soon as possible.	Directors of CH(C)Ps	tbc	Achieved in all CH(C)Ps.

3. IMPROVING HEALTH AND REDUCING INEQUALITIES

3.1 Increasing Healthy Life Expectancy in Scotland.

3.1.1 Determinants of Poor Health

In line with Equally Well (2008), we continue to work with our Community Planning Partners to tackle the determinants of lower life expectancy, particularly in deprived communities. Programmes of work include employability, reducing and prevention of chronic diseases, reducing smoking and alcohol misuse and improving diet and levels of physical activity.

There is clear evidence that work is good for your health and that long-term unemployment is associated with higher mortality and poorer physical and mental health.

The NHS has been involved in local employability partnerships through local community planning activities and national initiatives including Workforce Plus. In Glasgow, a local partnership called Glasgow Works has been established through the Department of Work and Pensions (DWP) City Pathfinder Initiative. The Glasgow partnership has been able to make significant progress towards meeting the Pathfinder targets agreed with the DWP and recent data shows a reducing trend in numbers on Incapacity Benefit, Job Seekers Allowance and Income support for lone parents (see table below). NHSGGC has been an active member of the partnership and Glasgow is committed to joining up the health and social care pathway with employability activity.

3.1.2 Glasgow Works: Monitoring Targets

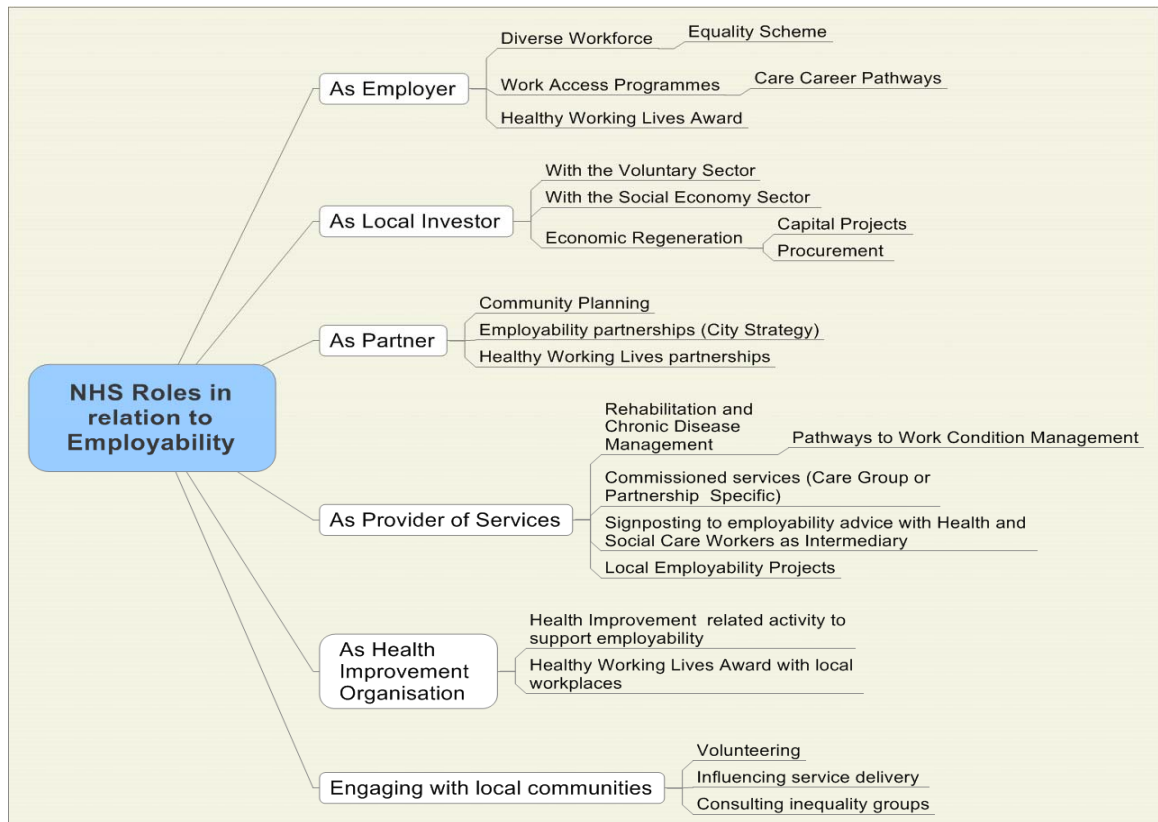
Headline Targets	Source	At start (May 06)	May 2007	August 2007	Nov 2007	Target (June 2009)
Numbers in receipt of Out of Work benefits	WPLS Quarterly May 2007	88,290	83,200	81,810	79,530	76,331
JSA		16,050	14,180	13,740	12,690	15,433
IB S and D		58,250	55,720	55,040	54,240	49,502
IS Lone Parents		13,990	13,300	13,030	12,600	11,396

Several joint initiatives have been implemented to contribute to joining up the health and social care pathway including:

- training with health and social care staff on employability and employment questions are now integrated into the shared assessment;
- the development of bridging services in each CH(C)P to support health and social care clients to find appropriate employment advice;
- work access programmes to support people with barriers to find employment with NHSGGC;
- work in acute services with stroke patients to create referral pathways to employability and financial inclusion advice;
- work in the Mental Health Partnership to develop locally delivered employability programmes;
- work on the Acute Services Review to maximise the beneficial impact on local communities of hospital redesign programmes;
- Keep Well programmes linked to employment advice.

A Work and Health Observatory has been established through the Glasgow Centre for Population Health to monitor the impact of our employability policies.

NHS roles in relation to employability:



3.1.3 Prevention of Chronic Diseases

Through our Locally Enhanced Service (LES), during 2007/08 93.8% of people with CHD registered with GP practices in the Greater Glasgow area were seen. We are working to improve the completeness of the data by negotiation with GPs on payment thresholds. Through Keep Well, the LES for secondary prevention of cardiovascular disease has been extended to Inverclyde and West Dunbartonshire (around 8,000 additional people with CHD). This LES includes literacy, money advice, services for housebound and assertive opportunistic primary prevention. A review of the IT screens for all LES was undertaken during 2007/08 to make them as user friendly as possible

A Wave 2 Keep Well pilot for primary prevention has been implemented in South West Glasgow CHCP. Keep Well Wave 1 pilots in the North and the East Glasgow CHCPs are fully operational and plans are being developed for sustainability of successful elements across NHSGGC.

The Heart MCN is reviewing all cardiology guidelines and introducing new LES for heart failure and hypertension.

The Heart Failure Liaison Nurse Service has been audited and has excellent patient satisfaction with 66% of patients feeling they had had better care than before (28% not known), 82% had a better understanding of disease (15% not known), 83% happy that the nurse service can change their medication (14% not known), 80% had no difficulty contacting service (14% not known) and 89% thought that they received good quality care from service (9% no response).

During 2007/08, the service saw 485 new patients and undertook 4,546 home visits and 2,759 clinic visits.

3.1.4 Diet and Exercise

Increasing the level of physical activity among our populations is a key strand in our approach to increasing life expectancy. The therapeutic exercise programme aims to increase activity in older adults and individuals living with long-term conditions, by enabling wider access to appropriate low-level group exercise classes. Developed by NHSGGC and Culture and Sport Glasgow, the programme is comprised of four levels of classes, ranging from strength and balance classes to low-level circuit classes. Patient pathways to the programme are initially being established within rehabilitation services, however the programme will be available opportunistically within communities later on in the year.

The pilot commenced in January 2008 and re-naming and branding of the programme is underway. The programme is being rolled out across all Culture and Sport Glasgow facilities with a formal Glasgow City launch planned for October. Initial discussions with all other Greater Glasgow and Clyde leisure providers have taken place and plans to roll-out the programme to the remaining areas are underway with full implementation across NHSGGC area expected by April 2009. Training for exercise instructors delivering the programme has been established, including training in postural stability and stroke.

The “Eat Up” programme has now been launched across all Greater Glasgow CH(C)P areas and will be operational in Clyde by Autumn 2008. Eat Up is a brand new healthy eating programme which offers interactive, group-based healthy eating information and behaviour change support to promote better food choices. The 6 week programme includes: key healthy eating messages; goal setting and motivation; cookery demonstrations and practical tips on how to prepare healthy meals and shopping tours to support meal planning and budgeting. Eat Up is offered as a component of the Local Enhanced Services for CHD, Stroke and Diabetes and will also be available opportunistically within communities later on in the year.

The “Live Active” Referral Scheme has now been expanded into all of the Clyde area, namely Inverclyde (two health counsellors); Renfrewshire (three health counsellors) and West Dunbartonshire (two health counsellors). This has resulted in the Scheme being rolled out across the full NHSGGC area. All counsellors for the Clyde area have been recruited as health counsellors which will be an expansion to the current Live Active model to include the behaviours of healthy eating and weight management in addition to physical activity.

The Board’s Food, Fluid and Nutrition Planning and Implementation Group has developed a healthy vending policy and an action plan to achieve the Healthy Living Award in all of our services.

Looking ahead, we are currently developing our Child Healthy Weight service with a focus on those children who are morbidly obese, and their families.

Many of the initiatives discussed in the next section under reducing risk factors will also contribute to improving healthy life expectancy.

3.2 Reducing Smoking, Excessive Alcohol Consumption and Other Risk Factors for a Healthier Life

3.2.1 Smoking

Clearly, reducing the numbers of people who smoke is a key aim in improving life expectancy and we have further developed our smoking cessation services over the last year.

We have implemented the recommendations of the previous evaluation of our smoking cessation services, including creating one coherent, branded service across the Board area and increased targeting of the most deprived groups;

We have continued the roll-out of effective pharmacy and group service throughout Greater Glasgow and Clyde with a total of 13,700 people who have accessed services setting a quit date in 2007.

The interim report of the more recent evaluation of smoking cessation services shows that there is successful targeting of deprived, heavily addicted smokers. The Group service no longer has lower quit rates if analysed by gender, deprivation or age and both pharmacy and group services are extremely cost effective.

In addition, Smoke-free Me and Smoke-free Class is in operation in all Greater Glasgow schools with plans to roll out in Clyde over this year and smoking cessation services in maternity acute have all been standardised based on an evidence-based model.

Activities including the development of buddy schemes, more intensive pharmacy service and additional smoking cessation services, have been implemented through the Keep Well pilots and a successful pilot project on smoking cessation for looked after and accommodated young people has been undertaken with plans to establish a permanent post to sustain this programme.

3.2.2 Alcohol

Alcohol has been identified as a major priority and growing challenge for NHSGGC in terms of our own action and our work with partners, particularly through community planning.

There are a range of activities underway around alcohol over-consumption led by the Alcohol Action Team. These include:

- work with licensing boards on over-provision of licensing outlets and liaison with supermarkets on cheap alcohol deals;

- further development of brief interventions in A&E with plans to implement systematically in primary care;
- inclusion of FAST screening tool in primary and secondary prevention screens in primary care;
- training of primary care staff and development of additional community alcohol support services as part of Keep Well.

As part of our joint work with Local Authorities, we have contributed to the development and implementation of the Joint Alcohol Policies with Glasgow City Council, East Renfrewshire Council, Renfrewshire Council and Strathclyde Police. These policies include actions on reducing alcohol related death and hospital admissions through continuous improvement of alcohol services, reducing alcohol consumption levels in the whole population and specific target groups, reducing harm to children affected by alcohol problems in the family, promoting responsible alcohol consumption among our employees and raising awareness of alcohol related harm in our role as an employer, as partners and as procurer of services and reducing alcohol related crime, violence and disorder.

3.2.3 Drug Misuse

We have continued to develop our Addictions Partnership with Glasgow City Council and are seeking to widen the approach across the NHSGGC area. Key priorities for the Addictions Partnership in 2007/08 were to:

- increase access to care and treatment;
- consolidate numbers on the Methadone programme and increase take up of social care support;
- increase access to rehabilitation services;
- streamline service delivery through integrated assessment and working practices;
- enhance opportunities for education, training and employment as part of peoples recovery and re-integration;
- reduce waiting times;
- increase numbers of individuals with a named care manager.

What we have achieved:

- Care and treatment:
 - we achieved a 6.4% increase in the number of adults accessing care and treatment and a 7.8% increase in the number of young people. The total number of people in contact with our locality community addiction teams at March 2008 was 12,765, compared with 6,605 in 2003/04.

- Methadone programme:
 - we achieved our target of consolidating the number of individuals on the programme with the overall numbers increasing by 0.01% and we further closed the gap in terms of the overall numbers receiving social care support from 911 to 508.
- Rehabilitation:
 - we met and exceeded our target for community rehabilitation with 2,256 people receiving this type of support a further 750 people accessed residential rehabilitation/respice or crisis care.
- Streamlined service delivery:
 - more people than ever receive streamlined, integrated assessment, from direct access community addiction teams - over 3,000 single assessments, linked to immediate service delivery were completed.
- Employability:
 - we exceeded our target in relation to employability and have taken further strides to ensure close engagement with training, education and employment support providers. Some 2,220 individuals benefited from support towards employability. This is a core part of the Partnership's approach to enhancing recovery and promoting integration.
- Waiting times:
 - Glasgow City and Greater Glasgow and Clyde are now amongst the best performing areas for measures of access to services. Waiting times of less than 14 days were achieved in 94% of all cases in Glasgow City and 74% in Greater Glasgow and Clyde against a national average of 67% (ISD Jan - March 2008). Glasgow City accounts for 29% of all new Scottish referrals in this period.
- Named care managers:
 - we exceeded our target with 93% of individuals having a named care manager against a target of 92%. Named care managers are critical to ensuring care planning, and continuity of provision of care can be achieved.

- Children affected by parental substance misuse:
 - this remains a key priority for the addiction service and we will continue to support staff to meet their responsibilities in this context. The partnership has developed practice guidance and an assessment tool to ensure children at risk are identified, supported or referred as appropriate;
 - the Partnership has recruited a development officer who will support and drive the agenda with a strong focus on enabling front line staff to meet their responsibilities through continuous learning and development. This stream of work is being taken forward as part of the SWIA action plan for the City of Glasgow.

- Other key achievements in 2007/08:
 - GAS has developed and expanded its acute liaison service to further bridge hospital and community settings;
 - completed and implemented our review of co-morbidity services with The Mental Health Partnership;
 - we have made a significant impact on shifting the balance of care from residential to community based rehabilitation whilst retaining and increasing access to residential rehabilitation;
 - we are putting significantly more effort into assertive forms of intervention and follow up for people most at risk;
 - GAS has recently agreed a comprehensive service user and carer involvement strategy which seeks to put service users and carers at the heart of service design and evaluation;
 - implemented mandatory drug testing, a roll out of Arrest Referral schemes and the development of a partnership approach to persistent offenders jointly with Strathclyde Police;
 - continued the success of the Glasgow Drug Court;
 - developed an NHSGGC wide strategy and framework for prevention and education;
 - successfully completed a pilot scheme to contribute to reducing drug related deaths via training of users and carers and widening availability of self administered naloxone;
 - expanded the scope and range of our community pharmacy needle exchange programme to reduce the transmission of BBVs.

Priorities for 2008/09 include:

- better, faster access to more effective services;
 - to make a significant contribution to the assessment, support and protection of children made vulnerable by their parents alcohol and/or drug use;
 - increase the number of adults being supported by our Community Addiction Teams each year and at the same time decrease our waiting times for CATs and ensure the quickest access possible;
 - deliver plans for a new purpose built in patient unit serving South Glasgow and Clyde;

- Better range and choice of quality services with clear outcomes for people:
 - ensure that young people have a quality experience and are supported effectively by our youth teams within CATs;
 - maintain the number of people on the methadone programme and to offer new choices in substitute prescribing;
 - ensure that everyone on substitute prescribing programmes has access to adequate levels of social care support and are encouraged to begin to take up opportunities for personal development;
 - ensure that addiction services can do everything possible to reduce alcohol and drug deaths in the city;
 - increase the take-up of community based rehabilitation to help people reduce dependency and live better quality lives removed from addiction.

- Intensive support and treatment for those most in need:
 - improve and streamline access to partial hospitalisation services for people with more complex needs that cannot be safely treated in the community, but who can be cared for whilst still living at home;
 - expanding access to occupational therapy services to help people live more independent, fulfilling lives;
 - ensuring acute and community services are more effectively joined up by better liaison arrangements;
 - increase and develop pharmacy contributions to public health, treatment, care and good governance;
 - implement our review of medical services, aligning resources to support CATs and secondary services.

- Reducing inequality and increasing public confidence:
 - implement our Board-wide strategy and framework for prevention and education;
 - complete our new framework for diet and nutrition to improve the health of our population who misuse drugs and alcohol;
 - increase the contribution of addiction services to the city's social renewal by offering ever higher numbers of people access to training, employment, education and voluntary work experiences;
 - implement throughout our services our corporate commitment to addressing health and social inequalities which are caused by gender inequality, racism, disability or discrimination on the basis of sexual orientation

3.3 Sexual Health Strategies and the HPV Implementation Programme

During 2007/08, the following actions to promote sexual health were implemented:

- full implementation of the Sandyford Hub model with the last two of the planned four new Hubs being established in the North and South West. Inverclyde and East Renfrewshire hubs are also fully operational and the Renfrewshire and West Dunbartonshire hubs will open in summer 2008;
- improvements to Termination of Pregnancy services in each Glasgow Sandyford Hub, with waiting times for consultation and from consultation to admission less than five working days in line with the RCOG good standard;
- completion of pilot project for Talk2 on supporting parents to discuss sexual health with their children. There are plans to roll-out through Culture and Sport Glasgow during the coming year;
- the Open Road project for prevention of Blood Borne Viruses is fully operational;
- a Support and Regeneration post has been recruited within Glasgow City Council to improve the response of schools in supporting young women who become pregnant while still at school. This posts links closely with the link midwife for teenage pregnancy to ensure access to appropriate care and minimal disruption to learning;
- the Open Road project for prevention of Blood Borne Viruses in men involved in prostitution is fully operational.

In keeping with the national HPV programme, NHSGGC will be implementing this vaccination programme starting in September this year. To plan for the implementation of this programme, NHSGGC set up a local implementation group involving all stakeholders including representatives from all CH(C)Ps, vaccine

holding pharmacies, education and child health information management colleagues.

In preparation for the implementation over 800 local staff have already been trained and resources have been made available to vaccine holding pharmacies to increase fridge capacity for vaccine storage.

NHSGGC has also been funded to take on the national child health school system to record immunisations in schools and also to implement the Call/Recall system. Currently administration staff are being recruited to operate the child health school system.

The resources that were provided by the Scottish Government were made available to CH(C)Ps to recruit additional staff for the administration of this vaccine at school. The plan is to recruit temporary nursing staff during August and have them trained for the start date of the programme in September.

Our local planning is on track to implement the campaign based on the national timetable, however, there remain some risks regarding timely recruitment of both administration and nursing staff.

3.4 Working with other Organisations to Deliver Shared Outcomes for Improving Health and Tackling Inequalities.

We work with a range of other agencies through new community planning structures, effectively implemented with all Local Authorities and have agreed shared priorities around early years and parenting, child poverty and alcohol misuse.

We have implemented a programme of health impact assessments in Glasgow City in particular for the economic strategy for food policy in schools and for the Commonwealth Games.

The establishment of the Joint Director of Public Health post between the NHS and Glasgow City Council allows public health to be appropriately represented on the Corporate Management Team of the Council.

Culture and Sport Glasgow are implementing the Healthy Living Award and we are working closely with them to ensure a healthy vending policy and healthy food in their canteens.

We have planned an ambitious programme of staff health jointly with Glasgow City Council which will be launched later this year focusing on mental health, alcohol and physical activity.

The Glasgow Centre for Population Health has published CH(C)P profiles and the Director of Public Health with the Lead Officer in the Glasgow Centre for Population Health have worked with CH(C)P and local community planning partners to discuss the implications of the profiles and the Director of Public Health report, for local working on health improvement and health inequalities.

The Glasgow Centre for Population Health has recently had its external review and we will continue to work in partnership with the Local Authority and the University in taking forward the work of the Centre.

NHSGGC is committed to improving its effectiveness and efficiency in responding to health inequalities across areas of greater and lesser need as well as to the poor health outcomes that can arise from the experience of different forms of inequality and discrimination in line with the priority given to this in Better Health Better Care and Equally Well. To aid its transformation and to ensure that activity designed to address inequalities moves from the margins to the mainstream, a set of 10 Goals has been identified for the organisation.

The Goals have implications for both mainstream health care and for NHSGGC as a partner contributing effectively to shared outcomes. The table below summarises examples of what NHSGGC currently has in place to meet the goals as both a provider of health care and a partner.

3.4.1 Stage of Development 2007/08

Goals	Closing the Gap	Addressing Discrimination
Engaging with Populations and Patients		
The Inequalities Sensitive Health Service:		
1. Knows and understands the inequalities and discrimination faced by its patients and population.	<ul style="list-style-type: none"> - CH(C)P profiles containing full postcode and social class data available for planning purposes. Development plans for CH(C)Ps being constructed using this information. 	<ul style="list-style-type: none"> - Increasing collection and disaggregation of patient information by sex, race, disability and sexual orientation.
2. Engages with those experiencing inequality and discrimination.	<ul style="list-style-type: none"> - Public Patient Forums established which facilitate involvement from and dialogue with people from deprived areas. - Maintenance of Healthy Living Centres where effective and sustainable to engage and respond to needs of disadvantaged communities. 	<ul style="list-style-type: none"> - Funding available to support participation by disabled people in development of new services. - Community engagement programmes associated with the Acute Services Review relating to communities of interest. - Maternity User Survey with women experiencing multiple disadvantage to inform

Goals	Closing the Gap	Addressing Discrimination
		service and practice development.
3. Knows that people's experience of inequality affects the health choices they make.	<ul style="list-style-type: none"> - Keep Well/Anticipatory Care programme focuses on redefining primary care approaches in areas of greatest need to support individuals to change risk behaviours. - Tobacco Plan designed to create sustainable support services targeting areas of disadvantage. 	<ul style="list-style-type: none"> - Keep Well links to employability and financial inclusion builds capacity into primary care to address experience of poverty more consistently. - Gender sensitive smoking cessation in maternity services builds capacity to support pregnant women quit smoking. - Programme to develop poverty and gender sensitive addiction services supports staff to address underlying determinants of addiction problems. - NHSGGC Infant Feeding Strategy includes high risk interventions such as peer support in areas with low breastfeeding rates to develop social capital, and multiple interventions for the most vulnerable sick and premature infants.
4. Removes obstacles to services and health information caused by inequality.	<ul style="list-style-type: none"> - Direct access hubs being planned to ensure that people in disadvantaged areas can access health and social care service more easily. - Housebound Service to enable delivery of primary care to hard to reach group. - Literacy Plan to enable communication via written information helps primarily to meet needs of people in disadvantaged areas. 	<ul style="list-style-type: none"> - Communication, Support and Learning Plan to facilitate staff to improve communication and enhance attendance, easier diagnosis and management of health problems. - Facilities plan to address the DDA as part of routine activity. - Mental health service modernisation for people with sensory impairment.

Goals	Closing the Gap	Addressing Discrimination
5. Uses an understanding of inequality and discrimination when devising treatment and care.	<ul style="list-style-type: none"> - Inequalities Sensitive Practice Initiative (ISPI) in four settings supports maternity, primary care mental health, addictions and children's services to identify and address patients' experiences of poverty and creates a methodology for implementation in other settings. 	<ul style="list-style-type: none"> - ISPI programme designed to support four settings to understand the role gender plays in health problems, eg, through the experience of gender-based violence.
Developing the Workforce		
The Inequalities Sensitive Health Service:		
6. Has a workforce which represents our diverse population.	<ul style="list-style-type: none"> - Working for Health programme develops practices which support recruitment of people distant from the labour market in areas of disadvantage. 	<ul style="list-style-type: none"> - Working for Health programme develops practices which support recruitment of people distant from the labour market as the result of physical impairment, learning difficulties or cultural expectations.
7. Creates a non-discriminatory working environment and a workforce which has the skills to tackle inequality.	<ul style="list-style-type: none"> - Employability awareness training improves competency of staff to support patients into employment. 	<ul style="list-style-type: none"> - Anti-discrimination and anti-bullying policies. - Learning and Education Framework on equality and diversity created to develop staff awareness.
8. Uses its core budget and staff resources differently to tackle inequality.	<ul style="list-style-type: none"> - Resource Allocation Plan for CH(C)Ps for children's and older people's services using deprivation as the indicator. - Health Visitor Review has allowed reallocation of key resource more systematically to areas of greatest need. 	<ul style="list-style-type: none"> - Programme of EQIA promotes continuous improvement in services to ensure barriers to effective health care are addressed. - Development of routine inquiry in maternity, A&E and mental health services of gender-based violence helps to shift approach of frontline staff. - Enhancement of Interpreting and translation budget by 30% to £1.4million.

Goals	Closing the Gap	Addressing Discrimination
The Health Service's Role in Society		
The Inequalities Sensitive Health Service:		
9. Spends the money being invested in buildings, goods and services in a way which tackles the determinants of poor health.	<ul style="list-style-type: none"> - Acute Services Review programme linked to local regeneration and local transport developments thus contributing to tackling poverty and enhancing access to health care by those in greatest need. - Development of Employability Strategy. 	
10. Works with partners to reduce health inequality by addressing issues such as income inequality, social class inequality, gender inequality, racism, disability, discrimination and homophobia.	<ul style="list-style-type: none"> - Development of employability strategy as part of Glasgow Works. - Development of multi-agency Financial Inclusion Strategies - Leadership of Glasgow City Council Health Improvement Working Group to facilitate mainstreaming of health improvement and health inequalities into core business of local authority. - Support for Health Impact Assessment (HIA) of Commonwealth Games as part of effective planning for benefits realisation. - HIA of GCC Economic Strategy to facilitate actions to address inequalities. - Active engagement in the development of Single Outcome Agreements across 10 Local Authorities. 	<ul style="list-style-type: none"> - Glasgow-wide Race Equality Strategy as part of Community Planning. - BME employability programme. - Violence Against Women multi-agency activity.

3.5 Breaking the Link between Early Life Adversity and Poor Health and Other Outcomes in Later Life

In line with the generational cycles identified in Equally Well (2008), our approach to breaking the link between early life adversity and poor health is twofold. We aim to promote the protective factors and reduce the risk factors of the effects of early childhood adversity.

3.5.1 Protective Factors

- Good parenting is a protective factor against poverty. Our Parenting Strategy has been developed in a multi-agency, multi-disciplinary group and will be finalised later this month. Additional resources are being allocated to this through the Fairer Scotland Fund.
- Progress with Implementation of Hall4, review of health visiting and training in integrated assessment improving targeting of health visiting and associated resources (including Parents and Children Together teams) to the most vulnerable families.
- Additional support is being provided for parents going back to work with further development of affordable child care. This is being led by a group on extended childcare services and employability.
- Infant feeding strategy has been launched and is currently being implemented, including improvements in coverage of vitamin supplementation, particularly in those at highest risk of vitamin D deficiency.
- Inequalities sensitive practice initiative: working alongside practitioners in integrated children's services and maternity settings to identify the key ingredients of inequalities sensitive practice and the policy and planning needed to support it. Maternity care pathways are being developed around learning disabilities, BME status, alcohol use, drug misuse, gender based violence, and the vulnerable infant.
- Redesign of maternity services includes developing Special Needs in Pregnancy services to identify and provide additional support to vulnerable women.
- Link midwife approach for pregnant teenagers was introduced in July 2007 to ensure that appropriate supports are in place to meet the needs of pregnant teenagers of school age. This approach offers additional support for vulnerable teenagers such as those with disabilities, living in supported accommodation, socially isolated, and those with complex social needs. There is also a midwife dedicated to working with homeless women.
- Childsmile and Oral health Action Teams. The Childsmile oral health promotion programme addresses diet, regular toothbrushing at home and in education settings, dental registration, dental attendance and dental health monitoring. In addition, the programme delivers active clinical preventive techniques to children from the age of 18 months. The

programme links the Health Visitor Service with General Dental Practices in the most deprived communities of NHS Greater Glasgow and Clyde. Health Visitors identify newborn children who were at greatest risk of developing dental decay and Dental Health Support Workers deliver oral health promotion messages and to promote attendance at selected Childsmile General Dental Practices. The programme has been closely monitored and adapted to ensure that it evolves to meet the needs of its target populations. The programme incorporates nursery and schools toothbrushing programmes.

- Healthy Schools. Senior health improvement officers are working with Education Quality Improvement Officers in our partner Local Authorities to monitor health promoting schools progress and accredit individual schools with health promoting school status. Health and Education officers are working together to develop a system for the integration of health promoting school development support to mainstream education quality improvement functions. Health and wellbeing outcomes are being developed as part of the implementation of the duties and responsibilities outlined in The Schools Health Promotion and Nutrition Act (2007).
- Immunisation is still one of the most effective ways of protecting children against disease and strenuous efforts continue to keep uptake rates of primary immunisations high.
- Redesign of children's services to provide more community based alternatives in caring for the most vulnerable children and young people.

3.5.2 Risk Factors

- Smoking cessation services in maternity hospitals show high quit rates if women are referred into the service. New plans in place to ensure we identify all smokers at booking through routine carbon monoxide monitoring.
- An autism waiting list initiative has resulted in reducing the time children are waiting to be assessed.
- A vision care pathway has been developed which informs children's service practitioners about what to look out for and how to respond to children's and families' concerns about their eyesight.
- Strengthening of child protection services including introduction of the graded care profile for measuring the care of children.

- Injury prevention: Evidenced linkages between child injuries and inequalities established. Children Services developing measures to establish priority areas for action. Pilot programme established with evaluation being undertaken.
- A midwifery post has been established in the homeless families health care team to make sure pregnant women who are homeless receive the care they require and to coordinate care with social work, health visiting, the Women's Reproductive Health Service and child protection services.

3.6 Playing an Active Role in Community Planning Partnerships within the Single Outcome Agreement Framework to Address Complex Local Health Problems such as Violence and to contribute to Services such as School Education

As emphasised in 'Equally Well' we recognise that we can only make progress on some of the most difficult challenges facing our communities by working in partnership. We play an active role in Community Planning partnerships across all the Local Authorities in the Greater Glasgow and Clyde area, with representation on Community Planning Boards at Chief Executive or Director level. There is strong participation from relevant lead officers on specific topic groups and to develop actions with local communities.

We have actively influenced the priorities for community planning partnerships, particularly in relation to the focus on alcohol and children and young people which is a common theme across partnerships. We have worked to ensure that all the Single Outcome Agreements reflect the commitment of the NHS both to the HEAT targets and to actions which can only be delivered in partnership. Community Planning and the Single Outcome Agreements are also underpinned by joint planning structures with Local Authorities and other partners in key areas such as children's services, older people's services, drugs and alcohol and sexual health.

Specific joint working has included the development of Community Safety Strategic Assessments, active links with the Violence Reduction Unit at Strathclyde Police, delayed discharges, playing a lead role on the development of parenting support strategies and chairing the Local Data Sharing Partnership which covers all the Local Authorities in Greater Glasgow and Clyde.

For example, we are working with partners including the Violence Reduction Unit, Glasgow Community Safety Services, Glasgow City Council and a range of voluntary and community organisations to develop a radical pilot approach to gang crime and violence - the Community Initiative to Reduce Violence - in the East End of Glasgow. We will work with partners to support high risk individuals

and families, and to ensure that those who wish to make the transition from violent street life are supported by health services including addictions and mental health. This is linked to our wider work on parenting support, supporting vulnerable families and working with Community Justice Authorities to support offenders.

4. SHIFTING THE BALANCE OF CARE TOWARDS PRIMARY AND COMMUNITY CARE

4.1 Mental Health Services

The Modernising Clyde Mental Health Services Strategy was developed and agreed with partners in principle during 2007/08 and subsequently agreed by the Board in June 2008 and reviewed by the Independent Scrutiny Panel thereafter. It is now the subject of public consultation.

The Strategy sees a shift in the balance of care through:

- reprovision of long stay care in community rather than hospital settings;
- increased investment in community and primary care services;
- reduced reliance on high levels of inpatient beds, offset by investments in crisis, community and primary care services;
- improving the environment of inpatient care.

In overall terms by the end of the strategy implementation period, we will see redirection of funds from inpatient care to community and primary care as follows:

- development of community services = £3.7m;
- closure and reprovision of continuing care beds in range of community placements = £3.5m;
- reduction in inpatient beds of 54 acute admission beds and 185 continuing care beds;
- improved quality of inpatient environments for patient care on a range of sites.

During 2007/08 progress has been made on those areas where implementation is not subject to public consultation processes as follows:

1. Development of crisis services for the management of acute care in community rather than hospital settings:
 - extension of crisis catchments to include ex-Argyll and Clyde catchments of East Renfrewshire and West Dunbartonshire Councils;
 - development work on crisis services for Renfrewshire which became operational in April 2008;
 - reduction in acute bed levels by 23 beds (Renfrewshire and Inverclyde as at June 2008);
 - extension of Greater Glasgow crisis services capacity for extended day and overnight provision.

2. Development of primary and community services:
 - mainstreaming funding of Doing Well with Depression pilot in Renfrewshire;
 - capital investment to develop CMHT resource centre in West Dunbartonshire Council.
3. Commencement of discharge and reprovion programme to reprovide long stay care in community rather than inpatient settings:
 - 55 people discharged from long stay hospital care into community placements (Renfrewshire and Inverclyde as at June 2008).
4. Commencement of inpatient ward improvements works in Inverclyde.

4.2 Management (including Self Management) of Long-term Conditions

Our approach to the management of long term conditions centres on developing a more systematic approach to care arising out of the development of evidence based “care pathways”, better disease management and care co-ordination, and a structured approach to call and recall. We aim to impose a scrutiny and a drive to enhance Primary/secondary/social care co-ordination, resulting in a reduction in handovers and smoother delivery of care for patients. This is being delivered though the various patient pathway workstreams being undertaken in our Managed Clinical Networks (MCNs) and Planning Groups.

We aim to build on the central role of effective primary care in supporting people with long term conditions, in line with the expectation in Better Health Better Care that timely access to strong primary care is key to both management of long term conditions and reducing health inequalities. For example, we have continued look at how best to use the flexibility offered by the Scottish Enhanced Services Programme to target long term conditions, with the implementation of national and local enhanced services, including Diabetes, CHD, COPD, Rheumatoid Arthritis, Epilepsy, Heart Failure and Hypertension. We are also continuing to develop the role of community pharmacy, to ensure that there is access to support and advice at a wider range of locations and times, for example through the minor ailments scheme and the development of the community pharmacy pilots in Braehead and Central Station.

4.2.1 Self Management Framework

With the right support many people can learn to be active participants in their own care, living with and managing their conditions. This can help them to prevent complications, slow down deterioration, and avoid getting further conditions.

People living with chronic conditions often know best how to manage their conditions, but they need to be supported in this. We aim to develop a self management framework in line with that identified in Better Health, Better Care that identifies existing support systems within the system on a disease specific basis at each stage of the patient journey, including details on peer support, patient information, structured education programmes, condition specific and generic self management programmes, health behaviour and mental health services, motivational coaching and behaviour change; and carer and family support to address and maximise quality of life issues such as employment and financial inclusion.

Within NHSGGC's LTC strategy, which includes all of the key components of the national LTC toolkit, there is a commitment to provide a menu of self-management approaches. Work is progressing within disease specific and health professional led structured education programmes such as DESMOND, DAFNE and Glasgow Supported Self-management randomised controlled Trial for patients with moderate and severe COPD (GsuST).

The Chronic Disease Self-Management Programmes (CDSMP) developed by Lorig et al (1999) is a six-week course for people with chronic or long-term conditions, delivered by trained and accredited tutors who are also living with a long-term health condition. It aims to give people the confidence to take more responsibility and self-manage their health, while encouraging them to work collaboratively with health and social care professionals. Course topics include healthy eating, dealing with pain and extreme tiredness, relaxation techniques and coping with feelings of depression.

We are commissioning the delivery of 10 Chronic Disease Self-Management Programmes across Greater Glasgow and Clyde CH(C)Ps throughout 2008/2009. Cited benefits of this programme include improved self-efficiency, improved psychological and general health and reduced use of health care resources. Particular emphasis will be placed on recruitment of harder to reach groups, linking with GP practices, rehabilitation services, Healthy Living and Stress Centres and return to work programmes to target individuals living with LTCs

4.2.2 Links to Voluntary and Community Organisations

We will continue to foster links in order to understand and develop the potential contribution to be made by voluntary and community organisations and build on the valuable work already being undertaken in partnership. This is a process already underway through the contribution of the voluntary sector to the membership of our MCNs and disease specific planning groups

4.3 Pharmacy Prescribing

During 2007/08, the Pharmacy and Prescribing Support Unit's (PPSU) work has focussed on getting structures for pharmacy staff aligned with those in the Directorates and CH(C)Ps. Working with Directors, Clinical Directors and Finance teams, PPSU has devolved much of its "middle management" tier of clinical pharmacists to posts as Lead pharmacist with each Directorate/CH(C)P. Staff take up their new posts in September/October 2008, and it is anticipated that each will become a member of the Director's senior team. Their role in every Directorate/CH(C)P will be to lead on all aspects of medicines management within their new team including:

- cost-effective management of prescribing, including: expert advice on horizon scanning and budget setting for medicines; analysis of prescribing trends; identification of areas for improved prescribing without impairment of patient care;
- clinical governance of medicines, including: ensuring adherence to policies such as Safe and Secure handling of Medicines, management of Controlled Drugs; management of medication related incidents; development of the medicines related aspects of the Scottish Patient Safety Programme; development of Directorate/CH(C)P risk registers for medicines;
- liaison with their counterparts across Primary and Acute care, specialist pharmacists and PPSU Executive members to ensure cohesive approach to medicines management across all settings

In 2007/08, PPSU, along with the chairs of Prescribing Management Group and the Area Drug and Therapeutics Committee, worked to reconstruct the Medicines related Advisory structures for the Board to create a single system which supports the Board, Directorates and CH(C)Ps to discharge their duties in relation to the safe, effective and cost effective use of medicines. Having reconstructed the committees in 07/08, the work now focuses on completing production of single system policies and guidance for prescribers and managers on topics such as:

- therapeutics handbook for junior prescribers in hospitals;
- single system formulary/process for the managed entry of new medicines;
- guidance in acute and primary care on non-formulary prescribing;
- guidance on unlicensed medicines prescribing and management;
- guidance on the management of "exceptional use" and "orphan" medicines;
- safer use of medicines in all settings;
- non-medical prescribing policies and guidance;
- safe use of antimicrobials.

We are currently working on increasing the accessibility to guidance on medicines to all clinicians through prominent Intranet access in the restructured Staffnet site

In specific areas where prescribing in one setting has impact on another setting we have worked to influence prescribing habits in the following areas (not an exhaustive list):

- antidepressants;
- cardiovascular: antiplatelets, angiotensin II, clopidogrel, statins;
- non-SMC approved medicines;
- treatment of osteoporosis;
- wound dressings;
- urinary continence management;
- dietetics - sip feeds and anti-obesity drugs;
- respiratory: inhalers;
- pain control;
- diabetes management;
- smoking cessation products and management;
- vaccines.

In the longer term, PPSU plans to use specialist pharmacists currently in hospital settings to support clinical pharmacists in both primary and acute care. However, we are not yet at a stage of development to make this happen in 2008/09. In addition, the new Community Pharmacy contract is not finalised (anticipated for roll out to be starting some time during 2009) and the format this takes will shape the way in which we structure support for primary care colleagues by acute care specialists.

4.4 Optical and Dental Services

The main area of coordinated activity to date has involved developing services with Ophthalmology. This has focused on extending the scope of practice of Community Optometrists through CH(C)P networks to improve education, training and governance; and also improve working relationships with both general practice and Acute Division colleagues. Community optometry is well resourced, local, accessible and a source of untapped expertise. The scheme has the potential to facilitate shared care and offset demand for AMD and Retinopathy managing stable eye disease and post-operative care in the community. It may also help to maintain improvement in ophthalmology waiting times. It also meets objectives of Eye Care Review. However, realising this potential may have some resource implications that need careful consideration by key stakeholders.

A successful bid was also made against the Eye Care Review Fund which resulted in £760k across Greater Glasgow and Clyde of pump-priming investment over two years to develop integrated working in Visual Impairment. Of this £350k will support the development of Local Optometry Networks linked to ophthalmology which will improve clinical standards, referral and post-operative management.

In relation to dental services, we have continued to shift the balance of care by the local provision of Consultant Supported Restorative Dentistry provision at Greenock Health Centre and Plein Street with plans in place for the expansion of dental access for Community and Salaried Dental Services at these two sites from July 2008 onwards.

Inverclyde and Renfrewshire CHPs have also been funded to introduce Oral Health Action Teams (OHATs) to support 0-5 years through specific children oral health improvement initiatives and toothbrushing programmes.

4.5 CH(C)P Development

NHSGGC sees primary care as having a key role in delivering many of the priorities set out in Better Health Better Care and our organisational purpose and local priorities. We are committed to the development of CH(C)Ps as a focus for local planning and engaging with communities to ensure that primary care is supported to do this. We also recognise the need for an overall strategy for primary care development which brings together common themes and makes best use of all the levers and drivers for change at our disposal. Specifically during 2007/8 we have:

- developed CH(C)P profiles which give a comprehensive assessment of population needs and health;
- published a report on the Shape of Primary care in NHSGGC which sets out current services and activity in primary care, setting us a series of challenges and informing future planning;
- continued the Keep Well initiative and adapted this to meet local circumstances and priorities. We have begun a process of wider engagement on inequalities to understand how primary care can be better supported to help address health inequalities;
- reviewed the resource allocation to CH(C)Ps and begun to implement changes to our children's services and older people's budgets to more explicitly reflect need, for example deprivation;
- continued the development of a comprehensive set of Local Enhanced Services, expanding from focus on chronic diseases to wider health improvement;

- continued to use the flexibilities of the contracts for pharmacists, opticians and dentists to improve access and choice for patients, particularly in deprived areas.

We will continue this work in 2008/9 with a view to having an updated NHSGGC-wide primary care strategy in early 2009

We have supported the development of the CH(C)Ps in a number of ways both as a whole system, and within each CH(C)P. Here are some local examples from CH(C)Ps:

4.5.1 South East Glasgow CHCP

- Community engagement:
 - in consultation with local communities about the best way to identify key local health issues and develop innovative ways of responding to them, 5 Health Forums have been established across the CHCP area, attended by a range of statutory, voluntary and community representatives. These will be charged with producing a Joint Health Improvement Plan during 2008/09.
- Communications:
 - communications champions have been recruited in order to provide the CHCP with a more robust mechanism for securing feedback and for developing its communication processes across all service areas. This group has overseen the first staff conference and has produced a Communications Strategy which will be taken forward and implemented during 2008/09. They have also assisted with the production of a South East CHCP Service directory, which provides information on the range of services provided by the CHCP, along with their locations and contact details.

4.5.2 East Dunbartonshire CHP

The work on developing a Joint Action Plan for Older People's Services with the Council as part of the wider work to develop a Joint Community Care Plan, which has recently been launched.

4.5.3 West Dunbartonshire CHP

A notable and significant development has been new single management arrangements for community care services between the CHP and West Dunbartonshire Council. This has been manifested by three joint senior management appointments introduced on 1st April 2008:

- Head of Assessment and Community Support;
- Head of Residential, Day Care and Commissioning;
- Head of Mental Health, Addictions and Learning Disability.

The CHP and the Council have also agreed to review the totality of local children's services for health, social work and education; and will report by August 2008 with proposals for an integrated service.

5. ACCESS TO SERVICES, INCLUDING WAITING TIMES

5.1 Progress towards the 18 Week Referral to Treatment Target due for Delivery in 2011 Including Interim Milestones

In line with Better Health Better Care (2007) we have made major progress in improving access to services. The 18 week targets for new outpatients and inpatients/daycases were achieved by December 2007 in all specialties. They have been maintained, with the exception of a very small number of patients since that time. Systems and processes have been reviewed to ensure that no further breaches occur and routine monitoring takes place on a weekly basis to ensure all patients have been dated within the appropriate timescales.

With regard to progress towards the 18 week RTT target, initial work has commenced and the Planned care infrastructure has been maintained to ensure progress towards the re-design elements of the new target is maintained and enhanced.

NHSGGC is working towards the delivery of 15 weeks for new outpatients and inpatients/daycases by March 2009 and, at the end of May, the figures were as follows:

New outpatients:

May milestone . 15 weeks	1300
Actual > 15 weeks	1062

Inpatients/Daycases

May milestone	370
Actual > 15 weeks	267

5.1.1 Diagnostic Waits

By the end of July 2007 the maximum wait from referral to MRI scan, CT scan, non-obstetric ultrasound and barium studies was set as a guarantee of 9 weeks. In terms of supporting achievement of waiting time targets the diagnostics team need to ensure consideration is also given to the 4 hour A&E target, the 62 day cancer wait including the 31 day diagnostic target as these targets provide an additional impact on demand.

Within GGC, we embraced the diagnostic collaborative and identified the drivers for effecting improvements in imaging allowing us to develop an action plan to support the achievement of the HEAT targets. This included:

- capacity, demand and redesign;
- workforce - modernisation and extended day;
- technology development;
- improving the patient experience - patient and CH(C)P collaboration.

A significant endeavour by the diagnostics team has resulted in a real understanding of the improvements required to be made on the points denoted above and a comprehensive programme was implemented.

As a result the guarantee waiting time of 9 weeks, for all four imaging modalities, was achieved by the target date of July 2007. This position was maintained and delivered throughout the year.

The magnitude of this achievement should not be underestimated when the waiting time in the previous year was for MRI - 40 weeks and for CT and Ultrasound 20 weeks.

With the achievement of the 9 week guarantee our attention now turns to the 18 week referral to treatment standard with a target date of March 2011. As a milestone in achieving the 18 week standard, the maximum wait from referral to MRI scan, CT scan, non-obstetric ultrasound, barium studies, will be 6 weeks by the end of March 2009.

Diagnostics has developed a plan to move towards and achieve this milestone and is on target with the timescale identified.

5.1.2 Waits for Cancer Services

Since last year steady progress has been seen in performance in cancer services with the exception of quarter 4 of 2007. The first quarter of 2008 has seen this progress maintained and further work toward the target of 95% is underway.

There have been improvements in performance in prostate, colorectal, lymphoma and melanoma. Within lung our position is unchanged and further work is in progress to refine this pathway, however it must be noted that late presentation and co morbidities are factors within these complex pathways often requiring multiple testing. Further redesign work has been undertaken within Head and Neck to fast track urgent appointments. Also, the PET/CT service is now up and running and this should allow better pathway management for upper and lower GI, lung and head and neck particularly for frail elderly patients who could not readily travel to Aberdeen.

The move of thoracic surgery to the Golden Jubilee in Clydebank caused some operational challenges which are in the main resolved.

Urgent patients waiting more than 100 days reduced by more than 50% between Q3 and Q4 2007.

5.1.3 A&E Waits

The 98% target was achieved in NHSGGC in December 2007 and this level of performance has been sustained in each of the subsequent months. Performance for patients presenting with Minor Injury or Illness at all sites is now 99% or above.

The Unscheduled Care Collaborative Programme was launched nationally in May 2005 and established in Glasgow in August 2005. The aim of the Unscheduled Care Programme is to *“ensure that 98% of all patients attending A&E are seen, treated and discharged within 4 hours either directly home or admitted/transferred to another service provider”*.

The programme was designed to facilitate and encourage joint health and social care system wide changes that would deliver improved patient care and help achieve and underpin the 98% Emergency Access Target. This commitment was set out in the Scottish Executive Document “Fair to all, Personal to Each”.

Compliance against the target for patients requiring admission to a downstream medical or surgical bed has been challenging. Addressing this required effective and proactive capacity management, discharge planning and implementation of the agreed action plans and Diagnostic Visit recommendations across NHSGGC. Performance in this flow has shown the most improvement over the course of the UCC Programme and this should be set in the context of a 7% increase in A&E attenders and admissions since December 2005.

When the Programme began in 2005, NHSGGC’s 4 hour performance was an outlier in national terms - in December 2006 the national target was 95% - NHSGGC’s compliance was 90%. NHSGGC did not meet the interim target until June 2007. Given this starting point, the meeting of the 98% milestone has been a considerable achievement.

5.2 **Access to Primary Care**

The new extended hours DES was introduced in April 2008 and is aimed at encouraging GP practices to offer appointments outwith the contracted hours of 8.00 am to 6.30 pm, Monday to Friday. Practices can open for times/frequencies based on patient list sizes. The 48 hour DES previously in place has not been

commissioned in 2008-09 due to the introduction of the new extended hours DES and changes in the GP contract quality and outcomes framework around access.

At the end of March 2008, all 271 GP practices in the Board area had complied with the 48 hour target, ie, they were able to offer routine/urgent appointments within the target

5.3 Access to NHS Dental Services

Improvements in access to NHS dental services have also been made over the past year including improved access to paediatric dentistry at Yorkhill Hospital and reduced waiting times. Accessing dentistry for adults with special needs who require general anaesthesia has also improved with patients being seen within 10 weeks.

5.4 Delayed Discharges and the Role of Concordats with Local Authorities/Single Outcome Agreements in Delivering Targets

The Board and its partners successfully ensured that no patients were waiting for more than 6 weeks for discharge in April 2008, there had been 71 patients the previous April. This was a significant achievement and required close working with our partner Local Authorities.

The total number of patients waiting for discharge also fell from 148 to 107 over the same period and the number of patients with complex needs from 76 to 66. The percentage of acute bed days occupied by patients waiting for discharge also fell from 3.7% to 1.7%. This delivery across the whole spectrum of indicators illustrates that arrangements with each of our local authority partners have focussed on delivering sustainable service change by developing community infrastructure and rapid response to people's needs.

6. SERVICE CHANGE AND REDESIGN, INCLUDING PFPI

6.1 The Presumption against Centralisation of Services

NHSGGC has an agreed acute services strategy for Greater Glasgow and South of the Clyde. The Acute Services Review (ASR) for Greater Glasgow was approved in 2002 and is now well into implementation. The ASR does set out a number of proposed changes that will see centralisation of services. These are vital in order to be able to provide safe, sustainable health services in modern 21st century health care environments, staffed by an appropriate workforce. There is a small number of specialities where in-patient care will be centralised across South of the Clyde following the development of the acute services strategy in 2006/07, approved by the then Minister of Health in March 2007. Less than 3% of the population across south of the Clyde will be affected by the changes which were proposed and received agreement because of their unsustainability as services currently exist.

The views of patients and the public have been sought as part of these developments and this is described more fully in section 6.3.

Across Clyde in mental health and maternity services there are proposals out to consultation that involve some elements of centralisation of services. The reason for centralisation in the case of mental health is to enable the board to move from an institutionalised model of care to a modern community care based model, reducing the number of beds and significantly investing in community services, supporting people to remain at home with access to appropriate services locally - see section 4.1 for more detail. In relation to maternity services the case for centralisation of over 130 deliveries annually is predominantly a financial one with underuse of the CMUs at both the IRH and VoL. These arguments are rehearsed in the consultation documentation and have been discussed with local people. A report will come back to the Board in August 2008.

6.2 The Role of Independent Scrutiny

The Board has worked with an Independent Scrutiny Panel (ISP) in their scrutiny of four streams of work across Clyde including older people's services in Renfrewshire; community midwifery services, mental health services and unscheduled medical admissions at the Vale of Leven Hospital.

The Board provided comprehensive feedback to the Scottish Government Health Directorate in response to the consultation on this approach based on our experience of working with the ISP. In particular the response asked for clarity in the respective roles of ISPs and the Scottish Health Council.

The Board notes that it is only in relation to significant service change that ISP panels will be established.

6.3 PFPI

NHSGGC's PFPI activity aims at moving towards the concept of a mutual NHS as set out in Better Health Better Care, where there is more shared ownership of decision making and clear accountability to local populations. This involves our activities in terms of public involvement and links to local democratic structures, eg, through our committees and involvement of elected councillors, and through patient centred activity including specific initiatives such as supported self management and Better Together as well as in improving patient focus in all aspects of our services and interaction between patients and professionals.

We are committed to meeting our obligations under the NHS Reform (Scotland) Act 2004 and adhering to national policy and guidelines on patient and public involvement.

We are developing a set of principles to guide PFPI activity, including:

- the ultimate purpose of Patient Focus and Public Involvement is to shape and deliver NHSGGC's goals and services;
- PFPI is integral to service delivery and development - it is not separate from patient care;
- PFPI will be fully integrated within service planning, clinical governance and quality management;
- there is a "presumption of involvement" of stakeholders in all aspects of service delivery and development;
- there should be no barriers to involvement for reasons of disability, ethnicity, gender, faith, sexual orientation, age or socio-economic status;
- individuals and representative organisations should have opportunities to engage with and become involved with NHS Greater Glasgow and Clyde if they choose to take them;
- we will offer to work in partnership across all communities of interest;
- we will encourage a culture of patient focus among our staff which allows them to develop an empathic perspective on how services users view our services and processes;
- ultimate ownership of Patient Focus and Public Involvement will rest with individual members of NHS staff;
- we will support Patient Focus and Public Involvement with communications based on the principles of openness, honesty, the use of appropriate language and methods for different groups and individuals, sensitivity and understanding, listening to what is said and being sensitive to the reactions of others and providing effective feedback.

Overall governance of PFPI is the responsibility of the NHS Board and a special sub-committee - the Involving People Committee - exists to discharge this responsibility.

Patient focus is primarily attained at service level, given its close linkages to clinical governance and quality management. Leadership is provided by co-ordinating groups at Divisional and Partnership level and direct patient influence is achieved at the individual level through feedback, surveys and initiatives such as *Patient Stories*. There are also many patient and patient advocacy groups which contribute to the development and improvement of services, including those attached to Managed Clinical Networks.

At a local level the Public Partnership Forums (PPFs) attached to CH(C)Ps are managing an increasing workload of representing patient interests. Their influence is extending also into all kinds of wider and regional service development, not just those linked to specific communities.

PPFs, along with other groups, are linked to NHSGGC's Involving People Network, which comprises over 5,000 individuals and groups with an interest in healthcare. The network allows a free exchange of information and opportunities to attend events and take part in engagement. It also provides a resource of people who may be willing to be involved in supporting service or strategy development where no existing patient representation exists - for example, earlier this year, around 200 people from the network expressed an interest in shaping future prescribing policy.

NHSGGC's PFPI Framework is in the process of being re-written to take account of service reorganisation and the latest national guidance and initiatives, including Independent Scrutiny Panels and the introduction of elected NHS Boards. The framework will provide NHSGGC's strategic vision for PFPI and ensure that services and staff are working in a complementary fashion to ensure that patient and public involvement is integral to the delivery of healthcare.

Specific examples of patient involvement in significant service developments include:

- New Children's Hospital - Youth and Family Panels have been instrumental in informing the re-design of services to be housed in the new hospital, following a shift in focus away from the architectural design of the hospital building
- New South Glasgow Hospital - there has been significant engagement with communities around the site of the Southern General site to raise awareness of the wider opportunities offered by the project for local people

and the planning process. Briefings have been provided to local elected members, agencies and stakeholder forums with an interest in the socio-economic benefits

- West of Scotland Regional Heart and Lung Centre - the creation of a regional service, at the GJNH which opened in February 2008, followed consultation and user engagement in 2004. There was further engagement with users at the end of 2007 which led to some changes to the way pre and post-op diagnostic, preparatory and follow-up appointments were organised to make sure the system was as efficient as possible for patients
- Clyde Services Modernisation - there was extensive preparation and engagement from late 2006 onwards to find solutions to long standing structural and sustainability issues with services inherited from the former NHS Argyll and Clyde. These led to recent and current consultation on older people' services, inpatient disability services, maternity services and Mental Health services

6.4 Carers Information Strategies

In line with the commitment to carers set out in Better Health Better Care, NHSGGC's Carers Information Strategy is part of our wider approach to working with carers and carers group to ensure they are involved in service planning and decision making, and supported in their caring responsibilities and their own health. We recognise that many carers present themselves in health care settings before they make contact with other services, for example Social Work. We estimate that 11% of our population has significant caring responsibilities, and some of our major service strategies such as Long Term Conditions and Rehabilitation depend on working effectively with carers.

The lead responsibility for planning services and support with carers lies with our 10 CH(C)Ps and their joint planning structures with the 6 Local Authorities in the Greater Glasgow and Clyde area. This makes sure that developments fully take account of local needs and the views of local communities, and are joined up with partners including carers groups and voluntary sector organisations.

Actions taken to improve involvement of carers and carers groups, and information for both carers and staff, include:

- active carers representation through PPFs and Community Planning community engagement structures;
- service user and carer participation in planning groups;

- joint commitments with Local Authorities, for example the Inverclyde Carers' Charter;
- involvement in and support to carers' centres;
- development of carers registers through the Directed Enhanced Service
- carers Information boards in key locations such as health centres;
- carers information and support line to provide a single point of contact for carers about rights and support available;
- training and information for staff about recognising carers and linking to support available.

Further areas for development include updating our “Are you looking after someone?” series of information leaflets, focusing on the needs of young carers and ensuring that information and support takes account of the needs of different groups and communities. We will specifically consider how to make sure that the views and experiences of carers inform service changes and developments as part of the “Better Together” programme.

7. IMPROVING TREATMENT FOR PATIENTS

7.1 Enabling and Supporting Patients to be Partners in their Care

We have already discussed some of the ways in which we are supporting patients to be partners in their care in terms of Long Term Conditions (4.2) and PFPI (6.3).

7.1.1 Better Together

Understanding patients' needs and empowering them to affect change at the within NHS treatment planning and delivery is a guiding principle of the Scottish Government's "Better Together" patient experience programme. In 2008, NHSGGC responded to an invitation by the Scottish Government to pilot a programme of work within Regional Cancer Services that would support this work.

In line with the key aims and objectives of the Better Together programme, NHSGGC (in partnership with the West of Scotland Cancer Network), has developed a pilot model that seeks to capture the experiences of cancer patients and use them as practical tools for service re-design. In essence, if re-orientate our perspective from that of provider to that of user, we can better understand (and therefore remove) the barriers that prevent us from delivering the most effective and appropriate care for our communities.

A small, dedicated team will work alongside patients and practitioners to chart the patients' journey into, through and out of our care. During the journey, patients' experiences and views will be recorded via a number of engagement techniques (also being piloted) to create a shared understanding and develop a related action plan to meet the diverse needs of our service users.

The proposed work allows for investigation of any barriers to equality of treatment that may exist within our services and will specifically target potential areas of differential treatment outcomes in relation to gender, socio-economic status, sexual orientation, age, disability faith and belief and ethnicity.

Due to the complex and diverse range of cancer services and to ensure the forthcoming national bowel-screening programme is as effective as possible it has been agreed to focus the work in the areas of colorectal cancer screening and chemotherapy services.

The work will be conducted over a three-year period with learning being taken forward into other service delivery areas.

We also look forward to developing “Better Together” in two other key areas, namely within surgery and within mental health. Involving the Surgical Directorate in the pilot gives us the opportunity to explore important linkages with the Scottish Patient Safety Programme, as the first phase of that programme significantly focuses on the Directorate of Surgery and Anaesthetics.

However, we felt it was important also that the pilot phase should not concentrate only on the acute hospital sector. For that reason, we are keen that a ward or wards within the Mental Health Partnership should also be able to be included within the study.

7.1.2 Wider Engagement and Consultation

In terms of wider engagement and consultation, NHSGGC has widened the range of techniques and channels available to ensure that everyone who wants to take part in any given public consultation process has the opportunity to do so. We are developing our website to include audio and video clips that allow key staff to set out key issues and information - a useful way of overcoming the difficulties some people have with purely visual or written information. We design consultation events to suit service users - for example, during the Clyde Maternity Services Consultation which ended on 27th June 2008, we put considerable effort into organising drop-in sessions at maternity units and other locations in daytime as mothers and mothers-to-be found these to be more flexible and preferable to “traditional” public meetings held in the evening. Whenever we launched public consultations, we organised a co-ordinated communications campaign - media, web, advertising, direct mail to interested parties, phonelines, one-to-one meetings and group meetings to ensure that everyone who wants to contribute can do so. We also review our consultations to ensure that equal opportunities standards have been met and that we are not excluding any part of the population.

There has been progress across a range of different services and initiatives in 2007/08. This includes:

- Patient Information Points - modular pods piloted at Easterhouse Health Centre and Gartnavel General Hospital to overcome patient and visitor problems in finding leaflets and information. Survey feedback at the sites indicates very high approval ratings.
- NHSGGC Website - focus group feedback to indicate how successful the January 2007 redesign of the website (itself based on user feedback) had been. There were high approval ratings, particularly for innovations such as video sequences and British Sign Language captions.

- Maternity Services - an engagement programme based on a survey of women using the Southern General Maternity and community focus groups which contributed to plans for future services and the Final Business Case for the New South Glasgow Hospital.
- Clyde Services Modernisation - there was extensive preparation and engagement from late 2006 onwards to find solutions to long standing structural and sustainability issues with services inherited from the former NHS Argyll and Clyde. These led to recent and current consultation on older peoples' services, inpatient disability services, maternity services and mental health services
- "Our Health" Events - two events (numbers six and seven) in the long running series were staged at Glasgow Royal Concert Hall. The first, "Getting the Best from your NHS" attracted over 600 delegates and the second was an innovative online debate based on the Director of Public Health's report
- Patient Befriending Volunteers - an innovation based on using trained and supported volunteers at the Southern General to assist patients with eyesight or literacy difficulties.
- Health News - five editions of the NHSGGC's newspaper reached a combined circulation of over 1.5 million. Particular effort has been made in the content to cover major issues of interest to the public, including a special West of Scotland edition focusing on cancer services
- Long Term Conditions - During the development of this strategy, service users were invited to share their experiences and provided valuable input to the shaping of the framework. They were encouraged to share the positive aspects of their experiences together with areas where things could be improved, and their ideas for the future. The involvement of service users will be integral to future planning, monitoring, development and delivery of services relating to Long Term Conditions across NHS Greater Glasgow and Clyde.

Current mechanisms of engagement include the various Managed Clinical Networks established within the health board area and their related service user forum, and Public Partnership Fora within CH(C)Ps. Both mechanisms provide opportunities for engagement with patients, carers and the public, and will be utilised not just as single entities but also as partners working together across the NHS system. The role of voluntary sector organisations (both nationally and locally) will also play a key role in the process of engaging and involving people; providing links to a wide network of service users and the public

7.2 Making Health Care Safer - including Clinical Governance, Clinical Effectiveness, Risk Management and any Issues Arising from Ombudsman's Reports

NHSGGC performance against the national standards for Clinical Governance and Risk Management (NHS QIS) were internally reviewed and, given our progress against standard one on risk management, deemed to be in line with the HEAT target.

NHSGGC is also participating in the Scottish Patient Safety Programme, which commenced in October 2007. This led initially to the setting up of nine pilot locations in January 2008 that are taking forward implementation of reliable designs for safety critical clinical and communication processes. In addition we have reviewed the role of leadership and have given much greater prominence to the priority attached to patient safety within NHSGGC. We see our involvement in the SPSP as an opportunity to bring about major improvements in patient safety.

In 2007/2008 we have continued to build on existing approaches by;

- enhancing adverse incident surveillance through establishment of single system reporting arrangements;
- sustaining considerable focus on learning from significant clinical incident and improved staff capability to identify system failures through a programme of Root Cause Analysis training;
- sustaining a programme of clinical audit through strategic groups and local services to improve care through the measurement and development of evidence based practice;
- establishing independent checks of clinical governance arrangements through internal Audit reports and follow up action to NHSGGC Board assurance arrangements.

Responding to the recommendations in Ombudsman's reports are initially the responsibility of the specific service management team. Action points which can be immediately completed are confirmed in the first response to the Ombudsman. Any longer term, more complex issues are tracked and linked to the routine of regular reporting to the NHSGGC Clinical Governance Committee. This is used, along with the Ombudsman's summary reports, to create awareness of broad themes for action. This includes action plans for local record keeping arrangements and an ongoing review of interventions to improve clinical communication with patients and carers.

7.3 HAI and Infection Control

Reduction of Staphylococcus aureus bacteraemia by 35% by 2010. NHSGGC is currently ahead of trajectory and will continue to focus on this priority area in 2008/09 and 2009/10, to continue progress towards the 35% reduction target.

This is the first year of a three-year programme and during the year the focus has been on collecting data and evaluating different feedback mechanisms. Several strategies are currently being employed/evaluated. Infection Control Teams across the Board area are collecting enhanced data (using a data collection form developed by Health Protection Scotland) in order to target not only areas with a high prevalence but also interventions associated with the acquisition of bacteraemia, eg, central venous catheterisation. In addition, Statistical Process Control Charts have been introduced into all clinical areas, with the aim of providing information systematically and timeously to those with the ability to change clinical practice.

NHSGGC is committed to quality improvement in infection control practice and is actively promoting the implementation of the newly developed Health Protection Scotland 'Care Bundles' especially those specifically designed to optimise care with regard to the insertion and maintenance of both centrally and peripherally inserted venous catheters.

7.3.1 The Scottish National Hand Hygiene Campaign

Audit Activity

Audits commenced in February 2007 with the focus on key areas in acute sites based on previous prevalence data.

- 115 wards were audited for compliance in 2007/08;
- a total of 2,460 staff contacts were recorded in the audits;
- any staff member present on the ward at that time is subject to the audit;
- 20 opportunities for Hand Hygiene are recorded, based on World Health Organisation guidelines for contacts within the acute setting;
- the results are immediately given to ward management verbally;
- written reports are then compiled and sent to Lead Nurses and Infection Control Leads for distribution;
- the figures also contribute to the Ward Profiles.

NHSGGC reported a rise in compliance from 62% in February 2007 to 82% in September 2007. The 3rd National Audit in February 2008 showed that overall compliance was 83%. The indicative figure for May 2008 demonstrates a further increase in compliance to 87%.

7.3.2 Surveillance - National Programmes and Mandatory Requirements

NHS Greater Glasgow and Clyde are compliant with mandatory surveillance as set out in HDL (2006)38.

Surveillance to day-30 post-operation is now mandatory and although this is in place for all of orthopaedic procedures, the implementation of this with regards to caesarean section procedures has been problematic. NHSGGC has however been compliant with caesarean section surveillance requirements since June 2008.

7.3.3 Education/Cleanliness Champions (CC)

The Cleanliness Champions Programme was introduced by NHS Education Scotland in 2002. NHSGGC was asked to facilitate the training of 983 CCs, a target that was exceeded in March 2008 and which now stands at 1193. This target required a significant investment in time and resources and the priority for 2007/08 was to provide a structure to support the ongoing education and commitment of the CC and link this to other HAI initiatives, eg, Scottish Patient Safety Programme, QIS HAI Standards.

7.3.4 Patient Focused Public Involvement

NHSGGC is committed to involving the public in decisions pertaining to the Prevention and Control of Infection and the planning and delivery of the Infection Control Service. In addition to public representation on the Board Infection Control Committee we have recruited members of the public into three key Patient Focus Public Involvement (PFPI) groups:

- Public and Peer Review of the National Monitoring Framework for Domestic Services;
- Board HAI Public Information Review Group - this group, which is led by the Nurse Consultant Infection Control, reviews information developed to inform patients and the public of HAI issues. This group is also consulted on the implementation of specific HAI initiatives, eg, the NHSGGC Prevention and Control of Infection Programme of Work. A member of this group sits on the Board Infection Control Committee;
- QIS HAI Standards Implementation Group.

7.3.5 Antimicrobial Management Team

The Greater Glasgow and Clyde Antimicrobial Management Team (AMT) was formed in May 2007. This group consists of a Lead Physician, Lead Microbiologist and Lead Pharmacist. The AMT reports to the Chairman of the Board's Prescribing Management Group. Its work is supported and guided by a sub-group of the Board-level Area Drug and Therapeutics Committee - the Antimicrobial Utilisation Committee (AUC), whose membership reflects the full range of stakeholders with responsibility for prudent prescribing of antimicrobial medicines.

7.3.6 Antimicrobial Management Team achievements to date

Development and approval of:

1. Infection Management Guidelines (Medicine);
2. Intravenous to Oral Switch Therapy Policy (IVOST);
3. Alert Antibiotic Scheme;
4. Accident and Emergency Antibiotic Guidelines;
5. Gentamicin Guidelines.

In process of development:

1. Surgical Sepsis Management Guidelines;
2. Vancomycin Guidelines;
3. Gentamicin/Vancomycin electronic dosage calculator for doctors/pharmacists.

7.3.7 Healthcare Associated Infection (HAI): Roles and Responsibilities of Chief Executives.

NHSGGC have undertaken an initial review of progress against the "high priority" and "priority" guidance appended to the Director General Health and Chief Executive NHS Scotland's letter of 27th June 2008. All areas are being progressed within NHSGGC via the Board Infection Control Committee and the Annual Infection Control Programme.

7.4 Spreading Best Practice

Clinical Governance uses a framework of five key mechanisms identified by research to promote the use of evidence and best practice. The mechanisms and examples of action are as follows:

- dissemination: all national guidance published or promoted via NHS QIS is disseminated on a targeted basis to include key clinical services, planning structures including MCNs, practice development and professional leads. There are also a range of review or reporting arrangements linked to clinical governance arrangements. This includes formally supported dissemination through committees, working groups, bulletins and informal means such as local good practice conferences and seminars;
- interaction: a high number of NHSGG&C staff participate in national bodies promoting research and contributing to the development of evidence based practice guidance;
- social influence: there are many examples of using champions, through practitioners who are clinically recognised as excelling, or through training as with Infection Control Champions. Practice development occurs through the mutual interaction of clinical and managerial leaders collaboratively enabling change;
- facilitation: NHSGGC has a range of technical specialists who are deployed across the services, interacting directly with clinical teams or indirectly through education.
- reinforcement: mechanisms such as job planning, appraisal and KSF are all being used to confirm expectations of clinical performance and practice.

7.5 Modernising Services through Better use of Technology

In 2007/08, NHSGGC used technology to improve services to patients in a wide number of areas.

7.5.1 Acute

- Picture Archiving and Communication System (PACS) - NHSGGC was the first Board to implement PACS. This is complete and patients are benefiting from better quality of image and faster sharing of results.
- Accident and Emergency (A&E) - NHSGGC has implemented the national A&E system across North Glasgow and Clyde (South Glasgow/Yorkhill already have a system). This enables clinicians/managers to manage A&E with real-time information ensuring both a speedy response and appropriateness of prioritisation. This has supported the operational

management to enable NHSGGC to consistently be amongst the highest performers in the NHS.

- Endoscopy - A single endoscopy system now covers NHSGGC, enabling cross-system working leading to better support of patients and support for delivering diagnostic access targets.

7.5.2 CH(C)Ps/Primary Care

- Primary care: replaced infrastructure for all GPASS systems enabling a number of key deliverables:
 - development and implementation of templates for local and direct enhanced services to patients for
 - Keep Well;
 - coronary heart disease;
 - stroke;
 - diabetes;
 - successful implementation of Scottish Cervical Call/Recall System (SCCRS) including lessons learnt event at the Beardmore.
- Community: rolled out Community Nursing System, enabling community staff to see and record vital patient information at point of care and share with other clinical/care staff appropriate.

8. FINANCE, EFFICIENCY AND WORKFORCE

8.1 Financial Performance and Planning (Revenue and Capital) and Maintaining Financial Balance

The Board's expenditure remained within its revenue resource limit for 2007/08 of £2,014,370 by £646,000. During the year the Board expended non-recurring funding of £27.3m which was carried forward from 2006/07, deploying this predominantly on the achievement of waiting times targets, particularly related to the abolition of Availability Status Codes.

The Board also continued to work towards restoring the Clyde area of its management responsibilities to a position of financial breakeven, successfully implementing a series of cost savings measures which reduced the gap between recurring funding and expenditure by £7m, to £19m by 31st March 2008. During 2008/09 and 2009/10 the Board plans to eliminate this residual gap, working closely with colleagues in the Health Directorates, through the implementation of further cost savings measures.

In 2007/08, the Board incurred £122.3m of capital expenditure, remaining within its capital resource limit by £400,000. Major individual capital schemes included £6.3m to complete the new Beatson Cancer Care Centre, £5m on enabling works and equipment related to the two new Ambulatory Care Hospitals which are scheduled to come on stream in April 2009, and £3.5m on a new West of Scotland Adolescent Inpatient Psychiatry Unit. Other schemes included £12m on replacement medical equipment and £7m to purchase additional medical equipment to support the achievement of waiting times targets across Greater Glasgow and Clyde.

8.2 Efficiency Savings, including Efficient Government Targets

The Board continued to meet its cumulative target for efficiency savings in 2007/08, with recurring cost savings achieved of £16.4m giving a cumulative total of £50.4m for the three year period to March 2008. This allowed it to meet its target for that period. In addition, non-recurring savings of £4m were secured during 2007/08, which contributed towards offsetting, in part, the residual gap existing between recurring funding and expenditure commitments related to Clyde. £7m of the £16.4m efficiency savings measures which were successfully implemented during 2007/08 related to Clyde and were made possible by closer integration of services within the wider Greater Glasgow and Clyde area.

8.3 Staff Governance

A comprehensive staff governance action plan was agreed with the Area Partnership Forum and reported regularly to the Area Partnership Forum and the Staff Governance Committee. The plan covers the 5 components of the standard. This was publicised widely throughout the organisation through an awareness-raising leaflet.

A corporate communications plan is in place and staff communication takes place on a regular basis through a frequent core brief, and regular Staff News magazine.

A safe and healthy working environment is being taken forward through the Health and Safety Forum, which is harmonising all health and safety policies and overseeing the work towards the Healthy Working Lives Award.

A series of staff focus groups have been set up to engage staff and hear at first hand the issues which most impact on their working lives.

8.4 Partnership Working

The Area Partnership Forum meets on 8 occasions per annum, with agendas divided between strategic plans, and workforce/HR issues. The Acute Division Partnership Forum is well established and there are Staff Partnership Fora in each CH(C)P. There have been some difficulties in dealing with issues which affect staff across CH(C)Ps, where it has not been possible to achieve the level of staff engagement required. This is being addressed through the better engagement of the Area Partnership Forum.

Issues such as Agenda for Change implementation including the Knowledge and Skills Framework are reported regularly. The financial plan and strategic developments such as the New South Glasgow Hospital have been debated frequently. The Board's work on tackling health inequalities has also been a key issue for the Forum in the past year.

The APF has been leading on the harmonisation of the HR policies. This has proven to be a significant piece of work bringing together the former policies of 6 organisations and on elements of the Discipline and Grievance procedures there is currently a dispute. However a process has been established to seek a resolution.

8.5 Pay Modernisation

The implementation of Agenda for Change is nearing completion with over 33,000 staff having been assimilated and fewer than 2,500 staff remaining to be assimilated. This involves considerable work in Payroll given that the staff remaining to be assimilated have had a number of posts or changes to their circumstances since October 2004. Additional capacity has been established in payroll to deal with this, and the task should be completed in September 2008.

The implementation of the Knowledge and Skills Framework (KSF) continues and by the end of March 2008 30% of staff had KSF based personal development plans, on route to achieving the target of 100% by March 2009.

8.6 Workforce, Financial and Delivery Planning

The Board's workforce projections are now complete reflecting the Board's financial and delivery plans. The projections are based on work being undertaken in the Acute Directorates and CH(C)Ps to consider the impact of a tight labour market, the demographics of the population and the need to ensure the most effective use of available skills. This has resulted in competency based workforce modelling around the profiles in the NHS Careers Framework.

This work is being supported by the Strategic Alliance between the Board and Higher and Further Education which will ensure that there is adequate educational provision to support the future shape of the workforce.

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