ANNUAL REVIEW 2007

CHAIRMAN’S SELF ASSESSMENT

10TH OCTOBER 2007
# NHS GREATER GLASGOW AND CLYDE
## ANNUAL REVIEW 2007

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1. INTRODUCTION

Statement from Chairman

Throughout 2006-07 we have seen a continuation of the rapid pace of change affecting the health system across Greater Glasgow and Clyde. Overall we are making good progress on many fronts to transform health and health services in ways that will bring many benefits to local citizens.

In addition, the level of improvement we have made in order to meet and in some cases exceed many key national targets has been impressive. We have also built on work since last year on our approach to communications which helps ensure that our plans and services are better understood and that they reflect better people’s needs and preferences. The Our Health events have been engaging, well received and informative.

A year on, our organisational transformation has begun to deliver benefits, many of which are referred to in the following chapters, including the impact of Community Health Partnerships (CHPs) and Community Health (and Care) Partnerships (CH(C)Ps), the improved efficiency of a single acute division, and in the service focus of our Mental Health partnership.

The challenge for the components of our system remains significant. We know that while in general the health of our population is improving, this masks real and significant variations in health for people living in different circumstances in different parts of the NHS Greater Glasgow and Clyde area. Health inequalities are widening and we must ask whether we are doing the right things to address this, whether we are doing enough of the right things to address this and whether we need some new strategies.

Our focus now, both nationally and locally, must be on reducing inequalities and improving health; with significant action on alcohol and smoking behaviours and the reasons behind them, child poverty and children’s health. None of this can be achieved alone so our role as a partner has never been more important.

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

Professor Sir John Arbuthnott
Chairman, NHS Greater Glasgow and Clyde
### 2. PROGRESS ON MAIN ACTIONS FROM 2006 ANNUAL REVIEW

<table>
<thead>
<tr>
<th>Action</th>
<th>Timescale</th>
<th>Progress</th>
<th>Status</th>
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<tbody>
<tr>
<td>Provide a more detailed presentation about Boards IT strategy, including plans for roll-out and how the strategy will contribute to better, faster patient care.</td>
<td>November 2006</td>
<td>A full update on progress and development of Board IT Strategy submitted to Scottish Government on 30 November 2006.</td>
<td>Complete</td>
</tr>
<tr>
<td>Consider how best to support Area Partnership Forum members in developing the right skills so that they can contribute fully to the partnership’s business.</td>
<td>Ongoing</td>
<td>Being planned and implemented with Employee Director. Proposal to establish training programme developed.</td>
<td>On Schedule</td>
</tr>
<tr>
<td>Work with Area Partnership Forum to keep up the momentum on Agenda for Change, and to adhere to agreed timetables.</td>
<td>Ongoing</td>
<td>Job evaluation and reviews will then be overseen by a sub group of Area Partnership Forum. Discussions ongoing in relation to mainstreaming Agenda for Change activity particularly job evaluation and development of Knowledge for Skills Framework outlines.</td>
<td>On Schedule</td>
</tr>
<tr>
<td>Bring forward, in partnership with the local Council, a CHP proposal for Inverclyde.</td>
<td>As soon as possible and Before the end of 2006</td>
<td>A Scheme of Establishment for Inverclyde CHP was submitted to Scottish Government on 30 November 2006.</td>
<td>Complete</td>
</tr>
<tr>
<td>Report on compliance with all QIS infection control standards.</td>
<td>By March 2007</td>
<td>Active management of Hospital Acquired Infections established in all health settings has resulted in significant improvements for Board in QIS compliance. Update note submitted to Scottish Government. New QIS standards to be agreed by autumn 2007.</td>
<td>Complete</td>
</tr>
<tr>
<td>Provide an update on effective interventions and innovative approaches in addressing misuse of alcohol.</td>
<td>By end 2006</td>
<td>Corporate Action Plan for Drugs and Alcohol 2006-07 previously submitted to Scottish Government. Policy statement agreed with Glasgow City Council based on most effective interventions also provided to</td>
<td>Complete</td>
</tr>
<tr>
<td>Action</td>
<td>Timescale</td>
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<tr>
<td>Scottish Government. A similar process is planned with all other local authorities in Board area. More detail provided in Health chapter.</td>
<td></td>
<td></td>
<td>Complete</td>
</tr>
<tr>
<td>Provide a note on interventions being put in place by CHPs/CH(C)Ps across the Glasgow and Clyde area to tackle multiple hospital re-admissions.</td>
<td>By December 2006</td>
<td>Incorporated as key action for Board financial planning for 2007/08 to improve demand management. Addressed as part of Board Local Delivery Plan (LDP) for 2007-08 signed off by Scottish Government in March. Forms part of consideration of Board long term conditions strategy currently in development. Key targets and measures included as part of CH(C)P performance reporting.</td>
<td>Complete</td>
</tr>
<tr>
<td>Provide a note about progress with shifting the balance of care from secondary to primary care.</td>
<td>By March 2007</td>
<td>Forms key action of Board financial planning for 2007-08 reported in April 2007. Included in regular progress update to Scottish Government on Delivering for Health.</td>
<td>Complete</td>
</tr>
<tr>
<td>Provide the results of evaluation of the impact of the Board's work in reducing dental disease in deprived areas.</td>
<td>By March 2007</td>
<td>Implementation of ‘Childsmile’ taking place across 60 outlets with 24 dental health support workers recruited across six CH(C)P areas. Seventy schools in Glasgow City engaged in toothbrushing programmes for P1 and P2 children plus a further 22 schools in Inverclyde and Renfrewshire. Much of this activity already routinely reported to the Government. Progress on “Childsmile” reported to West of Scotland steering group and communicated to Chief Dental Officer.</td>
<td>Complete</td>
</tr>
<tr>
<td>Action</td>
<td>Timescale</td>
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<tr>
<td>Improve waiting times for colorectal and urological cancer patients to achieve the target of 95% of patients moving from urgent referral to treatment within two months.</td>
<td>As soon as possible</td>
<td>An updated action plan on colorectal cancer has been submitted to Scottish Government and an action plan for urological cancer is was agreed for the visit of the Cancer Performance Support Team on 21 December. More detail available in Treatment chapter.</td>
<td>Complete</td>
</tr>
<tr>
<td>Ensure the phasing out of Availability Status Codes by the due date in line with planned trajectories in the Local Delivery Plan.</td>
<td>End 2007</td>
<td>Actions underway. Trajectory in Board LDP for 2007/08 forecasts achievement in advance of the December 2007 target. More detail available in the Treatment chapter.</td>
<td>On Schedule</td>
</tr>
<tr>
<td>Review the primary care aspects of the Board's pay modernisation benefits plan in the light of further information about the available benefits and submit a revised plan to the Department.</td>
<td>As soon as possible</td>
<td>An updated plan was submitted to Scottish Government on 6 December and discussed with civil servants on 8 December.</td>
<td>Complete</td>
</tr>
<tr>
<td>Continue to meet financial targets throughout 2006-07, and restore recurring financial balance in the Clyde area.</td>
<td>By March 2009</td>
<td>Achieved financial targets in 2006-07. Detailed (three year) financial recovery plan is being prepared and will be finalised by autumn 2007.</td>
<td>On Schedule</td>
</tr>
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3. HEALTH IMPROVEMENT AND HEALTH INEQUALITIES

3.1. Introduction

A focus on health improvement and health inequalities permeates all of our activities both in the partnerships and the acute division. Over the past year we have continued to develop the capacity of the organisation to promote health and address inequalities through establishment of public health networks, development of a health improvement framework and review of the public health workforce. We continue to make progress in key areas including smoking cessation and implementation of phase two of the Board’s smoking policy, development of a joint alcohol policy, publication of our physical activity strategy, evaluation of the food in schools initiatives and implementation of wave one of Keep Well.

Addressing health inequalities will require change in the social determinants of health and there is therefore considerable work being undertaken with our partners on worklessness and employability as a means to reduce poverty.

As part of increasing the organisation’s capacity to improve health, a number of developments have taken place in the role of the Public Health function in the planning, design and delivery of services, including:

- Establishment of the Public Health Resource Unit;
- Development of the Public Health Network; and
- Review of the Public Health Workforce.

NHS Greater Glasgow and Clyde (NHSGG&C) is seeking to maximise its contribution to addressing inequalities and health by ensuring that an understanding of the way different forms of inequality affect health and the identification of appropriate action are incorporated into its core business. This requires a cultural shift in which a social, as well as a biomedical, model informs all its actions. As such, it is recognised as a significant organisational challenge and a number of building blocks have been put in place.

3.1.1. Development of Policy and Planning

Planning and priorities guidance is produced on an annual basis by the Corporate Planning & Policy Team, in dialogue with the component parts of the NHSGG&C system. This is used as the basis of three year Development Plans incorporating a set of
corporate and transformational themes. A key aspect of the guidance is the onus on inequalities and the requirements of a mainstreaming approach.

NHSGG&C is currently reviewing arrangements for the development and approval of policies across the organisation. This will include a requirement for all policies to be assessed for their impact on equalities, with guidance and clear templates for use by policy owners. A clearer approvals and consultation process will support the identification and addressing of any equalities issues. Ensuring that policy processes and systems address equalities issues is an explicit part of the remit of the Head of Policy, working within the Corporate Planning & Policy Team.

3.1.2. System Support

A Corporate Inequalities Team has been established as part of Corporate Planning and Policy, to work alongside the Directors of Corporate Planning and Policy, Public Health and Finance. Its primary role is to facilitate and support the development of an equalities sensitive approach within the key functions of the organisation. The work includes the development of policy, management of the legal requirements of the public sector equality duties, development of an effective framework for monitoring the extent of organisational change with respect to inequalities and its impact on health outcomes and client satisfaction and new, effective strategies for changing services and practice. It is supported by the Equality and Diversity Team established within the Organisational Development structure. Health Improvement and Inequalities Managers also have responsibility to support change within their parts of the organisation.

3.1.3. Systematic Approach to Equalities Legislation

NHSGG&C recognises that the experience and impact of discrimination are crucial factors in determining poor health and the ability by individuals to access the pre-requisites for good health including health care. Taking equalities legislation seriously is therefore considered to be essential in addressing health inequalities and poor health outcomes more generally. A unified Equality Scheme and associated action plan which brings together all the separate legislative strands has been produced and all the component parts of the organisation – CH(C)Ps, Acute Operating Division, Mental Health Partnership,
Addictions Partnership and Learning Disability Partnership have produced their individual action plans. Pan-organisational functions such as Human Resources, IT and Estates have also produced action plans. The first monitoring report will be produced by December 2007.

Initial outcomes of the Scheme will include:

- improved access to services and communication with patients by the implementation of the Language Plan;
- improved health outcomes for those experiencing gender based violence through implementation of the Gender Based Violence Plan;
- changes to policy, planning and delivery of frontline services through the implementation of an Equality Impact Assessment programme;
- a systematic approach to capital planning and management of our estate to reflect the requirements the Disability Discrimination Act and the new public sector duty for disability; and
- improvements in the collection of routine data to better reflect a diverse community.

3.1.4. Systematic Approach to the Development of Inequalities Sensitive Practice

A key factor in improving the effectiveness of health organisations with respect to an understanding of inequalities is ensuring that the transaction between frontline professionals and their patients takes all the factors that affect health presentations into account. The Inequalities Sensitive Practice Initiative, funded as part of the Scottish Government’s Multiple and Complex Needs programme, is working alongside four key settings – primary care mental health, addictions, children’s services and maternity services - to develop new ways of assessing health presentations which reflect the experience of poverty and the impact of gender on individuals. It is anticipated that management of the presenting health problems will then take these factors into account more explicitly, thereby providing the opportunity to create different forms of packages of care. The initiative is based on preliminary work already undertaken within NHSGG &C which has been evaluated to show improvements in health outcomes and patient satisfaction.
3.1.5. Developing Exemplar Service Design

Opportunities are also being created to translate the aims of the Equality Scheme and an understanding of the impact of poverty on people’s lives into the delivery of services. As part of the Equality Scheme Action Plan of the Mental Health Partnership, the Corporate Inequalities Team is working alongside Forensic Mental Health Services to support service redesign – the development of the Rowanbank medium secure unit and the reconfiguration of low secure services. The impact of this work will be a more effective approach to recovery and risk management through a better understanding of the impact of male socialisation and gender inequality on criminal behaviour and mental health.

Equivalent activity is being progressed or about to commence in maternity services, sexual health services (the Sandyford Initiative), accident and emergency services and cancer services. The Keep Well programme is also a component of this approach and is described later in this chapter.

3.1.6. Planning for Equality Proofed Resource Allocation

A review of resource allocation to the CH(C)Ps is currently taking place, with a particular focus on children and families and older people/disability budgets. This review aims to ensure that resource allocation is based on needs rather than historical patterns of service provision and that is supports initiatives to tackle inequalities.

The policy direction for primary care is also being reviewed. The contribution of primary care to addressing inequalities is part of this review, which will include consideration of the role of Keep Well with hard to reach groups, and how primary care resources match need across NHSGG&C.

3.1.7. Supporting Marginalised Groups – the Implementation of the Health and Homelessness Standards

NHSGG&C works with the Glasgow Homelessness Network (GHN) and in conjunction with the Glasgow Homelessness Partnership (GHP) to ensure the delivery of the Health and Homelessness Standards. This work is carried out within the wider context of the work on inequalities in recognition of the added value that this brings – homeless people face issues of socioeconomic, gender, race and disability inequality and discrimination in the same way that the rest of the population
does. In July 2006 the Board, GHP and GHN developed a Health & Homelessness action planning framework for CH(C)Ps to achieve the Standards. All city CH(C)Ps have completed a draft Health & Homelessness Action Plan.

Since 2006, key progress has been made in the integration of CH(C)P structures with local housing and homelessness structures, and this partnership has been achieved at both planning and delivery level. Additionally, the implementation of the Homelessness Integrated Assessment increases the quality of data available to the Board to inform service developments. The July 2007 Health and Homelessness Action Plan Progress Report highlights five main themes for further action: further development of service user involvement, developing Inequalities sensitive practice, improving accessibility of mainstream services, further identification of homelessness risk assessment, greater clarity of the responsibilities of CH(C)Ps within their development plans.

In recognition of the disproportionate numbers of homeless people of both sexes who have experienced gender based violence, either as children or in adulthood, there is also a programme of work being undertaken to improve assessment and service responses to this issue.

3.1.8. Supporting Marginalised Groups – Offenders and Health

NHSGG&C is actively involved in the Community Justice Authorities (CJAs) in Glasgow City and North Strathclyde. We have been working with the CJAs to identify specific health issues for offenders, particularly in the areas of mental health and substance misuse, and on the interface between prison health services and community health services. We have a number of initiatives in place to support offenders including active involvement in Drug Treatment and Testing Orders as an alternative to custodial sentences and in reach services to prison. As part of the development of CJA area plans we are looking at how we can ensure offender issues are better reflected in other priority areas of work, including employability and homelessness.

3.1.9. Supporting Marginalised Groups – Black and Minority Ethnic populations

NHSGG&C has strategically approached meeting the health needs of Black and Ethnic Minority (BME) populations through
the development and implementation of its Equality Scheme and associated action plan. The Equality Scheme and action plan were endorsed at the December 2006 Board meeting. The various components of our system have responded within the strategic framework by producing their own action plan against which they will be held accountable for progress. The direction and progress can be described as follows:

- **Understanding the needs** – NHSGG&C recognises the importance of capturing data through which we can identify trends in disease patterns associated with ethnicity, lifestyle factors associated with ill-health, and issues associated with access to services and our service response. The major challenge we face is in establishing robust information with regard to our minority ethnic populations. Data capture is at best sporadic in relation to morbidity and mortality information. In 2006 we reported on the BME Health and Well-being survey undertaken in 2005, and continue to engage with BME populations through the work of our community engagement team in the design of new build facilities to ensure cultural and religious needs are considered. NHSGG&C were also involved in the HMIE (Her Majesty’s Inspectorate for Education) joint inspection of local services for children of asylum seekers in Glasgow City Council area, and in locally based research into A8 (Accession countries) migrant workers in the Glasgow area. Qualitative research backs up anecdotal evidence and indicates that BME communities continue to face racial discrimination and abuse.

- **Communication and Language** – NHSGG&C continues to be a key partner in the Glasgow Interpreting Partnership which strategically manages the provision of interpreting support within our boundaries. Internally we have developed an interpreting policy and access protocol which is regularly reviewed. In addition we jointly fund a BME advocacy service with the City Council. NHSGG&C also commissioned an update to the Multilingual Health Information Directory which covers 17 different topics in 14 different languages, five of which are associated with migrant worker populations. At a national level we contribute to TICSIG (Translating, Interpreting, Communications Support Implementation Group) and a working group established by Health Scotland to consider interpreting and translation needs across Scotland. As part of NHSGG&C’s Equality Scheme actions,
a Communication and Language plan is being developed in 2007/08.

- Meeting needs – NHSGG&C is piloting an approach to Equality Impact Assessment within services it provides across primary and secondary care. This approach considers the issues of access and service response for various disadvantaged groups. We anticipate that this programme will be rolled out across our system during 2007/08. Work around consultation on catering is ongoing. Consultations were held with African/Caribbean and Sikh and Hindu communities and these continue with regard to the new three week menu cycle. This builds upon work previously undertaken with regard to Halal and Kosher menu options.

- Employment – NHSGG&C continues to be a partner in the development of a business plan for the City Strategy on employability. One of the strands in this work is BME communities. In addition we have projects running to understand how best to attract, retain and develop BME people in to the NHS through Working for Health and other programmes, and a similar approach to refugees and other non-UK nationals is adopted.

3.1.10. Supporting Marginalised Communities – Migrant Workers and Health

Whilst some of the issues facing NHSGG&C in identifying and meeting the needs of migrant workers vary from those of BME communities, there are commonalities. These largely relate to communication and language, in particular around knowledge of how to access services and the quality of communication exchange between health professional and patient. A welcome pack from migrant workers is being developed which includes information about access to health services. The recently completed research into A8 nationals in the Glasgow area suggests that in general the demographic profile of migrant workers differs from the other BME populations and consequently the health related issues are different. The age profile of migrant workers is younger and concentrated in the 18-34 age range. They are predominately single with the male:female ratio being 60:40. The research indicated that only 58% of the migrant workers were registered with a GP. This in itself poses some issues relating to late attendance for
treatment, potential pools of infection in the community, and inappropriate use of A&E services.

There are particular issues with a small but significant Slovakian Roma community where immunisation is particular concern particularly with diseases such as TB. The local response to these identified issues has been the appointments of a senior nurse for children’s services with responsibility for A8 nationals along with a part-time Health Visitor, and the commissioning of outreach work to liaise directly with the Roma community. This community seems to be transient in nature and continuity of contact can be difficult. In general however the NHSGG&C approach has been to integrate migrant workers into the mainstream services.

A leaflet was developed to tackle identified inequalities in awareness of services and problems with accessing addiction services amongst minority ethnic groups. This leaflet is available in ten different languages English, Urdu, Punjabi, Hindi, Chinese, Arabic, Somali, French, Turkish and Farsi. It has information on a range of different services including Community Addiction Teams, BME Alcohol and Drug Service, Glasgow Drug Crisis Centre, Glasgow Council on Alcohol and Smoking Concerns. In addition to this a complimentary language line using the National Interpreting Service has also been developed that aims to make referral pathways to services easier.

3.1.11. Improving the Role of NHSGG&C in Addressing the Determinants of Poor Health

NHSGG&C recognises that improving health and addressing inequalities requires the efforts of national and local agencies. Nevertheless, it has a key role to play as a partner in both clarifying its own role in addressing the determinants of poor health and identifying and supporting the contribution of others. The implications of multi-agency planning arrangements such as Community Planning to maximise health impact are discussed elsewhere as are specific initiatives aimed at key determinants such as improving employability. The Glasgow Centre for Population Health (GCPH) has developed further its work in building understanding, evidence for action, and fresh approaches to improving health and tackling health inequalities. As well as linking directly with the Board’s corporate functions, members of the Centre’s team work with CH(C)Ps, council colleagues, and other partnership structures to support the
application of information and evidence to planning and practice. GCPH seminars and events are well attended by a large range of stakeholders and contribute to learning and professional development across the Board’s area. During the year, information from ‘Let Glasgow Flourish’ has been widely used across the system and further work has been carried out to provide similar data at CH(C)P level. The ‘GoWell’ programme, which is exploring the health and wellbeing impacts of neighbourhood regeneration, completed its first year and the baseline results were presented at the annual event in March. The Centre has contributed significantly to public health developments with Glasgow City Council, including through evaluations of the food provision in schools and through the application of Health Impact Assessment methods. Other significant developments include an ongoing evaluation of the (cost-)effectiveness of smoking cessation services; research and monitoring on employability and health; and provision of a city-level contribution to the work of the WHO Commission on the Social Determinants of Health.

3.2. Inequalities in CHD Mortality

A range of actions are being taken to ensure we continue to increase the rate of improvement in a number of health conditions in our most deprived communities. Action being taken includes the range of work described below related to tackling obesity, reducing smoking and increasing physical activity. A key initiative proving successful in engaging those at risk is Keep Well.

The Keepwell programme has been established in the North and East CH(C)Ps. A total of 18 GP Practices across north and east are participating in the project together with a range of health and wellbeing services from statutory, voluntary and community organizations. The table below illustrates activity to date:

<table>
<thead>
<tr>
<th>Community Health and Care Partnership</th>
<th>No. of patients eligible (45 – 64 years)</th>
<th>No. of patients contacted to date</th>
<th>No. of patients attended to date</th>
</tr>
</thead>
<tbody>
<tr>
<td>North</td>
<td>9619 patients</td>
<td>2730</td>
<td>1122</td>
</tr>
<tr>
<td>East</td>
<td>8836 patients</td>
<td>4196</td>
<td>1414</td>
</tr>
</tbody>
</table>
Activity in local GP Practices is part of the programme evaluation. Initial developments in practice however include:

- increased access to services with a number of practices opening earlier in the morning; later in the evening or Saturday mornings to accommodate patients;
- GP Practices using a skill mix in the delivery of the health assessment offered;
- An increase in capacity in the form of practice nursing and healthcare support workers with only a limited increase in GP capacity.
- Appointment of health councillors to provide motivational support to address physical activity, health eating and weight management issues (286 referrals to date);
- establishing pathways from primary care to money advice services (121 referrals to date); and
- Pharmacy consultations to support medication concordance (200+ referrals to date).

3.2.1. The Heart Disease Managed Clinical Network

During 2006-07 the Heart Disease Managed Clinical Networks (MCNs) in Greater Glasgow and Clyde have amalgamated. There is now a robust structure in place to deal with these and similar challenges, and to plan ahead to deliver consistent services and standards across the whole area. The MCN has public health and health improvement input across a wide range of issues.

There is a health improvement sub-group whose role has been to deliver across stroke, diabetes and heart disease, since so many of the pre-disposing risk factors are common between them. One particular success has been to incorporate health improvement as a substantial part of the Local Enhanced Service (LES) for each of these.

The health improvement sub-group is closely involved in managing the transition from separate services in Clyde and the former Greater Glasgow to one set of services, with similar standards and referral pathways. This includes cardiac rehabilitation and the exit strategy from HaHP (Have a Heart Paisley), ensuring close links to all community health improvement services – no gap, no overlap – and delivery, where possible, on community sites to promote attendance and exercise perseverance.
The MCN has set up a patient forum to support our Patient Focus Public Involvement agenda. Training and support provided allows patients to contribute effectively in the executive and steering groups.

Local guidelines which are currently under review under the aegis of the Heart Disease MCN (following the publication of a set of SIGN guidelines relating to heart disease), will have input from this forum to ensure that patient’s concerns are included, and also to deliver lay versions of the guidelines so that patients can understand the standards that they can expect.

A web site has been developed and will become live to the public shortly. This will deliver a one stop access for the public, for patients and for health professionals to local services, standards and health related information around heart disease, stroke and diabetes. It will include lay and health professional versions of guidelines.

The MCN took the opportunity to appoint a single team leader for the Heart Failure Liaison Nurse Service across the whole of the area. It has also put in place equitable service provision, in terms of staffing, for all hospital catchments. A common set of protocols and guidelines is in use and the service is now able to ensure that at times of holidays or sick leave, patients in any area are not disadvantaged. Previously single handed practitioners were fairly isolated, but the new team structure ensures support for staff in terms of professional development, difficult cases, and cross cover when necessary. Working as a team rather than as small stand-alone units brings advantage in staff retention as well, providing service stability for patients.

The MCN has delivered close collaboration between primary and secondary care in a number of areas. As well as some issues described above, dedicated services such as the Rapid Access Chest Pain clinics, the palpitations service (technician led) and direct access echo services are underpinned by the collaboration. Putting the patient at the centre of our work and ensuring standards, easy diagnostic pathways and responsive services, are fundamental to the work of the MCN. To deliver on these, the MCN ensures that all those with a stake in cardiac disease prevention, diagnosis and care are involved and collaborate where appropriate to ensure an effective joined up approach. This approach now includes a larger geographical area, more health staff, additional local authorities and approximately one third more patients. There are still difficult challenges ahead with different
levels of service in different areas, but our early wins are paving the way.

Chronic Heart Disease (CHD) is associated with high levels of risk factors such as hypertension, overweight, smoking and high cholesterol levels as well as increasing levels of deprivation. Secondary prevention can substantially reduce the risk of myocardial infarction and progression of the disease once it is diagnosed.

A system of enhanced CHD care has been implemented in general practices in Greater Glasgow and plans are being developed to implement this in the Clyde area.

The LES in Greater Glasgow ensure a systematic approach to secondary prevention not only using the medical model but also attention to other risk factors that can contribute to risk reduction. Depression or other mental health problems can limit a person’s ability to make lifestyle changes so these are addressed within the programme. The programme includes provision of training and resources for practice staff, development of patient pathways across primary and secondary care, cardiac rehabilitation, liaison with mental health services and robust monitoring systems.

### 3.3. Alcohol

- **Overview**

  The available epidemiological material demonstrates misuse of alcohol represents a major public health challenge within Greater Glasgow and Clyde. Creating effective responses to this challenge is a priority for the Health Board and its partners and will require sustained effort in order to shift the damaging health profile that is currently evident. The complex and multiple nature of the factors contributing to population health problems related to alcohol mean that a coordinated multi-agency effort is required. This must be derived from the emerging evidence base, be well resourced and be sustained over time in order to bring about lasting change. Presented below are examples from the multi-agency work that is currently underway to address alcohol-related harm in NHSGG&C.

#### 3.3.1. City Centre Initiatives

**Community Prevention Trial (CPT)** – International evidence confirms that a multi-component programme, where each component is backed by evidence of effectiveness, is more
effective than individual activities delivered in isolation. Therefore
as part of this initiative, process data was collected from the
Ambulance Service, Strathclyde Police and Accident &
Emergency Departments with a view to identifying and influencing
alcohol related accident and violence trends. The data gathered
will be analysed and used to direct future preventative activity.
Another aspect of the CPT being progressed is the systematic
review of local and national media to monitor coverage of alcohol
issues. This is with a view to identifying the pattern of media
engagement during the trial, considering alcohol issues in general
and specific issues and initiatives affecting the city centre.

**Glasgow Matters Community Television** – Launched in April
2006 and used to broadcast public messages through 10 screens
at high footfall venues to people visiting the city. Glasgow was the
first such system to go live in Scotland. The Alcohol Action Group
has utilised the system to broadcast a total of 128,334 alcohol
harm reduction messages including ‘Play safe’ imagery.

**Nite Zone** – The aim is to reduce violent crime, disorder, anti
social behaviour and the fear of crime within the night time
economy in Glasgow City Centre and draws together a variety of
community safety strands which help to facilitate the prompt and
safe exit of users of the night time economy. Examples of
initiatives included in the project are bus marshals, taxi marshals,
white lighting, and the night radio network.

### 3.3.2. Pricing and Taxation Policies

**Irresponsible Promotions Policy** – The focus of this initiative by
Glasgow City Licensing Board is to inhibit the use of irresponsible
alcohol promotions in bars and clubs - such as double measures
for the price of a single measure, and instead ensure that the
price of alcohol remains the same all day. The rationale is to
encourage safer drinking patterns and discourage binge drinking.

Enforcement of existing laws, particularly on under-age sales and
drink-driving.

**Custody Card Initiative** - Following the successful evaluation of
the pilot scheme the project was extended in July 2006 to all four
Glasgow police divisions with prisoner handling facilities. The
initiative includes the display of posters within the custody suites
of the police Divisional Headquarters and a related credit card
sized information booklet containing information on sensible
drinking guidelines, the number of units in common drinks, how
alcohol can affect behaviour and where to go for support. These
booklets are distributed to individuals in police custody who have
been arrested due to alcohol-related behaviour to ensure they
receive harm reduction advice and information on support opportunities for alcohol problems.

**Glasgow City Centre Off Sales Campaign** – Involves developing initiatives to decrease the incidences of underage purchase of alcohol and increase safety in the off-trade in the City Centre. Examples of initiatives within this area of work include agent purchasing schemes and the establishment of a radio network across the City Centre.

3.3.3. Advertising and Promotion

**Best Bar None Award Scheme** – Aimed at creating a safer environment in the pubs, bars and clubs of Glasgow by encouraging them to take an inward look at their management practices with a focus on public safety and customer care. An element of this initiative is highlighting good practice in relation to advertising and promotions in these establishments. The scheme represents a partnership involving Strathclyde Police, Glasgow’s Safer City Centre Initiative, BEDA Scotland, the Scottish Licensed Trade Association and Greater Glasgow Alcohol Action Team and is sponsored by the world’s leading premium drinks manufacturer, Diageo.

**Safer Licensed Premises** – The aim of this project is to address the theme of responsible serving and management and customer care practices. Examples of initiatives that are included in this project are comfort zones, night radio link and steward training.

3.3.4. Education

**Alcohol and Drug Education Consultancy Service for Secondary Schools** – The aim of the service is to provide support for individual mainstream secondary schools in Glasgow City to improve the quality of drug and alcohol–related education in line with national best practice guidelines and “Glasgow’s Health” curriculum guide. This was achieved by providing a consultancy service to enable schools to review current practice and identify areas for action. Individual secondary schools were then provided with appropriate support by Create Consultancy to undertake developments in relation to providing quality drug and alcohol education.

**Play Safe Campaign** – This initiative uses an exciting multi-media approach including a dedicated website to promote the broad themes of Safer Drinking, Safe Socialising and Safer Transport Home. As part of the campaign, in 2006/07, the Glasgow Council on Alcohol and Scotland’s Health at Work Team devised alcohol awareness sessions that were then delivered in
the workplace setting throughout the campaign period by the Glasgow Council on Alcohol.

3.3.5. Licensing New Premises

**Outlet Density** – International evidence supports the fact that increased availability of alcohol (through extending hours and times of sale and through increased licensed premises outlet density) has a direct association with increased levels of alcohol related harm. The focus of this initiative therefore is on working with licensing colleagues on ways of considering the existing outlet density position in Glasgow City Centre in line with the requirements of the Licensing (Scotland) Bill. As part of that a research company has now been commissioned to carry out a literature review on outlet density, overprovision and alcohol related harm.

**Supporting the implementation of the Licensing (Scotland) Act 2005** – One of the key elements of the forthcoming Licensing (Scotland) Bill will be the mandatory training of all licensees and bar staff. The Safer Licensed Premises Sub Group therefore have been working in partnership with Serve wise to offer subsidised training courses to City Centre bar staff. As a result of these courses evaluating positively, subsidised distance learning training workbooks have also been distributed to members of staff in Glasgow City Centre nightclubs.

3.3.6. NHSGGC Specialist and Primary Care Services

**Acute Action Plan Implementation** - The overall aim of the three year Plan is to develop good practice guidelines and establish consistent approaches across all general hospitals in Glasgow in relation to screening and assessment for individuals with alcohol and drug problems, prescribing and withdrawal management, interventions, harm reduction, and education and training. Examples of the types of work being developed are:

- an alcohol-screening tool for citywide use in A&E, acute medical receiving wards, maternity, and all other hospital areas for all patients;
- looking at current practice and considering ways to reduce harm to children as a result of parental alcohol and/or drug use;
- ensure acute staff receive child protection and substance misuse training to recognise potential problems and adhere to child protection procedures, and feel confident to provide brief interventions;
• addressing problematic drinking and substance misuse in the under 18s presenting at A&E departments;
• assess current recording practice across acute services for patients where an addiction is identified as the primary reason for admission to hospital, or as a secondary diagnosis;
• consider all training requirements and commission training programmes as appropriate; and
• Implementation of the city wide nurse liaison service.

Community Setting Action Plan Implementation – This work is progressing in a similar format to the acute action plan with a focus on training and education, screening and assessment, interventions, health and safety, harm reduction and managing withdrawals.

3.4. Smoking

The most recent national data (2005) gives an adult smoking rate of 28.3%, against the national 2010 target of 21.5%.

Access to cessation services is excellent in Greater Glasgow (estimated annual uptake of 8% total smokers). Cessation rates in NHSGG&C are above average and validated. This percentage closely reflects the projected throughput of patients based on best practice.

Comprehensive integrated smoking cessation services have been established in all organisational entities within NHSGG&C. There is an ongoing training and development programme associated with this to ensure continuous improvement, quality assurance and service promotion. (Over 500 people including medical staff, dental staff, medical students and pharmacists attended brief intervention training and briefings on how to support smokers across NHSGG&C last year.) The Board has established a strong governance arrangement for tobacco related issues led by the Director of Public Health and specialist Health Improvement Team through the establishment of a Tobacco Planning and Implementation Group.

The services targeting acute inpatients and pregnant women have excellent quit rates for difficult target groups, 38% & 37% respectively. The success rate in pregnancy is up 9% since last year. Other hard to reach groups include young people being looked after and accommodated by the Local Authority. A pilot project joint funded by Glasgow City Council includes work with foster carers and staff on tobacco awareness; reducing the effects of second hand smoke and establishing a cessation service providing Nicotine Replacement Therapy and support for young people to stop smoking.
The extension of the pharmacy smoking cessation service ‘Starting Fresh’ into Clyde, has to date seen 49 of the 78 pharmacies involved, with another 12 attending training to become accredited in September. In terms of outcome data from 2005, Eastwood/Levern Valley, which was a shared CHP between Glasgow and Clyde, is showing 10.3% quit rates among people 12 months after stopping smoking.

The challenge remains in converting access to services into successful quit attempts. This is linked to issues in relation to the nature of smoking as a chronic relapsing condition, smoking as a coping mechanism and smoking as the ‘norm’ in some communities.

Despite a strong national focus on the development of smoking cessation services, sustained effort has remained on prevention and smoke free environments which place NHSGGC in a strong position with regard to the recommendations in ‘Towards a Future Without Tobacco’. This includes the jointly funded ‘smoke free me’ initiative in primary schools and smoke free classes in secondary schools. The ‘Smoke Free Homes’ initiative in the East of Glasgow has over 200 homes signed up to keeping their homes smoke free.

An increased emphasis on wider tobacco control, prevention and the roles of CH(C)Ps and Local Authorities are critical to the progression of this agenda and need to be harnessed. All CH(C)Ps have been consulted on a proposal to develop an overarching strategic tobacco document for NHSGG&C including high level priorities for action, and an action plan framework that can be used flexibly to reflect local structures. Glasgow City Tobacco Strategy is being updated incorporating new organisational structures and the changing priorities in Tobacco Control. Other activities addressing broader tobacco control have been undertaken including a successful conference hosted by NHSGG&C Strathclyde Fire & Rescue and Glasgow City Council on fire safe cigarettes. NHSGG&C are a signatory to the European Campaign for the introduction of Fire Safer Cigarettes that will reduce the number of deaths and injury caused from household fires.

3.5. **Obesity**

3.5.1. **Childhood Obesity**

Many of the initiatives to prevent obesity by promoting a healthy diet are covered in more detail in the section on healthy eating. We would want to particularly emphasise work in schools including: breakfast clubs, free fruit in schools, healthy school meals programmes such as the “Fuel Zones”, and access to free drinking water in schools.
The Glasgow Centre for Population Health has recently undertaken an evaluation of these initiatives and found that the physical and social environment exerts an important influence on pupils’ uptake and experience of school meals and that effective management and co-ordination by school staff during lunchtime has a positive impact on pupils’ experience of lunch and on the general atmosphere in school canteens. Active encouragement by teaching and catering staff as well as practical steps to make healthy foods easily accessible and attractive to pupils can increase uptake. The study also confirmed that the majority of primary school pupils bring crisps, sweets or chocolate into school to eat during break time although free fruit distribution during the school day is a successful way of encouraging pupils to eat fruit regularly at school.

A seminar on the research was organised by the centre which enabled discussion with stakeholders including local authorities on how to improve healthy eating habits of school children. The output of the research and the seminar has been fed into discussion with Glasgow City Council and Community Planning Partnerships.

The Board’s Child Health Strategy Group has set up work to review the evidence on prevention of childhood obesity. The results showed a disappointing lack of evidence of effective interventions but have led to the establishment of an advisory group to develop a Board-wide strategy for obesity for local action based on our best estimate of what will work. This will report over the next few months.

3.5.2. Adult Obesity

Our approach to weight management combines both prevention and management. The activities that support prevention are described below and relate to food and physical activity (these are described as Level 1 activity). Glasgow Weight Management Service (GWMS) provides two further levels of service:

- **Level 2** - Provision for those who are overweight or wish to maintain their weight (BMI of > 25)

- These interventions focus on population based healthy eating and physical activity messages and provides an opportunity to tailor these messages to promote weight management among groups of individuals.
• Level 3 - Provision for those who are most overweight (BMI of >35 or >30 when the client has a relevant co-morbidity).
This has now been rolled out to the final four Greater Glasgow Community Health Partnerships of GGNHS from 1st May 2007. The service can now be accessed by all GPs registered in the former NHSGG area. This has been a major achievement due to the numbers of referrals being considerably greater than anticipated (around 400/month). The referral number has required a significant increase in capacity and the GWMS team has doubled in size in response.

Substantial progress has been made in relation to the surgical intervention pathway; protocols are currently being piloted and the post surgical group service is currently in development.

The ongoing development of the Level 3 service is informed by patient involvement and focus groups/patient feedback are regularly undertaken. Additional developments have included the introduction of low impact exercise Taster sessions which are being piloted by the service to enable people into activity. There is a programme of ongoing training to support the introduction of this service into dispersed venues, offering more local access, as well as considerable support provided to national initiatives and events.

Future developments include roll-out to Inverclyde and West Dunbartonshire (Clyde part of the CHP), planned for early 2008.

A key achievement in 2007 has been the establishment of ‘Shape Up;’ a quality assured weight management programme designed and developed in conjunction with the weight management service and Glasgow City Council, currently being delivered by 6 out of 8 of our local authority partners. Shape Up comprises workshops covering healthy eating, physical activity, motivation, realistic goal setting and a weigh-in and measuring session. The sessions are held in Leisure Centres and community venues. The programme has included the development of shared resources, training of instructors, awareness raising within primary care, joint marketing of services across Local Authorities and provision of incentives such as free fitness classes.

Future developments include the rollout to Renfrewshire and Inverclyde planned for autumn 2007, establishment of pathways from secondary care and promotion of Shape Up with NHS staff.
Physical Activity: Key Activities Undertaken in Last Year

• **Physical Activity Strategy**

We have recently published our physical activity strategy for Glasgow. This broad strategy includes recommendations for reducing the obesogenic environment as well as initiatives to encourage and support people to be more active. Implementation is being taken forward through community planning partnerships both within Glasgow and extending into other Local Authority areas.

• **Live Active Exercise Referral Scheme**

The Live Active exercise referral scheme has continued to develop and expand over the last year including initial steps to expand geographically into the Clyde area, with work underway in the remaining three Local Authority areas to ensure system-wide continuity, consistency and coverage. In 2006, 6,071 referrals were made to the scheme across Greater Glasgow. Further analysis found that 60.6% of those referrals were from less affluent areas (Dep Cat areas 5, 6 and 7). By recording patients’ BMI classification it was shown that the majority of people attending the baseline appointment are classified as being either moderately obese (38.3%) or overweight (30.4%).

The impact of the scheme on local authority facilities is significant and the number of visits generated by the scheme demonstrates the additional value achieved by operating in partnership:

<table>
<thead>
<tr>
<th>LOCAL AUTHORITIES</th>
<th>ANNUAL VISITS LINKED TO EXERCISE REFERRALS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Culture and Sport Glasgow</td>
<td>54,649</td>
</tr>
<tr>
<td>West Dunbartonshire Council</td>
<td>6,769</td>
</tr>
<tr>
<td>East Dunbartonshire Council</td>
<td>4,129 + community services</td>
</tr>
<tr>
<td>East Renfrewshire</td>
<td>8,374</td>
</tr>
<tr>
<td>South Lanarkshire Leisure</td>
<td>3,356</td>
</tr>
</tbody>
</table>

Over the last year the Scheme has undergone a range of enhancements to ensure the needs of hard to reach groups are addressed, this has been made possible in part, due to funding received from the Scottish Executive. These include:
Live Active motivator project; 15 volunteer motivators have been recruited to provide peer support/buddying to support people who are currently inactive to participate into physical activity;

First Steps programme is a gentle introduction to exercise for people and includes activity taster sessions, education and a chance to meet other people who are new to physical activity;

Centralised administration for the scheme-ensuring a co-ordinated booking system across Glasgow city and links to other Local authorities; and

Commissioning of an in-depth research study into the scheme’s longer-term impact on behaviours, wider effects and the impact of the recent enhancements. Initial findings from this research have been very positive and include:

- Alignment with the desired target groups with over 50% of participants living within the 15% most deprived areas, the ethnic profile of participants closely reflecting the 2001 census; the majority (79%) are on medication and 76% of people were either overweight or obese;

- A significant reduction in mean BMI for all patients between baseline and six month recall stage. A significant movement towards the maintenance stage (regularly physically active) for patients between baseline and six month recall and between the six month and 12 month recall;

- An increase in mean minutes of physical activity as people progressed through the scheme mean (at baseline 389; mean at six month recall 560 and mean at 12 month recall 623);

- 75% of respondents saw themselves as being regularly physically active and for longer than six months;

- 90% of respondents exercise at or above the level which should result in health gain benefits (ie accumulation of 30 minutes of physical activity on at least five days of the week);

- When asked about their confidence to exercise independently (using an ascending scale of confidence from 0 to 100), the mean score was 84. 91% of respondents thought that Live Active has a positive impact on their ability to exercise independently; and

- 88% of respondents felt the scheme has a positive impact on the way they felt about themselves.

Therapeutic Exercise Programme.
A Therapeutic Exercise Programme has been developed in partnership with Culture and Sport Glasgow to provide structured community based low-level physical activity opportunities that are accessible, suitable for the needs of older adults, individuals living with long-term conditions and individuals with low functional ability.

We have recently reviewed the provision of our "condition specific” activity classes. These classes are operated by local authorities for patients on discharge from a range of NHS rehabilitation service including cardiac rehabilitation, back pain, Chronic Obstructive Pulmonary Disease and osteoporosis. We identified areas that required improvement to increase uptake and effectiveness and are now piloting a new programme with wider access. Qualified instructors work with physiotherapy services to deliver a quality assured programme and the classes reflect the individual's level of functional ability rather than their condition. There are five levels of class ranging from a maintenance class for strength and balance that targets those at risk of a fall or who have had a fall and then four progressive levels of circuit based classes. Full implementation across Glasgow with take place from April 2008 with rollout to other local authorities during summer 2008.

3.6. **Food and Health: Key Activities Undertaken in Last Year**

3.6.1. **Food and Health Framework Review**

The Food and Health Working Group, under the auspices of the then Glasgow Healthy City Partnership, established the Food and Health Action Framework in 2001. Its purpose was to ‘maximise awareness, availability, access and affordability of safe and nutritious food for everyone but particularly for people living in deprived communities or who experience local social exclusion’ with a further focus on improving children’s diet. The Framework was a vehicle for delivering the Scottish Diet Action Plan at a local level, through employing a multi-agency approach with key players influencing food and diet.
The Framework spanned the five-year period between 2001 and 2006, during which time the multi-agency group developed a series of Action Plans in relation to identified national priorities and local needs. Partners included NHS Greater Glasgow, Glasgow City Council, local health projects and the University of Glasgow. At the end of this period, an external research agency was commissioned with the purpose of reviewing the activities of the Food and Health Framework from 2001-2006, and assess the current situation and to make recommendations for developing a New Plan for Action for 2007-2012.

Key Achievements:

- Increased access to healthy food and water in schools and pre-5 units through a range of initiatives including introduction of free breakfast service and free fruit provision, curriculum development, staff training and installation of water machines;
- Launch of NHS Greater Glasgow Infant Feeding Policies & Guidelines for Health Professionals;
- Improved food provision in workplaces and catering establishments (including Community Cafés), with the Scottish Healthy Choices Award as the main vehicle;
- Increased support for breastfeeding through development and evaluation of a ‘Peer Support Breastfeeding Network’; and
- Increased support for Community Projects, largely through appointment of Health Promotion Officer as Community Facilitator.

The review highlighted themes for future action to address gaps in the Action Plans these include:

- Maintaining momentum in ‘improving children’s diet;’
- Link with other national initiatives such as obesity and physical activity;
- Address commitment to community groups;
- Review role of Community Facilitator in the light of new Community Health and Care Partnership structures (CH(C)P’s);
- Focus on retailer involvement; and
- Maximised use of the new GP contracts.
A priority objective within NHSGG&C Food, Fluid and Nutrition policy is ‘the promotion of a healthy and safe diet for the population of Greater Glasgow & Clyde’. In order to progress findings from the Food and Health review on a Board-wide basis and maximise engagement of Community Health Partnerships and Local Authorities, a system-wide Food and Health Planning Group has been established with representation from CHPs, Acute Services and Voluntary Sector Organisations. The group will link with wider strategic planning arrangements including Glasgow Community Planning and Joint Health Improvement Plans.

3.6.2. Food Fluid and Nutritional Care

In 2004 a NHS Greater Glasgow Food Policy Working Group was established to update the Food and Health Policy and to enable NHS Greater Glasgow to respond to NHS Quality Improvement Scotland (NHS QIS) ‘Clinical Standards for Food, Fluid and Nutritional Care’. These standards primarily relate to nutritional assessment, provision of food and fluid to patients and staff, patient information and staff training.

The view of the Policy Working Group, endorsed by the Corporate Management Team was that whilst the QIS standards would be a core component of NHSGG&C's Food, Fluid and Nutritional Care Policy, the policy needed to reflect the wider health improvement role of NHSGG&C.

Subsequently a Food, Fluid and Nutrition Planning and Implementation Group (FFN PIG) has been established to lead the adoption and implementation of the policy across NHSGG&C. In order for the policy objectives to be met, the FFN PIG has established working groups with devolved responsibility to devise development plans and core criteria to satisfy the policy objectives.

Key Achievements Include:

- Review of Catering undertaken with formal reporting to Policy, Planning and Performance group Autumn 2007;
- Menu specification and nutritional analysis undertaken;
- Development of Nutritional Assessment Training and Assessment Tool implementation programme;
- Greater Glasgow audit and procurement of nutritional assessment equipment;
- Patient Satisfaction Surveys established;
• Recruitment of a project team to support implementation of policy; and
• Development and ongoing implementation of Infant Feeding policy.

3.6.3. Hearty Eating

A healthy eating programme ‘Eat Up’ is being developed to support the Local Enhanced Service Chronic Disease Management programmes. This programme will replace the current Hearty Eating programme, promoting wider healthy eating messages, increased motivational support for clients, increased interactive/visual activities for participants including shopping tour and cookery sessions. The programme will be delivered in a range of community settings and will develop strong links to community groups. The programme will be delivered across all CH(C)Ps by spring 2008.

3.7. Health Promoting Health Service

The Health Promoting Health Service (HPHS) framework is recognised by the World Health Organisation as good practice approach.

The implementation of key Health Improvement and Equality Policies across NHSGGC is fundamental to the delivery of HPHS standards. Over the past year the integration, development, adoption and implementation of a range of policies has been undertaken by the new organisational entities within NHSGGC directly outlining strategic commitment to our public health, service delivery and employer role within the HPHS framework. Each organisational entity has specifically described their Health Improvement actions within Local Development Plans.

Examples of system wide policies supporting Health Improvement include:

• Harmonisation and implementation NHSGG&C Smoking Policy;
• Integration of NHSGG&C Human Resource policies;
• Development of NHSGG&C Food, Fluid and Nutrition Policy; and
• NHSGGC Single Equality Scheme and local action plans.

A targeted approach to health improvement in Acute Services has been developed. This includes:
• Maximizing the opportunity of the review of acute services to consider service configuration, capital development, models of care, patient flows and service redesign to address diverse patient needs and maximise health improvement. The Acute Services Review Board has remitted a working group to define a health improvement and equality programme, reflective of the HPHS standards for adoption within the ASR.

• The Royal Alexandra Hospital in NHSGG&C is one of four Health Promoting Hospitals in Scotland and we seek to build on this as a pragmatic way to continue to deliver health improvement across our acute services.

• Work has been undertaken to identify models of pre-habilitation and establish patient pathways to health improvement services supporting the increased opportunity for health improvement provided by all patient service contacts. Examples include:
  - Acute based alcohol intervention services;
  - Outpatient clinic smoking cessation assessment linked community based services;
  - Cardiac rehabilitation discharge to exercise referral; and
  - Signposting to financial inclusion services including appointment of jointly funded Welfare Rights Officer with MacMillan Cancer Support at the Beatson Cancer Centre.

• A Written Patient Information policy has been developed and is currently undergoing consultation.

• Promoting a Healthy Workplace - We are working jointly with Glasgow City Council to develop evidence based programmes and campaigns to improve the health of our staff and their families. With over 75,000 staff the impact on overall health in NHSGG&C will be considerable. We will focus on alcohol and weight management and have established a planning process with Occupational Health, Healthy Working Lives staff, Human Resources and Public Health.

• A pro-active approach to supporting the interface between acute services and CHPs has been adopted with key streams of work established with acute and lead CH(C)Ps responsibilities. This includes nationally recognised streams such as the Planned and Unscheduled Care Collaboratives but also local priorities such as Children’s’ Services Planning and Managed Clinical Networks.
3.8. Promoting Good Mental Health

Overall during 2006-2007, there has been significant, and in many cases highly innovative activity in the sphere of mental health improvement by Greater Glasgow and Clyde Health Board and its many partners. This includes pan-Board activity (e.g. Anti-Stigma Partnership), work at the level of community planning partnerships (e.g. Choose Life programmes), with CH(C)Ps.

While there is still a significant amount of planning, development and delivery work to do, there are encouraging signs that we are building an effective multi-agency approach that will yield tangible benefits for population health.

3.8.1. Leadership and Strategy

The Mental Health Partnership has a leadership role not only in relation to advancement of high quality mental health services but in creating effective, evidence-based approaches to improving population mental health. During 2006-07 the Partnership created a Mental Health Improvement Framework (which includes focus on promoting positive mental health, preventing mental ill health – particularly depression, and preventing suicide, promoting recovery and tackling inequalities). This has been issued to all CH(C)Ps and is being backed up with a series of development resources to help advance practice (examples below). This work is being underpinned by the development of a Mental Health Improvement Network to allow practitioners of all kinds to share and learn from emerging good practice.

In order to create further momentum, the Mental Health Partnership found significant additional non-recurring investment during 2006-07, amounting to £260,000. This has been deployed to support a variety of local and central developments, including expansion of healthy reading schemes in conjunction with public libraries, healthy living course pilots for users of community mental health teams, research and development work on mental health of asylum seekers, training work around deaf community awareness in mental health sphere, funding local service user group-led research into stigma and employment issues.

3.8.2. Preventing Suicide and Self Harm

The Board is taking forward major programmes of activity in close cooperation with partner agencies. One of the major elements of this is the Choose Life programme. Examples of activity in Glasgow City include: continued support for funded community prevention programmes including better preparing vulnerable men
for their release from prison; counselling and support work via a community mental health project (including bereavement support) and a community-based support service for those at risk of self harm and suicide, including work with vulnerable young people. Diverse community based programmes are being taken forward across the other Choose Life areas within the Board as well, including public awareness raising and education work, and policy work.

Considerable activity continues into clinical assessment and risk management systems, and in the roll out of mental health service programmes such as ESTEEM, which provides early intervention for people with newly diagnosed psychosis – a period of known suicidal risk.

The Board is giving particular attention to inequalities, equalities and diversity dimensions in taking forwards its programmes of mental health improvement. Initiatives include *Mosaics of Meaning* programme with black and ethnic minority communities, emerging work with deaf community on mental health and services, long standing developments on employment and employability, service user involvement initiatives, recovery and social inclusion programmes and development of local Mental Health Networks aimed at fostering ever-closer working among local community partners for the benefit of users of mental health services.

Improving physical health of people who have severe and enduring mental illness is a high priority and the Mental Health Partnership are supporting health improvement and well-being of patients/service users through a variety of linked approaches. Central to this is our national pilot initiative - health promoting hospitals (mental health) in conjunction with Health Scotland based at Leverndale Hospital. This three year project is due to complete in March 2008 and has made achievements in smoke free environments, physical health and values based work.

3.9. **Promoting Employment**

“Vocational rehabilitation is a process to overcome the barriers an individual faces when accessing, remaining or returning to work following injury, illness or impairment. This process includes the procedures in place to support the individual and/or employer or others eg family and carers. In addition vocational rehabilitation includes the wide range of interventions to help individuals with a health condition and/or impairment overcome barriers to work and so remain in, return to or access employment” (DWP, 2004).
Within Glasgow, over 20% of the working age population are currently not working, either due to unemployment or being out of work due to ill health or disability. In some areas of the city, the percentage rises as high as 60% of the working age population currently not being in work. Furthermore, there are high numbers of people across Glasgow, who although currently in employment, are at risk of short or long-term sickness absence due to a variety of mental and physical health conditions.

For individuals with a health condition, there are many biological, psychological, social, occupational and environmental obstacles to retaining or returning to work. Hence it is necessary that for someone to be able to retain employment or consider a return to work, rehabilitation must address all of the real and perceived barriers to work. To do this, it is argued that biopsychosocial rehabilitation must be combined with occupational health/employment services in liaison with any continuing clinical management.

One such example is “Pathways to Work”- a joint programme, led by the Department for Work and Pensions in partnership with the Department of Health, the Scottish Government and the Welsh Assembly. In Glasgow, the initiative sees Jobcentre Plus and NHSGG&C work in partnership to support the health and employability agenda for Incapacity Benefit (IB) claimants. It aims to help people with long-term, mild to moderate health conditions, who are in receipt of IB, to return to the labour market.

The Condition Management Programme (CMP) is the health element in the package of choices offered to IB claimants as part of an evolving vocational rehabilitation strategy. The Glasgow CMP staff are from a variety of backgrounds, including physiotherapy, occupational therapy and nursing. Based within local Jobcentre Plus offices, there are five teams of NHS staff, each linked to one of the five Glasgow City CHCPs, providing the Condition Management service across the whole of Glasgow City.

3.10. Reducing Teenage Pregnancies and Improving Sexual Health

Update on Developments/Achievements 2006-07

- Archway Glasgow: The final development and opening (April 2007) of the first Sexual Assault Referral Centre in Scotland. Funded as a two year pilot by the Scottish Government, the Archway provides a high quality centralised forensic, medical and support service for recent victims of rape and sexual assault.
• Sandyford Hub Programme: New integrated sexual health community clinics, known as Sandyford Hubs were opened in Parkhead, Greenock, Springburn and Barrhead. These clinics provide a wide range of services in a local setting to a more diverse client group. Development work also took place for remaining facilities in Pollok, Paisley, Alexandria and Kirkintilloch.

• 2006/07 saw the completion of a merger of sexual health services in Clyde with those in Greater Glasgow under a single management structure at Sandyford. GUM and Family Planning in Clyde were previously distinct services and they are now merged under the same structure.

• TOPAR: The TOPAR service (Termination of Pregnancy and Referral) has expanded to offer direct access for both medical and surgical termination at all Glasgow gynaecology units. Waiting times for termination have decreased from 14 to seven days with much more choice and less distress for the patient.

• Open Road: This dedicated project was established to identify and address the needs of men involved in prostitution (ie those selling sex). The project team is now in place building a strong partnership to tackle the issues and providing direct support to vulnerable men.

• Health improvement: In 2006/07 the Health Improvement Team for Sexual Health was co-located at Sandyford. The team continued to deliver training and up-skilling of the health improvement workforce on sexual health issues, including teachers. Two major cross NHS board campaigns were “Equal” on lesbian and gay sexual health issues and “Be” on delaying sexual activity in young people. There also was continued targeted strategic work for African communities and adults with a Learning Disability.

• Local Authority Partnerships: Sexual Health Strategy Groups have been established in all Local Authorities in Greater Glasgow and Clyde developing local actions and linking in with the central Sexual Health Planning and Implementation Group. Sexual Health is a key component in all Local Authority Joint Health Improvement Plans. All are heavily engaged in re-developing the core curriculum for Sexual Health and Relationships Education. Other highlights include targeted work with teenage parents, young people in care and joint work with youth services outside of school.

• Prisons: Sandyford led the Scottish Prison Service Sexual Health Development Group and subsequently is supporting service development in Barlinnie, Cortonvale, Polmont and Low Moss prisons.
In terms of lesbian, gay, bisexual and transgender (LGBT) people, it is gay and bisexual men that have continued to demonstrate the greatest sexual health need being the group that acquires the greatest proportion of newly acquired HIV infection. In terms of addressing their needs NHSGGC has specific strategy in place to facilitate sexual health improvement. This years activity has included:

- The Steve Retson Project (dedicated sexual health service for gay and bisexual men) relocating its Thursday clinic to new premises at the Glasgow LGBT Centre in Bell Street. In terms of wider health improvement NHSGGC put out to competitive tender the contract for voluntary organisations to run community based health improvement services. NHSGG&C was pleased to award this contract to Gay Men’s Health which has been operating since April 2007 and is poised to re-energise HIV prevention work across the board. LGBT Youth continue to provide the sexual health outreach initiative with young people who are LGBT in youth venues and on the commercial gay scene.

- This year the feasibility of community based syphilis testing was further explored through the successful Easy Test pilot undertaken on the commercial gay scene in Glasgow. This has proved successful and will be explored further this year.

- As young gay men are under-represented within sexual health service attendance data, a consultation in partnership with LGBT Youth has been undertaken to identify factors which can increase accessibility.

- A process has been initiated in partnership with BME community organisations to develop actions to meet the needs of men who have sex with men from BME communities.

- In partnership with NHS Ayrshire and Arran and NHS Lanarkshire, NHSGG&C has developed the award winning “Equal” mass media campaign which promotes positive sexual health messages to lesbians and gay men into its third year of operation, as well as commissioning a formal evaluation of the work to date. The three health boards have also collaborated on a lesbian sexual health needs assessment to inform future work in this area.

- Sandyford continues to facilitate the Trans Support Group and this year both Sandyford and the Support Group participated in the Scottish Trans Alliance which has succeeded in securing funding from the Scottish Government to fund a dedicated post to take forward trans health issues. In a wider health context the NHSGG&C has begun the process of developing corporate policy for the service on health care for trans people.
3.11. Vaccination Against Cervical Cancer

Following the announcement by the Cabinet Secretary on 20 June 2007, that it has been agreed in principle to introduce a new vaccine in Scotland against Human Pappilomavirus (HPV), the causal agent for 99% of cervical cancer, for girls around 12-13 years of age by autumn 2008, we are awaiting further guidance from the Scottish Government. Meanwhile NHSGG&C is undertaking a review of the infrastructure both for the delivery of the vaccine at school and also the data collection system to support the programme. As a result of this review, the Board has agreed to adopt the national school health system which would enable us to comply with the national recommendation. Further planning will be undertaken by a local implementation group following additional guidance from the Scottish Government.

3.12. Increasing Breast and Cervical Screening for Women from Deprived Communities

We have commissioned a systematic literature review to examine the factors surrounding attendance/non-attendance for cervical and breast screening and its findings have influenced existing practice. Practices and CH(C)P receive comparative data on the uptake rates for screening to enable them to target their action and there is an existing Local Enhanced Service agreed with the Practices to enhance the invitation process to breast screening.

3.13. Dementia – National Priority Status

Services for older people with mental health problems are managed by GG&C’s CH(C)Ps. In each local authority area there are planning groups developing strategies to improve services for older people, working with users, carers and voluntary organisations. The Mental Health Partnership has developed Older People’s Community Health Teams in Glasgow and hopes, subject to the results of the independent review and public consultation, to develop similar services in Clyde. A Dementia Nurse Specialist has been appointed, with the support of Alzheimers Scotland, to work with staff at the Royal Alexandra Hospital in Paisley and it is hoped that this is a model that could be developed for other acute hospitals.

We share the view that dementia should be a national priority. It impacts on high numbers of service users and carers and challenges providers to respond to needs both at home and in institutional settings, provide treatment, care and protection services and support ordinary lives and
opportunities and empowerment for our valued citizens. We support any national agenda and priority aimed at developing a dementia friendly society.
4. EFFICIENCY

4.1. Financial Performance

The Board’s expenditure remained within its revenue resource limit for 2006/07 by £27.3m. This was attributable to disposal proceeds from property transactions during the year, in particular the disposal of the former hospital site of Woodilee in Kirkintilloch. This funding is predominantly earmarked for expenditure in 2007/08 on the achievement of waiting times targets, particularly related to Availability Status Codes, where there is a high level of non-recurrent expenditure planned, and required in 2007/08.

The Board continued to meet its cumulative target for efficiency savings in 2006/07 with savings achieved of £14.2m giving a cumulative total of £34m for the two year period to March 2007. This compared with a target of slightly less than £33m for the equivalent period. This was achieved notwithstanding the delivery of an exceptionally high level of recurring savings in 2004/05 as part of Greater Glasgow’s corporate recovery plan for that particular year. (The level of savings achieved in 2004/05 was £6m in excess of what would have been generated by a 1% savings target for that year).

For 2007/08, the Board’s financial plan is forecasting the achievement of its Revenue Resource Limit with recurring expenditure commitments matched by recurring funding, with the exception of the Clyde area of its management responsibilities. For Clyde the Board is working closely with SGHD colleagues to address a recurrent gap between its funding and expenditure commitments of £30m over a three year period. For 2007/08, the Board has developed a cost savings plan to address £7m of this gap on a recurrent basis, with further savings of £4m to be delivered on a non-recurrent basis, and is discussing with SGHD colleagues arrangements for addressing the residue of the deficit through a combination of transitional funding provided by SGHD and further cost savings which might be identified by the Board. This mirrors the joint approach which was adopted in addressing the Clyde deficit in 2006/07. In addition, the Board is currently working through a series of consultation processes related to service(s) redesign for the Clyde area, and is aiming to produce a full three year plan to address the £30m deficit in full by March 2010. This will be available on conclusion of the aforementioned consultation processes, during 2007/08.

For 2007/08, the Board is targeting additional recurring cost savings of £9.4m related to the Greater Glasgow area of its management responsibilities, giving an overall recurring savings total of £16.4m in
2007/08. This ensures that the cumulative total of recurring savings achieved in the three years to March 2008 remains in line with the efficient government target of 1% cumulative recurrent savings for the three year period to March 2008.

4.2. **Sickness Absence**

The 4% sickness absence target is a significant challenge to NHSGG&C, and the purpose of the attendance management process is to provide the necessary focus to ensure the Board successfully meets this challenge.

A draft Attendance Management Policy has been developed, to replace a range of existing policies in place under previous divisional management arrangements within Glasgow and Clyde.

Full and effective implementation of this policy will be crucial in delivering the required reduction in sickness absence rates, and therefore publication of the policy is coinciding with the roll out of a training programme for managers and staff.

The critical areas of application of the Attendance Management Policy involve the use of Return to Work Interviews, Trigger Points, Referrals to Occupational Health, Referrals to Occupational Health, regular communication with absent staff and formal action where necessary. Regular reporting to the appropriate Board forum on these elements of the policy will take place to monitor compliance.

Access to accurate and timely information on sickness absence is critical to the delivery of effective absence management. Work has been ongoing to ensure the accuracy of sickness absence data and this work has now been completed for the Acute Division with information on sickness absence rates available at Divisional, Directorate and Departmental level. Similar levels of information are now available within the Mental Health Partnership and CH(C)Ps/CHPs.

The provision of regular sickness absence information, and the subsequent identification of sickness absence ‘hotspots’ will enable action to be focused areas of concern.

Absence management is embedded in the objective setting process for individual managers at all levels of the organisation. Clear targets are being set for each management area down to departmental level.
4.3. **Education and Training**

4.3.1. **Single System Learning & Education (L&E) Plan**

Local planning processes have enabled us to identify emergent and established themes which will form the basis of a single system Learning Plan (to be produced in September). This will:

- Demonstrate our organisational commitment to learning and development for all our employees and highlight the critical features of this commitment, eg Knowledge for Skills Framework (KSF) based Personal Development Plans (PDP)/access to learning opportunities, induction;

- Act as a signpost to more detailed information about learning provision in Greater Glasgow and Clyde; and

- Describe the medium and long term themes which will shape the direction of learning and education support and provision in Greater Glasgow and Clyde and give some detail on the actions which will support these themes, eg service redesign and modernisation, resourcing of mandatory training, leadership and management development.

4.3.2. **L&E Intranet Site**

The L&E Intranet site is now established and is accessible to all our employees as a shop window for learning opportunities.

4.3.3. **Staff Governance Action Plan 2007/08**

In addition to the development of the learning plans, the Staff Governance Action Plan for 2007/08 has now been ratified by the Area Partnership Forum and the Staff Governance Committee. The Appropriately Trained standard, commits us to specific actions including:

- Establishment of a Single System Staff Bursary Scheme: A proposal has been submitted to the Greater Glasgow and Clyde Endowments Committee via the Director of Finance. Subject to funds being released the Bursary Scheme will be publicised and promoted in autumn 2007.

• Development of Single System Management Development Programme:
  Proposal approved in May 2007, currently being implemented.

• KSF Mainstreaming:
  50% of staff to have KSF based PDP by December 2007, 80% of staff to have KSF based PDP by March 2008. Significant resources are being invested by the KSF Central Support Team in the areas of training, outline development, advice and guidance to the service in support of these challenging targets.

4.4. Implementing MMC

We have recruited over 1,400 junior doctors in Greater Glasgow & Clyde, which makes us the biggest recipient of new doctors in the UK and the process has gone very well.

We have gaps in a number of areas, but they are single posts, they frequently relate to problems such as maternity leave, people taking other jobs at very short notice and work permit validation issues.

4.5. Securing Best Value from Pay Modernisation

The Board has had a Pay Benefits Realisation Plan in place for some time, and this has been updated in March 2007. The plan details the areas where benefits are expected, under the themes of:

• Meeting national access/waiting times targets;
• Service redesign; and
• Staff governance.

The plan details the baseline position, the actions to be taken and the anticipated results.

4.6. Agenda for Change

Since the last of the large job families was assimilated in May the focus has been on assimilating those staff whose assimilations were not previously successful, mainly because they had more than one job, secondment or acting arrangement in the period since October 2004, and at the same time, dealing with current assimilations as remaining posts have been matched.
At the end of July, we had assimilated 28,500 staff onto Agenda for Change, and of these 19,467 have received arrears of pay. There remain around 4,500 to assimilate.
5. ACCESS

5.1. Performance Against Waiting Times Targets

5.1.1. Inpatient/Day Case True Waiting List

The Division met the maximum waiting time of 18 weeks for all patients on the waiting list in December 2006. The Division has maintained this position since December 2006 and will continue to achieve the 18 week maximum wait in the next period.

5.1.2. Inpatient/Day Case Availability Status Codes (ASCs)

By December 2007, Availability Status Codes (ASCs) require to be eradicated with the implementation of the “New Ways” guidance within that timescale. The position within the Acute Division is demonstrated in the following table:

<table>
<thead>
<tr>
<th></th>
<th>Jan-07</th>
<th>Feb-07</th>
<th>Mar-07</th>
<th>Apr-07</th>
</tr>
</thead>
<tbody>
<tr>
<td>Greater Glasgow</td>
<td>8622</td>
<td>7917</td>
<td>7082</td>
<td>6121</td>
</tr>
<tr>
<td>Yorkhill</td>
<td>1429</td>
<td>1393</td>
<td>1283</td>
<td>1060</td>
</tr>
<tr>
<td>Clyde</td>
<td>2284</td>
<td>2318</td>
<td>2233</td>
<td>2196</td>
</tr>
<tr>
<td>Total</td>
<td>12335</td>
<td>11628</td>
<td>10598</td>
<td>9377</td>
</tr>
<tr>
<td>Monthly Reduction</td>
<td>-707</td>
<td>-1030</td>
<td>-1221</td>
<td></td>
</tr>
</tbody>
</table>

The overall position demonstrates a total of 9377 patients waiting in April 2007. This represents a reduction of 2958 patients on January 2007 (24% reduction) and a reduction of 1221 patients on March 2007 (12% reduction).

The vast majority of ASC Codes relate to patient driven codes, with 50% of the total codes applied because the patient has asked to delay admission for personal reasons or has refused a reasonable offer of admission. Only 9% of codes have been applied for service driven admission reasons.

It has recently been agreed that the use of certain codes will cease at an earlier date, with the result that ASC codes 3 (low clinical priority) and 8 (did not attend) will no longer be used by the end of September 2007 and code 4 (highly specialized treatment) by the end of October 2007. Work is underway to ensure these earlier targets are delivered.
The IT systems required for implementing the abolition of ASC codes are those being developed to delivery ‘New Ways’. There is not a single system for Greater Glasgow and Clyde.

Greater Glasgow and Clyde are confident that the target will be achieved.

5.1.3. Outpatient Waiting Times

NHSGGG&C delivered the waiting times target for outpatients in 2006/07.

The national target of a maximum waiting time of 18 weeks for all new outpatients has to be achieved by December 2007. The current position throughout the Division is outlined below:

**Outpatients waiting over 18 Weeks**

<table>
<thead>
<tr>
<th></th>
<th>Jan-07</th>
<th>Feb-07</th>
<th>Mar-07</th>
<th>Apr-07</th>
</tr>
</thead>
<tbody>
<tr>
<td>Greater Glasgow</td>
<td>2803</td>
<td>2632</td>
<td>2562</td>
<td>2256</td>
</tr>
<tr>
<td>Yorkhill</td>
<td>483</td>
<td>232</td>
<td>91</td>
<td>65</td>
</tr>
<tr>
<td>Clyde</td>
<td>956</td>
<td>828</td>
<td>693</td>
<td>645</td>
</tr>
<tr>
<td>Total</td>
<td>4242</td>
<td>3692</td>
<td>3346</td>
<td>2966</td>
</tr>
<tr>
<td>Monthly Reduction</td>
<td>-550</td>
<td>-346</td>
<td>-380</td>
<td></td>
</tr>
</tbody>
</table>

The overall position demonstrates a total of 2,966 outpatients waiting over 18 weeks in April 2007. This represents a reduction of 1276 patients on January 2007 (30% reduction) and a reduction of 380 patients on March 2007 (11% reduction).

Greater Glasgow and Clyde are confident that the December 2007 target will be achieved.

5.1.4. Cataract Targets

The national target of a maximum wait of 18 weeks from referral to treatment for patients requiring cataract surgery must be achieved by December 2007. The target has two key elements – the initial outpatient wait (target - 10 weeks) and the surgical component (target – 8 weeks). The target is measured by the patient numbers waiting in excess of the targets outlined. The current position shows:
Within Glasgow there has been a sustained reduction in the number of outpatients waiting over 10 weeks. There has been modest reduction in the number of surgical patients waiting in excess of eight weeks. Within Clyde there has been a significant reduction in the number of outpatients waiting over 10 weeks and a modest reduction in the number of surgical patients waiting in excess of eight weeks. The overall position demonstrates a reduction of 208 patients on January 2007 (59% reduction) and a reduction of 56 patients on March 2007 (29% reduction).

5.1.5. Hip Fracture

The national target details that by December 2007, 98% of all hip fracture patients will be operated on within 24 hours of admission to an orthopaedic unit, subject to medical fitness and during safe operating hours (8 am – 8 pm, 7 days a week).

A total of 118 patients were admitted in April 2007 and 98.3% of patients had operations performed within 24 hours thus only two patients were not operated on within the 24 hour period following admission.

For prior months the following performance was achieved.

*Hip Fracture to Surgery within 24 hours*

<table>
<thead>
<tr>
<th></th>
<th>Jan-07</th>
<th>Feb-07</th>
<th>Mar-07</th>
<th>Apr-07</th>
</tr>
</thead>
<tbody>
<tr>
<td>Greater Glasgow</td>
<td>Not Available</td>
<td>96%</td>
<td>99%</td>
<td>100%</td>
</tr>
<tr>
<td>Clyde</td>
<td>97%</td>
<td>100%</td>
<td>96%</td>
<td>95%</td>
</tr>
</tbody>
</table>
5.2. **Accident & Emergency 4 Hour Wait**

At present 95% of Accident & Emergency patients should be treated and discharged, admitted or transferred within four hours of arrival at the department. By the end of 2007 this target rises to 98%.

Progress over recent months is demonstrated in the table below:

*Percentage of Patients Discharged, Admitted or Transferred Within Four Hours of Arrival*

<table>
<thead>
<tr>
<th>Location</th>
<th>Dec-06</th>
<th>Jan-07</th>
<th>Feb-07</th>
<th>Mar-07</th>
<th>Apr-07</th>
</tr>
</thead>
<tbody>
<tr>
<td>Western</td>
<td>85</td>
<td>80</td>
<td>84</td>
<td>87</td>
<td>90</td>
</tr>
<tr>
<td>GRI</td>
<td>83</td>
<td>85</td>
<td>87</td>
<td>90</td>
<td>93</td>
</tr>
<tr>
<td>Stobhill</td>
<td>89</td>
<td>85</td>
<td>90</td>
<td>90</td>
<td>92</td>
</tr>
<tr>
<td>Yorkhill</td>
<td>97</td>
<td>97</td>
<td>97</td>
<td>98</td>
<td>98</td>
</tr>
<tr>
<td>Southern</td>
<td>95</td>
<td>92</td>
<td>93</td>
<td>93</td>
<td>93</td>
</tr>
<tr>
<td>Victoria</td>
<td>94</td>
<td>94</td>
<td>95</td>
<td>95</td>
<td>98</td>
</tr>
<tr>
<td>RAH</td>
<td>95</td>
<td>96</td>
<td>96</td>
<td>97</td>
<td>96</td>
</tr>
<tr>
<td>IRH</td>
<td>98</td>
<td>97</td>
<td>97</td>
<td>96</td>
<td>97</td>
</tr>
<tr>
<td>VoL</td>
<td>99</td>
<td>98</td>
<td>97</td>
<td>97</td>
<td>98</td>
</tr>
<tr>
<td><strong>Board Average</strong></td>
<td><strong>92</strong></td>
<td><strong>90</strong></td>
<td><strong>92</strong></td>
<td><strong>94</strong></td>
<td><strong>95</strong></td>
</tr>
</tbody>
</table>

Since December 2006 compliance with the target has improved from 92% to 95%. Key areas of improvement during this period are:

- Western Infirmary – 5% improvement in performance; and
- Glasgow Royal Infirmary – 10% improvement in performance.

The main focus of work across all areas has been:

- introducing the Estimated Date of Discharge (EDD) Planning Tool across all medical wards across all sites – this supports the freeing up of beds earlier in the day to meet emergency demand as well as supporting seven day discharging which will increase bed capacity and help to reduce the number of patients who require to be boarded;
- working with partners in the community to look at ways in which we could shift the balance of care – through early supported discharge; managing patients in their own homes; reviewing referrals to Accident & Emergency to identify inappropriate attenders; referrals from GPs both in and out of hours; mental health/addiction services; nursing home referrals and delayed discharges; and
- Working towards the 100% compliance target for minor injuries.
• Local Development Plans identify specific improvements and service changes for each site. Greater Glasgow and Clyde are confident that the December 2007 target will be achieved.

5.3. Cancer Waiting Times

All urgent referrals with suspected cancer should currently wait a maximum of 62 days from urgent referral to treatment (31 days for breast cancer). There has been significant progress against this target. Weekly monitoring is in place across the specialties for patients with cancer. All patients referred as urgent are tracked to ensure monitoring of the progress along the patient journey. Progress for tracked patients treated within the month is as follows:

Glasgow & Clyde Cancer Targets

<table>
<thead>
<tr>
<th></th>
<th>Feb-07</th>
<th>Mar-07</th>
<th>Apr-07</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No of Pats</td>
<td>No Within Target</td>
<td>% Within Target</td>
</tr>
<tr>
<td>Breast</td>
<td>31</td>
<td>30</td>
<td>97%</td>
</tr>
<tr>
<td>Lung</td>
<td>27</td>
<td>26</td>
<td>96%</td>
</tr>
<tr>
<td>Colorectal</td>
<td>9</td>
<td>9</td>
<td>100%</td>
</tr>
<tr>
<td>Ovarian</td>
<td>11</td>
<td>10</td>
<td>91%</td>
</tr>
<tr>
<td>Head &amp; Neck</td>
<td>5</td>
<td>5</td>
<td>100%</td>
</tr>
<tr>
<td>Melenoma</td>
<td>4</td>
<td>4</td>
<td>100%</td>
</tr>
<tr>
<td>Leukaemia</td>
<td>2</td>
<td>2</td>
<td>100%</td>
</tr>
<tr>
<td>Lymphoma</td>
<td>3</td>
<td>3</td>
<td>100%</td>
</tr>
<tr>
<td>Urology</td>
<td>26</td>
<td>20</td>
<td>77%</td>
</tr>
<tr>
<td>Upper Gl</td>
<td>11</td>
<td>9</td>
<td>82%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>129</strong></td>
<td><strong>115</strong></td>
<td><strong>89%</strong></td>
</tr>
</tbody>
</table>

5.4. Diagnostic Waiting Times

The maximum wait of nine weeks for four modalities – MRI, CT, Non-Obstetric Ultrasound and Barium Enema was expected to be achieved by July 2007. We achieved this target in all four areas.

The table overleaf details the actual position through to April 07.
The CT waits have been close to target over the past few months. The number of patients waiting greater than nine weeks is being closely monitored.

Over the four months MRI has seen a reduction in outpatient waiting times from 19 to 15 weeks at April 2007. This has been achieved through waiting list initiatives and extended hours. The number of patients waiting more than nine weeks has been monitored and is showing a steady reduction. This position will be closely monitored as we approach the target date.

Despite the slight increase in Ultrasound waiting times in February this modality continues to make progress towards the nine week target.

Barium studies have a waiting time consistently below nine weeks.

**Endoscopy/Cystoscopy**

There has been significant progress within Endoscopy/Cystoscopy to meet the target. This is detailed in the table below:

<table>
<thead>
<tr>
<th></th>
<th>Jan-07 Max Waiting Time in Weeks</th>
<th>Feb-07 Max Waiting Time in Weeks</th>
<th>Mar-07 Max Waiting Time in Weeks</th>
<th>Apr-07 Max Waiting Time in Weeks</th>
<th>Apr 07 Total No of Patients Waiting over 9 Weeks</th>
</tr>
</thead>
<tbody>
<tr>
<td>CT</td>
<td>11</td>
<td>11</td>
<td>10</td>
<td>10</td>
<td>2</td>
</tr>
<tr>
<td>MRI</td>
<td>19</td>
<td>19</td>
<td>19</td>
<td>15</td>
<td>192</td>
</tr>
<tr>
<td>Ultrasound</td>
<td>14</td>
<td>16</td>
<td>14</td>
<td>10</td>
<td>192</td>
</tr>
<tr>
<td>Barium</td>
<td>6</td>
<td>6</td>
<td>6</td>
<td>6</td>
<td>0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Upper endoscopy</th>
<th>Lower Endoscopy</th>
<th>Colonoscopy</th>
<th>Cystoscopy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan-07 Waiting Time in Weeks</td>
<td>14</td>
<td>15</td>
<td>16</td>
<td>15</td>
</tr>
<tr>
<td>Feb-07 Waiting Time in Weeks</td>
<td>14</td>
<td>16</td>
<td>16</td>
<td>16</td>
</tr>
<tr>
<td>Mar-07 Waiting Time in Weeks</td>
<td>13</td>
<td>15</td>
<td>12</td>
<td>15</td>
</tr>
<tr>
<td>Apr-07 Waiting Time in Weeks</td>
<td>11</td>
<td>14</td>
<td>11</td>
<td>13</td>
</tr>
<tr>
<td>Apr 07 Total No Of Patients Waiting over 9 Weeks</td>
<td>6</td>
<td>15</td>
<td>28</td>
<td>23</td>
</tr>
</tbody>
</table>
5.5. **Cardiac Surgery**

The 16 week end to end target for cardiac treatment comprises, two weeks Rapid Access Chest Pain Clinic, four week cardiology diagnostic phase and 10 weeks for cardiac surgery or interventional cardiology. Further central guidance is awaited on how the total journey will be measured and local Information Services are considering how this might be achieved and reported within the Division. The table below relates to the 10 week phase for cardiac surgery.

<table>
<thead>
<tr>
<th></th>
<th>Jan 07</th>
<th>Feb-07</th>
<th>Mar-07</th>
<th>Apr-07</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total No Waiting</strong></td>
<td>229</td>
<td>217</td>
<td>230</td>
<td>235</td>
</tr>
<tr>
<td><strong>Waiting &gt; 10 weeks</strong></td>
<td>53</td>
<td>48</td>
<td>43</td>
<td>38</td>
</tr>
</tbody>
</table>
6. TREATMENT

6.1. Delayed Discharges

The key target for delayed discharges was the April census when the Board exceeded the target set for those delayed longest in hospital and achieved the target set for those occupying short stay beds.

<table>
<thead>
<tr>
<th></th>
<th>Over 6 weeks Target</th>
<th>Over 6 weeks Actual</th>
<th>Short Stay Target</th>
<th>Short Stay Actual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Glasgow</td>
<td>40</td>
<td>34</td>
<td>10</td>
<td>9</td>
</tr>
<tr>
<td>Clyde</td>
<td>41</td>
<td>37</td>
<td>9</td>
<td>10</td>
</tr>
<tr>
<td>Total</td>
<td>81</td>
<td>71</td>
<td>19</td>
<td>19</td>
</tr>
</tbody>
</table>

The national targets for April 2008 are as follows:

- No patient who is clinically ready for discharge should be delayed by more than six weeks; and
- No patient who occupies a bed in a short-stay specialty should be delayed for more than three days.

Efforts to meet the April 2008 target are focusing on ensuring early involvement of social work in discharge planning; ensuring patients and families choose interim care home places and implementing performance management systems and targets for each step of the discharge process. The partnerships’ success in achieving these targets is based on a whole system approach to discharge planning that ensures patients, their families, health and social care staff are all fully involved in planning for discharge at the earliest possible opportunity. It is recognised that reducing length of stay and starting discharge planning prior to or on admission assists in the reduction of delayed discharge. Links with the Unscheduled and Planned Care Collaboratives ensure that this approach is embedded across all hospital services not just specialist services for older people.

6.2. Reducing Hospital Acquired Infections (HAI)

Within NHSGG&C we have made significant progress against our objectives on HAI and Infection Prevention and Control. This is of particular note when placed within the context of the development of single system working across NHSGG&C and the additional challenge of incorporating NHS Clyde into these systems.
Key developments during 2006/07 Included:

- Agreement and implementation of a single system infection control structure;
- Appointment of a Nurse Consultant in Infection Control;
- Enhanced MRSA bacteraemia programme involving additional data collection of all cases and epidemiology to produce prevention strategies;
- The work of the educational sub-group in developing a specific strategy for education and training in HAI;
- Extension of the NHSGG Infection Control Policies to Clyde provides a comprehensive set of infection prevention and control policies across the new single system NHSGG&C; and
- Completion of a challenging programme of audits of decontamination practice in Partnerships.

Key Priorities for 2007/08

During 2007/08 the Board’s Annual Infection Control Programme is firmly focused on the implementation/delivery of the national priorities and legislative requirements including:

- The HEAT Targets for reductions in MRSA and MSSA Bacteraemias through continued enhanced MRSA, MSSA bacteraemia programme involving additional data collection of all cases and epidemiology to produce prevention strategies;
- The Local Delivery Plan Target for the training of Cleanliness Champions through provision of a dedicated resource to facilitate the programme within NHSGG&C;
- Hand Hygiene through the actions of our dedicated Local Health Board Hand Hygiene Coordinator;
- Repeating the National HAI Prevalence Study in key areas within NHSGG&C as a vehicle for effective targeting of Infection Control resources;
- Decontamination in Primary Care/Partnerships through implementation of action plans based on risk assessed output from the PCAT audits; and
- Patient Safety and Public Engagement.
6.3. **Ensuring Quality and Managing Risk**

NHS Quality Improvement Scotland completed a peer review of NHSGG&C Performance against the national standards for Clinical Governance & Risk Management on 27 September 2006. The overall position was assessed as level six (that the board was deemed to be implementing its policies, strategies and systems). This level of assessment also applied to each of the three contributing standards.

Comparison with other NHS Bodies being reviewed in the same cycle confirms that this level is at the median of performance across NHS Scotland. The assessment level assigned by the NHS QIS peer review precisely matched the internal self assessment and given that this took place in the fairly immediate aftermath of large scale reorganisation, it was deemed to be an accurate reflection on the organisational position.

The breakdown of performance across the standards is as follows:

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<tr>
<th><strong>Standard 1 – Safe &amp; Effective Care in Services</strong></th>
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<tbody>
<tr>
<td>Section a</td>
<td>Risk Management</td>
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<tr>
<td>Section 1b</td>
<td>Emergency &amp; Continuity Planning</td>
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<tr>
<td>Section 1c</td>
<td>Clinical Effectiveness &amp; Quality Improvement</td>
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<th><strong>Standard 2 – The Health, Wellbeing and Care Experience</strong></th>
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<tr>
<td>Section 2a</td>
<td>Access, referral, treatment and discharge</td>
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<tr>
<td>Section 2b</td>
<td>Equality &amp; Diversity</td>
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<td>Section 2c</td>
<td>Communication</td>
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<th><strong>Standard 3 – Assurance &amp; Accountability</strong></th>
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<tr>
<td>Section 3a</td>
<td>Clinical Governance &amp; Quality Assurance</td>
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<tr>
<td>Section 3b</td>
<td>Fitness to Practice</td>
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<td>Section 3c</td>
<td>External Communication</td>
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<tr>
<td>Section 3d</td>
<td>Performance Management</td>
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<td>Section 3e</td>
<td>Information Governance</td>
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The information arising from the self assessment and the NHS QIS local report has been disseminated across NHSGG&C, targeting those posts that hold specific accountability for elements of the standards. This framework of accountability is specified in the Clinical Governance & Risk Management Strategy. Those individual accountable post holders are taking forward the implementation process integrating the requirements of the standards into their own development plans. A full review of progress, by completing an internal self assessment, is scheduled for later in 2007 which will allow an updated position to inform submissions of NHSGG&C performance around the HEAT targets in February 2008.

6.4. Risk Register

At 31 March 2007, NHSGG&C had republished a new Board-wide Risk Management Strategy that was subjected to full consultation and approval, along with a new Risk Register Policy. Each Acute Service Division Directorate and Community Health Partnership was supported to meet the requirements of the policy in developing its own risk register. This support is ongoing as the quality of content and connections between risk registers is refined. A decision to implement new software to enable greater consistency and monitoring of risk register management across the whole Board area was approved and this will be made available to services during the forthcoming year. A new approach to corporate risk review was developed to take into account the newly formed organisation. In particular this reflected the greater focus on performance management arrangements, which as part of its process addressed risks to key organisational objectives. A corporate risk review report was published along with a proposed new model of managing the corporate risk register, which has been reviewed and approved by the Audit Committee. There is ongoing review of this process and a critical evaluation, linking views of internal audit is scheduled for August 2007.

6.5. Patient Safety

Patient safety has been identified as a priority area for the board, as part of our wider approach to clinical governance.

Our focus during 2006/7 has been to ensure that patient safety systems are developed in line with the new organisational arrangements to support single system working. Reporting systems are in development across the organisation and there are some examples of good practice across the organisation, including the application of statistical process control, consideration of patient safety issues across organisations (eg between emergency services and NHS24), and comprehensive incident review and follow up in women and children’s services and mental health, for example.
To ensure senior leadership for patient safety, a corporate event for Directors and other senior managers was held in May 2007. Following this a short life working group has been established to assess local systems in detail and produce a comprehensive development plan. This will address key issues such as culture, reporting systems, patient safety systems in primary care, links to risk management and wider governance, and whole system priorities for change. We are actively involved in national work on patient safety including the National Advisory Group for the Scottish Patient Safety Alliance.

6.6. Mental Health Services

The strategy to modernise mental health services in the Clyde area was approved by the Board in June 2007 as the basis for submission to external review and public consultation.

The strategy focus is adult and elderly mental health services and its main thrust is a rebalancing of community and inpatient services based on increased investment in comprehensive community services internally funded from resources released from the reconfiguration of inpatient and continuing care services. The strategy is consistent with the main themes of the Mental Health Delivery Plan commitments and will enable substantial progress in meeting the Delivery Plan requirements.

Other developments in mental health include:

- Improvement of the inpatient environment of care: continued build programme of Gartnavel new hospital development, in readiness for operational opening in Autumn 2007/08;
- Development of community and crisis services: continued recruitment to extended crisis service hours to provide 24/7 access to treatment in community settings;
- Development of specialist services: continued build programme of secure unit; completion and operational opening in July 2007 of the Rowanbank Clinic secure care facility;
- Development of specialist services: development of specialist community eating disorders service: recruitment started in 2006/07 and still in progress; and
- Operational integration of community mental health services into CH(C)Ps based on joint management of integrated teams.
7. SERVICE CHANGE AND REDESIGN

7.1. Introduction

This self assessment demonstrates the scale and complexity of NHSGG&C’s work programme and we are constantly driving and evaluating a large programme of service change and redesign. Many elements of which are mentioned throughout the document and further significant examples include:

- The development of an integrated assessment framework for children;
- Completion of a review of the role of Health Visiting;
- Opening of the new Beatson Oncology Centre; and
- Continuing work on the redesign of acute services including the provision of Ambulatory Care and Diagnostic Units (ACADs).

7.2. Notable Patient Focus Public Involvement Activity

A wide range of successful activities have been undertaken in 2006/07. A small number of these are summarised here. More detail can be provided on request:

- Redesigning Local Children’s’ Services for Inverclyde, Public Consultation

One of the early issues that NHSGG&C had to resolve on taking responsibility for services in Clyde was the disposition and sustainability of children’s’ services in Inverclyde. Proposals were developed on the basis of previous engagement and review by the previous NHS Board. Early discussion took place with the Scottish Health Council around the proposals and consultation arrangements. It was mutually agreed that, given the urgency of particular staffing and safety issues, a swifter than normal consultation period was required, on the basis that the consultation would be extended if there was public demand to do so.

The consultation included:

- Development of a summary consultation leaflet (which was tested for language and clarity of meaning with patient representatives);
- Distribution of the leaflet across a wide range of public, voluntary and part contacts, including neighbouring NHS Boards serving communities in Ayrshire and the Isle of Bute;
- Distribution to parents in Inverclyde via every school child of a letter announcing the consultation;
An advertisement in the Greenock Telegraph;
A major public meeting at the Tontine Hotel in Greenock;
A media release, which was also submitted to publications serving Ayrshire and Bute;
Meetings with community groups and key individuals across the catchment area for the services concerned; and
Webpages specifically set up for the consultation, including an ‘inbox’ for submissions.

Our Health Event - Celebration of Volunteers

As part of a celebration of the vital role played by the 2,000 volunteers who help NHSGGC deliver its services, 500 of the volunteers from across the area were honoured at a gala lunch. Comedian Andy Cameron was compere for the event with three volunteers giving after-lunch speeches.

A twelve page volunteer’s supplement to coincide with event was also distributed throughout Greater Glasgow and Clyde. The supplement, described the different types of services the volunteers were able to contribute to, and was inserted in every Evening Times.

The relationship between NHSGG&C and the voluntary sector is facilitated through a wide range of activities and mechanisms both locally within CHPs, the Mental Health Partnership and Acute Division. Recently further focus has been applied in relation to NHSGG&C volunteering policy, Involving People Committee and related PFPI arrangements and the Healthy Organisations programme.

7.3. Acute Services Review

The Board’s Acute Services Plan was approved in autumn 2002, following a Parliamentary debate and vote. The strategy provides for full Accident and Emergency and Trauma services to be delivered from two sites – Glasgow Royal Infirmary and the Southern General Hospital; these sites will also provide the bulk of the other in-patient secondary and tertiary specialist services, with the third in-patient site at Gartnavel General housing the West of Scotland Cancer Centre (the Beatson Oncology Centre), GP-assessed medical and surgical emergencies (note: not 'Blue Light' emergencies brought by ambulance) and a number of smaller in-patient specialties, including; Ophthalmology and Infectious Diseases.
The Stobhill and Victoria Hospitals will deliver Ambulatory Care, maintaining locally some 82% of patient contacts with the acute hospitals’ sector, involving 400,000 and 500,000 patient contacts each year. The Golden Jubilee National Hospital in Clydebank will house the West of Scotland Heart and Lung Centre and will be the sole site from which Interventional Cardiology Services are provided within Greater Glasgow.

In autumn 2004, the strategies for Maternity and Specialist Children’s Services were also finalised. Approval has been given for two maternity delivery units, sited with Adult Acute Services, and made provision also for the early re-location of the Sick Children’s Hospital, to be provided on the same site as Adult Acute and Maternity services. After a further round of consultative process, Ministerial approval was given to re-locate the Sick Children’s Hospital to the Southern General site.

The strategy is now well into its implementation stages. The Beatson Oncology Centre is open and the transfer of services from the Western Infirmary to the new development has recently been completed. The new development is an imaginatively designed, patient sensitive facility, which contains many additional diagnostic and treatment facilities also. Construction work has been underway on both Ambulatory Care Hospitals for over six months, with both developments scheduled for completion by late 2009. The Heart/Lung Centre at the Jubilee will open in November this year. Importantly, there is now virtually unanimous support from senior clinical staff for the Acute Services Plan. While in 2002 there were significant pockets of resistance to the plan among staff, that position has moved significantly, as has the view among many community groups. In response to the criticism made of our approach to public consultation in 2002, we invested in a small community engagement team which has given the Board a much improved means of ongoing dialogue with a broad range of communities. For the first time in more than two decades, senior clinical staff believe that the Acute Services Plan will now be delivered and that many of them can look forward to offering first class care to their patients from facilities built in 2009 rather than 1874.

The next stage of implementation – the re-development of the Southern General site is pivotal; the re-developed Southern will house Scotland’s largest specialist adult acute hospital and its largest Children’s Hospital also. The challenge for the Board is to bring forward this summer an affordable plan.

Work is ongoing on the development of the Outline Business Case (OBC) for the new Adult and new Children's Hospitals on the Southern
General Hospital site, with the intention to submit the OBC to the Capital Investment Group of the Scottish Government Health Department early in 2008. The new Adult and Children’s Hospitals represent the next major plank in the modernisation plan for Glasgow's Acute Services. Funding options are being explored to ensure the most appropriate and affordable model. Discussions are ongoing with Glasgow City Council to obtain outline planning permission for this project, which takes transport, the environment and other issues into account.

7.4. **Community Planning**

NHSGG&C is committed to the development of community planning across all of the Local Authority areas we cover. We see community planning as having a significant role in improving partnership working and addressing the determinants of health. A recent stock take of community planning activity across NHSGGC demonstrates that there is representation at Chief Executive or Director level on all community planning partnerships and extensive representation on sub groups and community engagement activities. We have been involved in a wide variety of partnership activities to identify and address health inequalities. Examples include a number of statutory and voluntary sector agencies coming together to work with the growing Roma population in South East Glasgow who have significant health and other support needs. The merger of pathfinder and community planning structures in Glasgow City, and the development of an integrated CH(C)P in East Renfrewshire, are an opportunity to further support partnership working through innovative organisational arrangements.