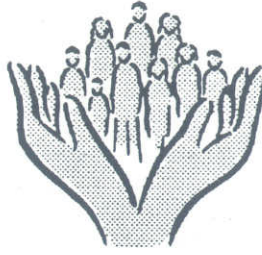


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**GREATER GLASGOW
HEALTH BOARD**

THE NHS IN GREATER GLASGOW

DRAFT

HEALTH IMPROVEMENT PROGRAMME

2000 - 2005

2000 - 2005 MEA / GGHB

DECEMBER 1999

12/081



WORLD HEALTH ORGANIZATION
HEALTH CARE

THE WHO IN GREAT BRITAIN

DRAFT
HEALTH IMPROVEMENT PROGRAMME
2000 - 2005

DECEMBER 1999

**HEALTH IMPROVEMENT PROGRAMME 2000/2005
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THE NHS IN GREATER GLASGOW

HEALTH IMPROVEMENT PROGRAMME 1999 – 2004

INTRODUCTION

This is our third Health Improvement Programme, its purpose is to describe what the NHS in Greater Glasgow intends to do to improve the health of our population. Improving health is an endeavour which does not show quick results and in which the Health Service is only one of the important players. This structure and content of Health Improvement Programme reflects the significance of :-

- Partnership working on which there is a new section,
- Work with Local Authorities, which is covered in detail.
- The importance of our work with communities and individuals which is reflected throughout the programme.
- From the emerging Government Policy Framework, a range of new initiatives aimed at tackling the root causes of ill health and inequality is described in our local context.

As well as our responsibilities to contribute to the collective effort on health improvement this programme describes our plans for health service.

- For acute services the strategic direction remains similar to previous Health Improvement Programmes. The detailed plan section reinforces the framework described in last year's Health Improvement Programme and proposes a process to move it forward.
- In primary care a clearer strategic direction is emerging as the new organisational arrangements enable a clearer articulation of how primary care services can develop and the huge contribution it can make to the wider health improvement agenda. The detailed plan section reflects the significant efforts of local coops to develop and implement their plans and priorities
- For community care the strategic direction remains the same, but good progress has been made with Local Authorities in delivering the detailed plans we described last year, for a number of client groups. Resources remain a significant issue particularly for the elderly.
- A comprehensive set of proposals develop within the strategic framework to modernise mental health services are out to consultation, including significant new investment.
- Improving the health of children and service and prevention for cancer and coronary heart disease remain high priorities.

On the resources side there remain major issues. This programme maintains our commitment to invest more money in health improvement priorities, including the health of children and young people, community development, addictions, community care and mental health. There are many pressures in acute care which are described in the financial framework section, and these need to be collectively addressed, but not at the expense of abandoning the priorities which derive from our absolute commitment to play our part in improving the health of Greater Glasgow's people.

We continue to make greater efforts to involve interest groups, members of the public and elected representatives in the development of this programme and our routine work, this is described in more detail in a new section of this document.

This programme has been developed in the first year of the new Trust Structures, with Trusts teams substantially involved in it's production.

CHAPTER ONE

STRATEGIC CONTEXT

1.1 POPULATION AND MAJOR HEALTH ISSUES

This section will update the description of the Greater Glasgow population and its health, as presented in the Health Improvement Programme for 1999-2004. In addition, the baseline position for Greater Glasgow in relation to the targets set in the Health White Paper will be presented. The survey required to yield these data is currently being carried out.

1.2 PROMOTING HEALTH AND REDUCING INEQUALITIES

1.2.1 In setting-out the strategic framework for the Board's work to promote health and reduce inequalities, our previous Health Improvement Programmes (HIPs):

- Established that the HIP was underpinned by a model of health which has physical, mental and social dimensions; and that our aim is not only to reduce levels of ill health and premature death within the population but also to enhance quality of life
- Set out the working principles which guide our activities: partnership with agencies in the public, private and voluntary sectors to tackle the fundamental determinants of health, empowerment of local people by providing opportunities for them to have greater control over the decisions which affect their health, and accountability through increased levels of communication with the Greater Glasgow population
- Presented a framework for improving health status, emphasising that social and economic factors are the overriding determinants of health in modern society
- Highlighted the importance of *relative circumstance*, and the fact that in order to improve the population's health we need to concentrate more on narrowing the gaps that exist between different subgroups and communities
- Gave a commitment that action to reduce health inequalities would guide all components of the HIP. This commitment is also reflected in our financial framework and investment priorities.

1.2.2 In translating this direction into programmes of action to reduce inequalities in health, we established a four-level approach comprising initiatives designed to:

- strengthen individuals
- strengthen communities
- improve access to services and facilities
- encourage macro-economic and cultural change

1.2.3 Each of these levels of action is applied to the three broad foci for action set out in the Health White Paper *Towards a Healthier Scotland*. These three foci are life circumstances, lifestyles, and direct work on priority health topics. In this HIP, for the first time, we present our detailed plans for promoting health and reducing inequalities in relation to these three foci for action and the priorities set out in the White Paper.

1.2.4 In last year's Health Improvement Programme we described briefly the major strategic developments in 1998 which had a significant influence on our priorities and action programmes. These included the Health White Paper, the Glasgow Alliance Strategy, the establishment of Social Inclusion Partnerships, and the introduction of New Community Schools. Each of these remains a major influence on our work programmes, as reflected in this current HIP, and we now have in place long-term plans and commitment to these strategies.

1.2.5 1999 has seen both increased emphasis on these strategies and the introduction of further major developments. Of particular importance were the launch of the **Social Inclusion Strategy for Scotland**, more recently developed into a **vision for delivering social justice**. This vision has five key components:

- A Scotland in which **every child matters**, where every child, regardless of their family background, has the best possible start in life
- A Scotland in which **every young person** has the opportunities, skills and support to make a successful transition to working life and active citizenship
- A Scotland in which **every family** is able to support itself - with work for those who can and security for those who can't
- A Scotland in which **every person beyond working age** has a decent quality of life
- A Scotland in which **every person** both contributes to and benefits from the community in which they live.

Ambitious milestones and targets have been set for each of these five components. GGHB is committed to working with its partners towards making this vision of social justice reality for the Greater Glasgow population.

1.2.6 Another major policy emphasis that has informed our programmes this year is the importance being placed on life-long learning. In addition to the Community Schools programme, we are working with our local authority partners on Education Action Planning, and Community Learning Strategies. Within the NHS the new *Learning for Life* initiative will make an important contribution to improving health and quality of life for NHS staff.

1.2.7 Common strategic themes from this strategic framework include:

- a strong focus on children and young people
- an emphasis on very local working within communities, involving local people, and addressing local needs and issues
- increased attention to the prevention of problems, particularly through work with those at highest risk

- the need to establish and maintain strong partnerships with other agencies
- the importance of social policy and investment in social support and infrastructure
- a recognition of the value of learning, and not only in relation to employment

These themes are strongly reflected in the action plans presented in Chapter 5.

1.3 PRIMARY CARE

- 1.3.1 Greater Glasgow Health Board and the Primary Care Trust are committed to the development of primary care services. It is recognised that it will need an investment of additional resources sustained over time within a clear strategic development framework.

An overarching strategy is being developed to guide local implementation and relate actions on a wide-ranging front. It will enable us to;

- agree a vision and set of principles
- establish a coherent and unified planning approach
- demonstrate the capacity and willingness to take on the challenge
- engage the support of the public and service partners
- secure the resources needed to do the job

Developing primary care is not just about bolting new resources onto what we already do – it involves re-shaping ways of working to achieve greater effectiveness.

A particular challenge is to achieve incremental change while developing strategic planning, rather than that process blighting development.

The establishment of the Primary Care Trust and Local Health Care Co-operatives gives us the vehicle for a unified approach. Their growing partnership with the community care and community development further enhances our capacity to shift the focus of the health system.

- 1.3.2 The challenge is for primary health care to demonstrate that it can meet these expectations to fundamentally improve the way services are delivered and the way we work together. That is, create a co-ordinated service system that is highly competent, makes the best possible use of new technologies and knowledge and is responsive to the needs of patients, families and communities.

The first step in developing a strategic framework was the open space event '**Shaping the Future of Primary Care in Glasgow**'. Over 350 participants met at Celtic Park in Parkhead to generate ideas and identify the issues that need to be addressed to enable primary health care to realise its full potential. It involved representatives of Local Health Care Co-operatives, community and voluntary organisations, Local Authorities, Greater Glasgow Health Board, academic and professional bodies and the Scottish Executive.

The event maximised involvement. Initially a list of over sixty issues was created which covered a wide range from specific health problems in the community, target

groups, organisational and finance arrangements. Later, fifteen of these issues were identified for further work on the day.

The issues have been categorised under 5 headings:

- Service Developments and Improvements
- Service Partnerships and Multidisciplinary Teamwork
- Community and Consumer Participation
- Equity & Priority Groups
- Quality Improvement

In addition there is series of important issues that will need to be addressed to ensure that primary care infrastructure and support is enhanced to fulfil this ambitious.

A process of wide consultation amongst stakeholders has now commenced. This is necessary to ensure that all of the issues and priorities have been identified. In particular the open space event was not designed to gain the views of the public or users of services. It will be necessary to undertake work to identify their understanding, perception, experience and vision for primary health care. This is likely to involve identification of existing sources of data and commissioning new work where necessary.

- 1.3.3 Primary health care is not a single organisation, profession or way of working. Changes in technology, treatments and health needs are occurring rapidly and are difficult to predict over the long term. This diversity and pace of change means that it would not be possible or desirable to create a master plan that predicts every detail of our future actions. Described below for debate are a set of principles which are proposed to give a consistent approach to the development of our plans.

Service Development and Improvements

Equitable access to a basic range of health promotion, early detection, assessment and treatment services.

A holistic approach that recognises the social determinants of health and treats people as more than a collection of illnesses or problems.

Service Partnerships and Multi-disciplinary Teamwork

Co-ordinated service delivery through multi-disciplinary teamwork

Inter-agency partnerships and working together to meet the needs of people

Community and Consumer Participation

Community and user participation in service planning, delivery and evaluation

Services will promote the ability of individuals, families and communities to take self-responsibility for maintaining and promoting health

Equity and Priority Groups

Targeting services and programmes to those groups in the community with the lowest health status

Interventions should be the minimum that are effective and matched to the needs of people not service providers

Respect for the way in which people identify and interpret health problems and their solutions

Quality Improvement

A commitment to continuous improvements in quality

Investment in activities that can demonstrate health improvements

Providing the public with value for money in the way services are delivered.

1.4 ACUTE SERVICES

Last year's Health Improvement Programme explained why change in the role of acute hospitals is inevitable:

- changes in clinical practice and technologies have reduced lengths of hospital stay, with a significantly increasing proportion of patients treated on a day case or out-patient basis. What is called "Ambulatory Care" is now the principal type of experience that the vast majority of patients have with hospitals;

- increased specialisation makes it difficult unfailingly to offer the safest and most appropriate expertise if the specialists themselves, their specialist support staff and equipment are too thinly spread between different hospitals;
- shorter working hours and a stronger educational focus for junior doctors, with more rigorous policing of these conditions by Postgraduate Deans and Royal Colleges, have led to greater demands being placed on hospital consultants who are themselves subject to the EU maximum working hours directive. This leads to further stretching of the available specialist expertise;
- pressure from Government and Parliament on securing more efficient use of taxpayers' money is continuously exerted on the NHS. Cash spent on inefficiently used buildings and equipment means less availability of hands-on care of patients by clinical staff. More recently the additional cash provided by the Government's Comprehensive Spending Review has been linked to an understanding that it will be reciprocated by NHS commitment to drive up standards and efficiency.

1.4.2 We described the potential for these influences to cause significant problems unless they are constructively managed. The alternative, 'salami slicing' of bed numbers and yet more stretching of specialists, will seriously compromise the quality of services available to patients. We suggested the development of larger specialist clinical teams with a good critical mass of senior and junior medical staff, large enough to organise stronger round the clock emergency services on fewer sites while still providing locally accessible out-patient and day case services (which is what most patients' experience of hospitals now is). The reports of the Royal College of Surgeons on Emergency Surgical services, the Audit Commission Report on Accident & Emergency services, the Senate of Surgery Report on Consultant Numbers and Subspecialisation and a BMA/Royal Colleges document on Acute Hospital Services, all reinforced the growing consensus that larger clinical teams, serving populations of between 400,000 and 500,000 are needed. As the BMA/Royal Colleges document on Acute Services said: "The present distribution of hospital units providing acute and emergency and surgical care needs to change if patients are to benefit fully from recent advances in acute care."

1.4.3 Scotland's Acute Services Review, led by the Chief Medical Officer, reported in May 1998. It had been set up to report on how planning for acute services should respond to these and other influences, ensuring the maintenance of the highest quality hospital services for the country as a whole. We do not try to describe in full the conclusions of the Review here, but have drawn out its key elements for Glasgow.

- 1.4.1 The Review Report reaffirmed that a model of numerous hospitals usually currently attempting to be self sufficient in meeting the needs of their catchment population, will be difficult if not impossible to sustain unless there is a change of approach. It established the concept of managed clinical networks as a model for the organisation of clinical services - sharing expertise and resources across traditional organisational and service boundaries. This model has the aim of addressing the requirements of modern clinical practice while maintaining as much local access to services as possible. It involves modifying and reshaping the existing network of hospitals. Most out-patient, routine diagnostic and day case services would remain locally provided as now. Some in-patient services would continue to be provided locally as long as patient safety and appropriate expertise can be made available. In other instances it would be safer if patients went to a more distant hospital where the right clinical skills and equipment could be assured. Our approach of wanting to build strong clinical teams and organising their commitments more efficiently is consistent with this approach.
- 1.4.5 The Review also recommended development of the trauma centre concept (in Glasgow, Edinburgh, Dundee and Aberdeen) and integrated regional vascular surgery services. On emergency care it recognised the potential for better integrated primary and secondary care services, and encouraged innovation in models of service delivery. The Audit Commission has also pointed us in this direction.
- 1.4.6 In addition to these trends that exist everywhere Glasgow faces the challenge of what to do about a pattern of hospital facilities which is seriously unsatisfactory. Not one of the existing five adult acute hospitals is fully physically fit for purpose and many of the buildings are old. Creating a pattern of five new state of the art hospitals, at a capital cost of not less than £600 million and more likely nearer £1 billion is not feasible. We do need to achieve significant new capital investment, but it will need to be affordable (in an era of capital charges) and will necessarily depend on hospitals developing complementary roles with new investment targeted to provide fit for purpose facilities for those roles.
- 1.4.7 The Acute Services section of Chapter 5 sets out our progress in considering how the major implications of these issues for Glasgow, with its unsustainable position of 5 adult acute hospitals, (each attempting to provide a full range of services), serving around 1.2 million people, can be managed.

1.5 COMMUNITY CARE

1.5.1 Our shared agenda with local authorities has continued to be:

- striking the right balance between institutional and community care and social and healthcare provision.
- achieving services which are integrated and cohesive.
- improving the quality range and reliability of services.

1.5.2 The progress and plans for each client group are set out in the detailed sections. Strategic issues which are a focus of debate and will be more fully reflected in the final HIP include:-

- dealing with demand pressures in a collective way which reflects joint responsibility for community care.
- Rigorous consideration of whether the NHS adds any value and should have any significant role in the provision of long term residential care.
- Developing models of joint working which genuinely break down barriers between services
- Achieving an approach to devolution of decision making and resources to local level which fully exploits the potential for joined up working between coops and local authority teams.
- The tension between the policy objective of enabling more people to remain in their own homes and the high costs of such provision compared to institutional solutions.

1.6 CHILD HEALTH

1.6.1 This section should be seen in the context of the broader strategy of the overall HIP. For example, strategies to reduce inequalities in health, the primary care strategy and the mental health framework are relevant to improving child health. Other issues such as sexual health, tobacco control and community safety will also have important implications for child health.

1.6.2 There is a growing basis for the belief that the early years of life are crucial for future development.

Evidence shows that effective early support for children and their families

- Improves young children's quality of life
- Increases children's educational performance, vocational potential and social skills
- Decreases the likelihood that children will become involved in expensive and damaging anti-social behaviour.

1.6.3 The Health Board is committed to intervening in early life to improve the health of children, families and the future health of adults. The Board established a Child Health Strategy Group during 1999/2000, chaired by the Chief Executive of the Board with membership from Trusts, public health and health promotion. The group aims to take an overview of strategic developments in child health, to co-ordinate the health service response to a range of other relevant initiatives (see below) and to review and plan for specific health services such as community child health, A&E services and community dentistry.

1.6.4 Significant new policy initiatives the group will be considering include:

- Support for Families with Very Young Children
- Central Government Response to Safeguarder's Review
- New Opportunities Fund
- Excellence Fund for Schools - New Community Schools
- "Working together for a Healthier Scotland"
- Primary care strategy and development of LHCCs
- Community Safety
- Social Justice

1.6.5 A particular challenge is to link the work of the Health Strategy Group to detailed planning work with each Local Authority.

1.6.6 The key components of the emerging GGHB strategy include:

- Enhanced emphasis on improving health of all children and reducing inequalities in children's and young people's health.
- Family support – flexible co-ordinated support should be available for all families. This includes parenting education, home visiting programmes and group based interventions.
- Specialist services for children at risk should be available at the heart of universal family support provision.
- Joint working with education, social work, culture and leisure departments in the development of community based family learning centres, offering a range of centre-based and outreach family support
- Partnership with parents and local communities
- Working through existing partnership structures, particularly social inclusion partnerships and local authority children's planning structures to improve the circumstances in which children grow up.
- Establishment of a planned approach to the development of tertiary paediatric services on a regional and national basis.
- Secondary care services delivered where possible in an ambulatory care setting
- Within the context of reconfiguration of acute services, ensuring that the most appropriate children are cared for within RHSC
- Improved targeting of surveillance and screening services for children to ensure that the most needy children have access to services

1.6.7 The Strategy Group has established a number of subgroups covering:

- Community Child Health
- A Review of Health Visiting
- A Review of Community Dentistry
- Teenage Health

1.6.8 Detailed proposals drawing together this wide range of issues will be developed over the next 6 months.

1.7 MENTAL HEALTH

1.7.1 Mental health remains one of the major priorities for the NHS in Scotland. Following the publication of the National Framework for Mental Health Services in September 1997, the Board, in partnership with Local Authorities and the Community and Mental Health Services NHS Trust, carried out a major strategic review of mental health services and prepared a Joint Mental Health Strategy. The Strategy, which was adopted by the Board in May 1999, set out a six-year programme of change in mental health services to address the significant levels of mental health morbidity across Greater Glasgow.

1.7.2 Following the completion of the Strategy, a major review encompassing the future configuration of mental health provision, including hospital locations and bed numbers, has been carried out. The proposals for the review have been issued as a Consultation Paper "Modernising Mental Health Services" and are summarised in the Detailed Plans Chapter.

1.7.3 A priority for mental health services emerging from the Strategy is the need to ensure mental health issues are given a high priority in the developing work on Social Inclusion and tackling poverty and depression across Glasgow. The clear correlation between poor mental health status and deprivation is well established and this is often exacerbated by the increasing incidence of major mental illness and associated drug and alcohol abuse. There is, therefore a need for the Mental Health Strategy and implementation to dovetail with the ongoing work on drugs and alcohol and the Social Inclusion Partnership Boards.

1.7.4 Much of the strategic work on mental health to date has addressed the needs of people who already have severe and enduring mental health problems. During 2000/01, there is a requirement to develop more preventative approaches and to identify and help people at risk of becoming mentally ill. This again links to the inequalities in health agenda with a particular emphasis needing to be directed towards developing strategies for prioritising the mental health and wellbeing of children and young people.

1.8 PUBLIC INVOLVEMENT

1.8.1 The White Paper 'Designed to Care' made a number of commitments to extend the effective involvement of patients and the public. These commitments were reinforced by Management Executive Guidance in April 1999, requiring Health Boards and Trusts to designate a director to lead this work and establishing the following priorities:-

- Developing patient focussed services, including improving reliability and co-ordination, clinical effectiveness, patient involvement in decision making and better information for patients.
- Increasing public involvement in primary care.
- Developing and improving advocacy services.
- Addressing issues in mixed sex accommodation.
- Improving services for ethnic minorities.
- Achieving best practise in dealing with complaints.
- Producing better information for patients.
- Delivering more timely discharge information.
- Working more effectively with Local Health Councils.
- Implementing the volunteering strategy.

1.8.2 We see these requirements as fundamental to the way services are delivered to individual patients and how the public are involved in decisions about healthcare. Progress in a number of the key areas is included in the detailed sections and the final HIP will include a specific set of commitments addressing these priority areas for each Trust.

1.8.3 Involving the public and other interests in policy making and planning remains a significant challenge. As well as a number of seminars for the health council, briefings for MSPs, discussion with Local Councillors, we have consulted extensively on a number of service strategies and plans. Particular efforts have been made to achieve engagement and dialogue on maternity services, with user workshops; on mental health, with the development of a user network; with the new SIP Boards and with the Medical advisory structure in developing this programme. The financial framework section of this programme reflects on the need to achieve greater transparency in setting investment priorities.

1.8.4 We are open to suggestions and proposals about how we make further progress to improve the level of public engagement.

1.9 PARTNERSHIP WORKING

1.9.1 None of the work described in this Health Improvement Programme can be delivered by GGHB alone - and indeed, none of the plans has been developed by GGHB alone. All of our work is collaborative; developed and implemented in conjunction with our many partners.