NHS GREATER GLASGOW AND CLYDE

ANNUAL REVIEW SELF ASSESSMENT 2012

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1. INTRODUCTION

During 2011-12 NHSGGC made significant progress against most of the 2011-12 HEAT targets and standards and across a wide range of strategic programmes. Key highlights include:

- Exceeding our health improvement targets in relation to alcohol brief interventions, cardiovascular health checks, child healthy weight interventions, smoking cessation (SIMD) and the wider smoking cessation programme;

- Further reductions in *Staphylococcus aureus bacteraemia* and C Difficile;

- Consolidating, and extending our work in relation to the Scottish Patient Safety Programme;

- Implementing the recommendations of the Health Environmental Inspections and more recently from the Older people's Acute Care Inspections;

- Continuing delivery of our 18 weeks Referral to Treatment waiting time guarantee as at December 2011 for over 90% of patients;

- Maintaining our financial balance and delivering on our efficiency savings targets;

- Implementation of major capital works programme including the significant progress in building the New South Glasgow Hospitals which continue to be on schedule and on budget. The Laboratory and Facilities Management Building is now open and fully operational – a significant milestone in NHSGGC's progress towards 2015 and beyond;

- The implementation and development of Facing the Future Together (FTFT), our systematic approach to organisational change; and

- The implementation of the six Change Fund Plans, improving the care of older people and delivering a reduction in bed days lost to delayed discharges.

This self-assessment provides an overview of progress during 2011-12 in relation to each of these areas and other national and local priority areas.

2. SUMMARY OF PROGRESS AGAINST 2011 ANNUAL REVIEW ACTIONS

REF	ACTION POINTS AGREED	PROGRESS
1	The Board must keep the Health Directorate informed of progress on the local implementation of the Quality Strategy.	The key dimensions of the Quality Strategy are incorporated within the Board's Quality Policy Framework and reflected in all local development plans. Progress is reported to the Board's Quality and Performance Committee. The Board has prioritised the Improvement of Services for Older People as its key quality initiative launched at an event on 16 December 2011 involving patients, volunteers, clinical and managerial staff. The outcome of the event resulted in prioritising ways in which the Board can implement improvements in the way services and care can be delivered to elderly patients and their families, which the participants at the event will monitor to ensure the improvements are achieved.
2	The Board must continue to review, update and maintain robust arrangements for controlling Healthcare Associated Infection.	The Board achieved its targets on reducing Healthcare Associated Infection. Progress against this action is outlined in Section 4 of the Self Assessment, **page 10**.
3	The Board must keep the Health Directorate informed on progress on maintaining all access targets, including the 4-hour A&E standard and 18 weeks RTT Target.	Progress to date is outlined in Section 5 of the Self Assessment, **page 12**.
4	The Board must provide a detailed projection for future years on the number of children who will benefit from insulin pumps; the Government will keep the Board's position on the provision of insulin pumps under close review.	We have reported our plans to health Directorates.
5	The Board must keep the Health Directorate up to date with progress on the local efforts to increase breastfeeding.	Breastfeeding remains a major focus reinforced through our performance routines and with areas where progress has been made supporting improvement elsewhere.

REF	ACTION POINTS AGREED	PROGRESS
6	The Board must keep the Health Directorate up to date with progress on maintaining the zero delayed discharge standard with its planning partners.	Progress has been routinely reported through the census information.
7	The Board must continue to achieve in-year and recurring financial balance.	The Board delivered an end of year financial balance. More detail is provided in Section 8 of the Self Assessment, **page 22.**
8	The Board must keep health Directorate informed of progress in implementing the local efficiency savings programme.	The Board achieved the 2011/12 efficiencies from the efficiency savings programme. More detail is outlined in Section 8 of the Self Assessment, **page 22.**

3. EVERYONE HAS THE BEST START IN LIFE AND IS ABLE TO LIVE LONGER, HEALTHIER LIVES

During 2011-12 NHSGGC performed well in relation to the HEAT targets in this area.

Alcohol Brief Interventions - a total of 19,886 alcohol brief interventions were reported in March 2012, exceeding the planned number of 14,066 interventions by 41%.

Inequalities Targeted Health Checks - a total of 19,466 cardiovascular health checks were carried out by March 2012, exceeding the target of 7,050. The programme was delivered by 98 participating GP practices in Glasgow City, Inverclyde, Renfrewshire and West Dunbartonshire CH(C)Ps.

Evaluation of the first phase of Keep Well identified a number of areas for programme improvement, which will be implemented in 2012/13. NHSGGC is supporting practices to achieve higher levels of patient engagement, reduce unwarranted clinical variation and achieve closer integration with health improvement services. A key need was a more targeted approach to meet the needs of South Asian patients, a risk group for cardiovascular disease and associated long term conditions. Accordingly, the South Asian Anticipatory Care (SAAC) project was established in June 2011 to pilot a customised programme delivering culturally appropriate Keep Well services to this population subgroup. SAAC had successfully delivered 789 Keep Well consultations by March 2012. SAAC funding was subsequently extended for a further 12 months to March 2013 and over this period, further evaluation will test this approach to identifying and engaging with South Asian individuals aged 35-64 years.

NHSGGC will incrementally seek to achieve 100% coverage of SIMD Quintile 1 (most deprived) populations. During 2012/13, a further 32 GP practices are scheduled to join the programme, creating a total of 130 practices participating in the programme.

Drug and Alcohol Treatment - at March 2012, 93.2% of drug and alcohol clients started treatment within three weeks of referral, exceeding the target of 90%.

Across NHSGGC there was a reduction in the **6 – 8 weeks exclusive breastfeeding** rates recorded. During April 2011 – March 2012 rates reduced from 23.6% in 2010-11 to 23.0% for the same period 2011-12. Whilst not a HEAT target, breastfeeding remains a major priority for NHSGGC and a range of actions are in place to support a renewed focus on best practice to support breastfeeding.

- **Cancer Referrals and Waits 62 & 31 days -** Cancer waiting times continued to exceed target with **97% of patients referred urgently with a suspicion of cancer beginning treatment within 62 days of receipt of referral** in NHSGGC exceeding the target of 95%. Similarly, **98.4% of patients diagnosed with cancer began treatment within 31 days** exceeding the target of 95% as at December 2011.

Child Healthy Weight Interventions - a total of 1,134 children completed the child healthy weight intervention programme by March 2012, exceeding the target of 1,131.

Smoking Cessation – during 2011-12 NHSGGC supported a total of 12,129 successful quits (exceeding the target of 6,762) and a total of 6,575 successful smoking quits were recorded in the most deprived areas, again exceeding the 4,054 target. Our focus on the prevention of smoking in young people has been continued with new tobacco programmes launched in primary and secondary schools, as well as a prominent youth advocacy tobacco programme building on promising data from the Glasgow schools survey (2011) showing a reduction in smoking amongst young people from 9.7% in 2007 to 8.4% in 2010.

Dental Health – NHSGGC exceeded the target for the percentage of three and four year olds who received at least two **fluoride varnishing applications**, reporting 3.87% against a target of 3% at March 2012.

Early Years and Antenatal Access - the commitment to address health inequalities around the **Early Years** agenda will focus on early intervention and prevention.

- **The Healthy Children Programme** will result in a comprehensive outcome based assessment of need using a Universal Assessment Tool based on GIRFEC principles. This will be supported by delivery of evidence based interventions targeting the more vulnerable children and families and will ensure that children who require additional support around communications and behaviour are identified and supported into services;

- **The Parenting Framework** has been reviewed to ensure that the more vulnerable parents are able to access a range of parenting interventions based on their specific needs. These programmes can also be accessed through Education, Housing and Third Sector organisations;

- **The Family Nurse Partnership** will target vulnerable teenagers and also provide useful learning about making a difference in Early Years that has longer term implications for the child and their family. Other services including SNIPs and PACT teams will continue to support those not engaged in the Family Nurse Partnership;

- Our focus on inequalities will be enhanced with the continuation of **Healthier Wealthier Children**. Staff in the Children & Families Teams have also been trained in **Routine Sensitive Enquiry**. The implementation of the **Injury Prevention Strategy** will enable us to reduce numbers of children who incur an avoidable injury;

- A challenge for NHSGGC and our partners is to ensure that **Getting it Right for Every Child** and the **National Practice Model** are implemented including

those elements relating to Named person, Lead professional, Single and Joint assessments, Single Child Plan and promoting effective inter agency working;

- The review of **school health** will create a sharper focus on the role of school nursing as part of the overall children and family locality teams as well as improving the interface between school nursing, community and acute paediatric nursing; and

- **Ante Natal Care** –our aim is to ensure at least **80% of pregnant women** in each SIMD quintile will have booked for antenatal care by the **twelfth week of gestation** by March 2015. The measures will include:

    - Increase in the number of **smoking quits/quit rate for pregnant women** through support provided within both maternity and community services;
    - Increase in the number of **Alcohol Brief Interventions** delivered through maternity services to help women to reduce or abstain from alcohol during pregnancy;
    - Increase in the initiation and maintenance of **breastfeeding** to meet local targets; and
    - Improvement in the **quality of care** for vulnerable pregnant women.

In addition improvements in Maternity Services are being progressed to:

- Implement measures that improve interfaces between midwives, health visitors and GPs, especially in relation to sharing information on women and the child during pregnancy and at handover;
- Implement the timely discharge process for women who have given birth without complications;
- Revise and implement the vulnerable pregnancy protocol; and
- Review the findings from the work on the delivery and organisation of post natal care, from the pilot in Rutherglen Health Centre and pilot a similar approach in Glasgow.

In improving the overall effectiveness in **Responding to Inequalities** NHSGGC created a framework, 10 Goals for an Inequalities Sensitive Health Service, which it uses to support cultural change. A five year review of progress has been carried out and this has identified significant progress. This includes:

- Policy and planning processes are more explicitly focussed on tackling inequalities and discrimination;
- Improved ability to test access to care though collection of patient information through staff training and changes to some of our data collection systems;
- Improvement in involving people from all equality groups as a part of patient engagement;
- Improved understanding and provision of communication support has decreased the likelihood of discrimination or poor service delivery;
- More effective in identifying and removing physical barriers to services for disabled patients and for planning for greater accessibility;
- Equality impact assessment is now part of our organisational culture;

- Improvement in our services as the result of routine inquiry about financial difficulties and experience of gender based violence; and
- Procurement processes have been strengthened to assess risk in relation to inequality in order to limit discrimination by our providers.

NHSGGC developed a **Detect Cancer Early Health Improvement Strategy 2012-2015** to reduce the prevalence of risk factors among our residents and staff. This focuses on efforts to stop the increase in risk factors, based on available evidence. Detailed implementation plans will be fully integrated into services across NHSGGC.

In recognition of the modest decline in **suicide rates** in NHSGGC over the past decade, the Board has established a new Suicide Prevention Group, which commenced its work in April 2012. This group will work in partnership with the six Choose Life Programmes operating in the Board area, and with the national Choose Life Programme. Its functions will include collating and reviewing data on trends and risk factors, developing recommendations for priority action for coordination across relevant services, overseeing a continued programme of training for frontline staff, and disseminating good practice approaches. The group will develop proposals for a strengthened suicide prevention approach by November 2012.

NHSGGC has established a **Primary Care Deprivation Group.** This is a multi professional group of front line practitioners working in Primary Care with people experiencing deprivation. The group aims to share experience, provide education and support, identify current good practice, engage all disciplines in partnership and develop and lead change through joint working. The group has developed a series of service proposals as well as influencing the wider Board strategy.

4. HEALTHCARE IS SAFE FOR EVERY PERSON, EVERY TIME

NHSGGC has performed well against the key performance targets in this area including:

C.Difficile - the National Report published in July 2012 (January – March 2012) shows the rate of C. difficile within NHSGGC as 0.25 per 1,000 occupied bed days in 65 years+ and places the Board below the national mean (0.28 per 1,000 OBD in 65 years+) and also below the revised HEAT target, to be attained by 31 March 2013 of 0.39 cases per 1,000 total occupied bed days. Infection Control Teams in NHSGGC complete the Health Protection Scotland Trigger Tool if there are two or more linked HAI cases of CDI in any clinical area in a two week period. Part of this process includes the referral to the Antimicrobial Management Team who will review the use of antibiotics within the area.

MRSA/MSSA - for the reporting quarter (January – March 2012) NHSGGC reported 0.275 cases per 1,000 AOBDs (Acute Occupied Bed Days), NHS Scotland reported 0.292 per 1,000 AOBDs. The revised National HEAT target requires all Boards in Scotland to achieve a rate of 0.26 cases per 1,000 AOBDs or lower by 31 March 2013. NHSGGC have implemented Infection Control enhanced surveillance methodology and reports in relation to MRSA/MSSA bacteraemia are being reviewed routinely in order to provide directorates with accurate information with regards to where and why these types of infections are occurring. Directorate reports utilise improvement methodology such as Pareto and run charts to allow directorates to target and plan areas for intervention. Multi disciplinary representatives review this information and make plans to prevent avoidable infections. The primary interventions were based in Acute and this will continue, but there is now a focused piece of work being progressed to investigate community onset HAIs (COHAI). The aim is that targeted intervention in this area will reduce the incidence of MRSA/MSSA bacteraemia further.

Hand Hygiene Compliance - NHSGGC has demonstrated a steady rise in Hand Hygiene Compliance during the National Audit periods from a 62% baseline in February 2007 to achieve the 90% target in September 2008 and a current figure of 95% (LHBC Audits) reported in the July 2012 HPS report. Hand Hygiene Compliance audits are carried out on a monthly basis in the majority of wards and departments in NHSGGC and these results populate the HAIRT. This information is used at local level to improve practice. Results are fed back through Directorate based reporting mechanisms which allows management to view the progress of individual wards.

The audit process has been revised to reflect Combined Compliance, as well as opportunities taken. Combined Compliance involves taking the opportunity and completing Hand Hygiene to a required standard. If this does not occur then the overall score awarded is a failure. Elements of these criteria include being bare below the elbows and following a six step technique that covers all areas of staff hands.

Scottish Patient Safety Programme (SPSP) - good progress continues to be made in implementing SPSP. Feedback from the national support team has

remained positive throughout 2011-12. The Acute Division have demonstrated reliability in 25 distinct measures of clinical and communication processes in the pilot teams. The last two years have seen the programme focus on spreading the reliable models of practice to all relevant clinical areas. During 2011-12 NHSGGC also launched a local SPSP programme in Primary Care, Mental Health Services and Obstetrics.

Healthcare Environmental Inspections (HEI) - NHSGGC remains focused on improving the quality of the services provided and making the necessary changes in light of the recommendations and requirements from the HEI inspections. During 2011-12 a total of nine announced and 11 unannounced Healthcare Environmental Inspections took place, from which 32 individual requirements and 41 recommendations were made. Most requirements and recommendations have been completed however, sustainability compliance with some will require continual monitoring. Actions outstanding are generally concerned with recommendations that require wider system changes or where the tools or technology are in development.

Also during 2011-12 three **HEI Care of Older People in Acute Hospital Inspections** took place. Improvement plans have been developed and implemented to support a culture of continuous improvement in the way we care for older patients. Within the Acute Services Division full governance arrangements are in place to ensure that relevant lessons learned from reports are progressed and implemented across the Division.

Safe Use of Medicines by a Diverse Population - as part of the ongoing Safer Use of Medicines programme, specific work has been carried out with the Black and Ethnic Minority (BME) community. The outreach programme has led to:

- Increased understanding of why medicines should not be shared;
- Improved understanding and engagement with the services provided by community pharmacies; and
- Information in community languages tailored to the issues raised through community discussions.

5. EVERYONE HAS A POSITIVE EXPERIENCE OF HEALTHCARE

18 weeks RTT and legal treatment time guarantee - at December 2011, 90.2% of patients were treated within 18 weeks of Referral to Treatment across NHSGGC.

4 hour A&E waiting time - NHSGGC reported a Board average of 95.3% of patients waiting less than the target of 98% for 2011-12. This performance peaked during July 2011 at 97.2%.

Access to Stroke Unit - at March 2012, 73% of patients were admitted to a stroke unit on the day of admission or the day following presentation, below the expected target of 80%.

Across NHSGGC a number of ways have been established for **patients to feedback** their experience whilst in our care both within Acute and CH(C)Ps. This includes feedback from carers and relatives as well as patients. Directorates have defined processes to gather, assess and respond to this feedback and to take the appropriate action to improve services. Key examples include:

- **Acute Services** – as part of the Better Together initiative, questionnaires are sent out to patients based on a randomised sample of overnight stay patients and they are also handed out and gathered back within the wards.

- NHSGGC launched a pilot project to produce **patient experience films** which aim to use stories of inpatient care to encourage staff to reflect on the issues that are of importance to patients. By the end of May 2012, the first phase of three films were released and distributed across the Acute Division. At the end of each film viewers are encouraged to visit StaffNet to find out what improvements have been made to service provision in relation to themes raised in the interviews;

- **Patient Feedback Pilot** - NHSGGC has been participating in the 'Patient Opinion' pilot which has given valuable real time information about the experience of patients. This has been made available to staff in the areas concerned to ensure they can see and learn from the feedback received; and

- Renfrewshire CHP have developed a **Patient Experience Community of Action Resource** which provides evidence, guidance and tools to enable a systematic approach to embedding the use of patient feedback within the CHP to recognise achievements and drive forward service improvement actions. The methods applied are 'tried and tested' by members of Renfrewshire CHP's Patient Experience Community of Action, who have collectively explored ways of genuinely capturing our patients experience in a much more proactive and meaningful way.

During 2011-12 as part of our **Older People's Programme** we held a major event with patients, carers, third sector representatives and staff to discuss the experience of older people in our services. As a result of this, we have produced

a checklist and action plan for all areas to make sure they can consider and learn from the experience of older people in their services.

Access To Primary Care - access to services has been a focus of our Primary Care framework over the last year and all CH(C)Ps have been working with practices to develop methods for routine reporting of access to appointments.

Patient Information Centres (PiC's) - located in the Ambulatory Care Hospitals have provided tailored health and wellbeing information to 10,557 clients during 2011/12. The PiCs host a range of drop in health improvement services for patients, visitors and staff. They offer money advice, physical activity opportunities, carers support and infant feeding support. The service is currently developing an outreach information service to other hospital sites.

Person Centred Care, Patient Engagement and Tackling Inequalities - key to person centred care is an understanding of patients' experience of inequality and discrimination. This year, NHSGGC has:

- Decreased the potential for discrimination in 61 additional frontline services as the result of a EQIA (Equality Impact Assessment) process, making 204 in total;
- Improved the awareness of staff of their role in tackling discrimination. 5,360 members of staff have completed e-learning modules and other training;
- Launched a new in house spoken language Interpreting Service. This service places over 250 spoken language interpreters across NHSGGC service to ensure a barrier free service for our patients whose first language is not English. Since its launch the new service has delivered 16,141 appointments with spoken language interpreters across 59 languages;
- Published 37 new resources in accessible formats;
- Trained a further 784 staff in routine enquiry on gender based violence;
- Held three open meetings with Deaf people to further identify their needs and experiences of health care; and
- Established a Health Equalities Network to consult with 47 organisations that specifically represent the needs of patients with protected characteristics.

Building on the 2010 Mental Welfare Commission visit to Rehabilitation and Assessment Directorate wards an action plan is being implemented to respond to 'Decisions for Dignity' and the Dementia Standards. Key actions include:

- The appointment of an **Alzheimer's Scotland Nurse Consultant for Dementia** in March 2012,
- The first cohort of NHSGGC staff graduating as 'Dementia Champions' in March 2012; and
- The development of an Adults With Incapacity (AWI) training resource for acute staff to improve their knowledge and understanding.

Patient Focus and Public Involvement – during 2011-12 NHS Boards were asked to develop improvement plans based on the findings from the 2010-11 self assessment. Our improvement actions include:

- To improve the arrangements on how patients and the public are being engaged in the development of an improvement plan to respond to the findings of the Better Together Inpatient survey;

- Senior charge nurses in the Rehabilitation and Assessment Directorate are undertaking monthly sampling of patient experience using the Better Together questionnaire. Feedback from this is reported in the form of three highlights and three lowlights. The reporting proforma also includes actions being taken in response to lowlights. High/lowlight reports are displayed along with other quality indicator data on public notice boards within each ward area. Performance run charts are produced to aid interpretation of the data and to provide patients and the public information on improvements; and

- Ensuring prescription drugs are more accessible via community pharmacies to patients with a visual impairment. The main focus of this work is to produce "tip cards" for all community pharmacists to raise awareness of the communication issues facing visually impaired people when being prescribed and taking medication. The tip cards will be produced in partnership with visually impaired people and then promoted through local media, talking newspapers and wider community information outlets.

The continued implementation of **Releasing Time to Care (RTTC)** to support direct patient care and improve patient experience has resulted in a consistent approach to quality improvement, allowing us to capture the learning from the wards and ensure that knowledge can be spread. Increasing productivity, such as reducing time at shift handovers through improved communication systems, has resulted in an increase in the time nursing staff spend on direct patient care in many wards. This time is reinvested in patient care e.g. more time can be spent with patients who require support at meal times and this can be evidenced through the wards' improved compliance with the Food, Fluid and Nutrition clinical quality indicator.

6. STAFF FEEL SUPPORTED AND ENGAGED

NHSGGC aims to develop a workforce which feels positive about being part of NHSGGC, feels listened to and valued and were all staff take responsibility to identify and address issues in their area of work in terms of quality, efficiency and effectiveness, with a real focus on improving the care we deliver to patients.

Facing the Future Together (FTFT) - is our Organisational Change Programme; a high profile, board wide programme, focussed on engagement with staff at all levels. The programme has five key strands, each underpinned by a detailed work plan. These are:

- Our patients;
- Our people;
- Our leaders;
- Our resources; and
- Our culture.

Examples of the actions in place help ensure staff feel supported and engaged include:-

- **Local Staff Awards** building on the success of the established Chairman's awards recognise staff for their innovation or for 'going the extra mile' to improve the quality of care to patients or the effectiveness of their service. The awards have a high profile within the organisation; and

- **Senior Management 'walkarounds'** - based on the Scottish Patient Safety Programme senior managers in Acute Services conduct 'walkarounds' They then take any corrective actions required based on this first hand experience and build stronger relationships with frontline staff and support middle managers.

Attendance management remains a productivity and staff welfare issue for NHSGGC. Across NHSGGC the rate of **sickness absence** was 4.65% during 2011/12. Work to reduce sickness absence continues.

The **Healthy Working Lives Initiative (HWL)** is recognised as having the potential to minimise sickness absence levels. To date, we have achieved 11 HWL gold awards and a further 5 HWL Mental Health and Wellbeing Commendations Awards across NHSGGC in a wide range of areas including CH(C)Ps, Mental Health Services, Forensic Mental Health and Learning Disabilities Services and NHSGGC clusters.

The development of workstreams within the **Healthy Children Programme** have progressed by actively engaging staff in working groups. Over 30% of staff from Children & Families teams have been consulted on developments through staff consensus events.

Both ***Releasing Time to Care*** and **Leading Better Care** are being rolled out across the Children & Families Teams across the Board to increase direct patient time by 5% and to ensure that staff have regular clinical and caseload supervision.

Staff Health Strategy Implementation - NHSGGC continues to support staff health through the implementation of the Staff Health Strategy (joint strategy with Glasgow City Council) and the HWL programme. Achievements within the strategy include:

- A Mental Health Wellbeing policy;
- Alcohol and drug training for managers;
- Statements of intent for physical activity and healthy eating; and
- Implementation of a Small Grant Fund for health improvement activity targeting low paid workers.

A key strand of our Primary Care development approach has been to support better **engagement with independent contractors**. We have established locality groups in each CH(C)P enabling GPs to engage with community services to participate in decisions on day to day deployment of resources and influence longer term planning.

The NHSGGC **Workforce Plan 2012/13** was developed in partnership and published on the NHSGGC website at the end of August 2012 in line with SGHD requirements. The Workforce Plan is a high level summary of the workforce implications of service plans across NHSGGC.

The Workforce Plan has been developed using the NHS Scotland six steps methodology and the NHS Careers Framework. Both of these workforce models enable us to take a coherent view of the workforce across all job families and sub-groups. The Career Framework in particular is a useful tool for modelling and implementing workforce change and we are promoting and encouraging the use of this tool in NHSGGC.

The workforce implications of service change and redesign are set out in financial and service plans at Board and Divisional/CH(C)P level. These workforce implications are further analysed in the Project Initiation Documents (PIDs) which are prepared to support any significant service change and which set out the financial, workforce and equality impacts of any proposed changes to achieve full integration of workforce, financial and service plans. All of the above workforce information is analysed and summarised by the workforce planners in order to develop the NHSGCC Workforce Plan.

The plan was developed by two partnership groups specifically convened to oversee the development process, the Workforce Plan Reference Group and the Workforce Plan Core Group. Thereafter the plan was widely consulted upon through GGC including all management teams, the Area Partnership Forum, Area Clinical Forum and the Staff Governance Committee of the Board.

Overall the Board is projecting a workforce reduction of 578 wte across nine job families primarily as a consequence of a review of administrative services driven by new technologies such as digital dictation and mobile computing, the 25% reduction in Senior Managers which was set by the SGHD in 2010 and is due for implementation in 2015, the continued implementation of the Acute Division Bed model and a number of other service redesigns e.g. AHPs, Facilities and Healthcare Sciences.

NHSGGC is fully committed to the redeployment of any staff affected by continued workforce change and manages this process through the GGC Workforce Change Policy.

7. PEOPLE ARE ABLE TO LIVE WELL AT HOME OR IN THE COMMUNITY

Change Fund Plans - NHSGGC is a partner in six change fund plans with Local Authorities, including three integrated health and social care partnerships. Year two change fund plans are informed by a clear evidence base and are linked to demonstrable improvements particularly in relation to bed days lost to delayed discharges in acute hospitals. 2011-12 was been a developmental year for the Change Fund as the funding was only confirmed in March 2011.

All partnerships are now implementing a wide range of planned intervention programmes in a range of areas including supported discharge provision, anticipatory care, early geriatric assessment, enhanced home care and reablement, Single Point of Access, Assistive Technology and Telecare and community capacity building, including supporting third sector groups.

The comprehensive internal monitoring programme continues to keep track of progress against key indicators on a monthly basis and performance against key measures around delayed discharge is beginning to show an improvement on the baseline years' performance.

Progress has been made in providing more services in primary and community care settings. Examples include the full implementation of 'Vitality', a community based physical activity programme that supports participants to exercise at a level suitable to their abilities, including adults with impaired functional ability. This has been delivered in partnership with all local authorities securing 74,899 attendances during 2011-12.

In November 2011, we took responsibility for healthcare services in HMP Barlinnie, HMP Greenock and HMP Low Moss and have already made substantial improvements.

Our local Primary Care Framework provides the overall direction for our work in relation to **delivering Quality in Primary Care**. Progress over the last year includes:

- Development of our extensive programme of enhanced services to improve outcomes for patients and ensure that multi morbidity can be addressed;
- Working with all practices to assess and improve access for patients, including supporting the use of the Access Toolkit;
- Planning the development of the Scottish Patient Safety Programme in Primary Care;
- Using the Quality and Outcomes Framework Quality and Productivity points to provide better information for practices through new Practice Activity Reports, and improving dialogue between primary and secondary care on patient pathway and improvements to services;
- Using our locality groups to engage GPs and community services in joint development of services and resolving operational concerns; and
- Strong involvement of Primary Care in our Clinical Services Fit for the Future process.

Psychological Therapies - monthly reporting of data to Information Services Division (ISD) of the Scottish Government commenced in May 2011, with the reporting of Primary Care Mental Health Team service data. Community Mental Health Team data followed in June 2011, and will be added to through the delivery of a rolling plan for gathering service data.

During 2011-12 we provided information and guidance to operational staff about the target reporting mechanisms so that activity data could be utilised by staff across the organisation. Key to this was encouraging the local use of Lean methodologies such as system maps, data and process control to identify natural process variance and focus areas for service improvement.

The **Dementia** target for NHSGGC was 8,677, and was based on approximately 61% of predicted prevalence. NHSGGC was the first Board in Scotland to successfully meet the Dementia HEAT target in March 2010, a year early. Since then, NHSGGC has continued to exceed the target, with a total of 9,266 people diagnosed with dementia on registers as at the end of March 2012. Work continues with GPs to highlight the importance of registering patients with a dementia diagnosis to ensure they get the support they need, and to ensure that we continue to exceed this standard.

Faster Access to Child Adolescent Mental Health Services (CAMHS) - as at March 2012 the longest wait for access to Child and Adolescent Mental Health Services was 48 weeks but we have an extensive programme of work to ensure this is substantially reduced during 2012/13.

In February 2012, NHSGGC launched the **Clinical Services Fit for the Future** programme which will respond to the National 2020 vision and ensure that in the face of increasing demands and changing circumstances, we can continue to provide high quality sustainable health services to the population we serve and ensure the best clinical outcomes are achieved for patients. The key aims of developing a new strategy will be to ensure:

- Care is patient focused with clinical expertise focused on providing care in the most effective way at the earliest opportunity within the care pathway;
- Services and facilities have the capacity and capability to deliver modern healthcare with the flexibility to adapt to future requirements; and
- Sustainable and affordable clinical services can be delivered across NHSGGC.

The programme is being taken forward by eight clinically led groups, looking at:

- Population Health;
- Emergency Care and Trauma;
- Planned Care;
- Child and Maternal Health;
- Older People's Services;
- Chronic Disease Management;
- Cancer; and

- Mental Health.

The clinical working groups have involved patient representatives and have been supported by wider patient reference groups, involving patients, carers and voluntary groups.

The timescale for the next stage of the programme is:

Timetable	**Key Activities**
September to December 2012	Test out case for change Develop service models
January to March 2013	Test out service models Develop options for delivery

8. BEST USE IS MADE OF AVAILABLE RESOURCES

NHSGGC remained in **financial balance** and met the **cash efficiency** target at the end of March 2012, whilst at the same time delivering on a range of service developments and improvements.

In 2002, the Scottish Executive approved the Health Board's plans for a programme of modernisation of Glasgow's hospitals, as set out in the Board's **Acute Services Review (ASR**). The programme is being implemented, in two phases, over a thirteen year period. The first phase, the development of the two ambulatory care hospitals, was completed in 2009, and the strategy has now moved into the final stage of its implementation, which will see the construction of two new hospitals and a new laboratory facility on the Southern General site.

The ASR Bed Model was a key savings scheme in 2011/12 as Acute Services continue to be modernised and redesigned in line with the move to the new South Glasgow Hospitals in 2015. ASR savings totalled £8.3m in 2011/12 from Bed Model, nursing, medical and facilities areas.

In 2011/12 we planned £50 million of savings for 2012/13. Examples of further savings programmes within the Savings Plan included:

- **Primary Care Prescribing** - GP practices implementing improvements in prescribing supported through analysis of their prescribing against 65 prescribing indicators. In addition GP practices tightened their prescribing processes through a Local Enhanced Service that encouraged improvements to repeat prescribing. Other initiatives included improving the prescribing to patients in nursing homes, reviewing the prescribing of supplementary foods and other targeted initiatives;

- **Acute Prescribing** - directorates continually review prescribing practice and deliver initiatives to improve efficiency. This is supported by the implementation of Directorate specific 12 point action plans. These plans include the establishment of cost containment groups, reviews of top 20 expenditure, medicines, protocol development, audit and inter-ward comparisons;

- **Acute Services Review (ASR) Bed Model** - this included reducing bed numbers in line with the ASR bed model through moving activity from inpatient to day case, reducing average length of stay (ALOS), and reducing multi site working across specialties. It also included redesign of Older Peoples Services. The implementation of the bed model resulted in nursing savings, medical savings and estates savings including maintenance and capital charges;

- **Procurement Savings** - national initiatives were shared with staff and savings implemented. Local initiatives also took place to standardise the products used by reducing the number of items/choice within the order catalogue. Volume of items used has also been examined to ensure excess usage is stopped;

- **Reduction in Senior Manager and Administration costs -** senior Manager savings were made in line with SGHD's policy on reducing expenditure by 25%. Administration posts were reduced across clinical and non clinical areas by moving to reduced administration support for managers and reduced office costs through agile working;

- **Medical EPA Reductions** - this was achieved largely with all new clinicians being employed on a 9:1 job plan resulting in additional clinical time being available; and

- **Catering Strategy -** implementation of the cook-chill process resulted in less wastage of products and also saved on staffing costs.

Development of Capital Programme - during 2010/11, the Board worked with SGHD colleagues to confirm the level of capital funding available for 2011/12. These discussions enabled the Board to agree with SGHD a capital funding allocation against which it could plan for 2011/12.

Most Schemes were classified as "ring-fenced" and included the New South Glasgow Hospitals project, Possilpark Health Centre, Alexandria Medical Centre, GRI University Tower, PET CT Scanning, Radiotherapy Equipment Replacement and a contribution to be made to the HUB procurement initiative. Funding made available by SGHD in 2011/12 for each project did not exceed actual expenditure incurred on each individual project with any slippage/underspend on individual projects returned to SGHD. In addition, the Board ensured that total spend incurred on each project did not exceed the total funding allocation approved for that project.

The Board's share of the national formula allocation for 2011/12 was utilised by NHSGGC to address prioritised requirements in Medical Equipment, Healthcare Associated Infection and Heath & Safety.

Construction of the new laboratory facilities commenced in February 2010 and was completed on time, and under budget, in March 2012. The new laboratory is one of the most modern in the UK, and is being equipped with state of the art technology to deliver diagnostic services across the city. A phased migration of services involving approximately 700 diagnostic staff was completed in July 2012.

The Board supports the **State of the Estate Report** and it will be a key tool in the allocation and prioritisation of resources nationally.

The presence of comparative figures gives the Board the opportunity to benchmark its performance and to undertake management reviews and knowledge comparisons with other Health Boards. In 2015 there will be a significant improvement against the indicators in the Property and Asset Management Strategy as much of the older estate becomes surplus and eligible for disposal. The Clinical Services Review will be a pivotal point for the future property strategy and investment profile of the estate in Acute and partnership premises.

The Board is an active participant in the Facilities and Shared Services reviews and welcomes the opportunity to have developed national contingency initiatives for production services that are key to supporting clinical activity.

FREQUENTLY USED ACRONYMS

ABIs	**Alcohol Brief Interventions** – interventions to target individuals who are drinking alcohol at harmful levels.
ACF	**Area Clinical Forum** - brings together clinicians from a range of professional disciplines to ensure that NHS Boards decision-making on local and national policy issues is informed by a clinical and professional perspective.
ADPs	**Alcohol & Drug Partnerships** – the focal point for local action on drug misuse. NHS Boards and local authorities are accountable for delivering outcomes for alcohol and drug misuse through NHS performance management arrangements and single outcome agreements respectively.
AHP	**Allied Health Professional** - health care professionals distinct from dentistry, nursing, medicine and pharmacy. They provide a range of diagnostic, technical, therapeutic and direct patient care and support services e.g. Occupational Therapists, Speech and Language Therapists, Podiatrists etc.
APF	**Area Partnership Forum** – made up of staff, trade union and NHS Board representatives. The purpose of the Forum is to lead, facilitate and monitor the effectiveness of partnership working between management and staff across the NHS Board area.
AR	**Annual Review** - an annual event aimed at discussing how effectively NHS Boards have delivered local services in the preceding year and exploring developments and challenges over the next year.
CAMHS	**Child and Adolescent Mental Health Service** – NHS Boards must ensure they deliver faster access and treatment for specialist Child and Adolescent Mental Health Services.
CEL	**Chief Executive Letters** - Scottish Government Health Directorates guidance issued to NHS Boards.
C.diff or CDI	**Clostridium difficile Infections** - the most important cause of hospital-acquired diarrhoea. People who have been treated with broad spectrum antibiotics, people with serious underlying illnesses and the elderly are at greatest risk.
CGRM	**Clinical Governance & Risk Management standards** – rigorous Clinical Governance and robust risk management are fundamental activities for any Board.
CH(C)P	**Community Health and (Care) Partnership** – CHP which incorporates care and health services.

CHP **Community Health Partnership** – the key mechanism for providing integrated health and social care in primary and community settings. One of the core purposes is to deliver local health improvement that helps to close the health inequality gap that exists in Scotland, and the integration of health and social care services is integral to achieving this.

CMS **Chronic Medication Service** – a scheme which allows patients who need regular repeat prescriptions to have more care provided by their community pharmacist.

COPD **Chronic Obstructive Pulmonary Disease** - any disorder that persistently obstructs the airways.

CRL **Capital Resource Limit** - the financial resources made available by the Scottish Government to NHS Boards for large investments like hospital buildings and large equipment.

EWTD **European Working Time Directive** - limits all employees to a maximum 48-hour week, averaged over a six month period. It lays down minimum requirements in relation to working hours, rest periods and annual leave.

GGC **Greater Glasgow and Clyde Health Board**

HAI **Healthcare Associated Infection** - infections such that patients acquire during the course of receiving treatment for other conditions within a healthcare setting which was not present or incubating at the time of admission.

HEAT **Health Improvement, Efficiency, Access, Treatment** - the key objectives, targets and measures against which NHS Boards are publicly monitored and evaluated. HEAT targets contribute towards delivery of the Scottish Government's Purpose and National Outcomes and NHSScotland's Quality Ambitions.

HEI **Healthcare Environment Inspectorate** - established in April 2009 to undertake at least one announced and one unannounced inspection to all acute hospitals across NHSScotland every three years. Remit now expanding to cover wider range of healthcare facilities.

HIS **Healthcare Improvement Scotland** - helps NHSScotland and independent healthcare providers to deliver high quality, evidence-based, safe, effective and person-centred care and to scrutinise services to provide public assurance about the quality and safety of that care.

HSCP **Health and Social Care Partnerships** – under proposals for new legislation to encourage the integration of health and social care, these would replace CHPs. The intention is that the NHS Board and local

authority would be jointly responsible for improving the quality and consistency of care for older people.

HSMR **Hospital Standardised Mortality Ratio** - an indicator of healthcare quality that measures whether the death rate at a hospital is higher or lower than you would expect.

ISD **Information Services Division** - provides health information, health intelligence, statistical services and advice that support the NHS in progressing quality improvement in health and care and facilitates robust planning and decision making.

IVF **In vitro fertilisation** – a treatment for infertility when other methods of assisted reproductive technology have failed.

KSF **Knowledge and Skills Framework** - a useful tool for NHS Boards to identify the knowledge, skills and development that staff need to do their job.

LDP **Local Delivery Plan** - an agreement between the Scottish Government and a NHS Board. It details how the NHS Board aims to contribute to meeting the Scottish Government's targets and outcomes for the NHS.

LEAN An improvement methodology providing an integrated approach to designing and improving work to eliminate waste.

MCN **Managed Clinical Network** - linked groups of health professionals and organisations from primary, secondary and tertiary care, working in a co-ordinated manner to deliver high quality care to a population across a large geographical area.

MRSA **Methicillin Resistant Staphylococcus Aureus** - a type of bacterial infection that is resistant to a number of widely used antibiotics. This means it can be more difficult to treat than other bacterial infections.

MSSA **Methicillin-Sensitive Staphylococcus Aureus** - a type of bacterial infection that is unable to resist some antibiotics.

NPD **Non-Profit Distributing projects** – financing model which ensures that any surplus funds can be reinvested for public benefit.

NRAC **NHSScotland Resource Allocation Committee** - ran from 2005 to 2007 to improve and refine the Arbuthnott Formula to allocate NHS funds to Health Boards. The responsibility for maintaining, updating, and refining the formula for dividing the NHS budget among the NHS Boards has been transferred to the Technical Advisory Group on Resource Allocation (TAGRA).

OPAC **Older People in Acute Care** - Health Improvement Scotland carries out a programme of inspections to provide assurance that the care of older people in acute hospitals is of a high standard.

PAMs **Property and Asset Management Strategy** – a detailed plan developed by each Health Board, outlining its plans for the development, maintenance and efficient use of its major capital assets.

PFI **Private Finance Initiative** - a method of providing funds for major capital investments where private firms are contracted to complete and manage the projects. These contracts can last up to 30 years.

PFPI **Patient Focus and Public Involvement** - NHS Boards involve people in designing, developing and delivering the health care services they provide for them. Patient Focus is about involving you in discussions and decisions when you are a patient. Public Involvement is about NHS Boards involving patients, carers and members of the public in how it plans and delivers services, develops policies and strategies.

PPF **Public Partnership Forums** - a network of patients, carers, community groups, voluntary organisations and individuals interested in the development and design of local health and social care services. They are the main link between local communities and the Community Health Partnerships (CHPs).

PPP **Public Private Partnership** - a venture which is funded and operated through a partnership of public sector authority and one or more private sector companies.

RRL **Revenue Resource Limit** - the financial resources allocated by the Scottish Government to individual NHS Boards to cover annual running costs.

RTT **Referral to Treatment** - the 18 week RTT standard will address the whole patient care pathway, from receipt of a GP referral, up to the point at which each patient is actually admitted to hospital for treatment.

SABs **Staphylococcus Aureus Bacteraemias** - a group of different infections (such as MRSA, MSSA) that are caused by staphylococcus bacteria. One of the biggest challenges in treating staphylococcal infections is that many strains of the S. aureus bacteria have developed resistance against a number of different antibiotics.

SDS **Self Directed Support** – aims to support individuals in the community, increase flexibility, choice and control over the care they receive and promote living independently in their own home.

SGHSCD **Scottish Government Health and Social Care Directorates** – a range of teams and professional groups in the Scottish Government responsible for progressing Ministers' core Healthier Scotland objective.

SHC **Scottish Health Council** - supports NHS Boards in Scotland to effectively involve patients, carers and communities in planning and providing healthcare.

SoA **Single Outcome Agreement** - the focus of our public services is being placed on improving outcomes, that is to focus on actions which make a meaningful difference to people's lives. And, led by councils, local partners are increasingly working together in pursuit of shared local priorities, as set out in Single Outcome Agreements.

SPSP **Scottish Patient Safety Programme** - is being implemented in every acute hospital in the country to steadily improve the safety of hospital care.

SFT **Scottish Futures Trust** – a public corporation, set up to improve public infrastructure investment. It is run by a Board of non-executive directors who are appointed by Scottish Ministers.

TAGRA **Technical Advisory Group on Resource Allocation** - established to carry on the work of overseeing the maintenance and development of the NRAC formula.

WTE **Whole-Time Equivalent** - a way to measure a worker's involvement. A WTE of 1.0 means that the person is equivalent to a full-time worker, while 0.5 signals that the worker is only half-time.

SAAC South Asian Anticipatory Care.

PiCs Patient Information Centres.