



## **NHS GREATER GLASGOW AND CLYDE**

### **ANNUAL REVIEW 2010 SELF ASSESSMENT**

## 1. PROGRESS ON 2009 REVIEW'S ACTION POINTS

Action Point	Progress
<p>The Board should keep SGHD up to date with progress on the local efforts to minimise alcohol misuse.</p>	<p>We have continued to actively lobby MSPs, MPs and councillors on the advantages of minimum pricing. We have worked with licensing boards and fora to influence licensing policy through a Health Impact Assessment of Glasgow City's Licensing Policy and analysis of overprovision to link into all council's overprovision statements. The Glasgow Centre for Population Health has completed very useful research on young people's views of drinking which will enable us to undertake health promotion more effectively. We have worked with young people to produce a DVD about binge drinking to use with young people's groups. Some other examples of work include:</p> <ul style="list-style-type: none"> <li>• multi component off sales campaign tackling underage sales and agent purchasing with associated diversionary activities for young people rolled out across several areas;</li> <li>• the continued work on the rollout of Alcohol Brief Intervention training to acute and primary care staff;</li> <li>• annual GRAND week of events to support communities to tackle alcohol and drugs issues locally (GRAND = "Getting Real About Alcohol and Drugs");</li> <li>• annual Play Safe in Glasgow campaign and workplace workshops to promote safer drinking, safer socialising and safer transport to users of Glasgow City's night-time economy;</li> <li>• establishment and implementation of a comprehensive Alcohol and Drugs Prevention and Education framework across the Board area, based on an evidence-based 12 core elements of activity;</li> <li>• Commissioning of a major contract to deliver a core prevention and education service for alcohol and drugs in Glasgow City (jointly funded by NHS GGC and Glasgow City Council), commencing August 2010.</li> </ul>
<p>The Board should provide further updates on progress with the range of local substance misuse treatments and services.</p>	<p>The Board, with Local Authorities have significantly increased the level of community alcohol treatment and care available across all areas, through the introduction of new targeted nursing and medical posts. The Board has increased access to substance misuse treatments such as suboxone in all areas and continued to work to deliver the Government's priority of recovery by supporting rehabilitation and employment initiatives. The Board led the national roll out of naloxone and resuscitation skills to reduce drug related deaths.</p>

<b>Action Point</b>	<b>Progress</b>
The Board should maintain the momentum in effectively addressing infection control issues.	The Board has continued its strong focus on addressing infection control issues, with regular reports to Board meetings. HEAT targets relating to both Clostridium difficile and staphylococcus aureus bacteraemia have been achieved.
The Board must continue to work to achieve in-year and recurring financial balance, and maintain regular contact with SGHD.	The Board has successfully operated within its agreed revenue and capital resource limits and has delivered the cash efficiency target.
The Board should regularly update SGHD on its efforts to maintain the downward momentum in sickness absence rates.	There was a strong focus on sickness absence throughout the year and this was discussed regularly with SGHD.
The Board must continue to deliver all waiting/access and HEAT performance targets.	The Board delivered its challenging access performance targets, ensuring improved waiting times in GP practice, cancer referrals, outpatient, inpatient and daycase appointments and in key diagnostic tests

## **2. IMPROVING THE QUALITY OF CARE AND TREATMENT FOR PATIENTS**

### **2.1. Related HEAT Targets**

In this section we present our performance against HEAT targets which relate to the quality of the care and treatment we have provided for patients, such as improving waiting times, and helping people who have long-term health conditions. We also reflect on how we have responded to the Scottish Government's new Quality Strategy including how services have improved and how we have organised our work to improve our focus on quality.

#### **2.1.1. T2: QIS clinical governance and risk management standards improving**

The overall performance against NHS Quality Improvement Scotland (QIS) Clinical Governance and Risk Management Standards is rated by NHS QIS using four descriptive assessment categories. These are translated into a numerical score that was linked into the HEAT framework. The expectation was that NHS GG&C would show a single increment rise each year and be at a level nine attainment in performance by the end of March 2010. This level was confirmed as achieved in the NHS QIS independent peer review at September 2009.

It was also confirmed in the report that NHS GG&C has:

- clearly embedded risk management structures throughout the organisation;
- demonstrated a strong commitment to clinical effectiveness and quality improvement across the organisation;
- a sound cycle of annual clinical governance reporting arrangements for operational entities with devolved responsibilities;
- a robust performance management framework that provides the context to support statistics with a high level of qualitative information.

**2.1.2. T3: Reduce the annual rate of increase of defined daily dose per capita of anti-depressants to zero by 2009/10, and put in place the required support framework to achieve a 10% reduction in future years.**

NHS GG&C, in common with the position nationally, has been unsuccessful in achieving this target, with the number of DDDs prescribed rising since 2008. Work around this target has always concentrated on ensuring that the level of prescribing has been appropriate, and to this end two local performance targets have been pursued under the auspices of the Mental Health Collaborative:

- the percentage of Fluxoxetine/Citalopram prescribed against a selection of anti-depressant medication (>65%);
- the percentage of Escitalopram prescribed against all SSRIs (<5%). (SSRIs – Selective Serotonin Reuptake Inhibitors – the modern class of anti-depressants).

The first target, relating to Fluxoxetine/Citalopram, looks to see an increase in the prescribing of these particular anti-depressants, as they are clinically and cost effective, whilst the second target, relating to a reduction in Escitalopram prescribing, is a proxy for appropriate use of second line drugs in the treatment of depression.

Progress against these local measures is more encouraging with all Community Health & Care Partnerships CH(C)Ps reflecting positive outcomes relating to the target of focusing attention on the appropriate prescribing of anti-depressants and in raising awareness of the benefit of reviewing the prescriptions. Monitoring of performance on these local measures is broken down to GP Practice level.

**2.1.3. T4: Reduce the number of readmissions (within one year for those that have had a psychiatric hospital admission of over 7 days by 10% by the end of December 2009).**

This HEAT Target has been achieved. NHS GG&C has been successful in reducing the number of readmissions within a year of discharge.

We are however, continuing to work towards further reductions, and as at March 2010 (people who were discharged between April 2008 and March

2009) the figure for re-admissions within 365 days was 985, a reduction of 18%.

**2.1.4. T6: To achieve agreed reductions in the rates of hospital admissions and bed days of patients with primary diagnosis of COPD, Asthma, Diabetes or CHD, from 2006/7 to 2010/11.**

The focus of this target is changing in 2010/11 from admissions, which continue to increase year-on-year, to bed days, with which GGC are currently showing a gradual reduction. Key initiatives to support this include a focus on reducing length of stay for patients with COPD and Asthma through the specialist nurse-led supported discharge schemes; a focus on community led interventions to slow down the progression of long term conditions. We feel it is critical to have an effective disease and symptom predictive model and are developing capability around this.

**2.1.5. T8: Increase the level of older people with complex care needs receiving care at home.**

The Board achieved this target.

**2.1.6. T9: Each NHS Board will achieve agreed improvements in the early diagnosis and management of patients with a dementia by March 2011.**

The Board exceeded this target, registering 8,738 people on dementia registers, against a target of 7,990.

**2.1.7. T10: To support shifting the balance of care, NHS Boards will achieve agreed reductions in the rates of attendance at A&E, between 2007/08 and 2010/11.**

This target presents a very significant challenge for NHSGG&C as A&E attendances have been rising in recent years. Following detailed discussion with Scottish Government, the scale of this challenge is recognised and we have agreed a plan for the Board to cap, rather than reduce, A&E attendances. Actions underway include:

- Piloting Out-of-Hours GP telephone support to Scottish Ambulance Service;
- Development of Emergency Nurse Practitioner Minor Injury Services;
- Opening of two nurse-led MIUs in 2009 at the new Ambulatory Care Hospitals in the North and South of Glasgow;
- Consideration of the findings and recommendations of the NHS Grampian Unscheduled Care Campaign in developing social marketing approaches in Greater Glasgow and Clyde;
- Commissioning of an audit of patients who attend A&E, building on a similar study carried out by NHS Lothian;
- Analysis of A&E attenders who are experiencing disadvantage;
- Development of routine information-sharing on A&E attendances at CH(C)P and GP practice level;

- Consideration of how to identify patients not registered with a GP and how to encourage and assist them to register.

**2.1.8. A8: Provide 48 hour access or advance booking to an appropriate member of the GP Practice Team by 2010/11.**

By 2009/10 91.2% of respondents reported that they were able to access a member of the GP practice team within 48 hours, in compliance with the target.

**2.1.9. A9: The maximum wait from urgent referral with a suspicion of cancer to treatment is 62 days; and the maximum wait from decision to treat to first treatment for all patients diagnosed with cancer will be 31 days from December 2011.**

In line with the 95% target, 96.3% of cancer patients waited less than 62 days for treatment.

**2.1.10. A10: Deliver 18 weeks referral to treatment from 31 December 2011. No patient will wait longer than 12 weeks from referral to a first outpatient appointment from 31 March 2010. No patient will wait longer than 9 weeks from being placed on a waiting list to admission for an inpatient or day case treatment from 31 March 2010.**

As at March 2010, no patient waiting longer than 12 weeks for an outpatient appointment. The Board also met the target that no patient waited over nine weeks for treatment as in inpatient/daycase.

## **2.2. Quality**

### **2.2.1. Improving Quality**

In this section, we give some examples of how the quality of services has been improved during the last year.

- **Senior Charge Nurse Review**

Patients have highlighted that they wish the Senior Charge Nurse to be more visible, identifiable and accessible. Across all service areas we are well on target to ensure all ward based Senior Charge Nurses will have completed the Senior Charge Nurse Review by December 2010. As an organisation we are committed to ensuring that we provide the highest standard of professional leadership for staff providing care to patients. The national uniform is being introduced to ensure patients know who is in charge.

- **Clinical Quality Indicators**

The outcomes of audits on the quality of care are displayed in many ward areas to reassure staff, patients and their relatives of our commitment to improving the quality of care.

A comprehensive and systematic audit of the quality of nursing care in Mental Health Addictions and Learning Disability Services is well established which supports a culture of continuous quality improvement.

- **Releasing Time To Care**

This is designed to equip front line staff with known improvement methods which allow them the opportunity to release time to care for patients by implementing known care interventions. Patients who get safe and dignified care reliably all day every day will get better sooner, thus improving the patient experience. A recent evaluation in wards where this programme has been introduced demonstrates that changing the lay out of the ward and having information placed on a patient status board, reduces non productive activity and allows nurses more time for direct patient care. The evaluation also evidences that staff morale has improved as result of this process.

- **Infection Control**

In 2007 the Scottish Government Health Directorates issued an LDP HEAT target in relation to Staphylococcus Aureus Bacteriemia (SABs) which required NHSGGC to reduce SABs by at least 35% by April 2010. This target has been achieved within NHSGGC (in 2010/11 this target was extended by an additional 15%).

The National Report published in February 2010 showed a further reduction in the rate of C. difficile within NHSGGC and clearly placed the Board below the national mean (0.52 per 1,000 Occupied Bed Days (OBDs) over 65s) and also below the 0.9 per 1,000 OBD HEAT target for 2011.

The Surgical Site Infection rates in NHSGGC, for the last quarter of 2009/10, remained below the national average for all procedures.

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 figure of 92% at March 2010.

All areas within NHSGGC scored green (>90%) in the most recent report on the National Cleaning Specification.

The Healthcare Environment Inspectorate undertook two Inspection visits within NHSGGC during 2009/10. Inverclyde Royal Hospital was visited in January 2010 and Southern General Hospital was visited in March 2010. The reports for both Inspections have been published on the QIS website.

Infection control staff within NHSGGC make every effort to ensure that members of the public and patients are consulted on Hospital Acquired Infections (HAI) issues and that members of the Infection Control Team

(ICT) link closely to the main Public Involvement structures. A public partner currently attends the Board Infection Control Committee.

Members of the ICT have participated in a variety of public events e.g. Royal Highland Show, Deaf Connections and Fun in the Park. The Assistant Director of Nursing (Infection Control) and the Local Board Hand Hygiene Coordinator regularly attend meetings of the Patients Panel.

Patient Information leaflets, when updated or developed, are circulated to the Public Involvement leads in the CH(C)Ps, the patients panel and the public partner representative on the Board Infection Control Committee for comment and amendment before they are issued. Versions of information leaflets have been converted into downloadable MP3 versions for patients with visual impairment.

Infection Control Safe Patient Environment audits are carried out in all wards and departments in NHS GG&C at set intervals of six, twelve or eighteen months depending on previous audit results. These audits review the patients' environment, application of policies and observation of infection control practice. Audits results and action plans are fed back locally but also to senior managers and clinicians for action.

Local Infection Control Teams in NHS GGC collect data on the occurrence of cases of C. difficile and MRSA and this information is returned to all wards and departments using Statistical Process Control Charts. The local teams then return them to the Senior Charge Nurse and Lead Nurse/Clinical Service Manager for each area. These charts set limits for each ward in relation to healthcare associated infections and enable both local and senior teams to target additional infection control actions if required in real time. Although Statistic Process Control charts are a method of viewing what is going on at a local level, the aim is to reduce the variability of the results and eventually over time, to demonstrate that fewer patients acquire hospital infections.

- **Service Redesign**

We have been undertaking service redesign across many of our services in order to improve their effectiveness and the patient's experience. Some examples in our Mental Health Services include:

- Ward Management Leadership Development Programme;
- Plan Do Study Act - improvement approach on admissions to Parkhead;
- Area Clinical Governance User Carer Involvement;
- Audit Register maintained by Area Clinical Governance – three audits being undertaken this year by Psychology students; admissions and readmissions, evaluation of crisis services and access to psychological therapies.

## **2.2.2 Organising for Quality**

In this section we discuss how we have been building on our planning and governance processes to ensure a focus on quality, in response to the NHS Scotland's Healthcare Quality Strategy.

The NHSGGC Policy Framework: 'Quality: Creating a Person-Centred and Mutual NHS' sets out the Board's approach to quality. The framework is a core part of the guidance for development plans for each part of the organisation, and ensures that improving quality is a focus of activity and planning for Acute Division, Mental Health Partnership and each CH(C)P. The framework describes actions and outcomes for Safe and Effective Care; Person Centred Care; Patient Experience and Public Involvement.

A governance and accountability structure for the Quality Strategy has been established, the Policy Development Group for Quality, and its role includes:

- Developing system-wide guidance to drive and support quality improvement across the organisation building on the established Policy Framework for Quality;
- Inform the development and implementation of performance measures for quality;
- Contribute to the development of the full range of Policy and Planning Frameworks (PPFs);
- Provide a forum to appraise good practice from within and outwith NHS GGC and consider how to promote wider implementation;
- Ensure quality improvement is carried out in a way which promotes equality, tackles discrimination and addresses health inequalities.

## **2.3. Patient Experience**

### **2.3.1. Public Involvement**

The financial year 2009/10 saw a range of developments with regard to Public Involvement. Notably, April 2009 saw the launch of a major publicity campaign to support the opening of the New Stobhill and Victoria Hospitals.

The NHS Board has continued to make progress across the key actions drawn from the Board's Framework for Patient Focus and Public Involvement (PFPI) and agreed as priorities through last year's PFPI self-assessment process. These have included:

- Joining forces with local authorities as well as the voluntary and further education sectors to link to existing literacy initiatives and develop alternative engagement and consultation options for service-users with low literacy levels;
- Development of a Policy Framework: Quality - Creating a Person-Centred and Mutual NHS as one of a suite of Board-wide Planning and Policy Frameworks;

- In 2009/10, NHSGGC made good progress across the key actions drawn from the Board's framework for PFPI and agreed as the priorities through last year's self-assessment process - including the launch of Better Together inpatient and GP surveys, development of a Quality Policy framework and continued development of the PPFs.

The 2009/10 self-assessment report on the Board's PFPI activity was reviewed by 40 patient and community representatives at a stakeholder event in May, before being submitted to the Scottish Health Council (SHC). The SHC subsequently verified that the report presented a fair and accurate account of progress made by the Board in the year.

Acute Services have a **PFPI Steering Group** with representation from each Directorate. Each Directorate is required to regularly complete a log of PFPI activity. The log has recently been reviewed for its appropriateness in relation to the 10 Community Engagement Standards which form the basis of the Participation Standards as part of the Mutual NHS. These directorate logs include PFPI activity that focuses on engagement with others to improve patient care. The activities may also be linked to other initiatives e.g. 18 week Referral To Treatment, Better Together Programmes, action plans for Ombudsman reports, etc.

**Acute Services Community Engagement Team** have carried out extensive engagement and involvement of patients and the public as part of the Acute Services Review and the development of the new South Glasgow Hospitals. Of particular note has been the involvement of children and young people in the planning and design of the new children's hospital.

**Child and Adolescent Mental Health Services** have been working on the implementation of CAPA (the Choice and Partnership Approach) and the continuing development of the UK CAMHS Outcomes Research Consortium (CORC). The former is a UK wide piece of work based on lean processes to improve timely access to CAMHS and team processes regarding case allocation, case management and discharge. We intend to carry out an EQIA on the implementation of CAPA which will allow us to look at the impact on the whole population of service users. The CORC process focuses on clinical outcomes including standardised assessments and views of service users that can be compared with other services across the UK and now Norway.

At the September 2009 meeting of West Glasgow CH(C)P's PPF, Executive Group members raised a number of concerns regarding a lack of services and support for **services users and carers affected by memory loss, dementia (including early on set dementia) or Alzheimer's**. At the following meeting after a presentation on existing services a number of priorities were identified with the support of PPF members and a work plan agreed. West Glasgow CH(C)P Dementia Draft Action Plan was presented to PPF Executive group for approval at the November meeting and an Interim Dementia Services & Resources Directory produced. These actions and priorities influenced and were included in the West Glasgow CH(C)P Draft Development Plan 2010-13.

East Glasgow CH(C)P have held a **Carers** event in December (to coincide with Carer's Rights Day) at Celtic Park. The event was organised with support from the PPF. The theme was information and included speakers on legal issues such as Power of Attorney as well as Employment and the Cancer Information Service. A Young Carers DVD was also created, following discussion at a school summit and was funded by Carers Information Strategy funding. Pupils from a local school in East Glasgow have developed and produced the DVD that highlights the issues of young carers, and this is used along with a teaching pack in schools.

### **2.3.2. Hearing Patients' Views - Better Together**

During 2009/10 the pilot 'Better Together' Programme', The Patient Experience Inpatient Survey was undertaken in Glasgow Royal Infirmary and Gartnavel Hospital.

The pilot phase concluded with a 46% response rate. From the results we were able to select five highlights and five lowlights. The highlights were against areas where we scored well and the lowlights were areas of concern. Work was undertaken to develop a draft action plan. This was then circulated to directors to commence their own action plans as an interim measure until the results of the full survey were known.

In January the full survey was sent to 18,969 patients. The sample size was large to ensure we would receive meaningful results per hospital site and per directorate.

The full survey results were received at end of July 2010 for hospital sites. The response rate was 47%. We currently await ratified Directorate results as this was a customised piece of work for our health board only.

Since receiving the hospital results, a draft action plan has been developed and includes mechanisms to engage with patients and staff.

Some other examples of our work to ensure patients can have their views heard include:

- Continued development by CH(C)Ps of their Public Partnership Forums (PPFs), with a particular focus on increasing awareness of PPFs and associated local networks;
- Providing opportunities for PPF representatives from different CH(C)P areas to network with one another and contribute to discussion about strategic change to health services.

### **2.3.3. Service Improvements as a result of patient feedback**

Outlined below are a number of examples of how we have improved our services as a result of patient feedback:

- We have reviewed our **complaints policy and procedures** to improve access to information on how to complain; improve staff awareness of our complaints procedure and good practice; and promoting the use of

Independent Advice and Support Services (IASS), for example through the introduction of IASS Caseworkers at the Patient Information Centres in the new Stobhill and Victoria Hospitals;

- Current examples of service redesign include **urology and vascular centralisation** where patients and staff from all disciplines are involved in discussion of quality improvements in the patient pathway. In Urology, patient user and community representative groups have been given the opportunity to comment on the current state of the urology service, based on their experience and to input to the future shape of the service;
- Patients and staff of all disciplines are included in redesign initiatives, such as in the **18 week team**, which has a dedicated Patient Engagement Officer who is linked in through the corporate team and is tasked with seeking patient feedback on specific issues/areas when required.

### 3. IMPROVING HEALTH & REDUCING INEQUALITIES

#### 3.1. Introduction

In this section we reflect on our work to improve the health of our population this year, and on the continuing challenge we face in reducing health inequalities.

In many ways, people living in Greater Glasgow and Clyde have never been healthier. Deaths from coronary heart disease have significantly reduced over the last ten years. The overall age and sex standardised Coronary Heart Disease mortality fell from 198 per 100,000 population in 1998 to 122 per 100,000 in 2007, a reduction of almost 40%. Cancer survival is also getting better – the most recent cancer survival statistics available show:

- Survival for female breast cancer patients has increased substantially, from 61% for those diagnosed in 1983-1987 to 81% in 2003-2007;
- (Relative) 5-year survival from colorectal cancer for men (aged 15-74) has improved from 41% to 58% and for women (aged 15-74) improvement is from 42% - 60%.

Relative survival is estimated as the *observed* survival divided by the *expected* survival in the general (Scottish) population of the same age and sex and calendar year.

The table below shows improvements in life expectancy at birth, in Scotland and in Greater Glasgow and Clyde.

	2006-08 Years	1996-98 Years	2006-08 Rank	1996-98 Rank	Difference in years	% change
Scotland	77.5	75.3	-	-	2.2	2.9
Greater Glasgow and Clyde	75.7	73.5	14	14	2.2	3.0

Despite progress, our health challenges remain considerable. Social disparities and poverty continue to harm and kill many in our population, as do experiences of discrimination faced by different groups. Greater Glasgow and Clyde still experiences some of the widest variations in health between the affluent and poor in society.

### **3.2. Related HEAT Targets**

#### **3.2.1. H2: 80% of all 3 to 5 year olds to be registered with an NHS Dentist by 2010/11.**

At end of March 82.3% of 3-5 year olds in NHSGGC were registered with a NHS Dental Practice.

The association between socio-economic deprivation and dental health continues to be apparent, even at the age of three years, with those children living in deprived communities experiencing more decay and being more likely to experience dental decay than their peers in more affluent communities.

A future HEAT target is likely to focus on fluoride varnishing for three and four year olds in each SIMD quintile to have fluoride varnishing twice a year. In preparation for this we are:

- Implementing Childsmile Programme which includes Childsmile Practice and Nursery;
- Encouraging Health Visitors to advise parents to register child with Dentist at same time as with GP;
- Informing parents of the need to take their children to the Dentist every six months;
- Encouraging dental practices to sign up as Childsmile Practices;
- Commencing Childsmile Nursery which targets the 20% most deprived children only and our dental teams will apply fluoride varnishing to these children twice yearly;
- Any child seen by specialist dental staff, is offered fluoride varnishing, if parent/guardian consents;
- Dedicated oral health staff;
- Campaign to challenge culture where some children are only taken to dentist when they have toothache.

In order to ensure all GDPs carry out fluoride varnishing, it will be crucial to have this included in the Statement of Dentists Remuneration.

Planning is taking place to commence Childsmile Nursery in partnership with CH(C)Ps. General Dental Services will also do three and four year old Fluoride Varnish applications.

**3.2.2. H3: Achieve agreed completion rates for child healthy weight intervention programme (ACES) by 2010/11.**

ACES is making slow but steady progress towards the target. While the slow start was anticipated, given the complexity in developing and establishing the service, performance since January has significantly improved and we continue to monitor this closely. Local Implementation groups have focused recent efforts on the promotion of ACES through local presentations, distribution of leaflets, business cards and most recently by showing the newly produced DVD in different settings such as Education and local Leisure Services. In addition, we are developing a revised delivery model, on a more preventative basis, which is aimed at whole school classes, and is linked to the curriculum. This less intense model will offer greater capacity to increase numbers.

Sign posting to the programme and the successful transfer onto starting the programme remain the greatest challenge and efforts will be increased and maintained in order to meet the target.

Overall, 56 children had completed the programme, at the end of March, falling short of the target of 205.

**H4: Achieve agreed number of screenings using the setting-appropriate screening tool and appropriate alcohol brief intervention by 2010/11**

A total of 21,285 alcohol brief interventions were completed by March 2010, exceeding the planned number of 16,902 interventions.

**3.2.3. H5: Reduce suicide rate between 2002 and 2013 by 20%, supported by 50% of key frontline staff in mental health and substance misuse services, primary care, and accident and emergency being educated and trained in using suicide assessment tools/ suicide prevention training programmes by 2010.**

Significant progress is being made in GGC with suicide prevention training for key front line staff in line with the guidance associated with the HEAT target. Between December 2009 and June 2010 the proportion of relevant staff trained rose from 27% to 36%, with further plans to progress towards the 50% target. This progress is being achieved by a combination in place of an overall corporate plan - with leadership provided by the Mental Health Partnership - coupled with enhanced local training capacity and the engagement of key clinicians and managers.

Notable new developments include a programme of training frontline A&E nursing staff, which is now underway across hospital sites, plus negotiation of additional national support resource to enable further STORM courses to be delivered during the autumn. While there are still challenges in meeting the overall target, there is considerable training momentum underway, which will enable a further significant advance by December 2010. Discussions are ongoing with Scottish Government about opportunities to improve the efficiency of the training required.

**3.2.4. H6: By 31st March 2011, NHS GG&C to support 8% of their smoking population (21,235) to have stopped smoking four weeks after their quit.**

The actual number of quits were 7,702 between April 2009 and March 2010, against a target of 8,088. We therefore ended the 4.8% variance from target.

However, improvements in performance in the early part of 2010/11 mean that for Quarter 1 of this year, we are ahead of target, with a further 1,868 individuals stopping smoking, against a target of 1,834.

Both Pharmacy and Group Services now offer dual NRT products to patients for the first four weeks of therapy, in line with set criteria.

Pharmacists trained as Independent/Supplementary Prescribers will, after the development of a Clinical Management Plan, be able to prescribe varenicline to suitable patients. In addition, a Patient Group Directive will be put in place throughout GGC to allow a broad spectrum of community pharmacists to prescribe varenicline. Currently the GGC spend on varenicline is £1.5million per annum but few patients receive stop smoking support and thus the majority are not counted in the HEAT target. This new model ensures that patients are linked into a Service before varenicline is prescribed

GPs will be contacted and reminded that NRT should no longer be prescribed by GPs/Nurse Prescribers but instead by community pharmacists as part of the Smokefree Services programme

All clients registered as having stopped smoking at four week post quit date are followed up at 12 weeks. If smoking again, clients are now asked if they would like to receive a call from a Smoking Cessation Adviser who would discuss current opportunities available to them.

Each CH(C)P will be asked to share data in terms of group numbers, venues, drop-offs and timings. This way we will be able to share "best practice" throughout the whole Health Board area.

**3.2.5. H7: Increase the proportion of new-born children exclusively breastfed at 6-8 weeks from 26.6% in 2006/07 to 33.3% in 2010/11.**

Whilst the reported 23.7% of babies exclusively breastfeeding at six– eight weeks is below the 28% milestone for GGC this year, this performance does represent an improvement on the 23.1% reported last year.

In the last decade rates across Scotland have been fairly static or in decline and this remains the case. For NHS GGC, the initial challenge has been to stem the downward trend.

In terms of improvements in 2009, across Scotland, only five hospital units had increases in breastfeeding rates. The two larger GG&C units had very significant increases (7.4 and 4.6%).

Across Scotland 13 CHP/CH(C)Ps had increasing rates and five are in NHS GG&C. The area with the biggest increase is North Glasgow with a 17.2% improvement. West Glasgow had a 7.2% increase.

The NHSGGC Infant Feeding Strategy work streams are well underway. The main intervention includes the population based (also has elements of targeting) UNICEF UK Baby Friendly Initiative. This is part of a rapid implementation programme and all areas are on target for full accreditation (or reaccreditation in maternity services). Progress includes:

- All maternity units have been UNICEF accredited and are working on improvements in the standards;
- All 10 CHP/CH(C)P's have achieved stage 1 accreditation and five stage 2 (no other areas in Scotland have achieved this);
- Neonatal areas are implementing the UNICEF Neonatal standards;
- Locally targeted, peer support initiatives for vulnerable families, teenage pregnancies and other specific local need groups have been developed;
- Targeting of premature and sick infants admitted to Neonatal and Paediatric services is underway.

The strategies needed to effectively promote and support breastfeeding that have the highest potential impact on rates are likely to need an approach that takes into account the interrelated nature of these evidence based actions. These strategies take time to embed but NHSGGC is at an advanced stage of successful implementation. A Board wide summit on breastfeeding is planned for this month to ensure continued focus.

**3.2.6. H8 Achieve agreed number of inequalities targeted cardiovascular health checks during 2009-10**

While NHSGGC failed to achieve 2009/10 HEAT target, performance for 2010/11 it is already ahead of target.

In 2009/10, we completed a total of 3,879 health checks against a target of 9,764. There was a misunderstanding on what particular health check interventions could be counted, resulting in primary prevention activity in

Inverclyde and West Dunbartonshire, and follow up health checks in North and East Glasgow, being excluded from the total.

For 2010/11 a clear definition has been agreed with the Scottish Government regarding what qualifies as a health check. The table below demonstrates our performance so far this year:

**2010/11 Performance to date**

	1 <sup>st</sup> Quarter	2nd Quarter	3 <sup>rd</sup> Quarter	4 <sup>th</sup> Quarter
Target	2112	4224	6336	7038
<b>Total Completed</b>	<b>2394</b>			

The Board are confident of meeting the 2010/11 target.

**3.3. The Inequalities Challenge in 2009/10**

Outlined below are some examples of our work to tackle the gap in health inequalities.

NHSGGC have produced an **Accessible Information Policy**. The policy aims to ensure we have the ability to respond to patients needs with regard to accessible formats such as other languages, BSL, Easy Read, and audio formats of our all our health information. The policy will be launched in November 2010. As part of the implementation of this Policy NHSGGC have designed a repository for all its information which will be populated with quality assured information and resources and enable accessible formats to be delivered in time and to meet the needs of patients more easily.

Working with multi-disciplinary staff groups, service users and the Scottish Transgender Alliance, NHSGGC has developed a **Transgender Policy** that seeks to protect transgender people from the risk of discrimination in the provision of goods and services. The Policy protects both staff members and patients. NHSGGC is the first territorial Health Board in Scotland to produce a policy of this kind. The work has been referenced in the Equality and Human Rights Commissioning Good Practice Transgender Guidance and several other Health Boards in Scotland have used the Policy to help shape their own responses to formally protecting transgender staff and service users.

NHSGGC have made a commitment within the Equality Scheme 2010 - 2013 to ensure **best practice in relation to sensory impaired patients** across our services. We have produced best practice guidelines for staff to ensure they are aware of how to communicate with those with sensory impairment and ensure that patients experience are not affected detrimentally by their impairment. We have audited our Acute Service for hearing loops and increased our provision by almost 40%.

A tool has been developed to support the planning and delivery of good practice on **enquiring and responding to gender based violence** which can be used as prototype for sensitive enquiry on the impact of other social inequalities. This is part of our wider Gender Based Violence action plan which aims to ensure that all staff:

- understand the social and health impact of gender-based violence;
- are confident and competent in sensitively enquiring about service users' experiences of GBV;
- are equipped and supported to respond effectively to disclosures and to the impact of the abuse on the service user;
- have performance management systems in place to monitor performance and report on progress.

NHSGGC, Local Authorities and Glasgow Centre for Population Health have been successful in attracting £1 million funding from the Scottish Government Social Inclusion Division for **Healthier Wealthier Children**: a Child Poverty and Financial Inclusion Project. Income maximisers and development officers for all CH(C)Ps are employed for 15 months from September 2010. The project is working closely with antenatal and community child health services to target pregnant women and families with young children experiencing, or at risk of, child poverty, as this is an underdeveloped area for financial inclusion referrals; with costs increasing and employment patterns changing around the time of a birth of a child.

NHSGGC has written an **Assistance Dog Policy**. This policy ensures that we have a consistent approach to assistance dogs coming into our services. The policy will enable those with sensory impairment to access our sites as patients and visitors, confident that we have a consistent approach to their assistance dog. For example if someone presented at A&E with an assistance dog who was then subsequently admitted to hospital, we now have procedures in place to ensure the dog is cared for until it is picked up by a family or friend or by a voluntary organisation.

#### **3.4. Board's contributions to delivering shared local outcomes, such as those in SOAs**

Single Outcome Agreements (SOAs) are the means by which Community Planning Partnerships in each local authority area set out the outcomes they aim to achieve, either individually or jointly, and show how the achievement of these outcomes will contribute to the Scottish Government's fifteen National Outcomes. NHS Greater Glasgow and Clyde is a partner in the development and delivery of six SOAs covering Glasgow City, West Dunbartonshire, East Dunbartonshire, Inverclyde, Renfrewshire and East Renfrewshire.

In defining its contribution to each SOA, it is essential that NHS Greater Glasgow & Clyde has a clear view of the outcomes it is aiming to achieve in relation to health improvement and health inequalities and that these inform the development of and are consistent with the local priorities of each Community Planning Partnership and the targets set in each SOA.

The Board has developed a series of Planning Frameworks to provide a clear sense of direction for planning in all critical areas of activity. The approach signals a shift to outcome-based planning, where we establish clear outcomes that we aim to deliver over the three year planning cycle; signal the changes and actions required to deliver those outcomes; and report through performance management routines our progress towards delivering them. Alongside the Planning Frameworks, we have developed a series of Policy Frameworks, which develop

and articulate our approach to issues or areas of activity which require to be read across into all of our corporate and local planning processes and establish outcomes which need to be appearing in all our plans.

The Frameworks are not plans but set the context and direction within which each part of the organisation will develop its plan. We also see a two-way flow of influence and direction between the Planning and Policy Frameworks and the plans, strategies and policies developed with each Local Authority; hence the Planning and Policy Frameworks also provide a basis for NHS input to community planning and SOAs.

The Board's contribution to our local SOAs has been in relation to the four national priority areas of:

- Health inequalities;
- Early years;
- Tackling poverty and socio-economic inequality;
- Economic recovery.

The outcomes, indicators and actions are drawn from the following NHSGG&C Policy & Planning Frameworks:

- Tackling Inequality Policy Framework;
- Children and Young People's Services Planning Framework;
- Employability, Financial Inclusion and Responding to the Recession Policy Framework.

It is well accepted that the early years are a crucial stage in attempting to address inequalities. Key aspects of our approach through all SOAs have included both a universal approach, including a campaign to change the culture around the acceptability of accessing parenting support, and a targeted approach, focussing on those most at risk.

In taking this forward, we have agreed joint funding with Glasgow City Council of £4m, working closely with Education, Addictions and Social Work, the programme will train over 800 staff to provide evidence based parenting support to families across a range of settings.

Renfrewshire and Inverclyde Local Authorities have both identified funding to support the programme and we are in active discussions with East Dunbartonshire and East Renfrewshire.

West Dunbartonshire, whilst already having a range of parenting support available including FAST (Families and Schools Together), are keen to incorporate Triple P more substantially into their parenting work.

## 4. DELIVERING QUALITY IN PRIMARY CARE

### 4.1. Delivering Improvements in Primary Care

In this section we discuss some of the developments in Primary Care in the last year, as we work to improve the quality of primary care. Some improvements we have made this year include:

- Liverpool Care Pathway rolled out across primary care;
- Improved access to diagnostic testing and results; a major joint piece of work between West CH(C)P and Acute Division's Diagnostics Directorate;
- Reduction in the proportion of tests repeated within short timescales e.g. three months;
- Extended Enhanced Services Board-wide and introduced new Local Enhanced Services (LES's) in COPD and Heart Failure;
- Successful large scale vaccination programmes for H1N1 and the Human Papilloma Virus;
- Identifiable increase in GP use of SCI Store and electronic system for transferring referrals;
- Development of referral pathways that facilitated improved GP access to Imaging;
- Structured Feedback between GP's and Directorate of Diagnostics;
- Reduced prescribing costs per individual: continued development of comprehensive benchmarking information enabling comparisons across CH(C)Ps and practices, with prescribing advisors working directly with practices. This has enabled a reduction in prescribing (GIC) costs per patient, of approximately £1.00 per year. (GIC stands for Gross Ingredient Cost - Cost of drugs and appliances before deduction of any discount).

#### 4.1.1. Primary Care Framework

Through the Primary Care Framework, we aim to address the following core challenges for primary care:

- Changing demography and significant health challenge;
- Addressing marked inequalities;
- Financial environment;
- Relationships and working together effectively;
- Access to Services;
- Primary/Secondary Interface;
- Primary Care Team.

There is a comprehensive action plan to deliver on the outcomes identified in the framework and NHSGGC has undertaken extensive and inclusive development work with a wide range of stakeholders to produce the primary care framework for the board, firmly establishing primary care at the heart of NHSGGC. CHPs and CH(C)Ps led local engagement and development of the framework in their own areas, to ensure that local priorities and issues were reflected and that a wide range of primary care professionals, including

the four independent contractor groups, were involved in shaping the framework.

#### 4.1.2. Integrating Services with Councils

We have worked closely with Inverclyde and West Dunbartonshire Councils and are pleased to have reached agreement on the establishment of integrated Community Health and Care Partnerships (CH(C)Ps) in these areas.

East Renfrewshire CH(C)P, now in its 6th year, continues to benefit from integration in terms of not only front line service delivery, but in management and information processes and in spending decisions. One example involves developments around children affected by parental substance misuse; a priority under the Single Outcome Agreement theme of 'More of our children have a better start in life and are ready to succeed.' A needs assessment undertaken by the CH(C)P identified gaps in provision for children affected by parental substance misuse and for vulnerable children using mainstream childcare provision. An action plan was developed to create a new early intervention service for children aged under eight years of age affected by parental substance misuse What About Me? (WAM)) and a family centre-based early intervention service for pre-school children. In 2009/10 these two services were established. Early intervention services use the Integrated Assessment Framework to ensure holistic assessment of needs. An outcome-focused target of securing a measurable improvement in at least one area of assessed need for 45 children involved in early intervention was set with an aim of ensuring that 70 per cent were engaged in leisure and recreation opportunities. Over 2009/10, the WAM service worked with 45 children both individually and in groups. All children were given passports to leisure services. By the end of 2009/10, 85% of children were accessing mainstream community and leisure opportunities.

Despite a significant amount of effort in trying to retain the Glasgow City CH(C)Ps, this has not been possible, and work is now well underway to create an NHS only CHP for Glasgow.

#### 4.2. Progress in providing more services in primary & community care settings

##### 4.2.1. Shifting the Balance of Care Improvement Areas

	<b>Improvement Area</b>	<b>Developments in NHS GG&amp;C</b>
1	Flexible and responsive care at home with support for carers.	Further roll out of LES for diabetes, stroke and Coronary Heart Disease, with new LESs from December 2010 in COPD and Heart Failure. Supported Discharge teams at every acute hospital site preventing admission and facilitating discharge. Joint work on re-enablement with all Local Authorities. MOFFAT - evaluation - raising acute hospital staff's awareness of the needs of carers.
2	Integrate health and	Implementation of Community Rehabilitation

	social care for people in need and at risk.	and Enablement Framework - for older people, older people with mental ill health and adults with physical disabilities. Long Term Conditions Supported Self Management Integrated teams for learning disabilities, adult mental health and older adults mental health.
3	Reduce avoidable unscheduled attendances and admissions to hospital.	Evaluation of experience of A&E by people from vulnerable groups. Community Falls Service.
4	Improve capacity and flow management for scheduled care.	Opened two Ambulatory Care Hospitals. 18 week RTT programme including referral management, daycase rates increases, and redesign of patient pathways. Same day admissions units. Referral management centre. Electronic triage of referrals.
5	Extend the range of services outside acute hospitals provided by non medical practitioners.	Diabetes key workers. Chronic Medication Service. Triple P implementation.
6	Improve access to care for remote and rural populations.	Supporting transport for cancer patients. Piloting electronic transport information initiatives. Ongoing implementation of SPT Access To Healthcare Facilities. Support for development of West of Scotland Community Transport Association. Implementation of marketing campaign for Vale of Leven Public Transport. Formation of Argyll and Bute NHS Transport group - supported by NHSGGC.
7	Improve palliative and End of Life care.	Living and Dying Well Plan. Electronic palliative care summary. Palliative care health needs assessment. Caring Together Project - Heart Failure and Palliative care, with Marie Curie and BHF. Each CHP has a Palliative Care Planning Group. Roll out of Liverpool Care Pathway.
8	Improve joint use of resources.	Resource allocation model implemented for Children's and Families and Older People. Joint Community Occupational Therapy equipment store - EquipU is now including stair lifts and linking with education. Joint capacity planning for care home beds across all Local Authorities. Join financial frameworks for learning disabilities, older people, mental health and addictions.

		<p>Renfrewshire Health and Social Care Centre. Intergrated CH(C)Ps approved in Inverclyde and West Dunbartonshire.</p> <p>Integrated Resource Framework. Although not a pilot site, NHSGGC has been undertaking a financial mapping exercise to map our NHS resources to local populations and to compare this with the resources used within each locality. The next step will be to identify one or two pilot sites to carry out more detailed analysis and identify scope to realign resource use and improve service delivery.</p>
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#### 4.2.2. Changes made as a result of Reshaping Care for Older People

We have made progress in reshaping care across health and social care boundaries, and in redesigning our hospital care. In recent years, we have reduced the number of inpatient geriatric beds, reduced length of stay, and reduced the number of NHS continuing care beds. We have developed community services across health and social care, for example through the development of integrated rehabilitation and enablement teams. In East Renfrewshire CH(C)P, for example, there has been a reduction of 2,200 bed days since the formation of the CH(C)P, against a rising trend in the five years prior to this.

Our approach to developing services for older people is to ensure that all parts of the system work together to prevent people having to go into hospital and care homes where that can be avoided, and improve recovery and rehabilitation.

We have identified the key challenges of providing services for older people in GGC as:

- Ageing population, including higher numbers of 'older old';
- Patterns of deprivation and ill-health will mean longer periods of ill-health in older age;
- More older people have more complex needs and long term conditions, including mental health problems and dementia;
- Different parts of Greater Glasgow and Clyde have different patterns of age and ill health;
- The need to identify and address the requirements of older people in general services;
- The need to make change across the whole system of care, including hospitals and care homes, GP services, community nursing, home care, and other services in the community;
- The need to make services less complex and easier to understand, access and manage.

The strategic priorities for 2010-13 are to:

- Enable people to remain active in later life, continue to have meaningful things to do and be part of their local communities;

- Ensure people with care and support needs have a say in finding solutions which meet their individual needs and aspirations;
- Support people to live as independently and safely as possible, and recognise carers as full partners in care;
- Maximise opportunities for recovery and re-ablement by providing a rehabilitation and enablement joint health and social work service with single point of access;
- Take advantage of the opportunities associated with telecare and telehealth in supporting people safely in home;
- Reduce avoidable hospital admissions as the single most significant area that can deliver better outcomes for individuals and release resources;
- Work across the system to target people in higher risk groups, with a multi-agency approach to identify and support those at risk;
- Contribute to and influence strategic housing plans to ensure appropriate supply of affordable housing suitable for older people with a disability;
- Review the inpatient bed model for older people in the light of the acute services review and shifting balance of care;
- Develop day hospital service model to complement the inpatient bed model and Rehabilitation Framework;
- Develop and manage care pathways for people with dementia across the whole system, including community, care home, hospital and end of life care;
- Deliver better end of life care through Liverpool Care Pathway in all care settings.

Our approach to reshaping care now needs to ensure that all these initiatives and changes will add up to meet the challenge of the aging population. We remain committed to planning jointly with Local Authorities to meet local needs and priorities. However, we have also set up a planning group to oversee our planning for the ageing population across NHSGG&C.

#### **4.3. Extending the role of Community Pharmacy - Chronic Medication Service**

The final component of the community pharmacy contract, the Chronic Medication Service (CMS), commenced its phased roll out in May 2010.

The service marks a significant change in pharmacy practice and complements medical care with pharmaceutical care which focuses on enhancing support for patients with their medicines. The service is designed to improve the clinical outcomes as well as strengthening the relationship between the patients, GPs and community pharmacists.

CMS will also allow community pharmacists to manage repeat prescriptions, offering improved convenience for patients.

#### **4.4. Modernising Community Nursing**

##### **4.4.1. District Nurses**

We are undertaking a focused piece of work looking at the productivity of district nurses, to free up time for direct patient care. The work will be carried out in partnership with trade union representatives and will take

cognisance of 'Modernising Nursing in the Community'. It will focus on clarity of roles, responsibility and competence of the whole District Nursing Team, and the relationship of these teams to general practice.

#### **4.4.2. Health Visiting and School Nurses**

Our focus on health visiting and school nursing continues to be the development of Children and Family Teams combining the expertise of Health Visitors and School Nurses into single teams to care for children and young people and their families from 0 - 19 years of age. The main emphasis this year has been on the implementation of the parenting programme, Triple P, across Glasgow City.

We are working particularly closely with the Modernising Nursing in the Community Programme Board to align our work to that of the Programme Board's sub group looking at Children and Young People.

### **5. FINANCE & EFFICIENCY, INCLUDING WORKFORCE PLANNING & SERVICE CHANGE**

#### **5.1. Related HEAT Targets**

##### **5.1.1. E4: NHS Boards to deliver agreed improved efficiencies for first outpatient attendance DNA, non-routine inpatient average length of stay, review to new outpatient attendance ratio and day case rate by March 2011.**

The Board has achieved its targets with regard to daycase rates, non-routine inpatient average length of stay, new to return outpatient ratio. However, we have not been successful in achieving the required reduction in new outpatient DNA rates. Detailed work is underway to understand the reasons why specific groups of individuals do not attend their appointments, and also to draw on examples of best practice in reducing DNA.

##### **5.1.2. E5: NHS boards to operate within their agreed revenue resource limit; operate within their capital resource limit; meet their cash requirement.**

This target has been achieved.

##### **5.1.3. E6: NHS boards to meet their cash efficiency target.**

This target has been achieved.

##### **5.1.4. E7: To increase the percentage of new GP outpatient referrals into consultant led secondary care services that are managed electronically to 90% from December 2010.**

Performance at the end of the year fell slightly short of the target, at 32% against a target of 40%. However this was significant progress from last year when only 1% of referrals were managed electronically.

A roll-out across directorates has started, focusing on the large specialties with high numbers of referrals. Significant progress has been made in Surgery & Anaesthetics with most specialties now using the eTriage system. The roll-out is now underway within Emergency Care and Medicine alongside the implementation of weekly reporting of performance and issues to allow progress to be closely monitored and problems to be addressed.

#### **5.1.5. E9: Achieve universal utilisation of CHI (radiology requests).**

This target has been achieved.

#### **5.1.6. E10: NHS Boards to ensure at least 80 per cent of staff covered by Agenda for Change to have their annual Knowledge Skills Framework (KSF) development reviews completed and recorded on e-KSF by March 2011.**

The reported level of performance in relation to this target is indicative only as we continue to experience difficulties in reporting information due to anomalies in the e-KSF reporting process and the challenges with the information provided by the SWISS system. However, the Board expects to meet the revised KSF PDP target for 2010/11.

### **5.2. Efficiency and Governance**

#### **5.2.1. Links between financial and workforce planning**

During last year, we established an improved planning process across the entire organisation, spanning primary and secondary care with a clear focus on outcomes. This is made up of a series of 17 Corporate Planning and Policy Frameworks which knit together across the breadth of our business. The Planning Frameworks are:

- Acute Services
- Adult Mental Health
- Alcohol and Drugs
- Cancer
- Disability
- Long Term Conditions
- Maternity
- Older People
- Primary Care
- Sexual Health
- Unplanned Care

The Policy Frameworks are:

- Employability
- Health Improvement
- Quality
- Financial Inclusion and Responding to the Recession
- Tackling Inequality
- Unpaid Care
- Sustainability

The frameworks contain a review of current workforce, service and performance, maps out the outcomes required, and the financial and workforce reshaping required to deliver these outcomes.

These frameworks form the basis of the development plans that are produced annually by each part of the business, and against which they are held to account for their performance.

### **5.2.2. Financial efficiency and planned service change**

- **The New Victoria and Stobhill Hospitals**

The New Victoria Hospital opened its doors to patients for the first time on 8th June 2009, shortly after the opening of the New Stobhill Hospital on 11th May. These £100 million hospitals are among the most modern and well equipped in Scotland.

They provide an attractive and welcoming environment for patients and visitors with light, airy public spaces, comfortable waiting areas and modern consulting rooms. Patients will not only benefit from modern new facilities. The way care is provided from the hospital has also changed for the better. For example, the day case rates across GGC have significantly improved following the opening of the hospitals, the rate in July 2009 was 68.9% and in July 2010 has increased to 80%.

Services have been redesigned around the needs of the patient to enhance the quality of care and speed up diagnosis and treatment.

About 400,000 patients will attend each of the new hospitals every year.

The new Victoria Hospital provides, in addition to outpatient clinics, day surgery and diagnostic services, a number of specialist services such as cardiology and gynaecology.

For the first time, patients from south-east Glasgow, Rutherglen and Cambuslang requiring an MRI scan, renal dialysis or chemotherapy are able to get this locally at the New Victoria Hospital.

The New Stobhill Hospital provides also outpatient clinics, day surgery and diagnostic services and a number of specialist services such as cardiology, renal dialysis and gynaecology. And for the first time, patients requiring an MRI scan will also be able to have this performed locally at the hospital. Both hospitals also have new Minor Injuries Units, each with its own dedicated entrance for rapid access to a highly skilled clinical team.

- **Development of the New South Glasgow Hospitals Campus**

Work has started on the £840 million New South Glasgow Hospitals Campus with Health Secretary Nicola Surgeon cutting the first sod. The first building to be complete on the site will be the impressive laboratory development followed by the new children and adults hospital. This is also seen as the first steps towards major

regeneration and economic benefit to Govan and the wider local community.

The new South Glasgow Hospitals Campus will deliver a truly gold standard of healthcare on the Govan site with maternity, children's and adult acute services all together on the one campus. It will also have the biggest critical care complex and one of the biggest Emergency Departments in Scotland.

Brookfield Europe, a major international builder, is the preferred contractor to construct the new hospitals which will be the largest single NHS hospital build project in Scotland.

- **New Adult Hospital**

The plans for the complex will see a brand new 14-floor adult hospital with 1,109 beds. Every patient in the wards will have their own single room with an en-suite.

Each adult general ward will have 28 single bedrooms with en-suite facilities; this will assist in addressing HAI, mixed sex, privacy and dignity issues.

- **New Children's Hospital**

A new children's hospital, with a separate identity and entrance, will be adjoined to the adult hospital. With 256 beds over five storeys it will replace the existing Royal Hospital for Sick Children. Innovative designs include a covered roof garden where young patients can enjoy a range of activities in the fresh air including their own stage where they can put on theatrical productions. The design of the roof garden ensures that children can be brought out to the roof garden in their beds if necessary.

The new children's hospital will be a mix of four-bedded and single-bedded accommodation as it's been shown that a child's health benefits from being around other children.

The new children's hospital will not only be linked to the adult hospital but also to the redeveloped maternity hospital.

- **New Maternity Hospital**

£28million has been invested in refurbishing the Southern General Maternity Unit which was completed at the end of 2009, marking the latest milestone of an ambitious strategy to improve services for mothers and children across the city.

Among its world-class facilities is a new fetal medicine department providing specialist diagnostic facilities and treatment to unborn babies from across Scotland. The hospital will also be a national

centre for certain specialist services for newborn babies and provide state-of-the-art intensive care services.

- **New Laboratory Facility**

Brookfield started construction on the new Laboratory facility in early 2010. The laboratory will accommodate blood sciences, pathology, genetics, microbiology, postmortem and mortuary services.