NHS Greater Glasgow and Clyde

Acute Services Plan

2013 - 2016

1. EARLY INTERVENTION AND PREVENTING ILL- HEALTH

The key outcomes are:

- Improve identification and support to vulnerable children and families
- Enable disadvantaged groups to use services in a way which reflects their needs
- Increase identification of and reduce key risk factors (smoking, obesity, alcohol use).
- Increase the use of anticipatory care planning
- Increase the proportion of key conditions including cancer and dementia detected at an early stage
- Enable more older people to stay healthy prolonging active life and reducing avoidable illness, particularly associated with chronic disability and dependency, and/or premature mortality

	ACTION TO DELIVER CORPORATE PRIORITIES	PERFORMANCE MEASURE	BASELINE 2011-12	YEAR ONE TARGET 2013-14	2016 TARGET
1	**Acute Services**				
1.1	Increase the proportion of key conditions detected at an early stage by publishing clear and agreed referral management guidelines for these conditions for GPs.	Number of referral management guidelines agreed by Local Medical Committee and published for use by GPs.	115 referral guidelines currently on the system	Ensure that clear referral guidelines are in place for 'Urgent Suspicion of Cancer ' referrals re Bowel, Breast and Cervical	To be developed.
1.2	Maintain the 18 week RTT access and the 12 week TTG.	18 week RTT performance sustained at 90%. Patient treated 12 weeks from decision to treat.	**18 Weeks RTT:** 91.6% at December 2012 **TTG:** TTG not measured at 11/12.	**18 Weeks RTT**: 90% or greater **TTG**: No patient waiting longer than 12 weeks for IPDC treatment.	As per 2013/14 target.

	ACTION TO DELIVER CORPORATE PRIORITIES	PERFORMANCE MEASURE	BASELINE 2011-12	YEAR ONE TARGET 2013-14	2016 TARGET
1.3	Assess the impact of the national publicity campaigns re detecting Breast, bowel and lung cancer on the increase of referrals to the Acute Division and plan the delivery of services to accommodate the additional workload.	Impact assessed and capacity plans developed to deal with additional workload. Deployment of DCE funding to Diagnostics, Oncology, Breast & Bowel.	N/A new campaign	Bowel 60% Breast 70% Cervical 80%	To be developed. To be developed
1.4	Ensure that there is adequate capacity within the Acute Division to enable access to diagnostic tests to identify key conditions, including the Detect Cancer Early priorities, within the target access times.	Diagnostic tests available within 3 weeks.	N/A	100% within 3 week timescale for 8 key diagnostic tests.	As per 2013/14 target.
1.5	Maintain cancer access targets.	62days/31 days	62 days - 95.1% 31 days - 97.3%	62 days - 95% 31 days - 95%	As at 2013/14 target.
1.6	Implement Triple AAA screening programme and provide vascular interventions where positive screening results are shown and intervention is deemed appropriate.	Screening programme is fully implemented in line with guidelines	N/A as screening programme not in place in 2011-12	Screen 70% of the target population. Ensure 97% of results are available the same day. Ensure 75% of AAA greater than 55mm sees a vascular specialist within 10 days. Ensure 60% of AAA greater than 55mm and appropriate for	To be developed.

	ACTION TO DELIVER CORPORATE PRIORITIES	PERFORMANCE MEASURE	BASELINE 2011-12	YEAR ONE TARGET 2013-14	2016 TARGET
				intervention are operated on within 40 days.	
2	**Children and Maternity**				
2.1	Continue to implement the Vulnerable Women's Pathway.	Vulnerable Women's Pathway is fully implemented Link midwife services in place. At Least 80% of pregnant women in each SIMD quintile will be booked for antenatal care by 12th week gestation by 2015	N/A as pathway not fully established 62.8% (2010 baseline)	Complete review of the Pathway and implement 71.4%	To be developed. 80%
2.2	Continue effective delivery of the Special Needs in Pregnancy service (SNIPS) and Link Midwife Services established for Asylum Seekers, Gender Based Violence, Alcohol Interventions and Smoking Cessation.	SNIP service is reviewed and evaluated and has link midwifery services in place	SNIP service in place	Review service against refreshed Framework for Maternity Services to include identifying gaps in electronic data collection to ensure targets can be established and accurately measured	To be developed.
2.3	Reduce alcohol consumption in pregnancy through enhanced identification of drinking and implementation of alcohol screening and brief intervention in pregnancy	Number of women screened. .	Number screened: 98%.	Number screened: 100%.	To be developed.

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		Increase number of women disclosing drinking (record on PNBS/SHWMR system). Number of ABIs in Ante-natal. Number of staff trained	Number reporting drinking: 0.3%. Number of ABIs: 25.	Targets to be confirmed on roll out of Maternity IT system	
2.4	Continue to develop and deliver smoking cessation services for pregnant women	Smoking in pregnancy Number of Quits /. Quit rate in SIMD areas.	Number of pregnant women setting quit date: 608. Number of Quits:213. Quit rate: 35%. SIMD Number of Quits. SIMD Quit rate:	10% increase in women setting quit date: Quit rate: 35% Increase Number of SIMD Quits/ Quit rate	National target to be established.
2.5	Develop maternal obesity intervention and referral pathways: • Develop pilot intervention • Deliver staff training	Pilot developed and reviewed Number of staff trained.	No service available at present.	Pilot service launched and baseline data collected.	Targets to be set during 2014/15.
2.6	Increase uptake of Long Acting Reversible Contraception (LARC) in maternity services.	% increase in LARC in Maternity services	This data is recorded in the case notes at present and during this year we will work to establish a baseline and recording methodology	Targets to be confirmed on roll out of maternity IT system	Targets to be confirmed
2.7	Breastfeeding: • Increase breastfeeding initiation • Increase uptake of breastfeeding support prior to discharge	Reduce breastfeeding drop off rates from birth to discharge Improve breastfeeding rates at: • birth target 53.6% • hospital discharge target 41.6%	Drop off rate from birth to discharge 11.4% Number of women receiving support: Pregnancy & Newborn	Drop off rate from birth to discharge 10% Support baseline to be established by Sept 13	Drop off rate from birth to discharge 7.4% Target to be confirmed Sep-13

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		• Number of women receiving support	Bloodspot Screening (PNBS) data development		
2.8	Utilise A&E data to inform delivery of Childhood injury prevention framework to reduce: • Liquitab chemical ingestion • Burns and scalds<15yrs	Reduce number of Liquitab presentations at audit Reduce number of Liquitab admissions. Reduce number of admissions burns and scalds	Liquitab:18 attendances 9 admissions Burns & Scalds: 77 admissions	Reduction from baseline presentation / admission Reduction from baseline admission	Reductions in admission data during campaign periods
2.9	Provide accessible patient centred information and support through the development of Patient Information Centres % Family Information (FI) Support Services • Develop patient data system to identify young carers and provide support pathways • Develop sustainable pathway for financial inclusion / Healthier Wealthier Children.	% increase Patient Information Centre (PiC) interventions annually. Number of young carers identified. Number of FI referrals from Midwifery Number of FI referrals from RHSC	PiC Interventions: 10500 tbc Midwifery: 142 (April-Oct 12 RHSC: 120	PiC Interventions: 11550 Develop data collection system for Young Carers Acute referrals: 500	10% annual increase Targets to be confirmed 2014/15 To be developed.
2.10	Develop mental health assessment pathway in A&E work.	Maintain number of appropriate staff trained in Suicide Prevention	Staff trained: 35	Number of staff trained based on 6.7% turnover Annual target: 35	Maintain number of staff trained (Reduce suicide rate between 2002 and 2013 by 20%)

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2.12	Smoking: • Increased referral to Smoking cessation services (Inpatient/ Pre Op & Outpatient). • Increase staff smoking cessation rates.	Smoking Cessation Referrals. Number of Quits / Quit rate. (SIMD) Staff Smoking Cessation Quits.	Smoking Cessation Referrals: **1696** Number of Quits Quit rate: **32%** SIMD 1 Number of Quits: 513 SIMD Quit rate Staff Smoking Cessation: **174** Quit Rate: **40%**	Smoking Cessation Referrals: **1696** Number of Quits / Quit rate:**35%** SIMD Number of Quits: **min 40%** SIMD Quit rate: Staff Smoking Cessation Quits: **250** Quits: **40%**	To be developed. Maintain Quit rates. Increase SIMD uptake/ outcomes.
2.13	Obesity: Implement routine Brief Intervention (BI) for physical activity • Deliver Healthy Eating (Health Promoting Health Service) HPHS interventions. • Deliver Physical Activity HPHS interventions.	Introduction of BI in service areas. Number of BI interventions. Number staff trained. Number HPHS interventions. Increased infrastructure (staff gyms, LA gyms, walking routes, fitness classes, cycle promotion etc.) for Staff physical activity (% total initiatives). Promotion of physical activity	BI in service areas: 0. Interventions: unavailable. Number staff trained:25. 100% Healthy Living Award. 100% Healthy Vending. 0% Healthy Retailer. 40% Fruit and veg. Infrastructure: 84%of 10 sites Promotional intervention complete.	BI in service areas: 4. Establish monitoring system with AHPs. Number staff trained 100. 100% Healthy Living Award. 100% Healthy Vending. 10% Healthy Retailer. 80% Fruit and veg. Infrastructure 100% of 10sites. Annual promotional intervention on all sites.	BI in service areas: 12. Targets to be confirmed 14/15. Number staff trained 300. 100% Healthy Living Award. 100% Healthy Vending. 100% Healthy Retailer. 100% Fruit and veg. Expansion of infrastructure wider than 10 sites. Annual promotional intervention on all sites.

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		annually on all sites. Number of referrals to Physical Activity pathway (Live Active).	Number of referrals to Live Active: baseline unavailable.	Number of referrals to Live Active baseline collected.	Targets to be confirmed 14/15.
	Review Weight management services to provide: Community Weight Management Services (Tier2) Specialist obesity intervention services (Tier3) Surgical intervention pathway for target groups (Tier4)	Acute Referrals. Service Uptake. Service Outcomes.	TBC	Establish all Tiers of service by April 2014.	Targets to be confirmed 14/15.
2.14	Alcohol use: • Deliver Alcohol Brief Interventions (ABIs) across a number of acute settings • Maintain ABI training levels	Number of ABIs in A&E settings. Number of ABIs in Wider settings / number of new settings. Number of ABI by SIMD. Number of staff trained.	Number of ABIs in A&E settings: **6000.** ABI SIMD 1: 43%. Number of ABIs in Wider settings: **150.** Number of new settings: 1. Number of staff trained: **500.**	Number of ABIs in A&E settings: **4698.** **ABI SIMD 1:** Number of ABIs in Wider settings: **180** Number of new settings: 2. Number of staff trained annually: 500.	Number of ABIs in all settings: 15,000. Number of staff trained 1,500.
2.15	Increase provision of insulin pumps for under 18s.	25% of under 18s on insulin pump therapy by March 2013.	45	135	To be developed

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3	**Long Term Conditions**				
3.1	Increase effectiveness of Supported Self Care (SSC) framework through use at all points of patient contact: • Provide condition specific patient information in a range of accessible formats to patients on their acute pathway.	Patient endorsed information books providing support for patients and carers.	Heart, Stroke and Diabetes Handbooks available.	Review existing material. Extend to cover Rheumatology, Respiratory and Chronic Pain supporting information.	Extend coverage to other specified LTCs currently not covered.
3.2	Increase post rehabilitation referrals to community based physical activity programmes (Vitality).	Acute Referrals to physical activity programmes.	Vitality referrals: 400.	Vitality referrals: 500.	Vitality referrals: 700.

Financial outcomes from Corporate Plan:

- A shift in spending to prevention and early intervention, including from hospital care. However this is dependent on the impact of rising demand
- Being able to evidence that shift and its financial effectiveness.
- Focusing on interventions which are effective and reduce demand.
- Care is provided in the most appropriate place by the most appropriate professionals.

2. SHIFTING THE BALANCE OF CARE

The key outcomes are:-

- Fewer people cared for in settings which are inappropriate for their needs.
- There are agreed patient pathways across the system, with roles and capacity clearly defined including new ways of working for primary and community care.
- We offer increased support for self care and self management which reduces demand for other services.
- More carers are supported to continue in their caring role.
- More people are able to die at home or in their preferred place of care.

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1	**Acute Services**				
1.1	Deliver more appropriate use of A&E and Minor Injuries Units (MIU) by providing clear advice on how to use these services to the local population.	Reduction in A&E attenders. Increase in MIU attenders.	A&E 426,168. Stobhill MIU 15,360. Victoria MIU 18,444.	% reduction in A&E attendances. % increase in MIU attendances.	To be developed.
1.2	Encourage patients to choose, where possible, to die at home or in their preferred place of care.	ISD % of days spent in community in last six months of life	Over 65 years 47.9% Over 75 years 48%	This target is being developed by the Living and Dying Well Group	To be developed.
1.3	Fewer people are cared for in settings which are inappropriate to their needs and only patients who need acute care are admitted to hospital.	Reduction in the rate of growth in acute non elective admissions Reduction in ALOS	212,161 6.3 days	0% growth in emergency admissions (against a growth in emergency admissions) 6 days	To be developed. 5 days

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1.4	Identify with Partnerships and through Change Fund, the areas where hospital activity can be reduced and implement the actions necessary to deliver this shift	Clear care pathways are in place to ensure that patients are treated in the right place for their condition.	Current pathways	tbc	To be developed.
1.5	Implement the recommendations from the review of GP Out of Hours Services.	Achieve Quality Indicators as set down by Health Improvement Scotland (note: these have still to be received)	To be established when review is complete.	tbc	To be developed.
1.6	Promote carer awareness to staff, including when planning discharges, and improve signposting into carer support services from Acute Division	Evidence of acute staff training programme.	Posters and booklets distributed to hospitals. Carers' week supported.	Update posters and leaflets & re- distribute. Additional promotional material developed. Carer DVD developed for staff training	To be developed.
2	**Cancer**				
2.1	Improve access to radiotherapy by supporting the development of an additional radiotherapy facility in the West of Scotland.	New facility developed and opened by 2015/16. 12th Linac being developed.	N/A Second site currently does not exist.	Site to be agreed by WOS RCAG and SGHD	Unit opened and functioning.
2.2	Improve access to chemotherapy by using the cancer planning processes to	Appropriate local chemotherapy service expansion in other West	N/A Relates to new SMC drugs	Process for reviewing all new drugs via	All existing and new drugs regularly

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	consider on which locations chemotherapy can appropriately be delivered.	of Scotland Boards to include new SMC-approved therapies. - CEPAS system - increased number of chemotherapy treatments delivered out with BWOSCC		RCAG Prescribing Advisory Sub-group (PASG) and agreeing Clinical Management Guidelines to be agreed.	evaluated for local prescribing.
3	**Children and Maternity**				
3.1	Redesign acute paediatric services to ensure that more paediatric activity is delivered in the community.	Increase in the number of community/outreach clinics developed with Partnerships.	531	580	To be developed.
4	**Long Term Conditions**				
4.1	Reduce use of hospital inpatient care through providing support for the care planning and management process via the MCNs and specialist nursing teams.	Increase in no of anticipatory care plans.	An anticipatory Care Plan is in place and agreed by specialist nurse and patient	A 10% increase in the number of anticipatory care plans in place per disease area	To be developed. To be developed.
4.2	Reduce hospital follow up and the number of return appointment attendances through risk stratifying patients' need for review and by providing alternative means of maintaining patient contact that avoids the need for attendance.	Acute outpatient new to return ratio.	2.3 return outpatients to every new outpatient attendance (1:2.3). This position relates to adult services only.	1:2.2	To be developed.

Financial outcomes from Corporate Plan:

- A shift in spending from hospital to community services.
- This will require creation of levers and incentives for our existing and new Partnerships to change patterns of demand.
- We also need to reshape spending on community and primary care services, including controlling growth in prescribing, to free up resources to invest in local services.

3. RESHAPING CARE FOR OLDER PEOPLE

The key outcomes are:-

- Clearly defined, sustainable models of care for older people.
- More services in the community to support older people at home and to provide alternatives to admission where appropriate.
- Increased use of anticipatory care planning which takes account of health and care needs, and home circumstances and support.
- Carers are supported in their caring role.
- Improved partnership working with the third sector to support older people.
- Improved experience of care for older people in all our services.

	ACTION TO DELIVER CORPORATE PRIORITIES	PERFORMANCE MEASURE	BASELINE 2011-12	YEAR ONE TARGET 2013-14	2016 TARGET
1	**Acute Services**				
1.1	Deliver the actions for the Acute Division from the Change Fund Plans.	No of acute bed days lost to delayed discharges	107,708	47,196	Tbc
		Reduce the rate of emergency inpatient bed days for people 75+ per 100,000 population by at least 12% between 2009/10 and 2014/15	6,401	5,711	5,630
1.2	Deliver programme of improvement in older people care in Pressure Care, Falls, Nutrition and Dignity and Respect	Clinical Quality Indicators (CQIs)	95%	95%	95%

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1.3	Pilot method of capturing patient experience as part of person centred care programme	Feedback via GGC produced website Local Better Together Questionnaires delivered by Senior Charge Nurses Key themes from complaints across Directorates. Feedback received from Patient's Panel.	No baseline, currently in development	GGC is developing a website to receive patient feedback	To be developed
1.4	Work with partners to reduce delays in discharges for older people.	No of people delayed in hospital 4 weeks or more beyond their ready for discharge date.	117,013 bed days used by delayed discharges in 2011/12	Target will come from CHP partners linked to 2013/14 Change Fund Plans.	To be developed

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2	**Older People**				
2.1	Deliver the priorities outlined in the Dementia Strategy:				
	• Implement the Abbreviated Mental Test (AMT) for all admissions aged over 65 years	See above % use of AMT screening in inpatients over 65 years	 20%	 80%	 100%
	• Develop and implement new Care Plans (including Dementia care plan)	Introduce new Care Plans (including dementia care plan) % use of 'This is Me' document for all inpatients with diagnosed dementia	N/A N/A Document being launched by Minister in May 2013	Care plan implemented Document evidenced in documentation audits – 100% where appropriate	Use of care plan evidenced in documentation audits Carers feed back greater involvement in care planning
	• Ensure staff are training in trained in dementia	Number of staff trained	2,000	6,000	12,000
	• Ensure Dementia champions deliver local improvement in dementia care	Agreed work plan completed and evidenced	14 champions – cohort 1	41 champions	41 champions – no more acute champions being created
	• Review national Delirium Bundle when complete and consider for implementation in GGC	Introduction of Delirium Bundle	N/A	Bundle piloted in two sites	100 % implementation on all sites

Financial outcomes from Corporate Plan:

- Demonstrating the value for money of the change fund and other community service investments.
- Directing our resources to support primary care to do more for older people.
- Reducing spending on hospital care for older people.

4. IMPROVING QUALITY, EFFICIENCY AND EFFECTIVENESS

The key outcomes are:-

- Making further reductions in avoidable harm and in hospital acquired infection.
- Delivering care which is demonstrably more person centred, effective and efficient.
- Patient engagement across the quality, effectiveness and efficiency programmes.
- Developing the Facing the Future Together programme to support our staff to improve quality, hear and respond to patient feedback.
- Improve appropriate access on a range of measures including waiting times, access to specialist care, physical access and needs responsive access.

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1	**Acute Services**				
1.1	Deliver the final stages of the Acute Services Strategy through the six work streams of the 'On the Move Programme'				
	• Develop operational policies for all services.	All departments in NSGH have agreed and widely shared operational policies for the new hospital.	N/A	All services have agreed Operational Policies.	Operational Policies for all services are in use in the new South Glasgow Hospitals.
		All support services have robust plans in place to deliver the requirements identified in the Operational Policies	N/A	Services have developed plans in conjunction with all Directorates.	Plans are implemented in New South Glasgow Hospitals.

	ACTION TO DELIVER CORPORATE PRIORITIES	PERFORMANCE MEASURE	BASELINE 2011-12	YEAR ONE TARGET 2013-14	2016 TARGET
	• Finalise redesign of services for move to new hospitals.	Service redesign plans developed, agreed and signed off by Programme Board	N/A	Service redesigns for all specialties completed.	Redesign implemented for services in NSGH
	• Conclude the workforce planning, staffing profiles and ensure appropriate roles numbers / skill mix.	Workforce Plans developed and agreed.	Existing Acute Workforce Plan	Workforce Plan is signed off by Programme Board.	Workforce Plan is implemented.
	• Define the clinical transition plan for moving services to the new hospitals and closing the Western Infirmary, Victoria Infirmary and Mansionhouse Unit and Yorkhill.	Transition Plan developed and agreed by Clinical Transition sub-group	N/A	Transition Plan is signed off by Programme Board.	Transition Plan is fully implemented.
	• Finalise plans for the distribution of services to remaining acute sites and develop a capital planning programme to support this as required	Plans and capital programme are developed and agreed.	Acute Services Review	All GGC sites are accounted for in the strategy and capital programmes are in place to support the reconfiguration required.	To be developed.
	• Develop a plan, including capital works, to re-provide the existing Out Patient Clinics at the Western Infirmary on the	Plan developed and costed to re-provide Western Infirmary Out Patient Clinics on Gartnavel General site.	Out Patient Clinics are currently provided on Western Infirmary site.	Complete capital works programme to enable commissioning and transfer of	OP Clinics are transferred from WIG to GGH site and are fully

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	Gartnavel General site.			services.	operational
	• Complete refurbishment of University Tower at GRI for Laboratory Medicine as the final part of the Laboratory Strategy for Glasgow. • Complete the implementation of the Clyde Laboratory Strategy.	Microbiology and Virology are redesigned and transferred into the University Tower Building with the Reference Laboratories. Successful migration of blood sciences and Microbiology to the RAH central hub	N/A Partial implementation of Strategy	Refurbishment complete and laboratory opened. Strategy fully implemented.	N/A year one target N/A year one target
1.2	Deliver the KPIs for 'On the Move' in respect of reducing ALOS and increasing the day cases and day surgery rates.	Meet ALOS KPIs Meet Day Case Rate KPIs	Bed Model targets by Directorate Bed Model targets by Directorate	Bed Model 2A targets by Directorate Bed Model 2A targets by Directorate	Bed Model 2B targets by Directorate Bed Model 2B targets by Directorate
1.3	Ensure the delivery of the Bed Model to ensure that the targets for Model 2A and 2B are being met.	Bed model targets by specialty achieved.	Current Bed Model targets.	Bed Model 2A implemented	Bed model 2B implemented
1.4	Deliver the access targets: • 18 week RTT • 12 week TTG	 See Section 1 See Section 1			
1.5	Continue to review and develop agreed referral management pathways	See section 1			

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	into acute and communicate these to GPs.				
1.6	Develop and implement a programme to improve communication and joint working with GPs to include:				
	• Establishing clear referral guideline	% of referrals received electronically	100%	100%	100%
	• Two way electronic communication	% of referrals returned to referrer due to non compliance with the protocol	TBC	Target to be set by RMG.	Target to be set by RMG.
	• Discharge information	% of Immediate Discharge Letters (IDLs) and Final Discharge Letters (FDLs) delivered electronically to GPs	TBC	90%	95%
	• Medicines reconciliation	% of emergency admissions undergoing medicines reconciliation	TBC	60%	98%
	• Active participation in the Interface Group.	Group established and work plan in place	N/A new group	Group established meeting regularly and work plan developed.	TBC
1.7	Review boarding arrangements to ensure that it is minimised as much as possible. (needs further discussion)	Reduction in umber of bed days borrowed across acute Directorates in each week	To be established	To review as part of unscheduled care work	TBC
1.8	Deliver improvement in stroke services to ensure access to an acute stroke	90% of stroke patients admitted to a stroke unit on day of	71.6% at end of March 2012	Achieve 90% target	Achieve 90% target

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	unit within day of admission or day following presentation.	admission or day following presentation.			
1.9	In light of the legacy of equipment in primary care, there is a requirement to further review the feasibility of whether the remaining radiology provision should transfer from primary care settings into acute imaging departments which can provide a digital environment.	Decision taken and implemented on future radiology provision in primary care	Radiology is currently provided in 6 Primary Care settings	Discuss options and agree actions	To be developed.
1.10	Achieve improved patient experience measures as set out in Better Together in relation to • Interpreting Service use • Food Fluid & Nutrition (FFN) Policy	Increase in satisfaction in patient surveys: Annual Interpreting Service Survey Better Together Patient Experience /Catering satisfaction survey	Unavailable – 1st round of survey 13/14 Baseline being currently compiled 81% increase meal satisfaction 81% increase in assistance provided	Targets to be confirmed 14/15 8% increase meal satisfaction 8% increase in assistance provided	90% and above 90% and above
1.11	Promote positive attitudes and interactions between staff, patients and communities through appropriate training and inclusion of key patient groups within PFPI activity	Increase participation in Staff Equalities Survey Data Customer care initiatives Number staff trained	1,026 Acute Staff Number staff trained	10% increase in participation CC initiative in each Directorate Number staff trained	Increased participation / numbers trained annually

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		Protected characteristic groups engaged through PFPI	Unavailable	No. PFPI participants from PC groups	
1.12	Continue programme of prescribing efficiency and effectiveness	Monitor prescribing guideline adherence through MCN primary care reviews	Each MCN has established a prescribing subgroup to support and promote safe, high quality and cost effective prescribing for all patients	Top 5 guideline drugs routinely reviewed for practice usage prescribing rates against prevalence, trends and outliers identified	Tbc
1.13	Further reduce healthcare associated infections	Increase Hand Hygiene compliance	97%	95%	95%
		Reduction in the rate of C. Diff infections(per 100,000 occupied bed days)	0.21	0.39	0.39
		MRSA/MSSA Bacterium (per 100,000 occupied) bed days	0.296	0.27	0.27
1.14	Alcohol	Reduce rate of alcohol related admissions	10.7	0.1 reduction	0.3 reduction

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2	**Cancer**				
2.1	Ensure cancer outcomes are maximised by the creation and sustainment of high volume centres of excellence for cancer treating surgical services.	Establishment of high volume surgical centres	Current organisation of surgical services	N/A this is a 2015 target	High volume surgical centres established and operating.
2.2	Deliver the requirements of 'Cancer in Scotland: Action for Change'.	Availability of continuous hyper-fractionated accelerated radiotherapy (CHART) as a treatment for lung cancer – number of fractions delivered New Children's Hospital to have dedicated facilities for teenagers with cancer	1800 Limitations of current facilities	Patients who requires this specialised treatment receive it within 42 days Dedicated teenage facilities are designed for the NCH	To be developed Dedicated facilities for teenagers with cancer are available in the NCH.
3	**Children and Maternity**				
3.1	Deliver the capital scheme to upgrade the Assisted Conception Service facility from a clinical and patient perspective.	Scheme delivered within agreed timeframe, and to agreed national standards and theatre and laboratory services repatriated to the unit by beginning of Jan-14.	Limitations of current facilities	Scheme is delivered within agreed timeframe to agreed national standards by beginning of 2014.	To be developed.
3.2	Develop a capacity plan to enable the service to deliver additional treatment cycles to enable the HEAT target to be met.	Eligible patients receive first IVF treatment within 12 months of referral to service by Mar-15.	Current waiting times are 24 months	Reduction in waiting times for first IVF treatment, working towards 12 month target.	Eligible patients receive first IVF treatment within 12 months of referral by Mar-15.

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4	**Long Term Conditions**				
4.1	Deliver the national policy on insulin pumps – number of people on insulin pump therapy to triple by March 2015.	Increase number of Pump Centres in GGC from one to four.	Existing Pump centre at GGH.	Pump Centres operational at GGH, Stobhill, SGH and RAH with staff trained to deliver insulin pump initiation.	Pump Centres operational at GGH, Stobhill, SGH and RAH with staff trained to deliver insulin pump initiation.
		Increase the number of sites delivering T1 structured education.	Delivered from GGH, Victoria and RAH.	Provision increased to include SGH, Stobhill and RAH.	All GGC diabetes sites able to provide structured education.
4.2	Support the development of a primary care multi-morbidity LES, thorough MCN guidance on risk stratifying patient need.	Increased coverage of LTC patients for LES review.	Existing LES programme.	No of patients and conditions covered by LES programme increased from April 2014.	To be developed.
	Each MCN to maximise opportunities for early intervention and anticipatory care interventions.	Programme of evidence based high value interventions specified for each condition specific pathway.	Each MCN has an agreed programme of evidence based interventions applicable to each condition pathway	A 10% increase in number of patients accessing relevant interventions on condition pathways	To be developed.

Financial outcomes from Corporate Plan:

- Use technology to further drive forward flexible and agile working to further reduce our office and support costs.
- Encourage and support our staff to generate and deliver ideas which make better use of resources.
- Develop our benchmarking activity to understand where there may be potential for change or improvement.
- Rationalise the number of sites which we occupy.
- Deliver a number of whole system redesigns which reduce costs and increase efficiency and effectiveness including for district nursing and mental health.
- Continue our focus to deliver effective and efficient services, based on best practice and value for money including reducing the numbers of hospital beds the use of hospital services.

5. TACKLING INEQUALITIES

The key outcomes are:-

- We plan and deliver health services in a way which understands and responds better to individuals' wider social circumstances.
- Information on how different groups access and benefit from our services is more routinely available and informs service planning.
- We narrow the health inequalities gap through clearly defined programmes of action by our services and in conjunction with our partners.

	ACTION TO DELIVER CORPORATE PRIORITIES	PERFORMANCE MEASURE	BASELINE 2011-12	YEAR ONE TARGET 2013-14	2016 TARGET
1	**Acute Services**				
1.1	Work with partnerships to reduce DNAs in priority service areas in relation to Deprivation / Gender / BME inequalities	Improve DNA % in 3 priority service areas by patient postcode identified by SIMD rating / Gender differential and BME differential	12.7% for all adult specialties	Review DNA data and establish 3 priority areas	To be developed.
1.2	Implement the A&E Inequalities Plan.	Achieve related targets e.g. Suicide Reduction, GBV etc and reduce complaints Improve communication with GPs, other NHS services and A&E Departments	223 A&E staff trained in GBV 36 A&E staff trained in Suicide prevention	Achieve targets set out in Inequalities Plan.	To be developed.
1.3	Deliver range of staff training initiatives to reflect patient needs/ life circumstances	Number of staff trained: • Inequalities Sensitive practice • Health Related Behaviour Change (all progs)	Number trained ISP: 225 (6mth data) Number trained HRBC: 635	20% increase in numbers trained 20% increase in numbers trained	To be developed.

	ACTION TO DELIVER CORPORATE PRIORITIES	PERFORMANCE MEASURE	BASELINE 2011-12	YEAR ONE TARGET 2013-14	2016 TARGET
		• HI service briefings (FI / Welfare reform etc)	5 Briefings		To be developed.
1.4	Undertake and implement EQIAs in priority service areas / service redesign	Increase lead reviewers trained Ensure agreed targets and improvements are met through monitoring at Directorate Performance Review Group (PRG) process. Number of EQIAs completed.	10% lead reviewers trained tbc 40 EQIA	90% lead reviewers completed training. Number EQIA action plans competed: 40 Number of EQIAs: 10 priority areas	To be developed.
1.5	Reduce discrimination faced by LGB, Trans people, Sensory Impaired people and people with learning disabilities in our services by using service improvement approaches.	Number of service improvement activities carried out in priority area locations (A&E/Outpatients/RAD). Increase in staff trained in E&D	tbc	Service improvement activities carried out in 3 priority area locations. 20% increase in staff doing equality e-modules.	Service improvement activities rolled out across all priority areas.
1.6	Remove barriers to services for people with protected characteristics (race & disability)	Increase in staff trained in E&D	Number trained:6920 (6mth data /all E&D)	20% increase in staff doing equality e-modules.	To be developed.

	ACTION TO DELIVER CORPORATE PRIORITIES	PERFORMANCE MEASURE	BASELINE 2011-12	YEAR ONE TARGET 2013-14	2016 TARGET
1.7	Deliver accessible buildings through routine audit and response	Access Audit completion Number of Patient facing locations compliant with foundation level access criteria	2 audits annually Baseline being currently compiled	2 audits minimum, annually.	2 audits minimum, annually.
1.8	Vulnerable groups are targeted by HI Services	Proportion of services used by SIMD / improved SIMD outcomes: • Breastfeeding • ABI • Smoking/ smoking in pregnancy	Described in service areas		To be developed.
2	**Cancer**				
2.1	Identify and address issues regarding access to cancer services and reduce any inequalities in access. • Bowel Cancer	Number positive screening conversion to diagnostic attendance by SIMD. Increase in numbers with early diagnosis by stage.	TBC	20% improvement in earlier stage of diagnosis	25% improvement in earlier stage of diagnosis.
3	**Child and Maternity**				
3.1	Improve breastfeeding rates at birth and on discharge and reduce the SIMD differential through development of peer and professional support models.	See Early Intervention section			
3.2	Support women to reduce smoking in pregnancy.	See Early Intervention section			

	ACTION TO DELIVER CORPORATE PRIORITIES	PERFORMANCE MEASURE	BASELINE 2011-12	YEAR ONE TARGET 2013-14	2016 TARGET
4	**Long Term Conditions**				
4.1	Increase access for people with long term conditions to: • to financial advice and employability services • To support services in the community By ensuring acute staff are aware of and able to signpost individuals to financial inclusion support services and support in the community.	No of referrals to financial inclusion services made via outpatient clinics. Implement ALLIS system in acute outpatient clinics.	TBC Not currently available within acute.	Increase in no. of referrals. System is implemented	TBC TBC
5	**Older People**				
5.1	Ensure services in acute comply with age discrimination legislation.	Staff trained in age protected characteristic: Increase in staff doing equality e-modules.	299 (6mth data). 6920 (6mth data /all E&D).	20% increase in staff doing equality e-modules. TBC	To be developed. To be developed.
		Number of complaints or patient feedback records highlighting age based discrimination.	Baseline 1 complaint in 2011	Reduction in no. of complainants/patient feedback highlighting age discrimination.	To be developed.

Financial outcomes from Corporate Plan:

- Demonstrate that we have shifted our use of resources to deliver on these inequalities outcomes.
- Considered the inequality impact in all of our financial decisions.

6. Financial Planning

6.1 The Acute Services Division provides secondary and tertiary care for the 1.2 million population of NHSGGC. It also provides secondary and tertiary care for other West of Scotland Boards and some national tertiary services. The budget supporting the delivery of these services is approximately £1.5 billion, which is made up of £1 billion in Pays and £0.5 billion Non Pays. The key expenditure areas for pays include £368m on nursing and £284m on medical staffing and in non pays £160m in pharmacy supplies for drugs, dressings and sundries.

6.2 During 2012/13, the financial challenges continued to be addressed as the Acute Services Division worked towards delivering financial breakeven and meeting the £29.3m CRES target.

Meeting the target has proved very challenging for the Division with increasing medical admissions and pressures on beds which has affected the delivery of the target ASR bed model in-year. Overall however the Division is forecasting an in-year breakeven financial position.

6.3 Outlook for 2013/14

Moving forward into 2013/14 is likely to see similar pressures on both additional activity and challenges in delivering the ASR bed model. Within the Board Financial Plan for 2013/14 there exists a financial challenge of £33.2m of which, after significant prescribing procurement efficiencies there will be a CRES target allocated to the Division of over £7m. In addition to this there remains undelivered recurrent 2012/13 CRES efficiencies in the face of the pressures described above of circa £6m bringing the overall challenge to in excess of £13m. Delivery of this programme of efficiencies will be key to addressing further pressures in the Modernising Medical Careers agenda, implementation of the Nursing Workforce Tool together with Winter costs and other areas not recognised for funding in the Board Financial Plan.

Achievement of a successful 2013/14 Acute services Plan will require close working with the Board , ensuring key actions are identified and performance managed to ensure delivery and a keen focus on productivity and redesign of services.

At a high level this will be delivered through:

- Reviewing current services, staffing, finance and what will require to be delivered.
- Ensuring that we optimise the use of resources through redesign and improved productivity and efficiency
- Understanding the impact of pay modernisation and the link to workforce development to reduce or sustain costs
- Controlling utility and maintenance costs within our buildings

The approach to the financial challenge is:

- Synchronisation with the Board approach
- Development of the Acute Plan to ensure clear action plans are in place with performance measures to monitor progress
- Pan- acute and directorate savings targets
- Ownership with those who commit expenditure
- Productivity focus to target effort in defined areas to ensure productivity and efficiency activity is delivered and targets met

- Establishing robust mechanisms to ensure financial plan is met with regular monitoring through the Directorate Performance Reviews

Within the timeframe of the plan there will be a focus on the following areas:

6.4 Implementation of the Accelerated ASR and Clyde Strategies

Rationalisation and centralisation of services set out in the Acute Services Review and Clyde Strategies will continue to be progressed over the next few years. During 2013/14 work will continue to explore the opportunities to reduce multi-site specialty working in relation to inpatient service delivery across GGC.

During 2012/13 the Clinical Services Review was established as a significant strategic piece of work to review the existing strategies across Glasgow and Clyde to plan for the period from 2015 onwards. This work is considering and testing whether the extant strategies remain fit for purpose or as new challenges in relation to finance and workforce emerge and as clinical service models evolve, to determine whether new longer term strategies are required and a unified Greater Glasgow and Clyde strategy developed. The opportunity for further rationalisation of services and the development of leading edge service models will is being explored. Underpinning this work is the ongoing clinical pathway activity which is seeking to reduce variation in practice. This will be supported by work to link staffing and other resources to activity.

6.5 Use of Benchmarking in the Acute Sector to Ensure Service Efficiency and Productivity

Within the Acute Services Division a programme of benchmarking is underway using both internal and external benchmarking.

- Bed Model benchmarking includes elective and non elective activity; day case rates; length of stay; pre-operative stays; and occupancy

- Outpatients benchmarking includes new to return ratios; DNA rates; cancelled / reduced clinics

- Theatres benchmarking includes available sessions; utilisation of sessions and cancelled sessions

7. Effective Organisation

7.1 HI&T Systems

The Division has successfully implemented TRAKcare in all Clyde and South Glasgow Hospitals and the final stage of the rollout to North Glasgow Hospitals will take place in spring 2013. GP Order Comms is also being implemented.

The Division continues to progress work to rollout the Electronic Patient Record (EPR) and this will be a key feature of the new South Glasgow Hospitals.

7.2 FTFT

There is a significant transformational organisational and cultural change agenda to be implemented over the period of this plan and beyond. This will require a focused approach on redesign and service modernisation to deliver improvements in efficiency and productivity as well as preparing services for the opening of new state of the art acute and children's hospitals on the Southern General site in 2015. This will include integration of existing teams, new ways of working,

changes to roles and responsibilities and the development of new skills and learning.

To ensure success the Acute Services Division will continue to develop and deliver a comprehensive range of interventions designed to support organisational, team and individual development. All of this work will align to NHSGGC's change programme Facing the Future Together (FTFT) which focuses specifically on improvements which will benefit our patients, our people, our use of resources, our leaders and our culture.

To ensure a cohesive and structured approach, this programme of service change will be underpinned by a clearly defined culture describing behaviours and attitudes required of all staff across the Acute Service Division. This approach, together with the actions described in the acute plan, will be used to ensure that the requirements of the Acute Division translate into organisational and individual objectives with supporting personal development plans through the Individual Performance Management System for senior managers and clinicians and the Knowledge and Skills Framework. This will ensure that there is clarity of roles, responsibilities and accountabilities at all levels of the organisation with a strong focus on the desired attitude and behaviours required to continually improve the quality of the care provided and the patient experience.

With this level of change and service transition it is important that there is a strong organisational development (OD) approach with commitment to incorporating OD activity early in the change process to address typical reactions and issues associated with this. This may include:

- Exploring practical issues to address different ways of working, traditional thinking to seek agreement and commitment to a newly defined way of working to support effective integrated models of delivery and the implementation of new HI&T systems and processes.
- Cultural issues aligned to this e.g. attitudes and behaviours and unpicking the unwritten rules which define " how we do things around here"
- Clarifying new roles/responsibilities and standard operating procedures or integrated processes required in the new model
- Expressing and addressing fears/anxieties/hopes and aspirations and assumptions/misconceptions arising from the change through a systematic approach to engaging our workforce on changes impacting on them
- Considering how best to ensure that staff moving from previous site(s) are not just expected to "be made to fit into" an existing site
- Ground rules/action plans to support all of the above and gain commitment to integrated team working
- Identifying training and development needs to ensure staff have the right skills and knowledge to perform effectively in their role.

To support the development of highly effective, engaged management and leadership teams to deliver change and service delivery in a financially challenging environment, it will be important to work closely with management teams to ensure that they build on existing skills to lead change effectively through the use of a range of tools/techniques and OD interventions. This work will be referenced

against the Change Management Policy and Toolkit as well as providing advice and support on the human reactions and resistance to change and strategies for addressing these.

In addition, during 2013/14, we will place stronger emphasis on leadership /effective team working and staff engagement at all levels of the organisation and use the self-assessment tools available through FTFT to support and monitor this.

An annual detailed analysis of key groups affected by the changes within each of the directorates will be undertaken and this information will be used to inform a planned programme of prioritised organisational development which will be reviewed and updated on a quarterly basis. This will ensure that any planned activity is focused on both short and long term issues to ensure early engagement of key stakeholders and staff affected by change. A range of leadership and personal development opportunities will be available to identified groups of staff; which will include access to leadership modules; coaching; mentoring; 360 appraisal; Ready to Lead etc. Proposals and recommendations will be reported via the Organisational Development Group and the On the Move Group to ensure this activity is focused effectively within the organisation to achieve the organisation's goals. We will also review the Year 1 Action Plan for implementation of FTFT within the Division and develop a Year 2 Plan which will be reported via the OD Group and the Operational Management Group.

The development of a more strategic approach to continuous improvement across the whole system will continue to be progressed by adopting lean methodology across NHSGGC. This will accelerate, integrate and sustain service change across NHSGGC which will in turn coordinate and connect planning, redesign and planned interventions to support change management activity. A planned programme of improvement activity will be progressed to support delivery of the Quality Strategy. This will encompass value stream analysis, rapid improvement events, implementation of Releasing Time to Care and the Productive Series and will continue to build on the success of the implementation of the Scottish Patient Safety Programme. In addition there will be continued development of capability and capacity of staff on continuous improvement methodology to support change management and this will be built into all planned leadership development activity.

It is envisaged that all of this activity will support the development of a culture of continuous and sustainable improvement strongly focused on performance management to ensure delivery of national, board and divisional service objectives. Redesigning services and developing leaders, teams and individuals will be critical to the delivery of high quality, safe and efficient services for patients, families and carers. This more involving and collaborative approach is intended to improve overall service effectiveness making the Acute Services Division a better place to work and an organisation that everyone is proud to be part of.

7.3 Administrative Systems and Support

The Division has completed a review of its Administrative and Clerical Staff and is working towards a 10% reduction in Administrative Services. The overall reduction to date stands at 6.5% and a detailed analysis of any impact from the introduction of Trakcare/EPR on heath records staff is underway.

7.4 Staff Sickness

Sickness Absence

The Acute Division Sickness Absence for 2012/13 has averaged at 4.90%. In the first quarters of 2012/13 the absence figures remained relatively static and were on trajectory for reduction towards the previous HEAT target of 4%. The latter part of 2012 and into 2013 have unfortunately, seen an increase in our absence figures with the last reported figure at December 2013 being 5.96%. Acute Directorates have now undertaken robust reviews of absence within their areas. There is a methodology to consider what would be deemed as hot spots i.e. areas where the average percentage is greater than the Acute figure. The HR Team have developed a mechanism to assess absence patterns over three years thus identifying trends and behaviours.

On a more positive note, the Directorate have been instrumental in managing stress audits, with all Directorates establishing staff focus groups and the development of action plans to support the Managing Stress Policy. The Division has also been instrumental in the development for 2013/14 of Musculo-Skeletal guidance which will shortly be issued via our Health and Safety teams to all Managers to consider a more pro active approach to the management of Musculo-Skeletal illness.

The Attitudes, Behaviours and Values programme will also be rolled out across Directorates, where appropriate, providing additional support in the areas which could lead to increased attendance management.

The Division in 2012/13 achieved its Gold Healthy Working Lives and Mental Health Commendation Award and we are currently maintaining these awards through a series of initiatives geared at improving the health and wellbeing of our staff and also supporting the Board's Staff Health Action Plan. This includes considering additional support for Smoking, Obesity, Mental Health and Physical Activity.

7.5 eKSF

The Acute Division maintained and in some cases surpassed the 80% target for staff to have a signed off PDP on eKSF up to September 2012. From September 2012 the figure has become more challenging. The Division is now focusing on detailed action plans within each area to maintain the 80% target for March 2013. The key emphasis for 2013 will not necessarily be a focus on the target but will be a focus on ensuring that all individuals do have the one to one opportunity with their managers to discuss their personal development. The Division have also strengthened its core and mandatory training programme which supports the delivery of PDPs.

7.6 Person Centred Care

The Acute Services Division Patient Experience Steering Group was established in January 2012 following the amalgamation of the Public Focus Patient Involvement and Better Together Steering Groups.

The Group has focussed its activity on:

- Piloting Patient Opinion on the New Victoria Hospital Site,
- Reviewing the third Better Together National Survey results and improvement planning,

- The Noise Reduction Project, funding for which was obtained from SGHD,
- Development of a new reporting template to record Directorate patient experience activity as well as incorporating the requirements for the Participation Standards submission,
- Review of Visiting Times across the Acute Services Division
- Development of a Patient Experience Stories Library. The notes within the template advise to include numbers involved, types of groups and equality groups that were involved to demonstrate the inclusiveness of the involvement, where relevant or applicable.
- Further development of the SCN Better Together Questionnaire and roll out across inpatient wards

Examples of Directorate specific activity include:

- Alzheimer's Scotland 'This is Me' documentation launched for use with patients with dementia (RAD)
- Development of Hospital Palliative Care booklet to better inform carers/family members about the approach to Palliative Care in Hospital. (RAD)
- Involvement of volunteers in improving the quality of patient experience (ECMS)
- Improving care for Learning Disabilities patients (development of training video) (ECMS)
- Patient feedback sampled as part of SPSP leadership walk rounds and internal HEI/OPAC inspection process (Regional Services).
- Pilot of Caring Behaviours Assurance System (CBAS) (Regional Services).
- Survey of inpatients with regards to use of National Spinal Injuries step down facilities (Regional Services)

During the coming year the division will be focusing on the introduction of Flexible Visiting Times across all in patient wards, the use of the Patient Experience Stories Library resource, the implementation of Active Patient Care and the continued monitoring and reporting of the Participation Standards implementation.

7.7 Complaints

Within the Division, we have a number of strategies to monitor our performance in responding to complaints timeously, and how we review and share the learning from complaints. This also involves reviewing and cascading learning not only as a result of complaints, but also in reviewing Reports and Decision Letters from the Scottish Public Services Ombudsman, and in relation to Fatal Accident Inquiries.

In relation to complaints, and specifically the regime around monitoring our performance in relation to meeting the national target of responding to 70% of formal complaints within 20 working days, this is reviewed by the Board on a quarterly basis.

The Acute Division Operational Management Group also receives a high level Complaints Report each month, which identifies not only run rate performance against the 70% target, but also the number of complaints received within each Directorate, the long waiters (i.e. those where the 20 working day target is not being met), and the issues and themes emerging from complaints.

At Directorate level, monthly reports are submitted to Directors, and they review their active / open complaints reports through their management / governance structures. Early issues of concern are raised at that stage. In addition a detailed

complaints paper is discussed at each Directorate Performance Review Group meeting (a quarterly meeting) which looks at complaints in greater detail to cover performance, and quality aspects.

In relation to learning outcomes, a summary of a small number of cases where service improvements have been put in place as a result of reviewing a complaint are included in the quarterly Board reports. At Directorate level each complaint that is upheld or partially upheld is reviewed to ensure that if there are any changes that need to be made these are captured on an action plan, and these are reported / followed through by the management / governance structures as above.

In relation to Scottish Public Services Ombudsman reports, these are reviewed on a monthly basis by the Senior Executive Team (COO, Nurse Director, Lead Director for Acute Medical Services, Associate Medical Director - Corporate, Head of Administration) to ensure that the senior team are aware of existing cases and draft/final Reports / Decision Letters likely to be published by the Ombudsman's office in the near future. Issues of concern can be flagged at that stage and taken forward with individual Directors.

The above group also looks at Fatal Accident Inquires, both from the point of view of preparations for forthcoming Inquiries and ensuring that there is a robust focus on the learning points arising from previous Determinations.

Both Ombudsman and FAI cases are reported to our Clinical Governance Committee on a monthly basis to ensure that the learning points are highlighted. The Board's Quality & Performance Committee is also provide with an update on Ombudsman cases, as part of the Complaints quarterly report, and a regular update is provided to Corporate Management Team (verbal) and Quality & Performance Committee (within the Scottish Patient Safety Programme update).

7.8 NMC Registrations

Each Directorate within the Division has a process in place to monitor and deal with any lapses in NMC Registrations. This process is in turn monitored through the Performance Review Group meetings which are held quarterly with each Directorate. The numbers of lapsed registrations is also reported to the CMT through the quarterly performance report.

7.9 Clinical Governance

The Division has identified six key priorities for implementation. These are

- Medicines reconciliation
- SBAR communication
- Safety briefings
- Thromboprophylaxis
- Early warning scoring systems
- Sepsis management

In addition there is a focus on communication with General Practitioners. The timeliness, format and quality of immediate and final discharge letters are audited on a regular basis.

Performance in these areas is monitored through the Directorate Performance Review Group meetings on a quarterly basis and bi-monthly at the Acute Clinical Governance Committee.

7.10 Infection Control

The Division continues to monitor performance against the targets for reduction in Staphylococcal bacteraemia and Clostridium difficile infection. There is a particular focus on antimicrobial prescribing, hand hygiene and implementation of the PVC care bundle. These are reviewed regularly though the Acute Infection Control Committee. Outcome of HEI inspections are also reviewed and implementation of any action plans monitored