NHS Greater Glasgow & Clyde

NHS
Greater Glasgow and Clyde

NHS BOARD MEETING

Head of Performance **19 April 2016** **Paper No: 16/18**

NHS GREATER GLASGOW AND CLYDE'S INTEGRATED PERFORMANCE REPORT

Recommendation:-
Board members are asked to:

Note and discuss the content of the NHS Greater Glasgow and Clyde's Integrated Performance Report.

Purpose of Paper:-
To bring together high level information from separate reporting strands, to provide an integrated overview of the NHS Greater Glasgow and Clyde's performance in the context of the 2015-16 Strategic Direction/Local Delivery Plan.

Key Issues to be considered:-
Key performance status changes since the last report to the Board Report include:

Performance Improvements

- The percentage of patients waiting <18 weeks for RTT to Specialist Child and Adolescent Mental Health Services has improved since previously reported to the Board with current performance currently at 100%.

Performance Deterioration

- The number of bed days lost to delayed discharge has moved from ***green to red.***
- The percentage of patients waiting less than 4 weeks for a diagnostic test has moved from ***green to amber***
- The percentage of patients admitted to a stroke unit on day of admission or day following presentation has moved from ***green to amber.***

Measures Rated As Red

- Detect cancer early
- Suspicion of Cancer Referrals (62 days)
- Delayed Discharge > 14 days
- Bed days lost to Delayed Discharge
- SAB Infections (cases per 1,000 OBD)
- Sickness Absence Rate

Any Patient Safety /Patient Experience Issues:-
None.

Any Financial Implications from this Paper:-
None.

Any Staffing Implications from this Paper:-
None.

Any Equality Implications from this Paper:-
Identified under Strategic Priority 5 - Tackling Inequalities.

Any Health Inequalities Implications from this Paper:-
Identified under Strategic Priority 5 - Tackling Inequalities.

Has a Risk Assessment been carried out for this issue? If yes, please detail the outcome:-
No.

Highlight the Corporate Plan priorities to which your paper relates:- The report is structured around each of the five strategic priorities outlined in the 2015-16 Strategic Direction/Local Delivery Plan.

Tricia Mullen, Head of Performance, Corporate Planning and Policy
Tel No: 0141 201 4754
11 April 2016

NHS Greater Glasgow and Clyde

NHS GREATER GLASGOW AND CLYDE

Board Meeting
19 April 2016 **Paper No: 16/18**

Head of Performance

NHS GREATER GLASGOW AND CLYDE'S INTEGRATED PERFORMANCE REPORT (INCLUDES WAITING TIMES AND ACCESS TARGETS)

RECOMMENDATION

Board members are asked to note and discuss the content of the Board's Integrated Performance Report.

1. INTRODUCTION

The report brings together high level system wide performance information (including all of the waiting times and access targets previously reported to the Board) with the aim of providing members with a clear overview of the organisation's performance in the context of the 2015-16 Strategic Direction - Local Delivery Plan. An exceptions report accompanies all indicators with an adverse variance of 5% or more, detailing the actions in place to address performance and a timeline for when to expect improvement.

2. FORMAT AND STRUCTURE OF THE REPORT

The indicators highlighted in *italics* are those indicators that each of the Health and Social Care Partnerships (HSCPs) have a direct influence in delivering. Each of these indicators can be disaggregated by each of the HSCP areas. For those indicators that can be disaggregated, the Chief Officer of Partnerships experiencing a persistent adverse variance of 5% or more will report direct to the Board. This reflects the fact that the first line of scrutiny and oversight of performance improvement will be undertaken by each of the Integrated Joint Boards.

The report draws on a basic balanced scorecard approach, and uses the five strategic priorities outlined in the 2015-16 Strategic Direction - Local Delivery Plan. Some indicators could fit under more than one strategic priority, but are placed in the priority considered the best fit.

The indicators are made up of:

- Local Delivery Plan Standards (LDPS)
- Service Delivery Framework (SDF) indicators
- Health and Social Care Indicators (HSCI)
- Local Key Performance Indicators (LKPI) of high profile.

The report comprises:

- A summary providing a performance overview of current position.
- A single scorecard page, containing actual performance against target for all indicators. These have been grouped under the five Strategic Priorities identified in the 2015-16 Strategic Direction.

- An exceptions report for each measure where performance has an adverse variance of more than 5%.

The most up to date data available has been used which means that it is not the same for each indicator. The time period of the data is provided and performance is compared against the same time period in the previous year. From this, a direction of travel is calculated.

3. SUMMARY OF PERFORMANCE

Key performance status changes since last reported to the Board meeting include:

Performance Improvements

- The percentage of patients waiting < 18 weeks for RTT to Specialist Child and Adolescent Mental Health Services has improved since previously reported to the Board with current performance currently at 100%.

Performance Deterioration

- The number of bed days lost to delayed discharge has moved from ***green to red.***
- The percentage of patients waiting less than 4 weeks for a diagnostic test has moved from ***green to amber.***
- The percentage of patients admitted to a stroke unit on day of admission or day following presentation has moved from ***green to amber.***

Measures Rated As Red

- Detect cancer early
- Suspicion on cancer referrals (62 days)
- Delayed discharges > 14 days
- Bed days lost to delayed discharge
- SAB infection rate (cases per 1,000 population)
- Sickness absence.

Each of the measures listed above have an accompanying exceptions report outlining actions in place to address performance or a more detailed report on the agenda.

INTEGRATED PERFORMANCE REPORT

(INCLUDES WAITING TIMES AND ACCESS TARGETS)

19 APRIL 2016

PERFORMANCE SUMMARY

Outlined below is the key to the scorecard used on page 5 alongside a summary of overall performance against the five strategic priorities outlined in the 2015-16 Strategic Direction – Local Delivery Plan. For each of the indicators with an adverse variance of more than 5% there is an accompanying exceptions report identifying the actions to address performance.

Key to the Report

Key to Abbreviations		**Key to Performance Status**		**Direction of Travel Relates to Same Period Previous Year**	
LDPS	Local Delivery Plan Standard	**RED**	Outwith 5% of meeting trajectory	▲	Improving
LDF	Local Delivery Framework	**AMBER**	Within 5% of meeting trajectory	▶	Maintaining
HSCI	Health & Social Care Indicator	**GREEN**	Meeting or exceeding trajectory	▼	Worsening
LKPI	Local Key Performance Indicator	**GREY**	No trajectory to measure performance against.	▬	In some cases, this is the first time data has been reported and no trend data is available. This will be built up over time.
		TBC	Target to be confirmed.		

** It should be noted that the data contained within the report is for management information.*

Performance Summary At A Glance

The table below summarises overall performance in relation to those measures contained within the Integrated Performance Report. Of the 25 indicators that have been assigned a performance status based on their variance from targets/trajectories overall performance is as follows:

STRATEGIC PRIORITIES	**RED**	**AMBER**	**GREEN**	**GREY**	**TOTAL**
Preventing Ill Health and Early Intervention	2	1	1	0	**4**
Shifting The Balance of Care	1	1	0	4	**6**
Reshaping Care for Older People	2	0	0	1	**3**
Improving Quality and Effectiveness	2	5	8	4	**19**
Tackling Inequalities	0	0	2	0	**2**
TOTAL	**7**	**7**	**11**	**9**	**34**

PERFORMANCE AT A GLANCE - APRIL 2016									
PREVENTING ILL HEALTH AND EARLY INTERVENTION									
Ref	**Type**	**Local Delivery Plan Standard**	**As At**	**2014-15 Actual**	**2015-16 Actual**	**2015-16 Target**	**Perform Status**	**Dir of Travel**	**Exceptions Report**
1	LDPS	Early diagnosis and treated in first stage cancer	July - Sep 15	23.5%	26.5%	**28.1%**	RED	↑	Page 12
2	LDPS	Suspicion of Cancer Referrals (62 days)*	Feb-16	89.2%	83.0%	**95%**	RED	↓	Page 14
3	LDPS	All Cancer Treatments (31 days)*	Feb-16	96.5%	93.5%	**95%**	AMBER	↓	
4	LDPS	Alcohol Brief Interventions	Apr - Dec 15	10,282	11,426	**9,162**	GREEN	↑	
SHIFTING THE BALANCE OF CARE									
Ref	**Type**	**Local Delivery Plan Standard**	**As At**	**2014-15 Actual**	**2015-16 Actual**	**2015-16 Target**	**Perform Status**	**Dir of Travel**	**Exceptions Report**
5	LDPS	A&E max. 4 hours wait	Feb-16	79.6%	92.7%	**95%**	AMBER	↑	
6	LKPI	A&E Attendances per 100,000 popu	Mar - Feb 16	2,926	2,511	**No Target**	GREY	↑	
7	HSCI	Delayed Discharge > 14 days (inc codes)	Feb-16	58	22	**0**	RED	↑	Page 17
8	HSCI	Delayed Discharge < 72 hours (inc codes)	Feb-16	N/A	8	**TBC**	GREY	—	
9	LDPS	*GP Access*	N/A	N/A	N/A	**90%**	GREY	—	
10	LDPS	*GP Advance Booking*	N/A	N/A	N/A	**90%**	GREY	—	
RESHAPING CARE FOR OLDER PEOPLE									
Ref	**Type**	**Local Delivery Plan Standard**	**As At**	**2014-15 Actual**	**2015-16 Actual**	**2015-16 Target**	**Perform Status**	**Dir of Travel**	**Exceptions Report**
11	HSCI	Acute bed days lost to delayed discharge							
		All patients (65 years+)	Feb-16	4,239	3,111	**0**	RED	↑	Page 18
		AWI patients (65 years+)	Feb-16	1,338	1,640	**0**	RED	↓	
12	LDPS	Number of people newly diagnosed with dementia in receipt of 1 years post diagnostic support	N/A	N/A	N/A	**TBC**	GREY	—	
IMPROVING QUALITY, EFFICIENCY AND EFFECTIVENESS									
Ref	**Type**	**Local Delivery Plan Standard**	**As At**	**2014-15 Actual**	**2015-16 Actual**	**2015-16 Target**	**Perform Status**	**Dir of Travel**	**Exceptions Report**
13	LDPS	18 Week Referral To Treatment (RTT)							
		Combined Admitted/Non Admitted	Feb-16	91.6%	91.6%	**90%**	GREEN	↔	
		Combined Linked Pathway	Feb-16	88.3%	88.7%	**80%**	GREEN	↑	
14	LDPS	12 week Treatment Time Guarantee (TTG)							
		Inpatient	Feb-16	100%	99.3%	**100%**	AMBER	↓	
15	LKPI	Patient unavailability (Adults)							
		Inpatient/Day Case	Feb-16	4,494	5,991	**N/A**	GREY	↓	
		Outpatient	Feb-16	2,212	2,879	**N/A**	GREY	↓	
16	LKPI	% of patients waiting < 4 weeks for diagnostic test	Feb-16	100%	99.5%	**100%**	AMBER	↓	
17	LDPS	% of new outpatient waiting < 12 weeks for an appointment	Feb-16	99.7%	95.7%	**99.9%**	AMBER	↓	
18	LDPS	% of eligible patients commencing IVF treatment within 12 months	Feb-16	100%	100%	**90%**	GREEN	↔	
19	LKPI	% of patients admitted to stroke unit	Feb-16	79%	89%	**90%**	AMBER	↑	
20	LDPS	% patient waiting < 18 weeks for RTT to Specialist Child and Adolescent Mental Health Services	Jan-16	99.8%	100%	**100%**	GREEN	↔	
21	LDPS	% patients who started treatment <18 weeks of referral for psychological therapies	Jan-16	95.5%	91.6%	**90%**	GREEN	↓	
22	LDPS	Drug and Alcohol: % of patients waiting < 3 weeks from referral to appropriate treatment	Jul - Sept 15	97.3%	96.8%	**91.5%**	GREEN	↓	
23	LDPS	SAB Infection rate (cases per 1,000 OBD rolling year)	Jan - Dec 15	0.26	0.33	**0.24**	RED	↓	Page 19
24	LDPS	C.Diff Infections (cases per 1,000 OBD rolling year)	Jan - Dec 15	0.29	0.31	**0.32**	GREEN	↓	
25	LDF	*% of complaints responded to within 20 working days*	Oct - Dec 15	84.0%	73.0%	**70%**	GREEN	↓	
26	LDPS/LDF	Financial Performance	Feb-16	(£0.0m)	(£2.5m)	**(£0.3m)**	AMBER	↓	Agenda Item 18
27	LDPS/LDF	Sickness Absence (rolling year)	Jan-16	5.30%	5.36%	**4%**	RED	↓	Page 21
		Long Term	Jan-16	3.52%	3.53%	**N/A**	GREY	↓	
		Short Term	Jan-16	1.78%	1.82%	**N/A**	GREY	↓	
TACKLING INEQUALITIES									
Ref	**Type**	**Local Delivery Plan Standard**	**As At**	**2014-15 Actual**	**2015-16 Actual**	**2015-16 Target**	**Perform Status**	**Dir of Travel**	**Exceptions Report**
28	LDPS	80% of pregnant women in each SIMD quintile have access to Antenatal Care at 12 week gestation	Oct - Dec 15	72.7%	83.6%	**80%**	GREEN	↑	
29	LDPS	Smoking Cessation - number of successful quitters at 12 weeks post quit in 40% SIMD areas (Data incomplete)	Apr - Dec 15	749	1108	**996**	GREEN	↑	

* Data still to be validated

Key		**Performance Status**		**Direction of Travel**	
LDPS	Local Delivery Plan Standard	RED	Adverse variance of more than 5%	Improving	↑
HSCI	Health and Social Care Indicator	AMBER	Adverse variance of up to 5%	Deteriorating	↓
LDF	Local Delivery Framework	GREEN	On target or better	Maintaining	↔
LKPI	Local Key Performance Indicator	GREY	No target		
		N/A	Not Available		—

Please note the information contained within this report is for management information purposes only as not all data has been validated.

AMBER COMMENTARY

(For those measures rated as Amber that show a downward trend when compared with the same period the previous year)

AMBER RATED MEASURES SHOWING A DOWNWARD TREND WHEN COMPARED WITH THE SAME PERIOD THE PREVIOUS YEAR

Ref	Measure	As At	2014-15 Actual	2015-16 Actual	2015-16 Target	Perform Status	Dir of Travel
3	All Cancer Treatments - 31 days (*data still to be validated*)	Feb 2016	96.5%	93.5%	95.0%	**AMBER**	↓

Commentary

As at February 2016, 93.5% of all patients diagnosed with cancer were treated within 31 days from decision to treat to first treatment. Current performance is below the 95% target and lower than the position reported during the same month the previous year.

Actions To Improve Performance

See exception report on Suspicion of Cancer Referrals (62 days) for the detailed actions in place to improve performance in relation to the cancer waiting times.

Ref	Measure	As At	2014-15 Actual	2015-16 Actual	2015-16 Target	Perform Status	Dir of Travel
5	A&E max. 4 hours wait	Feb 2016	79.6%	92.7%	95.0%	**AMBER**	↑

Commentary

As at February 2016, 92.7% of all patients were seen within 4 hours. Current performance is below the 95% target yet shows a 13% improvement on the position reported during the same month the previous year.

Actions To Improve Performance

The delivery of the Unscheduled Care 95% target continues to be the most challenging performance target for the Board. Each of the Acute Sectors has established action plans which they continue to implement. However, while the initiatives implemented to date have achieved improved performance compared to the same period last year, these have not delivered the sustained improvement required to regularly achieve the 95% target.
In recognition of this, a further system-wide review is being progressed to analyse patient flows, allocation and gearing of resources and key performance metrics. This review will drive a new system wide action plan for consideration by Board Members.

Ref	Measure	As At	2014-15 Actual	2015-16 Actual	2015-16 Target	Perform Status	Dir of Travel
14	% of Treatment Time Guarantee patients waiting < 12 weeks for an appointment	Feb 2016	100% (0)	99.34% (47)	100% (0)	**AMBER**	↓

Commentary

In February 2016, 99.34% of patients across NHS Greater Glasgow & Clyde (NHSGG&C) received their treatment within the 12 Week Treatment Time Guarantee (TTG). There were 47 patients waiting > 12 weeks for treatment in the following specialties: 43 in Urology and 1 in ENT in the South Sector, 2 in General Surgery in the North Sector and 1 in Neurosurgery in Regional Services.

Actions To Improve Performance

- **Neurosurgery (1) patient** - this patient was originally reported in November 2015 and has accepted a date for treatment in March 2016..
- **General Surgery (2) patients** - the 2 general surgery patients were waiting more than the 12 week TTG as a result of the decision to cancel routine procedures during the two weeks beginning 4 - 15 January 2016. Both patients were admitted in March 2016 for their procedures.
- **Urology (43) patients** - there are capacity issues within the Urology Service and work is currently underway to resolve this either through additional theatres being switched allocated (weekdays and weekend) and some patients being treated in the independent sector to help alleviate the capacity issues. Of the 43 patients waiting at February 2016 month end: *8* patients have since received their treatment during March 2016*,* 11 patients have a confirmed hospital admission date between April and May 2016*, 2* patients have since been removed from the waiting list, (one patient due to failure to contact the service in response to waiting list review letter sent and the other patient removed at the patient's own request), *1* patient has been given a provisional date to be admitted to hospital. The service is working with the remaining 21 patients to secure suitable dates for admission.
- **ENT (1) patient** - this patient was delayed due to the requirement to use and secure an operator for highly specialised equipment. This issue was resolved and the patient received their treatment on 15 March 2016.

Ref	Measure	As At	2014-15 Actual	2015-16 Actual	2015-16 Target	Perform Status	Dir of Travel
16	% of patients waiting < 4 weeks for diagnostic test	Feb 2016	100%	99.5%	100%	AMBER	↓

Commentary

As at February 2016, 99.5% of all patients waited less than four weeks for a key Diagnostic test. Current performance is below the 100% target and lower than the position reported during the same month the previous year.

15 patients waited more than 4 weeks for a cystoscopy test; 6 patients at Gartnavel General Hospital (GGH) and 9 patients at the Victoria ACH (VACH). There are capacity issues for this specific test as only 1 Consultant currently carries out these tests. The Directorate team is working on plans to expand capacity with Sector colleagues to clear this backlog.

Actions To Improve Performance

- A full review and overhaul of the service Waiting List procedures is ongoing, including training
- A capacity planning is exercise underway and a review of Consultants and Clinical Nurse Specialist job plans
- The Service is exploring the possibility of using Clinical Nurse Specialist led Flexible Cystoscopy sessions at the VACH and GGH, for repeats tests
- Cross-Sector working group to address core Urology issues

Ref	**Measure**	**As At**	**2014-15 Actual**	**2015-16 Actual**	**2015-16 Target**	**Perform Status**	**Dir of Travel**
17	% of new outpatients waiting < 12 weeks for an appointment	Feb 2016	99.7%	95.7%	99.9%	**AMBER**	↓

Commentary

As at February 2016 (month end), 95.7% of new outpatients patients were waiting for less than 12 weeks from the date of their referral for an outpatient appointment. Current performance is below the trajectory of 99.9% and represents a 13% increase on the number of patients reported the previous month.

The figure represents 2,518 patients waiting over 12 weeks at the end of February 2016 for a new outpatient appointment across the following Sectors and Directorates:

- **South Sector** - a total of 1,557 new outpatients were waiting > 12 weeks for a new outpatient appointment in the following specialties: 904 in Gastroenterology, 216 in Respiratory, 187 in Rheumatology, 121 in Anaesthetics, 60 in Cardiology, 42 in Diabetes, 18 in Endocrinology, six in General Medicine, two in Infectious Diseases and one in Geriatric Medicine.
- **North Sector** - a total of 348 new outpatients were waiting > 12 weeks for a new outpatient appointment in the following specialties: 333 in Anaesthetics and 15 in Respiratory Medicine.
- **Clyde Sector** - a total of 408 new outpatients were waiting > 12 weeks for a new outpatient appointment in the following specialties: 376 in Gastroenterology, 22 in Anaesthetics, eight in Rheumatology and two in Respiratory Medicine.
- **Regional Services** - a total of 532 new outpatients were waiting > 12 weeks for a new outpatient appointment in the following specialties: 528 in Neurology and four in Rehabilitation Medicine.

Actions To Improve Performance

- **South Sector** - 6% of the total number of available outpatients were waiting >12 weeks for a new outpatient appointment. There are ongoing capacity issues within a number of key specialties that are resulting in patients waiting over 12 weeks i.e. Gastroenterology - 904 (3.6% of total available list), Respiratory - 216 (0.9% of total available list), Rheumatology - 187 (0.7%) and Anaesthetics - 121 (0.5%) of the total waiting list. This position is being maintained despite the use of Waiting list initiatives.. Medical workforce options are being reviewed to identify available PA's from vacancies and consideration of alternative appointments such as Nurse Specialists and GPs. A review of clinic templates and utilisation is informing clinical dialogue to increase the number of booked patients and the number of clinics undertaken.

- **North Sector** - 3.5% of the total number of available outpatients were waiting > 12 weeks for a new outpatient appointment. 96% (333) of new outpatients waiting > 12 weeks were in the Chronic Pain Service which recently transferred to the North Sector. There remains significant pressure on the Chronic Pain Service outpatient list due to long term consultant absence and a maternity leave gap. The service has been experiencing very high referral rates which have caused capacity issues. Additional clinics have been arranged over the coming months to mitigate these challenges and further steps are being explored to address this, for example - review vetting to allow more patients to be seen by non-consultant staff in the first instance. In addition, the North experienced gaps in medical staffing due to long term sickness and vacancies.

- **Clyde Sector** - 2.5% of the total number of available outpatients were waiting > 12 weeks for a new outpatient appointment. The majority of the new outpatients (92%) waiting > 12 weeks were Gastroenterology patients. The sector continues to experience capacity pressures and is working to manage patients as effectively as possible. All urgent cancer cases are appointed as a priority. A business case has been developedto support the appointment of two additional gastroenterologists and two advance nurse posts on a cost containment basis to address capacity issues and reduce reliance on locums in Inverclyde Royal Hospital. While other specialties are maintaining access targets there is significant pressure in dermatology across the Board related to medical staffing vacancies and demand pressures and their ability to mainrtain the the 12 week target
- **Regional Services -** 8.6% of the total number of available outpatients were waiting > 12 weeks for a new outpatient appointment. The majority (99%) of the new outpatient waiting were

Neurology patients. A number of actions are being implemented to bring all 528 neurology outpatients reported in February 2016 back in line with the 12 week target. This includes: additional waiting list clinics remaining in place as well as Medinet assistance until the end of March with a second agency, Synaptic, commencing in April. The service awaits feedback from negotiations between Scottish Government Access Team and Medinet to determine if additional capacity may be offered in May. For clarity, the issue relating to the purchase of 800 appointments in the February 2016 Integrated Performance Report was corrected by Scottish Government who clarified that NHS Lanarkshire bought this capacity on behalf of NHS Scotland.

The service continues to look at elements of redesign, such as

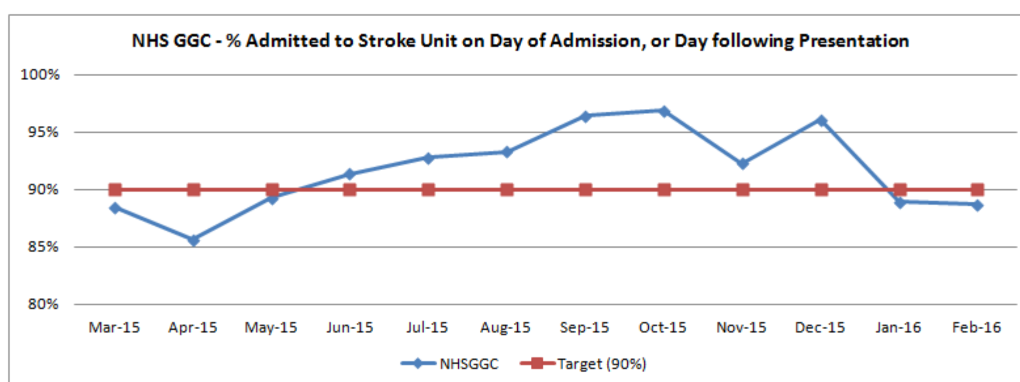
- undertaking a waiting list validation exercise to ensure all patients still require their appointment,
- in negotiation with Medinet to assess what additional clinics can be provided to enable a sustained reduction in the >12 week cases,
- displacing return outpatient activity away from Consultant Neurologists to the two newly appointed Epilepsy Clinical Nurse Specialists,
- discussing with Consultant staff their availability over the next three months to undertake further waiting list clinics,
- seeking to review practice elsewhere in the UK to understand alternative methods of managing referrals into the service,
- cleansing the waiting lists for those patients that have been incorrectly coded,

Scottish Government Access Team have negotiated additional national capacity from Medinet for February - March 2016 and will allocate this to NHSGG&C, in addition to the existing NHSGG&C contract for Waiting List Initiatives.

It is also hoped that substantive appointments to currently vacant posts will be possible from June/July 2016 from current NHS Scotland trainees.

Ref	Measure	As At	2014-15 Actual	2015-16 Actual	2015-16 Target	Perform Status	Dir of Travel
19	% of patients admitted to stroke unit	Feb 2016	79%	89.7%	90%	**AMBER**	↑

Commentary



As at February 2016, 89% of patients admitted to stroke unit on the Day of Admission, or Day following Presentation Current performance is below the target of 90% but a 10% improvement on the same period last year.

Actions To Improve Performance

The Clyde sector stroke team is now highlighting access to the stroke unit as part of the 3 site patient flow and safety huddles. The clinical and managerial team is ensuring that there is adequate flow of patients from the stroke unit to ensure that there is capacity to admit new stroke patients as early as

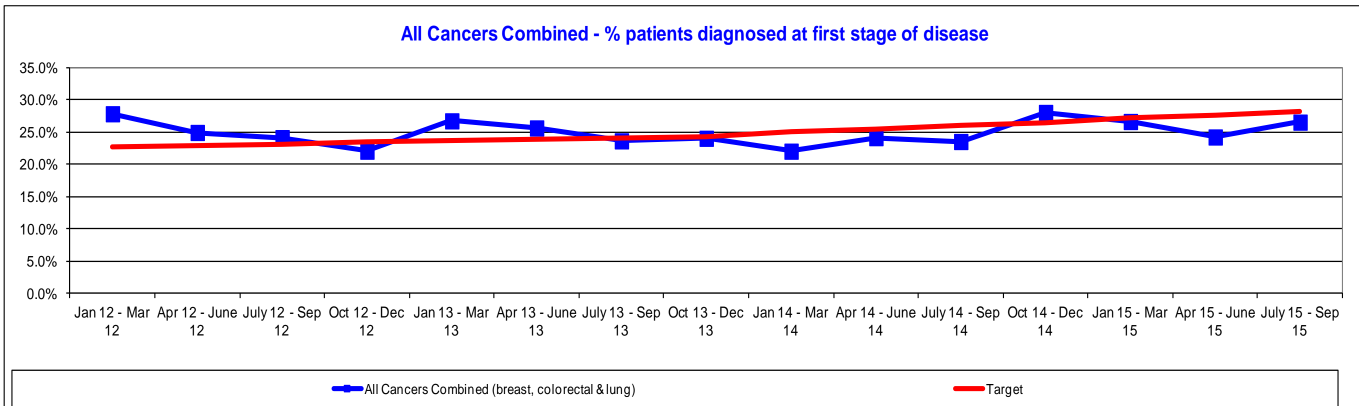
possible after presentation. The site performance for March 2016 although not yet formally reported has seen significant improvement in relation to admission to the stroke unit within the timescales of the target. In addition, the RAH now protect a dedicated bed in the stroke unit to support the admission target.

A wider review of stroke services is now underway to develop an implementation plan for the conclusions of the clinical services strategy.

PERFORMANCE EXCEPTIONS REPORTS

Exceptions Report: Detect Cancer Early

Measure	Detect Cancer Early (DCE)
Current Performance	Overall, for the period July - September 2015 the percentage of patients diagnosed with Stage 1 cancer was 26.5%. Current performance is lower than the trajectory of 28.1%. ***Please Note:*** *The DCE data is reported four months after the end of the reported quarter. This timeline had been agreed by Health Boards and ISD as the earliest timeframe in which complete data would be available.*
Lead Director	Gary Jenkins, Director of Regional Services



<u>Commentary</u>

For the period July - September 2015, the overall percentage of patients diagnosed with cancer at Stage 1 was 26.5% (*176 patients diagnosed with Stage 1 cancer against the total of 663 diagnosed*), lower than the 28.1% trajectory for that period. Current performance represents an improvement on the percentage of patients diagnosed at Stage 1 cancer reported during April - June 2015 24.2% (*160 patients diagnosed with Stage 1 cancer against the total of 662 diagnosed*). Two of the three cancer types are below trajectory namely breast and colorectal. 39.0% (*94 patients diagnosed with Stage 1 breast cancer against the total of 241 diagnosed*) of patients diagnosed with Stage 1 breast cancer, lower than the trajectory of 42.2% and 0.4% lower than the previous reporting period. 17.1% (*24 patients diagnosed with Stage 1 colorectal cancer against the total of 140 diagnosed*) of patients diagnosed with Stage 1 colorectal cancer, lower than the trajectory of 25.3%, however, current performance represents a 4.6% increase on the previous reporting period. The 20.6% (*58 patients diagnosed with Stage 1 lung cancer against the total of 282 diagnosed*) of patients diagnosed with Stage 1 lung cancer is currently exceeding the trajectory of 19.0% and represents a 1.2% increase on the previous reporting period.

<u>Actions to Address Performance</u>

<u>Breast Cancer</u>
The July - September 2015 position of 39.0% (*94 patients diagnosed with Stage 1 breast cancer against the total of 241 diagnosed*) represents a decrease on the April - June 2015 position of 39.4% (*82 patients diagnosed with Stage 1 breast cancer against the total of 208 diagnosed*) previously reported but, an improvement when compared to 35.7% (*78 patients diagnosed with Stage 1 breast cancer against the total of 217 diagnosed*) for the same period the previous year.

Review of previous quarters' performance throughout 2012 to 2015 demonstrates a degree of variation between quarters which may suggest that April to September data may be a result of normal variation between quarters rather than indicative of a trend. However, as breast cancer performance has now

been below trajectory for two consecutive quarters, a detailed review of the data will be undertaken to determine if there are underlying cause(s).

Colorectal Cancer

The July - September 2015 position of 17.1% (*24 patients diagnosed with Stage 1 colorectal cancer against the total of 140 diagnosed*) showed a significant increase when compared to April - June 2015 position of 4.6% (*18 patients diagnosed with Stage 1 colorectal cancer out against the total of 144 diagnosed*) but significantly below the trajectory of 25.3%. It is noted that the percentage of Stage 1 colorectal cancers has been consistently below the trajectory since Quarter 1 2013.

Bowel screening was introduced in NHSGG&C in 2009. As a result, it is likely that the volume of early stage presentations were picked up sooner than anticipated when the initial trajectory was set. An analysis of colorectal cancers indicates that the bowel screening crude detection rate has decreased whilst the uptake of bowel screening has not.

A comparison of data from 2010 and 2014 demonstrated a decrease in diagnoses via screening and a subsequent impact on the percentage of Stage 1 cancer diagnoses. The decrease in cancer diagnoses via screening may be indicative of the success of the screening programme in identifying/treating possible pre-cancerous conditions and preventing the development of invasive cancer. However, detailed statistical analysis would be required to substantiate this.

Comparison of published 2013/2014 data for NHS Scotland demonstrates that the percentage of Stage 1 colorectal cancers in NHSGG&C (17.9%) was higher than the NHS Scotland percentage (17.0%) and was the fifth highest percentage of the 14 NHS Boards. Discussions with other NHS Boards regarding 2015 data indicate that they are experiencing similar trends in colorectal cancer.

Lung Cancer

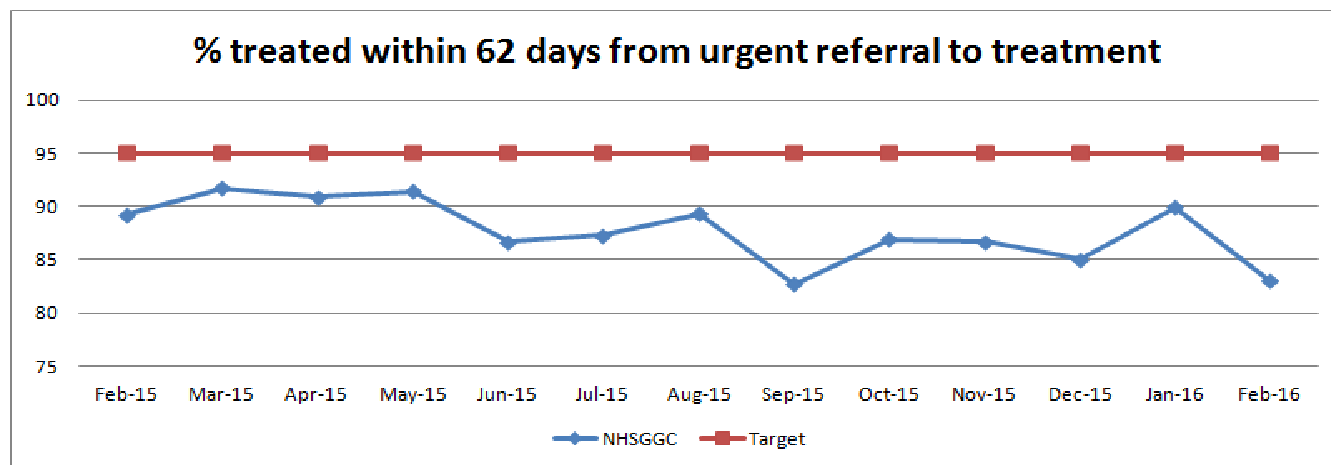
The July - September 2015 position of 20.6% (*58 patients diagnosed with Stage 1 lung cancer against the total of 282 diagnosed*) remains above the trajectory of 19.0% and highlights an improvement in the 19.4% position reported previously for April - June 2015 (*60 patients diagnosed with Stage 1 lung cancer against the total of 310 diagnosed*).

Timeline For Improvement

Ongoing with continual review of performance.

Exceptions Report: Suspicion of Cancer Referrals (62 days)

Measure	Suspicion of Cancer Referrals
Current Performance	As at February 2016, 83% of patients with an urgent referral for suspicion of cancer were treated within 62 days of the referral. (*Data provisional*)
Lead Director	Gary Jenkins, Director of Regional Services



Commentary

62-Day Target

As at February 2016, 83.7% (*251 out of 300 eligible referrals were treated within target*) of patients with an urgent referral for suspicion of cancer were treated within 62 days of referral and remains below the target of 95%. This is a significant reduction on the previous two reported months - 89.9% in January 2016 and 89.5% in December 2015.

The cancer types below the 95% target in February 2016 are as follows:

- Breast – 85.0% - (85/100 eligible referrals were treated within target)
- Cervical – 60%; - (3/5 eligible referrals were treated within target)
- Colorectal – 87.5% - (28/32 eligible referrals were treated within target)
- Head and Neck – 66.7% (18/27 eligible referrals were treated within target)
- Lung – 88.0% - (44/50 eligible referrals were treated within target)
- Lymphoma – 92.3% - (12/13 eligible referrals were treated within target)
- Upper GI – 88.0% - (22/25 eligible referrals were treated within target)
- Urology – 77.5%. - (31/40 eligible referrals were treated within target)

Table 1: 62-Day Target - Percentage Performance and Number of Breachers (Dec 2015 – Feb 2016)

	%	%	%	Number	Number	Number
	Dec-15	Jan-16	Feb-16	Dec-15	Jan-16	Feb-16
All	**89.5**	**89.9**	**83**	**25**	**24**	**50**
Breast (Non-Screened)	74.2	93.8	85.4	8	2	6
Breast (Screened)	98	89.9	84.7	1	4	9
Cervical (Non-Screened)	0	100	33.3	0	0	2

Cervical (Screened)	100	0	100.0	0	0	0
Colorectal (Non-Screened)	90.5	94.7	91.3	2	1	2
Colorectal (Screened)	100	50	77.8	0	2	2
Head & Neck	81.8	85.7	66.7	2	1	9
Lung	100	91.8	89.8	0	4	6
Lymphoma	100	100	92.3	0	0	1
Melanoma	100	100	100	0	0	0
Ovarian	100	100	100	0	0	0
Upper GI	88	85.7	88	3	3	3
Urological	75	83.3	77.5	9	7	9

Whilst overall Board performance has dropped approximately 6% December to February 2016, performance in Urology, Upper GI and Colorectal has remained relatively static.

There has however, been a deterioration in performance in Breast, Head and Neck and Lung accounting for 30 of the 50 patients that breached the 62 day standard in February 2016 compared with 11 of the 24 patients in January 2016 and again 11 of the 25 patients in December 2015.

February saw an increase in eligible patients treated – 300, compared with 237 in January 2016 and 238 in December 2015. The biggest increase was in Breast services as described below. Breaches are reported in the month patients are treated.

In addition to this, there were unusually 2 patients who breached the 62 day target in cervical cancer and again 1 patient who breached the 62 day target in Lymphoma.

31-Day Target
As at February 2016, 93.5% (*531 out of 568 eligible referrals were treated within target*) of patients with a decision to treat were treated within 31 days.

The cancer types below the 95% target in February are as follows:

- Breast – 87.4% - (104/119 eligible referrals were treated within target)
- Urology – 81.6%; - (80/98 eligible referrals were treated within target)

Actions to Address Performance

Urological Cancer

The main pressures within Urology are timely access to: GA surgical lists for core procedures, GA surgical lists for complex surgery (prostatectomy & nephrectomy), diagnostic procedures (flexible cystoscopy / ureteroscopy / TRUS & biopsy).

Urology continue to run additional evening and Saturday outpatient clinics, diagnostic sessions and operating lists with ongoing review of theatre slots to ensure maximise use of capacity. Urology pathways remain challenging and in order to make a sustained improvement, additional capacity is

required.

Breast Cancer

There has been significant pressure within the breast services in NHS GG&C, particularly in the South sector and Clyde sector. There is an unplanned absence within the surgical team in the South and the team continue to work collaboratively to cover requirements.

However, the challenges within the Breast service are described by the service as being largely short term in nature. Additional patients were treated in February (100 as opposed to 82 in January and 68 in December) and therefore, breaches reported in this month, which results in lower performance reported. Weekly performance throughout March has shown an improving picture.

Head & Neck Cancer

Head and Neck performance has been below the required 95% for some time and has taken a further decline in February 2016. The main pressures are in the front end of the Head and Neck pathway given the volume of referrals compared with the numbers of patients actually diagnosed with cancers.

With regard to other services under pressure or showing a decline in performance in February 2016:

Lung Cancer
Reduced performance in February 2016 can be attributed to loss of outpatient and diagnostic capacity over the festive period. Again weekly reporting through March suggests the lung performance has improved.

Colorectal Cancer

Colorectal performance for screening patients has been challenged of late and this trend has continued through March. A significant number of the bowel screening pathways for patients treated in Quarter 1 2016 were adversely affected by the festive period, resulting in a delay to bowel screening pre-assessment and colonoscopy.

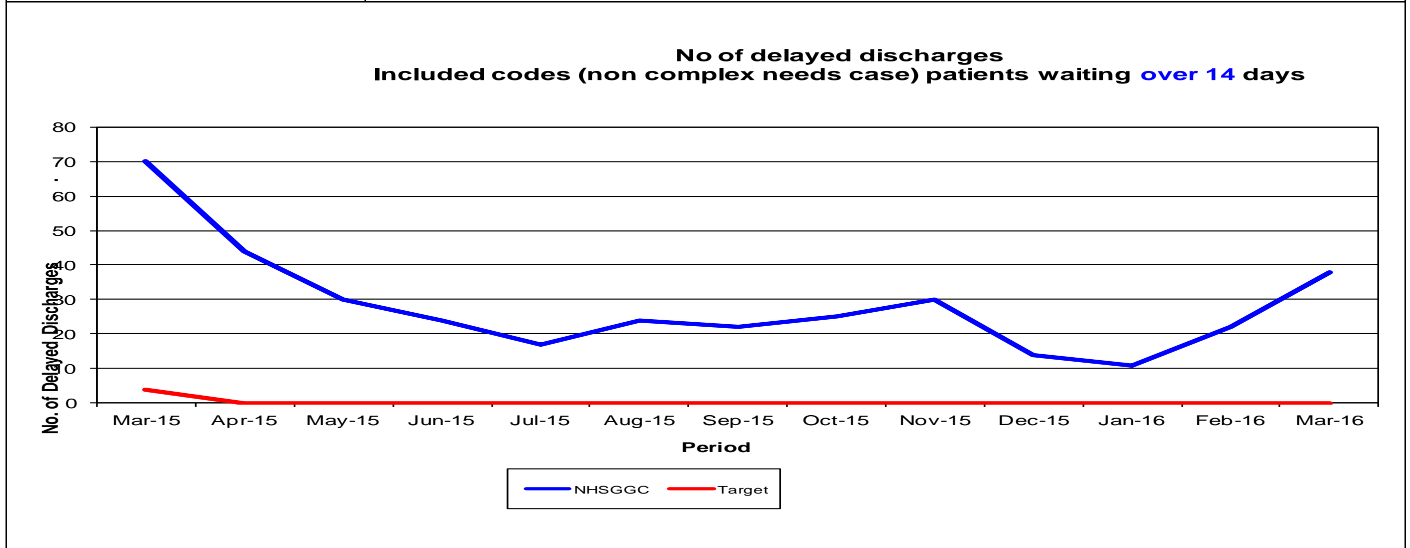
Whilst the actual numbers are low, further detailed analysis is being undertaken to assess whether there is any underlying trend emerging that requires further work.

Timeline For Improvement

The Directors' Cancer Access Meeting will review the cancer pathway issues and ensure a focus on sustainable improvement is delivered.

Exceptions Report: Delayed Discharge > 14 days

Measure	Delayed Discharges > 14 days
Current Performance	As at March 2016, 38 patients were delayed for > 14 days against a target of zero and 11 patients were delayed for < 72 hours.
Lead Director	Catriona Renfrew, Director of Planning & Policy



Commentary

The March 2016 position of 38 patients delayed > 14 days is deterioration on 22 reported in February 2016.

Of the total number of patients delayed > 14 days: 23 were residents of Glasgow City (14 residents from the North West Sector and nine residents from the South Sector); three were residents of West Dunbartonshire and one resident from East Dunbartonshire. The remaining 11 patients delayed were out with the Board area.

The above figures exclude the 95 patients delayed > 14 days for legal reasons and who lack capacity (AWI) in March 2016. The total comprises 66 patients from Glasgow City, eight from West Dunbartonshire, seven from Renfrewshire, two from Inverclyde, two from East Dunbartonshire, two from East Renfrewshire and the remaining eight patients were out with NHSGG&C boundary.

There was one patient delayed < 72 hours for legal reasons and who lacked capacity (AWI) in March 2016.

Actions to Address Performance

We continue to work with Partnerships to reduce delayed discharges, the deteriorating performance of GCC and South Lanarkshire have been escalated for urgent action. Previously agreed measure to improve performance has not had the agreed impact and we are looking to agree revised actions.

Timeline For Improvement

The aim is to achieve immediate and continuing reductions in the number of patients delayed given the pressures on hospital beds.

Exceptions Report: Bed Days Lost to Delayed Discharge (Inc Adults with Incapacity)

Measure	Bed Days Lost to Delayed Discharge For Adults with Incapacity (AWI) Patients (65 years+)
Current Performance	As at February 2016, the number of bed days lost to delayed discharge was 3,111 (1,640 for AWI patients).
Lead Director	Catriona Renfrew, Director of Planning & Policy

Table 1

Bed Days Lost to Delayed Discharge (inc AWIs) - Acute
(patients aged 65 & over on day of admission)

	2011/12	2012/13	2013/14	2014/15	2015/16
CH(C)P	Feb 12 Actual	Feb Actual	Feb Actual	Feb Actual	Feb Actual
East Dunbartonshire	526	579	271	413	276
East Renfrewshire	457	462	239	227	156
Glasgow City	**4,778**	**3,223**	**3,627**	**2412**	**2028**
Inverclyde	451	115	187	216	143
Renfrewshire	1,700	736	364	609	207
West Dunbartonshire	694	379	410	362	301
GGC(All above areas)	**8,606**	**5,494**	**5,098**	**4,239**	**3,111**

Table 2

Bed Days Lost to Delayed Discharge for AWIs - Acute
(patients aged 65 & over on day of admission)

	2011/12	2012/13	2013/14	2014/15	2015/16
CH(C)P	Feb 12 Actual	Feb Actual	Feb Actual	Feb Actual	Feb Actual
East Dunbartonshire	74	0	0	86	0
East Renfrewshire	29	0	0	0	51
Glasgow City	**1,433**	**637**	**690**	**552**	**1292**
Inverclyde	15	21	28	0	0
Renfrewshire	29	112	210	481	151
West Dunbartonshire	203	84	131	219	146
GGC(All above areas)	**1,783**	**854**	**1,059**	**1,338**	**1,640**

Commentary

As seen from *Table 1* above, in February 2016 the number of bed days lost to delayed discharge was 3,111 representing a **36%** reduction in February 2015 position.

Table 2 highlights a total of 1,640 bed days lost to delayed discharge for AWI patients in February 2016 representing a **12% reduction** on the number reported during the same period the previous year (from 1,338 bed days lost in February 2015 to 1,640 in February 2016). As part of the service and financial planning for 2016-17 we are aiming to agree with Partnerships a target of zero bed days lost.

Actions to Address Performance

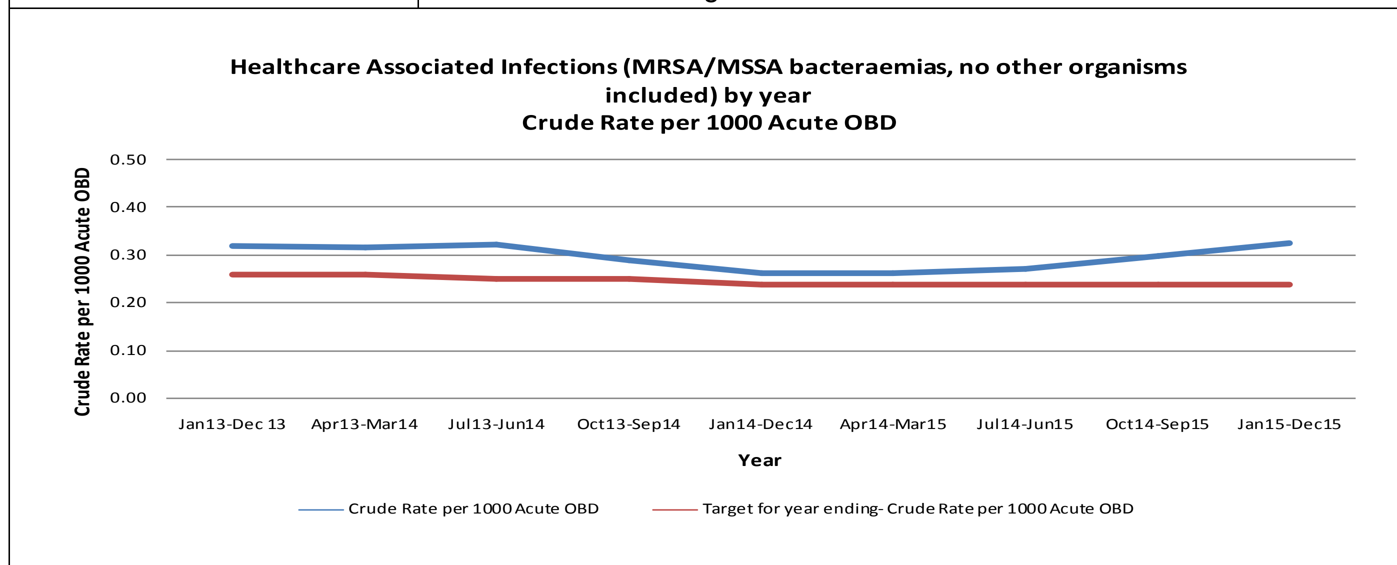
As per the actions outlined in the delayed discharge exception report.

Timeline for Improvement

As identified in the delayed discharge exception report.

Exceptions Report: MRSA/MSSA Bacteraemia (cases per 1,000 AOBD)

Measure	MRSA/MSSA Bacteraemia (cases per 1,000 AOBD)
Current Performance	As at the December 2015 rolling year, the number of MRSA/MSSA cases per 1,000 Acute Occupied Bed Days (AOBDs) was 0.33, higher than the trajectory of 0.24.
Lead Director	Dr Jennifer Armstrong



Commentary

All NHS Boards across Scotland were set a target to achieve *Staphylococcus aureus* Bacteraemia (SAB) of 24 cases or less per 100,000 AOBDs by 31 March 2015. This target has now been extended for one further year. For NHSGG&C this is estimated to equal 25 patients or less each month developing a SAB.

The most recent validated results for 2015, Quarter 4 confirm a total of 127 SAB patient cases for NHSGG&C, between October and December 2015. This equates to a SAB rate of 36.6 cases per 100,000 AOBD.

The Quarterly Rolling Year ending December 2015 rate as per the Local Delivery Plan for SAB is 0.33 cases per 1,000 AOBDs. This is against the March 2016 target of 0.24 cases per 1,000 AOBDs.

Agenda Item 8 – Board-wide Healthcare Associated Infection Exception Reporting Template (HAIRT) provides more detail on current position.

Actions to Address Performance

- PVC and CVC ward sweeps (audit of care plan) were undertaken in four acute sectors by ward staff using IPC sweep proforma. Final report issued to Acute Infection Control Committee membership which highlighted areas for further improvement. PVC care plan compliance was good at 87% across the completed sectors; however compliance with CVC care plan documentation was suboptimal at 67%. Local educational actions were undertaken in areas of poor compliance to improve standards of documentation.
- Validation audit February 2016: PVC and CVC ward sweeps were undertaken in every sector by IPC staff. This also included availability of PVC patient information leaflet for all applicable patients at time of sweep. Analysis/report currently underway by IPC Data Team.
- Focussed Quality Improvement work:
  1) Neonatal units: RAH,RHC & PRM
     Reduction of IV access device related SABs by standardised PVC/CVC insertion and maintenance bundles and care plans.
  2) Royal Alexandra Hospital wards
     Reduction of IV access device related SABs by increasing PVC care plan compliance in a pilot

medical ward.

3) <u>Community</u>
Reduction of non hospital acquired SAB cases (Community and Healthcare Associated Infection).

4) <u>Royal Hospital for Children: Neonatal Unit</u>
Reduction of IV access device related SABs by increasing PVC care plan compliance

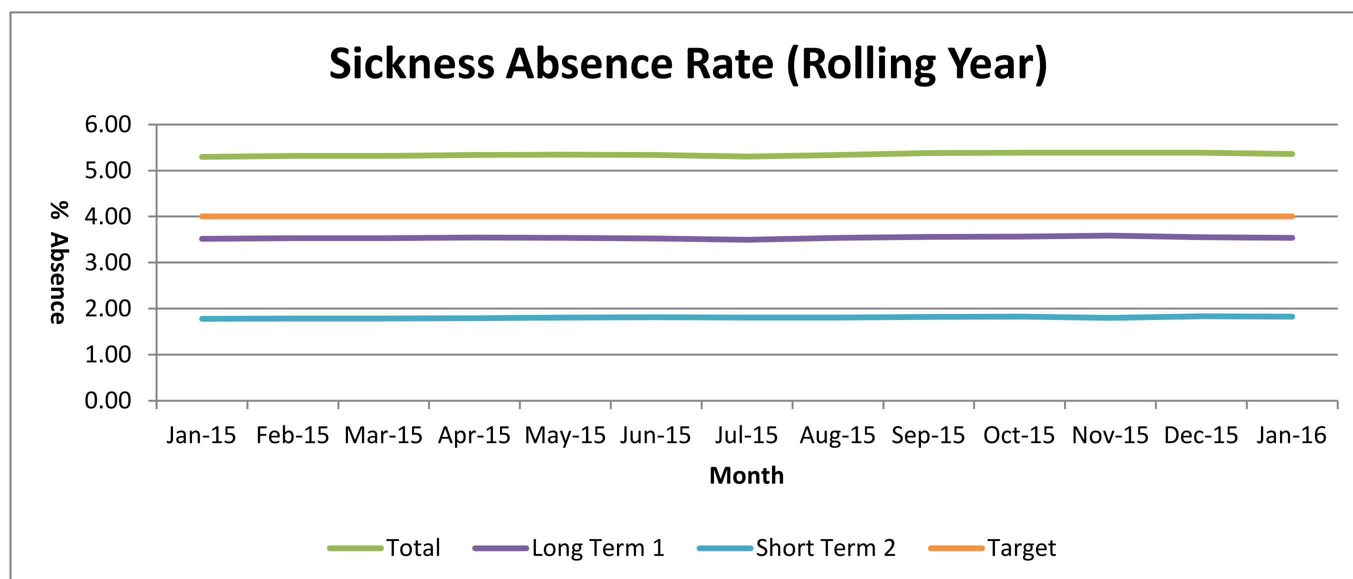
- Development and production of educational videos demonstrating adherence with aseptic technique when inserting and accessing PVCs and obtaining a blood culture. (This will be undertaken in conjunction with Practice Development).
- Increased focus on junior medical staff educational induction programme content to include information on prevention of bacteraemia <u>and</u> optimal practice with insertion, utilisation and maintenance of IV access devices (PVC/CVC/PICC).
- Review of PVC care plan commencement on device insertion in Emergency Departments and Theatres.
- Review of incorporation of PVC and CVC careplans as eForms within Nursing Admission Documentation.
- Assurance that medical staff induction and education incorporates healthcare associated infection information e.g. aseptic technique, venepuncture and cannulation.
- Information on LearnPro Aseptic Technique module completion by staff groups for 2015 highlighted that 97% of this module was completed by Nursing and midwifery staff. Further encouragement for medical staff and other clinical staff groups to successfully undertake this educational module should be upheld in 2016.
- Active promotion of antibiotic review to optimise timely IV to oral switch on all hospital sites: daily review of all patients receiving IV antibiotic therapy with minimum standard of documented review and plan at 72 hours.
- Incorporation of antibiotic IVOST indicators into PVC care plan.
- Incorporation of antibiotic review/IVOST and PVC review to “ward round checklist” (in development).
- AMT to retrospectively review clinical management of patients with SAB in Q3/4 2015.
- Promotion of SAB management guideline: ensure appropriate management of source and correct antibiotic therapy.
- IPC Data Team inform sector Antimicrobial Pharmacists of SAB patient CHIs to enable real time review of appropriate therapy and assurance that appropriate source control had been undertaken.
- Clinical staff have a requirement to comply with guidelines published by the NHSGG&C Antimicrobial Utilisation Committee.

<u>Timeline For Improvement</u>

Ongoing.

Exceptions Report: Sickness Absence

Measure	Sickness Absence Rate
Current Performance	As at January 2016, the rate of sickness absence across the Board was 5.36%.
Lead Director	Anne MacPherson, Director of Workforce & Organisational Development



Commentary

The 2015-16 Local Delivery Plan Standard requires '*NHS Boards to achieve a sickness absence rate of 4%'.* The overall sickness absence rate for the rolling year to January 2016 was 5.36%. This is higher than the rate reported for same period in the previous year (January 2015) which was 5.30%.

The split between long term and short term absence for the period under review is 3.53% and 1.82% respectively.

Actions to Address Performance

Absence figures for the last 12 months are detailed below, and whilst the actual overall total shows a slight increase on the total level for the board last year, the figures below show a reduction on the same period last year in both the Acute Division and the overall headline figure for Partnerships

Area	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16
Acute	6.74	6.29	5.92	5.78	5.53	5.59	5.89	5.87	5.84	5.89	5.96	6.18	6.37
Board Wide Facilities									8.46	8.69	9.38	8.31	8.95
Other Functions	4.79	4.99	4.37	4.32	3.94	3.94	3.90	3.85	4.40	4.06	4.62	4.50	4.92
Partnership	6.42	6.09	5.90	5.46	5.68	5.84	5.74	5.56	5.94	6.22	6.17	6.08	6.35

Within the absence figures reported for January 2016, it should be noted that an improved position has been achieved within the Acute Division in the North Sector (down from 6.14% to 6.06%) andSupport Services (down from 6.09 to 5.84%) from their reported absence levels in December.

Within Partnerships, absence levels within East Renfrewshire had reduced (down from 5.25% to 4.51%) and also in Inverclyde HSCP (down from 6.50 to 6.47%)

The overall increase in absence levels in the months October - January is representative of previous years. The increase in absence can be seen as continuing throughout the winter months, generally until February each year before beginning to reduce. Current absence levels reported are higher than in previous years, and this is generally the case across services within NHS Greater Glasgow and Clyde.

It should be noted, however, that the organisation is not complacent regarding this trend and work continues within all Directorates, Partnerships and Sectors to implement the Attendance Management policy for all absences within service areas.

Current activity includes

- Trajectories and improvement plans in place within service areas to support reduction in absence levels
- Emphasis on the use of return to work interviews and documented discussion following each absence episode
- Early and appropriate interaction with Occupational Health
- Consistent application of policy trigger points
- Use of attendance management clinics to review absence data, schedule regular discussion with staff and ensure support of trade union colleagues to explore opportunities for absence issues to be concluded
- Appropriate recording of reasons for absence and continued appropriate contact with individual staff members during their period of absence

The need for continued proactive engagement by all within H R has been emphasized to ensure the appropriate management supports are in place to seek an improvement to levels of both short and long term absence as quickly as possible.

Timeline For Improvement

Ongoing attendance management remains a key productivity and staff welfare issue for NHSGG&C and action to improve performance is ongoing.