NHS GREATER GLASGOW AND CLYDE

Board Meeting
23 June 2015 **Paper No: 15/34**

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 and format of the Board's integrated performance report. Members should also note that this first iteration of the integrated performance report is work in progress requiring further development.

1. BACKGROUND

At the Quality and Performance Committee held in May 2015, a paper was presented outlining the future accountability and governance arrangements to reflect the new organisational structure and the establishment of Integration Joint Boards (IJB) as new statutory bodies. The paper outlined the revised performance arrangements reflecting the fact that the Board continues to have responsibility for the allocation of resources, strategic direction (working with IJBs) and a statutory governance role across a range of domains. Performance reporting needs to reflect the requirement for the Board to exercise oversight of those responsibilities.

The report highlighted the first line, detailed, Committee scrutiny will be through the arrangements which replace the Quality and Performance Committee.

The new Acute Committee which will function in a similar way to IJBs for acute services, including undertaking detailed scrutiny of the Acute Divisions performance across the full range of domains.

Each IJB will undertake detailed scrutiny of the new Partnership planning and operational responsibilities. For operational responsibilities the reporting will reflect the Service Delivery Framework which covers financial, staff, clinical and quality governance. These arrangements will also take account of the developing revised Clinical Governance arrangements discussed at the April 2015 Board Committee and there will be further discussion to develop the detail of the clinical reporting routines.

The report recommended the development of a Board-wide high level performance report reflecting all Local Delivery Plan standards, key service delivery indicators from the Service Delivery Framework that was developed to support the role of each IJB in the operational delivery of services across the Boards statutory responsibilities of governance across clinical quality and safety, staff and employment, complaints, equalities and finance.

2. INTRODUCTION

This 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 will accompany all indicators with an adverse variance of 5% or more, detailing the actions in place to address performance and indicating a timeline for when to expect improvement. The report is work in progress and welcomes input from members to inform further development. 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 IJBs.

3. STRUCTURE OF THE REPORT

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 the 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.

INTEGRATED PERFORMANCE REPORT

(INCLUDES WAITING TIMES AND ACCESS TARGETS)

23 JUNE 2015

Performance Summary

Outlined below is the key to the scorecard used on page 3 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 23 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	0	2	2	0	**4**
Shifting The Balance of Care	1	1	0	4	**6**
Reshaping Care for Older People	1	0	1	0	**2**
Improving Quality and Effectiveness	2	3	8	1	**14**
Tackling Inequalities	1	1	0	0	**2**
TOTAL	**5**	**7**	**11**	**5**	**28**

PERFORMANCE AT A GLANCE - JUNE 2015									
PREVENTING ILL HEALTH AND EARLY INTERVENTION									
Ref	**Type**	**Performance Measure**	**As At**	**2014-15 Actual**	**2015-16 Actual**	**2015-16 Target**	**Perf Status**	**Dir of Travel**	**Exceptions Report**
1	LDPS	Early diagnosis and treated 1st stage cancer	Oct - Dec 14	28.0%	N/A	26.3%	GREEN	–	
2	LDPS	Suspicion of cancer referrals (62 days)	Apr-15	90.4%	90.9%	95%	AMBER	↑	
3	LDPS	All cancer treatment (31 days)	Apr-15	92.2%	94.2%	95%	AMBER	↑	
4	LDPS	*Alcohol Brief Interventions*	Apr - Mar 15	14,797	N/A	14,579	GREEN	↓	
SHIFTING THE BALANCE OF CARE									
Ref	**Type**	**Performance Measure**	**As At**	**2014-15 Actual**	**2015-16 Actual**	**2015-16 Target**	**Perf Status**	**Dir of Travel**	**Exceptions Report**
5	LDPS	A&E max. 4 hours wait	May-15	89.7%	90.6%	95%	AMBER	↑	
6	LKPI	A&E Attendances per 100,000 popu	May-15	3,022	2,866	No Target	GREY	↑	
7	HSCI	*Delayed discharge > 14 days (inc codes)*	May-15	86	30	0	RED	↑	Page 7
8	HSCI	*Delayed discharge < 72 hours (inc codes)*	May-15	–	41	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**	**Performance Measure**	**As At**	**2014-15 Actual**	**2015-16 Actual**	**2015-16 Target**	**Perf Status**	**Dir of Travel**	**Exceptions Report**
11	HSCI	*Acute bed days lost to delayed discharge*							
		patients (65 years+)	Apr-15	4,971	3,893	3,994	GREEN	↑	
		AWI patients (65 years+)	Apr-15	1,056	1,241	1,103	RED	↓	Page 8
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**	**Performance Measure**	**As At**	**2014-15 Actual**	**2015-16 Actual**	**2015-16 Target**	**Perf Status**	**Dir of Travel**	**Exceptions Report**
13	LDPS	18 weeks Referral To Treatment (RTT)							
		Combined Admitted / Non Admitted	Apr-15	90.6%	90.4%	90%	GREEN	↓	
		Combined Linked Pathway	Apr-15	87.3%	88.2%	80%	GREEN	↑	
14	LDPS	12 week Treatment Time Guarantee							
		Inpatient	Apr-15	99.9%	99.9%	100%	AMBER	↔	
15	LKPI	Patient Unavailability							
		Inpatient / Daycase	Apr-15	3,946	5,616	N/A	GREY	↓	
		Outpatient	Apr-15	2,362	2,052	N/A	GREY	↓	
16	LKPI	% of patients waiting > 4 weeks for a diagnostic test	Apr-15	0%	0.28%	0%	AMBER	↓	
17	LDPS	% of new outpatient appointments < 12 weeks	Apr-15	99.9%	99.8%	99.6%	GREEN	↓	
18	LDPS	% of eligible patients commencing IVF treatment within 12 months	Mar-15	100%	N/A	90%	GREEN	↑	
19	LKPI	% of patients admitted to stroke unit	Apr-15	87%	86%	90%	AMBER	↓	
20	LDPS	*% of patients waiting < 18 weeks for RTT to Specialist Children's Services*	Apr-15	100%	N/A	100%	GREEN	↔	
21	LDPS	*% of patients waiting < 18 weeks for RTT to psychological therapies*	Jan - Mar 15	95.7%	N/A	90%	GREEN	↑	
22	LDPS	*Drug and alcohol: % of patients waiting < 3 weeks from referral to appropriate treatment*	Oct - Dec 14	96.1%	N/A	90%	GREEN	↓	
23	LDPS	SAB infection rate (cases per 1,000 OBD)	Jan - Dec 14	0.26	N/A	0.24	RED	↑	Page 9
24	LDPS	C.Diff infections (cases per 1,000 OBD)	Jan - Dec 14	0.29	N/A	0.32	GREEN	↑	
25	LDF	*% of complaints responded to within 20 working days*	Jan - Mar 15	76%	81%	70%	GREEN	↑	
26	LDPS/LDF	*Financial performance*	May-15	1st financial monitoring return not scheduled until end of month 3					
27	LDPS/LDF	*Sickness absence (rolling year)*	Apr-15	4.94%	5.34%	4%	RED	↓	Page 11
		Long Term	Apr-15	3.29%	3.55%	No Target	GREY	–	
		Short Term	Apr-15	1.65%	1.79%	No Target	GREY	–	
TACKLING INEQUALITIES									
Ref	**Type**	**Performance Measure**	**As At**	**2014-15 Actual**	**2015-16 Actual**	**2015-16 Target**	**Perf Status**	**Dir of Travel**	**Exceptions Report**
28	LDPS	*% of pregnant women from each SIMD quintile accessing antenatal care at 12 week gestation*	Jan - Mar 15	76.9%	N/A	80%	AMBER	↑	
29	LDPS	*Smoking cessation - number of successful quits at 12 weeks post quit in 40% SIMD areas*	Apr - Dec 14	749	N/A	TBC	RED	–	Page 12

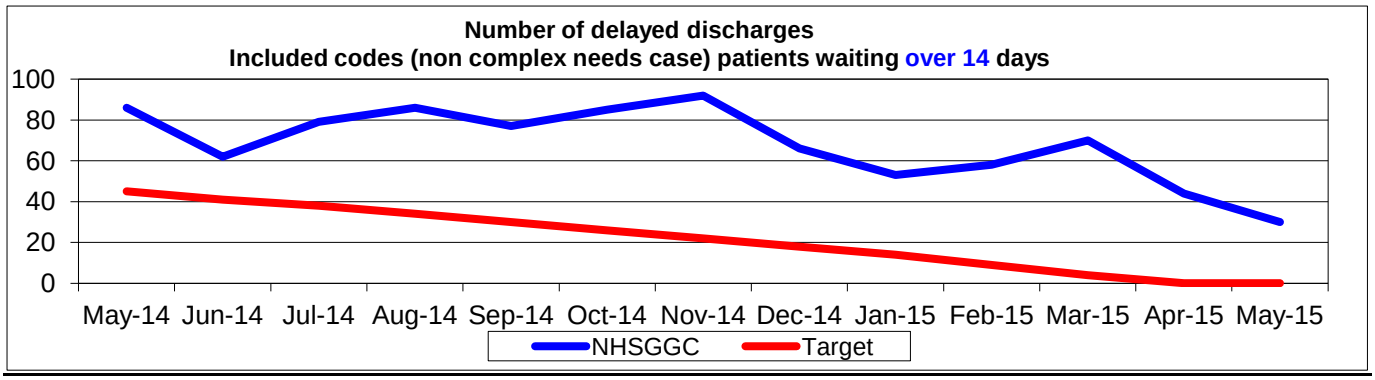
Key		**Rating**		**Direction of Travel**	
LDPS	Local Delivery Plan Standard	RED	5%	Improving	↑
HSCI	Health and Social Care Indicator	AMBER	Adverse variance of up to 5%	Deteriorating	↓
LDF	Local Delivery Framework	GREEN	On target or better	Maintaining	↔
LKPI	Local Key Performance Indicator	GREY	No target		—
		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.

PERFORMANCE EXCEPTIONS REPORTS

Exceptions Report: Delayed Discharge > 14 days

Measure	Delayed Discharges > 14 days
Current Performance	As at May 2015, 30 patients were delayed for > 14 days against a target of 0 and 41 patients were delayed for < 72 hours.
Lead Director	Catriona Renfrew, Director of Corporate Planning and Policy



Commentary

As at May 2015, a total of 30 patients were delayed > 14 days, a reduction on the above the 86 reported during the same month the previous year. Of the total number of patients delayed > 14 days, 22 are residents of Glasgow City (11 residents from the North West and 11 from the South Sector, there were no patients delayed in North East Sector), one resident from East Renfrewshire CHCP and the remaining seven are from outwith the Board area.

A total of 41 patients were delayed for less than 72 hours in May 2015.

These figures exclude the 62 patients delayed > 14 days and three patients < 72 hours for legal reasons and who lack capacity (AWI).

Actions to Address Performance

- Chief Officers and the Director of Corporate Planning and Policy, co-ordinating for the acute services, continue to work to identify and address the issues causing delays.
- Revised scrutiny and escalation arrangements are in place with Glasgow City Council.
- Agreement has been reached with Chief Officers to fund the temporary accommodation of these patients in two identified nursing homes but remaining in the care of the NHS until legal issues are resolved. This ensures that acute beds are not compromised by these patients.
- There is a continued focus with Councils on achieving discharge for patients in hospitals scheduled to close to avoid the transfer of these patients to the new hospital.

Timeline For Improvement

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

Exceptions Report: Bed Days Lost to Delayed Discharge for Adults with Incapacity

Measure	Bed Days Lost to Delayed Discharge For Adults with Incapacity Patients
Current Performance	As at April 2015, the number of bed days lost to delayed discharge for Adults with Incapacity (AWI) patients was 1,241 against a monthly target of 1,103.
Lead Director	Catriona Renfrew, Director of Corporate Planning and Policy

Bed Days Lost to Delayed Discharge for AWIs - Acute

(patients aged 65 & over on day of admission)

							2014/15	2015/16	
CH(C)P	**2009/10**	**2010/11**	**2011/12**	**2012/13**	**2013/14**	**2014/15**	**Apr Actual**	**Apr Actual**	**Apr 50% Target**
East Dunbartonshire	3,200	2,075	1351	63	15	1,185	30	210	133
East Renfrewshire	1,219	829	60	386	31	213	30	0	51
Glasgow City	**18,704**	**13,319**	**19,188**	**9,341**	**8,936**	**8,987**	**664**	**556**	779
Inverclyde	300	582	352	53	108	31	30	0	13
Renfrewshire	2,128	1,190	1647	2,050	2288	4,301	196	351	89
West Dunbartonshire	931	3,160	1798	1,872	1547	2,127	106	124	39
GGC(All above areas)	**26,482**	**21,155**	**24396**	**13,765**	**12,925**	**16,844**	**1,056**	**1,241**	**1,103**

Commentary

Whilst the overall bed days lost to delayed discharge target was set four years ago, April 2015 was the first month that the monthly target was met reporting 3,893 monthly bed days lost against a monthly target of 3,994. The April 2015 performance represents a 22% reduction in April 2014 position.

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	**April Actual**	**April Actual**	**April Actual**	**Apr Actual**	**Apr Actual**	**Apr 50% Target**
East Dunbartonshire	600	326	408	424	462	307
East Renfrewshire	307	514	274	309	164	201
Glasgow City	**6,132**	**4,207**	**3,004**	**3277**	**2204**	2,213
Inverclyde	379	478	195	301	138	280
Renfrewshire	1,409	1,409	625	244	529	675
West Dunbartonshire	730	600	454	416	396	318
GGC(All above areas)	**9,557**	**7,534**	**4,960**	**4,971**	**3,893**	**3,994**

However, as at April 2015, a total of 1,241 bed days were lost to delayed discharge for AWI a slight increase on the number report during the same period the previous year (from 1,056 bed days lost in April 2014 to 1,241 in April 2015).

As seen from the table above, there were no bed days lost to delayed discharge for AWI in both Inverclyde and East Renfrewshire CHCPs. All other partnerships reported bed days lost to delayed discharge for AWI with Glasgow City reporting almost half the bed days lost for AWI.

Actions to Address Performance

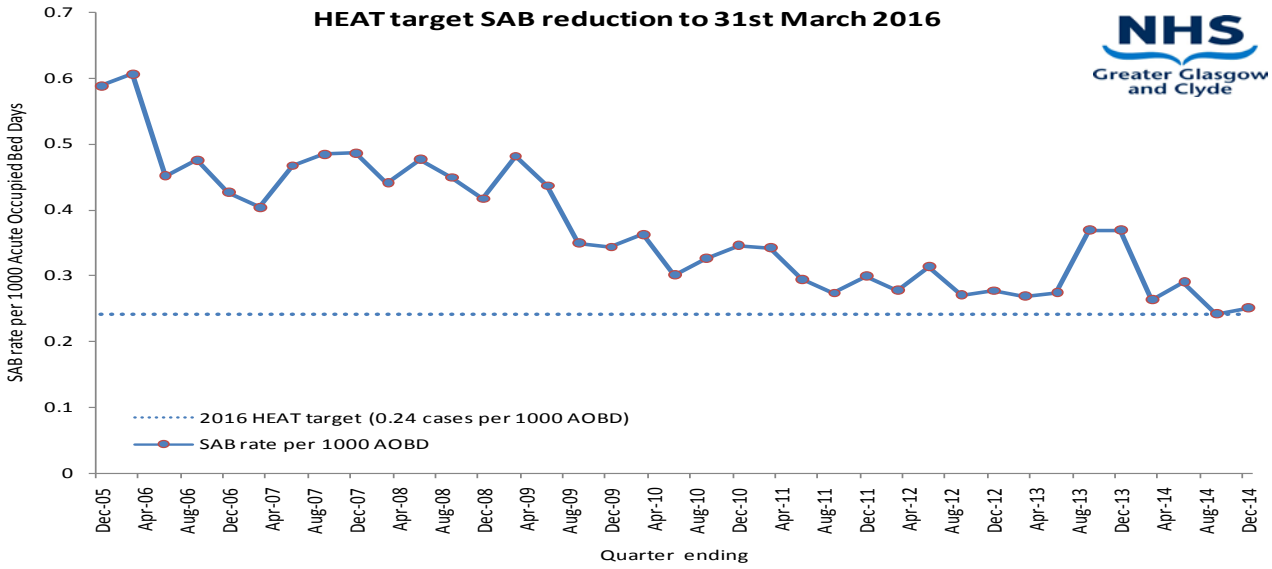
As per the actions outlined in the delayed discharge exceptions report.

Timeline for Improvement

As identified in the delayed discharge exceptions report.

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

Measure	MRSA/MSSA Bacteraemia (cases per 1,000 OBD)
Current Performance	As at the December 2014 rolling year, the number of MRSA/MSSA cases per 1,000 Acute Occupied Bed Days (AOBDs) was 0.26, higher than the trajectory of 0.24.
Lead Director	Dr Jennifer Armstrong



Commentary

All Scottish NHS Boards are to achieve *Staphylococcus aureus* Bacteraemia (SAB) HEAT target 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 2014, Quarter 4 confirm a total of 93 SAB patient cases for NHSGG&C, between October and December 2014. This equates to a SAB rate of 25.1 cases per 100,000 AOBD.

The Quarterly Rolling Year ending December 2014 rate as per LDP for SAB is **0.26** cases per 1,000 AOBDs*.* This is against the December 2014 Board trajectory of **0.24** cases per 1,000 AOBDs.

Key points to note:

- The NHSGG&C SAB case rate per 1,000 AOBD demonstrated a statistically significant decrease upon the previous year in the year ending December 2014.
- NHSGG&C had the fifth lowest case rate in 2014 out of Scotland's 15 Boards that submit data for national reporting.
- Quarter 4, 2014 is the second lowest reporting Quarter to date for NHSGG&C with 93 patient cases.
- 51% of Hospital acquired SABs in Quarter 4, 2014 were Intravenous (IV) access device related. Adherence to IV access device insertion and maintenance requirements within NHSGG&C, as detailed in two new SOPs, remains of paramount importance in the continued reduction of all bloodstream infections and not just those caused by *Staphylococcus aureus*.

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

Actions to Address Performance

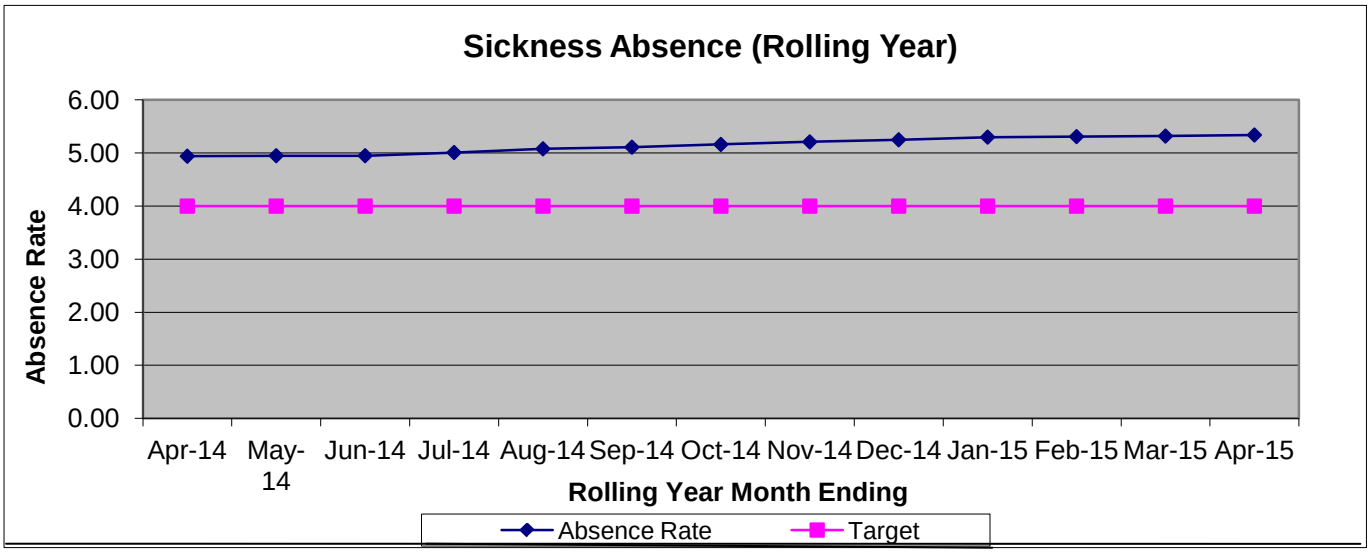
- All SAB data is sent quarterly to Health Protection Scotland as part of the National eSAB Surveillance Programme.
- Enhanced SAB data given to Antimicrobial Prescribing Team for analysis of appropriate prescribing and treatment of each case.
- Clinical Review Tools are issued to the Consultant in Charge of each patient with a Hospital Acquired SAB, or those that are Healthcare Associated and are linked to a clinical specialty or have an invasive device *in situ* to enable prospective local clinical review to idenitify any areas that may be amenable to improvement.
- Ward audit of IV access device care plan undertaken by Infection Prevention and Control Team in SAB cases attributed to CVC or PVC – Nurse in Charge and HON prospectively notified of audit result. This is collectively reported in Monthly Enhanced SAB report; and HON meeting.
- Patient specimen information on blood cultures deemed as 'contaminants' reported to Consultant in Charge and HON to enable local review of Blood Culture aseptic technique.
- Continued adherence to CVC and PVC Standard Operating Procedures for all healthcare workers within NHSGG&C clinical teams remains crucial in reducing the number of hospital acquired or healthcare associated cases that are attributed to IV access devices.
- Bi - monthly Cross Directorate (Sector) SABs group will continue to meet to discuss current SAB status and enable a forum for sharing best practice on local strategies for improvement.

Timeline For Improvement

- Ongoing.

Exceptions Report: Sickness Absence

Measure	Sickness Absence Rate
Current Performance	As at April 2015, the rate of sickness absence across the Board was 5.34% (rolling year).
Lead Director	Anne MacPherson



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 April 2015 was 5.34%. This is higher than the rate reported for same period in the previous year (May 2013 to April 2014) which was 4.94%.

The split between long term and short term absence for the period under review is 3.55% and 1.79% respectively.

Actions to Address Performance

Local HR teams can offer support to Line Managers to help them effectively manage sickness absence. Attendance Management continues as an objective in performance plans for 2015-16. Line management must strive for a balance between pursuing service efficiency and also responding compassionately to individual circumstances. HR and Occupational Health support line management in trying to achieve that balance.

NHSGG&C continues to offer support to those suffering genuine health problems and will continue to be vigilant against any instances where the genuine nature of absences may be in question.

Healthy Working Lives initiatives also have the potential to minimise sickness absence levels and different parts of NHSGG&C are in receipt of Silver and Gold Awards.

Timeline For Improvement

Ongoing attendance management remains a key productivity and staff welfare issue for NHSGG&C.

Exceptions Report: Number of successful smoking quits, 12 week post quit (in Boards 40% most deprived areas)

Measure	Smoking Cessation 12 Week Post Quit
Current Performance	Provisional data shows for the period April – December 2014 a total of 749 smoking quits 12 weeks post quit below the trajectory of 1,695 quitters.
Lead Director	Linda de Caestecker

Commentary

Our concerns with the ability to deliver the new smoking cessation (40% most deprived areas within Board) 12 week post quit HEAT target introduced in April 2014 remain.

The number of people going through smoking cessation services continues to be low, with a 7,363 decrease in total number setting quit dates in the smoking cessation services compared to the same period in 2013 (a 37% reduction). The HEAT target now relates only to individuals from the 40% most deprived areas and there has been a 31% reduction in numbers in this group setting a quit date in 2014 (3,509 individuals) compared to the same period in 2013.

The smoking cessation HEAT target, now based on a 12 week quit rate (formerly four week), continues to be more difficult to follow up clients effectively. This is mainly due to pharmacists being responsible for conducting the 12 week follow up for their clients, however, pharmacists are restricted in capacity and timing of phone calls (not able to call in evenings when more people likely to be available). The Public Health Pharmacy Team has put supports in place to improve pharmacy compliance with follow up calls. In addition, the community programme follow up is conducted by an external company and from January 2015 the community follow-up calls have been conducted by local areas. It is anticipated that the low success rates are likely to be due to the process of follow up calls and not as a result of fewer people quitting successfully.

It should be noted that all Health Board's across Scotland are currently below trajectory for this measure.

Actions to Address Performance

Actions to address the issues include:

- Research has been commissioned with smokers and recent ex-smokers within NHSGG&C SIMD 1 & 2 areas to investigate motivation levels and preferred quit method, awareness of services and how these can be improved to meet needs. The recommendations from this report will be taken forward by the Tobacco PIG.
- Work will continue with community services to try to improve the targeting of services within areas of deprivation.
- Acute Services will continue to provide support for their clients as opposed to handing over to community services to test whether this improves the retention of clients and reduce drop off rate.
- The Public Health Pharmacy Team will continue to increase awareness around data input and follow up issues. This will be supported with pharmacy visits, bulletins and offers of additional support.

Timeline For Improvement

There are a number of actions in place to improve current performance, however, there are still concerns on whether the target is achievable.