NHS GREATER GLASGOW AND CLYDE

Board Meeting
18 August 2015 **Paper No: 15/45**

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. Members should also note that the integrated performance report continues to remain as work in progress requiring further development.

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. WHAT'S NEW IN THIS REPORT?

Following comments received at the last Board meeting, the report now includes commentary for those measures rated as amber that show a deterioration in performance when compared to the same period the previous year. In addition, the report also provides a summary of key performance status changes since previously reported to Board members.

4. SUMMARY OF PERFORMANCE

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

Performance Improvements

- All cancer treatments (31 days) has moved from ***amber to green***.

Performance Deterioration

- Suspicion of cancer referrals (62 days) has moved from ***amber to red***.
- % of new outpatient appointments < 12 weeks has moved from ***green to amber***.

Measures Rated As Red

- Suspicion on cancer referrals (62 days) ***new***
- Delayed discharges > 14 days
- Acute bed days lost to delayed discharge for Adults with Incapacity
- SAB infection rate (cases per 1,000 population)
- Sickness absence
- Smoking cessation.

INTEGRATED PERFORMANCE REPORT

(INCLUDES WAITING TIMES AND ACCESS TARGETS)

18 AUGUST 2015

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 24 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	1	0	3	0	**4**
Shifting The Balance of Care	1	1	0	4	**6**
Reshaping Care for Older People	1	0	1	1	**3**
Improving Quality and Effectiveness	2	5	7	1	**15**
Tackling Inequalities	1	1	0	0	**2**
TOTAL	**6**	**7**	**11**	**6**	**30**

PERFORMANCE AT A GLANCE - AUGUST 2015									
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	Oct - Dec 14	28%	N/A	**26.3%**	**GREEN**	–	
2	LDPS	Suspicion of Cancer Referrals (62 days)	Jun-15	91.0%	86.7%	**95%**	**RED**	↓	Page 10
3	LDPS	All Cancer Treatments (31 days)	Jun-15	96.4%	96.5%	**95%**	**GREEN**	↑	
4	LDPS	*Alcohol Brief Interventions*	Apr - Jun 15	3,715	2,818	**2,618**	**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	Jun-15	91.3%	91.8%	**95%**	**AMBER**	↑	
6	LKPI	A&E Attendances per 100,000 popu	Jun-15	3,028	2,829	No Target	**GREY**	↑	
7	HSCI	*Delayed Discharge > 14 days (inc codes)*	Jul-15	79	17	**0**	**RED**	↑	Page 11
8	HSCI	*Delayed Discharge < 72 hours (inc codes)*	Jul-15	N/A	14	**TBC**	**GREY**	**N/A**	
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+)	Jun-15	4,753	2,658	**3,994**	**GREEN**	↑	
		AWI patients (65 years+)	Jun-15	1,443	1,254	**1,103**	**RED**	↑	Page 12
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	Jun-15	92.4%	91.1%	**90%**	**GREEN**	↓	
		Combined Linked Pathway	Jun-15	88.4%	87.8%	**80%**	**GREEN**	↓	
14	LDPS	12 week Treatment Time Guarantee (TTG)							
		Inpatient	Jun-15	100%	99.9%	**100%**	**AMBER**	↓	
15	LKPI	Patient unavailability							
		Inpatient/Day Case	Jun-15	3,818	5,421	**N/A**	**GREY**	–	
		Outpatient	Jun-15	2,906	2,897	**N/A**	**GREY**	–	
16	LKPI	% of patients waiting < 4 weeks for diagnostic test	Jun-15	100%	99.9%	**100%**	**AMBER**	↓	
17	LDPS	% of new outpatient appointments < 12 weeks	Jun-15	99.9%	99.4%	**99.7%**	**AMBER**	↓	
18	LDPS	% of eligible patients commencing IVF treatment within 12 months	Jun-15	N/A	100%	**90%**	**GREEN**	–	
19	LKPI	% of patients admitted to stroke unit	Jun-15	89%	89%	90%	**AMBER**	↔	
20	LDPS	*% patient waiting < 18 weeks for RTT to Specialist Child and Adolescent Mental Health Services*	Jun-15	100%	100%	**90%**	**GREEN**	↔	
21	LDPS	*% patients waiting <18 weeks for referral to treatment for psychological therapies*	Apr - Jun 15	92.1%	96.1%	**90%**	**GREEN**	↑	
22	LDPS	*Drug and Alcohol: % of patients waiting < 3 weeks from referral to appropriate treatment*	Jan - Mar 15	95.5%	N/A	**91.5%**	**GREEN**	–	
23	LDPS	SAB Infection rate (cases per 1,000 OBD)	Apr - Mar 15	0.26	N/A	**0.24**	**RED**	–	Paper No 15/39 Page 14
24	LDPS	C.Diff Infections (cases per 1,000 OBD)	Apr - Mar 15	0.29	N/A	**0.32**	**GREEN**	–	
25	LDF	*% of Complaints responded to within 20 working days*	Jan - Mar 15	81%	N/A	**70%**	**GREEN**	–	
26	LDPS/LDF	*Financial Performance*	Jun-15	(£0.9m)	(£4.4m)	**Breakeven**	**AMBER**	↓	Paper No 15/46
27	LDPS/LDF	*Sickness Absence (rolling year)*	Jun-15	4.96%	5.34%	**4%**	**RED**	↓	Page 16
		Long Term	Jun-15	3.30%	3.53%	**N/A**	**GREY**	↓	
		Short Term	Jun-15	1.66%	1.81%	**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*	Jan - Mar 15	76.9%	N/A	**80%**	**AMBER**	–	
29	LDPS	*Smoking Cessation - number of successful quitters at 12 weeks post quit in 40% SIMD areas (Provisional Data)*	Apr - Mar 15	1,340	N/A	**2,823**	**RED**	↓	Page 17

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
14	12 week Treatment Time Guarantee (TTG)	June 2015	100%	99.9%	100%	**AMBER**	↓

Commentary

Overall 99.9% of patients were treated within the 12 week treatment time guarantee marginally lower that the same month the previous year. A total of two patients were not treated within the treatment time guarantee period. These were in neurosurgery and renal medicine specialties.

The neurosurgery patient was booked for treatment prior to their TTG date. Unfortunately the surgeon was ill on the scheduled day of surgery and then subsequently suffered a bereavement and was unable to return to work until the end of June 2015. The patient was treated in July 2015.

The renal medicine patient was scheduled for admission within their guarantee date. However they were cancelled due to three emergency admissions with higher clinical priority for surgery. A new date for surgery will be agreed with the patient following their return from holiday.

Actions

All specialties continue to closely monitor their waiting lists to ensure that patients are offered admission dates as soon as possible and within their guarantee date.

Timeline for Improvement

Ongoing.

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 tests	June 2015	100%	99.9%	100%	**AMBER**	↓

Commentary

Overall 99.9% of patients waited less than four weeks of referral for diagnostic tests at June 2015. The 0.1% who waited more than four weeks related to two patients waiting more than four weeks for a Cystoscopy diagnostic test. Both delays were the result of administrative errors. Specifically, the waiting list entries were initially, incorrectly, treated as non diagnostic inpatient waiting list entries and managed in line with that guarantee.

Actions

An action to reinforce the standard waiting list management process and ensure that all staff, including those undertaking temporary duties are aware of and adhere to this has been implemented.

Timeline for Improvement

Immediate implementation with ongoing monitoring and review.

Ref	Measure	As At	2014-15 Actual	2015-16 Actual	2015-16 Target	Perform Status	Dir of Travel
17	% of new outpatient appointments < 12 weeks	June 2015	99.9%	99.4%	99.7%	**AMBER**	↓

Commentary

As at June 2015, 99.4% of patients received a new outpatient appointment within 12 weeks of referral, slightly below the trajectory of 99.7% and lower than the position reported during the same month the previous year.

The figure represents 365 patients waiting over 12 weeks for a new outpatient appointment across the following specialty areas; one patient within Orthopaedics, 95 patients within Gastroenterology, and 269 patients within Neurology.

Actions

Orthopaedics: The referral for the patient waiting over 12 weeks for an Orthopaedic appointment was not processed at the vetting stage accurately and the patient was added to the incorrect list, a waiting list for community podiatry.

Gastroenterology: The Gastroenterology Service has been under pressure for a number of months due to the increase in referrals. The number of referrals has risen by 22% since July 2014. In addition there has been a reduction in the number of junior doctors available to assist with the outpatient work due to a reduction in overall numbers. The service report that there is a significant gap between capacity and demand at present. Contributory factors also include staff leave; with one Consultant currently off on long term leave, and another on Paternity leave.

Neurology: There is a national (UK wide) shortage of Consultant Neurologists. Posts have been advertised on multiple occasions and it has proven difficult to recruit locum cover except via high cost agency. We currently have an advert out for two NHSGG&C Consultants, interviews scheduled for November 2015; one General Neurology and one Muscle. In addition NHS Lanarkshire is also seeking to recruit a Consultant in the same timeframe.

- Two new consultants from previous round have started in post in May 2015 and July 2015.
- Locum contract was stopped due to high agency cost.
- Outside Agency Medinet continue to provide OPD new clinics for General Neurology capacity.
- Two GPWSI appointed and commenced April/May – First Seizure, Headache.
- Additional WLI clinics remain in place.
- Review of vetting practice for General Neurology referrals - further work is planned on introduction of small vetting team to standardise practice across sites.
- Job plans/clinic profiles are being reviewed to ensure they are standardised across the region.

We are optimistic that we will be able to recruit Consultant staff in the current round; however staff appointed may not be able to take up posts until early 2016. In the short term, to recover the position as early as possible in 2015, the feasibility of increasing the capacity we currently have with the independent sector (Medinet) is being actively explored.

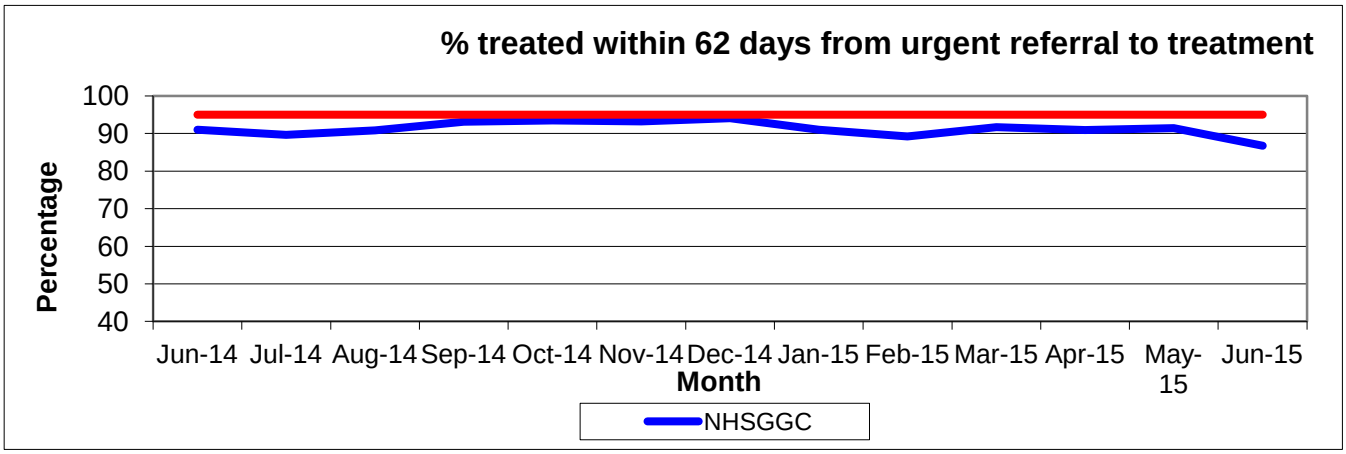
Timeline for Improvement

Ongoing.

PERFORMANCE EXCEPTIONS REPORTS

Exceptions Report: Suspicion of Cancer Referrals (62 days)

Measure	Suspicion of Cancer Referrals
Current Performance	As at June 2015, 86.7% of patients with an urgent referral for suspicion of cancer were treated within 62 days of the referral.
Lead Director	Gary Jenkins



Commentary

As at June 2015, 86.7% of patients with an urgent referral for suspicion of cancer were treated within 62 days of the referral, lower than the target of 95%.

One of the main areas contributing to NHS Greater Glasgow & Clyde's (NHSGG&C's) overall deterioration in performance is in relation to urology where 69% were treated within 62 days. This is mainly due to the reduction of three WTE consultant urologists in recent months due to long term sickness absence. Performance in urology is also part of a national challenge faced by all other Health Boards across Scotland with the exception of Ayrshire & Arran, Fife and Lanarkshire.

Actions to Address Performance

Action to address performance includes:

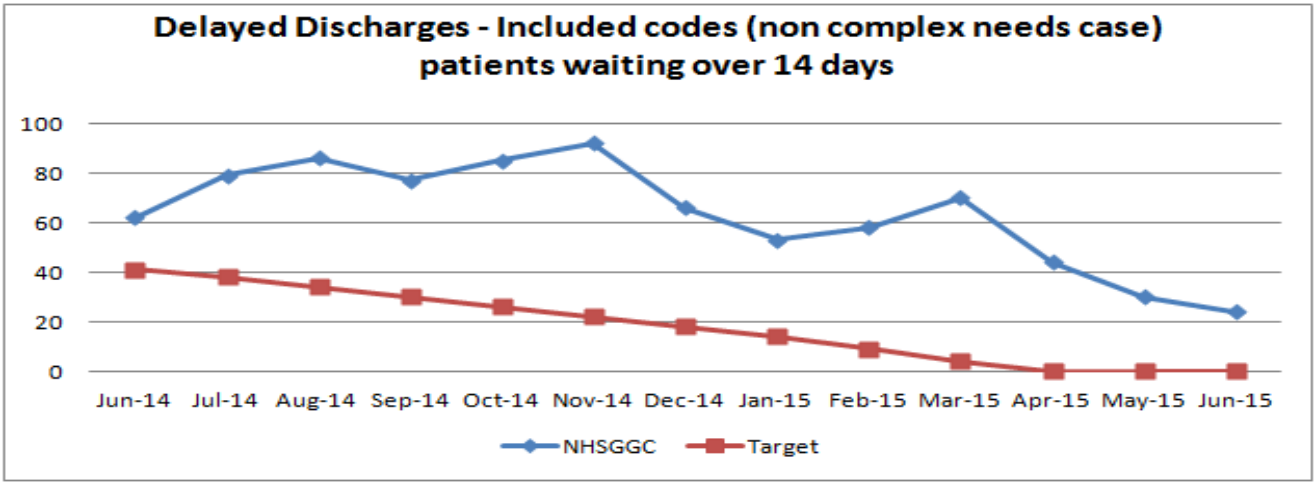
- Working collaboratively with the Scottish Government's Cancer Support Team to identify additional revenue support for unfunded demand.
- An advert for the appointment of two consultant urologists is scheduled for 21 August.
- The introduction of a single handed practitioner undertaking laparoscopic prostatectomy.
- A bid has been developed for a urological diagnostics suite at the Princess Royal Maternity Hospital.
- We have been undertaking additional Transrectal Ultrasonography (TRUS) lists to get patients through the pathway in addition to reducing the number of steps within the patient pathway.
- Work is underway to prioritise theatre lists.

Timeline For Improvement

Ongoing.

Exceptions Report: Delayed Discharge > 14 days

Measure	Delayed Discharges > 14 days
Current Performance	As at July 2015, 17 patients were delayed for > 14 days against a target of zero and 14 patients were delayed for < 72 hours.
Lead Director	Catriona Renfrew, Director of Corporate Planning and Policy



Commentary

As at July 2015, a total of 17 patients were delayed > 14 days, the lowest number of delays reported since the measure was introduced in April 2013. Of the total number of patients delayed > 14 days; eight were residents of Glasgow City (five residents from the North West and three from the South Sector, there were no patients delayed in North East Sector), two were from East Dunbartonshire and the remaining seven patients delayed were from outwith the Board area.

A total of 14 patients were delayed for < 72 hours in July 2015.

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

There were no patients delayed < 72 hours for legal reasons and who lacked capacity (AWI).

Actions to Address Performance

- Chief Officers and the Director of Corporate Planning and Policy, coordinating 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 patients in two identified nursing homes but remaining in the care of the NHS until legal issues are resolved. This will ensure that acute beds are not compromised.

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 for Adults with Incapacity

Measure	Bed Days Lost to Delayed Discharge For Adults with Incapacity (AWI) Patients (65 years+)
Current Performance	As at June 2015, the number of bed days lost to delayed discharge for AWI patients was 1,254 against a monthly target of 1,103.
Lead Director	Catriona Renfrew, Director of Corporate Planning and Policy

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		2015/16	
CH(C)P	**June 11 Actual**	**June Actual**	**June Actual**	**June Actual**	**June Actual**	**Jun 50% Target**	**Cumulative Actual 2015/16**	**Cumulative 50% Target**
East Dunbartonshire	680	393	270	283	287	307	1,207	920
East Renfrewshire	291	539	236	274	112	201	360	604
Glasgow City	**5,799**	**3,709**	**3,514**	**3311**	**1513**	2,213	**5,823**	**6,639**
Inverclyde	703	246	294	116	80	280	315	841
Renfrewshire	1,577	1,253	558	356	436	675	1,447	2,026
West Dunbartonshire	483	510	295	413	230	318	910	955
GGC(All above areas)	**9,533**	**6,650**	**5,167**	**4,753**	**2,658**	**3,994**	**10,062**	**11,983**

Commentary

Whilst the overall bed days lost to delayed discharge target was set four years ago, in June 2015 the monthly target was met reporting 2,658 monthly bed days lost against a monthly target of 3,994. The June 2015 performance represents a 44% reduction in June 2014 position.

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		2015/16	
CH(C)P	**June 11 Actual**	**June Actual**	**June Actual**	**June Actual**	**June Actual**	**Jun 50% Target**	**Cumulative Actual 2015/16**	**Cumulative 50% Target**
East Dunbartonshire	140	30	0	53	63	133	427	400
East Renfrewshire	0	60	0	30	7	51	7	152
Glasgow City	**1,703**	**782**	**808**	**905**	**752**	779	**1,946**	**2,338**
Inverclyde	30	0	0	0	0	13	0	38
Renfrewshire	116	252	156	330	321	89	1,074	266
West Dunbartonshire	128	125	120	125	111	39	328	116
GGC(All above areas)	**2,117**	**1,249**	**1,084**	**1,443**	**1,254**	**1,103**	**3,782**	**3,310**

As at June 2015, a total of 1,254 bed days were lost to delayed discharge for AWI a decrease of 13% on the number reported during the same period the previous year (from 1,443 bed days lost in June 2014 to 1,254 in June 2015).

As seen from the table above, there were no bed days lost to delayed discharge for AWI in Inverclyde CHCP. All other partnerships reported bed days lost to delayed discharge for AWI with Glasgow City reporting 60% of the bed days lost for AWI and Renfrewshire reporting 26% of the bed days lost for AWI.

Actions to Address Performance

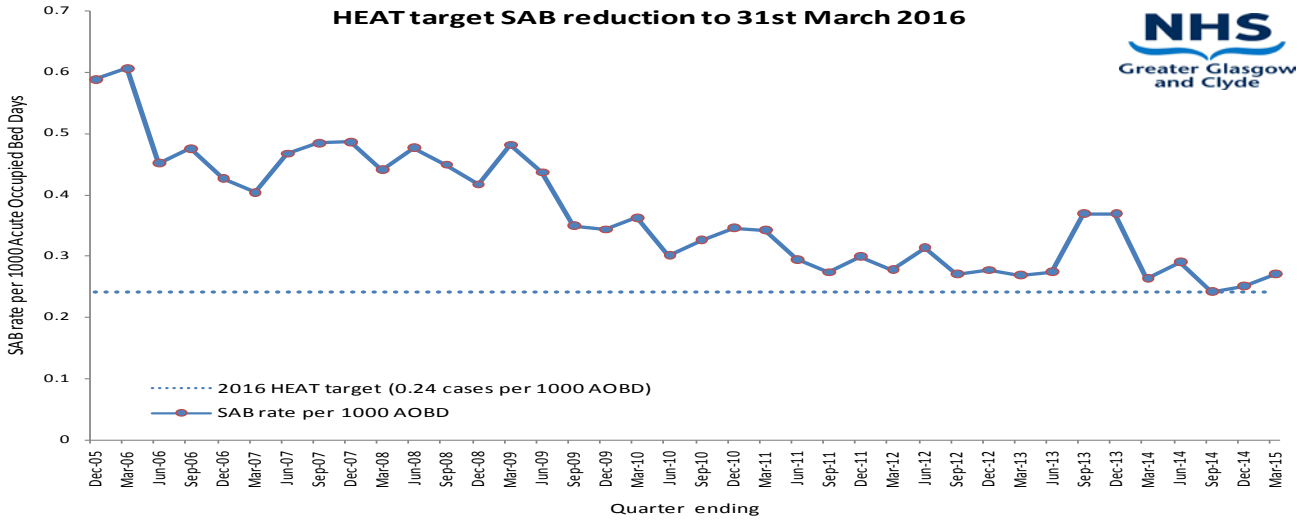
As per the actions outlined in the delayed discharge exceptions report.

Timeline for Improvement

As identified in the delayed discharge exceptions report.

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

Measure	MRSA/MSSA Bacteraemia (cases per 1,000 AOBD)
Current Performance	As at the March 2015 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 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 1 confirm a total of 102 SAB patient cases for NHSGG&C, between January and March 2015. This equates to a SAB rate of 27.1 cases per 100,000 AOBD.

The Quarterly Rolling Year ending March 2015 rate as per LDP for SAB is **0.26** cases per 1,000 AOBDs. This is against the March 2015 Board target 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 March 2015.
- NHSGG&C again had the fifth lowest case rate in the year ending March 2015 out of Scotland's 15 Boards that submit data for national reporting.
- There was an increase in the proportion of community cases in Quarter 1, 2015 compared to the previous quarter (31% in Quarter 1 compared to 17% in Quarter 4, 2014). Of these community cases, 44% were people who use intravenous illicit drugs. Community cases are less amenable to any improvement interventions that may be delivered within the Acute Services.
- 38% of Hospital acquired SABs in Quarter 1, 2015 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 more detail on current position.

Actions to Address Performance

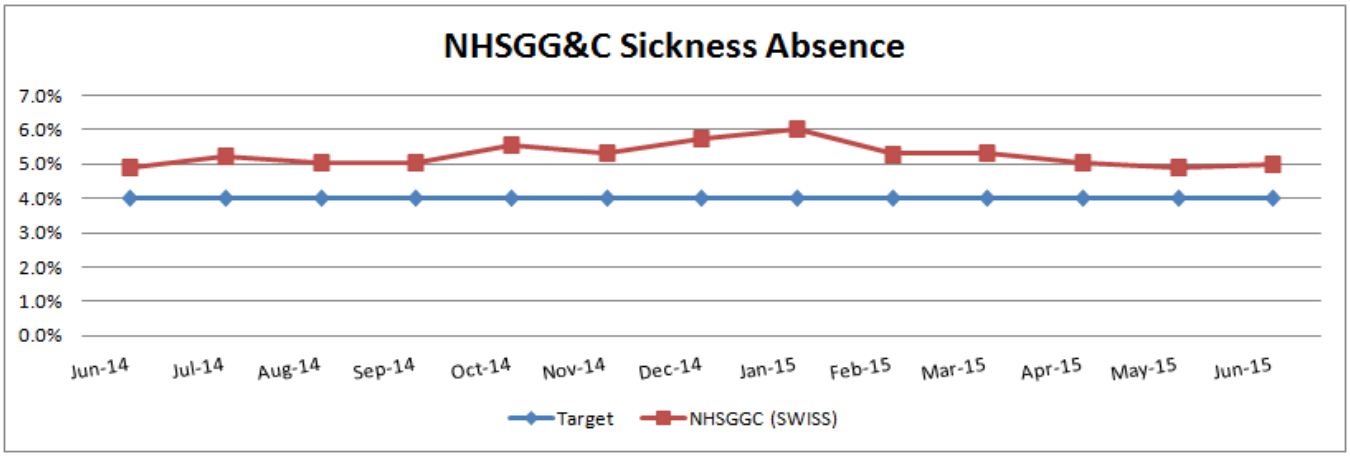
- All SAB data is sent quarterly to Health Protection Scotland as part of the National eSAB Surveillance Programme.
- Enhanced SAB data given to Antimicrobial Prescribing Team for analysis of appropriate prescribing and treatment of each case.
- Clinical Review Tools are issued to the Consultant in Charge 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 Chief Nurse prospectively notified of audit result. This is collectively reported in the Monthly Enhanced SAB report.
- Patient specimen information on blood cultures deemed as 'contaminants' reported to Consultant in Charge and Chief Nurse 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.
- *Staphylococcus aureus* Bacteraemia is a standing agenda item at the Bi-monthly Acute Control of Infection Committee.

Timeline For Improvement

Ongoing.

Exceptions Report: Sickness Absence

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



Commentary

The 2015/16 Local Delivery Plan (LDP) Standard requires '*NHS Boards to achieve a sickness absence rate of 4%'.* The overall sickness absence rate for the rolling year to June 2015 was 5.34%. This is higher than the rate reported for same period in the previous year (June 2014) which was 4.96%.

The split between long term and short term absence for the period under review is 3.53% and 1.8% 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.

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 2014 - March 2015 a total of 1,340 smoking quits 12 weeks post quit were achieved. Actual performance is -52.5% below the target of 2,823 quitters. (It should be noted that these figures are still provisional due to follow-up time lag).
Lead Director	Emilia Crighton

Commentary

The board has failed to meet the 12 week post quit HEAT target (40% most deprived areas within Board) introduced in April 2014, reaching only 47.5% of the target. Although we are still waiting for outcomes for a number of clients due to follow up time lag, this will not allow the HEAT target to be met.

The total number of people going through smoking cessation services in 2014-15 has been significantly lower than previous years, with a 9,715 decrease in the total number setting quit dates in the smoking cessation services compared to the same period in 2013-14 (a 35% reduction). The HEAT target now relates only to individuals from the 40% most deprived areas within the board and there has been a 27% reduction in numbers in this group setting a quit date in 2014 (4,174 individuals) compared to the same period in 2013-14.

The smoking cessation HEAT target, now based on a 12 week quit rate (formerly four week), has been challenging to meet due to difficulties with follow up. The majority of clients go through the pharmacy service and so pharmacists became 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) and the national data systems are not straightforward. The Public Health Pharmacy Team put supports in place to improve pharmacy compliance with follow up calls and database entry and there are early indications that this has improved.

In January 2015, all non-pharmacy services took over follow up calls from an external company and again, there are early indicators that there has been improvement in contact made with clients.

Targeting of services for the 40% most deprived has improved in 2014-15 with 62% of those setting a quit attempt from the target areas, compared to 55% in 2013-14. This, however, could still be improved.

It should be noted that with the exception of NHS Shetland all other Health Board's across Scotland are currently below target for this measure.

Actions to Address Performance

Actions to address the issues include:

- The Head of Health Improvement and two Health Improvement Leads (Tobacco) are conducting visits with each HSCP to look closely at community and pharmacy services, highlighting areas of potential improvement in each locality and identify any corporate support actions.
- In order to improve accessibility, contact and quit rates, rolling groups were introduced in January 2015. This should assist in improving 12 week follow up.
- Research was conducted 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 and findings from the report will be incorporated in a large scale, board-wide communications campaign running September 2015.
- There is a strong indication that the significant drop in services across Scotland may be in part due to the increased popularity and use of e-cigarettes. Findings from the research conducted locally confirmed that e-cigarettes are now considered a popular option for quitting smoking. In line with this information, community services became an e-cigarette friendly service in January 2015, supporting

those who choose to use an e-cigarette to quit regular tobacco (although we do not supply the product).

- The Public Health Pharmacy Team will continue to work closely with pharmacies to target effort in areas of deprivation and ensure timeous and accurate completion of data.
- Prescribing guidance has been reviewed to increase the use of Varenicline (Champix). Quit rates are higher for varenicline users, but many have been prescribed the product by GPs and have no contact with services and are thus not being recorded as quitters. Varenicline can now be prescribed by Smokefree Pharmacy Services via PGD which should increase the support available to those using this medication. It will also ensure these quits are recorded.
- Smokefree Pregnancy Services have been reviewed and a number of improvement measures are being tested, ensuring all stages of the process are tightened.

Timeline For Improvement

There are a number of actions being implemented to improve performance but will obviously not assist for 2014-15 period. We anticipate that actions will improve performance for new LDP standard for 2015-16 (to replace the HEAT target) which is 40% lower than 2014-15 to reflect the large drop in numbers through services across Scotland. However, despite this reduction, this will remain a significant challenge, similar to all boards in Scotland.