**NHS GREATER GLASGOW AND CLYDE**

**Board Meeting**
**20 October 2015** **Paper No: 15/55**

**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**

- % of patients waiting < 4 weeks for a key diagnostic test has moved from ***amber to green***.
- % of patients admitted to stroke unit has moved from ***amber to green***.
- % of pregnant women booking an antenatal care appointment at 12 weeks gestation has moved from ***amber to green***.

**Performance Deterioration**

- Early diagnosis and treatment in first stage cancer has moved from ***green to amber***.
- All cancer treatments (31 days) has moved from ***green to amber***.

**Measures Rated As Red**

- Suspicion on cancer referrals (62 days)
- 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)

## 20 OCTOBER 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 | 2 | 1 | 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 | 3 | 9 | 1 | **15** |
| Tackling Inequalities | 1 | 0 | 1 | 0 | **2** |
| **TOTAL** | **6** | **6** | **12** | **6** | **30** |

| PERFORMANCE AT A GLANCE - OCTOBER 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 | Apr - June 15 | 22.0% | 26.6% | **27.2%** | **AMBER** | ↑ | |
| 2 | LDPS | Suspicion of Cancer Referrals (62 days)* | Aug-15 | 90.8% | 89.3% | **95%** | **RED** | ↓ | Page 10 |
| 3 | LDPS | All Cancer Treatments (31 days)* | Aug-15 | 94.6% | 93.1% | **95%** | **AMBER** | ↓ | |
| 4 | LDPS | *Alcohol Brief Interventions* | Apr - June 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 | Aug-15 | 89.7% | 94.1% | **95%** | **AMBER** | ↑ | |
| 6 | LKPI | A&E Attendances per 100,000 popu | Sept - Aug 15 | 3,019 | 2,734 | No Target | **GREY** | ↑ | |
| 7 | HSCI | *Delayed Discharge > 14 days (inc codes)* | Aug-15 | 86 | 24 | **0** | **RED** | ↑ | Page 12 |
| 8 | HSCI | *Delayed Discharge < 72 hours (inc codes)* | Aug-15 | N/A | 16 | **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+)* | Aug-15 | 5,336 | 2,732 | **3,994** | **GREEN** | ↑ | |
| | | *AWI patients (65 years+)* | Aug-15 | 1,355 | 1,425 | **1,103** | **RED** | ↓ | Page 13 |
| 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 | Aug-15 | 92.0% | 92.1% | **90%** | **GREEN** | ↑ | |
| | | Combined Linked Pathway | Aug-15 | 88.5% | 87.7% | **80%** | **GREEN** | ↓ | |
| 14 | LDPS | 12 week Treatment Time Guarantee (TTG) | | | | | | | |
| | | Inpatient | Aug-15 | 99.9% | 99.9% | **100%** | **AMBER** | ↔ | |
| 15 | LKPI | Patient unavailability | | | | | | | |
| | | Inpatient/Day Case | Aug-15 | 3,360 | 4,137 | **N/A** | **GREY** | ↓ | |
| | | Outpatient | Aug-15 | 3,325 | 3,567 | **N/A** | **GREY** | ↓ | |
| 16 | LKPI | % of patients waiting < 4 weeks for diagnostic test | Aug-15 | 100% | 100% | **100%** | **GREEN** | ↔ | |
| 17 | LDPS | % of new outpatient appointments seen < 12 weeks | Aug-15 | 99.8% | 98.7% | **99.7%** | **AMBER** | ↓ | |
| 18 | LDPS | % of eligible patients commencing IVF treatment within 12 months | Jul-15 | N/A | 100% | **90%** | **GREEN** | – | |
| 19 | LKPI | % of patients admitted to stroke unit | Aug-15 | 88% | 93% | 90% | **GREEN** | ↑ | |
| 20 | LDPS | *% patient waiting < 18 weeks for RTT to Specialist Child and Adolescent Mental Health Services* | Aug-15 | 99.4% | 100% | **90%** | **GREEN** | ↑ | |
| 21 | LDPS | *% patients waiting <18 weeks for referral to treatment for psychological therapies* | Apr - June 15 | 92.1% | 96.1% | **90%** | **GREEN** | ↑ | |
| 22 | LDPS | *Drug and Alcohol: % of patients waiting < 3 weeks from referral to appropriate treatment* | Apr - June 15 | 97.1% | 96.1% | **91.5%** | **GREEN** | ↓ | |
| 23 | LDPS | SAB Infection rate (cases per 1,000 OBD rolling year) | Jul - June 15 | 0.32 | 0.27 | **0.24** | **RED** | ↑ | Paper No 15/50 Page15 |
| 24 | LDPS | C.Diff Infections (cases per 1,000 OBD rolling year) | Jul - June 15 | 0.29 | 0.30 | **0.32** | **GREEN** | ↓ | |
| 25 | LDF | *% of complaints responded to within 20 working days* | Apr - June 15 | 81.0% | 81.5% | **70%** | **GREEN** | ↑ | |
| 26 | LDPS/LDF | Financial Performance | Aug-15 | (£1.4m) | (£5.3m) | **(£1.7m)** | **AMBER** | ↓ | Paper No 15/57 |
| 27 | LDPS/LDF | *Sickness Absence (rolling year)* | Aug-15 | 5.1% | 5.3% | **4%** | **RED** | ↓ | Page 17 |
| | | *Long Term* | Aug-15 | 3.4% | 3.5% | **N/A** | **GREY** | ↓ | |
| | | *Short Term* | Aug-15 | 1.7% | 1.8% | **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* | Apr - June 15 | 77.8% | 81.6% | **80%** | **GREEN** | ↑ | |
| 29 | LDPS | *Smoking Cessation - number of successful quitters at 12 weeks post quit in 40% SIMD areas (Data Incomplete)* | Apr - June 15 | 353 | 267 | **332** | **RED** | ↓ | Page 19 |

* 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*) | Aug 2015 | 94.6% | 93.1% | 95.0% | **AMBER** | ↓ |

**Commentary**

As at August 2015, 93.1% of all patients diagnosed with cancer were treated within 31 days from decision to treat to first treatment. Current performance is below the target of 95% and lower than the position reported during the same month the previous year.

**Actions To Improve Performance**

See exceptions report on Suspicion of Cancer Referrals (62 days) for the detailed actions in place to improve performance.

| 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 appointment | Aug 2015 | 99.7% | 98.6% | 99.7% | **AMBER** | ↓ |

**Commentary**

As at August 2015 (month end), 98.6% of new patients were waiting for less than 12 weeks from the date of their referral for an outpatient appointment, this is slightly below the trajectory of 99.7% and lower than the position reported during the same month the previous year.

The figure represents 854 patients waiting over 12 weeks at the end of August 2015 for a new outpatient appointment across the following Sectors and Directorates:

- **Regional Services** – a total of 398 patients were waiting > 12 weeks for a new outpatient appointment. All patients waiting were within the Neurology specialty.
- **South Sector** – a total of 451 patients were waiting more than 12 weeks for a new outpatient appointment in the following specialties: 417 in Gastroenterology; 20 in Cardiology; 12 in Rheumatology and two in Diabetes.
- **Clyde Sector** – a total of five patients were waiting > 12 weeks for a new outpatient appointment in Gastroenterology.

**Actions To Improve Performance**

- **Regional Services** - There is an on-going national (UK wide) shortage of Consultant Neurologists. Posts have been advertised on several occasions, and it has proven difficult to recruit locum cover except via agency. The Directorate is currently in the process of recruiting two NHSGG&C Consultants, interviews scheduled for October 2015; one General Neurology and one Muscle. In addition NHS Lanarkshire are also seeking to recruit a Consultant in the same timeframe.
  - Two new consultants from previous recruitment rounds have started in post in May and July 2015.
  - Outside Agency Medinet continue to provide OPD new clinics for General Neurology capacity.
  - Two GPWSI appointed and commenced April/May – First Seizure, Headache. These individuals will complete their training programme by November 2015. At that point they will be able to see 32 new headache referrals per month.

- Additional WLI clinics remain in place, an average of 15 clinics per month is undertaken.
- 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.

Interviews are scheduled for Wednesday 7 October 2015; there is one applicant for the Muscle post and two applicants for the General Neurology post. The service notes that staff appointed may not be able to take up posts until early 2016.

In the immediate term, between October – December 2015, Neurology are working on a plan to bring all new outpatient waits back into line with the 12 week target. In addition to the measure noted above, the service is actively:

- 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 for the period October – December 2015. The service has currently secured capacity for September and October, however an increase has been requested to reduce the waiting list overall rather than simply stand still.
- 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.

Despite the above measures, it is likely that the service will continue to experience an increase in >12 week cases for the next four to six weeks whilst the above steps take effect and begin to reduce the number of >12 week cases.

The aim of the Directorate team is to return to a 12 week target by January 2016.

- **South Sector**
  - 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 26.6% since August 2014.
  - The new service model has been implemented in the South Sector where the majority of inpatient services are provided at the QEUH. This has led to considerable changes in working arrangements for senior and junior medical staff.
  - Consultants at the VI have taken on the new responsibility of providing an emergency GI bleeding service and this has reduced their availability for outpatient work. In addition junior staff who worked between wards and clinics are no longer available on the Victoria site to support clinics.
  - A new capacity plan is being prepared for the service and it will also form part of the national Delivering Outpatient Integration Together work.
  - As this work progresses, a more detailed update will be provided by the Sector regarding the recovery of the 12 week target.

- **Clyde Sector**
  - The Gastro position in Clyde has been impacted by short notice leave being taken by the Locum consultant; a number of booked patients had to be rescheduled and the service could not accommodate all patients within their guarantee date. This has been further impacted by Consultant sickness which also resulted in clinical cancellations and patient rescheduling. The sector continues to experience capacity pressures and is working to manage patients as effectively as possible.

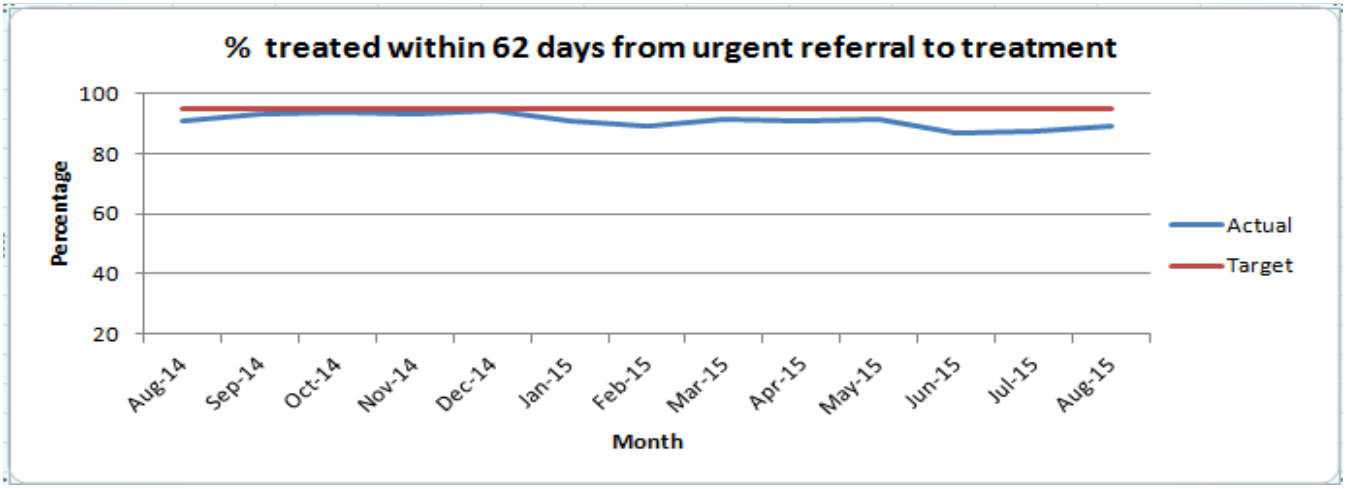
**Timeline for Improvement**

Ongoing.

# PERFORMANCE EXCEPTIONS REPORTS

**Exceptions Report: Suspicion of Cancer Referrals (62 days)**

| | |
|---|---|
| **Measure** | Suspicion of Cancer Referrals |
| **Current Performance** | As at August 2015, 89.3% of patients with an urgent referral for suspicion of cancer were treated within 62 days of the referral. (D*ata still to be validated*). |
| **Lead Director** | Gary Jenkins |




**Commentary**

As at August 2015, 89.3% of patients with an urgent referral for suspicion of cancer were treated within 62 days of the referral, lower than the target of 95%.

The main areas contributing to NHS Greater Glasgow & Clyde's (NHSGG&C's) overall performance is in relation to Urology (61.8%), Head and Neck (76.5%), Upper GI (85.7%), Lung (92.7%) and Colorectal (92.8%). Each of the areas mentioned have demonstrated an improvement in performance when compared to the previous months' position of Urology (53.8%), Head and Neck (57.1%), Upper GI (78.3%), Lung (92.5%) and Colorectal (92.0%).

**Actions to Address Performance**

Action to address performance includes:

- Weekly conference calls with the Scottish Government's Cancer Performance Support Team (CPST) have been established to monitor performance in real time and take action to obviate potential patients waiting longer than the 62 day standard.
- In recognition of the impact that the patients currently waiting longer than 62 days will have on NHSGGC's ability to recover the 62 day position, an additional non recurring resource allocation will be made to alleviate a number of ongoing pressures in relation to Urology, Breast, Colorectal and Upper GI, Head and Neck and Lung Tumors.

- **Urological Cancer**
  The most significant impact to assist with Urological performance is additional TRUS (Trans-rectal Ultrasound) +/- biopsy capacity. A pathway review identified that 25 out of 48 cases may require this diagnostic procedure. Additionally, based on the same volume of 25 cases, a combination of additional cystoscopy capacity, and TURBT (Trans-Urethral Resection of Bladder Tumour) and TURP (Trans-Urethral Resection of Prostate) would assist in managing the patient flow and improving performance within the month of October. The CPST accepted this proposal and allocated £160,000 for additional capacity. To date 15 cases have been treated, and a further five patients have been invited to attend. In addition to this allocation a further 12 patients have been invited to have their TRUS procedures undertaken on Saturday 10 October. It is envisaged that this measure will deliver

an improvement of the current urological cancer position for the end of October.

- **Breast Cancer**
  15 breast cases were identified within the analysis where surgery with associated localisation would improve the overall 62 day performance position. In order to undertake these cases, it is proposed that four additional theatre lists are undertaken. The CPST accepted this proposal and allocated £22,800 for additional capacity. Two full days of operating capacity for breast patients have been identified in October. Diagnostics are currently trying to secure localisation capacity to allow the lists to progress. Patients will be invited to attend over the coming two week period.

- **Colorectal Cancer**
  There are 14 cases currently in tracking on the colorectal cancer pathway. Whilst the main reason for patients waiting longer than 62 days is the planning time required for anal cancers undergoing first treatment with concomitant chemo radiation therapy; that problem is exacerbated by delays earlier in the diagnostic pathway. In order for cases to arrive at an earlier point in both the specialist oncology and surgical pathway, it was proposed that two additional colonoscopy list were undertaken at the weekend. The CPST accepted this proposal and allocated £6,000 for additional capacity. A colonoscopy list ran on 19 September allowing patients to be brought forward, a second list is scheduled to take place on 17 October.

- **Head & Neck Cancer**
  The delays in the head and neck pathway are mainly associated with first outpatient appointment within 14 days, and pan endoscopy. There are two Consultant Surgeon vacancies, and a significant number of waiting list initiative list clinics are already in place to meet the outpatient targets. The service has explored the options for locum and substantive consultants as additional activity from existing consultants has been maximised. In order to meet the 62 day target, NHSGG&C propose to convert existing routine outpatient appointments to urgent suspicion of cancer slots.

  It was proposed that by sending 40 routine referrals to the private sector, NHSGGC would release capacity to prioritise efforts on USC referrals and redirect sessions to provide additional pan endoscopy theatre access. The CPST accepted this proposal and allocated £6,000 for additional capacity. All 40 patients have been booked, 30 for the 10th of October and 10 for the 16th of October.

- **Lung Cancer**
  Additional Respiratory clinics are already in place to accommodate first appointment for USC within 14 days. Clinical Oncology sessions have been released to allow an additional Consultant to participate in the North East Lung Cancer team. A re-modelling of Diagnostic Imaging capacity has enabled a reduction in the wait for CT to seven days, rather than 14 days. This occurred with effect from 31 August and will run for a three month period to evaluate the impact.

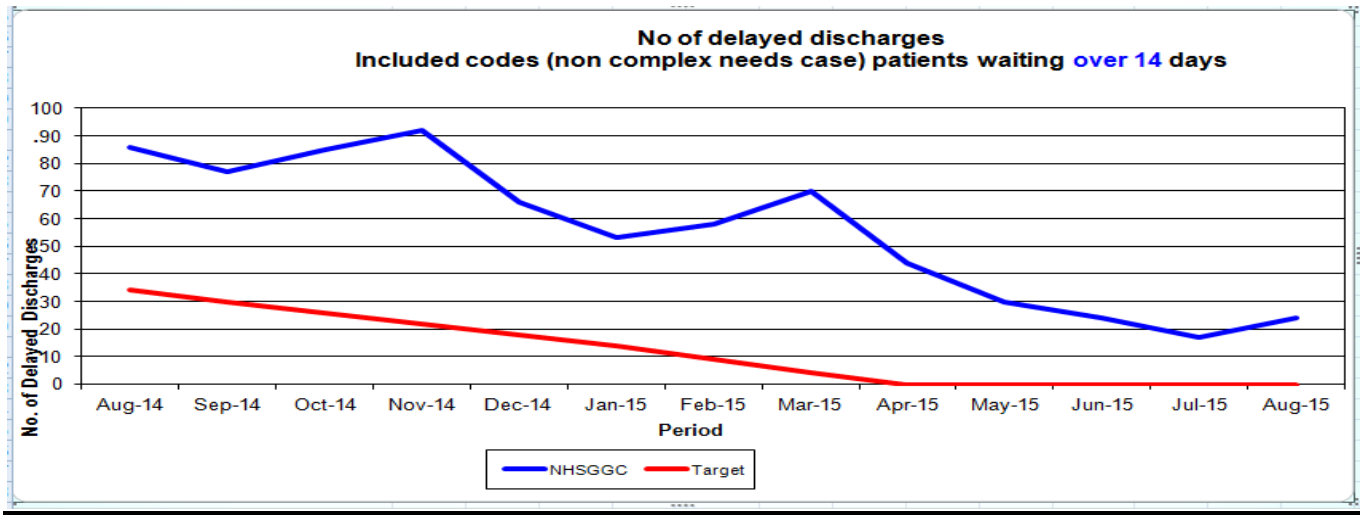
- **Upper GI Cancer**
  Additional Gastroenterology clinics are already in place to accommodate first appointment for USC within 14 days. As with lung cancer, a re-modelling of Diagnostic Imaging capacity has enabled a reduction in the wait for CT to seven days, rather than 14 days. This occurred with effect from 31 August and will run for a three month period to evaluate the impact.

**Timeline For Improvement**

The aim of all of the above measures is to improve the overall 62 day performance position for the end of October 2015.

**Exceptions Report: Delayed Discharge > 14 days**

| | |
|---|---|
| **Measure** | Delayed Discharges > 14 days |
| **Current Performance** | As at August 2015, 24 patients were delayed for > 14 days against a target of zero and 16 patients were delayed for < 72 hours. |
| **Lead Director** | Catriona Renfrew, Director Planning and Policy |




**Commentary**

As at August 2015, a total of 24 patients were delayed > 14 days. Of the total number of patients delayed > 14 days; 12 were residents of Glasgow City (nine 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, one from Renfrewshire and the remaining nine patients delayed were from outwith the Board area.

A total of 16 patients were delayed for < 72 hours in July 2015. Of the total number of patients delayed < 72 hours; seven were from Glasgow City (four residents from North West; two from South Sector and one from the North East Sector), three from East Dunbartonshire, two from Inverclyde, one from West Dunbartonshire and the remaining three patients delayed were from outwith the Board area.

These figures exclude the 61 patients delayed > 14 days and the two patients delayed < 72 hours for legal reasons and who lacked capacity (AWI).

**Actions to Address Performance**

- Chief Officers and the Director of Planning and Policy, coordinating for the Acute services, continue to work to identify and address the issues causing delays.
- A draft 2015-16 Acute Winter Plan has been developed detailing specific actions to address delays and each of the partnerships are currently developing Winter Plans detailing actions to support the reduction in delays.
- The revised scrutiny and escalation arrangements in place with Glasgow City Council continues to have an impact in that delays > 14 days have reduced from the 86 reported in August 2014 to 24 reported in August 2015.
- 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 particularly with winter approaching.

**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 August 2015, the number of bed days lost to delayed discharge for AWI patients was 1,425 against a monthly target of 1,103. |
| **Lead Director** | Catriona Renfrew, Director Planning and Policy |

**Table 1**

**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 | Aug 11 Actual | Aug Actual | Aug Actual | Aug Actual | Aug Actual | Aug 50% Target | Cumulative Actual 2015/16 | Cumulative 50% Target |
| East Dunbartonshire | 171 | 0 | 0 | 93 | 36 | 133 | 525 | 667 |
| East Renfrewshire | 0 | 62 | 0 | 31 | 19 | 51 | 57 | 254 |
| **Glasgow City** | **1,539** | **794** | **715** | **929** | **1033** | 779 | **3,869** | **3,897** |
| Inverclyde | 31 | 18 | 0 | 0 | 0 | 13 | 0 | 63 |
| Renfrewshire | 140 | 158 | 124 | 170 | 217 | 89 | 1,661 | 443 |
| West Dunbartonshire | 62 | 151 | 124 | 132 | 120 | 39 | 585 | 194 |
| **GGC(All above areas)** | **1,943** | **1,183** | **963** | **1,355** | **1,425** | **1,103** | **6,697** | **5,517** |

**Table 2**

**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 | Aug 11 Actual | Aug Actual | Aug Actual | Aug Actual | Aug Actual | Aug 50% Target | Cumulative Actual 2015/16 | Cumulative 50% Target |
| East Dunbartonshire | 574 | 468 | 163 | 477 | 216 | 307 | 1,731 | 1,533 |
| East Renfrewshire | 246 | 444 | 170 | 206 | 155 | 201 | 615 | 1,006 |
| **Glasgow City** | **5,295** | **3,839** | **3,264** | **3568** | **1668** | 2,213 | **9,062** | **11,065** |
| Inverclyde | 308 | 367 | 281 | 389 | 167 | 280 | 624 | 1,401 |
| Renfrewshire | 1,655 | 1,141 | 590 | 199 | 284 | 675 | 2,154 | 3,376 |
| West Dunbartonshire | 770 | 554 | 459 | 497 | 242 | 318 | 1,415 | 1,591 |
| **GGC(All above areas)** | **8,848** | **6,813** | **4,927** | **5,336** | **2,732** | **3,994** | **15,601** | **19,972** |

**Commentary**

As seen from *Table 2* above, in August 2015 the 50% monthly reduction target was met reporting 2,732 monthly bed days lost against a monthly target of 3,994. The August 2015 performance represents a 49% reduction in August 2014 position.

*Table 1* highlights a total of 1,425 bed days lost to delayed discharge for AWI patients in August 2015 representing a 5% increase on the number reported during the same period the previous year (from 1,355 bed days lost in August 2014 to 1,425 in August 2015). There were no bed days lost to delayed discharge for AWI in Inverclyde. All other partnerships reported bed days lost to delayed discharge for AWI patients with Glasgow City reporting 72% of the bed days lost for AWI and Renfrewshire reporting 15% of the bed days lost for AWI.

**Actions to Address Performance**

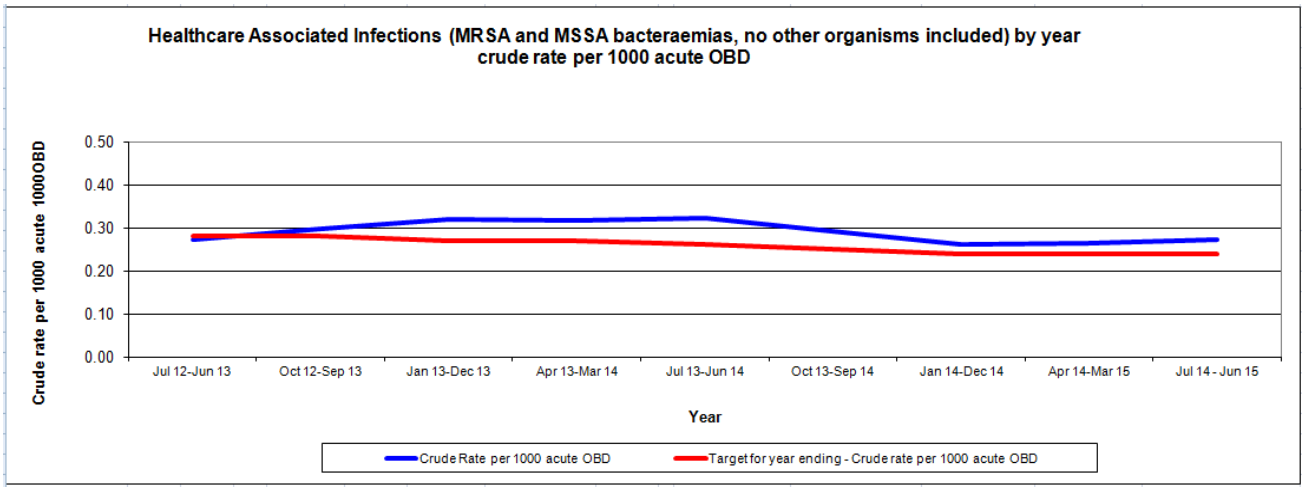
As per the actions outlined in the delayed discharge exceptions report.

**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 OBD) |
| **Current Performance** | As at the June 2015 rolling year, the number of MRSA/MSSA cases per 1,000 Acute Occupied Bed Days (AOBDs) was 0.27, current performance is above 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 2 confirm a total of 116 SAB patient cases for NHSGG&C, between April and June 2015. This equates to a SAB rate of 33.0 cases per 100,000 AOBD.

The Quarterly Rolling Year ending June 2015 rate as per the Local Delivery Plan for SAB is 0.27 cases per 1,000 AOBDs***.*** This is against the June 2015 trajectory 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**

- In clinical areas that have an increased incidence of HAI SAB cases, a prospective review of all patients is undertaken by the Infection Prevention and Control Team and the Clinical team. This enables real time review, evaluation of features that may be amenable to improvement and development of local clinical action plans for improvement.
- 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 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.

- Compliance with GGC SOPs for the insertion, care and mantenance of CVC and PVC will now be monitored via the Infection Prevention and Control Audit. Audit results will be returned to the Chief Nurses for the area and included in the sector/directorate monthly reports.

- Trajectories have been issued to sectors/directorates in order for them to assess their performace against the SAB HEAT target.

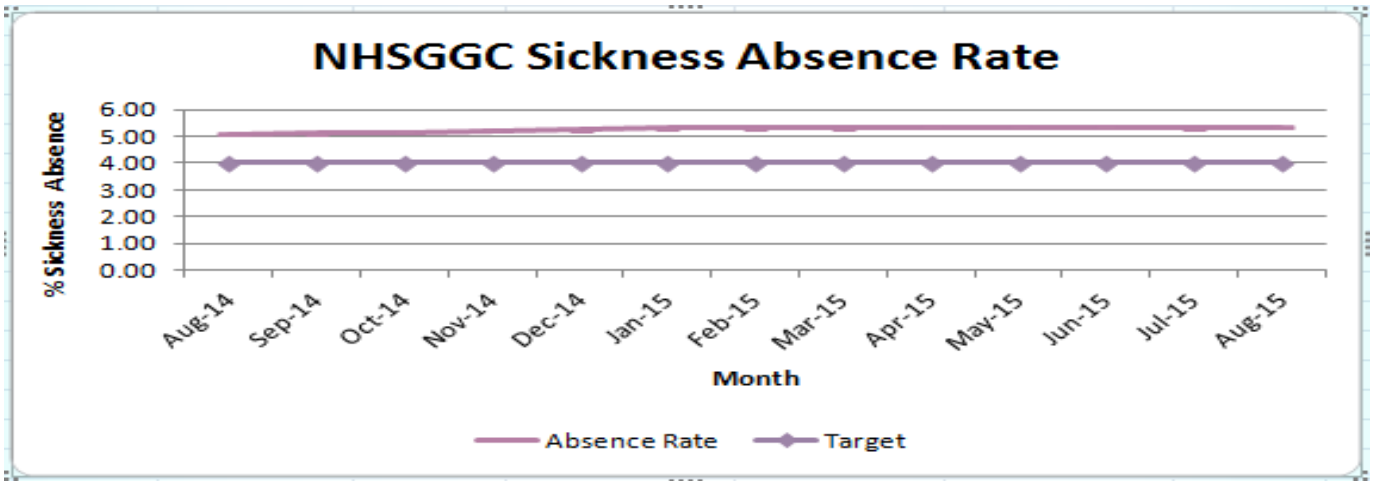
- A bi-monthly Cross Sector SABs group will be reconvened in November 2015. This will enable review and discussion of all reported SAB cases and permit sharing of best practice initiatives to cultivate a standardized improvement approach.

**Timeline For Improvement**

Ongoing.

**Exceptions Report: Sickness Absence**

| | |
|---|---|
| **Measure** | Sickness Absence Rate |
| **Current Performance** | As at August 2015, the rate of sickness absence across the Board was 5.3%. |
| **Lead Director** | Anne MacPherson, Director of Workforce and Organisational Development |




**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 August 2015 was 5.34%. This is higher than the rate reported for same period in the previous year (August 2014) which was 5.09%.

The split between long term and short term absence for the period under review is 3.5% and 1.8% respectively.

**Actions to Address Performance**

Attendance management continues as an objective in performance plans for 2015-16. In recognition of the importance of ensuring staff attendance at work and to facilitate an improvement in attendance levels the Human Resources and Organisational Development function will continue to apply the NHSGG&C Attendance Management Policy. To support the delivery of the objectives for improved staff attendance we will share good practice across the Board and will implement the RESOLVE absence model which facilitates a culture and values based approach to absence management. This has been piloted in the Facilities Directorate and achieved improvements in staff attendance levels in some areas of high absence.

The Human Resources and Organisational Development function will also undertake a line management survey in readiness for the new Human Resources and Organisational Development structure to identify support requirements for current and new line managers which will inform the line management Human Resources capability programme. This work will be led by the Organisational Effectiveness Unit to help line managers effectively manage sickness absence.

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. All staff are invited to participate in the Flu Immunisation clinics and managers should encourage individuals to maintain their health and well being by engaging with Board initiatives to promote good health and to seek support from their line manager if they have any health issues which impact on their ability to attend work.

**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** | For the period April 2015 – June 2015, a total of 267 smoking quits 12 weeks post quit were achieved. Actual performance is -19.6% below the target of 332 smoking quits. (*It should be noted that these figures are still incomplete due to follow-up time lag*). |
| **Lead Director** | Emilia Crighton, Interim Director of Public Health |

**Commentary**

As part of wider review of cessation services across NHSGG&C, reporting now includes a three stage model with indicative requirements in terms of the number of quit attempts and successful quits at four weeks required in order to reach the 12 week LDP Standard.

Stage two of the model is a proxy measure – the number of success quits at four weeks post quit and at present performance indicates a variance of -1.7%.

Current performance in relation to the number of successful 12 week post quit (in Boards, most deprived areas) represents approximately 75% of the April – June 2015 period. This is due to the follow-up period for these patients not due to end until 20 October 2015. The complete data for 12 week quits will therefore not be available until early November 2015.

The 12 week quit rates since January 2015 have increased significantly compared to the same period the previous year. If current 12 week quit rates for April and May 2015 are projected through to the end of June 2015 then we expect the April to June 2015 target to be met.

It should be noted that ISD are implementing a new quality control process across the Scottish Cessation database over the next few weeks. We expect this to identify learning opportunities across the country and this may impact on the current reported data around successful quit attempts.

It should also be noted that while the 12 week quit rates have increased across the Board area the overall numbers of patients making quit attempts with NHSGG&C stop smoking services has decreased by 24% for the period April – June 2015 (1,966) compared to the same period the previous year (2,571). This context of declining service uptake is reflected nationally and remains a significant challenge in achieving smoking cessation targets as less smokers choose to access support.

**Actions to Address Performance**

A series of improvement reviews have taken place across the six HSCPs and a number of emerging themes and lessons learned have been identified including:

- Variations in the patient journey/process maps within Community Services have impacted on outcomes.
- Variations in defining the service across the Partnerships contributes to low levels of service awareness delivering Community Services.
- Variations in quality and messages communicated via marketing materials across Partnerships.
- The need for improved joint working between Community and Pharmacy Services.
- Opportunities to ensure appropriate use of the most effective pharmaceuticals.
- Work with GP Practices leading to increased service uptake.
- Further development of the targeting of services to meet the needs of smokers in 40% most deprived areas.
- Workforce development and facilitated shared learning across partnership areas.

A number of actions are taking place as a result of the review process. These include:

- The development of a new range of marketing materials based upon the business principles of creating a desirable product for the customer.
- A multi-media campaign planned for January 2016 including local radio advertising.
- Introduction of a board wide Pharmacy smoking service steering group to facilitate better joint working between Community and Pharmacy Services; including development of a common core dataset for Pharmacy services.
- Good practice guidelines for Community Services in working with GP Practices around referral, engagement and prescribing data.
- Good practice guidelines for the patient journey to ensure best client management and maximum data capture towards LDP standard reporting.
- Development activity that generates appropriate referrals via health professionals rather than direct awareness raising by the cessation workforce.

**Timeline For Improvement**

Initial improvements around 12 week quit rates are already appearing. For example, the Community Services quit rate for the period January to May 2015 was 36% compared to 18% for the full year April – March 2014-15. We expect this level to be sustained for the remainder of 2015-16. The Pharmacy 12 week quit rates are also increasing and if sustained will have a positive impact on our ability to meet the target at year end.

In the medium term, the increasing number of referrals into the service via the marketing campaign will be closely monitored and reported in early 2016.