NHS Greater Glasgow & Clyde

NHS BOARD MEETING

Head of Performance **28 June 2016** **Paper No: 16/27**

NHS GREATER GLASGOW AND CLYDE'S INTEGRATED PERFORMANCE REPORT

Recommendation:
Board members are asked to:

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

Purpose of Paper:
To bring together high level information from separate reporting strands, to provide an integrated overview of the NHS Greater Glasgow and Clyde's performance in the context of the 2015-16 Strategic Direction/Local Delivery Plan (*until the 2016-17 Local Delivery Plan has been approved*).

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

Performance Improvements

- The percentage of patients admitted to a stroke unit on day of presentation or following presentation, has improved since previously reported to the Board with current performance currently exceeding target at 93%.
- The Board's final 2015-16 outturn was an under spend of £0.2m against the breakeven target.

Performance Deterioration

- The percentage of patients waiting < 18 weeks for RTT to Specialist Child and Adolescent Mental Health Services has deteriorated since previously reported to the Board with current performance currently at 99.8%.

Measures Rated As Red

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

Any Patient Safety/Patient Experience Issues:
None identified.

Any Financial Implications from this Paper:
None identified.

Any Staffing Implications from this Paper:
None identified.

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

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

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

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

Tricia Mullen, Head of Performance
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28 June 2016

NHS GREATER GLASGOW AND CLYDE

Board Meeting
28 June 2016 **Paper No: 16/27**

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 (*until the 2016-17 Local Delivery Plan has been approved*). 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 THE REPORT?

At the last Board meeting members requested that an update against the Child and Adolescent Mental Health 12 week internal waiting times target be provided. A 90% target was set for this internal measure and the March 2016 position shows that 90.1% of patients waited less than 12 weeks from referral to start treatment. *Appendix 1* provides an overview of performance against the internal target of 12 weeks during the past two years. In addition, the stroke care bundle measures have been included in the Performance At A Glance scorecard.

4. SUMMARY OF PERFORMANCE

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

Performance Improvements

- The percentage of patients admitted to a stroke unit on day of presentation or following presentation has improved since previously reported to the Board with current performance currently exceeding target at 93%.
- The Board's final 2015-16 outturn was an under spend of £0.2m against the breakeven target.

Performance Deterioration

- The percentage of patients waiting < 18 weeks for RTT to Specialist Child and Adolescent Mental Health Services has deteriorated since previously reported to the Board with current performance currently at 99.8%.
- The percentage of complaints responded to within 20 working days.

Measures Rated As Red

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

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

INTEGRATED PERFORMANCE REPORT

(INCLUDES WAITING TIMES AND ACCESS TARGETS)

28 JUNE 2016

PERFORMANCE SUMMARY

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

Key to the Report

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

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

Performance Summary At A Glance

The table below summarises overall performance in relation to those measures contained within the Integrated Performance Report. Of the 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	2	1	1	0	**4**
Shifting The Balance of Care	1	1	0	4	**6**
Reshaping Care for Older People	1	0	0	1	**2**
Improving Quality and Effectiveness	3	4	8	4	**19**
Tackling Inequalities	0	0	2	0	**2**
TOTAL	**7**	**6**	**11**	**9**	**33**

PERFORMANCE AT A GLANCE - JUNE 2016									
PREVENTING ILL HEALTH AND EARLY INTERVENTION									
Ref	**Type**	**Local Delivery Plan Standard**	**As At**	**2015-16 Actual**	**2016-17 Actual**	**2016-17 Target**	**Perform Status**	**Dir of Travel**	**Exceptions Report**
1	LDPS	Early diagnosis and treated in first stage cancer	Oct - Dec 15	26.6%	–	**28.5%**	**RED**	↓	Page 12
2	LDPS	Suspicion of Cancer Referrals (62 days)*	Apr-16	90.9%	86.5%	**95%**	**RED**	↓	Page 14
3	LDPS	All Cancer Treatments (31 days)*	Apr-16	94.2%	92.0%	**95%**	**AMBER**	↓	
4	LDPS	*Alcohol Brief Interventions*	Apr - Mar 16	15,980	–	**13,086**	**GREEN**	↑	
SHIFTING THE BALANCE OF CARE									
Ref	**Type**	**Local Delivery Plan Standard**	**As At**	**2015-16 Actual**	**2016-17 Actual**	**2016-17 Target**	**Perform Status**	**Dir of Travel**	**Exceptions Report**
5	LDPS	A&E max. 4 hours wait	Apr-16	89.9%	93.9%	**95%**	**AMBER**	↑	
6	LKPI	A&E Attendances per 100,000 popu	May - Apr 16	2,905	2,462	**No Target**	**GREY**	↑	
7	HSCI	*Delayed Discharge > 14 days (inc codes)*	May-16	30	34	**0**	**RED**	↓	Page 16
8	HSCI	*Delayed Discharge < 72 hours (inc codes)*	May-16	41	18	**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**	**2015-16 Actual**	**2016-17 Actual**	**2016-17 Target**	**Perform Status**	**Dir of Travel**	**Exceptions Report**
11	HSCI	*Acute bed days lost to delayed discharge*							
		All patients (65 years+)	Apr-16	3,893	3,415	**0**	**RED**	↑	Page 17
		AWI patients (65 years+)	Apr-16	1,241	1,690	**0**	**RED**	↓	
12	LDPS	*Number of people newly diagnosed with dementia in receipt of 1 years post diagnostic support*	N/A	N/A	N/A	**TBC**	**GREY**	–	
IMPROVING QUALITY, EFFICIENCY AND EFFECTIVENESS									
Ref	**Type**	**Local Delivery Plan Standard**	**As At**	**2015-16 Actual**	**2016-17 Actual**	**2016-17 Target**	**Perform Status**	**Dir of Travel**	**Exceptions Report**
13	LDPS	18 Week Referral To Treatment (RTT)							
		Combined Admitted/Non Admitted	Apr-16	90.4%	90.2%	**90%**	**GREEN**	↓	
		Combined Linked Pathway	Apr-16	88.2%	88.5%	**80%**	**GREEN**	↑	
14	LDPS	12 week Treatment Time Guarantee (TTG)							
		Inpatient	Apr-16	99.9%	97.3%	**100.0%**	**AMBER**	↓	
15	LKPI	Patient unavailability (Adults)							
		Inpatient/Day Case	Apr-16	4,925	6,847	**N/A**	**GREY**	↓	
		Outpatient	Apr-16	2,019	3,151	**N/A**	**GREY**	↓	
16	LKPI	% of patients waiting < 6 weeks for diagnostic test	Apr-16	100%	99.8%	**100%**	**AMBER**	↓	
17	LDPS	% of new outpatient waiting < 12 weeks for an appointment	Apr-16	99.9%	95.4%	**99.9%**	**AMBER**	↓	
18	LDPS	% of eligible patients commencing IVF treatment within 12 months	Mar-16	100%	–	**90%**	**GREEN**	↔	
19	LKPI	Stroke Care Bundle	Apr-16	61%	58%	**80%**	**RED**	↓	Page 18
		% of patients admitted to stroke unit	Apr-16	86%	93%	**90%**	**GREEN**	↑	
		% of patients CT/MRI scanned within 24hrs of Admission	Apr-16	94%	97%	**90%**	**GREEN**	↑	
		% of patients with swallow screen carried out on Day of admission	Apr-16	79%	61%	**90%**	**RED**	↓	
		% of Patients prescribed aspirin on Day of Admission, or Day following	Apr-16	91%	96%	**90%**	**GREEN**	↑	
20	LDPS	% patient waiting < 18 weeks for RTT to Specialist Child and Adolescent Mental Health Services	Apr-16	100%	99.8%	**100%**	**AMBER**	↓	
21	LDPS	% patients who started treatment <18 weeks of referral for psychological therapies	Jan - Mar 16	92.4%	–	**90%**	**GREEN**	↓	
22	LDPS	Drug and Alcohol: % of patients waiting < 3 weeks from referral to appropriate treatment	Jul - Sept 15	97.9%	–	**91.5%**	**GREEN**	↑	
23	LDPS	SAB Infection rate (cases per 1,000 OBD rolling year)	Jan - Dec 15	0.33	–	**0.24**	**RED**	↓	Page 20
24	LDPS	C.Diff Infections (cases per 1,000 OBD rolling year)	Jan - Dec 15	0.31	–	**0.32**	**GREEN**	↓	
25	LDF	*% of complaints responded to within 20 working days*	Jan - Mar 16	81%	72%	**70%**	**GREEN**	↓	
26	LDPS/LDF	Financial Performance	Mar-16	£1.2m	£0.2m	**Breakeven**	**GREEN**	↓	Agenda Item 11
27	LDPS/LDF	Sickness Absence (rolling year)	Apr-16	5.34%	5.42%	**4%**	**RED**	↓	Page 22
		Long Term	Apr-16	3.55%	3.58%	**N/A**	**GREY**	↓	
		Short Term	Apr-16	1.79%	1.84%	**N/A**	**GREY**	↓	
TACKLING INEQUALITIES									
Ref	**Type**	**Local Delivery Plan Standard**	**As At**	**2015-16 Actual**	**2016-17 Actual**	**2016-17 Target**	**Perform Status**	**Dir of Travel**	**Exceptions Report**
28	LDPS	80% of pregnant women in each SIMD quintile have access to Antenatal Care at 12 week gestation	Oct - Dec 15	83.6%	–	**80%**	**GREEN**	↑	
29	LDPS	Smoking Cessation - number of successful quitters at 12 weeks post quit in 40% SIMD areas (Data incomplete)	Apr - Dec 15	1223	–	**996**	**GREEN**	↑	

* Data still to be validated

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

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

AMBER COMMENTARY

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

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

Ref	Measure	As At	2014-15 Actual	2015-16 Actual	2015-16 Target	Perform Status	Dir of Travel
3	All Cancer Treatments - 31 days (*data still to be validated*)	April 2016	94.2%	92.0%	95.0%	**AMBER**	↓

Commentary

As at April 2016, 92.0% of all patients diagnosed with cancer were treated within 31 days from decision to treat to first treatment. Current performance is below the 95% target and lower than the position reported during the same month the previous year.

Actions To Improve Performance

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

Ref	Measure	As At	2014-15 Actual	2015-16 Actual	2015-16 Target	Perform Status	Dir of Travel
14	Treatment Time Guarantee - number of patients waiting > 12 weeks for an appointment	April 2016	99.9%	97.3%	100%	**AMBER**	↓

Commentary

Overall, 97.3% of patients were treated within the 12 week Treatment Time Guarantee (TTG) at April 2016 (month end). The remaining 2.7% patients represents a total of 188 patients that were not treated within the 12 week TTG in the following specialties: Urology (73), Neurosurgery (62), Trauma and Orthopaedic Surgery (28), Oral Maxillofacial Surgery (20) and General Surgery (5).

Actions To Improve Performance

- **Neurosurgery (62) patients and Oral Maxillofacial (20) patient** - since April 2016 (month end), 17 of the Neurosurgery and six of the Oral Maxillofacial (OM) patients have since received their treatment; 14 Neurosurgery and two OM patients now have a confirmed date for their procedures to be carried out; 27 neurosurgery and 10 OM patients are waiting for a date to be confirmed for their procedure to be carried out; two Neurosurgery and two OM patients have been removed from the list and the remaining two Neurosurgery patients were unavailable. The theatres have been closed since 26 February 2016 due to sewage in the recovery areas of the first floor theatre complex within the Institute of Neurological Science. Following the remedial works carried out to resolve the problem both Health Protection Scotland and Health Facilities Scotland carried out an inspection and confirmed on 16 May that NHSGG&C met the criteria outlined in their report. Theatres 2, 3, 6 and 7 were brought back into clinical use on 17 May. The service now has six fully operational theatres. Additional capacity of 22 neurosurgery sessions and five OMS sessions have been established for the period 23 May – 12 June to commence the elective recovery programme. Further sessions are also currently being modelled.

- **Urology (73) patients** (*72 in South and one in North Sectors*) - the capacity issues within the Urology Service in the South Sector remain challenging. Of the 73 Urology patients waiting at April 2016 month end: 20 patients have since received their treatment, a further five patients have a confirmed hospital admission date for their procedure to be carried out between June and July 2016, two patients have since been removed from the waiting list, and the remaining 46 patients have no date for admission booked as yet. At present there is no capacity to address the outstanding patients who are waiting for routine procedures and do not have any clinical urgency however, all cancer patients have been prioritised.

- **Trauma and Orthopaedics (28) patients** - 21 patients are waiting for a date to be confirmed for their procedure and in many cases the patients have cancelled several times. The service is working to re-book these patients, six have since received their procedure in May 2016 and the one remaining patient was removed from the list.
- **General Surgery (5) patients** - three of the five General Surgery patients have a confirmed date to receive their treatment; one patient has been removed from the list and the one remaining patient is waiting for a date to be confirmed for their procedure to be carried out.

Ref	Measure	As At	2014-15 Actual	2015-16 Actual	2015-16 Target	Perform Status	Dir of Travel
16	% of patients waiting < 6 weeks for diagnostic test	April 2016	100%	99.8%	100%	**AMBER**	↓

Commentary

As at April 2016, 99.8% of all patients waited less than four weeks for a key Diagnostic test. Current performance just the 100% target and lower than the position reported during the same month the previous year.

A total of five patients waited more than six weeks for a cystoscopy test. There are capacity issues for this specific test as only one Consultant currently carries out these tests. The Directorate team is working on plans to expand capacity with Sector colleagues to clear this backlog.

Actions To Improve Performance

- A full review and overhaul of the service waiting list procedures has been undertaken, including training.
- Consultant job plans have been changed to free up some additional capacity at the Victoria ACH in order to deliver more activity.
- Clinical Nurse Specialist Check Cystoscopy list implemented for one session per week at the Victoria ACH on Friday afternoons, with a view to increase by an additional session in the near future (constrained to specific patient returns and pre-determined criteria, but frees up capacity for Consultants to see for initial cystoscopies).
- The Service is exploring the possibility of developing Nurse-led Diagnostics within the next 18-24 months.
- Additional Consultant job plan changes are in progress to provide additional diagnostic capacity and will require a collaborative approach with other Sectors.
- A Cross-Sector working group remains in place to address core Urology issues.

Ref	Measure	As At	2014-15 Actual	2015-16 Actual	2015-16 Target	Perform Status	Dir of Travel
17	% of new outpatients waiting < 12 weeks for an appointment	April 2016	99.9%	95.4%	99.9%	**AMBER**	↓

Commentary

As at April 2016 (month end), 95.4% of new outpatients patients were waiting for less than 12 weeks from the date of their referral for an outpatient appointment. Current performance is below the trajectory of 99.9%.

Current performance represents a total of 3,290 new outpatients waiting > 12 weeks for a new outpatient appointment and a 29% increase on the number of patients reported in March 2016. The patients waiting over 12 weeks at the end April 2016 for a new outpatient appointment were in the following Sectors/Directorates:

- **South Sector** - a total of 1,471 new outpatients were waiting > 12 weeks for a new outpatient appointment in the following specialties: 1,029 in Gastroenterology, 180 in Rheumatology, 163 in Respiratory, 65 in Diabetes, 22 in Cardiology, 10 in Endocrinology, one in Infectious Diseases and one in Allergy.

- **North Sector** - a total of 840 new outpatients were waiting > 12 weeks for a new outpatient appointment in the following specialties: 677 in Anaesthetics, 134 in Respiratory Medicine and 29 in Gastroenterology.

- **Clyde Sector** - a total of 473 new outpatients were waiting > 12 weeks for a new outpatient appointment in the following specialties: 378 in Gastroenterology, 94 in Rheumatology and one in Cardiology.

- **Regional Services** - a total of 506 new outpatients were waiting > 12 weeks for a new outpatient appointment in the following specialties: 504 in Neurology and two patients in Rehabilitation Medicine.

Actions To Improve Performance

- **South Sector** - 5.7% of the total number of available outpatients were waiting >12 weeks for a new outpatient appointment. There are ongoing capacity issues within a number of key specialties that are resulting in patients waiting over 12 weeks i.e. Gastroenterology - 1,029 (4% of total available list), Respiratory - 163 (0.6% of total available list) and Rheumatology - 180 (0.7%) of the total waiting list. There are a number of vacancies and sickness absences in relation to the above specialties and work is underway to recruit new consultants where vacancies exist e.g. a rheumatology consultant post is scheduled to be filled in July 2016; interviews for a replacement cardiologist will take place in July 2016 and the advert for a respiratory consultant is expected to go out within the next month. Some of the gaps in service provision are being filled with paid additional waiting list clinics.

- **North Sector** - 7% of the total number of available outpatients were waiting > 12 weeks for a new outpatient appointment. 81% (677) of new outpatients waiting > 12 weeks were in the Chronic Pain Service which recently transferred to the North Sector. There remains significant pressure on the Chronic Pain Service outpatient list due to long term consultant absence and a maternity leave gap. The service has been experiencing very high referral rates which have caused capacity issues. Additional clinics have been arranged over the coming months to mitigate these challenges and further steps are being explored to address this, for example - review vetting to allow more patients to be seen by non-consultant staff in the first instance. In addition, the North experienced gaps in medical staffing due to long term sickness and vacancies. Pressures also remain in Respiratory due to capacity shortfalls and staffing shortages and likely to continue until the two new consultants that have been appointed start and scheduled to start in August 2016 with an improvement in performance expected to follow thereafter.

- **Clyde Sector** - 2.7% of the total number of available outpatients were waiting > 12 weeks for a new outpatient appointment. The majority of the new outpatients (80%) waiting > 12 weeks were Gastroenterology patients and a further 20% were Rheumatology patients. The service continues to work with two locum consultants whilst waiting to appoint two new substantive gastroenterology consultants. It is anticipated that these new appointments once recruited will lead to performance improvements. In terms of rheumatology the demand at the Royal Alexandria Hospital (RAH) outweighs the capacity despite pulling a session from Inverclyde Royal Hospital (IRH), the rigorous implementation of back to referrer processes and changing the alignment of the catchment area for referring. Demand and capacity profiling is also currently underway which may lead to a business case. There has also been a long term sickness absence affecting all three sites in relation to the Rheumatology Clinical Nurse Service which has further increased the pressure on the consultants.

- **Regional Services** - 8% of the total number of available outpatients were waiting > 12 weeks for a new outpatient appointment. With the exception of two patients (which were coding errors and

should have been more appropriately listed as return patients), all of the new outpatients waiting > 12 weeks were Neurology patients. The pressure remains within the Neurology outpatients services and a number of actions are currently being implemented to bring all 504 neurology outpatients back in line with the 12 week target including:

- The provision of ongoing waiting list initiative clinics to provide extra capacity.
- Four new consultant posts covering West of Scotland have been agreed with potential interview dates in August 2016.
- The Scottish Government are in discussion with the independent sector for the provision of additional capacity.
- A redesign of Multiple Sclerosis services has been organised for July 2016 to address capacity issues.

Ref	Measure	As At	2014-15 Actual	2015-16 Actual	2015-16 Target	Perform Status	Dir of Travel
20	% of patients waiting < 18 for RTT to Specialist Children and Adolescent Mental Health Services	April 2016	100%	99.8%	100%	**AMBER**	↓

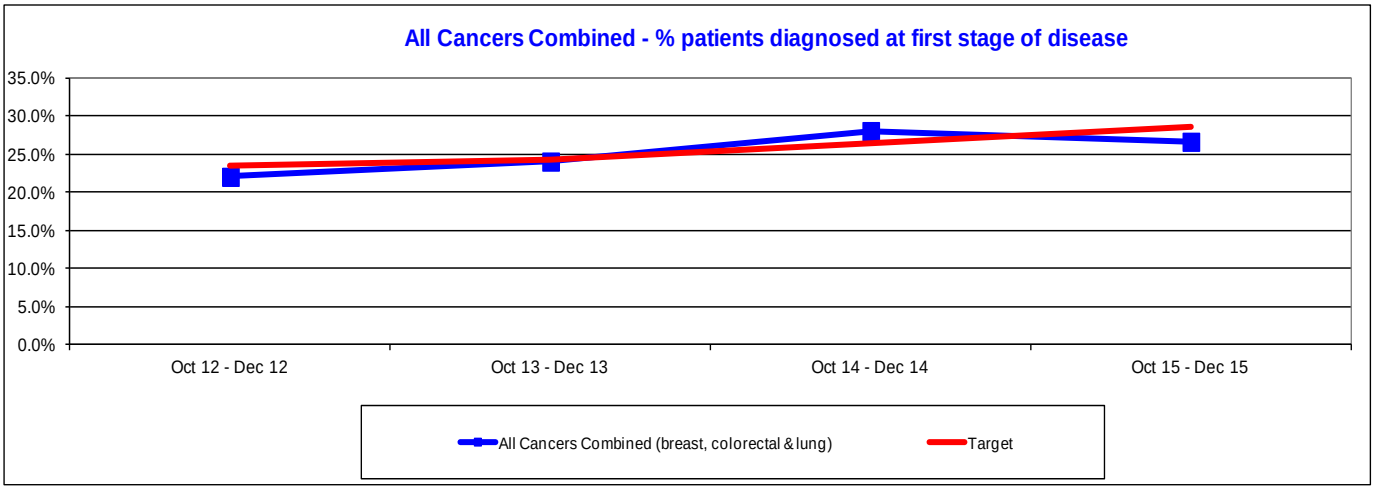
Commentary

As at April 2016, 99.8% of all patients waited less than 18 weeks from referral to start treatment. The two patients from East Renfrewshire HSCP that waited > 18 weeks have since received their treatment.

PERFORMANCE EXCEPTIONS REPORTS

Exceptions Report: Detect Cancer Early

Measure	Detect Cancer Early (DCE)
Current Performance	Overall, for the period October - December 2015 the percentage of patients diagnosed with Stage 1 cancer was 26.6%. Current performance is lower than the trajectory of 28.5%. ***Please Note:*** *The DCE data is reported four months after the end of the reported quarter. This timeline had been agreed by Health Boards and ISD as the earliest timeframe in which complete data would be available.*
Lead Director	Gary Jenkins, Director of Regional Services



Commentary

All Cancers Combined

There has been a 0.1% increase in patients diagnosed at stage 1 for October - December 2015 (26.6%) compared to July - September 2015. The October - December 2015 position is 1.9% below the trajectory for this period (28.5%). Early data for 2014/2015 demonstrate 25.2% of patients diagnosed at stage 1. In terms of cancer types performance is as follows:

Breast Cancer

There has been a 6.1% increase in patients diagnosed at stage 1 for October - December 2015 (45.1%) compared to July - September 2015. The October - December 2015 position is 2.4% above trajectory for this period (42.7%). Early data for 2014/2015 demonstrate 39.4% of patients diagnosed at stage 1.

Colorectal Cancer

There has been a 3.8% decrease in patients diagnosed at stage 1 for October - December 2015 (13.3%) compared to July - September 2015. The October - December 2015 is 12.5% below trajectory for this period (25.8%) Early data for 2014/2015 demonstrate 15.6% of patients diagnosed at stage 1.

Lung Cancer

There has been a 3.7% decrease in patients diagnosed at stage 1 for October - December 2015 (16.9%) compared to July - September 2015. The October - December 2015 position is 2.6% below trajectory for this period (19.5%). Early data for 2014/2015 demonstrate 20.0% of patients diagnosed at stage 1.

Actions to Address Performance

Breast Cancer

The October - December 2015 data demonstrates an overall improvement in performance when compared to previous two quarters and has brought performance back above trajectory.

Colorectal Cancer

The October - December 2015 data highlights a decrease in performance when compared to previous

quarter. As previously noted, the baseline data may have been affected by the introduction of the bowel screening programme and discussions with other NHS Boards regarding data indicate that they experienced similar trends in DCE for colorectal cancer. For example, Bowel screening was introduced in NHSGG&C in 2009. As a result, it is likely that the volume of early stage presentations were picked up sooner than anticipated when the initial trajectory was set. An analysis of colorectal cancers indicates that the bowel screening crude detection rate has decreased whilst the uptake of bowel screening has not.

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

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

Lung Cancer

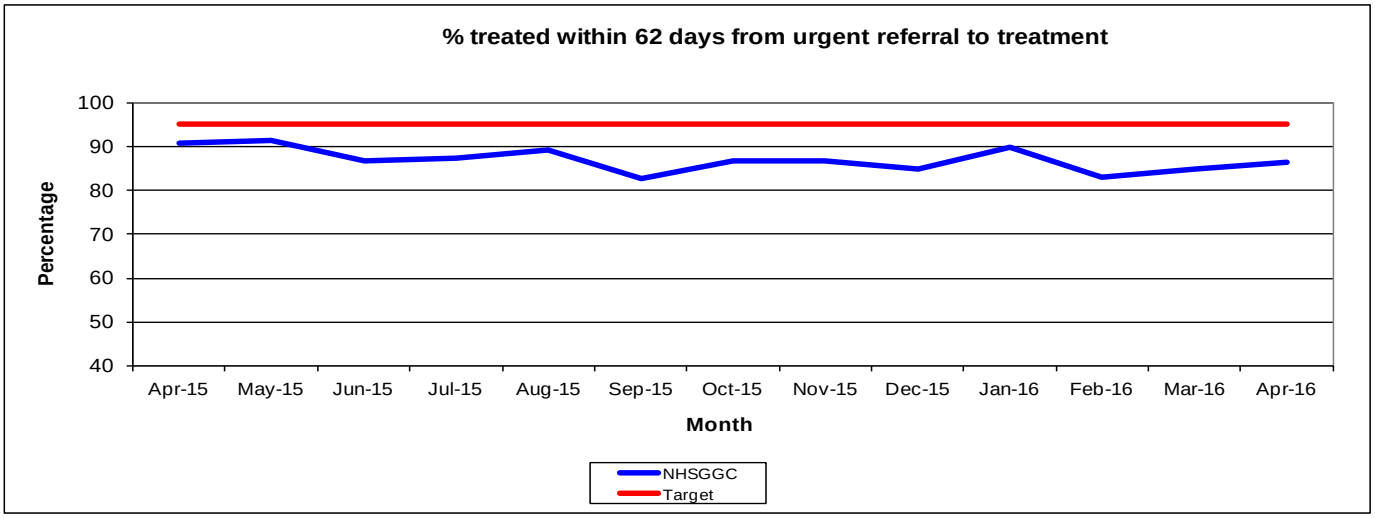
The October - December 2015 data demonstrated a decrease compared to previous quarter and is under trajectory. However, it is noted that performance throughout other quarters in 2013 and 2014 was above trajectory.

Timeline For Improvement

Ongoing with continual review of performance.

Exceptions Report: Suspicion of Cancer Referrals (62 days)

Measure	Suspicion of Cancer Referrals
Current Performance	As at April 2016, 86.5% of patients with an urgent referral for suspicion of cancer were treated within 62 days of the referral. Current performance is below the target of 95%. (*Data provisional*)
Lead Director	Gary Jenkins, Director of Regional Services



Commentary

62-Day Target

As at April 2016, 86.5% (*230 out of 266*) of eligible referrals with an urgent referral for suspicion of cancer were treated within 62 days of referral below the target of 95%. Current performance shows an improvement on the March 2016 position of 85%.

The cancer types currently below the 95% target are as follows: Urology 66.7.% (*24 out of 36 eligible referrals treated within target*), Head and Neck 90.9% (10 *out of 11 eligible referrals treated within target*), Upper GI 91.4% (*32 out of 35 eligible referrals treated within target*), Colorectal - screened excluded 90.5% (*20 out of 22 eligible referrals treated within target*), Colorectal - screened only 35.7% (five *out of 14 eligible referrals treated within target*) and Breast - screened only 84.2% (*32 out of 38 eligible referrals treated within target*).

31-Day Target

As at April 2016, 93.5% (*463 out of 495 eligible referrals were treated within target*) of patients with a decision to treat were treated within 31 days.

The cancer types below 95% were Breast - screened only 76.3% (*29 out of 38 eligible referrals treated within target*), Urology 81.8% (*63 out of 77 eligible referrals treated within target),* Head and Neck 91.4% (32 *out of 35 eligible referrals treated within target*) and Colorectal - screened only 93.3% (*14 out of 15 eligible referrals treated within target*).

Actions to Address Performance

Urological Cancer

The main pressures within Urology are timely access to general anaesthetic surgical lists for core procedures, general anaesthetic surgical lists for complex surgery (prostatectomy and nephrectomy), diagnostic procedures (flexible cystoscopy/ureteroscopy/TRUS and biopsy). There is also pressure on timely access to the urological oncology service, especially clinical oncology.

An improvement plan was presented to the Acute Strategic Management Group in May 2016.

Confirmation was received from the Cancer Performance Support Team on 25 May 2016 that an initial non recurring revenue would be allocated to NHSGG&C to support the development of the above improvement measures. Further funding is being determined as this point. In relation to Urology, this plan includes the following measures and sectors are currently finalising implementation plans:

- Additional urological diagnostic (flexible cystoscopy/TRUS and biopsy) sessions (North and South sectors).
- Introduction of TURis (Trans-urethral resection in saline) service (North and South sectors).
- Additional theatre sessions for renal surgery (South sector).
- Additional Clinical Oncologist.
- Additional Pathologist/laboratory support.

The above measures are anticipated to help alleviate pressures and allow more timely access to urological diagnostic and surgical procedures and specimen reporting. Therefore an improvement in cancer waiting times performance would be anticipated.

Breast Cancer

Overall breast performance has shown an improvement compared to recent months. Work is progressing on the NHSGG&C Breast model and a further review of this tumour type will be undertaken once the outcome of the NHSGG&C Breast model is concluded.

Colorectal Cancer

Colorectal performance for screening patients has been challenging. Detailed analysis of cases has demonstrated that timely access to colonoscopy pre-assessment and colonoscopy is variable. It is also noted that bowel screening cases are not currently tracked pre-diagnosis and are only added to tracking once there is a histological diagnosis reported.

The following improvement measures now in place should improve waiting times performance:

- Increased dedicated colonoscopy pre-assessment capacity.
- Introduction of bowel screening tracker to allow early identification of pre-diagnosis issues and peaks in demand and earlier identification of cancer diagnoses.
- A review of bowel screening colonoscopy capacity as part of overall review of endoscopy capacity within sectors.
- An action plan is currently in place and being progressed.

Head and Neck Cancer

Head and Neck performance in April 2016 showed an improvement compared to previous months, with only one case treated in April breaching the 62-day target. However, it is recognised that there is still significant pressure on the front end of the Head and Neck pathway given the volume of referrals compared with the numbers of patients actually diagnosed with cancer. Additional clinics continue to be implemented.

Upper GI

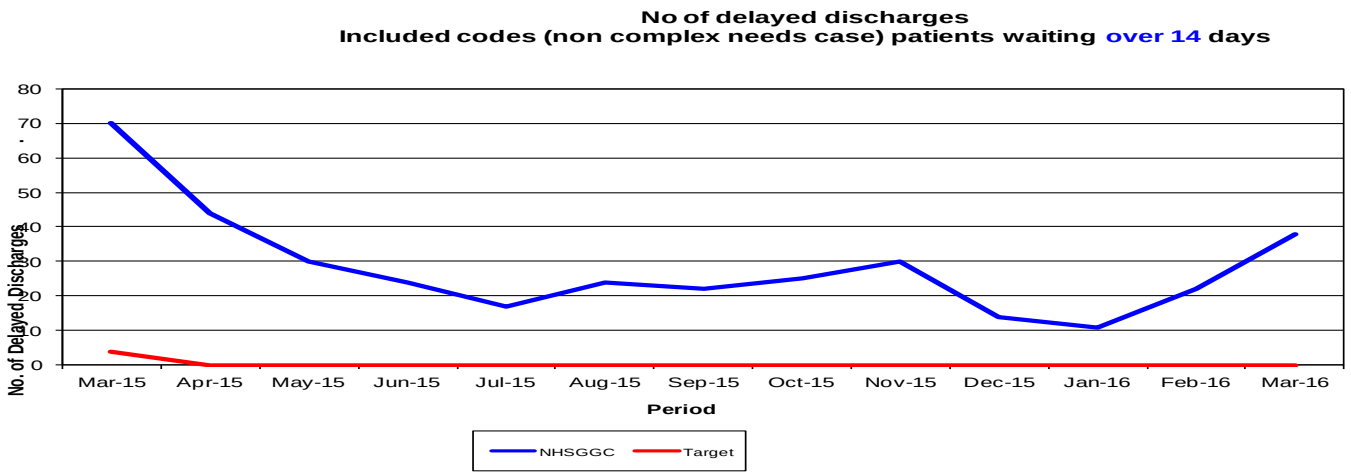
April 2016 performance demonstrates an improvement compared to Quarter 1 2016. It is recognised that a 62-day pathway is challenging for some Upper GI patients due to the number of steps on their standard pathway. Work continues to ensure a 7-day rather than 14-day wait for CT.

Timeline For Improvement

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

Exceptions Report: Delayed Discharge > 14 days

Measure	Delayed Discharges > 14 days
Current Performance	As at May 2016, 34 patients were delayed for > 14 days against a target of zero and 18 patients were delayed for < 72 hours.
Lead Director	Catriona Renfrew, Director of Planning & Policy



Commentary

The May 2016 position of 34 patients delayed > 14 days is an improvement on the 38 reported in March 2016.

Of the total number of patients delayed > 14 days: 29 were residents of Glasgow City (14 residents from the North West Sector; 13 from the South Sector and two from North East Sector); one was a resident of West Dunbartonshire and the remaining four patients delayed were outwith the Board area.

The above figures exclude the 90 patients delayed > 14 days for legal reasons and who lack capacity (AWI) in May 2016. The total comprises 59 patients from Glasgow City, nine from West Dunbartonshire, six from Renfrewshire, three from East Renfrewshire, two from Inverclyde and two from East Dunbartonshire and the remaining nine patients were outwith NHSGG&C boundary.

There were 18 patients delayed < 72 hours for legal reasons and who lacked capacity (AWI) in May 2016.

Actions to Address Performance

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

Timeline For Improvement

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

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

Measure	Bed Days Lost to Delayed Discharge For Adults with Incapacity (AWI) Patients (65 years+)
Current Performance	As at April 2016, the number of bed days lost to delayed discharge was 3,415 (1,690 for AWI patients).
Lead Director	Catriona Renfrew, Director of Planning & Policy

Table 1

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

	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
HSCP	**April Actual**	**April Actual**	**April Actual**	**Apr Actual**	**Apr Actual**	**Apr Actual**
East Dunbartonshire	600	326	408	424	462	187
East Renfrewshire	307	514	274	309	164	206
Glasgow City	**6,132**	**4,207**	**3,004**	**3277**	**2204**	**2359**
Inverclyde	379	478	195	301	138	104
Renfrewshire	1,409	1,409	625	244	529	212
West Dunbartonshire	730	600	454	416	396	347
GGC(All above areas)	**9,557**	**7,534**	**4,960**	**4,971**	**3,893**	**3,415**

Table 2

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

	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
HSCP	**April 11 Actual**	**April Actual**	**April Actual**	**Apr Actual**	**Apr Actual**	**Apr Actual**
East Dunbartonshire	96	23	0	30	210	0
East Renfrewshire	0	30	0	30	0	117
Glasgow City	**1,527**	**1,281**	**692**	**664**	**556**	**1286**
Inverclyde	60	0	0	30	0	0
Renfrewshire	184	189	78	196	351	130
West Dunbartonshire	215	151	120	106	124	157
GGC(All above areas)	**2,082**	**1,674**	**890**	**1,056**	**1,241**	**1,690**

Commentary

As seen from *Table 1* above, in April 2016 the number of bed days lost to delayed discharge was 3,415 representing a 12.3% reduction in April 2015 position.

Table 2 highlights a total of 1,690 bed days lost to delayed discharge for AWI patients in April 2016 representing a 36% increase on the number reported during the same period the previous year (from 1,241 bed days lost in April 2015 to 1,690 in April 2016). As part of the service and financial planning for 2016-17 we are aiming to agree with Partnerships a target of zero bed days lost.

Actions to Address Performance

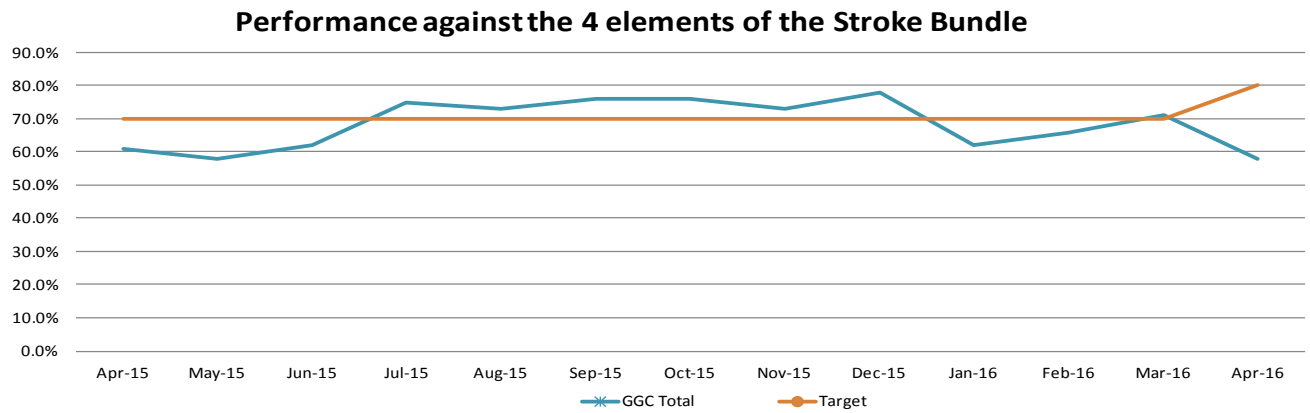
As per the actions outlined in the delayed discharge exception report.

Timeline for Improvement

As identified in the delayed discharge exception report.

Exception Report: Stroke Care Bundle

Measure	Stroke Care Bundle
Current Performance	As at April 2016, overall performance against the Stroke Care Bundle was 58% which is below the target of 80%.
Lead Director	Catriona Renfrew, Director of Planning & Policy



Commentary

As seen from the graph above, current performance in relation to the stroke bundle was below target in April 2016 at 58% against a target of 80%. Performance across each of the four hospitals delivering the stroke care bundle was below the 80% target with IRH at 65%; RAH at 63%; Glasgow Royal Infirmary (GRI) at 55% and Queen Elizabeth University Hospital (QEUH) at 57%.

The current stroke bundle position is mainly driven by performance in relation to the Swallow Screen element of the stroke care bundle which has remained a challenge across the Acute Division. As of the 1 April, the swallow screen element of the stroke care bundle was revised from the swallow screen test to be carried out on day of admission to now being carried out within four hours of admission in addition to the target being revised upwards from 90% to 100%.

Overall performance against the swallow screen element was 61%, below the 100% target as at April 2016. Performance across each of the hospital sites was below target: the IRH at 65%; RAH at 75%; GRI at 59% and QEUH at 58% overall performance was 61%. This element of the stroke care bundle remains particularly challenging as seen in the performance and further work is required to ensure stroke teams and medical receiving teams understand the target and focus on improving performance.

Actions to Address Performance

There is a system wide review of Stroke Care currently underway to address the challenges across the Division. In addition, a number of short term improvement actions to address performance are currently underway across Acute and at each of the hospital sites including:

- Across Acute - work is currently underway in all Emergency Departments to ensure that all patients (not just stroke related patients) that require a swallow screen test receive it.

Specific action at hospital sites include:

- RAH/IRH - the stroke audit coordinator has recommenced live time reporting of patients that do not receive their swallow screen within four hours of admission to the clinical team (SCN/Consultant and Stroke CNS) alongside weekly meetings with the team to review performance and target areas for improvement. An analysis of all patients that did not have their swallow screen test carried out on time will take place to ensure that support and training is provided to the clinical teams. Key staff from the Stroke Emergency Department and AMU have met and reviewed the approach that is taken

to meet the new four hour swallow screen assessment target. Speech and Language Training for Emergency Department staff at the IRH was completed in March 2016.

- GRI - there continues to be a focus on achieving the target through the following actions:

  - The Lead Nurse (medicine) conducts a weekly walk round of receiving wards raising awareness of the stroke swallow screen and undertaking 'spot checks' of notes.
  - Where swallow screen is not undertaken in time, a thorough analysis is undertaken to understand the reasons.
  - There is Stroke CNS presence on receiving wards on weekdays.
  - A weekly swallow performance report is sent to relevant Charge Nurses.
  - Ongoing education by Stroke CNS with the offer of additional training to individual staff teams from SLT as required.

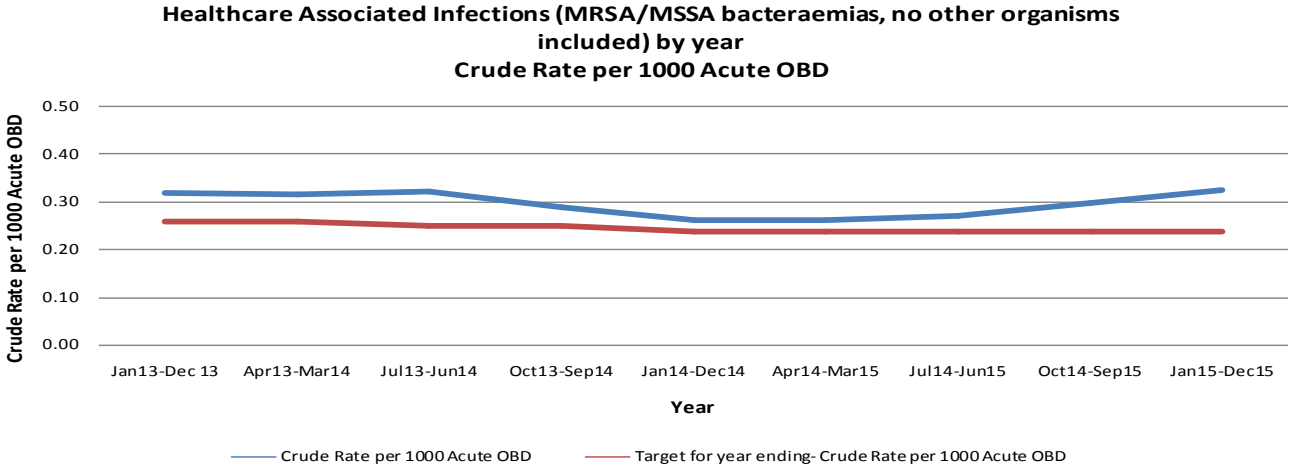
- QEUH - the stroke specialist nurses review each case where a patient did not receive a swallow screen within the four hours and report to stroke team meetings to ensure improvements can be made. There is also a review of stroke nursing currently taking place to clarify the role of the stroke specialist nurses and senior ward nurses (Band 6+). A particular element of this is looking at how the stroke nursing staff support patients on admission especially whilst the patients are in Emergency Departments.

Timeline For Improvement

A Stroke Care Review Group has been established to oversee developments in relation to Stroke Care. The outcome of the review will shape and inform the future delivery of Stroke Care and drive improvement in performance across the Division.

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

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



Commentary

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

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

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

Agenda Item 6 – Board-wide Healthcare Associated Infection Exception Reporting Template (HAIRT) provides more detail on current position.

Actions to Address Performance

- PVC and CVC ward sweeps (audit of care plan) were undertaken in four acute sectors by ward staff using IPC sweep proforma. Final report issued to Acute Infection Control Committee membership which highlighted areas for further improvement. PVC care plan compliance was good at 87% across the completed sectors; however compliance with CVC care plan documentation was suboptimal at 67%. Local educational actions were undertaken in areas of poor compliance to improve standards of documentation.

- Validation audit February 2016: PVC and CVC ward sweeps were undertaken in every sector by IPC staff. This also included availability of PVC patient information leaflet for all applicable patients at time of sweep. Analysis/report currently underway by IPC Data Team.

- Focussed Quality Improvement work:
  - Neonatal Units: RAH,RHC & PRM
    Reduction of IV access device related SABs by standardised PVC/CVC insertion and maintenance bundles and care plans.

- RAH Wards
  Reduction of IV access device related SABs by increasing PVC care plan compliance in a pilot medical ward.
- Community
  Reduction of non hospital acquired SAB cases (Community and Healthcare Associated Infection).
- RHC: Neonatal Unit
  Reduction of IV access device related SABs by increasing PVC care plan compliance.

- Development and production of educational videos demonstrating adherence with aseptic technique when inserting and accessing PVCs and obtaining a blood culture. (This will be undertaken in conjunction with Practice Development).

- Increased focus on junior medical staff educational induction programme content to include information on prevention of bacteraemia and optimal practice with insertion, utilisation and maintenance of IV access devices (PVC/CVC/PICC).

- Review of PVC care plan commencement on device insertion in Emergency Departments and Theatres.

- Review of incorporation of PVC and CVC careplans as eForms within Nursing Admission Documentation.

- Assurance that medical staff induction and education incorporates healthcare associated infection information e.g. aseptic technique, venepuncture and cannulation.

- Information on LearnPro Aseptic Technique module completion by staff groups for 2015 highlighted that 97% of this module was completed by Nursing and midwifery staff. Further encouragement for medical staff and other clinical staff groups to successfully undertake this educational module should be upheld in 2016.

- Active promotion of antibiotic review to optimise timely IV to oral switch on all hospital sites: daily review of all patients receiving IV antibiotic therapy with minimum standard of documented review and plan at 72 hours.

- Incorporation of antibiotic IVOST indicators into PVC care plan.

- Incorporation of antibiotic review/IVOST and PVC review to “ward round checklist” (in development).

- AMT to retrospectively review clinical management of patients with SAB in Q3/4 2015.

- Promotion of SAB management guideline: ensure appropriate management of source and correct antibiotic therapy.

- IPC Data Team inform sector Antimicrobial Pharmacists of SAB patient CHIs to enable real time review of appropriate therapy and assurance that appropriate source control had been undertaken.

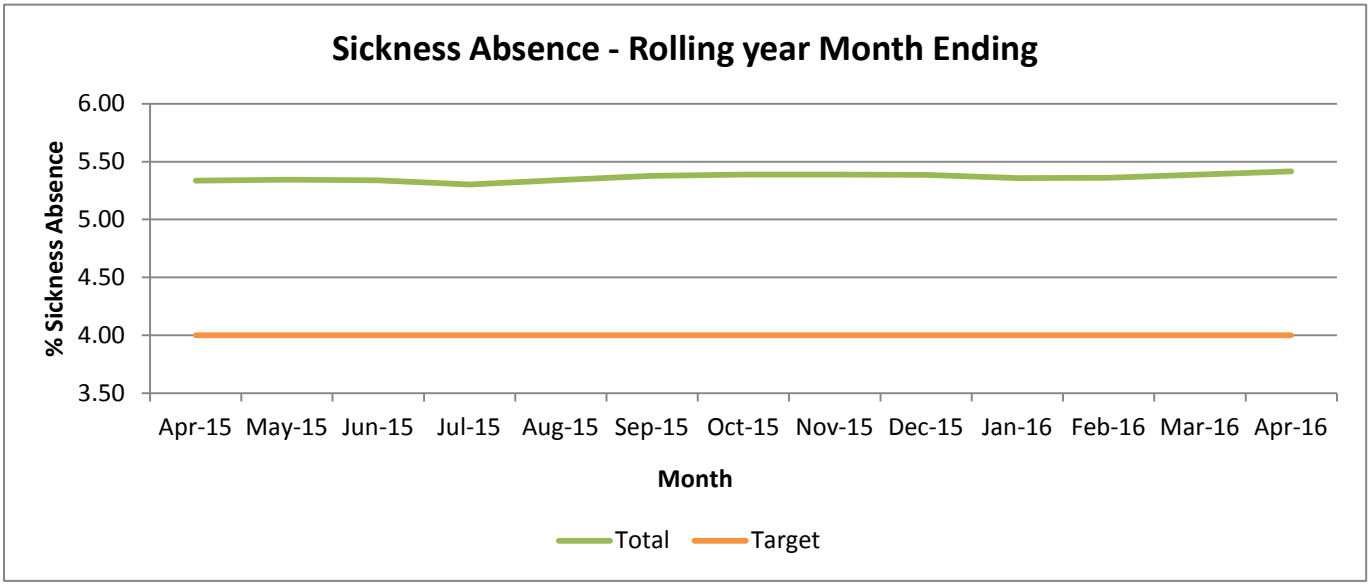
- Clinical staff have a requirement to comply with guidelines published by the NHSGG&C Antimicrobial Utilisation Committee.

Timeline For Improvement

Ongoing.

Exceptions Report: Sickness Absence

Measure	Sickness Absence Rate
Current Performance	As at April 2016, the rate of sickness absence across the Board was 5.42%.
Lead Director	Anne MacPherson, Director of Workforce & Organisational Development



Commentary

The 2015-16 Local Delivery Plan Standard requires '*NHS Boards to achieve a sickness absence rate of 4%'.* The overall sickness absence rate for the rolling year to April 2016 was 5.42%. This is higher than the rate reported for same period in the previous year (April 2015) which was 5.34%.

The split between long term and short term absence for the period under review is 3.58% and 1.84% respectively.

Actions To Address Performance

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

Area	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
Acute	5.78	5.53	5.59	5.89	5.87	5.84	5.89	5.96	6.18	6.37	6.05	6.03	5.78
Board Wide Facilities						8.46	8.69	9.38	8.31	8.95	9.12	8.25	8.50
Other Functions	4.32	3.94	3.94	3.90	3.85	4.40	4.06	4.62	4.50	4.92	5.22	4.94	4.53
Partnership	5.46	5.68	5.84	5.74	5.56	5.94	6.22	6.17	6.08	6.35	6.50	6.09	5.45
GG&C	**5.58**	**5.44**	**5.52**	**5.69**	**5.63**	**6.03**	**6.12**	**6.26**	**6.25**	**6.52**	**6.42**	**6.19**	**5.88**

The breakdown below details the information for each of the service areas:

Acute Directorates	**Partnerships/HSCPs**
North Sector– 5.31%	East Dunbartonshire– 5.99%
South Sector– 6.85%	East Renfrewshire – 5.95%
Womens & Childrens – 5.66%	Glasgow City– 5.62%
Diagnostics– 5.04%	West Dunbartonshire– 5.03%
South Clyde – 5.38%	Renfrewshire – 5.64%
Facilities (**Board Wide**) – 8.5%	East Dun OH – 3.63%
Regional Services –6.18%	Inverclyde – 5.27%

Acute Division

Within the absence figures reported for 2016, it should be noted that an improved position on previous months has been achieved within the Acute Division across all service areas apart from the South Sector, which is currently reporting absence at 6.85% for the month of April 2016, a reversal of an improved position of 6.54% for February 2016 and 6.58% for March 2016.

In recognition of the continued high levels of absence in this area, a specific range of work has been commissioned to deliver improvement in attendance. The actions include specifically targeting absence management in a range of areas across the site. In recognition of the importance of the SCN role in attendance management, HR Support unit staff are participating in a local SCN action learning network. HR staff are also focused on ensuring all attendance procedures regarding return to work meetings, formal processes and outcomes are firmly embedded across service areas. Each SCN is being offered one to one discussions to address any concerns or to assist in the management of specific cases. Enhanced workforce data reporting is also in place to assist managers in highlighting absence trend information to ward level, reasons for absence and identification of 'hot spots' to allow further targeted activity on an ongoing basis over the coming months

Partnerships

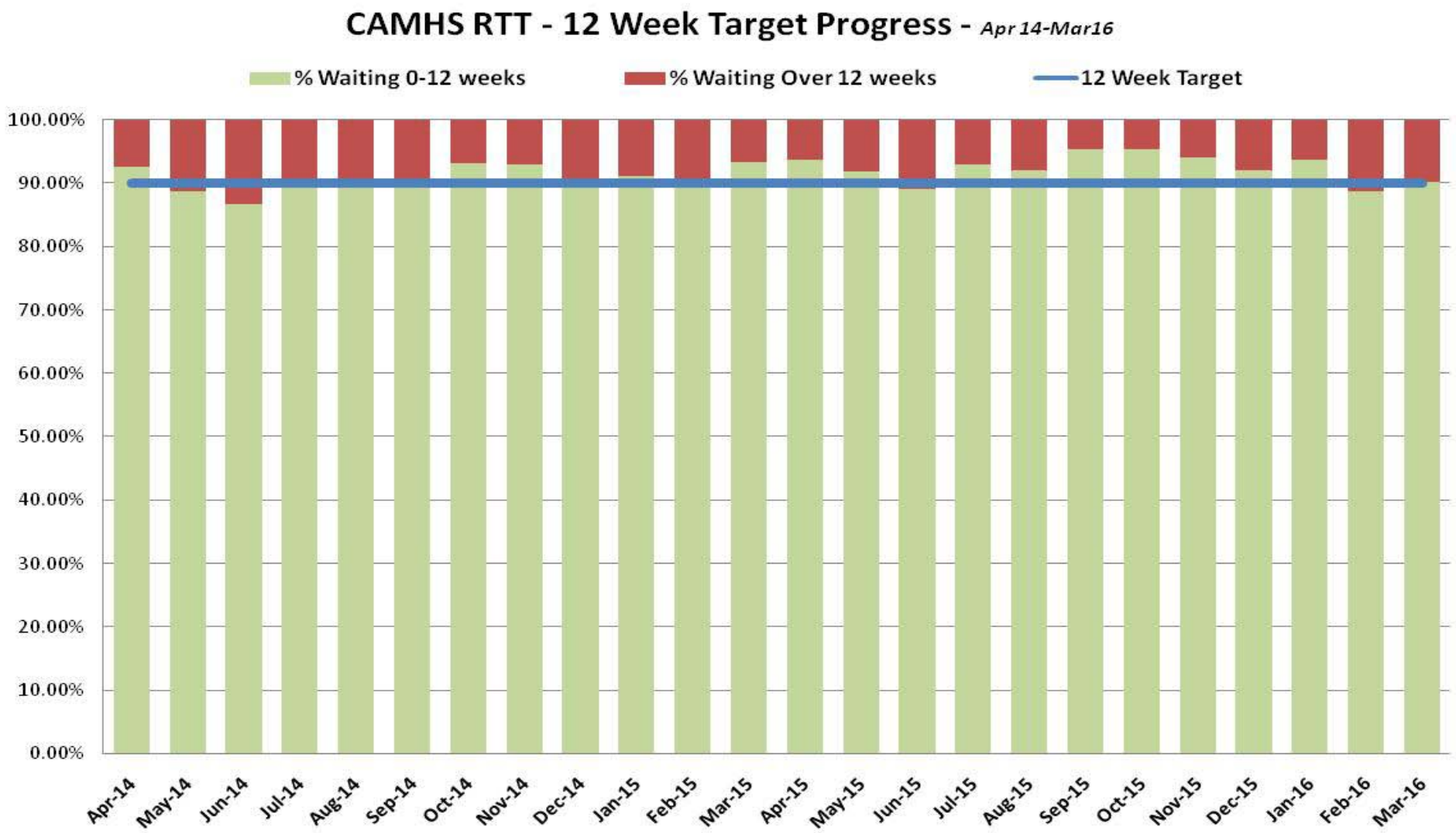
Within Partnerships, absence levels have generally improved, apart from those within East Renfrewshire and Inverclyde HSCPS, both have seen a slight increase on previous months' position.

All HSCPs have local action plans in place, but recent activity includes increased use of workforce data now available through the Workforce Information Microstrategy site. This has given consistent access to detailed data, allowing ongoing focus on absence trends, identification of hot spots and information available at a local service area level. Other activity within partnerships has included the development of 'joint' absence review clinics and the opportunity of shared learning across both health and social care partners in relation to health and wellbeing arrangements. This is ensuring a joint approach in a number of areas to the Healthy Working Lives process, which in turn is providing additional access to activity and events to seek to maintain good attendance levels within the workplace.

Timeline For Improvement

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

Appendix 1


CAMHS RTT - 12 Week Target Progress - Apr 14-Mar16
% Waiting 0-12 weeks
% Waiting Over 12 weeks
12 Week Target
100.00%
90.00%
80.00%
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
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