NHS Greater Glasgow & Clyde

NHS BOARD MEETING

Head of Performance **18 October 2016** **Paper No: 16/63**

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 2016-17 Strategic Direction/Local Delivery Plan.

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

Performance Improvements:
- The Board continues to exceed target in relation to a number of health improvement indicators including access to antenatal care, the number of alcohol brief interventions and access to drug and alcohol treatment.
- Performance continues to exceed target in relation to a number of key access and waiting times targets including 18 week RTT, access to IVF, ante-natal care, psychological therapies and child and adolescent mental health services.

Performance Deterioration:
- The waiting time target relating to the percentage of patients referred urgently with a suspicion of cancer to treatment within 62 days deteriorated from 88.1% reporting in June 2016 to 80.7% in August 2016.
- The percentage of patients waiting less than 4 hours from arrival at A&E to admission, discharge or transfer for A&E treatment deteriorated since the last Board meeting reducing from 94.3% in June 2016 to 92.6% in August 2016.
- The number of inpatients waiting > 12 week Treatment Time Guarantee continued the month on month deterioration with August 2016 position of 1,056 patients waiting > 12 weeks for a procedure.
- The % of new outpatients waiting < 12 weeks for a new appointment continued to deteriorate from 94.4% in June 2016 to 90.5% in August 2016.
- The stroke care bundle performance of 64% for June 2016 reported at the last Board meeting has deteriorated to 62% in August 2016.

Measures Rated As Red:
- Detect cancer early
- Suspicion on cancer referrals (62 days)
- Delayed discharges < 72 hours and > 72 hours
- Bed days lost to delayed discharge
- 12 week Treatment Time Guarantee (***new***)
- % of new outpatient waiting < 12 weeks for an appointment

- Stroke care bundle
- 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 2016-17 Strategic Direction/Local Delivery Plan.

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Tel No: 0141 201 4754
18 October 2016

NHS GREATER GLASGOW AND CLYDE

Board Meeting
18 October 2016 **Paper No: 16/63**

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 with the aim of providing members with a clear overview of the organisation's performance in the context of the 2016-17 Local Delivery Plan. An exceptions report accompanies all indicators with an adverse variance of more than 5%, 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 as outlined in the 2015-16 Strategic Direction. 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?

Members should note that there have been a number of significant changes to the reporting of delayed discharges and targets. These changes are detailed in the delayed discharge exception report.

4. SUMMARY OF PERFORMANCE

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

Performance Improvements

- The Board continues to exceed target in relation to a number of health improvement indicators including access to antenatal care, the number of alcohol brief interventions and access to drug and alcohol treatment.
- Performance continues to exceed target in relation to a number of key access and waiting times targets including 18 week RTT, access to IVF, ante-natal care, psychological therapies and child and adolescent mental health services.

Performance Deterioration

- The waiting time target relating to the percentage of patients referred urgently with a suspicion of cancer to treatment within 62 days deteriorated from 88.1% reporting in June 2016 to 80.7% in August 2016.
- The percentage of patients waiting less than 4 hours from arrival at A&E to admission, discharge or transfer for A&E treatment deteriorated since the last Board meeting reducing from 94.3% in June 2016 to 92.6% in August 2016.
- The number of inpatients waiting > 12 week Treatment Time Guarantee continued the month on month deterioration with August 2016 position of 1,056 patients waiting > 12 weeks for a procedure.
- The % of new outpatients waiting < 12 weeks for a new appointment continued to deteriorate from 94.4% in June 2016 to 90.5% in August 2016.
- The stroke care bundle performance of 64% for June 2016 reported at the last Board meeting has deteriorated to 62% in August 2016.

Measures Rated As Red

- Detect cancer early
- Suspicion on cancer referrals (62 days)
- Delayed discharges < 72 hours and > 72 hours
- Bed days lost to delayed discharge
- 12 week Treatment Time Guarantee (***new***)
- % of new outpatient waiting < 12 weeks for an appointment
- Stroke care bundle
- 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)

18 OCTOBER 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 2016-17 Local Delivery Plan. For each of the indicators with an adverse variance of > 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**	Out with 5% of meeting trajectory	▲	Improving
LDF	Local Delivery Framework	**AMBER**	Within 5% of meeting trajectory	▶	Maintaining
HSCI	Health & Social Care Indicator	**GREEN**	Meeting or exceeding trajectory	▼	Worsening
LKPI	Local Key Performance Indicator	**GREY**	No trajectory to measure performance against.	—	In some cases, this is the first time data has been reported and no trend data is available. This will be built up over time.
		TBC	Target to be confirmed.		

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

Performance Summary At A Glance

The table below summarises overall performance in relation to those measures contained within the Integrated Performance Report. Of the 23 indicators that have been assigned a performance status based on their variance from targets/trajectories overall performance is as follows:

STRATEGIC PRIORITIES	RED	AMBER	GREEN	GREY	TOTAL
Preventing Ill Health and Early Intervention	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	5	3	6	1	**15**
Tackling Inequalities	0	0	2	0	**2**
TOTAL	**9**	**5**	**9**	**6**	**29**

PERFORMANCE AT A GLANCE - OCTOBER 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	Jan - Mar 16	26.6%	–	**28.5%**	**RED**	↔	Page 11
2	LDPS	Suspicion of Cancer Referrals (62 days)*	Aug-16	89.3%	80.7%	**95%**	**RED**	↓	Page 13
3	LDPS	All Cancer Treatments (31 days)*	Aug-16	93.1%	93.0%	**95%**	**AMBER**	↔	
4	LDPS	*Alcohol Brief Interventions*	Apr - Jun 16	2,953	3,270	**3,263**	**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	% of patients waiting <4 hours at A&E	Aug-16	94.1%	92.6%	**95%**	**AMBER**	↓	
6	LKPI	Number of A&E presentations	Aug-16	35,944	36,619	**No Target**	**GREY**	↓	
7	HSCI	*Delayed Discharge < 72 hours (inc codes)*	Aug-16	–	32	**0**	**RED**	–	Page 17
8	HSCI	*Delayed Discharge > 72 hours (inc codes)*	Aug-16	–	48	**0**		–	
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+)	Aug-16	1,348	1,867	**377**	**RED**	↓	Page 19
		AWI patients (65 years+)	Aug-16	136	445	**158**		↓	
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	Aug-16	92.1%	90.8%	**90%**	**GREEN**	↓	
		Combined Linked Pathway	Aug-16	87.7%	88.1%	**80%**	**GREEN**	↑	
14	LDPS	12 week Treatment Time Guarantee (TTG)							
		Number of inpatients waiting > 12 weeks	Aug-16	6	1056	**0**	**RED**	↓	Page 21
15	LKPI	Patient unavailability (Adults)							
		Inpatient/Day Case (inc Endoscopy)	Aug-16	4,812	1,950	**N/A**	**GREY**	↑	
		Outpatient	Aug-16	3,567	1,804	**N/A**	**GREY**	↑	
16	LKPI	% of patients waiting < 6 weeks for a key diagnostic test	Aug-16	100%	95.4%	**100%**	**AMBER**	↓	
17	LDPS	% of new outpatient waiting < 12 weeks for an appointment	Aug-16	99.2%	90.5%	**99.9%**	**RED**	↓	Page 22
18	LDPS	% of eligible patients commencing IVF treatment within 12 months	Aug-16	100%	100%	**90%**	**GREEN**	↔	
19	LKPI	Stroke Care Bundle	Aug-16	73%	62%	**80%**	**RED**	↓	Page 23
		% of patients admitted to stroke unit	Aug-16	93%	90%	**90%**	**GREEN**	↓	
		% of patients CT/MRI scanned within 24hrs of admission	Aug-16	95%	97%	**95%**	**GREEN**	↑	
		% of patients with swallow screen carried out on within 4 hours of admission	Aug-16	83%	69%	**100%**	**RED**	↓	
		% of Patients prescribed aspirin on Day of Admission, or Day following	Aug-16	91%	94%	**95%**	**AMBER**	↑	
20	LDPS	% patient waiting < 18 weeks for RTT to Specialist Child and Adolescent Mental Health Services	Aug-16	100%	99.5%	**100%**	**AMBER**	↓	
21	LDPS	% patients who started treatment <18 weeks of referral for psychological therapies	Apr - June 16	96.1%	94.8%	**90%**	**GREEN**	↓	
22	LDPS	Drug and Alcohol: % of patients waiting < 3 weeks from referral to appropriate treatment	Apr - June 16	96.0%	96.8%	**91.5%**	**GREEN**	↑	
23	LDPS	SAB Infection rate (cases per 1,000 OBD rolling year)	Jul - June 16	0.27	0.33	**0.24**	**RED**	↓	Page 25
24	LDPS	C.Diff Infections (cases per 1,000 OBD rolling year)	Jul - June 16	0.30	0.29	**0.32**	**GREEN**	↑	
25	LDF	% of complaints responded to within 20 working days	Apr - June 16	82%	69%	**70%**	**AMBER**	↓	
26	LDPS/LDF	Financial Performance	Aug-16	(£5.3m)	(£12.9m)	(£14.0m)	**GREEN**	↓	Agenda Item 12
27	LDPS/LDF	Sickness Absence (rolling year)	Jul-16	5.30%	5.47%	**4%**	**RED**	↓	Page 27
		Long Term	Jul-16	3.50%	3.65%	**N/A**	**GREY**	↓	
		Short Term	Jul-16	1.81%	1.81%	**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	Apr - June 16	81.7%	81.1%	**80%**	**GREEN**	↔	
29	LDPS	Smoking Cessation - number of successful quitters at 12 weeks post quit in 40% SIMD areas (Data incomplete)	Apr - Mar 16	1,340	1,868	**1,328**	**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)

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

Ref	Measure	As At	2015-16 Actual	2016-17 Actual	2015-16 Target	Perform Status	Dir of Travel
5	% of patients waiting <4 hours from arrival to admission, discharge or transfer for A&E treatment	Aug 2016	94.1%	92.6%	95.0%	**AMBER**	↓

Commentary

As at August 2016, 92.6% of all patients presenting at A&E Departments across NHS Greater Glasgow and Clyde (NHSGG&C) waited less than 4 hours from arrival to admission, discharge or transfer for A&E treatment a slight reduction on the 94.1% reported during the same month the previous year.

The delivery of the Unscheduled Care 95% guarantee continues to be a challenging performance target. Each of the sectors have established action plans which they continue to implement. However, the initiatives implemented to date have not delivered the sustained improvement required to regularly achieve the 95% guarantee.

In recognition of this, a system-wide review of unscheduled care is being conducted to analyse patient flows, allocation and the gearing of resources and key performance metrics. It is anticipated that this review will drive a new system wide action plan - see Agenda Item 10 for more details.

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 a key diagnostic test	Aug 2016	%	95.4%	100%	**AMBER**	↓

Commentary

As at August 2016 (month end), 95.4% of patients were waiting < 6 weeks for a key diagnostic test. The 4.6% of patients waiting > 6 weeks for a key diagnostic test represents a total of 694 patients for the following tests:

- 209 patients were waiting > 6 weeks for an upper endoscopy procedure
- 37 patients were waiting > 6 weeks for a lower endoscopy procedure
- 360 patients were waiting > 6 weeks for and endoscopic procedure in Colonoscopy
- 88 patients were waiting > 6 weeks for an endoscopic procedure in Cystoscopy.

Most of the above patients waiting were in the South (580 patients) and Clyde Sectors (113).

South Sector

The main reasons for delay include:

- The South Sector has historically had demand and capacity issues. This has been exacerbated with a further reduced capacity from GS and GI consultants following service reconfiguration. Options to increase capacity have been developed.
- Nurse Endoscopy vacancy.
- There is a backlog of surveillance patients who were overdue their repeat scope prior to the handover of services. Investigations are complete and these numbers have reduced significantly.

Actions to address performance include:

- A locum consultant is in place until the end October 2016 and another locum is being sought.

- Working with GS/GI colleagues to increase capacity where we can, including reviewing all training lists.
- Working on an Endoscopy Nurse led service to increase capacity and control over cancellations.
- Obtaining quotes for a Vanguard service which will also increase capacity.
- Continue to run Waiting List Initiative sessions during weekends.
- Further training of two nurse endoscopists is underway.

Clyde Sector

The main reason patients are waiting > 6 weeks for a key diagnostic test in Clyde is a lack of capacity to meet demand, particularly at the RAH.

There is a proposal to increase the number of endoscopy rooms from two to four on the Royal Alexandria Hospital (RAH). In addition, waiting list initiatives are run for approximately four Saturdays per month across the Clyde Sector (two in Inverclyde Royal Hospital (IRH) and two at the RAH) but this does not meet the demand. In addition to the number of patients waiting > 6 weeks for a key diagnostic test, there are a significant number of surveillance patients overdue their repeat scope, particularly on the RAH site. There has been a focus on surveillance patients in order catch up on this high risk group and reduce the numbers overdue which will have a further impact on patients waiting for new diagnostic tests.

Additional physical capacity is required to bring the waiting times down to six weeks. In addition, the training of two nurse endoscopists is underway and this will improve the ability to back fill cancelled sessions once their training has been completed. The benefit of this will be realised during 2017.

Ref	Measure	As At	2014-15 Actual	2015-16 Actual	2015-16 Target	Perform Status	Dir of Travel
20	% of patients waiting < 18 Wks for RTT to Specialist Children and Adolescent Mental Health Services	Aug 2016	100%	99.5%	100%	**AMBER**	↓

Commentary

As at August 2016, 99.5% of all patients waited less than 18 weeks from referral to start of treatment. A total of four patients waited > 18 weeks to start their treatment and have since started their treatment during September 2016.

Ref	Measure	As At	2014-15 Actual	2015-16 Actual	2015-16 Target	Perform Status	Dir of Travel
25	% of complaints responded to within 20 working days	Apr – Jun 2016	82%	69%	70%	**AMBER**	↓

Commentary

For the period April – June 2016 a total of 69% of complaints were responded to within 20 working days. Whilst performance is marginally below the target of 70%, this was expected. The complaints department within Acute is sub-divided into three teams (accounts for the majority of complaints received across the Board). During Quarter 4, two of the teams moved sites (from the Western and Victoria Infirmaries, to the West ACH). In addition, there was a further move within the West ACH from one floor to another causing temporary disruption to the service. Also during the same time, the Complaints Department experienced significant sickness absence, with around 30% of the entire team being absent at one point. This, coupled with annual leave due to the end of the financial year had a negative impact on performance.

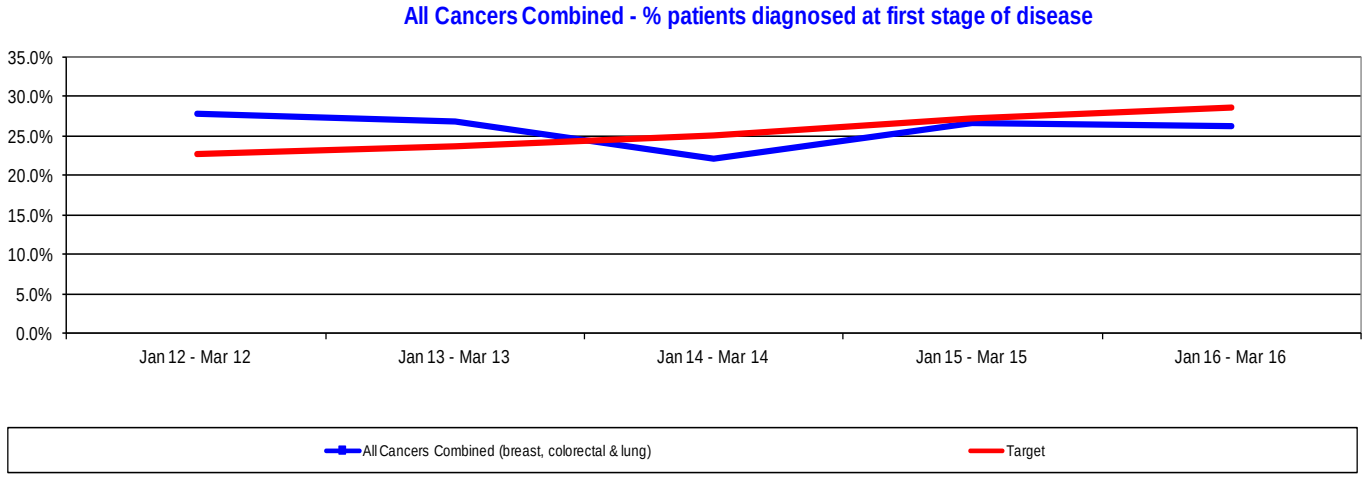
Towards the end of the quarter, a new Board Complaints Manager started in post, whose role is to

provide direction and leadership to the team. Regular meetings (weekly) have been put in place to review performance with Team Leads for areas under pressure and action taken as a result. Performance will continue to be monitored closely on an ongoing basis. All of the actions have been put in place and, performance during the first quarter of 2016-17 was expected to remain below target due to the timing of when the actions were implemented but thereafter should begin to result in improved performance.

PERFORMANCE EXCEPTIONS REPORTS

Exceptions Report: Detect Cancer Early

Measure	Detect Cancer Early (DCE)
Current Performance	Overall, for the period January – March 2016 the percentage of patients diagnosed with Stage 1 cancer was 26.6%. Current performance is lower than the trajectory of 28.5% for December 2015. ***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



Q1 (Jan - March) 2016

	Stage 1		Stage 2		Stage 3		Stage 4		Not Known		Total	
Cancer Type	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Breast	**92**	**40.7%**	94	41.6%	19	8.4%	20	8.8%	1	0.4%	226	100.0%
Colorectal	**34**	**19.0%**	35	19.6%	55	30.7%	39	21.8%	16	8.9%	179	100.0%
Lung	**58**	**20.2%**	18	6.3%	67	23.3%	128	44.6%	16	5.6%	287	100.0%
All (Breast/Colorectal/Lung) Combined	**184**	**26.6%**	**147**	**21.2%**	**141**	**20.4%**	**187**	**27.0%**	**33**	**4.8%**	**692**	**100.0%**

Commentary

The delivery date for the DCE target (25% increase in Stage 1 diagnoses) ended in December 2015.

2014/2015 combined data for NHS Scotland demonstrate that 25.1% of people were diagnosed with breast, colorectal and lung cancer at the earliest stage (stage 1), an 8.0% increase from the baseline 2010/2011 combined. For the same period 25.2% of people were diagnosed with breast, colorectal and lung cancer at the earliest stage (stage 1) in NHSGG&C, a 12.5% increase from the baseline 2010/2011 combined.

NHSGG&C will continue to collect and submit data on the three cancer types included within this measure whilst we await confirmation on how the DCE programme will progress e.g. whether new baselines will be set or whether the programme will be rolled out to other cancer types.

The above data relates to the period January - March 2016 and uses the December 2015 target in which to measure performance against. As seen from the data above 26.6% of all cancers listed above were detected at Stage 1. Current performance remains below the delivery target of 28.5% set for December 2015.

In terms of cancer types performance is as follows:

Breast Cancer

40.7% of patients were diagnosed at Stage 1 for the period January – March 2016 (*92 out of 226 patients*) slightly below the target of 42.7% for December 2015.

Colorectal Cancer

19.0% of patients were diagnosed at Stage 1 for the period January – March 2016 (*34 out of 179 patients*) below the target of 28.5% for December 2015.

Lung Cancer

20.2% of patients were diagnosed at Stage 1 for the period January – March 2016 (*58 out of 287 patients*) above the target of 19.5% for December 2015.

Actions to Address Performance

A national DCE conference was held on 2 September 2016. A number of speakers presented on varying topics. While it was acknowledged that the challenging 25% increase in Stage 1 cancers had not been achieved, on the whole the feeling was that the programme had been successful in achieving an increase in Stage 1 cancer diagnoses and hopeful for further improvement.

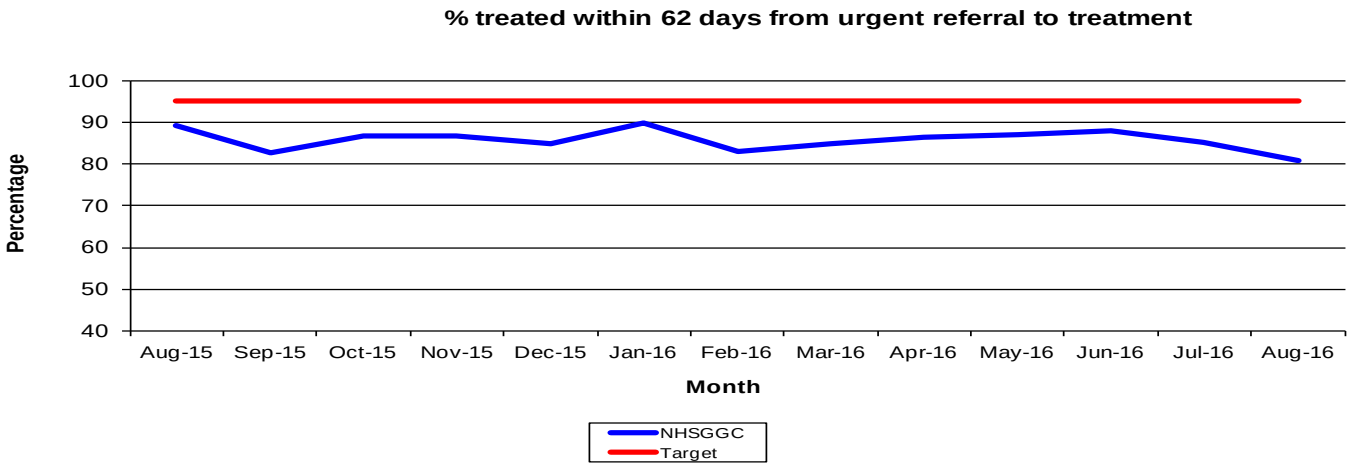
At a national level, work continues to encourage people to participate in screening programmes and to present early to GPs with worrying symptoms. A recent National Bowel Screening advertising campaign has been broadcast on Scottish TV and plans are in place for further campaigns on lung cancer and breast cancer.

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 August 2016, 80.7% of patients with an urgent referral for suspicion of cancer were treated within 62 days of the referral. (*Data provisional*)
Lead Director	Gary Jenkins, Director of Regional Services



Commentary

62-Day Target

As at August 2016, 80.7% (221 out of 274) of eligible referrals with an urgent referral for suspicion of cancer had first treatment within 62 days of referral, below the target of 95%. Unfortunately the improvement (88.1%) seen in June and (85.1%) July 2016 has not been sustained.

The cancer types currently below the 95% target are as follows: Urological 57.4% (*27 out of 47 eligible referrals treated within target*), Head and Neck 66.7% (*10 out of 15 eligible referrals treated within target*), Upper GI 72.2% (*13 out of 18 eligible referrals treated within target*), Breast 84.0% (*74 out of 88 eligible referrals treated*), Colorectal 84.8% (*28 out of 33 eligible referrals treated within target*) and Lung 90.9% (*40 out of 44 eligible referrals treated* within target). The remaining cancers namely, Cervical (100%), Lymphoma (100%), Melanoma (100%) and Ovarian (100%) all exceeded target.

The drop in performance in Breast and Urological cancers contributed most to the overall % drop seen between July and August 2016 performance.

31-Day Target

As at August 2016, 93.0% (*529 out of 569*) of eligible referrals with a new diagnosis of cancer had first treatment within 31 days of decision to treat. Current performance is a slight deterioration on the previous months' performance of 94.1%.

The cancer types below the 95% target are as follows: Urological 83.5% (*91 out of 109 eligible referrals treated within target*) and Breast 86.6% (*97 out of 112 eligible referrals treated within target*).

Actions to Address Performance

General

At the end of August the Scottish Government confirmed allocation of £545k non-recurring funding to support measures to improve cancer waiting times. Short-term plans have been put in place from September 2016 for a three month period. The main aim is to reduce the number of potential breaches coming through the pathway and at the same time, reduce the backlog of patients who have already

breached and are awaiting treatment.

The following actions are planned:

Tumour	Directorate	Description	Impact	Planned Start Date	Expected Duration (with allocation provided)
Breast	North	3 x new urgent clinics per week in North/East	45 additional patients seen in clinic for first appointment per week (improve waiting time to first clinic appointment).	September 2016	3 months
Colorectal	Clyde	2 x bowel screening sessions per week reducing waiting time for scope to 7-10 days	8 additional slots for bowel screening colonoscopy per week (improve waiting time to BS colonoscopy).	October 2016	3 months
Colorectal	Clyde	1 x general colonoscopy session per week providing an additional 4 scopes per week	4 additional slots for colonoscopy (improve waiting time to colonoscopy).	October 2016	3 months
Colorectal	North	3 x bowel screening sessions per week reducing waiting time for scope to 7-10 days	12 additional slots for bowel screening colonoscopy per week (improve waiting time to BS colonoscopy).	October 2016	3 months
Colorectal	North	1 x general colonoscopy session per week providing an additional 4 scopes per week	4 additional slots for colonoscopy (improve waiting time to colonoscopy).	October 2016	3 months
Colorectal	North	2 x theatre sessions per week providing additional 3 patients per week	Improved access to theatre for 3 additional patients a week (improve waiting time to surgery).	October 2016	3 months
ENT	South	Development of same day admission area to facilitate patient recovery and discharge for patients unsuitable for ACH based treatments	Improved access to ENT diagnostic scopes (improve waiting time to diagnosis).	TBC	TBC
ENT	South	25 additional clinics per month providing 300 additional appointments per month	300 additional patients seen in clinic for appointment per month (improve waiting time to clinic appointment).	August 2016	3 months
Upper GI	North	Provision of EUS and UGI sessions - split to be determined as funding is less than bids	Flexible additional Upper GI endoscopy and EUS sessions to be run to allow earlier access to these procedures.	October 2016	3 months
Urology	Clyde	2 x additional clinics per month to improve access to one stop and urgent appointments	24 additional patients seen in clinic for first appointment per month (improve waiting time to first clinic appointment).	September 2016	3 months
Urology	North	1 x theatre session to provide additional 4 cases per week (Ureteroscopy/ TURBT)	4 additional TURBT/ureteroscopy slots a week (improve waiting time to treatment/diagnosis).	October 2016	3 months

Tumour	Directorate	Description	Impact	Planned Start Date	Expected Duration (with allocation provided)
Urology	North	2 x urgent clinics per week to improve access to outpatient appointments	24 additional patients seen in clinic per week (improve waiting time to clinic appointment).	October 2016	3 months
Urology	North	2 x consultant EPA sessions for surgery and diagnostics. 6 patients a week minimum	Earlier access to diagnostic procedures and treatment (TURBT) for 6 patients a week. (Improve waiting time to treatment/diagnosis).	October 2016	3 months
All	Diagnostics	Additional pathology resource to support additional biopsy activity	Additional pathology activity to be implemented as required to ensure delays prevented given additional pathology specimens as result of additional lists above.	September 2016	3 months

Urological Cancer

Implementation of the Urology Improvement plan pan-GG&C continues and specifically includes the following:

- Additional urological diagnostic (flexible cystoscopy/TRUS & biopsy) sessions (North & South sectors) through the development of two Diagnostic Hubs.
- Introduction of TURis (Trans-urethral Resection in saline) service (North & South Sectors).
- Additional theatre sessions for renal surgery (South Sector).
- Additional Clinical Oncologist.
- Additional Pathologist/laboratory support.

The above measures are to allow more timely access to urological diagnostic and surgical procedures as well as specimen reporting and therefore, deliver an improvement in cancer waiting times performance.

Sector implementation plans were developed to deliver incremental implementation of the measures above from July to December 2016, the North Sector complete their implementation plan in October.

Measures implemented to date include:

- Additional Consultant Pathologist commenced August 2016.
- Consultant Clinical Oncologist was appointed in July 2016 (to commence in October 2016).
- Introduction of TURis service (North & South Sectors)
- Eight additional urological diagnostic sessions to improve the pre-diagnosis stage of the patient pathway (North & South Sectors).

By December 2016, a further 10 urological diagnostic sessions will be introduced as will an additional two renal surgery lists per week.

Breast Cancer

As anticipated, August figures for performance against the 62-day and 31-day target show a decrease compared to July 2016. Pressures over the summer period resulted in delays to first appointment and surgery in the breast service. It is anticipated that September figures will also be adversely affected.

Discussion has taken place with NHS Lanarkshire to explore the possibility of capacity support for routine and screened referrals to release capacity within NHSGG&C. This is under consideration as a short-term solution on a case-by-case basis.

Colorectal Cancer

Colorectal performance for screening patients has been challenged recently. 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 measures are being implemented to 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.
- Review of bowel screening colonoscopy capacity as part of an overall review of endoscopy capacity within sectors.

The first two factors above have been addressed: Temporary pre-assessment capacity was introduced for July and August with permanent additional resource implemented in September. Bowel screening tracking commenced at end of September.

The third factor, namely, review of bowel screening colonoscopy capacity, is being undertaken within sectors as part of an overall review of endoscopy capacity. Weekly monitoring would suggest an improvement in performance for bowel screening through September.

Head & Neck Cancer

It is recognised that there is significant pressure on outpatient and diagnostic capacity within Head and Neck services given the volume of referrals compared with the numbers of patients actually diagnosed with cancer. Additional clinics continue to be implemented with 26 additional clinics run in August (303 additional patients seen) and 26 additional clinics run in September (293 additional patients seen). In addition, a bid for aforementioned non-recurring short-term cancer monies has been approved and non-recurring funds allocated to develop a same day admission area to facilitate patient recovery and discharge for patients unsuitable for ACH based procedures.

Lung Cancer

The virtual lung cancer clinic pilot commenced in September 2016 to assess the effectiveness of a virtual clinic to streamline the initial stages of the lung pathway. A new referral template has recently been agreed through the Referral Management Group and is being piloted in the North East Sector to support the virtual clinic.

Timeline For Improvement

The aforementioned measures being undertaken to ensure more timeous steps on the patient pathways are expected to show an incremental improvement expected through Quarter 4 (October - December) 2016 and Quarter 1 (January - March) 2017. It should be noted that due to the nature of Cancer Waiting Times reporting and the fact that cases are reported in the month of treatment, additional activity to clear the backlog of cases is likely to result in a dip in performance in monthly figures initially.

With the support of the Directors, there is increased focus in the month of October to significantly reduce the backlog of patients awaiting treatment with meetings now taking place three times a week to ensure that November onwards will begin to demonstrate an improved performance.

Exceptions Report: Delayed Discharges < 72 hours and > 72 hours (included codes)

Measure	Delayed Discharges < 72 hours and > 72 hours (included codes)
Current Performance	As at August 2016 (census date 25 August), a total of 32 patients were delayed for < 72 hours and a further 48 patients were delayed for > 72 hours.
Lead Director	Catriona Renfrew, Director of Planning and Policy

Monthly trend data is currently unavailable due to changes in the reporting system.

Commentary

It should be noted that there have been a number of significant changes to the reporting of delayed discharges and targets including:

- The delayed discharge targets now relate to patients delayed > and < 72 hours from the date they were ready for medical discharge.
- As of July 2016, the national reporting for delayed discharges details both the full months' data as well as a snapshot of patients delayed on the last Thursday of the month.
- The emphasis is now on the number of bed days lost as opposed to previously the number of patients.
- All delayed patients in non hospital locations i.e. patients in interim beds in care homes (awaiting choice of care home or completion of guardianship) are now *not* included in the national reporting. Previously delayed patients in Fourhills, Greenfield Park, Darnley and Quayside were included in the monthly reporting.

In August 2016, a total of 80 patients were delayed in hospital sites across Acute Services. 32 of the patients were delayed < 72 hours of being fit for discharge. All partnership areas with the exception of East Renfrewshire reported patients delayed for < 72 hours (included codes) from the date that they were seen as fit for discharge. These comprise 18 patients from Glasgow City; 3 patients from Inverclyde; 2 patients from Renfrewshire; 2 patients from West Dunbartonshire; 1 patient from East Dunbartonshire and the remaining 6 patients delayed < 72 hours were from out with the Board area.

During the same period a total of 48 patients were delayed > 72 hours (included codes) comprising 17 patients from Glasgow City, 5 patients from West Dunbartonshire; 5 patients from East Dunbartonshire; 4 patients from Inverclyde; 3 patients from East Renfrewshire, 1 patient from Renfrewshire and the remaining 13 patients were from outwith the Board area.

The above figures exclude the 5 patients delayed < 72 hours and 23 patients delayed > 72 hours for legal reasons and who lack capacity (AWI) in August 2016. The total comprises 23 patients from Glasgow City; 2 patients from Renfrewshire; 1 patient from West Dunbartonshire and the remaining 2 patients were out with NHSGG&C boundary.

The main reasons cited for the number of patients delayed are as follows:

- East Dunbartonshire – 5 patients are waiting for care homes and 1 patient is waiting for the completion of community care arrangements.
- East Renfrewshire – 2 patients are waiting for care homes and 1 patient is delayed due to patient/carer related reasons i.e. legal issues such as informed consent and/or adult protection issues.
- Glasgow City – the majority of patients are delayed either because they are waiting for a care home placement, an intermediate facility or the completion of a community care assessment.
- Inverclyde – 4 patients are waiting for care home placements and 3 patients waiting for the completion of community care arrangements.
- Renfrewshire – 1 patient is waiting for the completion of community care arrangements and 2 patients waiting for a care home placement.
- West Dunbartonshire – 7 patients waiting for care home placements.

Actions to Address Performance

We continue to work with Partnerships to reduce delayed discharges. There are particular issues with Glasgow City Council which we are actively working with the Partnership to address.

Timeline For Improvement

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

Exceptions Report: Bed Days Lost to Delayed Discharge (Patients aged 65 years+)

Measure	Bed Days Lost to Delayed Discharge (Including Adults with Incapacity AWI) for patients aged 65 years+
Current Performance	As at August 2016, the number of bed days lost to delayed discharge was 1,867. Current monthly performance is higher than the monthly target of 377.
Lead Director	Catriona Renfrew, Director of Planning & Policy

As mentioned in the delayed discharges exceptions report, the changes to the way in which delayed discharges are reported also impacts on reporting of the number of bed days lost to delayed discharges. The figures below exclude those patients in non hospital locations i.e. patients in interim beds in care homes (awaiting choice of care home or completion of guardianship) as they are *not* included in the national reporting e.g. those patients residing in partnership beds such as Fourhills, Greenfield Park, Quayside and Darnley are now not recorded on Edison (the national recording and reporting system) as part of the national monthly reporting process.

Table 1

Bed Days Lost to Delayed Discharge (inc AWIs) - Acute

(patients aged 65 & over on day of admission)

	2016/17					
HSCP	**Apr Actual**	**May Actual**	**June Actual**	**July Actual**	**Aug Actual**	**August Target**
East Dunbartonshire	145	88	228	163	191	53
East Renfrewshire	89	215	81	58	66	26
Glasgow City	**893**	**892**	**1,075**	**1,000**	**1,157**	**201**
Inverclyde	104	95	115	180	179	33
Renfrewshire	112	136	162	128	75	27
West Dunbartonshire	202	211	216	86	199	37
GGC(All above areas)	**1,545**	**1,637**	**1,877**	**1,615**	**1,867**	**377**

Table 2

Bed Days Lost to Delayed Discharge for AWIs - Acute

(patients aged 65 & over on day of admission)

	2016/17					
HSCP	**Apr Actual**	**May Actual**	**June Actual**	**July Actual**	**Aug Actual**	**August Target**
East Dunbartonshire	0	0	0	0	0	0
East Renfrewshire	0	0	13	0	0	0
Glasgow City	**134**	**66**	**129**	**218**	**403**	**95**
Inverclyde	0	0	0	0	0	0
Renfrewshire	40	45	18	13	8	44
West Dunbartonshire	19	0	42	17	34	19
GGC(All above areas)	**193**	**111**	**202**	**248**	**445**	**158**

Commentary

As seen from *Table 1* above, in August 2016 the number of bed days lost to delayed discharge was 1,867. This represents a 38% increase on the August 2015 position (from 1,348 bed days lost in August 2015 to 1,867 in August 2016). The August monthly performance is significantly higher than the monthly target of 158 (*based on a 75% reduction of the 2015-16 performance*).

Table 2 shows that a total of 445 bed days were lost to delayed discharge for AWI patients in August 2016 representing a significant increase in the numbers reported during the same month the previous year (increasing from 136 bed days lost for AWI patients in August 2015 to 445 in August 2016). Current performance is also significantly higher than the monthly target of 158 (*based on a 75% reduction of the*

2015-16 performance).
Actions to Address Performance We have agreed measures to transfer a number of AWI patients from our main acute sites and expect to see a substantial improvement in performance over the next few weeks.
Timeline for Improvement As above.

Exception Report – Treatment Time Guarantee (TTG)

Measure	12 week Treatment Time Guarantee (TTG)
Current Performance	As at August 2016 (month end), a total of 1,056 patients waited more than the 12 week TTG.
Lead Director	All Acute Directors

Number of patients waiting longer than the 12 week Treatment Time Guarantee													
	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	TOTAL
2014/15 TOTAL	1	2	0	7	2	0	0	1	0	1	0	1	15
2015/16 TOTAL	1	1	2	4	6	30	9	2	4	34	47	87	227
2016-17 TOTAL	188	430	590	829	1056								3093

Commentary

As at August 2016 (month end), whilst a total of 7,655 TTG inpatients received their inpatient treatment within the 12 week TTG, a total of 1,056 patients were waiting > 12 weeks in the following specialties: Trauma and Orthopaedic Surgery (424); General Surgery (269); Urology (238); Neurosurgery (49); Ear, Nose and Throat (32); Oral and Maxillofacial Surgery (28); Plastic Surgery (8); Surgical Paediatrics (4); Ophthalmology (3) and Vascular Surgery (1).

Actions to Address Performance

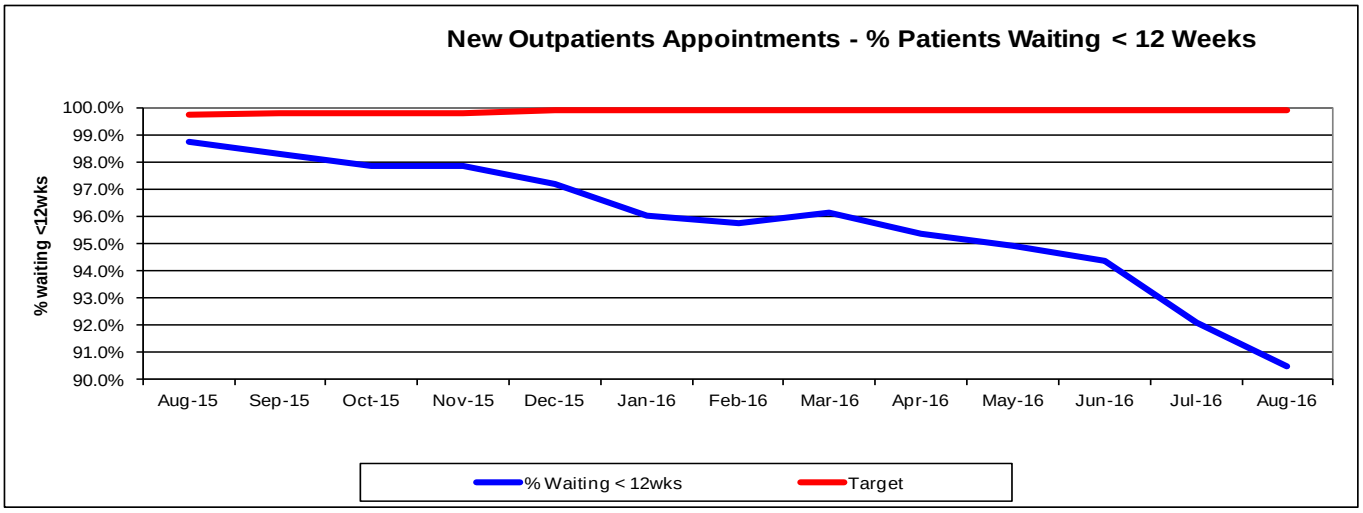
In addressing the month on month deterioration in performance, an urgent detailed review process is underway to get clarity on the levels of supply, demand and productivity that can be delivered for each specialty within budget to reduce variance and maximise output. An integral part of this work will include benchmarking activity at a specialty, sector, NHSGG&C, Scottish and UK level. The output of this work is expected to be presented at the Board away day scheduled to be held on 1 November 2016.

Timeline for Improvement

The findings of the system wide review of supply, demand and productivity will be presented at the Board away day scheduled for 1 November 2016.

Exception Report: % of New Outpatients waiting < 12 weeks for a new Outpatient Appointment

Measure	% of new outpatient waiting < 12 weeks for a new outpatient appointment
Current Performance	As at August 2016, 90.5% of new outpatients waited less than 12 weeks for a new outpatient appointment. Current performance is lower than the target of 99.9%.
Lead Director	All Acute Directors



Commentary

As at August 2016 (month end), 90.5% of new outpatients waited <12 weeks for a new outpatient appointment, current performance is below the target of 99.9% and lower than the position reported during the same month the previous year (98.75%).

Performance across each of the three Sectors and Regional Services was below target of 99.9% in August 2016: the North Sector 88% of available new outpatients, South Sector 87% of available new outpatients, Clyde Sector 95% of available new outpatient and Regional Services 85% of available new outpatients were given an appointment <12 weeks.

The remaining 9.5% of available new outpatients were waiting > 12 weeks for a new outpatient appointment representing 7,290 patients. Current performance represents a 19% increase on the number of new outpatients waiting > 12 weeks for a new outpatient appointment reported in the previous month (6,102 available new outpatients in July 2016). The 7,290 new outpatient waiting > 12 weeks for a new outpatient appointment were in the following specialities: Gastroenterology (1,874); Neurology (1,062); Respiratory (974); Orthopaedics (837); General Surgery (670); Chronic Pain (636); Rheumatology (551); Ophthalmology (224); Ear, Nose and Throat (189); Dermatology (100); Cardiology (56); Diabetes (41); Endocrinology (37); Neurosurgery (20); Urology (13); Oral Maxillofacial Surgery (3); Infectious Diseases (2) and General Medicine (1).

Actions to Address Performance

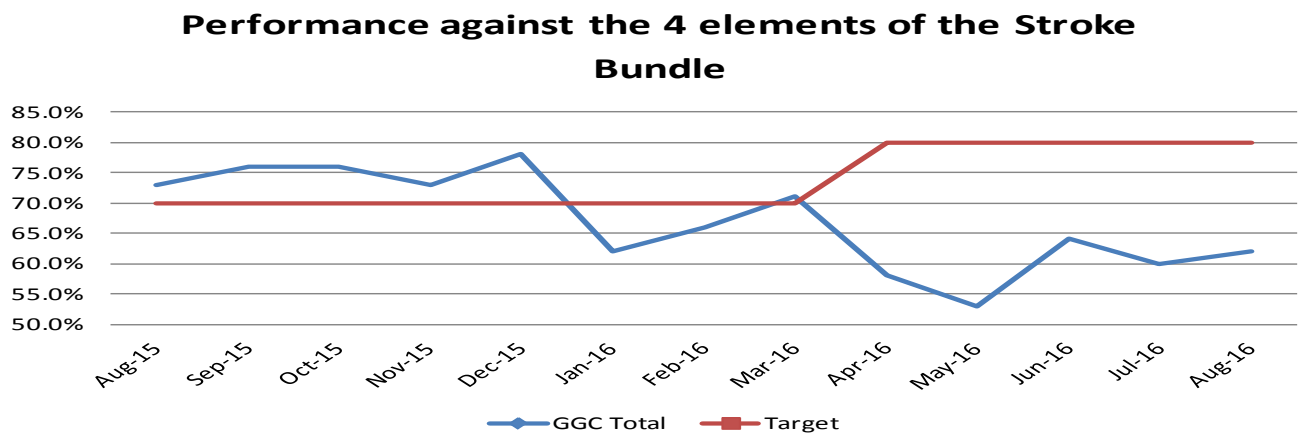
In addressing the month on month deterioration in performance, an urgent detailed review process is underway to get clarity on the levels of supply, demand and productivity that can be delivered for each specialty within budget to reduce variance and maximise output. An integral part of this work will include benchmarking activity at a specialty, sector, NHSGG&C, Scottish and UK level. This work is expected to be presented at the Board away day scheduled to be held on 1 November 2016.

Timeline For Improvement

The findings of the system wide review of supply, demand and productivity will be reported at the Board away day scheduled for 1 November 2016.

Exception Report: Stroke Care Bundle

Measure	Stroke Care Bundle
Current Performance	As at August 2016, overall performance against the Stroke Care Bundle was 62% which is below the target of 80%.
Lead Director	Sector Directors across Acute



Commentary

As seen from the graph above, current performance in relation to the stroke bundle was below target in August 2016 at 62% against a target of 80%. Performance across all four hospitals delivering the stroke care bundle was below the target of 80% with IRH 78%; Glasgow Royal Infirmary (GRI) 66%; RAH 60% and the Queen Elizabeth University Hospital (QEUH) 58%.

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 2016, the swallow screen element of the stroke care bundle was revised from the previous swallow screen test to be carried out on day of admission, to the test 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 69% for August 2016, current was below the 100% target as at August 2016. Performance across each of the hospital sites was below target: the IRH 78%; RAH 76%; GRI 72% and QEUH 64%.

Actions to Address Performance

There is a system wide review of Stroke Care currently underway to address the challenges across the Division. The results of this will begin to be evidenced through sustained performance improvements however, this has been slower than anticipated. In the meantime, there are a number of short term improvement actions to address the swallow screen element of the stroke care bundle being implemented across each of the hospital sites including:

Swallow Screen

IRH/RAH
A number of actions across both hospital sites are currently underway including:

- Weekly performance data is distributed to both sites.
- Specialist Clinical Nurses utilise opportunities to learn from this feedback and address areas where standard has not been achieved.
- Speech and Language Therapists have provided specific training sessions to both sites.
- Nursing staff have been alerted to the training materials on staffnet and encouraged to complete to raise awareness levels.

- While the focus is on stroke patients, good practice is for all patients with suspected swallowing problems to be screened prior to being given fluids or food (the relevant medical conditions are highlighted during training).

GRI

- New arrangements have been agreed with the ED team to facilitate swallow testing being undertaken within the target timescale. Performance has not improved as quickly as anticipated and a further meeting has been arranged between DOME, ED and the Stroke MCN Coordinator to work through some examples where patients have not received their swallow screen with a view to driving improvement.

QEUH

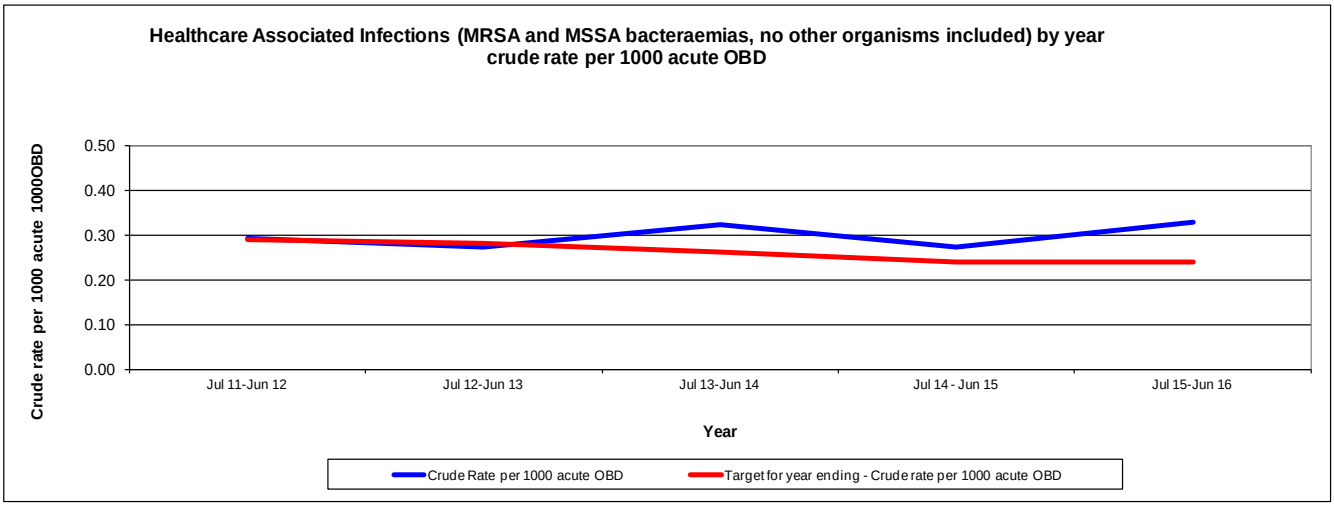
- Within QEUH work is underway to ensure both the Stroke Team and ED staff carry out this role. This is in line with work to review the pathways for all admissions (including Thrombolysis patients) admitted via EDs. Work continues to agree/implement pathways.

Timeline For Improvement

Our expectation is that performance should start to improve towards the target.

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

Measure	MRSA/MSSA Bacteraemia (cases per 1,000 AOBD)
Current Performance	As at the June 2016 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

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 2017. For NHSGG&C this is estimated to equal 25 patients or less each month developing a SAB.

The most recent validated results for 2016, Quarter 2 confirm a total of 110 SAB patient cases for NHSGG&C, between April and June 2016. This equates to a SAB rate of 31.4 cases per 100,000 AOBD. This is an increase of 3.8% upon the previous quarter in SAB patient cases.

The Quarterly Rolling Year ending June 2016 rate as per the Local Delivery Plan for SAB remains at 0.33 cases per 1,000 AOBDs. This is against the March 2017 target of 0.24 cases per 1,000 AOBDs.

Agenda item 9 – Board-wide Healthcare Associated Infection Exception Reporting Template (HAIRT) provides more detail on current position.

Actions to Address Performance

Guidance/Education

A full set of guidance documents, including care plans, were developed and promoted locally by Practice Development Nurses and IPC Nurses in wards and departments across NHSGG&C and reinforced during all educational sessions linked to the use and management of Intravascular Devices (IVDs).

A short video on the correct management of one of the most commonly used IVDs (Peripheral Vascular Cannula or PVC) was developed in 2016 and disseminated via the Chief of Medicine and the Chief Nurses. The video is https://www.youtube.com/watch?v=41V3eO3u5HU and is also promoted through existing educational sessions.

Antimicrobial Management Team (AMT)

Prospective information on cases of SAB is referred to the AMT by the IPC Data Team and a review is undertaken to ensure that patients are on the correct treatment regimen. The AMT are also reviewing all

cases for six months post infection to try and demonstrate the long term consequences of this infection.

Audit

Local SAB surveillance data shows that IVDs account for about a third of all hospital acquired SAB infections. In 2014 care plans and guidance documents were reviewed and redeveloped to support the implementation of the Health Protection Scotland National Care Bundles to prevent infections caused by PVC and Central Venous Catheters (CVC).

Community

Thirty per cent of all SABs are now defined as community acquired. A short-life working group (SLWG) was established February 2016 to review community SAB Data and to identify areas where focussed improvement work could be implemented. Two SAB cohorts were identified for further exploration; illicit drug use and those with diabetes. It should be noted that it is extremely difficult to modify risk behaviours in the first of these groups and a collaborative approach involving Public Health and Addictions Teams is necessary.

Testing for *S. aureus* in Renal Dialysis Patients

Evidence from the literature suggests that a substantial proportion of *S. aureus* bacteraemia originate in the patient's nose and 50% of hospitalised patients have nasal carriage of *S. aureus*. Scientific literature suggests that decolonising patients who are natural carriers of *S. aureus* may reduce the incidence of infection. Although *S. aureus* is not part of any national screening policy, in this specific group of patients it may be useful in preventing SABs. In collaboration with Renal Services Clinicians, all renal haemodialysis patients will be screened for *S. aureus*. It is planned that this screening process will commence in November 2016. If patients are positive they will be commenced on a decolonisation regimen to reduce the amount of bacteria on their skin and nose and this in turn should reduce SABs. Depending on the impact, this may be extended to other high-risk groups.

Paediatrics and Neonatology

Interventions to reduce SABs in neonates and children are extremely complicated. Neonates especially are much less tolerant to the insertion of vascular access devices because of their fragility. The Chief Nurse for Paediatrics and Neonates is currently chairing a quality improvement group to look at the literature and policies and procedures in relation to the use of these devices in this group of patients.

IPC Quality Improvement Facilitator (QIF)

In collaboration with Health Improvement Scotland a QIF was appointed to test using improvement methodology/new ways of managing IVDs. This work is currently ongoing in GRI directed by a SLWG of clinical staff based in GRI and includes the following work strands:

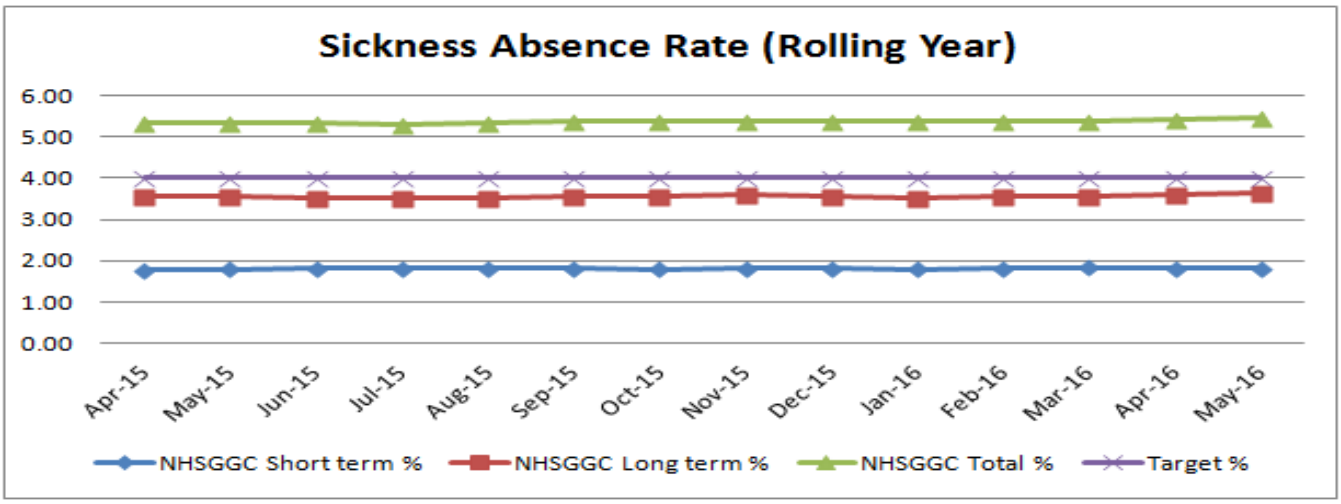
- Avoiding the use of IVDs in the first instance. Decision making acronym to encourage clinical staff to consider if the device is necessary in the first place.
- Audit of how many of the IVDs are used in practice. This will support the use of tools detailed in the above bullet.
- Update and testing of new PVC Care Plan (two wards in GRI) with scheduled PDSA cycles.
- Testing of methods to encourage clinical staff in EDs and Theatres to complete insertion criteria.
- Ward based education.
- PVC Driver Diagram developed.
- Education resource for clinical staff.

Timeline For Improvement

Work continues on an ongoing basis to improve performance.

Exceptions Report: Sickness Absence

Measure	Sickness Absence Rate
Current Performance	As at August 2016, the rate of sickness absence across the Board was 5.49%.
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 August 2016 was 5.49%. This is slightly higher than the rate reported for same period in the previous year (August 2015) which was 5.34%.

The split between long term and short term absence for the period under review is 3.67% and 1.82% respectively.

Actions to Address Performance

The figures showing comparative absence for the last 12 months across the board are detailed below

Area	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16
Acute	5.87	5.84	5.89	5.96	6.18	6.37	6.05	6.03	5.78	5.53	5.40	5.28	5.23
Board Wide Facilities		8.46	8.69	9.38	8.31	8.95	9.12	8.25	8.50	8.86	8.69	8.15	8.39
Other Functions	3.85	4.40	4.06	4.62	4.50	4.92	5.22	4.94	4.53	4.96	5.15	4.53	4.59
Partnership	5.56	5.94	6.22	6.17	6.08	6.35	6.50	6.09	5.45	5.94	6.19	5.96	5.93

Whilst the actual overall total shows a slight increase on the total level for the board last year, the figures below show a similar level of absence as in the same period last year in the Acute Division. The overall headline figure for Partnerships, however, does show an overall increase when compared with August 2015.

The detailed breakdown across both Acute Services, Facilities and Partnerships is detailed below.

Acute Directorates	**Partnerships/HSCPs**
North Sector – 5.24%	East Dunbartonshire – 5.96%
South Sector – 6.35%	East Renfrewshire – 5.83%
Women & Children's – 4.95%	Glasgow City – 6.22%

Acute Directorates	Partnerships/HSCPs
Diagnostics – 4.46%	West Dunbartonshire – 5.40%
Clyde – 4.93%	Renfrewshire – 5.04%
Facilities (**Board Wide**) – 8.39%	East Dun OH – 3.53%
Regional Services – 4.97%	Inverclyde – 8.20%

Acute Division

Within the absence figures, it should be noted that an improved position has been achieved within the Acute Division for all service and sector areas as compared to the previous figures reported to the Board for May 2016. Between the months of May and August there were slight fluctuations, but in general all areas reported an improved position as should be expected at this point in the calendar year.

Partnerships

Within Partnerships, absence levels within East Dunbartonshire and Inverclyde have shown an increase. All other HSCPs have seen a reduction on the previous months reported.

HR Activity

The centralisation of the HR support unit has allowed an increased emphasis on consistency of approach in continuing to proactively manage absence across the Board. The primary source of operational HR support for absence management comes from this team.

Centrally, since the establishment of the service in May, a series of attendance management clinics have run across all major sites. This has supported a targeted response in areas of high absence including individual support for Senior Charge Nurses and tailored training for managers. This has worked particularly well in a number of areas of high absence. Continued emphasis on this work will continue in the coming months.

At a more strategic, managerial team level, the Heads of People and change have ensured a range of training and emphasis of good absence practice across the Board. This has included use of Occupational Health case reviews for complex and difficult cases, continued monitoring of cases of both short and long term absence and action planning with managers around individual cases.

A number of attendance management working groups, including partnership representation have been established to support the identification of trends or issues in services areas, to emphasis a more flexible approach where possible to allow individuals to return to alternative posts and to also focus on assessment and management of absence in line with pay arrangements. This is ensuring a focus on cost containment, where possible, to get staff back to work or to support the decision making process about continued employment. Again, there will be a continuing focus on seeking the early return of individuals to work in alternative roles, where available, to ensure a sustained approach to absence reduction.

As well as training, there has been an active focus on improving management capability and confidence in managing attendance, including the delivery of training in terms of challenging conversations. There has also been a range of work and close support to services and departments in areas with the highest absence.

A continuing activity has also seen a review of return to work interviews and attendance management issues to identify good practice and ensure consistency across service areas. This detail is reported in terms of monthly progress reports monitored through Senior Management Teams and Performance Review Groups and local performance management processes.

Going Forward

In long term absence cases, the majority of cases relate to significant underlying health problems but one area of continued focus is in terms of stress. With effective use of the HR case management system, metrics and tracking of cases, the organisation can get early warning of departments showing strain. Stress Audits and iMatter action plans will help engagement with the local team and workforce in plans to improve working lives.

There is continued review of the approach to ill health termination and work to improve timely initiation of the conclusion of absence cases and early engagement with staff side colleagues on potential outcome of long term sickness issues.

The use of data and metrics will allow continued trend analysis and there is an emphasis on the use of trajectories within service areas to work to reduce areas of absence.

Timeline For Improvement

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