

NHS GREATER GLASGOW AND CLYDE'S INTEGRATED PERFORMANCE REPORT

Recommendation

Board members are asked to:

Note and discuss the content of NHS Greater Glasgow and Clyde's (NHSGG&Cs) Integrated Performance Report.

Purpose of Paper

To bring together high level information from separate reporting strands, to provide an integrated overview of NHSGG&C's performance in the context of the 2016-17 Strategic Direction/Local Delivery Plan.

Key Issues to be Considered

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

Performance Improvements

- Performance in relation to the overall number of delayed discharges has been showing a month on month improvement since January 2017.
- Access to drug and alcohol treatment, Alcohol Brief Interventions, Antenatal Care Psychological Therapies and IVF treatment continues to exceed target.
- Performance in relation to the overall Stroke Care Bundle is beginning to show an improvement albeit, is still below target.

Performance Deterioration

- The number of patients waiting longer than the national waiting times standards for a number of key Local Delivery Plan targets continues to remain challenging, namely:
 - 12 week Treatment Time Guarantee (TTG)
 - New outpatient waiting >12 weeks for a new outpatient appointment
 - Number of patients waiting >6 weeks for a key diagnostic test
 - Cancer 62 day wait for suspicion of cancer referrals.

Measures Rated As Red (10)

- Detect Cancer Early
- Suspicion of Cancer Referrals (62 days)
- Delayed discharges and bed days occupied by delayed discharge patients
- 12 week TTG
- % of new outpatient waiting <12 weeks for an appointment
- Stroke Care Bundle
- % of patients waiting >6 weeks for a key diagnostic test

BOARD OFFICIAL

- SAB infection rate cases per 1,000 population
- Smoking Cessation 3 months post quit
- Sickness Absence

Each of the measures listed above have an accompanying exceptions report outlining actions in place to address performance.

Any Patient Safety/Patient Experience Issues

Yes, all of the performance issues have an impact on patient experience. As detailed in the related exceptions reports, work is underway to try and address these issues.

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.

Tricia Mullen, Head of Performance
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27 June 2017

NHS GREATER GLASGOW AND CLYDE

Board Meeting
27 June 2017

Paper No: 17/26

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. 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% from target/trajectory.

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. POINTS TO NOTE

The data in relation to access to psychological therapies is estimated to be between 20 – 30% complete which means no conclusions can be drawn at this point. The reason for the low data completeness is the service is migrating to a new patient management system and this is having an impact on the completeness of data submitted to ISD therefore caution should be taken when making comparisons between quarters. Given NHSGG&C have continued to exceed performance year on year during the past three years, there is no reason to believe this will not continue and once the migration to the new patient management system is complete in July 2017.

4. SUMMARY OF PERFORMANCE

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

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**INTEGRATED PERFORMANCE REPORT
(INCLUDES WAITING TIMES AND ACCESS TARGETS)**

27 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 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 25 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 and Reshaping Care for Older People	1	1	0	4	6
Improving Quality and Effectiveness	7	3	7	1	18
Tackling Inequalities	1	0	1	0	2
TOTAL	11	5	9	5	30

PERFORMANCE AT A GLANCE - JUNE 2017									
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 16	26.6%	20.9%	28.5%	RED	↓	Page 10
2	LDPS	Suspicion of Cancer Referrals (62 days)*	Apr-17	86.5%	83.6%	95%	RED	↓	Page 12
3	LDPS	All Cancer Treatments (31 days)*	Apr-17	93.5%	92.7%	95%	AMBER	↓	
4	LDPS	Alcohol Brief Interventions*	Apr - Mar 17	15,659	15,379	13,085	GREEN	↓	
SHIFTING THE BALANCE OF CARE AND 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
5	LDPS	% of patients waiting <4 hours at A&E	May-17	92.3%	90.7%	95%	AMBER	↓	
6	LKPI	Number of A&E presentations	May-17	37,565	38,531	No Target	GREY	↓	
7	HSCI	Total number of patients delayed across NHS GG&C (taken at Census point)	May-17	—	133	TBC	RED	—	Page 15
		Acute Patients	May-17	—	99			—	
		Adult Mental Health Patients	May-17	—	34			—	
8	HSCI	Total number of Bed Days Lost to Delayed Discharge*	May-17	—	4,327			—	
		Acute Bed Days Lost	May-17	—	3,076			—	
		Mental Health Bed Days Lost	May-17	—	1,251	—			
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	—	
11	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
12	LDPS	18 Week Referral To Treatment (RTT)							
		Combined Admitted/Non Admitted	Apr-17	90.2%	88.6%	90%	AMBER	↓	
		Combined Linked Pathway	Apr-17	88.5%	87.4%	80%	GREEN	↓	
13	LDPS	12 week Treatment Time Guarantee (TTG)							
		Number of inpatients waiting >12 weeks	Apr-17	188	3,231	0	RED	↓	Page 18
14	LKPI	Patient unavailability (Adults)							
		Inpatient/Day Case (inc Endoscopy)	Apr-17	7,493	1,464	N/A	GREY	↑	
		Outpatient	Apr-17	3,316	1,163	N/A	GREY	↑	
15	LKPI	Number of patients waiting >6 weeks for a key diagnostic test	Apr-17	5	3,165	0	RED	↓	Page 26
16	LDPS	% of new outpatient waiting <12 weeks for a new outpatient appointment	Apr-17	95.6%	81.3%	99.9%	RED	↓	Page 21
17	LDPS	% of eligible patients commencing IVF treatment within 12 months	Apr-17	100%	100%	90%	GREEN	↔	
18	LKPI	Stroke Care Bundle	Apr-17	58%	65%	80%	RED	↑	Page 24
		% of patients admitted to stroke unit	Apr-17	93%	91%	90%	GREEN	↓	
		% of patients CT/MRI scanned within 24hrs of admission	Apr-17	97%	97%	95%	GREEN	↔	
		% of patients with swallow screen carried out on within 4 hours of admission	Apr-17	61%	74%	100%	RED	↑	
		% of Patients prescribed aspirin on Day of Admission, or Day following	Apr-17	96%	89%	95%	RED	↓	
19	LDPS	% patient waiting <18 weeks for RTT to Specialist Child and Adolescent Mental Health Services	Apr-17	99.8%	99.1%	100%	AMBER	↔	
20	LDPS	% patients who started treatment <18 weeks of referral for psychological therapies	Jan - Mar 17	92.4%	94.7%**	90%	GREEN	↑	
21	LDPS	Drug and Alcohol: % of patients waiting <3 weeks from referral to appropriate treatment	Oct - Dec 16	97.9%	96.7%	91.5%	GREEN	↓	
22	LDPS	SAB Infection rate (cases per 1,000 OBD rolling year for 15 years+)	Oct - Dec 16	0.30	0.31	0.24	RED	↓	Page 28
23	LDPS	C.Diff Infections (cases per 1,000 OBD rolling year)	Oct - Dec 16	0.31	0.28	0.32	GREEN	↑	
24	LDPS	% of complaints responded to within 20 working days	Jan - Mar 17	72%	74%	70%	GREEN	↑	
25	LDPS/LDF	Financial Performance	Mar-17	£0.2m	£0.8m	(£0.0m)	GREEN	↑	
26	LKPI	Freedom of Information Requests	Jan - Mar 17	92.0%	85.2%	90.0%	AMBER	↓	
27	LDPS/LDF	Sickness Absence (rolling year)	Apr-17	5.42%	5.48%	4.0%	RED	↓	Page 33
		Long Term	Apr-17	3.58%	3.64%	N/A	GREY	↓	
		Short Term	Apr-17	1.84%	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	Jan - Mar 17	83.7%	83.5%	80%	GREEN	↓	
29	LDPS	Smoking Cessation - number of successful quitters at 12 weeks post quit in 40% SIMD areas	Apr - Dec 16	1,229	1,241	1,503	RED	↑	Page 30

* Data has still to be validated

** Data estimated to be 20% - 30% complete as a result of being in the process of migrating to a new patient management system.

Key	Performance Status	Direction of Travel
LDPS	RED	Improving
HSCI	AMBER	Deteriorating
LDPS/LDF	GREEN	Maintaining
LKPI	GREY	—
	N/A	—

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	2016-17 Target	Perform Status	Dir of Travel
3	All Cancer Treatments (31 days wait)	Apr 2017	93.5%	92.7%	95%	AMBER	↓

Commentary

As at April 2017, 92.7% of all patients diagnosed with cancer were treated within 31 days from decision to treat to receiving their first treatment. Current performance is below target and marginally lower than the position reported the same month the previous year. Six out of 10 cancer types exceeded target however, the remaining four cancer types were below target namely, Breast (92.1%), Melanoma (90.5%), Head and Neck (90%) and Urology (77.6%). Details of work underway to address performance in relation to each of the cancer types below target are linked to the Cancer 62 day waits and outlined in the exception report.

Ref	Measure	As At	2015-16 Actual	2016-17 Actual	2016-17 Target	Perform Status	Dir of Travel
5	A&E 4 hour waits	May 2017	92.3%	90.7%	95%	AMBER	↓

Commentary

As at May 2017, 90.7% of all patients waiting at A&E Departments were waiting <4 hours to be seen, treated or transferred, below the target of 95% and lower than the position reported the same month the previous year.

The findings of the comprehensive “root and branch review” of unscheduled care identified a number of practical projects that are aimed at tackling the bottlenecks in ED and delivering improvements. The review has also identified examples of best practice and learning that will enable our clinical teams to introduce new ways of working to improve the quality of care we provide and make our processes more effective. In addition, work also continues with HSCPs in tackling delayed discharge with robust plans to support recovery in place.

Ref	Measure	As At	2015-16 Actual	2016-17 Actual	2016-17 Target	Perform Status	Dir of Travel
13	18 Week Referral To Treatment	Apr 2017	99.2%	88.6%	90%	AMBER	↓

Commentary

As at April 2017, 88.6% of all patients referred for treatment waited less than 18 weeks for a Referral To Treatment marginally below the target of 90% and lower than the position reported the same month the previous year. Current performance is partly due to the recent focus on reducing the number of patients with long waiting times which means once patients have received their treatment their whole patient journey is reported and this will be longer than the 18 weeks therefore bringing down the Board-wide average.

Ref	Measure	As At	2015-16 Actual	2016-17 Actual	2016-17 Target	Perform Status	Dir of Travel
26	Freedom of Information Requests	Jan - Mar 2017	92.0%	85.2%	90%	AMBER	↓

Commentary

For the quarter ending March 2017, 85.2% of Freedom of Information (FOI) requests received were completed within 20 working days. During this period, a total of 248 FOI requests were received, 243 requests responded to and of this total, 207 requests were responded to within 20 working days. The decrease in performance when compared to the same period the previous year is mainly attributed to the increase in volume and complexity of requests received.

During the same quarter the previous year, a total of 198 FOI requests were received, 187 were responded to and of this total, 172 requests were responded to within 20 working days. The volume of requests received increased by 25% when compared to the same period the previous year, the number of requests responded to increased by 30% and the number of requests responded to within the 20 working day standard also increased by 20%. The average number of requests received during this reporting period was 84 per month, compared to 66 per month in the same quarter last year.

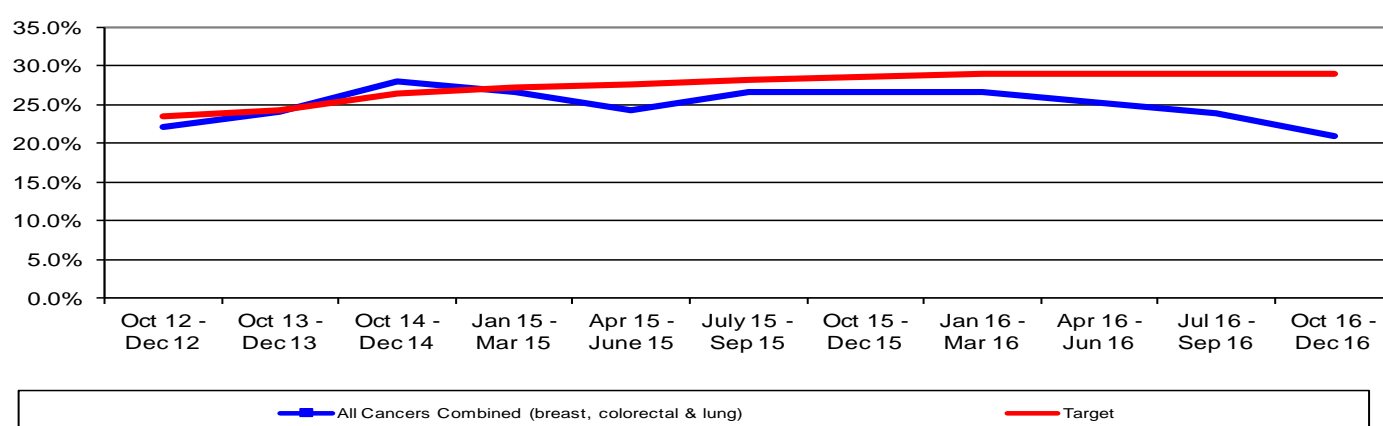
FOI staffing has not increased since the previous reporting period. However FOI staff are required to react to the peaks and troughs in the number of requests received. While we do our best to ensure business continuity and 'resilience' it is sometimes difficult to achieve this within small specialised teams, and unplanned absence will no doubt have played a part in the reduced performance during this time.

PERFORMANCE EXCEPTIONS REPORTS

Exceptions Report: Detect Cancer Early

Measure	Detect Cancer Early (DCE)
Current Performance	Overall, for the period October - December 2016 the percentage of patients diagnosed with Stage 1 cancer was 20.9%. Current performance is lower than the local target of 29.0% for the period under review. <i>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.</i>
NHS Scotland <i>(Latest published data available)</i>	The 2014/15 combined data for NHS Scotland demonstrates 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 2010-11 combined whereas NHSGG&C reported a 12.5% increase on the 2010-11 baseline.
Lead Director	Linda de Caestecker, Director of Public Health

All Cancers Combined - % patients diagnosed at first stage of disease



Commentary

The delivery date for the DCE target (25% increase in Stage 1 diagnoses) ended in December 2015. The 2014/15 combined data for NHSScotland demonstrates 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 2010/11 combined. For the same period 25.2% of people were diagnosed with breast, colorectal and lung cancer at the earliest stage (Stage 1) across NHSGG&C, a 12.5% increase from the baseline 2010/11 combined. Of the 14 Health Boards reporting performance, seven reported an increase on the overall baseline position including NHSGG&C (12.5% increase on the baseline).

Whilst the agreed target delivery date was December 2015, NHSGG&C will continue to collect and submit data on the three cancer types included within this measure and await confirmation on how the DCE programme will progress e.g. whether new baselines will be set or whether the programme will be fully rolled out to other cancer types.

When the DCE programme board discussed and stratified the options for extending the programme to other tumour types, melanoma scored highest. Three pilot projects for melanoma are currently underway in NHS Tayside, NHS Grampian and NHS Fife. The Scottish Government wrote to all NHS Boards in November 2016 inviting applications for funding of further projects aimed at enhancing current or introducing novel referral methods which would allow for optimal triage of suspected melanomas and/or raise diagnostic expertise in primary care and the community and outline project submissions were to be submitted by February 2017, NHSGG&C did not propose any projects.

The data relates to the period October - December 2016 and uses the December 2015 target in which to measure performance against. As seen from the table above, 20.9% of all cancers combined were detected at Stage 1. Current performance remains below the local target of 29.0% set for that period and also below performance in July - September 2016 (23.9%).

In terms of cancer types performance is as follows:

Breast Cancer

30.8% of patients were diagnosed at Stage 1 for the period October - December 2016, a reduction on the July - September 2016 position of 35.7% and below the local target of 43.1%.

Colorectal Cancer

13.9% of patients were diagnosed at Stage 1 for the period October - December 2016, a reduction on the July - September 2016 position of 17.6% and below the local target of 26.2%.

Lung Cancer

18.5% of patients were diagnosed at Stage 1 for the period October - December 2016, a marginal reduction on the July - September 2016 position of 18.6% and below the local target of 19.9%.

The reduction in early stage cancer diagnosis appears limited to breast and bowel. There was no meaningful change in lung cancers during this period. Uptake figures for the breast and colorectal screening programmes during this time period are not yet available so any changes in screening uptake that may contribute to these changes are not yet known. There is no established screening programme for lung cancer.

Actions to Address Performance

The introduction of the new FIT screening test for bowel cancer will begin in November 2017 and is expected to increase uptake by around 5%. The test is easier to use and also provides increased sensitivity and detection at earlier stages and will be a major strand of DCE programme. Launch will be supported by local communication plan.

NHSGG&C will re-introduce the Bowel screening 'teaser' letter to new participants based on analysis suggesting a reduction in uptake following removal. Further multi-variant analysis of screening data is underway to further understand uptake in specific population groups.

Ongoing partnership with Cancer Research UK Healthcare Engagement Programme targeting primary care staff includes; training to improve awareness of and confidence to use referral guidelines; work to reduce barriers to participation in screening programmes and tailored behavioural change interventions to reduce cancer risks. Links have been established with 173 (71%) of NHSGG&C practices and detailed follow up from the programme has taken place in 56% of engaged practices. Analysis of data to identify practices with outlying uptake levels is ongoing and followed up by Cancer Research UK.

Cancer Research UK community awareness raising sessions routinely taking place in Your Cancer Awareness Hubs (six venues across NHSGG&C) with aim to increase prevention activities as well as raising awareness of risk and early symptoms with general public.

Locally a Breast Screening Promotion protocol has been developed to engage local practices and community networks with timely awareness raising materials linked to the schedule of Mobile Breast Screening Service visits. Scheduling of mobile service is under review to optimise attendance in localities.

Targeted events to raise awareness of screening programmes with people with Learning Disabilities (and carers) have been undertaken across Glasgow City.

Timeline For Improvement

Whilst awaiting confirmation from the Scottish Government on the future of the DCE programme we will continue to review performance locally against the endpoint local target however the target will remain a challenge for NHSGG&C where significant changes to diagnostic arrangements were introduced ahead of the introduction of the target post 2015.

The introduction of FIT from November 2017 will support improved uptake and diagnosis of colorectal

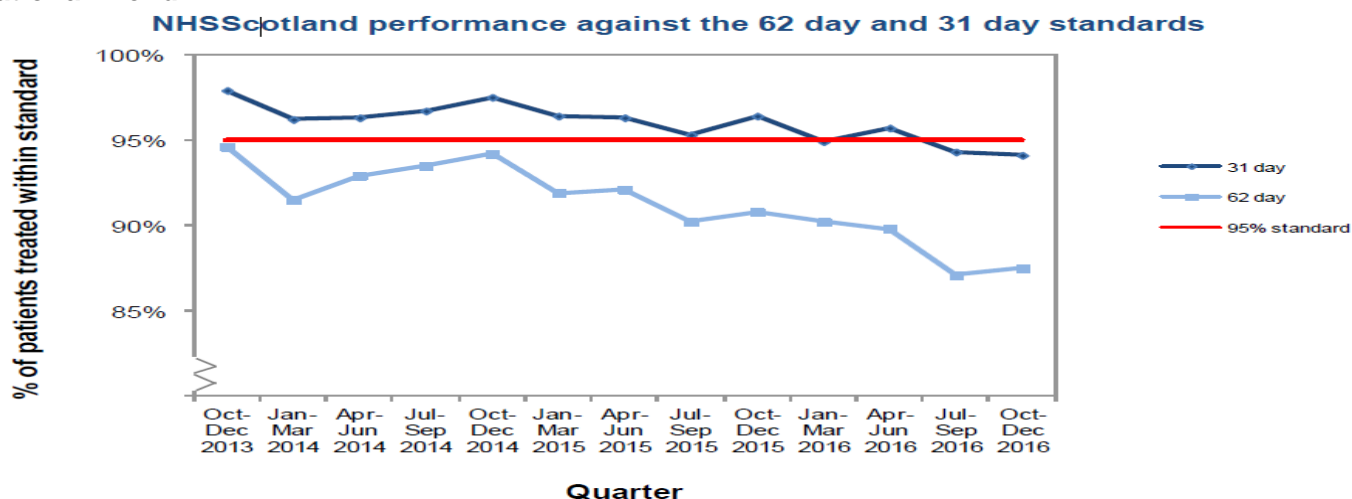
cancer. Activities to promote screening programmes and reduce barriers remains ongoing.

Exceptions Report: Suspicion of Cancer Referrals (62 days)

Measure	Suspicion of Cancer Referrals
Current Performance	As at April 2017, 83.6% of patients with an urgent referral for suspicion of cancer were treated within 62 days of the referral. (Data provisional)
NHSScotland (Latest published data available)	For the quarter October - December 2016, 87.5% of patients with an urgent referral for suspicion of cancer were treated within 62 days of the referral.
Lead Director	Gary Jenkins, Director of Regional Services

NHSScotland's Performance

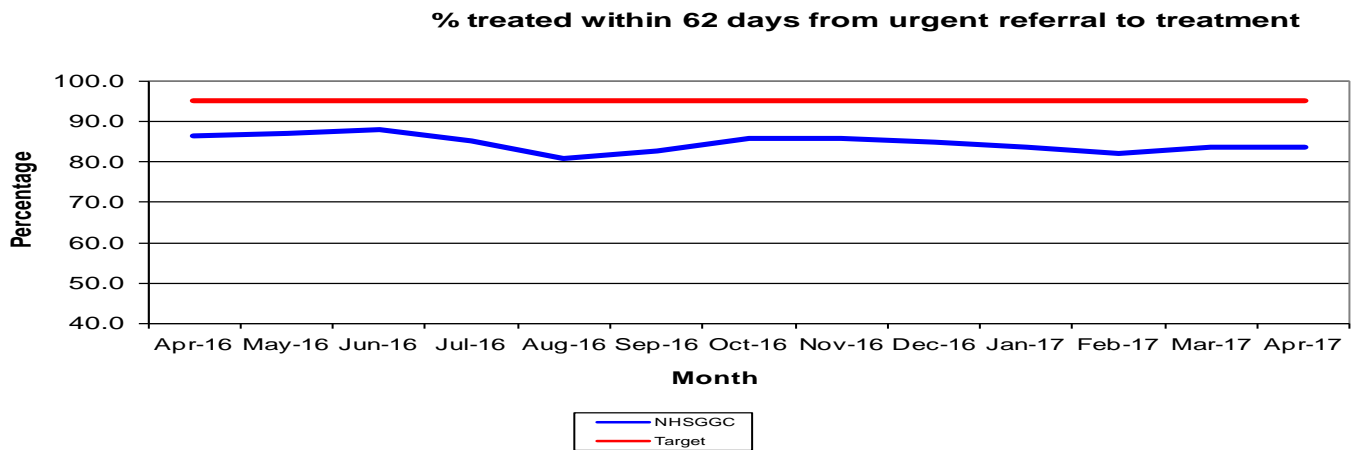
National Trend



As seen from the table above, since December 2014, there has been a downward trend in overall performance in relation to the percentage of eligible patients urgently referred with a suspicion of cancer starting their first cancer treatment across NHSScotland. During October - December 2016, 87.5% of eligible patients who were urgently referred with a suspicion of cancer started their first cancer treatment within 62 days of referral. This is an increase on the 87.1% reported in the previous quarter July - September 2016. The 62 day standard was met by five Health Boards namely NHS Borders, NHS Dumfries & Galloway, NHS Lanarkshire, NHS Orkney and NHS Shetland.

During the period October - December 2016, the 62 day standard was not met for any of the 10 cancer types included across NHSScotland however, NHSGG&C met the standard for three cancer types namely Breast (95%), Cervical (100%) and Ovarian (100%) during this period. The variation in NHSScotland's performance relating to cancer types ranged from 94.8% (840 of the 890 eligible patients) breast cancer patients starting their treatment within 62 days of referral to 74.7% (407 of the 545 eligible patients) urological cancer patients starting their treatment within 62 days of referral. NHSGG&C's position during this time for the same cancer types was 95% (227 of the 239 eligible patients) breast cancer patients starting their treatment within 62 days of referral and 60.8% (76 of the 125 eligible patients) urology patients starting their treatment within 62 days of referral.

During this period the average number of days waited from receipt of an urgent referral with a suspicion of cancer referral to first cancer treatment was 40 across Scotland and across NHSGG&C it was 42 days.

NHS Greater Glasgow & Clyde's Performance

As at April 2017, 83.6% (219 out of 262) of eligible referrals with an urgent referral for suspicion of cancer had first treatment within 62 days of referral, below the target of 95%. The cancer types currently below the 95% target are as follows: Urological 48.8% (20 out of 41 eligible referrals treated within target), Upper GI 78.9% (15 out of 19 eligible referrals treated within target), Colorectal 91.4% (32 out of 35 eligible referrals treated within target), Head and Neck 76.9% (10 out of 13 eligible referrals treated within target), Lung 89.6% (43 out of 48 eligible referrals treated within the target), Breast 92% (69 out of 75 eligible referrals treated within target) and Melanoma 91.7% (11 out of 12 eligible patients). The three remaining cancer types currently exceeding target are Cervical (100%), Lymphoma (100%) and Ovarian (100%).

Three of the seven cancer types below the 62 day standard highlight an improvement on the previous months' performance namely Breast, Colorectal and Lymphoma (now exceeding target).

Actions to Address Performance**General**

Short-term additional activity continues to support measures to improve cancer waiting times.

The following actions are in place for those cancer types currently below the 62 day waiting time standard.

Urological Cancer

April 2017 saw a decrease in 62-day performance compared with March 2017 (52.5% to 48.8%). As previously predicted performance in Urology for the 62-day and 31-day targets was expected to drop as there remains a significant number of patients awaiting treatment. Additional capacity from February 2017 onwards has assisted in clearing the backlog, particularly in relation to renal cancer where two consultants have now taken up post with sessions dedicated to treatment of renal cancer. However, due to the numbers of cases, it is anticipated that it will be Q2 (April - June) before the backlog is cleared. It is recognised that the prostate cancer pathway for patients undergoing surgery is challenged at present. As cancer waiting times are reported against month of treatment, treatment of these cases may result in a drop in overall performance. A system wide urology event is planned to review all patient pathways and ensure optimum productivity.

Breast Cancer

Performance in Breast increased from 90.8% in March 2017 to 92.0% in April 2017. Additional clinics have resulted in a reduced wait to first appointment. Additional clinics continued in May 2017. The non-recurring allocation of Lanarkshire breast screening patients to NHS Lanarkshire continued through April and May 2017.

A redesign of breast services to address variation in patient pathways is currently underway.

Colorectal Cancer

Performance in relation to Colorectal increased from 82.9% in March 2017 to 91.4% in April 2017. Additional non recurring funding has been allocated to support further colonoscopy lists across the three sectors.

Head & Neck Cancer

Performance in relation to Head and Neck decreased from 88.9% in March 2017 to 76.9% in April 2017. 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 continued to be implemented in May 2017.

A combined 'neck lump' clinic is being established within the South and Clyde Sectors with Radiology support to reduce the need for multiple attendances.

Upper GI Cancer

Performance in relation to Upper GI decreased from 90.0% in March 2017 to 78.9% in April 2017. It is recognised that some patients on the Upper GI pathway can undergo a significant number of staging investigations in order to ensure that they receive the optimal treatment. Monthly performance against the 62-day target is variable dependent on case mix of patients treated in the month.

Lung

Performance in relation to Lung decreased from 91.9% in March 2017 to 89.6% in April 2017. Monthly performance against the 62-day target is variable dependent on case mix of patients treated in the month.

Melanoma

Performance in relation to Melanoma decreased from 100% in March 2017 to 91.7% in April 2017, which related to one breacher, a case referred from Dermatology to Plastic Surgery and treated on day 64.

Timeline For Improvement

The above measures are being undertaken to ensure more timeous steps on the patient pathway. However, it should be noted that it is not anticipated that Quarter 2 (April - June) 2017 will demonstrate the desired improvement. There are still a significant number of cases who have waited longer than the target and are still awaiting treatment, particularly in Urology. 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.

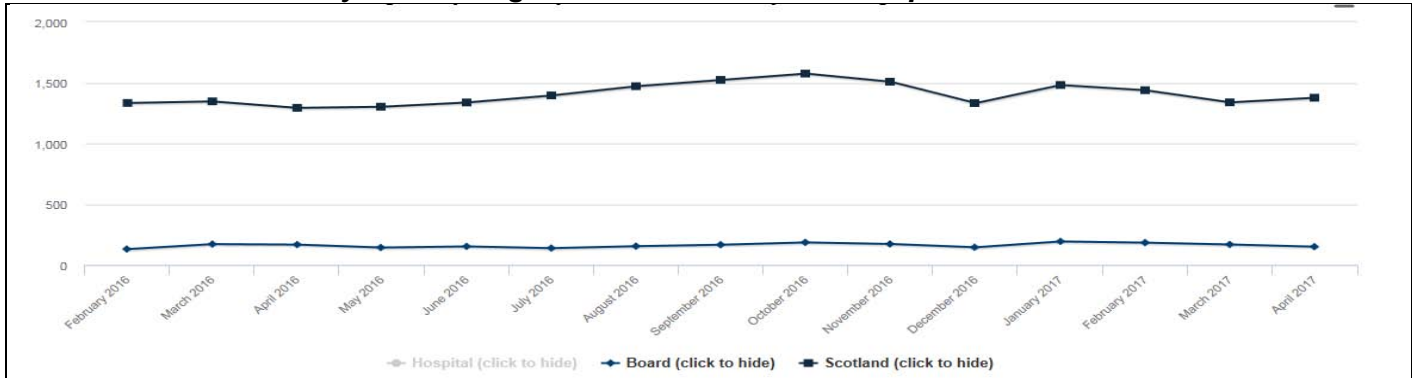
Exceptions Report: Delayed Discharges and Bed Days Lost to Delayed Discharge

It should be noted that the data below is indicative of performance and will be subject to validation by ISD.

Measure	Bed Days Lost to Delayed Discharge (inc Adults with Incapacity)
Current Performance	As at May 2017, there were a total of 133 delayed discharge patients resulting in the loss of 4,327 occupied bed days across NHSGG&C.
NHSScotland (Latest published data available)	As at April 2017, there were a total of 1,377 patients delayed resulting in the loss of 40,925 occupied bed days across NHSScotland.
Lead Director	Jonathan Best, Interim Chief Operating Officer

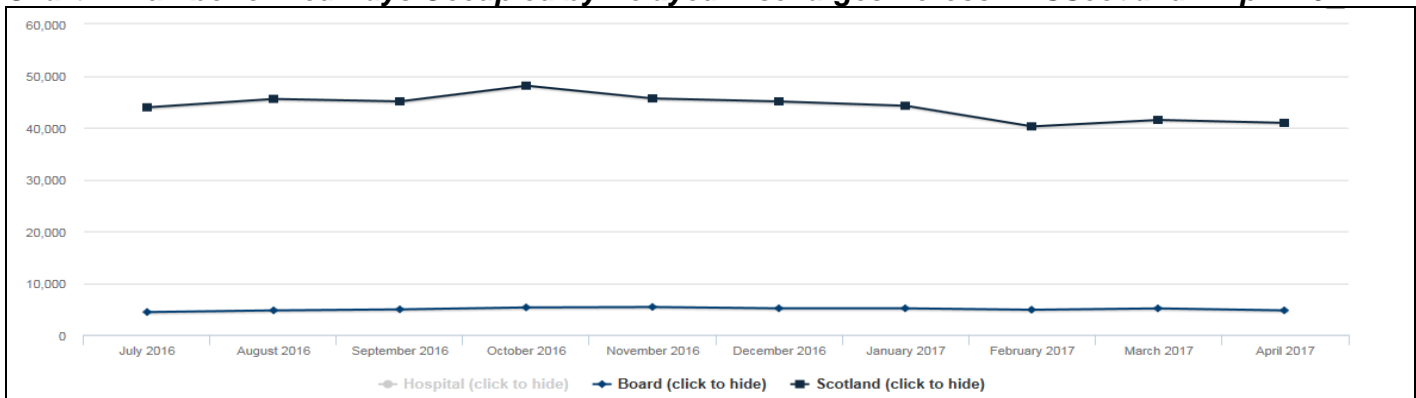
NHSScotland's Performance

Chart 1: Number of Delayed Discharges across NHSScotland – April 2017



Across NHSScotland, there were a total of 1,377 patients delayed at the April 2017 census, NHSGG&C accounted for 11% (151) of the total number of delayed patients reported across Scotland. Across NHSScotland there had been a month on month reduction in the number of patients delayed since January 2017 however, this reduction was not sustained in April 2017 with current performance representing a 3% increase on the previous month's performance and a 6% increase on the same month the previous year. In NHSGG&C there were further reductions in the numbers reported in the previous months (169 delayed discharges in March 2017 and 184 delayed discharges in February 2017).

Chart 2: Number of Bed Days Occupied by Delayed Discharges Across NHSScotland – April 2017



The 1,377 patients delayed across NHSScotland resulted in the loss of 40,925 occupied bed days a marginal reduction (1.3%) on the number reported the previous month (41,493). NHSGG&C accounted for 11.6% (4,743) of total occupied bed days lost to delayed discharge across Scotland representing a 7.5% reduction on the number reported the previous month (5,127) and the lowest number of bed days lost across NHSGG&C since July 2016.

NHSGG&C's Performance**Table 1 – May 2017 – Total Delayed Discharges and Bed Days Lost – NHSGG&C**

TOTAL DELAYED DISCHARGES	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17
Total number of patients delayed (at census point)	139	155	167	186	173	146	194	184	169	151	133
Total number of delayed discharge episodes (month end)	407	412	421	423	454	413	427	425	490	437	471
Total number of bed days occupied by delayed discharge patients (month end)	4,421	4,747	4,943	5,313	5,397	5,138	5,147	4,863	5,133	4,743	4,327

Table 2 – May 2017 – Acute Delayed Discharges and Bed Days Lost

ACUTE DELAYED DISCHARGES	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17
Total number of patients delayed (at census point)	-	-	111	121	111	97	142	127	117	107	99
Total number of delayed discharge episodes (month end)	-	-	335	335	373	337	360	356	414	368	404
Total number of bed days occupied by delayed discharge patients (month end)	-	-	3,282	3,517	3,522	3,404	3,544	3,319	3,576	3,285	3,076

As seen from *Table 1* above, at the May 2017 census point an overall total of 133 patients were delayed across NHSGG&C resulting in the loss of 4,327 bed days across the Acute and Mental Health Services. Current performance has seen a month on month reduction in the number of delayed patients since January 2017 and represents the lowest number of delayed patients and subsequent bed days lost since July 2016.

As seen on *Table 2*, a total of 99 delayed patients were in Acute hospitals, resulting in the loss of 3,076 bed days across the Acute Division. All HSCP areas reported delayed patients across Acute hospitals with 35 from Glasgow City; 10 from West Dunbartonshire; 7 from East Dunbartonshire; 6 from East Renfrewshire; 9 from Inverclyde; 11 from Renfrewshire and the remaining 21 were residents from out with the Board area. Those out with the Board area comprise North Lanarkshire (7); South Lanarkshire (7); Argyll and Bute (4); North Ayrshire (2) and 1 other.

The number of patients delayed in Acute Hospitals resulted in the 3,076 Acute bed days lost to delayed discharge across NHSGG&C during May 2017. Each of the HSCPs reported bed days lost comprising East Dunbartonshire (222 bed days); East Renfrewshire (99 bed days); Glasgow City (1,303 bed days); Inverclyde (233 bed days); Renfrewshire (255 bed days) and West Dunbartonshire (289 bed days). The remaining bed days lost were from patients out with the NHSGG&C (675 bed days). Those out with the Board area comprise North Lanarkshire (151 bed days); South Lanarkshire (286 bed days); Argyll & Bute (109 bed days); North Ayrshire (75 bed days) and the remaining 54 bed days lost were from other unspecified areas.

Actions to Address Performance

A number of actions have been implemented since the previous Board meeting:

Within NHSGG&C

- An urgent retrieval plan was requested from West Dunbartonshire HSCP to address the high level of delays that emerged relatively recently which has resulted in performance in the number of patients delayed improving - reducing from the 18 delayed patients reported in February 2017 to 10 patients delayed at May 2017. We have continued to support the HSCP to secure a flow of patients into the previous continuing care beds at St Margaret's.
- We have also asked Glasgow City HSCP for a revised plan and timescale to deliver the level of 20 delayed patients which was agreed would be delivered from the end of March 2017, the current level is exceeding that.

Outwith NHSGG&C

- We met South and North Lanarkshire and agreed actions they will take to improve performance.
- Weekly conference calls have been established with Ayrshire Acute and HSCPs to ensure a tighter focus on moving patients through.

Across the Acute Division

- Arrangements have been revised to transfer all patients ready for discharge from our three major acute ED sites to other beds within the Division to ensure that the impact of delays is minimised while continuing to work with HSCPs to reduce delays.

Financial Arrangements

- From the start of the new financial year we have charged the costs of delays to Boards outwith NHSGG&C.

Timeline for Improvement

The aim is to achieve immediate and continuing reductions in the number of patients delayed with short term impact of actions outlined above.

Exceptions Report: 12 Week Treatment Time Guarantee

Measure	12 week Treatment Time Guarantee (TTG)
Current Performance	As at April 2017 (month end), a total of 3,231 patients waited >12 weeks TTG for an inpatient/daycase procedure.
NHSScotland <i>(Latest published data available)</i>	As at March 2017, there were 11,168 patients waiting >12 weeks TTG for an inpatient/daycase admission across NHSScotland.
Lead Director	Jonathan Best, Interim Chief Operating Officer

NHSScotland's Performance

Table 1 - NHSScotland's Performance - Number of Ongoing Waits Over 12 weeks for an Inpatient or Daycase Admission: NHSScotland - Up to Month Ending March 2017

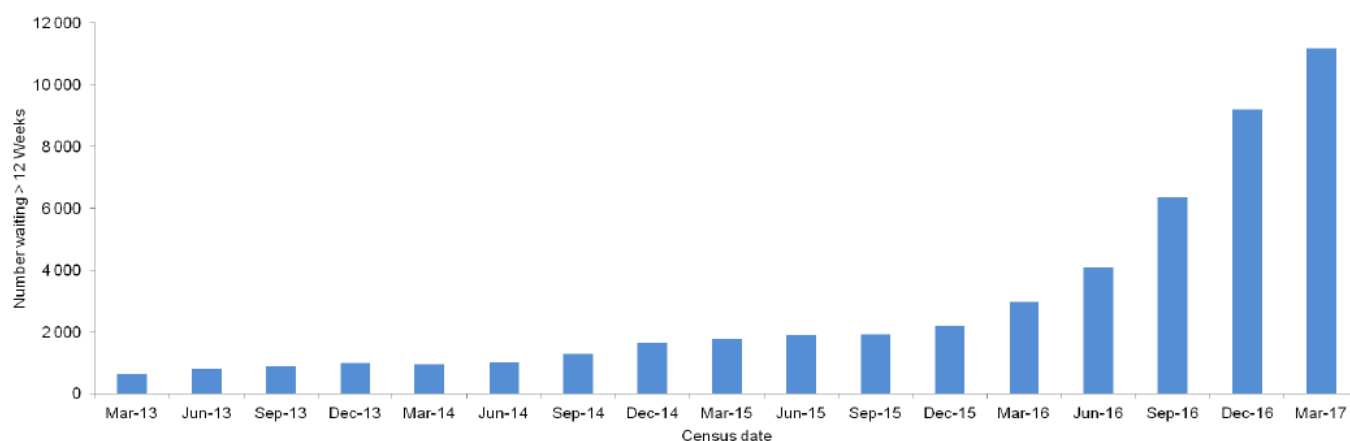
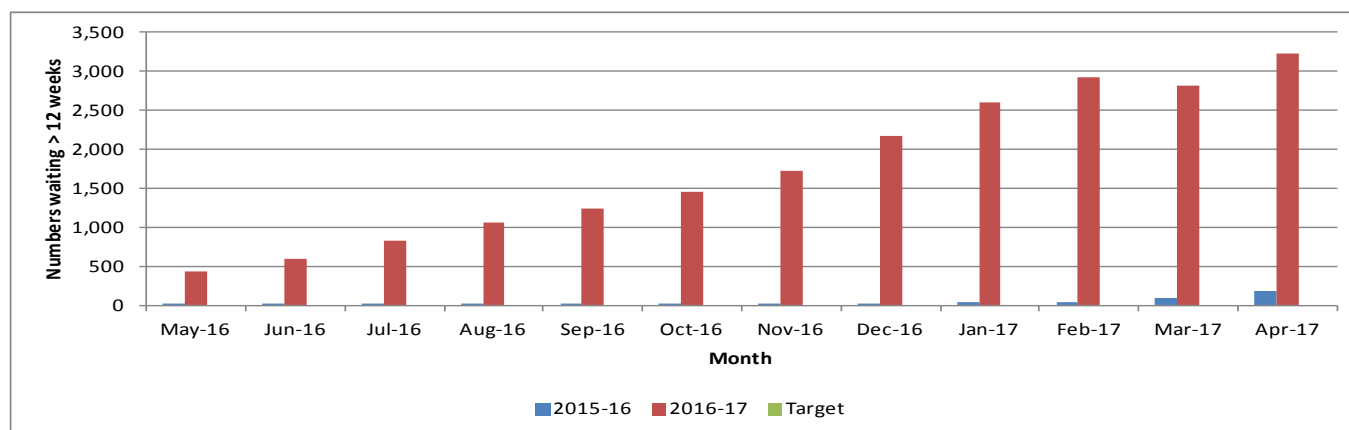


Table 2 - NHSGG&C's Performance - Up to month Ending April 2017



During the quarter ending March 2017, 82.1% of patients admitted for an inpatient or daycase procedure were seen within the 12 week TTG across NHSScotland. A total of six Health Boards were below the Scotland figure, whereas across NHSGG&C, 87.2% of patients treated were seen within the 12 week TTG.

During the same quarter the median wait for patients covered by the TTG standard was 49 days across NHSScotland. A total of eight Health Boards were above the national median wait whereas, NHSGG&C was below at 41 days. There were only three other Health Boards reporting fewer days waiting (median waits) to be seen namely NHS Western Isles, NHS Borders and NHS Ayrshire and Arran.

During the quarter ending March 2017, there were a total of 11,168 patients waiting >12 weeks across NHSScotland for an inpatient/daycase procedure, of which NHSGG&C accounted for 26% (2,869) of the

total. The charts on the previous page illustrates a steady increase in the number of patients waiting >12 weeks for an inpatient/daycase admission across NHSScotland and the pattern is the same across NHSGG&C.

NHSGG&C

As at April 2017 (month end), a total of 3,231 patients waiting >12 week TTG for an inpatient/daycase procedure representing a 15% increase on the number of patients waiting the previous month.

Number of patients waiting > than the 12 week Treatment Time Guarantee												
	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17
2015-16	1	2	4	6	30	9	2	4	34	47	87	188
2016-17	430	590	829	1,056	1,246	1,452	1,723	2,174	2,608	2,915	2,809	3,231
Target	0	0	0	0	0	0	0	0	0	0	0	0

The main specialties with patients waiting >12 weeks for an inpatient/daycase procedure are listed below:

Number of Patients Waiting >12 weeks				
Specialty	Jan-17	Feb-17	Mar-17	Apr-17
Orthopaedic Surgery	1353	1513	1435	1613
Urology	496	504	481	516
General Surgery	296	349	314	377
Paediatric Surgery	135	151	146	202
Neurosurgery	77	90	92	83
Ophthalmology	84	88	54	61
Paediatric ENT	25	56	134	195
Oral Maxillo Facial	33	38	13	44
Paediatric Plastic Surgery	33	37	44	43
ENT	31	34	32	29

Actions to Address Performance

As part of the LDP process all NHS Boards have been asked to take account of what can be done to make scheduled care services more sustainable. As seen from the above figures and those of the new outpatients waiting >12 weeks for a new OP appointments, there are a number of pressures on the delivery of scheduled care, our aim is to maximise delivery of the national targets while remaining within the available resources.

However, the programme of demand and capacity gap assessment and improvement is currently underway with the aim of:

- Examining the current gap with and without the use of additional sessions funded through WLIs.
- Developing a series of productivity and efficiency actions for each specialty at Division and Sector level that will increase the available capacity.
- Reassess the potential gap between demand and the improved capacity after actions have been put in place to identify priority areas for any additional funds.

The programme has four phases:

- Phase 1: Analysis of the elective activity and utilisation across all elective specialties during the year 2016-17.
- Phase 2: Estimate the additional capacity that could be gained if efficiency metrics were achieved.
- Phase 3: Develop a sector level specialty action plan, agreed through a series of sector workshops.
- Phase 4: Implementation of the agreed actions and the ongoing tracking of those actions and their impact on the delivery of access targets through the Acute Director's Access meeting.

Phase 3 of the programme currently underway is scheduled to be complete late June 2017. Sectors and specialties within Sectors are confirming their predicted productivity gains that will inform the final gap assessment and action plan for improvement.

In addition, the national Access Team have provided additional funding to assist in reducing the number of both inpatients and new outpatients waiting >12 weeks. Most of the specialties under pressure and listed on the previous page have been targeted alongside the number of patients expected to benefit in each.

Timeline for Improvement

The additional Access Funding that will be used to increase inpatient/daycase capacity will help reduce the number of TTG patients waiting >12 weeks in key specialties currently experiencing demand and capacity pressures. The output of the demand and capacity assessment is scheduled to be complete by the end of June 2017 and a realistic improvement plan will be developed and implemented across each of the Sector's specialties from July 2017 onwards with the aim of increasing the available capacity. The impact on the delivery of the 12 week TTG waiting times standard should become evident from there on in.

Exceptions Report: % of New Outpatients Waiting <12 Weeks for a New Outpatient Appointment

Measure	% of New Outpatients Waiting <12 Weeks for a New Outpatient Appointment
Current Performance	As at April 2017, 81.3% of new outpatients had been waiting 12 weeks or less for a new outpatient appointment. Current performance is lower than the target of 99.9%. <i>NB: Overall figures now include Glasgow Dental Hospital.</i>
NHS Scotland (Latest published data available)	At 31 March 2017, 80.7% of patients waiting for a new outpatient appointment had been waiting 12 weeks or less across NHSScotland.
Lead Director	Jonathan Best, Interim Chief Operating Officer

NHSScotland’s Performance

As at March 2017, 80.7% of patients had been waiting 12 weeks or less for a new outpatient appointment across NHSScotland. A total of five Health Boards were below the Scotland figure, whereas across NHSGG&C, 86.1% of patients waiting for a new outpatient appointment had been waiting 12 weeks or less.

As at March 2017, a total of 59,029 new outpatients had been waiting >12 weeks for a new outpatient appointment across NHSScotland. Of the total number of patients waiting >12 weeks for a new outpatient appointment 73.6% (43,436) were waiting >16 weeks. NHSGG&C accounted for 20% (11,910) of NHSScotland patients waiting >12 weeks for a new outpatient appointment and of this total 66.3% (7,892) were waiting >16 weeks.

Chart 1: NHSScotland’s Performance – Number of patients waiting >12 and 16 weeks for a new outpatient appointment – Up to month ending March 2017

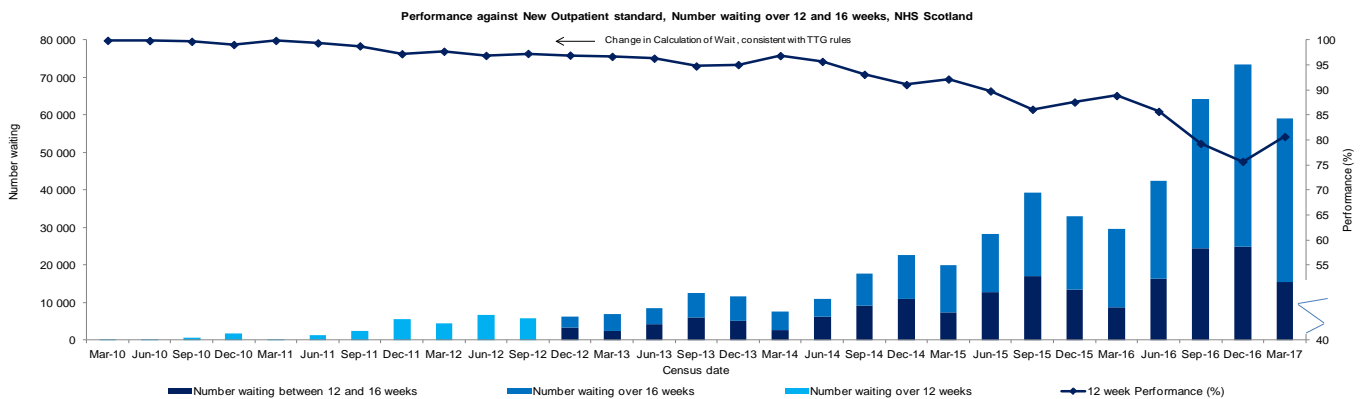
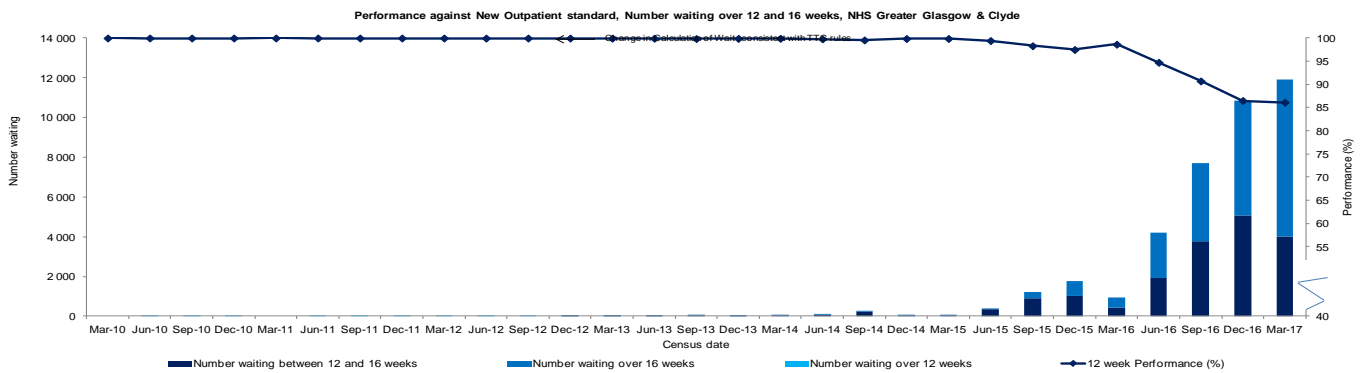


Chart 2: NHSGG&C Performance - Number of patients waiting >12 and 16 weeks for a new outpatient appointment – Up to Month ending March 2017



While the national standard applies to the number of patients waiting, the number of patients seen shows

the complete picture of waiting time experienced. During the quarter ending March 2017, a total of 371,004 new outpatients patients across NHSScotland were seen within 12 weeks. Of the total number of patients seen, the median number of days waited was 45 days. During the same period a total of 100,599 new outpatients were seen within 12 weeks across NHSGG&C, accounting for 27.1% of NHSScotland's total. The median number of days waiting for those patients seen across NHSGG&C was 49 days.

NHSGG&C's Performance

As at April 2017 (month end), 81.3% 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 (95.3%).

Performance across each of the three Sectors and Regional Services was below target of 99.9% in April 2017: the North Sector 90.1% of available new outpatients, South Sector 67.0% of available new outpatients, Clyde Sector 91.4% of available new outpatients and Regional Services 88.0% of available new outpatients were waiting <12 weeks for a new outpatient appointment.

The remaining 18.6% (16,662) of available new outpatients were waiting >12 weeks for a new outpatient appointment. The main specialties where the 16,662 new outpatients were waiting over 12 weeks are listed below:

Number of New Outpatients Waiting >12 weeks				
Specialties	Jan 17	Feb 17	Mar 17	Apr 17
Orthopaedics	3629	4025	4194	5427
General Surgery	1471	1723	1710	2126
Gastroenterology	1759	1546	1315	1468
Ophthalmology	1136	1353	1287	1560
Respiratory	1249	1118	882	1095
Urology	836	953	959	1263
Neurology	838	802	604	817
ENT	615	688	648	1262
Pain	487	410	297	362
Neurosurgery	171	303	278	365
Cardiology	176	199	149	195
Rheumatology	327	151	166	247
General Medicine	76	117	82	125
Endocrinology	68	108	115	150

Actions to Address Performance

As indicated in the TTG exception report, the LDP process requires all NHS Boards to take account of what can be done to make scheduled care services more sustainable. As seen from the above figures and the TTG performance, there are a number of pressures on the delivery of scheduled care and our aim is to maximise delivery of the national targets while remaining within the available resources.

The actions outlined in the TTG exception report are also being applied to address new outpatient waiting times performance. In addition, in response to the Scottish Government's Modernising Outpatient Programme, NHSGG&C have set up a Modern Outpatient Programme Board with the aim of redesigning outpatient activity and providing practical examples of change, which if adopted at scale, could have a significant impact in addressing pressures on outpatient services and improve productivity.

Implementation proposals to date include:

- Agreeing and implementing core principles of the Modern Outpatients agenda as the norm for all

specialties.

- Agreeing and implementing a Patient Focused Booking roll out programme to all services currently working within the waiting time standards.
- Establishing a Short Life Working Group tasked with developing a specification of the administrative infrastructure and IM&T necessary to support the 'Modern Outpatient' agenda.
- All of the above will be implemented at specialty level either as part of existing service reviews or as part of a programme of change and supported by a dedicated project team.

Also, the National Access Team have provided funding to provide additional outpatient capacity targeted at those patients waiting >12 weeks and those patients reporting the longest waits. Most of the outpatient specialties currently experiencing pressures have been allocated some additional funding. Each of the bids have identified the expected number of patients that will benefit from the additional resource and activity will be tracked month on month.

Timeline for Improvement

The additional Access Funding that will be used to increase outpatient capacity will help reduce the number of new outpatients waiting >12 weeks for a new outpatient appointment in key specialties currently experiencing demand and capacity pressures. Phase 3 of the more comprehensive review of capacity and productivity opportunities currently underway to identify the level of performance that can be achieved across each of the specialties within current resources is expected to be complete by late June 2017. From this a series of productivity actions will be identified and implemented for each specialty at Division and specialty level from July 2017 onwards with the aim of increasing the available capacity without additional capacity funding. The impact on the delivery of the new outpatient 12 week waiting times standard should become evident from there on in.

Exception Report: Stroke Care Bundle

Measure	Stroke Care Bundle
Current Performance	As at April 2017, overall performance against the Stroke Care Bundle was 65% which is below the target of 80%.
Lead Director	Jonathan Best, Interim Chief Operating Officer

Comparison with previous years (data taken from Scottish Stroke Care Audit Annual Report 2015 published July 2016)

	2011	2012	2013	2014	2015
GG&C Stroke Care Bundle Performance	34%	37%	48%	57%	64%

Chart 1

Performance against the 4 elements of the Stroke Bundle

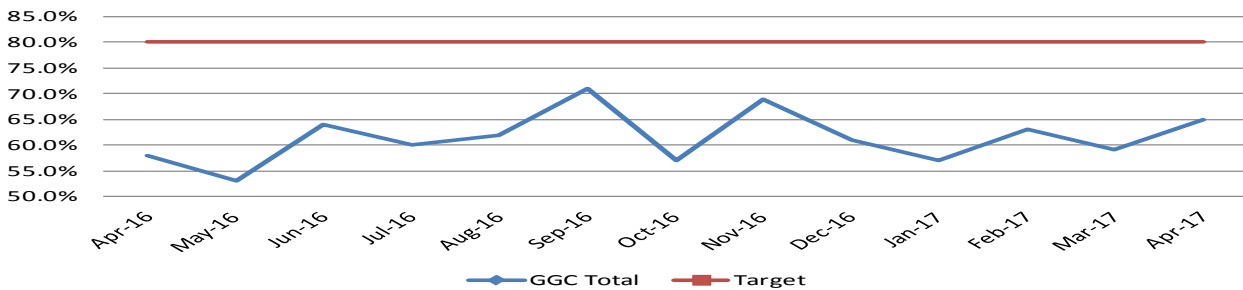
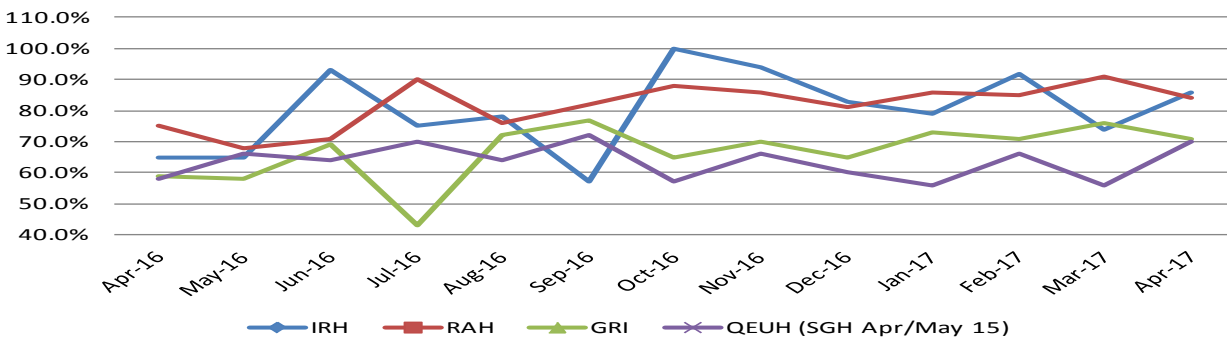


Chart 2

% of Patients with Swallow Screen Carried out on day of Admission



Commentary

Chart 1 demonstrates that overall performance against the stroke care bundle in April 2017 was 65% against a target of 80%. Whilst performance has remained persistently below the national standard of 80%, there has been an improvement in overall performance against the stroke care bundle. Overall performance in relation to the stroke care bundle is mainly driven by the swallow screen target which requires all suspected stroke patients to have a formal swallow screen carried out within four hours of hospital admission.

Chart 2 highlights performance against the swallow screen element of the stroke care bundle. April 2017 performance against the swallow screen element was 74%, the highest compliance rate reported since September 2016 and a significant improvement on the 68% reported the previous month. The biggest improvements in performance when compared to the previous month were reported at:

- IRH - 86% ↑ on the 74% reported the previous month.
- QUEH - 70% ↑ on the 56% reported the previous month.

The two remaining hospitals reporting a decrease in performance in relation to the swallow screen:

- RAH - 84% ↓ on the 91% reported the previous month.
- GRI - 71% ↓ on the 76% reported the previous month.

April 2017 shows a decrease in performance in relation to the percentage of patients prescribed aspirin on day of admission or the day following admission. Current performance of 89% is the lowest reported against this element of the bundle since May 2015 and is mainly driven by the deterioration at the RAH reducing from 96% in March 2017 to 71% in April 2017. All other hospital locations show an increase in performance when compared with the previous month and performance against each is in excess of 90% - IRH (92%); GRI (98%) and QUEH (91%).

Actions to Address Performance

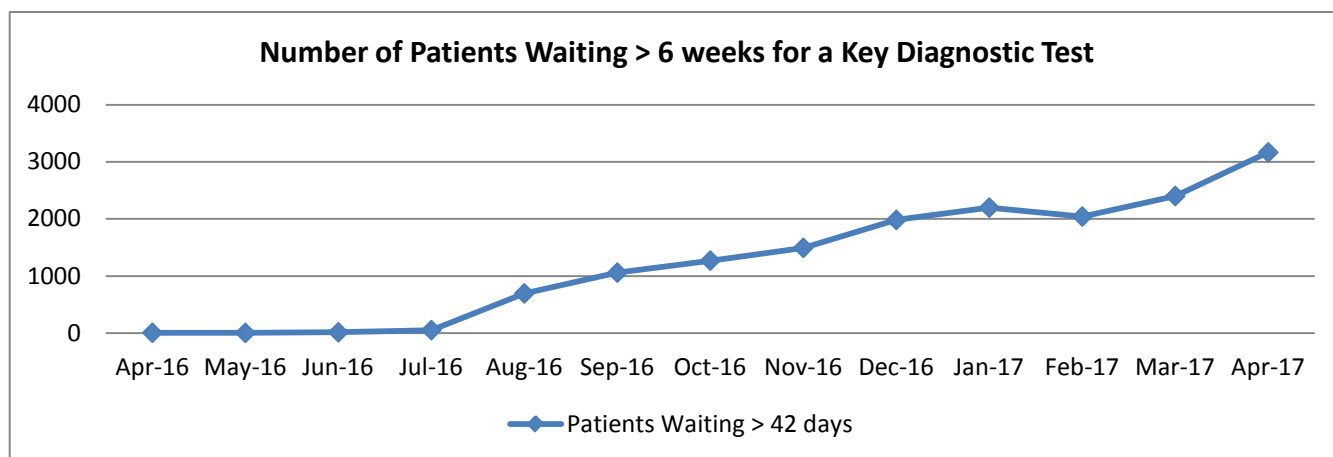
Improvement processes are in place particularly around the swallow screen element of the stroke care bundle. The detailed review of stroke care is now complete and has identified a series of recommendations to improve stroke care. The direction given by the Board Nurse Director early in the review process that swallow screen is an important safety issue and must be consistently undertaken by ED nursing staff is beginning to show in performance at the QUEH and the IRH. However, the direction has not yet driven the sustainable improvement required and further emphasis has now been given to senior nursing staff and the expectation is that the returns for June 2017 will confirm this issue has now been addressed.

Timeline For Improvement

The report on the recommendations of the Stroke Care Review is now complete and a major event for all stroke clinical staff across the Division took place in May 2017 to launch the wider programme of service improvement across the Acute Division. The improvements of this are expected to play through performance by June/July 2017.

Exception Report – Number of Patients Waiting >6 Weeks for Access to a Key Diagnostic Test

Measure	Number of Patients Waiting >6 Weeks for a Key Diagnostic Test
Current Performance	As at April 2017 (month end), there were a total of 3,165 patients waiting >6 weeks for a key diagnostic test. Current performance is below the target of 0.
Lead	Jonathan Best, Interim Chief Operating Officer



Commentary

As at April 2017 (month end) there were a total of 3,165 patients waiting >6 weeks for a key diagnostic test representing 15.5% of the total number of patients on the waiting list for the eight key diagnostic tests. Current performance represents a 24% increase in the number of patients (2,401) waiting >6 weeks for a key diagnostic test the previous month. Overall, patients were waiting >6 weeks for the following key diagnostic tests:

- 1,056 patients were waiting >6 weeks for an upper endoscopy test
- 250 patients were waiting >6 weeks for a lower endoscopy test
- 1,563 patients were waiting >6 weeks for a Colonoscopy test
- 296 patients were waiting >6 weeks for a Cystoscopy test.

The majority of patients waiting >6 weeks were waiting for a South Sector appointment (2,155 patients) or a Clyde Sector appointment (974 patients). In Clyde, the lack of capacity to meet demand particularly at the RAH remains. The South Sector has historically had demand and capacity issues which have been exacerbated with further reduced capacity from GS and GI Consultants following service reconfiguration and flexibility across Acute to pick up sessions has also reduced.

Actions to Address Performance

Actions to address performance in the South Sector include:

- Working with GS/GI colleagues to increase capacity where possible, including continual review of all training lists to ensure appropriate scheduling in place.
- Working on developing an Endoscopy Nurse led service to increase capacity and maximise efficiency with the completion of further training of two nurse Endoscopists in May 2017.
- Exploring the potential to increase capacity in the short term by exploring options outwith NHS e.g. Vanguard.
- Continuing to run WLI sessions during weekends.
- A group has been established with Gastroenterology colleagues to review referrals and consider how improvements can be made around vetting with the aim of reducing the requirement for a number of Endoscopies to be undertaken.

Actions to address performance in the Clyde Sector include:

- Additional capacity is being provided at week-ends to support the booking of urgent and surveillance patients to try and maintain capacity for routines. One trainee nurse Endoscopist is nearing completion of training and once this is completed this individual will work across the three sites to backfill cancelled lists.
- Additional nurse Endoscopist resource is required to backfill Consultant lists and maintain utilisation and capacity for these patients.
- One further trainee nurse Endoscopist has had a period of sickness absence however, this is expected to be resolved in the near future.
- Funding has been secured from the national Access Team to see 504 additional patients between June 2017 and the end of the year with priority given to urgent and surveillance patients.
- The North Sector is providing additional scope lists where possible to assist Clyde.

Timeline For Improvement

South Sector

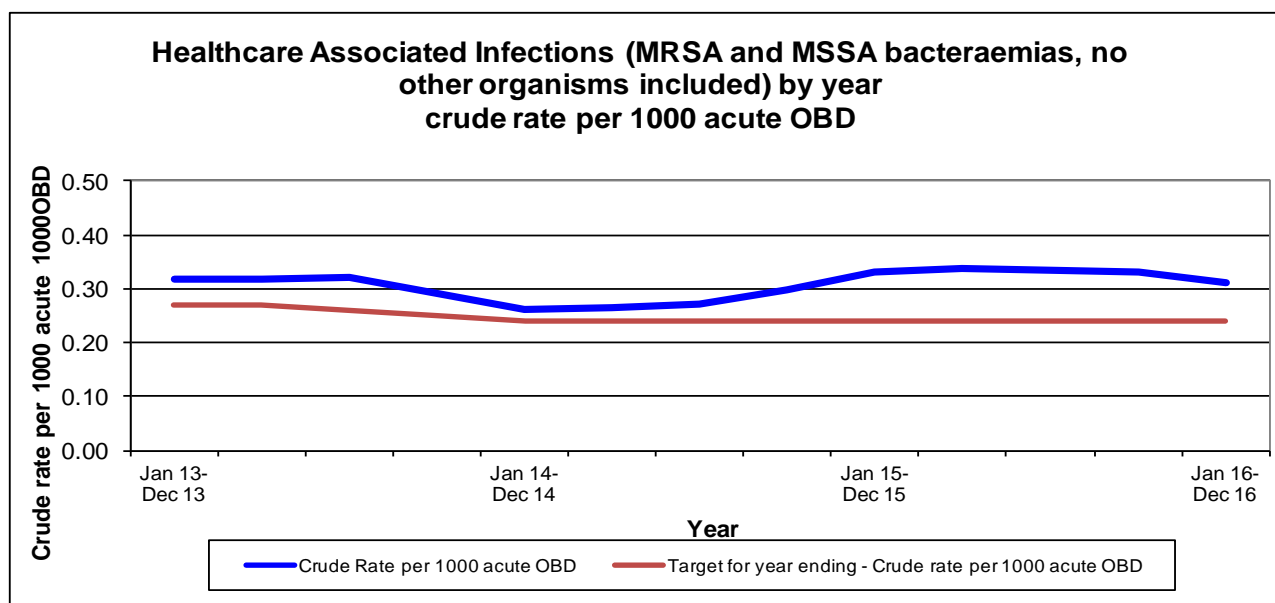
Whilst having secured access to Glasgow University to dual train five Nurse Endoscopists this will future proof the service for flexibility to meet changes in demand but not increase capacity per se. Two Nurse Endoscopists completed their training in April 2017 and this will assist with back filling Consultant cancellations. There is the potential to increase capacity with funding of vacant unfunded sessions however, this will be dependent on funding being available.

Clyde Sector

Within Clyde, the main solution is increased physical endoscopy space and associated staffing. However, the completion of training for one Nurse Endoscopist in 2017 and a further Nurse Endoscopist in 2018 will backfill sessions cancelled due to on call and annual leave. Whilst this will improve utilisation and help improve the position regarding surveillance backlogs/urgent patients, it will not achieve a full reduction in the number of patients waiting >6 weeks.

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

Measure	MRSA/MSSA Bacteraemia (cases per 1,000 AOB)
Current Performance	For the quarter ending December 2016, the number of MRSA/MSSA cases per 100,000 Acute Occupied Bed Days (AOBDs) was 30.1; current performance is higher than the trajectory of 24.0.
National Performance	For the quarter ending December 2016, the number of MRSA/MSSA cases per 100,000 Acute Occupied Bed Days (AOBD) across NHSScotland was 32.9.
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 AOBs by 31 March 2017. For NHSGG&C this is estimated to equal 25 patients or less each month developing a SAB.

As seen from the figures above the most recent validated results for 2016, Quarter 4 confirm a total of 104 SAB patient cases for NHSGG&C, between October and December 2016. This equates to a SAB rate of 30.1 cases per 100,000 AOBs. This is a decrease of 11% upon the previous quarter in SAB patient cases. Current performance is also below NHSScotland's performance of 32.9 cases per 100,000 AOBs.

The Quarterly Rolling Year ending December 2016 rate as per the Local Delivery Plan for SAB is 0.31 cases per 1,000 AOBs. This is against the March 2017 target of 0.24 cases per 1,000 AOBs.

Actions to Address Performance**Guidance/Education**

The vascular access device policy is currently being reviewed and will be issued and promoted by IPCT and Practice Development Colleagues when ratified.

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 available at <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 also reviewed all cases for six months post infection to examine long term consequences of this infection. Based on an audit of 99 cases of adult SAB in Quarter 3 of 2016 there was clear evidence of under treatment and high relapse rate/mortality despite availability of guidance and regular recommendations made by colleagues in microbiology and infectious diseases.

Two actions were identified and implemented:

- In those patients with SAB who are clinically improving with source control, completion of IV antibiotic therapy through OPAT may be possible following referral via Trakcare and contacting OPAT.
- Infection Prevention & Control Nurses currently issue antimicrobial guidelines to clinical staff when a SAB has been identified in order to support best practice in relation to prescribing. From June 2017 the IPCNs will also place a SAB 'sticker' in the patient's case notes to provide a prompt for appropriate management and to highlight guidance. This should be completed and dated by medical staff during treatment of the SAB.

Audit

Local SAB surveillance data shows that IVDs account for about a third of all hospital acquired SAB infections. These audits continue and a continuous improvement strategy is being developed with the Chief Nurses in order to support areas with poor compliance.

Community

Thirty per cent of all SABs are now defined as community acquired. A short-life working group was established February 2016 to review community SAB data and to identify areas where focussed improvement work could be implemented. Unfortunately the group conceded that because of the lack of significant risk factors to establish interventions that this group should be stepped down.

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*. This screening process began in February 2017. 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.

See agenda item 15 for more detail.

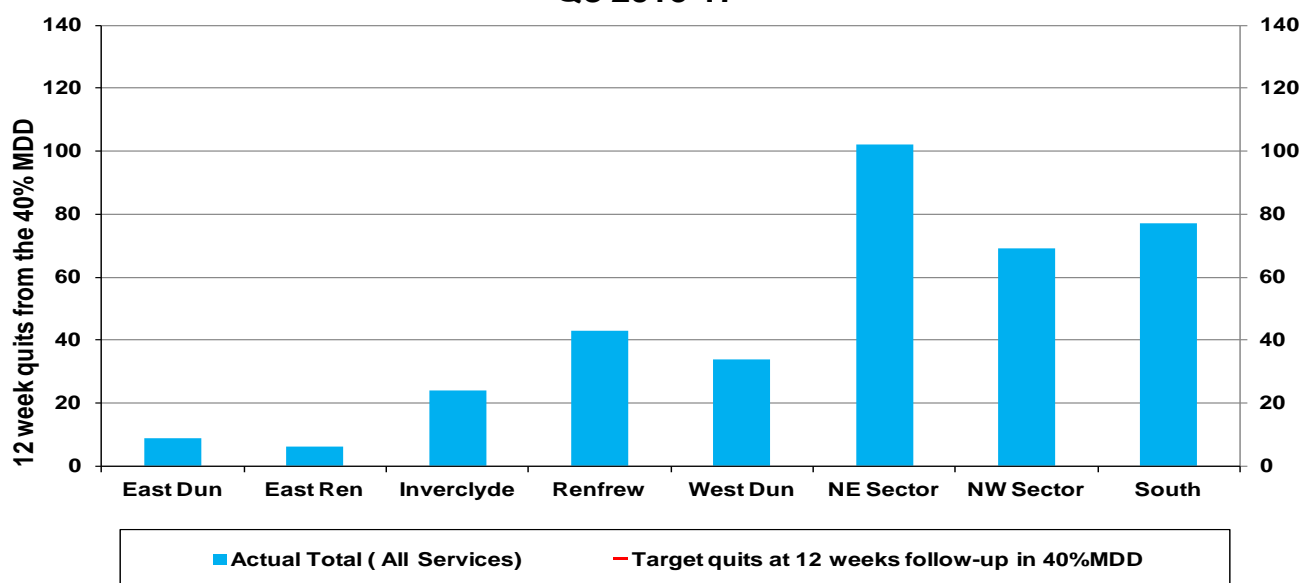
Timeline For Improvement

As detailed in the above actions, work continues on an ongoing basis to drive improvement however, despite these efforts performance seems to be at an irreducible minimum and every effort will continue to be made to maintain and improve where possible.

Exception Report: Smoking Cessation

Measure	Smoking Cessation – 3 months post quit in the 40% most deprived within Board SIMD areas
Current Performance	For the period April – December 2016 there were a total of 1,244 successful smoking quits. Current performance is below the trajectory of 1,503 successful quits for this period.
Lead Director	Linda de Caestecker, Director of Public Health

**12 week quits from the 40% MDD within Board areas
Q3 2016-17**



Commentary

The current performance gives rise for concern and reflects the challenge that NHSGG&C has been set as part of the LDP Standard for 2016-17. As previously highlighted the new target represents a 51% increase on 2015-16 and is higher than the Scottish average increase of 29%.

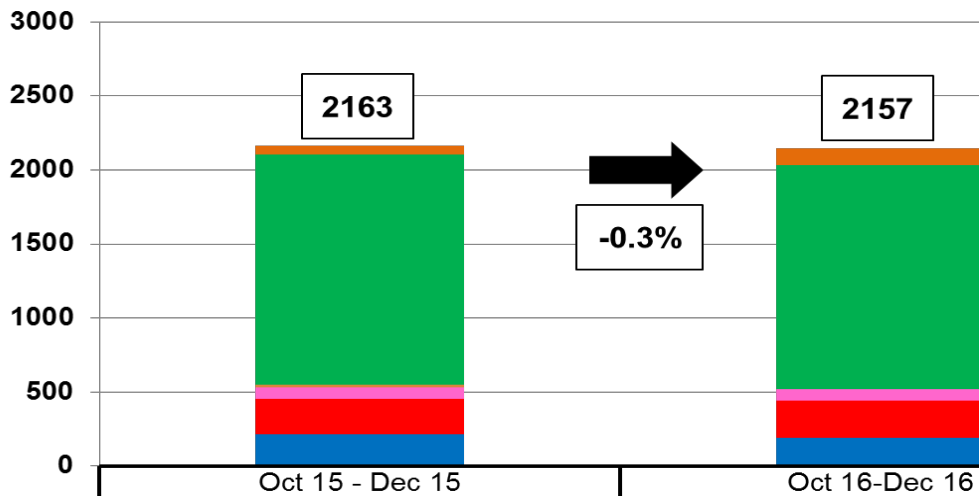
This significant challenge is somewhat mitigated when we calculate the increase in outcomes we need to achieve compared to what was delivered in 2015-16. The actual increase in 12 week outcomes is therefore just over 6% throughout the year. This 6.4% increase in 12 week outcomes is the key benchmark we are working towards when we analyse our service patterns compared to any time period from 2015-16.

Chart 2 shows that the quit attempts made in Quarter 3 this year compared to Quarter 3 in 2015/16 are comparable and that the actual number of successful quits from the 40% most deprived areas has increased by 3% in 2016/17 reflecting the effort that local areas have put in to improve performance.

However, given that the target for 2016/17 has increased significantly, the increased quits in Quarter 3 is not sufficient to meet our Quarter 3 target with services only achieving 81% of the required 12 week quits in Quarter 3.

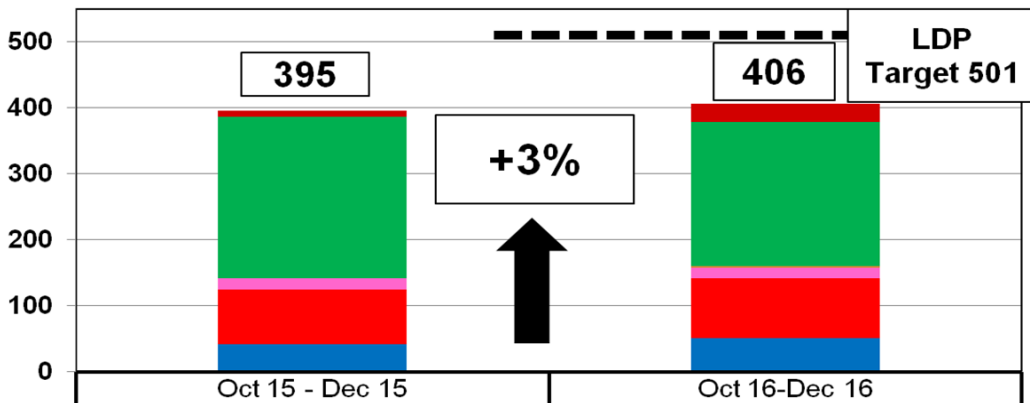
In terms of cumulative figures for Quarter 1 - Quarter 3, NHSGG&C services have achieved 1,244 successful quits at 12 weeks compared to a target of 1,503 which is 80% of the Quarter 1 - Quarter 3 target and equates to 67% of the annual target for NHSGG&C. Nationally, NHSScotland has achieved 73% of the Quarter 1 - Quarter 3 target and 55% of the annual target. Therefore, despite being below target NHSGG&C is performing above the national average and better than the majority of NHS Boards in Scotland reflecting the scale of the challenge presented by the new target.

Chart 2: NHSGGC Smokefree Services Quit Attempts 40% MDD Q3 15-16 and Q3 16-17



	Oct 15 - Dec 15	Oct 16-Dec 16
PRISONS	60	115
PHARMACY	1557	1514
MENTAL HEALTH	14	4
MATERNITY	80	76
COMMUNITY	241	253
ACUTE	211	187

Chart 5 - NHSGGC Smokefree Services 12 week Quits Q3 15-16 and Q3 16-17 40% MDD within Board areas



	Oct 15 - Dec 15	Oct 16-Dec 16
PRISONS	9	27
PHARMACY	244	219
MENTAL HEALTH	0	3
MATERNITY	18	15
COMMUNITY	83	91
ACUTE	41	51

We do not have the 12 week quit data for Quarter 4, but available data indicates that the number of quit attempts for this quarter has increased from 3,050 in 2015/16 to 3,148 in 2016/17. Given our quit rate of 19% this indicates that we can anticipate a further 599 quits by the end of Quarter 4. This means that we will achieve a total of 1,843 12 week quits over 2016/17 compared to a target of 2,005 (92% of target) and therefore we anticipate that NHSGG&C will not meet the LDP smoking cessation standard for 2016/17.

Actions to Address Performance

We continue to implement the actions to improve performance that were previously highlighted. These include working with smoking cessation teams within HSCPs on:

- A focus on engagement with primary care to generate quit attempt activity.
- A focus on developing joint working models with Smokefree Pharmacy.
- A move towards establishing a cluster based approach to service delivery.
- Replicating the successful Possil model with agreed joint working proposals between Pharmacy and Community Services in Bridgeton, Castlemilk, Govan and Pollok.

During January - March 2017 we implemented a new social media campaign with an enhanced level of targeting at the data zones that support the LDP standard. We have analysed the cost effectiveness of this approach and as a result will be continuing to use this as a means of promoting services.

We have produced a report on key actions to improve engagement and communication and will be implementing the recommendations through the Tobacco Control sub group of the Tobacco PIG going forward.

We are proposing to focus on smoking cessation in pregnancy and smoking cessation in prisons and anticipate increased numbers coming through the services as a result.

We are working closely with pharmacy colleagues to improve data collection and accuracy and to increase the level of varenicline prescribing which again we anticipate will have positive results in terms of improved performance.

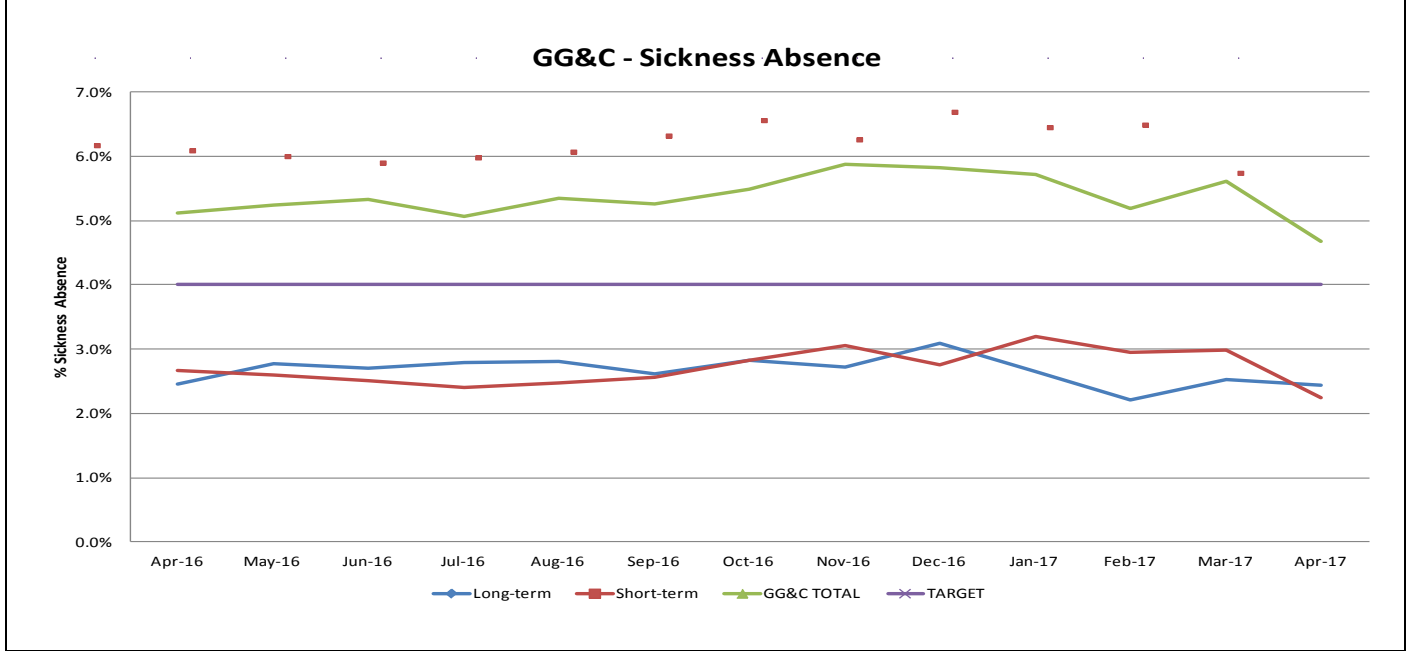
Timeline for Improvement

We anticipate that there will be an improvement in performance as measured by the actual number of quits at 12 weeks in 2016-17 compared to 2015-16 but this will be insufficient to meet the required target.

The actions we have put in place will continue to yield improvements in performance and the new programmes proposed for both pharmacy and pregnancy, in combination with improved reporting and increased varenicline prescribing will mean that this improvement will continue with the expectation that we will achieve the target in 2017-18.

Exception Report: Sickness Absence

Measure	Sickness Absence Rate
Current Performance	As at April 2017 (rolling year), the rate of sickness absence across the Board was 5.48%.
Lead Director	Anne MacPherson, Director of Workforce & Organisational Development



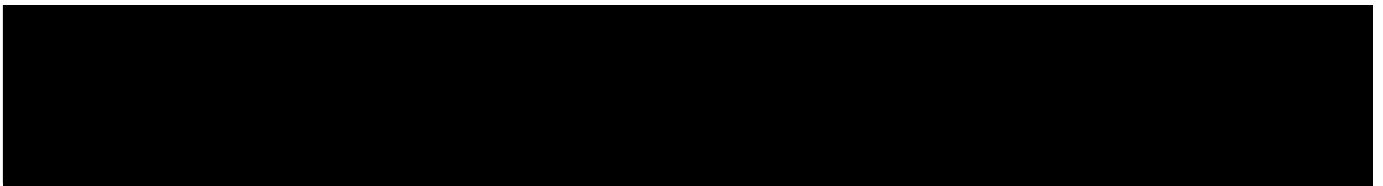
Commentary

The reported sickness absence rate in April 2017 for NHSGG&C is 4.68%. The split between short term and long term absence for April 2017 is 2.24% for short term absence and 2.44% for long term absence. The April 2017 figure has decreased from 5.61% in March 2017.

The Board overall sickness absence rate for the current rolling year from May 2016 to April 2017 is 5.48% comprising 3.64% long term absence and 1.84% short term absence.

Performance

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



Acute Division

The Acute Division absence rate in April 2017 was reported at 4.91%. Sickness absence within the Acute Division has continued to decrease for the fourth consecutive month and is now 0.87% less than the same period. The absence rates for Acute Sectors and Directorates during the period January to April 2017 is detailed in the table overleaf.

Acute - Sickness Absence	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	Variance Mar-17 to Apr 17
North	5.3%	5.3%	5.3%	5.2%	5.2%	5.0%	5.6%	5.9%	5.9%	5.7%	4.8%	5.2%	4.7%	-0.5%
South	6.8%	6.8%	6.3%	5.9%	6.3%	6.1%	6.2%	6.0%	6.4%	6.5%	6.3%	5.6%	5.4%	-0.3%
Clyde	5.4%	5.1%	5.2%	5.0%	4.9%	5.2%	5.6%	5.8%	5.9%	5.5%	5.5%	5.4%	5.0%	-0.4%
Regional	6.2%	5.8%	5.7%	5.8%	5.0%	5.4%	5.3%	5.8%	5.8%	6.1%	5.8%	5.6%	5.4%	-0.2%
W&C	5.7%	5.0%	5.3%	5.4%	5.0%	5.0%	5.7%	5.9%	5.8%	6.0%	5.5%	5.2%	5.0%	-0.2%
Diagnostics	5.0%	4.8%	4.5%	4.1%	4.5%	4.1%	4.0%	4.6%	4.7%	4.5%	4.4%	4.1%	4.0%	-0.2%
ACUTE TOTAL	5.8%	5.5%	5.4%	5.3%	5.2%	5.2%	5.5%	5.7%	5.8%	5.8%	5.4%	5.2%	4.9%	-0.3%

In the sectors/directorates which continue to show high absence, there are still a range of management and Human Resources interventions underway to support the continued reduction in absence.

In the South Sector, the Sector had worked to reduce the number of long term cases including reducing the number of cases in excess of 100 days. The level of non attendance has improved within Acute Medicine and Surgery for example, as a result of the focus on long term absence. The Sector will introduce an enhanced absence reporting model to address the increase in frequent short term absence which will combine a reporting model and a support model designed to assist individuals with any concerns/issues that maybe impacting on their attendance at work.

In the Clyde Sector, long term absence is regularly monitored by the Clyde senior team with continuous review and focused meetings to discuss ongoing cases with Human Resources and referral to Occupational Health Services for long term health issues. People and Change Managers and the Human Resources Support and Advice Unit continue to work with service managers to review absence patterns for individuals on short term absence and identify if there are any patterns of absence. Departmental visits were undertaken during March and April 2017 to seven areas in the Clyde Sector to audit return to work documentation. The records for 33 staff were reviewed to check whether return to work meetings were taking place in line with policy and the findings have identified areas which will require additional support and guidance.

Regional Services is experiencing a downward trend in absence during the last three months. The best performing areas have been WestMARC, Dental Laboratories, Radiotherapy and Spinal. The progress in WestMARC and National Spinal Injuries over recent months is worthy of note and is down to significant management attention to this issue i.e. consistency of return to work interviews taking place, good uptake of absence clinics, appropriate engagement with Occupational Health, processing ill health terminations and retirements efficiently. Proving to be more of a challenge is the management of absence within the Young Physically Disabled team, QEUH Renal, Forensic Mental Health In-Patient (certain wards) and Neurosurgery.

Partnerships

The overall headline figure for Partnerships is reported at 5.5% in April 2017 and has decreased from the March 2017 figure of 6.2%. East Renfrewshire HSCP at 7.2%, Inverclyde HSCP at 6.6% and Glasgow City HSCP at 5.6% continue to report high levels of staff absence.

As described above, East Renfrewshire HSCP continues to report high absence levels in particular within Mental Health and Learning Disabilities. Long term absence in particular is a challenge. In order to address the increase in absence rate within East Renfrewshire, there is an Attendance Action Plan in place. This includes local training on Attendance Management for all local authority and NHS managers who line manage health employees. The team have recently introduced Absence Review Panels which

involve line managers and Human Resources staff reviewing all absences and agreeing action plans to progress and manage individual absences. This model has proven to work elsewhere in the Board.

The Head of People and Change within Inverclyde HSCP has been asked to lead a focus on managing attendance and is now holding monthly meetings with service managers with close liaison with Occupational Health for advice and support. Those staff who have previously been monitored and cannot sustain reasonable levels of attendance are highlighted for a range of interventions. To support newly appointed managers, Human Resources and Organisational Development are providing coaching and ongoing support to managers.

Glasgow City HSCP is actively reviewing all short and long term cases and taking action to ensure that absence clinics and case conference facilities provided by Occupational Health are utilised. Glasgow City has piloted an enhanced management reporting tracker which identifies all cases requiring Human Resources intervention and to date this tool has proven helpful in ensuring that managers are seeking Human Resources advice and guidance on absence case management.

Actions to Address Performance

The Director of Human Resources and Organisational Development is directing a work programme to improve performance management Board wide. Three meetings have now taken place with Heads of People and Change representing all Board areas and have provided an opportunity to share best practice. An absence monitoring tool has been developed which at a glance provides Human Resources staff with reports which detail staff who are absent from work and where there is no recorded management/Human Resources intervention. This process allows an informed dialogue between service managers and Human Resource staff on the actions taken to manage staff who are absent and who are not in a formal process.

The Acute Partnership Forum staff focus groups took place in May 2017 across a range of Hospital sites to enable staff to provide feedback on the operation of the Attendance Management policy and suggested improvements in how we can support staff health and help staff return to work. The feedback from the groups will inform a report with recommendations on improvements which will feed into considerations Board wide on the application of the Board Attendance Management Policy in particular with a focus on supporting staff with stress and mental health related absences using the new policies developed through the Staff Health Strategy.

As part of a commitment to continual improvement, further work has commenced in reviewing Attendance Management Guidance materials to support managers and staff in managing attendance. The revised guidance will be published on HR Connect.

The People Management Programme which includes managing absence as a key learning module continues to receive positive feedback from staff. The Attendance Management module will continue to be delivered monthly. Additional sessions are also being delivered to specific areas. These areas are identified by Service Managers and/or Heads of People and Change. A more robust evaluation process is being reviewed with the Attendance Management module to gather information about the actual application of learning after delegates have attended the session. Initial feedback has highlighted a future requirement to support managers in holding "Difficult Conversations" with their staff.

Attendance management clinics continue to operate across NHS GG&C to ensure focused health support for line managers and staff. The Human Resources Support and Advice Unit are analysing the actual clinic utilisation rates per Sector/Directorate/Partnership and this information will be correlated against the absence levels per area. Initial feedback indicates that clinic utilisation can be improved to ensure there is a positive uptake on clinic support.

Timeline For Improvement

This remains an ongoing priority for the Board and will be subject to continued performance monitoring and evaluation of work to ensure activity is targeted to absence hot spots.