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Argyll and Bute Council
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8 June 2018

SUPPLEMENTARY PACK 1

COMMUNITY SERVICES COMMITTEE - **COUNCIL CHAMBERS, KILMORY, LOCHGILPHEAD** on **THURSDAY, 14 JUNE 2018** at **10:00 AM**

I enclose herewith **item 10 (ARGYLL AND BUTE HSCP - NATIONAL HEALTH AND WELLBEING OUTCOMES PERFORMANCE REPORTNG FRAMEWORK AND EXCEPTION REPORTING ARRANGEMENTS - FQ3 2017/18)** which was marked to follow on the Agenda for the above meeting.

Douglas Hendry
Executive Director of Customer Services

ITEM TO FOLLOW

10. ARGYLL AND BUTE HSCP - NATIONAL HEALTH AND WELLBEING OUTCOMES PERFORMANCE REPORTNG FRAMEWORK AND EXCEPTION REPORTING ARRANGEMENTS - FQ3 2017/18

Report by Head of Strategic Planning & Performance, Argyll and Bute HSCP
(Pages 3 – 26)

Community Services Committee

Councillor Jim Anderson
Councillor Robin Currie
Councillor Lorna Douglas
Councillor Kieron Green (Vice-Chair)
Councillor Jim Lynch
Councillor Yvonne McNeilly (Chair)
Councillor Iain Paterson
Councillor Elaine Robertson
Margaret Anderson
William Hamilton
Councillor Rory Colville
Councillor Mary-Jean Devon
Councillor Audrey Forrest
Councillor Graham Hardie
Councillor Julie McKenzie
Councillor Barbara Morgan
Councillor Alan Reid
Councillor Andrew Vennard
William Shaw
Alison Palmer

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Argyll & Bute Health & Social Care Partnership

Community Services Committee

Agenda item :

Date of Meeting : 14th June 2018

Title of Report : Argyll & Bute HSCP- National Health and Wellbeing Outcomes Performance Reporting Framework and Exception Reporting Arrangements

Presented by : Stephen Whiston, Head of Strategic Planning & Performance

The Community Services Committee is asked to:

- Consider the HSCP performance report in line with the current national reporting requirement
- Note the content of the IJB performance scorecard within the Pyramid System

1. Introduction

The National Health and Wellbeing Outcomes (NHWBO) provide a strategic framework for the planning and delivery of health and social care services. These suites of outcomes, together, focus on improving the experiences and quality of services for people using those services, carers and their families. These outcomes focus on improving how services are provided, as well as, the difference that integrated health and social care services should make, for individuals.

The Argyll & Bute HSCP is required to publish an Annual Performance Report which will set out how the national health and wellbeing outcomes are being improved. This will include reports on a core suite of indicators and measures, identified by the integration authority in line with guidance from the Scottish Government, and contextualising data to provide a broader picture and a rationale of local performance.

2 National Context

Currently there are 9 key National Health and Wellbeing Outcomes (NHWBO) and 23 sub-indicators which form the basis of the reporting requirement by the HSCP. The data for the 23 sub-indicators will be provided to the partnership and in addition current outstanding methodologies attached to a small number of the indicators will be finalised in order that reporting can take place. There is also an expectation that the HSCP 's will add in their own performance measures to support the 23 core indicators and currently the implementation of the carers act is one such area.

The HSCP also reports on a suite of integration performance targets as set by the Ministerial Steering Group for integration

The Ministerial Strategic Group for Health and Community Care (MSG) has agreed that for 2017/18 it will direct Integration Authorities to monitor progress across the following domains:

- Reduce unplanned (Emergency) admissions – by increasing anticipatory care activity in the community and in primary care
- 10% reduction in occupied bed days for unscheduled care (emergency);
- A&E performance;- meet the 4 hour target and reduce unnecessary attendance
- Delayed discharges – reduce the amount of time (occupied bed days) patients are delayed in hospital
- End of life care – increase the provision of patient end of life care in the community
- The balance of spend across institutional and community services by 2021 have the majority of the health budget being spent in the community

3. Pyramid Performance Scorecard

The scorecard uses a balanced scorecard design, indicators on performance are limited to either red or green, noting either on or off track against agreed targets. The Pyramid system offers scope for full management commentary in relation to establishing granularity in relation to trends/projected pathways and detail on action in hand to meet targets.

4. Performance Exception Reporting & Briefing Frequency

The performance of the HSCP against the NHWBO indicators and Ministerial Steering Group targets for Quarter 3 2017/18 is detailed in the attached report

The Integrated Joint Board will receive an exception report on a quarterly basis generally focusing on 2 NHWBO indicators and the developing MSG targets this will be taken from a live snapshot of the current overall HSCP performance; focussing on those measures showing as below target performance. The officer/management leads designated as responsible for the service performance will to identify and progress action to address any underperformance identified, using an exception reporting approach.

This report will also be shared with its host bodies as detailed in the table below:

Group	Briefing Frequency
Argyll and Bute Council – Community services Committee	Quarterly
NHS Board	Quarterly
Community Planning Partnership *	Quarterly
Area- Community Planning Groups*	Quarterly

]

Note * Reports relating to Single outcome agreement

5 Governance Implications

5.1 Contribution to IJB Objectives

The PPMF is in line with the IJB objectives as detailed in its strategic plan.

5.2 Financial

There are a number of NHWBO indicators which support the quality and financial performance of the HSCP including productivity, value for money and efficiency.

5.3 Staff Governance

A number of indicators under outcome 8 are pertinent for staff governance purposes

5.4 Planning for Fairness:

The NHWBO indictors help provide an indication on progress in addressing health inequalities.

5.5 Risk

Ensuring timely and accurate performance information is essential to mitigate any risk to the IJB governance, performance management and accountability.

5.6 Clinical and Care Governance

A number of the NHWBO indicators support the assurance of health and care governance

5.7 Public Engagement and Communication

A number of the NHWBO indicators support user and patient experience/assessment of the HSCP services

Stephen Whiston
Head of Strategic Planning and Performance

Appendices

Appendix 1- IJB Performance Report
Appendix 2- IJB Exception Report

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Argyll & Bute Health & Social Care Partnership

Integrated Joint Board

Agenda item :

Date of Meeting: May 2018

Title of Report: Argyll & Bute HSCP- Performance Report- National Health and Well Being Outcome indicators

Presented by: Stephen Whiston, Head of Strategic Planning & Performance

The Integrated Joint Board |(IJB) is asked to:

- Note the HSCP performance against National Health and Well Being Outcomes: 9 & Customer Services- FQ3 17/18
- Note the actions identified to address deficiencies in performance as detailed in the exception reports
- Note the performance with regards to MSG targets

1. Background

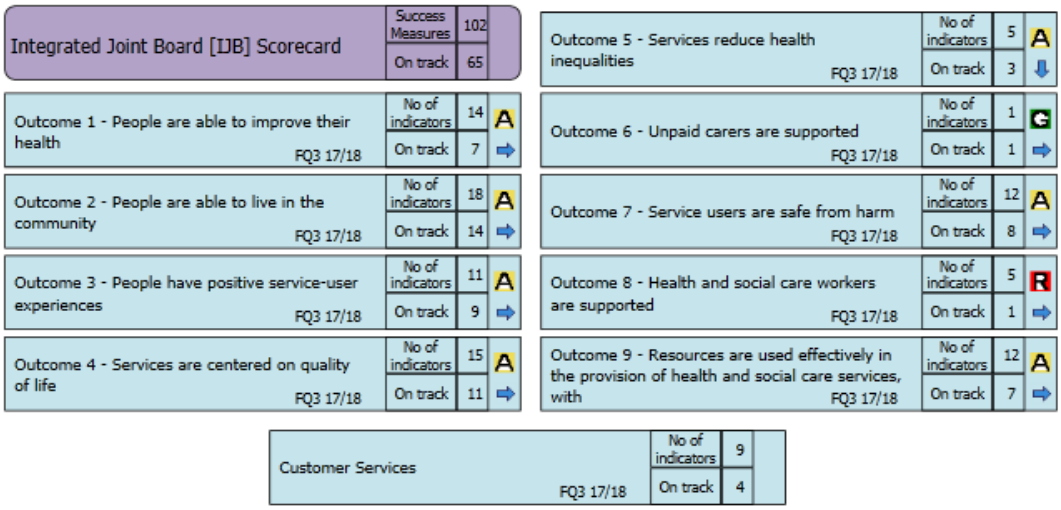
The national health and wellbeing outcomes provide a strategic framework for the planning and delivery of health and social care services. These suites of outcomes, together, focus on improving the experiences and quality of services for people using those services, carers and their families. These outcomes focus on improving how services are provided, as well as, the difference that integrated health and social care services should make, for individuals.

Currently there are 9 key National Health and Wellbeing Outcomes (NHWBO) and 23 sub-indicators which form the basis of the reporting requirement for the HSCP.

2. HSCP Performance against the NHWB outcomes for Financial Quarter 3 17/18

Table 1 below provides a summary of the performance on the pyramid reporting system, noting the 102 scorecard success measures and of these 65 are currently reported as being on track for FQ3 17/18.

With regards to FQ4 17/18 the current reporting snapshot shows that 52 indicators are on track. It is expected that this current performance will improve as the final data submissions are collected and reported over the June period. FQ4 will be reported to the IJB in August.



2.1 FQ3 17/18- IJB Scorecard

Outcome 9:

7 Indicators are showing on track with 4 indicators reported as off track

Outcome: Customer Service:

4 indicators are currently on track, 4 are not reported and 1 is off track

3. Details for Performance Report Outcome Indicators 9 & Customer Services

Outcome-9

Outcome / Performance Indicator	Trend	Target	Actual	Responsible Manager
CJ63 - % CPO cases seen without delay - 5 days	⇓	80.0 %	68.8 %	Alex Taylor
SCRA43 - % of SCRA reports submitted on time	⇓	75 %	67 %	Alex Taylor
Falls rate per 1,000 population aged 65+ (Quarterly Conversions)	⇒	22	26	Lorraine Paterson
% of new outpatient appointments DNA rates	⇓	6.9	12.3	James Littlejohn

Customer Service

Outcome / Performance Indicator	Trend	Target	Actual	Responsible Manager
% of NHS simple complaints - achievement against 20 days	⇑	80%	33%	Liz Higgins

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4. MSG Measures Performance Reporting FQ3 (17/18)

MSG Indicator	Objective	Cumulative Target for FY 17/18	Q3 Target 17/18	Cumulative FQ3 Performance	RAG
Unplanned Admissions	2017/18 change: Expected target 8256 based on 5% reduction in overall total compared to FY16/17	**8256**	**6192**	**6730**	
Unplanned Bed Days	2017/18 change: Expected target 64942 based on 0.6% reduction in overall total compared to FY16/17	**64942**	**49014**	**45802**	
A& E Attendances	2017/18 change: Expected target 16079 based on sustained levels in overall total compared to FY16/17	**16079**	**12059**	**11989**	
Delayed Discharges	2017/18 change: Expected target 6403 based on 10% reduction in overall total compared to FY 16/17	**6403**	**4797**	**5855**	

Area specific performance for each of the 4 MSG measures can be found with Pyramid, the link is as follows:

http://pyramidlive.argyllbute.gov.uk/QPR2015/Portal/QPR.lsapi.dll?QPRPORTAL&*prmav&SES=VYn0DKG29VvoGLFvWWpmew&FMT=p&LAN=en%2c1&DTM=&RID=1040317409572032312

DRAFT

5. Governance Implications

5.1 Contribution to IJB Objectives

The PPMF is in line with the IJB objectives as detailed in its strategic plan.

5.2 Financial

There are a number of NHWBO indicators which support the quality and financial performance of the HSCP including productivity, value for money and efficiency.

5.3 Staff Governance

A number of indicators under outcomes 9 & Customer Services are pertinent for staff governance purposes

5.4 Planning for Fairness:

The NHWBO indictors help provide an indication on progress in addressing health inequalities.

5.5 Risk

Ensuring timely and accurate performance information is essential to mitigate any risk to the IJB governance, performance management and accountability.

5.6 Clinical and Care Governance

A number of the NHWBO indicators support the assurance of health and care governance and should be considered alongside that report

5.7 Public Engagement and Communication

A number of the NHWBO indicators support user and patient experience/assessment of the HSCP services and planning processes

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Argyll & Bute Health and Social Care Partnership

Performance Exception Report for Integrated Joint Board
Outcomes 9 & Customer Service (FQ3-17/18) - May 2018

Performance & Information Team

"People in Argyll and Bute will live longer, healthier, happier, independent lives"

Exception Reporting & Briefing Frequency

The Integrated Joint Board will receive this performance and exception report on a 6 weekly basis, this will be taken from a live snapshot of the current overall HSCP performance; focussing on those measures showing as below target performance. The layout of the report is designed to give IJB members a quick easy-read overview of exception across the IJB Scorecard, the format of the report uses the key aspects of the Pyramid Performance Management System in order to ensure continuity and consistency. Trend indicators are included within the report to ensure that performance variance and movement is reflected against the most recent reporting episodes.

This exception report format will be used to communicate performance across the HSCP and key stakeholders including its host bodies. The table below notes the groups and briefing frequency:

Group	Briefing Frequency
Integrated Joint Board	Quarterly
Local Area Committees	Quarterly
NHS Board	Quarterly
Community Planning Partnership *	Quarterly
Locality Planning Groups	Quarterly
East & West Operational Management Teams	Quarterly

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Exception Reporting FQ3 (17/18)

Outcome Indicators - 9 Resources are used effectively in the provision of health and social care services

	Outcome / Performance Indicator	Trend	Target	Actual	Responsible Manager
	CJ63 - % CPO cases seen without delay - 5 days	⇓	80.0 %	68.8 %	Alex Taylor
	SCRA43 - % of SCRA reports submitted on time	⇓	75 %	67 %	Alex Taylor
	* Falls rate per 1,000 population aged 65+ *(Appears as a PI in Outcomes 2,4,7)*	⇒	22	26	Lorraine Paterson
	% of new outpatient appointments DNA rates	⇓	6.9	12.3	James Littlejohn

Outcome Indicator- Customer Service

	Outcome / Performance Indicator	Trend	Target	Actual	Responsible Manager
	% of NHS simple complaints - achievement against 20 days	⇑	80%	33%	Liz Higgins

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FQ3 17/18 Other NHWBO indicators currently off track presented for IJB reference

Outcome/Performance Indicator	Trend	Target	Actual	In charge
Outcome 1				
AC1 - % of Older People receiving Care in the Community (Joint Planning & Performance)	⇓	83 %	73 %	James Littlejohn
AC15 - No waiting more than 12 weeks for homecare service - assessment authorised (Home Care & Day Support Services)	⇓	6	10	James Littlejohn
A&B - % of LD Service Users with a PCP (LD Care Management)	⇓	90 %	87 %	James Littlejohn
No of alcohol brief interventions in line with SIGN 74 guidelines (Health & Social Care Partner Data)	⇑	765	385	Lorraine Paterson
NHS-H7 - Proportion of new-born children breastfed - STANDARD (Quarterly Conversions)	⇒	33.3 %	30.0 %	Alex Taylor
No of ongoing waits >4 wks for the 8 key diagnostic tests (Health & Social Care Partner Data)	⇓	0	281	Lorraine Paterson
% >18 type 1 Diabetics with an insulin pump (Health & Social Care Partner Data)	⇒	12 %	7 %	Lorraine Paterson
Outcome 2				
AC5 - Total No of Delayed Discharge Clients from A&B (Delayed Discharge)	⇓	12	32	James Littlejohn

DRAFT

% of patients who wait no longer than 18 wks for Psychological therapies (Health & Social Care Partner Data)	⇓	90 %	50 %	Lorraine Paterson
Outcome 3				
No of patients with early diagnosis & management of dementia (Health & Social Care Partner Data)	⇓	890	844	Lorraine Paterson
Outcome 4				
AC11 - Average working days between Referral & Initial AP Case Conference (Adult Protection)	⇓	15 Days	18 Days	James Littlejohn
No of outpatient ongoing waits >12 wks (Health & Social Care Partner Data)	⇓	0	399	Lorraine Paterson
% of patients on the admissions waiting lists with medical unavailability (Health & Social Care Partner Data)	⇓	2.0 %	2.4 %	Lorraine Paterson
Outcome 5				
No of treatment time guarantee ongoing waits >12 wks (Health & Social Care Partner Data)	⇓	0	1	Lorraine Paterson
Outcome 7				
CP15 - % of Children on CPR with no Change of Social Worker (Child Protection)	⇒	80 %	60 %	Alex Taylor
CP16 - % of Children on CPR with a completed CP plan (Child Protection)	⇓	100 %	81 %	Alex Taylor
CP17 - % of CP investigations with IRTD within 24 hours (Child Protection)	⇓	95 %	86 %	Alex Taylor

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Outcome 8				
Health & Social Care Partnership % of PRDs completed (HR2 - PRDs A&B Council)	⇓	90 %	58 %	Alex Taylor
Social Work staff attendance	⇑	3.8 Days	4.4 Days	James Littlejohn
% of NHS sickness absence (Health & Social Care Partner Data)	⇓	4.00 %	5.05 %	Lorraine Paterson
% of NHS staff with a completed & recorded KSF/PDP review (Health & Social Care Partner Data)	⇑	20.00 %	13.81 %	Lorraine Paterson

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Appendix 1 New Quarterly IJB Performance Reporting Timetable

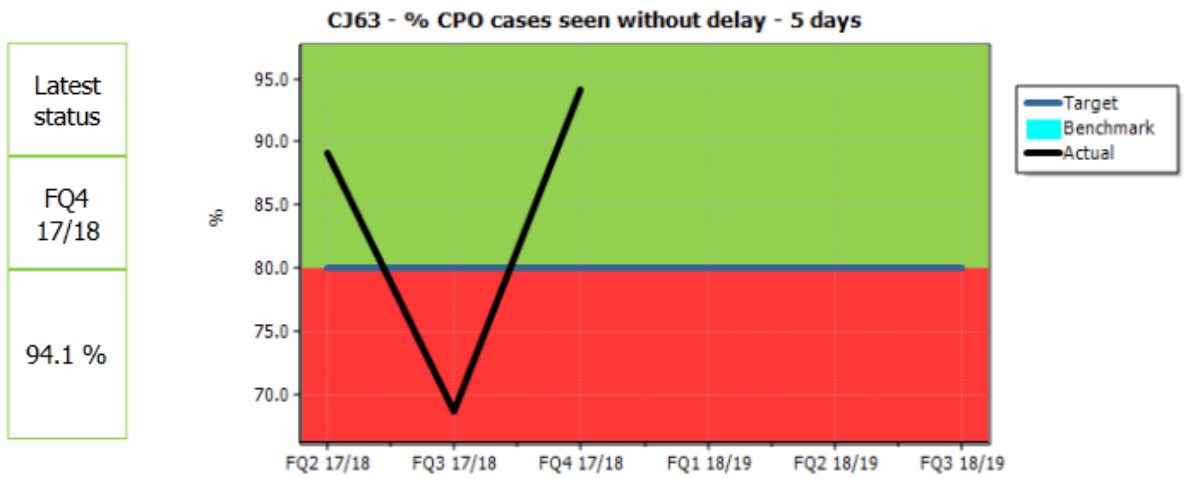
IJB Dates	Reporting Period	Paper for SMT	Papers for Sheena	Pre- Agenda Meeting
30th May	FQ3 17/18(Oct- December)	7th May	14th May	18th May
1st August	FQ4 17/18 (Jan- Mar)	6th August	13th August	17th August
28th November	FQ1 18/19(April- June)	5th November	12th November	16th November
? February 2019	FQ2 18/19(July- Sept)	TBC	TBC	TBC

Management Exception Report

Performance Indicator: CJ63 - % CPO cases seen without delay - 5 days	**Responsible Manager:** Alex Taylor
Target: 80% Actual: 68.8%	Date of Report: FQ3 17/18

Description of Exception

(Consideration should be given when describing the nature of the exception with regards to previous trends, reasons for exception, external /internal influences on performance, previous action taken to address performance, actions current in place to improve performance)



The criminal justice service had a Community Payback Officer on long term sickness and was carrying a vacancy during this period. The service has as a consequence been operating at a 50% staffing level. More specifically of the cases that were not seen within timescale:

- One was in custody and the order was revoked
- One order was notified to us late by Greenock Sheriff Court
- The last Order was not seen due to service user failing to attend 2 scheduled appointments.

Actions Identified to Address Exception and Improve Performance

(Consideration should be given when describing actions to address performance with regards what requires to be done, who is going to do it and how will this improve performance)

An appointment has been made to the vacant post and the Community Payback Officer is back at work. .

Actions Identified to Address Current /Future Barriers

(Consideration should be given when describing barriers with regards to, how are the barriers going to be managed, who will take this work forward)

I have brought this Exception Report to the attention of the Service Manager CJSW to ensure offenders placed on a Community Payback Order are seen within 5 days of sentencing. No further

Draft

action is required at present.
Additional Support Requirements Identified
None at present

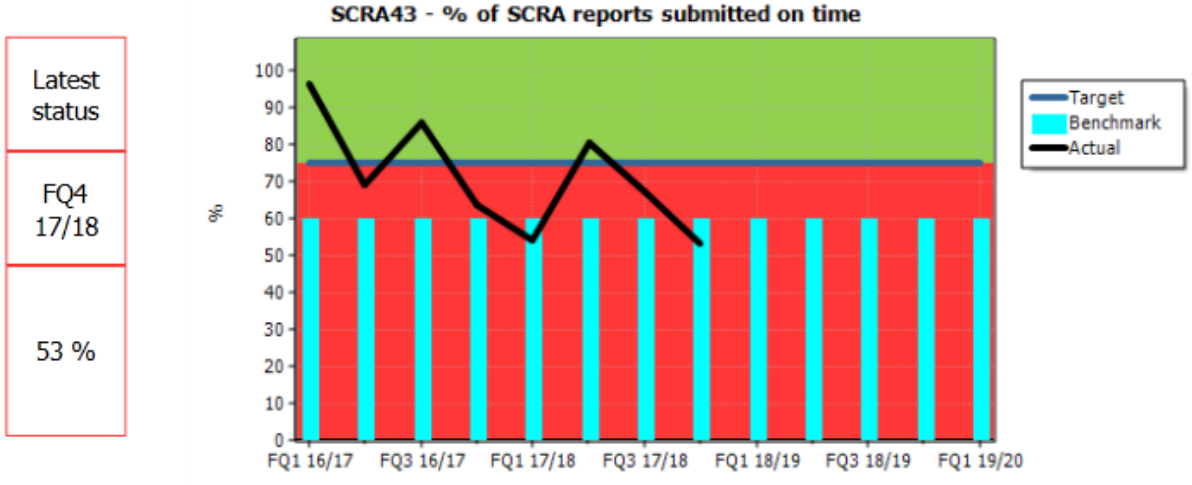
Improvement Forecast Date:	**Review Date:**
FQ1 2018	July 2018

Management Exception Report

Performance Indicator: SCRA43 - % of SCRA reports submitted on time	**Responsible Manager:** Alex Taylor
Target: 75% Actual: 67%	Date of Report: FQ3 17/18

Description of Exception

(Consideration should be given when describing the nature of the exception with regards to previous trends, reasons for exception, external /internal influences on performance, previous action taken to address performance, actions current in place to improve performance)



There has been an issue of capacity within the Children and Families Area Teams due to staff vacancies and long term sickness.

Actions Identified to Address Exception and Improve Performance

(Consideration should be given when describing actions to address performance with regards what requires to be done, who is going to do it and how will this improve performance)

Vacancies are being recruited to and where necessary the use of locum social workers has been approved. The Head of Service has asked the Children and Families Locality Managers to prioritise this area of performance and ensure systems are place to effectively monitor the productions of reports for the Scottish Children's Reporter Administration (SCRA).

Actions Identified to Address Current /Future Barriers

(Consideration should be given when describing barriers with regards to, how are the barriers going to be managed, who will take this work forward)

None at present.

Additional Support Requirements Identified

None at present.

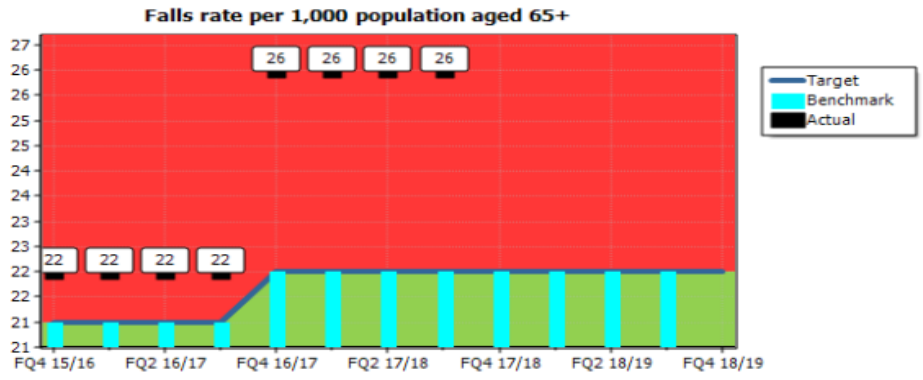
Improvement Forecast Date:	Review Date:
FQ1 2018	July 2018

Management Exception Reporting

Performance Indicator: Outcome 7 Falls rate per 1,000 population for adults aged 65+	Responsible Manager: Lorraine Paterson
Target: 22 Actual: 26	Date of Report: FQ3 17/18

Description of Exception

Latest status
FQ3 17/18
26



QUARTERLY CONVERSION – Shows annual values
The focus of this indicator is the rate per 1,000 population of falls that occur in the population (aged 65 plus) who were admitted as an emergency to hospital.
Linked to IJB Outcome 2, 4, 7 and 9.

Actions Identified to Address Exception and Improve Performance

Argyll and Bute has a quarter of the population over 65 years of age. This is significantly higher than Scotland as a whole and the number of people 75+ is projected to increase by 36% (NRS, 2014). Our demographic makes having a hospital admission due to a fall more likely. Half of people over 80 years of age fall each year and occupied bed days for 2016/17 in Argyll and Bute show the majority of bed occupancy for falls is for this group. It has been identified by the HSCP that we require falls admission data at a hospital and locality level to understand who is being admitted, where and why. We have work starting this year with the national falls programme, ISD and ALIP to develop a quality dashboard for falls for incidences of admissions due to hip fracture and falls in localities and to determine where people come into contact with services such as emergency department, telecare alarms, Scottish Ambulance Service.

Argyll and Bute is taking action to reduce falls and each locality has an action plan based on the national minimum standards set out in the Framework for Prevention and Management of Falls in the http://www.gov.scot/Resource/0045/00459959.pdf through the 4 stages identified. In Stage 1 to raise awareness of falls as an issue with people who may be beginning to experience difficulties with their mobility and balance, we are promoting the national 'Move and Improve Campaign' https://www.facebook.com/notes/argyll-and-bute-hscp/take-the-balance-challenge-move-improve-takethebalancechallenge/1835018406813438/ . We are working with partners to provide evidence based exercise programmes in our communities for older people to improve strength and balance which reduces risk of falls.

In Stage 2, to identify those at highest risk, Argyll and Bute HSCP is working to provide the best opportunities for people to remain independent through the systematic application of evidence based interventions known to prevent falls. Individual multifactorial falls risk screening and interventions based on modifiable risk factors and the provision of evidence based exercise programmes are being applied systematically.

Work is ongoing with Scottish Fire and Rescue service (in the context of Building Safer Communities) to identify older people at high risk at home safety checks and to signpost them on to have a multi factorial falls risk screening and interventions using our postcard developed in Argyll and Bute.

Work with Scottish Ambulance Service to embed pathways to avoid conveyance to hospital where possible and to refer on for community interventions to reduce risk has been very slow and we are currently seeking to increase the pace and scale with this work.

Falls and frailty are linked in older age groups and the identification of frail individuals through the efrailty tool would allow the concept of realistic medicine to be more effectively applied in our communities to avoid hospital admissions. Management of falls and frailty in community settings identifying transitions through stages of frailty has the potential to address advanced frailty as a palliative condition with anticipatory care planning and care at home. This is particularly relevant in view of our demographic projections from NRS which show an 80% increase in over 75's in the next 25 years (see appendix).

Actions Identified to Address Current /Future Barriers

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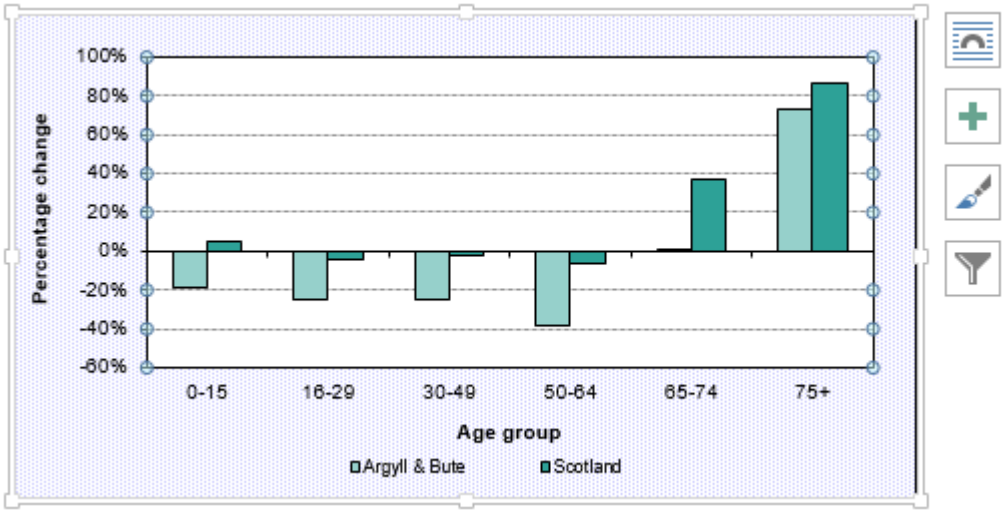
Development work is taking place with National Programme Manager for Prevention of Falls, LIST team from ISD and the support of the Active and Independent Living Programme to produce a quality dashboard of falls data for each locality. The data will have both outcome and process measures. This will be used to increase understanding of how we are intervening to reduce falls risk for individuals and our communities and to drive improvement. Meetings are arranged for January 2018 and testing will begin shortly working with service planning quality improvement team to identify in each locality where people who fall are presenting to services and what interventions they are currently having.

Pathways for people who require assistance for a fall are in development. The test site in Helensburgh and Lomond has been very slow. The pathway developed for testing in August 2017 by Helensburgh community team has had very few referrals so far from Scottish Ambulance Service. Support is being provided from the National Programme Manager to develop pathways with Scottish Ambulance Service to avoid unnecessary conveyance for falls. Locality work in Bute with SAS and community team planned for Feb 2018. A scale up and spread of the pathway for intervention by the community teams across A&B should be relatively straightforward as numbers are low and should be manageable in each locality.

Pathways for responding to individuals who have fallen and do not require SAS attendance but require assistance to get up are being progressed on a locality level. Locality Area Managers are being asked to update the Falls Lead for A&B about arrangements in place in each locality and a phone call will take place by Falls Lead to each LAM to finalise the response in each locality in Jan/Feb 2018. We require a single point of contact phone number for Argyll and Bute for this pathway. Lead AHP is progressing these discussions.

Appendix

Percentage change in population in Argyll & Bute and Scotland, 2012-2037 (2012-based projections)



National Records of Scotland accessed 22.01.18 https://www.nrscotland.gov.uk/statistics-and-data/statistics/stats-at-a-glance/council-area-profiles

Additional Support Requirements Identified	
Improvement Forecast Date:	**Review Date:**
July 2018	February 2018

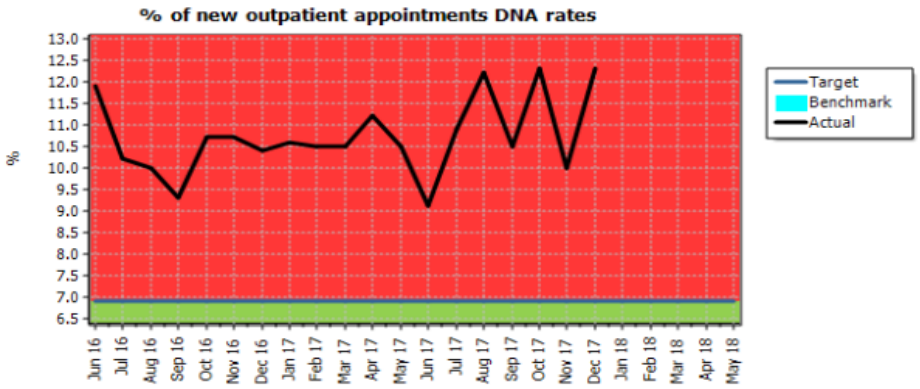
Management Exception Report

Performance Indicator:	Responsible Manager:
% of new outpatient appointments DNA rates	James Littlejohn/Lorraine Paterson
Target: 6.9% Actual: 12.3%	Date of Report: Q3 2017/18

Description of Exception

(Consideration should be given when describing the nature of the exception with regards to previous trends, reasons for exception, external /internal influences on performance, previous

Latest status
Dec 17
12.3 %



Dec-17	Attendances			DNAs			% DNAs to Total		
	New	Return	Total	New	Return	Total	New	Return	Total
Argyll & Bute* Mental Health	36	276	312	18	57	75	33%	17%	19%
Dunoon	60	66	126	12	12	24	17%	15%	16%
Islay	-	-	-	-	-	-	-	-	-
Rothesay	15	46	61	2	7	9	12%	13%	13%
Lorn & Islands Oban	315	510	825	40	66	106	11%	11%	11%
Campbeltown	124	135	259	9	12	21	7%	8%	8%
Mid Argyll	74	124	198	6	9	15	8%	7%	7%
Mull	11	4	15	2	0	2	15%	0%	12%
HSCP total	**635**	**1161**	**1796**	**89**	**163**	**252**	**12%**	**12%**	**12%**

Source: Outpatient Statistics by Hospital

Source - TrakCare PMS

This target records the Do Not Attend (DNA) rates for patients attending new appointments for outpatient clinics in Argyll and Bute hospitals for consultant led specialties. The total DNA performance has exceeded the target consistently over the years.

Reasons for this include:

- Small numbers of patients attending clinics
- Specialties with high DNA rates e.g. Mental health and paediatric
- Patient choice in selecting dates
- Late notification of non-attendance

Differences in administrative practices across some departments

Actions Identified to Address Exception and Improve Performance

(Consideration should be given when describing actions to address performance with regards what requires to be done, who is going to do it and how will this improve performance)

The need for a consistent focus on performance across the HSCP sees the need for concentrated and consistent management actions to reduce DNA rates to best performance e.g. Rothesay and Mid Argyll.

Other action will include further media campaigns to alert patients to attend or notify etc. and more prominence in the performance report to operational management

Local data is being sourced to provide more up to date information and performance management.

Actions Identified to Address Current /Future Barriers

(Consideration should be given when describing barriers with regards to, how are the barriers going to be managed, who will take this work forward)

None at present.

Additional Support Requirements Identified

None at present.

Improvement Forecast Date:	Review Date:
FQ1 2018	July 2018

DRAFT

Management Exception Report

Performance Indicator: % of NHS simple complaints - achievement against 20 days	**Responsible Manager:** Liz Higgins
Target: 80% Actual: 0%	Date of Report: FQ3 17/18

Description of Exception

(Consideration should be given when describing the nature of the exception with regards to previous trends, reasons for exception, external /internal influences on performance, previous action taken to address performance, actions current in place to improve performance)

	Oct 17	Nov 17	Dec 17
Complaints Maximum complaints received month	3	1	6
Complaints **R**esponse within 20 days	33%	0%	33%

Complaint information is captured from NHS highland balance score card return and there is a significant lag in the availability of the data.

Actions Identified to Address Exception and Improve Performance

(Consideration should be given when describing actions to address performance with regards what requires to be done, who is going to do it and how will this improve performance)

A number of actions are being implemented by the Clinical Governance Manager and the Governance and Risk Manager, Argyll and Bute Council (in conjunction with localities and services in receipt of complaints) to support achievement of response timescales for both NHS and Council complaints including the development of training for investigators. The aim is to deliver training in each locality commencing in July 2018.

Local data is being sourced to provide more up to date information and performance will be reported at the Care and Clinical Governance committee.

Actions Identified to Address Current /Future Barriers

None at present.

Additional Support Requirements Identified

None at present.

Improvement Forecast Date:	**Review Date:**

DRAFT

FQ1 2018	July 2018

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