Argyll & Bute Health and Social Care Partnership

Performance Exception Report for Integrated Joint Board
28th September 2016

Performance & Improvement 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
Local Authority –PR Committee	Quarterly
NHS Board	Quarterly
Community Planning Partnership *	Quarterly
Area- Community Planning Partnerships*	Quarterly

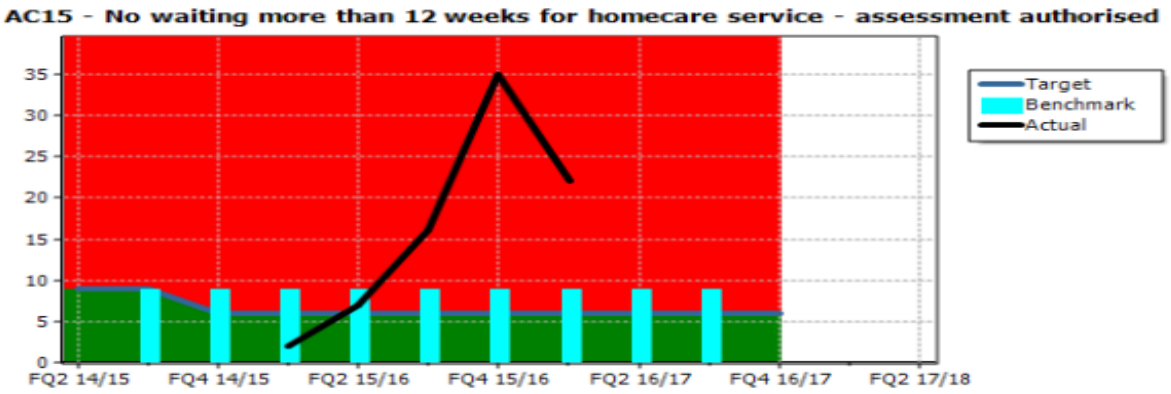
Performance Measure / Outcome		Target	Actual	Trend	Period	Responsible Manager
1	AC15 - No waiting more than 12 weeks for homecare service - assessment authorised.	6	22	↑	FQ1 16/17	Allen Stevenson
1	AC1 - % of Older People receiving Care in the Community	80%	76%	↓	FQ1 16/17	Allen Stevenson
1	No of alcohol brief interventions in line with SIGN 74 guidelines	255	164	↑	FQ1 16/17	Lorraine Paterson
1	NHS-H7 - Proportion of new-born children breastfed	33.3%	26.8%	↔	FQ1 16/17	Louise Long
1	No of ongoing waits >4 wks for the 8 key diagnostic tests	0	3	↓	FQ1 16/17	Lorraine Paterson
1	% >18 type 1 Diabetics with an insulin pump	12%	4%	↔	FQ1 16/17	Lorraine Paterson
Performance Measure / Outcome		**Target**	**Actual**	**Trend**	**Period**	**Responsible Manager**
2	Emergency Admissions bed day rate	73597	77,924	↔	FQ1 16/17	Lorraine Paterson
2	AC5 - Total No of Delayed Discharge Clients from A&B	12	19	↓	FQ1 16/17	Allen Stevenson
2	CPC01.4.4 - % Waiting time from a patient's referral to treatment from CAMHS	90%	75%	↓	FQ1 16/17	Louise Long
2	% of patients who wait no longer than 18 wks for Psychological therapies	90%	62%	↑	FQ1 16/17	Lorraine Paterson

Management Exception Reporting

Performance Indicator: Outcome 1 AC15 - No waiting more than 12 weeks for homecare service - assessment authorised	Responsible Manager: Allen Stevenson
Target: 6 Actual: 22	Date of Report: FQ1 16/17

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)



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)

This target relates to new service users waiting for packages of care at home. We have particular pressures in the west relating to care at home.

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)

We are actively working to address this issue by working with providers in Oban to move from time and task to agreeing outcomes with service users and giving providers the opportunity to work more flexibly with people to meet their agreed outcomes.

We are also working with providers to patch work and reduce travel and crossover of providers in our localities.

Additional Support Requirements Identified

Continue to develop new ways of delivering care and support at home and in community settings. As the re-design work moves forward opportunities will be created to invest more in community services.

Improvement Forecast Date:	Review Date:
This work is on-going and should be reviewed regularly.	Monthly

Management Exception Reporting

Performance Indicator: Outcome 1 AC1 Care in the Community	Responsible Manager: Allen Stevenson
Target: 80% Actual: 76%	Date of Report: FQ1 16/17

Description of Exception

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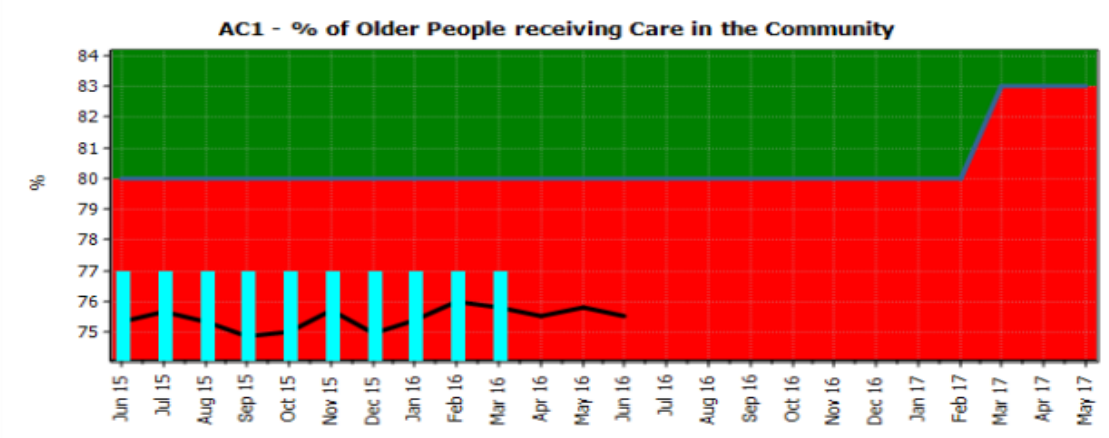

Actions Identified to Address Exception and Improve Performance

(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 work on the new HSCP quality and finance plan is now underway. To help us achieve our target of 80% we need to follow through on our re-design proposals as detailed in the quality and finance plan.

It will take a further period of time across both East and West and will be led by the Heads of Service Adult Care and with the support of Locality Managers and Local Area Managers.

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)

The aim is clearly to shift resources from hospital and care home beds to supporting older people to live at home or in community settings.

Reduce the number of hospital beds across East and West through re-design.

Improve the process around the collation of data in relation to the balance of care ensuring improved accuracy.

Additional Support Requirements Identified

The balance of care across the HSCP will improve as we deliver on our ambitious plans to re-design services and meet the increased expectations of older people and their families/carers.

Additional Scottish Government monies for funding the DD, ICF and TEC workstreams will help to shift the balance of care further.	
Improvement Forecast Date:	**Review Date:**
The work around the balance of care will be on-going with no specific end date. It is more important to review our progress on a regular basis.	Quarterly

Management Exception Reporting

Performance Indicator: Outcome 1 No of alcohol brief interventions in line with SIGN 74 guidelines	**Responsible Manager:** Lorraine Paterson
Target: 1024 (Cumulative) (250 by June) Actual: 164	Date of Report: FQ1 16/17

Description of Exception

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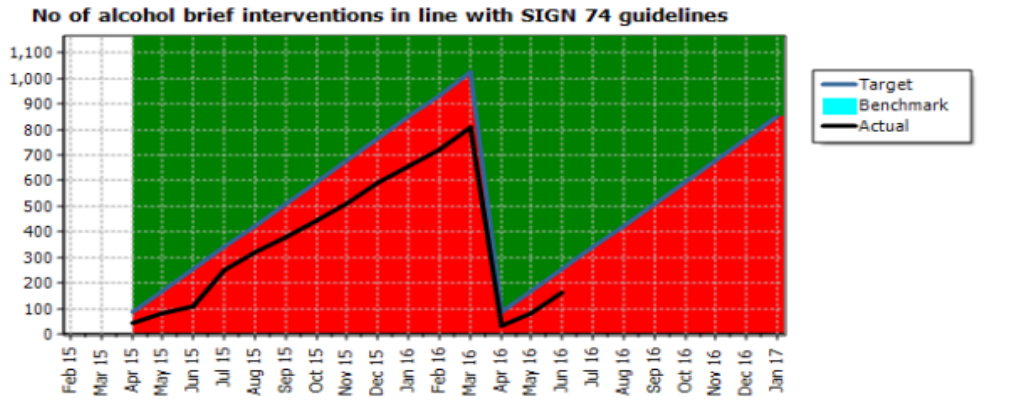


Actions Identified to Address Exception and Improve Performance

(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)

Locality Planning groups, utilising their locality profiles are identifying alcohol concerns as a priority. As part of the action plans, Alcohol Brief Interventions (ABI) will be promoted across services, which includes GP surgeries, A&E departments and maternity clinics.

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)

Barriers to progression are;
Cultural Perception of level of alcohol problems in the community.
Reluctance of individuals to admit need for help.

LPG's will identify actions to change perception, and encourage uptake of ABI.
Locality managers and Local area managers will work with staff to promote uptake.

Additional Support Requirements Identified

Further work required to identify any gaps.

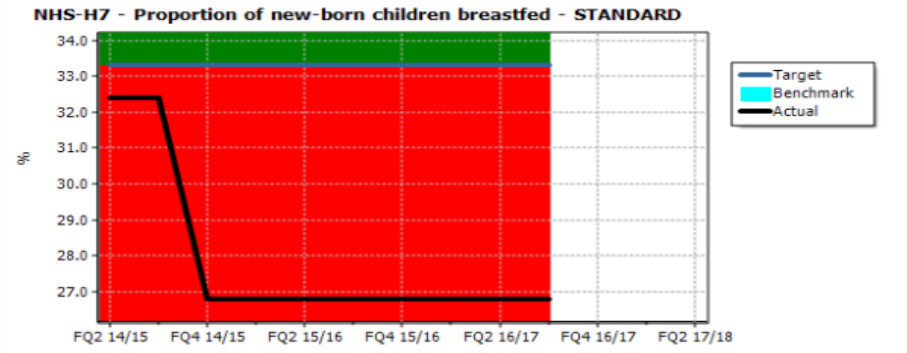
Improvement Forecast Date:	**Review Date:**
This work is a continuing process.	Monthly

Management Exception Reporting

Performance Indicator: Outcome 1 NHS-H7 - Proportion of new-born children breastfed	**Responsible Manager:** Louise Long
Target: 33.3% Actual: 26.8%	Date of Report: FQ1 16/17

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)



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)

This is a national indicator which is updated in October each year when ISD publish the data set.
This data is recorded for the quarter before and there has been a steady increase from 21.8% in March 2015 to the current 37.2% however, this is variable across the HSCP linked to areas of greater deprivation. To address this, Peer volunteers have been trained in Campbeltown, Helensburgh, Oban, Dunoon and Bute, with attendance at groups reaching the average of 25-30 facilitated with a focus on wellbeing and rather than problem focussed. Key workers have been trained in each locality. Social media by the infant feeding co-ordinator to communicate with all Peers. Data is available at locality and GP practice level to facilitate targeted interventions. Actions identified to address current/future barriers - - Maintaining peers and setting up new groups in all areas. - Implementing school breastfeeding awareness sessions due to work capacity and staffing levels. - Engage GPs with training due to workload and time limitations. - UNICEF on-line learn-pro breastfeeding management, training has been brought in for all GPs and face to face training in some areas. - Breastfeeding awareness sessions have been delivered in nurseries across Argyll and Bute.

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)

Maintaining UNICEF baby friendly status, a national requirement, which requires all venues: hospitals, clinics to adhere to World Health Organisation/UNICEF baby

friendly status. - Promoting baby friendly sticker scheme in public venues within HSCP. - Training of wider HSCP teams in social work and supported services. - Developing the 'don't lag behind project', this was a scheme piloted in Cowal to proactively address infants with identified risk factors for weight lag. While a small project, results were encouraging and will continue to be monitored.
Additional Support Requirements Identified
Currently, the activities to support breastfeeding, the training and co-ordination of 57 peers supporters, training of 12 key workers and engaging with communities to increase the profile of breastfeeding within the SCP is undertaken by the HSCP infant breastfeeding co-ordinator. This is a temporary post funded out of non-recurring MINF fund. The equivalent post in highland is a permanent senior health promoting role. To sustain this change the wider remit of this role within the HSCP working across health, adult and children's services needs recognised.

Improvement Forecast Date:	**Review Date:**
Ongoing monitoring	Quarterly

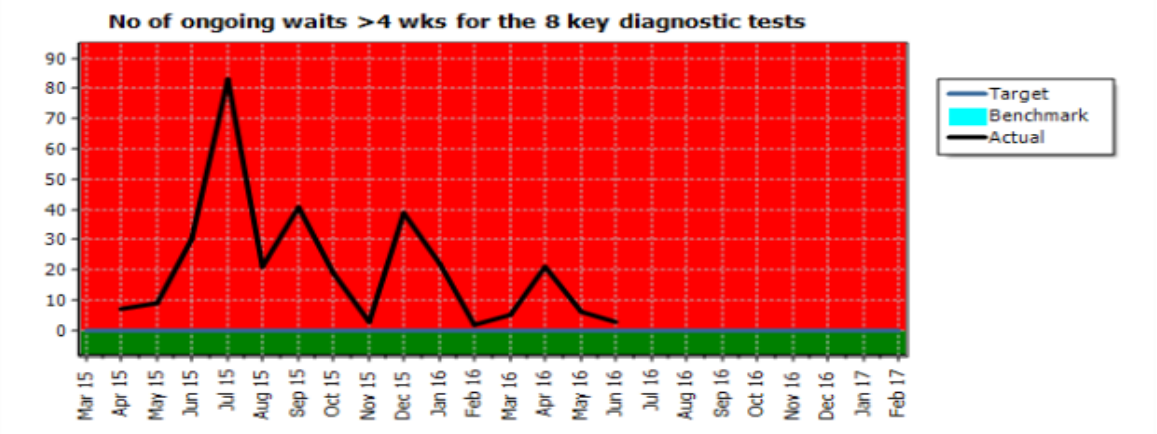
Management Exception Reporting

Performance Indicator: Outcome 1 The number of people waiting more than 4 weeks for the eight key diagnostic tests at the end of the month	**Responsible Manager:** Lorraine Paterson
Target: 0 Actual: 3	Date of Report: FQ1 16/17

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)

Latest status
Jun 16
3



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 8 key diagnostic tests are:

Endoscopy

- Upper Endoscopy
- Lower Endoscopy (excluding Colonoscopy)
- Colonoscopy
- Cystoscopy

Radiology

- CT Scan
- MRI Scan
- Barium Studies
- Non-obstetric ultrasound

Peak in waiting time in 2015 was due to gaps in the establishment due to sickness and absence and vacancies in diagnostic services specifically ultrasound.

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) Vacancies in service considered difficult to fill posts. Immediate external advertising of vacancies. Oban Locality manager and medical records manager continue to work on ensuring forward prediction of breaches and putting in place action to mitigate this which has seen the significant improvement in performance.
Additional Support Requirements Identified

Improvement Forecast Date:	**Review Date:**
This is subject to ongoing review.	Monthly

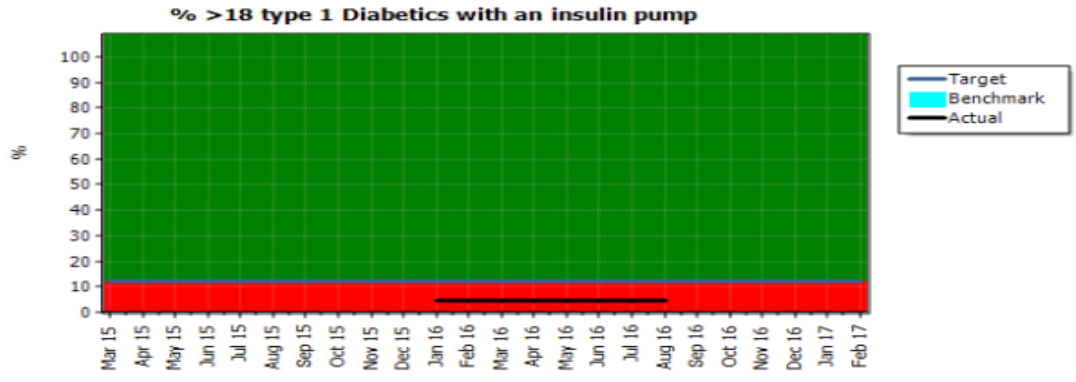
Management Exception Reporting

Performance Indicator: Outcome 1 % >18 type 1 Diabetics with an insulin pump	**Responsible Manager:** Lorraine Paterson
Target: 12% Actual: 4% (15 people)	Date of Report: FQ1 16/17

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)

Latest status
Aug 16
4 %



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)

This measure will see a slow increase to reach the target of 12% due to the process under taken. Heidi courses are offered to diabetics to address their understanding of the condition and to monitor the condition effectively. From the courses, people may feel that the insulin pump might be the way forward and then they are referred to GGHB for assessment for the insulin pump. N.B. not all people are suitable for a pump. Some people feel that they have been educated to manage their condition without a pump for the time being. The process can take from 3 to 6 months to be fitted with a pump.
At the moment, four people are going through this process and if all are successful, we will see a slight increase of around 2% within the next few months. This measure has a longer term goal which gives flexibility and choice to diabetic adults over 18.

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)

Promotion of the use of a pump.
Further roll out of Heidi training.

Additional Support Requirements Identified

Funding to support training.

Improvement Forecast Date:	Review Date:
March 17	Jan 17

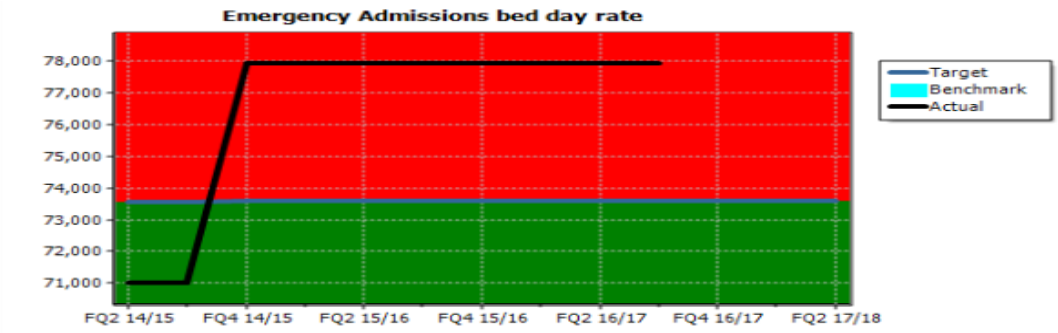
Management Exception Reporting

Performance Indicator: Outcome 2 Emergency Admissions bed day rate	**Responsible Manager:** Lorraine Paterson
Target: 73,597 Actual: 77,924	Date of Report: FQ1 16/17

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)

Latest status
FQ2 16/17
77,924



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)

All areas are currently undertaking a self-assessment against the Scottish Government 6 essential actions for unscheduled care. This will inform the winter plan, and actions for prevention of admission strategies.

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)

Implementation of robust Anticipatory Care Plans (ACP's).
Community and AHP response to Emergency Departments.
Short term assessment beds.
Community "pull through" from assessment beds.
Step up/down beds implemented.
Single Point of Access to community teams.
Community (virtual) Wards in place.
Lead professional in place.
Rollout of Universal Adult assessment (UAA).

Additional Support Requirements Identified

Pump priming resource for community teams from ICF funding

Improvement Forecast Date:	Review Date:
March 17	Dec 16

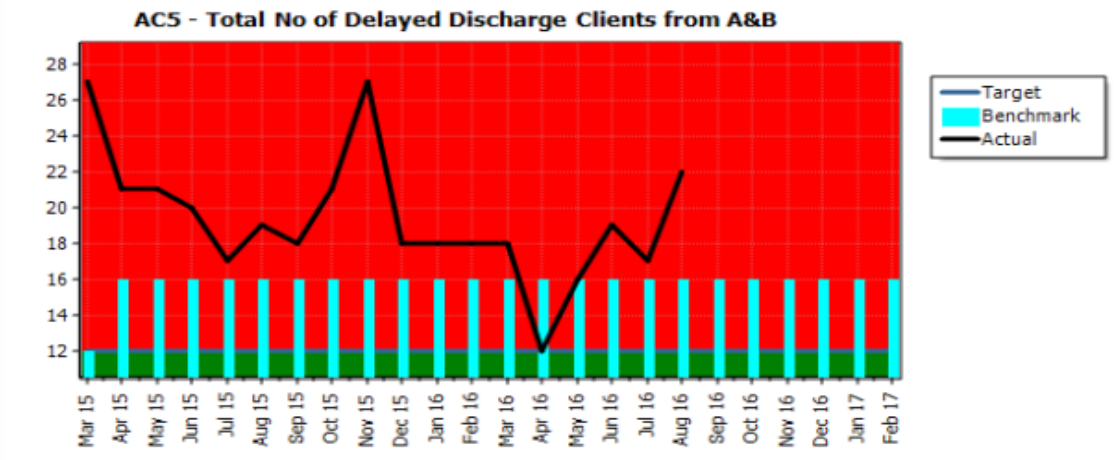
Management Exception Reporting

Performance Indicator: Outcome 2 AC5 - Total No of Delayed Discharge (DD) Clients from A&B	**Responsible Manager:** Allen Stevenson
Target: 12 Actual: 22	Date of Report: FQ1 16/17

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)

Latest status
Aug 16
22



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 August performance in relation to delayed discharge is a total of 22 delays within Argyll and Bute. The actions below describe some of the current actions we are undertaking to improve our performance. There are two key areas of interest currently and they are

1/ increasing our pool of assessment staff and

2/ increase availability of care at home packages in the west

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)

1. We have successfully made the administrative and operational changes to the reporting timescales and reporting of DD internally as per instructions of the Scottish Government. Our staff completed the necessary activity on the Edison system as per new timescales and this is now embedded in practice.
2. We have merged our unscheduled care improvement work and continuous improvement activity around delayed discharge with our management teams to ensure there is no duplication of effort as we go forward.
3. In May we updated our guidance and re-launched our AWI guidance which includes the use of 13ZA guidance. This has had a positive effect on our exemption coded delays with only one person currently delayed as a result of AWI.
4. We are completing our work relating to our new Universal Adult Assessment and will be using two localities in the West by the end of October to roll this out. This will start to address the issue of people waiting for assessments.
5. We are working with commissioning staff to develop alternative ways to deliver care at home in

some of our remote and rural communities. In Appin, near Oban we are developing a social enterprise model using SDS.
6. Our commissioning staff are attending workforce fayres with our providers to promote the benefits of careers in social care. Last month our providers worked with DWP with a potential group of 12 people who have expressed an interest.
7. Delayed Discharge report attached within this measure on Pyramid for IJB members to scrutinise.
8. NHS GG&C have indicated that they wish to see a 75% reduction in occupied bed days due to Delayed Discharges in its hospitals and has requested that all its HSCPs including Argyll and Bute detail this in their commissioning intentions of their Service Level Agreements (SLAs). This is to support a shift in the resource from acute to community for 2017/18.

Additional Support Requirements Identified

Locality Managers/Local Area Managers to ensure a sense of urgency around DD is required to ensure patients are discharged from hospital timeously.

Ensure ADT policy is followed by hospital and community staff.

Heads of Service to monitor progress weekly to ensure scrutiny across all locality teams.

Staff in Helensburgh; continue to liaise and proactively identify people delayed in Glasgow hospitals.

Commissioning team to assist in the development of new ways of delivering care at home through SDS options.

Developing access to NHSGG&C “Orion” IT system to allow real time identification of A&B patients admitted to NHSGG&C hospitals to aid discharge planning. Adjustments to the SLA with NHSGG&C activity and finance schedules and transfer of resources to localities. Financial planning of the HSCP to action this.

Improvement Forecast Date:	Review Date:
Ongoing monitoring of performance on a weekly basis to ensure a sense of urgency is created and maintained across all localities.	Monthly

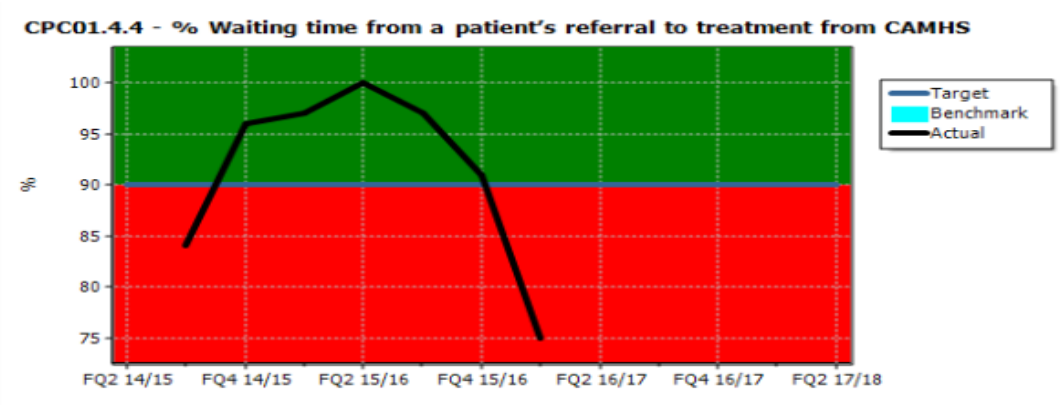
Management Exception Reporting

Performance Indicator: Outcome 2 CPC01.4.4 - % Waiting time from a patient's referral to treatment from CAMHS	**Responsible Manager:** Louise Long
Target: 90% Actual: 75% (12 people)	Date of Report: FQ1 16/17

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)

Latest status
FQ1 16/17
75 %



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)

One consultant is absent due to maternity leave and the Service has been unable to recruit a locum to cover the specialised 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)

There are no funds for a locum, however, given the priority additional funding has been allocated. The team lack resilience due to the size of the teams and the geography of Argyll and Bute. The consultant posts is specialised and despite approaching other health boards neither Glasgow or NHS Highland can offer any additional consultant support. An advert has been placed in market however has attracted no interest.

Additional Support Requirements Identified

Improvement Forecast Date:	Review Date:
Ongoing Monitoring	Monthly

Management Exception Reporting

Performance Indicator: Outcome 2 % of patients who wait no longer than 18 wks for Psychological therapies	**Responsible Manager:** Lorraine Paterson
Target: 90% Actual: 62%	Date of Report: FQ1 16/17

Description of Exception

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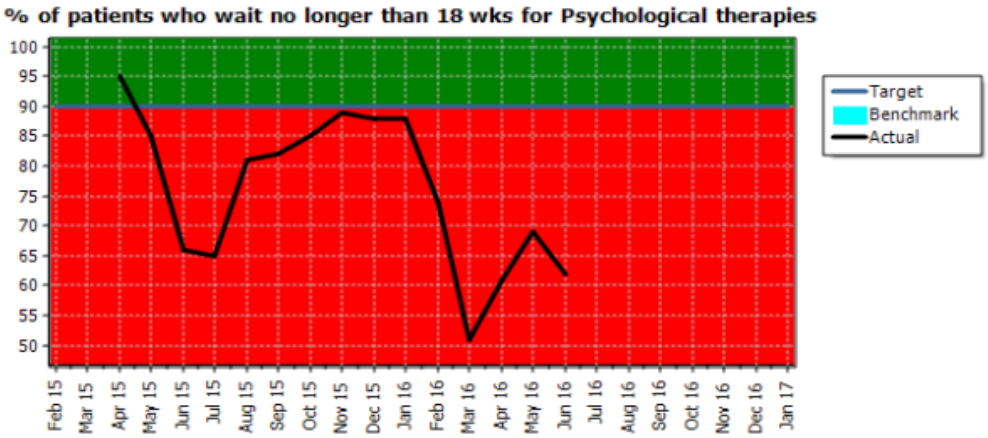

Actions Identified to Address Exception and Improve Performance

(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 remains a significant ongoing recruitment and availability issues for psychological therapies in Argyll and Bute. A review of current services is to be undertaken in line with mental health review over the next 6 months

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)

Process mapping exercise for access to psychological services.
Caseload Review.
Potential RPIW process application for Feb 2017
Roll out of Mastermind programme as part of national Technology enabled Care programme to improve access to Cognitive Behavioural Therapies from October 2016.

Additional Support Requirements Identified

Improvement methodologies and DCAQ analysis.

Improvement Forecast Date:	Review Date:
On-going review	March 17