# Argyll & Bute Health and Social Care Partnership

Performance Exception Report for Integrated Joint Board
30th November 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 |

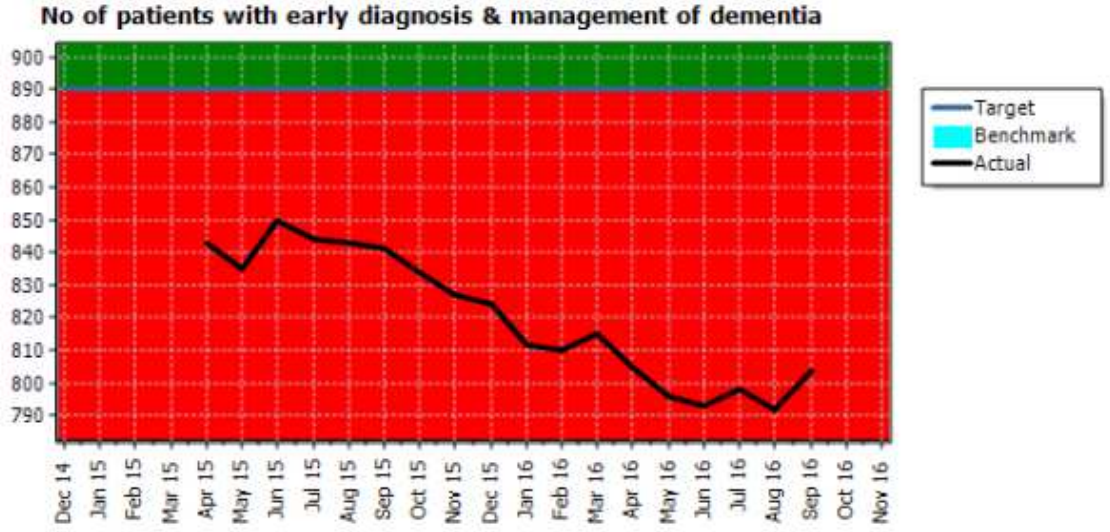
| Performance Measure / Outcome | | Target | Actual | Trend | Period | Responsible Manager |
|---|---|---|---|---|---|---|
| 3 | No of patients with early diagnosis & management of dementia | 890 | 804 | ↑ | FQ2 | Lorraine Paterson |
| **Performance Measure / Outcome** | | **Target** | **Actual** | **Trend** | **Period** | **Responsible Manager** |
| 4 | Falls rate per 1,000 population aged 65+ | 20 | 23 | → | FQ2 | Lorraine Paterson |
| 4 | Rate of emergency admissions per 100,000 population for adults | 11,865 | 12,045 | → | FQ2 | Lorraine Paterson |
| 4 | % of health & care resource spend on hospital stays, patient admitted in an emergency | 22% | 23% | → | FQ2 | Allen Stevenson |
| 4 | No of outpatient ongoing waits >12 wks | 0 | 58 | ↓ | FQ2 | Lorraine Paterson |
| 4 | % of patients on the admissions waiting lists with social unavailability | 15.7% | 26% | ↓ | FQ2 | Lorraine Paterson |
| 4 | % of patients on the admissions waiting lists with medical unavailability | 2.0% | 2.7% | ↓ | FQ2 | Lorraine Paterson |

# Management Exception Reporting

| **Performance Indicator: Outcome 3**<br>No of patients with early diagnosis & management of dementia | **Responsible Manager:**<br>Lorraine Paterson |
|---|---|
| Target: 890 Actual: 804 | Date of Report: FQ2 |

## 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 performance measure used for this standard is the number of people with a diagnosis of dementia on the Quality and Outcomes Framework (QOF) dementia register and other equivalent sources. The standard supports a commitment to achieve improvements in the early diagnosis and management of people with dementia. This should be supported by physical and mental health reviews every 15 months along with an assessment of carers needs which includes an appraisal of the impact of caring on the care giver.

## 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)

Following the abolition of QoF within the GP contract, there has been a fall in performance against this standard. The locality community dementia teams are continuing to support and advise primary care.

Scotland's National Dementia Strategy 2016-19. Was published in March 2016. The HSCP is now establishing a Dementia Programme Board recognising that work has stalled on this. The Board will be meeting on the 12th December 2016; the Board is chaired by the Lead Nurse.

It is expected that a suite of actions will be identified to address the deficiency in performance and will be monitored by the Programme Board and at locality level.

## 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)

| Additional Support Requirements Identified | |
|---|---|
| | |
| **Improvement Forecast Date:** | **Review Date:** |
| March 2017 | monthly |

# Management Exception Reporting

| **Performance Indicator: Outcome 4**<br>Falls rate per 1,000 population for adults aged 65+ | **Responsible Manager:**<br><br>Lorraine Paterson |
|---|---|
| Target: 20 Actual: 23 | Date of Report: FQ2 16/17 |

## Description of Exception

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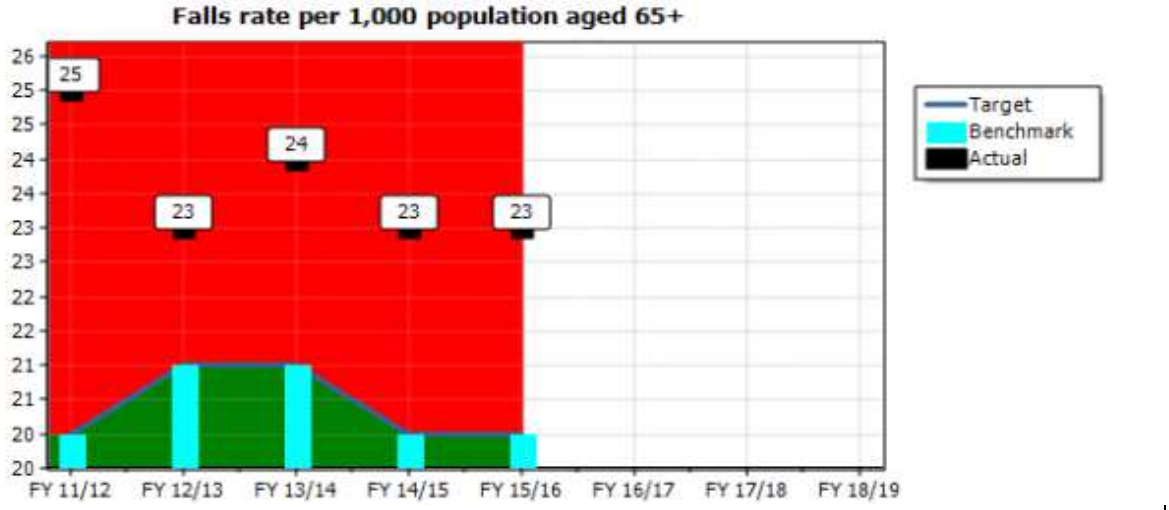


The indicator is measured using data gathered by Information Services Division (ISD) on the number of patients aged 65 plus who are discharged from hospital with an emergency admission code 33 - 35 and ICD10 codes W00 – W19.

## 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 localities are working through the National Framework for Action on the Prevention and Management of Falls in the community, and have supporting action plans. The HSCP Falls prevention advisor Dr Christine MacArthur is leading on this work working within localities

Level 1 screening postcards have been implemented with appropriate training. Mangar-elk, lifting apparatus has been allocated to each area and staff training is being implemented through 2016.

Level 2 multi-factorial falls risk screening is being carried out by some third sector organisations following training.

Community responders for non-injured falls are being implemented detail and coverage per locality is being mapped

## 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 actions identified focused on preventative work in the community and this will take time to work through. The actions identified are well evidenced and should have an impact on meeting the target.

A recently published economic evaluation provided an estimate of the cost to health and social care services in Scotland of managing the consequences of falls: in excess of £470 million (http://www.ncbi.nlm.nih.gov/pubmed/24215036) and without intervention is set to rise over the next decade as our population ages and the proportion with multi- morbidity and polypharmacy increases.

## Additional Support Requirements Identified

Will be reviewed once training programme and initiatives outlined above have been completed and evaluated

| Improvement Forecast Date: | Review Date: |
|---|---|
| March 2016 | On-going |

# Management Exception Reporting

| Performance Indicator: Outcome 4<br>Rate of emergency admissions per 100,000 population for adults | Responsible Manager:<br><br>Lorraine Paterson |
|---|---|
| Target: 11,865 Actual: 12,045 | Date of Report: FQ2 16/17 |

## Description of Exception

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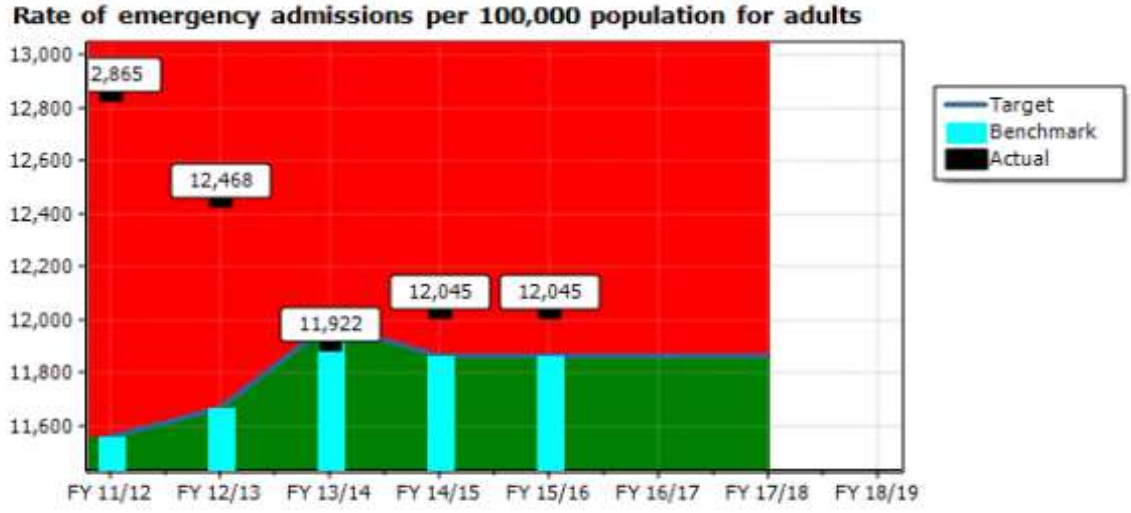


Rate of emergency admissions per 100,000 population for adults.

Published data: ISD Inpatient and Day Case Activity (2013/14)
Frequency: Financial Year, data available June each year.

Definition: Based on SMR01 returns for acute hospitals, and SMR04 data for psychiatric hospitals (note that some further work will be undertaken by ISD regarding this data source).
Linked to IJB Outcome 1,2,4,5 & 7.

## 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 prevention of avoidable emergency admissions continues to be an area of focus for the localities.

Applying the 6 essential actions for unscheduled care, including Anticipatory Care planning, community "pull through" and step up support his work.

Community teams continue to have challenges with the provision of homecare, to fully facilitate these actions.

Work with independent homecare providers and the commissioning team continues to support homecare provision.

Performance information is being developed at locality level reflecting greater sensitivity for local performance

## 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)

## Additional Support Requirements Identified

| Improvement Forecast Date: | Review Date: |
|---|---|
| | |

# Management Exception Reporting

| **Performance Indicator: Outcome 4**<br>% of health & care resource spend on hospital stays, patient admitted in an emergency | **Responsible Manager:**<br><br>Allen Stevenson |
|---|---|
| Target: 22% Actual: 23% | Date of Report: FQ2 16/17 |

## Description of Exception

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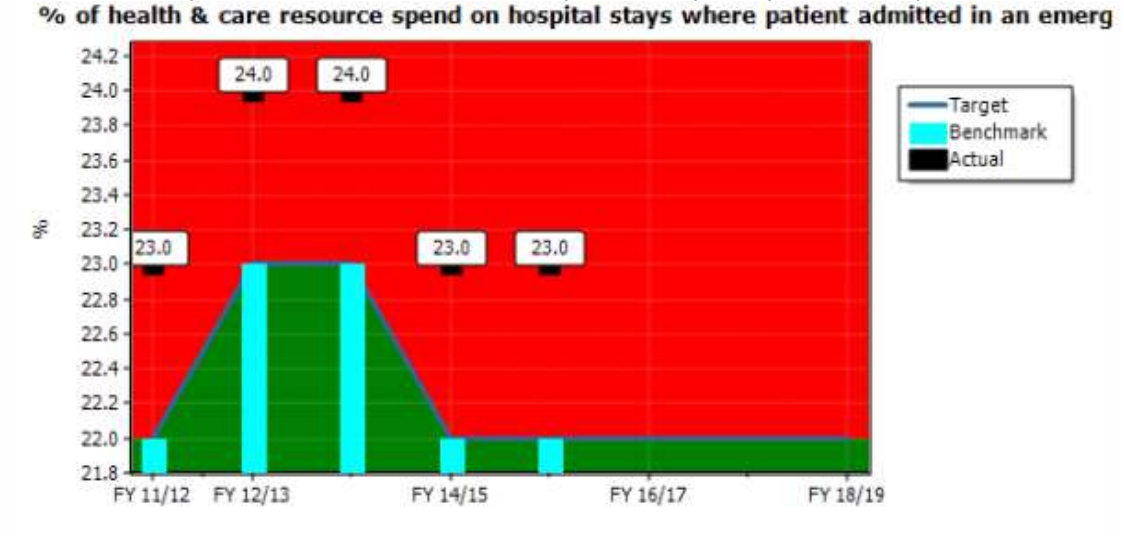


Percentage of health and care resource spend on hospital stays where the patient admitted in an emergency.

Published data: ISD Standard Outputs - Health and Social Care Data Integration Frequency: Annual

Definition: Cost of emergency bed days for adults - Includes admissions from all hospital specialties, acute, geriatric long stay and mental health.

## 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)

Our HSCP staff are actively working to reduce emergency admissions to hospital across Argyll and Bute. Our community teams are attempting to intervene earlier when older people start to deteriorate at home and encounter problems with their physical or mental health.

Our approach to re-ablement is currently under review as we attempt to increase the impact of this work on sustaining people at home for longer and maximise their independent living skills. Re-ablement work increases confidence levels and people generally feel more able to undertake daily living tasks by themselves.

The early implementation of planning for discharge starts as soon as patients arrive

in hospital with target discharge dates identified shortly after admission. A recent example of this improvement work was highlighted as a result of an RPIW workshop in Oban where the team have been able to sustain lowering the number of days patients stay in hospital. Lessons learned from this activity need to be shared more effectively across all localities.

## 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 need to ensure our re-ablement model is working effectively across all our community teams. We are currently planning a review of our progress across our community teams which will help deliver increased consistency of approach to re-ablement.
- We need to ensure we share and spread the good outcomes from a recent RPIW in Oban which has delivered shorter length of stay for the patients admitted to hospital.
- We need to accelerate work towards shifting the balance of care from hospital to community and ensure we achieve the current 80% target. This will only be achieved if we accelerate our re-design work across localities.

## Additional Support Requirements Identified

The actions described above need to be secured to deliver our desired outcome of shifting the balance of care.

This is a medium term focusing on shifting the balance of care and hence seeing a corresponding shift in resources by disinvesting from acute and reinvesting in community services

| Improvement Forecast Date: | Review Date: |
|---|---|
| | Quarterly |

# Management Exception Reporting

| **Performance Indicator: Outcome 4**<br>No of outpatient ongoing waits greater than12 wks | **Responsible Manager:**<br>Lorraine Paterson |
|---|---|
| Target: 0 Actual: 58 | Date of Report: FQ2 16/17 |

## Description of Exception

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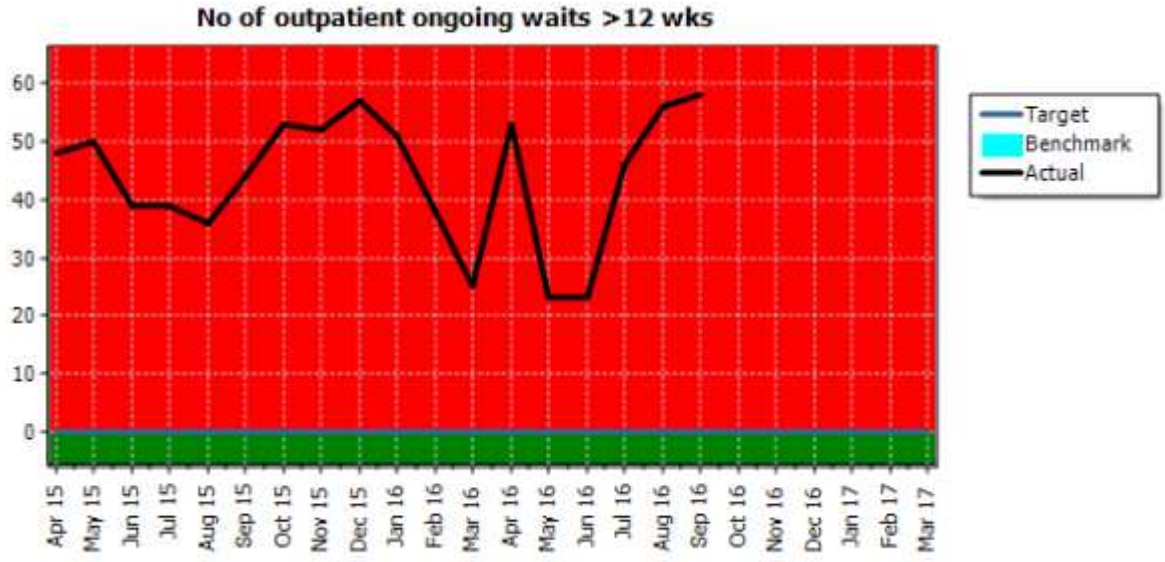



## Actions Identified to Address Exception and Improve Performance

(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 table below details the breakdown of the waits in Argyll and Bute:

| Hospital | Specialty | Number Waiting over 12 Weeks at end Sep16 |
|---|---|---|
| Campbeltown Hospital | Dermatology | 1 |
| Campbeltown Hospital Total | | 1 |
| Lorn and Islands Hospital | Chronic Pain Management Service | 25 |

| | | |
|---|---|---|
| | Oral Surgery | 16 |
| | Dermatology | 7 |
| | Orthopaedics | 4 |
| | Gynaecology | 1 |
| | Haematology | 1 |
| | Ophthalmology | 1 |
| Lorn and Islands Hospital Total | | 55 |
| Mull And Iona Community Hospital | Cardiology | 1 |
| | Ophthalmology | 1 |
| Mull And Iona Community Hospital Total | | 2 |
| **A&B HSCP Total** | | **58** |

The most significant waits are in Pain, Oral Surgery and Dermatology at LIH.

There has been historical use of initiative clinics to reduce these waiting times, however these are expensive options and not affordable.

## 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 has been historical use of initiative clinics to reduce these waiting times, however these are expensive options and not affordable.

The most significant breach remains in the Pain Service delivered by the single consultant anaesthetist from LIH Oban. This is primarily due to the Consultant's capacity and the chronic nature of the pain patients requiring continual follow up thereby resulting in low number of patient discharges.

The HSCP has been working to look to maximise efficiencies within the service and have done the following:

- Redesigned the pathway by issuing patient questionnaires to get as much information from the patient to reduce appointment times
- Follow up the questionnaire with a telephone triage appointment to establish the best and most appropriate route for the patient to get treatment. This should reduce the amount of outpatient appointments required and will increase capacity.
- Physiotherapists participating in the pain service to triage, treat and manage appropriate patients which will allow the patients to be discharged from the Consultant caseload along with OT support.

- Self management tools for patients are being examined and rolled out to patients
- The waiting list administration for the service has been centralised to Oban Lorn and Islands hospital to ensure equity of appointing across the HSCP as waiting times differed depending on the availability of the Consultant to visit that area Oban, Kintyre and Mid Argyll).
- Utilising Technology Enabled Care (TEC) by using “Florence” a text reminder service to help patients self manage their pain control. There are 5 patients currently using Florence.
- Patients are being appointed in chronological order, ensuring the longest waiter is appointed first. Whilst there is still a long waiting list, the Service is stabilising and a significant reduction has been seen within the waiting time and breach numbers although this remains high.

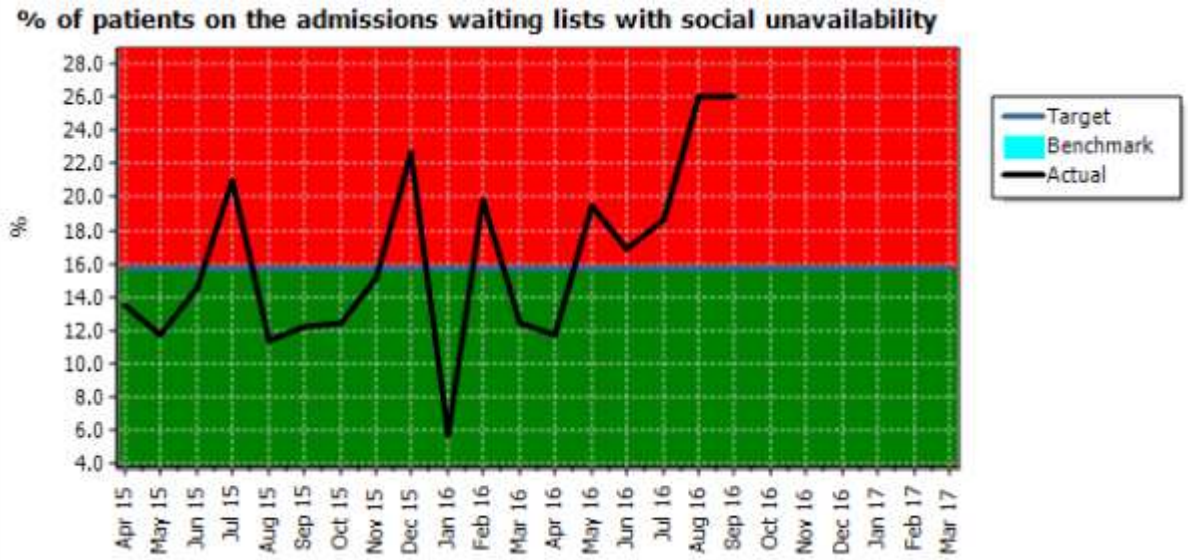
| Additional Support Requirements Identified | |
|---|---|
| Solution is a combination of additional capacity and further redesign. However, sourcing an anaesthetic consultant with the relevant expertise for what is probably 1 or 2 extra sessions a month is unlikely and expensive if waiting list initiative rates are used. | |
| **Improvement Forecast Date:** | **Review Date:** |
| Not in the next 6 months | On-going |
| | |

# Management Exception Reporting

| **Performance Indicator: Outcome 4**<br>% of patients on the admissions waiting lists with social unavailability | **Responsible Manager:**<br>Lorraine Paterson |
|---|---|
| Target: 15.7% Actual: 26% | Date of Report: FQ2 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)




This target relates to day case and inpatient admissions at Lorn and Island hospital Oban (primarily general surgery). The patient focused booking system allows patients to revise their appointments and in some cases defer admission due to personal circumstances and this is coded as social unavailability, due to patient personal choice.

## 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 local team have been alerted to the increasing trend since May and an investigation into the increase is underway. It should be noted that LIH admission and day case waiting time is less than 7 weeks as at 4th November 2016.

## 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)

## Additional Support Requirements Identified

| Improvement Forecast Date: | Review Date: |
|---|---|
| March 2017 | Monthly |

# Management Exception Reporting

| **Performance Indicator: Outcome 4**<br>% of patients on the admissions waiting lists with medical unavailability | **Responsible Manager:**<br>Lorraine Paterson |
|---|---|
| Target: 2% Actual: 2.7% | Date of Report: FQ2 16/17 |

## Description of Exception

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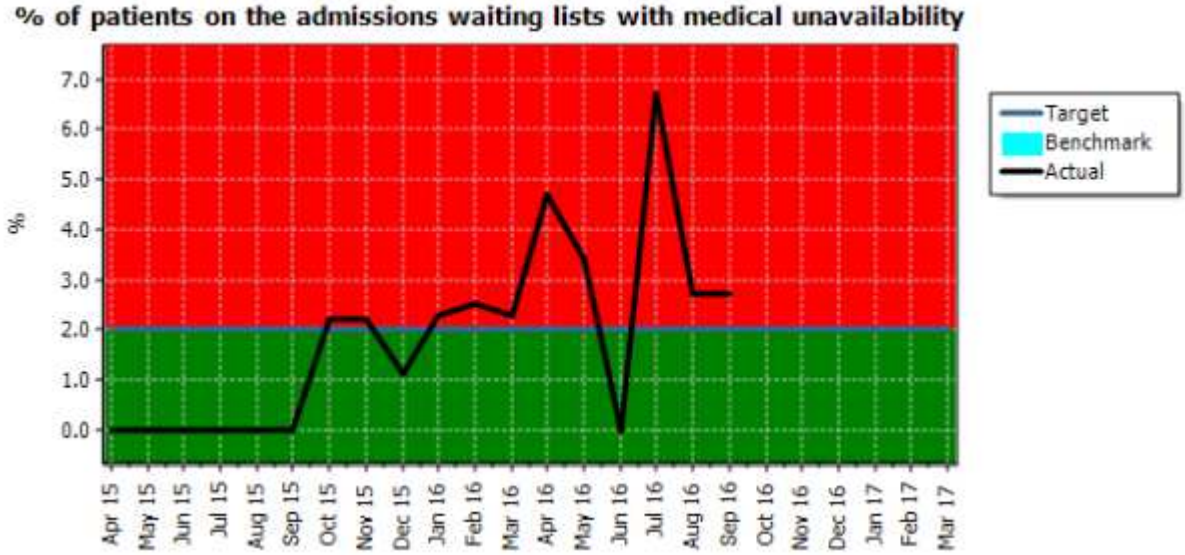


## Actions Identified to Address Exception and Improve Performance

(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)

This is solely dependent on a clinical decision, usually made at pre-assessment, if people are too unwell to be admitted.

## 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)

## Additional Support Requirements Identified

| Improvement Forecast Date: | Review Date: |
|---|---|
| | |