Argyll & Bute Health and Social Care Partnership

Performance Exception Report for Integrated Joint Board
Outcomes 1 & 2 (FQ4-17/18) - August 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

Exception Reporting FQ4 (17/18)

Outcome Indicators - 1 People are able to improve their health

	Outcome / Performance Indicator	Trend	Target	Actual	Responsible Manager
	Rate of emergency admissions per 100,000 population for adults *(Linked to IJB Outcome 1,2,4,5 & 7)*	⇑	11,959	12,066	Lorraine Paterson
	AC1 - % of Older People receiving Care in the Community	⇓	81 %	74.4 %	Lorraine Paterson/Phil Cummins
	No of alcohol brief interventions in line with SIGN 74 guidelines	⇑	1024	397	Lorraine Paterson
	NHS-H7 - Proportion of new-born children breastfed - STANDARD	⇓	33.3%	31.9%	Alex Taylor
	No of ongoing waits >4 weeks for the 8 key diagnostic tests	⇓	0	368	Lorraine Paterson
	% >18 type 1 Diabetics with an insulin pump	⇑	12%	11%	Lorraine Paterson

Outcome Indicator – 2 People are able to live in the community

	Outcome / Performance Indicator	Trend	Target	Actual	Responsible Manager
	% of adults supported at home who agree they are supported to live as independently	⇓	81%	79%	Phil Cummins
	Falls rate per 1,000 population aged 65+ *(Appears as a PI in Outcomes 2,4,7,9)*	⇑	22	26	Lorraine Paterson

	AC5 - Total No of Delayed Discharge Clients from A&B	⇓	12	28	Phil Cummins
	CPC01.4.4 - % Waiting time from a patient's referral to treatment from CAMHS	⇓	90%	89%	Alex Taylor
	% of patients who wait no longer than 18 weeks for Psychological therapies	⇒	90%	50%	Lorraine Paterson

FQ4 17/18 Other NHWBO indicators currently off track presented for IJB reference

Outcome/Performance Indicator	Trend	Target	Actual	In charge
Outcome 1				
As above				
Outcome 2				
As above				
Outcome 3				
No of patients with early diagnosis & management of dementia (Health & Social Care Partner Data)	⇓	890	814	Lorraine Paterson
Outcome 4				
No of outpatient ongoing waits >12 weeks (Health & Social Care Partner Data)	⇓	0	411	Lorraine Paterson
Outcome 5				

No of treatment time guarantee ongoing waits >12 weeks (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 %	99 %	Alex Taylor
Outcome 8				
Health & Social Care Partnership % of PRDs completed (HR2 - PRDs A&B Council)	⇓	90 %	53 %	Alex Taylor
Social Work staff attendance	⇓	3.8 Days	5.7 Days	Phil Cummins
% of NHS sickness absence (Health & Social Care Partner Data)	⇓	4.00 %	5.36%	Lorraine Paterson
% of NHS staff with a completed & recorded KSF/PDP review (Health & Social Care Partner Data)	⇑	20.00 %	18.47 % Data for Feb & March still to be supplied	Lorraine Paterson
Outcome 9				
SCRA43 - % of SCRA reports submitted on time	⇓	75 %	53%	Alex Taylor
% of new outpatient appointments DNA rates	⇓	6.9%	9.1%	Phil Cummins

Customer Services				
Resolve your queries the first time you contact us – C&F	⇓	90%	81%	Alex Taylor
% of NHS simple complaints - achievement against 20 days	⇓	80%	0%	Liz Higgins

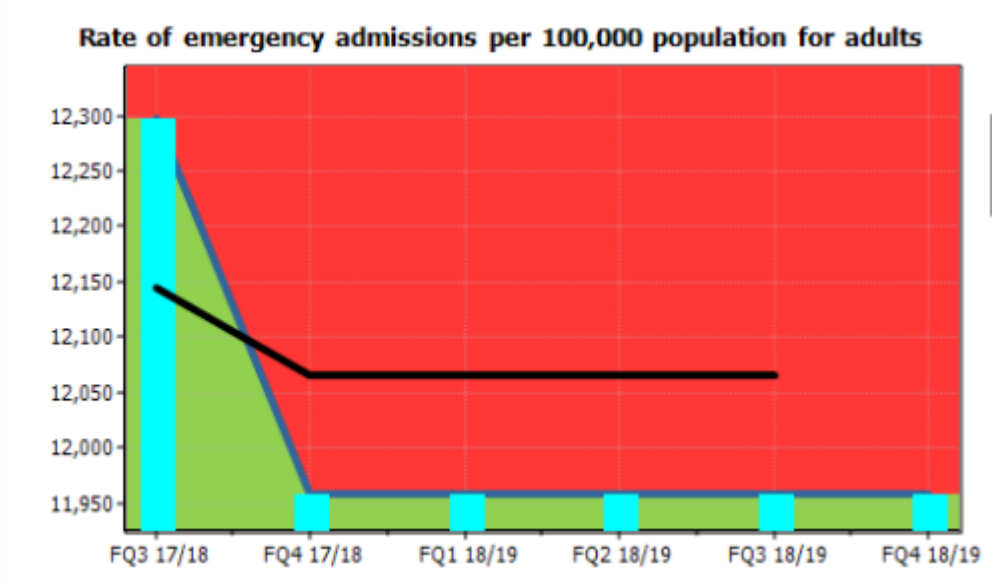
Management Exception Report

Performance Indicator: Outcome 1 Rate of emergency admissions per 100,000 population for adults	**Responsible Manager:** Lorraine Paterson
Target: 11959 Actual: 12066	Date of Report: FQ4 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)

Latest status
FQ2 18/19
12,066



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 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.

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) ISD will be releasing data for FY 17/18 by September 2018.
Additional Support Requirements Identified

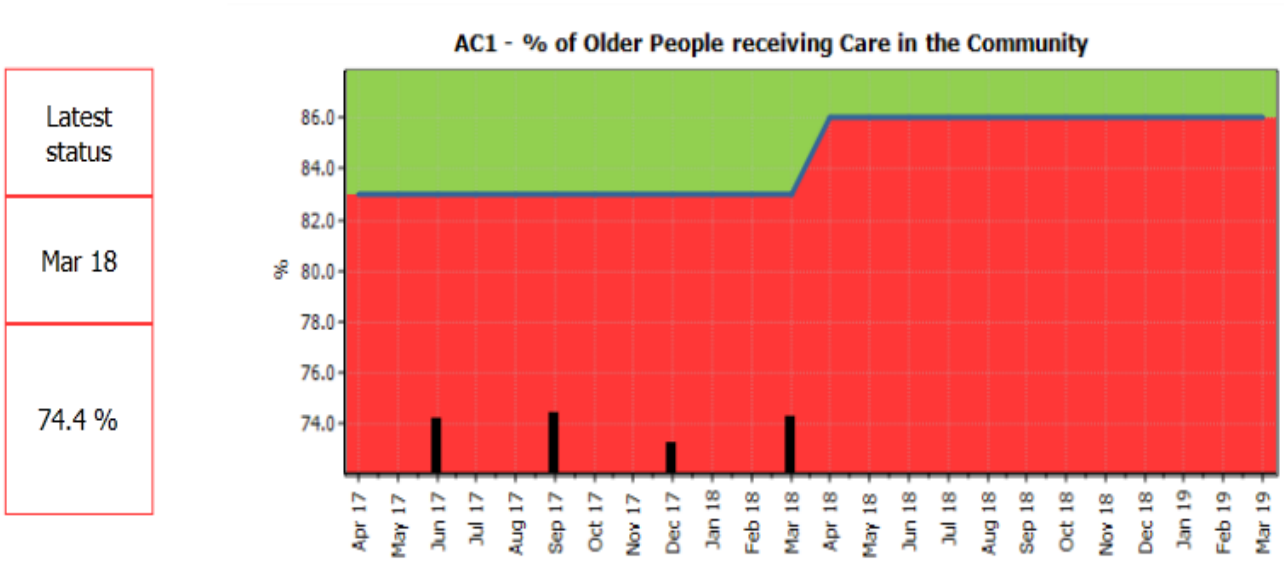
Improvement Forecast Date:	**Review Date:**
	Quarterly

Management Exception Report

Performance Indicator: Outcome 1 AC1 - % of Older People receiving Care in the Community	**Responsible Manager:** Phil Cummins/ Lorraine Paterson
Target: 83% Actual: 74.4%	Date of Report: FQ4 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)



Care in the community brings services closer to users/patients. It is a means of supporting people to remain in their own homes and their own communities for as long as possible, whilst ensuring that their care and support needs are met and risks to their well-being are minimised.

Community Care Packages are devised following a comprehensive assessment of the needs of the service user and carers (where this is applicable and the carer consents to assessment). A person-centred plan is agreed then implemented and will include as many aspects of care in the community as are necessary to meet the assessed needs. Person-centred plans are regularly reviewed and updated.

Linked to Joint Improvement Plan 2016/18, Quality Indicator 1.
Target - 2016/17 - 80%/20%, 2017/18 - 83%/17%, 2018/19 - 86%/14%

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)

To help us achieve our target of 83% we need to follow through on our 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

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 quarterly basis.	

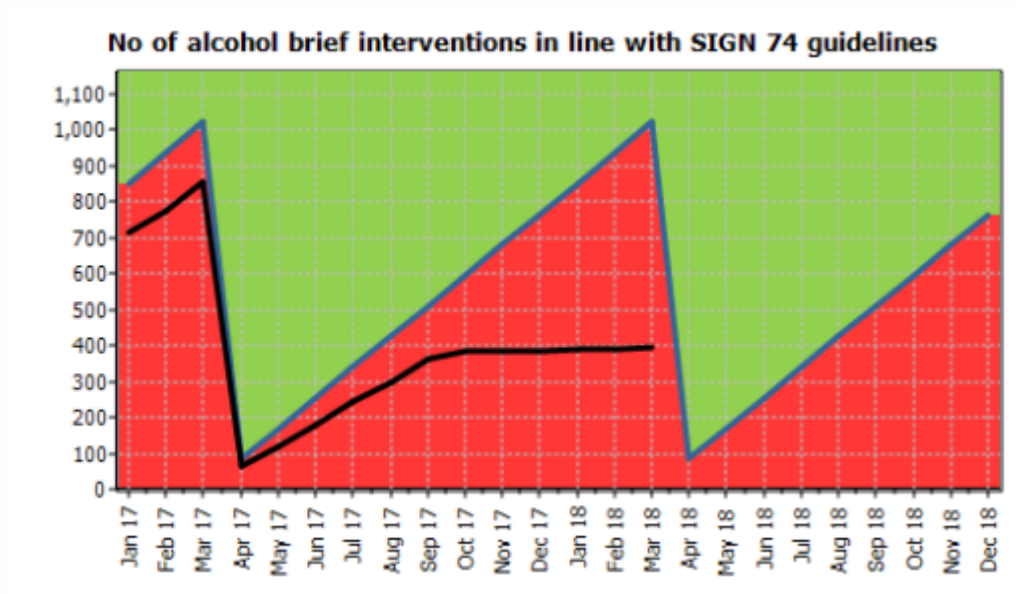
Management Exception Report

Performance Indicator: Outcome 1 No of alcohol brief interventions in line with SIGN 74 guidelines	**Responsible Manager:** Lorraine Paterson
Target: 1024 Actual: 397	Date of Report: FQ4 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)

Latest status
Mar 18
397



The number of alcohol brief interventions in line with SIGN 74 guidelines.

Target: 1024 by March 2018 (monthly target of 85, accumulative.)

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, ABI will be promoted across services, which includes A&E departments, and maternity clinics.

GP surgeries were conducting the ABIs but this process has ceased. A new improved process is being discussed and recording of data to be pursued through CareJust within CareFirst system. The data could then be interfaced to the Daisy system for national recording.

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) Cultural Perception of level of alcohol problems in the community. Reluctance 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	
Improvement Forecast Date:	**Review Date:**
This work is a continuing process.	

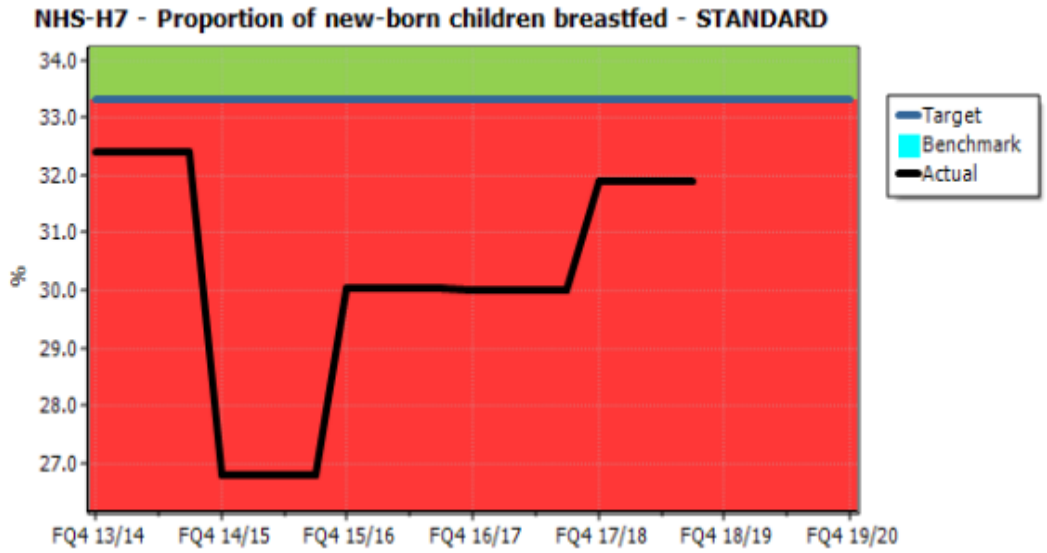
Management Exception Report

Performance Indicator: Outcome 1	Responsible Manager:
NHS-H7 - Proportion of new-born children breastfed - STANDARD	Alex Taylor
Target: 33.3% Actual: 31.9%	Date of Report: FQ4 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)

Latest status
FQ2 18/19
31.9 %



QUARTERLY CONVERSION - Shows annual figures - For ICPS 2014-17

Action: All partners are involved in ensuring that young mothers are aware of the benefits of breast feeding.

Performance Indicator: 33.3% or above babies are exclusively breast fed at 6-8 weeks.

Target: 33.3% or above. 2018 target 34%

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)

Infant feeding Coordinator and colleagues have undertaken a lot of work to improve the number of new born children being breastfeed. This includes the adoption of the UNICEF Baby Friendly Initiative and our application to UNICEF for the Gold Award for Achieving Sustainability. The Children and Families Service have given a very high priority to this target as it is strongly linked to health and wellbeing outcomes. The Percentage of children exclusively breastfed at 6-8 weeks is included in the Children and Young Peoples

Service Plan (2017 to 2020) which is tabulated below.

Performance Indicators	Baseline %	Target %	Profiling Yr1 (2018)	Yr2 (2019)	Yr3 (2020)
Percentage of children exclusively breastfed at 6-8 weeks	28%	34%	28% (Actual 31.9%) **Achieved**	32%	34%

The percentage of children exclusively breastfed at 6-8 weeks is 31.9% and as you will see we aim to be at 34% by 2020.

Actions Identified to Address Current /Future Barriers

Current measures should achieve the target of 34% in 2020.

Additional Support Requirements Identified

Improvement Forecast Date:	Review Date:
On target	NA

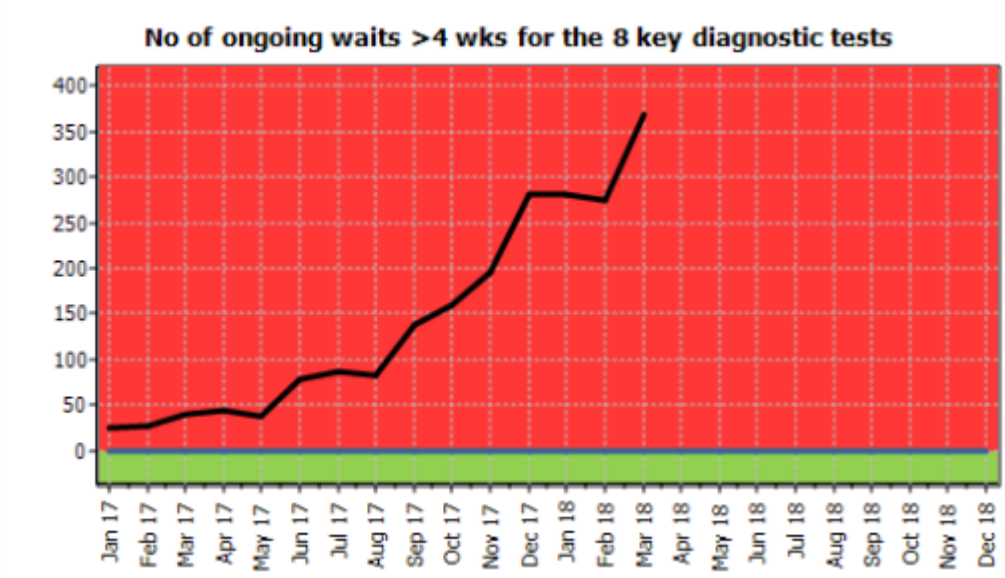
Management Exception Report

Performance Indicator: Outcome 1 No of ongoing waits >4 weeks for the 8 key diagnostic tests	**Responsible Manager:** Lorraine Paterson
Target: 0 Actual: 368	Date of Report: FQ4 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)

Latest status
Mar 18
368



The number of ongoing waits for the eight key diagnostic tests at the end of the month over 4 weeks.

Published data: NHS Balance Scorecard
Frequency: Monthly
Target: Zero

Definition: The eight tests are Upper Endoscopy, Lower Endoscopy, Colonoscopy, Cystoscopy, CT Scans, MRI Scans, Barium Studies and Ultrasound all conducted in LIH.

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)

Constant monitoring is in place for 4 week target. Peaks can be attributed to vacancies in service providers. Oban Locality manager and medical records manager to work on

ensuring forward prediction of breaches and putting in place actions.
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 providers, considered difficult to fill posts. - Immediate external advertising of vacancies.
Additional Support Requirements Identified

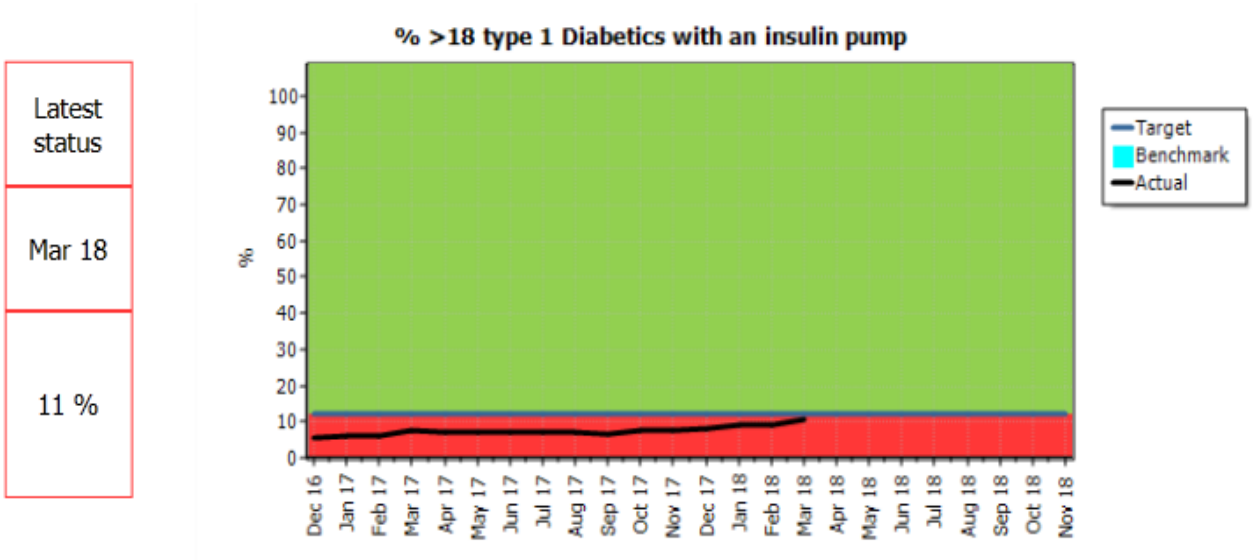
Improvement Forecast Date:	**Review Date:**
2019	September 2018

Management Exception Report

Performance Indicator: Outcome 1	Responsible Manager:
% >18 type 1 Diabetics with an insulin pump	Lorraine Paterson
Target: 12% Actual: 11%	Date of Report: FQ4 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 percentage of type 1 diabetics over 18 years old with an insulin pump in Argyll and Bute.
Target: 12%
Data source: SCI Diabetes from GGHB

Actions Identified to Address Exception and Improve Performance

Argyll & Bute Basal Bolus Insulin Education (ABBBIE) is the structured education programme which over 18's would attend if they would like to be referred for an insulin pump. These programmes are available yearly in each locality or more often should the waiting list indicate this.

Actions Identified to Address Current /Future Barriers

Our Diabetes Dietitian for Argyll & Bute left her post in June 2017, the recruitment process takes some time, and someone was recruited to the post in February 2018, unfortunately this person has since left and there is a replacement starting in August 2018, this dietitian will be educated on the delivering the training programme and this may reduce the number of programmes available until their education is completed.

We have excelled in improving our performance by 6% rather than the 2% suggested. This measure has a longer term goal which gives flexibility and choice to diabetic adults over 18. At the moment, four people are going through this process and if all are successful we will achieve the target of 12%

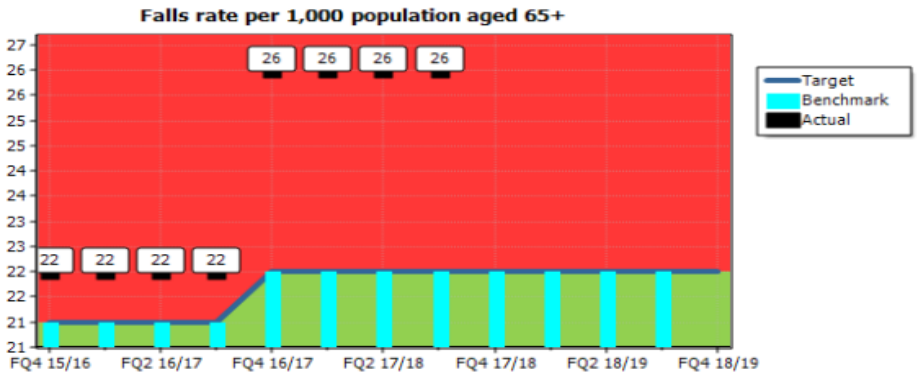
Additional Support Requirements Identified	
Improvement Forecast Date:	**Review Date:**
	FQ2 2018

Management Exception Reporting

Performance Indicator: Outcome 2	Responsible Manager:
Falls rate per 1,000 population for adults aged 65+	Lorraine Paterson
Target: 22 Actual: 26	Date of Report: FQ4 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

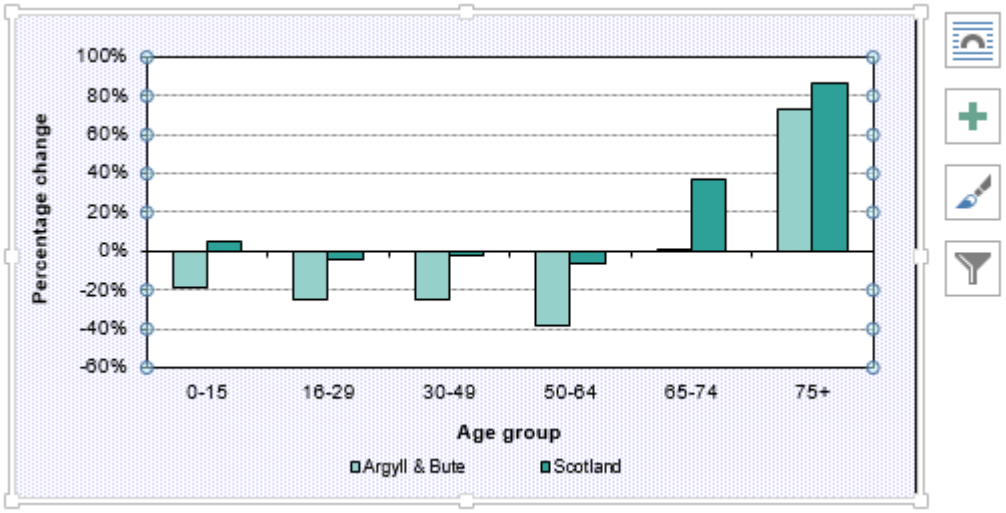
Development work is taking place with National Programme Manager for Prevention of Falls, LIST team from ISD and the support of the Active and Independent Living Programme to produce a quality dashboard of falls data for each locality. The data will have both outcome and process measures. This will be 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	September 2018

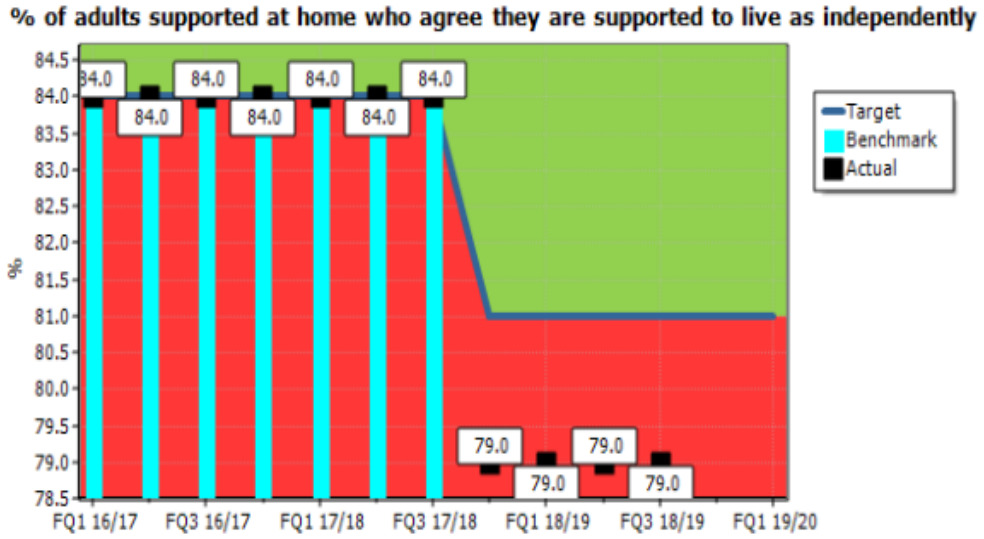
Management Exception Report

Performance Indicator: Outcome 2	Responsible Manager:
% of adults supported at home who agree they are supported to live as independently	Lorraine Paterson
Target: 81% Actual: 79%	Date of Report: FQ4 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)

Latest status
FQ1 18/19
79.0 %



QUARTERLY CONVERSION – Shows annual values
Percentage of adults supported at home who agree that they are supported to live as independently as possible.
Published data: Health and Care Experience Survey
Frequency: Biennial.
Benchmark: Scottish average

Definition: In the biennial health and care experience survey: I was supported to live as independently as possible".
As this is a biennial (every two years) measure, it may need to be reported in the measurement year and the year after however the Guidance states: "While national user feedback will only be available every 2 years, it is expected that Integration Authorities' performance reports will be supplemented each year with related information that is collected more often."

Then survey demonstrates a reduction in people who feel supported to live as independently as possible.
This can be attributed to;

1. Emergency admissions to care homes have increased. This is because we are managing more complex and frail people in the community. A simple infection can significantly impact on functional ability and lead to an increase in 24 hour care. 2. There are a number of patients who remain in hospital longer than they should due to difficulty in provision of care at home in some areas.
Actions Identified to Address Exception and Improve Performance
Ongoing work with all community teams to increase our preventative and anticipatory approaches eg, falls and frailty initiatives, reablement and anticipatory care plans. The focus of a number of our Transformation Together groups will impact on our ability to increase numbers who can live longer and more independently at home, reduce length of stay in hospitals and maximise the use of different housing and care home models.
Actions Identified to Address Current /Future Barriers
Workforce is a longstanding issue. Workforce plan in final stages of drafting. Modern apprentices being rolled out. Multi-agency work in localities to address workforce issues.
Additional Support Requirements Identified
Transformation approach with project management – in place. Community investment funding-in place.

Improvement Forecast Date:	**Review Date:**
June 2019	Dec 2018

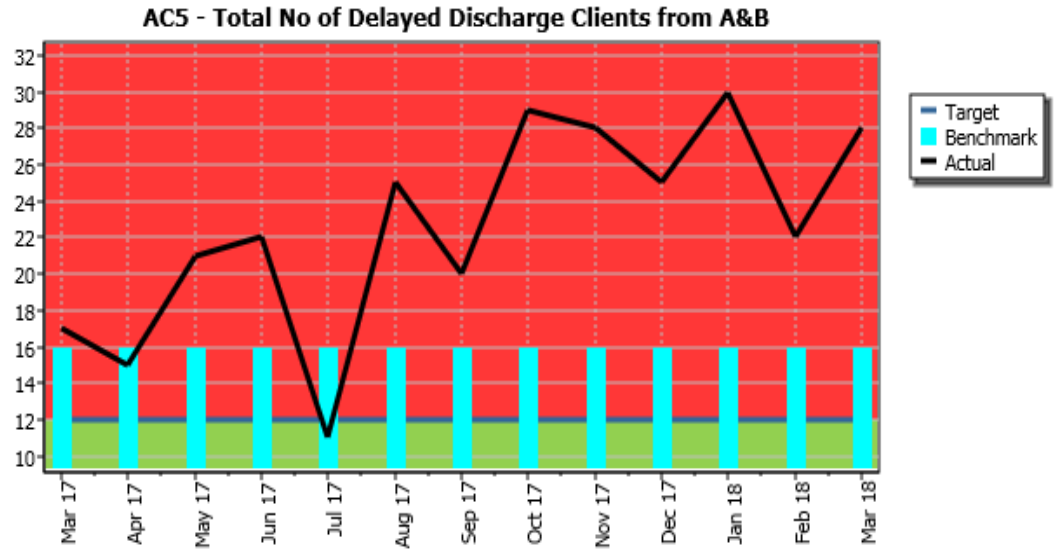
Management Exception Report

Performance Indicator: Outcome 2 AC5 - Total No of Delayed Discharge Clients from A&B	**Responsible Manager:** Phil Cummins
Target: 12 Actual: 28	Date of Report: FQ4 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)

Latest status
Jun 18
23



The total number of delayed discharge clients within hospitals from Argyll and Bute Area who are medically fit for discharge including Complex Needs Codes 9, 9/51X and 9/71X

Complex Needs are categorised as:-

Code 9 - Exemption Code

Code 9/51X – AWI cases (Adult with Incapacity)

Code 9/71X Interim placement outwith local area is unreasonable

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)

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.

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.

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

Ensure Admission, discharge and transfer policy is followed by hospital and community staff.

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

Actions Identified to Address Current /Future Barriers

We are working with commissioning staff to develop alternative ways to deliver care at home in some of our remote and rural communities.

Additional Support Requirements Identified

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

Improvement Forecast Date:	Review Date:
FQ4 2018	September 2018

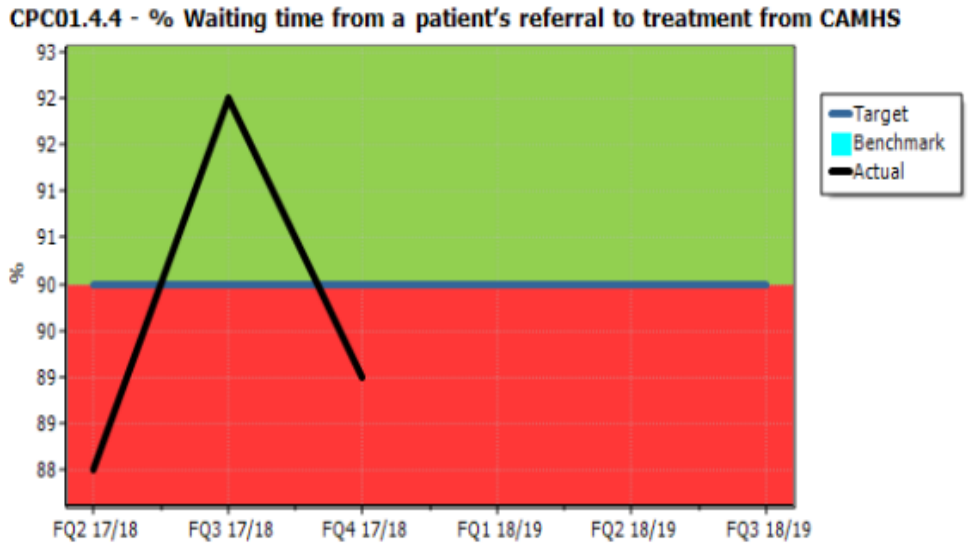
Management Exception Report

Performance Indicator: Outcome 2 CPC01.4.4 - % Waiting time from a patient's referral to treatment from CAMHS	**Responsible Manager:** Alex Taylor
Target: 90% Actual: 89%	Date of Report: FQ4 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)

Latest status
FQ4 17/18
89 %



CPC01.4.4 - CAMHS HEAT Target: maximum 26 week waiting time from a patient's referral to treatment for specialist Child and Adolescent Mental Health (CAMH) services from March 2013, reducing to 18 weeks from December 2014.

Due to CAMHS data being provided by individual practitioners as well as from the Trakcare patient management system, it is normally compiled by the 24th of the following month to give individuals time to prepare and submit data.

Target - 90%
Data Source - NHS HEAT measure

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)

CAMHS missed the HEAT target of 90% response within 18 weeks of referral in FQ4 by 1% having met the target the previous quarter by 2%. Given the small numbers involved this fluctuation may have not statistical significance, however achieving the target has historically been challenging and has been caused by low capacity within the team and high demand. A review of tiers 2 and 3 begun in 2017 has concluded with the recommended restructuring achieving increased capacity within the service. It is

likely that significant improvement in performance may take up to a year as all posts are filled and the expanded team and renewed processes begin to reduce waiting times.
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 primary barrier is that of capacity. The restructuring of the service should make better use of the available resources.
Additional Support Requirements Identified
None at this time.

Improvement Forecast Date:	**Review Date:**
FQ4	31st March 2018

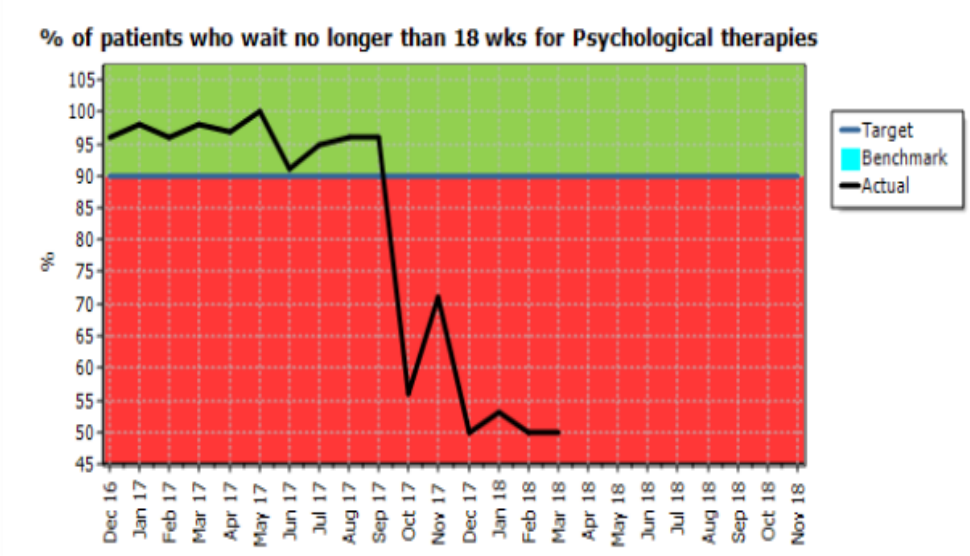
Management Exception Report

Performance Indicator: Outcome 2	Responsible Manager:
% of patients who wait no longer than 18 weeks for Psychological therapies	Lorraine Paterson
Target: 90% Actual: 50%	Date of Report: FQ4 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)

Latest status
Mar 18
50 %



The percentage of patients will wait no longer than 18 weeks from referral to treatment for Psychological Therapies at end of month.

Published data: Care Track PMS
Frequency: Monthly
Target: 90%

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)

Staff teams have had vacancies and these vacancies are advertised. This has continued to adversely affect the provision of psychological therapies.

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)

A time limited ring-fenced improving access to psychological therapies monies are available.

A small project team will include hours for an information analyst 0.5 WTE, a coordinator 0.5 to develop a dashboard to ensure reporting is correct and to identify the therapy slots A and B wide to ensure patients have equality of access and to ensure that we are utilising all area slot s for therapy. This has gone to WFM.

In MAKI we are piloting Attend Anywhere from mid-July in conjunction with TEC to reduce travel time and increase capacity.

Exploration of online CBT (Cognitive Behavioural Therapy)

Introduction of ccbt for mild to moderate conditions

Additional Support Requirements Identified	
Improvement Forecast Date:	**Review Date:**
January 2019	