NHS
Eileanan Siar
Western Isles

Local Delivery Plan Reporting Summary and Activity Report

June 2018

BOARD MEETING 27.06.18
Agenda Item: 10.2
Purpose: For Assurance

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Performance & Activity Report: 2017/18 Quarter 4

1) Target Performance: Local Delivery Plan (LDP) Trajectories and Local Delivery Plan

This report contains a review of Western Isles NHS performance status against the current Local Delivery Plan (LDP) standards for 2017/18 (previously HEAT targets/standards). The LDP standards are those targets retained from previous years as ongoing performance measures and reported as part of SG Scotland Performs framework. They are intended to provide assurance on sustaining delivery which will only be achieved by evolving services in line with the 2020 Vision.

The report is based around following three sections:

a) Current LDP Standards
b) LDP Key Performance Measures (KPMs) monitoring update for 2017/18 Quarter 4 January to March.
c) Exception report on KPMs not meeting latest planned trajectory.

a) Current LDP Standards

LDP Standards

- To increase the proportion of people diagnosed and treated in the first stage of breast, colorectal and lung cancer by 25%.
- At least 80% of pregnant women in each SIMD quintile will have booked for antenatal care by the 12th week of gestation so as to ensure improvements in breast feeding rates and other important health behaviours.
- NHS Boards to operate within their agreed revenue resource limit; operate within their capital resource limit; meet their cash requirement.
- Deliver faster access to mental health services by delivering 18 weeks referral to treatment for specialist Child and Adolescent Mental Health Services (CAMHS) services; and 18 weeks referral to treatment for Psychological Therapies.
- To deliver expected rates of dementia diagnosis, and, all people newly diagnosed with dementia will have a minimum of a year's worth of post-diagnostic support coordinated by a link worker, including the building of a person-centred support plan.
- Eligible patients will commence IVF treatment within 12 months of referral.

- Further reduce healthcare associated infections so that NHS Boards' staphylococcus aureus bacteraemia (including MRSA) cases are 0.24 or less per 1000 acute occupied bed days; and the rate of Clostridium difficile infections in patients aged 15 and over is 0.32 cases or less per 1000 total occupied bed days.

- NHSScotland to deliver universal smoking cessation services to achieve a number of successful quits, at 12 weeks post quit, in the 40% most deprived within board SIMD areas (60% for island health boards).

- 95% of all patients diagnosed with cancer to begin treatment within 31 days of decision to treat, and 95% of those referred urgently with a suspicion of cancer to begin treatment within 62 days of receipt of referral.

- 90% of planned/elective patients to commence treatment within 18 weeks of referral.

- Provide 48 hour access or advance booking to an appropriate member of the GP Practice Team.

- To respond to 75% of Category A calls within 8 minutes across Scotland (Scottish Ambulance Service).

- 98% of patients will wait less than 4 hours from arrival to admission, discharge or transfer for accident and emergency treatment.

- 90% of clients will wait no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery.

- NHS Boards to achieve a sickness absence rate of 4%.

- 95% of all patients referred for first outpatient appointment must wait no longer than 12 weeks from referral (all sources). In addition to this, long waits for outpatient appointments are unacceptable and NHS Boards must also eradicate waits over 16 weeks, which is the longstop.

- 100% of inpatients and daycases are to be seen within the 12 week Treatment Time Guarantee.

- NHS Boards and Alcohol and Drug Partnerships (ADPs) will sustain and embed alcohol brief interventions (ABI) in the three priority settings (primary care, A&E, antenatal). In addition, they will continue to develop delivery of alcohol brief interventions in wider settings.

b) Performance Review and Improvement Plans

A summary of performance status to date and plans for improvement is provided below for those KPMs which are identified above as not meeting their planned trajectory – highlighted Red in RAG status.

Please note: no new data received for:

Detect Cancer Early.

Standards not meeting target in March 2018:

6a	GP Access – Advance booking with GP
8	All Cancer Treatment – 62 days
10	Number of people on QoF Dementia Register
13	MRSA/MSSA Bacterium
15	Delivery of Alcohol Brief Interventions
16	Smoking Cessation
20	Psychological Therapies Waiting Times
27	Sickness Absence
92a	New Outpatients waiting over 12 weeks
92b	New Outpatients waiting over 16 weeks
98	Early Access to Ante-Natal Services
129	Dementia Post-Diagnostic Support

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LOCAL DELIVERY PLAN STANDARD MEASURES 2017/18 – QUARTER 4

The LDP Standards are intended to provide assurance on sustaining delivery which will only be achieved by evolving services in line with the 2020 Vision.

All measures reported to Quarter 4 unless otherwise stated. Some of these figures are local and provisional and may be subject to amendment.

REF	STANDARD	*Associated Key Measures*	*Latest Period*	Latest Status	Comments
6a	Advance booking – GP Percentage of patients, who indicate that they were able to book an appointment with a GP more than 2 days ahead.	***Able to book an appointment with a GP more than 48 days in advance or 48-hour access to an appropriate member of the GP Practice Team. Biennial patient satisfaction survey.***	*Mar-18*	**R**	Standard: 90% **Actual: 85.2%** Variance: 5.3%
6b	48 Hr Access – GP Practice Team At least 90% of patients respond that they were able to obtain a consultation with a GP or appropriate healthcare professional within 2 working days of initial contact.		*Mar-18*	**G**	Standard: 90% **Actual: 99.3%** Variance: 10.3%
7	Faster access to specialist CaMHS Deliver 18 weeks from referral to treatment for specialist CaMHS services.	***90% of patients to be seen within 18 weeks.***	*Mar-18*	**G**	Standard:90% **Actual: 100%** Variance: 11.1%
8	Suspicion-of-cancer referrals (62 days) % of urgent referrals (inc. via A&E) with suspicion of cancer seen within 62 days of treatment starting.	***The maximum wait from urgent referral with a suspicion of cancer, to treatment is 62 days; the maximum wait from decision to treat to first treatment for all patients diagnosed with cancer is 31 days.***	*Mar-18*	**R**	Standard: 95% **Actual: 88.9%** Variance: 6.4% *16 of 18 seen within 62 days*
9	All Cancer Treatment (31 days) % of cancer patients treated within 31 days of diagnosis.		*Mar-18*	**G**	Standard: 95% **Actual: 100%** Variance: 5.3% *14 of 14 seen within 31 days*
10	Dementia To deliver expected rates of dementia diagnosis using Eurocode prevalence model.	***To maintain Western Isles Dementia QOF Register (50% of estimated number of people with dementia) – target 324.***	*Mar-18*	**R**	Standard: 324 **Actual: 292** Variance: 9.9%
11	Financial Performance NHS boards to operate within their agreed revenue resource limit; operate within their capital resource limit; meet their cash requirement.	***No trajectories required for this financial performance target as monitored and reported in Monthly Finance returns.***	*Mar-18*	**G**	Breakeven standard maintained

REF	STANDARD	*Associated Key Measures*	*Latest Period*	Latest Status	Comments
13	MRSA/MSSA Bacterium To further reduce healthcare associated infections so that staphylococcus aureus bacteraemia (including MRSA) cases are 0.24 or less per 1000 acute occupied bed days.	***Boards achieving a rolling rate of 0.24 or less.***	*Mar-18*	**R**	Standard: 0.24 **Actual: 0.25 (Provisional)** Variance: 4.2% *7 in 12 months*
14	C. Diff infections To further reduce healthcare associated infections so that the rate of Clostridium Difficile in patients aged 15 and over is 0.32 cases or less per 1000 total occupied bed days.	***Boards to achieve a rolling rate of 0.32 or less.***	*Mar-18*	**G**	Standard: 0.32 **Actual: 0.14 (Provisional)** Variance: 56.3% *4 in 12 months*
15	Alcohol Brief Interventions Number of alcohol brief interventions delivered in SIGN settings.	***To maintain delivery of 317 ABIs; 80% of which should be in priority settings and 20% in wider settings.***	*Mar-18*	**R**	Plan: 317 **Actual: 391** Variance: 23.3% However, only 72% of priority settings target achieved
16	Smoking Cessation Delivery of universal smoking cessation services to achieve a number of successful quits at 12 weeks post quit in the 60% most deprived within-island board SIMD areas.	***To achieve 47 successful quits at 12wks post-quit for people residing in the three most deprived local quintiles.***	*Mar-18*	**R**	Plan: 47 **Actual: 36** Variance: 23.4% *Provisional figures likely to be incomplete*
17	Referral to Treatment: Drugs and Alcohol 90% of clients will wait no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery.	***The most appropriate treatments, interventions, support and services will be provided at the right time to everyone who will benefit, and wasteful or harmful variation will be eradicated.***	*Mar-18*	**G**	Standard: 90% **Actual: 92.0%** Variance: 2.2%
19	18 weeks Referral to Treatment 90% of planned/elective patients are to commence treatment within 18 weeks of referral.	***The most appropriate treatments, interventions, support and services will be provided at the right time to everyone who will benefit, and wasteful or harmful variation will be eradicated.***	*Mar-18*	**G**	Standard: 90% **Actual: 91.7%** Variance: 1.9%
20	Faster access to Psychological Therapies Deliver 18 weeks referral to treatment for Psychological Therapies.	***NHS Boards to achieve a rate of 90%.***	*Mar-18*	**R**	Standard: 90% **Actual: 74%** Variance: 17.8%
27	Sickness Absence % Hrs lost due to sickness absence.	***NHS Boards to achieve a sickness absence rate of 4%.***	*Mar-18*	**R**	Standard: 4.0% **Actual: 4.5%** Variance: 11.8% *Hours lost:6195*

REF	STANDARD	*Associated Key Measures*	*Latest Period*	Latest Status	Comments
55	Emergency Department Waiting Times – 4 hours The percentage of patients seen waiting no more than 4 hours from arrival to admission, discharge or transfer for accident and emergency treatment.	***Standard is 95% with stretch target of 98% Based on all new and unplanned attendances at all hospitals in Board.***	*Mar-18*	**G**	Standard: (95%) 98% **Actual: 97.7%** Variance against 95%: 2.8%
91	12 week Treatment Time Guarantee for Inpatients The proportion of inpatient and daycases that were seen within the 12 week Treatment Time Guarantee.	***100% compliance required.***	*Mar-18*	**G**	Standard: 100% **Actual: 100%**
92a	New Outpatients Waiting over 12 weeks The percentage of patients waiting no more than 12 weeks from referral (all sources) to a first outpatient appointment.	***95% with stretch 100%.***	*Mar-18*	**R**	Plan: 95.0% **Actual: 88.9%** Variance: 6.5% 814 of 916 pts seen within 12 wks *Provisional figures*
92b	New outpatients Waiting over 16 weeks Percentage of patients waiting no more than 16 weeks from referral (all sources) to a first outpatient appointment.	***100% compliance required. Waits over 16 weeks must be eradicated.***	*Mar-18*	**R**	Plan: 100% **Actual: 94.3%** Variance: 5.7% 864 of 916 pts seen within 16 wks *Provisional figures*
97	Detect Cancer Early NHS Scotland is to achieve a 25% increase in the proportion of people diagnosed and treated in the first stage of breast, colorectal and lung cancer by 2014/15. A 25% increase on baseline performance in 2010/11 equates to 29% diagnosed at Stage 1 by 2014/15.	***Data based on combined sets of 2 calendar years. Performance Jan 15 - Dec 16 should be at least 29%.***	*2015-2016*	**R**	Plan: 29% **Actual: 15.4%** Variance: 46.9% *18 of 117 diagnosed and treated at Stage 1*
98	Early Access to Antenatal Services At least 80% of pregnant in each SIMD quintile will have booked for antenatal care by the 12th week of gestation.	***Performance is calculated for each of the 5 quintiles and the lowest performing quintile will be reported. Provisional figures reported which are local and subject to change.***	*Mar-18*	**R**	Plan: 80% **Actual: 67%** Variance: 16.3% *Provisional figures*
101	IVF Treatment Waiting Times Eligible patients will commence IVF treatment within 12 months. The target will be based on the proportion of patients who were screened at an IVF centre within 12 months of the decision to treat.	***A proportion of WI patients are treated in Glasgow and will be included in waiting times for GG&C.***	*Mar-18*	**G**	Plan: 90% **Actual: 100%**
129	Dementia: Post-Diagnostic Support All newly diagnosed with dementia will have a minimum of a year's worth of post-diagnostic support co-ordinated by a link worker, including the building of a person-centered support plan.	***Percentage of people newly diagnosed who receive a minimum of one year of post-diagnostic support and who have a person-centered plan in place at the end of that support period.***	*Mar-18*	**R**	Standard: 100% **Actual: 21.74%** Variance: 78.3%

WI Balanced Scorecard Indicator:
PI6A GP Access - Advance booking - GP

Executive Lead:
Medical Director

QOM/HEAT/LOCAL Target:
90% patients able to book an appointment with a GP more than 3 days ahead.

Responsible Officer:
Stephan Smit

Trajectory Performance to date:

Period Ending	Actual	Target	Deviation (%)
31/03/2014	86.7	90.0	-3.7%
31/03/2016	89.4	90.0	-0.7%
31/03/2018	85.2	90.0	-5.3%

Supporting Analysis (where available):

1. Performance Narrative (include key reasons for under performance status)
The two biggest practices are struggling with capacity, so have changed access models to focus on urgent presentations.

2. Planned Performance Improvements:

1. Work ongoing with practice managers to influence access models.
2.
3.

3. Key Groups/Committees consulted:

1. Practice Managers Development Network
2.
3.

Completed by: Stephan Smit	Date Completed: 11/06/18
Section below to be completed following SOD/CMT review	
Date SOD/CMT Reviewed:	**Decision:** Noted/Further information required (detail below:)

WI Balanced Scorecard Indicator: PI8: Referral for Suspicion of Cancer – 62 days.	**Executive Lead:** **Nurse Director**
QOM/HEAT/LOCAL Target: 95% of all urgent suspected cancer referrals are treated within 62 days.	**Responsible Officer:** **Lachlan Macpherson, Hospital Manager**
Trajectory Performance to date:	**Supporting Analysis (where available):** *This calculation includes figures for WI patients treated in mainland boards.*

Quarter Ending	Actual	Planned Value	Deviation (%)
Sep-17	87.5	95	-7.9%
Dec-17	84.6	95	-10.9%
Mar-18	88.9	95	-6.4%

1. Performance Narrative (include key reasons for under performance status)

All breaches are dependent on mainland health boards and are out with our control, all are referred timeously from NHS Western Isles.

2. Planned Performance Improvements:

1. Continue to raise concerns via SLA monthly meetings
2. Risk Assessment escalated to SOD (13/04/2018)
3.

3. Key Groups/Committees consulted:

1. Performance
2. SLA
3. SOD

Completed by: Al Finlayson	Date Completed: 13/06/2018
Section below to be completed following SOD/CMT review	
Date SOD/CMT Reviewed:	**Decision:** Noted/Further information required (detail below:)

WI Balanced Scorecard Indicator:
PI10: Dementia – QoF Register

Executive Lead:
Medical Director

QOM/HEAT/LOCAL Target:
To deliver expected rates of dementia diagnosis (using the Eurocode Prevalence Rates) and maintain Western Isles Dementia QoF Register (50% of estimated number of people with dementia).

Responsible Officer:
Stephan Smit

Trajectory Performance to date:

Period Ending	Actual	Target	Deviation (%)
Jan-18	296	324	-8.6%
Feb-18	297	324	-8.3%
Mar-18	292	324	-9.9%

Supporting Analysis (where available):

1. Performance Narrative (include key reasons for under performance status)
QoF has been disbanded in 2016, and QoF related work been deprioritised.

2. Planned Performance Improvements:

1. Ongoing consolidation & rationalisation of dementia codes in collaboration with Health Intelligence, Dementia Clinical Nurse Specialist & GPs to improve recording.
2.
3.

3. Key Groups/Committees consulted:

1. Dementia MDT
2.
3.

Completed by: Stephan Smit | Date Completed: 11/06/18

Section below to be completed following SOD/CMT review

Date SOD/CMT Reviewed:

Decision: Noted/Further information required (detail below:)

WI Balanced Scorecard Indicator:
PI13: Staphylococcus aureus bacteraemia cases per 1000 acute occupied bed days.

Executive Lead:
Nurse Director

QOM/HEAT/LOCAL Target:
To achieve target rate of 0.24 (or less) cases of SAB (MRSA/MSSA) in patients (per 1000 acute occupied bed days).

Responsible Officer:
Head of Infection Prevention & Control

Trajectory Performance to date:

Quarter Ending	Actual	Planned Value	Deviation (%)
Sep-17	0.23	0.24	-4.2%
Dec-17	0.31	0.24	29.2%
Mar-18	0.25	0.24	4.2%

Supporting Analysis (where available):
Please note, figures in red relate to local data and are subject to change.

1. Performance Narrative (include key reasons for under performance status)

- **NHS Western Isles has missed its target by 0.01%**
- **Blood cultures are being aspirated more timeously on admission to hospital from patients presenting with a sepsis who also have underlying chronic conditions.**

2. Planned Performance Improvements:

1. The message of zero preventable SABs continues to be cascaded to all staff by the Infection Prevention & Control Team (IPCT) in their education sessions and visits to all clinical areas

2. Critical incident reports continue to be completed by a multi-disciplinary team for all patients who cultured either a MRSAB or a SAB.

All lessons learned from these reports are circulated with the appropriate staff groups within NHS Western Isles (NHS WI) to ensure the findings are appropriately acted on and lessons shared. The lessons learnt are also sent to the Board's learning review group to be included on their agenda.

3. The Infection Control Doctor has given Lectures which are available on the IPCT Intranet page which will enhance the education of all staff in the prevention of infection.

4. The IPCT will continue to monitor and audit invasive devices throughout the Western Isles and report the results in the monthly Infection Control Monthly Activity report (ICMAR) which is circulated widely within NHS Western Isles

3. Key Groups/Committees consulted:

1. ICC
2. SOD
3. AMT

Completed by: Janice Mackay	Date Completed: 04/06/2018
Section below to be completed following SOD/CMT review	
Date SOD/CMT Reviewed:	**Decision:** Noted/Further information required (detail below:)

WI Balanced Scorecard Indicator:
PI15 Alcohol Brief Interventions

Executive Lead:
Director of Public Health

QOM/HEAT/LOCAL Target:

To maintain delivery of 317 ABIs; 80% of which should be in priority settings and 20% in wider settings.

Responsible Officer:
Maggie Watts, Director Public Health

Trajectory Performance to date:

Period Ending	Actual	Target	Deviation (%)
Sep-17	218	160	36.3%
Dec-17	321	240	33.8%
Mar-18	391	317	23.3%

Supporting Analysis (where available):

Quarter Ending	*Priority Settings*	*Planned Value*	*compliance with 80%*
Sep-17	*83*	*128*	*32.7%*
Dec-17	*132*	*192*	*52.1%*
Mar-18	*182*	*254*	*71.8%*

Quarter Ending	*Wider Settings*	*Planned Value*	*compliance with 20%*
Sep-17	*158*	*32*	*249.2%*
Dec-17	*190*	*48*	*299.7%*
Mar-18	*209*	*63*	*329.7%*

1. Performance Narrative (include key reasons for under performance status)
Overall performance has over-reached the target number of ABIs. A much greater proportion than anticipated is being carried out in wider settings; this indicates the perceived relevance of ABIs across such settings.

2. Planned Performance Improvements:

1. We will continue to work with the priority settings to reinforce the need to undertake screening and progression to brief intervention or onward referral to services for appropriate individuals.
2.
3.

3. Key Groups/Committees consulted:

1. ADP
2.
3.

Completed by: Dr Maggie Watts | Date Completed: 24/5/18

Section below to be completed following SOD/CMT review

Date SOD/CMT Reviewed:

Decision: Noted/Further information required (detail below:)

WI Balanced Scorecard Indicator:
PI16: Delivery of universal smoking cessation services to achieve a number of successful quits at 12 weeks post-quit in 60% most deprived within-island board SIMD areas.

Executive Lead:
Director of Public Health

QOM/HEAT/LOCAL Target:
To achieve **47** successful quits at 12 weeks post-quit for people residing in the three most deprived local quintiles in 2017/18.

Responsible Officer/Lead:
Joanne O'Donnell

Trajectory Performance to date:

Period Ending	Actual	Planned Value	Deviation (%)
Sep-17	21	24	-12.5%
Dec-17	27	36	-25.0%
Mar-18	36	47	-23.4%

Supporting Analysis (where available):
Data for current quarter may be incomplete.

1. Performance Narrative (include key reasons for under performance status)

Our overall successful quit numbers will not be finalised until the end of June and we expect several more successful quits to be added to the above table. Currently 37 within 60% area.

One of the main factors in our under performance is the way in which we are measured. (SIMD) postcodes are highly inconsistent as a measure within the Western Isles and many of our successful quitters out with the current identified SIMD areas are justified in receiving our specialist support. The number of successful 3 month quits overall in this time period in all SIMD areas is 64.

Additional factors include:
The increased number of smokers that are using E-cigarettes
Referral rates lower than in previous years
New staff member
Staff illness
Poor Pharmacy support to public

2. Planned Performance Improvements:

1. Provide more training to our partners within the NHS setting and to GP practices in the referral process.
2. To encourage our Pharmacy colleagues to improve their referral process and to ensure that they provide a more structured service to the public. Improve follow up process and engage with specialist services to offer more intensive support to client group.
3. Identify possible solutions to the approach in identifying clients from within the current most deprived SIMD areas.

3. Key Groups/Committees consulted:

1.
2.
3.

Completed by: Joanne O'Donnell	Date Completed: 29/05/18
Section below to be completed following SOD/CMT review	
Date SOD/CMT Reviewed:	**Decision:** Noted/Further information required (detail below :)

WI Balanced Scorecard Indicator:
PI20. 18 weeks Referral to Treatment for Psychological Therapies

Executive Lead:
Chrisanne Campbell

QOM/HEAT/LOCAL Target:
Deliver 18 weeks referral to treatment for Psychological Therapies.
NHS Boards to achieve a rate of 90%.

Responsible Officer:
Mike Hutchison

Trajectory Performance to date:

Period Ending	Actual	Target	Deviation (%)
Sep-17	95	90.0	5.6%
Dec-17	94	90.0	4.4%
Mar-18	74	90.0	-17.8%

Supporting Analysis (where available):

1. Performance Narrative (include key reasons for under performance status)

Percentage of patients seen within 18 weeks is lower for a number of reasons.

Western Isles has a low referral rate by comparison with national average of 5.8 per thousand and increasing this is a desirable outcome. Referral rates have slightly increased (from 1.4/1000 to 1.7/1000) with awareness amongst GPs and MH colleagues of psychological interventions and availability. However capacity has not increased in line with increased demand. National guidance suggests 1 psychological therapist for high intensity per 6000 population. Current workforce for the Western Isles is 1.5wte. Lewis/Harris CBT Waiting list has been increasing over the past 6 months, which is starting to have an impact on allocating within 18 weeks.

There are patients on the waiting list in Uist & Barra who were referred either just before or not long after local part time CBT therapist retired – the new CPN in post is not trained to deliver CBT. Therefore there is reduced PT service available in U & B at present, but monthly clinical psychology clinic now onstream.

The DNA rate for first appointments with CBT therapist is higher than for return appointments (sitting at 30% in Q4). This reduces capacity to take on new referrals.

Staff trained in psychological therapies over last 12 months are not taking on additional PT referrals and some of that work is not included for target (eg CPNs). However, there should still be improvements in service provision for MH patients.

There are a few issues that may be impacting the data quality. However, local Data Analyst has been working hard over the past 6 months to identify these and tried to work around them. For example extracting an accurate waiting list has taken some time, as has system functionality. Data analyst now sending out a monthly list of both patients waiting and patients seen by clinician with the intention of verifying the return. Staff have managed their waiting list differently, some using the ticket system, some using the RMS postbag & CAMHS PT is integrated into their generic. Work is ongoing to increase consistency and a system has been developed to integrate all of this. A MHAIST project will improve this further to standardise management of caseloads and waiting lists.

Additionally some work was done with Medical Records to backdate appointment outcomes which will

improve the data quality.
2. Planned Performance Improvements:
1. Introduction of cCBT for mild anxiety and depression
2. Increased efficiency re use of clinic spaces and bookings.
3. Exploring other ways of increasing capacity e.g. other forms of cCBT pending MH Redesign Workforce changes which are ongoing.
4. Reviewing first appointment DNA rates and looking at solutions to reduce current figures of 30%.
3. Key Groups/Committees consulted:
1.
2.
3.

Completed by: Mike Hutchison	Date Completed: 31/05/2018
Section below to be completed following SOD/CMT review	
Date SOD/CMT Reviewed:	**Decision:** Noted/Further information required (detail below:)

WI Balanced Scorecard Indicator: PI129: Dementia Post-diagnostic Support	**Executive Lead:** **Nurse Director**
QOM/HEAT/LOCAL Target: All people newly diagnosed will have a minimum of a year's worth of post-diagnostic support co-ordinated by a link worker.	**Responsible Officer:** **Elizabeth Shelby**
Trajectory Performance to date:	

Period Ending	Actual	Target
Sep-17	9	100
Dec-17	19	100
Mar-18	22	100

1. Performance Narrative (include key reasons for under performance status)

Funding for provision of service across all islands is agreed at IJB level as 5 days of band 5 worker. New job description is waiting to be banded at a mainland matching panel. While waiting for MH redesign to allocate resources for PDS, there will be a fixed term contract for 12 months. . Dementia nurse posts in MH are planned to supply PDS as part of their role have been banded at 6 which is exceeds needs

There are no permanent workers in post and these continue to be covered with bank hours, which is precarious for both ensuring ongoing quality and waiting times.

People newly diagnosed by Old Age Psychiatry have a poor uptake of PDS and are have been declining referral**.**

2. Planned Performance Improvements:

1. The Old Age Psychiatrist has been provided with PDS leaflets to give to all newly diagnosed people.
2. Nurse led memory clinics are now in all surgeries and these have a high level of uptake for PDS.
3. Data collection for both services

3. Key Groups/Committees consulted:

1. Post Diagnostic Leads Quarterly Meeting
2. Dementia Managed Care Network
3. Mental Health Redesign Group

Completed by: Elizabeth Shelby	Date Completed: 07/06/18
Section below to be completed following SOD/CMT review	
Date SOD/CMT Reviewed:	**Decision:** Noted/Further information required (detail below:)

WI Balanced Scorecard Indicator:
PI92a: Number of outpatients waiting over 12 weeks at month end census.

Executive Lead:
Nurse Director

QOM/HEAT/LOCAL Target:
HS: Boards must eradicate all waits over 12 weeks.

Responsible Officer:
Lachlan Macpherson, Hospital Manager

Trajectory Performance to date:

Month Ending	Actual	Planned Value against 12 week target	Deviation (%) against 12 week target
Jan-18	88.0	95.0	-7.4%
Feb-18	88.0	95.0	-7.4%
Mar-18	88.9	95.0	-6.5%

Supporting Analysis (where available):

1. Performance Narrative (include key reasons for under performance status)

As clock resets are no longer permitted once a patient goes beyond initial guarantee date, when a patient goes beyond 12 weeks they will not have a clock reset for the rest of the wait regardless of whether they reject multiple reasonable offers, move appointments, make themselves unavailable or DNA multiple times.

The Planning Office continues to push for these patients to be discharged after 2 or more reasonable offers if deemed clinically appropriate by the responsible clinician. We also continue to request extra capacity utilising waiting times monies in specialties where visiting SLA does not provide sufficient slots to meet ongoing demand.

Details of breaching specialties are available in SOD papers (Item 8.3 1 - WT report).

2. Planned Performance Improvements:

1. Continue to highlight to consultants patients who have had reasonable offer package and ask if clinically appropriate to discharge back to referrer.
2. When WLI clinics run, continue to provide lists of patient who must be offered appointments on these clinic focusing on longest waits.
3. Consider if risk assessment is necessary to gauge impact of continuing to fail this target.

3. Key Groups/Committees consulted:

1. Performance
2. SOD
3. SLA

Completed by: Al Finlayson | Date Completed: 13/06/2018

Section below to be completed following SOD/CMT review

Date SOD/CMT Reviewed: | **Decision:** Noted/Further information required (detail below:)

WI Balanced Scorecard Indicator:
PI92b: Number of outpatients waiting over 16 weeks at month end census.

Executive Lead:
Nurse Director

QOM/HEAT/LOCAL Target:
HS: Boards must eradicate all waits over 16 weeks (longstop target linked to 12 week target).

Responsible Officer:
Lachlan Macpherson, Hospital Manager

Trajectory Performance to date:

Month Ending	Actual	Planned Value against 16 week target	Deviation (%) against 16 week target
Jan-18	94.9	100.0	-5.1%
Feb-18	94.5	100.0	-5.5%
Mar-18	94.3	100.0	-5.7%

Supporting Analysis (where available):

1. Performance Narrative (include key reasons for under performance status)

It is not possible to eliminate all waits > 16 weeks due to combination of the way the clock reset rules changed post TTG, requirement to take clinical judgment into account before exercising reasonable offer policy and infrequent clinics for certain locations and specialties.

As clock resets are no longer permitted once a patient goes beyond initial guarantee date, when a patient goes beyond 12 weeks they will not have a clock reset for the rest of the wait regardless of whether they reject multiple reasonable offers, move appointments, make themselves unavailable or DNA multiple times.

The Planning Office continues to push for these patients to be discharged after 2 or more reasonable offers if deemed clinically appropriate by the responsible clinician. We also continue to request extra capacity utilising waiting times monies in specialties where visiting SLA does not provide sufficient slots to meet ongoing demand.

2. Planned Performance Improvements:

1. Continue to highlight to consultants patients who have had reasonable offer package and ask if clinically appropriate to discharge back to referrer.
2. When WLI clinics run, continue to provide lists of patient who must be offered appointments on these clinic focusing on longest waits.
3. Consider if risk assessment is necessary to gauge impact of continuing to fail this target.

3. Key Groups/Committees consulted:

1. Performance
2. SOD
3. SLA

Completed by: Al Finlayson | Date Completed: 13/06/2018

Section below to be completed following SOD/CMT review

Date SOD/CMT Reviewed: | **Decision:** Noted/Further information required

	(detail below:)

WI Balanced Scorecard Indicator:
PI98: 80% of women in each SIMD quintile will have booked Ante-natal clinic by 12 weeks gestation

Executive Lead:
Nurse Director

QOM/LDP/LOCAL Target:
Planned value revised in 2014/15 to reflect national figure.

Responsible Officer:
Catherine MacDonald

Trajectory Performance to date:

Period Ending	Actual	Planned Value	Deviation (%)
Jun-17	*75.0*	80.0	-6.3%
Sep-17	*75.0*	80.0	-6.3%
Dec-17	*69.0*	80.0	-13.8%
Mar-18	*67.0*	80.0	-16.3%

Supporting Analysis (where available):
Please note, figures in red relate to local data analysis and are subject to change.
The figures below relate to previous reporting prior to changes being made to mainland deliveries to show improvements in performance when corrected:

Period Ending	Actual	Planned Value	Deviation (%)
Sep-17	75.0	**80.0**	-6.25%
Dec-17	53.8	**80.0**	-32.75%
Mar-18	57.1	**80.0**	-28.63%

1. Performance Narrative (include key reasons for under performance status)
Our main problem is the coding done by mainland units of women who have travelled there to deliver as they are coding the date of booking as date of being first seen at that unit which is usually in the 2nd or 3rd trimester of pregnancy ,beyond 12 weeks.
We therefore have to work in retrospect with local staff to correct the data submitted by other units. As you can see in the supporting analysis significant improvements to the data result once corrected and bring our figures beyond and up to the national target.
The reporting is always done on the lowest performing quintile in our area and this is usually Uist or Barra where most of the women deliver on the mainland.

2. Planned Performance Improvements:

1. Continue to support encourage women to book prior to 10 weeks gestation. (This message is delivered nationally and appears to be well published and documented, it does not seem to be the main problem for us at W.I .)
2. Strive to implement an electronic maternity system that will give us more accurate information, this will help with quicker resolution to incorrect data entry by mainland boards, but as coding is done at time of delivery in unit of delivery we will still get incorrect data for W.I.
3. Uist and Barra staff know to document in referral letters when the women book so that the information is available to mainland units on all correspondence.

3. Key Groups/Committees consulted:

1. Midwives/ consultants as of today
2. Discuss at next MSCGF on 10.8.18
3.

Completed by: C. Macdonald | Date Completed: 11.6.18

Section below to be completed following SOD/CMT review

Date SOD/CMT Reviewed:

Decision: Noted/Further information required (detail below:)

BOARD MEETING 27.06.18
Agenda Item: 10.2
Purpose: For Assurance

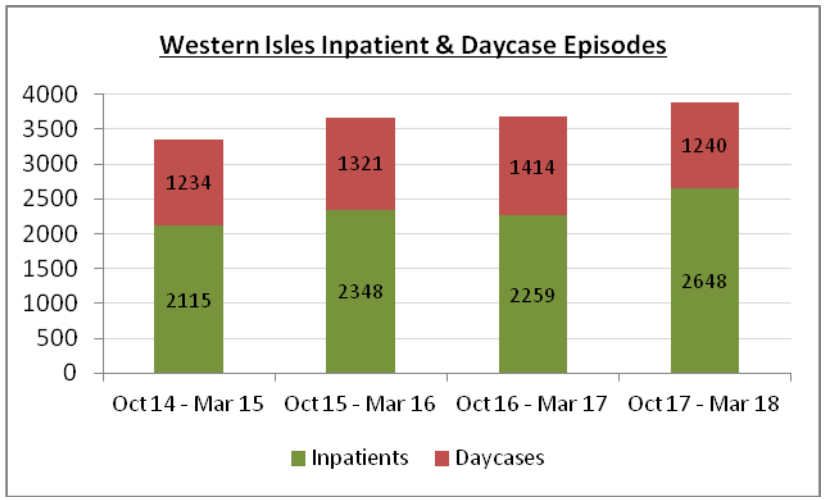
Patient Activity – October 2017 to March 2018 and trends

1.1 INPATIENT AND DAYCASE ACTIVITY WITHIN WESTERN ISLES

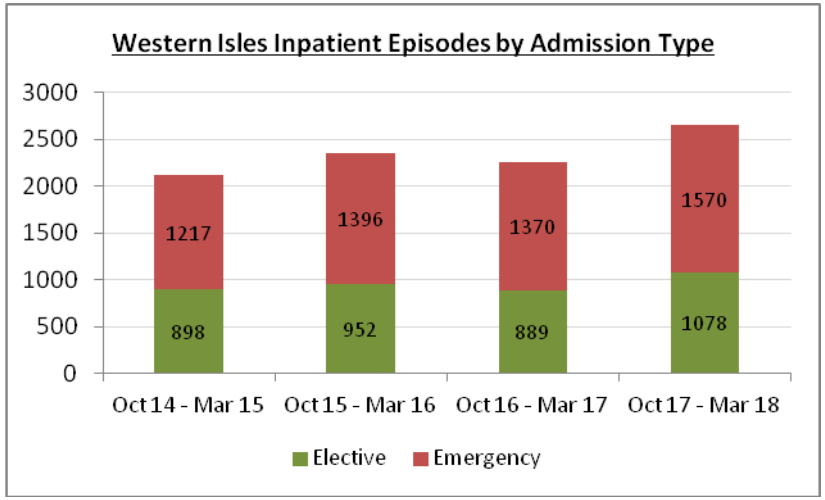
(Excludes Obstetrics and Psychiatry Specialties)

a) All Western Isles Hospitals

i)



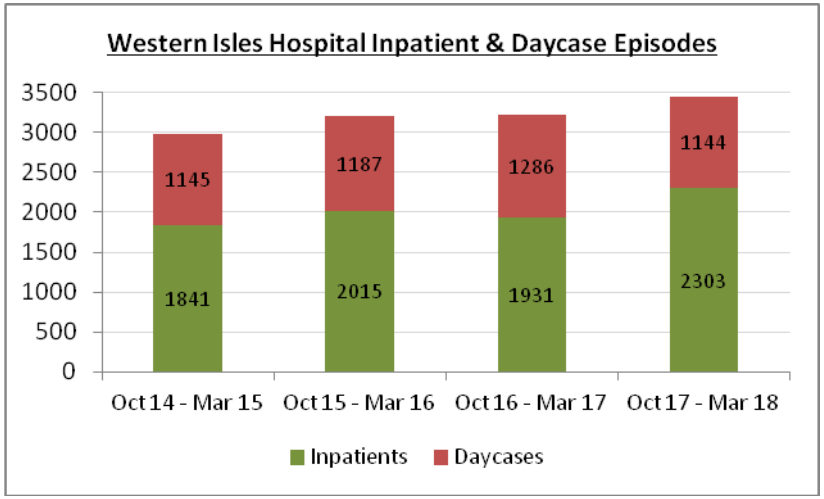
ii)

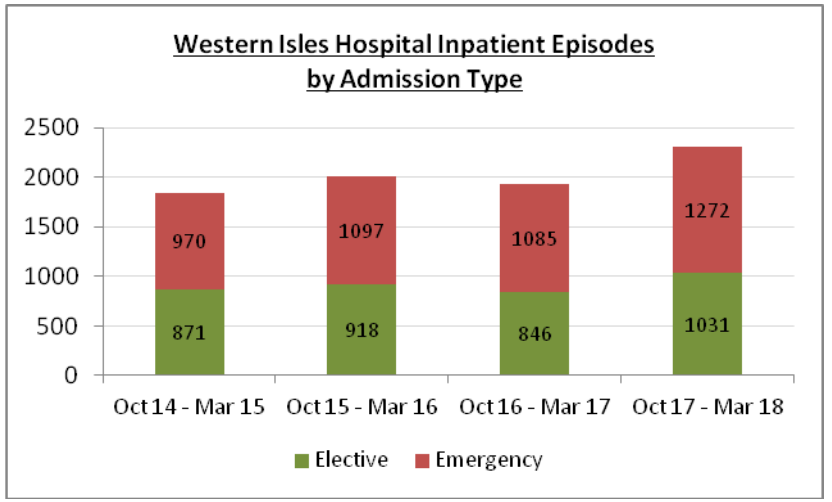


b) Western Isles Hospital

i)

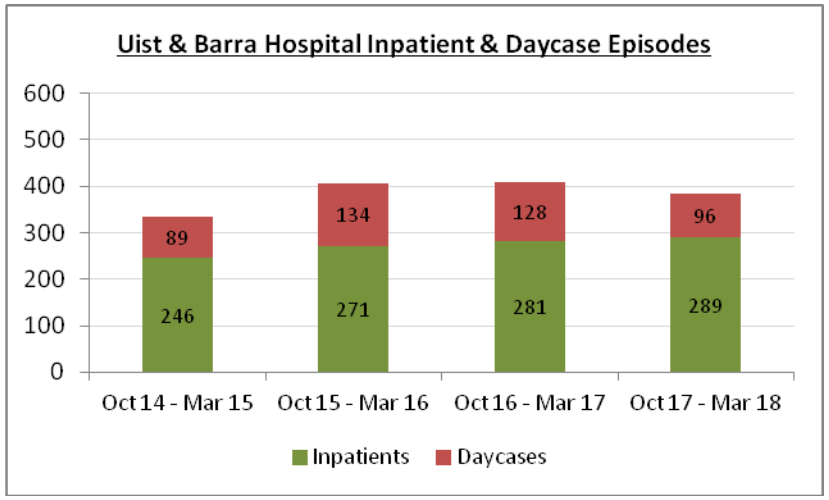
ii)





c) Uist & Barra Hospital

i)



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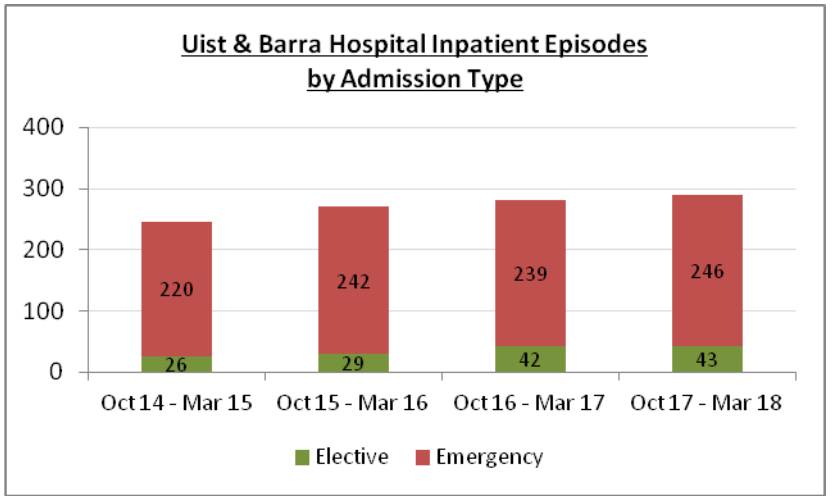
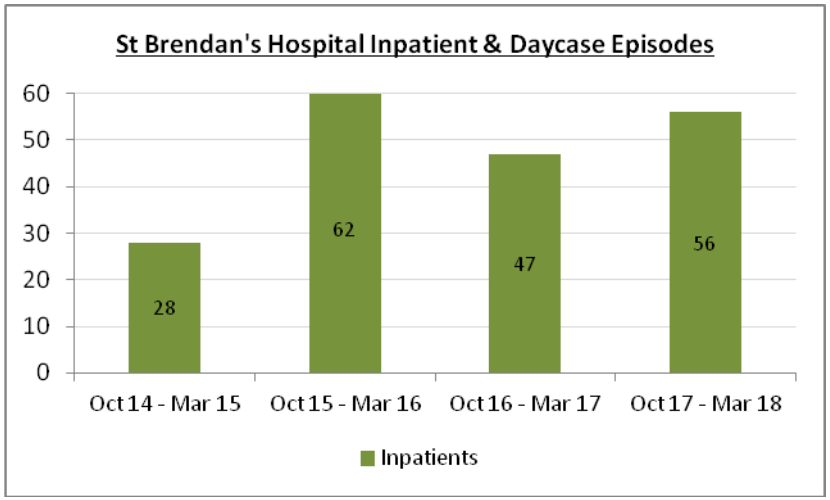
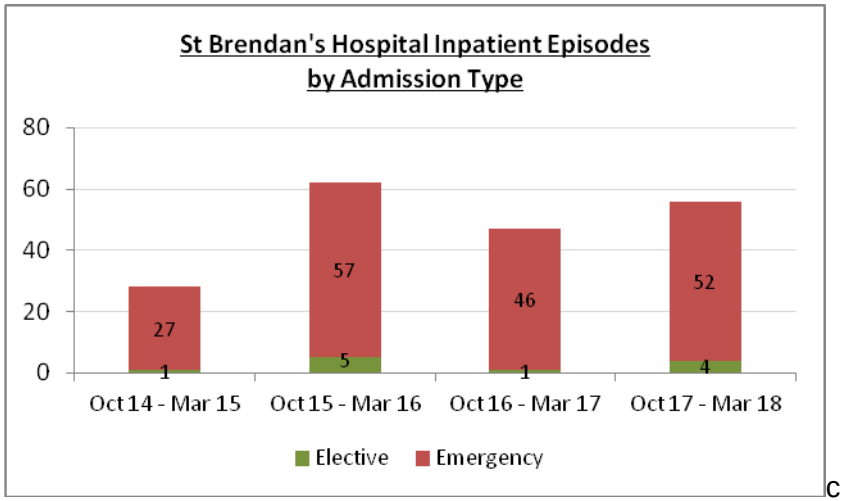


d) St Brendan's Hospital

i)



ii)

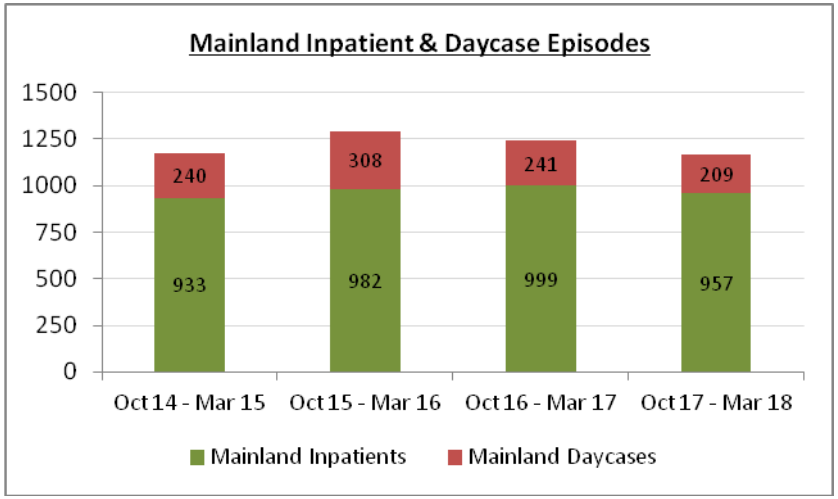


c

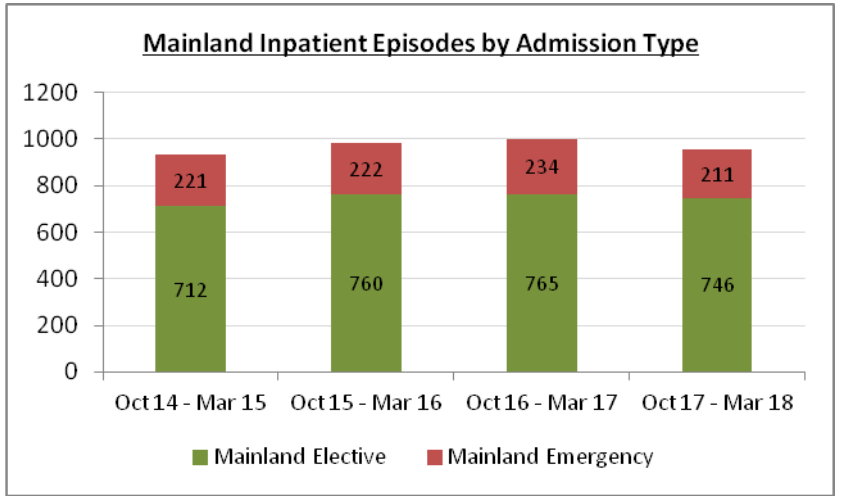
2.2 INPATIENT AND DAYCASE ACTIVITY OUTWITH WESTERN ISLES

All Mainland Locations

i)

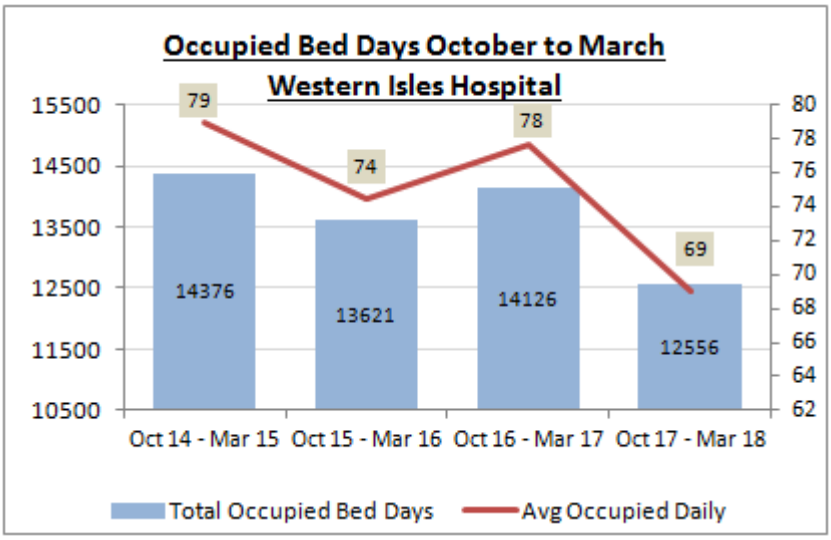


ii)

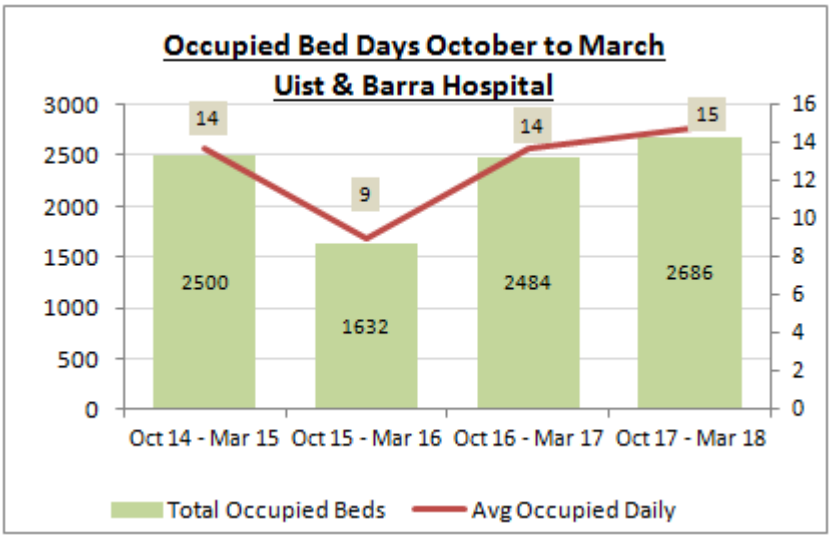


2.3 OCCUPIED BED DAYS AT WESTERN ISLES

a) Western Isles Hospital

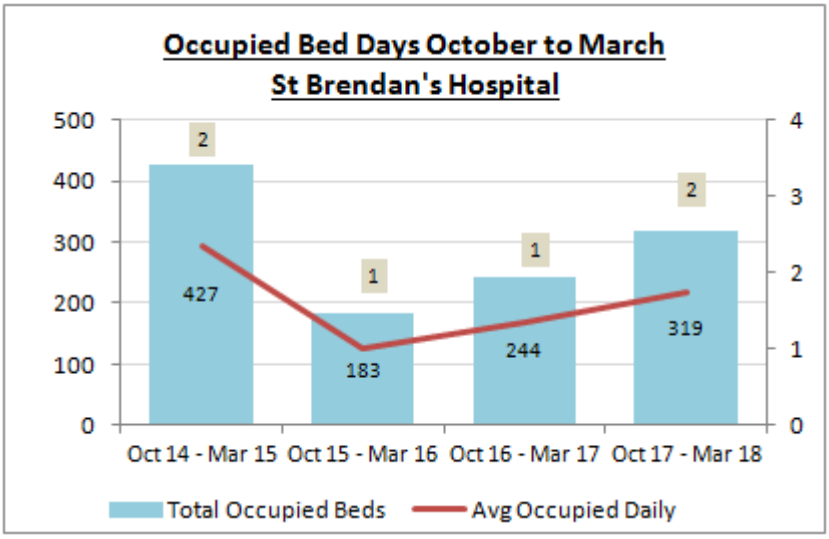


b) Uist & Barra Hospital



c) St Brendan's Hospital

BOARD MEETING 27.06.18
Agenda Item: 10.2
Purpose: For Assurance



d) Daily Percentage Occupancy – All Hospitals

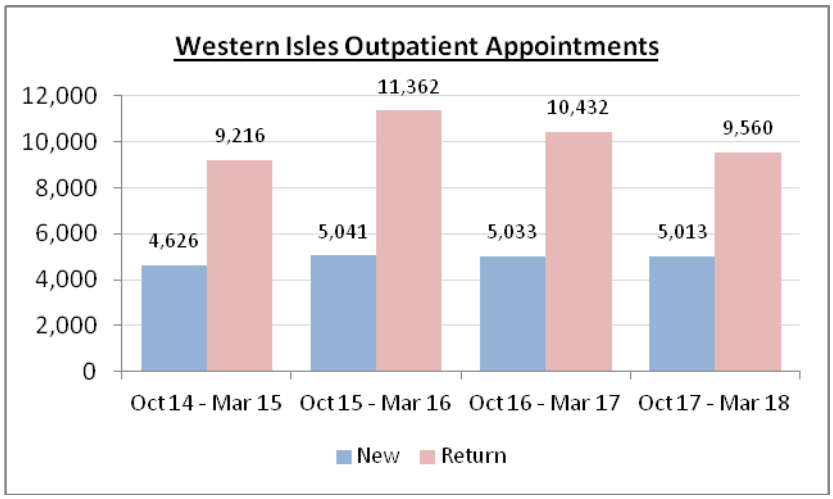
% OCCUPANCY	NUMBER OF DAYS DURING OCT 14 - MAR 15	NUMBER OF DAYS DURING OCT 15 - MAR 16	NUMBER OF DAYS DURING OCT 16 - MAR 17	NUMBER OF DAYS DURING OCT 17 - MAR 18
100	0	0	0	0
95-99	0	0	0	0
90-94	0	0	1	3
85-89	1	0	24	28
80-84	17	0	55	36
75-79	48	7	66	42
70-74	72	50	28	34
65-69	37	70	8	29
60-64	7	33	0	6
<60	0	23	0	4

2.4 OUTPATIENT ACTIVITY WITHIN WESTERN ISLES

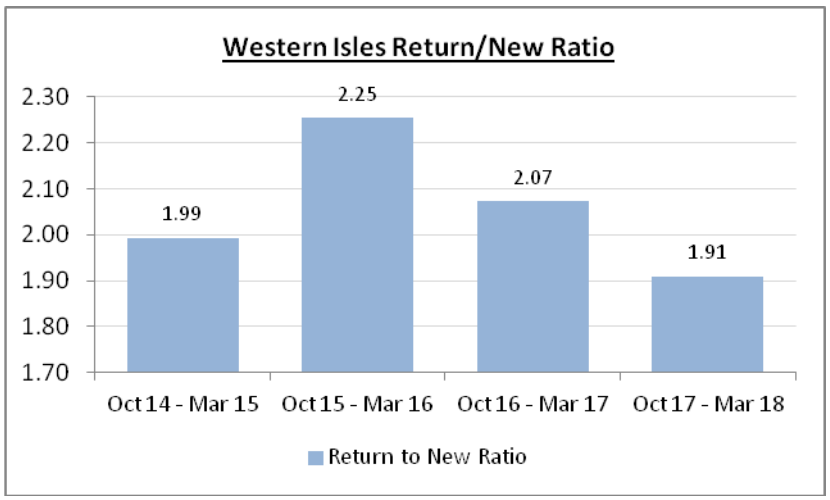
All Western Isles Locations

N.B. AHP Referrals and Appointments - 'R Specialties' - are excluded. Headings in blue are quick links to the relevant Qlikview report.

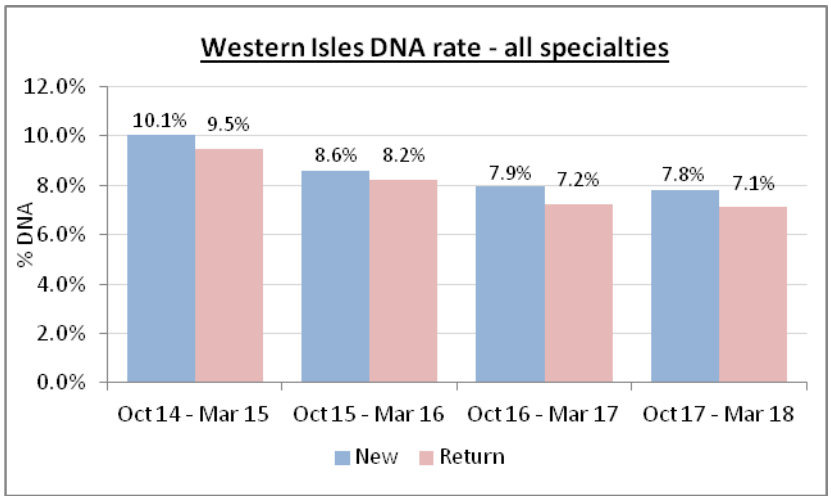
i) **Outpatient Appointments**



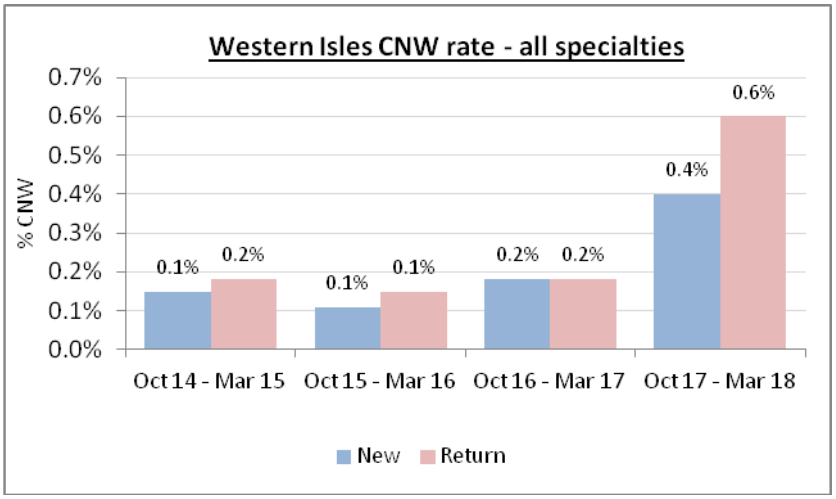
ii) **Return to New Ratio**



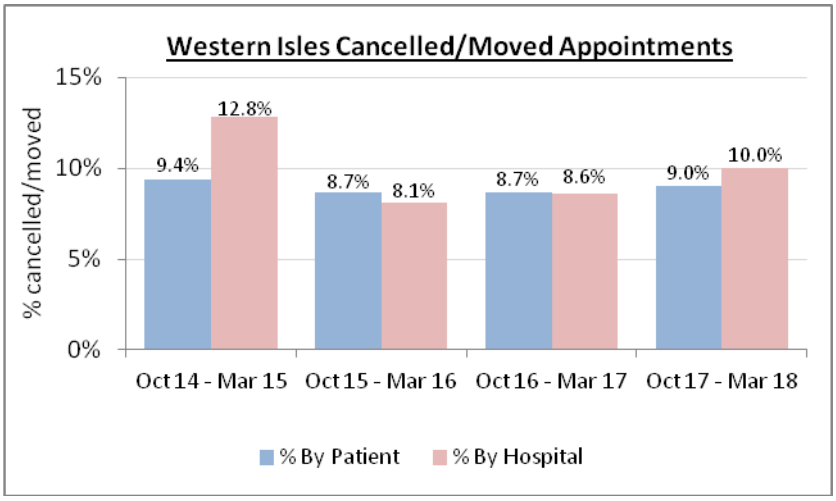
iii) **% DNA**



iv) **% CNW**

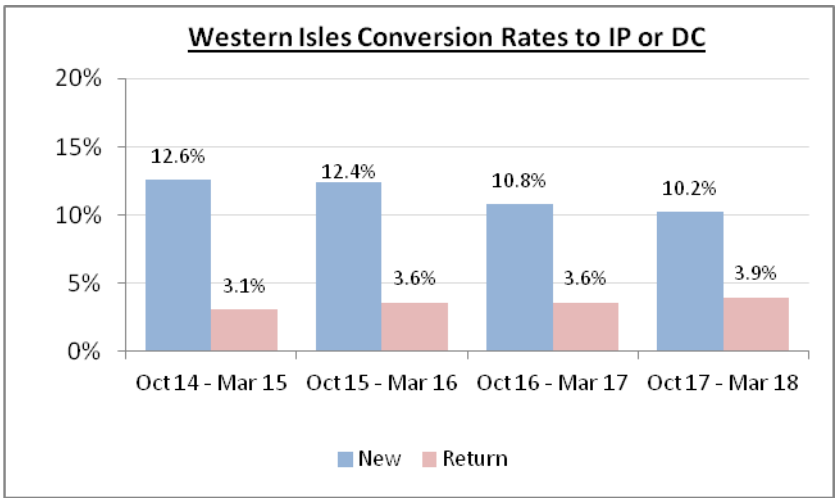


v) **% cancelled/moved appointments**



vi) **% Conversion to IP or Daycase**

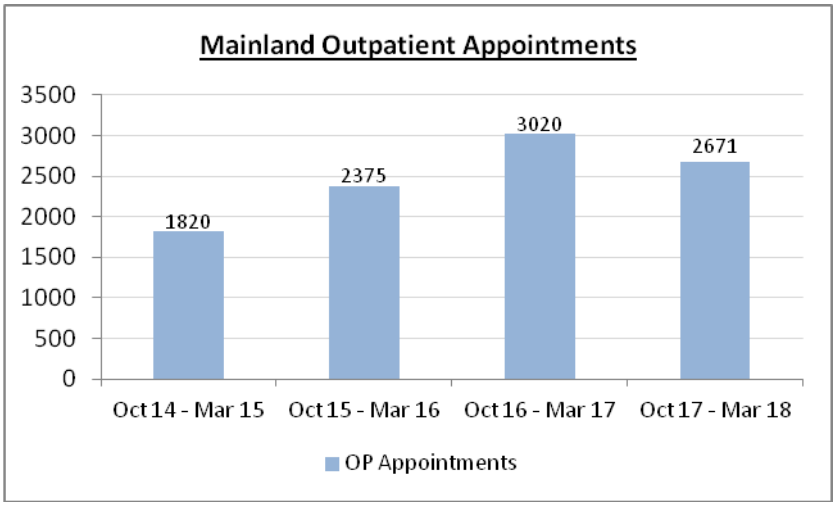
BOARD MEETING 27.06.18
Agenda Item: 10.2
Purpose: For Assurance



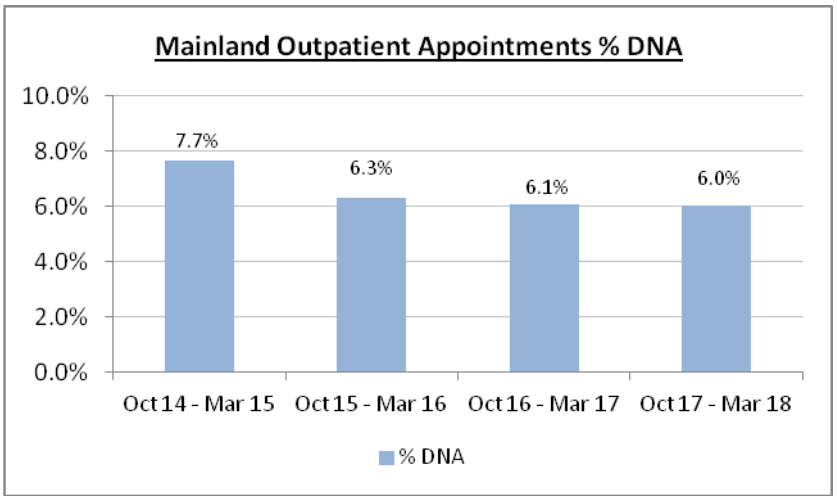
2.5 OUTPATIENT ACTIVITY OUTWITH WESTERN ISLES

All Mainland Locations

i)

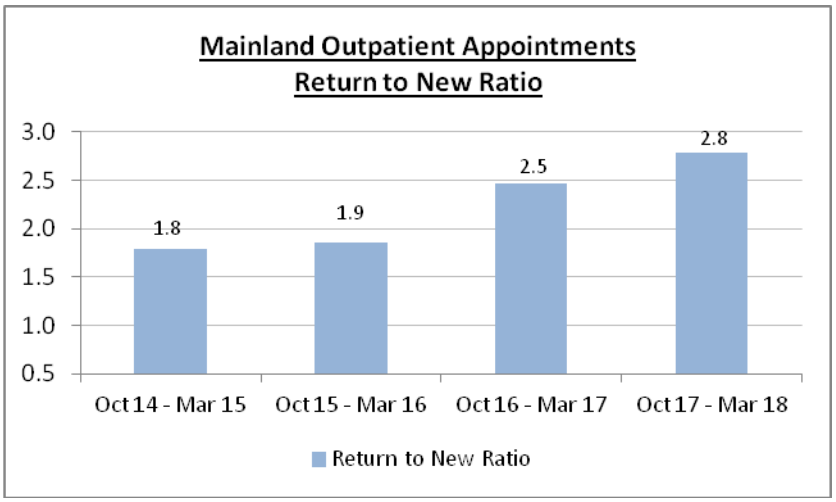


ii)



iii)

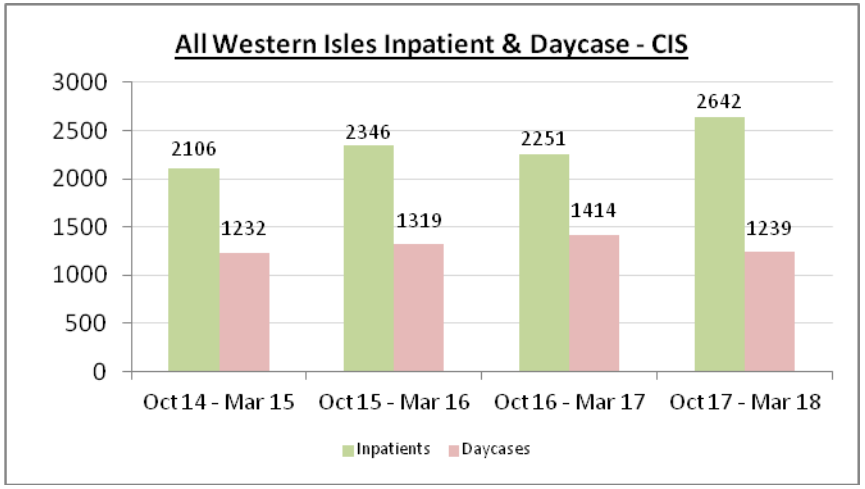
BOARD MEETING 27.06.18
Agenda Item: 10.2
Purpose: For Assurance



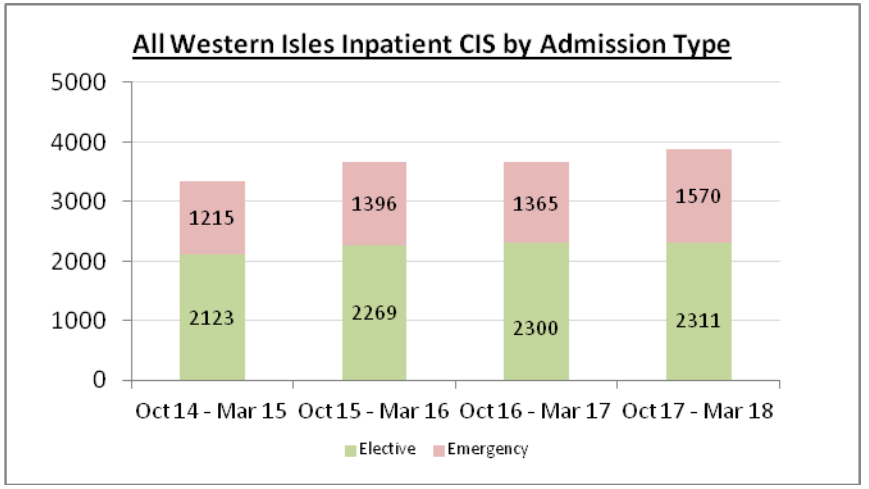
2.6 INPATIENT AND DAYCASE CONTINUOUS INPATIENT STAYS WITHIN WESTERN ISLES

a) All Western Isles Hospitals

i)



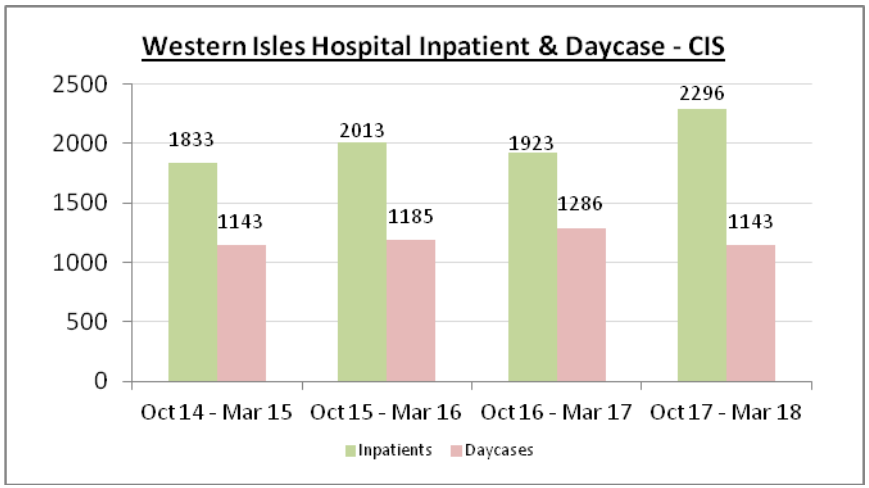
ii)

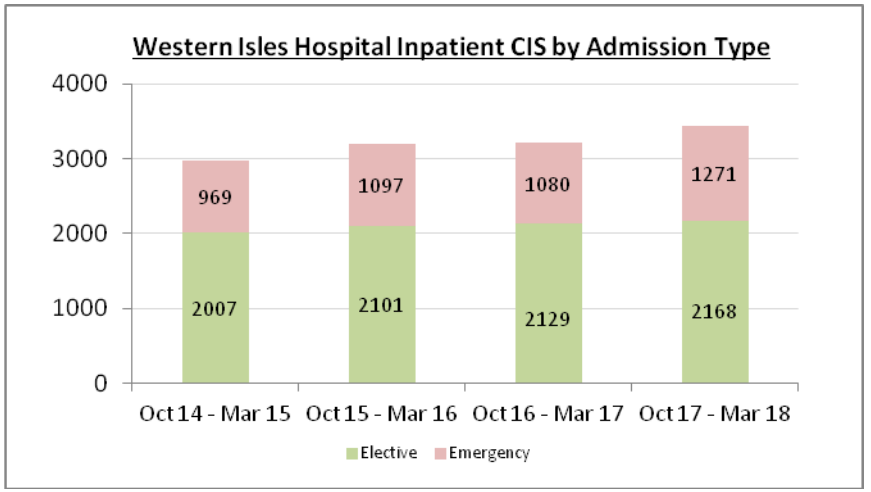


b) Western Isles Hospital

i)

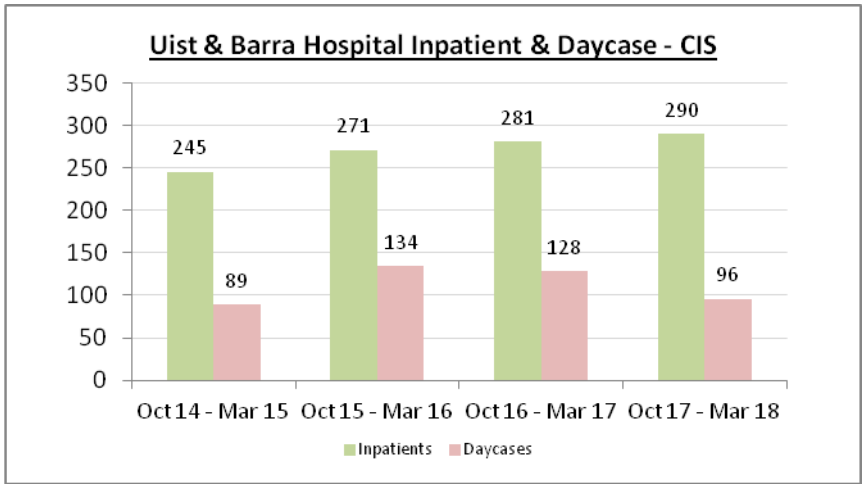
ii)


Western Isles Hospital Inpatient & Daycase - CIS
2500
2000
1500
1000
500
0
1833
1143
2013
1185
1923
1286
2296
1143
Oct 14 - Mar 15
Oct 15 - Mar 16
Oct 16 - Mar 17
Oct 17 - Mar 18
Inpatients
Daycases

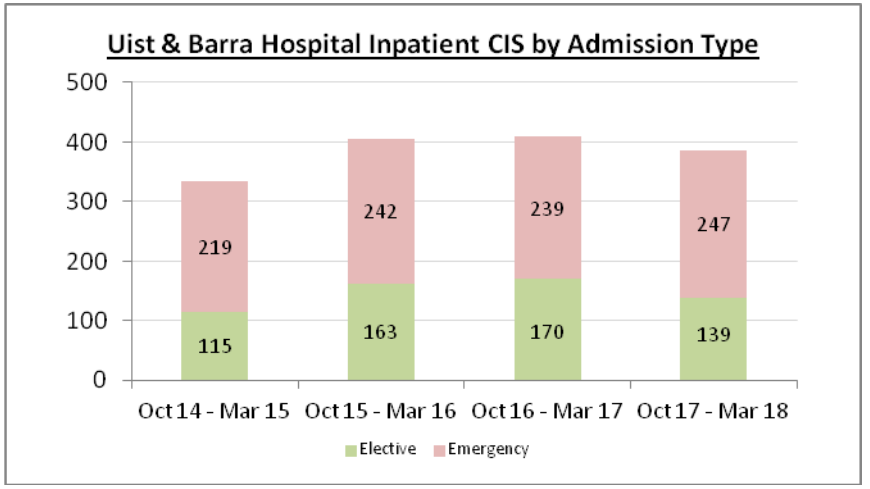

Western Isles Hospital Inpatient CIS by Admission Type
4000
3000
2000
1000
0
969
2007
1097
2101
1080
2129
1271
2168
Oct 14 - Mar 15
Oct 15 - Mar 16
Oct 16 - Mar 17
Oct 17 - Mar 18
Elective
Emergency

c) Uist & Barra Hospital

i)

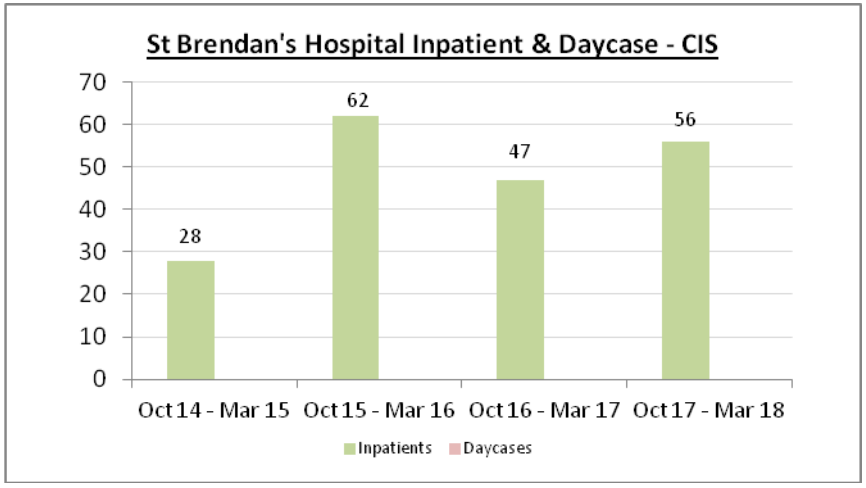


ii)

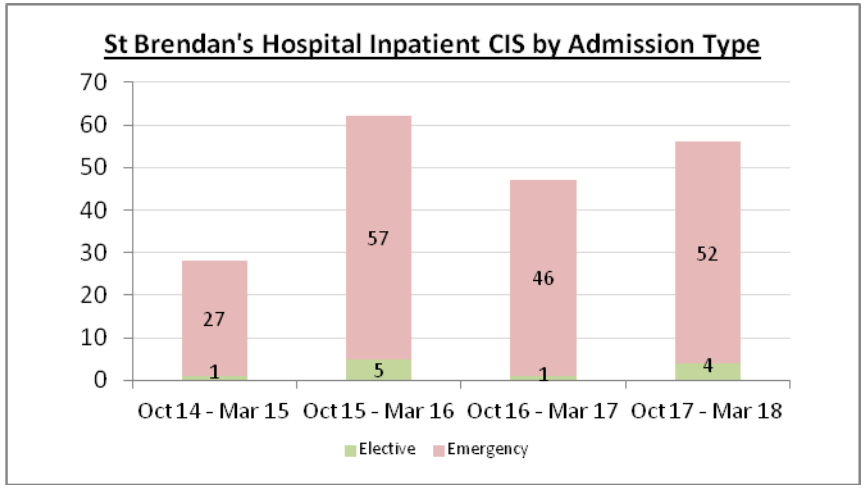


d) St Brendan's Hospital

i)



ii)



BOARD MEETING 27.06.18
Agenda Item: 10.2
Purpose: For Assurance

BOARD MEETING 27.06.18
Agenda Item: 10.2
Purpose: For Assurance
APPENDIX

INPATIENTS AND DAYCASES BY SPECIALTY

a) All Western Isles Locations - all specialties excluding Obstetrics and Psychiatry

Data relates to periods 01 October to 31 March incl. for each year

	Inpatients					Daycases					IP & DC
SPECIALTY	Oct-14 - Mar-15	Oct-15 - Mar-16	Oct-16 - Mar-17	Oct 17 - Mar 18	IP TOTAL	Oct-14 - Mar-15	Oct-15 - Mar-16	Oct-16 - Mar-17	Oct 17 - Mar 18	DC TOTAL	TOTAL
Ear, Nose & Throat (ENT)	13	9	9	4	35	31	42	51	60	184	219
General Medicine	1051	1188	1146	1378	4763	5	1	5	2	13	4776
General Surgery	370	457	439	492	1758	709	727	766	592	2794	4552
GP Other than Obstetrics	273	327	319	342	1261	46	1	2		49	1310
Gynaecology	62	52	38	44	196	53	24	33	63	173	369
Medical Oncology			1		1					0	1
Ophthalmology		1	3	7	11	194	238	245	270	947	958
Oral and Maxillofacial Surgery	3	1	2	4	10	9	9	17	11	46	56
Oral Surgery	3			1	4	2	1		3	6	10
Paediatrics	46	40	50	61	197	1		3	4	8	205
Renal Medicine					0		1			1	1
Trauma and Orthopaedic Surgery	286	273	250	315	1124	116	152	151	90	509	1633
Urology	8		2		10	68	125	140	144	477	487
Oral Medicine					0			1		1	1
Clinical Oncology					0				1	1	1
Grand Total	**2115**	**2348**	**2259**	**2648**	**9370**	**1234**	**1321**	**1414**	**1240**	**5209**	**14579**

b) Western Isles Hospital only - all specialties excluding Obstetrics and Psychiatry

Data relates to periods 01 October to 31 March incl. for each year

	Inpatients					Daycases					IP & DC
SPECIALTY	Oct 14 - Mar 15	Oct-15 - Mar-16	Oct-16 - Mar-17	Oct 17 - Mar 18	IP TOTAL	Oct 14 - Mar 15	Oct-15 - Mar-16	Oct-16 - Mar-17	Oct 17 - Mar 18	DC TOTAL	TOTAL
Ear, Nose & Throat (ENT)	13	9	9	4	35	31	42	51	60	184	219
General Medicine	1049	1186	1144	1378	4757	5		5	2	12	4769
General Surgery	370	453	431	488	1742	671	599	650	498	2418	4160
GP Other than Obstetrics	1		3	1	5					0	5
Gynaecology	62	52	38	44	196	53	24	33	63	173	369
Medical Oncology			1		1					0	1
Ophthalmology		1	3	7	11	194	238	245	270	947	958
Oral and Maxillofacial Surgery	3	1	2	4	10	9	9	17	11	46	56
Oral Surgery	3			1	4	2	1		3	6	10
Paediatrics	46	40	50	61	197	1		3	4	8	205
Renal Medicine					0		1			1	1
Trauma and Orthopaedic Surgery	286	273	248	315	1122	111	148	141	88	488	1610
Urology	8		2		10	68	125	140	144	477	487
Oral Medicine					0			1		1	1
Clinical Oncology					0				1	1	1
Grand Total	**1841**	**2015**	**1931**	**2303**	**8090**	**1145**	**1187**	**1286**	**1144**	**4762**	**12852**