AGENDA ITEM

8

Falkirk Health and Social Care Partnership

Title/Subject:	**Performance Report**
Meeting:	**Integration Joint Board**
Date:	**1 June 2018**
Submitted By:	**Chief Executive, NHS Forth Valley**
Action:	**For Noting**

1. INTRODUCTION

1.1 This report presents performance in relation to local performance indicators for the financial year 2017/18. This is measured against a baseline year of 2015/16, and is in line with other reporting for unscheduled care and delayed discharges.

2. RECOMMENDATION

The Integration Joint Board (IJB) is asked to:

2.1 note the content of the performance report

2.2 note the new format of the performance report

2.3 note that appropriate management actions continue to be taken to assess the issues identified through these performance reports

3. BACKGROUND

3.1 The purpose of this report is to ensure the Integration Joint Board fulfils its ongoing responsibility to ensure effective monitoring and reporting on the delivery of services, relevant targets, and measures which are included in the Integration Functions, and as set out in the Strategic Plan.

3.2 Contents of the report are monitored on an ongoing basis and also form the basis of the reporting through other arrangements, including: Unscheduled Care Programme Board, Winter Plan and Delayed Discharge Steering Group.

4. APPROACH

4.1 The Falkirk Performance and Measurement Group has compiled the performance report and developed a new format for the report. The group are also working to develop a more structured and themed timetable for performance reporting. It was intended this would be reported to the Board in June 2018, however work is still on-going, and will be presented to the IJB in September 2018.

4.2 The Pentana performance reporting system has been used to prepare the majority of this report. Within Pentana a variance range is required to be set for indicators. This defines the acceptable or tolerable spread between the numbers in a data set and RAG statuses.

5. PERFORMANCE REPORT STRUCTURE

5.1 A new performance report template has been devised and has been used to structure this report. This is attached for information.

5.2 The content of the report mainly focuses on unscheduled care and the local performance indicators for the period April 2017 to March 2018 against the baseline year 2015/16. Delayed discharges are as the census point March 2018. The report advises the IJB on the principal reasons for delay and the actions being taken by the services to mitigate these.

5.3 The report now has a Table of Contents to help readers navigate through the content more easily.

5.4 Section 1 provides a summary of key performance issues. The areas highlighted include:

- Emergency Department (ED) performance against the 4 hour standard
- Rate of ED Attendance
- Acute emergency bed days
- Delayed Discharges.

5.5 Section 2 of the report provides an ‘at a glance performance summary of local indicators’ with RAG status and direction of travel, as appropriate. Current performance is shown beside the baseline 2015/16.

5.6 Section 3 presents a summary of linked performance issues, providing additional detail about the indicators described within the Strategic Plan, as well as detail in respect of a number of other linked indicators relating to Unscheduled Care.

5.7 Appendix 1 – The Strategy Map details the Partnership’s vision, local outcomes, and maps these against the national Health and Wellbeing Outcomes, National Core Indicators, MSG integration indicators and local Partnership indicators. A review of the Strategy Map was recently undertaken to ensure contents remain current and relevant to the Strategic Plan. The local indicators are now numbered and the frequency of reporting is indicated for each.

5.8 Appendix 2 – A glossary has been provided to give explanation and context to abbreviations and areas contained within this report.

6. CONCLUSION

6.1 The Integration Joint Board is responsible for effective monitoring and reporting on the delivery of services, relevant targets and measures included in the Integration Functions, and as set out in the Strategic Plan.

Resource Implications
The management of performance is critical to managing the overall budget of the IJB. The resource requirements to ensure effective performance management and performance reporting are under review.

Impact on IJB Outcomes and Priorities
Only by managing performance can the delivery of the IJB outcomes and priorities be truly assessed, providing a sound basis from which to make decisions regarding investment and service change.

Legal & Risk Implications
Performance management is a legal requirement as defined in the IJB's Integration Scheme.

Consultation
The approach is defined in the Performance Management Framework and further developed through the Performance and Measurement Group with all parties represented.

Equality and Human Rights Impact Assessment
This is not required for the report.

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Date: 22 May 2018

List of Background Papers:

Falkirk
Health and Social Care
Partnership

Performance Report

June 2018

1. KEY PERFORMANCE ISSUES

1.1. Emergency Department Performance against the ED 4 hour Standard

Issue:

1) Analysis of 2017/18 performance against the Falkirk IJB baseline year 2015/16 reveals percentage variance in the monthly average of 6.1% down to 87.3% in 2017/18 from 93% in 2015/16.
2) The most significant drop in compliance of 10% occurring in those aged 85 year plus.
3) The reason for delay in 74% of those aged 85+ is 'Wait for a bed' and 'Wait for first assessment'.

1.2. Rate of Emergency Department (ED) Attendance

Issue:

1) The average monthly ED Attendance in Falkirk has increased by a narrow margin of 0.03% since the baseline year of 1,950 in 2015/16 to 1,954 in 2017/18.
2) The Falkirk position remains approximately 10% above the Forth Valley average at 1,774 in 2017/18.

2.3 Acute emergency bed days per 1,000

Issue:

1) The average rate per 1,000 population of unplanned bed days in Falkirk has increased by 4.8% the since 2015/16, exceeding the Forth Valley position by 8.9%.
2) The most significant percentage increase of 11% occurs in the 65-74 year age group from 1,238.61 in 2015/16 to 1,376.03 in 2017/18.

Action:

1) Unscheduled Care Programme Board (UCPB), led by the Medical Director and comprising of Chief Officers, General Managers, Unscheduled Care Teams with analytical support from Health and LIST analysts. The Board continually monitors ED performance against the MSG indicators and the six essential actions prescribed by the Scottish Government and the Day of Care Audit to ensure patients currently in a ward meet acute and community inpatient criteria.

2.4. Delayed Discharge

Issue:

1) With an average of 27 waits a month over the last financial year, Delayed Discharges of Falkirk residents from an NHS Forth Valley hospital account for 64% of the Forth Valley total
2) Standard Delays for the month of March 2018 for Falkirk are recorded as 23 out of 42 Forth Valley delays
3) Occupied bed days (OBD) attributed to delays in Falkirk equates to 786 out of 1,086 in Forth Valley OBDS. Overall this is 72% of delays within Forth Valley. However over the course of 2017/18 there has been a substantial decrease in occupied bed days attributed to delayed discharge from 816 to 472 in February 2018.

Action:

1) Additional funding has allowed the recruitment of a further 3 Discharge Coordinators
2) Extra staffing levels have resulted in 7 day coverage across all NHS sites
3) Input from team means patients are reviewed within 72 hours
4) Identify solutions and liaise with social work and community colleagues to ensure a safe discharge is achieved
5) Attend Multi Disciplinary Team (MDT) meetings to identify discharge pathways and goals
6) Support relatives and carers in arranging plans for discharge

2. AT-A-GLANCE PERFORMANCE SUMMARY OF LOCAL INDICATORS

The Partnership focus is across the local outcomes, with work ongoing to support a balanced approach to measurement and reporting. Trajectories have been set against national standards which could be applied to local outcomes, facilitating the development of local and national balanced scorecards.

The table below highlights local data for the financial year 2017/18 against the baseline 2015/16. The table also looks at a monthly breakdown of Delayed Discharges as at March 2018 census. Performance data covers adults aged 18 and over.

Key:

Direction of travel relates to previously reported position	
▲	Improvement in period
◄►	Position maintained
▼	Deterioration in period
–	No comparative data

2.3. Self Management Indicators 24 - 27

		Baseline 2015/16	2017/18	Direction of Travel
24	Emergency department 4 hour wait Forth Valley	94.5%	88.3%	▼
25	Emergency department 4 hour wait **Falkirk**	93.0%	87.3%	▼
26	Emergency department attendances per 100,000 Forth Valley Population	1,731.16	1,774.01	▼
27	Emergency department attendances per 100,000 **Falkirk**	1,949.58	1,954.58	▼

2.4. Autonomy & Decision Making Indicators 28 - 41

		Baseline 2015/16	2017/18	Direction of Travel
28.	Emergency admission rate per 100,000 Forth Valley population	1,037	969.06	▲
29	Emergency admission rate per 100,000 **Falkirk** population	1,054	985.82	▲
30.	Acute emergency bed days per 1000 Forth Valley population	766.98	784.83	▼
31	Acute emergency bed days per 1000 **Falkirk** population	821.64	861.08	▼
32	Number of patients with an Anticipatory Care Plan in Forth Valley	11,667	15,601	▲
33.	Number of patients with an Anticipatory Care Plan in **Falkirk**	N/A	6,685	–
34.	Key Information Summary as a percentage of the Board area list size Forth Valley	3.9%	4.9%	▲
35.	Key Information Summary as a percentage of the Board area list size **Falkirk**	N/A	4.2%	–

Self Directed Support (SDS) options selected: People choosing		Baseline March 2016	March 2018	Direction of Travel
37.	SDS Option 1: Direct payments (data only)	33 (1.4%)	26 (0.9%)	
38.	SDS Option 2: Directing the available resource (data only)	46 (1.9%)	99 (3.6%)	
39.	SDS Option 3: Local Authority arranged (data only)	1,505 (62.2%)	1,980 (71.3%)	
40.	SDS Option 4: Mix of options, 1,2 (data only)	30 (1.2%)	56 (2.0%)	
41.	No recorded SDS Option (data only)	805 (33.3%)	617 (22.2%)	▲

2.5. Safety -Indicators 42 - 49

		Baseline 2015/16	2017/18	Direction of Travel
42	Readmission rate within 28 days per 1000 FV population	1.84	0.61	▲
43	Readmission rate within 28 days per 1000 **Falkirk** population	2.20	0.73	▲
44.	Readmission rate within 28 days per 1000 **Falkirk** population 75+	1.53	1.28	▲
		Baseline 2015/16	**2017/18 H1**	**Direction of Travel**
45.	Number of Adult Protection Referrals (data only)	579	398	
46.	Number of Adult Protection Investigations (data only)	45	37	
47.	Number of Adult Protection Support Plans (data only)	12	16	
48.	The total number of people with community alarms at end of the period	4,526	4,469	
49.	Percentage of community care service users feeling safe	90%	90%	◄►

2.6. Service User Experience - Indicators 54 - 66

		Baseline 2015/16	2017/18	Direction of Travel
54.	Standard delayed discharges	24	23	▲
55.	Delayed discharges over 2 weeks	17	19	▼
56.	Bed days occupied by delayed discharges	809	786	▲
57.	Number of code 9 delays	7	25	▼
58.	Number of code 100 delays	1	4	▼
59.	Delays - including Code 9 and Guardianship	31	48	▼
60.	Percentage of service users satisfied with their involvement in the design of their care package	98%	98%	◄►
61.	Percentage of service users satisfied with opportunities for social interaction	93%	93%	◄►
62.	Percentage of carers satisfied with their involvement in the design of care package	92%	91%	▼
63.	Percentage of carers who feel supported and capable to continue in their role as a carer OR feel able to continue with additional support	89%	91%	▲

		Baseline 2015/16	2017/18 All	2017/18 Stage 1	2017/18 Stage 2
64.	The number of Social Work Adult Services (Stage 1 & 2) complaints completed within timescales.	113/156	77/122	70/110	7/12
	The proportion of Social Work Adult Services (Stage 1 & 2) complaints completed within timescales.	73.4%*	63.1%	63.6%	58.3%
65.	Proportion of Social Work Adult Services complaints upheld ***NB. 2015/16 were reported under the old complaints system**	% upheld		36.4	33.3
		% partially upheld		26.4	41.7
		% not upheld		37.2	25.0

		Baseline 2015/16	2017/18 to end Q3	Direction of Travel
66.	Sickness Absence in Social Work Adult Services (target – 5.5%)	7.9%	8.2%	▼

2.7. Community Based Support - Indicators 67 - 83

		Baseline 2015/16	2017/18	Direction of Travel
67.	The total respite weeks provided to older people aged 65+. Annual indicator	1,703	Annual Indicator data not available	
68.	The total respite weeks provided to older people aged 18-64. Annual indicator	724		
*****	**Please note that each year's Home Care data below is a snapshot of provision in a single reporting week at the end of the reporting period.**	**Mar 2016**	**Dec 2017**	**Direction of Travel**
69.	Number of people aged 65+ receiving homecare *****	1,867	1,642	▼
70.	Number of homecare hours for people aged 65+ *****	14,622	13,938	▼
71.	Rate of homecare hours per 1000 population aged 65+ *****	512.2	478.0	▼
72.	Number receiving 10+ hrs of home care *****	406	458	▲
73.	The proportion of Home Care service users aged 65+ receiving personal care *****	91.6%	90.7%	▼
		Baseline 2015/16	**2017/18 to end Q3**	**Direction of Travel**
76.	Percentage of Rehab At Home service users who attained independence after 6 weeks (target – 80%)	77.4%	69.4%	▼
77.	Percentage of Crisis Care service users who are retained in the community when service ends (target - 70%)	63.7%	73.8%	▲
		Baseline 2015/16	**2017/18**	**Direction of Travel**
78.	Number of new Telecare service users 65+ (data only)	142	132	
79.	The number of people who had a community care assessment or review completed	9,571	9,213	▼
80.	The number of Carers' Assessments carried out	1,936	1,656	▼
		March 2016	**At 09/04/18**	**Direction of Travel**
81.	The number of overdue 'OT' pending assessments at end of the period	352	285	▲
		2014/15	**2015/16**	**Direction of Travel**
82.	Proportion of last six months of life spent at home	86.1%	86.0%	◄►
83.	Number of days by setting during the last six months of life: Community	228,702	241,236	▲

3. SUMMARY OF LINKED PERFORMANCE ISSUES

3.1. Self Management - Falkirk Unscheduled Care Indicators 24 & 25:

Table 1 - Emergency Department Performance against ED 4 Hour Target (includes Minor Injuries Unit). This is 95% target	
Forth Valley Performance	88.3%
Falkirk HSCP Performance	87.3%

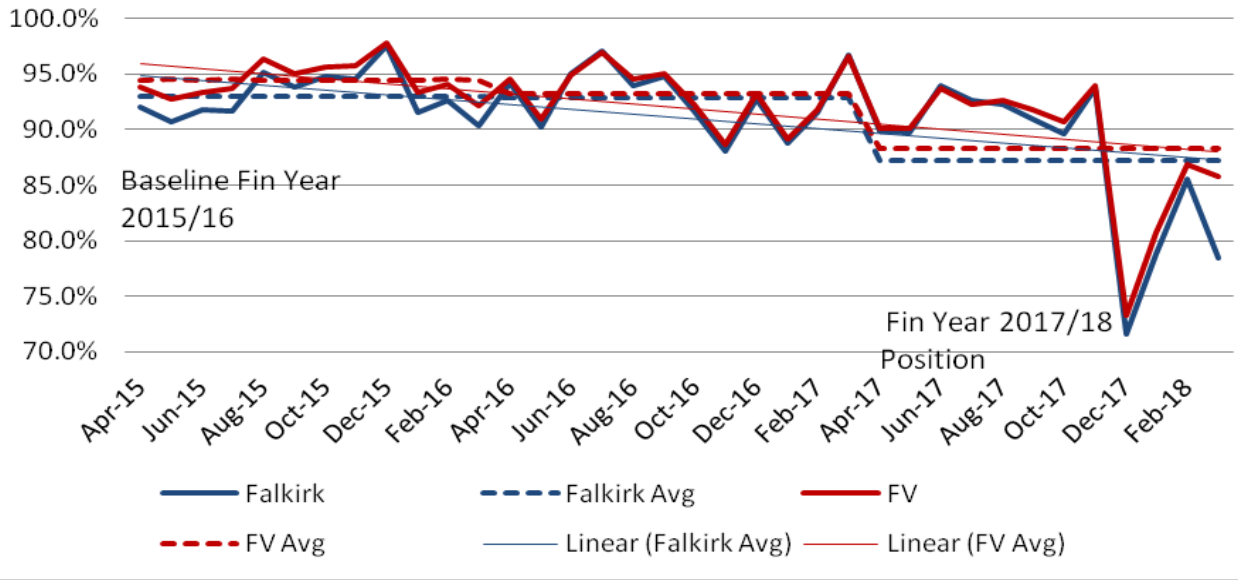
Purpose:
The national standard for A&E waiting times dictates 95% of patients will wait less than 4 hours from arrival to admission, discharge or transfer for accident and emergency treatment.

Position:
As described in chart 1 below, performance against the 4 hour ED target throughout Forth Valley has declined since the baseline year of 2015/16 by 6.5%. This position is mirrored across the partnership with Falkirk results decreasing by 6.1%.

Analysis shows waits are longer in the 85 plus age group down 10% from 86.3% compliance in 2015/16 to 77.4% in 2017/18.

39% of wait over 4 hours are recorded as 'Wait for a bed' with 34% having the longest wait attributed to 'Wait for first assessment'. In the 18-64 age range 51% of waits in 2017/18 occur due to 'wait for first assessment'. This has increased from 45% in the baseline year.

Figure 1 - Four Hour ED target throughout Forth Valley (Indicators 24 & 25)



3.2. Self Management - Falkirk Unscheduled Care Indicators 26 & 27

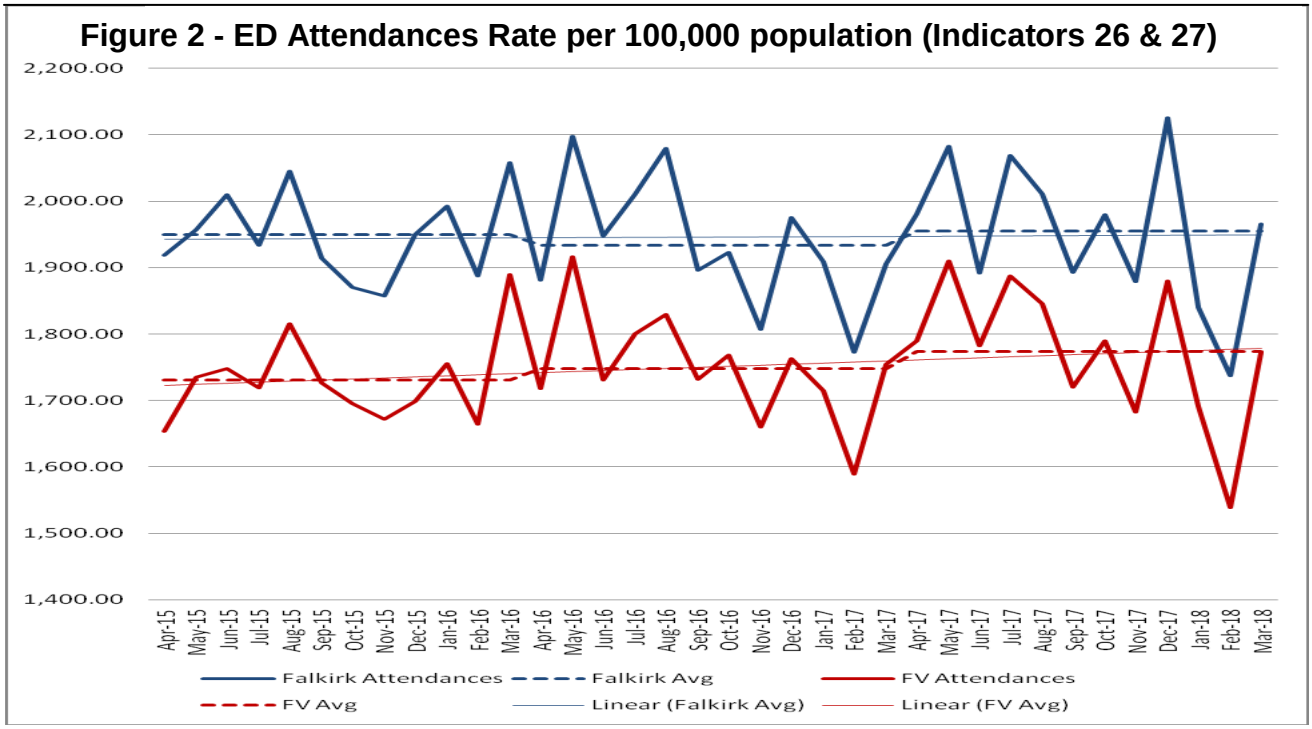
Table 2 - Emergency Department Attendance rate per 100,000 population	
Forth Valley Performance	Average monthly performance in 2017/18 1,774.01
Falkirk HSCP Performance	Average monthly performance in 2017/18 1,954.58

Purpose
It is the responsibility of the IJB to take action against increasing numbers of attendances to ED. Health and social care initiatives prevent patients presenting to ED, by signposting to more appropriate services where care needs are dealt with using an anticipatory approach. Through monitoring this activity the aim is to improve the patient experience by identifying the best use of resources and to prevent patients waiting longer than necessary in ED.

Position
The average monthly ED attendance rate in Forth Valley has increased from 1,731 per 100,000 population in 2015/1 to 1,774 per 100,000 population in 2017/18 to date. This is highlighted as a 2.5% increase.

Falkirk has seen a rise of 0.26% in 2017/18 to 1,954 per 100,000 population, from 1,949 per 100,000 population in 2015/16. Falkirk attendances remain above the Forth Valley average by 10%, although the attendance rate has remained relatively stable since the baseline year.

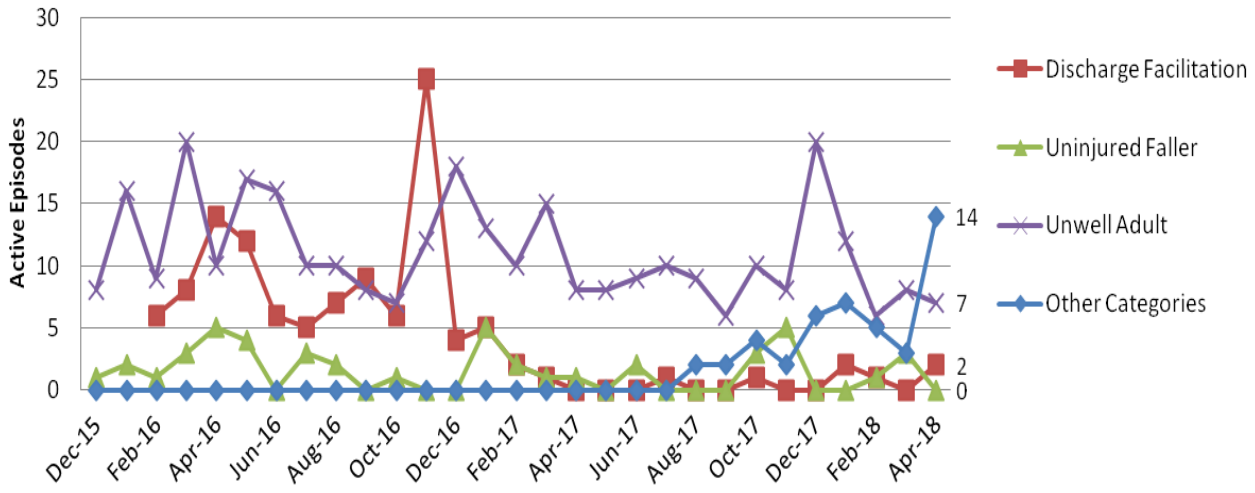
Figure 2 - ED Attendances Rate per 100,000 population (Indicators 26 & 27)



In order to reduce the number of A&E attendances and subsequent admissions to hospital, the Partnership is working to ensure that more residents receive appropriate support and treatment within the community.

The Enhanced Community Team (ECT) is working to relieve pressure on the 'front door'. The chart below shows the number of admissions (referrals to the ECT) for the Falkirk Partnership.

Figure 3 - Enhanced Care Team Admissions by Patient Categorisation April 2018



Admissions by Patient Categorisation show the most prevalent reason for admission remains to be unwell adult. However, use of the Service for Discharge Facilitation has shown a significant decrease since the baseline year. A review is underway to understand the change in the figures.

3.3. Autonomy and Decision Making – Emergency Admissions Indicators 28 & 29

Table 3 - Indicators 28 & 29	
Forth Valley Performance	Average monthly performance in 2017/18 = 969.06
Falkirk HSCP Performance	Average monthly performance in 2017/18 = 985.8

Purpose

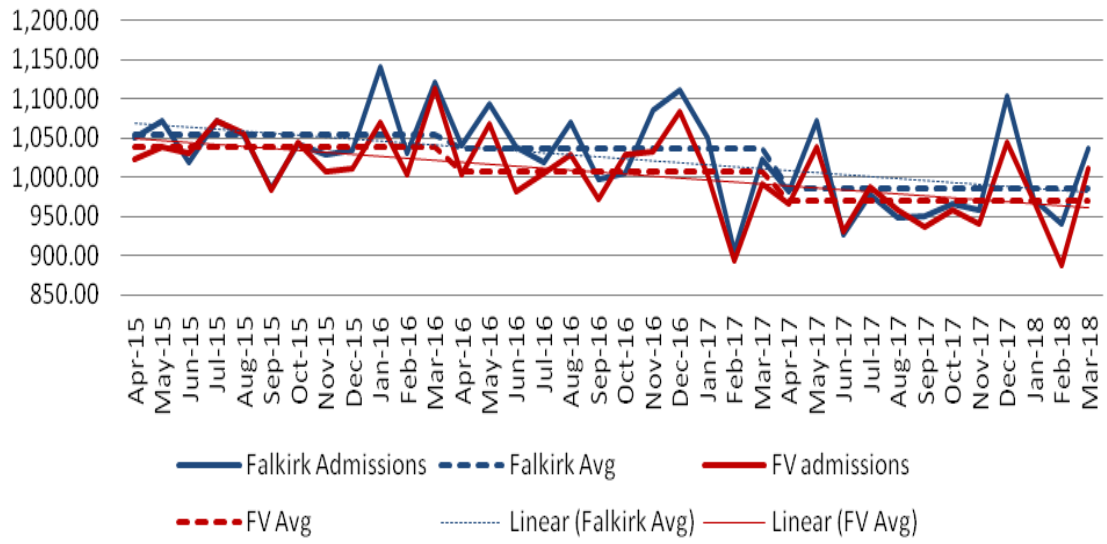
"For adults and older people, this outcome indicator should represent a shift from a reliance on hospital inpatient care towards proactive and coordinated care and support in the community. It should demonstrate the effectiveness of anticipatory care, identifying people who are at risk of emergency hospital admission, supporting people to be more confident in managing their long term conditions and providing coordinated care and support at home where safe and appropriate." *ISD*

Position

The average unplanned admission rate for both Falkirk and Forth Valley in 2017/18 has reduced. The admission rate for the financial year 2017/18 in Forth Valley is down by 6.6%, from 1,037 per 100,000 population to 969 per 100,000 population this financial year. Falkirk admissions remain above the Forth Valley average but have decreased from 1,054.1 per 100,000 population in 2015/16 to 985.8 per 100,000 population in 2017/18.

A breakdown by age range for adults shows an average decrease of approximately 6.9% across all age ranges. However the number of actual admissions for the 85 plus age group has risen by 1.9% indicative of a 2% rise in the population as per the National Records of Scotland mid year census.

Figure 4 - Unplanned Admissions Rate per 100,000 (Indicators 28 & 29)



3.4. Autonomy and Decision Making - Anticipatory Care Planning Indicators 32 & 33:

Table 4 - Indicators 32 & 33	
Forth Valley Performance	15,601 (4.9%)
Falkirk HSCP Performance	6,685 (4.2%)

Purpose
"Anticipatory Care Planning (ACP), in practical terms, are both about adopting a "thinking ahead" philosophy of care that allows practitioners and their teams to work with people and those close to them to set and achieve common goals that will ensure the right thing is being done at the right time by the right person(s) with the right outcome." *Scottish Government*

Position
ACP has been identified nationally as a priority to support the delivery of the 2020 vision and the Health and Wellbeing Outcomes linked with the Health & Social Care Integration agenda as highlighted in the recent Audit Scotland Report on Integration.

The figures above are supplied by ISD. The drop in number from circa 17,000 plans produced in 2017 is a result of ISD culling records for those patients who have since died or moved out with the area. The position of 15,548 accounts for 4.9% of Forth Valley residents and exceeds the target of 4,500 or 1.5%. 6,663 (4.2%) of the Falkirk population are in receipt of an ACP or Key Information Summary (KIS).

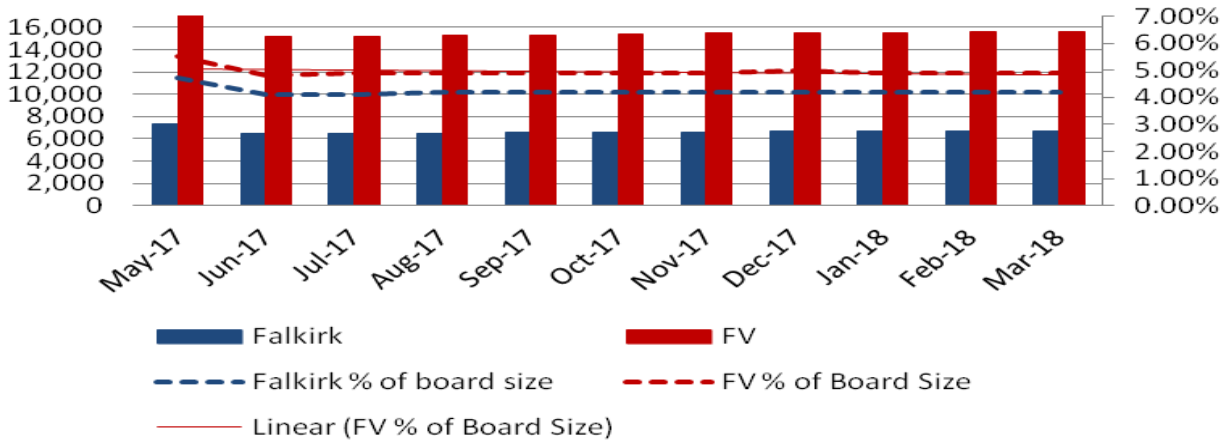
The assessment of the impact of the ACPs on patient care is ongoing. Deliberations need to be made via robust studies to assess at which stage in the patient journey referral for an ACP should be made determining the best use of current resource and identifying areas for development.

Since September 2017, the ACP and ALFY Service have gone through a period of restructuring. The Head of ACP Nursing in Clackmannanshire and Stirling is now the ALFY Manager working with community nursing and ACP Teams across both

partnerships to bring more effective communication and use of the referral processes to synchronise ALFY.

ALFY are now proactively contacting patients post discharge to gauge how well they are managing in the days following discharge from hospital and identifying those who would benefit from an ACP assessment. It is hoped this early intervention may save a further hospital admission and should admission be inevitable, by having an anticipatory care plan in situ, it is hoped this will reduce a patient's length of stay in hospital. Work is currently underway to assess the impact of this restructure. Furthermore, the impact of ALFY and other Closer to Home Services are being assessed as part of the conditions of funding from both Partnerships.

Table 5 - ACP and ACP/KIS - % of Board List 2017-18 (Indicators 32 & 33)



3.5. Autonomy and Decision Making – Acute Emergency Bed Days Indicators 30 & 31

Table 6 - Indicators 30 & 31	
Forth Valley Performance	Average monthly performance in 2017/18 = 784.8
Falkirk HSCP Performance	Average monthly performance in 2017/18 = 861.08

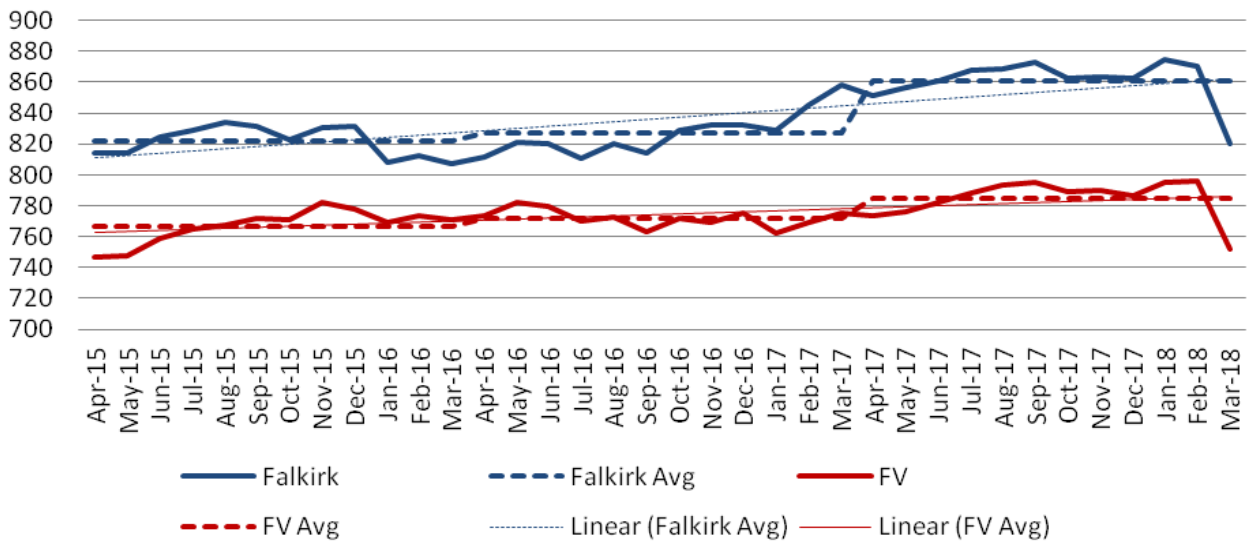
Purpose

The number of emergency bed days and emergency admissions balance each other and quality outcomes for both should be measured. A decrease over time for both emergency admissions and emergency bed days is desirable. It is possible for the rate of admissions to be decreasing with the rate of bed days increasing to as people are kept in hospital longer.

Position

In 2015/16 the average monthly rate in terms of unplanned bed days for Forth Valley was 766 per 1,000 population compared to 784 per 1,000 population in 2017/18. This represents a 2.3% increase. The rate per 1,000 of patients in the Falkirk local authority area has increased by 4.8% from 821 per 1,000 population in 2015/16 to 861 per 1,000 population in 2017/18. Further analysis shows a rise on all age groups over 65. The most significant rise occurs in the 65-74 year age range at 11.1%.

Figure 5 - Unplanned Bed Days Rate per 1,000 Population (Indicators 30 & 31)



Day of Care Survey Update as of 9 May 2018

In September 2014 an initial Day of Care survey was carried out within NHS Forth Valley which indicated that 21% of inpatients did not require ongoing care within an acute setting. A follow up survey in December 2014 showed that had risen to 31%.

Initial testing on a reliable fortnightly Day of Care survey started on 10 December 2015. The number of patients at that time who did not meet the criteria for an acute inpatient area was 26%. The latest survey (26 April 2018) has demonstrated that Forth Valley Royal Hospital (FVRH) is now at 16.2% (71 patients) not meeting acute in-patient criteria.

Within the community hospital setting there have been nine surveys so far. The first survey found that 52% of patients did not meet the inpatient criteria. The latest survey in April 2018 has demonstrated that this is now 44% (84 patients).

The current plan is to continue repeating the community hospital survey monthly in order to identify potential areas for improvement.

Next Steps

- The Day of Care survey will be carried out on a Friday afternoon instead of a Thursday morning. This will capture patients identified as not meeting in-patient criteria at the weekend and may highlight different reasons for remaining in hospital

- The community hospital Day of Care survey continues and the process now appears to be settled and embedded

- The Discharge Team, Social Work and 24/7 meet daily to discuss patients who have been identified as waiting for a community hospital bed or a package of care to allow the most appropriate patients to be moved

- The pilot of the daily dynamic discharge in the 2 community hospital wards continues with plans to roll out to the rest of the community hospitals and wards.

Figure 6 - Acute Day of Care % of patients identified as not meeting acute in-patients criteria

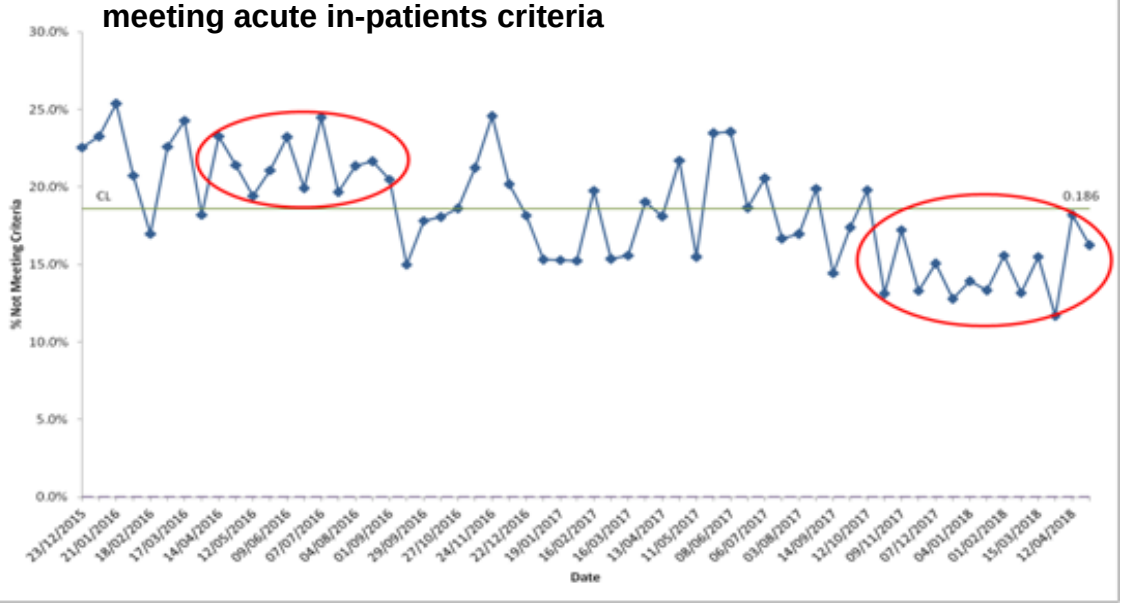
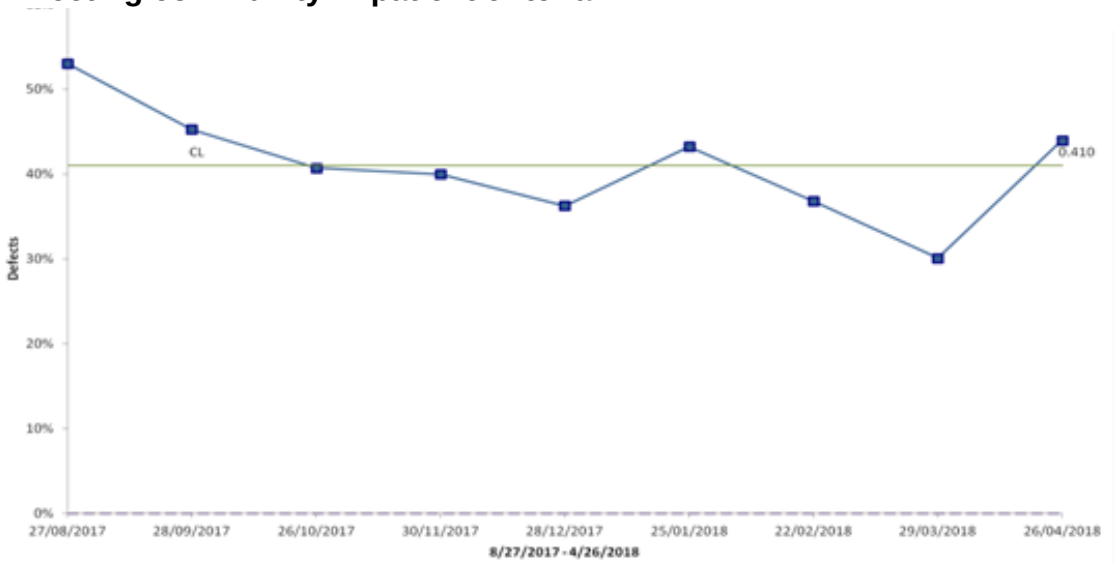


Figure 7 - Community Day of Care % of patients identified as not meeting community in-patient criteria



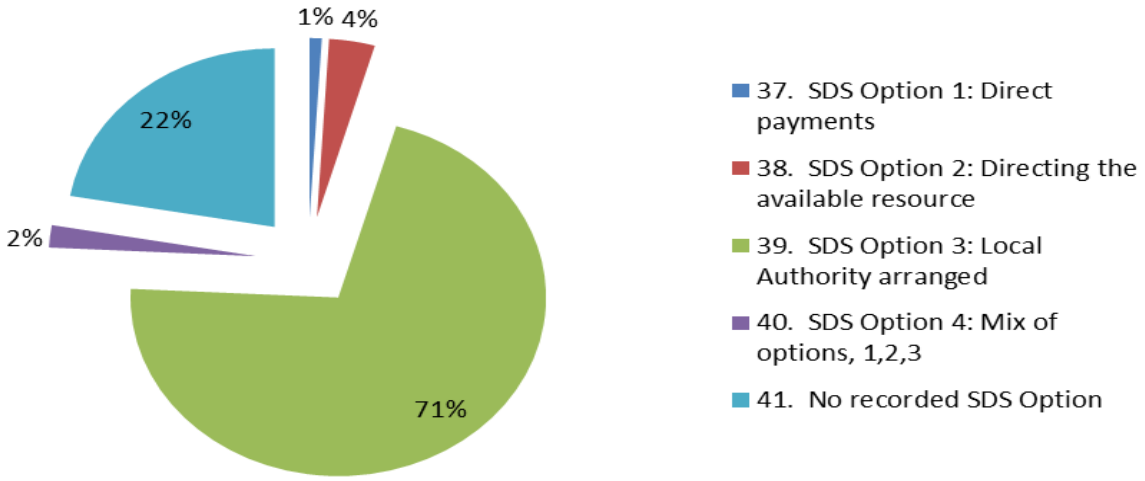
3.6. Autonomy and Decision Making – Self Directed Support (SDS) Options 1 to 4: Indicators 37 to 41

Table 7 - Indicators 37 to 41				
Self Directed Support (SDS) options selected: People choosing		**Baseline March 2016**	**March 2018**	**Direction of Travel**
37.	SDS Option 1: Direct payments	33 (1.4%)	26 (0.9%)	
38.	SDS Option 2: Directing the available resource	46 (1.9%)	99 (3.6%)	
39.	SDS Option 3: Local Authority arranged	1,505 (62.2%)	1,980 (71.3%)	
40.	SDS Option 4: Mix of options, 1,2	30 (1.2%)	56 (2.0%)	
41.	No recorded SDS Option	805 (33.3%)	617 (22.2%)	▲

Purpose
These indicators demonstrate the choices made by service users under each of the four SDS options shown. It also shows the declining number of people who have not yet made SDS choices. It also reflects an increase in the rise of people who are making choices which are recorded on SWIS.

Position
The majority of service users - 71% have chosen option 3, local authority arranged care. The other options show less than 2 percent differences over the period reported. However, the number of people who have not yet made SDS choices declined from 33.3 % in March 2016 to 22% in March 2018.

Figure 8 - Self Directed Support (SDS) options selected March 2018 (Indicators 37 to 41)



3.7. Safety – Unscheduled Care Rate of Readmissions Indicators 42 & 43

Table 8 - Indicators 42 & 43	
Forth Valley Performance	Average monthly performance in 2017/18 = 0.68
Falkirk HSCP Performance	Average monthly performance in 2017/18 = 0.73

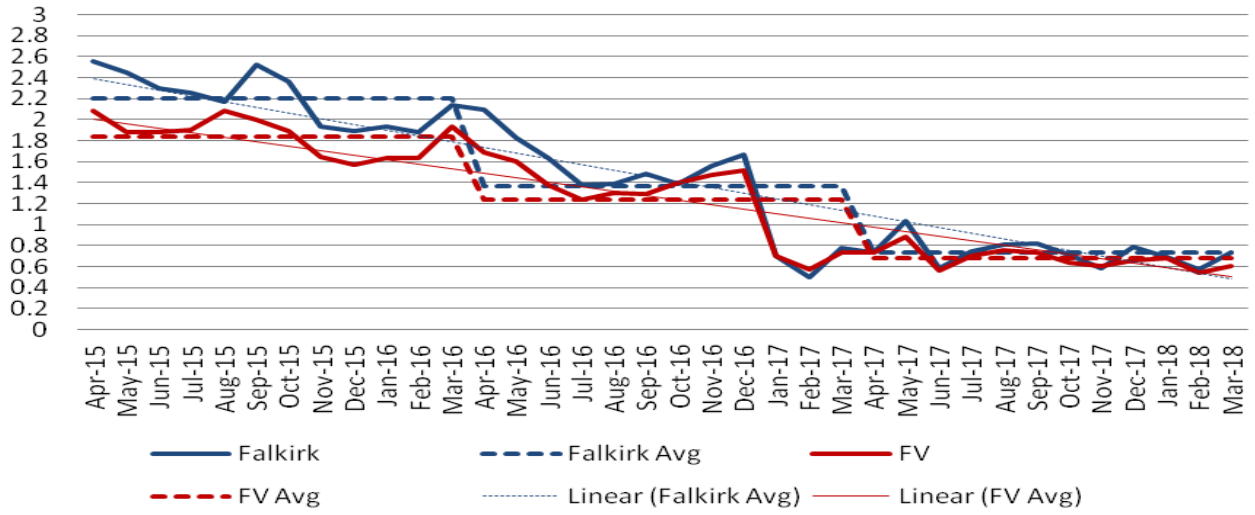
Purpose
Within Forth Valley the readmissions data are standardised by specialty and condition at readmission. This means that if a patient was admitted to a medical specialty initially with a respiratory condition and is readmitted with a broken leg, this is not categorised as a readmission as it is not relevant to the initial presentation at hospital. If however the patient is readmitted to the same specialty then this is classed as a readmission. In this way it enables targeting in areas that may require improvement.

Position
National data items relating to emergency readmissions show NHS Forth Valley in the mid range of outcomes against the Scottish position and peers. Work to identify areas for improvement is currently ongoing.

It should be noted that this differs from national publications reporting the crude rate of readmissions. This is defined as any readmission within 28 days to any specialty, within any health board regardless of the reason for readmission.

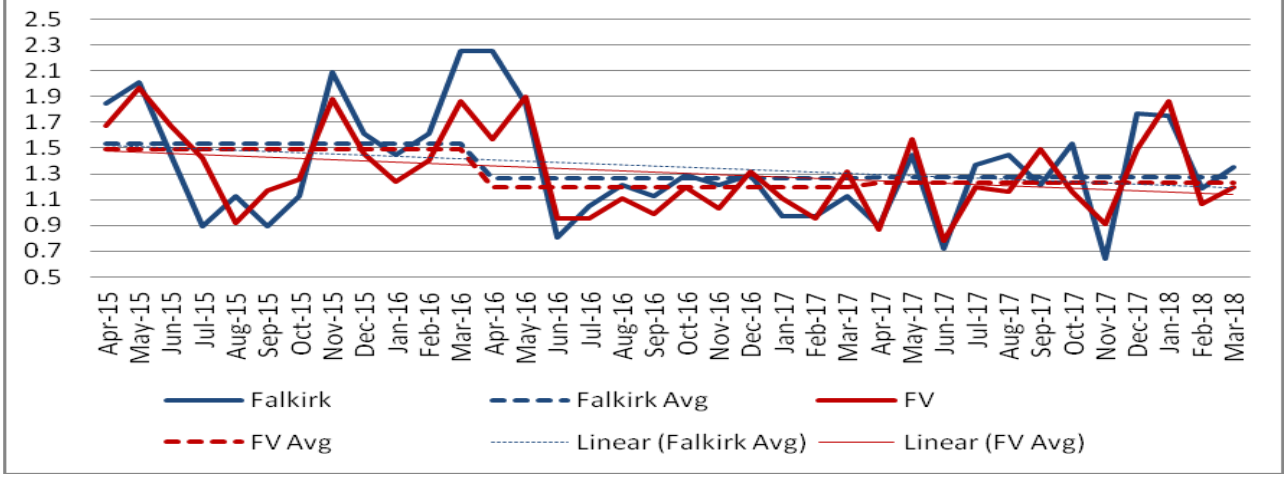
Chart 10 highlights a decrease in the rate of readmissions across Forth Valley from 1.84 per 1,000 population in 2015/16 to 0.68 per 1,000 population in 2017/18 year to date. This decreasing trend is mirrored within the Falkirk Partnership with a decrease from 2.20 per 1000 population in 2015/16 to 0.73 per 1,000 population in 2017/18 year to date.

Figure 9 - Readmissions Rate per 1,000 - 18 years plus population (Indicators 42 & 43)



Readmissions for those aged 75 and over have decreased in Forth Valley and Partnership wide. Forth Valley has decreased to 1.23 rate per 1,000 from 1.49 in 2015/16. The Falkirk position decreased from 1.53 rate per 1,000 in 2015/16 to 1.28 in 2017/18.

Figure 10 - Readmissions Rate per 1,000 75 years plus population (Indicator 44)



Pilot schemes across parts of the Partnership are assessing community focussed supports in a bid to see patients be treated at home or in a homely setting where appropriate.

Routine monitoring is to be adopted by the UCPB, and led by the Medical Director.

3.8. Service User Experience – Unscheduled Care, Delayed Discharge Indicator 54

Table 9- Indicator 54	
Forth Valley Performance	Monthly Number March 2018 = 42
Falkirk HSCP Performance	Monthly Number March 2018 = 23

Purpose
A delayed discharge occurs when a patient, clinically ready for discharge, cannot leave hospital because the other necessary care, support or accommodation for them is not readily accessible and/or funding is not available, for example to purchase a care home place. When a delayed discharge occurs it not only affects the patient experience but impacts upon hospital flow hence this indicator is part of the MSG Unscheduled Care Suite of Indicators addressed by the UCPB.

Position
As of the March 2018 census date, the following delays were recorded:

- 23 people delayed in their discharge (standard delays)
- 19 people who were delayed for more than 2 weeks (standard delays)
- 6 people identified as a complex discharge (code 9)
- 19 people proceeding through the guardianship process
- 4 people identified as a Code 100 delay.

The Integration Joint Board receives regular reports on Delayed Discharge and this remains an area of priority for the Board. The Falkirk Delayed Discharge Steering Group is in place to monitor operational performance and find solutions.

In March 2018 the number of standard delays in Forth Valley is 42. Falkirk accounts for 23 or 54.8% of all standard delays. 82% (19/23) Falkirk delays are waiting over 2 weeks at the March 2018 census point. These Falkirk patients account for 86% of Forth Valley waits over 2 weeks.

Figure 11 - Standard Delays 2017/18 (Indicator 54)

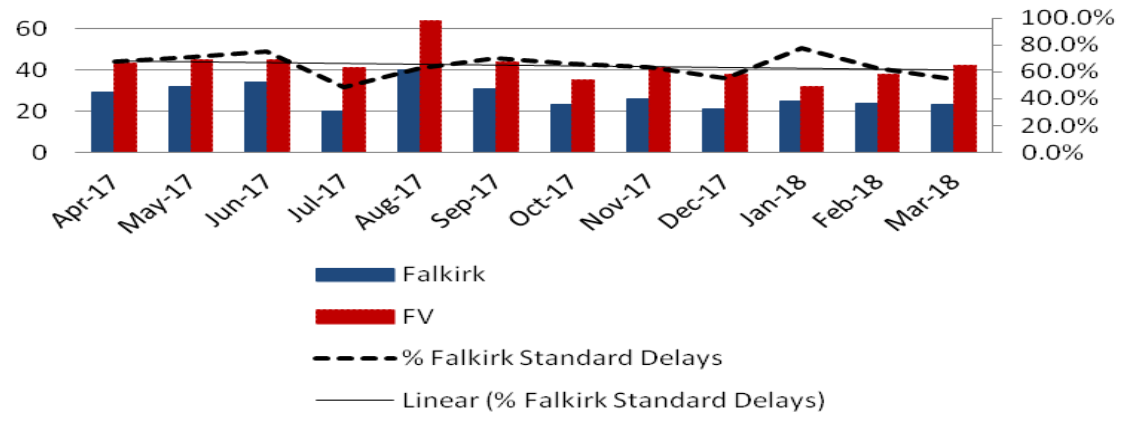


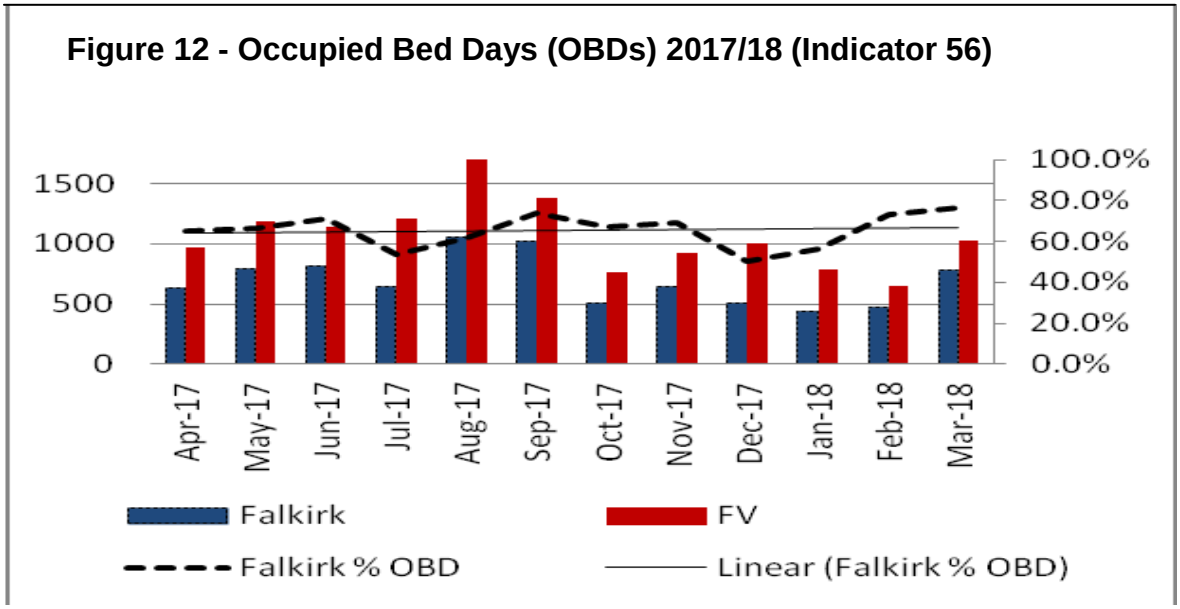
Table 10 - Standard Delays excluding Code 9 and Guardianship Delays from April 2017 to March 2018

	Apr 17	May 17	Jun 17	July 17	Aug 17	Sept 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18
Total Delay at census point	29	32	34	20	40	31	23	26	21	25	24	23
Total number of delays over 2 weeks	14	18	18	15	26	21	12	18	13	10	15	19

Across Forth Valley there has been an increase in the number of OBDs attributed to delayed discharges with the number at the March 2018 census 786 compared to 645 in February 2018.

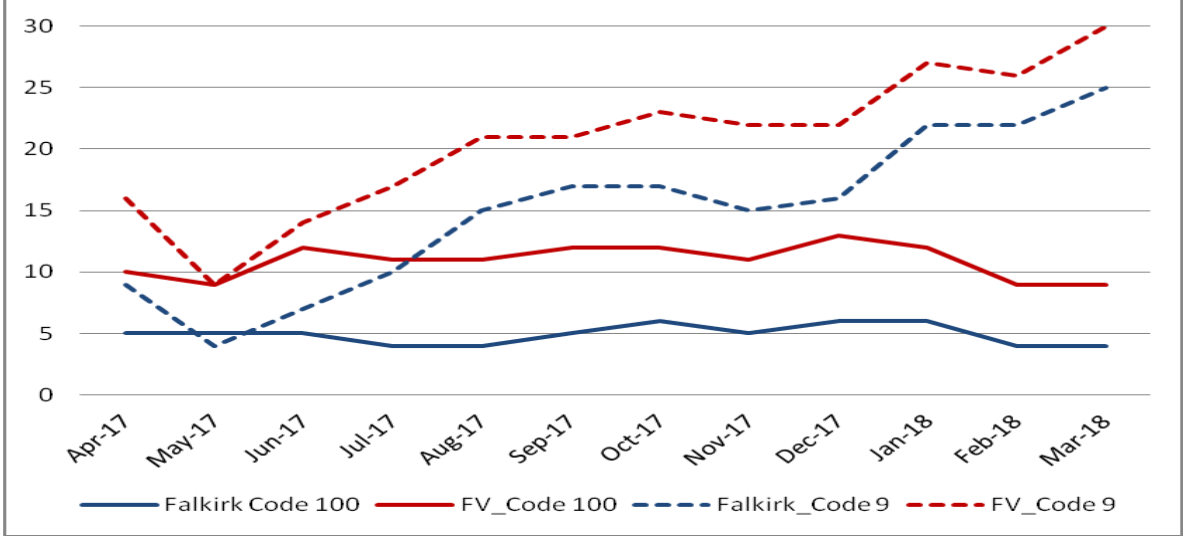
This is not indicative of a rising trend but a snap shot at the census point. Analysis since the baseline has shown the year of the most significant increase in OBDs occurred in 2016/17 with both Forth Valley and Falkirk rising by approximately a third. However the data for the financial year 2017/18 shows a 6% decrease in Forth Valley number from 1,129 in 2016/17 to 1,059 and 16.8% decrease in Falkirk from 831 in 2016/17 to 691 in 2017/18.

Figure 12 - Occupied Bed Days (OBDs) 2017/18 (Indicator 56)



There has been an increase in the number of Code 9 and Code 100 delays across Forth Valley. Across the Falkirk Partnership the position at the March 18 census is 25 Code 9 delays, with 30 for Forth Valley overall, therefore, 83% attributed to Falkirk residents within the Forth Valley setting.

Figure 13 - Code 9 and Code 100 Delay Codes (Indicators 57 & 58)



There are a number of key actions intended to support a reduction in delayed discharge through Partnership funded services:

- Identification of patients who are ready for discharge either home or from hospital to Short Term Assessment (STA)/Community Hospital or in appropriate cases to care homes.
- Identification of solutions and liaison with Social Work and Community colleagues to ensure a safe discharge is achieved. Seven day cover supports the review of and support to discharges at the weekend and identification of any potential issues regarding capacity prior to Mondays. Working at the weekend enables environmental visits to take place at more appropriate times to accommodate families.
- Review of patients who are identified for moves to community hospital to explore all options for discharge so that only those who require community hospitals are moved there.
- Assessment of equipment needs and review of home environments.
- Attendance at MDT meetings to identify discharge pathways and goals.
- Discharge Planning Meetings (DPMs) to enable full discussions in respect of patient's pathways and provision of support to relatives/carers in arranging plans for discharge
- Realise opportunities which have arisen with regards to preventing hospital admissions and keeping patients at home by providing equipment or referring to appropriate services.
- Identify and address gaps in knowledge in terms of the discharge processes and provide education and training as appropriate.

3.9. Service User Experience – Complaints to Social Work Adult Services; Indicators 64 & 65

Table 11 - Indicators 64 & 65					
		Baseline 2015/16	**2017/18 All**	**2017/18 Stage 1**	**2017/18 Stage 2**
64.	The number of Social Work Adult Services (Stage 1 & 2) complaints completed within timescales.	113/156	77/122	70/110	7/12
	The proportion of Social Work Adult Services (Stage 1 & 2) complaints completed within timescales.	73.4%*	63.1%	63.6%	58.3%
65.	Proportion of Social Work Adult Services complaints upheld ***NB. 2015/16 & 2016/17 were reported under the old complaints system (with 70% target). The target for 2017-18 is now 100%.**	% upheld		36.4	33.3
		% partially upheld		26.4	41.7
		% not upheld		37.2	25.0

Purpose:
Monitoring and managing complaints is an important aspect of governance and quality management. It also helps ensure that any necessary improvement actions arising from complaints are followed up and implemented.

Position:
In April 2017 the social work complaints handling procedure changed as to comply with SPSO requirements. Prior to this a series of training sessions were delivered to raise staff awareness of the new procedure. Support with logging and closing off complaints is now handled centrally. Weekly reports of complaints outstanding are provided to the Head of Service and Service Managers. Since April 2018 these are a standing item at the Adult Services managers' meetings. Performance has improved since 2016/17, but it is still below the target of 100%. However, the number of complaints is low (under 2%) given the large number of service user contacts during the year, with over 9,200 people receiving an assessment/review.

Figure 14 - Number of Social Work Adult Services (Stage 1&2) complaints completed (Indicator 64)

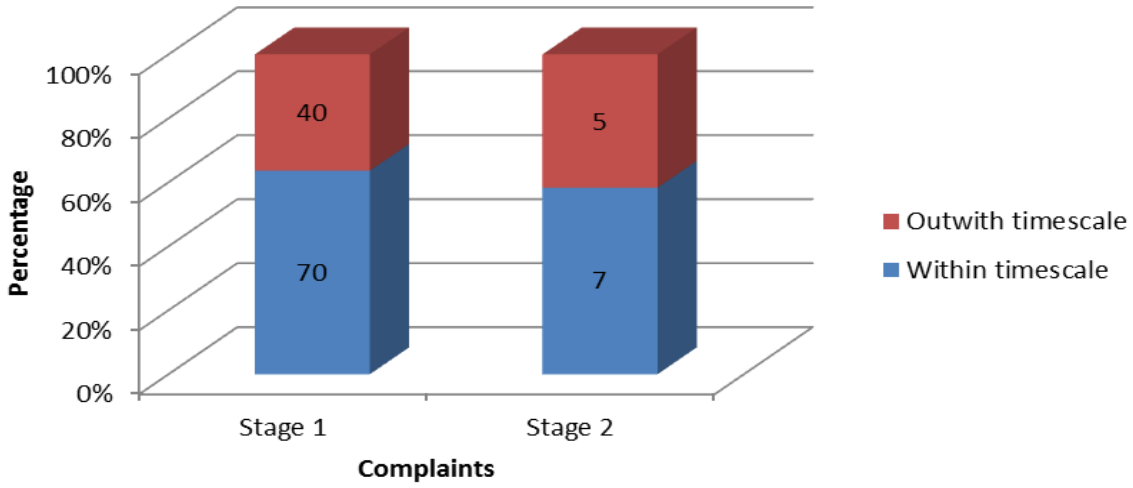
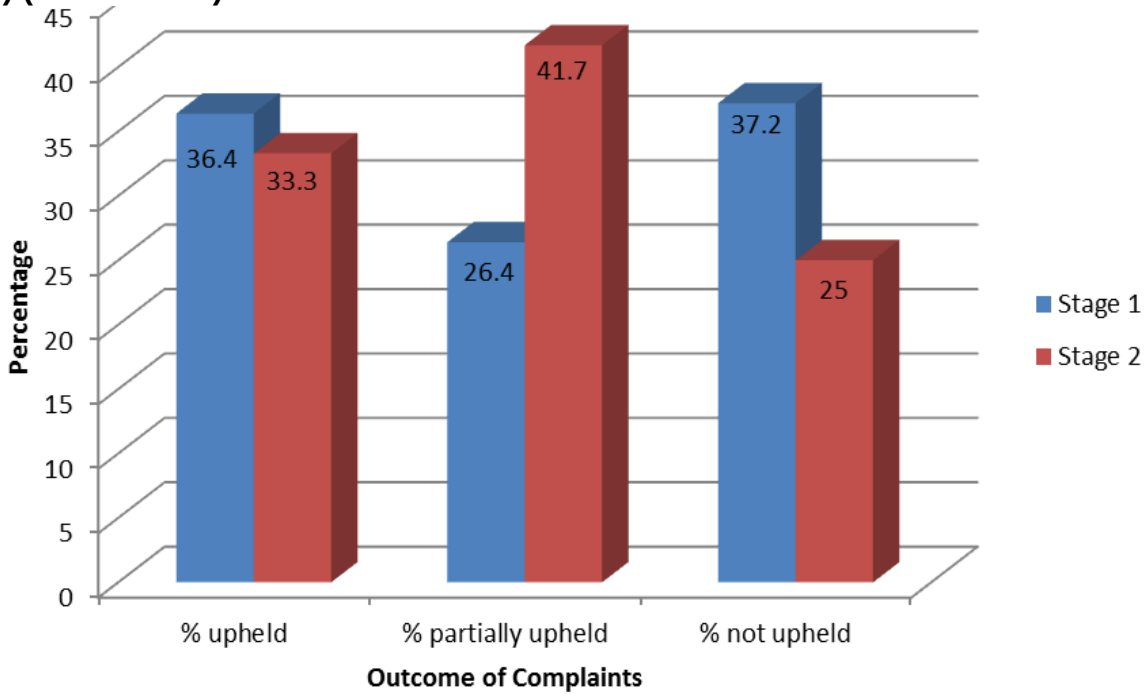


Figure 15 - Proportion of Social Work Adult Services complaints upheld (2017-18) (Indicator 65)



3.10. Service User Experience – Sickness Absence in Social Work Adult Services; Indicator 66

Table 12 - Indicator 66		
Sickness Absence in Social Work Adult Services (target – 5.5%)	**2015/16**	**2017/18 to end Q3**
	7.9%	**8.2%** ▼

Purpose:
The management of sickness absence is an important management priority since it reduces the availability of staff resources and increases costs of covering service. A target of 5.5% has been set for Social Work Adult Services in recognition of the fact that the service includes those engaged in Home Care and Residential Care which are recognised nationally as physically demanding and stressful occupations.

Position
2016/17 saw the implementation of significant planned change across the whole service, from service redesign to the introduction of new technology and new ways of working. All of this has impacted directly on employees. Whilst steps have been taken to engage and consult with staff, many report increased stress and anxiety, both work related and non work related. Traditionally, during the winter months Social Work Adult Services absence increases due to colds and flu. At the end of 2017 and beginning of 2018, flu hit the service and impacted on absence.

3.11. Service User Experience – Rehabilitation at Home services. Indicator 76

Table 13 - Indicator 76		
Percentage of Rehab At Home service users who attained independence after 6 weeks - (target – 80%)	2015/16	2017/18 to end Q3
	77.4%	69.4% ▼

Purpose:
A key objective in the integration of health and social care is to support people to remain independent at home, and to facilitate early discharge from hospital. It is a partnership priority to ensure that home care and support for people is available, particularly those with high levels of care needs.

Position:
This indicator notes people who have been enabled to leave the Rehab at Home service with no further package of care. This can be too limiting a measure when supporting people with complex care needs, as for some people a reduced package of care that maintains their independence can be a positive outcome. However, as shown above, performance has decreased by 8.1% to the end of Quarter 3.

Consideration will be given to broaden reporting to include reablement services provided through, for example, Summerford and Tygetshaugh.

3.12. Community Based Support – The number of Carers' Assessments carried out: Indicator 80

Table 14 - Indicator 80			
	Baseline 2015/16	2017/18	Direction of Travel
The number of Carers' Assessments carried out	1,936	1,656	▼

Purpose:
Supporting carers is recognised as an important element in the Falkirk Integrated Strategic Plan. So it is important to ensure we monitor and support carers through assessment and involvement in the planning and shaping of services required for the service user and for themselves.

Position:
The number of carers' assessments completed by community care teams declined between 2015-16 and 2016-17, but have remained stable between 2016-17 and 2017-18. The Service works in partnership and partly funds the Central Carers Association (CCA). The CCA supports carers in many different ways and now supports over 4000 carers in the Falkirk area. This decline in carer assessments by community care teams will be considered alongside the expanding role of the CCA to meet the requirements of the new Carers' Act in 2018.

It should be noted that the carer satisfaction indicators (indicators 62 and 63) show high levels of satisfaction amongst carers. Indicator 62 shows the percentage of carers satisfied with their involvement in the design of the care package for the person they support at 91% in 2017-18. Indicator 63 shows the percentage of carers who feel supported and capable to continue in their role as a carer, OR who feel able to continue with additional support has increased from 89% in 2015-16 to 91% in 2017-18.

3.13. Community Based Support – Overdue pending Occupational Therapy (OT) Assessments: Indicator 81

Table 15 - Indicator 81		
The number of overdue 'OT' pending assessments at end of the period	**March 2016**	**At 09 April 2018**
	352	**285 ▲**

Purpose:
The provision of OT assessments and the subsequent provision or arrangement of equipment or adaptations helps to maintain people in the community for longer.

Position:
Due to demographic pressures, demand for OT assessments has been increasing. Assessments can also be delayed by other competing pressures on staff resources, such as Adult Support and Protection work. However the number of overdue OT pending assessments as at March 2018 has reduced to 284 since March 2016.

Of those 284 cases144 (51%) were priority 2 and the remainder, 140 (49%) were priority 3. The service has consistently been able to respond to priority one assessment and there is no waiting list for these. This has resulted in priority 2 and 3 cases experiencing longer waits.

The reduction in outstanding assessments will partly be due to the work of the Reablement Project Team. This is a project team formed to test out new models of delivering reablement in a timeous and responsive way. It is made up of occupational therapists who have been redistributed from Community Care Teams to work in the Discharge to Assess model. The team has been small so the impact whilst moving in the right direction has been modest. However, the team is about to increase so it is predicted the impact will become more significant.

In addition, the introduction of the new eligibility framework will mean that service users with low level need will be sign posted to access their own solutions rather than waiting on pending lists for Occupational Therapist / Social Care Officer assessment. ADL Smartcare self assessment and Independence clinics will offer alternative solutions to Falkirk people with low/moderate need rather than requiring to wait for an assessment on a pending list. This development work is ongoing.

Chart Index

Table Index

Falkirk Integration Joint Board Strategy Map **Appendix 1**

Vision	**To enable people to live full independent and positive lives within supportive communities**				
Local Outcomes	***SELF MANAGEMENT-***	***AUTONOMY & DECISION MAKING***	***SAFETY***	***SERVICE USER EXPERIENCE -***	***COMMUNITY BASED SUPPORT -***
National Outcomes (9)	**1)** Healthier living **2)** Reduce Inequalities	**4)** Quality of Life	**7)** People are safe	**3)** Positive experience and outcomes **8)** Engaged work force **9)** Resources are used effectively	**2)** Independent living **6)** Carers are supported
National Indicators (23) (* Indicator under development nationally)	**1)** % of adults able to look after their health well/quite well **11)** Premature mortality rate	**7)** % of adults who agree support has impacted on improving/maintaining quality of life **12*)** Rate of Emergency admissions for adults **17)** % of care services graded 'good' (4) or better by Care Inspectorate	**9)** % of adults supported at home who felt safe **13*)** Emergency bed day rate for adults **14*)** Readmission to hospital within 28 days rate **16*)** Falls rate per 1000 population 65+yrs	**3)** % of adults who agree that they had a say in how their help/care was provided **4)** % of adults supported at home who agree their health and care services are co-ordinated **5)** % of adults receiving care and support rated as excellent or good **6)** % of people with positive GP experiences **10)** % of staff who recommend their place of work as good **19)** Rate of days people aged 75+ spend in hospital when they are ready to be discharged, **20)** % of total health and care spend on hospital stays where the patient admitted as an emergency **22*)** % people discharged from hospital within 72 hours of being ready **23)** Expenditure on end of life care	**2)** % of adults supported at home who agree they are supported to be independent **8)** % of carers who feel supported in their role **15)** % of last 6 months of life spent at home or in community **18)** % of adults 18+ years receiving intensive support at home **21*)** % of people admitted to hospital from home then discharged to care home **22*)** % people discharged from hospital within 72 hours of being ready
MSG Indicators	a. Number of A&E attendances and the number of patients seen within 4 hours	b. Number of emergency admissions into Acute specialties	c. Number of unscheduled hospital bed days, with separate objectives for Acute, Geriatric Long Stay and Mental Health specialties	d. Number of delayed discharge bed days	e. Percentage of last six months of life spent in the community f. Percentage of population residing in non-hospital setting for all adults and people aged 75+

Partnership Indicators

SELF MANAGEMENT	Freq	AUTONOMY & DECISION MAKING	Freq	SAFETY	Freq	SERVICE USER EXPERIENCE	Freq	COMMUNITY BASED SUPPORT	Freq
24. Emergency department 4 hour wait Forth Valley	M	28. Emergency admission rate per 100,000 Forth Valley population	M	42. Readmission rate within 28 days per 1000 FV population	M	54. Standard delayed discharges	M	67. The total respite weeks provided to older people aged 65+. Annual indicator	Y
25. Emergency department 4 hour wait Falkirk	M	29. Emergency admission rate per 100,000 Falkirk population	M	43. Readmission rate within 28 days per 1000 Falkirk population	M	55. Delayed discharges over 2 weeks	M	68. The total respite weeks provided to older people aged 18-64. Annual indicator	Y
26. Emergency department attendances per 100,000 Forth Valley Population	M	30. Acute emergency bed days per 1000 Forth Valley population	M	44. Readmission rate within 28 days per 1000 Falkirk population 75+	M	56. Bed days occupied by delayed discharges	M	69. Number of people aged 65+ receiving homecare	Q
27. Emergency department attendances per 100,000 Falkirk	M	31. Acute emergency bed days per 1000 Falkirk population	M	45. Number of Adult Protection Referrals (data only)	Q	57. Number of code 9 delays	M	70. Number of homecare hours for people aged 65+	Q
		32. Number of patients with an Anticipatory Care Plan in Forth Valley	M	46. Number of Adult Protection Investigations (data only)	Q	58. Number of code 100 delays	M	71. Rate of homecare hours per 1000 population aged 65+	Q
		33. Number of patients with an Anticipatory Care Plan in Falkirk	M	47. Number of Adult Protection Support Plans (data only)	Q	59. Delays - including Code 9 and Guardianship	M	72. Number receiving 10+ hrs of home care	Q
		34. Key Information Summary (KIS) as a percentage of the Board area list size Forth Valley	M	48. The total number of people with community alarms at end of the period	Q	60. Percentage of service users satisfied with their involvement in the design of their care package	Q	73. The proportion of Home Care service users aged 65+ receiving personal care	Q
		35. Key Information Summary (KIS) as a percentage of the Board area list size Falkirk	M	49. Percentage of community care service users feeling safe	M	61. Percentage of service users satisfied with opportunities for social interaction	Q	74. The proportion of Home Care service users aged 65+ receiving a service during evening/overnight	Q
		36. Long term conditions - bed days per 100,000 population	M	50. Number of new Telecare service users 65+	Q	62. Percentage of carers satisfied with their involvement in the design of care package	Q	75. The proportion of Home Care service users aged 65+ receiving a service at weekends	Q
		37. SDS Option 1: Direct payments		51. Rate per 1,000 Acute Occupied Bed Days attributed to Staphylococcus aureus bacteraemias (SABs)	M	63. Percentage of carers who feel supported and capable to continue in their role as a carer OR feel able to continue with additional support	Q	76. Percentage of Rehab At Home service users who attained independence after 6 weeks (target – 80%)	Q
		38. SDS Option 2: Directing the available resource		52. Rate per 1,000 Bed Days attributed to Device Associated Infections	M	64. The proportion of Social Work Adult Services (Stage 1 & 2) complaints completed within 20 days	M	77. Percentage of Crisis Care service users who are retained in the community when service ends (target - 70%)	Q
		39. SDS Option 3: Local Authority arranged		53. Rate per 1,000 Bed Days in the 65+age group attributed to Clostridium Difficile	M	65. The proportion of social work (Completed Stage 1 & 2) complaints upheld	M	78. Number of new Telecare service users 65+	Q
		40. SDS Option 4: Mix of options, 1,2,3				66. Sickness Absence in Social Work Adult Services (target – 5.5%)	M	79. The number of people who had a community care assessment or review completed	
		41. No recorded SDS Option						80. The number of Carers' Assessments carried out	
								81. The number of overdue 'OT' pending assessments at end of the period	
								82. Proportion of last 6 months of life spent at home or community setting	
								83. Number of days by setting during the last six months of life: Community	

Glossary

- **Accident & Emergency (A&E) Services** - Collectively the term Accident and Emergency (A&E) Services includes the following site types: Emergency Departments; Minor Injury Units, community A&Es or community casualty departments that are GP or nurse led.
- **Admission** - Admission to a hospital bed in the same NHS hospital following an attendance at an ED service.
- **Admission rate** - the number of admissions attributed to a group or region divided by the number of people in that group (the population).
- **ALFY** - Advice Line For You
- **Anticipatory Care Plan (ACP)** - The measure is the number of patients who have a Key Information Summary or Electronic Palliative Care Summary uploaded to the Emergency Care Summary. The Emergency Care Summary provides up to date information about allergies and GP prescribed medications for authorised healthcare professionals at NHS24, Out of Hours services and accident and emergency.
- **Attendance** - The presence of a patient in an A&E service seeking medical attention.
- **Attendance rate** - The number of attendances attributed to a group or region divided by the number of residents in that group (the population).
- **COPD – Chronic Obstructive Pulmonary Disease**
- ***Delayed Discharge***

Code 9 - Code 9 and its various secondary codes, are used by partnerships that are unable, for reasons beyond their control, to secure a patient's safe, timely and appropriate discharge from hospital:

- The patient is delayed awaiting availability of a place in a specialist facility, where no facilities exist and an interim move would not be appropriate i.e. no other suitable facility available
- Patients for whom an interim move is not possible or reasonable
- The patient lacks capacity, is going through a Guardianship process

Code 100 - Some patients destined to undergo a change in care setting should not be classified as delayed discharges and can be categorised as:

- Long-term hospital in-patients whose medical status has changed over a prolonged period of treatment and discharge planning such that their care needs can now be properly met in non-hospital settings. These might be Mental Health patients or Hospital Based Complex Clinical Care patients who have been reassessed as no longer requiring such care.
- Patients awaiting a 'reprovisioning' programme where there is a formal (funded) agreement between the relevant health and/or social work agencies
- Information on patients recorded as code 100 is not published but details are made available to the Scottish Government.

- **Emergency Department (ED)** – The department of a hospital responsible for the provision of medical and surgical care to patients arriving at the hospital in need of immediate care
- **4 hour wait standard** - since 2007 the national standard for A&E waiting times is that new and unplanned return attendances at an A&E service should be seen and then admitted, transferred or discharged within four hours. This standard applies to all areas of emergency care such as EDs, assessment units, minor injury units, community hospitals, anywhere where emergency care type activity takes place.
- **Frequent attenders** - Have been defined as patients who attend a health care facility repeatedly. The frequency of attendance has been variously defined between 3 and 12 attendances per annum.

- **HAI -** Healthcare Acquired Infections

- **MSG –** Ministerial Steering Group (Scottish Government)

- **Pentana –** Performance Management eHealth system formerly referred to as Covalent

- **RAG –** Red, Amber or Green status of a measure against agreed target.

- **Readmission –** admission to hospital within either 7 or 28 days of an index admission standardised by specialty

- **SAS** – Scottish Ambulance Service

- **Scottish Index of Multiple Deprivation** - The area based measurement of multiple deprivation ranking areas based on 38 indicators spanning 7 dimensions of deprivation; employment, income, health, education, housing, geographic access to services and crime**.**

- **Unscheduled Care -** is “NHS care which cannot reasonably be foreseen or planned in advance of contact with the relevant healthcare professional, or is care which, unavoidably, is out with the core working period of NHS Scotland. It relates to aim of reducing the number of patients and the amount of time they spend in hospital where it is not planned e.g. operation. Shorter lengths of stay results in better outcomes for patients, reduced risk of healthcare acquired infections, and improved patient flow through hospital systems.

- **Variance Range –** The percentage difference between data at 2 different points in time.