Agenda Item

5

Falkirk Integration Joint Board: Performance Report 1 April 2017 – 31 January 2018

Agenda Item 5

Falkirk Council

Title	**Falkirk Integration Joint Board: Performance Report 1 April 2017 – 31 January 2018**
Report	**Scrutiny Committee (External Organisations)**
Meeting Date:	**17 May 2018**
Submitted By:	**Chief Officer, Falkirk Health & Social Care Partnership**

1. PURPOSE OF REPORT

1.1. The purpose of this report is to provide a summary of the progress made by the Falkirk Health and Social Care Partnership [HSCP] to implement the Integrated Strategic Plan. This reports progress with performance since the last update to the Scrutiny Committee on 14 September 2017.

2. RECOMMENDATIONS

2.1. It is recommended that the Committee considers the performance of the Health and Social Care Partnership, and select a course of action from the following options:

- Approve the report and acknowledge progress by the HSCP in meeting its priorities under the Joint Strategic Plan;
- Request further information on specific aspects of the performance of the HSCP;
- Request a follow up report for future Scrutiny Committee consideration.

3. BACKGROUND

3.1. The Falkirk Integration Joint Board (IJB) is responsible for overseeing the planning, management and delivery of all relevant functions within scope of health and social care integration. The Board is also responsible for ensuring the delivery of its functions through the locally agreed operational arrangements. This involves the delegation of functions and services by Falkirk Council and NHS Forth Valley. These services are delivered through the Falkirk Health and Social Care Partnership (HSCP).

3.2. Membership of the Integration Joint Board is set out in legislation. The Board has 6 voting members – 3 Falkirk Council Elected Members; Councillors Black (who is vice-chair), Collie and Meiklejohn and 3 NHS Forth Valley non- executive Board members. The membership also includes senior officer representation from health, social work and wider stakeholders including service users, carers, third sector and staff representatives.

3.3. NHS Forth Valley and Falkirk Council delegate budgets to the IJB, who decide how resources are used to achieve the objectives of the Strategic Plan. The IJB then directs the partners, through the Health and Social Care Partnership, to deliver services in line with this plan. The Integration Joint Board controls an annual budget of approximately £200m.A governance framework is in place which includes the Integration Scheme, IJB Standing Orders, Risk Management and Clinical and Care Governance. This framework covers the rules and practices by which the IJB ensures that decision making is accountable and transparent.

3.4. The Falkirk Integrated Strategic Plan 2016-19 describes how the Falkirk HSCP will continue to make changes and improvements to health and social care services for all adults. The plan details how the partnership will prioritise services in response to the key issues for the Falkirk area as identified in the Joint Strategic Needs Assessment (JSNA).

3.5. The Strategic Plan identifies five specific local outcomes which align with the Scottish Government national health and wellbeing outcomes, the National Health and Social Care Delivery Plan and the Falkirk Community Planning Partnership Strategic Outcomes and Local Delivery (SOLD) Plan.

3.6. The HSCP Annual Performance Report 2016-17 was reported to the Scrutiny Committee (External) at its meeting on 14 September 2017. The Partnership must produce this report for the benefit of communities and partners.

4. IJB PERFORMANCE REPORTING ARRANGEMENTS

4.1. The IJB has a responsibility for the effective monitoring and reporting on the delivery of services and relevant targets and measures. The Board approved a Performance Framework in March 2016 and progress continues to be made to develop performance management and reporting arrangements.

4.2. The IJB receives regular performance reports at its meetings, and these are accessible online.

4.3. The Performance Report contains a Strategy Map. This has been created to ensure there is a direct link back from performance to the outcomes of the Strategic Plan. There are 5 specific outcomes identified in the Strategic Plan:

- **Self-Management**: Individuals, carers and families are enabled to manage their own health, care and wellbeing
- **Autonomy and Decision Making**: Where formal support is needed people should be able to exercise as much control and choice as possible over what is provided
- **Safe**: Health and social care support systems are in place, to help keep people safe and live well for longer

- **Service User Experience**: People have a fair and positive experience of health and social care
- **Community Based Support**: Informal supports are in place, which enable people, where possible, at home or in homely settings within their own community

In addition, the Strategy Map notes the links with the strategic vision and local outcomes to the national health and well-being outcomes against which performance on integration is audited at a Scotland wide level. A glossary of terms has also been provided to give explanation and context to abbreviations and areas contained within the report.

4.4. The Partnership is also required to produce quarterly reports to the Ministerial Strategic Group (MSG) for Health and Community Care. This is against 6 national integration themes and the planned trajectories to 2018/19 for:

- Unplanned Admissions
- Occupied Bed Days for unscheduled care
- A&E Performance
- Delayed Discharges
- End of life care
- Balance of Care Spend.

4.5. The management of performance is critical to managing the overall IJB budget by providing a sound basis from which to make decisions regarding services, redesign and disinvestment. The aim as set out in a recent Audit Scotland briefing is to ensure services are well integrated and that people receive the care they need at the right time, and in the right place. In support of this aim the HSCP has undertaken a range of integrated service redesign initiatives. These include:

- Development of an Integrated Reablement Pathway
- Redesign of day services for younger adults
- The introduction of a Home First [Discharge to Assess] approach to discharge planning for people who are in hospital
- Introduction of online self assessment enabling people to find readily accessible solutions to tasks of daily living
- Adoption of new ways of delivering primary care.

Appendix 1 provides a summary of some examples of integrated redesign programmes which support effective integrated performance.

4.6. The most recent Performance report to the April IJB is attached at Appendix 2 for information. This report presents performance in relation to local performance indicators for the period April to January 2018, unscheduled care and delayed discharges. The report also includes information on the submission to the MSG with agreed trajectories against the integration indicators for unscheduled care.

4.7. Key performance issues are considered in detail in Section 2 of the performance report. The IJB NHS performance indicators are presented in charts, in Section 3, showing Falkirk's performance, as well as the overall Forth Valley performance. There is also some commentary underneath the charts to explain performance and any related issues.

4.8. The social care IJB indicators are presented using the traffic lights system (red, amber, or green) plus some data only indicators. The distribution of these indicators is shown in Table 1 below.

Table 1: Social Care IJB Performance indicators

Green	Amber	Red	Data Only	Total
16	0	7	7	30

4.9. Sixteen indicators show positive performance. These include the home care measures (Inds 69-77) showing:

- number of people receiving the service
- volume and rate per 1000 home care hours
- number of people receiving more than 10 hours per week
- proportion receiving personal care
- percentage of crisis care service users being supported to remain in the community when service ends.

One home care indicator shows red and this reflects an area of service that has been changing during 2017-18 (see section 4.12 below). The number of people with community alarms and telecare (Inds 48 and 78) is increasing, and the service users' experience measures (Inds 49, 60 and 61) also show high levels of satisfaction ranging between 90 - 98%.

4.10. Carer satisfaction is more mixed with 92% recording satisfaction with their involvement in the design of the care package for the person they support (Ind 62), but fewer carers - at 79% - feel supported and capable to continue in their role as carer, or feel able to continue with additional support. This and a declining number of carers' assessments in recent years indicate a need to explore carer experience measures further. Current work on implementing the Carers (Scotland) Act 2016 will bring new focus to this area of work and will inform the development of new indicators for carers. Progress with these will be reported to the IJB in due course.

4.11. For seven indicators performance is shown as red and not performing to required levels. These include complaints to social work (Inds 64/65); sickness absence in Social Work Adult Services (Ind 66); and overdue OT assessments (Ind 81). In all three of these areas performance has improved in the latest reporting period. Both indicators on respite care show a decline in provision for older people aged 65 plus and for adults 18-64 (Inds 67/68). This is for a number of reasons, including changing service user/carer preferences with the implementation of self directed support

(SDS) for more flexible services away from traditional overnight residential respite service.

4.12. The percentage of Rehab at Home service users who attained independence after 6 weeks declined in 2017-18 compared to the previous year. This change is a consequence of service redesign. The service users being referred to the Service now have a higher level of relative need than was the case in the past. People with lower levels of need are being supported through reablement services. A new more meaningful indicator will be developed to reflect this changing area of service.

4.13. A further seven indicators are defined as data only indicators as these provide factual information about the relevant service areas. However, indicators such as the Adult Support & Protection (ASP) referrals, investigations and support plans data (Inds 45-47) are important in providing context, as high priority ASP work can affect performance in other areas of service, such as completing outstanding pending OT assessments. Similarly, the indicators on Self Directed Support (SDS Inds 37-41) provide a summary of the distribution of SDS choices made by service users but also show the positive progress in a steadily increasing proportion of people who now have a recorded chosen SDS support option.

4.14. In 2017/18, as in 2016/17, a modest underspend was reported for the in scope budget delegated by the Council to the HSCP. The delivery of a balanced budget, accompanied by realisation of significant savings, and avoidance of adverse impact on service quality is itself an indicator of effective performance and a promising foundation for achievement of our local outcomes.

5. CONSULTATION

There was no requirement to consult in the preparation of this report.

6. IMPLICATIONS

Financial

6.1. Effective and efficient performance across key areas of service delivery is an essential element of strategic and operational financial management. The performance detailed above has supported achievement of a balanced budget position.

Resources

6.2. Sustaining and improving performance requires effective deployment of resources, in particular management capacity and the frontline staffing resource. The redesign initiatives described in Appendix 1 are examples of how resources are being used in innovative ways to optimise outcomes.

Legal

6.3. Effective performance across the service activity detailed in this report supports fulfilment of statutory functions and obligations.

Risk

6.4. The performance detailed in the report has mitigated risk to reputation associated with any significant failure to achieve strategic objectives, and risk to services associated with any significant failure to meet budgetary responsibilities.

Equalities

6.5. An equality and poverty impact assessment was not required for this report.

Sustainability/Environmental Impact

6.6. This was not required for this report.

7. CONCLUSIONS

7.1. The integration of Health and Social Care in Falkirk and at the national level remains at an early stage in its development. This report summarises performance information covering a range of measures of key areas of service activity. The Partnership continues to make god progress across a range of Service areas. This is within a context of growing demand, ageing population, people living with more complex health conditions and financial constraints. The Scrutiny Committee is invited to consider recommendations at paragraph 2.1 of the Performance report presented by the Falkirk HSCP.

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Chief Officer, Health and Social Care Partnership

Author: Joe McElholm, Head of Adult Social Work Services
Suzanne Thomson, Programme Manager, Falkirk Health and Social Care Partnership

Date: 6 April 2018

Appendices:

1. **Falkirk HSCP Integrated Service Redesign Programmes**
2. **Performance Report, presented to IJB on 6 April 2018**

List of Background Papers:
None

Appendix 1

Falkirk Health and Social Care Partnership Service Redesign Programmes

In addition to the Performance report attached, there are a number of examples of service redesign and new developments that have been taken forward over 2017/18 that will be of interest to the Committee. These initiatives support effective performance and are briefly described below as background information for the Performance report.

1. Living Well in Falkirk

1.1. In partnership with ADL Smartcare the Falkirk Health and Social Care Partnership has developed *Living Well Falkirk.* Developed in association with the University of Newcastle, this is an online tool for people who live in the Falkirk area and who want information, support or help with everyday living. The tool gives people choice and control by sharing a wide range of information about local and national health and social care services.

1.2. Living Well Falkirk allows people to connect in to local groups and services and so helps them to live independently and do the things that they want to do. There is information about local fitness classes, local charities supporting a range of physical and mental health conditions, as well as how to access equipment privately or through the Joint Loan Equipment Store. People can also use it on behalf of someone they live with or who they help care for. If assistance is needed in using the tool, staff at local libraries are able to help.

1.3. The Living Well Falkirk website is now live www.falkirk.gov.uk/livingwell and over 200 employees across all agencies have been trained in its uses and are equipped to direct people to the online self assessment and in some cases guide them through it. This initiative will support a reduction in waiting times for some interventions, for example assessments leading to equipment provision, as people are enabled directly to access simple solutions.

2. Redesign of Day Services for Younger Adults

2.1. The Integration Joint Board agreed to a programme of redesign of day services for younger adults. This is in line with the outcome of consultation and engagement work with people who use services, their carers and staff. The redesign work reflects Self-Directed Support principles to empower and enable service users to have choice and control over the design of their own support and develop alternative community based services.

3. Discharge to Assess Pilot

3.1. Discharge to Assess is a new approach to identifying people in hospital who can be discharged as soon as clinically fit for discharge to their own home, thereby minimising their hospital stay. Avoiding unnecessary delays in a person's discharge from hospital is imperative to avoid deterioration in an individual's health and consequent loss of independence.

3.2. The Discharge to Assess Pilot commenced in December 2016 and continues as part of the Falkirk HSCP Integrated Reablement Service. Working initially with an external provider partner and now through the in house home care service, the approach identifies appropriate discharge pathways for people including those who can be discharged and assessed in their own home environment. Following discharge home, support with a reablement focus is provided for a period of up to six weeks. Regular reviews are completed and an outcome focussed assessment involving the individual will identify any subsequent support required. In addition to service users reporting satisfaction in regaining their independence, the reablement approach allows a substantial number of staff support hours to be made available to be allocated to people who do have a need for ongoing support.

4. Reablement Pathway and establishment of the Reablement Project Team

4.1. Considerable work has been undertaken on the implementation of a reablement approach across the HSCP. An integrated, Reablement Leadership Group has developed a high level integrated pathway for service delivery across the HSCP. The Reablement Leadership Group will continue to work to implement the changes required to deliver reablement to all service users who would benefit from this approach. This will not only support people to remain as independent as possible for as long as possible, but will potentially deliver savings by avoiding some people requiring to use into formal health and social care services.

4.2. A Reablement Project Team (RPT) was developed in Social Work Adult Services Assessment and Planning service in January 2017 to test out various reablement approaches and processes. The team consists of Occupational Therapists (with Community Care worker background) and Social Care Officers. Various strands of work have been completed over the past year including undertaking reviews from both the Community Care Teams and Home Care services where there is external home care provided. The reviews are being completed using a reablement and outcomes focussed perspective. Early indications suggest a significant impact of this work, with purchasing of care from external home care providers reducing by £200,000.

5. Carer's Act implementation

5.1. From 1 April 2018, the Carer's [Scotland] Act 2016 extends and enhances the rights of unpaid carers The Act aims to ensure that carers are supported more consistently, so they can continue to care if they wish, and are able to do so in good health and with a life alongside their caring responsibilities.

5.2. The IJB and Falkirk HSCP, has over the course of 2017/18 overseen and directed the preparations for the implementation of the Carers Act, locally. A Carers Act Implementation Group, drawing on appropriate membership from across the HSCP, Falkirk Council colleagues and importantly carers and carers' representative groups, has through effective engagement and co-production ensured that the requirements of the Act in relation to its introduction have been realised. A work programme to meet the additional ongoing requirements of the Act for 2018/19 has been developed.

6. Support at Home

6.1. The in-house home care service has focused on service review and improvements informed by findings from the CM2000 scheduling system and through engagement events targeted at the home care workforce. The objective in 2018 is to move the service forward and to ensure its fitness for the future when the service user base is likely to be older, frailer and have multiple disabilities. Initiatives currently being progressed include:

- achieving efficiencies in scheduling;
- embedding reablement and outcomes based approaches;
- upskilling and mobilising the workforce,
- steering the service towards delivery based on a locality model.

6.2. One current organisational change, that of transferring the hospital discharge to assess function to a recently formed Reablement Project Team supported by the in- house home care service, has already seen a sizable reduction in care package scale and to the number of support packages being outsourced to contracted home care providers. In 2018 a more robust client review process will ensure home care service levels being provided equate with service user needs and HSCP priorities.

7. Primary Care Transformation Programme

7.1. Primary Care Transformation is set within the context of the new GP contract and a background of general practice sustainability challenges. These challenges include an aging General Practitioner workforce, rising workload and a lack of Doctors training to be GPs. Within Forth Valley the need for and approach to transformation can be seen in both NHS Board managed practices, such as Kersiebank Health Centres, and practices with ongoing independent contractor status.

The Transformation Programme in place in Forth Valley is focusing on the following:

7.1.1. **Urgent Primary Care (GP) Out of Hours Transformation:** with the aim of implementing the recommendations of the "Report of the Independent Review of Primary Care Out of Hours Services", Nov 2015, a comprehensive multiagency GP out of hours case review was conducted in 2017. An OOH implementation plan developed to deliver on the aim of creating a safe and sustainable multidisciplinary approach to Urgent Out of Hours Care in Forth Valley. Five advanced nurse practitioner training posts have been filled to support the new model to work safely with fewer GPs, supported by Mental Health Nurses, Paramedic Specialists and improved integration with other over night supports.

7.1.2. **General Practice Based Transformation:** aims to encourage GP practices to work together in clusters, taking a multi-disciplinary approach to care within practice and the community. This involves developing the role of health professionals such as pharmacists, physiotherapists, mental health professionals and advanced nurse practitioners in delivering aspects of patient care – freeing up GPs to focus on more complex cases and provide clinical leadership. Across Forth Valley we are focussing on the following:

7.1.3. **Supporting the development of locality models of care**: The Primary Care Transformation Fund is supporting the delivery of locality priorities within both HSC Partnerships which aim to improve outcomes through enhanced primary and community or secondary care interfaces. In Falkirk through provision of pharmacy support to care homes.

7.1.4. **Development of multidisciplinary approaches:** This is the primary focus of the programme and focuses on testing out new ways of working which will inform the service redesign required for the new General Medical Services Contract proposal to reduce GP workload.

The key test of change within this stream is implementing mental health primary care nurses and additional pharmacy sessions. Four mental health nurses will provide an additional 300 triage and face to face mental health appointments in Falkirk West GP practices. Pharmacists will deliver eight clinical sessions per week across 4 GP practices for two years. Baseline data has been collected with 10% of GP appointments found to be for mental health support alone. A further 10% of consultations include a mental health component presented alongside other complaints.

7.1.5. **Enabling Primary Care Transformation:** A number of enabling supports are also in place including education and training for advanced practice, Practice Administration Optimisation and signposting, Technology based alternatives to appointments and development of Cluster Quality Improvement.

7.1.6. **Mental Health in Primary Care:** The investment for mental health services aims to improve access for people with mental health needs to the most appropriate support as quickly as possible, in the most appropriate setting. This aligns with the new mental health strategy for Scotland 2017-2027. The Primary Care Transformation fund is supporting the development of a more efficient and integrated model of post diagnostic support for dementia, which will bring Alzheimer Support Workers, the Dementia Outreach Team and social care dementia resource together to improve the matching of support to the needs of users.

The fund is also supporting the delivery of the Autism Strategy recommendations, developing an area wide resource to support the diagnostic pathway and post diagnostic support for people with autism spectrum disorders and their families.

8. Development of a Locality model for service delivery

8.1. A key statutory obligation set out in the legislation on integration is the requirement to establish integrated localities for the delivery of health and social care. Building on work that has already been taken forward to HSCP locality working, work was undertaken with key front line locality based leaders between October 2017 and March 2018 by Service Managers in Social Work services and the NHS. This work consisted of 12 development sessions across the 3 locality areas. The development sessions were attended by leaders from Community Care Teams, Community Nursing, GP locality co- coordinators, home care; CVS, Carers Centre, NHS Allied Health Professional leads; Housing and Community psychiatric nursing (older people).

8.2. The sessions focused on identifying areas of practice where there is already evidence of high quality integrated working and also identified opportunities for more mainstreamed working with less duplication. The groups also considered what infrastructure improvements may require to be made to support better integrated working for example IT solutions and shared building space. The interface between the SOLD plan and HSCP locality working was also explored. Each of the 3 locality groups began the work of identifying what the key priorities for improvement may be in their area. A common theme which was identified in all 3 localities was improving integrated services for people with dementia. This work continues in each locality and it will be important to identify resources to assure the continued necessary momentum of this work.

Appendix 2

Falkirk
Health and Social Care
Partnership

Title/Subject:	**Performance Report**
Meeting:	**Integration Joint Board**
Date:	**6 April 2018**
Submitted By:	**Head of Performance and Governance, NHS Forth Valley**
Action:	**For Noting**

1. INTRODUCTION

1.1 This report presents performance in relation to local performance indicators for the period April to January 2018, unscheduled care and delayed discharges.

1.2 The Ministerial Strategic Group for the Health and Community Care (MSG) indicators, Integration indicators and submitted trajectories are devised to evoke a collaborative approach to unscheduled care, as part of partnership working.

2. RECOMMENDATION

The Integration Joint Board (IJB) is asked to:

2.1 note the content of the performance report

2.2 note the Performance and Measurement Group will bring forward a themed timetable of reporting to the IJB at its June meeting.

2.3 note the submission to the MSG with agreed trajectories against the integration indicators for unscheduled care as laid out in Appendix 3.

2.4 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 Since the last paper was presented to the Board, Performance and Measurement Group has continued to oversee the progress across a variety of areas requiring consideration in terms of performance management and reporting.

3.3 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 an Delayed Discharge Steering Group.

4. APPROACH

4.1 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.

4.2 It should be noted that the Scottish Government is currently undertaking a review of two of its national data reporting sources: the Annual Social Care Survey and the nationally collated SOURCE data on Health and Social Care. This review seeks to combine these two sources into one data source. It is likely that some changes may have to be made to the data reported to the IJB. The review has not yet concluded, but once the new data requirements has been finalised a further update will be provided to the IJB.

4.3 The Performance and Measurement Group are working to develop a more structured and themed timetable for performance reporting, and intend to report this in the next performance report to the IJB.

4.4 In terms of delayed discharge, this report sets out the performance of the Falkirk Partnership, based on the census data of February 2018. The report advises the Integration Joint Board on the principal reasons for delay and the process by which actions are being taken forward by the services to mitigate the delays.

5. PERFORMANCE REPORT STRUCTURE

5.1 The content of the report mainly focuses on the local performance indicators for the period April to January 2018, unscheduled care and delayed discharges.

5.2 Section 1 of the Performance provides an ‘at a glance performance summary’. Work is required in terms of developing a Balanced Scorecard to provide a broader range of measures and build upon qualitative improvement and assurance. The IJB focus is across the five local outcomes with work to support a balanced approach to measurement and reporting.

5.3 Section 2 provides a summary of key performance issues. The areas highlighted include:

- Emergency Department Performance against the 4 hour Standard
- Rate of ED Attendance
- Delayed Discharges

5.4 Section 3 offers additional detail with regard to the indicators described within the Strategic Plan, as well as detail in respect of a number of other linked indicators relating to Unscheduled Care.

5.5 Section 4 of this report provides information from the latest national benchmarking report by the Improvement Service, published in February 2018. This provides national data on a range of social care and other services for 2016/17, and will be reported to Falkirk Council's Scrutiny Committee.

5.6 Appendix 1 – The Strategy Map details the Partnership's vision, the expected Local Outcomes, and maps these against the National Health and Wellbeing Outcomes, National Core Indicators, MSG 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.

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

6. MEASURING PERFORMANCE UNDER INTEGRATION

6.1 As previously reported to the IJB in February 2017, the Partnership submitted draft Local improvement objectives, related to the six integration themes, to the Scottish Government. This was in response to the request made by MSG.

6.2 The six MSG themes are:

- Unplanned Admissions
- Occupied Bed Days for unscheduled care
- A&E Performance
- Delayed Discharges
- End of life care
- Balance of Care Spend.

6.3 Trajectories have been approved at the most recent meeting of the Unscheduled Care Programme Board (USPB) chaired by the Medical Director, and submitted to the MSG. These trajectories will be monitored by the UCPB, with reports to the IJB incorporated into the performance report. The agreed trajectories are set out in Appendix 3 for information.

6.4 Definitions and methodologies relating to the Balance of Care Spend are pending agreement by the national subgroup of the Corporate Finance Network. Guidance will be issued nationally forthwith.

7. CONCLUSION

7.1 The Integration Joint Board is responsible for effective monitoring and reporting on the delivery of services and relevant targets and measures included in the

Integration Functions, and as set out in the Strategic Plan. This report represents the and presents a formal performance report to the Board.

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
Approach defined in the approved Performance Management Framework and further developed through the Performance and Measurement Group with all parties represented.

Equality and Human Rights Impact Assessment
Report not assessed. Content derived from national indicators.

Approved for submission by: Patricia Cassidy, Chief Officer

Author: Annette Kerr, ICF Support Officer, Philip Morgan-Klein, Performance & Information Service Manager, Vivienne Meldrum, Senior Information Analyst

Date: 28 March 2018

List of Background Papers:

Section 1: At a Glance Performance Summary

The Partnership focus is across the five Local Outcomes with work ongoing to support a balanced approach to measurement and reporting. It should be noted that work is required in terms of developing a Balanced Scorecard to provide a broader range of measures and build upon qualitative and quantitative data which will enable and support quality improvement and assurance.

Key:

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

H1 = Half year ending 30/9/17
Q3 = Quarter ending 31/12/17

The table highlights local data for the year to date position, April to January 2018, compared with the previous full year with the Delayed Discharge position at the January 2018 census is reported. Performance data pertain to adults aged 18 and over.

Partnership Indicator	**Falkirk**	
Local Outcomes: Self Management	**2016/17**	**2017/18**
24. Emergency department 4 hour wait Forth Valley	**93.2%**	**88.8% ▼**
25. Emergency department 4 hour wait Falkirk	**92.9%**	**88.1% ▼**
26. Emergency department attendances per 100,000 Forth Valley Population	**1,747**	**1,774 ▼**
27. Emergency department attendances per 100,000 Falkirk	**1,933**	**1,953 ▼**

Partnership Indicator	Falkirk	
Local Outcomes: Autonomy & Decision Making	**2016/17**	**2017/18**
28. Emergency admission rate per 100,000 Forth Valley population	**1,007**	**965 ▲**
29. Emergency admission rate per 100,000 Falkirk population	**1,036**	**981▲**
30. Acute emergency bed days per 1000 Forth Valley population	**637**	**649 ▼**
31. Acute emergency bed days per 1000 Falkirk population	**592**	**582▲**
32. Number of patients with an Anticipatory Care Plan in Forth Valley**	**16,541**	**15,548****
33. Number of patients with an Anticipatory Care Plan in Falkirk	**NA**	**6,663**
34. Key Information Summary as a percentage of the Board area list size Forth Valley**	**5.4%**	**4.9%****
35. Key Information Summary as a percentage of the Board area list size Falkirk	**NA**	**4.2%**
Self directed support (SDS) options selected: People choosing	**Mar 2017**	**Dec 2017**
37. SDS Option 1: Direct payments	**32 (1.2%)**	**26 (0.9%)**
38. SDS Option 2: Directing the available resource	**83 (3.1%)**	**98 (3.5%)**
39. SDS Option 3: Local Authority arranged	**1,749 (66.3%)**	**1,981 (70.7%)**
40. SDS Option 4: Mix of options, 1,2,3	**45 (1.7%)**	**50 (1.8%)**
41. No recorded SDS Option	**730 (27.7%)**	**648 (23.1%) ▲**

Partnership Indicator	RAG Falkirk		
Local Outcome: Safety	**2016/17**		**2017/18**
42. Readmission rate within 28 days per 1000 FV population	**1.24**		**0.70▲**
43. Readmission rate within 28 days per 1000 Falkirk population	**1.37**		**0.75▲**
44. Readmission rate within 28 days per 1000 Falkirk population 75+	**1.26**		**1.26 ◄►**
45. Number of Adult Protection Referrals (data only)	**540**		**398**
46. Number of Adult Protection Investigations (data only)	**47**		**37**
47. Number of Adult Protection Support Plans (data only)	**Mar-17**		**Sep-17**
	10		**16**
48. The total number of people with community alarms at end of the period	**2016/17**		**201718 Q3**
	4,481		**4,542 ▲**
49. Percentage of community care service users feeling safe	**2015/16**	**2016/17**	**2017/18 to end H1**
	90%	**91%**	**90%▼**

Partnership Indicator	RAG Falkirk	
Local Outcomes: Service User Experience	**Feb-17**	**Feb-18**
54. Standard delayed discharges	**38**	**24▲**
55. Delayed discharges over 2 weeks	**25**	**15▲**
56. Bed days occupied by delayed discharges	**816**	**472▲**
57. Number of code 9 delays	**16**	**22▼**
58. Number of code 100 delays	**2**	**4▼**
59. Delays - including Code 9 and Guardianship	**54**	**46▲**

	2015/16	**2016/17**	**2017/18 to end H1**
60. Percentage of service users satisfied with their involvement in the design of their care package	**98%**	**98%**	**98%◄►**
61. Percentage of service users satisfied with opportunities for social interaction	**93%**	**93%**	**92%▼**
62. Percentage of carers satisfied with their involvement in the design of care package	**92%**	**93%**	**92% ▼**
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%**	**81%**	**79% ▼**
64. The proportion of Social Work Adult Services (Stage 1 & 2) complaints completed within timescales.	**2015/16***	**2016/17***	**2017/18 to end Q3**
***NB. 2015/16 & 2016/17 were reported under the old complaints system (with 70% target). The target for 2017-18 is now 100%.**	**73.4%**	**57.4%**	**65.6% ▲**

	'2017/18 to end Q3'	**Stage 1**	**Stage 2**
65. Proportion of Social Work Adult Services complaints upheld –	**% upheld**	**33.3**	**22.2**
	% partially upheld	**27.2**	**44.5**
	% not upheld	**39.5**	**33.3**

	2015/16	**2016/17**	**2017/18 to end Q3**
66. Sickness Absence in Social Work Adult Services (target – 5.5%)	**7.9%**	8.4%	8.2%

Partnership Indicator		RAG Falkirk	
Local Outcomes: Community Based Support		**2015/16**	**2016-17**
NB. This data was reported to the IJB in the December 2017 Performance Report 67. The total respite weeks provided to older people aged 65+. Annual indicator	**2014/15** **1,834**	**1,703▼**	**1,527 ▼**
This data was reported to the IJB in the December 2017 Performance Report 68. The total respite weeks provided to older people aged 18-64. Annual indicator	**2014/15** **729**	**2015/16** **724▼**	**2016-17** **578 ▼**
		Mar 2017	**Sep 2017**
69. Number of people aged 65+ receiving homecare *		**1,807**	**1,756 ▼**
70. Number of homecare hours for people aged 65+ *		**13,949**	**14,304 ▲**
71. Rate of homecare hours per 1000 population aged 65+ *		**488.6**	**490.6 ▲**
72. Number receiving 10+ hrs of home care *		**401**	**456 ▲**
73. The proportion of Home Care service users aged 65+ receiving personal care *		**92.4%**	**91.9% ▼**
*** Note each year's Home Care data is a snapshot of provision in a single reporting week at end of reporting period.**			
76. Percentage of Rehab At Home service users who attained independence after 6 weeks (target – 80%)		**2016/17** **92.3%**	**2017/18 to end Q3** **69.4% ▼**
77. Percentage of Crisis Care service users who are retained in the community when service ends (target - 70%)		**75.2%**	**73.8% ▼**
78. Number of new Telecare service users 65+	**2015/16** **102**	**2016/17** **75 ▼**	**2017/18 to end Q3** **96 ▲**
79. The number of people who had a community care assessment or review completed	**2016/17** **8,932**		**2017/18 To end H1** **6,192 ◄►**

	2016/17	2017/18to end H1
80. The number of Carers' Assessments carried out	1,624	794 ▼
81. The number of overdue 'OT' pending assessments at end of the period	Mar 2017	At 20/02/18
	316	273 ▲
	2014/15	2015/16
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▲

Section 2: Key Performance Issues

1. ***Emergency Department Performance against the ED 4 Hour Standard***

Issue:

The average Falkirk monthly Emergency Department (ED) compliance from 2017/18 to the end of February 2018 is 88.1%, which reflects the average monthly Forth Valley compliance of 88.8%. Analysis of ED compliance for February by age group shows compliance is highest in the 18-64 age range at 88.5% with the lowest compliance level of 75% occurring in those aged 75 years and over. Reasons for delay in the over 75s in the reporting month show 50% were waiting for a bed with 30% having their wait attributed to a wait for first assessment.

Action:

In respect of supportive actions it should be noted that there has been a focus on patient safety with appropriate escalation processes in place, maximising capacity and contingency planning with an increased focus on decision making at the front door. Flu positive patients have been cared for appropriately with safe cohorting. Partnership working has been maximised utilising additional community capacity and the Enhanced Community Team.

A number of improvement processes/actions are in place with NHS Forth Valley working with the Scottish Government around the 6 Essential Action approach.

- Essential Actions 1-4 are about changes needed to the way hospital services are designed and provided. These includes strengthening clinical leadership and ownership of patient pathways, analysing and planning hour by hour to check that patients are on the right pathway and in the right place on their pathway, holding safety briefings and escalating and resolving issues quickly, providing assessment, diagnosis and treatments as soon as possible to support people to return home or to most suitable place of care earlier rather than later in the day.
- Essential Action 5 focuses on provision of services such as phlebotomy, diagnostics and medicines over seven days.
- Essential Action 6 *Ensuring Patients Are Cared For In Their Own Homes* is about avoiding attendance, avoiding admission, short and reduced length of stay. It is delivered through the initiatives and core provision mentioned elsewhere, rather than being a separate stream of work.

There has been recent recruitment to the post of Programme Manager for Unscheduled Care which will support work in respect of the priorities for improvement and will lead the work in terms of 6 essential actions.

Additionally, the Unscheduled Care Programme Board, headed by the Medical Director, is working with a view to maximising internal processes in terms of escalation and preventing breaches through focusing on the ‘6 Essential Actions’, and working in partnership with Integration Authorities looking at the whole system in support of sustainable improvement.

2. ***Rate of Emergency Department Attendance***

Issue:

The average monthly Emergency Department attendance rate in Forth Valley has increased from 1,747 per 100,000 population in 2016/17 to 1,774 per 100,000 population in 2017/18 to date. This is highlighted as a 1.5% increase.

Falkirk has seen a rise of 1% in 2017/18 to 1953 per 100,000 population, from 1,933 per 100,000 population in 2016/17. February 2018 has seen a 9% reduction in Forth Valley attendances since January 2018. This is not indicative of an improvement in numbers presenting, but is in keeping with a trend going back to at least 2015. Falkirk depicts a similar reduction of 5%.

The HSCP will continue to support work with NHS partners and others to ensure that more residents receive appropriate support and treatment within the community in order to reduce the number of A&E attendances and subsequent admissions to hospital.

Action:

Closer to Home - Enhanced Community Team including GP Fellows and ALFY February 2018 update

- The number of referrals to Closer to Home (Enhanced Community Team) has steadily increased each month since June 2017.
- Since 15 February, phone referrals to the team have been picked up by ALFY. It is very early days but initial improvements are that a broader range of options are available to the referrer, and that some clinical staff time is freed up.
- Work with night nursing is ongoing to ensure a more equitable response both in and out of hours.
- SAS referrals – falls pathway: Closer to Home (C2H) Team continue to take referrals from Scottish Ambulance Service for unwell, uninjured falls patients as part of a national initiative to reduce the number of falls patients being conveyed to hospital following a fall. This is being rolled out further as part of implementation plan.
- SAS referrals – COPD: the criteria for this is being revisited as there have been no referrals so far. GP Fellows to work with a small GP Practice to ID suitable parameters for COPD referrals to C2H.
- The use of a RAG system as an outcome measure has been shown to be helpful in identifying positive outcomes from interventions.
- Work with FVRH pharmacy department to develop a domiciliary IV antibiotic pathway is ongoing.

3. ***Delayed Discharges***

Issue:

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

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

The Falkirk Delayed Discharge Steering Group is in place to monitor operational performance and find solutions.

In February 2018 the number of standard delays for Forth Valley is 38. Falkirk accounts for 24 or 63.2% of all standard delays. 62.5% (15/24) Falkirk delays are waiting to over 2 weeks at the February 2018 census point. These Falkirk patients account for 83% (15/18) of Forth Valley waits over 2 weeks.

Table 1 shows the total number of standard delays April 2017 to February 2018.

Table 1 Standard Delays excluding Code 9 and Guardianship Delays

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

Across Forth Valley there has been a decrease in the number of occupied bed days attributed to delayed discharges with the number at the February 18 census 645 compared with 782 in January 2018.

The Falkirk Partnership position at the February census was 472 occupied bed days attributed to delayed discharges. This is 73% (472/645) of the occupied bed days within Forth Valley attributed to delayed discharges. However, over the course of the year, there has been a substantial decrease in occupied bed days attributed to delayed discharges in Falkirk. In February 2017 there were 816 occupied bed days attributed to delayed discharges in Falkirk, which is now down to 472.

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 February census is 22 Code 9 delays, with 26 for Forth Valley overall, therefore, 84.6% attributed to Falkirk residents within the Forth Valley setting.

Action:

The issues with Packages of Care have resolved and the situation has greatly improved. Whilst it is an improving position, the number of vacancies in care homes which can meet the needs of people with more complex cognitive issues awaiting placement remains challenging. The number of available care home places is challenged in respect of demand from the hospital setting as well as from people waiting for placement from their homes. Care home provision has been benchmarked with a review ongoing of care home criteria, care home places and capacity to support whole system capacity.

To further support improvements in the delayed discharge position and to support the winter plan there are a number of activities being undertaken:

- daily and weekly reviews through the discharge hub to support appropriate and timely discharge
- Discharge to Assess
- Work has commenced with regard to early promotion and guidance in respect of PoA
- Additionally work with regard to identifying barriers within the Guardianship Order process which results in people becoming delayed in hospital and recommendations with regard to this, are currently being focussed on
- Frailty at the Front Door Collaborative which will focus on identifying alternatives to hospital admission, by the multi disciplinary team, for people who are identified as Frail
- community hospital review
- intermediate care at home and reablement.

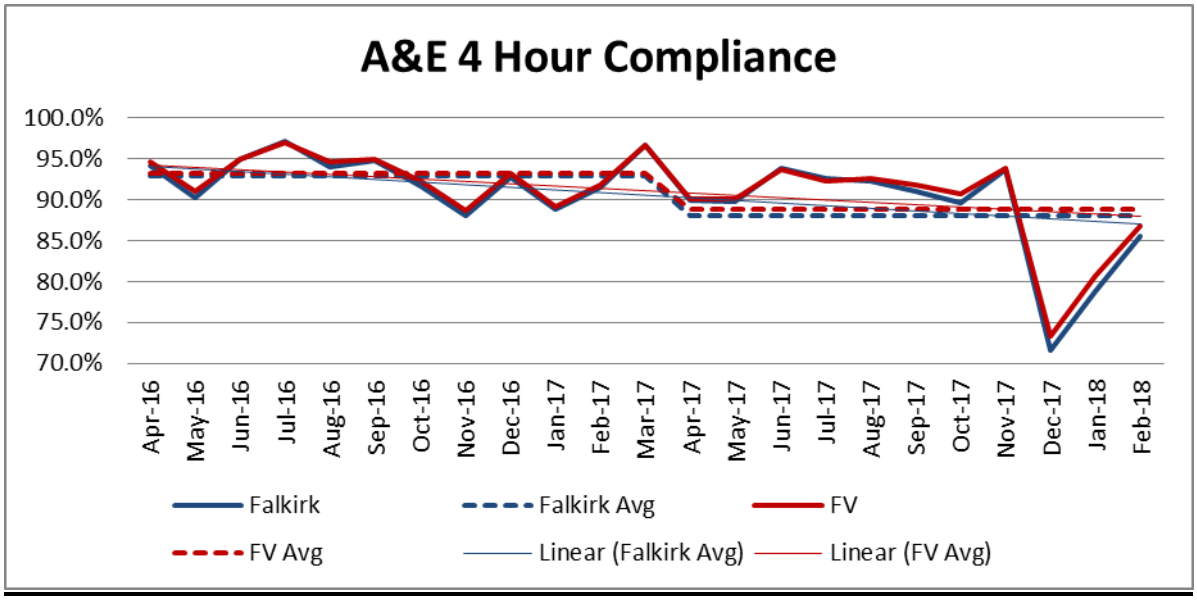
Section 3: Summary of Linked Performance Issues

Local Outcome – Self Management

- **Individuals, Carers and families are enabled to manage their own health, care and wellbeing**

Measure	Falkirk Unscheduled Care – Emergency Department Performance against the ED 4 Hour Target (includes Minor Injuries Unit). This is a 95% target.
Falkirk Partnership Performance	Average monthly performance in 2017/18 = 88.1%
Forth Valley Performance	Average monthly performance in the year to date , April to February 2017/18 = 88.8%

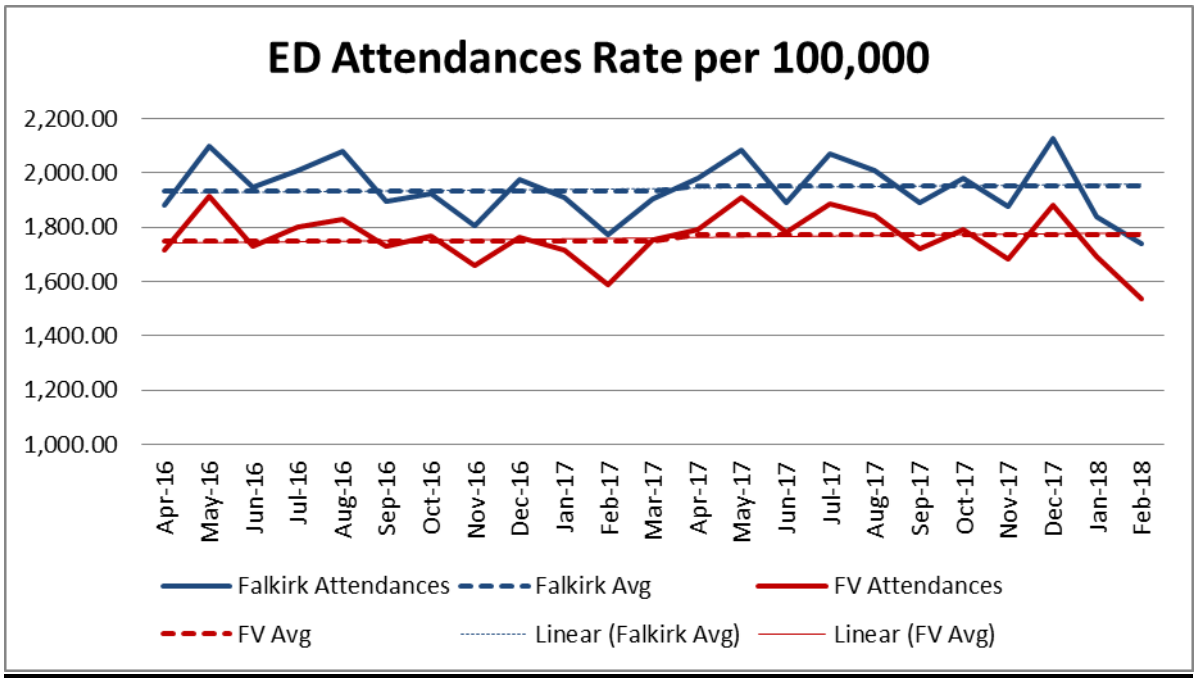
Chart 1: Emergency Department 4 Hour Compliance (Indicators 24 & 25)



- See commentary at Section 2 – Key Performance Issues

Measure	Falkirk Unscheduled Care – Emergency Department Attendance Rate per 100,000 population
Falkirk Partnership Performance	Average monthly performance 2017/18 = 1,953 per 100,000 population
Forth Valley Performance	Average monthly performance 2017/18 = 1,774 per 100,000 population

Chart 2: Emergency Department Attendance Rate (Indicators 26 & 27)



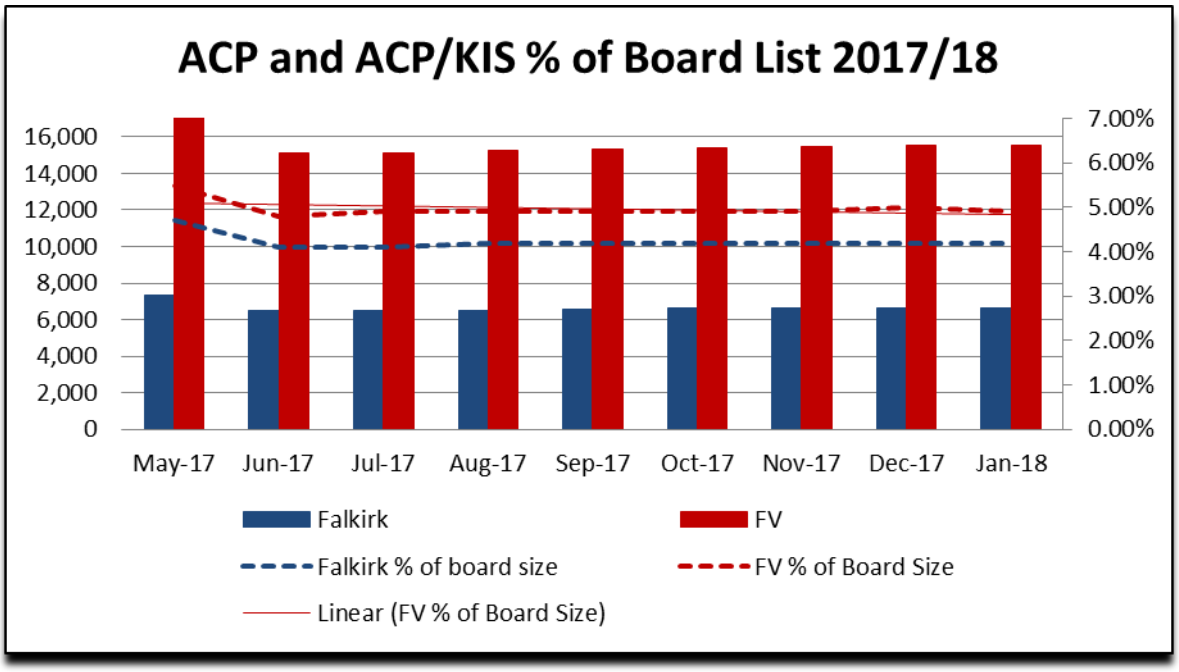
- See commentary at Section 2 – Key Performance Issues

Local Outcome – Autonomy and Decision Making

- **Individuals, Carers and families are enabled to manage their own health, care and wellbeing**

Measure	Anticipatory Care Planning
Falkirk Partnership Performance	Average monthly performance in 2017/18 = 6,663 (4.2%)
Forth Valley Performance	Average monthly performance in 2017/18 = 15,548 (4.9%)

Chart 3: Anticipatory Care Plan (Indicators 32 & 33)



Commentary

Anticipatory Care Planning (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.

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 outwith 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).

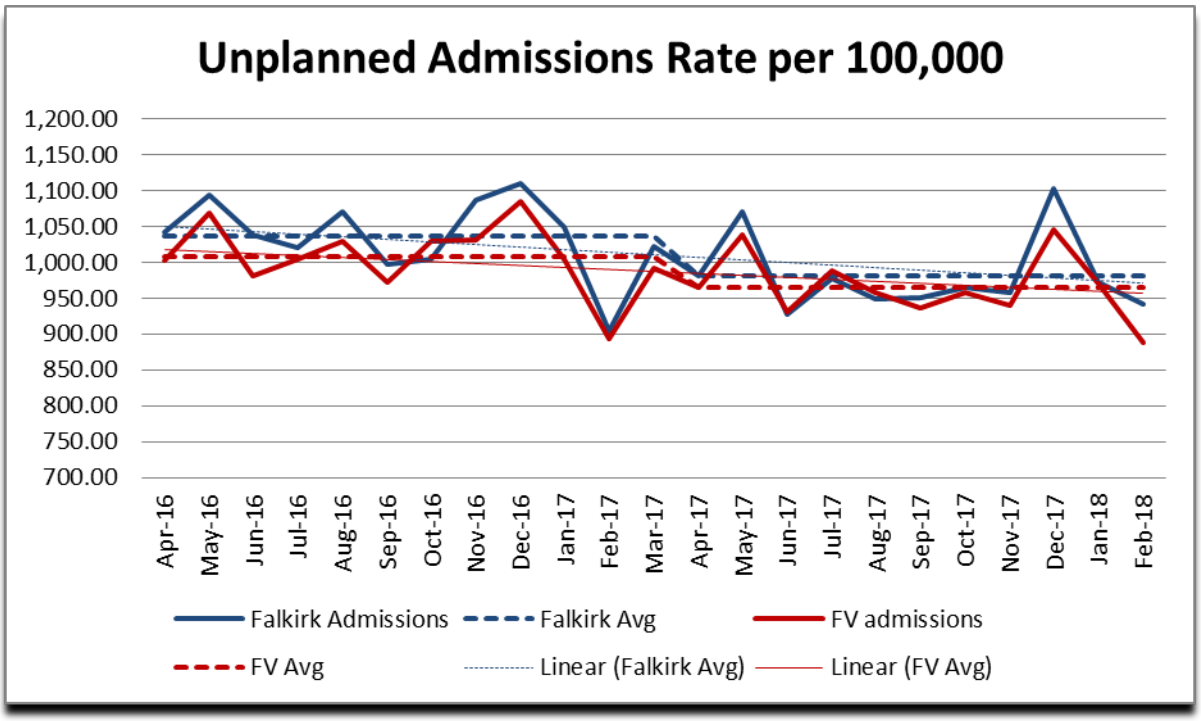
The impact of the ACPs on patient care is ongoing. Deliberations need to be made via robust studies to assess at which stage in the patient journey referral for an ACP should be made determining the best use of current resource and identify areas for development.

The ALFY Manager is working across both partnerships to bring communication and

referral processes into synchronisation between ALFY and nursing staff, who are tasked with assessing and delivering anticipatory care. Analysis is scheduled to be undertaken to measure the impact of the collaboration in terms of readmissions, and the average length of stays of acute of patients, who have a plan in place.

Measure	Emergency Admissions
Falkirk Partnership Performance	Average monthly performance in 2017/18 = 981.2
Forth Valley Performance	Average monthly performance in 2017/18 = 965.1

Chart 4: Emergency Admissions (Indicators 28 & 29)



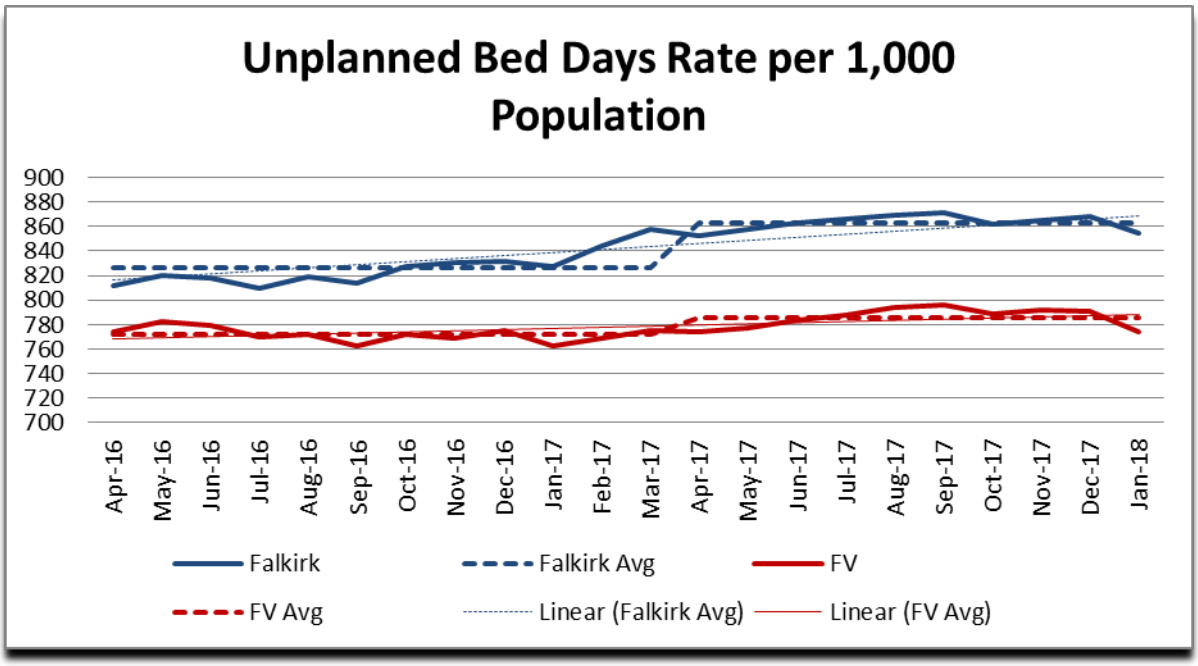
Commentary

The average unplanned admission rate for both Falkirk and Forth Valley in 2017/18 has reduced. The admission rate for the financial year 2016/17 in Forth Valley is down by 4.1%, from 1,007 per 100,000 population to 965 per 100,000 population this year to date. Falkirk admissions remain above the Forth Valley average. However, this has decreased from 1,036.5 per 100,000 population in 2016/17 to 981.2 per 100,000 population in 2017/18 year to date.

A breakdown by age range for adults shows an average decrease of approximately 5% across all age ranges.

Measure	Acute Emergency Bed Days
Falkirk Partnership Performance	Average monthly performance in 2017/18 = 584.4 rate per 1,000
Forth Valley Performance	Average monthly performance in 2017/18 = 649.8 rate per 1,000

Chart 5: Unplanned Bed Rate per 1,000 per population (Indicators 30 & 31)



Issue:

In 2016/17 the average monthly rate in terms of unplanned bed days for Forth Valley was 771 per 1000 population compared to 785 per 1000 population in 2017/18 to date. This highlights a 1.8% increase. The rate per 1,000 of patients pertaining Falkirk local authority area has decreased by 4.5% from 825 per 1000 population in 2016/17 to 862 per 1000 population in 2017/18.

Further analysis shows a rise on all age groups in the Falkirk Local Authority area, however
there is a significant decrease of 9% in the 65-74 age group.

Day of Care Results

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 (15.02.18) has demonstrated that FVRH is now at 13.2% (58 patients) not meeting acute in-patient criteria.

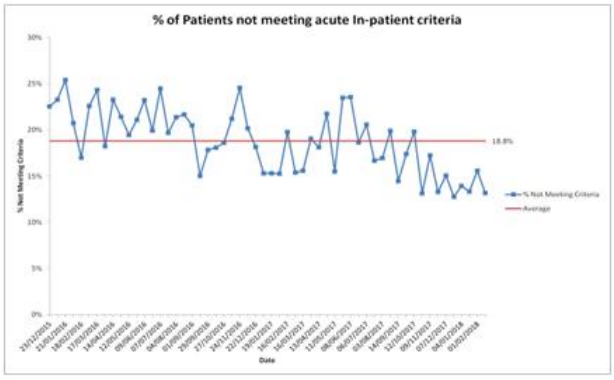
Within the Community hospital setting there have been seven surveys so far. The first survey found that 52% of patients did not meet the inpatient criteria. The latest survey in February 2018 has demonstrated that this is now 37%.

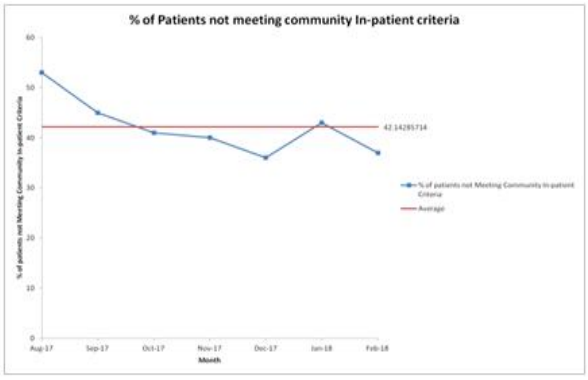
This is not yet a sustained reduction and the current plan is to continue repeating the Community Hospital survey monthly in order to identify potential areas for improvement.

Next Steps

- Discharge planning education sessions will be arranged and will be part of a rolling education programme for staff
- Review the process to assess how the survey is completed for Community Hospitals, learning from the Acute Hospital Day of Care, to ensure the survey is being conducted in a standardised approach. This will include action learning session with surveyors
- Continue with regular Community Hospital surveys
- Plan to review patients who have been identified as requiring a move to Community Hospital from Acute with a home first approach linking with social care and health community based services and explore options for discharge if home not appropriate i.e. Short term assessment. This should allow the most appropriate patients to move to Community Hospital or intermediate care facilities such as Summerford and Tygetshaugh.
- Roll out of the Daily Dynamic Discharges in Community Hospital should influence discharge destinations at an earlier point. Testing in 2 wards supported by the Discharge Coordinators;
- Utilise data to improve service delivery. For example, closer analysis of data between sites and wards.

Day of Care Results



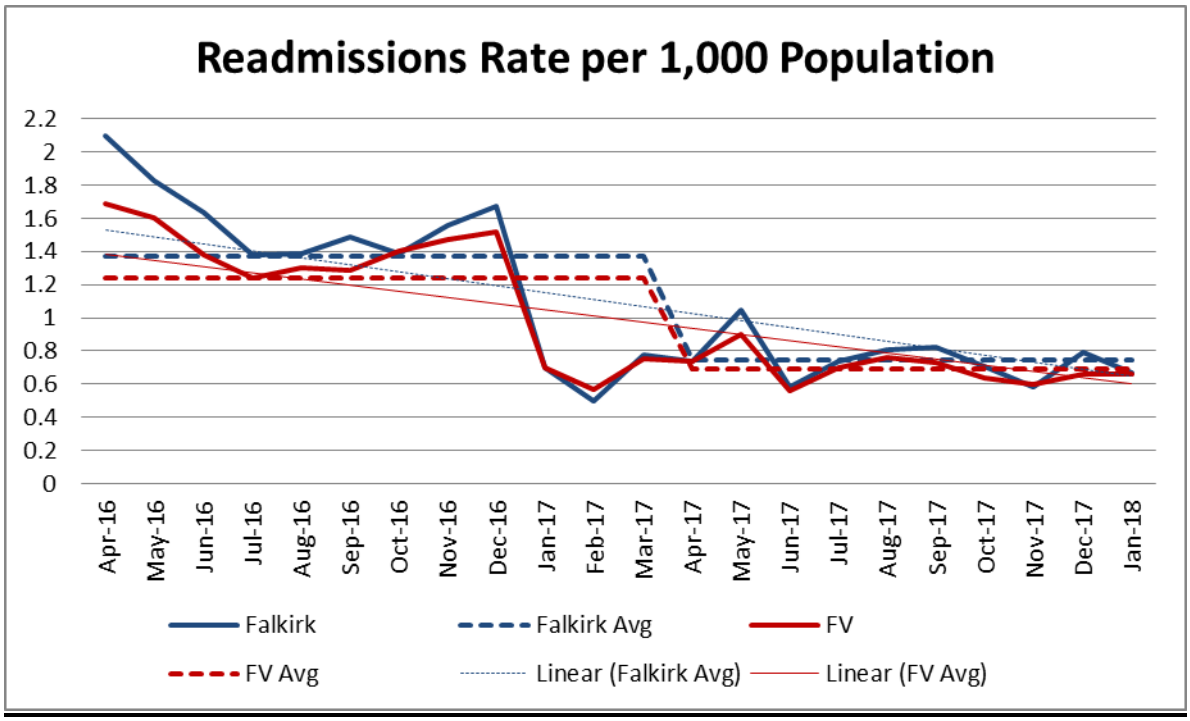


Local Outcome - Safety

- **Health & Social Care support systems are in place, to help keep people safe and live well for longer**

Measure	Unscheduled Care - Rate of Readmissions per 1,000 population Aged 18+
Falkirk Partnership Performance	Average Monthly Rate 2017/18 = 0.75 per 1,000 population
Forth Valley Performance	Average Monthly Rate 2017/18 = 0.70 per 1,000 population

Chart 6: Emergency Readmissions Rate (Indicators 42 & 43)



Commentary

Within Forth Valley the readmissions data is 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.

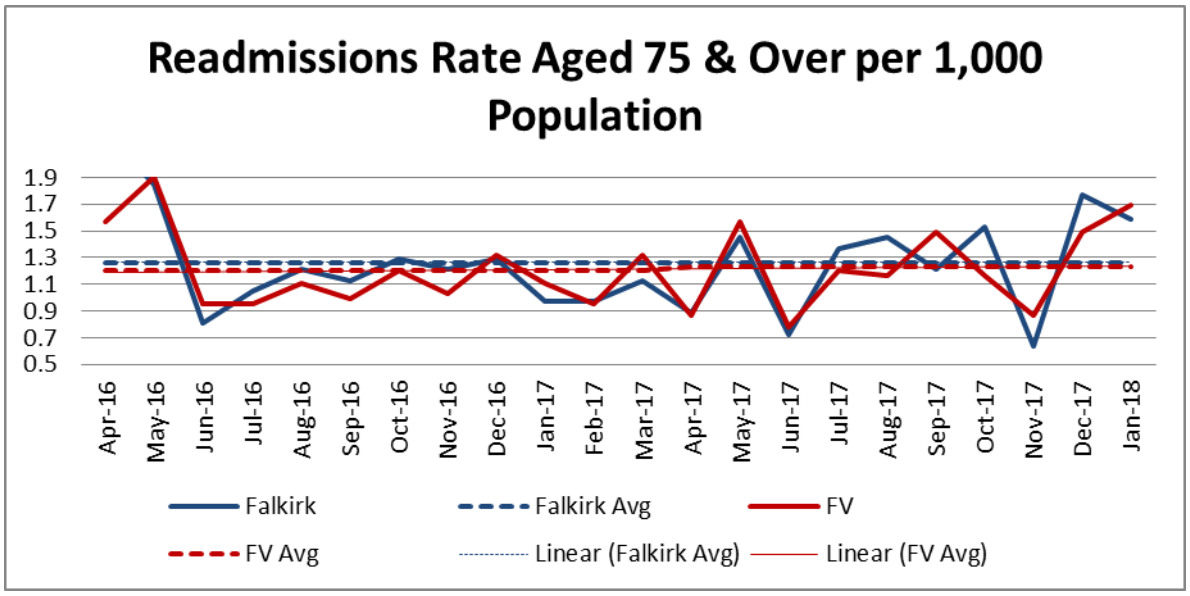
It should be noted that this differs from national publications that report the crude rate of readmissions which is any readmission within 28 days to any health board regardless of the reason for this readmission.

Chart 7 highlights a decrease in the rate of readmissions across Forth Valley from 1.24 per 1,000 population in 2016/17 to 0.70 per 1,000 population in 2017/18 year to date.

This decreasing trend is mirrored within the Falkirk Partnership with a decrease from 1.37 per 1,000 population in 2016/17 to 0.75 per 1,000 population in 2017/18 year to date.

Readmissions for those aged 75 and over have increased at a Forth Valley level. Forth Valley has increased to 1.23 rate per 1,000 population from 1.20 in 2016/17. The Falkirk position remains unchanged at 1.26 rate per 1,000 population.

Chart 7 Emergency Readmissions aged 75 years and Over (Indicator 44)



As referred to in previous sections work to assess the impact of the ACP on emergency readmissions is ongoing. The ALFY Service is led by the Head of the Anticipatory Care Team. As of September 2017, the Service is now proactively calling patients who have been recently discharged from hospital, to assess how well patients are managing at home post discharge. A direct referral can now be made to the ACP Teams across Forth Valley to carry out an ACP assessment identifying actions which can be taken to help keep patients at home where it is appropriate.

Local Outcome –Service User Experience

- **People have a fair and positive experience of health and social care**

Measure	Unscheduled Care – Delayed Discharges • Standard Delayed Discharges • Bed days lost attributed to delayed discharge • Code 9 and Code 100 delays
Falkirk Partnership Performance	Monthly Number February 2018 = 24
Forth Valley Performance	Monthly Number February 2018 = 38

Commentary

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

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

Chart 8: Delayed Discharges – Standard Delays (Indicator 54)

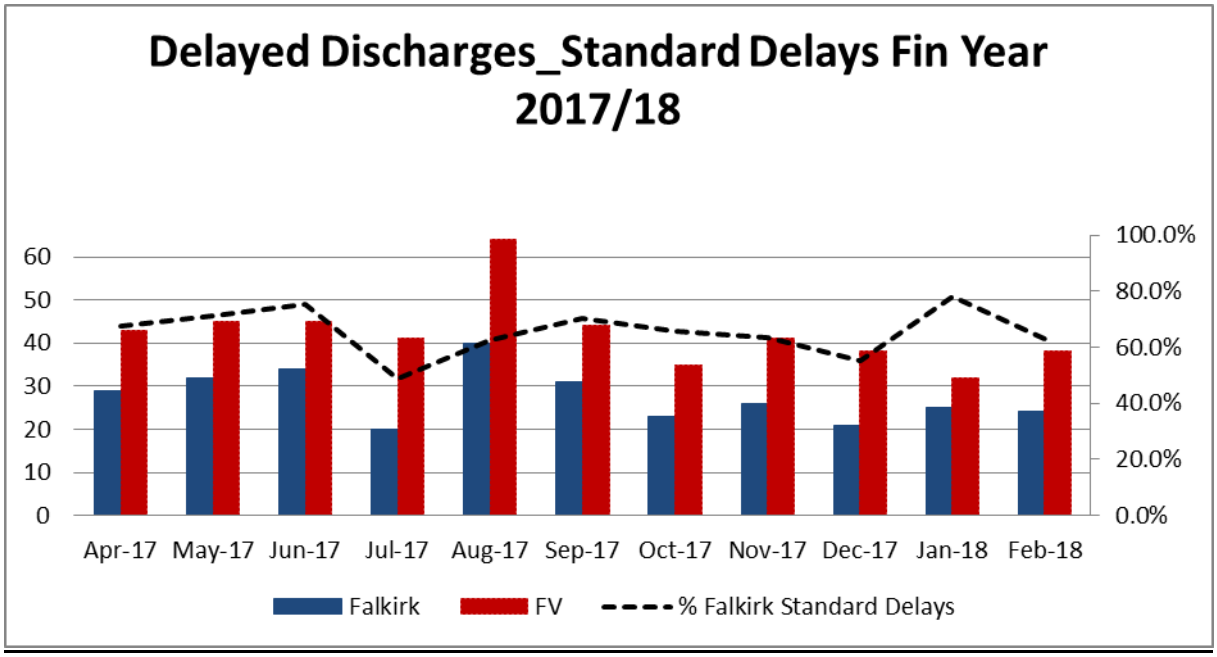


Chart 9: Occupied Bed Days Attributed to Delayed Discharges (Indicator 56)

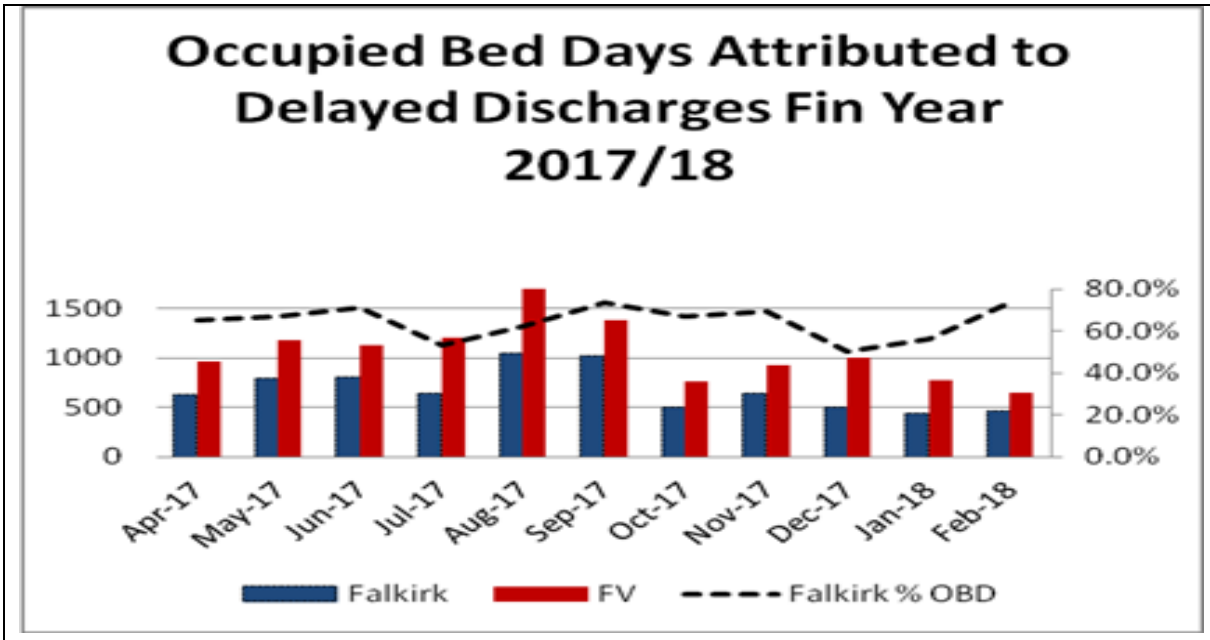
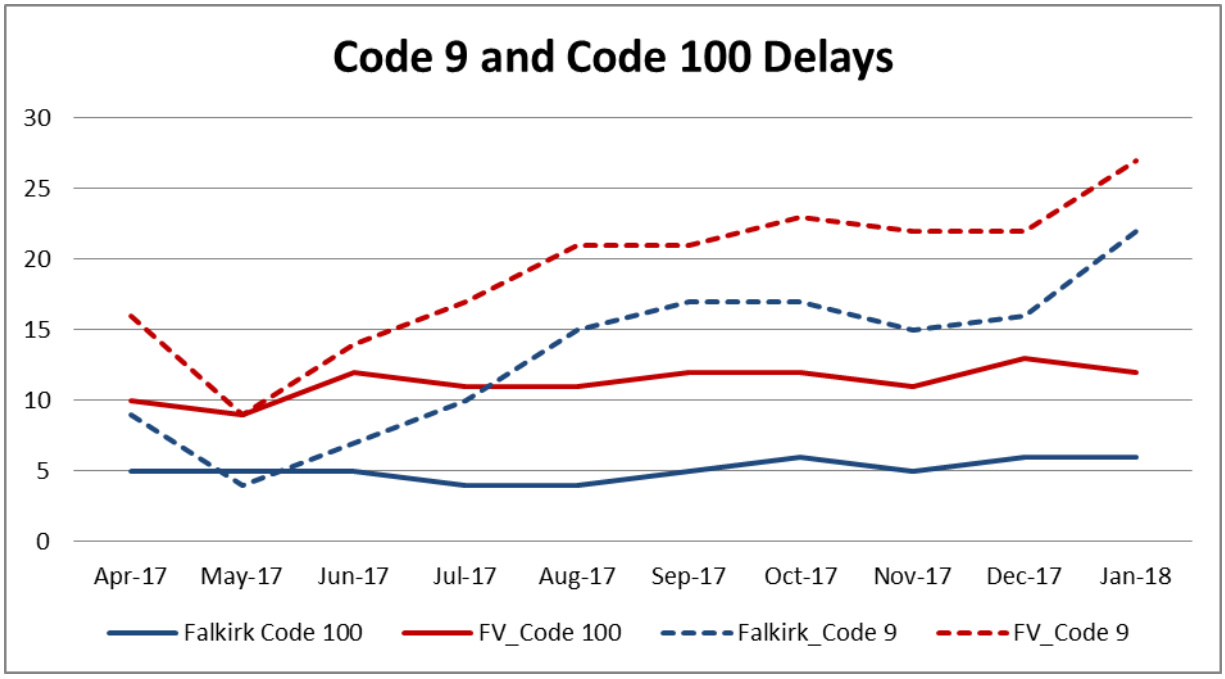


Chart 10 Code 9 and Code 100 Delays (Indicators 57 & 58)



- See Commentary – Section 2 Key Performance Issues

Indicators 64 & 65: Complaints to Social Work Adult Services

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

64. The proportion of Social Work Adult Services (Stage 1 & 2) complaints completed within 20 days (No.= 59/90)	**2015/16***	**2016/17***	**2017/18 to end Q3**
	73.4%	**57.4%**	**65.6% ▲**
65. Proportion of Social Work Adult Services complaints upheld –	**'2017/18 to end Q3'**	**Stage 1**	**Stage 2**
	% upheld	**33.3**	**22.2**
	% partially	**27.2**	**44.5**
	% not upheld	**39.5**	**33.3**

Position

Since April 2017, the new Social Work Adult Services Complaints Handling Procedure has been in place. The IJB CHP was also approved in June 2017.

Performance has improved since 2016/17, but it is still below the target of 100%.

It should be noted that Social Work Adult Services receive complaints about private service providers and these complaints are passed on. The timescales for responses to be provided are then dependent on information being received.

Managers now get a weekly report highlighting complaints that are open. We are reviewing the process to make sure that complaints are closed off in the system and that complaints we receive which are about private providers are logged and handled correctly.

Indicator 66: Sickness Absence in Social Work Adult Services

Purpose of Indicator: 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.

66. Sickness Absence in Social Work Adult Services (target – 5.5%)	**2015/16**	**2016/17**	**2017/18 to end Q3**
	7.9%	**8.4%**	**8.2% ▲**

Position

Sickness absence has reduced slightly in the first half of this year but remains higher than the Council target of 5.5% for Social Work Adult Services. Sickness absence is a key

managerial priority and the service continues to pursue initiatives to manage this issue as effectively as possible, in line with corporate HR policies and procedures. A new corporate HR system was introduced during quarter 3 and this is likely to have affected the data in the last quarter as it is likely to take some time to settle in.

A temporary HR Assistant post was created to assist managers within Homecare only to focus on absence management. This post was successful in supporting the service to manage absence. However, it has been vacant since the post holder moved post.

In the interim, a temporary HR Officer was appointed to undertake a wider role across Social Work Adult Services, to ensure a proactive approach to employees and managers with long term capability and short term monitoring. There was a positive shift with a 2% reduction in absences across the home care service. This post was extended to March 2018. HR are undertaking candidate interviews for the HR Officer, who will support both the service and the Council. In the meantime, support to progress absence cases continues to be provided to the wider service by HR Operations resource.

Local Outcome –Service User Experience

Indicators 67 & 68: Respite for older people aged 65+ and people aged 18-64

NB. This data and comments were reported to the IJB in the December 2017 Performance Report

Purpose of Indicator: The importance of supporting unpaid carers and enabling people to live independently at home are both well-established aspects of the Scottish Government's approach to health and social care. Short breaks are an essential part of the overall support provided to unpaid carers and those with care needs, helping to sustain caring relationships, promote health and well-being and prevent crises.

	2014/15	2015/16	2016-17
67. The total respite weeks provided to older people aged 65+. Annual indicator	**1,834**	**1,703▼**	**1,527 ▼**
68. The total respite weeks provided to older people aged 18-64. Annual indicator	**2014/15**	**2015/16**	
	729	**724▼**	**578 ▼**

Position

Respite to older people has decreased overall by 10% (overnight by 5%, daytime by 15%) and the number of service users by 8%.

Respite to other adults has reduced by 20% (overnight by 17%, daytime by 29%) and the number of service users by 9%.

There are a variety of reasons for usage reductions in both age groups, which generally reflects wider choice and options available to people, for example people are choosing alternative breaks to traditional care home respite e.g. caravans/ holidays and a reduction in demand.

Given these changing trends in respite in both service user and carer preferences and changes in the patterns of service provision and funding arrangements, it will be necessary to consider how best to monitor respite performance in future, and to review the targets which are currently set to maintain levels of local authority provision in an increasingly changing market.

Indicator 76: Rehabilitation At Home services

Purpose of Indicator: 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.

76. Percentage of Rehab At Home service users who attained independence after 6 weeks (target – 80%)	2016/17	2017/18 to end H1	2017/18 to end Q3
	92.3%	61.3% ▼	69.4%▲

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 increased by 8.1% in the latest quarter.

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

Indicator 81: Overdue pending Occupational Therapy (OT) Assessments

Purpose of Indicator: 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

81. The number of overdue 'OT' pending assessments at end of the period	Mar 2017	At 20/02/18
	316	273 ▲

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 has reduced to 273 as at 20 February.

Of those 273, only 121 (44%) were priority 2 and the remainder,152 (56%) were priority 3. This supports the case that the pending assessments are being addressed by priority need. The service has consistently been able to respond to priority one assessments and there is no waiting list for these. This has resulted in priority 2 and 3 cases experiencing longer waits.

The reduction in priority 2 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.

Section 4 – Local Government Benchmarking Framework (LGBF)

1. Purpose

The Local Government Benchmarking Framework (LGBF) National Benchmarking Overview Report 2016/17 was published in February 2018. The report includes six indicators on Adult Social Care and provides national data which shows how Falkirk is performing against Scotland averages and compared with other local authorities.

2. Background

The 2016/17 report is the Scottish LGBF's sixth annual report. Over the past seven years, the Improvement Service (IS) have worked with all 32 Scottish councils to develop a common approach to benchmarking, which is grounded in reporting standard information on the services that councils provide to local communities across the country.

3. Aims

The LGBF benchmarking framework reports on how much councils spend on individual services, service performance and service user satisfaction. The framework supports evidence based comparisons between similar councils so that they can work and learn together to improve their services. It should be noted that this framework sets out the national position, with wide-ranging variations in costs and performance across councils. The Improvement Service has set up 'Family Groups' of local authorities to explore the reasons for variations. These have found that some of the variations in financial indicators reflect differences in how local authorities assign expenditure within the Local Financial Returns to the Scottish Government. Other variations may reflect differences in local policies; for example, some local authorities have outsourced certain services such as home care, or care homes. Such variations impact on the comparability of the data. So these variations need to be taken into account when interpreting the national data. But the data does provide a framework for learning and improvement.

4. Objectives

This section focuses on the Adult Social Care indicators and how Falkirk is performing in comparison with the Scotland average.

5. Findings

5.1 Home Care Services

5.1.1 Home care costs per hour for people aged 65 or over

- Council spend on home care services has been standardised around home care costs per hour for each council, and there has been an increase of 1.7% in spending per hour on home care for people of 65 across Scotland.
- Movement between years has fluctuated, and variation has widened in the past two years. Rural councils have significantly higher costs, with average costs of £27.72 compared to £23.56 for urban councils, and £22.09 for semi-rural.
- In contrast, Falkirk's Home Care costs per hour for people aged 65 has gone down from £23.73 in 2011/12 to £14.74 in 2015/16. In 2016/17, Falkirk's Home Care costs per hour for people aged 65 or over was £16.24, ranking 6th in Scotland.

5.2 Balance of Care

5.2.1 The percentage of adults over 65 with intensive care needs receiving care at home

- The percentage of adults over 65 with intensive care needs (who receive 10+ hours of support) who are cared for at home is an area of increasing significance in an effort to care for more people in their own home rather than institutional setting such as hospitals.
- Across Scotland, the balance of care has shifted in line with policy objectives across the period with a rise in home care hours provided (9.6%) and a relative decline in residential places (-1.2%).
- Nationally, the percentage of people with intensive needs who are now receiving care at home has increased from 32.2% in 2010/11 to 35.3% in 2016/17.
- As importantly, the number of people receiving home care has decreased over time and the hours of care they receive on average has increased, i.e. in shifting the balance of care, a greater resource has become targeted on a smaller number of people with higher needs.
- In Falkirk, in 2016/17, there were 31.4% of people aged 65 or over with intensive needs receiving care at home. Falkirk ranked 20th in Scotland, with the Scotland average being 35.3%.
- Across Scotland, there is significant although narrowing variation across councils in relation to the balance of care, ranging from 22.9% to 50.4% across Scotland. There is no systematic relationship in the balance of care provided and deprivation, rurality or size of council.
- The data from 2015/16 onwards is not comparable with the previous years' data due to changes made to the definitions and source data used to report the number of people in continuous care placements in hospitals.

5.3 Direct Payments and Personalised Managed Budgets

5.3.1 SDS spend on adults 18+ as a % of total social work spend on adults 18+

- Since 1 April 2014, self-directed support has introduced a new approach that provides people who require social care support more choice and control over how their support is delivered.
- Nationally, in the last 12 months, the proportion of spend via Direct Payments and Personalised Managed Budgets reduced from 6.7% to 6.5%. However, as this national figure has been driven by a significant reduction in Glasgow Direct Payment, if you exclude Glasgow from the analysis, the proportion across Scotland has actually grown from 3.7% to 4.7% over the past 12 months.
- Falkirk's SDS spend on adults 18+ as a % of total social work spend on adults 18+ in 2016/17 has grown from 2.74 in 2015/16 with a rank of 20, to 3.73 in the past 12 months, also with a rank of 20. The Scottish average is shown to have decreased from 6.7 in 2015/16 to 6.5 in 2016/17.
- However, it is important to note that the national data reports only expenditure on SDS options 1 – Direct payments and SDS Option 2 – Directing the available resource. It specifically *excludes* data on the choices made of SDS Options 3 - Local authority arranged service; and SDS Option 4 where people have chosen a Mix of SDS Options 1, 2, or 3. This means the national data is not comparable as different local authorities have different policies on in-house provision and outsourcing of services to external providers. This is a particular issue in high expenditure service areas such as home care services. This would directly affect the balance of expenditure assigned to the different SDS Options in different local authorities shown in this report.

5.4 Care Homes

5.4.1 The net cost of care home services is a measure that has been standardised using net costs per week per resident for people over the age of 65 years.

- Nationally, over the five years for which we have comparable data, there has been a 4.6% reduction in unit costs from £393 to £375, driven by a -3.2% reduction in net expenditure, while the number of adults supported in residential care homes during this period increased by 1.5%.
- Across Scotland, in the last 12 months, the average cost per week increased by 0.6% from £373 to £375 per resident, reflecting a small increase in net expenditure (0.1%) and a small reduction in the number of residents (-0.5%).
- In Falkirk, residential costs per week per resident for people aged 65 or over in 2016/17 was £359.30, ranking 12th in Scotland. This was an increase in costs on the previous year, when it was £324.60, ranking 7th.
- This data should be treated with caution, as the Improvement Service acknowledges. Work within Family Groups and the Scottish Government report on Free Personal and Nursing Care have both identified that a key factor determining expenditure on residential care is the proportion of self-funders locally. So levels of expenditure in this area of service will reflect the levels of affluence of different local authority areas.

5.5 Percentage of Adults Satisfied with Adult Social Care Services

5.5.1 In 2015/16, two measures from the biennial Health and Care Experience Survey were introduced to the benchmarking suite to reflect service user satisfaction with social care services. These measures align with the initial core suite of HSC Integration Measures, and provide a more locally robust sample than is available from the Scottish Household Survey in relation to social care. These indicators are:

- % of adults receiving any care or support who rate it as excellent or good – In 2015/16 Falkirk's performance was 82.3%, which was below the Scotland Average of 85.
- % of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life – In 2015/16 Falkirk's performance was 84.1%, which was in line with the Scotland Average of 84%.

5.6 Summary of Findings

5.6.1 **Table 1** shows national and local performance over the past two reporting years.

Table 1 Summary of Findings

Indicator	**Scotland**		**Falkirk**			
	2015-16	**2016-17**	**2015-16**	**Rank**	**2016-17**	**Rank**
Home Care Services						
Home care costs per hour for people aged 65 or over	21.67	22.54	14.74	3	16.24	6
Balance of Care						
% of people aged 65 or over with intensive needs receiving care at home	34.8	35.3	30.92 *1	24	31.39	20
Direct Payments and Personalised Managed Budgets						
SDS spend on adults 18+ as a % of total social work spend on adults 18+	6.7	6.5	2.74	20	3.73	20
Care Homes						
Residential costs per week per resident for people aged 65 or over	373.00	375.00	339.28	7	359.30	12
	2013-14	**2015-16**	**2013-14**	**Rank**	**2015-16**	**Rank**
Percentage of Adults Satisfied with Adult Social Care Services						
% of adults receiving any care or support who rate it as excellent or good.	84	85	86.61	10	82.28	17
% of adults supported at home	81	84	86.90	10	84.13	17

who agree that their services and support had an impact in improving or maintaining their quality of life						

*1 NB. Changes were made to the definitions and source data relating to people in continuous care placements in hospitals, which means the data from 2015/16 onwards is not comparable with the previous years.

6 Considerations for Falkirk HSCP

The national data will be monitored and the reasons for variations in the service areas reported will be explored through participation in the Improvement Service's Family Groups. These will enable learning to be developed on the data and on areas where improvement may be identified.

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***- *of Health, Care and Wellbeing.*	***AUTONOMY & DECISION MAKING*** *– Where formal support is needed people can exercise control over choices.*	***SAFETY*** *- H&SC support systems keep people safe and live well for longer.*	***SERVICE USER EXPERIENCE*** *- People have a fair & positive experience of health and social care.*	***COMMUNITY BASED SUPPORT*** *- to live well for longer at home or homely setting.*
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

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	Q	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	

Appendix 2

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.

Appendix 3

Falkirk Health and Social Care Partnership: MSG Improvement Objectives – summary of objectives for adults aged 18+

Falkirk Health and Social Care Partnership	Unplanned admissions (18+ years)	Unplanned bed days (18+ years)	A&E attendances (18+ years)	Delayed discharge bed days (18+ years)	Last 6 months of life (all ages)	Balance of Care (75+ years)
Baseline 2015/2016	**2015/16** 13,537	Acute specialities **2015/16** - 111,250 Geriatric Long Stay **2015/16** – 21,837 Mental Health **2015/16** - 46,283	Attendances **2015/16** - 32,274 % seen within 4 hours **2015/16** – 93%	All reasons **2015/16** – 13,306	Community setting **2015/16** – 86.2%	Residing in a care home (all ages) **2015/16** – 0.6% of population Care home (75+) **2015/16** – 5.8% Supported at home (all ages) **2015/16** – 1.5% of population Supported at home(75+) **2015/16** – 11.7% At home unsupported (all ages) **2015/16** – 97.5% At home unsupported (75+) **2015/16** – 80.5%

Appendix 3

Falkirk Health and Social Care Partnership	Unplanned admissions (18+ years)	Unplanned bed days (18+ years)	A&E attendances (18+ years)	Delayed discharge bed days (18+ years)	Last 6 months of life (all ages)	Balance of Care (75+ years)
Objective 2018/2019	5% reduction in 2018/19 from the 2016/17 figures **2016/17** Increased to 14,050 **2017/18** data so far shows a further increase	Reduce numbers from current position with aim to get to 2015/16 or below. This is subject to further discussion on trajectories for the 3 areas through the Unscheduled Care Programme Board. <u>Acute specialities</u> **2016/17** Increased to 118,682 <u>Geriatric Long Stay</u> **2016/17** Increased to 22,040 <u>Mental Health</u> 2016/17 Increased to 48,069	95% target for 2018/19	Reduce numbers from current position with aim to get to 2015/16 or below **2016/17** Increased to 18,523	Increase from baseline to 90% by 2018/19	Maintain baseline %'s for 2015/17
How will it be achieved	Closer to Home – Enhanced Community Team (ECT) including GP Fellows (GPF) and Advice Line For You (ALFY) Ambulatory Emergency Care	Community Mental Health Team for Older Adults Daily Huddle – hubs and flow work Discharge to Assess Forth Valley 6 essential actions	Closer to Home – ECT, GPC, ALFY Implement Falls Pathway including uninjured fallers FV 6 Essential Actions Action Plan Keep-well	Anticipatory Care Planning Closer to Home – ECT, GPC, ALFY Comprehensive Geriatric Assessment process	Anticipatory Care Planning District Nursing End of Life and Palliative Care Transformation Group FV Palliative and End	Anticipatory Care Planning Care Home Psychiatric Liaison Carer support Develop locality arrangements

Appendix 3

Falkirk Health and Social Care Partnership	Unplanned admissions (18+ years)	Unplanned bed days (18+ years)	A&E attendances (18+ years)	Delayed discharge bed days (18+ years)	Last 6 months of life (all ages)	Balance of Care (75+ years)
	outpatients pathways Anticipatory Care Planning Develop Frailty Pathway Develop/review care pathways with acute Discharge to Assess Implement Reablement Pathway Implement the Carers Scotland Act Implement Falls Pathway including uninjured fallers New contract for Care at Home Partnership work with Scottish Ambulance Service Post diagnostic support services for people with dementia Review and redesigning Forth	Action Plan Fortnightly Day of Care Audit Frailty Pathway Mental Health AHP Mental Health Out of Hours pilot Multi-Disciplinary Assessments. Pharmacy First Implement Reablement pathway Streamline pathway through hospital Transforming Care Programme REACH Team Reablement Project Team	Programme MECS Pharmacy First initiative Primary Care Transformation Programme Implement Falls Pathway including uninjured fallers	Daily Huddle Delayed Discharge Action Plan Discharge Hub Discharge Tactical Group Discharge to Assess Falls prevention strategy Frailty Pathway Implement Reablement pathway Night Nursing Raise awareness of Power of Attorney and Guardianship Support Carers	of Life Care Transformation Programme Hospice at Home service Key Information Summary Marie Curie MECS Nurse Support OOH Palliative Care and Cancer helplines and initiatives Podiatry Service Redesign Primary Care Transformation Programme Review end of Life pathway Review of Equipment Service Single Shared Assessments Support Carers TEC	Establish Independence Clinics Implement ADL Smart care Implement Falls Pathway including uninjured fallers Implement Reablement pathway Increase access to Technology Enabled care Intermediate care bed provision New contract for care at home PDS workers and Community Connections Programme Pharmacy First Pharmacy Support project including medication management Primary Care Transformation

Appendix 3

Falkirk Health and Social Care Partnership	Unplanned admissions (18+ years)	Unplanned bed days (18+ years)	A&E attendances (18+ years)	Delayed discharge bed days (18+ years)	Last 6 months of life (all ages)	Balance of Care (75+ years)
	Valley GP Out of Hours Service Review partnership funded initiatives Support Carers					Programme Review of Care at Home service Review of day services Single Shared Assessment Whole system mapping – Understanding Our System Reablement Project Team MECS and overnight service
Progress (updated by ISD)						
Notes		Potential coding issues regarding community hospitals and if the stay is included.	Concern around the impact of demographic rises on figures.	Concern around the impact of demographic rises on figures.	Includes those people living at home as well as living in a care home within a homely setting	