Agenda Item: 9

Falkirk
Health and Social Care
Partnership

Title/Subject:	**Performance Report**
Meeting:	**Integration Joint Board**
Date:	**2 February 2018**
Submitted By:	**Head of Performance and Governance, NHS Forth Valley**
Action:	**For Noting**

1. INTRODUCTION

1.1 The purpose of this report is to present performance in relation to unscheduled care and delayed discharge, as part of a more targeted approach to performance reporting on thematic areas and in support of the Winter Plan. The reported partnership indicators are linked to the outcomes of the Strategic Plan.

1.2 The report also provides an update on the response to the Ministerial Strategic Group (MSG) six integration indicators.

2. RECOMMENDATION

The Integration Joint Board (IJB) is asked to:

2.1 note the content of the performance report.

2.2 note the submission to the MSG on the six integration indicators.

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

3. BACKGROUND

3.1 As per the approved Performance Management Framework, the IJB has a responsibility to ensure effective monitoring and reporting on the delivery of services, relevant targets and measures included in the Integration Functions, as set out in the Strategic Plan.

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

4. APPROACH

4.1 As described in previous IJB Performance Reports, a Strategy Map has been created, the aim of which is to ensure there is a direct link back from performance to the outcomes of the Strategic Plan (Appendix 1). This Map details the Partnership's Vision, expected Local Outcomes and then maps these against the National Health and Wellbeing Outcomes, National Core Indicators and local Partnership Indicators.

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

5. IJB PERFORMANCE REPORT & STRUCTURE

5.1 The content of this report mainly focuses on the indicators around unscheduled care, including delayed discharges.

5.2 Section 1 of the Performance report 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 and quantitative data which will enable and support quality 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 (ED) Performance against the 4 hour Standard
- Rate of Attendance at ED
- Rate of Unplanned Bed Days
- Delayed Discharges

5.4 Section 3 offers additional detail with regard to the indicators described above as well as detail in respect of a number of other linked indicators relating to Unscheduled Care and Delayed Discharge.

6. MEASURING PERFORMANCE UNDER INTEGRATION

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

6.2 In November 2017, the MSG requested an update of local objectives and ambitions relating to the six indicators, along with updated objectives for 2018/19. This included submitting proposed trajectories based on the six indicators noted below:

- Unplanned admissions
- Occupied bed days for unscheduled care
- A&E Performance
- Delayed Discharges
- End of life care
- Balance of care spend

6.3 Work is ongoing to agree trajectories, with the Unscheduled Care Programme Board (USCPB) overseeing the delivery and reporting arrangements. This is chaired by the Medical Director, NHS Forth Valley, with the group maintaining a system wide remit. The USCPB is scheduled to meet monthly.

6.4 Although the above indicators are monitored all year round, they are also monitored as part of the Winter Plan submitted to the Scottish Government in November 2017. The Winter Plan focuses on the period from November 2017 to March 2018 highlighting in particular, arrangements for the festive holiday periods in December and January.

7. FINANCE AND PERFORMANCE

7.1 As previously highlighted, in order to ensure a sound basis for decision making and prioritisation, performance information should be read alongside financial reports to give a rounded view of the overall performance and financial sustainability of the partnership.

8. CONCLUSION

8.1 The Integration Joint Board is responsible for effective monitoring and reporting on the delivery of services, relevant targets and measures included in the Integration Functions, and as set out in the Strategic Plan. This report presents performance in relation to unscheduled care and delayed discharge, as part of a more targeted approach to performance reporting on thematic areas.

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 Management Workstream 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, Kerry MacKenzie, Senior Performance Manager, Vivienne Meldrum, Senior Information Analyst

Date: 26 January 2018

List of Background Papers:

Section 1: At a Glance Performance Summary

The IJB focus is across the five Local Outcomes with work on-going 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 September 2017
- Q1 = Quarter ending 30 June 2017

The table highlights the year to date position, April to November 2017, compared with the previous full year.

Local Outcomes	Partnership Indicator	Falkirk	
Self Management	Emergency department 4 hour wait Forth Valley (FV)	**2016/17**	**2017/18**
		94.4%	**93%** ▼
	Emergency department 4 hour wait Falkirk	**2016/17**	**2017/18**
		94.1%	**92.6%** ▼
	Emergency department attendances per 100,000 FV Population	**2016/17**	**2017/18**
		1,758	**1,824** ▼
	Emergency department attendances per 100,000 Falkirk	**2016/17**	**2017/18**
		1,964	**2,035** ▼

Local Outcomes	Partnership Indicator	Falkirk	
Autonomy & Decision Making	Emergency admission rate per 100,000 FV population	**2016/17**	**2017/18**
		937	**897 ▲**
	Emergency admission rate per 100,000 Falkirk population All Ages	**2016/17**	**2017/18**
		965	**907▲**
	Acute emergency bed days per 1,000 FV population	**2016/17**	**2017/18**
		636	**650▼**
	Acute emergency bed days per 1,000 Falkirk population All Ages	**2016/17**	**2017/18**
		677	**714▼**
	Number of patients with an Anticipatory Care Plan in FV**	**2016/17**	**2017/18**
		16,541	**15,454****
	Number of patients with an Anticipatory Care Plan in Falkirk	**2016/17**	**2017/18**
		NA	**6632**
	Key Information Summary as a percentage of the Board area list size FV**	**2016/17**	**2017/18**
		5.40%	**4.9%****
	Key Information Summary as a percentage of the Board area list size Falkirk	**2016/17**	**2017/18**
		NA	**4.20%**

**Figures are supplied by ISD. The drop in number from circa 17,000 plans in May 2017 is a result of ISD culling records for those patients who have since died or moved outwith the area. The position of 15,392 accounts for 4.9% of Forth Valley residents and exceeds the local target of 4,500 or 1.5%.

Local Outcomes	Partnership Indicator	Falkirk	
Safety	Readmission rate within 28 days per 1,000 FV population All Ages	**2016/17**	**2017/18**
		1.4	**1.23▲**
	Readmission rate within 28 days per 1,000 Falkirk population All Ages	**2016/17**	**2017/18**
		1.56	**1.36▲**
	Readmission rate within 28 days per 1,000 Falkirk population 75+	**2016/17**	**2017/18**
		3.77	**3.54▲**

Local Outcomes	Partnership Indicator	Falkirk		
Service User Experience	Standard delayed discharges	**Dec-16**	**Dec-17**	
		37	**21▲**	
	Delayed discharges over 2 weeks	**Dec-16**	**Dec-17**	
		26	**13▲**	
	Bed days occupied by delayed discharges	**Dec-16**	**Dec-17**	
		895	**505▲**	
	Number of code 9 delays	**Dec-16**	**Dec-17**	
		12	**16▼**	
	Number of code 100 delays	**Dec-16**	**Dec-17**	
		3	**6▼**	
	Delays - including Code 9 and Guardianship	**Dec-16**	**Dec-17**	
		52	**46▲**	
	The proportion of Social Work Adult Services (Stage 1 & 2) complaints completed within 20 days (No.= 58/90) Stage 1 – **66.7%** (54/81) – *NB: Timescale for Stage 1 complaints is 5 days.* Stage 2 – **44.4%** (4/9) *2015/16 & 2016/17 were reported under the old complaints system (with 70% target)	**2015/16***	**2016/17***	**'2017/18 to end Q3'**
		73.4%	**57.4%**	**64.4% ▲**
	Proportion of Social Work Adult Services complaints upheld –	**'2017/18 to end Q3'**	**Stage 1**	**Stage 2**
		% upheld	**33.3**	**22.2**
		% partially upheld	**27.2**	**44.5**
		% not upheld	**39.5**	**33.3**

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 November 2017 is 92.6%, which reflects the average monthly Forth Valley compliance of 93%. In terms of attendance, throughout November 2017 there were a total of 6,600 attendances at ED, a daily average of 172 patients, with 8 occasions where attendance in the department was recorded between 180 and 200 patients.

The main reasons for waits beyond the 4 hour standard have remained unchanged since the summer of 2017 with, 'wait for first assessment' accounting for 37% of all breach reasons. 22% of delays were attributed to a 'wait for a bed'.

Achieving the 95% target on a consistent basis remains a challenge. Discussion with the Scottish Government regarding NHS Forth Valley's variation in performance has lead to thrice daily monitoring of performance on a number of occasions throughout the year, with monitoring recommenced in December 2017 as the hospital face winter challenges.

Of note is a 13% increase in the number of attendances at Accident & Emergency services across Forth Valley in December 2017 compared to December 2016, with 6996 attendances in December 2017 and 6186 attendances in December 2016. A corresponding increase is noted in the Falkirk partnership with a 12.7% increase in attendances at Accident and Emergency services; 3593 attendances in December 2017, 3189 attendances in December 2016. In respect of the 4 hour standard across Forth Valley, 76.6% of patients waited less than the standard from arrival to admission, discharge or transfer for accident and emergency. A similar position is noted for the Falkirk partnership with 75% of patients waiting less than 4 hours.

Over the period there have been a high number of confirmed Flu cases in the hospital. This is as a result of near patient testing; a new development that means a diagnosis of flu is available within half an hour of turning up at hospital. Respiratory Syncytial Virus (RSV) and Flu B cases are comparable with 2016/17, however over 240 cases of Flu A have been diagnosed as a result of near patient testing; there is no comparison with last year.

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; Discharge to Assess and 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 include 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 with the HSCPs with looking at the whole system in support of the sustainable improvement.

2. <u>Rate of Emergency Department Attendance</u>

Issue:
The average monthly Emergency Department attendance rate in Forth Valley has increased from 1758 per 100,000 population in 2016/17 to 1824 per 100,000 population in 2017/18 to date. This is highlighted as a 3.8% increase.

Falkirk has seen a rise of 3.7% in 2017/18 to 2035 per 100,000 population, from 1965 per 100,000 population in 2016/17. A breakdown by age group in the Falkirk local authority area shows a 3.9% rise in attendances in the 20-64 years age group and 3.6% in the 85 plus age range whilst there is decrease of 1.6% in those aged 75-84 year. There is no significant change in the 65-74 years.

The rise in the 85+ age group is following the 2016/17 pattern where attendances are on the increase from the end of August and throughout the winter months.

Action:
<u>Closer to Home - Enhanced Community Team including GP Fellows and ALFY</u>

The number of referrals to Closer to Home (Enhanced Community Team) has overall and in Falkirk. As part of a national initiative to reduce the number of falls patients being conveyed to an acute hospital, the Closer to Home Team are now accepting direct referrals from the Scottish Ambulance Service for unwell, uninjured falls patients. We now have 5 GP Fellows in post, who cover the whole of Forth Valley as part of the Enhanced Team. A RAG system is being employed as an outcome measure to help us identify that we have moved patients from being unwell to well.

Other initiatives include:

- Work is underway to understand the reasons why some GP Practices are not referring more suitable patients to the team:

- The lead nurse has developed links with the call handlers at the front door of Forth Valley Royal Hospital (FVRH) to identify suitable patients for the team. GP Fellows have also established links at the hospital front door to enable them to refer directly to ECT any patients they think would benefit from the service preventing hospital admission.

- Links have been established with GP Clusters in Falkirk to promote the service and gain

feedback on how we continually develop the service together.

- Work has commenced with the Pharmacy Service to develop a domiciliary IV antibiotic pathway; aiming to allow referral from primary and secondary care for IV antibiotic therapy within the home.

- The Team is liaising with Summerford intermediate care facility regarding the use of beds for step up/step down beds.

- The Team is working with Scottish Ambulance Service (SAS) to roll out the 'falls referral pathway' across all ambulance crews in Forth Valley and also work on a direct SAS referral pathway to the Closer to Home Team for chronic obstructive pulmonary disease (COPD) patients.

- A review of the referral criteria has taken place with more flexibility recognising the additional assessment and treatment, skills and support that GP Fellows bring to the Team.

3. Unplanned Bed Rate per 1,000 per population

Issue:
In 2016/17 the average monthly rate in terms of unplanned bed days for Forth Valley was 637 per 1,000 population compared to 650 per 1,000 population in 2017/18 to date. This highlights a 2% increase. The rate in Falkirk has increased by 5% from 678 per 1,000 population in 2016/17 to 714 per 1,000 population in 2017/18.

Further analysis shows a rise on all age groups in the Falkirk Local Authority area. However the most significant increase is in those aged 65-74 years (11%).

The Day of Care Audit has been in place since 2014. The purpose of this audit is to assess the appropriateness of patients admitted to the acute setting.

The most recent survey results from 7 December 2017 indicate 15.1% (n=70) of patients in an acute ward did not comply with acute inpatient criteria, which is below the average of 19.3%. Bed occupancy was documented as 101.9%.

The day of care data for the hospital is pulled at 6.10am. Each ward has a set number of beds calculated, which does not count contingency beds such as day medicine, capacity area 3, endoscopy etc. If a patient is in any of these beds this would take the occupancy over 100%.

Within the Community Hospital setting there have been three surveys so far with initial reports suggesting 40-50% of patients are not meeting the criteria for the inpatient stay. The plan is to continue with the Day of Care Audit within the community hospital setting to develop a greater understanding of systems and potential barriers to patient flow.

Action:
There have been several improvement measures introduced in Forth Valley as a result of the Day of Care Audit findings:

- There is now a daily safety huddle in place 7 days a week to identify suitable patients for discharge

- A daily discharge Multi Disciplinary Team (MDT) huddle is in place, where a forum of knowledgeable and expert team members identify alternative or more appropriate pathways for patients who have complicated needs listed for either community hospital or short term assessment beds.
- Standard Operating Procedures were devised for community, packages of care, social and Allied Health Professional (AHP) services to provide clearer pathways for identifying patients ready for discharge/transfer.

4. Delayed Discharges

Issue:
As of the December census date, the following delays were recorded:

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

In December 2017 the number of standard delays for Forth Valley is 44. Falkirk accounts for 21, 47.7% of all standard delays.

62% (13/21) Falkirk delays are waiting over 2 weeks at the December 2017 census point. These Falkirk patients account for 50% of (13/26) of Forth Valley waits over 2 weeks.

Table 1 shows the total number of standard delays in Falkirk from December 2016 to December 2017.

Table 1

	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
Total delays at census point	37	45	38	24	29	32	34	20	40	31	23	26	21
delays over 2 weeks	26	24	25	17	14	18	18	15	26	21	12	18	13

Occupied Bed Days Attributed to Delayed Discharges

The average number of occupied bed days across Forth Valley since April is 1140 with the position for the Falkirk partnership 733. The number of bed days for December 2017 is 1001 of which 505 are attributed to bed days of patients whose residence is within the Falkirk Partnership; 50% of the overall number of bed days.

There has been an increase in the number of Code 9 and Code 100 delays across Forth Valley and across the Falkirk Partnership with the position at the December census, 16 Code 9 delays (which include issues of guardianship) and 6 Code 100 delays.

Action:
Community Hospitals, Intermediate Care Capacity and Care at Home

There are a number of issues in relation to waits for care packages including care home placements and home care places which fluctuate on a day by day basis, with work going on to support this. The number of available care home places is dependent on demand from the hospital environment as well as from the community waiting for a placement.

Additionally, the loss of placements due to the impending Bield closures has impacted at the height of the winter pressures. Options are currently being explored and discussions are ongoing.

The availability of care home places is being closely monitored via the Winter Weekly Teleconference in a bid to predict capacity over the week ahead as described in the Winter Plan.

The Winter Plan describes a number of agreed key actions to be delivered by all partners in support of managing peaks in demand and activity, under the following areas of activity: preventing admissions and supporting discharge; specific arrangements for the festive period; preventing and responding to surges in demand; and, specific arrangements for GP Out of Hours.

To ensure appropriate Senior Management support and focus throughout the winter planning period, a weekly teleconference focussing on data that supports a review of the previous week and look forward to the week ahead is in place. A number of key indicators are monitored on a weekly basis to inform operational management and local work to implement improvement actions. These are detailed in the Plan. Additionally, in order to learn fully from experiences this winter, and to prepare for winter 2018-19, it is proposed to hold a Winter Plan debrief session in April 2018 with key stakeholders.

A number of initiatives are being developed to potentially lessen demand on the overall health and care system. This includes:

- A review of intermediate care at home including reablement models across the Falkirk Partnership
- A review of bed based intermediate care and capacity for step up and down beds has begun in the Partnership based on the pilot Summerford service and with plans to develop a new capital programme funded bed based service
- An NHS led review of community hospital pathways began in June 2017.

The Partnership continues to review existing packages of care in line with eligibility criteria and identified needs. The Partnership has benchmarked its care home provision and is reviewing care home criteria, care home places and capacity.

Pilot Discharge to Assess at Front and Middle Door

The method of evaluation of the model that has been operating since February and the dataset to be used have been agreed and work started. There is an Operational Guide that describes the model in detail.

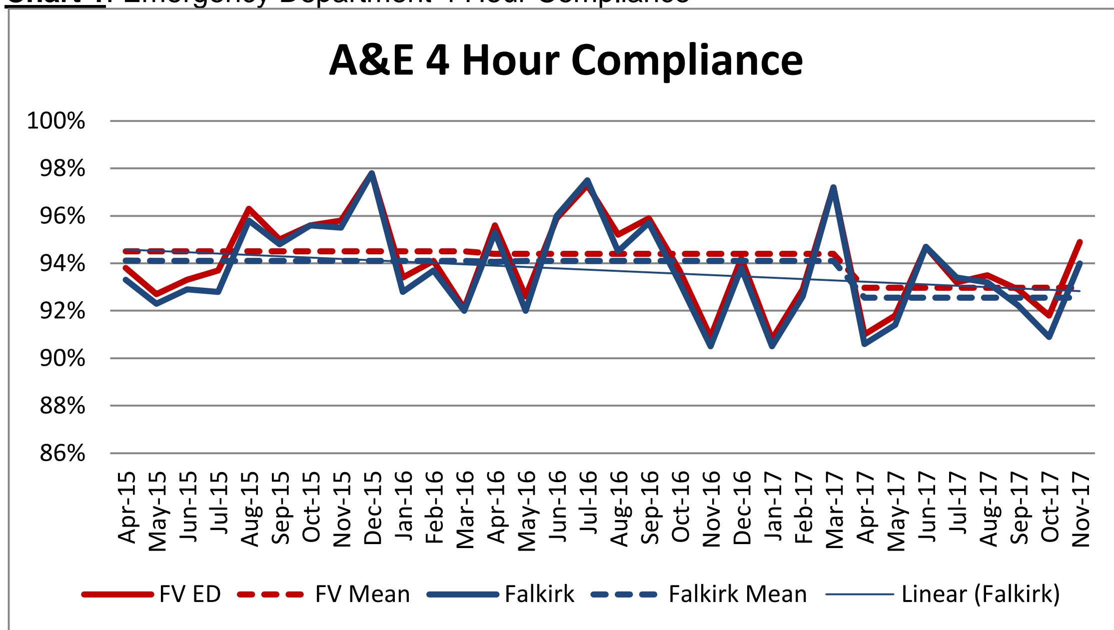
Section 3: Summary of Linked Performance Issues

Local Outcome – Self Management

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

Measure	Unscheduled Care – Emergency Department Performance against the ED 4 Hour Target (includes Minor Injuries Unit). This is a 95% target.
Falkirk Performance	Average monthly performance in 2017/18 = 92.6%
Forth Valley Performance	Average monthly performance in the year to date , April to November 2017/18 = 93%

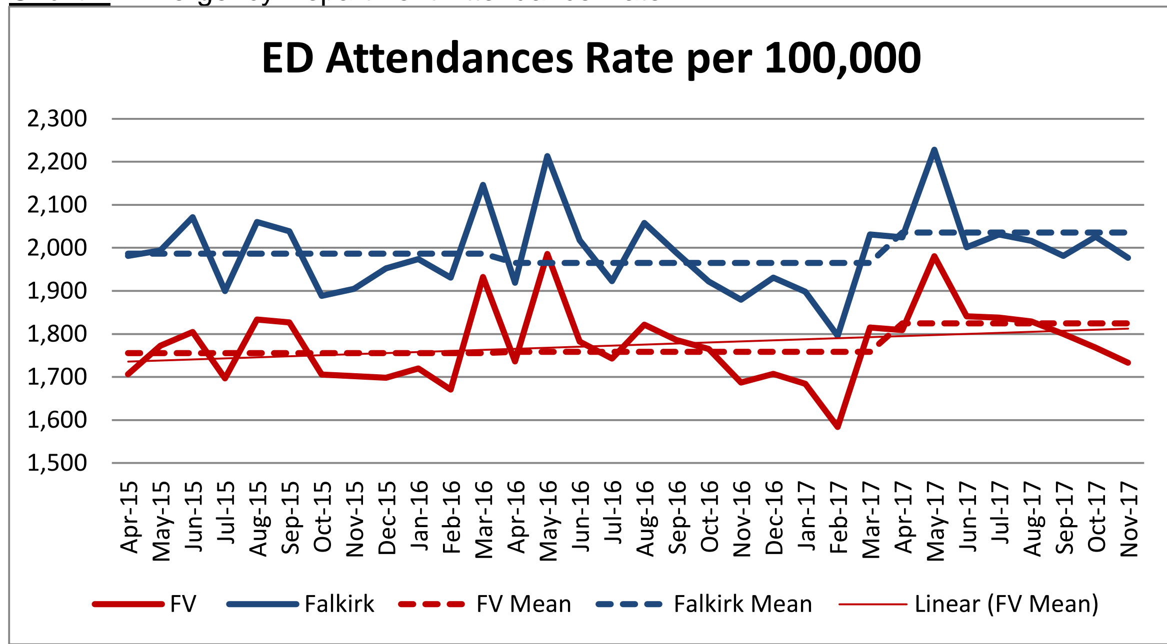
Chart 1: Emergency Department 4 Hour Compliance



- See commentary at Section 2 – Key Performance Issues on Page 8.

Measure	Unscheduled Care – Emergency Department Attendance Rate per 100,000 population
Falkirk Performance	Average monthly performance 2017/18 = 2035 per 100,000 population
Forth Valley Performance	Average monthly performance 2017/18 = 1824 per 100,000 population

Chart 2: Emergency Department Attendance Rate



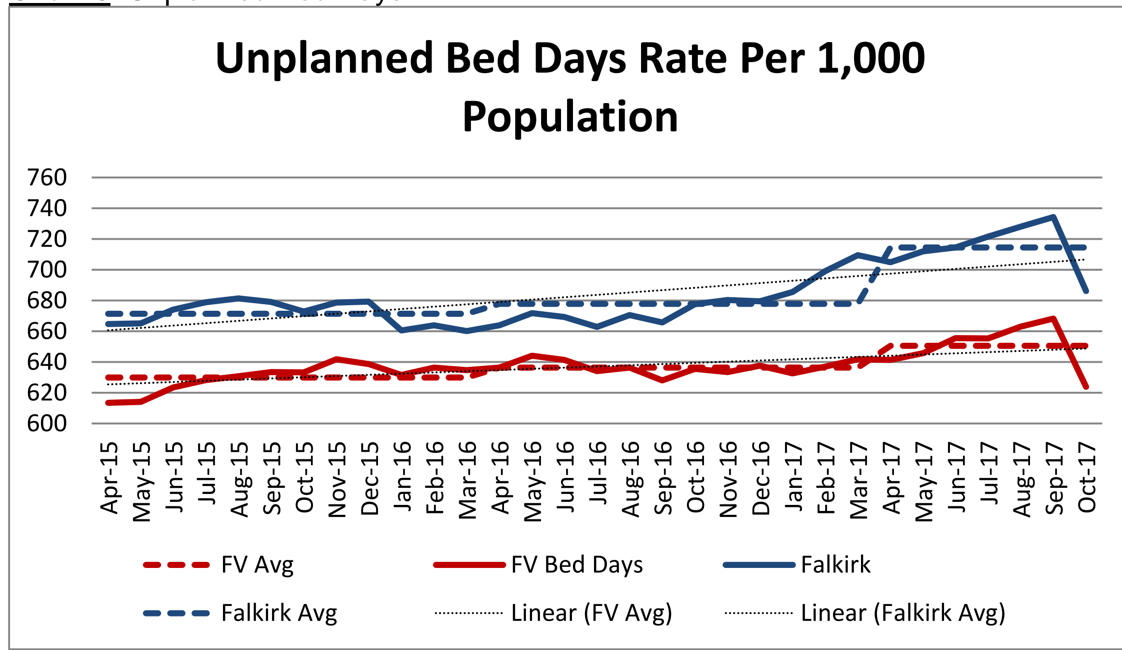
- See commentary at Section 2 – Key Performance Issues on Page 9.

Local Outcome – Autonomy & Decision Making

- **Where formal support is needed people should be able to exercise as much control and choice as possible over what is provided.**

Unscheduled Care	Falkirk Unscheduled Care - Rate of Unplanned Bed Days Rate per 1,000 population
Falkirk Performance	Average Monthly Rate 2017/18 = 714 per 1,000 population
Forth Valley Performance	Average Monthly Rate 2017/18 = 650 per 1,000 population

Chart 3: Unplanned Bed Days



Commentary

Issues have been highlighted previously in Section 2, page 11.

Factors influencing numbers of patients under 65 and over 65, both in acute setting and Community hospital settings who did not require ongoing care in hospital setting:

- The need to use The Adults with Incapacity (Scotland) Act 2000 (AWI) legislation to facilitate discharge due to patients lacking capacity to make decisions re their own welfare and no Power of Attorney (POA) in place. In general this can be a time consuming process with many factors outwith the control of the Partnership. Work is ongoing to try to streamline and identify areas for improvement.
- Despite some challenges being experienced regarding some care at home provision this has been improving through the collaborative daily meetings, delayed discharge micro management meetings and will continue with the reintroduction of Frailty Huddle at Emergency Department in the next few weeks. These meetings provide opportunities to timeously identify and explore joint options with regard to facilitating discharges.

- There have been challenges with regard to people with complex needs accessing care home places, and work is ongoing across the Partnership to find solutions and offer care home staff support and education where required.

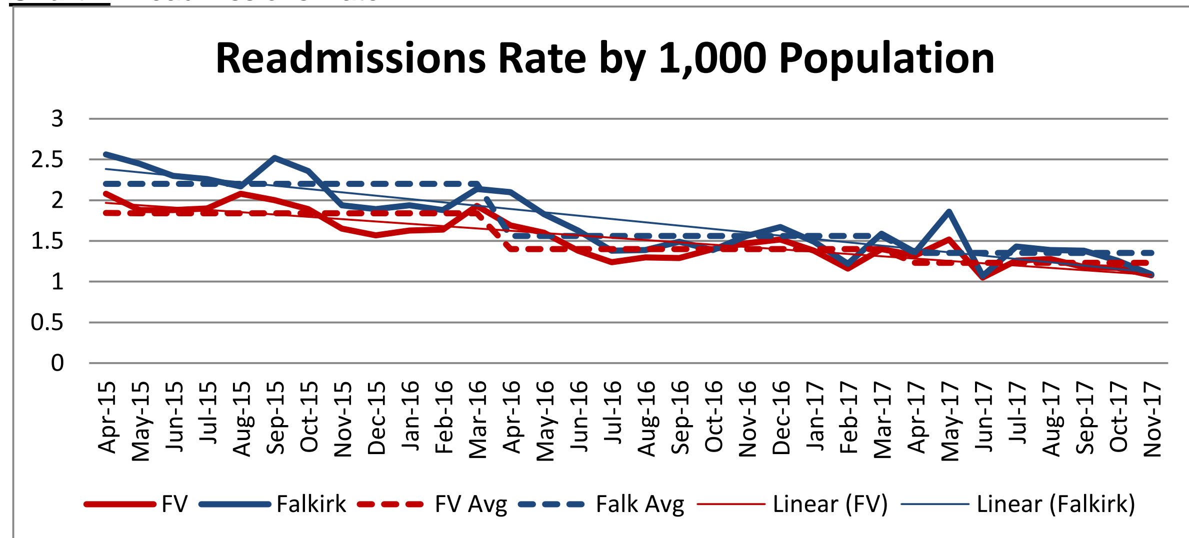
The daily multi-disciplinary meetings are resulting in prompt identification of suitable alternative pathways to a hospital in-patient stay, including intermediate care, discharge home with care and further assessment/reablement (discharge to assess) or ongoing social work assessment to facilitate discharge home.

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
Falkirk Performance	Average Monthly Rate 2017/18 = 1.36 per 1,000 population
Forth Valley Performance	Average Monthly Rate 2017/18 = 1.23 per 1,000 population

Chart 4: Readmissions Rate



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 comes back to hospital with a further respiratory condition 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 4 demonstrates the average monthly rate of readmissions across Forth Valley continues to decrease from 1.40 per 1000 population in 2016/17 to 1.23 per 1000

population in 2017/18 year to date. This decreasing trend is mirrored within Falkirk with a decrease from 1.56 per 1000 population in 2016/17 to 1.36 per 1000 population in 2017/18 year to date.

Pilot schemes across parts of the health board are assessing community focussed supports which may be able to help patients receive care at home where 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 Performance	Monthly Number November 2017 = 26
Forth Valley Performance	Monthly Number November 2017 = 41

Chart 5: Delayed Discharges – Standard Delays

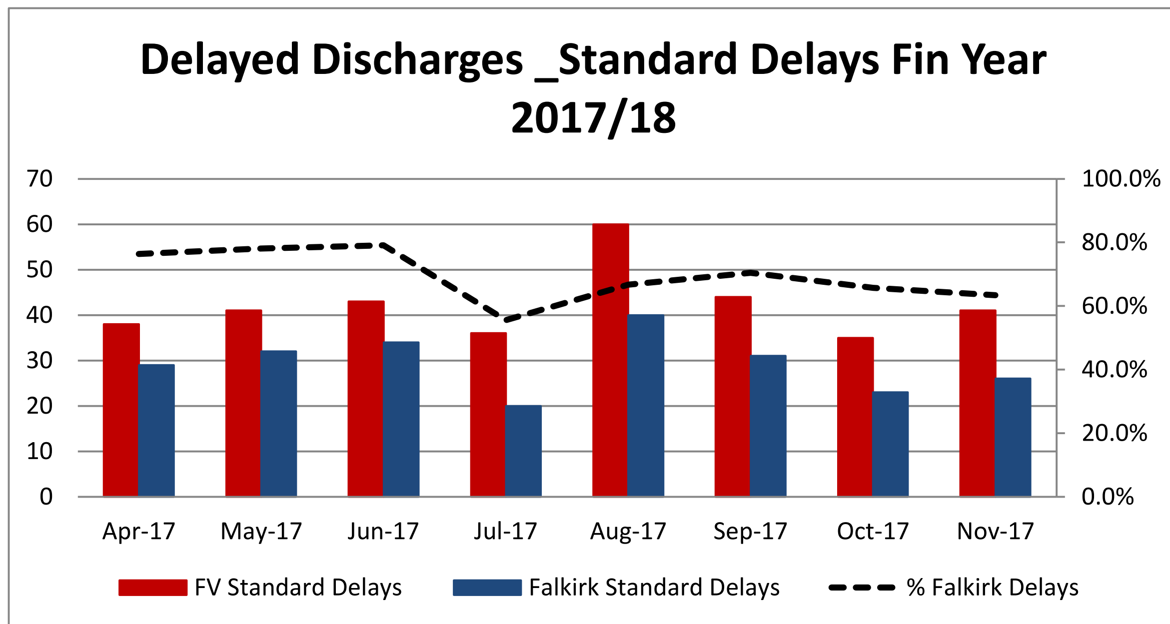


Chart 6: Occupied Bed Days Attributed to Delayed Discharges

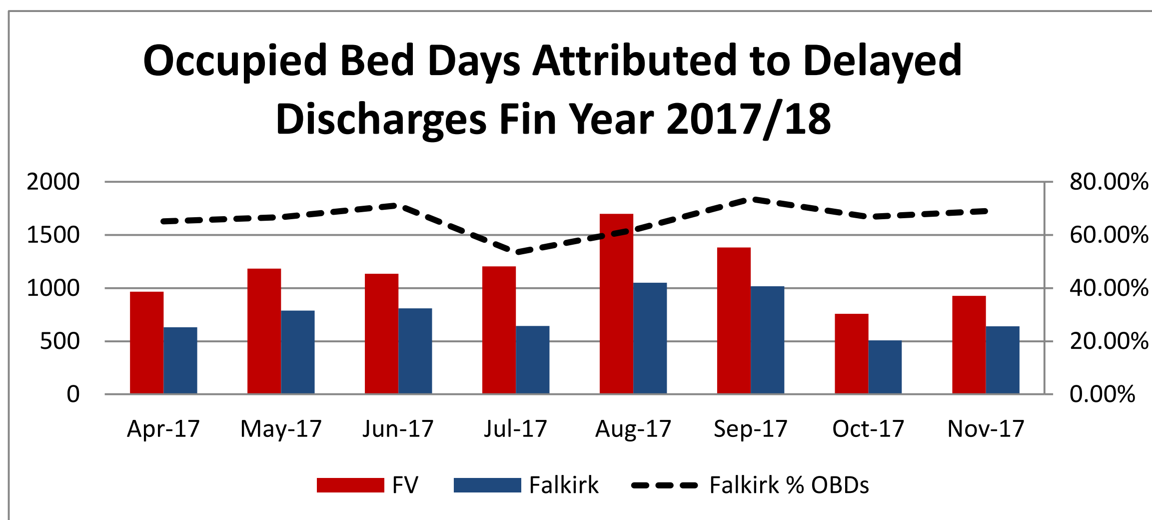
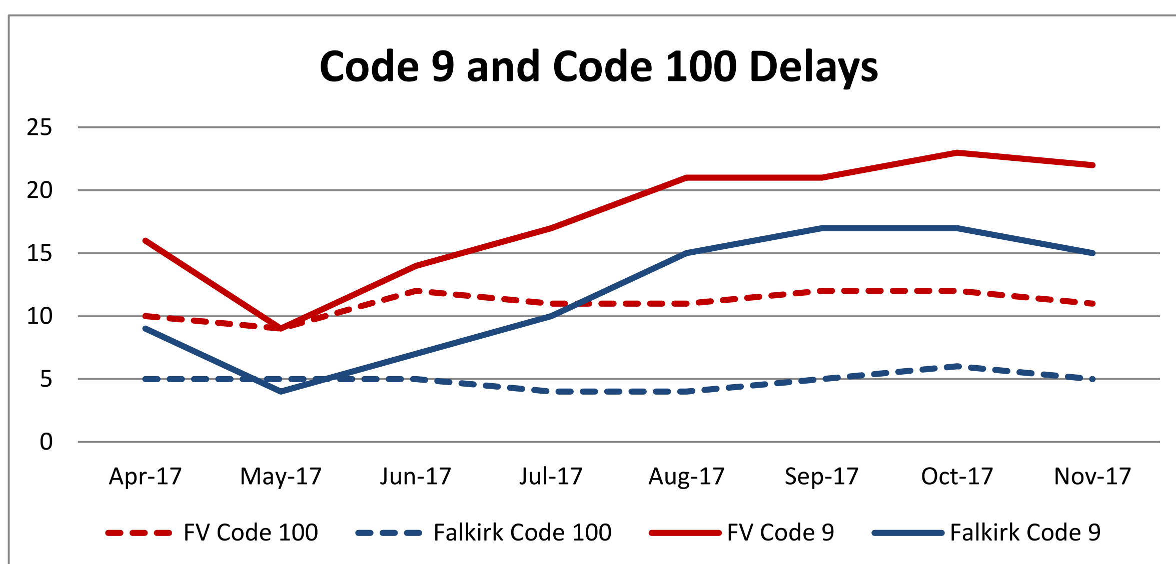
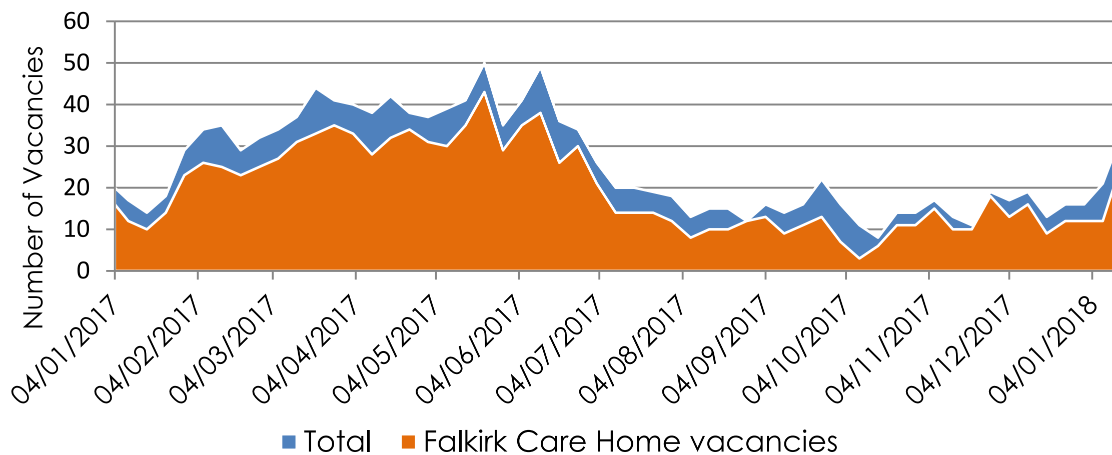


Chart 7: Code 9 and Code 100 Delays



- See commentary at Section 2 – Key Performance Issues on Page 11.

Chart 8: Care Home Vacancies by Type



Commentary

The Scottish Government has been working with the Partnership to review the current arrangements and actions being taken around delays in discharges. A report has been prepared and is being used as the basis for ongoing improvement activity.

Chart 8 is taken from the Delayed Discharge and Care Homes Weekly Monitoring Dashboard, and shows the number of care home vacancies by type, on a monthly basis. The orange represents all Falkirk Care Homes. The pale blue represents the total vacancies each week, including intermediate care bed vacancies, residential vacancies and out of area vacancies. Out of area vacancies include Blackfaulds House in Avonbridge, Linlithgow Nursing Home and Rumbling Bridge Nursing Home. It should be noted that numbers are released weekly on a Monday by the Forth Valley Discharge Hub. This represents a snapshot of the number of vacancies on a Monday and does not account for changes during the week.

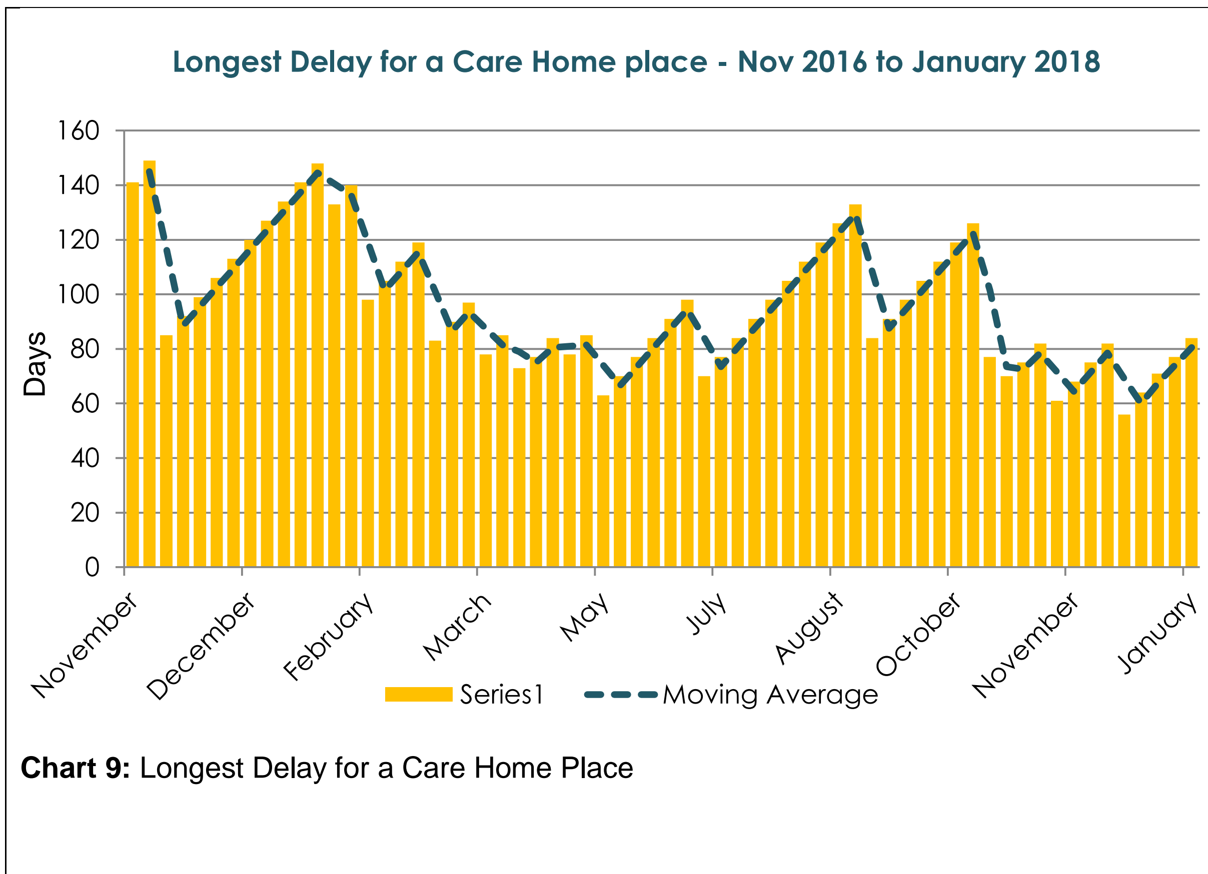


Chart 9: Longest Delay for a Care Home Place

Chart 10: Delayed Discharge – Weekly Control Chart

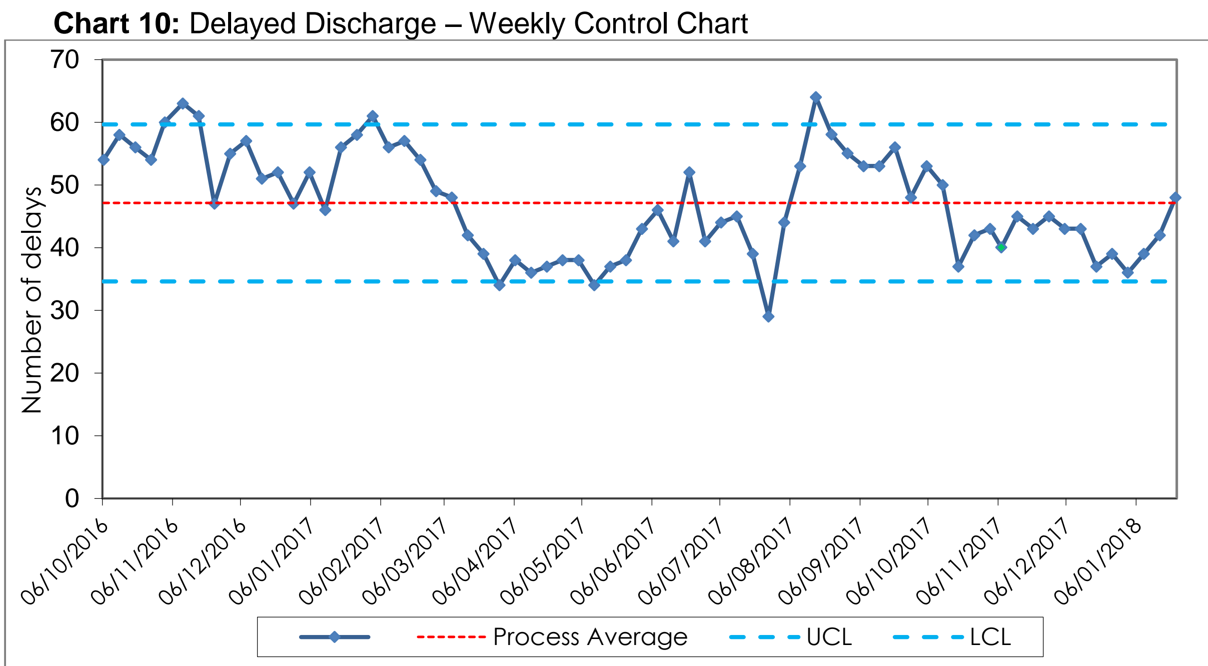


Chart 10 shows the weekly delayed discharge status, illustrating to operational managers when the figures go above or below the agreed upper and lower limits.

The tables and charts on this page have been taken from the Delayed Discharge & Care Homes Weekly Monitoring Dashboard, and are included in this report for illustration to the Integration Joint Board of examples of the type of management information available to operational managers re delayed discharges.

Table 2: Length of Delays

Length of Delay

* Excludes Code 9 Delays

Most recent week	< 3 days	< 2 weeks	> 2 weeks	> 4 weeks	> 6 weeks
16/01/2018	1	10	12	8	5

Note - The total number of delays is equal to the sum of '**<2 weeks**' + '**>2 weeks**'

Previous week	< 3 days	< 2 weeks	> 2 weeks	> 4 weeks	> 6 weeks
09/01/2018	7	10	14	8	4

Chart 11: Length of Delay

Indicator: 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.

Table 4: Complaints to Social Work Adult Services

The proportion of Social Work Adult Services (Stage 1 & 2) complaints completed within 20 days (No.= 58/90) Stage 1 – **66.7%** (54/81) – *NB: Timescale for Stage 1 complaints is 5 days.* Stage 2 – **44.4%** (4/9)	**2015/16***	**2016/17***	**'2017/18 to end Q3'**
*2015/16 & 2016/17 were reported under the old complaints system (with 70% target).	**73.4%**	**57.4%**	**64.4% ▲**
Proportion of Social Work Adult Services complaints upheld –	**'2017/18 to end Q3'**	**Stage 1**	**Stage 2**
	% upheld	**33.3**	**22.2**
	% partially upheld	**27.2**	**44.5**
	% not upheld	**39.5**	**33.3**

Position

Since April 2017, the 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 previously set 70% target. However, this target was met within 4 days of the target dates. There were 90 complaints during this three quarters period, this compares to 78 over the same period in 2016/17 under the previous procedure.

It should also 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.

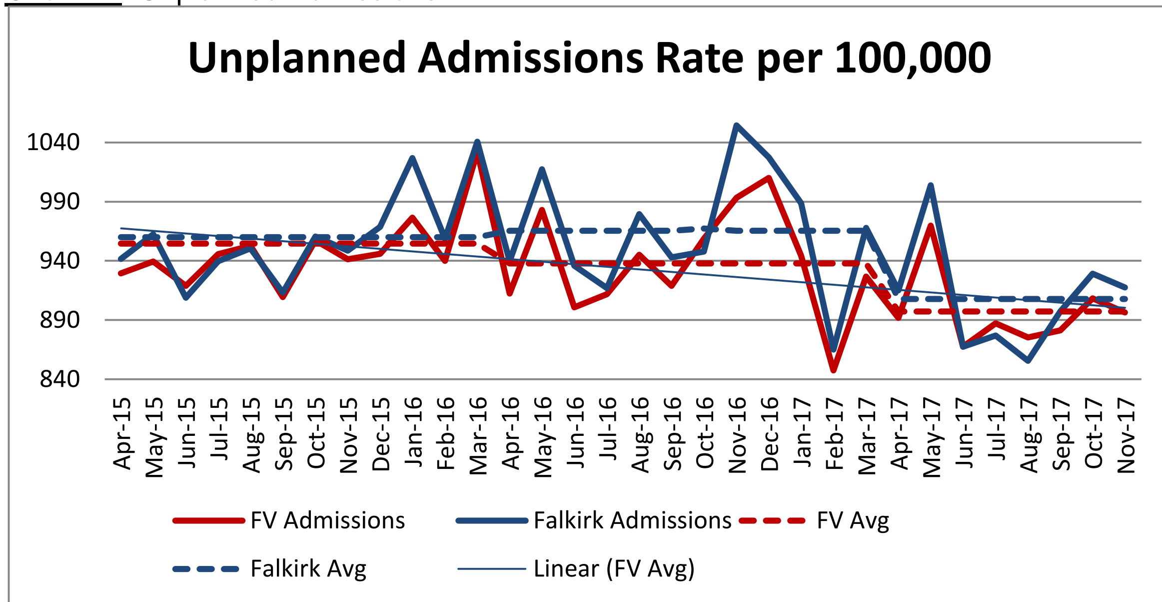
Further work is ongoing to develop performance information reports on the complaints received for the in-scope services of the HSCP. These will be presented in future reports to the IJB.

Local Outcome – Community Based Support

- **Informal supports are in place, which enable people, where possible, to live well for longer at home or in homely settings within their community**

Unscheduled Care	Falkirk Unscheduled Care – Rate of Hospital Emergency Admissions per 100,000 population
Falkirk Performance	Average Monthly Rate 2017/18 = 907 per 100,000 population
Forth Valley Performance	Average Monthly Rate 2017/18 = 899 per 100,000 population

Chart 12: Unplanned Admissions



Commentary

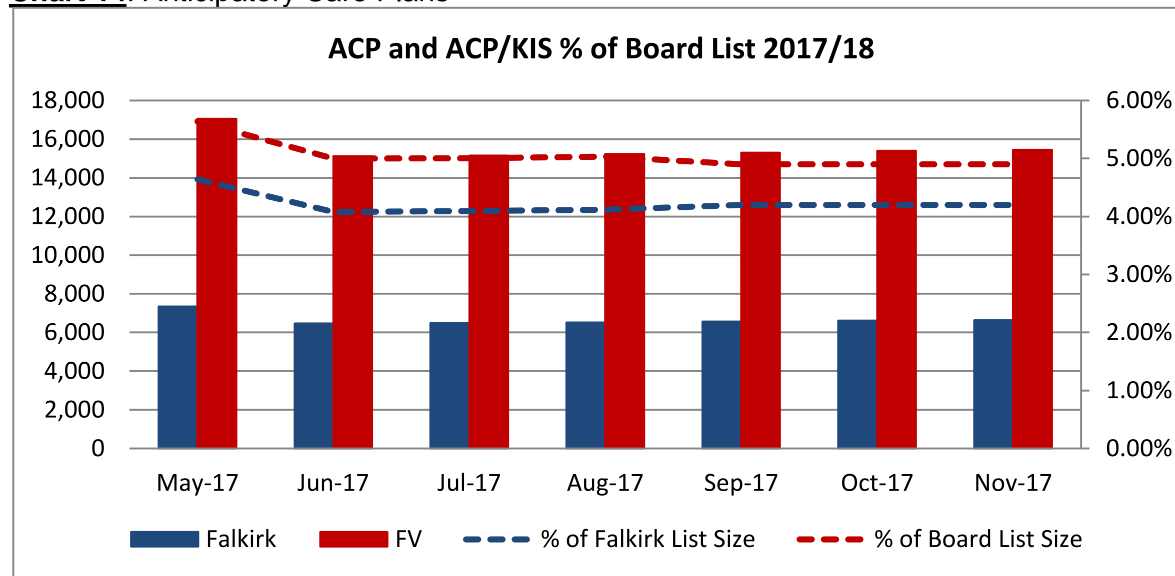
Despite the rise in Emergency Department Attendance the average unplanned admission rate for both Falkirk and Forth Valley in 2017/18 has reduced. The admission rate for the financial year 2016/17 in Forth Valley is down by 4.2%, from 938 per 100,000 per population to 897 per 100,000 per population this year to date. Although Falkirk admissions remain above the Forth Valley average the rate shows a 6.4% decrease from 965 per 100,000 per population to 907 per 100,000 per population from 2016/17 to 2017/18 year to date.

A breakdown by age range for adults shows an average 8% decrease in admissions across all groupings in the Falkirk local authority area.

- NHS Forth Valley in one Board who will work with Health Improvement Scotland (HIS) as part of a Frailty at the Front Door Collaborative. An update is provided in the Chief Officer report as a separate agenda item.

Unscheduled Care	Falkirk Unscheduled Care – Anticipatory Care Plans as percentage of Board List
Falkirk Performance	Number 2017/18 = 6,525 (4.1%)
Forth Valley Performance	Number 2017/18 = 15,231 (5.03%)

Chart 14: Anticipatory Care Plans



Commentary

Anticipatory Care Planning (ACP) has been identified nationally, including a recent Audit Scotland Report on Integration, as a priority to support the delivery of the 2020 vision and the Health and Wellbeing Outcomes.

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 15,454 accounts for 5% of Forth Valley residents and exceeds the target of 4,500 or 1.5%. 6,632 (4.2%) of the Falkirk population are in receipt of an ACP or Key Information Summary (KIS).

The impact of the Anticipatory Care Plans 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.

End of Life and Palliative Care

In addition to core funded Out of Hours Palliative Care and Cancer Helplines, initiatives include the Hospice at Home Project, night time MECS and nurse wound support. The End of Life (EoL) and Palliative Care Transformation Group is exploring the need for redesign of EoL patient pathways, workforce and communication.

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 *Note linkage to 'Experience'* **19)** Rate of days people aged 75+ spend in hospital when they are ready to be discharged, **(22*)** % people discharged from hospital within 72 hours of being ready

Partnership Indicators

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.*
Partnership Indicators	• ED 4 hour wait • ED Attendance 20-64, 65-74, 75-84, 85+	• Anticipatory Care plans (ACP) • Key information summary (KIS) • Emergency Admissions per 100,000 population 20-64, 65-74, 75-84, 85+ • Acute emergency bed days 20-64, 65-74, 75-84, 85+ • Long Term Conditions • Self Directed Support (SDS)	• Readmissions 75+ • Adult Protection • Community alarms • Service users feeling safe	• Patient/Service user Experience survey • Delayed discharge • Complaints • Absence • Financial and Budgetary information	• Care at home services, including Homecare patterns for clients 65+ • Respite weeks provided • Community care assessments • Carers' assessments • Proportion of last 6 months of life spent at home or community setting • Bed days in last 6 months of life
Partnership Indicators (Under development)	• Life expectancy age 65+ • Deaths from Cancer/CHD • Consent to share	• Dementia – post diagnostic support • Mental Health/Learning Disability SOLD measures • Emergency re-attendance – alcohol/drugs/mental health • Care home capacity • Single shared Assessment (SSA) data • AWI measures	• Falls – ED attendance/ Community teams • Mental Welfare Commission reports • Care Inspectorate reports • Mental Health patient Safety data • HAI Community Hospitals • Telecare data 65+	• Local service user/patient data • Staff Survey data	• Impact of Delayed discharges on readmissions • Balance of care 18-64 • Balance of care 65+ • Discharge to assess • Closer to Home

Glossary

Appendix 2

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.

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.

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).

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).

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.

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.

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.