# NHS Forth Valley Initial Escalation Plan - Draft Measurement Framework

## Purpose

This Draft Measurement Framework has been prepared to complement the Escalation Improvement Plan Version 2. It sets out measures that will be used to inform the next stages of improvement and describes measurement that we are using to provide evidence, to give assurance that improvements are being made and that these are having the intended outcomes. The Framework is focussed on the Leadership, Culture and Governance domains.

The driver diagrams in the first section describe rationale for the actions agreed in the Escalation Improvement Plan version 2 and illustrate high level types of measurement and evidence needed.

The tables following the driver diagrams develop the measurements and list more detailed actions and measurements.

Following on from the high-level domain analysis an example of the integrated absence data is also included to demonstrate the golden thread of control that will be embedded from Ward/Department level to Board (Appendix 1). In addition, examples of detailed performance data are included for Mental Health (Child and Adolescent Mental Health Services (Appendix 2) and Psychological Therapies (Appendix 3) and Urgent and Unscheduled Care (Appendix 4). A phased roll out of enhanced dashboards has been underway for some time and an explanation of that programme of work is included below.

Gaps in the data available to measure improvements set out in the Initial Escalation Improvement Plan, have been identified as part of the learning from other organisations and we are working to address these as part of the work with the Board members and the initiation of the discovery stage of the organisation-wide Culture and Leadership Programme. Work is underway to ensure that we have outcome, process, and balancing measures for all sections of the Improvement Plan, and this is evidenced in Version 2 of the Improvement Plan and the Measurement Framework.

Future Escalation Improvement Plans will be developed in an iterative way to include collectively agreed medium and longer term actions. These will be summarised in a high-level Plan on a Page to facilitate monitoring at a strategic level. Iterative versions of this Measurement Framework will be developed alongside to assist in measuring sustainability of improvements and benefits.

## Background

In December 2022, the Board of NHS Forth Valley approved the approach to the development and delivery of NHS Forth Valley's Escalation Improvement Plan. This included approving the NHS Board's Escalation Improvement Plan and actions to strengthen leadership, governance, and culture and, in doing so, deliver sustainable improvements in patient and staff experience as well as performance in a number of areas.

A Programme Governance Structure to direct and oversee the delivery of effective operational services, workforce and budget management, sustainable improvements, and organisational strategy was also approved. A Programme Plan is being developed, based on the Version 2 of

the Escalation Improvement Plan, and will be iterated alongside the development of future iterations of the Escalation Improvement Plan. The Programme Plan will include a robust monitoring approach to evidence progress.

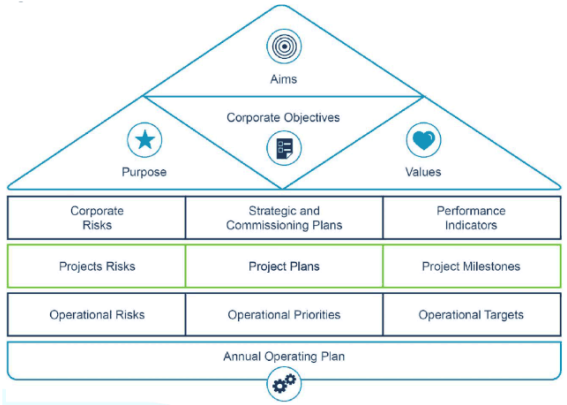
Information about the approach to developing the Escalation Improvement Plan Measurement Framework was presented to the Board's Escalation Performance and Resources Committee on the 24th of February 2023 and sent to Committee Chairs on 30th of March 2023 in advance of Committee on 5th of April.

## Approach

The Executive Leadership Team (ELT) and Escalation Programme Board and Committee have considered the approach to development of an Escalation Improvement Plan Measurement Framework in meetings from late February through March 2023. The Blueprint for Governance (second version) and other strategic documents and learning from elsewhere have been used to inform the Escalation Improvement Plan and the Measurement Framework.

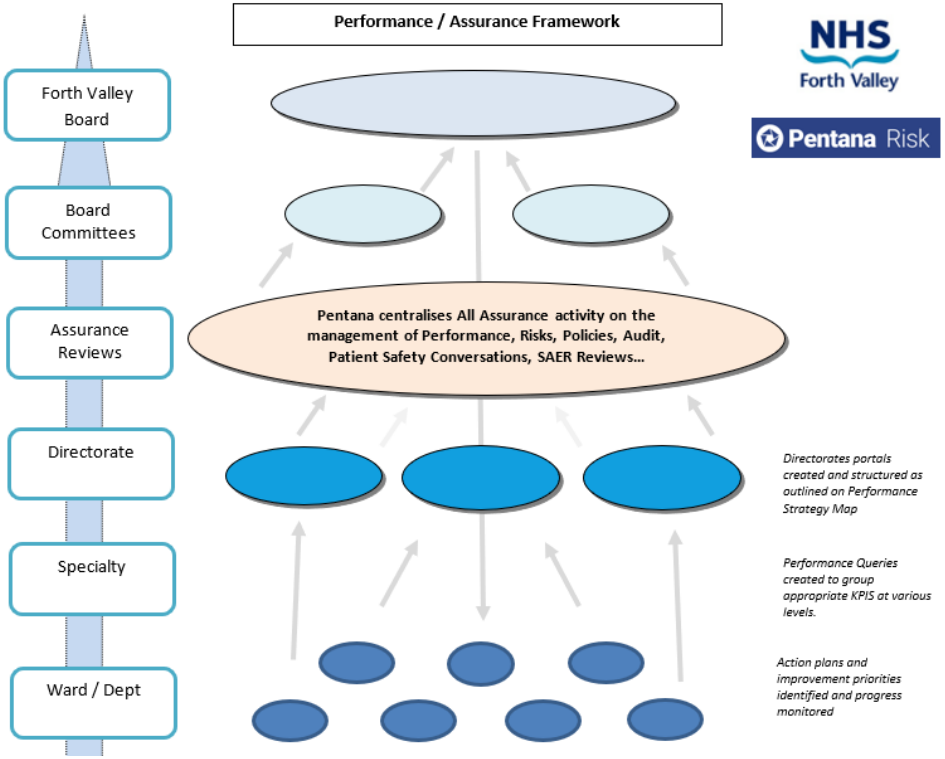
We plan to use existing performance trajectories and key performance indicators, as far as possible, to assess the impact of improvements. This Measurement Framework is not in place of key performance indicators currently used to monitor organisational performance e.g., the Recovery and Performance Scorecard. This Measurement Framework is an interim solution. It is specifically designed to allow understanding of progress of work to deliver the outcomes required by the Escalation Improvement Plan. However, the longer-term approach will be to integrate the measurement framework into the overall assurance approach and align measurements to approved strategies and appropriate governance committee in line with the assurance framework.

Figure Two – The Assurance Framework



Significant work is ongoing within Forth Valley to implement the key components of the Assurance Framework set out in the Blueprint for Good Governance. Work is ongoing to develop an integrated and hierarchical approach to reporting performance data. This is based on a hierarchical use of the Pentana Reporting System to facilitate tracking from operational units, such as wards and departments, to Directorates and then rolling up to Board level. Extensive data is accessible in Pentana for all levels of NHS Forth Valley including the Health & Social Care Partnerships (HSCPs) and is continuously expanded and improved.

An example of this is included at Appendix 1 covering absence reporting to illustrate the approach.




This system based hierarchical approach ensures the same information is used at all levels and is presented in a timely and level appropriate basis.

The implementation of this Performance Assurance Framework has been ongoing since 2021. Initial phases of this work focused on gaining Executive endorsement of approach. Following that there was significant investment in building the data flows and aligning the data to the Performance Strategy. The Performance team are now moving onto rolling Performance Dashboards out to operational areas. This requires significant work in building understanding of data, building dashboard views and training staff in how to access data. This is being carried out iteratively across key operational areas, including the HSCPs. The final phase of the work will focus on realising the benefits of this work by integrating the accountability and action planning into the process. This will enable Forth Valley to use data to plan improvements and actions and monitor the impact of those actions on data to support the next iteration of the Escalation Improvement Plan. This work is ongoing and will take time to embed.

Critical in our approach to using data for both assurance and improvement is to review our data visualisation and bring together meaningful data to allow staff at every level to understand the system and bring more critical challenge and focus on answering the ‘so what’ questions.

**NHS Forth Valley Escalation Improvement Plan v2**

**Draft Measurement Framework**

# Escalation Improvement Plan: Measurement Framework - All domains

| We need to ensure that... | Which requires... | |
|---|---|---|
| **Governance** - Effective governance arrangements are embedded throughout NHS Forth Valley based on the ten principles of good governance described in the revised Blueprint document, including active and collaborative governance, on a continuous improvement basis. | Primary functions of governance embedded throughout the Boards and Board Committees including:<br>• setting the direction<br>• holding colleagues to account<br>• managing risks<br>• engaging with key stakeholders and<br>• influencing/driving the organisation's culture | Board developed clear vision and values framework that everyone takes responsibility for working within . |
| **Good governance** is necessary to enable Forth Valley to achieve it's overall vision of delivering safe person centred care, money managed and a great place to work. – *is there a vision wording we can reference?* | | A clear and challenging set of corporate objectives reflected at every level of the organisation and good quality data to guide operational performance aligned with these. |
| **Leadership and Culture** Effective leadership and culture change is embedded throughout NHS Forth Valley based on the six cultural elements and leadership behaviours of the Culture Change and Leadership Programme NHS England » The Culture and Leadership programme and informed by Staff Governance Standards. Staff Governance Standard — NHS Scotland Staff Governance | Enabling conditions in place including:<br>• clearly defined roles and responsibilities and accountabilities for operational management and delivering change<br>• acquiring and retaining the necessary diversity, skills and experience<br>• creating relationships and conducting business in line with agreed values and behaviours | High quality support and compassion for staff, ensuring that they have the right working conditions and resources to support their own wellbeing and deliver consistently high standards of care and treatment that people expect. |
| | | Diversity is positively valued and everyone is included and respected, strengthening trust, transparency and staff wellbeing. |
| | Delivery conditions in place including assurance framework, integrated governance system and operating guidance. | Everyone taking responsibility for continuously improving quality, learning and innovating in safe and empowering conditions. |
| | | Effective team and inter-team working with everyone taking responsibility for creating collaborative relationships and working as a system. |

**NHS Forth Valley Escalation Improvement Plan v2**

**Draft Measurement Framework**

# Escalation Improvement Plan: Measurement Framework - Governance

| We need to ensure that... | Which requires... | Change activities – Include in Plan On a Page | Outcomes/Measurement |
|---|---|---|---|
| **Governance** - Effective governance arrangements are embedded throughout NHS Forth Valley based on the ten principles of good governance described in the revised Blueprint document, including active and collaborative governance, on a continuous improvement basis. | Primary functions of governance embedded throughout the Boards and Board Committees including:<br>• setting the direction<br>• holding colleagues to account<br>• managing risks<br>• engaging with key stakeholders and<br>• influencing/driving the organisation's culture | **Horizon 1 – Initial response activities**<br>External review of NHS Forth Valley Board and effectiveness of governance against Blueprint.<br>Self assessment and Individual Performance Appraisal for NHS Forth Valley Board.<br>External review of Integration Scheme(s) together with Local Authority partners.<br>Review effectiveness of new decision making matrix.<br>Delivery of the NHS HIS Improvement Action Plan.<br>Directorate/Partnership performance assurance review meetings implemented.<br>Implement initial areas of hierarchical assurance framework in key operational areas including Out of Hours, Urgent and Unscheduled Care and CAMHS and PT.<br>Develop high level Programme Plan on a Page to facilitate and progress tracking. | Delivery of milestones assessed using detailed in Plan on a Page. |
| | Enabling conditions in place including:<br>• clearly defined roles and responsibilities and accountabilities for operational management and delivering change<br>• acquiring and retaining the necessary diversity, skills and experience<br>• Creating relationships and conducting business in line with agreed values and behaviours | | Demonstrable ongoing improvement in Board's corporate governance arrangements. Delivery of actions identified from external reviews/self assessment - tracked through Pentana. Improved turnaround and completion of internal audit follow up actions by initial due date - tracked through Pentana. |
| Good governance is necessary to enable Forth Valley to achieve it's overall vision of a great place to work and an outstanding place to receive care. | Delivery conditions in place including assurance framework, integrated governance system and operating guidance. | | More effective risk management and escalation. Evidence that risks are being escalated appropriately, scores reduced and actions delivered on plan. |
| | | | Progress in key operational areas - KPIs tracked against trajectories in line with Scottish Government targets. Tracked through Pentana. Successful implementation of assurance framework. |
| | | | Improved collaboration across NHS Forth Valley with partners. Effectiveness of the decision making matrix. |

**NHS Forth Valley Escalation Improvement Plan v2**

**Draft Measurement Framework**

# Escalation Improvement Plan: Measurement Framework - Culture and Leadership

| We need to ensure that... | Which requires... | Change activities – Include in Plan On a Page | Outcomes/Measurement |
|---|---|---|---|
| **Leadership and Culture** Effective leadership and culture change is embedded throughout NHS Forth Valley based on the six cultural elements and leadership behaviours of the Culture Change and Leadership Programme NHS England » The Culture and Leadership programme and informed by Staff Governance Standards. Staff Governance Standard — NHS Scotland Staff Governance | Board developed clear vision and values framework that everyone takes responsibility for working within. | **Horizons 1 to 2 (Ref App 2)**<br>Board and ELT, Directorate, and HSCP team and individual objectives linked to corporate objectives designed through Board/ELT development programmes.<br><br>Invest in revised professional leadership and management structures across NHS Forth Valley.<br><br>Undertake discovery and diagnostic phases of the organisational culture change and leadership programme to capture staff voice and experience and inform the design and then delivery of the programme.<br><br>Launch annual staff wellbeing programme.<br><br>Improvement plan to enhance staff and patient voice including review of whistleblowing arrangements and Public Forum and strengthened involvement of Area Partnership Forum and Area Clinical Forum.<br><br>Maintain an effective Forth Valley Minority Ethnic Network.<br><br>Refresh the Board's Healthcare Strategy and People Strategy. | Ongoing improvement from baseline results assessed using measures for improvement agreed for each new workstream and project.<br><br>Baseline culture and leadership process and balancing measures incorporated in a Heat Map: PDP reviews, staff attendance, retention, grievances, essential training compliance, Whistleblowing, Speak Up, practice learning student feedback, iMatter ratings, staff voice evidenced in climate survey and focus group results.<br><br>Performance in key operational areas in balanced scorecard/dashboard - tracked through Pentana.<br><br>Outcomes and impact on quality of care (safe, effective, person centred) , patient and staff experience, staff health and wellbeing, leadership capacity and financial balance reviewed together in strengthened clinical and corporate governance structures. Assessed from reports including Safety & Assurance, Person Centred, Staff Wellbeing, Audit, Quality Improvement, R&D, Digital, Innovation, Organisational Development and Finance. |
| | A clear and challenging set of corporate objectives reflected at every level of the organisation and good quality data to guide operational performance aligned with these. | | |
| | High quality support and compassion for staff, ensuring that they have the psychologically safe working conditions and resources to support their own wellbeing and deliver consistently high standards of care and treatment that people expect. | | |
| | Diversity is positively valued and everyone is included and respected, strengthening trust, transparency and staff wellbeing. | | |
| | Everyone taking responsibility for continuously improving quality, learning and innovating in safe and empowering conditions . | | |
| | Effective team and inter-team working with everyone taking responsibility for creating collaborative relationships and working as a system. | Progress and completion of agreed actions set out in Plan on a Page detailing timelines through Horizon 1, 2 and 3 tracked through Pentana, programme delivery tool and action logs. | Progress in Quality Strategy Implementation and outcomes monitored through Quality Programme Board and Clinical Governance Committee - tracked through Pentana and internal audit. |

**NHS Forth Valley Escalation Improvement Plan v2**

**Draft Measurement Framework**

## OUR VISION

A great place to work and an outstanding place to receive care.

Our key priorities are:

- Supporting our staff - by ensuring that they have the right working conditions and resources to support their own wellbeing and deliver the best care and services possible.
- Putting patients first - everyone who uses our services should expect to receive consistently high standards of care and treatment.
- Working in partnership - building and sustaining a culture of collaboration with partners based on trust and respect, learning, and sharing of best practice.

1. **Supporting our staff - by ensuring that they have the right working conditions and resources to support their own wellbeing and deliver the best care and services possible - refer to LEADERSHIP AND CULTURE DRIVER DIAGRAM**

2. **Putting patients first - everyone who uses our services should expect to receive consistently high standards of care and treatment - refer to LEADERSHIP AND CULTURE DRIVER DIAGRAM**

| This requires:<br>(Actions from Escalation Improvement Plans) | Current measures and evidence that will help us measure improvement, provide assurance, and describe the outcomes in the form of impact and benefits.<br>(Include outcomes (o), process (p) and balancing (b) measures. | Data/information collection: source, how, who, when. How is it presented and to where. |
|---|---|---|
| Executive Leadership Team and Board Development Programmes. | Outcome:<br>Engagement and experience/satisfaction of Executive Leadership Team and Board members.<br><br>Process measures:<br>Completion of effective, timely 121s.<br><br>Completion of Organisational Development. | Survey data.<br><br>Report from external facilitator - completed.<br>Document provided by external OD (Organisational Development) describing proposed scope of development programme - completed. |

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| | Attendance of ELT at development sessions.<br><br>Balancing measure:<br>Current operational performance. | Development sessions attendance recorded by external OD.<br><br>Operational performance framework. |
| Learning from others focussed on leadership, culture, and governance. | Outcomes:<br>The Culture Change and Leadership Programme includes learning from elsewhere, particularly measurement for improvement and ways of evidencing impact.<br><br>Speak up improvement plan based on self-assessment against NHS GG&C actions.<br><br>Process measures:<br>Record of meetings, including outcomes and learning points.<br>Progress with delivery of improvement plan.<br><br>Balancing measures:<br>Staff engagement with Culture Change and Leadership Programme.<br>Patient, service user and public engagement with designing new models of care and services. | Meeting notes and action logs from speak up meetings and Culture and Leadership Project Team meetings.<br><br>Performance framework.<br><br>Updates and briefings from Human Resources Director.<br>Meeting notes and action logs from ELT and Escalation (e.g., Programme Board and P&R Committee) Meetings.<br>Addition to Pentana, of additional culture and leadership measures.<br><br>Analyses of discovery and diagnostic information presented in report.<br>Evaluation of patient and public involvement as part of end of project reports. |
| Implement reviewed professional leadership and management arrangements across NHS Forth Valley. | Outcome:<br>Staff clear about roles and responsibilities and aware of escalation and response process.<br>Reduced demand on Executives and Directors.<br>Results of increased change and innovation. | Climate surveys and focus groups as part of Culture Change and Leadership programme.<br>Improvement and innovation delivery plans. |

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| | Process measures:<br>Triumvirate weekly meetings in Acutes Services Directorate<br>Vacancies filled and returns to substantive posts.<br><br>Balancing measure:<br>Loss of organisational knowledge and talented staff who have been filling temporary posts. | Notes/actions from triumvirate meetings.<br>Recruitment records and updated organograms provided by the Acting Acute Services Directorate and Professional Leads.<br><br>Staff turnover data in Pentana. |
| Increase HSCP Leadership and Management Capacity. | Outcome:<br>Staff, patients, and service users feel safe and well supported in designing and delivering change and innovation.<br><br>Process measure:<br>Operational performance improvements<br><br>Balancing measures:<br>Quality of care indicators<br><br>Staff experience | Diagnostic thematic analysis report.<br>Improvement plans delivered and outcomes.<br><br>Operational performance framework.<br><br>Safety and Assurance Report and clinical and care governance group reports reviewed through clinical and care governance infrastructure.<br>Climate survey and focus group reports. |
| Board and ELT Leadership Capacity and Succession Planning. | Outcome:<br>Quality planning with longer term transformation and sustainability plans driving preventative care and service models and changes in the workforce that will meet future needs.<br><br>Process measure:<br>Resources prioritised to longer term planning.<br><br>Balancing measure:<br>Local plan alignment across the system. | Financial reports.<br><br>NHS Forth Valley Healthcare Strategy, H&SCP Strategic Plans and Community Planning Partnership updates. |

## NHS Forth Valley Escalation Improvement Plan v2

### Draft Measurement Framework

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|---|---|---|
| Strengthen the voice of patients and staff. | Outcome:<br>Staff, patients, and service users feel safe to be able to speak up and well supported in delivering change and innovation.<br>Process measures:<br>Number and mix of staff involved in Oversight Group and Culture Change Team.<br>Number and range of staff engaged through Discovery Phase and analyses of responses.<br>iMatter staff engagement data.<br>Exit interview themes and actions taken.<br>Number of new starts and leavers<br>Staff absence and reasons for absence<br>Number of bullying and harassment cases<br>Number of grievance cases<br>TURAS module completion<br>Balancing measure:<br>Number and trend of whistleblowing.<br>Patient experience.<br>Improvements in safe, effective and person centred care and support. | Diagnostic thematic analysis report.<br>Improvement plans delivered and outcomes.<br>Meeting notes and action logs from speak up meetings and Culture and Leadership Project Team meetings.<br>iMatter staff engagement annual survey<br>(Response rates for 2022 56% (national 55%), EEI (Employee Engagement Index) 76 (National 76) Action plan completion within 8 weeks 58% (national 47%).<br>Exit interview thematic report from Human Resource Director.<br>Pentana<br>Pentana<br>Pentana<br>Pentana<br>Pentana<br>Pentana<br>Person centred reports reviewed through clinical governance infrastructure.<br>Improvement and innovation portfolios reviewed via Clinical Governance Committee, Quality Programme Board and Digital and eHealth Programme Board. |

## Draft Measurement Framework

| 3. Working in partnership - building and sustaining a culture of collaboration with partners based on trust and respect, learning, and sharing of best practice - refer to GOVERNANCE DRIVER DIAGRAM | | |
|---|---|---|
| This requires:<br>(Actions from Escalation Improvement Plans) | Current measures and evidence that will help us measure improvement, provide assurance, and describe the outcomes in the form of impact and benefits.<br>(Include outcomes (o), process (p) and balancing (b) measures.) | Data/information collection: source, how, who, when. How is it presented and to where. |
| External review of governance and improved effectiveness of governance of performance issues. | Outcome:<br>Evidence that primary functions of governance, enabling conditions and delivery conditions are in place.<br><br>Process measures:<br>Completion of external review<br>Development of action plan<br>Completion of self-assessment and individual performance appraisal.<br>Delivery of actions identified in action plan.<br><br>Balancing measure:<br>Operational performance trends. | Output report from external review.<br><br>Action plan based on external review recommendations.<br><br>Tracking of delivery of action plan – tracked through Pentana.<br><br>Operational performance framework. |
| Accountability and governance - Partnership Working. | Outcome:<br>Governance that holds people to account and ensures that responsibilities are clear and embeds effective collaborative working.<br><br>Process measures:<br>Directorate/Partnership performance assurance review meetings implemented.<br><br>Risks logged and mitigating actions identified and completed. | Meeting notes and actions (Testing in Pentana).<br><br>Audit via risk register (number, quality, timely actions, and updates). |

| | | |
|---|---|---|
| | Escalated issues and responses.<br><br>Balancing measure:<br>Operational performance across system. | |
| Whole system governance – Integration. | Outcome:<br>Decisions made in timely way and in right place.<br><br>Process measures:<br>Decision making criteria and matrix approved.<br>Escalation/ response evidenced.<br><br>Balancing measure:<br>Operational performance across system. | Meeting notes and action logs from Directorate and H&SCP Performance Meetings.<br><br>Internal Audit |
| Transfer of remaining operational management of integration services, staff and budgetary arrangements and collaboratively led innovation | Outcome:<br>Effective integration scheme in place across Forth Valley.<br><br>Process measures:<br>Changed H&SCP and NHS Forth Valley reporting arrangements for Specialist Mental Health and Learning Disability services, Health Improvement and Primary Care services.<br>Due diligence review of integration.<br>Completion of recruitment to key management posts.<br>Action plan to address review findings.<br>Delivery of action plan.<br><br>Balancing measures:<br>Quality and safety of care indicators<br>Staff experience<br>Performance against budget | Recruitment records and updated organograms provided by Finance and Human Resources Teams to H&SCP Directors, and Professional Leads.<br><br>Output report from external review.<br><br>Action plan based on external review recommendations.<br><br>Tracking of delivery of action plan - tracked through Pentana.<br><br>Clinical and Care Governance Committee Reports from H&SCP Chief Officers<br>Culture Change and Leadership Programme climate survey and focus groups. Financial reports. |

## NHS Forth Valley Escalation Improvement Plan v2

### Draft Measurement Framework

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|---|---|---|
| Acute Services Leadership and Management. | Outcome:<br>Release senior leadership and management capacity in Acute Services.<br>Vacancies filled and returns to substantive posts.<br><br>Process measures:<br>Completion of recruitment to senior leadership posts.<br><br>Staff clear about roles and responsibilities.<br><br>Balancing measure:<br>Leaver's data. | Recruitment records and updated organograms provided by the Acting Acute Services Directorate and Professional Leads.<br><br>Staff culture discovery work (through Compassionate Leadership Programme). |
| Relationship Building. | Outcome:<br>Improved collaborative working through enhanced stakeholder engagement.<br><br>Process measures:<br>Staff side and CEO escalation meeting<br>Regular updates to "escalation on staff intranet"<br>Monthly MSP/MP meetings<br>Regular updates to ACF (Area Clinical Forum) meeting in place.<br>Monthly Chief Officer and Local Authority/NHS Chief Executive meetings in place.<br>Quarterly Leader/Chair meetings in place.<br><br>Balancing measure<br>Leaver's data. | Meeting agenda and action notes to confirm meetings have taken place.<br><br>Staff intranet<br><br>Leaver's data – tracked through Pentana |
| Performance. | Outcome:<br>Improved operational performance in OOH (Out of Hours) Services, CAMHS (Child and Adolescent Mental Health Services) and PT (Psychological | Balanced Scorecard via Pentana<br>Narrative to be enhanced and linked to interventions and impact.<br><br>Tracking of delivery of HIS Improvement Action Plan. |

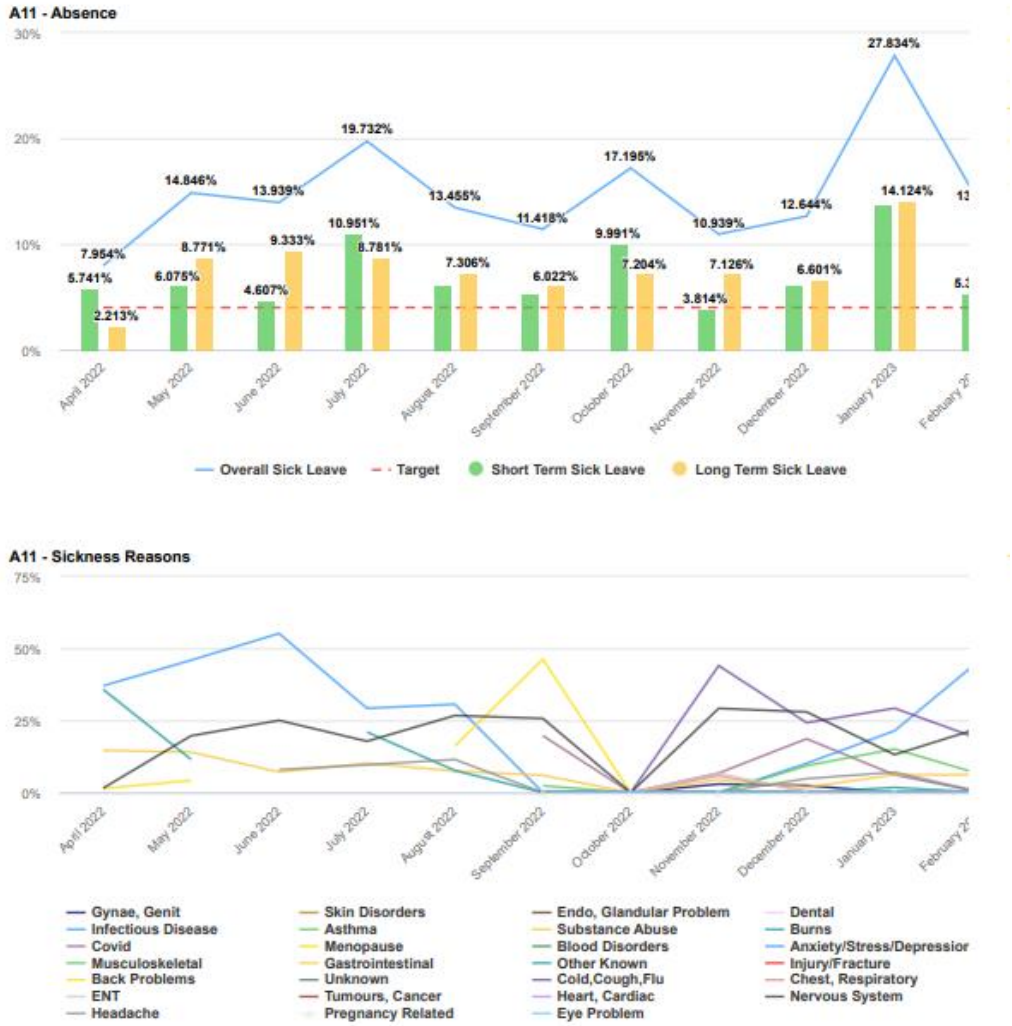
| | | |
|---|---|---|
| | Therapies), Urgent &Unscheduled Care against national targets and delivery of Safe Care.<br><br>Process measures:<br>Delivery of NHS HIS (Healthcare Improvement Scotland) Improvement Action Plan<br>Existing performance metrics for operational performance. | |
| Measurement Framework | Outcome:<br>Demonstrate progress against escalated domains.<br><br>Process measures:<br>All elements noted above. | Methods in place as described to track measures. |

**Appendix 1**

**Absence Analysis – Ward/Department**

Information is reviewed at Ward/Department level through an online portal which allows for logging and tracking of actions. This enables detailed oversight of specific issues to be undertaken at an appropriate level.

**Ward Level Absence Portal Extract**

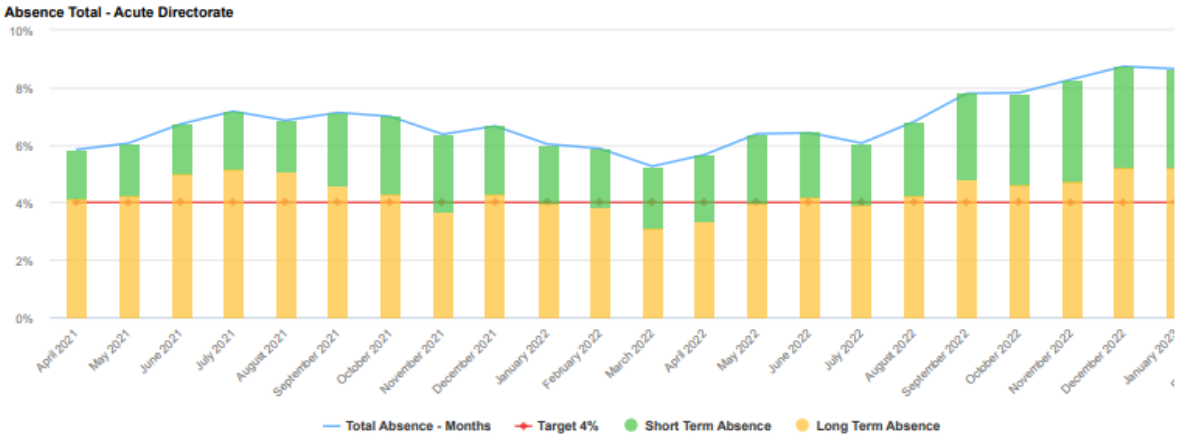


**Appendix 1**

## Absence Analysis - Directorate

Information is then reviewed at Directorate level. In some areas it is summarised at Speciality level where appropriate. This can be viewed through an online portal and actions can be logged and tracked. At a Directorate level systemic issues start to become apparent. This will allow specific actions to be identified and the impact of these interventions tracked over time

### Directorate Level Absence Portal Extract




**Acute Directorate Absence HOT SPOTS >5% (breakdown by individual roster)**

| ... | Title | Value | Target | Short Trend | Long Trend | History |
|---|---|---|---|---|---|---|
| | % of total hours attributed to SICK LEAVE per month - Ambulatory & Diagnos... | 9% | 4% | | | |
| | % of total hours attributed to SICK LEAVE per month - A&E ENP - FVRH | 8% | 4% | | | |
| | % of total hours attributed to All Sick Leave per month - Health Records AS A... | 10% | 4% | | | |
| | % of total hours attributed to All Sick Leave per month - Health Records AS A... | 15% | 4% | | | |
| | % of total hours attributed to All Sick Leave per month - Health Records AS ... | 9% | 4% | | | |
| | % of total hours attributed to All Sick Leave per month - Health Records AS ... | 9% | 4% | | | |
| | % of total hours attributed to All Sick Leave per month - Health Records AS S... | 12% | 4% | | | |
| | % of total hours attributed to All Sick Leave per month - Health Records AS ... | 9% | 4% | | | |
| | % of total hours attributed to All Sick Leave per month - Health Records X-Ra... | 17% | 4% | | | |
| | % of total hours attributed to All Sick Leave per month - Thistle Suite/Speciali... | 7% | 4% | | | |

**Acute - Sickness Absence Reasons**

| ... | Title | Value | Short Trend | Long Trend | History |
|---|---|---|---|---|---|
| | % of total hours attributed to Anxiety/stress/depression/other psychiatric illne... | 27% | | | |
| | % of total hours attributed to Other musculoskeletal problems - Acute Directo... | 7% | | | |
| | % of total hours attributed to Gastro-intestinal problems - Acute Directorate O... | 7% | | | |
| | % of total hours attributed to Other known causes - not otherwise classified - ... | 5% | | | |
| | % of total hours attributed to Injury, fracture - Acute Directorate Overall | 7% | | | |
| | % of total hours attributed to Back problems - Acute Directorate Overall | 4% | | | |
| | % of total hours attributed to Unknown causes/not specified - Acute Directora... | 1% | | | |
| | % of total hours attributed to Cold, cough, flu - influenza - Acute Directorate ... | 9% | | | |
| | % of total hours attributed to Chest & respiratory problems - Acute Directorat... | 4% | | | |
| | % of total hours attributed to Ear, nose, throat (ENT) - Acute Directorate Overall | 3% | | | |

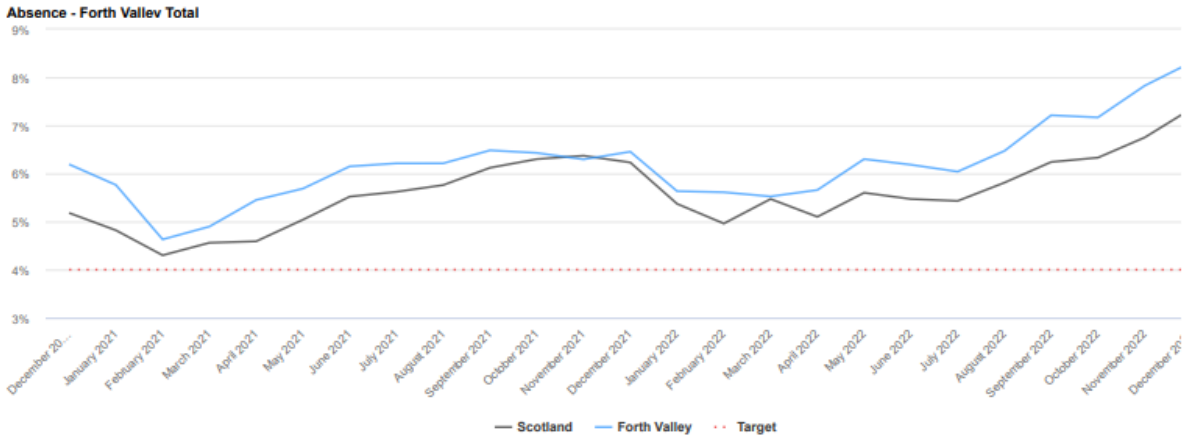
**Appendix 1**

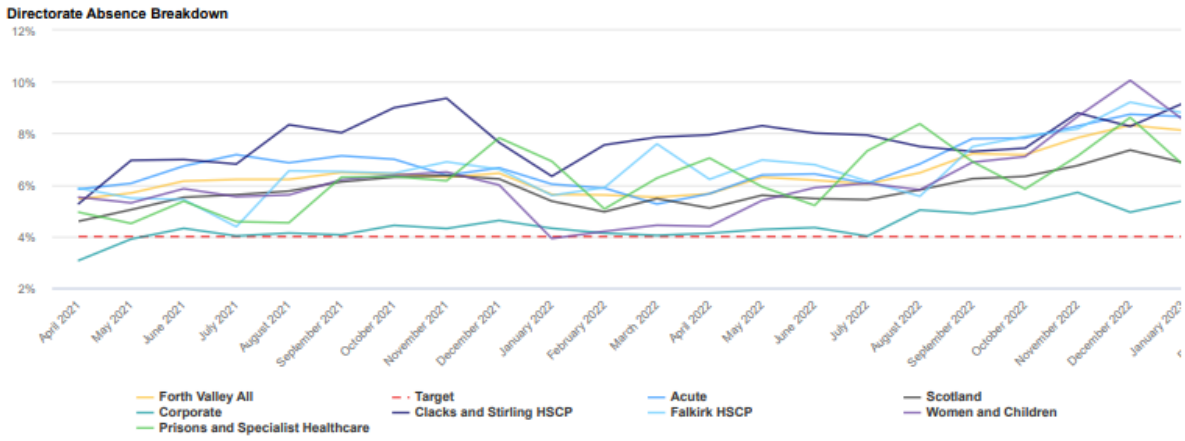
## Absence Analysis - Board

Finally information can be reviewed at Board level alongside the actions identified and commentary provided following Directorate review. At this level trends are clear. NHS Forth Valley is committed to actively managing these trends and ensuring action plans are in place to address. This integrated approach is being rolled out.

The integrated assurance activity and tracking of actions through the Pentana system provides the Board assurance that data is being monitored and actively managed throughout the organisation.

**Committee/Board Level Absence Portal Extract**




**Absence Directorates**

| Title | Value | Target | Short Trend | Long Trend | History |
|---|---|---|---|---|---|
| Acute Directorate - Overall Absence | 7.5% | 4% | | | |
| Corporate Services Directorate - Absence | 5.29% | 4% | | | |
| Prison Healthcare & Specialist Community Services (Dir) - Absence | 5.89% | 4% | | | |
| Clackmannanshire and Stirling Health and Social Care Partnership - Total Ab… | 7.26% | 4% | | | |
| Falkirk Health and Social Care Partnership - Total Absence | 8.54% | 4% | | | |
| Women & Children & Sexual Health Services - Overall Absence | 8.1% | 4% | | | |

# NHS Forth Valley Escalation Improvement Plan v2

## Draft Measurement Framework

**Appendix 1**

**Absence Reasons Table**

| ... | Title | Value | Short Trend | Long Trend | History |
|---|---|---|---|---|---|
| | % Total - Anxiety/stress/depression/other psychiatric illnesses | 30% | ↓ | ↑ | |
| | % Total - Other musculoskeletal problems | 7% | ↓ | ↑ | |
| | % Total - Gastro-intestinal problems | 7% | ↓ | ↑ | |
| | % Total - Other known causes - not otherwise classified | 7% | ↓ | ↓ | |
| | % Total - Injury, fracture | 6% | ↓ | ↓ | |
| | % Total - Back problems | 3% | ↑ | ↑ | |
| | % Total - Unknown causes/not specified | 4% | ↓ | ↑ | |
| | % Total - Cold, cough, flu - influenza | 7% | ↑ | ↓ | |
| | % Total - Chest & respiratory problems | 5% | ↑ | ↓ | |
| | % Total - Ear, nose, throat (ENT) | 3% | ↑ | ↓ | |

**Appendix 2**

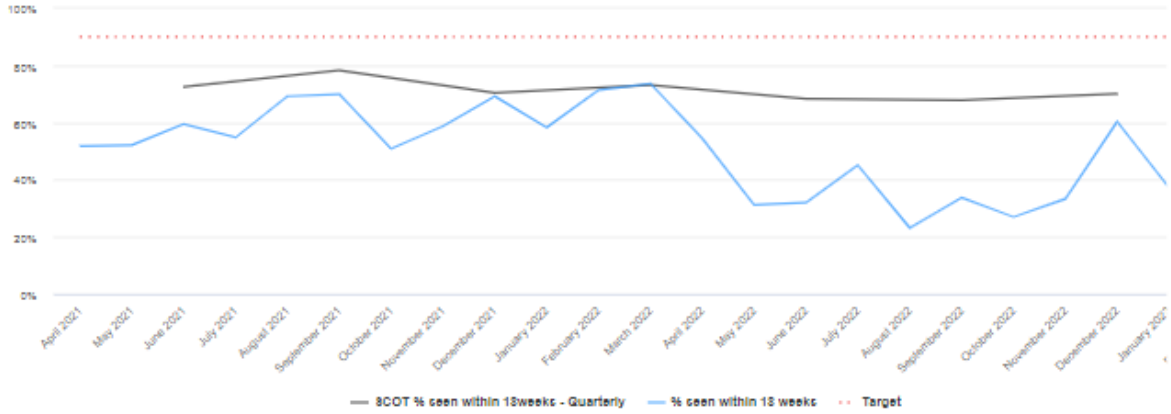
## Child & Adolescent Mental Health Service (CAMHS)

| 17 | 4 | 0 | 0 |
|---|---|---|---|
| All CAMHS | Red Status | Amber Status | Green Status |

| Urgent CAMHS referrals | New attendances | Return attendances | Number of patients discharged |
|---|---|---|---|
| February 2023 result | February 2023 result | February 2023 result | February 2023 result |
| 19 | 83 | 978 | 38 |

| Completed 18 Week RTT | Compliance against 12 week Stage of Trea... | Compliance against 18 week Referral to Tr... |
|---|---|---|
| February 2023 result | February 2023 result | February 2023 result |
| 45.9% | 75.57% | 48.37% |

CAMHS - Completed referral to Treatment - 18 Weeks




Compliance against 12 week standard ongoing waits

# Draft Measurement Framework
# CAMHS Dashboard

**Appendix 2**

CAMHS - Referral to Treatment ongoing waits

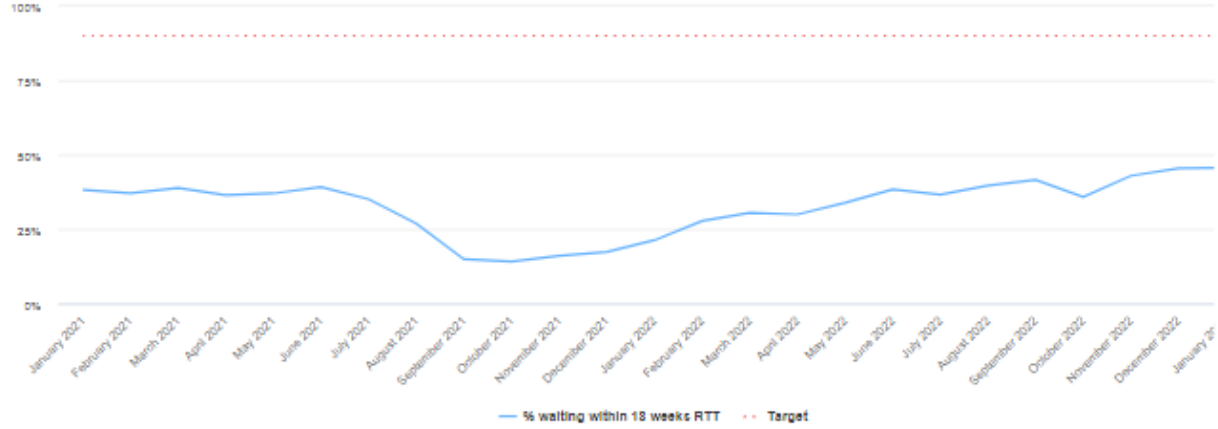



Table Results - Active Cases

| ... | Code & Title | Value | Next Update Due | Last Update | History |
|---|---|---|---|---|---|
| | ACTIVE.CAMH8 Total amount of active cases for Child & Adolescent Mental ... | 2,107 | 01 Apr 2023 | February 2023 | |

Active Cases - CAMHS


Table Results - New and Return DNA's

| ... | Code & Title | Gauge | Value | Target | Next Update ... | Last Update | History |
|---|---|---|---|---|---|---|---|
| | DNA.NEW.G2 New outpatient appointment DNA - Child and Adolescent Psyc... | | 7.78% | 5% | 01 Apr 2023 | February 2023 | |

# Draft Measurement Framework
# CAMHS Dashboard

**Appendix 2**

New and Return DNA's

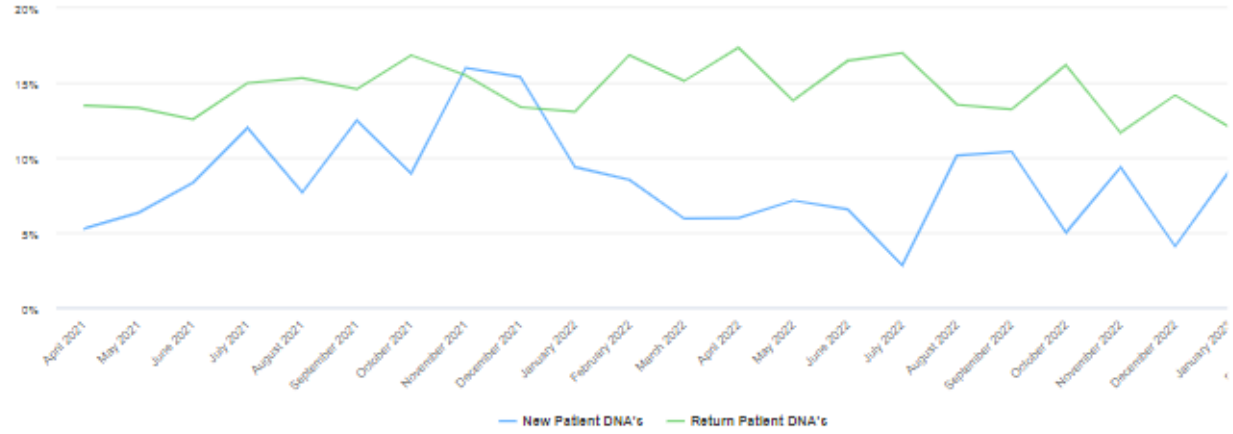



Table Results - Patients waiting for initial appointment

| ... | Code & Title | Value | Numerator | Denominator | Next Update ... | Last Update | History |
|---|---|---|---|---|---|---|---|
| | 8OT.O12WK.1.G2 Referral to First Contact measure, numbers waiting over ... | 24.43% | 54 | 221 | 01 Apr 2023 | February 2023 | |
| | 8OT.O18WK.1.G2 Referral to First Contact measure, numbers waiting over ... | 7.24% | 16 | 221 | 01 Apr 2023 | February 2023 | |
| | 8OT.O26WK.1.G2 Referral to First Contact measure, numbers waiting over ... | 0.9% | 2 | 221 | 01 Apr 2023 | February 2023 | |
| | 8OT.O62WK.1.G2 Referral to First Contact measure, numbers waiting over ... | 0.45% | 1 | 221 | 01 Apr 2023 | February 2023 | |

Table Results - Patients waiting for treatment

| ... | Code & Title | Value | Numerator | Denominator | Next Update ... | Last Update | History |
|---|---|---|---|---|---|---|---|
| | RTT.O12WK.S.G2 Referral to treatment measure, numbers waiting over 12 ... | 63.1% | 330 | 523 | 01 Apr 2023 | February 2023 | |
| | RTT.O18WK.S.G2 Referral to treatment measure, numbers waiting over 18 ... | 51.63% | 270 | 523 | 01 Apr 2023 | February 2023 | |
| | RTT.O26WK.S.G2 Referral to treatment measure, numbers waiting over 26 ... | 40.54% | 212 | 523 | 01 Apr 2023 | February 2023 | |
| | RTT.O62WK.S.G2 Referral to treatment measure, numbers waiting over 52 ... | 8.6% | 45 | 523 | 01 Apr 2023 | February 2023 | |

# TIMELY - Specialist Mental Health & Learning Disabilities

**Contents**



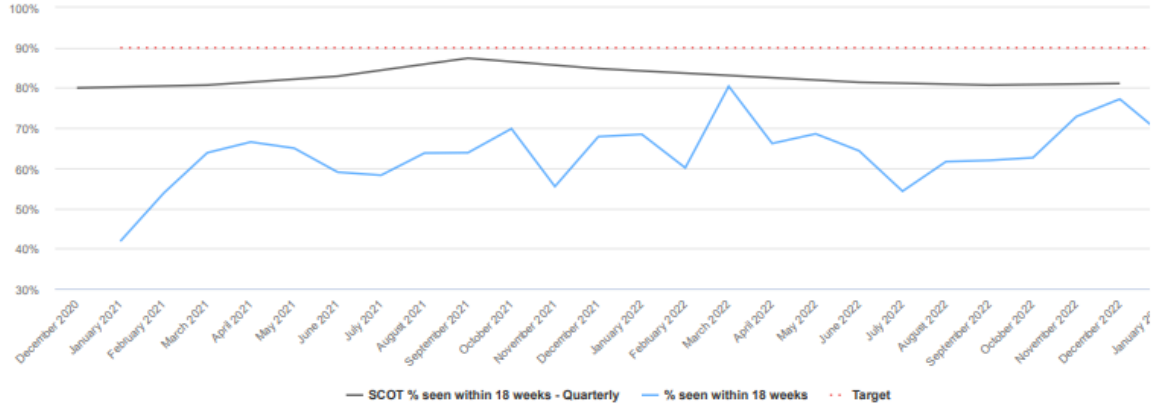
## Referral to Treatment (RTT) - Completed

**Completed RTT 18 Week**

**February 2023 result**

**66.42%**

**Psych Therapy - Referral to Treatment - 18 Weeks**




**Psychological Therapies Referral to Treatment**

| ... | Code & Title | Gauge | Value | Target | Next Update ... | Last Update | History |
|---|---|---|---|---|---|---|---|
| ✓ | **RTT.01.CHP.ACP** Clinical Psychology - Psychological Therapies Referral to ... | | 100% | 90% | 01 Mar 2023 | January 2023 | |
| ✓ | **RTT.01.CHP.PDT** 18 Week RTT (Psychodynamic Therapy) | | 100% | 90% | 01 Mar 2023 | January 2023 | |

## Did Not Attend (DNA) - Psychological Therapy Data

**New Patient DNA's**

**February 2023 result**

**10.66%**

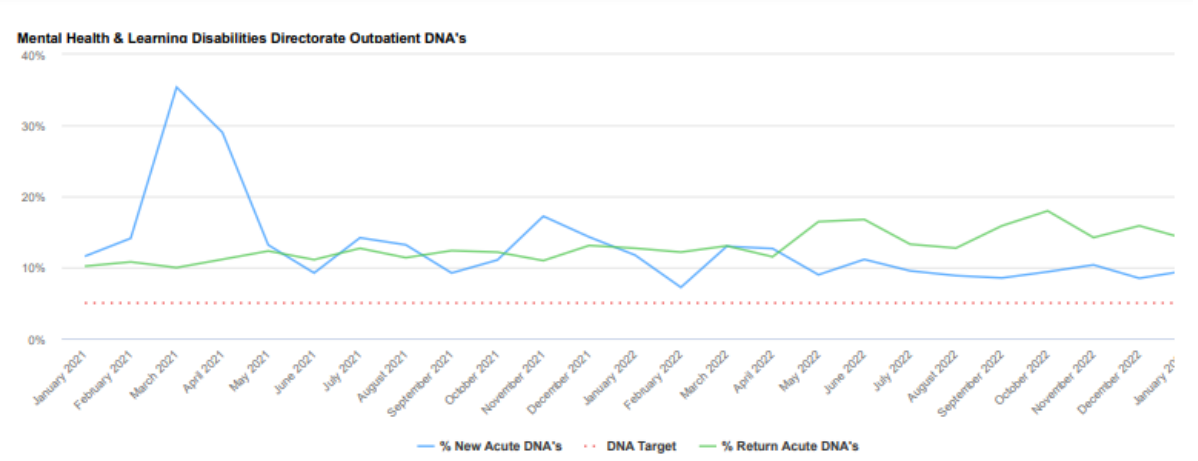
**Return Patient DNA's**

**February 2023 result**

**13.42%**

# Draft Measurement Framework
# Specialist Mental Health & Learning Disabilities Dashboard

**Appendix 3**




**Mental Health & Learning Disability Directorate New DNA's**

| ... | Code & Title | Gauge | Value | Target | Next Update ... | Last Update | History |
|---|---|---|---|---|---|---|---|
| ? | **DNA.NEW.G6** New outpatient appointment DNA - Psychotherapy | | n/a | 5% | 01 Apr 2023 | February 2023 | |
| ● | **DNA.NEW.R2** New outpatient appointment DNA - Clinical Psychology | | 10.66% | 5% | 01 Apr 2023 | February 2023 | |

**Mental Health & Learning Disability Directorate Return DNA's**

| ... | Code & Title | Gauge | Value | Target | Next Update ... | Last Update | History |
|---|---|---|---|---|---|---|---|
| ● | **DNA.RTN.G6** Return outpatient appointment DNA - Psychotherapy | | 7.69% | 5% | 01 Apr 2023 | February 2023 | |
| ● | **DNA.RTN.R2** Return outpatient appointment DNA - Clinical Psychology | | 13.52% | 5% | 01 Apr 2023 | February 2023 | |

Did Not Attend (DNA) - Community Mental Heath Team

**New Patient DNA's**

February 2023 result

● 8.54%

**Return Patient DNA's**

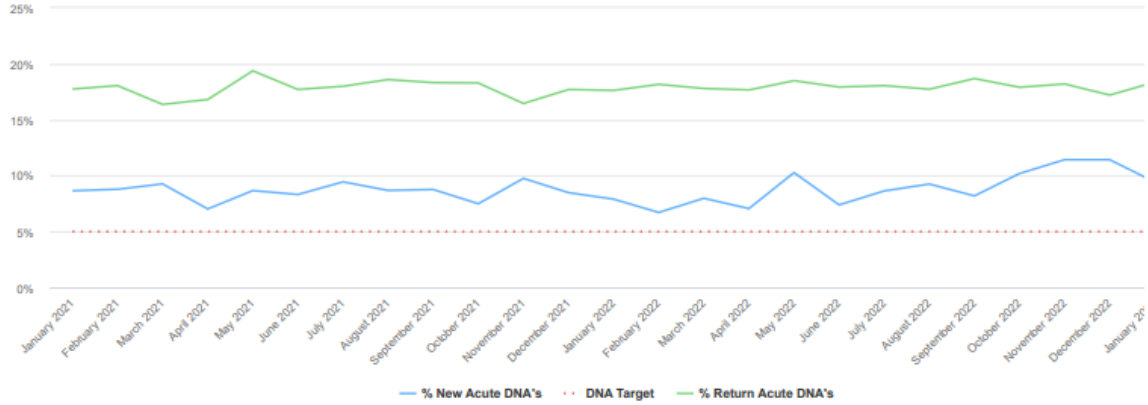
February 2023 result

● 18.61%

# Draft Measurement Framework
# Specialist Mental Health & Learning Disabilities Dashboard

**Appendix 3**

**Communitv Mental Health DNA's**




**Community Mental Health New appointment DNA's**

| ... | Code & Title | Gauge | Value | Target | Next Update ... | Last Update | History |
|---|---|---|---|---|---|---|---|
| | **DNA.NEW.G1** General Psychiatry Mental Illness Community Mental Health T... | | 10.39% | 5% | 01 Apr 2023 | February 2023 | |
| | **DNA.NEW.G3** Forensic Psychiatry Community Mental Health Team - New ou... | | 0% | 5% | 01 Apr 2023 | February 2023 | |
| | **DNA.NEW.G4** Psychiatry of Old Age Community Mental Health Team - New ... | | 2.83% | 5% | 01 Apr 2023 | February 2023 | |
| | **DNA.NEW.G5** Learning Disability Community Mental Health Team - New out... | | 6.25% | 5% | 01 Apr 2023 | February 2023 | |
| | **DNA.NEW.RU** Arts Therapies Community Mental HealthTeam - New outpatie... | | 20% | 5% | 01 Apr 2023 | February 2023 | |

**Community Mental Health Return appointment DNA's**

| ... | Code & Title | Gauge | Value | Target | Next Update ... | Last Update | History |
|---|---|---|---|---|---|---|---|
| | **DNA.RTN.G1** General Psychiatry Mental Illness Community Mental Health T... | | 23.01% | 5% | 01 Apr 2023 | February 2023 | |
| | **DNA.RTN.G3** Forensic Psychiatry Community Mental Health Team - Return ... | | 5% | 5% | 01 Apr 2023 | February 2023 | |
| | **DNA.RTN.G4** Psychiatry of Old Age Community Mental Health Team - Retur... | | 2.94% | 5% | 01 Apr 2023 | February 2023 | |
| | **DNA.RTN.G5** Learning Disability Community Mental Health Team - Return o... | | 8.48% | 5% | 01 Apr 2023 | February 2023 | |
| | **DNA.RTN.RU** Arts Therapies Community Mental Health Team - Return outpa... | | 1.18% | 5% | 01 Apr 2023 | February 2023 | |

## Unavailability

**Unavailability**

**January 2023 result**

**0%**

**Outpatient Unavailability**

| ... | Code & Title | Gauge | Value | Target | Next Update ... | Last Update | History |
|---|---|---|---|---|---|---|---|
| | **UNAV.MH.G6** Consultant-led OP Unavailability - Psychotherapy | | 0% | 1% | 01 Mar 2023 | January 2023 | |
| | **UNAV.MH.R2** Consultant-led OP Unavailability - Clinical Psychology | | 0% | 1% | 01 Mar 2023 | January 2023 | |
| | **UNAV.MHLD** Consultant-led OP Unavailability - Mental Health & Learning Di... | | 0% | 1% | 01 Mar 2023 | January 2023 | |

# Draft Measurement Framework
# Emergency Department (ED) and Minor Injury Unit(MIU) Compliance

**Appendix 4**

No significant improvement has been made in the 4-hour Emergency Access Standard (EAS) compliance performance. However, there is an improvement in the 12-hour breach compliance performance and good progress has been made on understanding the root causes. As of March 2023, the 12-hour compliance improved further and as at 21st of March was reported as 318 (December 649).

Activity has been undertaken to analyse reasons for 12-hour delays in ED, and several tests of change are in progress. In addition, work has been undertaken to improve processes and training of staff. This activity is driving a clear and observable reduction in patients breaching the 12-hour wait target.

Root cause analysis has identified that significant improvements are being made on improving the 4-hour EAS compliance rates during the week. However, there is a clear pattern that reduced weekend discharges are creating a pressure over weekends leading to flow and bed challenges at the start of each week. Work is ongoing to address these issues and includes:

- Detailed analysis of daily huddle data to identify patterns regarding bed waits
- Working with colleagues in both Health & Social Care Partnerships to improve weekend discharges
- Aligning Urgent and Unscheduled Care (U&USC) improvement work to the most challenged areas

Overall progress is being made against the 12-hour compliance target and there also been a reduction the use of contingency beds. The agreed next steps will be to maintain this progress and deliver a sustainable improvement in the 4-hour EAS compliance performance.

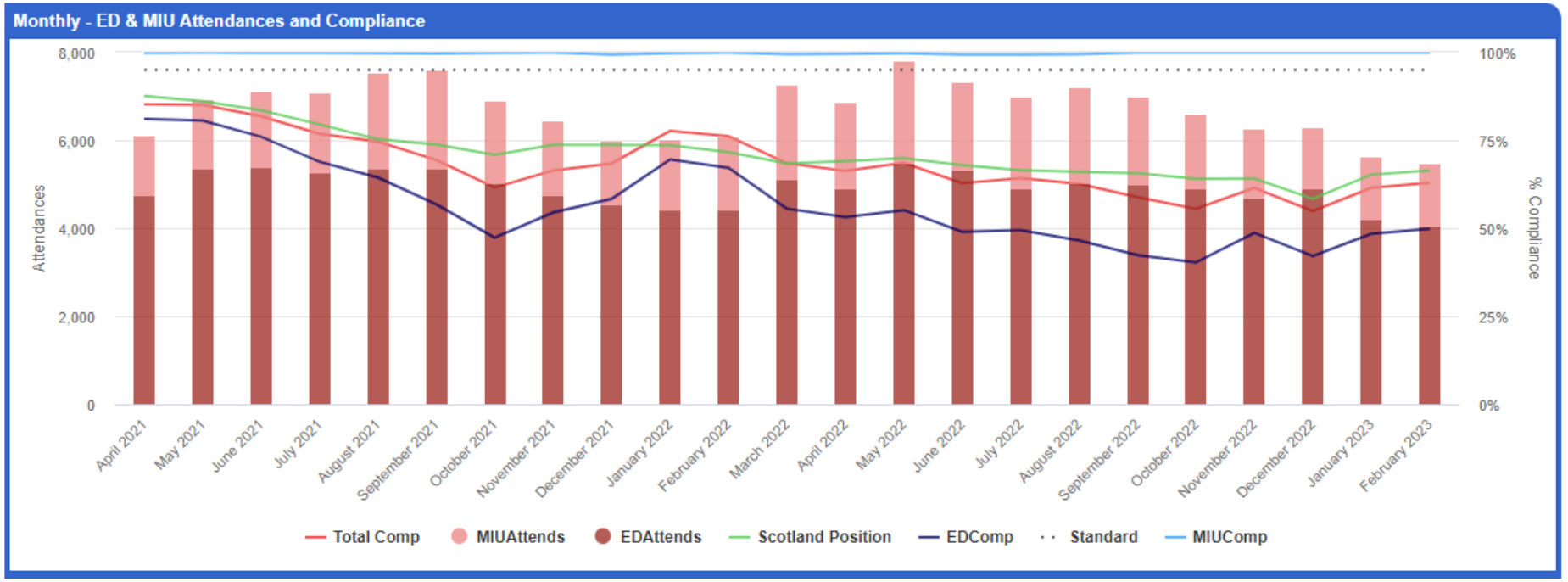
**Draft Measurement Framework**
**Emergency Department (ED) and Minor Injury Unit(MIU) Compliance**

**Appendix 4**

## ED & MIU Compliances and Attendances

| ED&MIU Total compliance | ED Only 4 Hour Compliance | MIU Only 4 Hour Compliance |
|---|---|---|
| February 2023 result | February 2023 result | February 2023 result |
| 62.9% | 49.8% | 99.9% |

| ED&MIU Total Attendances | ED Only Attendances | MIU Only Attendances |
|---|---|---|
| February 2023 result | February 2023 result | February 2023 result |
| 5,495 | 4,065 | 1,430 |

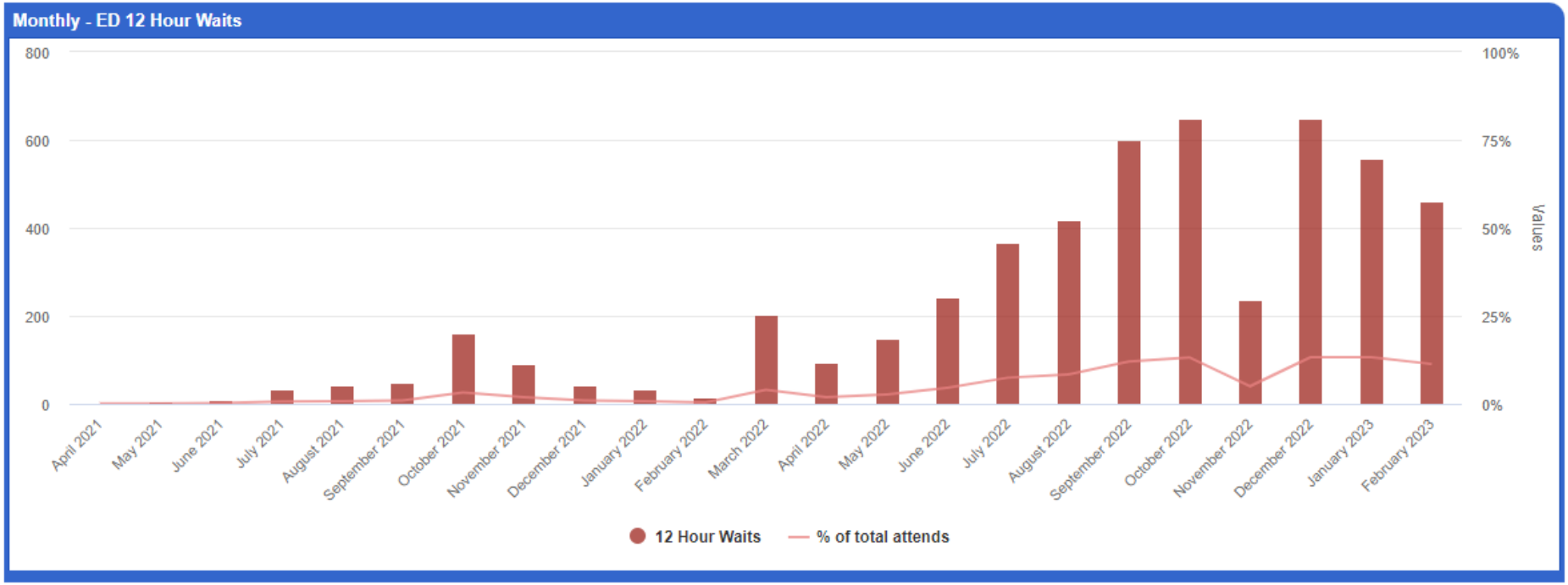


**Draft Measurement Framework**
**Emergency Department (ED) and Minor Injury Unit(MIU) Compliance**

**Appendix 4**

## ED 12 Hour Waits

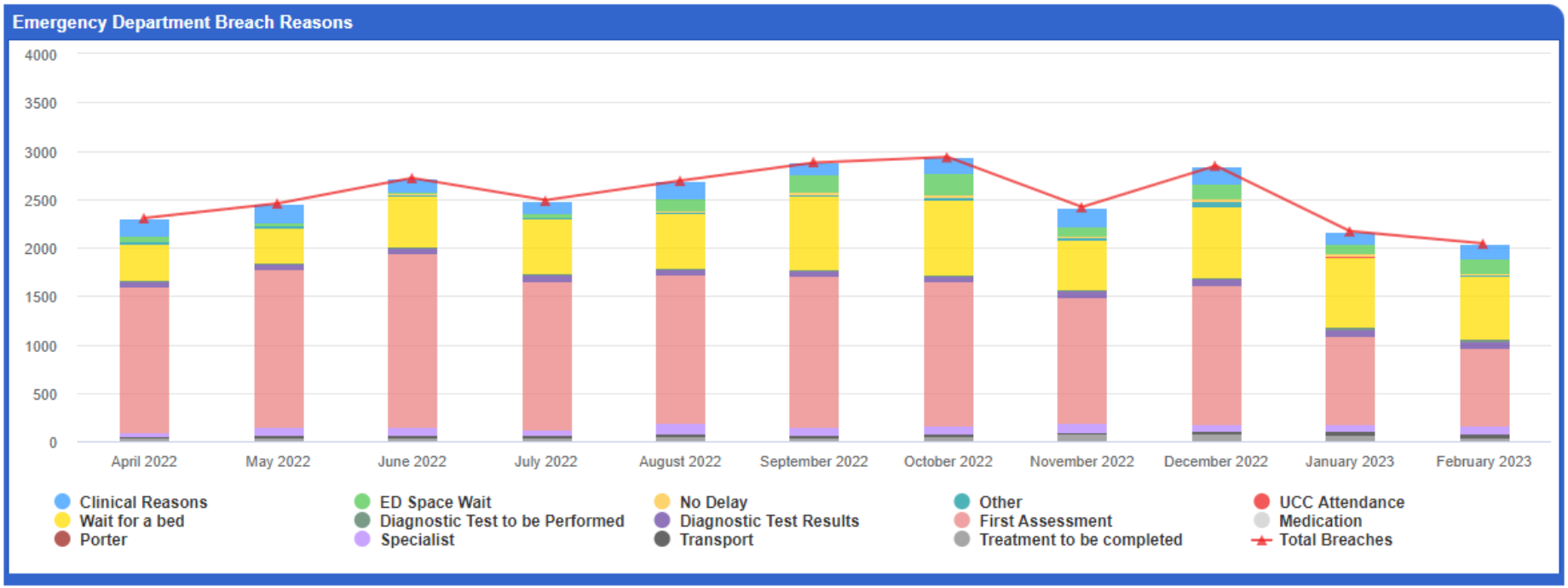
| % of 12 Hour Attendances | 12 Hour Waits |
|---|---|
| February 2023 result | February 2023 result |
| 11.3% | 460 |



**Draft Measurement Framework**
**Emergency Department (ED) and Minor Injury Unit(MIU) Compliance**

**Appendix 4**

## Monthly Reasons for total Emergency Department Breaches




**Reasons for Emergency Department Breaches (Click Value to list Top 5)**

| ... | Title | Value | Short Trend | Long Trend | History |
|---|---|---|---|---|---|
| | Reason for breach - Wait for First Assessment - Core ED Only | 811 | | | |
| | Reason for breach - Wait for Bed - Core ED Only | 651 | | | |
| | Reason for breach - Clinical Reasons Core ED Only | 155 | | | |
| | Reason for breach - ED Space Wait - Core ED Only | 142 | | | |
| | Reason for breach - Wait for Specialist - Core ED Only | 82 | | | |

1 of 3

**Draft Measurement Framework**
**Emergency Department (ED) and Minor Injury Unit(MIU) Compliance**

**Appendix 4**

## Delayed Discharge