AGENDA ITEM

11

Agenda Item: 11

Falkirk
Health and Social Care
Partnership

Title/Subject:	**Performance Report**
Meeting:	**Integration Joint Board**
Date:	**1 December 2017**
Submitted By:	**Head of Performance and Governance, NHS Forth Valley**
Action:	**For Noting**

1. INTRODUCTION

1.1 The purpose of this report is to ensure the Integration Joint Board fulfils its on-going responsibility to effectively monitor and report on the delivery of services and relevant targets and measures included in the Integration Functions, and as set out in the Strategic Plan.

2. RECOMMENDATION

The Integration Joint Board is asked to:

2.1 note the content of the performance report.

2.2 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 Integration Joint Board (IJB) has a responsibility to ensure effective monitoring and reporting on the delivery of services and relevant targets and measures included in the Integration Functions, and as set out in the Strategic Plan.

3.2 Since the last paper was presented to the Board, the Performance Management Workstream has continued to oversee progress on 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 between performance and the outcomes of the Strategic Plan. This details the Partnership's vision, local outcomes and then maps these against the National Health & Wellbeing Outcomes and National Core Indicators and local Partnership indicators. Further work is on-going to refine the partnership indicators which are detailed within the Strategy Map in Appendix 1.

4.2 The Pentana (previously 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 and amber RAG statuses.

5. PERFORMANCE REPORT STRUCTURE

5.1 This report focuses on two areas: (i) the local partnership indicators linked to the outcomes of the Falkirk Health and Social Care Partnership's Strategic Plan; and (ii) the latest national indicators published by NHS Information Services Division.

5.2 Section 1 of this report provides a performance overview of key performance in respect of local partnership indicators noting a RAG status where appropriate.

5.3 Section 2 of this report provides a summary of key performance, and detail, where relevant, of the partnership actions around areas for improvement. These are grouped under the five local outcome headings identified by the Falkirk partnership as described above.

5.4 Section 3 of this report provides an overview of National Integration Indicators and a summary of key national performance indicators. It should be noted that Outcome Indicators (1 to 10) in Table 2 are taken from the Biennial Health & Care Experience Survey which is sent to a random sample of service users. The survey and sampling approach have been developed by the Scottish Government in consultation with a range of stakeholders including NHS Boards, Integration Authorities and NHS National Services Scotland. A total of 711,159 questionnaires were sent out and 111,611 were returned, giving a response rate of 16 per cent. The survey was sent to 17,943 people registered with GP practices in the Falkirk Health and Social Care Partnership area, and 3,022 patients of those patients sent in feedback on their experiences at the practice.

5.5 The survey has been run every two years since 2009, and the 2017 survey is due to be sent out in November, with results due to be published towards the end of 2018.

5.6 This report shows the most up-to-date performance data available and, therefore, reporting periods vary throughout.

6. FINANCE AND PERFORMANCE

6.1 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.

6.2 Audit Scotland recently published their annual overview report of the NHS in Scotland 2017. This report highlighted that NHS boards are increasingly struggling to improve performance against national targets whilst also achieving financial balance. Undoubtedly local government is facing a similar challenge. The on-going difficulties of balancing these two priorities may have a significant impact on Integration Authorities.

6.3 Audit Scotland recently published their annual overview report of the NHS in Scotland 2017. This report highlighted that NHS boards are increasingly struggling to improve performance against national targets whilst also achieving financial balance. Undoubtedly local government is facing a similar challenge. The on-going difficulties of balancing these two priorities may have a significant impact on Integration Authorities.

7. CONCLUSION

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

Resource Implications
The resource requirements to ensure effective performance management and performance reporting are under review. These will be considered within the support services agreement.

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

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

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

Equality and Human Rights Impact Assessment
This is not required.

Approved for submission by: Patricia Cassidy, Chief Officer

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List of Background Papers:
IJB Performance Management Framework – Approved March 2016

SECTION 1 – Overview Local Partnership Indicators

KEY:

Direction of travel: relates to comparative 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
** = Year to date comparison April to October

Falkirk Health and Social Care - Partnership Indicators Performance (2017-18)

Local Outcomes	Partnership Indicator	RAG Falkirk	
1. Self Management of Health, Care & Wellbeing	1. Emergency department 4 hour wait Forth Valley**	**2016/17**	**2017/18**
		94.40%	92.70% ▼
	2. Emergency department 4 hour wait Falkirk**	**2016/17**	**2017/18**
		94.10%	92.30% ▼
	3. Emergency department attendances per 100,000 Forth Valley population**	**2016/17**	**2017/18**
		1,758	1,838 ▼
	4. Emergency department attendances per 100,000 Falkirk population All Ages**	**2016/17**	**2017/18**
		1,964	2,044 ▼

Local Outcomes	Partnership Indicator	RAG Falkirk	
2. Autonomy & Decision Making Where formal support is needed people can exercise control over choice	5. Emergency admission rate per 100,000 Forth Valley population**	**2016/17**	**2017/18**
		937	898 ▲
	6. Emergency admission rate per 100,000 Falkirk population All Ages**	**2016/17**	**2017/18**
		965	903 ▲
	7. Acute emergency bed days per 1000 Forth Valley population**	**2016/17**	**2017/18**
		636	647 ▼
	8. Acute emergency bed days per 1000 Falkirk population All Ages**	**2016/17**	**2017/18**
		677	712 ▼
	9. Long term conditions – bed days per 100,000 population**	**2016/17**	**2017/18**
		7582	8967 ▼
	10. Number of patients with an Anticipatory Care Plan in Forth Valley**	**2016/17**	**2017/18**
		16,541	15,231 ▼
	11. Number of patients with an Anticipatory Care Plan in Falkirk**	**2016/17**	**2017/18**
		NA	6,525
	12. Key Information Summary as Percentage of the Board area list size Forth Valley**	**2016/17**	**2017/18**
		5.47%	5.03% ◄►
	13. Key Information Summary as Percentage of the Board area list size Falkirk**	**2016/17**	**2017/18**
		NA	4.12%

	14. Self directed support (SDS) options selected: People choosing	**Mar 2017**	**Sep 2017**
	SDS Option 1: Direct payments	**32 (1.2%)**	**29 (1.1%)**
	SDS Option 2: Directing the available resource	**83 (3.1%)**	**100 (3.7%)**
	SDS Option 3: Local Authority arranged	**1,749 (66.3%)**	**1,844 (68.5%)**
	SDS Option 4: Mix of options, 1,2,3	**45 (1.7%)**	**49 (1.8%)**
	No recorded SDS Option	**730 (27.7%)**	**669 (24.9%) ▲**

Local Outcome	**Partnership Indicator**	**Falkirk**	
Safety	15. Readmission rate within 28 days per 1000 FV population All Ages**	**2016/17**	**2017/18**
		1.40	1.28 ▲
	16. Readmission rate within 28 days per 1000 Falkirk population**	**2016/17**	**2017/18**
		1.42	1.56 ▼
	17. Readmission rate within 28 days per 1000 population 75+**	**2016/17**	**2017/18**
		3.77	3.75 ▲
	18. Number of Adult Protection Referrals (data only)	**2015/16**	**2016/17**
		579	**540**
	19. Number of Adult Protection Investigations (data only)	**2015/16**	**2016/17**
		45	**47**
	20. Number of Adult Protection Support Plans (data only)	**Mar-16**	**Mar-17**
		12	**10**
	21. The total number of people with community alarms at end of the period	**2015/16**	**2016/17**
		4,526	**4,481▼**
	22. Percentage of community care service users feeling safe — **2015/16**	**2016/17**	**2017/18 to end H1**
	90%	**91%**	**90%▼**

Local Outcomes	Partnership Indicator	RAG Falkirk		
4. Service User Experience People have a fair and positive experience of Health & Social Care	23. Standard delayed discharges	**Oct-16**	**Oct-17**	
		39	23 ▲	
	24. Delayed discharges over 2 weeks	**Oct-16**	**Oct-17**	
		25	12 ▲	
	25. Bed days occupied by delayed discharges	**Oct-16**	**Oct-17**	
		882	508 ▲	
	26. Number of code 9 delays	**Oct-16**	**Oct-17**	
		15	17 ▼	
	27. Number of Code 100 delays	**Oct-16**	**Oct-17**	
		3	6 ▼	
	28. Delays - including Code 9 and Guardianship	**Oct-16**	**Oct-17**	
		54	46 ▲	
	29. Percentage of service users satisfied with their involvement in the design of their care package	**2015/16**	**2016/17**	**2017/18 to end H1**
		98%	**98%**	**98%◄►**
	30. Percentage of service users satisfied with opportunities for social interaction	**2015/16**	**2016/17**	**2017/18 to end H1**
		93%	**93%**	**92%▼**
	31. Percentage of carers satisfied with their involvement in the design of care package	**2015/16**	**2016/17**	**2017/18 to end H1**
		92%	**93%**	**92% ▼**
	32. Percentage of carers who feel supported and capable to continue in their role as a carer OR feel able to continue with additional support	**2015/16**	**2016/17**	**2017/18**
		89%	**81%**	**79% ▼**
	33. The proportion of Social Work Adult Services (Stage 1 & 2) complaints completed within 20 days (No.= 40/66) ***2015/16 & 2016/17 were reported under the old complaints system (with 70% target – now 100%).**	**2015/16***	**2016/17***	**2017/18 to end H1**
		73.4%	**57.4%**	**60.6% ▲**
	34. The proportion of social work (Completed Stage 1 & 2) complaints upheld			**2017/18 to end H1**
		% Upheld:		**36.4**
		% Partially Upheld:		**24.2**
		% Not upheld:		**39.4**

	35. Sickness Absence in Social Work Adult Services (target – 5.5%)	**2015/16**	**2016/17**	**2017/18 to end Q1**
		7.9%	**8.4%**	**8.5% ▼**

Local Outcomes	Partnership Indicator		RAG Falkirk	
5. Community Based Support to live well for longer at home or in a homely setting	36. The total respite weeks provided to older people aged 65+. Annual indicator	**2014/15**	**2015/16**	2016-17
		1,834	**1,703▼**	**1527 ▼**
	37. The total respite weeks provided to adults aged 18-64. Annual indicator	**2014/15**	**2015/16**	
		729	**724▼**	**578 ▼**
	38. Number of people aged 65+ receiving homecare *		**Mar 2016**	**Mar 2017**
			1,867	**1,807▼**
	39. Number of homecare hours for people aged 65+ *		**Mar 2016**	**Mar 2017**
			14,622	**13,949 ▼**
	40. Rate of homecare hours per 1000 population aged 65+ *		**Mar 2016**	**Mar 2017**
			512.2	**488.6 ▼**
	41. Number receiving 10+ hrs of home care *		**Mar 2016**	**Mar 2017**
			406	**401 ▼**
	42. The proportion of Home Care service users aged 65+ receiving personal care *		**Mar 2016**	**Mar 2017**
			91.6%	**92.4% ▲**
	43. The proportion of Home Care service users aged 65+ receiving a service during evenings/overnight *		**Mar 2016**	**Mar 2017**
			49.3%	**49.8% ▲**
	44. The proportion of Home Care service users aged 65+ receiving a service at weekends *		**Mar 2016**	**Mar 2017**
			79.9%	**81.4% ▲**
	* **Note each year's Home Care data is a snapshot of provision in a single reporting week at end of reporting period.**			
	45. Percentage of Rehab At Home service users who attained independence after 6 weeks (target – 80%)		**2016/17**	**2017/18 to end H1**
			92.3%	**61.3%▼**
	46. Percentage of Crisis Care service users who are retained in the community when service ends (target - 70%)		**2016/17**	**2017/18 to end H1**
			75.2%	**80.9% ▲**

	47. Number of new Telecare service users 65+	2015/16	2016/17	2017/18 to end H1
		102	75 ▼	88 ▲
	48. The number of people who had a community care assessment or review completed	2016/17	2017/18 To end H1	
	48. The number of people who had a community care assessment or review completed		8,932	6,192 ▲
	49. The number of Carers' Assessments carried out		2016/17	2017/18 to end H1
	49. The number of Carers' Assessments carried out		1,624	794 ▼
	50. The number of overdue 'OT' pending assessments at end of the period		Mar 2017	At 20/10/17
	50. The number of overdue 'OT' pending assessments at end of the period		316	300 ▲
			2014/15	2015/16
	51. Proportion of last six months of life spent at home		86.1%	86.0% ◄►
	52. Number of days by setting during the last six months of life: Community		2014/15	2015/16
	52. Number of days by setting during the last six months of life: Community		228,702	241,236▲

SECTION 2 - Summary of Key Performance – by Exception

LOCAL OUTCOME Self Management Individuals, Carers and families are enabled to manage their own health and wellbeing

Indicator 1: Emergency Department 4 hour wait

The national target is that 95% of patients will wait less than 4 hours from arrival to admission, discharge or transfer for accident and emergency treatment.

Compliance for September 2017 was 92.9% overall; Minor Injuries Unit 100%, Emergency Department 90.8%, with 9 patients waiting longer than eight hours and no patients waiting longer than 12 hours. The majority of breaches relate to 'wait for first assessment'. Of the 492 patients that waited longer than 4 hours in September, 294 were due to a wait for first assessment with 56 wait for a bed, 46 due to clinical reasons and 30 due to wait for treatment to be completed.

Daily performance is variable and following repeated episodes of Emergency Department performance dropping below 92%, thrice daily monitoring by the Scottish Government was commenced on 12 September 2017. This remained in place until the Emergency Department achieved 92% compliance with the 4 hour wait for 10 consecutive days. Following a protracted period, monitoring ceased on 17 November 2017.

Discussions are on-going with the Scottish Government in terms of support to NHS Forth Valley in respect of improvement work. There is a focus on the '6 Essential Actions' established by the Scottish Government, and on working in partnership looking at the whole system in support of sustainable improvement.

LOCAL OUTCOME Autonomy and Decision Making Where formal support is needed people should be able to express as much control and choice as possible over what is provided

Indicator 14: Self directed support (SDS) options

14. Self directed support (SDS) options selected: People choosing	Mar 2016	Mar 2017	Sep 2017
SDS Option 1: Direct payments	33 (1%)	32 (1.2%)	29 (1.1%)
SDS Option 2: Directing the available resource	46 (2%)	83 (3.1%)	100 (3.7%)
SDS Option 3: Local Authority arranged	1,505 (62%)	1,749 (66.3%)	1,844 (68.5%)
SDS Option 4: Mix of options, 1,2,3	30 (1%)	45 (1.7%)	49 (1.8%)
No recorded SDS Option	805 (33%)	730 (27.7%)	669 (24.9%) ▲

The figures recorded indicate that the SDS options are being discussed with more people at assessment/review and the number of people choosing an SDS option continues to increase. Many people already have support in place under Option 3 and where the support is working well they are likely to continue with this option. Staff are increasingly more confident in discussing the SDS options with individuals and carers to ensure they know they have choice. The local support service (SDS Forth Valley) continues to support individuals to understand the options and the responsibilities associated with each.

A survey of people using SDS was conducted by Self Directed Support Scotland (umbrella organisation for local support services in Scotland) and published in September 2016. The survey covered the Lothians and 2 other local authorities. It found that 83% of respondents were happy with the support in

place. The survey response rate was quite low (18%) but the information provided indicated that people are still unsure about taking on the additional responsibility of arranging their own support and, in particular, Option 1 was considered to be complex and difficult to manage. 53% of respondents had chosen Option 3. This reflects our local experience. Where we have been able to work with providers to deliver support that meets people's outcomes in the way that suits them, Option 3 is a popular choice. Local providers are increasingly demonstrating their willingness to engage in delivering flexible support in line with the principles of SDS, including within Option 3 support. This has been a learning process for all partners, including individuals and carers as partners in their own support arrangements, and continual development is required. We are confident that working together to improve outcomes focused support provision will ensure that people choosing Option 3 will continue to have increased levels of choice about how their support is delivered.

LOCAL OUTCOME Service User Experience – People have a fair and positive experience of health and social care

Indicators 23 – 28: Delayed Discharge

Measure	Delayed Discharges • Standard Delayed Discharges • Bed days lost attributed to delayed discharge • Code 9 and Code 100 delays
Falkirk Performance	Standard Delays October 2017 = 23
Forth Valley Performance	Standard Delays October 2017 = 40

Commentary

As at the October census date, the following delays were recorded:

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

Chart 1: Delayed Discharges – Standard Delays

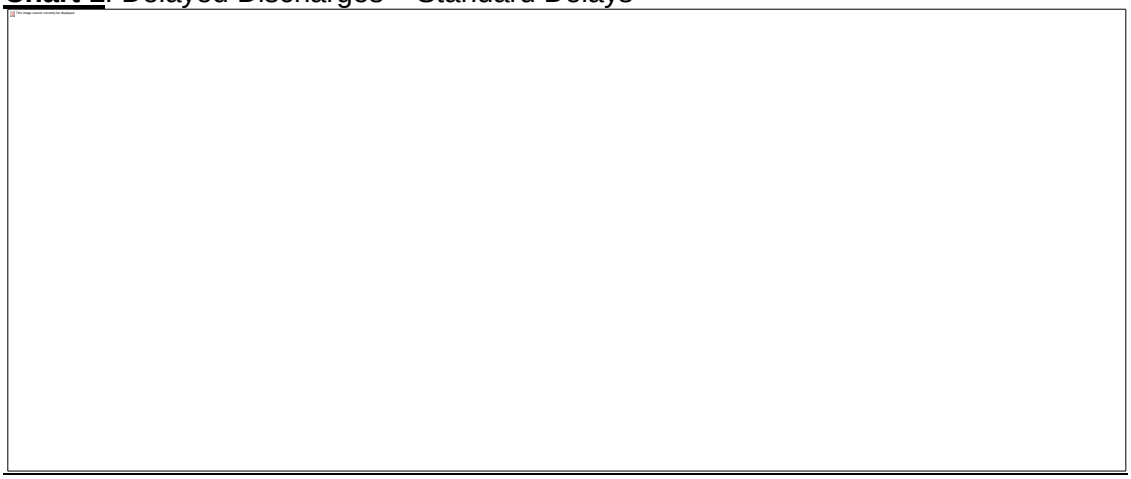


Chart 1 shows that in October 2017 the number of standard delays for Forth Valley was 40. Falkirk accounts for 23 or 57.5% of all standard delays. The October position for Falkirk is a 25% reduction in respect of the number of standard delays compared with the September 2017 position.

52% (12/23) Falkirk delays are waiting over 2 weeks at the October census point. These Falkirk patients account for 75% (12/16) of Forth Valley waits over 2 weeks.

Table 1 shows the total number of standard delays October 2016 to October 2017.

Table 1

	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17
Total delays at census point	39	35	37	45	38	24	29	32	34	20	40	31	23
Total number of delays over 2 weeks	25	22	26	24	25	17	14	18	18	15	26	21	12

Chart 2: Occupied Bed Days Attributed to Delayed Discharges

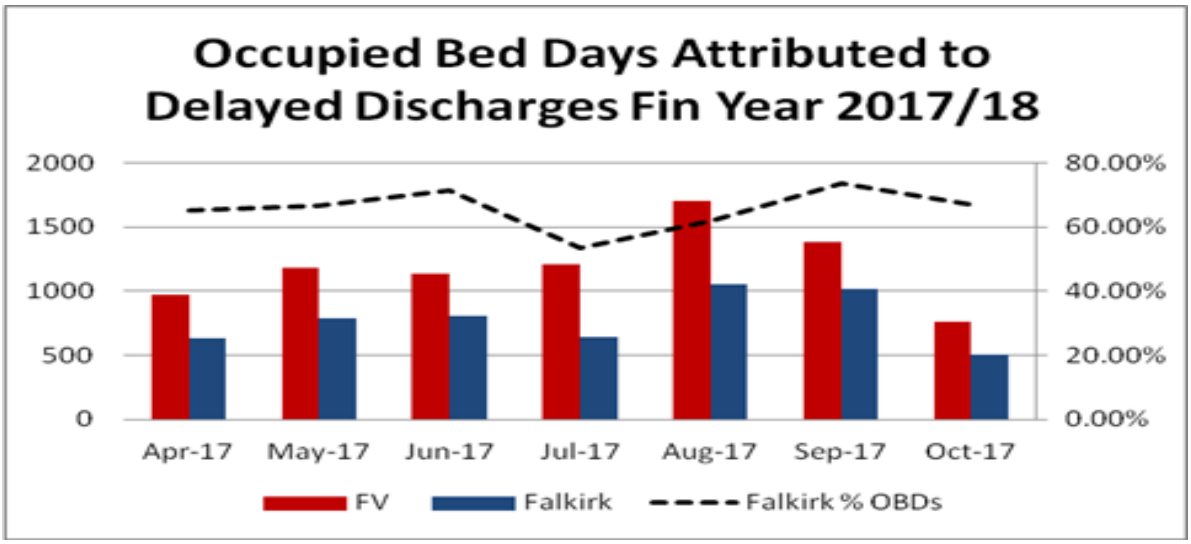


Chart 2 illustrates that, across Forth Valley, there has been a decrease in the number of occupied bed days attributed to delayed discharges with the number at the October 2017 census 760.

The Falkirk Partnership position at the October census highlights a significant reduction to 508 occupied bed days attributed to delayed discharges from 1017 at the September census. This is a 50% improvement in month.

Of the total occupied bed days within Forth Valley attributed to delayed discharges, 67% (508/760) are within the Falkirk Partnership.

Chart 3: Code 9 and Code 100 Delays

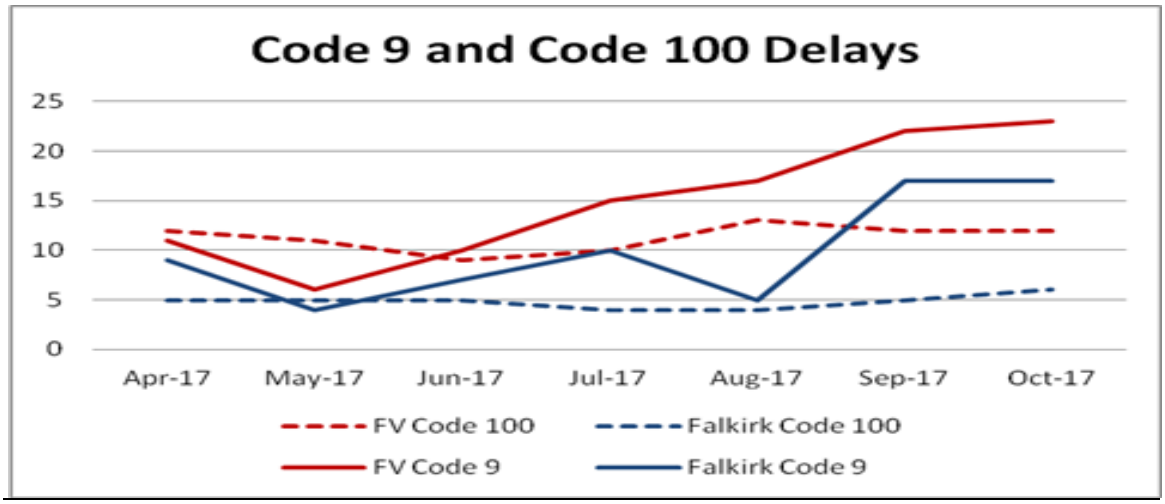


Chart 3 shows that there has been an overall increase in the number of Code 9 delays across Forth Valley with a static position in respect of Code 100 delays. Within the Falkirk Partnership there has been a corresponding increase in Code 9 delays with 17 at the October census; 15 guardianship and 3 code 9_other. A slight increase to 6 Code 100 delays is noted in October.

There are a number of issues in respect of waits for packages of care and care home places. The partnership is addressing waits for packages of care, with the number waiting fluctuating on a day by day basis. In support, the partnership has reviewed the provision of packages of care and identified future needs. The number of available care home places is challenged in respect of demand from the hospital setting as well as from people waiting for placement from their homes. Care home provision has been benchmarked with a review on-going of care home criteria, care home places and capacity to support whole system capacity.

To further support improvements in the delayed discharge position and to support the winter plan there are a number of activities being undertaken including community hospital review, Discharge to Assess, intermediate care at home and reablement, with daily and weekly reviews through the discharge hub to support appropriate and timely discharge.

Delayed Discharge Glossary:

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.

Indicator 33 & 34: 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.

33. The proportion of Social Work Adult Services (Stage 1 & 2) complaints completed within 20 days (No.= 40/66) ***2015/16 & 2016/17 were reported under the old complaints system (with 70% target – now 100%).**	**2015/16***	**2016/17***	**2017/18 to end H1**
	73.4%	**57.4%**	**60.6% ▲**
34. The proportion of social work (Completed Stage 1 & 2) complaints upheld:			
	% Upheld:		**36.4**
	% Partially Upheld:		**24.2**
	% Not upheld		**39.4**

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.

Further work is on-going 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.

Indicator 35: Sickness Absence in Social Work Adult Services

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

35. Sickness Absence in Social Work Adult Services (target – 5.5%)	**2015/16**	**2016/17**	**2017/18 to end Q1**
	7.9%	**8.4%**	**8.5% ▼**

Position

Sickness absence has increased very slightly in the first half of this year but remains higher than the Council target of 5.5% for Social Work Adult Services. Sickness absence is a key managerial priority and the service continues to pursue initiatives to manage this issue as effectively as possible, in line with corporate HR policies and procedures.

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

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

support to progress absence cases continues to be provided to the wider service by HR Operations resource.

LOCAL OUTCOME Community Based Support – to live well for longer at home or in a homely setting within their community

Indicator 36 & 37: Respite for older people aged 65+ and people aged 18-64

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

36.	The total respite weeks provided to older people aged 65+. Annual indicator	**2014/15**	**2015/16**	2016-17
		1,834	**1,703▼**	**1527 ▼**
37.	The total respite weeks provided to older adults people aged 18-64. Annual indicator	**2014/15**	**2015/16**	
		729	**724▼**	**578 ▼**

Position

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

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

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

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

Indicator 45: Rehabilitation At Home Service

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

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

This indicator notes people who leave the service with no further package of care. This can be too limiting a measure when supporting people with complex care needs, as for some people a reduced package of care, that maintains their independence, can be a positive outcome. Further analysis is on-going for this change in half year performance.

Indicator 50: Overdue pending OT Assessments

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

Position

	Mar 2017	At 20/10/17
50. The number of overdue 'OT' pending assessments at end of the period	316	300 ▲

Due to demographic pressures, demand for OT assessments has been increasing. Assessments can also be delayed by other competing pressures on staff resources, such as Adult Support and Protection work.

Of those 300, 130 (43%) were priority 2 and 170 (57%) priority 3. This is a shift down in the proportion of priority 2's (from 52% in March) and supports the position that the pending assessments are being addressed by priority need. The service has consistently been able to respond to priority one assessments and there is no waiting list for these. This has resulted in priority 2 and 3 cases experiencing longer waits.

The reduction in priority 2 assessments will partly be due to the work of the Reablement Project Team. This is a project team formed to test out new models of delivering reablement in a timeous and responsive way. It is made up of occupational therapists who have been redistributed from Community Care Teams to work with Avenue Care on the Discharge to Assess model. The team has been small so the impact, whilst moving in the right direction, has been modest. However, the team is about to increase, so it is predicted the impact will become more significant.

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

SECTION 3 – Overview National Integration Indicators

Table 2 - National Integration Indicators – Overview September 2017 data

	Indicator	National Outcome	Title	Period	Previous Score	Scotland	Period	Current score	Scotland
Outcome indicators	NI - 1	Healthier Living	Percentage of adults able to look after their health very well or quite well	2015/16	93%	94%	2017/18	*Biennial survey to be published in 2018.*	
	NI - 2	Healthier Living	Percentage of adults supported at home who agreed that they are supported to live as independently as possible	2015/16	86%	84%	2017/18	*Biennial survey to be published in 2018.*	
	NI - 3	Positive Experience & Outcomes	Percentage of adults supported at home who agreed that they had a say in how their help, care, or support was provided	2015/16	79%	79%	2017/18	*Biennial survey to be published in 2018.*	
	NI - 4	Resources are Used Effectively	Percentage of adults supported at home who agreed that their health and social care services seemed to be well coordinated	2015/16	81%	75%	2017/18	*Biennial survey to be published in 2018.*	
	NI - 5	Positive Experience & Outcomes	Total % of adults receiving any care or support who rated it as excellent or good	2015/16	82%	81%	2017/18	*Biennial survey to be published in 2018.*	
	NI - 6	Positive Experience & Outcomes	Percentage of people with positive experience of the care provided by their GP practice	2015/16	86%	87%	2017/18	*Biennial survey to be published in 2018.*	
	NI - 7	Quality of Life	Percentage of adults supported at home who agree that their services and support had an impact on improving or maintaining their quality of life	2015/16	84%	84%	2017/18	*Biennial survey to be published in 2018.*	
	NI - 8	Carers are Supported	Total combined % carers who feel supported to continue in their caring role	2015/16	45%	41%	2017/18	*Biennial survey to be published in 2018.*	
	NI - 9	People are Safe	Percentage of adults supported at home who agreed they felt safe	2015/16	87%	84%	2017/18	*Biennial survey to be published in 2018.*	
	NI - 10	Engaged Workforce	Percentage of staff who say they would recommend their workplace as a good place to work	2015/16	NA	NA	2017/18	*Biennial survey to be published in 2018.*	
	Indicator	**National Outcome**	**Title**	**Period**	**Previous Score**	**Scotland**	**Period**	**Current score**	**Scotland**
Data indicators	NI - 11	Reduce Inequalities	Premature mortality rate per 100,000 persons	2015/16	466	440	2016/17	NA	NA
	NI - 12	Quality of Life	Emergency admission rate (per 100,000 population)	2014/15	11,742	11,865	2016/17p	11,776	12,265
	NI - 13	People are Safe	Emergency bed day rate (per 100,000 population)	2014/15	124,198	112,091	2016/17p	143,941	124,663
	NI - 14	People are Safe	Readmission to hospital within 28 days (per 1,000 population)	2014/15	118	94	2016/17p	121	99
	NI - 15	Independent Living	Proportion of last 6 months of life spent at home or in a community setting	2014/15	85%	86%	2016/17p	86%	87%
	NI - 16	People are Safe	Falls rate per 1,000 population aged 65+	2014/15	19	20	2016/17p	20	22
	NI - 17	Quality of Life	Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections	2014/15	NA	NA	2016/17p	86%	84%
	NI - 18	Independent Living	Percentage of adults with intensive care needs receiving care at home	2014/15	64%	61%	2015/16	64%	62%
	NI - 19	Resources are Used Effectively	Number of days people spend in hospital when they are ready to be discharged (per 1,000 population)	2014/15	943	1,044	2016/17p	1,023	842

	NI - 20	Resources are Used Effectively	Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency	2014/15	23%	22%	2016/17p	27%	25%
	NI - 21	Independent Living	Percentage of people admitted to hospital from home during the year, who are discharged to a care home	NA	NA	NA	NA	NA	NA
	NI - 22	Resources are Used Effectively	Percentage of people who are discharged from hospital within 72 hours of being ready	NA	NA	NA	NA	NA	NA
	NI - 23	Positive Experience & Outcomes	Expenditure on end of life care, cost in last 6 months per death	NA	NA	NA	NA	NA	NA

Summary of Key Performance: National Indicators

In terms of indicators and measurement, it is crucial that the IJB is able to measure performance against the delivery of the Strategic Plan alongside the National Health & Wellbeing Outcomes and Core National Indicators developed by the Scottish Government. As regularly presented to the IJB, a 'Strategy Map' has been developed, Appendix 1, which details the Partnership's vision, expected Local Outcomes and then maps these against the National Health & Wellbeing Outcomes and National Core Indicators.

These are high level national indicators and, at times, it is difficult to draw firm conclusions. The data sources can date over long periods of time and hence are not as timeous as data collected more routinely. However monitoring these is a legislative role for the IJB and it has been agreed that these indicators will be presented twice a year. The indicators have been developed from national data sources so that the measurement approach is consistent across all areas. The most recent data update highlighted is Source Team, ISD September 2017.

It should be noted that there are four indicators with no national data available. These are:

- **National Indicator 10**
  Percentage of staff who say they would recommend their workplace as a good place to work

- **National Indicator 21 – National data not available**
  Percentage of people admitted to hospital from home during the year who are discharged to a care home

- **National Indicator 22**
  Percentage of people who are discharged from hospital within 72 hours of being ready

- **National Indicator 23**
  Expenditure on end of life care, cost in last 6 months per death.

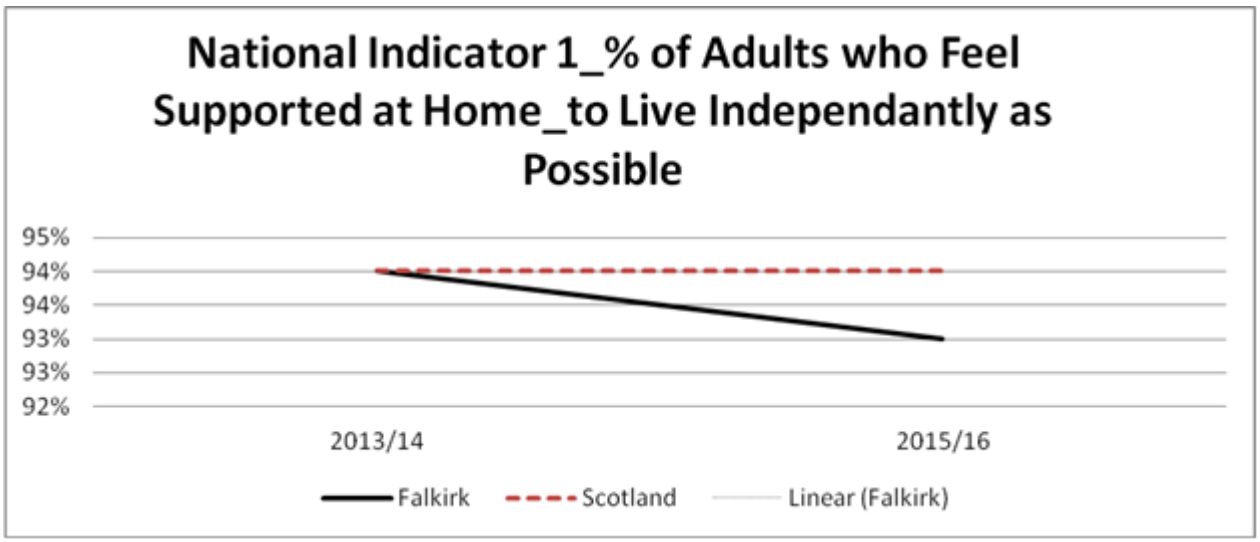
Local Outcome – Self Management

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

National Indicator 1
Percentage of adults able to look after their own health very well or quite well

Measure	Total combined % of adults able to look after their health very well or quite well. Annual breakdown.
Falkirk Performance	Annual performance for 2015/16 = 93%
Scotland Performance	Annual Performance for 2015/16 = 94%

Chart 4: % of adults able to look after own health very well or quite well, Forth Valley and Scotland performance up to 2015/16



Rationale for Indicator

This indicator is intended to measure the views of local people as to whether they feel they can look after their health. This may be more difficult for people with long term conditions, including mental illness or for some people with disabilities.

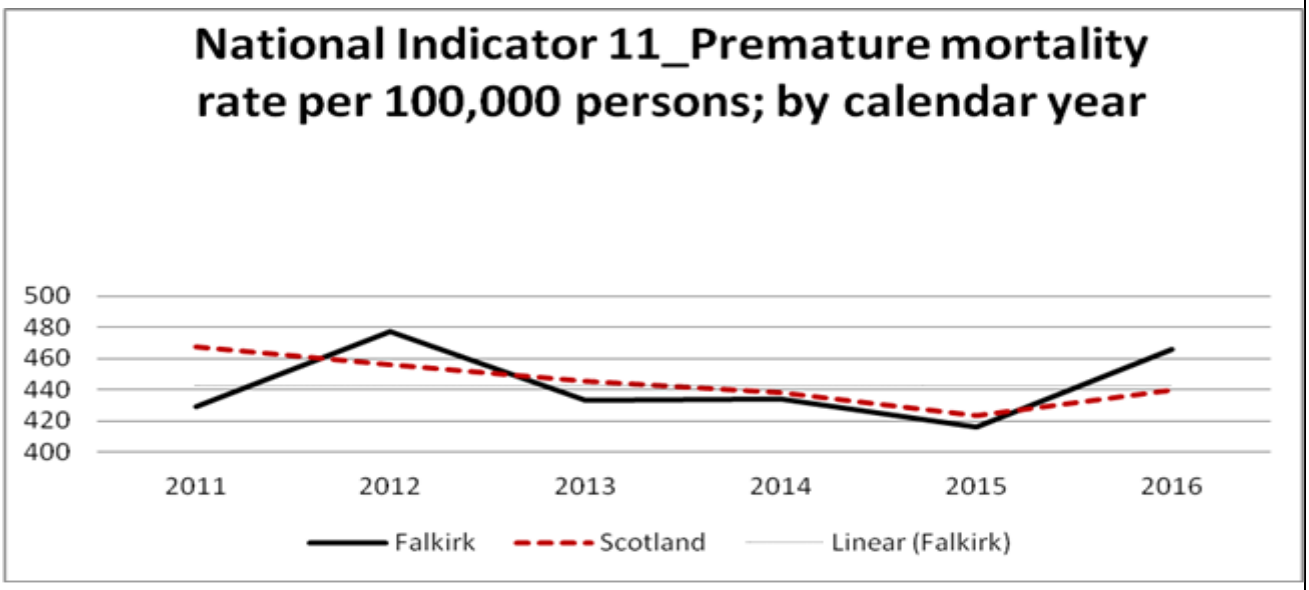
Responses were derived from 2015/16 Health and Care Experience Survey which aims to use public experiences of health and care services to improve service provision. The population consisted of patients across Scotland registered with a GP in Scotland in October 2015. This survey is a repeat of the 2013/14 Health and Care Experience survey. Of the 17,943 people registered with a GP practice within Falkirk local authority area, 3,022 sent in feedback. 2015/16 results show a decrease of 1% from the 2013/14 survey to 93% of patients rating their ability to look after themselves as good or very good.

The national average remains static from the 2013/14 survey at 94%.

National Indicator 11
Premature mortality rate per 100,000 persons; by calendar year

Measure	European age-standardised mortality rate per 100,000 for people aged under 75.
Falkirk Performance	Annual performance for 2016 = 466
Scotland Performance	Annual Performance for 2016 = 440

Chart 5: Premature mortality rate per 100,000 persons; by calendar year



Rationale for Indicator

Premature mortality is an important indicator of the overall health of the population. Scotland has the highest mortality rates in the UK. Between 1997 and 2013, the rate of mortality amongst those aged under 75 years decreased by 33%. Despite these decreases, more than 20,000 people aged under 75 still die each year. Deaths in this age group are more common in deprived areas with this indicator reflecting health inequalities.

Premature mortality rates for Falkirk have increased from 416 in 2015/16 to 466 in 2016/17. 5.9% above the Scottish average for 2016/17; the first time above the Scotland position since 2012. According to SIMD 2012 information areas such as Dunipace and Falkirk West are ranked within the 5% of most deprived areas in Scotland.

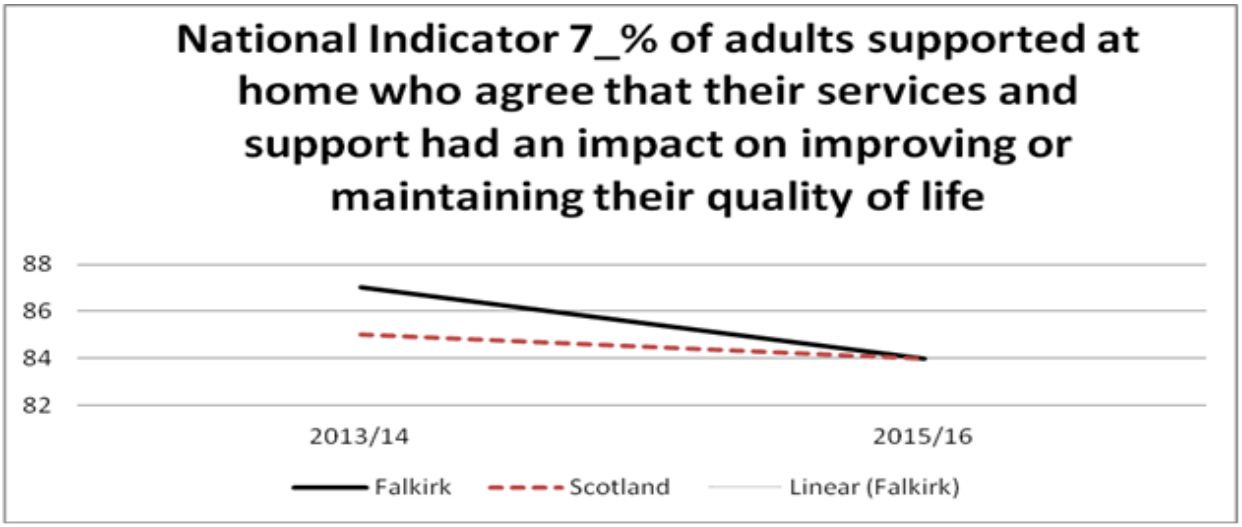
Local Outcome – Autonomy & Decision Making

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

National Indicator 7
Percentage of adults supported at home who agree that their services and support had an impact on improving or maintaining their quality of life

Measure	% of adults who either strongly agreed or agreed that their services and support had an impact on improving or maintaining their quality of life.
Falkirk Performance	Annual performance for 2015/16 = 84%
Scotland Performance	Annual Performance for 2015/16 = 84%

Chart 6: % of Adults agree healthcare had positive impact on maintaining/improving quality of life. Forth Valley and Scotland performance up to 2015/16.



Rationale for Indicator

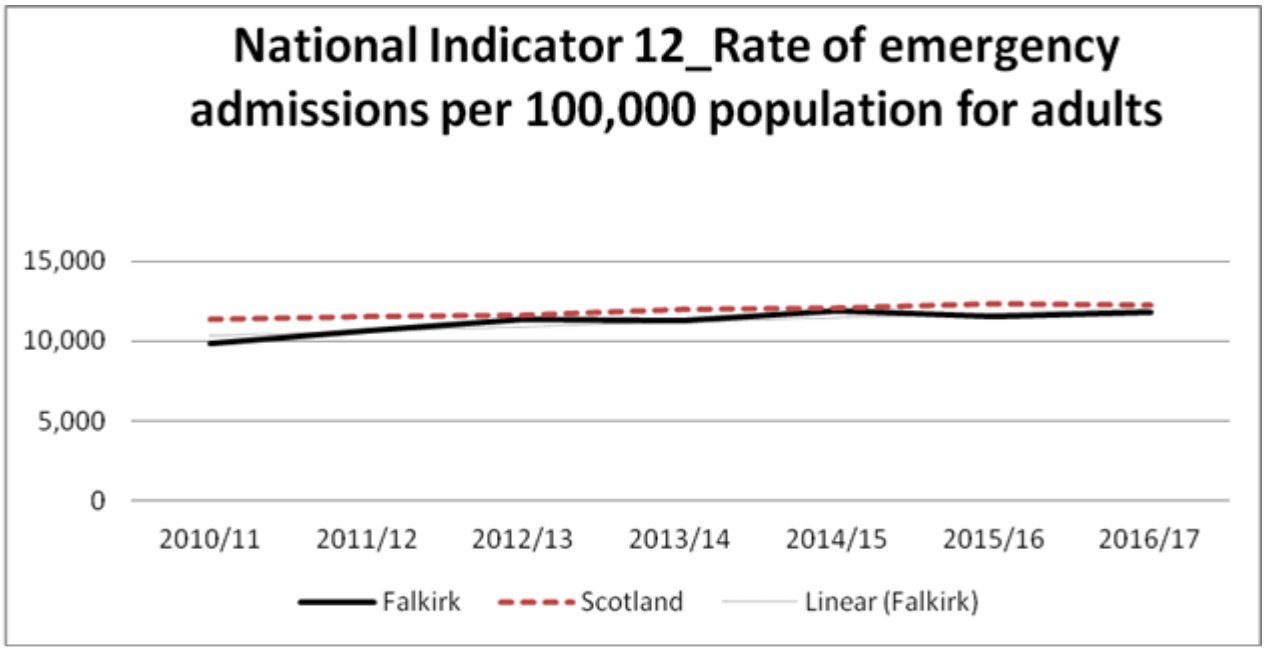
This indicator reflects the aggregate impact of local person centred work to improve personal outcomes, focusing on what is important for individuals' quality of life. It emphasises the increasing focus on personalisation of services, including the use of personal outcomes approaches.

84% of patients in Falkirk agreed services maintained or improved their quality of life in 2015/16. This is a decrease of 3% since 2013/14, but in line with the Scottish average of 84%. Results for other local authority areas vary from 74% to 98%.

National Indicator 12
Emergency admission rate

Measure	Rate of emergency admissions per 100,000 population for adults.
Falkirk Performance	Annual performance for 2016/17 = 11,776p
Scotland Performance	Annual Performance for 2016/17 = 12,265p

Chart 7: Emergency admission rate for Forth Valley and Scotland up to 2016/17



Rationale for Indicator

Excellent emergency services are necessary when people are at a point of crisis or suffer serious injury. However many people who come to hospitals in emergencies could potentially have been offered better support or services earlier on, which would have prevented the need for them to go to hospital, or may have involved a planned visit to hospital instead.

National figures calculate the rate of emergency admissions by area of residence. Therefore a Falkirk resident being admitted to a hospital outwith Forth Valley will be counted in the calculation. Emergency admissions by Falkirk residents in 2016/17 have increased by 2% since 2015/16. The average over 2015/16 and 2016/17 is down by 0.6% over the average taken across 2014/15 and 2015/16.

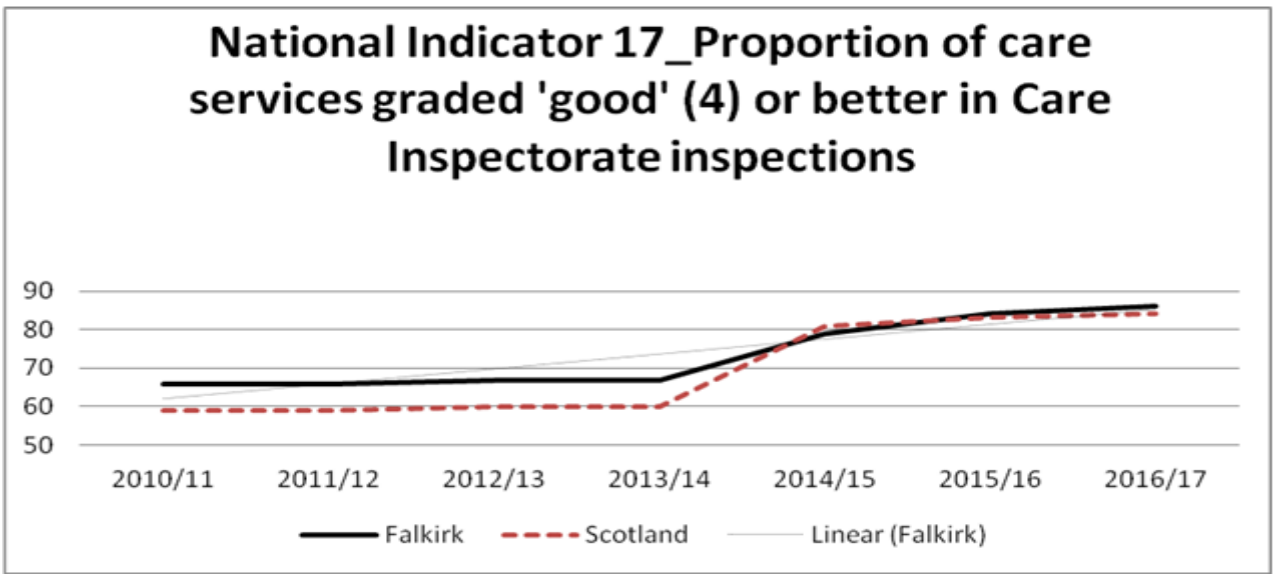
In 2016/17 the Falkirk rate was 4% below the Scottish average. This has been a consistent picture over the last 7 financial years.

With an ageing population a number of initiatives are underway, including NHS Forth Valley Board participating in the national frailty collaborative, At the Front Door project.

National Indicator 17
Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections

Measure	Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections
Falkirk Performance	Annual performance for 2016/17 = 86%p
Scotland Performance	Annual Performance for 2016/17 = 84%p

Chart 8: Proportion of care services graded 'good' or better in Care Inspectorate inspections Falkirk and Scotland up to 2016/17.



Rationale for Indicator

This indicator is intended to provide a measure of assurance that adult care services meet a reasonable standard. Care services would be expected to continuously improve.

Data from the Care Inspectorate show the proportion of Falkirk services graded as good or better in 2016/17 is currently at 86%, 2% above the Scottish average at 84% and up from 84% in 2015/16.

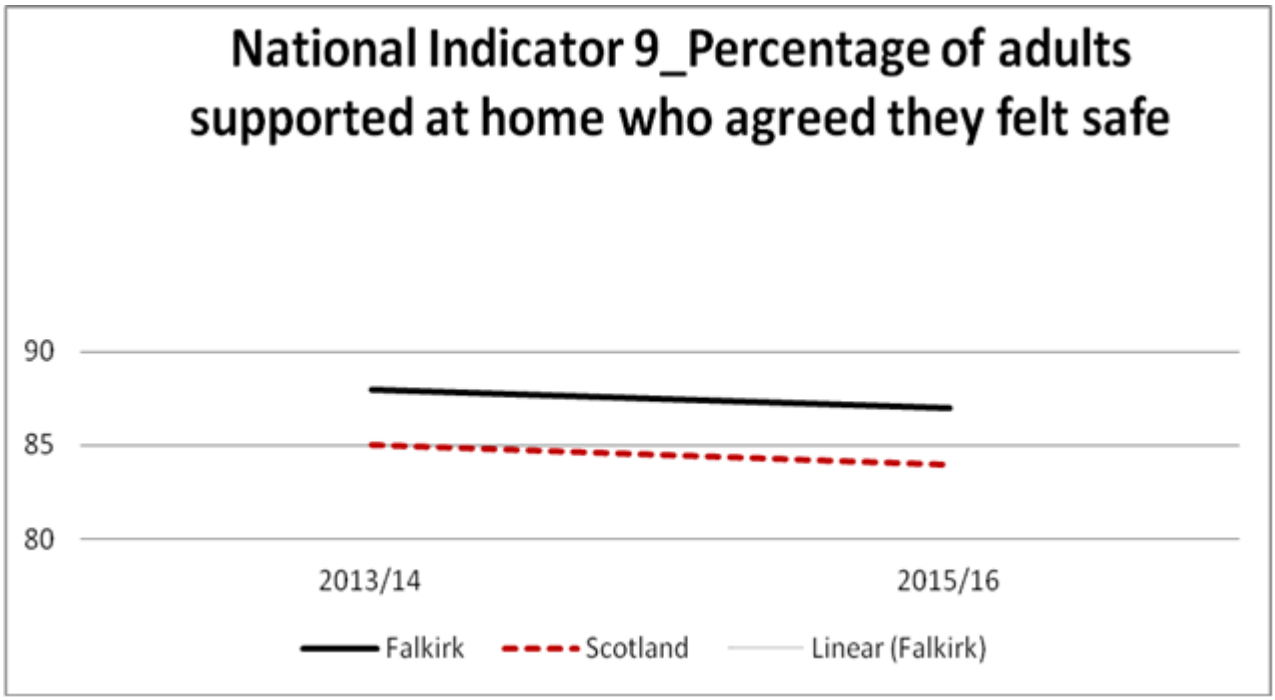
Local Outcome - Safety

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

National Indicator 9
Percentage of adults supported at home who agreed they felt safe

Measure	% of adults supported at home who either strongly agreed or agreed that they felt safe.
Falkirk Performance	Annual performance for 2015/16= 87
Scotland Performance	Annual Performance for 2015/16 = 84

Chart 9: Percentage of adults supported at home who agreed they felt safe



Rationale for Indicator

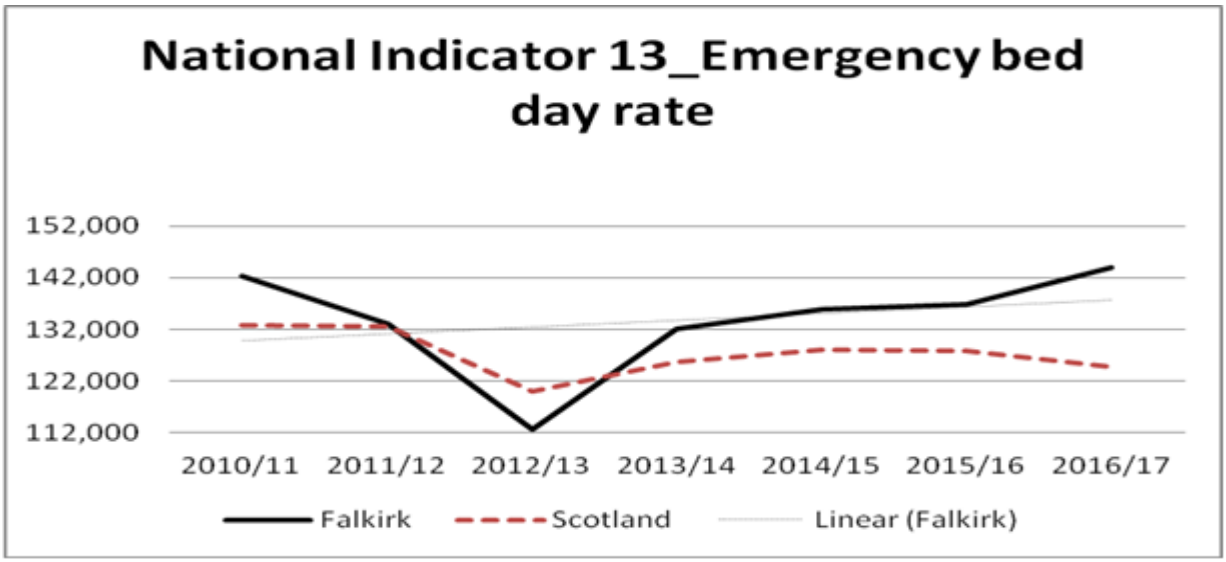
In carrying out their responsibilities, Health Boards, Local Authorities and Integration Authorities must ensure that the planning and provision of health and social care services protects people from harm.

Results from the 2015/16 Health and Care Experience Survey show 87% of Falkirk residents supported at home agree that they feel safe. The Scottish average is 84% for the same financial year.

National Indicator 13
Emergency bed day rate

Measure	Rate of emergency bed day per 100,000 population for adults.
Falkirk Performance	Annual performance for 2016/17= 143,941
Scotland Performance	Annual Performance for 2016/17= 124,663

Chart 10: Rate of emergency bed day per 100,000 population for adults



Rationale for Indicator

It is possible for the number of admissions to increase and bed days to reduce, and vice versa. Therefore this measure is included to ensure a balanced view. Integration Authorities have a central role in this by providing community-based treatment and support options, "step down" care and home care packages to enable people to leave hospital quickly once they are well enough.

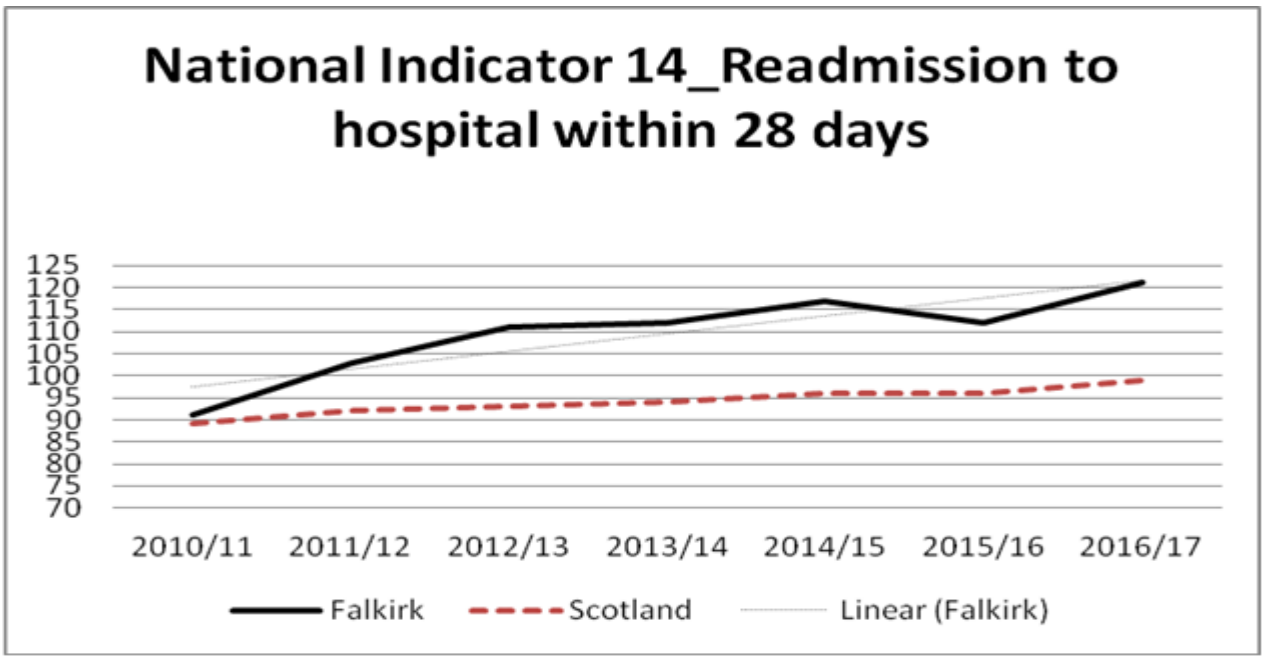
Emergency bed days pertaining to Falkirk residents in 2016/17 have increased by about 5% from 2015/16. The Scottish average has decreased by 2% over the same timeframe.

There have been several improvement measures initiated as part of the Day of Care Audit. This is inclusive of Standardised Operating Procedures being devised for community packages of care and other social and AHP services providing clearer pathways for identifying patients ready for discharge.

National Indicator 14
Readmission to hospital within 28 days

Measure	Based on Acute hospital (SMR01) activity data, this rate is calculated from number of re-admissions to an acute hospital within 28 days of discharge per 1,000 admissions.
Falkirk Performance	Annual performance for 2016/17= 121
Scotland Performance	Annual Performance for 2016/17= 99

Chart 11: Readmission to hospital within 28 days



Rationale for Indicator

This indicator is one of the national suite of Primary Care Indicators, and data are being made available for each General Practice in Scotland. As well as GP services, it reflects the links with other aspects of primary care in particular pharmacy and district nursing and as social services.

Emergency Readmission, in this instance, refers to Falkirk residents who were readmitted to a hospital, not necessarily in NHS Forth Valley, within 28 days of an initial elective or emergency admission. The readmission may not link directly to the primary admission; the primary admission may be respiratory in nature, however the readmission could be attributed to a fractured neck of femur.

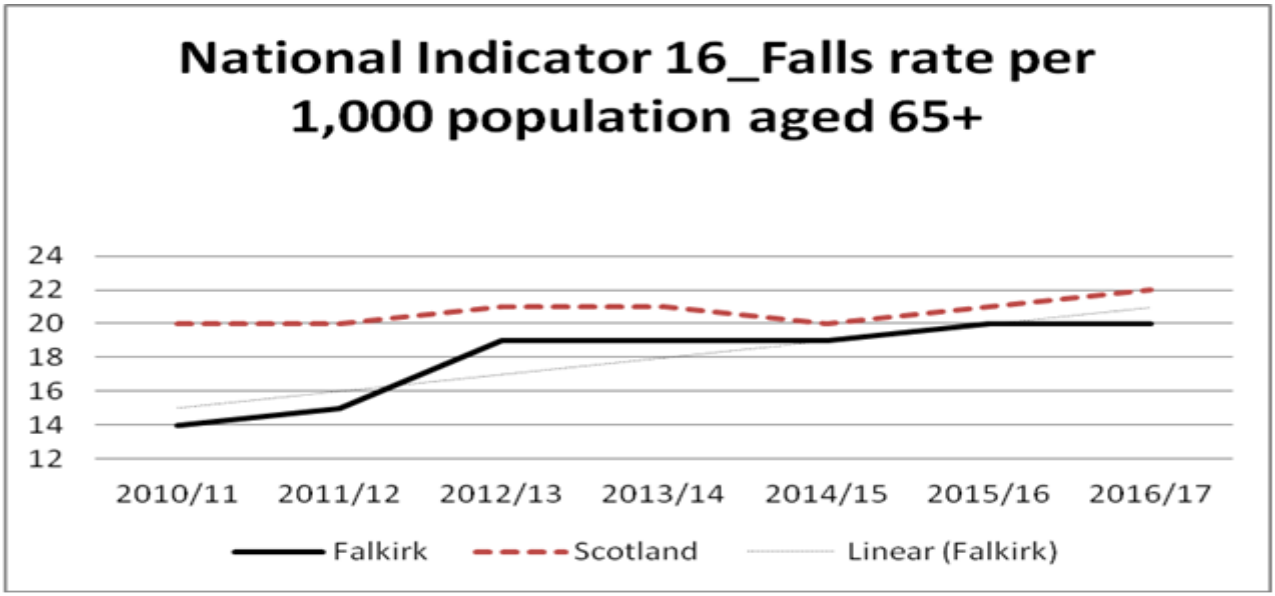
Falkirk readmissions have increased by 8% to 121 per rate per thousand population in 2016/17, 22% above the Scottish average.

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.

National Indicator 16
Falls rate per 1,000 population aged 65+

Measure	The focus of this indicator is the rate per 1,000 population of falls that occur in the population (aged 65 plus) who were admitted as an emergency to hospital.
Falkirk Performance	Annual performance for 2016/17 = 20
Scotland Performance	Annual Performance for 2016/17 = 22

Chart 12: Falls rate per 1,000 population aged 65+



Rationale for Indicator

With health and social care services striving to address the challenge of demographic change and rising demands on public services, falls among older people are a major and growing concern that is being addressed by a national improvement programme.

The Falkirk falls rate in those aged 65 plus in 2016/17 is reported as 20. This is static from the previous year and remains below the national average of 22.

Forth Valley has developed a Falls Management Pathway to support self management, identify those at risk, responses and immediate assistance and coordinate management. Older People's Services provide multidisciplinary assessments with ReACH and the Rehabilitation Centre.

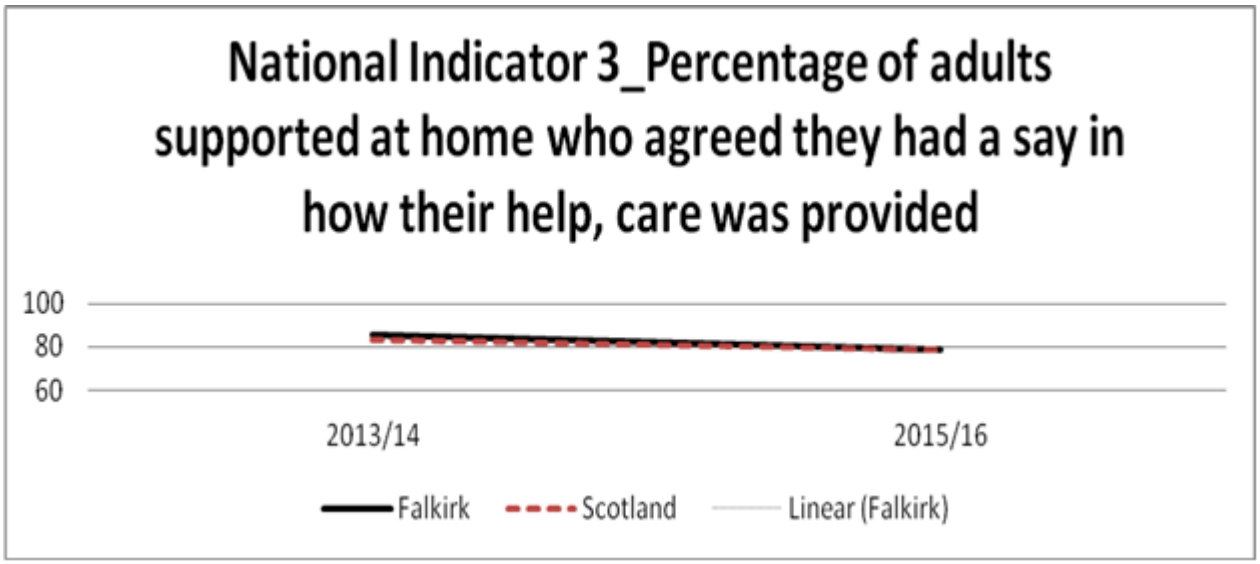
Local Outcome – Service User Experience

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

National Indicator 3
Percentage of adults supported at home who agreed that they had a say in how their help, care, or support was provided

Measure	% of adults who responded that they either strongly agreed or agreed that they had a say in how their help, care or support was provided
Falkirk Performance	Annual performance for 2015/16 = 79%
Scotland Performance	Annual Performance for 2015/16 = 79%

Chart 13: Percentage of adults supported at home who agreed that they had a say in how their help, care, or support was provided



Rationale for Indicator

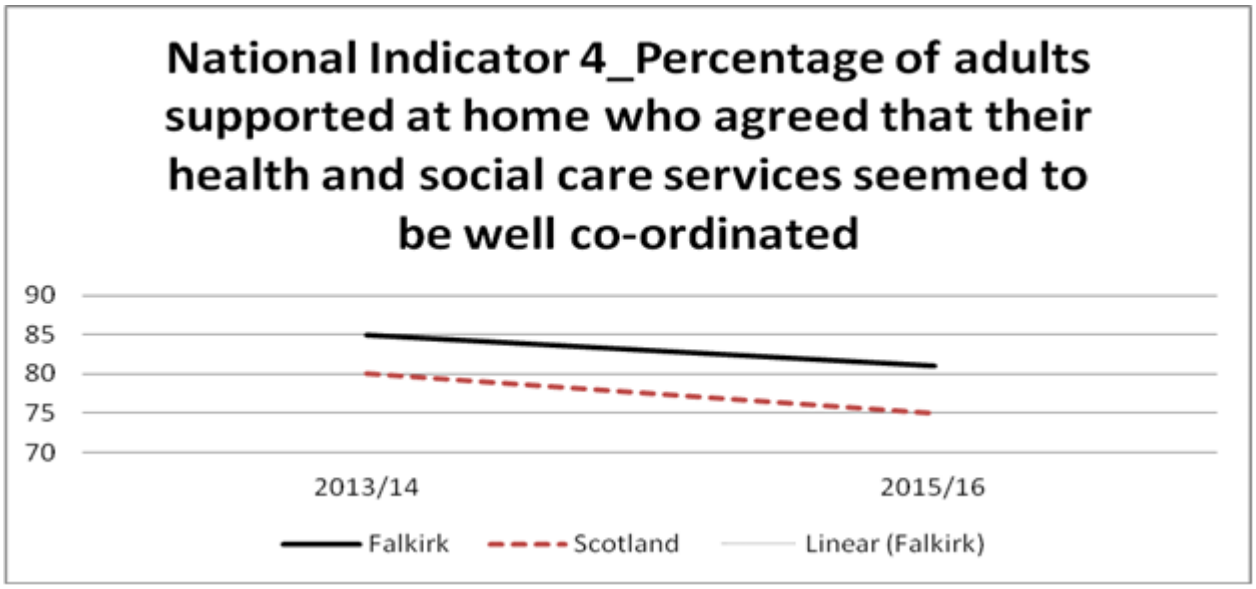
People who use health and social care services have positive experiences of those services, and have their dignity respected. People, including those with disabilities or long term conditions or who are frail are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.

In Falkirk 79% of respondents in the 2015/16 Health and Care Experience Survey agreed that they had a say in how their help, care or support was provided. This is a decrease of 7% since the 2013/14 survey, though equal to the Scottish average.

National Indicator 4
Percentage of adults supported at home who agreed that their health and social care services seemed to be well coordinated

Measure	% of adults who responded that they either strongly agreed or agreed that their health and social care services seemed to be well co-ordinated.
Falkirk Performance	Annual performance for 2015/16= 81
Scotland Performance	Annual Performance for 2015/16 = 75

Chart 14: Percentage of adults supported at home who agreed that their health and social care services seemed to be well co-ordinated



Rationale for Indicator

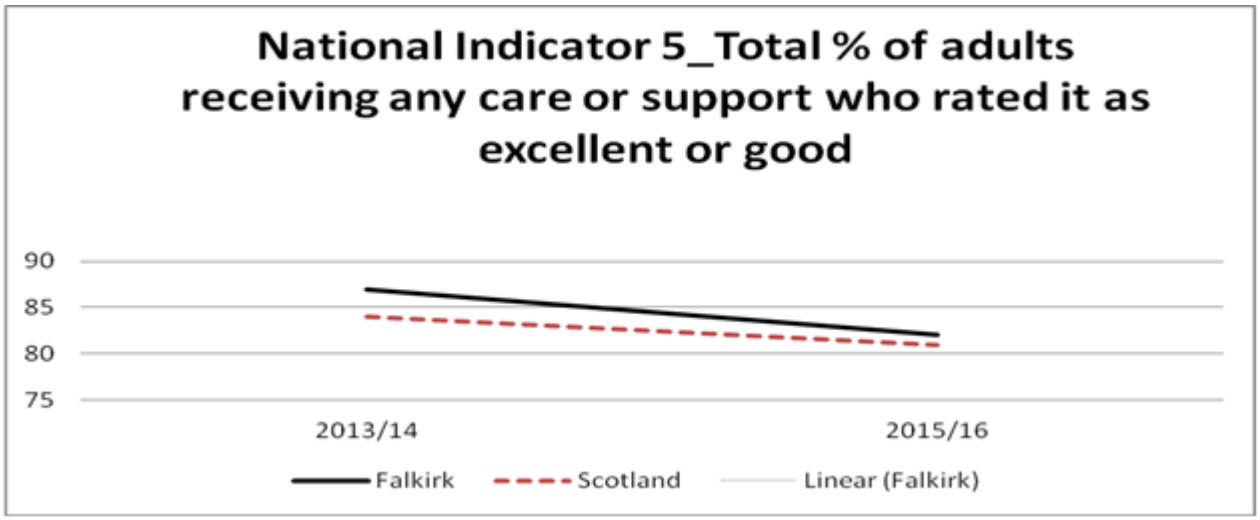
Person centred planning and delivery of services will ensure that people receive the right service at the right time, in the right place, and services are planned for, and delivered for, the benefit of people who use the service. This also reflects the resources outcome, as uncoordinated care is also likely to be inefficient and less effective.

Results are based upon agreement with question number 36 in the Health and Care Experience Survey: percentage of adults supported at home who agreed that their health and social care services seemed to be well coordinated. As of 2015/16, 81% of respondents were in agreement with the statement. This is above the national average of 75%. Overall results have decreased since the initial survey of 2013/14.

National Indicator 5
Total % of adults receiving any care or support who rated it as excellent or good

Measure	% of adults who rated their care or support as excellent or good.
Falkirk Performance	Annual performance for 2015/16 = 82%
Scotland Performance	Annual Performance for 2015/16 = 81%

Chart 15: Total % of adults receiving any care or support who rated it as excellent or good. Forth Valley and Scotland up to 2015/16.



Rationale for Indicator

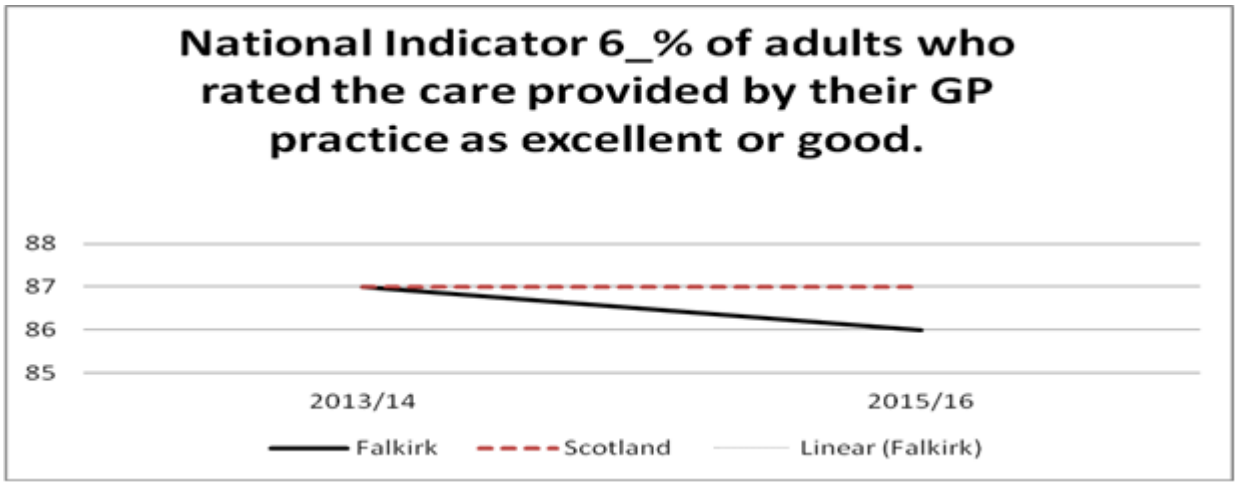
People who use health and social care services have positive experiences of those services, and have their dignity respected.

Results from the 2015/16 survey show 82% of respondents have highly rated the services they receive. This is a drop of 5% since the original survey in 2013/14. However Falkirk has consistently remained above the Scottish average of 81% in 2015/16 and 84% in 2013/14.

National Indicator 6
Percentage of people with positive experience of the care provided by their GP practice

Measure	% of adults who rated the care provided by their GP practice as excellent or good.
Falkirk Performance	Annual performance for 2015/16 = 86%
Scotland Performance	Annual Performance for 2015/16 = 87%

Chart 16: Percentage of people with positive experience of the care provided by their GP practice. Forth Valley and Scotland performance up to 2015/16.



Rationale for Indicator

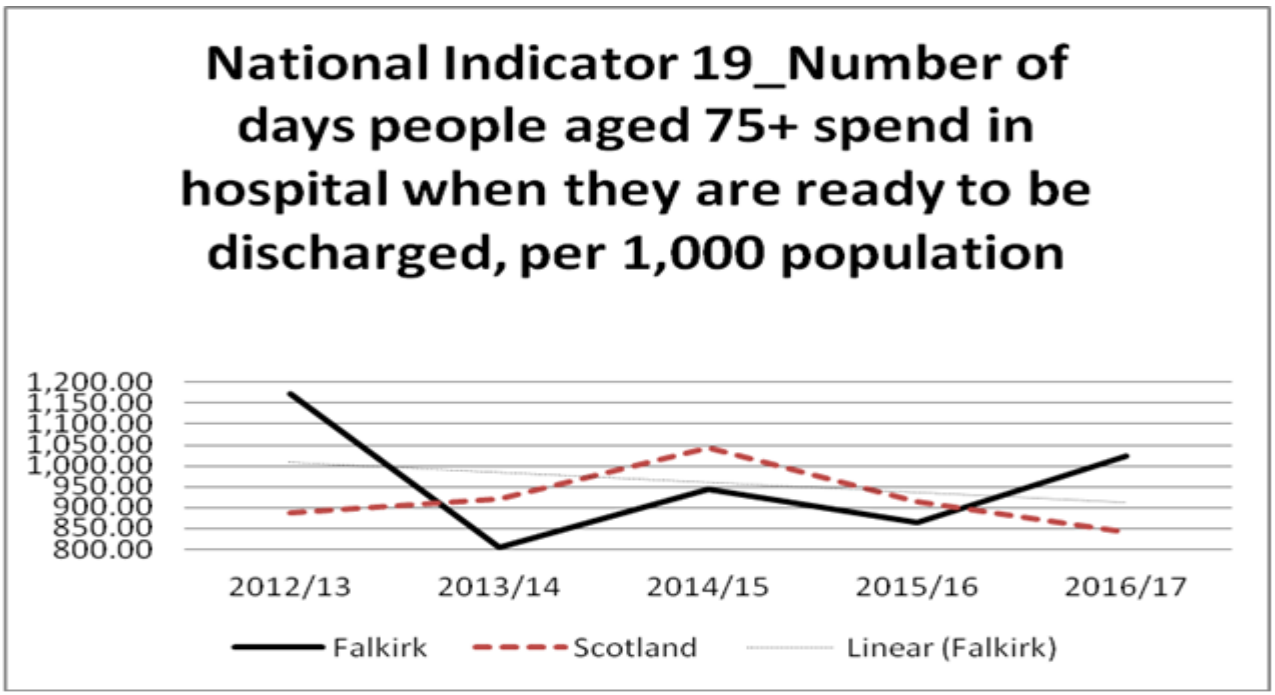
GP services are central to health and care services so it is important that Integration Authorities and GP practices work together, with partners, to contribute to patient outcomes.

86% of Falkirk residents rated the care provided by their GP practice as excellent or good. This is a 1% decrease since the 2013/14 survey and 1% below the Scottish average which has remained static at 87%.

National Indicator 19
Number of days people aged 75+ spend in hospital when they are ready to be discharged, per 1,000 population

Measure	The number of bed days due to delay discharge that have been recorded for people aged 75+ resident within the Local Authority area, per 1,000 population in the area.
Falkirk Performance	Annual performance for 2015/16 = 1023
Scotland Performance	Annual Performance for 2015/16 = 842

Chart 17: Number of days people aged 75+ spend in hospital when they are ready to be discharged, per 1,000 population



Rationale for Indicator

Older people admitted to hospital are more likely to be delayed there once their treatment is complete. This can have an impact on their health and independence. Improvements need to be made by better joint working and use of resources ensuring patients are discharged to an appropriate setting.

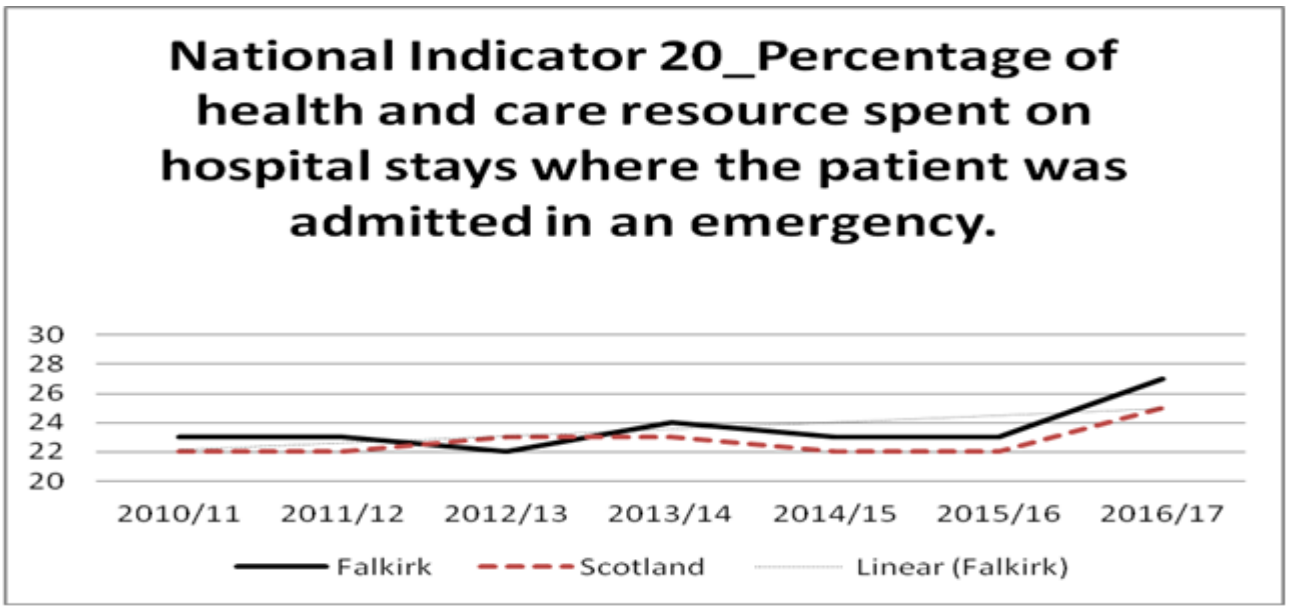
The provisional Falkirk 2016/17 data highlights an increase of 18% in the rate of days; this is 21% above the Scottish average.

The Day of Care Audit has now been extended to include community hospitals. Further work is on-going.

National Indicator 20
Cost of emergency bed days for adults

Measure	Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency.
Falkirk Performance	Annual performance for 2016/17= 27
Scotland Performance	Annual Performance for 2016/17 = 25

Chart 18: Cost of emergency bed days for adults



Rationale for Indicator

This indicator will provide an overall indication of the balance of care in each partnership area. Not all emergencies (non-elective stays) can be prevented or shifted to another setting, but where appropriate, care in another setting will benefit patients and also ensure resources are spent more effectively.

The percentage of resources spent on emergency admissions of Falkirk residents has increased from 25% in 2015/16 to a provisional 27% in 2016/17. The cost of emergency admissions in the last financial year is reported as £73,991,070 as a percentage of the total expenditure of £278,699,470.

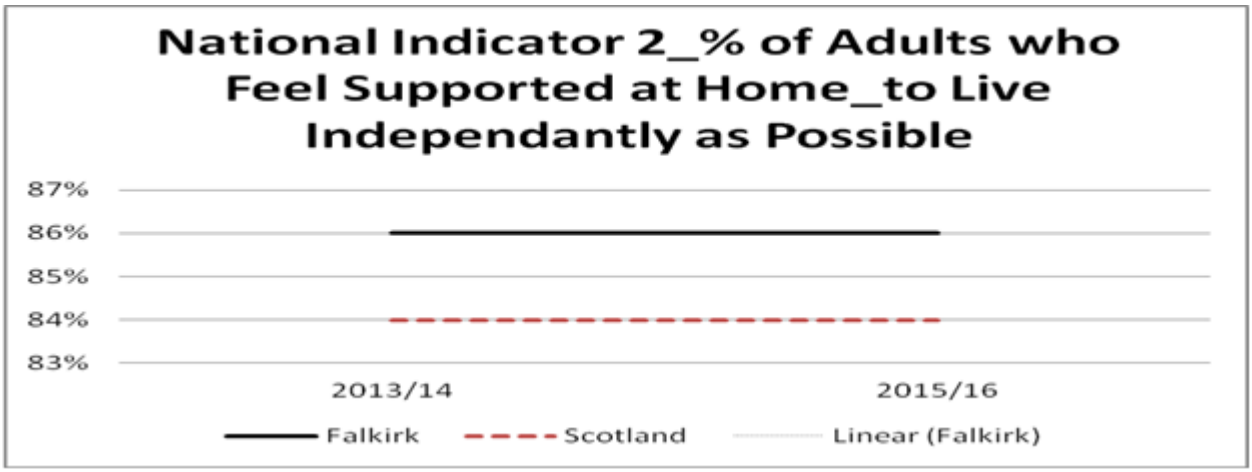
Local Outcome – Community Based Support

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

National Indicator 2
% of Adults supported at home who agree that they are supported to live as independently as possible

Measure	% of adults who responded that they either strongly agreed or agreed that they are supported to live as independently as possible.
Falkirk Performance	Annual performance for 2015/16 = 86%
Scotland Performance	Annual Performance for 2015/16 = 84%

Chart 19: % of Adults supported at home who agree that they are supported to live as independently as possible. Falkirk and Scotland position up to 2015/16



Rationale for Indicator

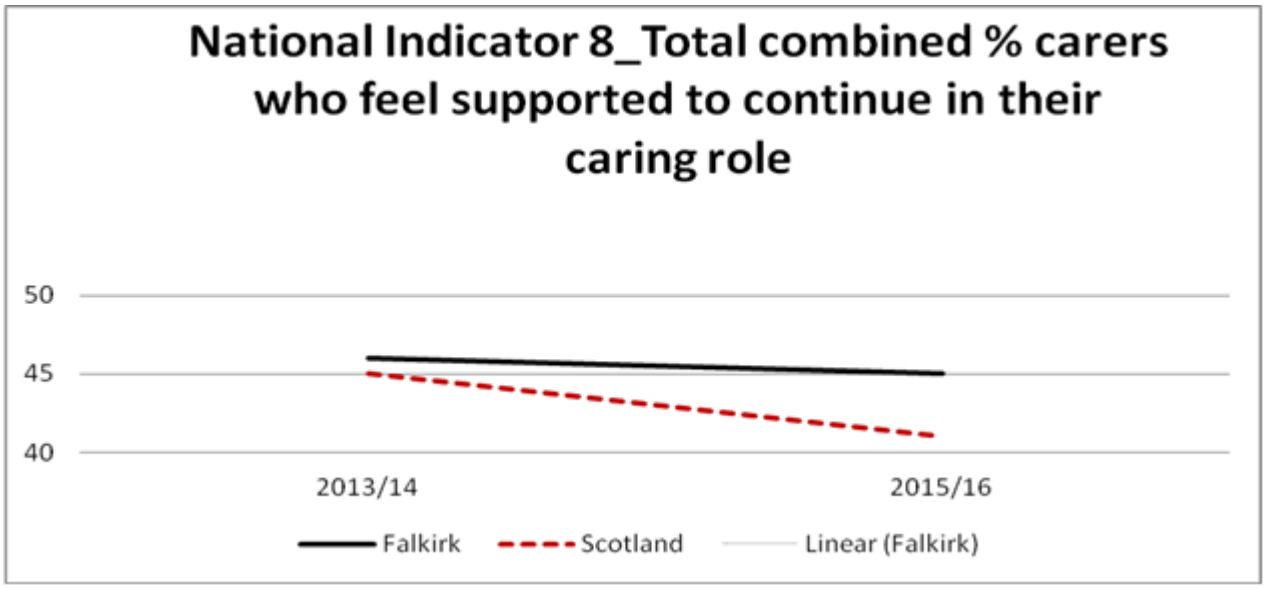
This indicator reflects whether people who need support feel that it helps them maintain their independence as much as possible.

86% of Falkirk service users feel supported to live as independently as possible. This position is held from the 2013/14 survey and remains 2% above the Scottish average of 84%.

National Indicator 8
Total combined % carers who feel supported to continue in their caring role

Measure	% of carers who either strongly agreed or agreed that they felt supported to continue in their caring role.
Falkirk Performance	Annual performance for 2015/16 = 45%
Scotland Performance	Annual Performance for 2015/16/ = 41%

Chart 20: Total combined % carers who feel supported to continue in their caring role



Rationale for Indicator

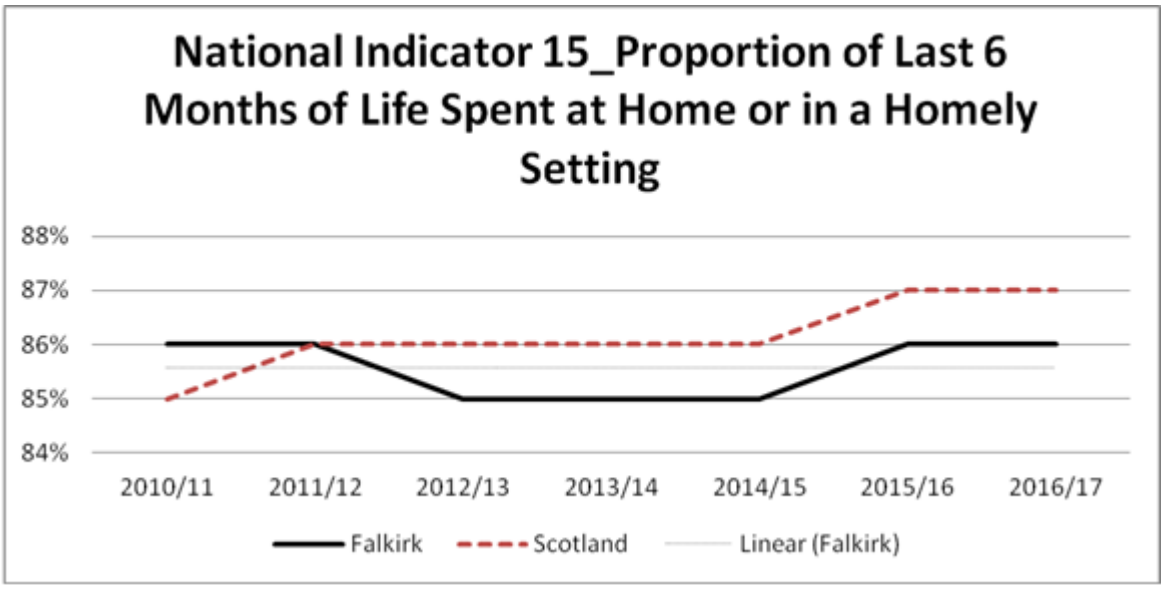
This indicator reflects the fact that health and social care services need to be planned and delivered with a strong focus on the wellbeing of unpaid carers.

45% of Falkirk residents agreed with the statement in the 2015/16 Survey that they feel supported to continue their caring role. The Scottish average being 41%.

National Indicator 15
Proportion of last 6 months of life spent at home or in a community setting

Measure	This indicator measures the percentage of time spent by people in the last 6 months of life at home or in a community setting.
Falkirk Performance	Annual performance for 2015/16 = 86%
Scotland Performance	Annual Performance for 2015/16 = 87%

Chart 21: Proportion of last 6 months of life spent at home or in a community setting



Rationale for Indicator

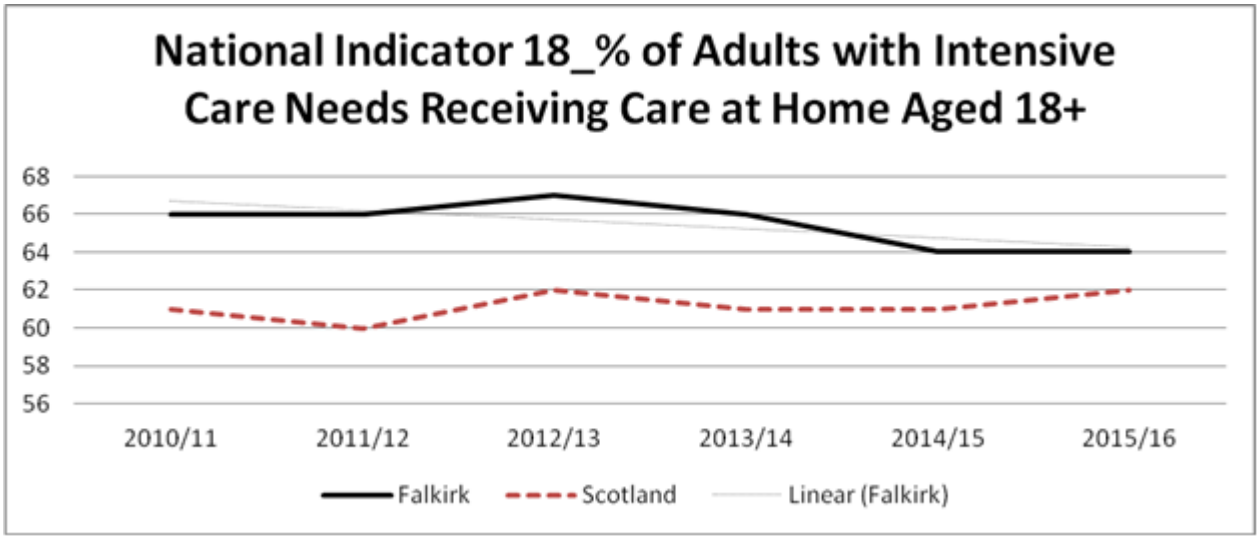
It is now possible to predict the progress of many diseases, enabling a planned approach to palliative and end of life care in ways which reflect best practice and which, as far as is practicable, in accordance with the needs and wishes of patients, carers and their families.

The above data exclude those whose death has been an external cause such as unintentional injury. The Scotland position has been recorded as 87% over the last 2 financial years. Provisional data indicate there were 1,645 deaths of residents in the Falkirk local authority area, 86% of whom spent time at home or in a community setting.

National Indicator 18
Percentage of adults with intensive care needs receiving care at home aged 18+

Measure	The number of adults (18+) is receiving personal care at home or direct payments for personal care, as a percentage of the total number of adults needing care.
Falkirk Performance	Annual performance for 2015/16 = 64%
Scotland Performance	Annual Performance for 2015/16 = 62%

Chart 22: Percentage of adults with intensive care needs receiving care at home aged 18+



Rationale for Indicator

The Scottish Government rationale for this indicator states, people, including those with disabilities or long term conditions or who are frail are able to live as reasonably practicable, independently and at home or in a homely setting in their community. Falkirk figures depict 64% of respondents to the Health and Care Experience Survey intimated their needs were being addressed in a homely environment. Falkirk compliance is consistently higher than the Scottish average over the last 6 financial years.

Appendix 1

Local Partnership Indicators – (aligned to National Indicators as appropriate)

Falkirk Integration Joint Board Strategy Map

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