AGENDA ITEM 10

Agenda No: 10

Falkirk Health and Social Care Partnership

Title/Subject: **Performance Report**

Meeting: **Integration Joint Board**

Date: **1 February 2019**

General Manager, Community Services and Head of Social Adult Services Work

Action: **For Noting**

1. INTRODUCTION

1.1 This report presents a comprehensive review of national performance indicators based upon 2017/18 data against the baseline year 2015/16, giving a year on year comparison. The national data is published on a biannual basis. National data items are provided via the SOURCE group on a quarterly basis. The financial year 2017/18 will not be fully updated until after quarter 1 of 2019/20.

2. RECOMMENDATION

The Integration Joint Board (IJB) 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 the issues identified through these performance reports.

3. BACKGROUND

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

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

3.3 The Unscheduled Care Programme Board is responsible for all aspects of emergency care, working in partnership with third party advisors on delivering improved access to services through a whole system approach.

4. APPROACH

4.1 The Falkirk Performance and Measurement Group are working to develop a more structured and themed timetable for performance reporting, and will be presented to the IJB later in the year.

4.2 The SOURCE performance dashboard has been used to prepare the majority of this report.

4.3 The group will seek to maintain consistency of reporting where possible, but performance reporting to the IJB also needs to be aligned with the Scottish Government's publications. This is to avoid the possibility of reporting different or discrepant data to the data reported to and by the Scottish Government. This may mean we need to consider amending the indicators reported to the IJB over the next year. The Performance report will signpost any future proposals on changes to the indicators to the Integration Joint Board, however, this is a challenge as we have no influence over how and when the Scottish Government decides to publish the national Health and Social Care Survey data.

5. FINDINGS

5.1 The national data lists twenty-three indicators within the report, but data is provided for only 19 of these. With one exception, the data reports 2017-18 data against the baseline year 2015/16. Of the published indicators listed below, 3 show improvement in performance between these dates; 2 show performance at the same level ; and 14 indicators show deteriorating performance by the Falkirk Partnership between 2015-16 and 2017-18. Nationally, 6 indicators showed improvement; one stayed the same; and 11 showed deteriorating performance during the same period.

5.2 **Improving National Indicators in Falkirk:**

- Ind. 11: Premature Mortality Rate per 100,000 persons 2017
- Ind. 15 – Proportion of last 6 months of life spent at home or in a community setting
- Ind. 17 - Proportion of care services graded 'good' (4) or better by Care Inspectorate inspections

5.3 **National Indicators staying the same in Falkirk:**

- Ind. 5 – Total % of adults receiving any care or support who rated it as excellent or good
- Ind. 20 – Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency

5.4 **Deteriorating National Indicators in Falkirk:**

- Ind. 1_Percentage of adults able to look after their own health well/quite well financial year 2017/18
- Ind. 2 – Percentage of adults supported at home who agreed that they are supported to live as independently as possible

- Ind. 3 – Percentage of adults supported at home who agreed that they had a say in how their help, care, or support was provided
- Ind. 4 – Percentage of adults supported at home who agreed that their health and social care services seemed to be well co-ordinated
- Ind. 6 – Percentage of people with positive experience of the care provided by their GP practice
- Ind. 7- % of Adults who agree support has impacted on improving /maintaining quality of life 2017/18
- Ind. 8 – Total combined % carers who feel supported to continue in their caring role
- Ind. 9 - Percentage of adults supported at home who agreed they felt safe
- Ind. 12 - Rate of emergency admissions per 100,000 population for adults 2017/18
- Ind. 13 - Emergency bed day rate (per 100,000 population)
- Ind. 14 - Readmission to hospital within 28 days (per 1,000 population)
- Ind. 16 - Falls rate per 1,000 population aged 65+
- Ind. 18 – The number of adults (18+) receiving personal care at home (or direct payments for personal care), as a percentage of the total number of adults needing care.
- Ind. 19 – Number of days people spend in hospital when they are ready to be discharged (per 1,000 population)

6. PERFORMANCE REPORT STRUCTURE

6.1 The content of the report presents the national performance indicators data for 2017/18 in comparison with the baseline year of 2015/16, allowing the Partnership to identify our impact on outcomes for people. The summary table reports this data for the Falkirk partnership, our 7 peer local authorities and the national data for Scotland as a whole. The Rationale for each of the indicators is taken from the Scottish Government's publications on Health and Social Care Integration.

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

6.3 Section 1 provides a summary of the national performance indicators for Falkirk, compared against our Peer Group and the National position.

6.4 Section 2 provides further information for each of the national indicators organised around the partnership's five Local Outcomes (and the National Outcomes).

6.5 Appendix 1 - Integration Joint Board Strategy Map.

6.6 Appendix 2 – A glossary is provided to give explanation and context to

abbreviations and other terms contained within this report.

7. CONCLUSION

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

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

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

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

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

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

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Date: 22 January 2019

List of Background Papers:
None

Falkirk
Health and Social Care
Partnership

Performance Report

February 2019

1. NATIONAL SUMMARY OF PERFORMANCE

1.1 National Performance Summary against Scotland and Comparators

	Indicator	Title	Falkirk 2015/16	Falkirk 2017/18	Direction of Travel	Average of Comparators 2017/18	Average of Comparators 2017/18	Scotland 2015/16	Scotland 2017/18
Outcome indicators	NI - 1	Percentage of adults able to look after their health very well or quite well	93%	92%	v	94%	93%	95%	93%
	NI - 2	Percentage of adults supported at home who agreed that they are supported to live as independently as possible	85%	83%	v	83%	81%	83%	81%
	NI - 3	Percentage of adults supported at home who agreed that they had a say in how their help, care, or support was provided	80%	76%	v	80%	75%	79%	76%
	NI - 4	Percentage of adults supported at home who agreed that their health and social care services seemed to be well co-ordinated	79%	72%	v	76%	77%	75%	74%
	NI - 5	Total % of adults receiving any care or support who rated it as excellent or good	81%	81%	< >	81%	81%	81%	80%
	NI - 6	Percentage of people with positive experience of the care provided by their GP practice	84%	81%	v	86%	83%	84%	83%
	NI - 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	84%	78%	v	82%	82%	83%	80%
	NI - 8	Total combined % carers who feel supported to continue in their caring role	43%	37%	v	39%	37%	40%	37%
	NI - 9	Percentage of adults supported at home who agreed they felt safe	85%	84%	v	83%	84%	83%	83%
	NI - 10	Percentage of staff who say they would recommend their workplace as a good place to work	*NA*	*NA*	*NA*	*NA*	*NA*	*NA*	*NA*
Data indicators	NI - 11	Premature mortality rate per 100,000 persons	440	427	^	429	416	441	425
	NI - 12	Emergency admission rate (per 100,000 population)	11,528	12,335	v	13,047	13,482	12,276	12,176
	NI - 13	Emergency bed day rate (per 100,000 population)	137,626	139,171	v	133,062	131,284	128,503	122,595
	NI - 14	Readmission to hospital within 28 days (per 1,000 population)	112	120	v	100	105	97	102
	NI - 15	Proportion of last 6 months of life spent at home or in a community setting	86%	87%	^	87%	88%	87%	88%
	NI - 16	Falls rate per 1,000 population aged 65+	20	22	v	21	21	21	22
	NI - 17	Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections	84%	88%	^	84%	88%	83%	85%
	NI - 18	Percentage of adults 18+ receiving personal care as a % of those requiring care - data available up to 2016/17	64%	63%	v	64%	63%	62%	61%
	NI - 19	Number of days people spend in hospital when they are ready to be discharged (per 1,000 population)	864	910	v	726	709	915	762
	NI - 20	Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency	25%	25%	< >	25%	25%	24%	24%
	NI - 21	Percentage of people admitted to hospital from home during the year, who are discharged to a care home	*NA*	*NA*	*NA*	*NA*	*NA*	*NA*	*NA*
	NI - 22	Percentage of people who are discharged from hospital within 72 hours of being ready	*NA*	*NA*	*NA*	*NA*	*NA*	*NA*	*NA*
	NI - 23	Expenditure on end of life care, cost in last 6 months per death	*NA*	*NA*	*NA*	*NA*	*NA*	*NA*	*NA*

Table 1.1 above presents national outcomes for the Falkirk Partnership via SOURCE data in comparison to the Scotland position and our peers. Our peer group has been compiled by taking an average outcome for each of the national indicators for the following local Authority areas:-

1) Clackmannanshire
2) Dumfries and Galloway
3) Fife
4) Renfrewshire
5) South Ayrshire
6) South Lanarkshire
7) West Lothian

In this report, with the exception of indicator 18, the data reported is 2017/18 against the baseline year 2015/16 when the Partnership was established.

2. FORMAT AND STRUCTURE

2.1 Format and Structure

This section provides further information and charts where appropriate for each of the national indicators for which data is reported in section 1 above. The indicators are presented under the Falkirk Partnership's five Local Outcomes categories (and mapped to the Scottish Government's nine National Health and Wellbeing Outcomes), as shown below, and in the Falkirk Integration Joint Board Strategy Map in Appendix 1:

Local Outcomes	National outcomes
1. Self management	1) Healthier Living; 5) Reduce inequalities
2. Autonomy and decision making	4) Quality of life
3. Safety	7) People are safe
4. Service user experience	3) Positive experience and outcomes; 8) Engaged workforce; 9) Resources are used effectively
5. Community based support	2) Independent living; 6) Carers are supported

2.2 Local Outcome: Self management

2.2.1 National Outcome 1) Healthier Living - National Indicator 1

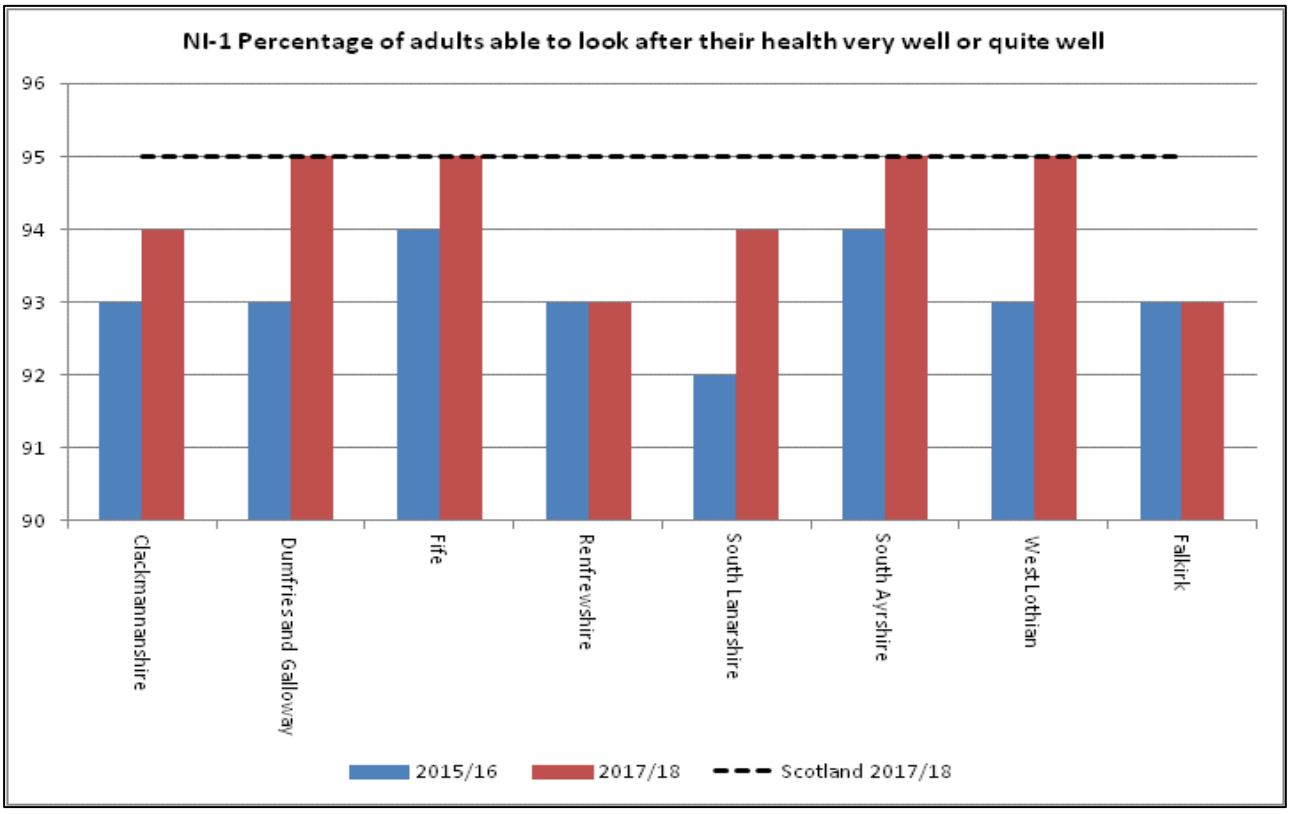
National Indicator 1_Percentage of adults able to look after their own health well/quite well financial year 2017/18	Outcome
Scotland position	93%
Peer Group average	93%
Falkirk HSCP	92%

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.

Integrated health and social care services can seek to influence this by the provision of appropriate information and support. They will also work with partners to improve the environmental and social factors that can act as barriers to health and wellbeing. This will involve working with individuals and communities to identify and build on their strengths.

Definition and Position:
The data source for this indicator has been extracted from the biennial health and social care experience survey relating to question 52: “In general, how well do you feel that you are able to look after your own health?”. Data for the financial year 2017/18 shows of the total respondents in the Falkirk partnership 92% of residents answered very well or quite well. This is a 1% decrease since the baseline year 2015/16. Peers of the Partnership have the same activity dropping to 93% from 94%. Falkirk 2017/18 results are most equated to Renfrewshire. The overall Scotland position has dropped from 95% to 93%.

Chart 1: National Indicator 1_ 2015/16_2017/18



2.2.2 National Outcome 5) Reducing Inequalities – National Indicator 11 - Premature Mortality Rate per 100,000 persons

National Indicator 11_Premature Mortality Rate per 100,000 persons 2017	Outcome
Scotland position	425
Peer Group average	429
Falkirk HSCP	427

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 less than 75 years decreased by 33%. Despite these decreases, more than 20,000 people under 75 still die each year.

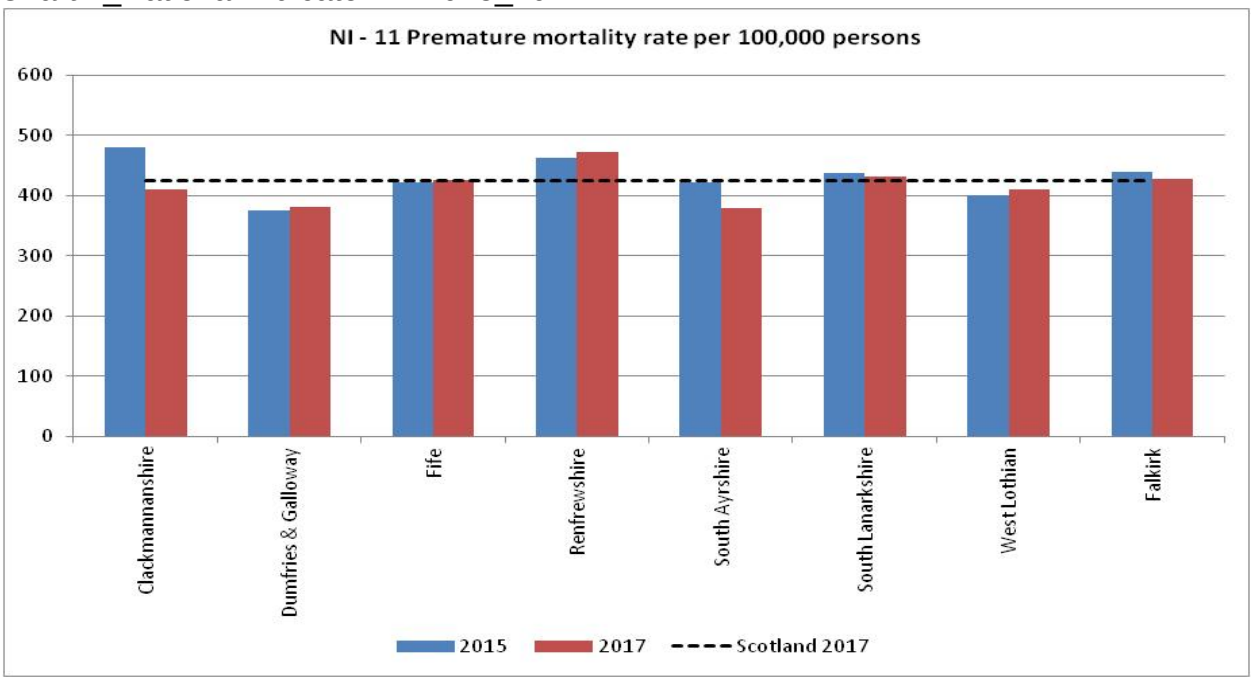
Delivering significant and sustainable improvements in health requires a focus on the underlying causes of poor health and inequalities. Poor health is not simply due to diet, smoking or other life style choices, but also the result of other factors such as people's aspirations, sense of control and cultural factors.

Tackling poverty, reducing unemployment, promoting mental wellbeing, increasing educational attainment and improving poor physical and social environments will, therefore, all contribute to reducing premature mortality. This needs to be complemented by specific action on the "big killer" diseases, such as cardiovascular disease and cancer where some of the risk factors, such as smoking, are strongly linked to deprivation, as well as addressing drug and alcohol problems and links to violence that affect younger men in particular.

Definition and Position:
Data are derived using the European Age – Standardised mortality rate per 100,000 for people aged under 75 years old in Scotland.

National data for 2017/18 for Falkirk show there has been a decrease of 3% in the premature mortality rate per 100,000 in 2017/18 at 440, to 427 since the baseline year of 2015/16. This percentage reduction is compatible with the peer average of 2.9% and the national picture of 3.6% decrease. Chart X shows a breakdown of results for the Falkirk Partnership against the individual peers.

Chart 2_National Indicator 11 2015_2017



2.3 Local Outcome: Autonomy and decision making

2.3.1 National Outcome 4) Quality of Life - National Indicators 7, 12 and 17

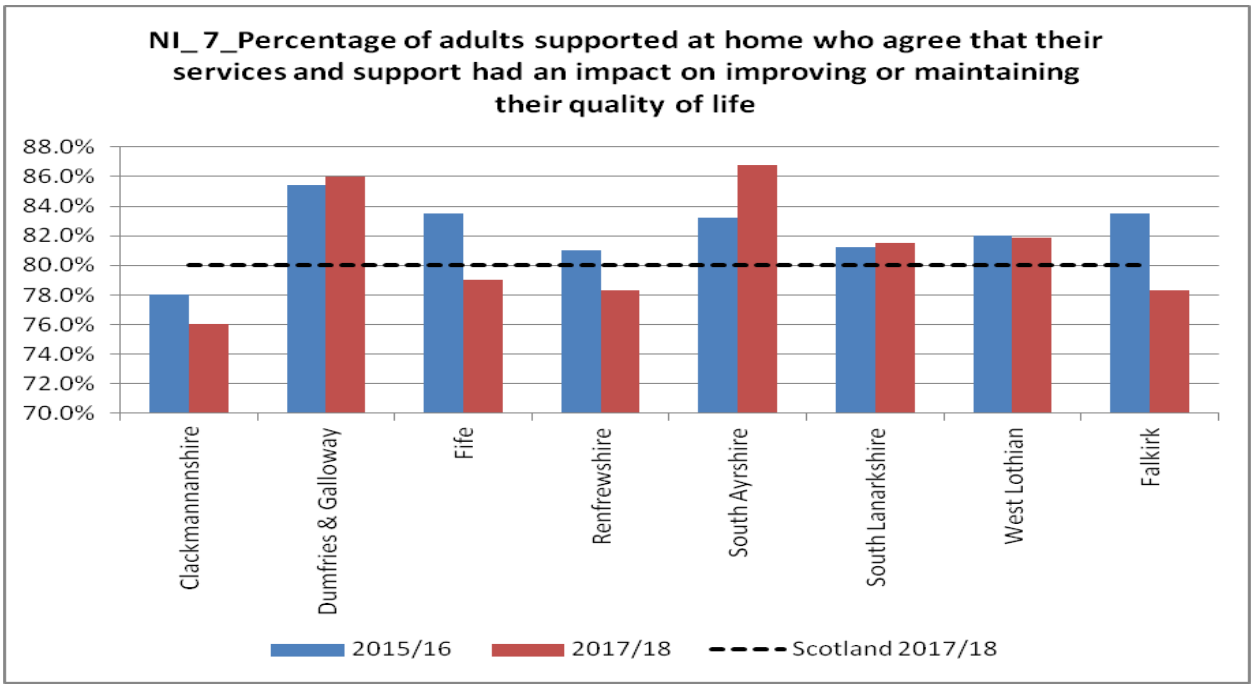
National Indicator 7_% of Adults who agree support has impacted on improving /maintaining quality of life 2017/18	Outcome
Scotland position	80%
Peer Group average	82%
Falkirk HSCP	78%

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.

Definition and Position
Based on agreement with the statement (Q36h) in the biennial health and care experience survey: "The help, care or support improved or maintained my quality of life". The number of people who agree or strongly agree divided by the total number answering.

The overall Scotland position demonstrates a national reduction of 3% since the baseline year in respondents who agreed with the above statement. 2017/18 sees a deterioration from 84% in 2015/16 to 78% in the last financial year. Our peer average for 2017/18 has remained static since 2015/16. The results range from 76% in Clackmannanshire to 86.5 in South Ayrshire recording services and support had a positive impact on their quality of life.

Chart 3_National indicator 7_2015/16_2017/18



National Indicator 12 - Rate of emergency admissions per 100,000 population for adults 2017/18	Outcome
Scotland position	12,176
Peer Group average	13,482
Falkirk HSCP	12,335

Rationale for Indicator:
Excellent emergency services are necessary when people are at a point of crisis or suffer serious injury. But 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.

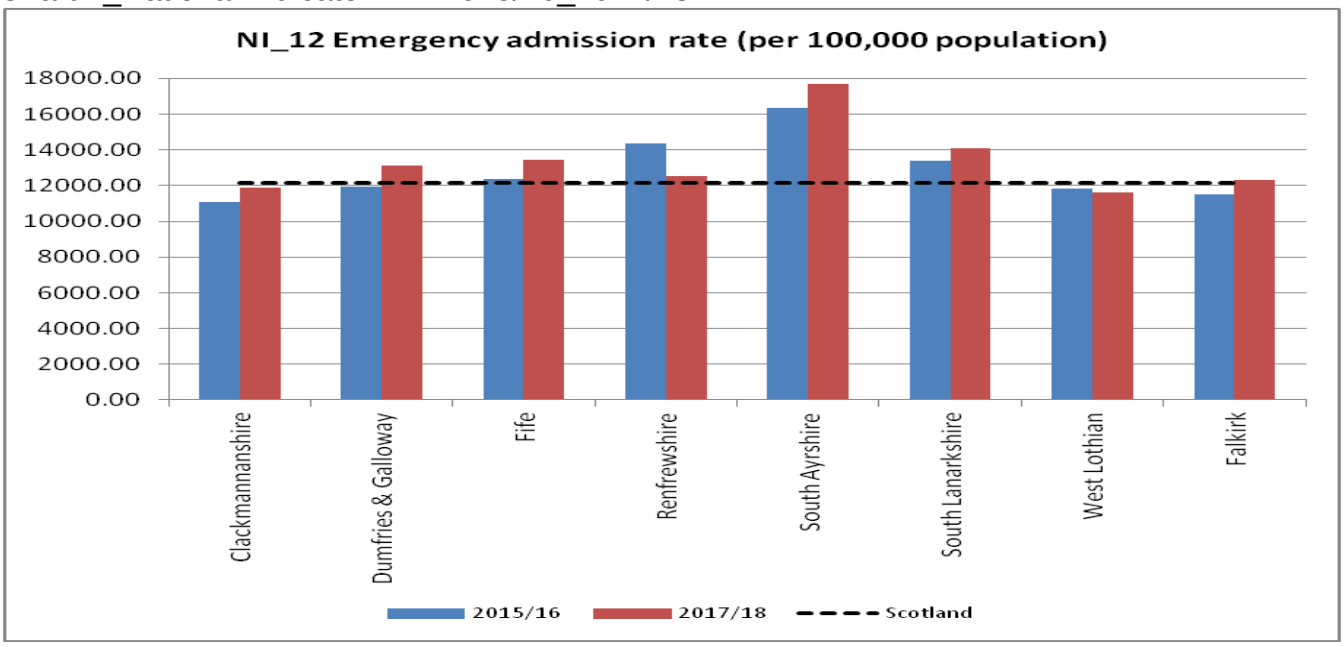
A reduction in this indicator should demonstrate improved partnership working. It should represent a shift from a reliance on hospital care towards proactive and coordinated care and support in the community. It should demonstrate the effectiveness of anticipatory care, identifying people who are at risk of emergency hospital admission, supporting people to be more confident in managing their long term conditions and providing coordinated care and support at home where safe and appropriate. Safe and suitable housing for people will also be important.

Other service aspects include: the options open to GPs in referring patients; decisions made by ambulance crews on arrival at an emergency situation; mental health service provision in the community; and for older people in particular the availability of alternatives such as short term rapid response services; and whether local systems are linked in a way that supports older people at critical times. Improvements in peoples overall health, and reducing health inequalities should also lead to fewer emergencies.

Definition and Position
Rate of emergency admissions per 100,000 population for adults. This will be based on SMR01 returns for acute hospitals, and SMR04 data for psychiatric hospitals (note that some further work will be undertaken by ISD regarding this data source). Results show the number of emergency admissions as a rate of the Falkirk adult population.

The overall Scotland position shows a decrease in the rate of emergency admissions per 100,000 from 12,276 to 12,176 since 2015/16. This is similar to the rate for Scotland of 12,176. To look more closely the actual number of admissions in Scotland increased by 0.4% against a rise in population of 1.2% in Scotland. The rate of emergency admissions for the Falkirk Partnership shows an increase of 7%. This calculation of the rate is based on an 8% increase in the number of emergency admissions between 2015-16 and 2017-18 which is offset by a rise in the Falkirk population of 1.4%. The average rise of the Partnership peers is 10% (rate =13,482) which is higher than the Scottish rate of 12,176. South Ayrshire emergency admissions showed a rate of 17,692 being the highest rate of admission of the peer group authorities.

Chart 4_National Indicator 12: 2015/16_2017/18



National Indicator 17 - Proportion of care services graded 'good' (4) or better by Care Inspectorate inspections	Outcome
Scotland position	85%
Peer Group average	88%
Falkirk HSCP	88%

Rationale for Indicator
This indicator is intended to provide a measure of assurance that adult care services meet a reasonable standard. It would be envisaged however that services should not just aspire to adequacy and therefore the indicator looks at those who are "good" or better on all gradings. Care services would be expected to continuously improve.

It will be important that all partners work together to improve the standards of care homes and care at home services whether provided by the Local Authority, Health Board, third sector or private sector.

Definition and Position
Care services included in this indicator are:

- Care Homes for adults and older people
- Housing Support Services
- Support Services including Care at Home and adult Daycare
- Adult placements
- Nurse Agency

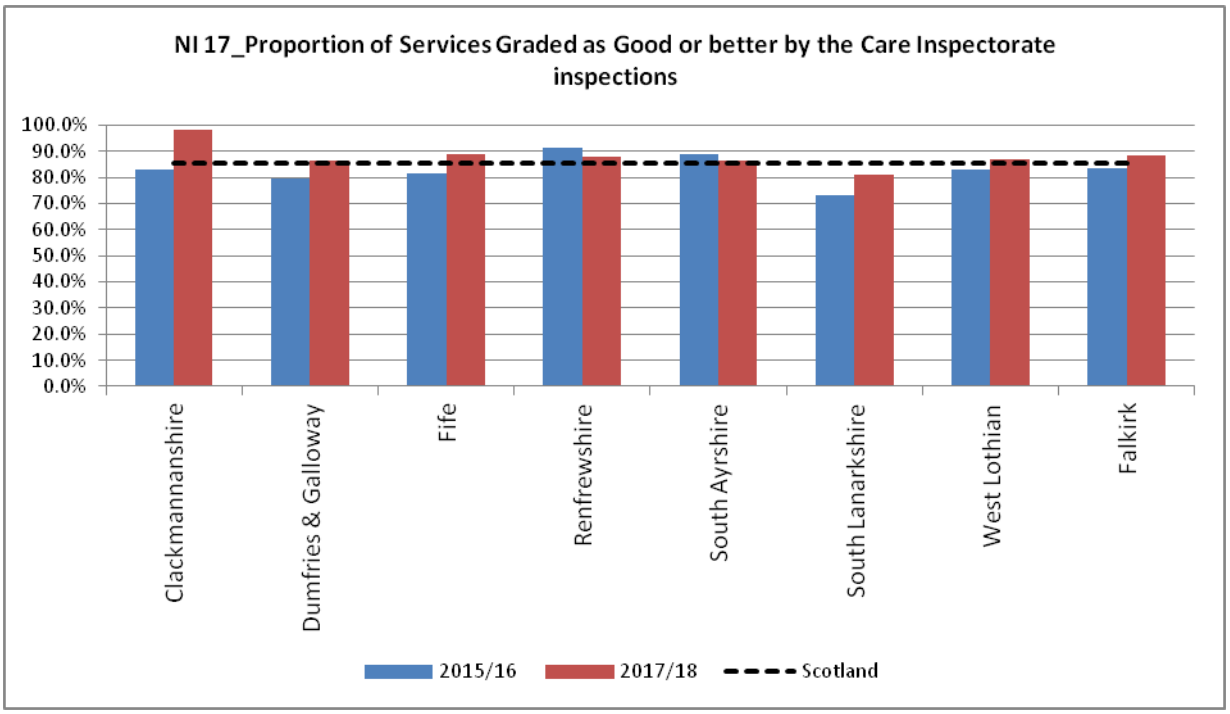
The Care Inspectorate grades care services on the following themes:

- Quality of Care and Support
- Quality of Environment (Care Homes only)
- Quality of Staffing
- Quality of Management and Leadership

Care services are graded on a six point scale: 1) Unsatisfactory; 2) Weak; 3) Adequate; 4) Good; 5) Very good; 6) Excellent

In 2017/18 the Care Inspectorate graded 88% of the Falkirk Partnership's care services as good or better. This is a 4% rise since the baseline year of 2015/16 which is in keeping with our peer group average and exceeds the Scottish average of 85%.

Chart 5_National Indicator 17_2015/16_2017/18



2.4 Local Outcome: Safety

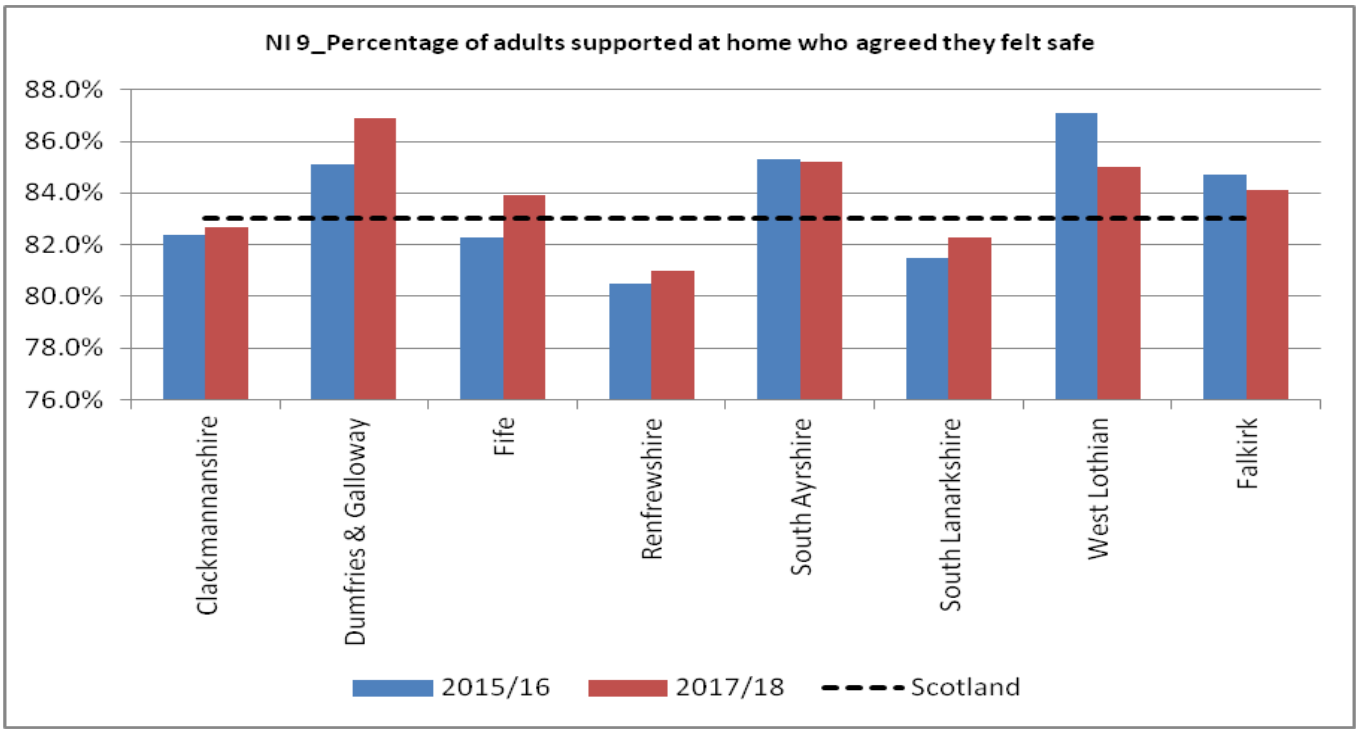
2.4.1 National Outcome 7) People are safe – National Indicators 9, 13, 14, 16

National Indicator 9 - Percentage of adults supported at home who agreed they felt safe	Outcome
Scotland position	83%
Peer Group average	84%
Falkirk HSCP	84%

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.

Definition and Position
The overall Scotland position has remained static at 83%. The Partnership position has reduced to 84% which is still above the Scottish average and equates to that of our peer group average.

Chart 6_National Indicator 9 2015/16_2017/18



However, one of the Falkirk Partnership's local indicators provides more specific and recent information on the experiences of service users receiving assessment/review from Social Work Adult Services. Local indicator 49 shows that in the half year ending September 2018, 89% of service users were recorded as feeling safe. This indicator is reported routinely within IJB Performance Reports. (IJB Performance Report 7th December, 2018, page 7)

National Indicator 13 - Emergency bed day rate (per 100,000 population)	Outcome
Scotland position	122,595
Peer Group average	131,284
Falkirk HSCP	139,171

Rationale for Indicator
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. Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services. People who use health and social care services are safe from harm.

It is possible for the number of admissions to increase and bed days to reduce and vice versa, so this measure is included to ensure a balanced view. Once a hospital admission has been necessary in an emergency, it is important for people to get back home as soon as they are fit to be discharged to avoid the risk of them losing their confidence and ability to live independently.

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. Additionally, care homes should where appropriate be able to support people with a wider range of physical and mental frailty and needs.

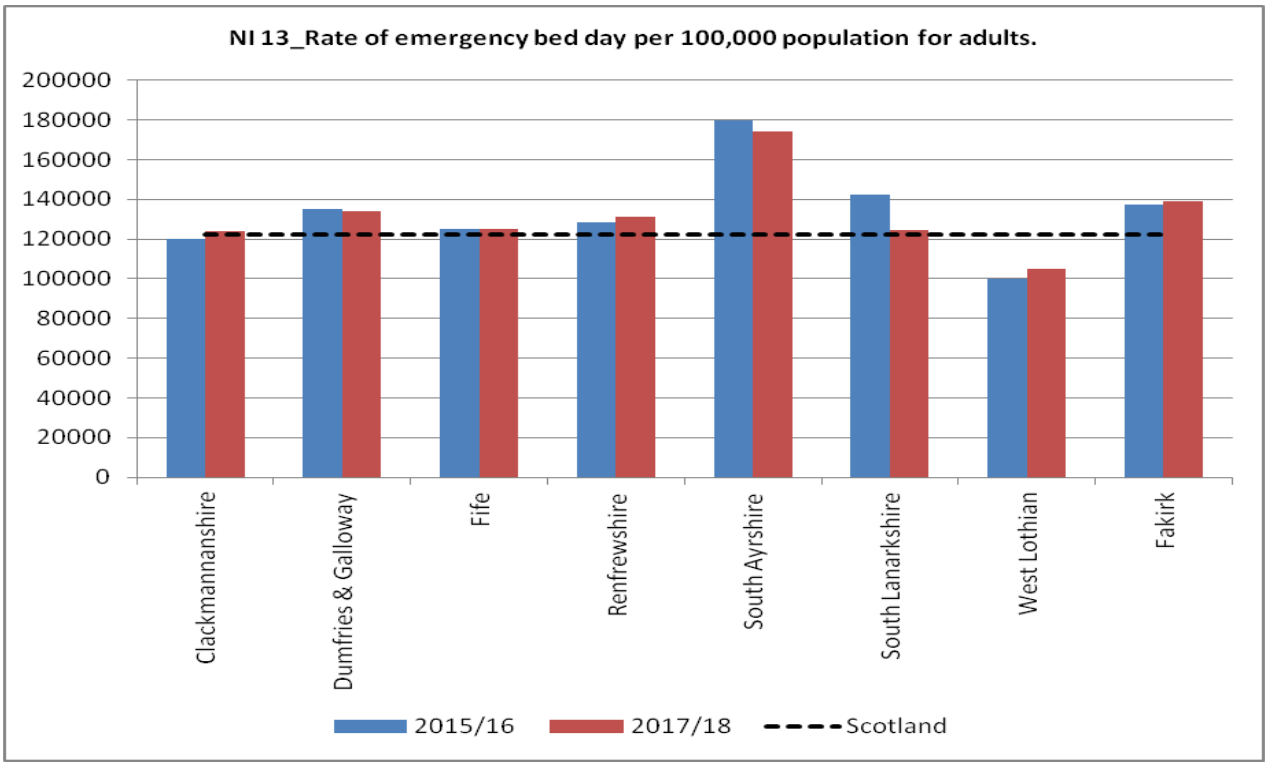
Hospitals also have a role to play, by streamlining their processes and sharing best practice to ensure more people can leave hospital quickly once they are well enough. This will include improving rehabilitation and also reducing the possibility of infections, harm and injury all of which can result in longer stays.

Definition and Position
Rate of emergency bed days per 100,000 population for adults. This will be based on SMR01 returns for acute hospitals, and SMR04 data for psychiatric hospitals.

Since the baseline year the Partnership rate of bed days has increased by 1.1%. However, during the 2016/17 bed days had risen to 146,301, (6% increase). Although bed days have increased since the baseline year they in fact reduced by 6.3% in the last 12 months.

A reduction in bed days is evident in the Scotland position and the peer average putting the Falkirk Partnership 13% above the national average and 6% above our peer group. The highest bed days rate is South Ayrshire with a rate of 174,305.1.

Chart 7_National Indicator 13 2015/16_2017/18



National Indicator 14 - Readmission to hospital within 28 days (per 1,000 population)	Outcome
Scotland position	102
Peer Group average	105
Falkirk HSCP	120

Rationale for Indicator

The readmission rate reflects several aspects of integrated health and care services - including discharge arrangements and co-ordination of follow up care underpinned by good communication between partners.

The 28 day follow-up was selected as this is the time that the initial support on leaving hospital, including medicines safety, could have a negative impact and result in readmission. A longer period of follow up would be more likely to include admissions that are unrelated to the initial one, whereas a shorter period (e.g. 7 days) is more likely to only pick up immediate issues linked to the hospital care.

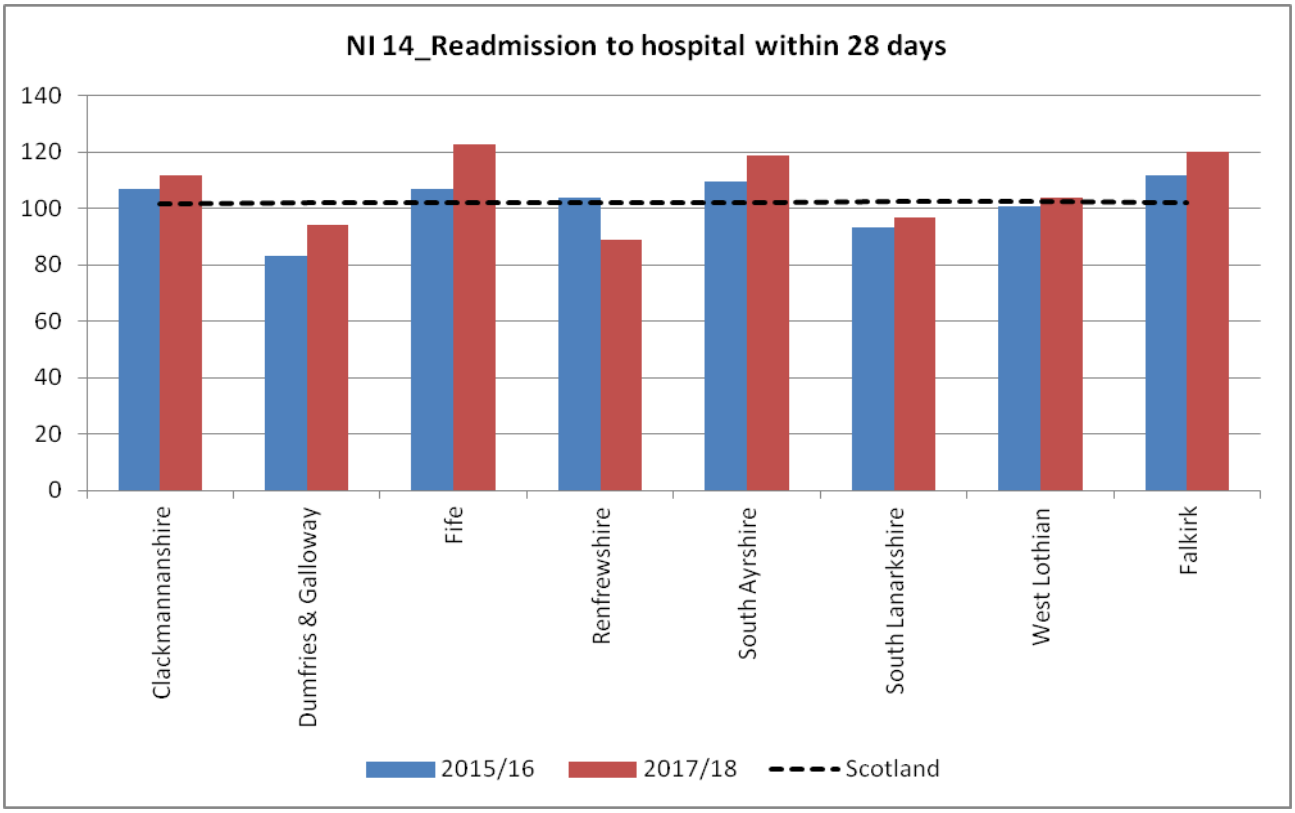
It will be important that Integration Authorities understand this data for their local area and identify any areas for improvement to support GP Practice efforts to improve on this.

Definition and Position

Based on the SMR01 acute hospital activity data, this rate is calculated from number of re-admissions to an acute hospital within 28 days of discharge per 1,000 population and not the population of Falkirk residents. The technical document states patients whose discharge type is death are excluded from the denominator. National results are not standardised by specialty or condition.

Nationally the rate of readmissions has increased by over 5% since 2015/16 from 97 to 102 per 1,000 population. The Falkirk Partnership has seen an increase of 7% in this timeframe from 112 to 120 which is 17.6% above the national average. The number of discharges in 2017/18 was 23,323 resulting in 2,790 emergency readmissions. Therefore 11% of all live discharges have returned on an emergency basis within 28 days. This is slightly down from 12% (Rate121) in 2016/17. Further work to establish reasons behind the increased rate of readmissions is underway.

Chart 8_National Indicator 14: 2015/16_2017/18



National Indicator 16 - Falls rate per 1,000 population aged 65+	Outcome
Scotland position	22
Peer Group average	21
Falkirk HSCP	22

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 which are being addressed by a national improvement programme.

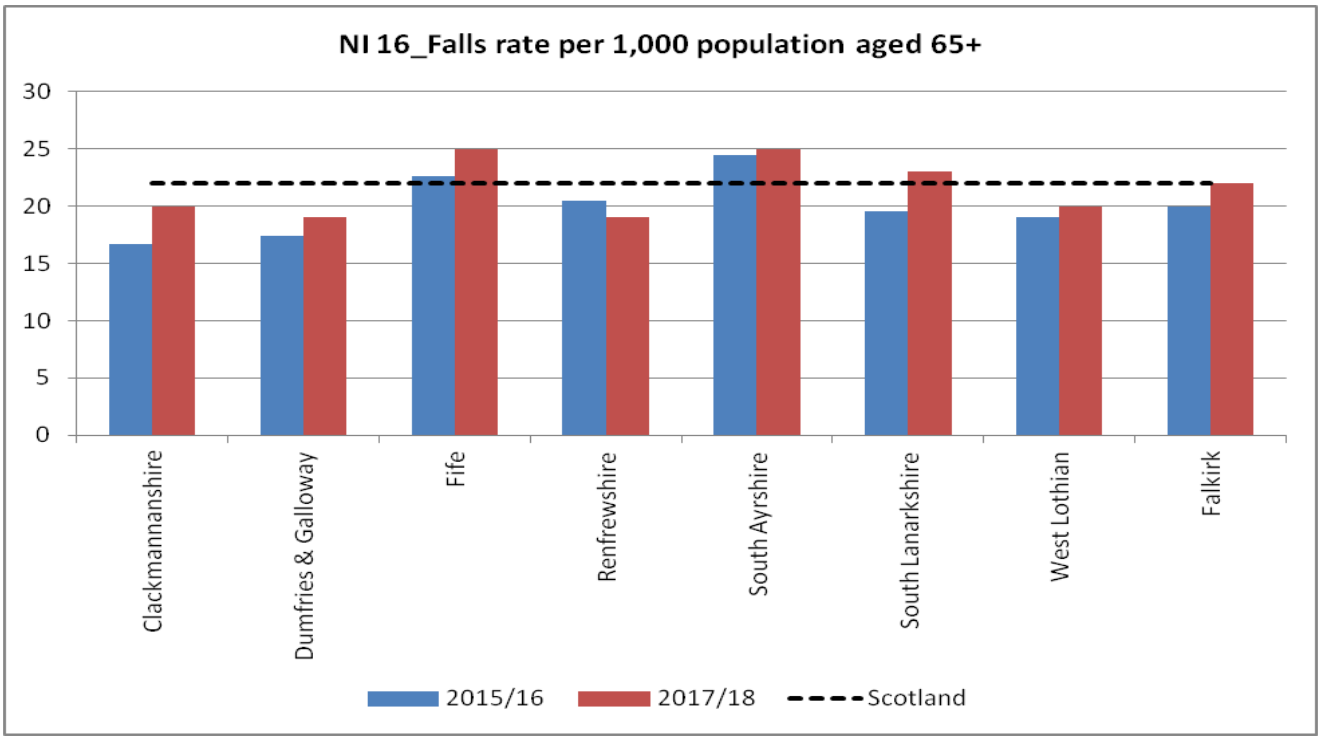
Falls can have a significant impact on an older person's independence and quality of life, impeding a person's mobility and confidence. However, falls are not an inevitable consequence of old age. Well-organised services, delivering recommended and evidence based practices can prevent many falls and fractures in older people in the community setting. Rehabilitation services are also key to preventing repeat falls. In addition, the safety of a person's immediate environment as well as their prescribed medicines will be important.

A recently published economic evaluation provided an estimate of the cost to health and social care services in Scotland of managing the consequences of falls: in excess of £470 million and without intervention is set to rise over the next decade as our population ages and the proportion with multi-morbidity and polypharmacy grows.

Definition and Position
The focus of this indicator is the number of falls that occur in the population (aged 65 plus). The indicator will be measured on the number of patients aged 65 plus who are discharged from hospital with an emergency admission code 33 - 35 and ICD10 codes W00 - W19.

The calculation has been based upon the midyear population estimate for 2017 for those aged 65 years plus, 29,530 of which 647 falls were recorded in 2017/18. This is a rate of 22 up from 20 in 2015/16. This is in keeping with the National average and the average of our peers. A detailed breakdown of Peer results against the Scotland position are charted below.

Chart 9_National Indicator 16: 2015/16_2017/18



2.5 Local Outcome: Service user experience

2.5.1 National Outcome 3: Positive experience and outcomes – National Indicators 3, 4, 5, 6

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	Outcome
Scotland position	76%
Peer Group average	79%
Falkirk HSCP	76%

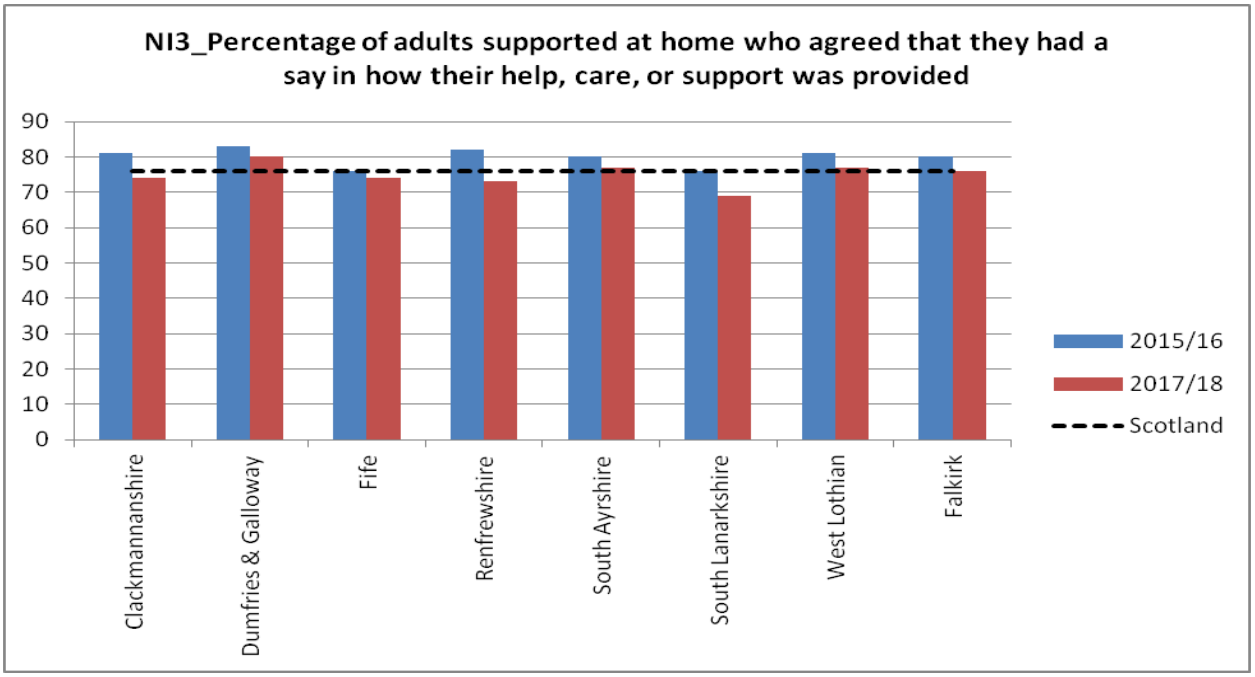
Rationale for Indicator

Choice and control over how their services are provided is very important to many people receiving care and support,. Ensuring that service users and carers have a say and feel involved in how their care is therefore important in the assessment and delivery of services. The increasing use of Self Directed Support should mean that more people feel that they have more control over the type of support they get.

Definition and Position

Based on agreement with the statement (Q36b) in the biennial Health and Care Experience Survey: "I had a say in how my help, care or support was provided". The number of people who agree or strongly agree divided by the total number answering. Seventy-six percent of the Partnership's residents answered favourably which mirrors the national position but it is a deterioration from the baseline year where the percentage was 80%. The Peer Group is relatively stable at 79% from 80% which puts it above the National average.

Chart 9_National Indicator 13 2015/16_2017/18



However, five local indicators provide more specific information on the experiences of service users and carers receiving support from Social Work Adult Services in the Falkirk Partnership area. These are reported routinely within IJB Performance Reports. Local indicator 60 shows that in the half year

ending September 2018, 98% of service users were satisfied with their involvement in the design of their care package. (IJB Performance Report 7th December 2018, page 8)

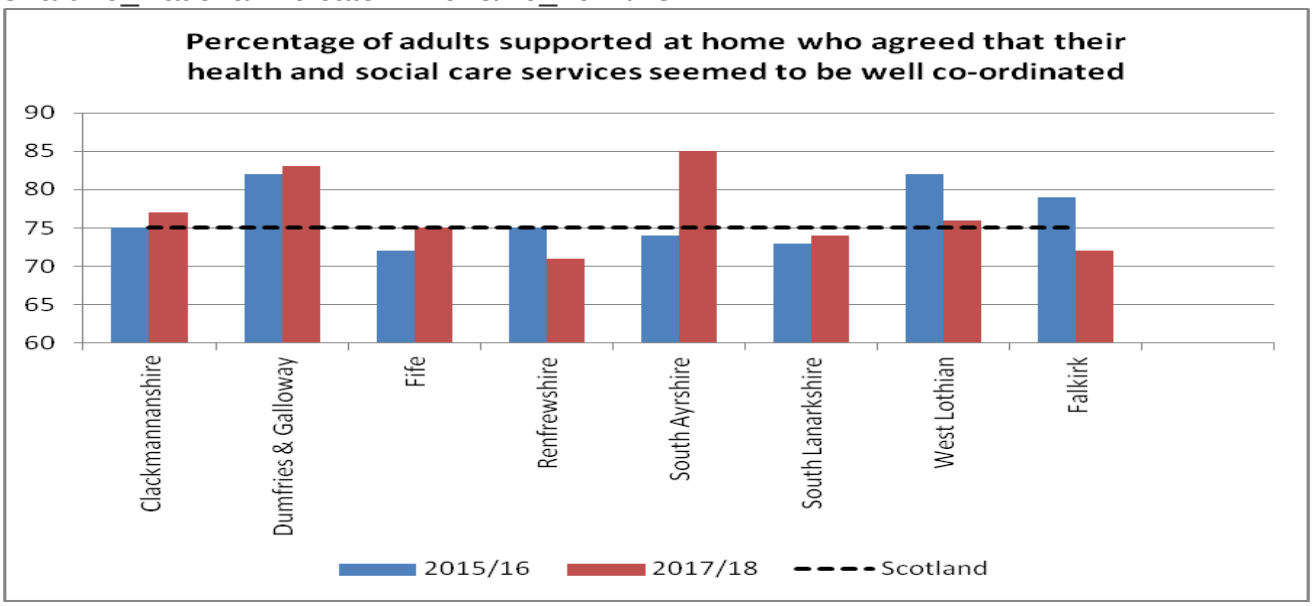
National Indicator 4 – Percentage of adults supported at home who agreed that their health and social care services seemed to be well co-ordinated	Outcome
Scotland position	74%
Peer Group average	77%
Falkirk HSCP	72%

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.

Definition and Position
Based on agreement with the statement (Q36e) in the biennial health and care experience survey: "My health and care services seemed to be well co-ordinated". The number of people who agree or strongly agree divided by the total number answering.

Results for the Partnership have declined from 79% in the baseline year to 72% in 2017-18. The Peer Group remains above the National average at 77%.

Chart 10_National Indicator 4 2015/16_2017/18



National Indicator 5 – Total % of adults receiving any care or support who rated it as excellent or good	Outcome
Scotland position	80%
Peer Group average	81%
Falkirk HSCP	81%

Rationale for Indicator

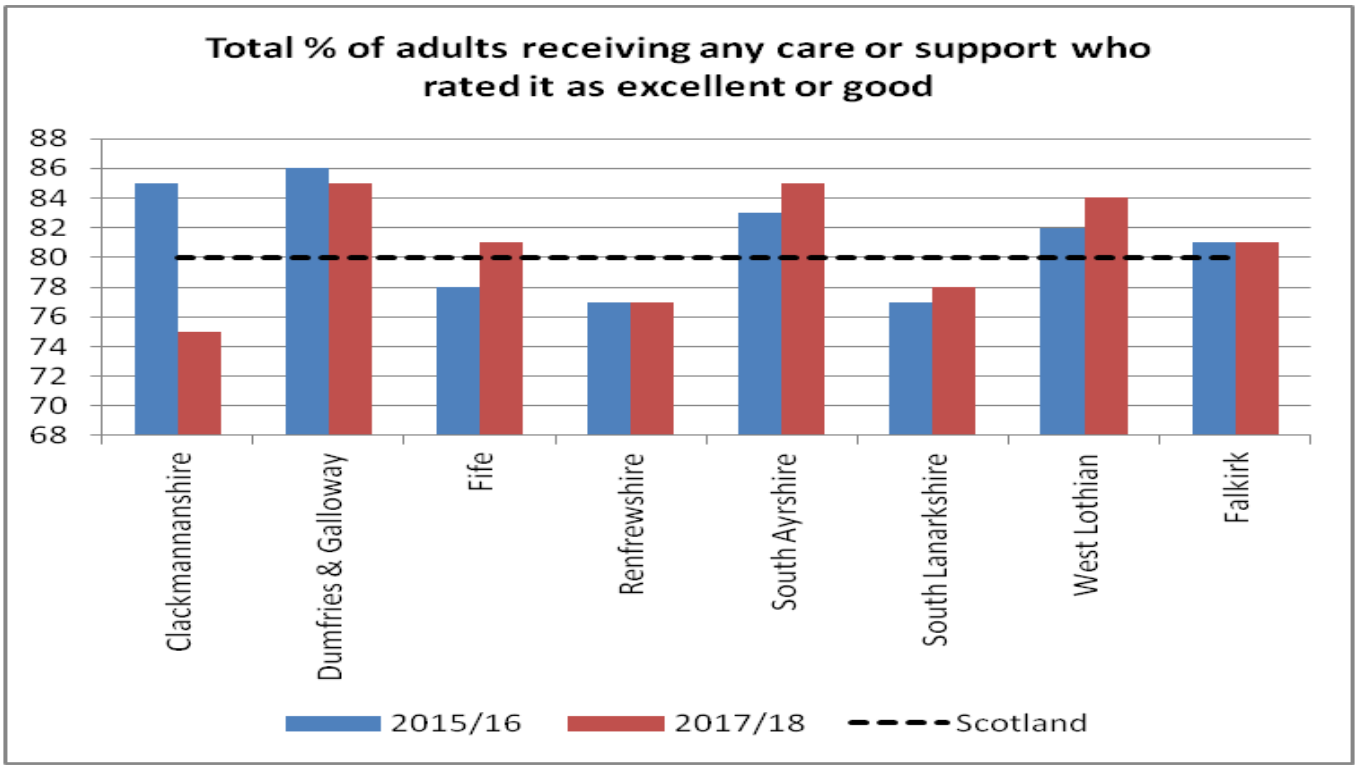
For people who use care and support services, their experience of those services should be positive and be continuously improving. This indicator is related to the indicator on co-ordination of care, as well as the indicator on impact of services on quality of life, but provides an overview of service quality from the patient/service user point of view - which will incorporate other factors about the service such as how well they were treated.

Definition and Position

Based on the question (Q37) in the biennial health and care experience survey: "Overall, how would you rate your help, care or support services?" The number of people answering excellent or good, divided by the total number answering the question.

Outcomes for the Partnership have remained static at 81% marginally above the national average of 80%. The Peer Group also remain static at 81% since the baseline year.

Chart 11 National Indicator 5 2015/16_2017/18

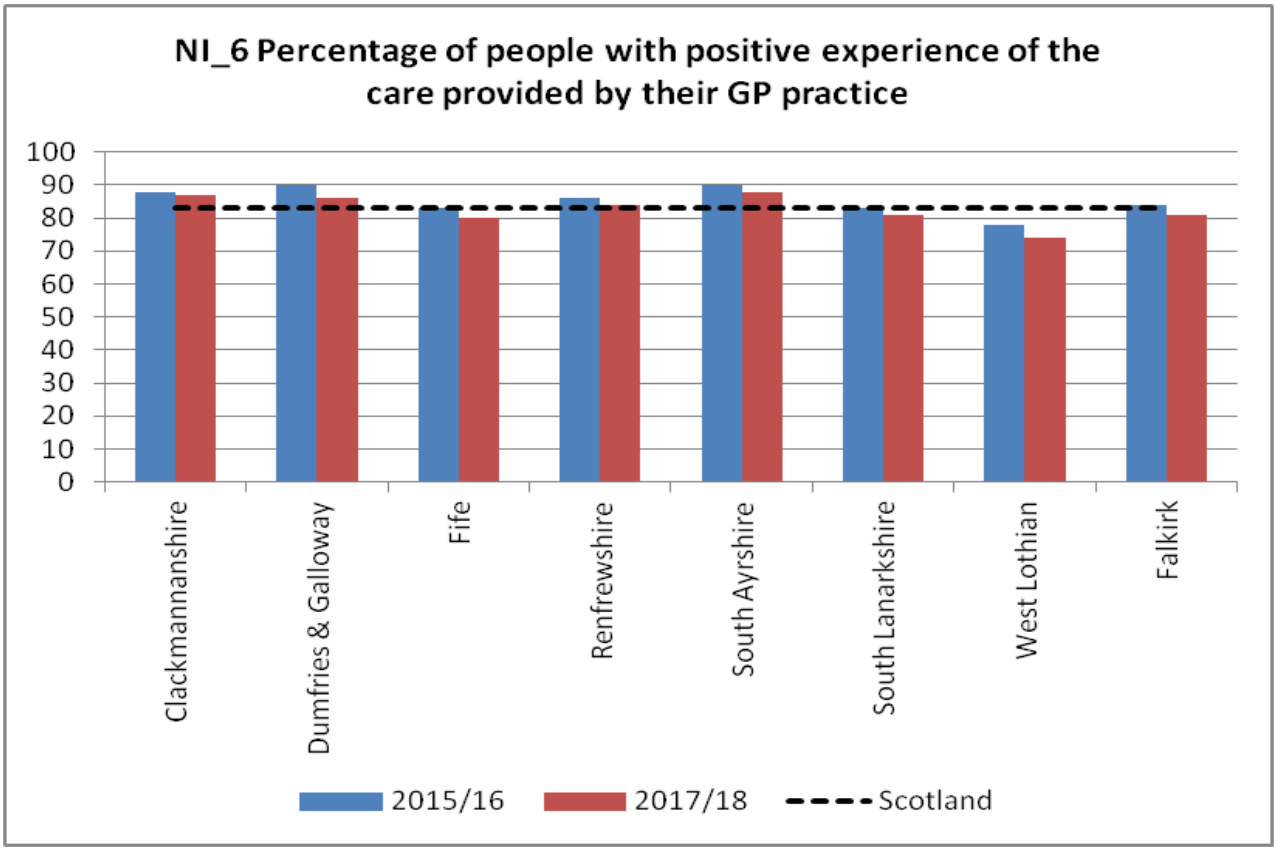


National Indicator 6 – Percentage of people with positive experience of the care provided by their GP practice	Outcome
Scotland position	83%
Peer Group average	83%
Falkirk HSCP	81%

Rationale for Indicator
GP services are central to health and care services so it is important that Integration Authorities work with GP practices to ensure they work with partners to contribute to patient outcomes.

Definition and Position
While GP practices will contribute to other indicators for example, co-ordination of care, overall rating of care and people's ability to look after their own health, GPs directly provide a wide range of care and treatment to a large proportion of the population. In Scotland 83% of patients rated their GP practice as good or excellent in 2017/18 compared with 84% in the baseline year. The Partnership stands at 81% down from 84% in 2015/16. The Peer Group has dropped to 83% from 86% over the same timeframe.

Chart 12 National Indicator 6 2015/16_2017/18



2.5.2 National Outcome 9: Resources are used effectively – National Indicators 19 and 20

National Indicator 19 – Number of days people spend in hospital when they are ready to be discharged (per 1,000 population)	Outcome
Scotland position	762
Peer Group average	709
Falkirk HSCP	910

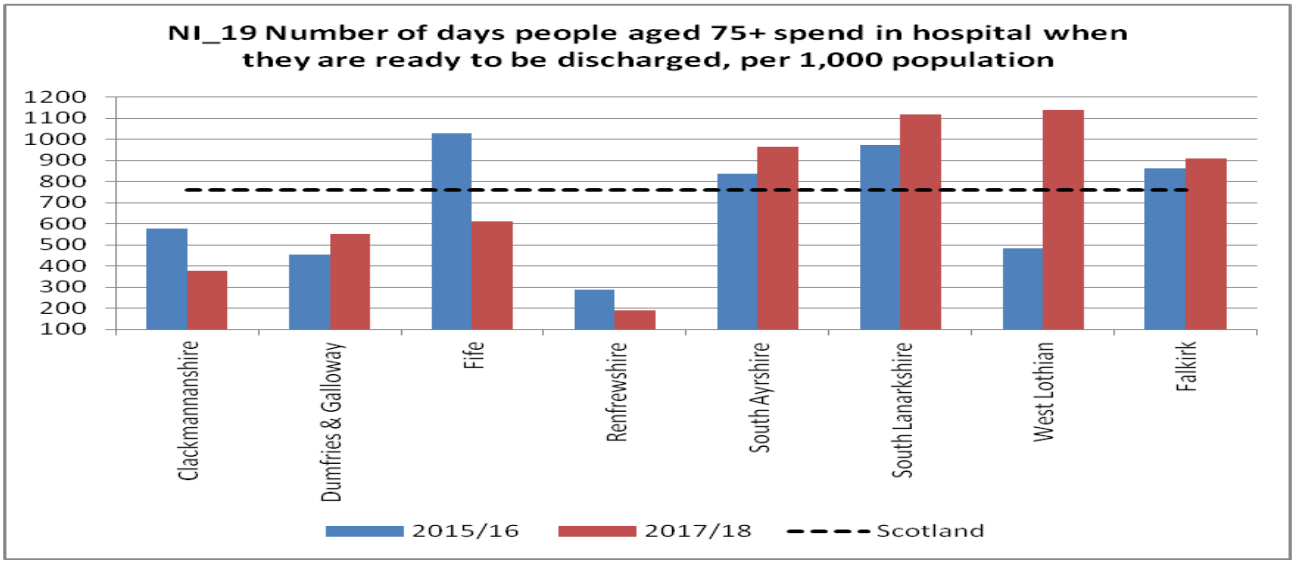
Rationale for Indicator
People should not have to wait unnecessarily for more appropriate care to be provided after treatment in hospital. Waiting unnecessarily in hospital is a poor outcome for the individual, is an ineffective use of scarce resource and potentially denies an NHS bed for someone else who might need it.

Older people admitted to hospital are more likely to be delayed there once their treatment is complete. This, in turn, can be bad for their health and independence. The indicator on its own however does not tell us about the outcomes, as people need to be discharged to an appropriate setting that is best for their reablement. Focusing on discharging patients quickly at the expense of this is not desirable, and improvements need to be achieved by better joint working and use of resources.

Definition and Position
The number of bed days due to delayed discharge that have been recorded for people resident within the Local Authority area, per 1,000 population in the area.

The proportion of bed days relating to patients within the partnership have increased by 5% since 2015/16 from 864 per 1,000 population to 910 in 2017-18. The overall Scotland position shows a decrease of 16% over this period. The Peer Group shows variable performance with 5 partnerships performance deteriorating and 3 improving, with an average decrease from 726 at the baseline to 709 in the last financial year. The allocation of change is shown in the chart below.

Chart 13 National Indicator 19 2015/16_2017/18



National Indicator 20 – Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency	Outcome
Scotland position	24%
Peer Group average	25%
Falkirk HSCP	25%

Rationale for Indicator

This indicator will provide an overall indication of the balance of care in each partnership area. Not all emergency (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. For people aged over 65, almost one third of spend (NHS and LA) in Scotland is on emergency hospital stays, and for the whole population the figure is 22%. It would be desirable to see this reducing over time.

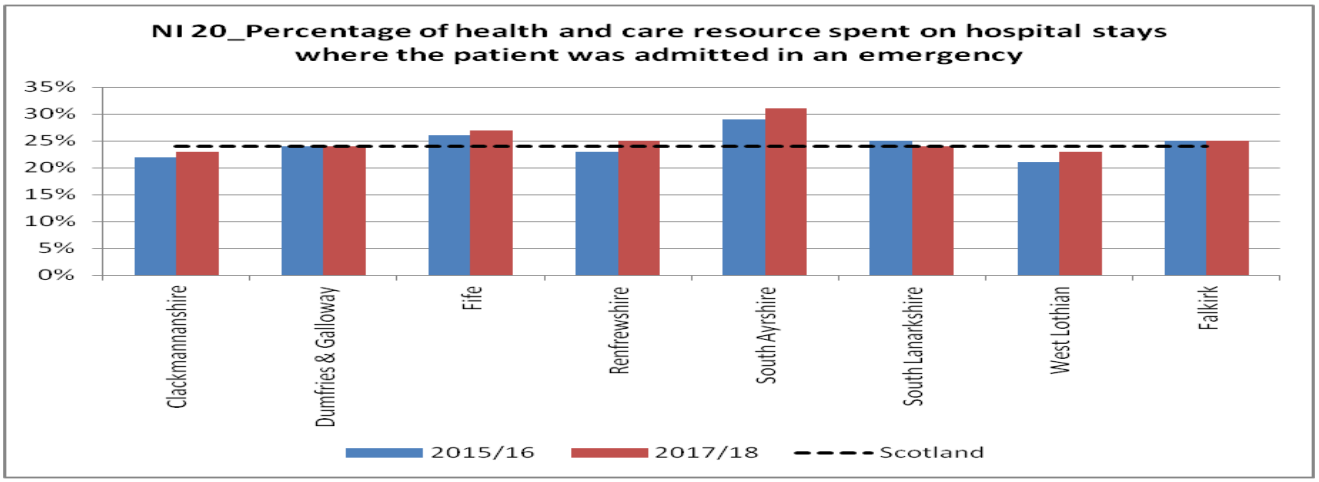
Health and Social Care Integration will allow the Integration Authorities, through the strategic plan, to commission changes in the health and social care pathway that will optimise (where appropriate) community based care. This is already happening in some places in Scotland, through for example intermediate care, anticipatory and preventative care. This ensures that emergency non elective resources (staff, beds, equipment) are used for those who need acute medical and trauma care.

Definition and Position

Emergency inpatient resource as a percentage of overall health and social care resource. The underlying data will be sourced from costed health activity data and social care aggregate data. ISD have linked all health activity and resource data that is currently available at individual level (around 70% of health expenditure). This data is available by age, by specialty, by location of care etc., so partnerships can understand emergency admissions for their population or a specific cohort.

According to ISD figures the total expenditure for the Falkirk Partnership in 2017/18 was £287,144,342, of which £72,195,894 was the cost of emergency bed days for adults. This equates to 25% of the total expenditure. The overall Scotland position is 24% as is that of our peers. South Ayrshire is most above the national average at 31%.

Chart 14



2.6 Local Outcome: Community based support

2.6.1 National Outcome 2: Independent living – National indicators 2, 15 and 18

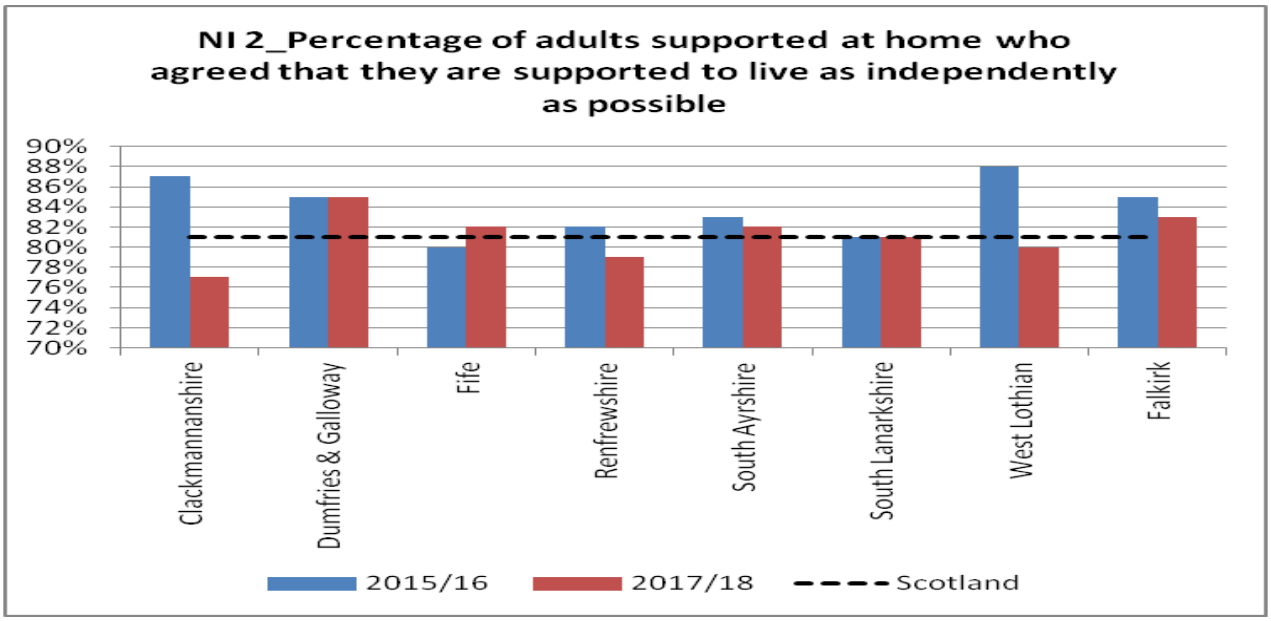
National Indicator 2 – Percentage of adults supported at home who agreed that they are supported to live as independently as possible	Outcome
Scotland position	81%
Peer Group average	81%
Falkirk HSCP	83%

Rationale for Indicator
This indicator reflects whether people who need support feel that it helps them maintain their independence as much as possible. Integration Authorities will need to provide community based services that focus on enablement, prevention and anticipatory care that mitigate increasing dependence on care and support. Housing services also have a critical role in delivering on this outcome, and there will be links to other areas such as transport. Health and social care services will need to work with partners and with communities to support social connectedness.

Definition and Position
Based on agreement with the statement (Q36f) in the biennial health and care experience survey: "I was supported to live as independently as possible". The number of people who agree or strongly agree divided by the total number answering.

In Scotland overall, 81% of people agreed that they felt supported to live as independently as possible. This position of is reflected across the average for the Peer Group with Falkirk residents answering slightly more favorably at 83%.

Chart 15 National Indicator 2 2015/16_2017/18



National Indicator 15 – Proportion of last 6 months of life spent at home or in a community setting	Outcome
Scotland position	88%
Peer Group average	88%
Falkirk HSCP	87%

Rationale for Indicator

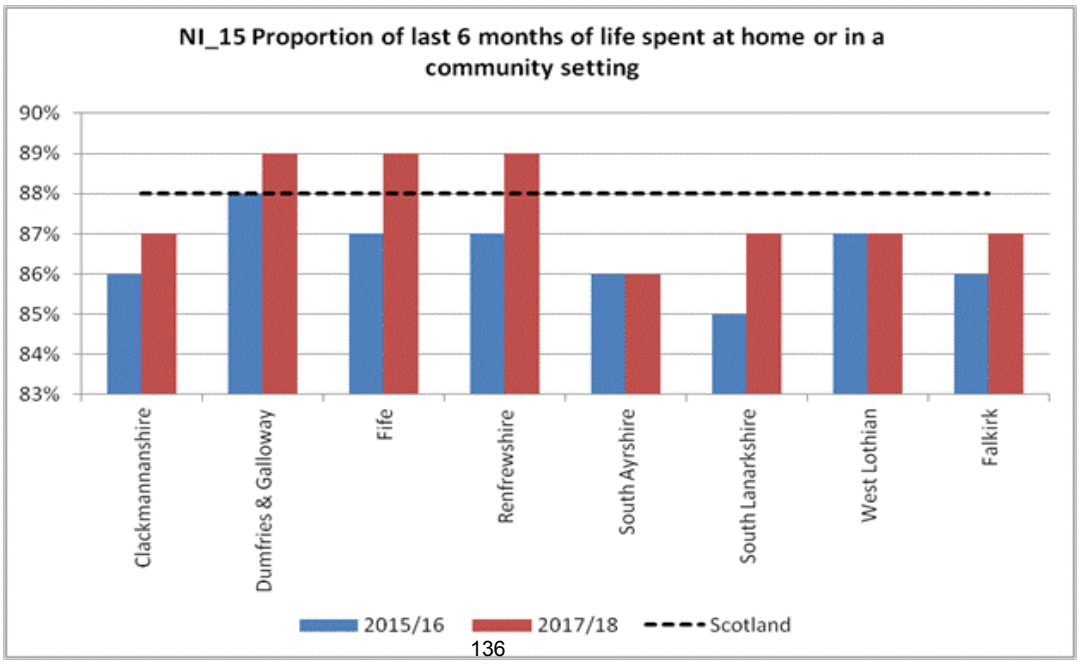
It is now possible to predict the progress of many diseases, enabling a planned approach to palliative and end of life care in ways which reflect best practice and which, as far as is practicable, in accordance with the needs and wishes of patients, carers and their families. Integration Authorities will be able to influence this by commissioning high quality end of life services, and working with communities, families and staff to enable discussion about planning for end of life. As more people have anticipatory care plans and as electronic palliative care summaries are rolled out throughout the country, then we should see a gradual increase in this measure in the medium to long term. The indicator should ideally represent the wishes and choices for patients and their carers and also demonstrate the effectiveness of having a planned approach to end of life care. For an individual, the preferred place of care can change as their condition and/or family circumstances change over time, making this very difficult to measure and track. Therefore this indicator has been chosen as an alternative. The last six months of life was chosen as this is the period when most hospital admissions occur, and the period when clinicians would tend to plan end life care if the patient was not expected to live longer than 6 months.

Definition and Position

This indicator measures the percentage of time spent by people in the last 6 months of life at home or in a community setting. It is derived by linking recorded deaths data with acute hospital bed day data to calculate the percentage of time spent outside acute hospitals in the 6 months at the end of people's lives. Accidental deaths are excluded.

The overall Scotland figure has remained fairly static since the baseline year, increasing from 87% in 2015-16 to 88% in 2017-18. This is similar to the Partnership which increased from 86% to 87% over the same period, which is the same outcome for the Peer Group. The most significant rise from individual group is 2% demonstrating a fairly even picture.

Chart 15 _National Indicator 15 2015/16_2017/18



National Indicator 18 – The number of adults (18+) receiving personal care at home or direct payments for personal care, as a percentage of the total number of adults needing care. - data available up to 2016/17	Outcome
Scotland position	61%
Peer Group average	63%
Falkirk HSCP	63%

Rationale for Indicator

People generally prefer to stay at home for as long as possible. But there is also significant evidence that this helps them remain more independent for longer. This makes it a priority to ensure that home care and support for people is available, particularly those with high levels of care needs. As the population ages, and the number of people with complex care needs increases, the need to provide appropriate care and support becomes even more important.

This can be achieved through moving services closer to people's own homes, developing more joined up home care services and ensuring that people have their needs for care properly assessed through, for example, single shared assessments. Jointly commissioned flexible care will become increasingly important through the integration of health and social care.

Definition and Position

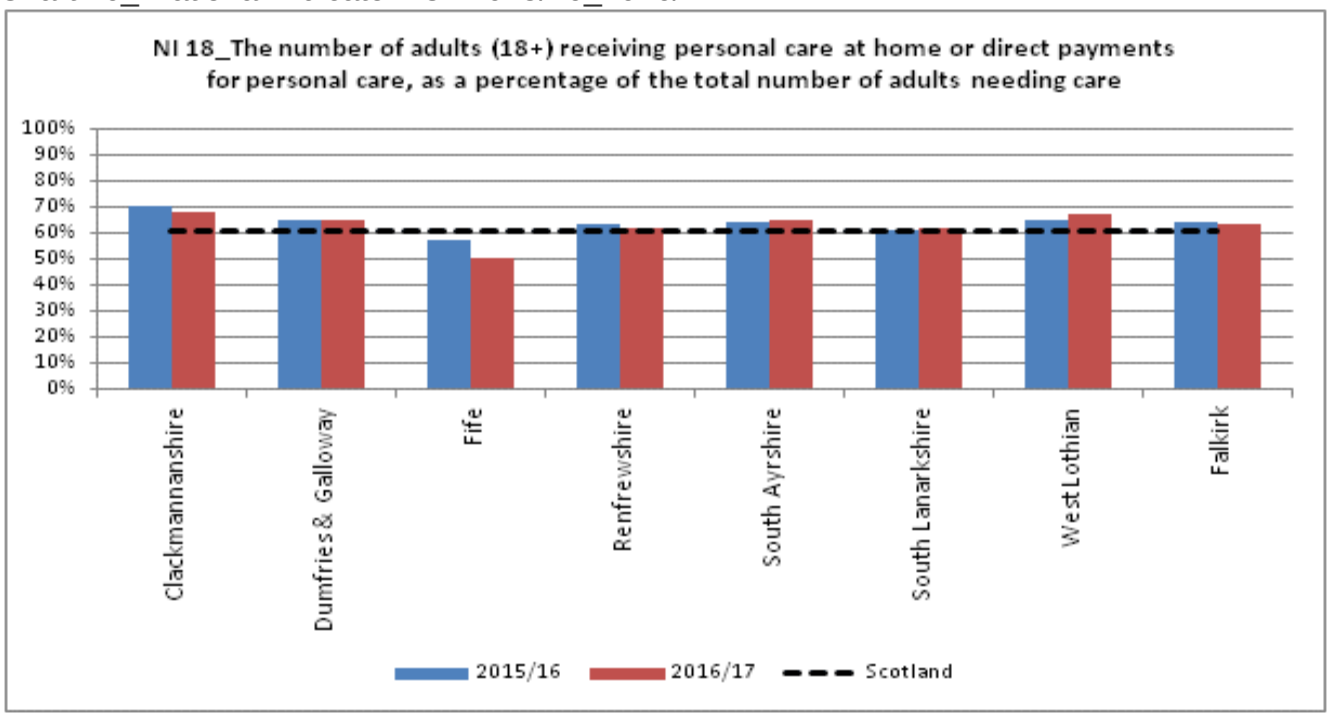
The number of adults (18+) receiving personal care at home or direct payments for personal care, as a percentage of the total number of adults needing care. The picture for this indicator shows around 60% for all three organisation groupings. Only 2016/17 data is reported for this indicator, and 63% of adults 18 years plus were in receipt of personal care as a percentage of the total number of adults needing care in Falkirk and in the Peer Group, compared to 61% in Scotland. More recent data was submitted to the Scottish Government for the period ending March 2018, but this has not yet been published.

This indicator has been changed by ISD/Scottish Government since it was last reported as the 'balance of care' indicator. It was previously based on the ratio between three services:

1. the number of people aged 65+ receiving more than 10 hours home care per week (ie. People aged 65+ receiving *intensive* home care;
2. the number of people in care homes; and
3. the number of people in NHS continuing care beds.

The ratio was calculated based on the proportion of 1 above, as a proportion of the total of services 1, 2 and 3 above. The numerator has now changed from 'service users aged 65+ receiving 10+ hours of home care' to: '*the number of adults aged 18+ receiving personal care or direct payments for personal care, as a % of the total number of people receiving services*' 1 to 3 above. This is clearly a very different group and results in a different number and ratio from previously published data. It is not clear whether the new indicator provides a useful measure of the balance of care.

Chart 16_ National Indicator 18: 2015/16_2016/17



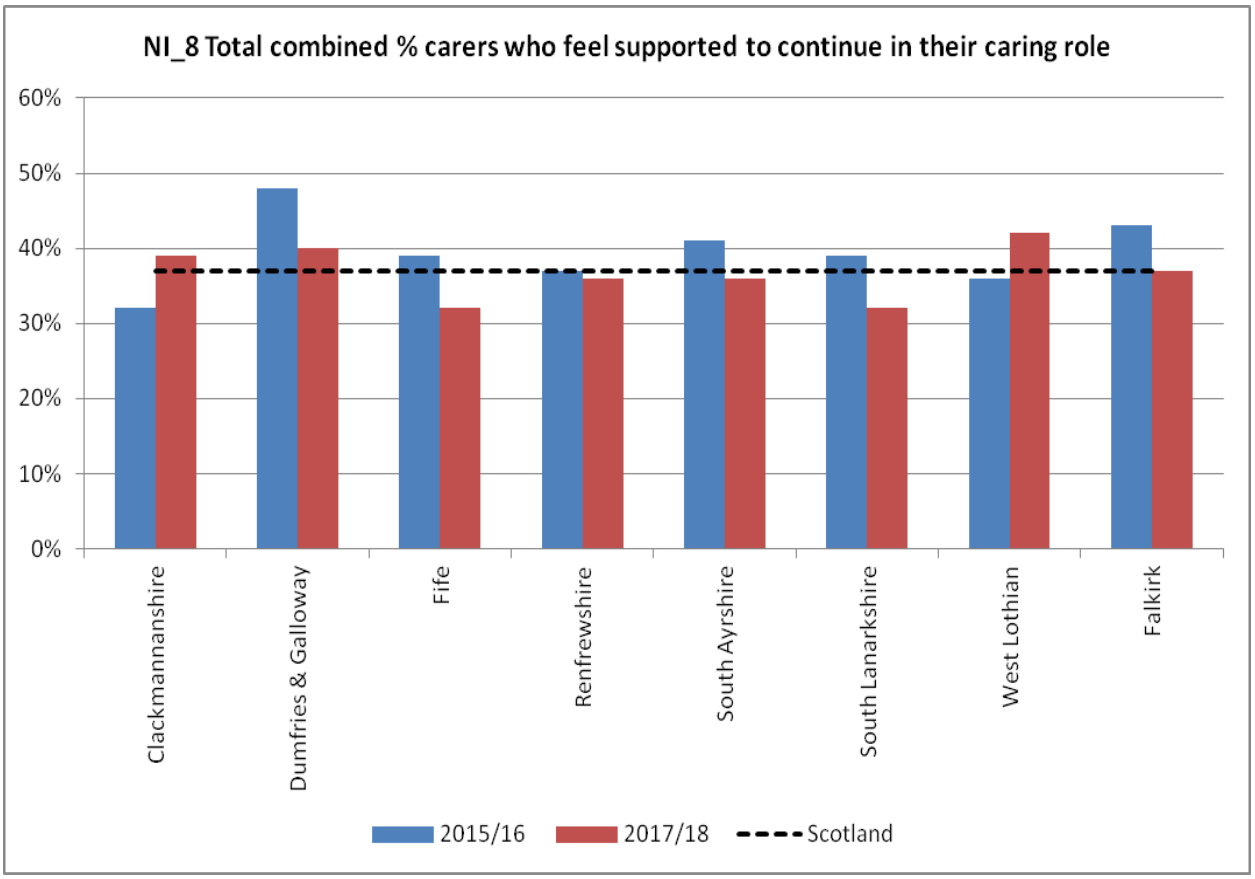
2.6.2 National Outcome 6: Carers are supported – National indicator 8

National Indicator 8 – Total combined % carers who feel supported to continue in their caring role	Outcome
Scotland position	37%
Peer Group average	37%
Falkirk HSCP	37%

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.

Definition and Position
Based on the agreement with the statement (Q45f) in the biennial health and care experience survey: "I feel supported to continue caring". The number of people who agree or strongly agree divided by the total number answering. Overall the percentage of carers who agree they feel supported is 37%. The Partnership position for 2017/18 is 37%. The Peer Group average is also 37%, however results range from 32% in Fife to 42% in West Lothian.

Chart 17_National Indicator 2015/16_2017/18



However, the profile shown above is based on a sample of the general population and shows a much lower figure compared to the local data on carers receiving assessment from Social Work Adult Services in the Falkirk partnership. Two local indicators provide more specific and recent information on the experiences of carers known to Social Work Adult Services. Local indicator 63 shows that in the half year ending September 2018, 92% of carers who received an assessment/review were recorded as feeling supported and capable to continue in their role as a carer OR felt able to continue with additional support. Local indicator 62 also shows that in the same period, 92% of carers were satisfied with their involvement in the design of the care package of the person they support. These indicators are reported routinely within IJB Performance Reports. (IJB Performance Report 7th December, 2018, page 8)

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

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

Partnership Indicators

SELF MANAGEMENT	Freq	*AUTONOMY & DECISION MAKING*	Freq	*SAFETY*	Freq	*SERVICE USER EXPERIENCE*	Freq	*COMMUNITY BASED SUPPORT*	Freq
24. Emergency department 4 hour wait Forth Valley	M	28. Emergency admission rate per 100,000 Forth Valley population	M	42. Readmission rate within 28 days per 1000 FV population	M	54. Standard delayed discharges	M	67. The total respite weeks provided to older people aged 65+. Annual indicator	Y
25. Emergency department 4 hour wait Falkirk	M	29. Emergency admission rate per 100,000 Falkirk population	M	43. Readmission rate within 28 days per 1000 Falkirk population	M	55. Delayed discharges over 2 weeks	M	68. The total respite weeks provided to older people aged 18-64. Annual indicator	Y
26. Emergency department attendances per 100,000 Forth Valley Population	M	30. Acute emergency bed days per 1000 Forth Valley population	M	44. Readmission rate within 28 days per 1000 Falkirk population 75+	M	56. Bed days occupied by delayed discharges	M	69. Number of people aged 65+ receiving homecare	Q
27. Emergency department attendances per 100,000 Falkirk	M	31. Acute emergency bed days per 1000 Falkirk population	M	45. Number of Adult Protection Referrals (data only)	Q	57. Number of code 9 delays	M	70. Number of homecare hours for people aged 65+	Q
		32. Number of patients with an Anticipatory Care Plan in Forth Valley	M	46. Number of Adult Protection Investigations (data only)	Q	58. Number of code 100 delays	M	71. Rate of homecare hours per 1000 population aged 65+	Q
		33. Number of patients with an Anticipatory Care Plan in Falkirk	M	47. Number of Adult Protection Support Plans (data only)	Q	59. Delays - including Code 9 and Guardianship	M	72. Number receiving 10+ hrs of home care	Q
		34. Key Information Summary (KIS) as a percentage of the Board area list size Forth Valley	M	48. The total number of people with community alarms at end of the period	Q	60. Percentage of service users satisfied with their involvement in the design of their care package		73. The proportion of Home Care service users aged 65+ receiving personal care	Q
		35. Key Information Summary (KIS) as a percentage of the Board area list size Falkirk	M	49. Percentage of community care service users feeling safe		61. Percentage of service users satisfied with opportunities for social interaction		74.	
		36. Long term conditions - bed days per 100,000 population	M	50. Number of new Telecare service users 65+	Q	62. Percentage of carers satisfied with their involvement in the design of care package		75.	
		37. SDS Option 1: Direct payments		51. Rate per 1,000 Acute Occupied Bed Days attributed to Staphylococcus aureus bacteraemias (SABs)	M	63. Percentage of carers who feel supported and capable to continue in their role as a carer OR feel able to continue with additional support		76.	
		38. SDS Option 2: Directing the available resource		52. Rate per 1,000 Bed Days attributed to Device Associated Infections	M	64. The proportion of Social Work Adult Services (Stage 1 & 2) complaints completed within 20 days		77.	
		39. SDS Option 3: Local Authority arranged		53. Rate per 1,000 Bed Days in the 65+age group attributed to Clostridium Difficile	M	65. The proportion of social work (Completed Stage 1 & 2) complaints upheld		78.	
		40. SDS Option 4: Mix of options, 1,2,3				66. Sickness Absence in Social Work Adult Services (target – 5.5%)		79. The number of people who had a community care assessment or review completed	
		41.						80. The number of Carers' Assessments carried out	
								81. The number of overdue 'OT' pending assessments at end of the period	
								82. Proportion of last 6 months of life spent at home or community setting	
								83. Number of days by setting during the last six months of life: Community	

Glossary

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

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

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

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

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

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

- **HAI -** Healthcare Acquired Infections

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

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

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

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

- **SAS** – Scottish Ambulance Service

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

- **SPSO** - The **Scottish Public Services Ombudsman (SPSO)** is the final stage for complaints about councils, the National Health Service, housing associations, colleges and universities, prisons, most water providers, the Scottish Government and its agencies and departments and most Scottish authorities.

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

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