Agenda Item: 11

Falkirk
Health and Social Care
Partnership

Title/Subject: **Performance Report**

Meeting: **Integration Joint Board**

Date: **16th June 2017**

Submitted By: **Head of Performance and Governance, NHS Forth Valley**

Action: **For Noting**

1. INTRODUCTION

1.1 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.

2. RECOMMENDATION

The Integration Joint Board is asked to:

2.1 Note the content of the performance report to the IJB

2.2 Note the exceptions highlighted and that appropriate action will be taken forward by the relevant NHS General Managers, in conjunction with the Chief Officer.

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 and relevant targets and measures included in the Integration Functions, and as set out in the Strategic Plan. In November 2016 the IJB received a full update on the partnership's position against the National Health and Wellbeing Outcomes, measured by the National Core Integration Indicators. As reported, the data sources can data over long periods of time and are therefore not as timeous as data collected more routinely. A year end position against the National Outcomes and National Core Integration Indicators will be presented in the Partnership Annual Report with work underway in this regard.

3.2 The Report in April was not considered by the Board with a request made for feedback on format and content. Unfortunately no comments were received and the format has been rolled forward into the June report. It is acknowledged that as there are new

members on the IJB some dedicated time around the performance agenda may be required.

3.3 This report focuses on partnership indicators linked to the outcomes of the Strategic Plan. Further work has been undertaken to refine the partnership indicators which are detailed within the Strategy Map in Appendix 1.

3.4 Since the last paper was presented to the Board, the Performance Management Workstream has continued to oversee progress across a variety of areas requiring consideration in terms of performance management and reporting. As the approach to performance management matures within the partnership, it is anticipated that focus will be given to the outputs of both the logic modeling exercise and whole system mapping to begin to reflect progress towards the desired outcomes. Work will be undertaken over the summer to take this forward and link this to core data already provided.

3.5 Initial discussions have taken place with the Director of Public Health, NHS Forth Valley, in respect of the inclusion of Health Improvement indicators supporting the Local Outcome of Self Management, with linkage to the Strategic Plan and the work of the Community Planning Partnership. A number of topic areas were proposed in the first instance including Smoking Prevalence, Pharmacy First, Respiratory Long Term Conditions and Patient Activation which describes the knowledge, skills and confidence a person has in managing their own health and health care. Work is required to further develop this for inclusion in the Strategy Map and reporting to the IJB.

4. APPROACH

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

4.2 The content of this report mainly focuses on indicators around capacity across the system including delayed discharges, with some measures of experience. Of note is the information provided around unscheduled care. As previously highlighted to the IJB, the Partnership submitted an Improvement Plan to the Scottish Government subsequent to the request made by the Ministerial Strategic Group for Health and Community Care (MSG) in a letter received by the Chief Officer on 19 January 2017. The next step is to submit trajectories based on the indictors noted below. Work is underway to agree trajectories, with the recently established Unscheduled Care Programme Board (USCPB) overseeing the approach. This is chaired by the Medical Director, NHS Forth Valley, with the group maintaining a system wide remit.

Indicators included:

- Unplanned admissions
- Occupied bed days for unscheduled care

- A&E performance
- Delayed Discharges
- End of Life care
- Balance of care spend

Within this report there is a detailed breakdown for a number of indicators based of varying age ranges, excluding children. All data have been reconciled with ISD publications. Information presented around ED performance (and attendance), emergency (unplanned) admissions, occupied bed days, and delayed discharges all indicate either a decline or variability in performance over a period of time. This will require consideration when setting trajectories and also agreement on targeted action across the area.

5. PERFORMANCE REPORT STRUCTURE

5.1 Section 1 of this report considers key exceptions for further focus. Section 2 provides a performance overview of key performance in respect of some local partnership indicators noting a RAG status where appropriate. Section 3 - Summary of Key Performance provides detail, where relevant, of the partnership action around improvement. These are grouped under the five local outcome headings identified by the Falkirk partnership as described above.

5.2 The 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.

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.

7. CONCLUSION

7. 1 The Integration Joint Board is responsible for effective monitoring and reporting on the delivery of services and relevant targets and measures included in the Integration Functions, and as set out in the Strategic Plan. This report represents the process in terms of presenting a formal performance report to the Board.

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

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

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

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

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

Approved for Submission by: Elaine Vanhegan, Head of Performance and Governance

Author – Elaine Vanhegan, Head of Performance and Governance
Date: 6 June 2017

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

SECTION 1 – Summary Exceptions

Local Outcome	Indicators	Comment
Self Management - *Of health, care and wellbeing*	- Emergency Dept (ED) 4 hour wait	- The in month position reported at April 2016 to 2017 indicates there has been deterioration in the ED 4 hour wait for patients in the Local Authority area. April and May 2017 have been particularly challenging locally.
	- Emergency Dept attendances per 100,000 over 20-64yrs, 65-74yrs, 75-84yrs and 85+yrs	- The in month April 2017 position shows deterioration in position in all groups with the exception of the 75-84 years age group. - However, the rate per 100,000 populations over the 2016/17 indicates a rise in the average monthly attendance rate in all age groups circa 2% with the exception of 1.7% reduction in patients aged 20-64. - Attendance rates per 100,000 in Falkirk for each age group exceed the Forth Valley monthly average over 2016/17. - The average takes into account seasonal variation.

Local Outcome	Indicators	Comment
Autonomy & Decision Making - *Where formal support is needed people can exercise control over choices.*	- Emergency Admission per 100,000 population 20-64yrs, 65-74yrs, 75-84yrs and 85+yrs	- The in month positions reported at April over the past 3 years depict a reduction in the average emergency admissions in age groups 20-64 and 65-74. An increase is evident for those aged 75+. This is in keeping with the monthly averages taken over 2015/16 and 2016/17.
	- Acute emergency bed days per 1,000 population 20-64yrs, 65- 74yrs, 75-84yrs and 85+yrs	- Acute Emergency Bed Days rates per 1000 population are based upon a rolling 12 month position. - February 2017 data reflects an increase in Acute Emergency Bed Days of 7.3% from February 2015. - The most significant rise of 4.7% occurs within the 85 years and over age range. Based upon an average from February 2015/16 to February 2016/17.
	- Long term condition admission	- Figures for those with specific Long Term conditions have risen – reflecting the national picture.
	- Number of Anticipatory Care Plans/Key	- The number of patients with an ACP has increased with further work required on

	Information Summaries - Self Directed Support (SDS)	the full impact of this and how Key Information Summaries are used - The breakdown of self-directed support choices made by service users and the number and percentages who have not had an SDS assessment or review are shown. As the figures are based on individual service user choices they are shown as data only indicators. However, it is worth noting that progress is being made as the proportion of service users without SDS options recorded is declining.

Local Outcome	Indicators	Comment
Safety - *Health and Social care support systems keep people safe and live well for longer*	- Hospital readmissions aged 75+	- The criteria for readmissions in this instance is standardised by Specialty in those aged 75+ years. The population is the population of Falkirk residents aged 75+. The in month positions reported at April over the past 3 years show an increasing performance and data indicates overall an improving trend. - Work to review readmission data, linking this to Anticipatory Care Plans and Long Term Conditions is underway.

Local Outcome	Indicators	Comment
Service User Experience - *People have a fair and positive experience of health and social care*	- Delayed Discharges	- In April 2017 there were 38 delays including Guardianship and Codes 9 delays with 14 delays over the 14 Day target of zero - Pressure remains in terms of Occupied Bed Days however the April 2016 to April 2017 shows an improving trend.
	- Percentage of carers who feel supported and capable to continue in their role as a carer OR feel able to continue with additional support	- There was a decline of 8% in the proportion of carers who feel supported in their caring role or who feel able to continue with additional support. Work is underway to review this position.
	- SW Adult Services Complaints	- Performance declined by 12.6% below the 70% target in 2016/17, but the overall number of complaints declined and small numbers can skew the position.
	- SW Adult Services Sickness Absence	- Sickness absence is almost 2.5% higher than the 5.5% Council target for Social Work Adult Services.

Local Outcome	Indicators	Comment
Community Based support - *To live well for longer at home or in homely setting*	- The total respite weeks provided to older people aged 65+ (Annual indicator)	- There was a 7% reduction in respite weeks provided in 2015-16 from the previous year, as reported in the February IJB report. There is an altered pattern of service provision with more alternatives in place. Work continues in partnership to ensure there is appropriate support is provided.
	- Rehab at Home users who attained independence, and Crisis Care service users who are retained in the community,	- These indicators are noted as green however to ensure that people are supported to remain independent at home it is a partnership priority to ensure that home care and support for people is available, particularly those with high levels of care needs.
	- Telecare service users	- The number of new Telecare service users aged 65+ declined by 27 (26%) from 2015-16.
	- The number of people who had a community care assessment or review completed	- The number of people who had a community care assessment/review completed in 2016-17 reduced by 6.7% from the previous year.
	- Carers' assessments	- The number of carers' assessments recorded has declined by 16% since 2015-16.
	- Provision of new adaptations	- There was a 9% decline in the provision of new adaptations in 2015/16.
	- Overdue pending OT Assessments	- The number of overdue OT assessments has reduced by just over 10% since March 2016.
	- Proportion of last 6 months of life spent at home and bed days in last six months of life	- The percentage of the last six months of life spent at home is noted as static however the number of bed days in the last six months have increased.

SECTION 2 - Overview

KEY:

Direction of travel: relates to comparative position	
▲	Improvement in period
◄►	Position maintained
▼	Deterioration in period
–	No comparative data

H1 = Half year ending 30th September 2016
H2 = Half year ending 31st March 2017
Q3 = Quarter ending 31st December 2016

Falkirk Health and Social Care - Partnership Indicator Performance (April 2017)

Local Outcomes	Partnership Indicator	RAG Falkirk		
1. Self Management of Health, Care & Wellbeing	1. Emergency department 4 hour wait	**April 2015**	**April 2016**	**April 2017**
		93.6%	**95.3%**	**90.6%▼**
	2. Emergency department attendances per 100,000 population 20-64 years	**April 2015**	**April 2016**	**April 2017**
		1,959	**1,971**	**2,079▼**
	3. Emergency department attendances per 100,000 population 65-74 years	**April 2015**	**April 2016**	**April 2017**
		923	**1,773**	**2,002▼**
	4. Emergency department attendances per 100,000 population 75-84 years	**April 2015**	**April 2016**	**April 2017**
		2,955	**2,505**	**2,473▲**
	5. Emergency department attendances per 100,000 population 85+ years	**April 2015**	**April 2016**	**April 2017**
		3,667	**3,667**	**4,349▼**

Local Outcomes	Partnership Indicator	RAG Falkirk	
2. Autonomy & Decision Making Where formal support is needed people can exercise control over choice	6. Emergency admission rate per 100,000 population 20-64 years	**April 2016**	**April 2017**
		748.9	**740.6 ▲**
	7. Emergency admission rate per 100,000 population 65-74 years	**April 2016**	**April 2017**
		1,593	**1,388 ▲**
	8. Emergency admission rate per 100,000 population 75-84 years	**April 2016**	**April 2017**
		2,847	**2,516 ▲**
	9. Emergency admission rate per 100,000 population 85+ years	**April 2016**	**April 2017**
		4,738	**4,901 ▼**
	10. Acute emergency bed days per 1000 population 20-64 years	**Feb 2016**	**Feb 2017**
		309.0	**312.6 ▼**
	11. Acute emergency bed days per 1000 population 65-74 years	**Feb 2016**	**Feb 2017**
		1,188	**1,246 ▼**
	12. Acute emergency bed days per 1000 population 75-84 years	**Feb 2016**	**Feb 2017**
		3,422	**3,512 ▼**
	13. Acute emergency bed days per 1000 population 85+ years	**Feb 2016**	**Feb 2017**
		8,251	**8,961 ▼**
	14. Long term conditions – bed days per 100,000 population	**Feb 2016**	**Feb 2017**
		7,635	**8,419 ▼**
	15. Number of patients with an Anticipatory Care Plan	**April 2016**	**April 2017**
		6379	**7558 ▲**
	16. Key Information Summary as Percentage of the Board area list size	**Feb 2016**	**Feb 2017**
		4.0%	**5.0% ▲**
	17. Self directed support (SDS) options selected: People choosing	**Mar 2016**	**Mar 2017**
	SDS Option 1: Direct payments	**33 (1%)**	**32 (1%)**
	SDS Option 2: Directing the available resource	**46 (2%)**	**83 (3%)**
	SDS Option 3: Local Authority arranged	**1,505 (62%)**	**1,749 (66%)**
	SDS Option 4: Mix of options, 1,2,3	**30 (1%)**	**45 (2%)**
	No recorded SDS Option	**805 (33%)**	**730 (28%) ▲**

Local Outcomes	Partnership Indicator		RAG Falkirk	
3. Safety Health & Social Care support systems keep people safe and live well for longer	18. Readmission rate within 28 days per 1000 population 75+	**April 2015**	**April 2016**	**April 2017**
		7.97	**5.23**	**3.22 ▲**
	19. Number of Adult Protection Referrals (data only)		**2015/16**	**2016/17 to Q3**
			579	**385**
	20. Number of Adult Protection Investigations (data only)		**2015/16**	**2016/17 to Q3**
			45	**39**
	21. Number of Adult Protection Support Plans (data only)		**Mar 2016**	**Mar 2017**
			12	**10**
	22. The total number of people with community alarms at end of the period		**2015/16**	**2016/17**
			4,526	**4,481▼**
	23. Percentage of community care service users feeling safe		2015/16	2016/17
			90%	**91%▲**

Local Outcomes	Partnership Indicator		RAG Falkirk	
4. Service User Experience People have a fair and positive experience of Health & Social Care	24. Standard delayed discharges	**April 2015**	**April 2016**	**April 2017**
		6	**27**	**29▼**
	25. Delayed discharges over 2 weeks	**April 2015**	**April 2016**	**April 2017**
		1	**18**	**14▲**
	26. Bed days occupied by delayed discharges	**April 2015**	**April 2016**	**April 2017**
		60	**657**	**631▲**
	27. Number of code 9 delays	**April 2015**	**April 2016**	**April 2017**
		11	**9**	**9 ◄►**
	28. Number of Code 100 delays	**April 2015**	**April 2016**	**April 2017**
		8	**6**	**5 ▲**
	29. Delays - including Code 9 and Guardianship	**April 2015**	**April 2016**	**April 2017**
		17	**36**	**38▼**
	30. Percentage of service users satisfied with their involvement in the design of their care package		**2015/16**	**2016/17**
			98%	**98% ◄►**
	31. Percentage of service users satisfied with opportunities for social interaction		**2015/16**	**2016/17**
			93%	**93% ◄►**
	32. Percentage of carers satisfied with their involvement in the design of care package		**2015/16**	**2016/17**
			92%	**93% ▲**
	33. 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**
			89%	**81%▼**
	34. The proportion of Social Work Adult Services complaints completed within 20 days (target – 70%)		**2015/16**	**2016/17**
			73.4%	**57.4% ▼**
	35. Sickness Absence in Social Work Adult Services (target – 5.5%)		**2015/16**	**2016/17 to end Q3**
			7.9%	**7.99% ▼**

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 **(This performance was reported to IJB in Feb 2017)**	**2014/15**	**2015/16**
		1,834	**1,703▼**
	37. The total respite weeks provided to older people aged 18-64. Annual indicator **(This performance was reported to IJB in Feb 2017)**	**2014/15**	**2015/16**
		729	**724▼**
	38. Number of people aged 65+ receiving homecare (Target to increase by 3%) *	**Mar 2016**	**Sep 2016**
		1,867	**1,856▼**
	39. Number of homecare hours for people aged 65+ (Target to increase by 3%) *	**Mar 2016**	**Sep 2016**
		14,622	**14,010 ▼**
	40. Rate of homecare hours per 1000 population aged 65+ (Target >=503.4) *	**Mar 2016**	**Sep 2016**
		512.2	**490.8 ▼**
	41. Number receiving 10+ hrs of home care (Target to increase by 3%) *	**Mar 2016**	**Sep 2016**
		406	**393 ▼**
	42. The proportion of Home Care service users aged 65+ receiving personal care *	**Mar 2016**	**Sep 2016**
		91.6%	**91.7% ▲**
	43. The proportion of Home Care service users aged 65+ receiving a service during evenings/overnight *	**Mar 2016**	**Sep 2016**
		49.3%	**49.5% ▲**
	44. The proportion of Home Care service users aged 65+ receiving a service at weekends *	**Mar 2016**	**Sep 2016**
		79.9%	**80.8% ▲**
	* **Note each year's Home Care data is a snapshot of provision in a single reporting week at end of reporting period. No update of data beyond September 2016 is currently available.**		
	45. Percentage of Rehab At Home service users who attained independence after 6 weeks (target – 80%)	**2015/16**	**2016/17 to end of Q3**
		77.4%	**89.9% ▲**
	46. Percentage of Crisis Care service users who are retained in the community when service ends (target - 70%)	**At end of 2015/16**	**At end of 2016/17**
		63.7%	**75.2% ▲**
	47. Number of new Telecare service users 65+	**2015/16**	**2016/17**
		102	**75 ▼**
	48. The number of people who had a community care assessment or review completed	**2015/16**	**2016/17**
		9,571	**8,932 ▼**
	49. The number of Carers' Assessments carried out	**2015/16**	**2016/17**
		1,936	**1,624 ▼**
	50. The number of new adaptations provided during the reporting year **(This performance was reported to IJB in Feb 2017)**	**2014/15**	**2015/16**
		1,766	**1,605 ▼**
	51. The number of overdue 'OT' pending assessments at end of the period	**Mar 2016**	**Mar 2017**
		352	**316 ▲**
	52. Proportion of last six months of life spent at home	**2014/15**	**2015/16**
		86.1%	**86.0%◄►**
	53. Number of days by setting during the last six months of life: Community	**2014/15**	**2015/16**
		228,702	**241,236▲**

SECTION 3 - Summary of Key Performance – by Exception

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

Indicator 1: Emergency Department 4 hour Wait

Target is 95% of patients to wait less than 4 hours from arrival to admission, discharge or transfer for accident and emergency treatment - with a stretch aim of 98%.

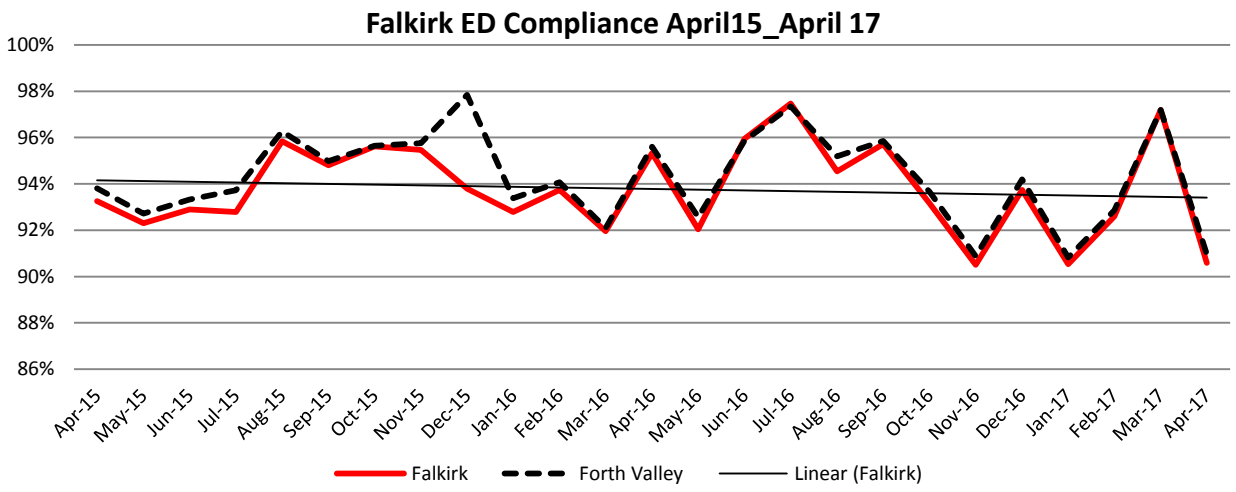
Position

	April 2015	April 2016	April 2017
Emergency department 4 hour wait	93.6%	95.3%	90.6%▼

As described in the summary there are on-going challenges in respect of the Emergency Department 4 Hour wait and Emergency Department attendances. When performance falls below 90% for a consistent period, the Scottish Government routinely request a period of thrice daily monitoring. Forth Valley has been on this regime three times recently; November 2016, February into March 2017 and May into June 2017. The most recent period ceased on 2nd June with performance seeing notable improvement. The majority of breaches recently have been categorized as 'wait for first assessment' rather than 'wait for bed'.

There was an increase in activity in April and into early May with Forth Valley Royal Hospital also seeing a rise in admission. Focused work underway, led by the Medical Director, to look at maximising internal processes in terms of escalation and preventing breaches, and to review the whole system in support of sustainable improvement.

Graph 1: % compliance with the 4 hour ED wait



The in month position reported at April from 2016 to 2017, graph 1 highlights a slight deterioration in the ED 4 hour wait for patients in the Local Authority area.

Indicator 2: Emergency Department attendances per 100,000 population 20-64 years
Indicator 3: Emergency Department attendances per 100,000 population 65-74 years
Indicator 4: Emergency Department attendances per 100,000 population 75-84 years
Indicator 5: Emergency Department attendances per 100,000 population 85

Purpose of Indicators: The most appropriate treatments, interventions, support and services will be provided at the right time to everyone who will benefit, and wasteful or harmful variation will be eradicated. The goal is a reduction in the rates of attendance at A&E.

Position

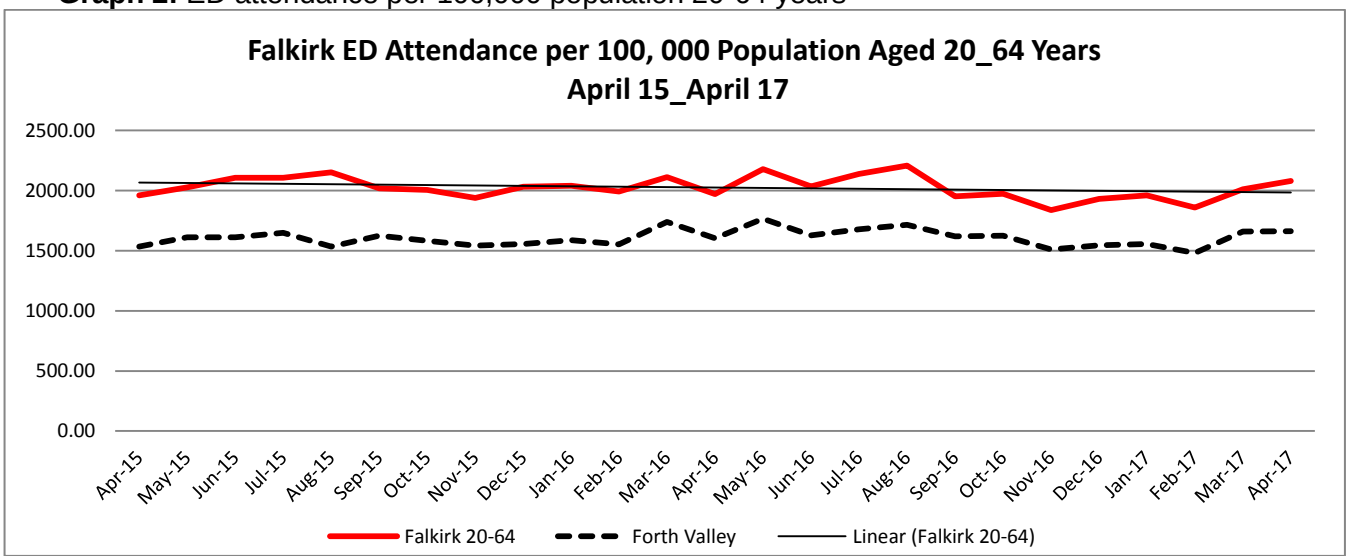
Emergency department attendances per 100,000 population 20-64 years	**April 2015**	**April 2016**	**April 2017**
	1,959	1,971	**2,079▼**
Emergency department attendances per 100,000 population 65-74 years	**April 2015**	**April 2016**	**April 2017**
	923	1,773	**2,002▼**
Emergency department attendances per 100,000 population 75-84 years	**April 2015**	**April 2016**	**April 2017**
	2,955	2,505	**2,473▲**
Emergency department attendances per 100,000 population 85+ years	**April 2015**	**April 2016**	**April 2017**
	3,667	3,667	**4,349▼**

Emergency Department attendances

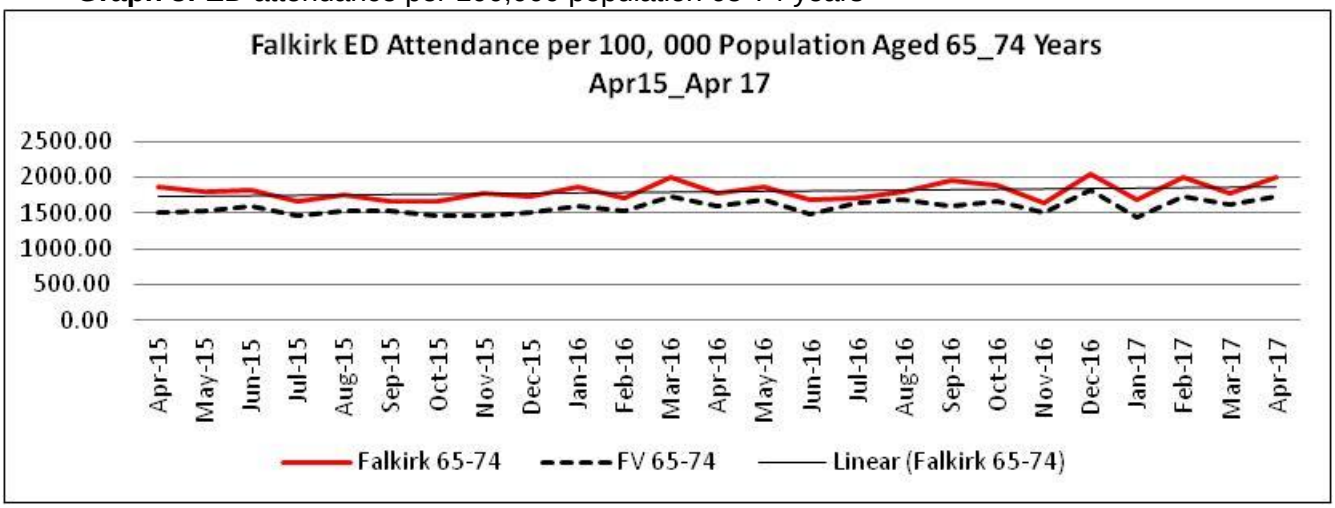
The graphs below illustrate a rising trend of approximately 2% in ED attendance in the 65-74, 75-84 and 85+ years age category for the Falkirk Partnership, with a 1.7% reduction in the 20-64 year age groups. Attendance rates per 100,000 in Falkirk for each age group exceed the Forth Valley wide monthly average over 2016/17.

Work is ongoing to map this information to front door activity, Closer to Home, ALFY, Intermediate care, the impact of Discharge to Assess and information regarding home care. The USCPB will oversee system wide activities, initiatives, actions and performance around unscheduled care to target improvement and work to meet trajectories once agreed.

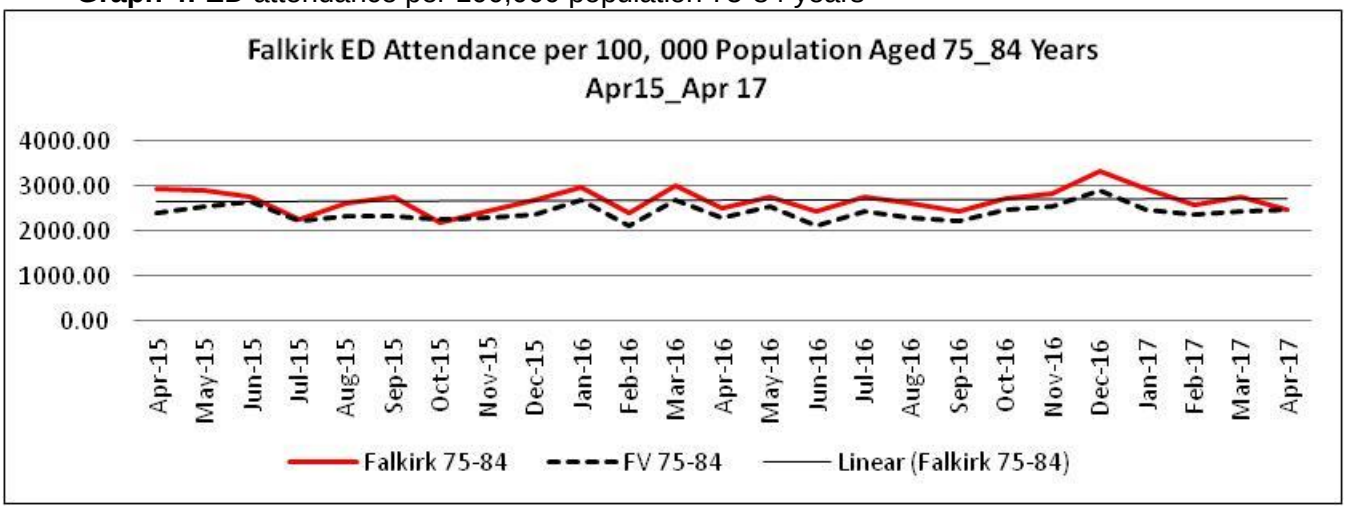
Graph 2: ED attendance per 100,000 population 20-64 years



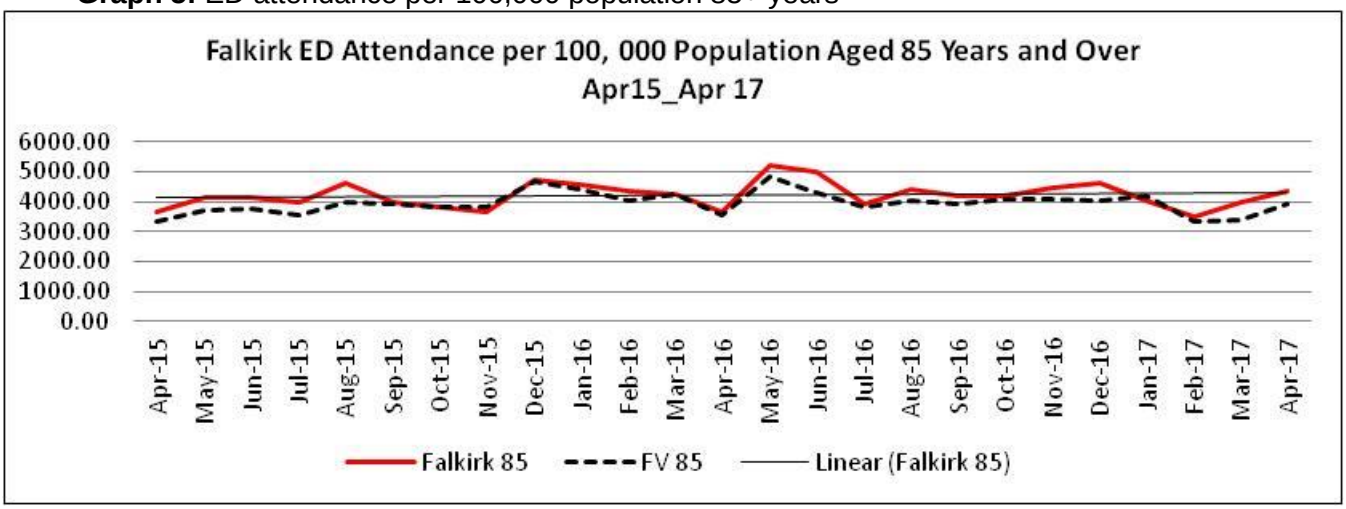
Graph 3: ED attendance per 100,000 population 65-74 years



Graph 4: ED attendance per 100,000 population 75-84 years



Graph 5: ED attendance per 100,000 population 85+ years



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

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

Indicator 6: Emergency admission rate per 100,000 population 20-64 years
Indicator 7: Emergency admission rate per 100,000 population 65-74 years
Indicator 8: Emergency admission rate per 100,000 population 75-84 years
Indicator 9: Emergency admission rate per 100,000 population 85+ years

Purpose of Indicator: To monitor a shift from a reliance on hospital care towards proactive and coordinated care and support in the community. Improvements in peoples overall health, and reducing health inequalities should also lead to fewer emergencies (the emergency admission rate is strongly related to patient age and to deprivation).

Position

Emergency admission rate per 100,000 population 20-64 years	**April 2016**	**April 2017**
	748.9	**740.6▲**
Emergency admission rate per 100,000 population 65-74 years	**April 2016**	**April 2017**
	1,593	**1,388 ▲**
Emergency admission rate per 100,000 population 75-84 years	**April 2016**	**April 2017**
	2,847	**2,516 ▲**
Emergency admission rate per 100,000 population 85+ years	**April 2016**	**April 2017**
	4,738	**4,901 ▼**

There is an improved position over the reporting period across all age categories other than patients over 85+. Close monitoring continues with work to link the determinants to admission over time e.g. health inequalities, multiple morbidity and long term conditions.

Indicator 10: Acute emergency bed days per 1000 population 20-64 years
Indicator 11: Acute emergency bed days per 1000 population 65-74 years
Indicator 12: Acute emergency bed days per 1000 population 75-84 years
Indicator 13: Acute emergency bed days per 1000 population 85+ years

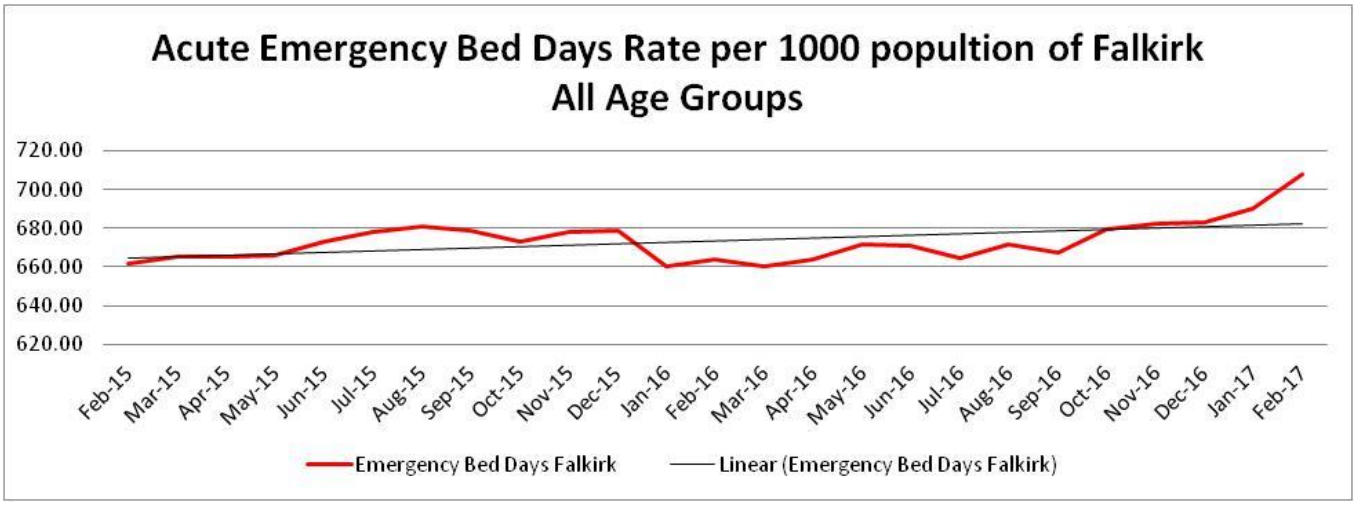
Purpose of Indicator: This measure is intended to support improved partnership working between the acute, primary and community care sectors ensuring the most appropriate treatments, interventions, support and services are provided at the right time to everyone who will benefit.

Position

Acute emergency bed days per 1000 population 20-64 years	**Feb 2016**	**Feb 2017**
	309.0	**312.6 ▼**
Acute emergency bed days per 1000 population 65-74 years	**Feb 2016**	**Feb 2017**
	1,188	**1,246 ▼**
Acute emergency bed days per 1000 population 75-84 years	**Feb 2016**	**Feb 2017**
	3,422	**3,512 ▼**
Acute emergency bed days per 1000 population 85+ years	**Feb 2016**	**Feb 2017**
	8,251	**8,961 ▼**

Deteriorating position noted over the reporting period across all age categories. Close monitoring continues.

Graph 6: Acute Emergency Bed Days rate per 1000 population - All Ages



Indicator 14: Long term conditions – bed days per 100,000 population

Purpose of Indicator: To support an improvement in ambulatory care for people with long term conditions in the community. Conditions currently included are Diabetes, Hypertension, Angina, Ischaemic Heart Disease, Chronic Obstructive Pulmonary Disease, Asthma and Heart Failure.

Position

	Feb 2016	Feb 2017
Long term conditions – bed days per 100,000 population	7,635	8,419 ▼

The Long Term Conditions (LTC) indicator has seen a rise over the reporting period. This is a longstanding measure with a similar pattern being seen nationally. Initial work has been undertaken to examine this further by reviewing LTCs by age range and by condition and linking this to emergency admissions and emergency bed days. Work to include other conditions such as those related to drugs and alcohol will also be undertaken.

Indicator 15: Number of patients with an Anticipatory Care Plan (ACP)
Indicator 16: Key Information Summary as Percentage of the Board area list size

Purpose of Indicator: The measure is the number of patients who have a Key Information Summary (KIS) or Electronic Palliative Care Summary (ePCS) uploaded to the Emergency Care Summary (ECS). The ECS 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.

Position

	April 2016	April 2017
Number of patients with an Anticipatory Care Plan	6379	7558 ▲
	Feb 2016	**Feb 2017**
Key Information Summary as Percentage of the Board area list size	4.0%	5.0% ▲

Anticipatory care can take many forms. It helps reduce avoidable unscheduled acute admissions for people with pre-existing conditions, particularly older people, and those with mental health conditions. Data highlights a month on month increase in the number of people with an Anticipatory

Care Plan supporting an increase in activity around planning ahead and ensuring that those vulnerable and at risk of admission or requiring additional support have a Key Information Summary.

Work is underway to look at the impact of these in respect of readmission and how Anticipatory Care Plans and the Key Information Summary are being used on a day to day basis. Work is on-going in respect of the 'Decision Making' Partnership Indicators in support of ensuring meaningful data and comparison.

Indicator 17: Self directed support (SDS) options

Self directed support (SDS) options selected: People choosing	Mar 2016	Mar 2017
SDS Option 1: Direct payments	**33 (1%)**	**32 (1%)**
SDS Option 2: Directing the available resource	**46 (2%)**	**83 (3%)**
SDS Option 3: Local Authority arranged	**1,505 (62%)**	**1,749 (66%)**
SDS Option 4: Mix of options, 1,2,3	**30 (1%)**	**45 (2%)**
No recorded SDS Option	**805 (33%)**	**730 (28%) ▲**

The recent IJB development session focused on SDS and was extremely informative. The importance of SDS moving forward is critical and, although there is work to do, progress is being made.

LOCAL OUTCOME Safety Health and social care support systems are in place, to help keep people safe and live well for longer

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

Indicator 18: Readmission rate within 28 days per 1000 population 75+ (note this is also a National Indicator)

Purpose of Indicator: The readmission rate reflects several aspects of integrated health and care service - 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.

Position

	April 2015	April 2016	April 2017
Readmission rate within 28 days per 1000 population 75+	**7.97**	**5.23**	**3.22 ▲**

The IJB received a report indicating a long standing challenge with readmissions across Forth Valley underlining that work to understand and address the position was being led by the Medical Director. The year on year comparator for the Falkirk partnership indicates an improved position to April 2017. Work continues to monitor this important indicator. Separately a review of readmissions for specific projects e.g. Discharge to Asses is underway.

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

Local Partnership Indicators – (aligned to National Indicators as appropriate - note delayed discharge not currently a national indicator)

Indicator 24: Standard delayed discharges
Indicator 25: Delayed discharges over 2 weeks
Indicator 26: Bed days occupied by delayed discharges
Indicator 27: Number of code 9 delays
Indicator 28: Number of code 100 delays
Indicator 29: Delays – including Code 9 and Guardianship delays

Purpose of Indicator: 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.

Position

Standard delayed discharges	**April 2015**	**April 2016**	**April 2017**
	6	**27**	**29▼**
Delayed discharges over 2 weeks	**April 2015**	**April 2016**	**April 2017**
	1	**18**	**14▲**
Bed days occupied by delayed discharges	**April 2015**	**April 2016**	**April 2017**
	60	**657**	**631▲**
Number of code 9 delays	**April 2015**	**April 2016**	**April 2017**
	11	**9**	**9 ◄►**
Number of Code 100 delays	**April 2015**	**April 2016**	**April 2017**
	8	**6**	**5 ▲**
Delays – including Code 9 and Guardianship	**April 2015**	**April 2016**	**April 2017**
	17	**36**	**38▼**

Delayed Discharges

At the April 2017 census date, in relation to delays which count towards the national, published delayed discharge target (standard delays), there were:

- 29 people delayed in their discharge (under and over 2 weeks) of which 14 people were delayed for more than 2 weeks
- 4 people identified as a complex discharge (code 9)
- 5 people proceeding through the guardianship process

Therefore 38 people in total were delayed in their discharge

- 5 people in addition were identified as a Code 100 delay.

Table 1 and graph 7, highlight an improving trend in respect of total delays and delays over 2 weeks. Here does however remain an ongoing challenge and is being closely monitored. Data excludes Codes 9 and 100.

Table 1: Total delays and delays over 2 weeks April 2016 to April 2017

	Apr 2016	May 2016	Jun 2016	Jul 2016	Aug 2016	Sep 2016	Oct 2016	Nov 2016	Dec 2016	Jan 2017	Feb 2017	Mar 2017	Apr 2017
Total delays at census point	27	23	32	45	51	46	39	35	37	45	38	28	29

Total number of delays over 2 weeks	18	12	18	30	33	29	25	22	26	24	25	17	14

Graph 7: Total delays and delays over 2 weeks April 2016 to April 2017

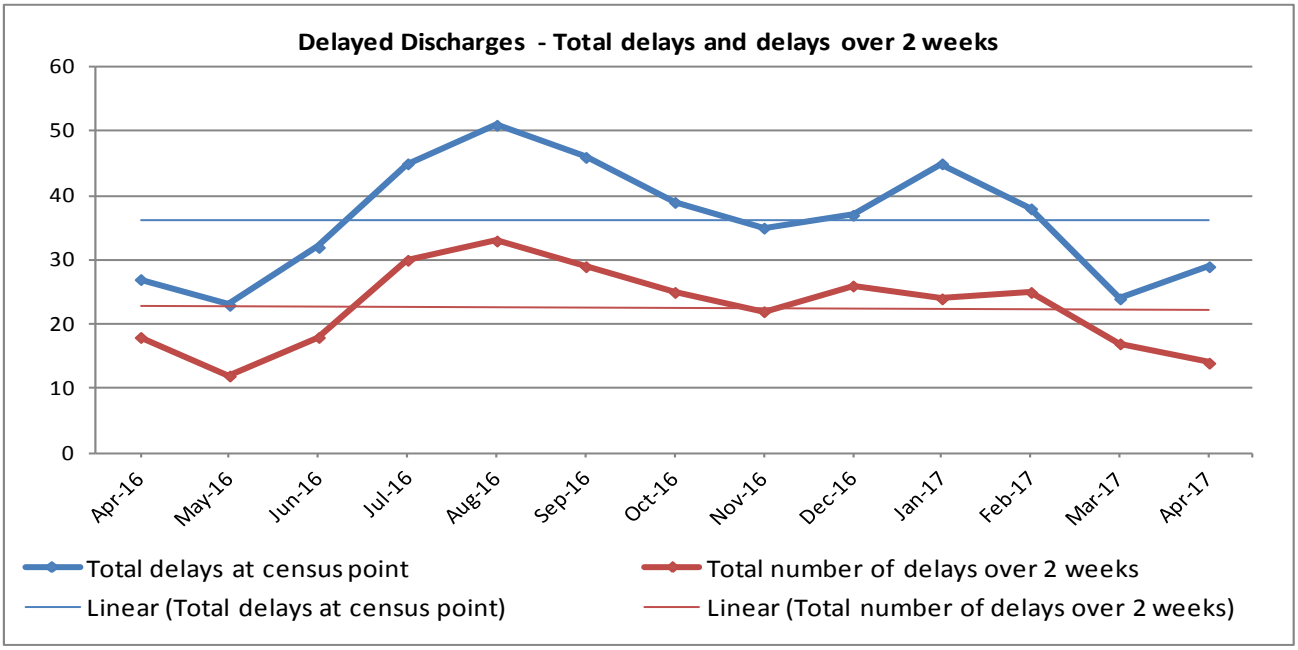


Table 2 and graph 8 show the total picture of delays in Falkirk Partnership across all categories expressed as occupied bed days. These figures are for full months to the end of April 2017 and continue to show pressure on bed days albeit an improvement compared with April 2016. From a high in August 2016 of 1468, the month on month position in respect of Bed Days Occupied by standard delayed discharges has improved to a position of 857 in April 2017. This improving trend is highlighted in graph 8. The equivalent in beds for April 2017 standard delays is 28 with 9 for Code 9 delays.

Table 2: Total occupied bed days in April 2016 to April 2017

	Apr 2016	May 2016	Jun 2016	Jul 2016	Aug 2016	Sep 2016	Oct 2016	Nov 2016	Dec 2016	Jan 2017	Feb 2017	Mar 2017	Apr 2017
Standard delays	975	875	854	1247	1468	1432	1393	1247	1247	1252	1171	964	857
Complex Delays/ Guardianships (Code 9)	277	186	158	256	275	376	454	374	374	377	428	421	273

Graph 8: Bed Days Occupied April 2016 – April 2017

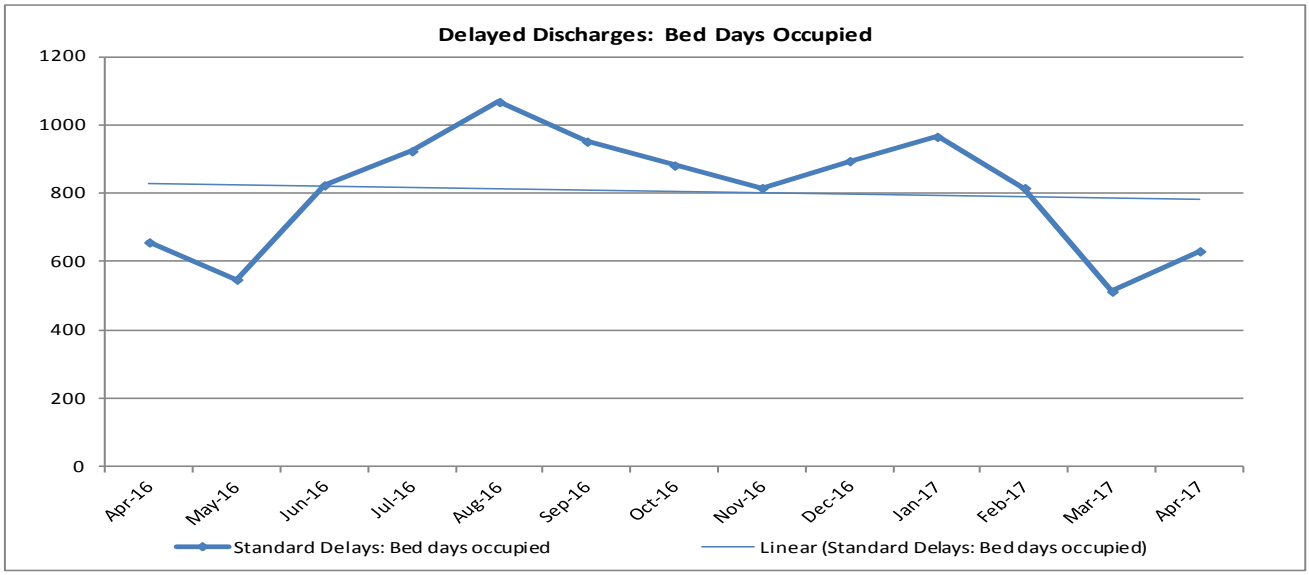


Table 3: Falkirk 2016/17 – Trajectory

	Dec-17	Jan-17	Feb-17	Mar-17	Apr-17
Target	56	47	42	30	-
Actual	49	58	54	31	38

In December 2016, the Scottish Government set a target for Forth Valley to ensure a 50% reduction in delayed discharges by the end of March 2017 inclusive of Guardianship and Codes 9 delays. The reduction was based on the total number of patients delayed across Forth Valley in November 2016. Trajectories were set from December onwards. Having exceeded the trajectory point of 56 at the December census with a position of 49, the position to February deteriorated however, the partnership only marginally missed the target at March 2017 with 31 delays against a target of 30. Into April 2017, there were 38 delays including Guardianship and Codes 9 delays. No further targets have been set by the Government at this stage.

Indicator 33: Percentage of carers who feel supported and capable to continue in their role as a carer OR feel able to continue with additional support

Purpose of Indicator: Supporting carers is recognised as an important element in the Falkirk Integrated Strategic Plan. So it is important to ensure we monitor and support carers through assessment and involvement in the planning and shaping of services required for the service user and for themselves.

Position

	2015/16	2016/17
Percentage of carers who feel supported and capable to continue in their role as a carer OR feel able to continue with additional	89%	81%▼

This indicator is recorded in two parts, and shows there was a 2% decline in carers feeling supported, and a 6% decline in the proportion of carers feeling able to continue with additional support. This decline contrasts with an increase by 1% in the proportion of carers who are satisfied with their involvement in the design of the care package of the person they support (Indicator 32). The Service works in partnership and partly funds the Central Carers Association. The CCA supports carers in many different ways and now supports over 4000 carers in the Falkirk area. Work will be undertaken to look into these findings alongside our carer support in light of the

changes required to meet the requirements of the new Carers' Act in 2018.

Indicator 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.

Position

	2015/16	2016/17 to end Q3
The proportion of Adult Social Work Service complaints completed within 20 days (Target – 70%)	73.4%	57.4% ▼

Performance has declined by 12.6% below the 70% target in 2016-17. However, it is important to note that the number of complaints is relatively small given the volume of service users seen by the Service, and can result in large percentage changes, which can be misleading. In 2015-16 for example, 46 complaints out of 154 complaints were completed outwith the timescale required; in 2016-17 there were 5 fewer complaints not completed on time (41), but the total *number* of complaints received also fell by 30% to 108 during 2016-17, resulting in a percentage decrease in the proportion completed on time. It should also be noted that in Social Work Adult Services we receive complaints about private service providers and these complaints are passed on. However, we do not always receive timely responses to these complaints. Changes have been made since April 2017 to the administration of complaints as part of continuous improvement in this area of performance.

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.

Position

	2015/16	2016/17 to end Q3
Sickness Absence in Adult Social Work Service (target – 5.5%)	7.9%	7.99% ▼

Sickness absence has increased slightly 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 dedicated HR Assistant post was created to focus on absence management with all Home Care Managers and Seniors receiving training and ongoing support in this area. This demonstrated a positive shift with a 2% reduction in absences across the home care service in general. A programme of awareness briefings for all home carers was held to target short-term absence to try to reduce our absence rates further. A new dedicated HR Assistant post was also created to fulfill the same function for the remaining sections within Social Work Adult Services however it has not been possible so far to recruit to this post on a temporary basis.

Indicator 36: Respite for older people aged 65+

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.

Position

	2014/15	2015/16
The total respite weeks provided to older people aged 65+ (overnight & daytime combined) **(This performance was reported to IJB in Feb 2017)**	**1,834.2**	**1,703 ▼**

There was a decline of 7% in the number of weeks of respite provided between 2014-15 and 2015-16. Increased activity and partnership working between the Central Carers Centre and the Short Breaks Bureau has created alternatives to traditional overnight respite/short breaks provision. For example, the Short Breaks Bureau's voucher scheme and "respitality" initiatives. Work during 2017 on implementation of the Carers [Scotland] Act 2016 will provide opportunities to work in partnership with carers on improvement actions around carers' breaks.

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

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

Indicators 45 and 46: Rehabilitation and Crisis care services

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

Position

	2015/16	**2016/17 to end of Q3**
Percentage of Rehab At Home service users who attained independence after 6 weeks (Target – 80%)	**77.4%**	**89.9% ▲**
	At end of 2015/16	**At end of 2016/17**
Percentage of Crisis Care service users who are retained in the community when service ends (Target - 70%)	**63.7%**	**75.2% ▲**

It is a partnership priority to ensure that home care and support for people is available. As shown above, the Rehabilitation at Home service and Crisis Care services are performing well in the latest reporting period.

Indicator 47: The number of new Telecare service users aged 65 plus

Purpose of Indicator: Supporting people to use technology solutions to support them to have more independence and control over their lifestyles and the management of their conditions is a partnership priority.

Position

	2015/16	**2016/17**
Number of new Telecare service users 65+.	**102**	**75 ▼**

The number of new telecare service users aged 65 plus has declined in 2016-17. The main reason for this is that the capacity of the Telecare service was reduced in 2016-17. The Telecare Co-ordinator post was vacant for a few months in 2016, and the capacity of Telecare Support officers has also been reduced by sickness absence. It is anticipated that the numbers will increase in 2017-18.

Indicator 48: Community Care Assessments/Reviews

Purpose of Indicator: This indicator provides an indication of the volume of demand and assessment activity in community care teams, and in particular the number of people who have had assessments completed by community care teams in the reporting period.

Position

	2015/16	2016/17
The number of people who had a community care assessment or review completed.	9,571	8,932 ▼

The number of people who had assessments/reviews completed in 2016-17 declined by 6.7% from the previous year. A contributory factor has been that team capacity has been reduced by difficulties with staff retention which this is being addressed through permanent recruitment to vacancies.

Indicator 49: Carers' Assessments

Purpose of Indicator: Supporting carers is recognised as an important element in the Falkirk Integrated Strategic Plan. So it is important to ensure we monitor and support carers through assessment and involvement in the planning and shaping of services required for the service user and for themselves.

Position

	2015/16	2016/17
The number of Carers' Assessments carried out	1,936	1,624 ▼

The number of recorded carer assessments has declined by 16% since 2015-16. As noted in the comment at indicator 33 above, the Service works in partnership and partly funds the Central Carers Association. The CCA supports carers in many different ways and now supports over 4000 carers in the Falkirk area. This decline in carer assessments will be considered alongside findings on carers views (see Indicator 33 above) with the Central Carers Association, and also in view of the changes required to meet the requirements of the new Carers' Act in 2018.

Indicator 50: New Adaptations

Purpose of Indicator: A key objective in the integration of Health and Social care is to support people to remain independent at home for as long as possible, and to support them to have more independence and control over their lifestyles and the management of their conditions.

Position

	2014/15	2015/16
The number of new adaptations provided during the reporting year **(This performance was reported to IJB in Feb 2017)**	1,766	1,605 ▼

There was a 9% decline in the number of recorded new adaptations provided during 2015-16 from the previous year. A project manager has been appointed to work on the Adapting for Change project with partners in Housing services and NHS Forth Valley to lead on the improvement of the adaptations process for service users. This is expected to lead to an improved, more streamlined process and more reliable recording of adaptations.

Indicator 51: The number of overdue pending assessments for OTs

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. However, 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.

Position

The number of overdue 'OT' pending assessments at end of the period	Mar 2016	At end Mar 2017
	352	316▲

The number of overdue pending OT assessments to the end of March 2017 has reduced by 10% since March 2016; however this is still too high. 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.

Of the outstanding OT assessments, 52% were at priority 2 and 48% at priority 3. However, it should be noted that some of the people waiting for a main assessment will have received OT equipment at an earlier stage of the assessment process as part of their Intake assessment.

The target is to reduce the number of pending assessments and this will continue to be a management priority. Community Care Teams have been tackling outstanding assessments in the last six months to speed up the provision of OT assessments and adaptations. This work is continuing.

Indicator 52: Proportion of last six months of life spent at home
Indicator 53: Number of days by setting during the last six months of life - Community

Purpose of Indicator: The Falkirk Health and Social Care Partnership and NHS Forth Valley are committed to enabling people to die in the location of their preference with research indicating that most people, when asked, would prefer to die at home. Admissions to hospital as an emergency in the last few days or hours of their lives are to be avoided.

Position

Proportion of last six months of life spent at home: Community	2014/15	2015/16
	86.1%	86.0%◄►
Number of days by setting during the last six months of life: Community	2014/15	2015/16
	228,702	241,236▲

The percentage of the last six months of life spent at home is noted as static however the number of bed days in the last six months has increased. The position reported is people who are in a Community setting which includes care home residents as well as those living in their own home. Further work is required to agree a more targeted approach to this indicator.

Appendix 1

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