AGENDA ITEM

12

Agenda Item 12

Falkirk
Health and Social Care
Partnership

Title/Subject:	**Performance Report**
Meeting:	**Integration Joint Board**
Date:	**6 October 2017**
Submitted By:	**Head of Performance and Governance, NHS Forth Valley**
Action:	**For Noting**

1. INTRODUCTION

1.1 The purpose of this report is to ensure the Integration Joint Board fulfils its on-going responsibility to 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. Further work has been undertaken to refine the partnership indicators which are detailed within the Strategy Map in Appendix 1.

1.2 This report presents performance in relation to unscheduled care and delayed discharge, as part of a more targeted approach to performance reporting on thematic areas. The reported partnership indicators are linked to the outcomes of 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 that appropriate management actions continue to be taken to address issued identified through these performance reports.

3. BACKGROUND

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

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

reporting.

4. APPROACH

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

4.2 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.

5. PERFORMANCE REPORT STRUCTURE

5.1 Section 1 of the Performance report provides an "at a glance performance summary". Work is required in terms of developing a Balanced Scorecard to provide a broader range of measures and build upon qualitative and quantitative data which will enable and support quality improvement and assurance. The IJB focus is across the five Local Outcomes with work to support a balanced approach to measurement and reporting.

5.2 The content of this report mainly focuses on indicators around unscheduled care, including delayed discharges. Of note is the information provided around unscheduled care. As previously reported to the IJB, the Partnership submitted an Improvement Plan to the Scottish Government. This was in response 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.

5.3 The next step is to submit trajectories based on the indictors noted below. Work is on-going to agree trajectories, with the 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.

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 presents performance in relation to unscheduled care and delayed discharge, as part of a more targeted approach to performance reporting on thematic areas.

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

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

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

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

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

Approved for submission by: Patricia Cassidy, Chief Officer

Authors:
Annette Kerr, ICF Support Officer, Philip Morgan-Klein, Service Manager, Kerry Mackenzie, Senior Performance Manager

Vivienne Meldrum, Senior Information Analyst, Elaine Vanhegan, Head of Performance and Governance

Date: 28 September 2017

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

At a Glance Performance Summary

Work is required in terms of developing a Balanced Scorecard to provide a broader range of measures and build upon qualitative and quantitative data which will enable and support quality improvement and assurance. The IJB focus is across the five Local Outcomes with work to support a balanced approach to measurement and reporting.

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

Local Outcome	Partnership Indicator	Falkirk	
Self Management	1. Emergency department 4 hour wait Forth Valley	**2016/17**	**2017/18**
		94.40%	92.80%
	2. Emergency department 4 hour wait Falkirk	**2016/17**	**2017/18**
		94.10%	92.70%
	3. Emergency department attendances per 100,000 Forth Valley population	**2016/17**	**2017/18**
		1,758	1,859
	4. Emergency department attendances per 100,000 Falkirk population All Ages	**2016/17**	**2017/18**
		1,964	2,060

Local Outcome	Partnership Indicator	Falkirk	
Autonomy & Decision Making	6. Emergency admission rate per 100,000 Forth Valley population	**2016/17**	**2017/18**
		937	898
	7. Emergency admission rate per 100,000 Falkirk population All Ages	**2016/17**	**2017/18**
		965	903
	12. Acute emergency bed days per 1000 Forth Valley population	**2016/17**	**2017/18**
		636	647
	13. Acute emergency bed days per 1000 Falkirk population All Ages	**2016/17**	**2017/18**
		677	712
	19. Number of patients with an Anticipatory Care Plan in Forth Valley	**2016/17**	**2017/18**
		*16541	15,231
	20. Number of patients with an Anticipatory Care Plan in Falkirk	**2016/17**	**2017/18**
		na	6,525
	21. Key Information Summary as Percentage of the Board area list size Forth Valley	**2016/17**	**2017/18**
		5.47%	5.03%
	22. Key Information Summary as Percentage of the Board area list size Falkirk	**2016/17**	**2017/18**
		na	4.12%

Local Outcome	Partnership Indicator	Falkirk	
Safety	23. Readmission rate within 28 days per 1000 FV population All Ages	**2016/17**	**2017/18**
		1.40	1.28
	24. Readmission rate within 28 days per 1000 Falkirk population	**2016/17**	**2017/18**
		1.42	1.56
	25. Readmission rate within 28 days per 1000 population 75+	**2016/17**	**2017/18**
		3.77	3.75

Local Outcome	Partnership Indicator	Falkirk
Service User Experience	28. Standard delayed discharges	**Aug-17**
		40
	29. Delayed discharges over 2 weeks	**Aug-17**
		26
	30. Bed days occupied by delayed discharges	**Aug-17**
		1052
	31. Number of code 9 delays	**Aug-17**
		15
	32. Number of Code 100 delays	**Aug-17**
		4
	33. Delays - including Code 9 and Guardianship	**Aug-17**
		55

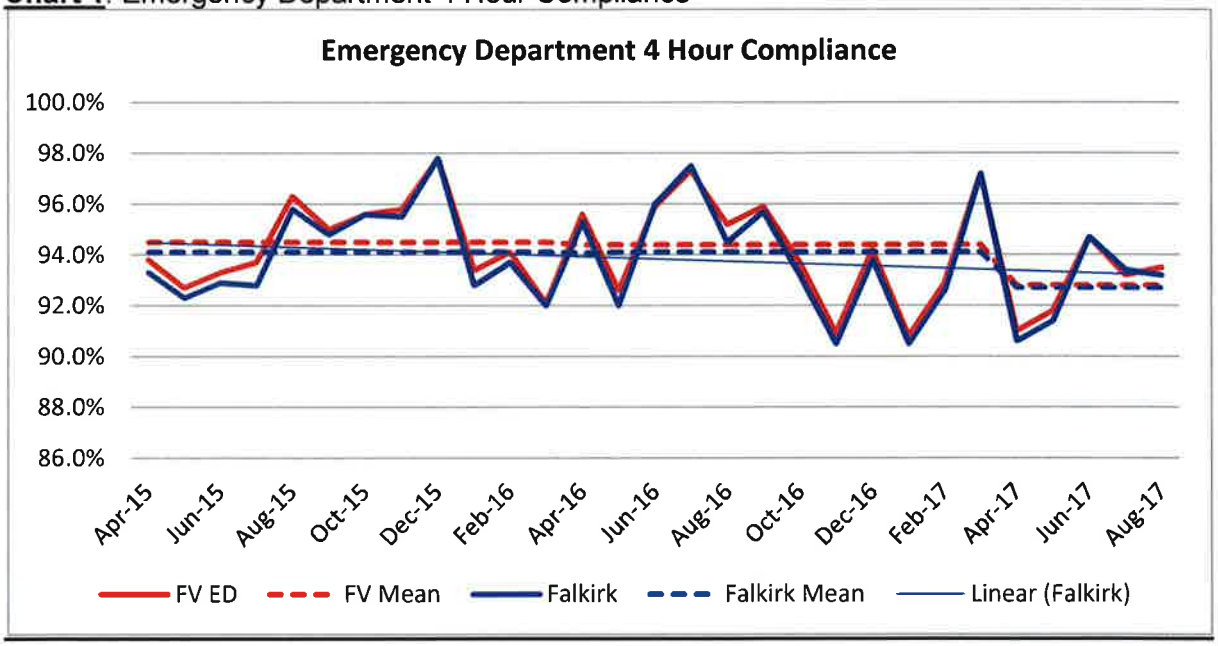
Local Outcome	Partnership Indicator	Falkirk	
Community Based Support	34. Number of people aged 65+ receiving homecare (Target to increase by 3%) *	Mar-16	Mar-17
		1667	1,607 (-3.2%)▼
	35. Number of homecare hours for people aged 65+ (Target to increase by 3%) *	Mar-16	Mar-17
		14022	13,369 (-4.6%)▼
	36. Rate of homecare hours per 1000 population aged 65+ (Target >=503.4) *	Mar-16	Mar-17
		512.2	488.6 (-4.6%)▼
	37. Number receiving 10+ hrs of home care (Target to increase by 3%) *	Mar-16	Mar-17
		406	401 (-1.2%)▼
	38. The proportion of Home Care service users aged 65+ receiving personal care *	Mar-16	Mar-17
		91.6%	92.4% ▲
	39. The proportion of Home Care service users aged 65+ receiving a service during evenings/overnight *	Mar-16	Mar-17
		49.3%	49.8% ▲
	40. The proportion of Home Care service users aged 65+ receiving a service at weekends *	Mar-16	Mar-17
		79.9%	81.4% ▲
	* Note each year's Home Care data is a snapshot of provision in a single reporting week at end of reporting period. No update of data beyond September 2016 is currently available.		
	41. Percentage of Rehab At Home service users who attained independence after 6 weeks (target – 80%)	**2015/16**	**2016/17 to end of Q3**
		77.40%	89.9% ▲

Local Outcome – Self Management

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

Measure	Unscheduled Care – Emergency Department Performance against the ED 4 Hour Target (includes Minor Injuries Unit). This is a 95% target.
Falkirk Performance	Average monthly performance in 2017/18 = 92.7%
Forth Valley Performance	Average monthly performance in the year to date , April to August 2017/18 = 92.8%

Chart 1: Emergency Department 4 Hour Compliance



Commentary

The average Falkirk monthly Emergency Department compliance for 2016/17 was 94.1%, synonymous with overall Forth Valley compliance of 94.4%. This highlights that Forth Valley as well as local Falkirk compliance has decreased by 2% in 2017/18 to date (April to August 2017). In order to put these results into context the trend in attendance must be looked at.

Achieving the 95% target on a consistent basis is challenging with a level of instability in performance. Discussion has taken place with the Scottish Government regarding NHS Forth Valley's variation in performance and what further support may be required. Over the months of July and August there were 15 occasions where attendances at the department were between 190 and 212.

The main reasons for breaching the 4 hour target are 'wait for first assessment', 'clinical reasons' and 'wait for treatment to be completed'.

Work is underway, led by the Medical Director, with a view to maximising internal processes in terms of escalation and preventing breaches, focussing on the '6 Essential Actions'

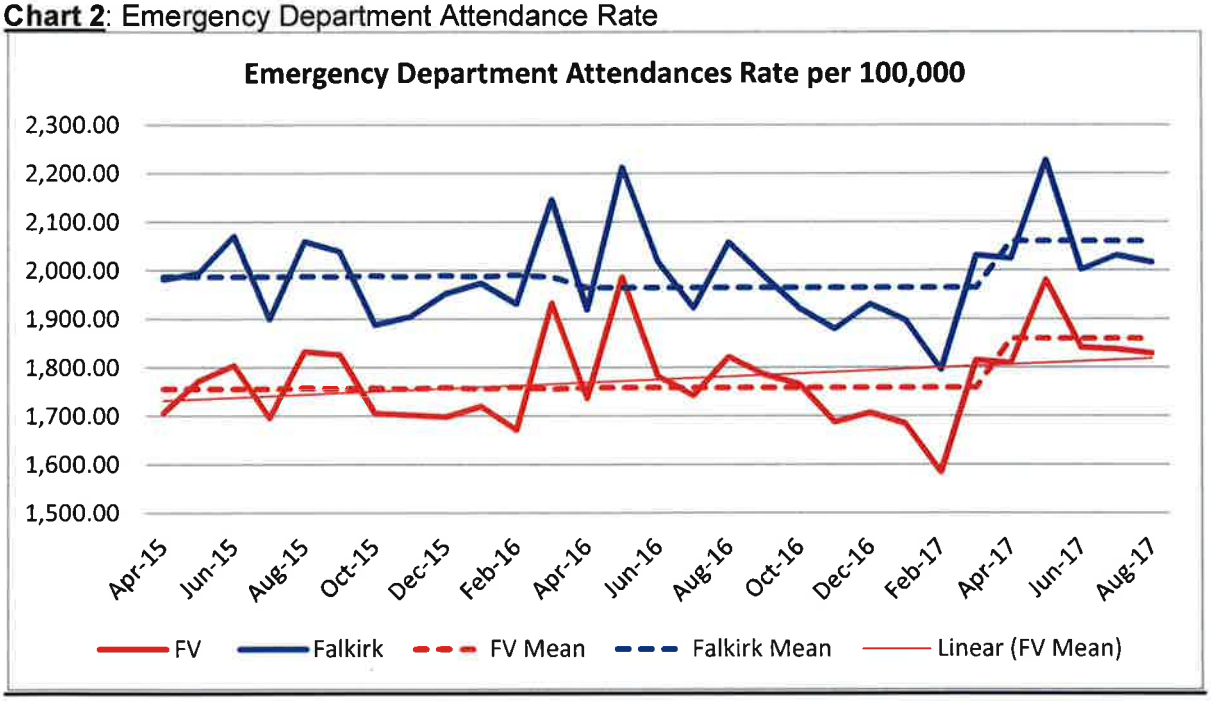
established by the Scottish Government, and working in partnership with Integration Authorities looking at the whole system in support of sustainable improvement. This will support the creation of realistic trajectories for the Partnership Improvement Plans around Unscheduled care. This work is currently on-going. The recently established Unscheduled Care Programme Board has an appropriate breadth of membership, including Chief Officers, to drive the required improvements.

Six Essential Actions to improve ED performance and increase flow (Includes IHO and ED review)

- A Six Essential Actions Programme Manager post has recently been advertised and an Emergency Department Clinical Session held to explore priorities for improvement.
- Essential Actions 1-4 are about changes needed to the way hospital services are designed and provided. These includes strengthening clinical leadership and ownership of patient pathways, analysing and planning hour by hour to check that patients are on the right pathway and in the right place on their pathway, holding safety briefings and escalating and resolving issues quickly, providing assessment, diagnosis and treatments as soon as possible to support people to return home or to most suitable place of care earlier rather than later in the day..
- Essential Action Five focuses on provision of services such as phlebotomy, diagnostics and medicines over seven days.
- Essential Action Six *Ensuring Patients Are Cared for in Their Own Homes* is about avoiding attendance, avoiding admission, short and reduced length of stay. It is delivered through the initiatives and core provision mentioned elsewhere, rather than being a separate stream of work.

Measure	Unscheduled Care – Emergency Department Attendance Rate per 100,000 population
Falkirk Performance	Average monthly performance 2017/18 = 2060 per 100,000 population
Forth Valley Performance	Average monthly performance 2017/18 = 1859 per 100,000 population

Chart 2: Emergency Department Attendance Rate



Commentary

The average monthly Emergency Department attendance rate in Forth Valley has increased from 1758 per 100,000 population in 2016/17 to 1859 100,000 population in 2017/18 to date. This is highlighted as a 5.8% increase.

Falkirk has seen a rise of 4.9% in 2018/17 to 2060 per 100,000 population, from 1965 per 100,000 population in 2016/17. A breakdown by age group in the Falkirk local authority area shows a 6% rise in attendances in the 20-64 years age group whilst there is a decrease of 2.1% in those aged 75-84 years. There is no significant change in the 65-74 years or the 85+ years age groups.

Studies to assess the impact of services established to alleviate pressure at the front door are currently being explored by the Unscheduled Programme Board.

Closer to Home - Enhanced Community Team including GP Fellows and ALFY

The GP Fellows are part of the Enhanced Community Team. There are currently three Fellows in post. It is anticipated that the two GP Fellows who were originally part of the Project will return to Forth Valley in late Autumn 2017. The use of GP Fellows will be extended to the whole of Forth Valley from 1st September 2017.

Activity data indicates that the number of referrals to the Enhanced Community Team (ECT)

is not increasing month on month. Linked with this, GP Fellows' patient contacts and interventions are not increasing.

Work has been done to understand reasons why GP Practices are not referring more and suitable patients to ECT. The ANP lead nurse for the ECT has developed links with the call handlers at the front door in order to identify suitable patients for the ECT and to promote the use of ECT before front door attendance. A joint meeting between the Enhanced Community Team and Ageing & Health Consultants to identify improved ways of working and focus on opportunities to optimise the role of the GP fellows is being held on 6th September.

A series of ECT changes are being tested or planned:

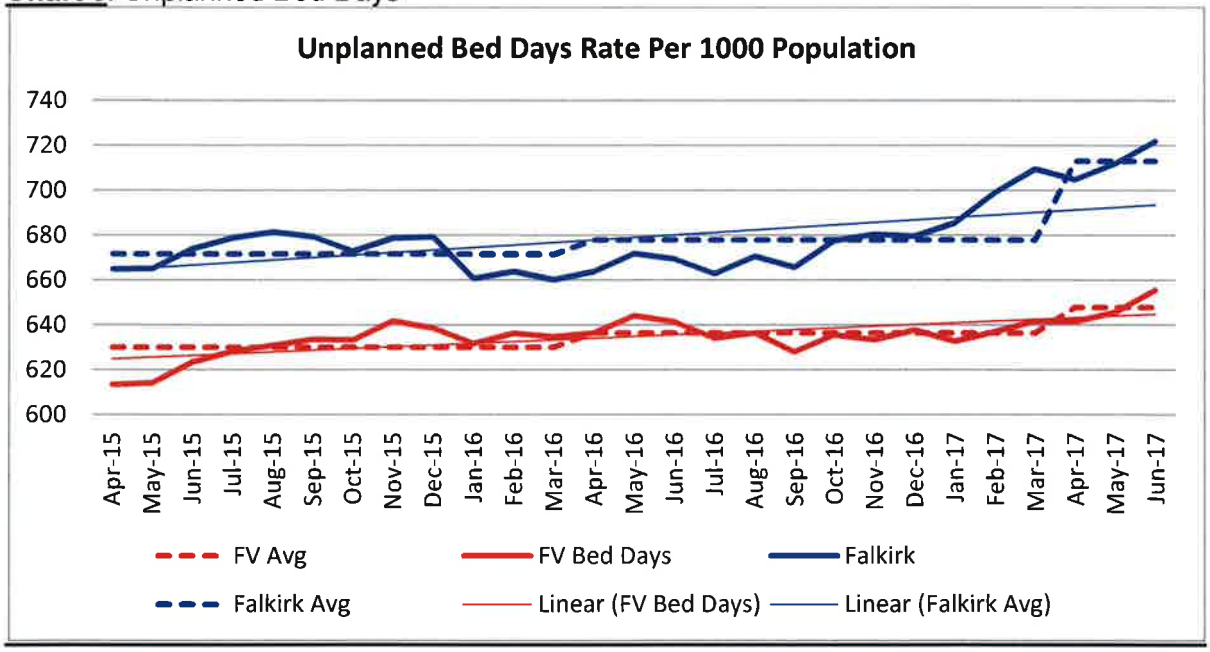
- Extending the criteria to include patients who have been reviewed by a practitioner within the last 24 hours (currently all patients require a GP diagnosis for referral to ECT)
- Use of step up bed in Summerford as part of re-ablement pathway development
- Work with GP Cluster to identify high admission rates and opportunities to redirect to ECT
- Working within re-ablement / nursing homes as alternative ways to utilise GP fellows and
- Improved communication about the ECT service.

The ALFY line is being reviewed as part of the development of Single Point of Contact, with tests of change to take place in Clackmannanshire and Falkirk.

Local Outcome – Autonomy & Decision Making • **Where formal support is needed people should be able to exercise as much control and choice as possible over what is provided.**

Unscheduled Care	Falkirk Unscheduled Care - Rate of Unplanned Bed Days Rate per 1000
Falkirk Performance	Average Monthly Rate 2017/18 = 713 per 1,000 pop
Forth Valley Performance	Average Monthly Rate 2017/18 = 648 per 1,000 pop

Chart 3: Unplanned Bed Days



Commentary

In 2016/17 the average monthly rate in terms of unplanned bed days for Forth Valley was 637 per 1000 population compared to 648 per 1000 population in 2017/18 to date. This highlights a 1.8% increase. The rate in Falkirk has increased by 5% from 678 per 1000 population in 2016/17 to 713 per 1000 population in 2017/18.

Further analysis shows a rise on all age groups in the Falkirk Local Authority area however the most significant increase in those aged 65-74 and 75-84 years.

It was agreed that a regular Day of Care survey should be carried out in order to identify areas of required improvement.

Within the Community Hospital a Day of Care Audit has been initiated however this is in its infancy with data outcomes awaited.

Initial testing on a reliable fortnightly Day of Care Survey started in December 2015. The number of patients at that time who did not meet the criteria for an acute inpatient area was 26%. The most recent three surveys, carried out over a 6 week period, have demonstrated that Forth Valley Royal Hospital has on average of 18% of patients not meeting the criteria with 95% occupancy.

As at August 2017 the top 5 reasons for the inappropriate placement are:

1) Awaiting completion of AHP Treatment
2) Home Care Support
3) Awaiting Consultant review/decision
4) Awaiting a community bed
5) Awaiting procedure/investigation results

There have been several improvement measures introduced in Forth Valley:

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

- A daily discharge MDT huddle is in place allowing a forum for discussion by knowledgeable and expert team members to identify alternative or more appropriate pathways for patients who have complicated needs, listed for either community hospital or short term assessment bed;

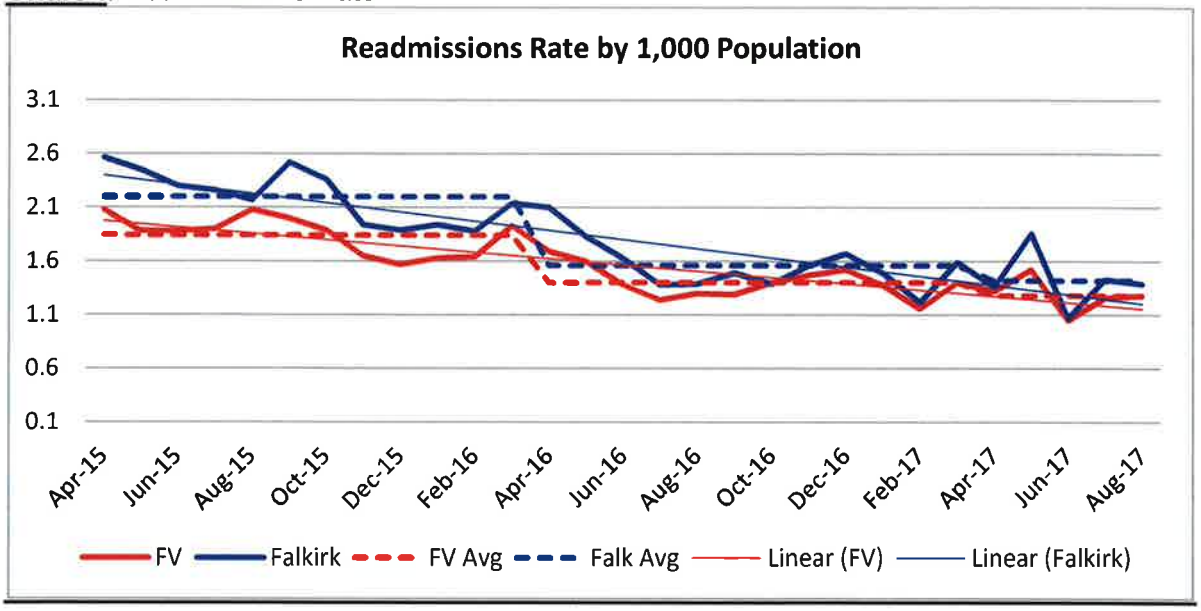
- Discharge planning education drop-in sessions were arranged for NHS Forth Valley staff during September 2016, during this time 130 staff members attended. These sessions covered all aspects of discharging planning in order to improve the patient's journey. Feedback was gathered at the end of each session with the overall response as positive with staff scoring, on average, at 8.4 out of 10 as being beneficial to them in their practice;

Standard Operating Procedures were devised for community, packages of care, social and AHP services to provide clearer pathways for identifying patients ready for discharge/transfer.

Local Outcome – Safety • **Health & Social Care support systems are in place, to help keep people safe and live well for longer**

Measure	Unscheduled Care - Rate of Readmissions per 1,000 population
Falkirk Performance	Average Monthly Rate 2017/18 = 1.42 per 1,000 population
Forth Valley Performance	Average Monthly Rate 2017/18 = 1.28 per 1,000 population

Chart 4: Readmissions Rate



Commentary

Within Forth Valley the readmissions data are standardised by specialty and condition at readmission. This means that if a patient was admitted to a medical specialty initially with a respiratory condition and is readmitted with a broken leg, this is not categorised as a readmission as it is not relevant to the initial presentation at hospital. If however the patient comes back to hospital with a further respiratory condition then this is classed as a readmission. In this way it enables targeting in areas that may require improvement.

It should be noted that this differs from national publications that report the crude rate of readmissions which is any readmission within 28 days to any health board regardless of the reason for this readmission.

Chart 4 highlights a decrease in the rate of readmissions across Forth Valley from 1.40 per 1000 population in 2016/17 to 1.28 per 1000 population in 2017/18 year to date. This decreasing trend is mirrored within Falkirk with a decrease from 1.56 per 1000 population in 2016/17 to 1.42 per 1000 population in 2017/18 year to date.

Pilot schemes across parts of the health board are assessing community focussed supports which may be able to help patients receive care at home where appropriate.

Local Outcome – Service User Experience • **People have a fair and positive experience of health and social care**

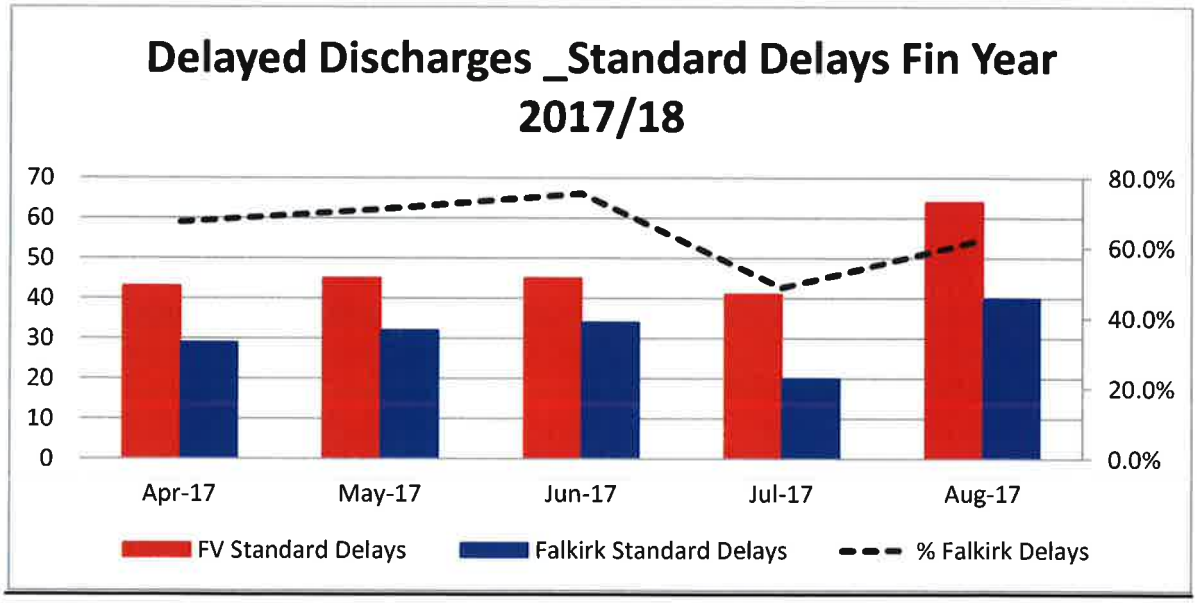
Measure	Unscheduled Care – Delayed Discharges • Standard Delayed Discharges • Bed days lost attributed to delayed discharge • Code 9 and Code 100 delays
Falkirk Performance	Monthly Number August 2017 = 40
Forth Valley Performance	Monthly Number August 2017 = 64

Commentary

As of the August census date, the following delays were recorded:

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

Chart 5: Delayed Discharges – Standard Delays



In August 2017 the number of standard delays for Forth Valley is 64. Falkirk accounts for 40 or 62.5% of all standard delays.

70% (26/37) of all standard waits over 2 weeks are attributed to Falkirk delays. At the August Census point Falkirk standard waits over 2 weeks account for 65% (26/40) of all standard waits for the Falkirk Partnership.

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

Table 1

	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17	May 17	Jun 17	Jul 17	Aug 17
Total delays at census point	51	46	39	35	37	45	38	24	29	32	34	20	40
Total number of delays over 2 weeks	33	29	25	22	26	24	25	17	14	18	18	15	26

Chart 6: Occupied Bed Days Attributed to Delayed Discharges

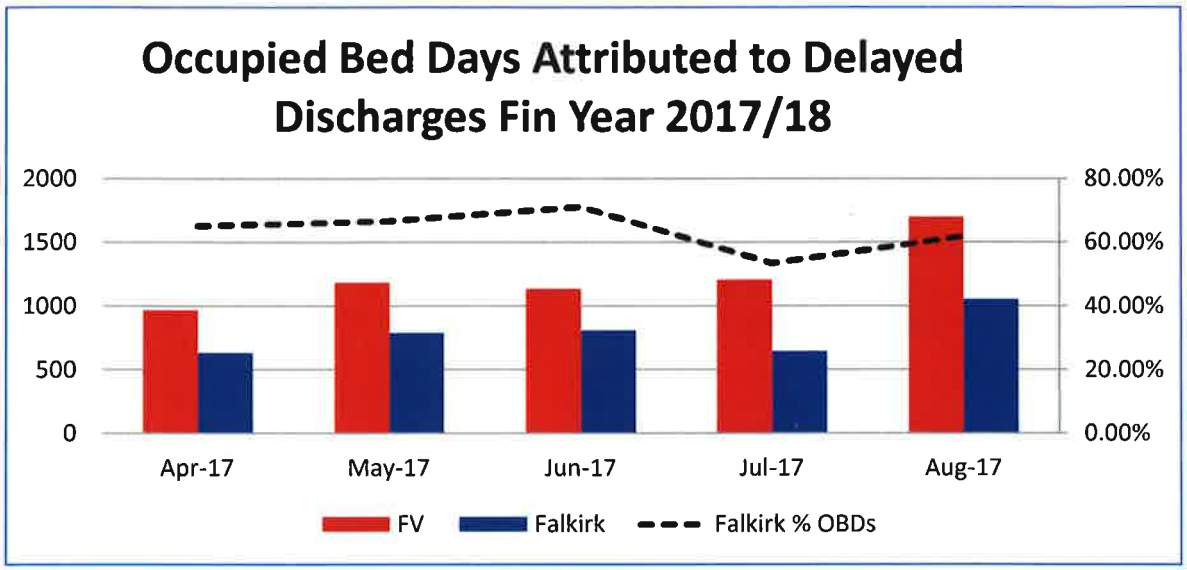
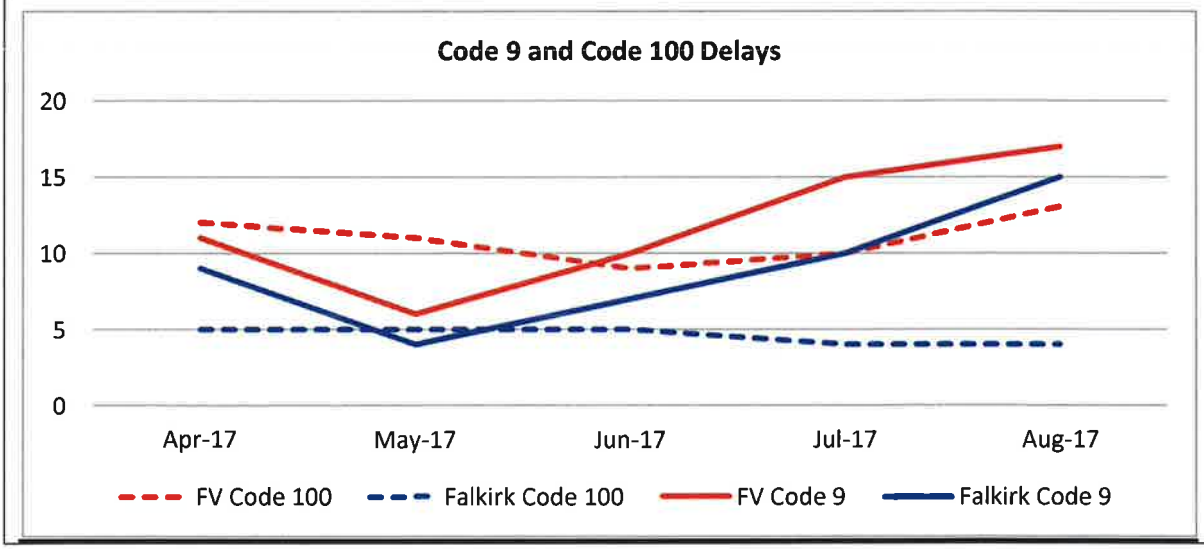


Chart 7: Code 9 and Code 100 Delays

Across Forth Valley there has been an increase in the number of occupied bed days attributed to delayed discharges with the number at the August 2017 census 1699.

The Falkirk Partnership position at the August census was 1052 occupied bed days attributed to delayed discharges. This is 62% (1052/1699) of the occupied bed days within Forth Valley attributed to delayed discharges.



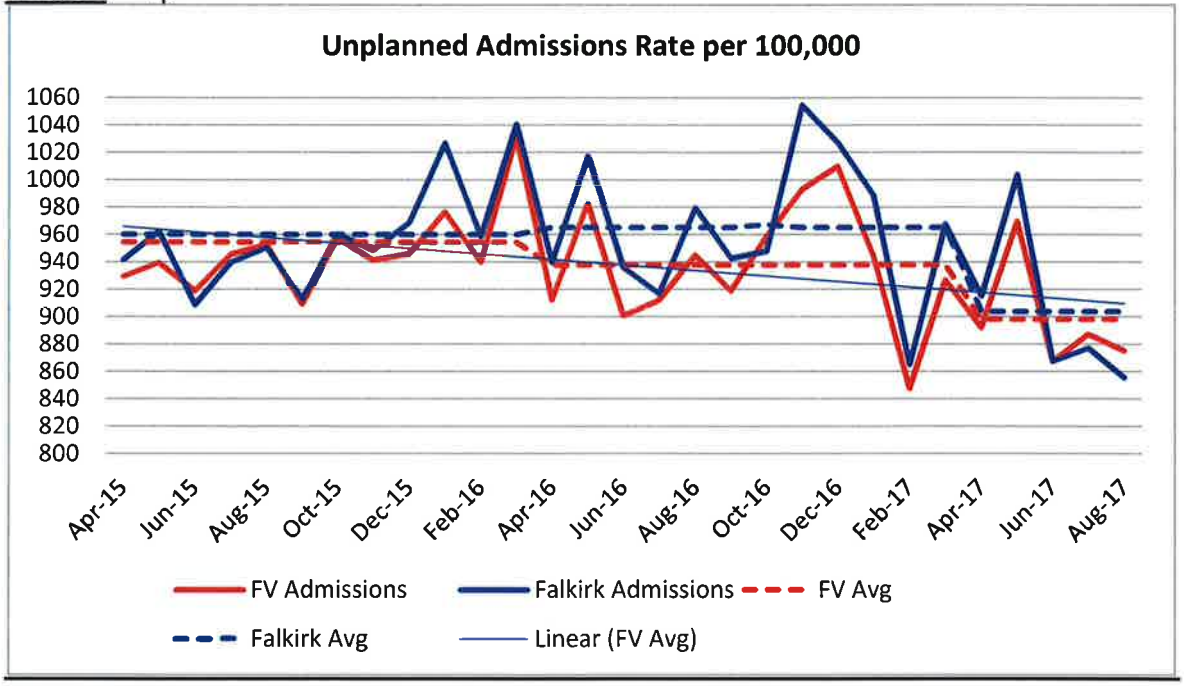
There has been an increase in the number of Code 9 and Code 100 delays across Forth Valley and across the Falkirk Partnership with the position at the August census, 15 Code 9 delays and 4 Code 100 delays.

Local Outcome – Community Based Support

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

Unscheduled Care	Falkirk Unscheduled Care - Rate of Hospital Emergency Admissions per 100,000 population
Falkirk Performance	Average Monthly Rate 2017/18 = 904 per 100,000 pop
Forth Valley Performance	Average Monthly Rate 2017/18 = 899 per 100,000 pop

Chart 8: Unplanned Admissions



Commentary

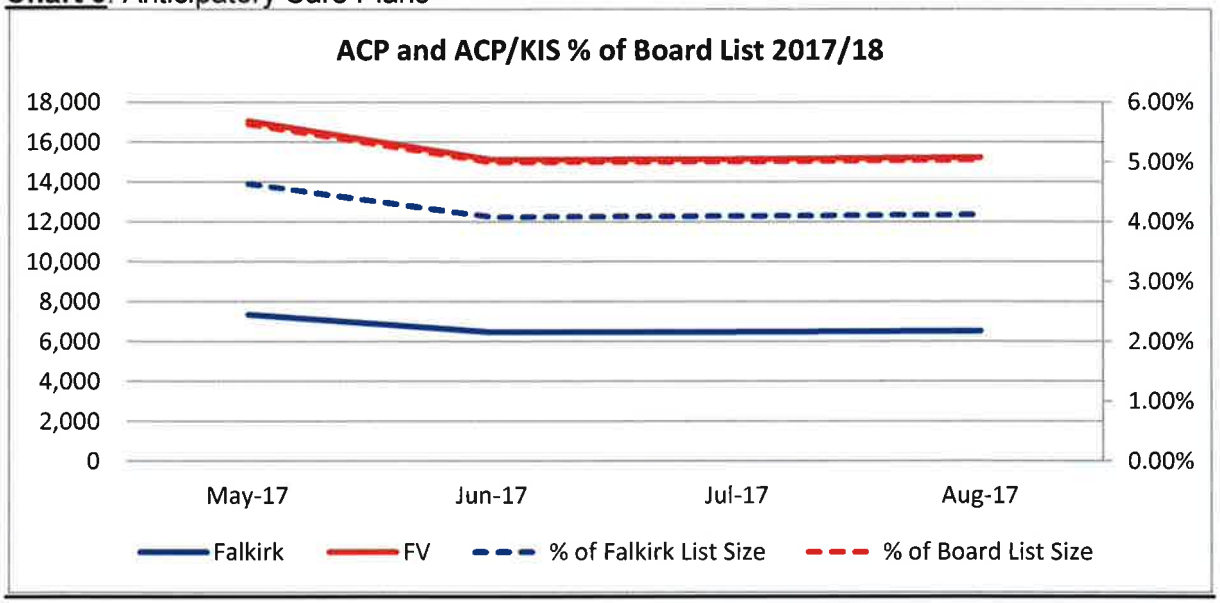
Despite the rise in Emergency Department Attendance the average unplanned admission rate for both Falkirk and Forth Valley in 2017/18 has reduced. The admission rate for the financial year 2016/17 in Forth Valley is down by 4.1%, from 938 per 100,000 population to 899 per 100,000 population this year to date. Although Falkirk admissions remain above the Forth Valley average the rate shows a 6.4% decrease from 966 per 100,000 population to 904 per 100,000 population from 2016/17 to 2017/18 year to date.

A breakdown by age range for adults shows an average 7% decrease in admissions across all groupings in the Falkirk local authority area.

- *Frailty screening, comprehensive geriatric assessment, frailty pathway*
  A joint submission has been made to HIS to take part in the Frailty Collaborative.

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

Chart 9: Anticipatory Care Plans



Commentary

Figures above are supplied by ISD. The drop in number from circa 17,000 plans produced in 2017 is a result of ISD culling records for those patients who have since died or moved outwith the area. The position of 15,231 accounts for 5% of Forth Valley residents and exceeds the target of 4,500 or 1.5%. 4.1% (6,525) of the Falkirk population are in receipt of an ACP or KIS.

The impact of the Anticipatory Care Plans on patient care is on-going. Deliberations need to be made via robust studies to assess at which stage in the patient journey referral for an ACP should be made determining the best use of current resource and identify areas for development.

End of Life and Palliative Care

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

Day services reviews
In both H&SC Partnerships, these reviews will contribute to better use of resources and support whole system capacity.

Home Care

The home care service is an important social care service in supporting people to remain in their own home for as long as possible. It is an important element within the 'whole system' of Health and Social Care. The service provides personal care support and the aim is to provide support and re-ablement of the person cared for. Most people's preferred outcome is to be supported at home for as long as possible and to avoid or defer the need to be cared for in a care home. The home care service can also help avoid hospital admissions through the Crisis care and Rehab at home services. Home care services are provided by a range of service providers, including in-house home care by the Council and and by other providers. The numbers reported below are for services for people aged 65 and over.

Performance on numbers of home care users and hours of support provided to people over the age of 65+ reflect the investment we have made in increasing capacity for reviews of support packages and implementing the reablement approach inclusive of our Re-Hab at home service, Discharge to Assess Project and our Reablement Project Team. These services are working with referrals from both the community and the hospital to support service users through reablement to maximise independence, moving to having no need for continuing service or less service than would otherwise have been the case. The reduction in overall numbers of service users is consistent with the most recent national picture reported in the Scottish Government's Social Care Survey [2-16]. The appropriateness of these indicators and our targets will be reviewed as part of the development of a new Social Work Services Plan.

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. The measures of how well care is focused on service users with the highest level of need show a broadly stable or slightly improving picture.

34. Number of people aged 65+ receiving homecare (Target to increase by 3%) *	Mar-16	Mar-17
	1887	1,807 (-3.2%) ▼

35. Number of homecare hours for people aged 65+ (Target to increase by 3%) *	Mar-16	Mar-17
	14622	13,949 (-4.6%) ▼

36. Rate of homecare hours per 1000 population aged 65+ (Target >=503.4) *	Mar-16	Mar-17
	512.2	488.6 (-4.6%) ▼

37. Number receiving 10+ hrs of home care (Target to increase by 3%) *	Mar-16	Mar-17
	406	401 (-1.2%) ▼

38. The proportion of Home Care service users aged 65+ receiving personal care *	Mar-16	Mar-17
	91.6%	92.4% ▲

39. The proportion of Home Care service users aged 65+ receiving a service during evenings/overnight *	Mar-16	Mar-17
	49.3%	49.8% ▲

40. The proportion of Home Care service users aged 65+ receiving a service at weekends *	Mar-16	Mar-17
	79.9%	81.4% ▲

41. Percentage of Rehab At Home service users who attained independence after 6 weeks (target – 80%)	**2015/16**	**2016/17 to end of Q3**
	77.40%	89.9% ▲

Falkirk Integration Joint Board Strategy Map

Appendix 1

Vision	**To enable people to live full independent and positive lives within supportive communities**				
Local Outcomes	***SELF MANAGEMENT*** - *Of Health, Care and Wellbeing.*	***AUTONOMY & DECISION MAKING*** – *Where formal support is needed people can exercise control over choices.*	***SAFETY*** - *H&SC support systems keep people safe and live well for longer.*	***SERVICE USER EXPERIENCE*** - *People have a fair & positive experience of health and social care.*	***COMMUNITY BASED SUPPORT*** - *to live well for longer at home or homely setting.*
National Outcomes (9)	**1)** Healthier living **2)** Reduce Inequalities	**4)** Quality of Life	**7)** People are safe	**3)** Positive experience and outcomes **8)** Engaged work force **9)** Resources are used effectively	**2)** Independent living **6)** Carers are supported

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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