This paper relates to Agenda Item **8**

Falkirk Health and Social Care Partnership

Title/Subject: **Performance Report**

Meeting: **Integration Joint Board**

Date: **3rd February 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 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

2.3 Note that the performance information in this report will be considered by Falkirk Council's Scrutiny Committee (External).

3. BACKGROUND

3.1 The purpose of this report is to ensure the Integration Joint Board (IJB) 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 Strategic Plans. The IJB in November 2016 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 date 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.

3.2 This report focuses on lower level partnership indicators linked to the outcomes of the Strategic Plan. Further work is required to refine these with a workshop session of the Performance Workstream taking place on the 27th January 2016 to consider this further. This will include consideration around targets and tolerances for further review by the IJB.

3.3 Challenges remain with data collection and ensuring measurement is meaningful. There can be a tendency of reporting what information is available with effort required

to consider what is actually needed to elicit service change at a local level. This report has attempted to begin to look at indicators at a partnership level with work required to move forward to consider information at a locality level over time.

4. APPROACH

4.1 As described in the previous IJB Performance Report, to ensure that there is a direct link back to the Strategic Plan, a Strategy Map was created (Appendix 1) which details the Partnership's Vision, expected Local Outcomes and then maps these against the National Health & Wellbeing Outcomes and National Core Indicators and local Partnership Indicators. As noted work is underway to further develop local partnership indicators against the Strategic Plan to sit underneath the National Indicators and grouped in such a way to make it meaningful to measure delivery of local outcomes across the spectrum of delegated functions including mental health, leaving disability, drug and alcohol services etc.

4.2 The content of the report mainly focuses on indicators around capacity across the system including delayed discharges with some measures of experience. It is acknowledged that delayed discharges are included in the Chief Officer report to the IJB and moving forward it is anticipated that the detail required will be included in the routine performance report in terms of the position and improvements required.

4.3 Correspondence was received by the Chief Executive, NHS Forth Valley, and the Chief Officer for the Falkirk Partnership in December 2016 regarding the Draft Budget 2017/18. Priorities for all Integration Authorities were made clear noting the responsibility for the planning and provision of social care, primary and community care and unscheduled hospital care for adults. Key areas were noted including aims to:

- Reduce occupied hospital beddays associated with avoidable admission and delayed discharges focussing on investment in care alternatives
- Increase the provision of good quality appropriate palliative and end of life care particularly in people's homes and communities or where appropriate in hospices
- Enhance primary care provision expanding multidisciplinary teams, sustainability, development of GP cluster etc.
- A focus on mental health improving outcomes and reducing variation
- Deliver agreed service levels for Alcohol and Drug Partnerships
- Provision for the living wage
- Continue implementation of Self Directed Support
- Prepare commencement of the Carer(Scotland) Act 2016

4.4 Further correspondence was received on 19th January 2017 from the Ministerial Strategic Group for Health and Community Care (MSG) intimating that partnerships are being invited to set out the local objectives for each of the indicators noted below by the end of February. This clearly sets out the expectation however timescales will be challenging and discussions are underway with the Scottish Government. Indicators:

- Unplanned admissions
- Occupied bed days for unscheduled care
- A&E performance
- Delayed Discharges
- End of Life care

- Balance of spend across institutional and community services.

4.5 Further work will be undertaken to ensure the performance reporting reflect activity across priorities effectively.

5. 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 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. Additionally, the triangulation of key performance indicators, measureable progress in delivering the priorities of the strategic plan and financial performance should be regarded as forming the cornerstone of demonstrating best value. Moving forward greater linkage will be made between the reports in preparation for the formulation of the Annual Report.

7. CONCLUSION

7.1 Integration Joint Boards are 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 Strategic Plans. This report represents the next step 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.

8. 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

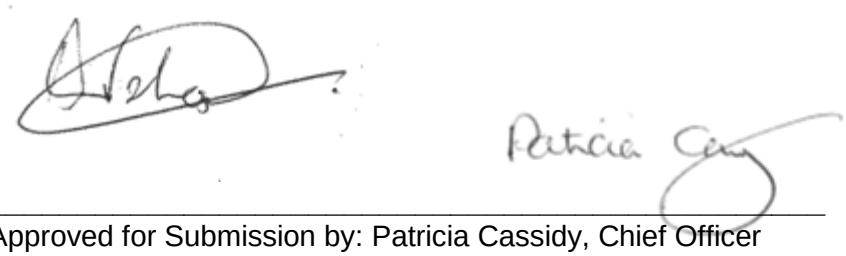
Performance management is a legal requirement as defined in the IJB's Integration Scheme.

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: Patricia Cassidy, Chief Officer
Author – Elaine Vanhegan, Head of Performance and Governance
Date: 26 January 2017

List of Background Papers:
IJB Performance Management Framework

Section 1 - Summary Exceptions

Local Outcome	Indicators	Comment
Self Management - *Of health, care and wellbeing*	- Emergency Dept (ED) 4 hour wait - Emergency Dept attendances over 65yrs, 75yrs and 85yrs	- The comparator of Dec 15 & Dec 16 indicates there has been a deterioration in the ED 4 hr wait for patients in the Local Authority area with a rise in ED attendance for each of the categories presented. This is both a local and national trend. - Variation across all measures occurs month on month and is monitored closely.
Autonomy Decision Making - *Where formal support is needed people can exercise control over choices.*	- Emergency Admission per 100,000 population/bed days 75+yrs - Long term condition admission and Number of ACPs	- There is a reduction in overall emergency admissions across the partnership over the time period, despite an increase in attendance at ED. The beddays for 75+ have also reduced although the figure for those with specific Long Term conditions has risen – reflecting the national picture. - The number of patients with an ACP has increased with further work required on the full impact of having an ACP
Safety - *Health and Social care support systems keep people safe and live well for longer*	- Two areas of measurement have been considered; readmissions and Adult Support and Protection	- As described in the previous IJB report further work is underway reviewing readmission data and linking this to Anticipatory Care Plans but an improved position is noted within the report for the partnership over the time period. - Three Adult Support and Protection indicators are reported here as data only indicators, as there is no 'good' number of ASP events.
Service User Experience - *People have a fair and positive experience of health and social care*	- Delayed Discharges including 50% reduction target - Self Directed Support Spend on Adults 18+ - SW Adult Services Complaints - SW Adult Services Sickness Absence	- Comparator taken from Dec 15 to Dec 16 with a deterioration over the time period however from mid December 2016 to into January 2017 improvement is noted. - The partnership is ahead of target against the 50 % reduction by the April census - Performance on this indicator has increased in the last year with Falkirk ranked 21. - Performance dipped 3% below the standard in the first half of 2016-17. - Sickness absence is 2% higher than the 5.5% Council target.

Local Outcome	Indicators	Comment
Community Based support - *To live well for longer at home or in homely setting*	- Respite for people aged 65+ - Carers' assessments - Provision of new adaptations - Overdue pending OT Assessments	- There was a reduction in provision of respite weeks provided to older people 65+ over the reporting period. - The number of carers' assessments has dipped in the first half of 2016-17. - There has been a 9% dip in the provision of new adaptations in 2016-17. - The number of overdue pending OT assessments has remained the same as at September 2016.

Section 2 - Overview

Falkirk Health and Social Care - Partnership Indicator Performance (as at September/December 2016)

Local Outcomes	Partnership Indicator	RAG Falkirk	
1. Self Management - of Health, Care & Wellbeing	1. Emergency department 4 hour wait	Dec 2015	Dec 2016
		97.8%	**93.8% ▼**
	2. Emergency department attendances per 100,000 population for 65+	2015	2016
		2,273.6	**2,402.8 ▼**
	3. Emergency department attendances per 100,000 population for 75+	2015	2016
		2,982.1	**3,149.2 ▼**
	4. Emergency department attendances per 100,000 population for 85+	2015	2016
		4,062.5	**4,408.7 ▼**
2. Autonomy & Decision Making – Where formal support is needed people can exercise control over choice	5. Emergency admission rate per 100,000 population	2014/15	2015/16
		10,311	**9,956 ▲**
	6. Acute emergency bed days per 1000 population for 75+	2014/15	2015/16
		484,451	**474,984 ▲**
	7. Long term conditions – bed days per 100,000 population	Dec 2015	Dec 2016
		6,765	**7,716 ▼**
	8. Number of patients with an ACP	Dec 2015	Dec 2016
		5,759	**6,915 ▲**
	9. KIS as Percentage of the Board area list size	Dec 2015	Dec 2016
		3.8%	**4.5% ▲**
3. Safety – Health & Social Care support systems keep people safe and live well for longer	10. Readmission rate within 28 days per 1000 population 75+	Dec 2015	Dec 2016
		5.15	**4.35 ▲**
	11. Number of Adult Protection Referrals (data only)	2015/16	2016/17 H1
		579	**257**
	12. Number of Adult Protection Investigations (data only)	2015/16	2016/17 H1
		45	**20**
	13. Number of Adult Protection Support Plans (data only)	Mar 2016	Sep 2016
		12	**9**
	14. The total number of people with community alarms at end of the period	2014/15	2015/16
		4,484	**4,526 ▲**
	15. Percentage of community care service users feeling safe	2015/16	2016/17 H1
		90%	**91% ▲**

Local Outcomes	Partnership Indicator	RAG Falkirk	
4. Service User Experience – People have a fair and positive experience of Health & Social Care	16. Total standard delayed discharges	Dec 2015	Dec 2016
		35	**37 ▼**
	17. Total delayed discharges over 2 weeks	Dec 2015	Dec 2016
		24	**26 ▼**
	18. Total bed days occupied by delayed discharge s	Nov 2015	Nov 2016
		1001	**1247 ▼**
	19. Number of code 9 delays	Dec 2015	Dec 2016
		8	**12**
	20. Number of Code 100 delays	Dec 2015	Dec 2016
		9	**3 ▲**
	21. Total delays		**Dec 2016**
			49▲
	○ 50% reduction target (30 by April 2017 census)		**56**
	22. Percentage of service users satisfied with their involvement in the design of their care package	2015/16	2016/17 H1
		98%	**98% ◄►**
	23. Percentage of service users satisfied with opportunities for social interaction	2015/16	2016/17 H1
		93%	**93% ◄►**
	24. Percentage of carers satisfied with their involvement in the design of care package	2015/16	2016/17 H1
		92%	**93% ▲**
	25. 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 H1
		89%	**80% ▼**
	26. Percentage of Adults satisfied with social care or social work services, and rank nationally (biennial indicator) (national Local Govt Benchmarking Framework (LGBF) indicator	2012/15	2013/16
		74% (1st)	**69% (3rd) ▼**
	27. Average weekly cost per care home resident, and rank nationally (LGBF indicator)	2014/15	2015/16
		£325 (6th)	**£339 (8th) ▼**
	28. Older Persons (65+) Home Care Costs per Hour and rank nationally (LGBF indicator)	2014/15	2015/16
		£16.33 (9th)	**£14.74 (2nd) ▲**
	29. Self Directed Support Spend on Adults 18+ as a % of Total spend on Adults 18+, and rank nationally (LGBF indicator)	2014/15	2015/16
		1.9% (29th)	**2.6% (21st) ▲**
	30. The proportion of Social Work Adult Services complaints completed within 20 days (target – 70%)	2015/16	2016/17 H1
		73.4%	**66.7% ▼**
	31. Sickness Absence in Social Work Adult Services (target – 5.5%)	2015/16	2016/17 H1
		7.9%	**7.7% ▼**

Local Outcomes	Partnership Indicator	RAG Falkirk	
5. Community Based Support – to live well for longer at home or in a homely setting	32. The total respite weeks provided to older people aged 65+ (overnight & daytime combined)	2014/15	2015/16
		1,834.2	1,703.7 ▼
	33. The total respite weeks provided to older people aged 18-64 (overnight & daytime combined)	2014/15	2015/16
		729.1	724.6 ▼
	34. Number of people aged 65+ receiving homecare (Target to increase by 3%) *	Mar 2016	Sep 2016
		1,867	1,856 ▼
	35. Number of homecare hours for people aged 65+ (Target to increase by 3%) *	Mar 2016	Sep 2016
		14,622	14,010 ▼
	36. Rate of homecare hours per 1000 population aged 65+ (Target >=503.4) *	Mar 2016	Sep 2016
		512.2	490.8 ▼
	37. Number receiving 10+ hrs of home care (Target to increase by 3%) *	Mar 2016	Sep 2016
		406	393 ▼
	38. The proportion of Home Care service users aged 65+ receiving personal care	Mar 2016	Sep 2016
		91.6%	91.7% ▲
	39. The proportion of Home Care service users aged 65+ receiving a service during evenings/overnight	Mar 2016	Sep 2016
		49.3%	49.5% ▲
	40. 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**		
	41. Percentage of Rehab At Home service users who attained independence after 6 weeks (target – 80%)	2015/16	2016/17 Q1
		77.4%	93.0% ▲
	42. Percentage of Crisis Care service users who are retained in the community when service ends (target - 70%)	2015/16	2016/17 Q1
		63.7%	73.3% ▲
	43. Number of new Telecare service users 65+	2014/15	2015/16
		124	142 ▲
	44. The number of people who had a community care assessment or review completed	2015/16	2016/17 H1
		9,571	5,492
	45. The number of Carers' Assessments carried out	2015/16	2016/17 H1
		1,936	818 ▼
	46. The number of new adaptations provided during the reporting year	2014/15	2015/16
		1,766	1,605 ▼
	47. The number of overdue 'OT' pending assessments at end of the period	Mar 2016	Sep 2016
		352	352 ▼

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.

Local Partnership Indicators – (aligned to national indicators as appropriate)

1. **Emergency Department 4 Hour wait**
   Purpose of Indicator: This is a system measure which can be impacted upon for a variety of reasons e.g. the availability of beds for admission, inappropriate ED attendance, multiple attendances all at once and it is not all within the control of the ED. The target is that 95% (moving to 98%) of people should wait no longer than 4 hours from arrival in the ED, to admission, discharge or transfer from the ED.

2. **Emergency Department attendances per 100,000 population for those aged 65+,**
3. **Emergency Department attendances per 100,000 population for those aged 75+ ;**
4. **Emergency Department attendances per 100,000 population for those aged 85+**

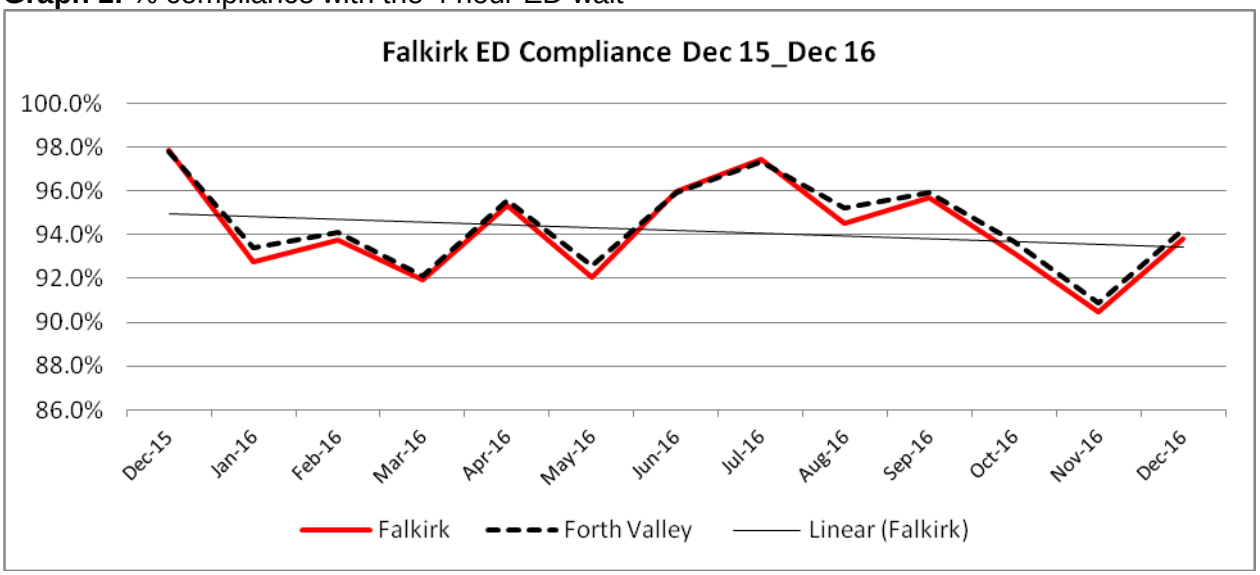
   Purpose of Indicators: The most appropriate treatments, interventions, support and services will be provided at the right time to everyone who will benefit, and wasteful or harmful variation will be eradicated. The goal is a reduction in the rates of attendance at A&E.

   There are on-going challenges in respect of Emergency Department 4 Hour wait and Emergency Department attendances both locally and nationally. In terms of the 4hr ED target, from a position above target of 97.4% (Board wide) in December 2015, performance throughout 2016 remained relatively stable across Forth Valley ranging on average between 94% and 95%. In October 2016 performance became more challenging averaging between 92% and 93% with a notable increase in breaches down to 'wait for bed' as the system was challenged with an increased number of delayed discharges. The other main reason for patents breaching the 4 hour wait period is 'wait for first assessment' with considerable work undertaken throughout the year to ensure all processes with the emergency Department are as efficient as possible.

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%.

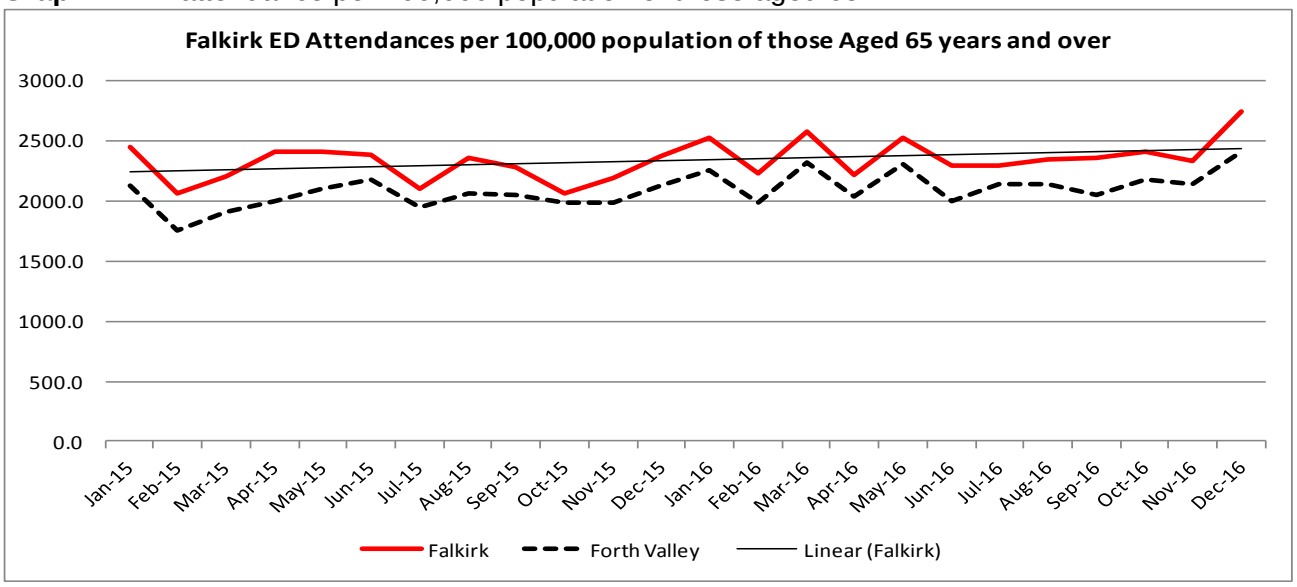
Graph 1: % compliance with the 4 hour ED wait



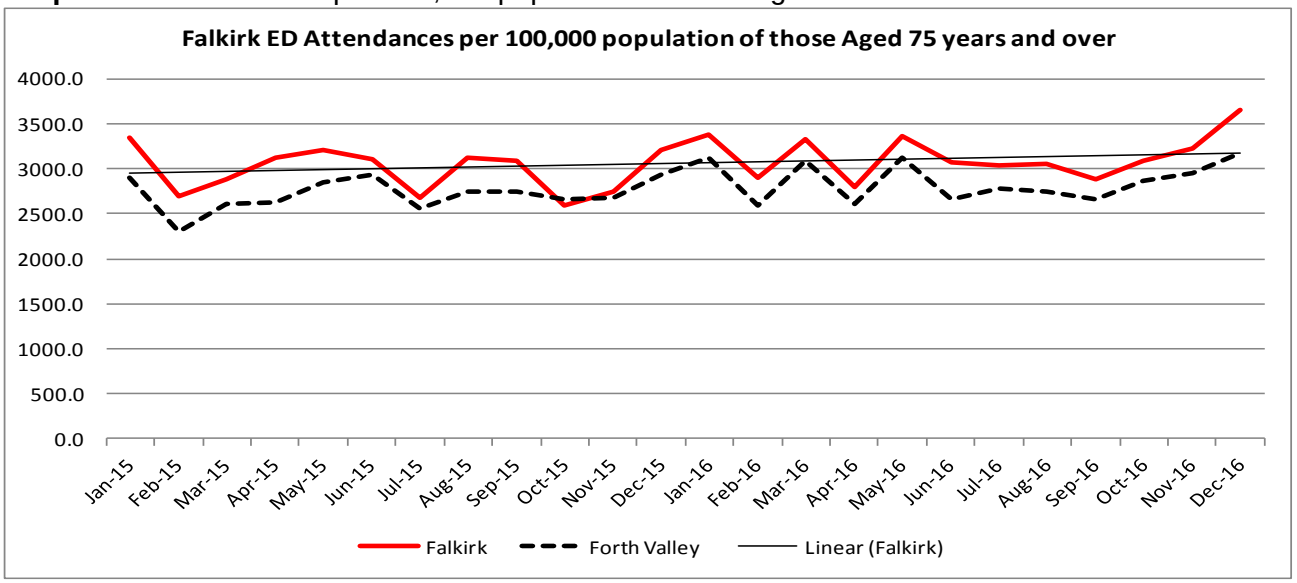
Emergency Department attendances

The graphs illustrate the rising trend of ED attendance but notably this has not been matched with a rising trend on admission or over 75+ beddays. Further work is required to correlate this information to activities at the front door, discharge routes e.g. Closer to Home, Intermediate care and now Discharge to Assess and information regarding home care.

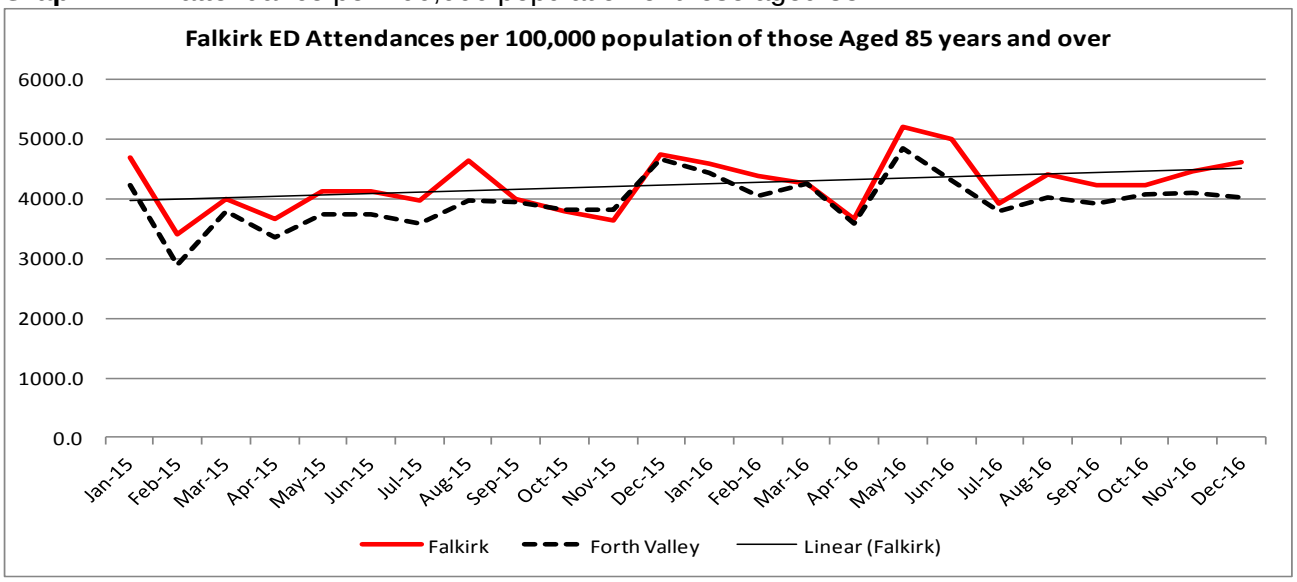
Graph 2: ED attendance per 100,000 population of those aged 65+



Graph 3: ED attendance per 100,000 population of those aged 75+



Graph 4: ED attendance per 100,000 population of those aged 85+



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)

5. Emergency admission rate per 100,000 population

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	2014/15	2015/16 ▲
	10,311	9,956

Improved position over the reporting period. Close monitoring continues with work to link the determinants to admission over time e.g. health inequalities multiple morbidityetc.

6. Acute emergency bed days per 1000 population for 75+

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 for 75+	2014/15	2015/16 ▲
	484,451	474,984

Improved position over the reporting period. Close monitoring continues.

7. 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

Long term conditions – bed days per 100,000 population	Dec 2015	Dec 2016▼
	6765	7716

The Long term conditions indictor has seen a rise over the reporting period. This is a longstanding measure with a similar pattern being seen nationally. Work is underway to consider this more locally and include other conditions such as those related to drugs and alcohol.

8. Number of patients with an ACP

9. KIS 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

KIS as Percentage of the Board area list size	**Dec 2015**	**Dec 2016▲**
	3.8%	4.5%

This is a useful indicator of an increase in activity around planning ahead and ensuring vulnerable at risk of admission or requiring additional support have a KIS. Further work is underway to look at the impact of these in respect of readmission and how ACPs and the KIS is being used on a day to day basis and kept in a timely fashion people have .

Work is on-going in respect of the Decision Making Partnership Indicators in support of ensuring meaningful data and comparisons.

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)

1. **Readmission rate within 28 days per 1000 population 75+ (note this is a National Indicator too)**
   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

	Dec 2015	Dec 2016▲
Readmission rate within 28 days per 1000 population 75+	5.15	4.35

   The IJB received a report indicating a long standing challenge with readmissions across Forth Valley underlining 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. Work continues to monitor this important indicator.

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 an national indicator)

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.

16. **Total standard delayed discharges**
17. **Total delayed discharges over 2 weeks**
18. **Total bed days occupied by delayed discharges**
19. **Number of code 9 delays**
20. **Number of code 100 delays**
21. **Total delays - 50% reduction in delayed discharges by April 2017 census**

There have been on-going challenges in respect of delayed discharges. In December, the Health Board Chief Executive and the Chief Officers of the Health and Social Care Partnerships in Forth Valley met with the Shona Robison, Cabinet Secretary for Health and Sport. The purpose of the meeting was to discuss performance against the national delayed discharge target and the actions the Health Board and Partnerships intend to implement to improve the position. At this meeting the overall situation was considered and it was agreed that a 50% reduction in delayed discharges was required by the end April Census. This was based the total number of patients across Forth Valley in November including Guardianships and Codes 9s. Trajectories have since been set from December onwards.

Delayed Discharges

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

- 37 people delayed in their discharge
- 26 people who were delayed for more than 2 weeks
- 5 people identified as a complex discharge (code 9)
- 7 people proceeding through the guardianship process
- 3 people identified as a Code 100 delay.

Although there has been a decrease in the position since the last report to the IJB as highlighted in table 1 and graph 1, this remains an ongoing challenge and is being closely monitored. Data excludes Codes 9 and 100.

Table 1: Total delays and delays over 2 weeks December 2015 to December 2016

	Dec '15	Jan '16	Feb '16	Mar '16	Apr '16	May '16	Jun '16	Jul '16	Aug '16	Sep '16	Oct '16	Nov '16	Dec '16
Total delays at census point	35	27	23	29	27	23	32	45	51	46	39	35	37
Total number of delays over 2 weeks	24	20	14	18	18	12	18	30	33	29	25	22	26

Graph 1: Total delays and delays over 2 weeks December 2015 to December 2016

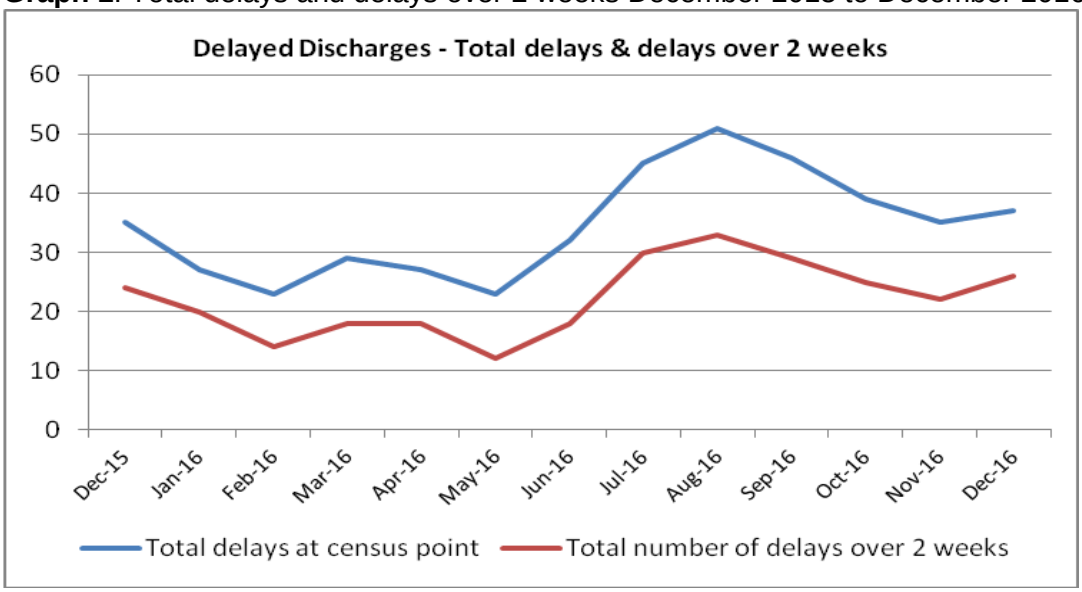


Table 2 shows the total picture of delays in Falkirk Partnership across all categories expressed as occupied bed days. These figures are for full months to the end of October and show increasing pressure on bed days compared with February 2016.

Table 2: Total occupied bed days in 2016

	Nov '15	Dec '15	Jan '16	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Equivalent Beds (Nov)
Standard delays	1001	1085	926	797	990	975	875	854	1247	1468	1432	1393	1247	40
Complex Delays/ Guardianships (Code 9)	231	248	236	217	265	277	186	158	256	275	376	454	374	12

Forth Valley agreement for reduction in Delayed Discharges December 2016-April 2017

Following a meeting with the Scottish Government in December 2016, targets for the remainder of the financial year, including the April census, have been agreed on a Forth Valley NHS Board basis. The target total includes all Code 9 but excludes Code 100.

Falkirk 2016/17 - Trajectory

	December	January	February	March	April
Target	56	47	42	34	30
Actual	49				

Improvement Plan

The Partnership Delayed Discharge Group has developed an Improvement Plan which covers in a single plan all of the strategic operational actions that partners require to take to improve and maintain the delayed discharge position. Updates on elements of the Plan will be provided on an ongoing basis as appropriate with a proposal that a full update is provided to the IJB on a six monthly basis.

Further detail is discussed in the Delayed Discharge Progress Report on the IJB Agenda.

29. Self Directed Support expenditure

Purpose of Indicator:
Self Directed Support allows people needing support to decide on the support they need and who will provide it. This indicator calculates the cost of Self Directed Support spend on adults as a proportion (%) of the total social work spend on adults. This indicator allows councils to monitor how much is spent on Self Directed Support as a proportion of their total spending on adult social work. Over time, this will help us establish if more clients wish to adopt Self Directed Support for themselves.

Position

	2014/15	2015/16
Self Directed Support Spend on Adults 18+ as a % of Total spend on Adults 18+, and rank nationally (LGBF indicator)	**1.9% (29th)**	**2.6% (21st) ▲**

This indicator is reported by the Improvement Service as one of four local Government Benchmarking Framework indicators and reports data on SDS expenditure. However, the data only includes expenditure under SDS options 1 and 2. The indicator excludes SDS expenditure where service users chose either local authority managed services, or services involving multiple SDS options 1, 2, or 3. For this reason, the data is not regarded as reliable for comparison across local authorities, but Falkirk rose from the fourth quartile, rank 29 in 2014-15 to third quartile, rank 21 in 2015-16.

Work has commenced on a new eligibility framework to complement the development of outcomes focused assessment practice. Alongside this work, where a person's need is assessed as being eligible a new approach to resource allocation will give an upfront indicative individual budget which is expected to lead to more people feeling confident about the SDS option of taking a direct payment [SDS option 1] or using their individual budget to direct the Council as to the use of the budget [SDS option 2].

30. 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 H1
The proportion of Adult Social Work Service complaints completed within 20 days (target – 70%)	**73.4%**	**66.7% ▼**

During 2017 changes will be made to the administration of complaints as part of continuous improvement in this area of performance.

31. 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 H1
Sickness Absence in Adult Social Work Service (target –		

5.5%)	**7.9%**	**7.7% ▼**

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 has been 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 from 10% absence down to the current 7.5%. A programme of awareness briefings for all home carers were held to target short-term absence to try to reduce our absence rates further. A new dedicated HR Assistant post has now been created to fulfil the same function for the remaining sections within Social Work Adult Services.

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– note delayed discharge not currently a national indicator)

32. 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)	**1,834.2**	**1,703.7 ▼**

There has been a decline 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 Carers Centre respite and Short Breaks Bureau "respitality" initiative. As across other areas of service provision there has been increased scrutiny of submissions for respite care under the current Eligibility Criteria. 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.

45. The number of Carers' assessments carried out

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 H1
The number of Carers' Assessments carried out	**1,936**	**818 ▼**

There has been a small decline in the number of Carers' assessments carried out by community care teams in the first half of 2016-17. However, it is important to note that in addition to carers assessments carers' experiences when carrying out assessments are also recorded (see Local partnership indicators 24, and 25).

The Council also work in partnership and partly fund the Central Carers Association. The CCA supports carers in many different ways. In 2015-16 they carried out 178 Carer Support Plans; 51 Support Plan reviews; and 314 carers received information and assistance on welfare benefits. In the first half of 2016/17 they have carried out 222 Carer Support Plans. The CCA now supports over 2000 carers in the Falkirk area. This indicator will be reviewed in light of the changes required to meet the requirements of the new Carers Act in 2018. The latter will also enable comparative national data to be reported.

46. The number of new Adaptations

Purpose of Indicator: The provision of adaptations to service users' homes helps to maintain people with intensive needs in the community, either at home or in a homely setting for longer. This also meets service users and carers preferences. So the provision or arrangement of adaptations supports the strategy of both improving service users experiences and supporting community based support services.

Position

	2014/15	2015/16
The number of new adaptations provided during the reporting year	**1,766**	**1,605 ▼**

This indicator is collated from 3 sources:

- adaptations purchased by Adult Social Work Services;
- adaptations provided to owner occupiers through grants accessed by Corporate & Housing; and
- adaptations provided to council tenants through Corporate & Housing Services.

There has been a decline of 9% in the number of new adaptations provided in the last reporting year. Work on adaptations can take time to complete depending on the characteristics of the property. Community Care teams have been tackling outstanding assessments in the last three months to speed up the provision of adaptations. This work will be reflected in the 2016-17 outturn report.

47. The number of overdue OT pending assessments

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

	Mar 2016	Sep 2016
The number of overdue 'OT' pending assessments at end of the period	**352**	**352 ▼**

The number of overdue pending OT assessments in the first half year of 2016-17 has remained stable, but 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, 40% were at priority 2 and 60% 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. As noted above, Community Care teams have been tackling outstanding assessments in the last three months to speed up the provision of adaptations. This work will be reflected in the 2016-17 outturn report.

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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
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+yrs 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 (Under development)	• ED Attendance • Life expectancy age 65+ • Deaths from Cancer/CHD	• *Dementia – post diagnostic tgt, • Mental Health/Learning Disability data • Self- directed support (SDS) • Care home capacity	• HAI • Telecare data 75+ • Adult Protection	• Local Client/patient data • Patient/Service user Experience survey • Complaints • Staff Survey data • Financial and Budgetary information	• Care at home services, including Homecare service patterns for clients 65+ • Respite weeks provided • Community care assessments • Carers' assessments • Em/Admission 65+75+ per 100,000