# AGENDA ITEM
# 10

Agenda Item: 10

Falkirk
Health and Social Care
Partnership

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|---|---|
| **Title/Subject:** | **Performance Report** |
| **Meeting:** | **Integration Joint Board** |
| **Date:** | **30 March 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.

3.2 Similar to the report presented to the February IJB, this report continues to focus on lower level 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.

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## 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.

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 also includes some of the indicators that now form the Partnership Improvement Plan, as requested by the Ministerial Strategic Group for Health and Community Care (MSG) in a letter received by the Chief Officer on 19 January 2017. As noted in the Chief Officer report, further work is required and this will be taken forward.

Indicators included:

- Unplanned admissions
- Occupied bed days for unscheduled care
- A&E performance
- Delayed Discharges.

There is more detailed breakdown for a number of indicators based of varying age ranges, excluding children. All data have been reconciled with ISD publications. Further work is underway in terms of drawing conclusions around what the data is suggesting and cross linking this to interventions that may be supporting improvement or where further action is required where there is a deterioration in performance.

## 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. 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 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.

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

**Author – Elaine Vanhegan, Head of Performance and Governance**
**Date:** 21 March 2017

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

## Section 1 - Summary Exceptions

| Local Outcome | Indicators | Comment |
|---|---|---|
| **Self Management**<br>- *Of health, care and wellbeing* | - Emergency Dept (ED) 4 hour wait<br><br>- Emergency Dept attendances per 100,000 over 20-64yrs, 65-74yrs, 75-84yrs and 85+yrs | - The comparator of February 2015 to February 2017 indicates there has been a deterioration in the ED 4 hour wait for patients in the Local Authority area with a rise in ED attendance per 100,000 in the 75-84 year age category February 2016-February 2017. A reduction in attendances is noted the 20-64, 65-74 and 85+ age categories over the same time period.<br>- Variation across all measures occurs month on month and is monitored closely. |
| **Autonomy Decision Making**<br>- *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<br>- Acute emergency bed days per 1,000 population 20-64yrs, 65-74yrs, 75-84yrs and 85+yrs<br>-<br>- Long term condition admission<br><br>- Number of Anticipatory Care Plans/Key Information Summaries<br><br>- Self Directed Support (SDS) | - There is a reduction in emergency admissions across all age categories within the partnership over the time period.<br>- Acute emergency bed days have increased in all age categories with the exception of the 75-84 year group.<br><br>- Figures for those with specific Long Term conditions have risen – reflecting the national picture.<br><br>- The number of patients with an ACP has increased with further work required on the full impact of this and how Key Information Summaries are used<br><br>- 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 at this stage. |
| **Safety**<br>- *Health and Social care support systems keep people safe and live well for longer* | - Hospital readmissions aged 75+ | - Work to review readmission data, linking this to Anticipatory Care Plans is on-going however an improved position is noted within the report for the partnership to the end of February 2017. |

| Local Outcome | Indicators | Comment |
|---|---|---|
| **Service User Experience**<br>- *People have a fair and positive experience of health and social care* | - Delayed Discharges including 50% reduction target<br><br>- SW Adult Services Complaints<br><br>- SW Adult Services Sickness Absence | - Comparator taken from February 2015 to February 2017 with a downward trend over the time period.<br>- The partnership is behind the 50% reduction target set by the Scottish Government.<br><br>- Performance dipped 7% below the standard in the first three quarters of 2016/17.<br>- Sickness absence is almost 2.5% higher than the 5.5% Council target. |
| **Community Based support**<br>- *To live well for longer at home or in homely setting* | - Rehab at Home users who attained independence, Crisis Care service users who are retained in the community, Telecare service users and completion of a community care assessment or review<br><br>- Carers' assessments<br><br>- Provision of new adaptations<br><br>- Overdue pending OT Assessments<br><br>- Proportion of last 6 months of life spent at home and bed days in last s months of life | - 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.<br><br>- The number of carers' assessments has dipped in the first half of 2016/17.<br><br>- There was a 9% dip in the provision of new adaptations in 2015/16.<br><br>- The number of overdue OT assessments has reduced by just under 9.6% since March 2016.<br><br>- 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

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

| Local Outcomes | Partnership Indicator | RAG Falkirk | | |
|---|---|---|---|---|
| **1. Self Management** - of Health, Care & Wellbeing | 1. Emergency department 4 hour wait | **Feb 2015** | **Feb 2016** | **Feb 2017** |
| | | **94.8%** | **93.7%** | **92.6% ▼** |
| | 2. Emergency department attendances per 100,000 population 20-64 years | **Feb 2015** | **Feb 2016** | **Feb 2017** |
| | | **1,720** | **1,991** | **1,860 ▲** |
| | 3. Emergency department attendances per 100,000 population 65-74 years | **Feb 2015** | **Feb 2016** | **Feb 2017** |
| | | **1,581** | **1,699** | **1,686 ▲** |
| | 4. Emergency department attendances per 100,000 population 75-84 years | **Feb 2015** | **Feb 2016** | **Feb 2017** |
| | | **2,462** | **2,419** | **2,580 ▼** |
| | 5. Emergency department attendances per 100,000 population 85+ years | **Feb 2015** | **Feb 2016** | **Feb 2017** |
| | | **3,407** | **4,381** | **3,472 ▲** |

| 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 | **2014/15** | **2015/16** |
| | | **7305** | **6853▲** |
| | 7. Emergency admission rate per 100,000 population 65-74 years | **2014/15** | **2015/16** |
| | | **16,269** | **16,002▲** |
| | 8. Emergency admission rate per 100,000 population 75-84 years | **2014/15** | **2015/16** |
| | | **30,982** | **29,885▲** |
| | 9. Emergency admission rate per 100,000 population 85+ years | **2014/15** | **2015/16** |
| | | **51,584** | **50,528▲** |
| | 10. Acute emergency bed days per 1000 population 20-64 years | **Dec 2015** | **Dec 2016** |
| | | **30,0657.8** | **31,337▼** |
| | 11. Acute emergency bed days per 1000 population 65-74 years | **Dec 2015** | **Dec 2016** |
| | | **126,359.5** | **132,231▼** |
| | 12. Acute emergency bed days per 1000 population 75-84 years | **Dec 2015** | **Dec 2016** |
| | | **3,504** | **3,436▲** |
| | 13. Acute emergency bed days per 1000 population 85+ years | **Dec 2015** | **Dec 2016** |
| | | **844,271** | **929,827▼** |
| | 14. Long term conditions – bed days per 100,000 population | **Dec 2015** | **Dec 2016** |
| | | **7,627** | **8,049 ▼** |
| | 15. Number of patients with an Anticipatory Care Plan | **Feb 2016** | **Feb 2017** |
| | | **7,209** | **8,104▲** |
| | 16. Key Information Summary as Percentage of the Board area list size | **Feb 2016** | **Feb 2017** |
| | | **4.55%** | **5.11%▲** |
| | 17. Self directed support (SDS) options selected: People choosing | **Mar 2016** | **Dec 2016** |
| | SDS Option 1: Direct payments | **33 (1%)** | **33 (1%)** |
| | SDS Option 2: Directing the available resource | **46 (2%)** | **69 (3%) ▲** |
| | SDS Option 3: Local Authority arranged | **1,505 (62%)** | **1,697 (66%)▲** |
| | SDS Option 4: Mix of options, 1,2,3 | **30 (1%)** | **35 (1%) ▲** |
| | No recorded SDS Option | **805 (33%)** | **751 (29%) ▲** |

| 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+ | **Feb 2015** | **Feb 2016** | **Feb 2017** |
| | | **3.78** | **4.27** | **2.82▼** |
| | 19. Number of Adult Protection Referrals (data only) **(This performance was reported to IJB in Feb 2017)** | | **2015/16** | **2016/17 H1** |
| | | | **579** | **257** |
| | 20. Number of Adult Protection Investigations (data only) **(This performance was reported to IJB in Feb 2017)** | | **2015/16** | **2016/17 H1** |
| | | | **45** | **20** |
| | 21. Number of Adult Protection Support Plans (data only) **(This performance was reported to IJB in Feb 2017)** | | **Mar 2016** | **Sep 2016** |
| | | | **12** | **9** |
| | 22. The total number of people with community alarms at end of the period | | **2014/15** | **2015/16** |
| | | | **4,484** | **4,526▲** |
| | 23. 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 | 24. Total standard delayed discharges | **Feb 2015** | **Feb 2016** | **Feb 2017** |
| | | **16** | **23** | **38▼** |
| | 25. Total delayed discharges over 2 weeks | **Feb 2015** | **Feb 2016** | **Feb 2017** |
| | | **7** | **14** | **25▼** |
| | 26. Total bed days occupied by delayed discharge s | **Feb 2015** | **Feb 2016** | **Feb 2017** |
| | | **316** | **615** | **816▼** |
| | 27. Number of code 9 delays | **Feb 2015** | **Feb 2016** | **Feb 2017** |
| | | **25** | **19** | **16 ▲** |
| | 28. Number of Code 100 delays | **Feb 2015** | **Feb 2016** | **Feb 2017** |
| | | **15** | **10** | **2 ▲** |
| | 29. Total delays - 50% reduction target (30 by March 2017) | **Nov 2016** | **Dec 2016** | **Feb 2017** |
| | | **Actual** | **Target: 56** | **Target: 42** |
| | | **58** | **49▲** | **54▼** |
| | 30. Percentage of service users satisfied with their involvement in the design of their care package | | **2015/16** | **2016/17 H1** |
| | | | **98%** | **98% ◄►** |
| | 31. Percentage of service users satisfied with opportunities for social interaction | | **2015/16** | **2016/17 H1** |
| | | | **93%** | **93% ◄►** |
| | 32. Percentage of carers satisfied with their involvement in the design of care package | | **2015/16** | **2016/17 H1** |
| | | | **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 H1** |
| | | | **89%** | **80% ▼** |
| | 34. The proportion of Social Work Adult Services complaints completed within 20 days (target – 70%) | | **2015/16** | **2016/17 to end Q3** |
| | | | **73.4%** | **62.8% ▼** |
| | 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**<br>**1,834** | **2015/16**<br>**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**<br>**729** | **2015/16**<br>**724▼** |
| | 38. Number of people aged 65+ receiving homecare (Target to increase by 3%) * | **Mar 2016**<br>**1,867** | **Sep 2016**<br>**1,856 ▼** |
| | 39. Number of homecare hours for people aged 65+ (Target to increase by 3%) * | **Mar 2016**<br>**14,622** | **Sep 2016**<br>**14,010 ▼** |
| | 40. Rate of homecare hours per 1000 population aged 65+ (Target >=503.4) * | **Mar 2016**<br>**512.2** | **Sep 2016**<br>**490.8 ▼** |
| | 41. Number receiving 10+ hrs of home care (Target to increase by 3%) * | **Mar 2016**<br>**406** | **Sep 2016**<br>**393 ▼** |
| | 42. The proportion of Home Care service users aged 65+ receiving personal care * | **Mar 2016**<br>**91.6%** | **Sep 2016**<br>**91.7% ▲** |
| | 43. The proportion of Home Care service users aged 65+ receiving a service during evenings/overnight * | **Mar 2016**<br>**49.3%** | **Sep 2016**<br>**49.5% ▲** |
| | 44. The proportion of Home Care service users aged 65+ receiving a service at weekends * | **Mar 2016**<br>**79.9%** | **Sep 2016**<br>**80.8% ▲** |
| | * **Note each year's Home Care data is a snapshot of provision in a single reporting week at end of reporting period**<br>**No update of data beyond September 2016 currently available** | | |
| | 45. Percentage of Rehab At Home service users who attained independence after 6 weeks (target – 80%) | **2015/16**<br>**77.4%** | **2016/17 to end H1**<br>**83.5% ▲** |
| | 46. Percentage of Crisis Care service users who are retained in the community when service ends (target - 70%) | **2015/16**<br>**63.7%** | **2016/17 to end H1**<br>**71.3% ▲** |
| | 47. Number of new Telecare service users 65+ | **2014/15**<br>**124** | **2015/16**<br>**142 ▲** |
| | 48. The number of people who had a community care assessment or review completed | **2015/16**<br>**9,571** | **2016/17 H1**<br>**5,492 ◄►** |
| | 49. The number of Carers' Assessments carried out | **2015/16**<br>**1,936** | **2016/17 H1**<br>**818 ▼** |
| | 50. The number of new adaptations provided during the reporting year | **2014/15**<br>**1,766** | **2015/16**<br>**1,605 ▼** |
| | 51. The number of overdue 'OT' pending assessments at end of the period | **Mar 2016**<br>**352** | **At end Dec 2016**<br>**318 ▲** |
| | 52. Proportion of last six months of life spent at home | **2014/15**<br>**86.1%** | **2015/16**<br>**86.0%** |
| | 53. Number of days by setting during the last six months of life: Community | **2014/15**<br>**228,702** | **2015/16**<br>**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.

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.

**Position**

| | Feb 2015 | Feb 2016 | Feb 2017 |
|---|---|---|---|
| Emergency department 4 hour wait | **94.8%** | **93.7%** | **92.6% ▼** |

2. **Emergency Department attendances per 100,000 population 20-64 years**
3. **Emergency Department attendances per 100,000 population 65-74 years,**
4. **Emergency Department attendances per 100,000 population 75-84 years**
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.

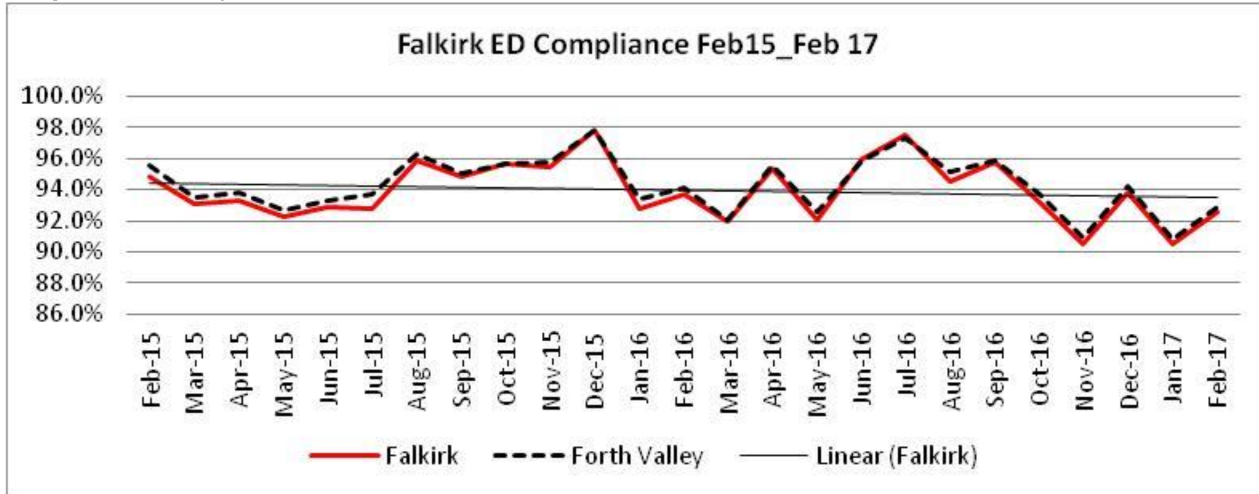
**Position**

| | Feb 2015 | Feb 2016 | Feb 2017 |
|---|---|---|---|
| Emergency department attendances per 100,000 population 20-64 years | **1,720** | **1,991** | **1860 ▲** |
| Emergency department attendances per 100,000 population 65-74 years | **1,581** | **1,699** | **1686 ▲** |
| Emergency department attendances per 100,000 population 75-84 years | **2,462** | **2,419** | **2580 ▼** |
| Emergency department attendances per 100,000 population 85+ years | **3,407** | **4,381** | **3472 ▲** |

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 4 hour ED target, from a position better 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%. From October 2016 performance became more challenging, with the position fluctuating. Average performance was between 92% and 93% with a period of thrice daily monitoring Scottish Government in place February and early March 2017. There was a notable increase in breaches due to 'wait for bed' as the system was challenged with an increased number of delayed discharges however into March this has become more settled. The other main reason for patents breaching the 4 hour wait period remains 'wait for first assessment'. Considerable work has been undertaken throughout the year to ensure all processes with the Emergency Department are as efficient as possible. The ED performance has improved significantly in the past 2 weeks.

**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

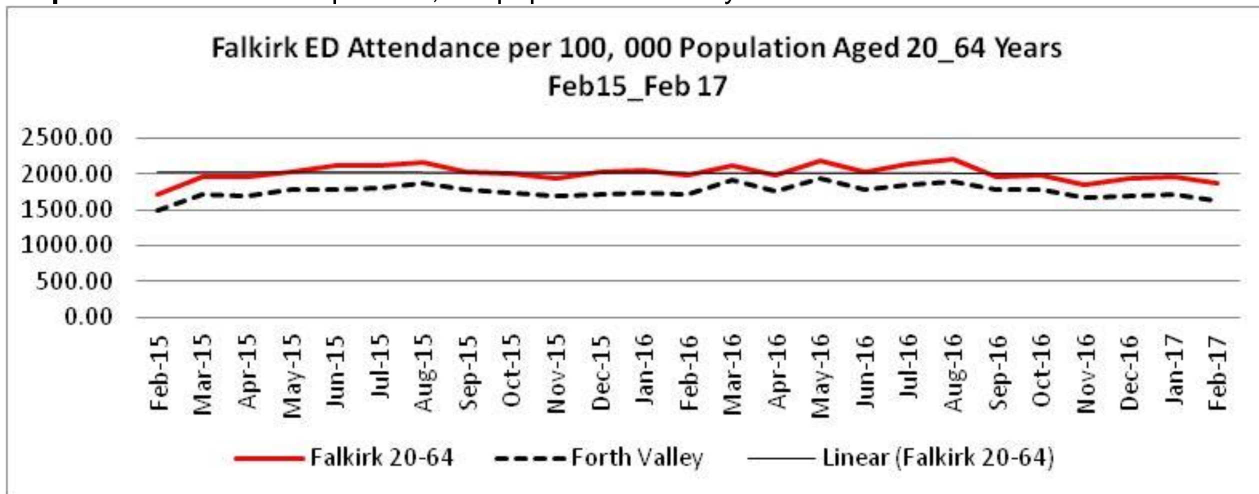



**Emergency Department attendances**
The graphs illustrate a rising trend of ED attendance in the 65-74, 75-84 and 85+ years age category for the Falkirk Partnership with a reduction in the 20-64 year age groups. However the February 2016 to February 2017 comparisons highlight an increase in the 75-84 year age category only.

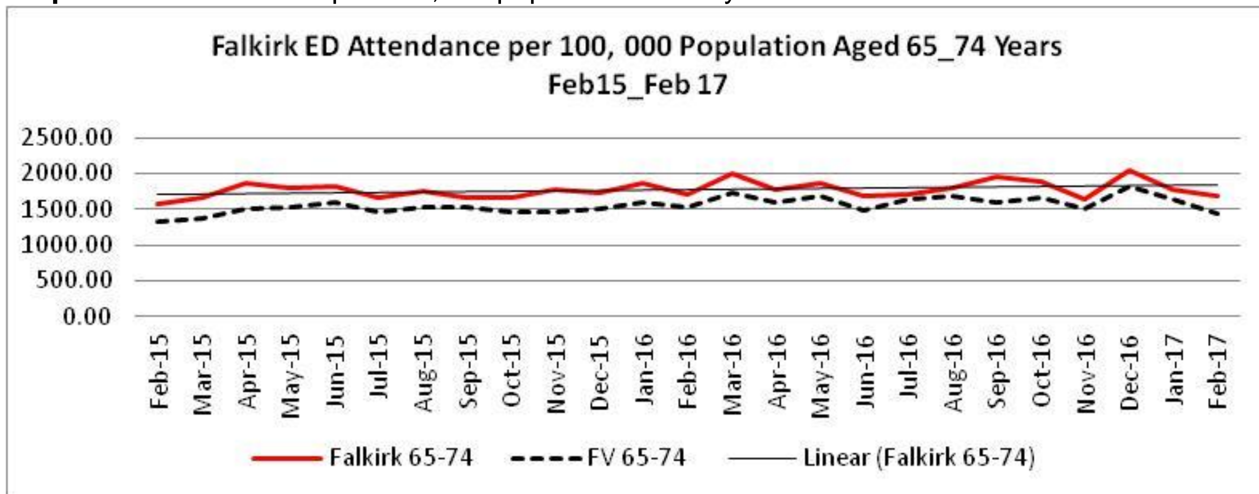
Acute emergency bed days have decreased in the 75-84 years age category however it should be noted that this has not been matched in the 20-64, 75-84 or 85+ year groups. The 75+ readmission rate has however improved.

Work is required 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. Linked aspects of Unscheduled Care are being taken forward and reviewed by the Unscheduled Care group led by Mr Andrew Murray, Medical Director, NHS Forth Valley. This is a multi agency group which includes IJB Chief Officers.

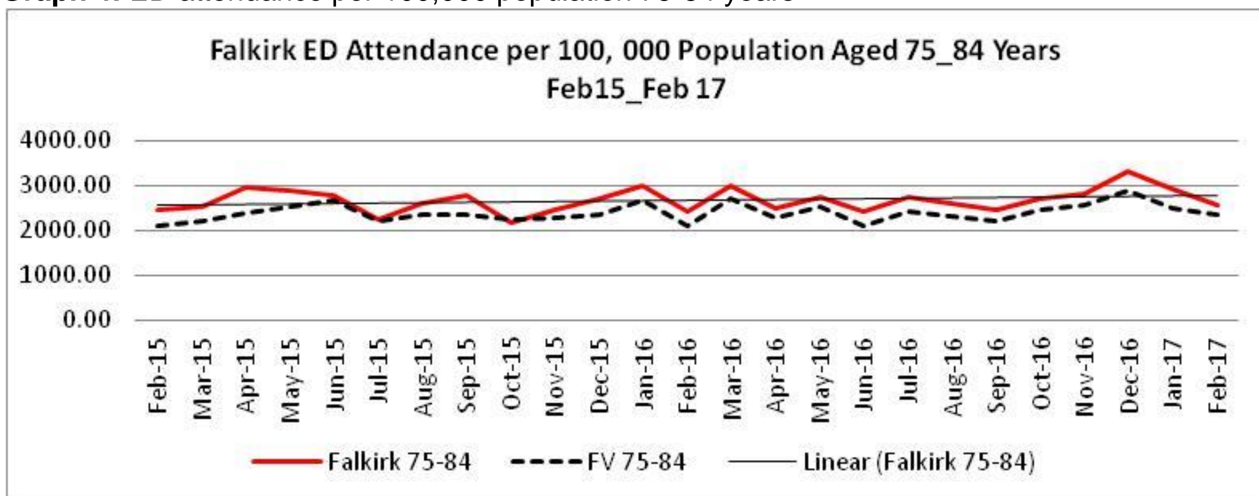
**Graph 2:** ED attendance per 100,000 population 20-64 years



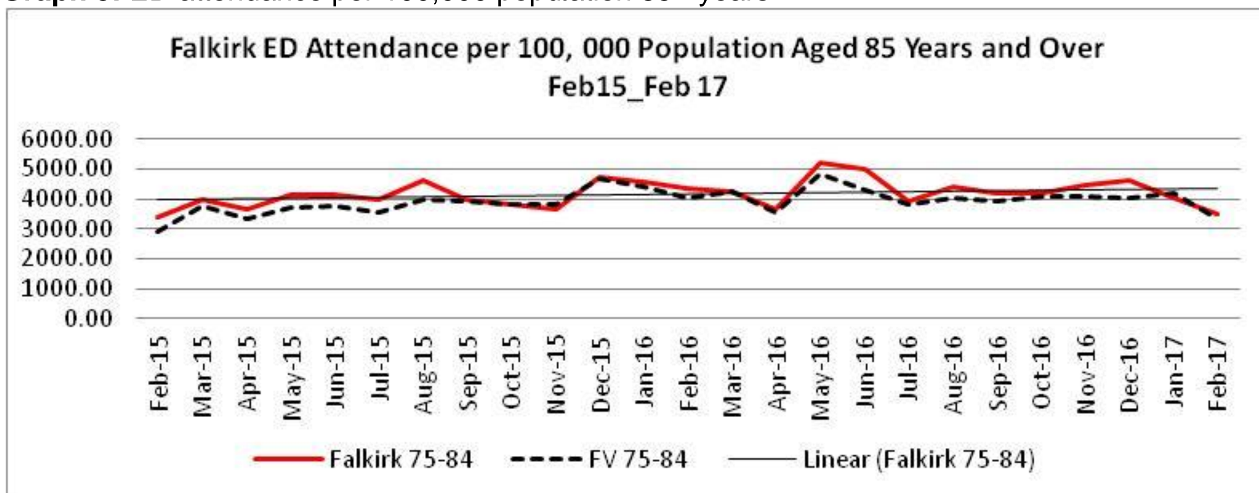
**Graph 3:** ED attendance per 100,000 population 65-74 years




**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)

6. **Emergency admission rate per 100,000 population 20-64 years**
7. **Emergency admission rate per 100,000 population 65-74 years**
8. **Emergency admission rate per 100,000 population 75-84 years**
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**

| Indicator | | |
|---|---|---|
| Emergency admission rate per 100,000 population 20-64 years | **2014/15** | **2015/16** |
| | **7305** | **6853 ▲** |
| Emergency admission rate per 100,000 population 65-74 years | **2014/15** | **2015/16** |
| | **16,269** | **16,002 ▲** |
| Emergency admission rate per 100,000 population 75-84 years | **2014/15** | **2015/16** |
| | **30,982** | **29,885 ▲** |
| Emergency admission rate per 100,000 population 85+ years | **2014/15** | **2015/16** |
| | **51,584** | **50,528 ▲** |

There is an improved position over the reporting period across all age categories. Close monitoring continues with work to link the determinants to admission over time e.g. health inequalities multiple morbidity etc.

10. **Acute emergency bed days per 1000 population 20-64 years**
11. **Acute emergency bed days per 1000 population 65-74 years**
12. **Acute emergency bed days per 1000 population 75-84 years**
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**

| Indicator | | |
|---|---|---|
| Acute emergency bed days per 1000 population 20-64 years | **Dec 2015** | **Dec 2016** |
| | 30,0657 | 31,337▼ |
| Acute emergency bed days per 1000 population 65-74 years | **Dec 2015** | **Dec 2016** |
| | 126,359.5 | 132,231 ▼ |
| Acute emergency bed days per 1000 population 75-84 years | **Dec 2015** | **Dec 2016** |
| | 3,504 | 3,436 ▲ |
| Acute emergency bed days per 1000 population 85+ years | **Dec 2015** | **Dec 2016** |
| | 844,271 | 929,827 ▼ |

Deteriorating position noted over the reporting period with the exception of the 75-84 years age category. Close monitoring continues.

**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**

| | Dec 2015 | Dec 2016 |
|---|---|---|
| Long Term Conditions – bed days per 100,000 population | 7,627 | 8,049 ▼ |

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.

The measure includes Diabetes, Hypertension, Angina, Ischaemic Heart Disease, Chronic Obstructive Pulmonary Disease, Asthma and Heart Failure. Work is underway to consider this more locally and include other conditions such as those related to drugs and alcohol.

**15. Number of patients with an Anticipatory Care Plan (ACP)**
**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**

| | Feb 2016 | Feb 2017 |
|---|---|---|
| Number of patients with an Anticipatory Care Plan | 7,209 | 8,104 ▲ |
| | Feb 2016 | Feb 2017 |
| Key Information Summary as Percentage of the Board area list size | 4.55% | 5.11% ▲ |

This is a useful indicator of 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 comparisons.

**17. Self directed support (SDS) options**

| Self directed support (SDS) options selected: People choosing: | Mar 2016 | Dec 2016 |
|---|---|---|
| SDS Option 1: Direct payments | **33 (1%)** | **33 (1%)** |
| SDS Option 2: Directing the available resource | **46 (2%)** | **69 (3%)** ▲ |
| SDS Option 3: Local Authority arranged | **1,505 (62%)** | **1,697 (66%)** ▲ |
| SDS Option 4: Mix of options, 1, 2, 3 | **30 (1%)** | **35 (1%)** ▲ |
| No recorded SDS Option | **805 (33%)** | **751 (29%)** ▲ |

The recent IJB development session focussed 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)

**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**

| | Feb 2015 | Feb 2016 | Feb 2017 |
|---|---|---|---|
| Readmission rate within 28 days per 1000 population 75+ | **3.78** | **4.27** | **2.82 ▲** |

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 to February 2017. 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)

**24. Total standard delayed discharges**
**25. Total delayed discharges over 2 weeks**
**26. Total bed days occupied by delayed discharges**
**27. Number of code 9 delays**
**28. Number of code 100 delays**
**29. Total delays - 50% reduction in delayed discharges by April 2017 census**

*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**

| | | | |
|---|---|---|---|
| Total standard delayed discharges | **Feb 2015** | **Feb 2016** | **Feb 2017** |
| | **16** | **23** | **38 ▼** |
| Total delayed discharges over 2 weeks | **Feb 2015** | **Feb 2016** | **Feb 2017** |
| | **7** | **14** | **25 ▼** |
| Total bed days occupied by delayed discharges | **Feb 2015** | **Feb 2016** | **Feb 2017** |
| | **316** | **615** | **816 ▼** |
| Number of code 9 delays | **Feb 2015** | **Feb 2016** | **Feb 2017** |
| | **25** | **19** | **16 ▲** |
| Number of Code 100 delays | **Feb 2015** | **Feb 2016** | **Feb 2017** |
| | **15** | **10** | **2 ▲** |
| Total delays - 50% reduction target (30 by March 2017) | **Nov 2016** | **Dec 2016** | **Feb 2017** |
| | **Actual** | **Target: 56** | **Target: 42** |
| | **58** | **49▲** | **54 ▼** |

**<u>Delayed Discharges</u>**

**Table 1:** Falkirk 2016/17 - Trajectory

| | December | January | February | March |
|---|---|---|---|---|
| Target | 56 | 47 | 42 | 30 |
| Actual | 49 | 58 | 54 | |

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 to discuss performance against the national delayed discharge target and the actions the Health Board and Partnerships intend to implement to improve the position. It was agreed that a 50% reduction in delayed discharges was required by the end of March 2017. 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. Having exceeded the trajectory point of 56 at the December census with a position of 49, the position in February has deteriorated. At the census point there were 54 delays against a trajectory point of 42, with the overall target a reduction to 30.

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

- 38 people delayed in their discharge
- 25 people who were delayed for more than 2 weeks
- 8 people identified as a complex discharge (code 9)
- 8 people proceeding through the guardianship process
- 2 people identified as a Code 100 delay.

Table 2 and graph 5, highlight an increasing trend in respect of total delays and delays over 2 weeks. This remains an ongoing challenge and is being closely monitored. Data excludes Codes 9 and 100.

**Table 2:** Total delays and delays over 2 weeks February 2016 to February 2017

| | Feb 2016 | Mar 2016 | Apr 2016 | May 2016 | Jun 2016 | Jul 2016 | Aug 2016 | Sep 2016 | Oct 2016 | Nov 2016 | Dec 2016 | Jan 2017 | Feb 2017 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Total delays at census point | 23 | 29 | 27 | 23 | 32 | 45 | 51 | 46 | 39 | 35 | 37 | 45 | 38 |
| Total number of delays over 2 weeks | 14 | 18 | 18 | 12 | 18 | 30 | 33 | 29 | 25 | 22 | 26 | 24 | 25 |

**Graph 6**: Total delays and delays over 2 weeks February 2016 to February 2017

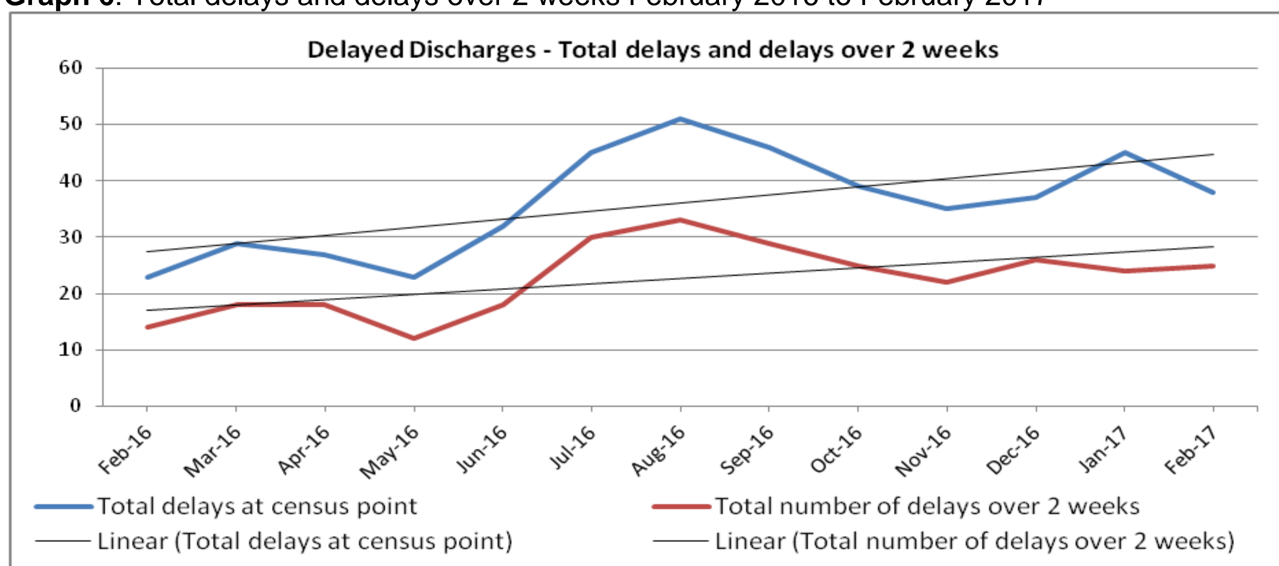


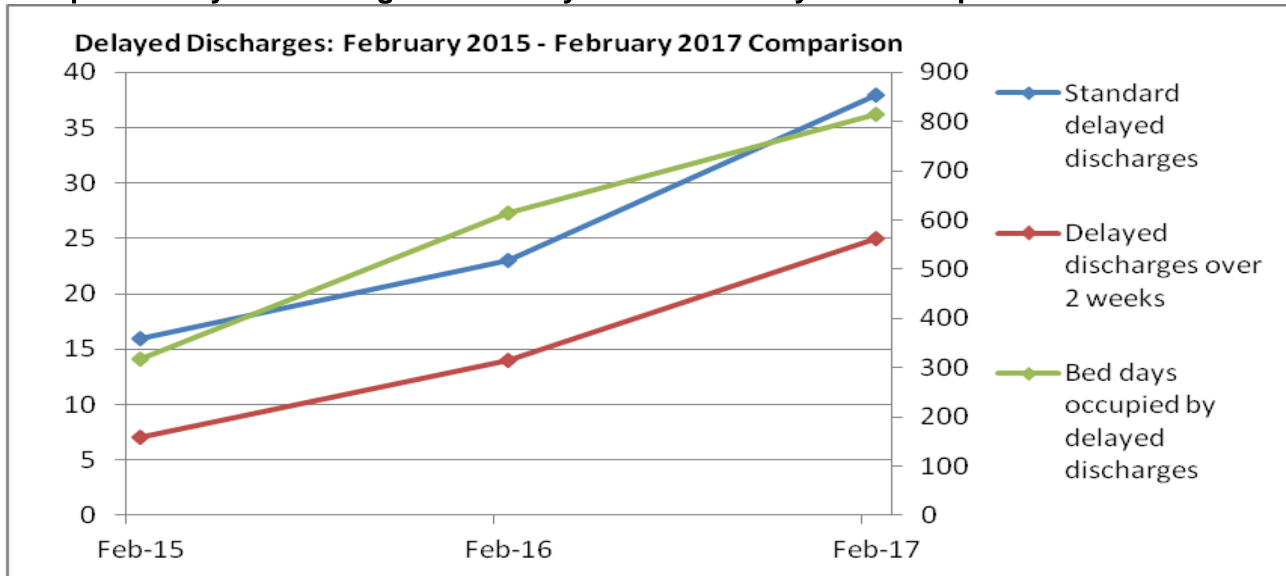

Table 3 shows the total picture of delays in Falkirk Partnership across all categories expressed as occupied bed days. These figures are for full months to the end of February 2017 and show increasing pressure on bed days compared with February 2016. The equivalent in beds for February 2017 standard delays is 42 with 15 for Code 9 delays.

**Table 3:** Total occupied bed days in 2016/17

| | Feb 2016 | Mar 2016 | Apr 2016 | May 2016 | Jun 2016 | Jul 2016 | Aug 2016 | Sep 2016 | Oct 2016 | Nov 2016 | Dec 2016 | Jan 2017 | Feb 2017 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Standard delays | 797 | 990 | 975 | 875 | 854 | 1247 | 1468 | 1432 | 1393 | 1247 | 1247 | 1252 | 1171 |
| Complex Delays/ Guardianships (Code 9) | 217 | 265 | 277 | 186 | 158 | 256 | 275 | 376 | 454 | 374 | 374 | 377 | 428 |

Graph 7 highlights the increasing trend in respect of standard delays, delays over 2 weeks and bed days occupied by delayed discharges February 2015 to February 2017.

**Graph 7: Delayed Discharges - February 2015 – February 2017 Comparison**




**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.

## 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

| The proportion of Adult Social Work Service complaints completed within 20 days (target – 70%) | 2015/16 | 2016/17 to end Q3 |
|---|---|---|
| | 73.4% | 62.8% ▼ |

Performance has dipped below target in the first three quarters of 2016-17. However, it is important to note that the number of complaints is small and small numerical differences can result in large percentage changes, which can be misleading. During 2017 changes will be made to the administration of complaints as part of continuous improvement in this area of performance.

### 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 this year by almost one percent since 2015-16. 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 were held to target short-term absence to try to reduce our absence rates further. A new dedicated HR Assistant post was also created to fulfil 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.

**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)

### 51. 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 | At end Dec 2016 |
|---|---|---|
| The number of overdue 'OT' pending assessments at end of the period | 352 | 318 ▲ |

The number of overdue pending OT assessments to the end of December 2016 has reduced by 9.6% 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, 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. 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.

### 52. Proportion of last six months of life spent at home

**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**

| | 2014/15 | 2015/16 |
|---|---|---|
| Proportion of last six months of life spent at home: Community | 86.1% | 86.0% |
| | **2014/15** | **2015/16** |
| Number of days by setting during the last six months of life: Community | 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 have 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<br>**2)** Reduce Inequalities | **4)** Quality of Life | **7)** People are safe | **3)** Positive experience and outcomes **8)** Engaged work force<br>**9)** Resources are used effectively | **2)** Independent living<br>**6)** Carers are supported |
| **National Indicators (23)<br>(* Indicator under development nationally)** | **1)** % of adults able to look after their health well/quite well<br>**11)** Premature mortality rate | **7)** % of adults who agree support has impacted on improving/maintaining quality of life<br>**12*)** Rate of Emergency admissions for adults<br>**17)** % of care services graded 'good' (4) or better by Care Inspectorate | **9)** % of adults supported at home who felt safe<br>**13*)** Emergency bed day rate for adults<br>**14*)** Readmission to hospital within 28 days rate<br>**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<br>**4)** % of adults supported at home who agree their health and care services are co-ordinated<br>**5)** % of adults receiving care and support rated as excellent or good<br>**6)** % of people with positive GP experiences<br>**10)** % of staff who recommend their place of work as good<br>**19)** Rate of days people aged 75+ spend in hospital when they are ready to be discharged,<br>**20)** % of total health and care spend on hospital stays where the patient admitted as an emergency<br>**(22*)** % people discharged from hospital within 72 hours of being ready<br>**23)** Expenditure on end of life care | **2)** % of adults supported at home who agree they are supported to be independent<br>**8)** % of carers who feel supported in their role<br>**15)** % of last 6 months of life spent at home or in community<br>**18)** % of adults 18+ years receiving intensive support at home<br>**21*)** % of people admitted to hospital from home then discharged to care home<br><br>*Note linkage to 'Experience'*<br>**19)** Rate of days people aged 75+ spend in hospital when they are ready to be discharged,<br>**(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<br>• ED Attendance 20-64, 65-74, 75-84, 85+ | • Anticipatory Care plans (ACP)<br>• Key information summary (KIS)<br>• Emergency Admissions per 100,000 population 20-64, 65-74, 75-84, 85+<br>• Acute emergency bed days 20-64, 65-74, 75-84, 85+<br>• Long Term Conditions<br>• Self Directed Support (SDS) | • Readmissions 75+<br>• Adult Protection<br>• Community alarms<br>• Service users feeling safe | • Patient/Service user Experience survey<br>• Delayed discharge<br>• Complaints<br>• Absence<br>• Financial and Budgetary information | • Care at home services, including Homecare patterns for clients 65+<br>• Respite weeks provided<br>• Community care assessments<br>• Carers' assessments<br>• Proportion of last 6 months of life spent at home or community setting<br>• Bed days in last 6 months of life |
| **Partnership Indicators (Under development)** | • Life expectancy age 65+<br>• Deaths from Cancer/CHD<br>• Consent to share | • Dementia – post diagnostic support<br>• Mental Health/Learning Disability SOLD measures<br>• Emergency re-attendance – alcohol/drugs/mental health<br>• Care home capacity<br>• Single shared Assessment (SSA) data<br>• AWI measures | • Falls – ED attendance/ Community teams<br>• Mental Welfare Commission reports<br>• Care Inspectorate reports<br>• Mental Health patient Safety data<br>• HAI Community Hospitals<br>• Telecare data 65+ | • Local service user/patient data<br>• Staff Survey data | • Impact of Delayed discharges on readmissions<br>• Balance of care 18-64<br>• Balance of care 65+<br>• Discharge to assess<br>• Closer to Home |