Perth & Kinross Integration Joint Board

AUDIT & PERFORMANCE COMMITTEE

.

19 June 2018

PEFORMANCE FRAMEWORK FOR OLDER PEOPLE & UNSCHEDULED CARE

Report by Chief Financial Officer (G/18/86)

PURPOSE OF REPORT

This report seeks to provide the Audit and Performance Committee with a proposed set of indicators that will support the understanding of the Partnership's performance in relation to the Programme of Care: Older People / Unscheduled Care.

1. RECOMMENDATION

It is recommended that the Audit and Performance Committee:

- Note the proposed indicator set;
- Note the development of Programmes of Care;
- Note that the setting of targets and monitoring will be the responsibility of the Older People / Unscheduled Care Programme Board ;
- Note that the format of reporting to the Audit and Performance Committee will move to a qualitative and quantitative approach;
- Agrees that six monthly reports on performance will be received by the Audit and Performance Committee moving forward.

2. BACKGROUND

2.1 Programmes of Care

As part of the refresh of the Strategic Commissioning Plan, the P&K Health and Social Care Partnership have remodelled their service delivery into 4 Programmes of Care.

- Older People / Unscheduled Care
- Mental Health and Wellbeing
- Carers Services
- Primary Care

This will enable a more effective and focussed method of the planning, delivery and continuous improvement of these service areas and will be an essential enabler in delivering the key priorities of the refreshed Strategic Commissioning Plan.

These Programmes of Care will be supported by their Programme Boards. In the area of performance, this Board will be responsible for the monitoring and review of the indicators and the setting of targets.

The Board will be responsible for agreeing the final data set for performance and can, throughout the year, add and/or remove indicators as challenges and priorities change.

2.2 Programme Board Support

The development of the Programme Boards required also the development of robust governance which included dedicated Programme Leads, Programme Managers and Project Management support. These roles will bring a layer of scrutiny to the activity in the localities and its performance reporting back to the Programme Board.

In addition, the recent alignment of the Council's Business Support teams into the Partnership has created an opportunity to move that support into the key priorities of the partnership represented by the 4 Programmes of Care.

These business support teams bring additional resources into the partnership that encompasses finance, performance, performance reporting, programme and project management and support for transformation, change and improvement.

2.3 Older People / Unscheduled Care Reporting

It is planned to develop a performance reporting format for the Board and for Audit & Performance Committee that will focus on narratives to better explain the behaviour of the indicator

These narratives shall identify the actions and activity that have had a positive or negative impact on the relative indicator and will rely on additional causal indicators during analysis.

Ultimately it is the intention of move to exception reporting to focus attention on the areas of issue when indicators / measures are moving away from their target value

2.4 Indicators / Measures

As with all indicators and their use in performance frameworks, there is a very large selection of indicators that can be used to demonstrate performance. It will be the role of the Board to agree which ones are to be used that tells the story.

To support that selection process and refine it, the indicators in Appendix 1 have been placed into themes that represent natural groupings of indicators. Currently these groups are:

- Balance of Care
- Delayed Discharge
- Frailty
- Unscheduled Care

These indicators can be both local and national but the national indicators do come with a lag / delay in the period they report on

3. CONCLUSION

The Partnership is committed to developing comprehensive performance reporting that will accurately describe the challenges and progress of change and improvement within each of the Programmes of Care

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APPENDIX

Appendix 1 – Proposed dataset for Programme of Care group: Older People / Unscheduled Care

Proposed Older People / Unscheduled Care Dataset **Appendix1**

Theme	Measure	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	% Change over period
Balance of Care	Number of people receiving Home Care Option 2 & 3 65+	1118	1100	1111	1108	1097	1097	1093	1092	1103	1071	1083	1081	-3.31%
Balance of Care	All people receiving Free Personal Care - 65+	1403	1396	1387	1387	1377	1376	1388	1403	1425	1416	1424	1420	1.21%
Balance of Care	% of people with intensive care needs receiving Care at Home	36.0%	36.3%	36.7%	37.2%	38.3%	38.0%	37.7%	37.6%	37.8%	38.8%	39.1%	38.6%	7.08%
Balance of Care	Number of people receiving reablement	206	218	190	202	193	187	202	218	238	273	278	279	35.44%
Balance of Care	% of people requiring no homecare following reablement	30.6%	32.9%	34.8%	38.4%	32.7%	43.6%	32.7%	37.0%	17.9%	29.4%	21.0%	31.6%	3.47%
Balance of Care	Number of people 65+ living in a Residential care home	424	425	415	413	424	425	424	422	425	430	401	389	-8.25%
Balance of Care	Number of people 65+ living in a Nursing care home	409	416	434	431	427	429	422	413	407	405	378	362	-11.49%
Delayed Discharge	Number of days people spend in hospital when they	1437	1221	1364	1339	1285	1506	1586	1245	1184	1060	1073	1204	-16.23%

Theme	Measure	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	% Change over period
	are ready to be discharged (All inc code 9)													
Delayed Discharge	Number of days people spend in hospital when they are ready to be discharged (Standard Delays all exc code 9)	1209	1036	1242	1296	1264	1506	1576	1245	1184	1060	1073	1199	-0.85%
Delayed Discharge	Number of days people spend in hospital when they are ready to be discharged (Complex Delays code 9 only)	228	185	0	42	21	0	10	0	0	0	0	5	-97.81%
Delayed Discharge	PRI progress to stable 8 target 2920 DD days	7004	6709	6600	6387	6235	6160	6034	5934	5850	5562	5374	5205	-25.69%
Frailty	Number of hospital admissions due to a fall	**51**	**66**	**71**	**50**	**51**	**49**	**52**	**60**	**102**	**63**	**61**	**56**	
Frailty	Number of people with Technology Enabled Care - Source SWIFT	1,052	1,064	1,092	1,100	1,128	1,147	1,152	1,155	1,178	1,171	1,156	1,172	11.4%

Theme	Measure	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	% Change over period
Frailty	Number and rate per 1,000 of readmissions to hospital within 28 days (exclude mental health)	11.4%	12.0%	10.7%	13.0%	10.4%	10.9%	12.0%	11.2%	12.2%	LAG	LAG	LAG	7.02% Waiting ISD Output
Unscheduled Care	Number of A&E attendances (Ninewells and PRI)	2706	2999	2669	2678	2795	2874	2695	2530	2976	2446	2399	LAG	-11.35%
Unscheduled Care	Number of unscheduled hospital admissions, split by Acute (SMR01), Geriatric Long Stay (SMR01E) and Mental Health (SMR04) specialties.	1163	1323	1298	1196	1286	1179	1175	1213	1398	1329	LAG	LAG	14.27% Waiting ISD Output
Unscheduled Care	Number of unscheduled hospital bed days, split by Acute (SMR01), Geriatric Long Stay (SMR01E) and Mental Health (SMR04) specialties.	9023	8688	8584	7839	7726	7994	8126	7991	8548	8290	LAG	LAG	-8.12% Waiting ISD Output

Theme	Measure	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	% Change over period
Unscheduled Care	Number of emergency admissions into Acute (SMR01) specialties from A&E	477	567	470	512	509	548	486	478	632	503	LAG	LAG	5.45% Waiting ISD Output
Unscheduled Care														