Perth and Kinross Health and Social Care Partnership

Older People and Unscheduled Care Board

Summer 2019 Performance report v Final

1 Performance summary

Indicator	Page	Summary	2018/19 P&K	2018/19 Scotland	2019/20 objective	2019/20 to date performance[1] *(value to meet target)*
Fall Admission rates EASR/1,000: 65+	3	65+ falls admission rates continue to be regularly lower than for Scotland	2,158	2,403	Continue to reduce rates	**2,425** *(2,158)*
Number of 65+ A&E & MIIU attendances	4	Per capita rates for 2018/19 are approximately 30% lower than for Scotland although complex causality	8,289	11,602**Error! Bookmark not defined.**	Maintain or improve on 18/19	**1,478** *(1,382)*
Emergency admissions	5	Stable performance that continues to be lower per capita than Scotland	14,756	16,371[ii]	Maintain or improve on 18/19	**2,503** *(2,460)*
Unscheduled bed days	6	Stable performance that continues to be lower per capita than Scotland for adult age groups (especially 75+)	99,259	104,072[ii]	Continue reducing trend between 15/16&17/18	**7,563** *(7,460)*
65+ community care home crisis admissions	7	Gradual reduction in total numbers per year over three years	162	N/A	To be developed	**N/A** (needs target)
% of total H&SC spend on emergency hospital stays	8	Reduced from 28% to approx. 25% of total spend for 18/19, and continues to be 2.5% to 3.5% above Scottish value	25.7%	22.4%	To be developed	No data to date
75+ 7-day readmissions per 1,000	9	Performing well in relation to the rest of Scotland	23	30	To be developed	**N/A** (needs target)
75+ 28-day readmissions per 1,000	10	Performing well in relation to the rest of Scotland	55	73	To be developed	**N/A** (needs target)
Delayed discharges bed days	11	Moved from *worse-than* to *better-than* Scotland at turn of year, and currently below required MSG target trajectory	14,203	14,533[ii]	Continue 17/18-18/19 trend (equates to 13,331)	**2,636** *(3,333)*
CAH people per week: 65+	12	Substantial shift from to more personalised support (option 3 to option 2) during mid-2017, slight increase for all options since April 2019	2275		To be developed	**1820**
CAH hours per person per week: 65+	13	Slight reduction in weekly hours from January 2019	10.47		outrun	**9.34**
CAH total hours per week: 65+	14	Substantial shift from to more personalised support (option 3 to option 2) during mid-2017, slight increase for all options since April 2019	146,595		To be developed	**71,959**
Median wait for HART: 65+	15	Reducing trend continues from 12 days in early 2018 to around 7 days in June 2019	11		To be developed	**8**
Number receiving reablement per month: 65+	16	Maintaining performance since positive increase in the numbers receiving reablement seen over late 2018	1033		To be developed	**691**
% requiring no CAH following reablement: 65+	17	Averaging 37% over recently reported 12 months	36.58%	No data	To be developed	**38.91%**
65+ with TEC and Com alarm	18	Very slow increasing trend for both values	5050		To be developed	**4416**
Percentage of last six months of life in a community setting: 75+	19	Very gradual improvement over the last three years that tracks the Scottish value	No data	No data	To be developed	**N/A** (needs target)
Premature Mortality Rate per 100,000	20	Consistently better than Scotland - stable since general reduction seen both locally and nationally during 2000s	n/a	n/a	To be developed	**N/A** (needs target)

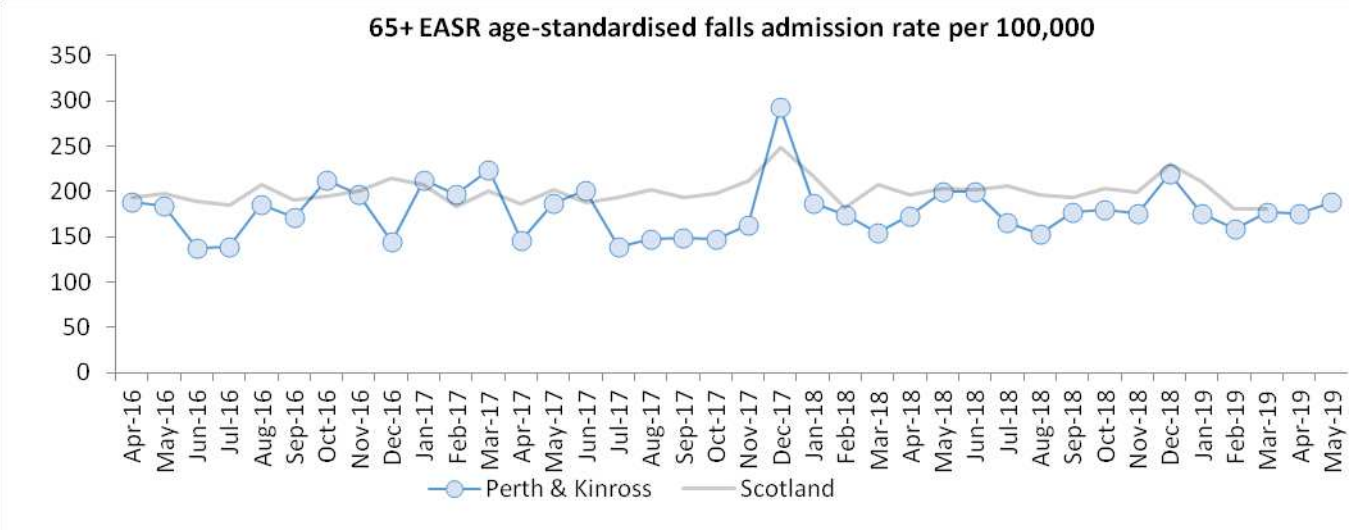
[1] RAG status determined by recent value relative to that needed to meet/exceed objective: Green within 5%; Amber 5% to 10%; Red >10%

2 Key performance indicator analyses and responses

2.1 65+ Falls Admissions per 100,000 EASR age standardised

Descriptor	In an ageing population, falls among older people are a major and growing concern. This indicator is based on the number of 65+ patients discharged from hospital with an emergency admission coded as resulting from a fall[2]. EASR age standardisation[i] is used to allow national comparison.
Objective	To reduce the rate of falls for frail elderly people
Source	ISD
Strategic Priority	Thriving Communities
Delivery leads	To be determined
Target	Proposed target is to meet or improve on 2018/19 rate of 2,158 65+ Falls Admissions per 100,000 EASR age standardised

Annual 65+ falls admissions per 100,000 EASR standardised rate[i]	**2016/17**	**2017/18**	**2018/19**	***2019/20 year end projection[3]***
Perth & Kinross rate	2196	2087	2158	*2425*
Scotland rate	2366	2431	2403	



Analysis
• 65+ age-standardised falls admissions rates are regularly lower than for Scotland as a whole. • Based on only two months data, a 12% increase above FY18/19 is projected for FY19/20.

Actions
• Continue to embed SG Framework for Action 'Falls Prevention and Management in the Community' • Further spread and embed Care about Physical Activity CAPA in care homes and care at home providers • Establish a Falls Intelligence Group to improve performance management, monitoring and to identify and support improvements.

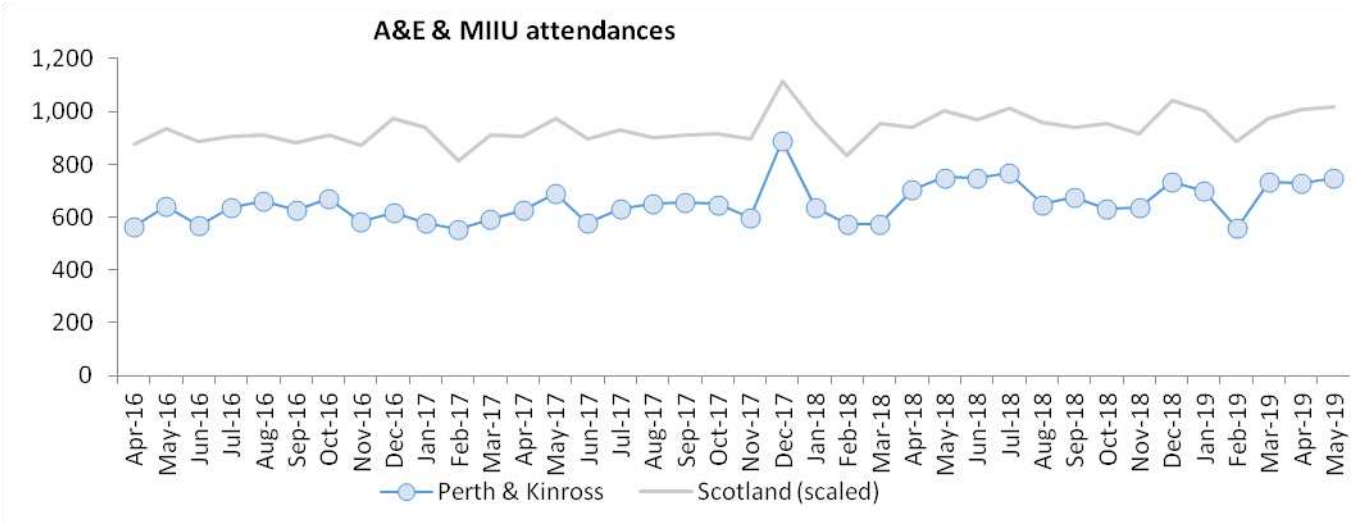
[2] Fall admission coding: ISD admission code 33 - 35 (emergency injury admissions excluding self-inflicted or RTA); and ICD10 codes W00 – W19 (slipping, tripping, stumbling and falls).

[3] Year end projection is calculated by scaling financial year-to-date value according to the portion of the year complete.

2.2 A&E attendances (65+) (includes MIIU) (MSG)

Descriptor	To monitor A&E and MIIU presentations and the influence of projects/interventions on reducing unnecessary and/or avoidable presentations for elderly people
Indicator objective	To reduce this over time towards a level that reflects the opportunities afforded by community prevention and community-based crisis management.
Data Source	ISD MSG 3a data
Strategic Priority	Shifting the Balance of Care
Delivery leads	Paul Henderson, Amanda Taylor
Target	Based on submitted MSG targets. Target is to maintain 18/19 number: 8,289

65+ A&E/MIIU attendances by year	**2016/17**	**2017/18**	**2018/19**	***2019/20 year end projection[4]***
Perth & Kinross total	7,297	7,753	8,289	*8,868*
Scotland raw rate applied to PK population[ii]	10,829	11,203	11,602	



Analysis

- Perth and Kinross are performing well in this area with a 29% lower per-capita A&E attendance rate compared to Scotland as a whole (2018/19).
- Over the last few months the A&E/MIIU numbers have increased. However, we are currently 7% above the number required to meet our target which is within amber tolerance.

Actions

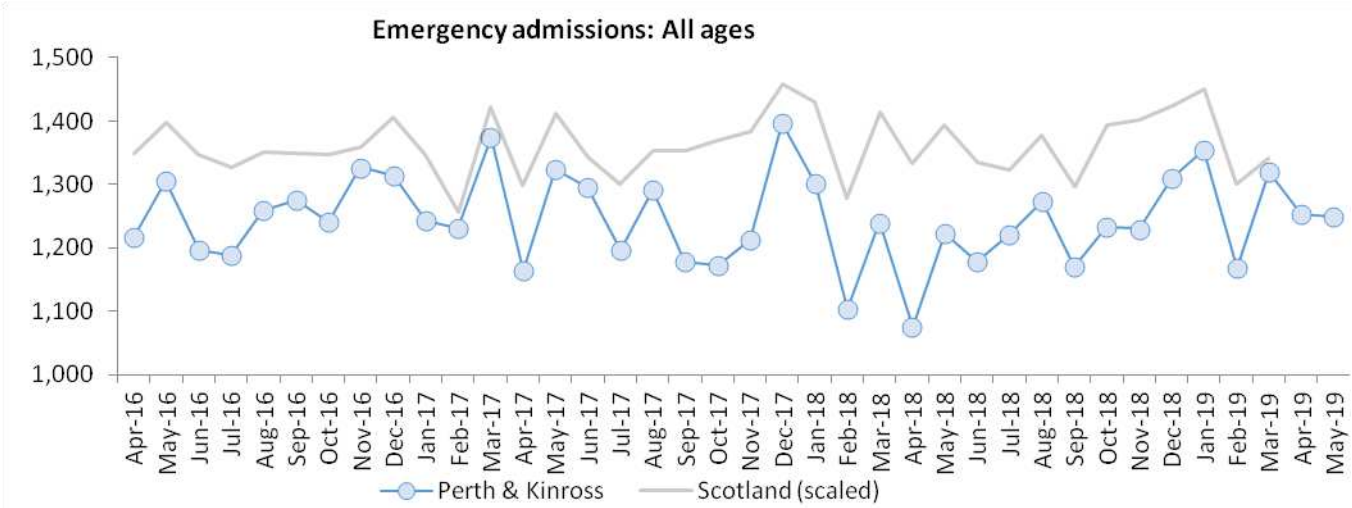
- Work in partnership with NHS Tayside on the delivery of Transforming Tayside, Out of Hours, and Reshaping Urgent Care.
- Analyse the week of care audit (completed during August) to inform our understanding and to identify improvement opportunities.

[4] Year end projection is calculated by scaling financial year-to-date value according to the portion of the year complete.

2.3 Emergency Admissions (MSG)

Descriptor	Many people coming to hospital in emergencies could potentially be offered better support or services earlier on to prevent the need for them to go to hospital, or for planned hospital care instead.	
Indicator objective	A reduction in this indicator should demonstrate improved partnership working. It should represent a shift from a reliance on hospital care towards proactive and coordinated care and support in the community. To inform the performance narrative, we analyse unscheduled admissions data according by diagnostic groupings, specialty and age-group.	
Data Source	ISD MSG	
Strategic Priority	Shifting the Balance of Care	
Delivery leads	Intermediate Specialist GP Lead, Locality Managers	
Targets	**Based on submitted MSG targets**	All ages
	2019/20	14,756

Annual emergency admissions (all ages)	**2016/17**	**2017/18**	**2018/19**	***2019/20 year end projection[5]***
Perth & Kinross total	15,173	14,880	14,756	*15,018*
Scotland raw rate applied to PK population[ii]	16,258	16,394	16,371	



Analysis

- Perth and Kinross is performing well compared to the rest of Scotland particularly in relation to older adults
- Based on the first two months of the financial year we are performing within expectations to achieve financial year end target.
- The increase in admissions for 65+ in December correlates with an increase in admission at this time due to respiratory problems

Actions

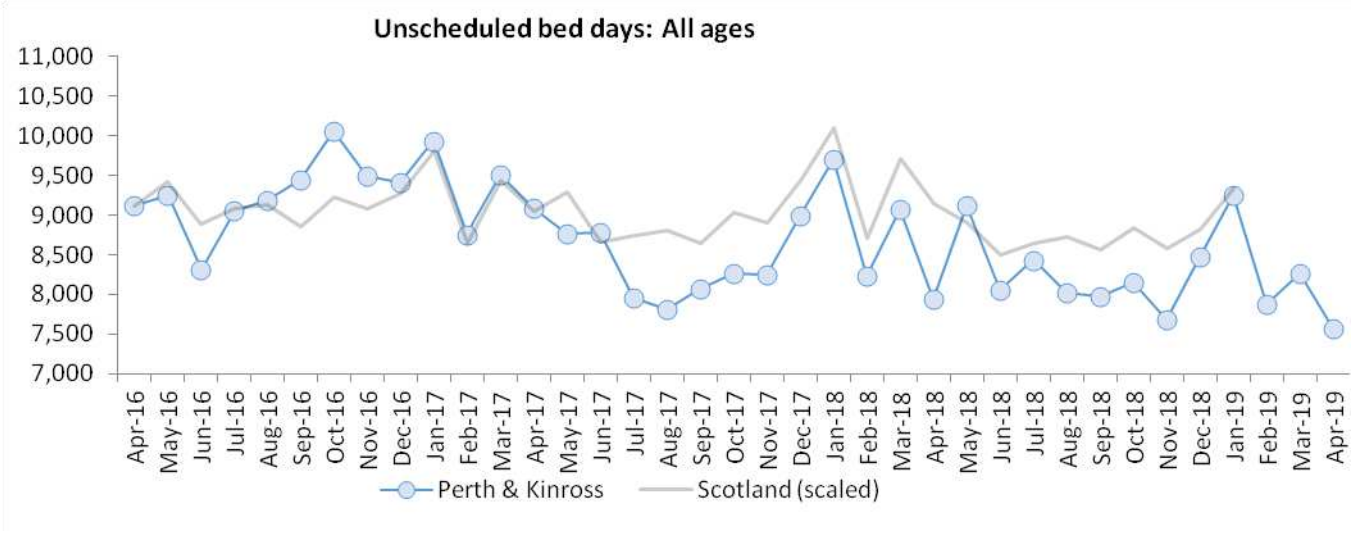
- The Older People and Unscheduled Care Board are overseeing improvement actions to support the reduction of admissions; the investment into a specialist Community Respiratory team and integrated intermediate care service to support early intervention and prevention approaches. These actions are being taken forward and their impact is likely to be over the medium to long term.
- Perth and Kinross Health and Social Care Partnership were successful in their bid to work with the Improvement Hub to test the Living and Dying Well collaborative approach. The aim is to identify people 65+ living with frailty to access preventative support in the community.

[5] Year end projection is calculated by scaling financial year-to-date value according to the portion of the year complete.

2.4 Unscheduled bed days (MSG)

Descriptor	To protect resilience it is important for people to get home as soon as they are fit for discharge. This is a balance measure as it is possible for admissions to increase, bed days to reduce and vice versa.
Indicator objective	This is a balance measure as it is possible for admissions to increase, bed days to reduce and vice versa. To inform the performance narrative, we analyse unscheduled admissions data according by diagnostic groupings, specialty and age-group.
Data Source	ISD MSG data reports
Strategic Priority	Shifting the Balance of Care
Delivery leads	Intermediate Specialist GP Lead, Locality Managers
Target	Submitted MSG All Ages 2019/20 target: 89,305. This is based on a continued trend using the reduction measured between 15/16 baseline and 17/18.

Annual unscheduled bed days (all ages)	**2016/17**	**2017/18**	**2018/19**	***2019/20 year end projection[6]***
Perth & Kinross total	111,543	103,006	96,915	*90,756*
Scotland raw rate applied to PK population[ii]	109,967	109,081		



Analysis
• We are performing favourably compared to the rest of Scotland, especially in relation to 65+. • The value for month one of the current financial year is in line with meeting the year end target.

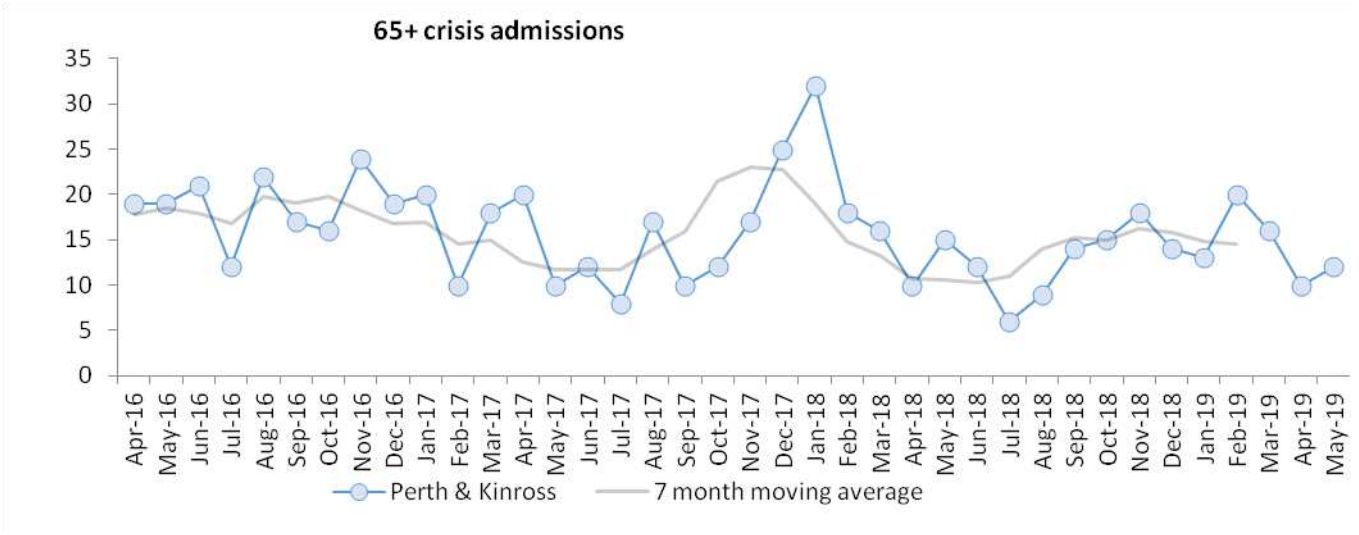
Actions
• There are a range of improvement actions under the heading of Shifting the Balance of Care in the Older People and Unscheduled Care Strategy in relation to this. • The Royal Voluntary Service is commencing in PRI to support patients who require low-level support in the community to facilitate more timely discharge from hospital. • A project is underway to complete an integration of the Discharge Hub and Hospital Discharge Team to improve performance.

[6] Year end projection is calculated by scaling financial year-to-date value according to the portion of the year complete.

2.5 Crisis admissions to care homes from community

Descriptor	Crisis admissions are an indicator that community services are not able to sustain the person in the community. Crisis placements can often continue and become permanent care home placements.
Indicator objective	To monitor the inability of community services to maintain people in the community during crisis periods.
Data Source	PKC
Strategic Priority	Shifting the Balance of Care
Delivery leads	OPUSC Strategic Lead
Target	•

Data	2016/17	2017/18	2018/19	2019/20
Total	217	197	162	



Analysis
• Three year reduction in crisis placements, current year not yet available • Could represent more efficiency in screening and authorisation of care home funding, as people in crisis placements requiring permanent placements are authorised • Peak at end of 2017, beginning of 2018 likely related to winter health conditions

Actions
• Deep dive to be undertaken to understand peak at start of 2018

2.6 Percentage of total health and care spend on hospital stays where the patient was admitted in an emergency

Descriptor	Emergency inpatient resource as a percentage of overall health and social care resource. The underlying data will be sourced from costed health activity data and social care aggregate data. Health and Social Care Integration will allow the Integration Authorities, through the strategic plan, to commission changes in the health and social care pathway that will optimise (where appropriate) community based care[7]. To illustrate whether there is a trend towards spend being allocated in community settings rather than a hospital setting
Objective	This indicator will provide an overall indication of the balance of care in each partnership area. Not all emergency (non-elective stays) can be prevented or shifted to another setting, but where appropriate care in another setting will benefit patients and also ensure resources are spent more effectively.
Data Source	ISD
Strategic Priority	Improving Patient Flow and Pathways/Shifting the Balance of Care
Delivery leads	Inpatient Service Manager, OPUSC Strategic Lead
Target	To be set

	2016/17	2017/18	2018/19	2019/20
Perth and Kinross	26.7%	27.9%	25.7%	*
Scotland	24.3%	25.1%	22.4%	*

Analysis

- Perth and Kinross has a higher proportion of over 65s compared to Scotland as a whole therefore it is understandable that we are over the Scottish value for this indicator, however we decreased last year

Actions

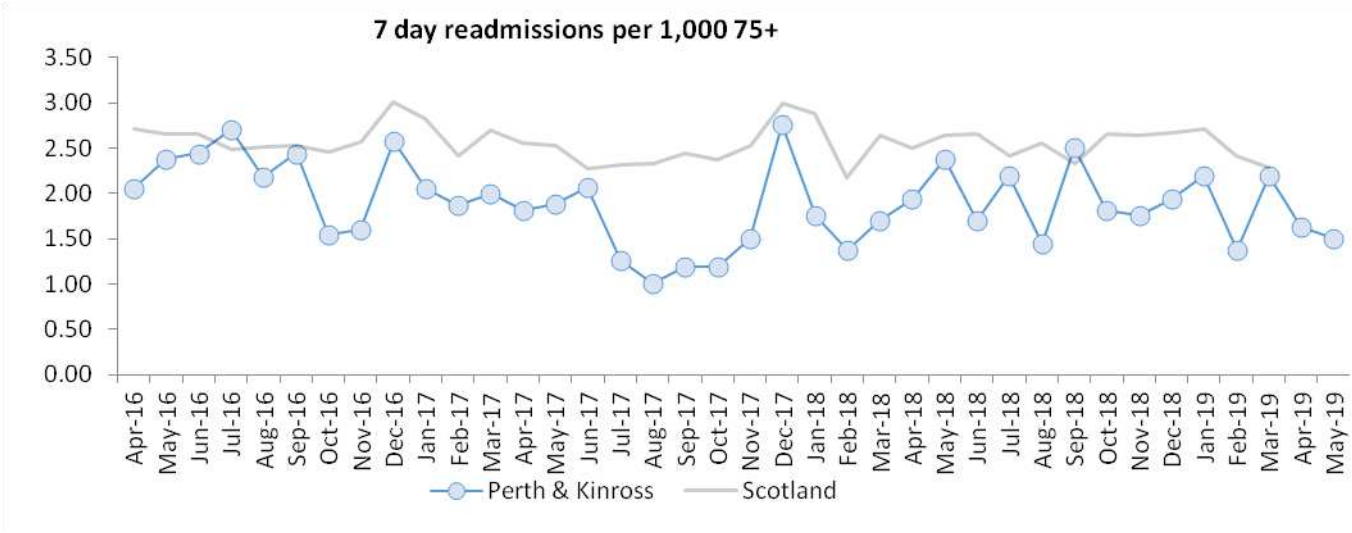
- Improvement actions are in progress in relation to Improving Patient Flow and Pathways with work especially focused on deeper integration to reduce unnecessary duplication that impacts negatively on patient waits. There is also a redesigning of clinical / medical pathways to enhance geriatrician input in localities and community hospitals.
- Improvement actions are co-ordinated across NHS Tayside through the Unscheduled Care Board.

[7] Health & Social Care Integration: Core suite of indicators. Scottish Government. 2015

2.7 75+ 7-day readmissions per 1,000

Descriptor	"The readmission rate reflects several aspects of integrated health and care services - including discharge arrangements and co-ordination of follow up care underpinned by good communication between partners." (Scottish Government[8]).
Indicator objective	7 day readmissions are more likely to pick up immediate issues linked to hospital care.
Data Source	ISD
Strategic Priority	Shifting the Balance of Care
Delivery leads	To be determined
Target	• Target setting is complex based on a range of local readmission studies/audits/deep dives. From this work we were unable to ascertain common opportunities for readmission prevention and only a small proportion were identified that were categorised as "potentially avoidable".

Year	2016/17	2017/18	2018/19
Perth and Kinross	26	20	23
Scotland	32	30	30



Analysis
• Perth and Kinross is performing well in relation to the rest of Scotland

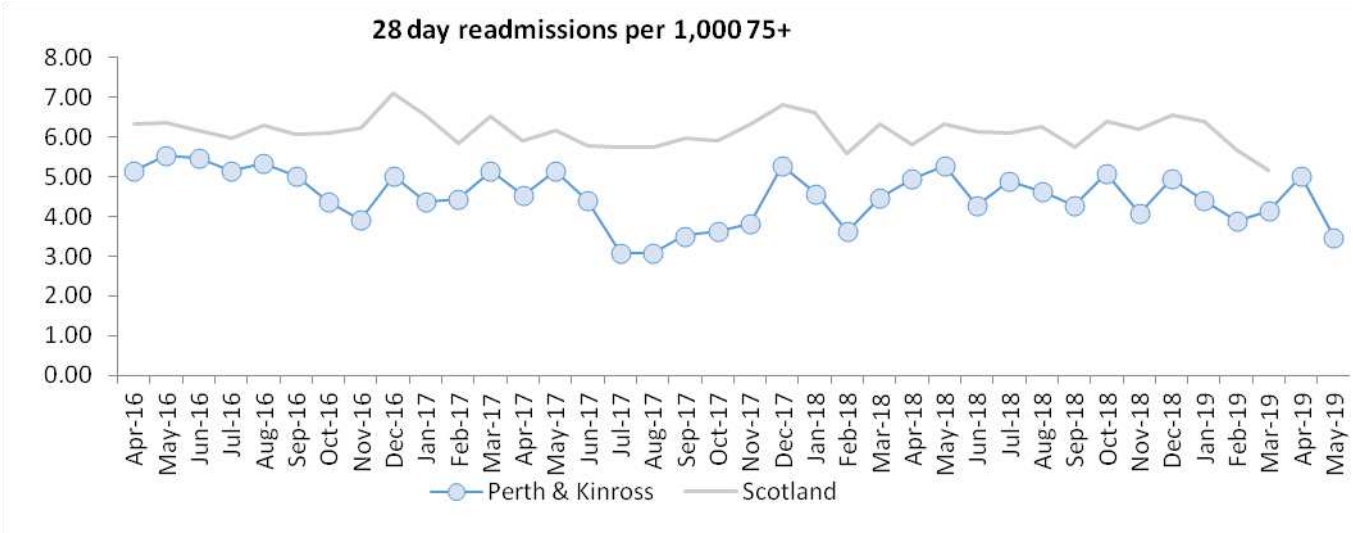
Actions
• Continue with actions as per Strategic Delivery Plan

[8] https://www.gov.scot/publications/health-social-care-integration-core-suite-indicators/pages/3/

2.8 75+ 28-day readmissions per 1,000

Descriptor	"The readmission rate reflects several aspects of integrated health and care services - including discharge arrangements and co-ordination of follow up care underpinned by good communication between partners." (Scottish Government[9]).
Indicator objective	28 day follow-up relates to support on leaving hospital that could have a negative impact and result in readmission.
Data Source	ISD
Strategic Priority	Shifting the Balance of Care
Delivery leads	To be determined
Target	• Target setting is complex based on a range of local readmission studies/audits/deep dives. From this work we were unable to ascertain common opportunities for readmission prevention and only a small proportion were identified that were categorised as "potentially avoidable".

Year	2016/17	2017/18	2018/19
Perth and Kinross	59	49	55
Scotland	76	73	73



Analysis
• Perth and Kinross is performing well in relation to the rest of Scotland

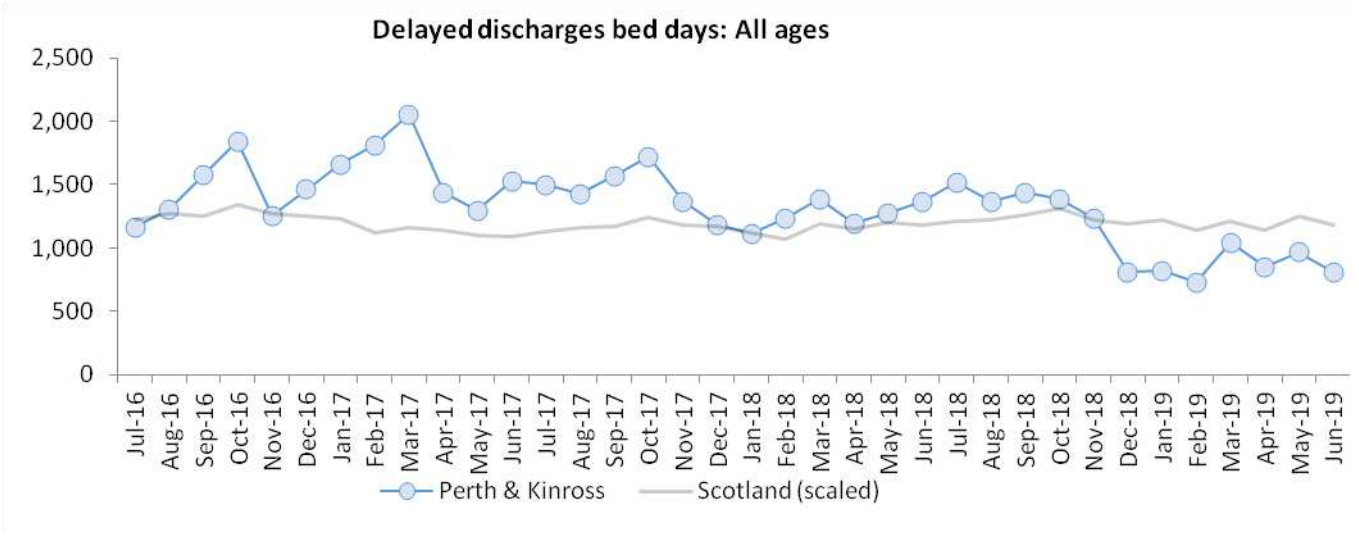
Actions
• Continue with actions as per Strategic Delivery Plan

[9] https://www.gov.scot/publications/health-social-care-integration-core-suite-indicators/pages/3/

2.9 Delayed discharge bed days

Descriptor	The number of bed days due to delayed discharge that have been recorded for people resident within the Local Authority area
Objective	To monitor effectiveness of service provision and improvements in relation to supporting patients that are medically fit home from hospital. To inform the performance narrative, we regularly analyse delayed discharge data according to reason for delay and age group.
Data Source	ISD
Strategic Priority	Improving Patient Flow and Pathways
Delivery leads	Inpatient Service Manager, OPUSC Strategic Lead
Target	All ages MSG target: 2019/20: 13,331

Annual delayed discharge bed days (all ages)	**2016/17**	**2017/18**	**2018/19**	***2019/20 year end projection[10]***
Perth & Kinross total	18,872	16,785	14,203	*10,544*
Scotland raw rate applied to PK population[ii]	14,839	13,763	14,533	



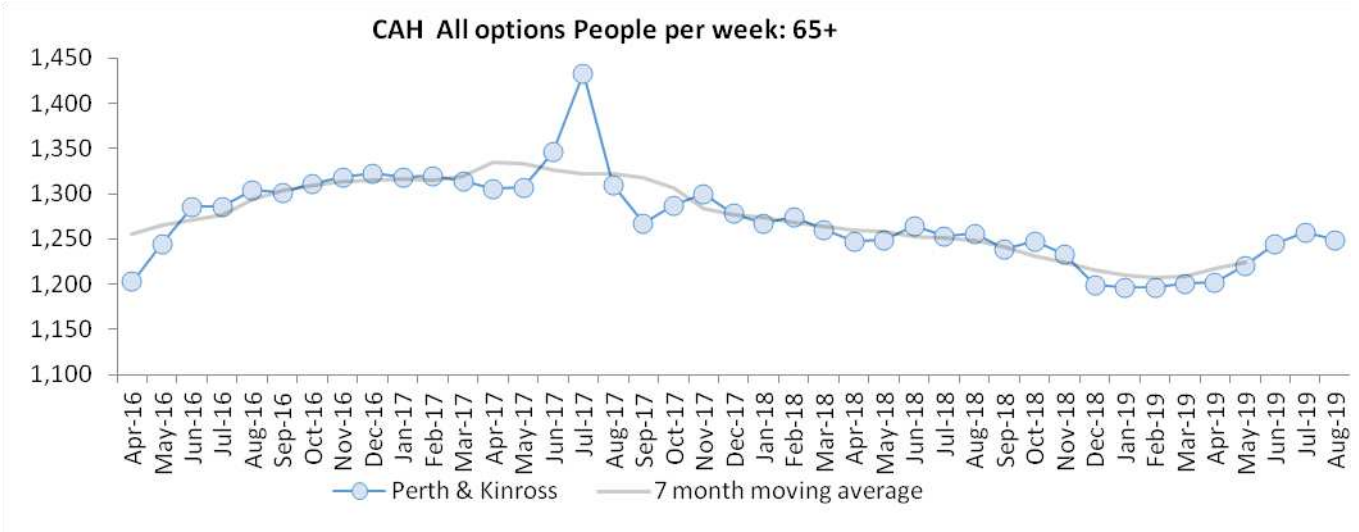
Analysis
• Perth and Kinross has shown significant sustained improvement in this area for the over 75 age group and is performing well compared to the rest of Scotland • Based on the first three months of the current financial year we are projecting well below target.

Actions
• Continuing with the improvement actions in the Older People and Unscheduled Care Strategic Deliver Plan, in particular, continuation of HART and development of fully Integrated Discharge Hub and processes

[10] Year end projection is calculated by scaling financial year-to-date value according to the portion of the year complete.

2.10 Care at Home 65+ clients

Descriptor	Our strategic aim is to support people to remain at home for as long as possible and care at home provision is an important element to achieve this. These indicators track numbers of people, average hours per person and also the use of SDS options 1, 2 and 3.
Indicator objective	This is a complex indicator due to the strategic intent of health promotion to delay the need for the service as well as supporting people as long as possible prior to e.g. care home admission.
Data Source	PKC
Strategic Priority	Shifting the Balance of Care/Thriving Communities
Delivery leads	OPUSC Strategic Lead
Target	To be agreed

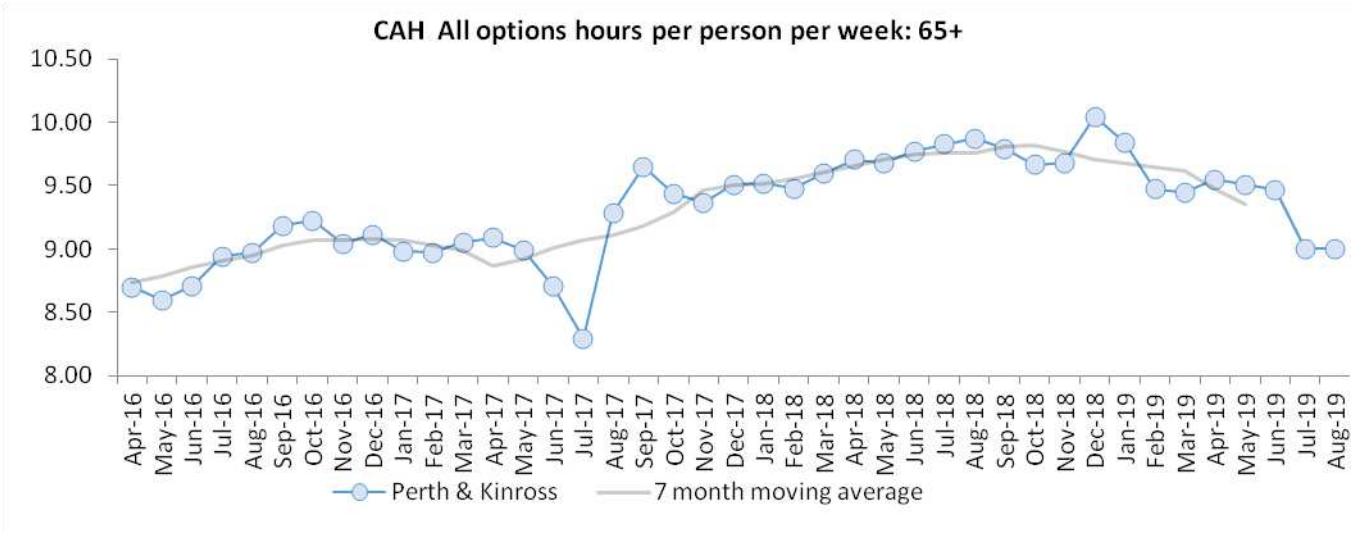


Analysis
• Substantial shift from option 3 to option 2 during mid-2017, slight increase for all options since April 2019.

Actions
• A Care at Home improvement group has been initiated by contracts and commissioning with the independent sector to ensure we are delivering high quality care • A recovery plan has been developed to ensure scrutiny of care package's in line with Best Value

2.11 Care at Home hours per 65+ person per week

Descriptor	Average number of hours people receive care at home for per week. People want to stay at home for as long as possible and remain more independent for longer. As the population ages and number of people with care needs increases, the need to provide appropriate care and support becomes more important.
Indicator objective	Increased hours of SDS option 1 and 2's indicate more personalised services where people have more control over their care
Data Source	PKC
Strategic Priority	Shifting the Balance of Care/Thriving Communities
Delivery leads	OPUSC Strategic Lead
Target	To be determined

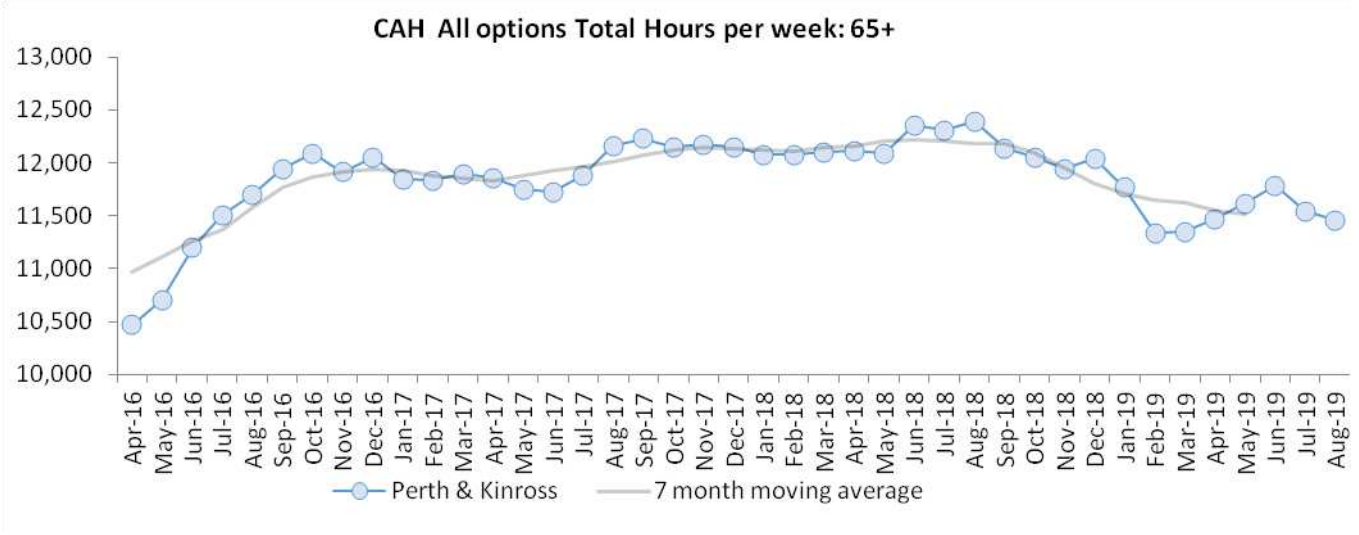


Analysis
• A more detailed exploration evidences that there has been a shift in hours towards more personalised SDS options 1 and 2 indicating a shift in line with our strategic direction. The hours per person has been increasing up to the end of 2018 • The decrease from 2019 occurred at the same time that a Recovery plan was initiated

Actions
• A Care at Home improvement group has been initiated by contracts and commissioning with the independent sector to ensure we are delivering high quality care • A Recovery plan has been developed to ensure scrutiny of care package's in line with Best Value

2.12 Care at Home 65+ clients total hours

Descriptor	Number of care at home hours in total delivered per week
Indicator objective	People want to stay at home for as long as possible and remain more independent for longer. As the population ages and number of people with care needs increases, the need to provide appropriate care and support becomes more important.
Data Source	PKC
Strategic Priority	Shifting the Balance of Care/Thriving Communities
Delivery leads	OPUSC Strategic Lead
Target	

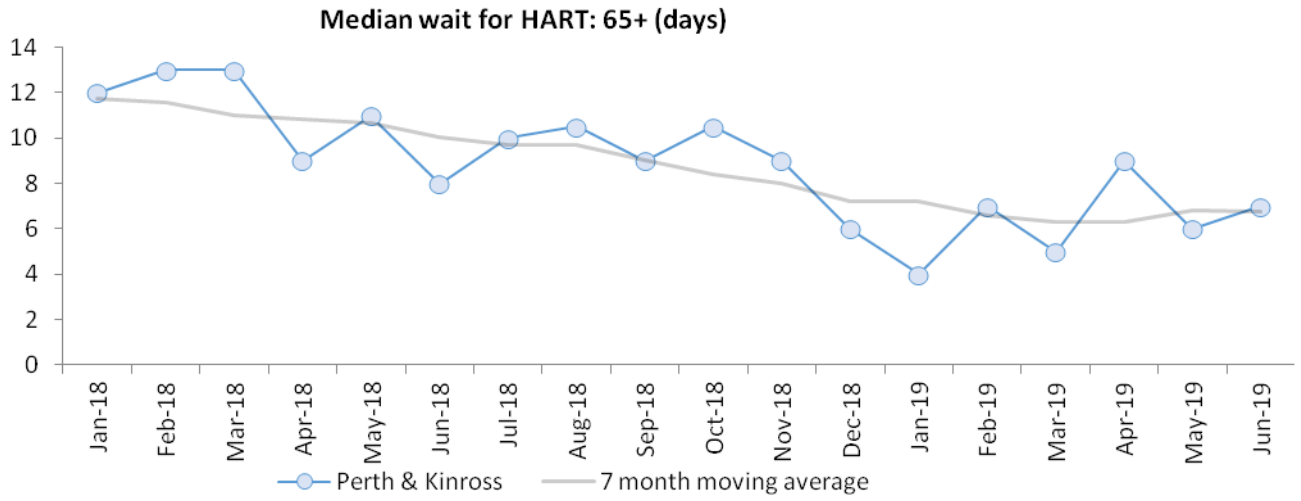


Analysis
• The number of people receiving care at home services has declined slightly whilst the numbers of average hours per person has increased. • The number of people receiving provision via SDS option 1 and 2 has increased whilst the numbers of people receiving provision via option 3 has decreased. • The recovery plan is the likely source for the reduction in total weekly hours from January 2019.

Actions
• A Care at Home improvement group has been initiated by contracts and commissioning with the independent sector to ensure we are delivering high quality care • A Recovery plan has been developed to ensure scrutiny of care package's in line with Best Value

2.13 HART median referral to start date: 65+

Descriptor	Referral from end of assessment to start of HART service.
Indicator objective	To monitor the length of time people are waiting for a HART service as an indicator of reducing delayed discharge and waits in the community
Data Source	PKC
Strategic Priority	Improving Patient Flow and Pathways/Shifting the Balance of Care
Delivery leads	OPUSC Strategic Lead
Target	



Analysis

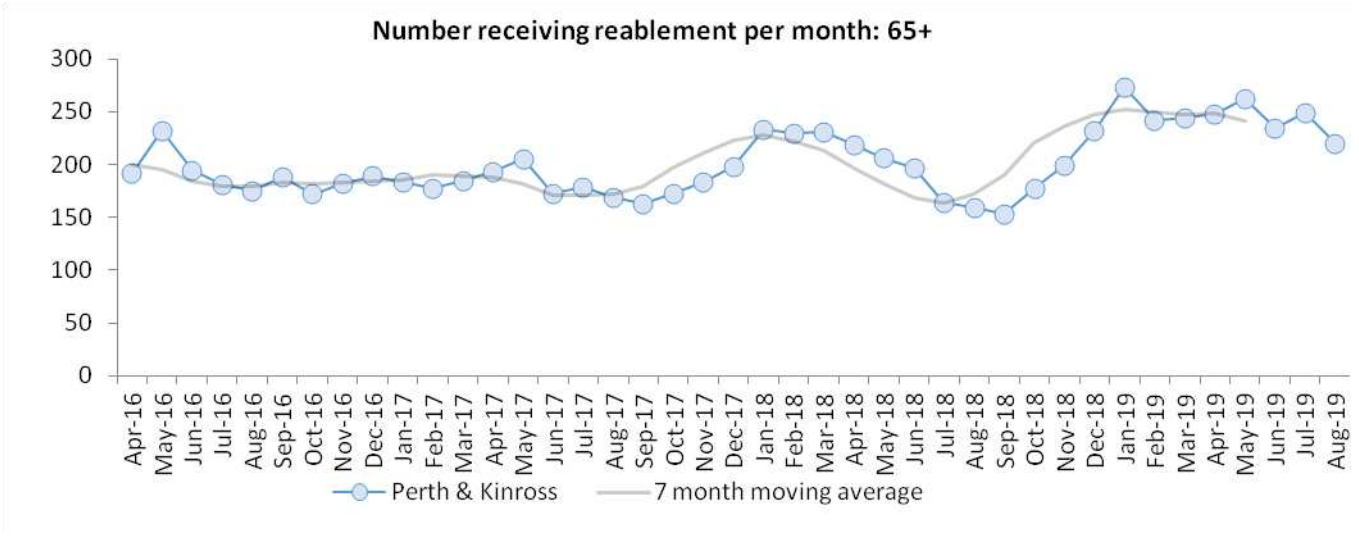
- There has been a sustained reduction in waits for HART/Care at Home as HART has become embedded, and this is reflected in our positive delayed discharge performance. A high intake into hospital in February and March resulting in above average numbers of people requiring HART is thought to be behind the increased delays from February 2019
- There continues to be a 2% vacancy factor within HART.
- 27% of HART capacity provides Care at Home.

Actions

- Continue with HART improvement plan specifically to ensure recruitment is a priority to avoid reduced capacity

2.14 Number of people receiving reablement per month 65+

Descriptor	Number of people who have been recorded as receiving a reablement service (this does/does not include clients receiving a care at home service from the HART team)
Objective	To monitor the use of reablement with increasing numbers of people accessing reablement as a positive. A reduction in this figure could impact negatively on the numbers of people being able to maintain themselves at home
Data Source	PKC
Strategic Priority	Shifting the Balance of Care
Delivery leads	OPUSC Strategic Lead
Target	• To be agreed

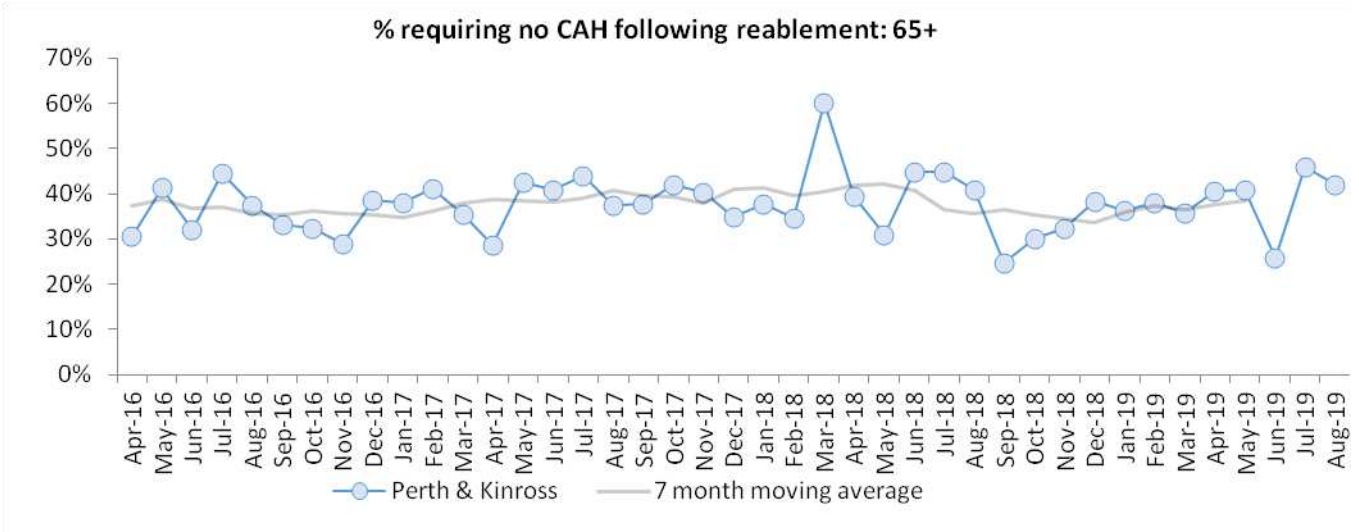


Analysis
• There has been a positive increase in the number of people receiving reablement. This increase may have impacted on the reduction of people receiving care at home but further analysis would be required to confirm this.

Actions
• Ensuring the Home Assessment Recovery Team is running with minimum staff vacancies to continue its operational effectiveness

2.15 Percentage of 65+ requiring no Care at Home support following reablement

Descriptor	Number of people who do not require a package of care due to being fully reabled
Indicator objective	To monitor the positive impact of reablement and its effectiveness. A reduction in this figure would be a negative indicator
Data Source	PKC
Strategic Priority	Shifting the Balance of Care
Delivery leads	OPUSC Strategic Lead
Target	2019/20: 45%; 2020/2021: 47%

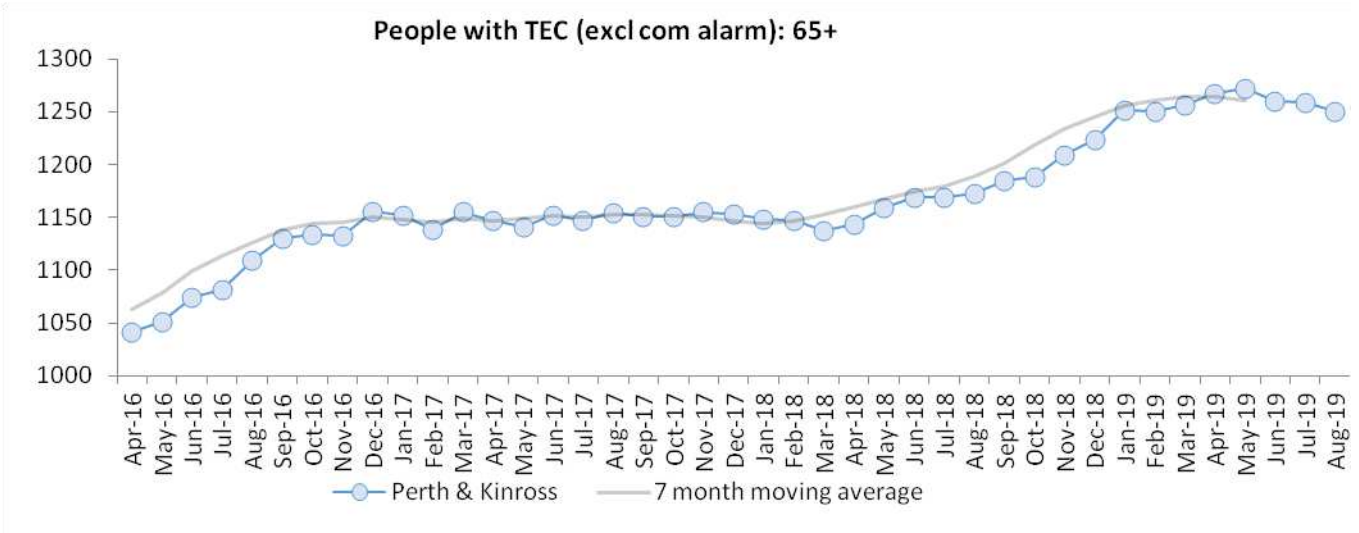


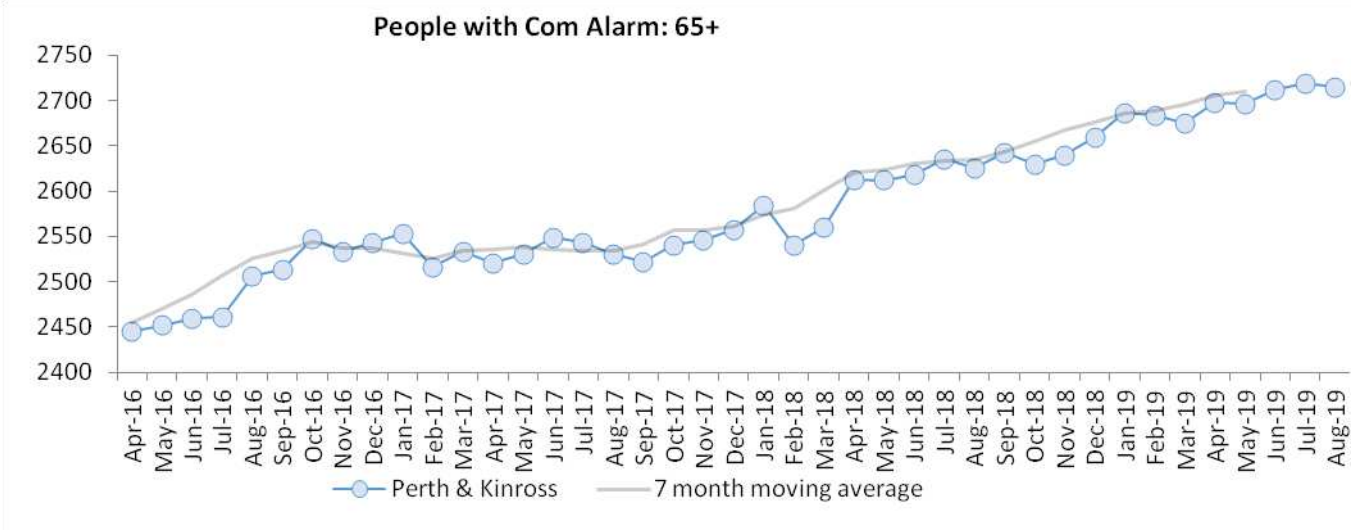
Analysis
• Over the last three years the percentage of people requiring no further service has been fairly stable. However, as there have been increased numbers of people receiving reablement the numbers requiring no further care services has increased

Actions
• Continue recruitment programme for HART to ensure there is enough capacity within the service to meet demand • Work with contracts and commissioning teams to explore options to reduce the Care at Home provided by HART and so free up HART capacity

2.16 People with TeC and Community Alarm

Descriptor	The number of people who have technology enabled care to support them at home
Indicator objective	To ensure that we are increasing our spread of technology enabled care to support more people in the community
Data Source	PKC
Strategic Priority	Shifting the Balance of Care
Delivery leads	OPUSC Strategic Lead
Target	To be agreed upon completion of the TEC strategy



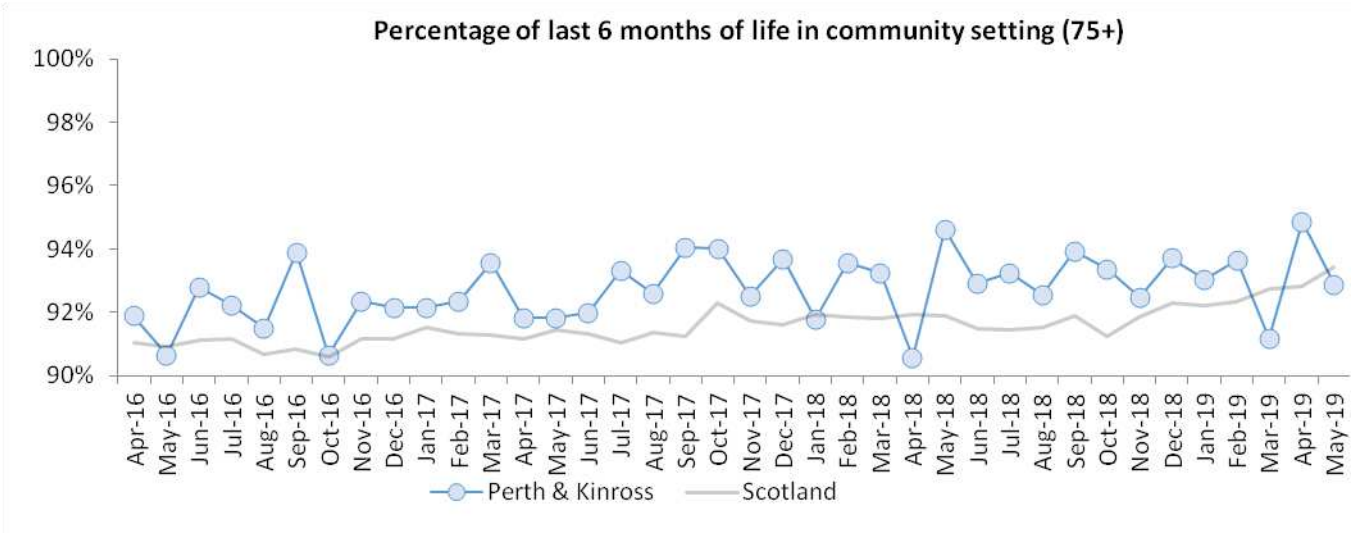


Analysis
• Number of clients with TEC is increasing steadily and implementation of the new strategy should realise a steeper uptake of equipment

Actions
• Continue with awareness raising of TEC among assessing teams to increase uptake of TEC • Continue work in line with Recovery plan to consider TEC in all new care packages • Completion of TEC strategy

2.17 Percentage of last six months of life in a community setting (75+)

Descriptor	This indicator measures the percentage of time spent by people in the last 6 months of life at home or in a community setting.
Indicator objective	This indicator should increase as further opportunities are created that allow people to maximise time spent in the community during the last six months of their life
Data Source	ISD
Strategic Priority	Shifting the Balance of Care
Delivery leads	Lindsey Bailie
Target	Target of 95% - to be discussed

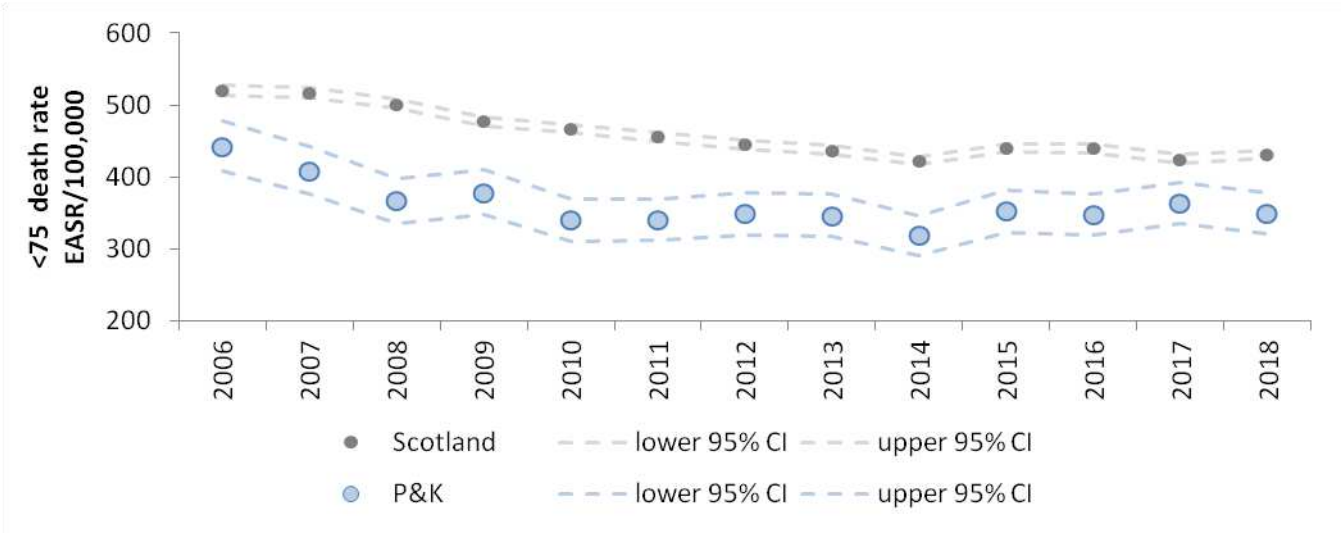


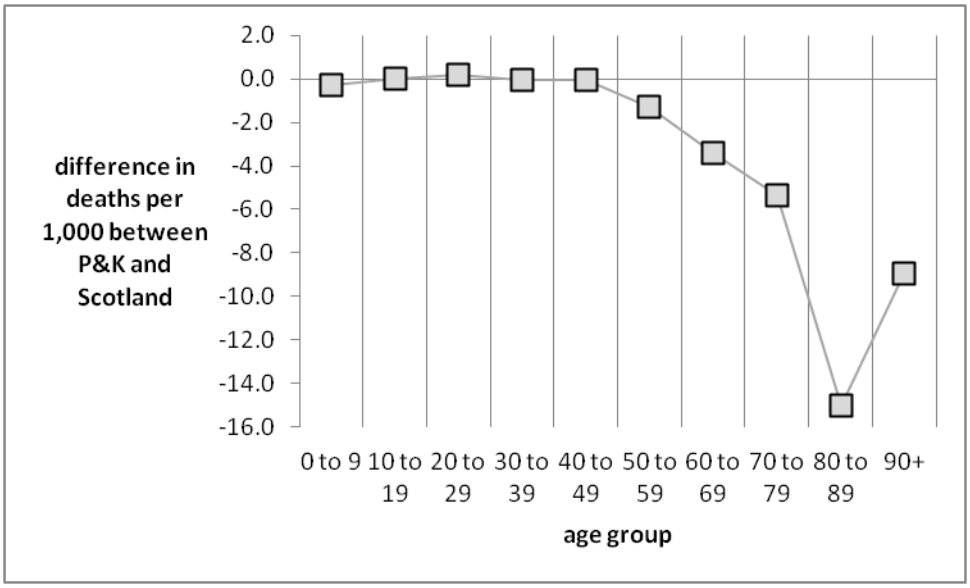
Analysis
• Very gradual improvement over the last three years that tracks the Scottish value.

Actions
• Delivery of education and training programmes for all staff providing care and support to people with palliative / end of life care needs. • Continue to work in collaboration with the Tayside Palliative and End f Life Care Managed Clinical Network (TayPEOLC MCN)

2.18 Premature Mortality Rate per 100,000

Descriptor	Premature mortality is an important indicator of the overall health of the population. Scotland has the highest mortality rates in the UK.
Indicator objective	To reduce this figure by providing appropriate supports in the right place at the right time.
Data Source	ISD annual data
Strategic Priority	Shifting the Balance of Care
Delivery leads	Locality Managers





Analysis
• Under-75 deaths per 1,000 are reduced during the 2000s, and are lower than for Scotland as a whole. Age-specific death rates are especially lower in the 50s to 70s age groups.

Actions
• Redesign and continue to improve community prevention pathways including within integrated care teams across localities.

End notes

[i] Standardised rates are often used to allow for fairer comparison between populations with different age structures. The European Age Standardised Rate (EASR) is a form of standardisation that provides adjusted rates to account for underlying differences in the age structure of populations relative to a reference "European Standard Population" - a widely-used theoretical (but nominally representative) population structure.

[ii] For numerical indicators, Scotland values are scaled to a P&K comparator by applying the age-specific Scotland per-capita rate to the P&K population numbers within the same age-group.