East Lothian
Integration Joint Board

REPORT TO: East Lothian Integration Joint Board

MEETING DATE: 5 December 2019

BY: Chief Officer

SUBJECT: IJB Performance Framework 2019-20

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1 PURPOSE

1.1 To update the Integration Joint Board (IJB) on the development of a Performance Framework.

1.2 To update the IJB on responsibilities in relation to Ministerial Steering Group indicators as well as reporting relationships with partner bodies.

2 RECOMMENDATIONS

The IJB is asked to:

2.1 Note the aims of performance monitoring and management, including: clarity of reporting structures, ensuring robust monitoring, identifying areas for development, making best use of local intelligence and delivering high quality services.

2.2 Note the Performance Framework Performance Indicator hierarchy chart which details the various levels of reporting to ensure effective delivery across the IJB delegated service areas. (Table 1).

2.3 Review and accept the IJB Performance Framework as an accurate reflection of the local reporting requirements and intention to ensure robust monitoring of services.

2.4 Note that there may be ongoing evolution of Performance Indicators which will be updated by Planning and Performance.

2.5 Support planning and Performance to continue to have dialogue with Community Planning Partners to agree a relevant set of Indicators which are reflective of IJB priorities.

2.6 Note that to ensure ongoing progress and use of local data, ongoing support from partner bodies will be required to ensure appropriate Information Governance and infrastructure.

3 BACKGROUND

3.1 The Public Bodies (Joint Working)(Scotland) Act 2014 sets out the process by which an Integration Joint Board reports on performance indicators through the publication of its Annual Performance Report.

3.2 The IJB has responsibility for overseeing various high level indicators, including the Ministerial Strategic Group (MSG) Indicators and Core Integration Indicators. Additional guidance is available which highlights the rationale of the Core Integration Indicators to be included within the Annual Performance Report.[1]

3.3 The IJB 2019-20 Directions and associated Delivery Plan were approved on 31st October 2019 following a review of the local approach to Directions. The IJB Delivery Plan sets out local Performance and Process Indicators to measure progress.

4 ENGAGEMENT

4.1 The IJB Performance Framework has been developed in collaboration with the East Lothian Health and Social Care Data Group which includes representatives from Public Health and the Local Intelligence Support Team (LIST), and the ELHSCP Core Management Team.

4.2 Further engagement and discussion has been carried out with East Lothian Council and Community Planning Partners.

4.3 The Performance Framework takes into account Key Performance and Process Indicators as identified by Change Groups during the development of the IJB Delivery Plan.

5 POLICY IMPLICATIONS

5.1 There are no new policy implications arising from this paper.

6 INTEGRATED IMPACT ASSESSMENT

6.1 The subject of this report does not affect the wellbeing of the community or have a significant impact on equality, the environment or the economy.

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[1] https://www2.gov.scot/Resource/0047/00473516.pdf

7 DIRECTIONS

7.1 The paper, its recommendations and accompanying documents are supportive of planned and future work to further establish Directions as drivers for service development and delivery of strategic and operational priorities.

8 RESOURCE IMPLICATIONS

8.1 Financial – There are no financial implications directly associated with the recommendations contained in this paper.

8.2 Personnel – There are no personnel implications directly associated with the recommendations contained in this paper.

8.3 Other – None

9 BACKGROUND PAPERS

9.1 Appendix 1. 2019-20 Performance Framework

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DATE	28 November 2019

East Lothian
Integration Joint Board

IJB Performance Framework 2019-22

1. Our Approach

The East Lothian Integration Joint Board (IJB) has a responsibility to ensure robust monitoring and oversight of delegated health and social care services delivered in East Lothian. The East Lothian Health and Social Care Partnership (ELHSCP) is responsible for delivering on the National Health and Wellbeing Outcomes[1]. The Integration Joint Board (IJB) published its 2019-2022 Strategic Plan on the 28th March 2019 which sets out local strategic priority areas. The East Lothian IJB Directions and the associated Delivery Plan 2019-20 were approved on the 31st October 2019.

The IJB Performance Framework describes the role of performance monitoring across the Health and Social Care Partnership, including outlining relationships with its partner bodies. It also provides a framework for understanding how local data and intelligence should be used to embed a culture of continuous improvement.

Performance Management in health settings is defined as 'the practice of actively using performance data to improve the public's health.' This practice involves the strategic use of performance measures and standards to establish performance targets and goals.'[2]

The ELHSCP aims for performance monitoring include:

- Providing clarity regarding reporting structures for delegated areas
- Ensuring robust monitoring and assessment of performance
- Identifying areas for development and generation of solutions
- Making use of local intelligence and findings to guide and assess improvement
- Delivering effective and high quality services

2. Performance Monitoring and Management

Timely and accurate data and information is essential for effective performance monitoring. Information Services Division (ISD) has developed a range of tools aimed at providing core intelligence needed to support Performance planning and management for Health and Social Care Partnerships via the Source Tableau Platform[3].

[1] https://www2.gov.scot/Topics/Health/Policy/Health-Social-Care-Integration/National-Health-WellbeingOutcomes

[2] Silos to Systems: Using Performance Management to Improve Public Health Systems – prepared by the Public Health Foundation for the Performance Management National Excellence Collaborative, 2003)

[3] https://www.isdscotland.org/Health-Topics/Health-and-Social-Community-Care/Health-and-Social-Care-Integration/Introduction/

Locally there is a need to ensure accurate information is available to the Core Management team on a regular basis and that data is provided nationally for assurance and monitoring processes. It is the responsibility of Service Managers to ensure systems and resources are in place (either in form of an electronic Information System or other data collection methods) to collect the agreed service information for performance monitoring purposes. It is the duty of the service and staff to collect and record data accurately and in a timely manner.

The Planning and Performance team will provide centralised support to ensure ongoing performance monitoring, however will rely on operational services to ensure accurate data collection and reporting, and subsequent contextualisation of data analysis. The East Lothian HSCP will continue to develop robust approaches to capturing outcomes and impact on individuals which will further contextualise high level reporting measures.

The East Lothian HSCP is responsible for various levels of performance reporting in relation to the National Health and Well-being Outcomes. In addition local process and outcome indicators may be identified to ensure ongoing progress against the IJB Strategic Plan. Appendix 1 details indicators in Level 1, Level 2 and Level 3.

Table 1. Performance Framework Performance Indicator Reporting Hierarchy Chart

Level 1: National Integration and MSG Indicators	The Core Suite of Indicators are developed from national data sources and are grouped into Outcomes Indicators (Indicators 1-10) and Indicators derived from organisational data (Indicators 11-23). The Ministerial Steering Group has also identified a set of performance indicators which are intended to provide a view of how Partnerships are progressing against a range of whole system level measures. IJBs are responsible for setting MSG targets on an annual basis.
Level 2: National Delegated Targets for Health and Social Care	A subset of the parent bodies publicly accountable targets and standards have been delegated to Health and Social Care Partnership for delivery. A range of NHS Local Delivery Plan (LDP) targets and Local Authority Statutory PIs have been agreed for delegation to the IJB where delivery is provided wholly or in large part via services managed by the East Lothian HSCP.
Level 3: Delivery Plan, Service Plan	Local indicators to measure performance against strategic objectives have been agreed with Change Boards and are described in the local IJB Delivery Plan. The IJB Delivery Plan is crucial for translating strategic priorities into measurable targets, aligning with finance and workforce development issues. The IJB Strategic Plan and Delivery Plan will be used to inform related operational and strategic plans of NHS Lothian and East Lothian Council. Within the Delivery Plan KPIs are a range of process and outcomes indicators which will be used to ensure progress against the IJB Strategic priorities. There may also be additional PIs not directly aligned to the Strategic Plan deliverables however which are critical for monitoring the full range of Integration service functions.

Level 4: Senior Management Team and Clinical Care Governance Reports	Regular operational reports will be provided to Senior Management based on up-to-date intelligence and data which can be used for smaller tests of change. The Clinical Care and Governance Committee provides clinical oversight to services including highlighting service risks and areas for improvement.

3. Ensuring Quality of Health and Social Care Services

The East Lothian Health and Social Care Partnership, supported by the actions of its partner bodies, is responsible for ensuring the quality of services provided locally, including both internally managed and delivered health and social care services as well as commissioned services delivered by third sector and independent providers. This requires a robust approach which includes proactive Quality Planning, Quality Assurance and Quality Improvement, embedded in and delivered through the actions of management and operational teams. In addition, ensuring high quality services which appropriately meet the needs of the local population requires a robust approach to monitoring and tackling health inequalities and the use of Integrated Impact Assessments at an early stage in the planning of services. This may include short-term measures such as embedding health inequalities measures into our local monitoring and evaluation, and ensuring that services are designed to address the socially determined factors that may limit people's chances to live longer, healthier lives. It also means ensuring that the IJB and ELHSCP is monitoring health inequalities in the long-term and establishing services that will result in more equitable access to health and social care services.

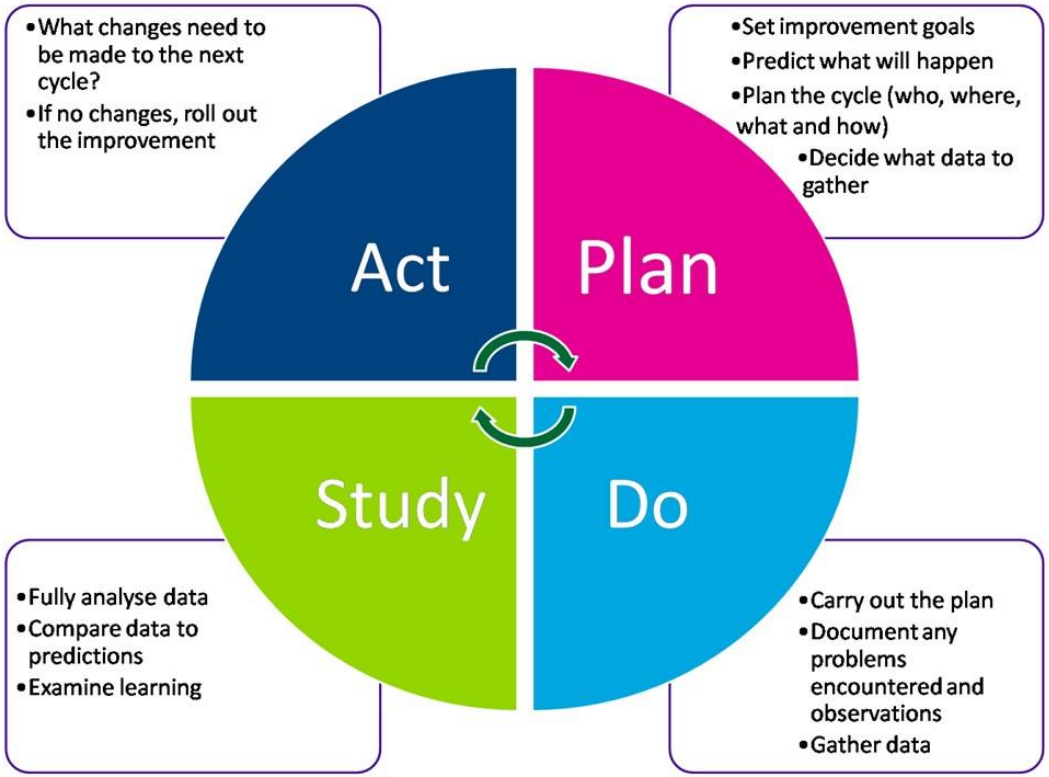
Measuring compliance against the National Outcomes for Health and Well-being and the National Ministerial Steering Group (MSG) Indicators provides assurance that we are meeting our identified objectives. It also enables us to compare performance against identified targets and make decisions based on the difference.

Quality control measures are in place both internally and externally through participation in audits and inspections, for example through Healthcare Improvement Scotland, Social Care and Social Work Improvement Scotland (The Care Inspectorate), and Audit Scotland. Future actions will be identified as appropriate and reflected in future Team, Service and Delivery Plans, with a summary of findings included in the Annual Performance Report.

Quality Improvement includes a systematic approach of carrying out smaller tests of change based on local need to generate a continual cycle of learning which shapes services that are more responsive and effective. The Plan-Do-Study-Act cycle (Figure 1) is a Model for Improvement commonly used for testing change and providing a structured approach that supports the delivery of care that is safe, timely, effective, efficient, equitable and cost effective. The Plan-Do-Study-Act cycle provides a structured framework for identifying what we are trying to accomplish, measuring the impact of changes, and making adjustments accordingly. A range of approaches should also be used locally to inform and drive

service improvements, including needs assessments that take into account Health Inequalities and wider social determinants, the development of local outcomes frameworks to capture individual level impacts, ongoing stakeholder engagement and understanding the best available evidence to know what works best, for whom and in which context.
Support for ongoing improvement can be provided internally from Planning and Performance, as well as externally from the Local Intelligence Support Team (LIST), Public Health Scotland and Healthcare Improvement Scotland to support continuous improvement.

Figure 1. Plan Do Study Act Cycle [4]

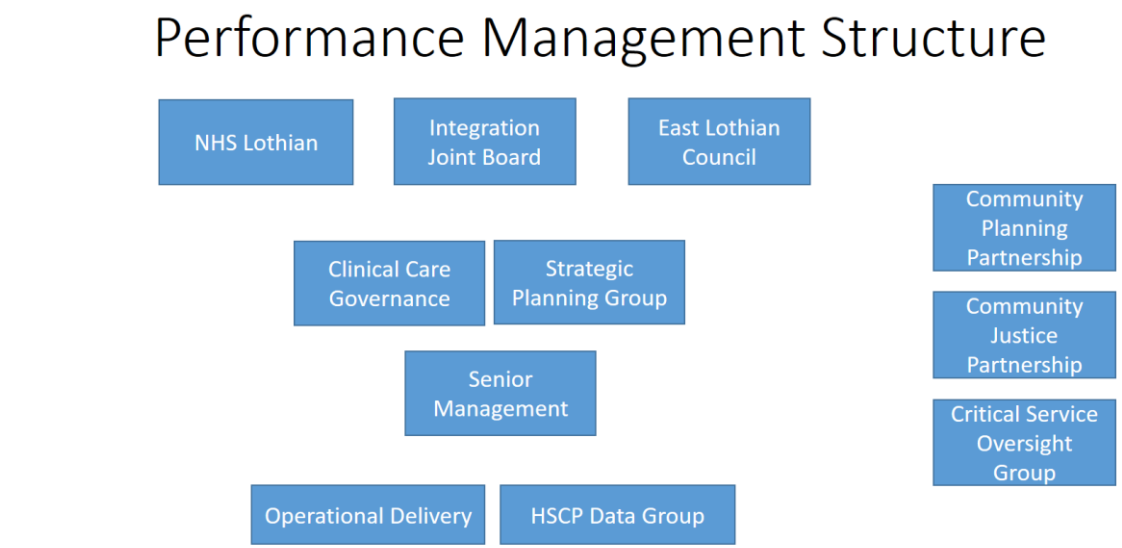


[4] https://ihub.scot/project-toolkits/diabetes-think-check-act/diabetes-think-check-act/getting-started/plan-do-study-act/

4. Scrutiny and Assurance

The landscape of governance and assurance across Integration Joint Boards, Local Authorities and NHS Boards is complex. It is important to consider the potential overlaps of performance management that could result in dual reporting, and where possible to align targets and measures across structures. For example the Local Delivery Plan (LDP) remains the contract the NHS Board has with Scottish Government, however some of the standards within it relate to delegated functions of the IJB.

Figure 2 highlights the role of the IJB as well as its partner bodies in providing oversight and scrutiny. For certain delegated service areas reporting is required across the Community Planning Partnership, Community Justice Partnership, and the Critical Services Oversight Group (CSOG).



The Public Bodies (Joint Working) (Content of Performance Reports) (Scotland) Regulations 2014 requires an Annual Performance Report which will report on progress against the IJB's strategic priority areas, and which will include performance in relation to the Core Integration Indicators and the MSG Indicators.

Level 1 Indicators will be included in the Annual Performance Report. Progress against MSG targets will also be reported to the IJB Business Sessions via an agreed performance reporting template.

Level 2 Indicators are reported regularly via NHS Lothian and East Lothian Council, including performance against LDP Targets, the Local Government Benchmarking Adult Social Care Framework, and any additional targets as approved by the IJB. Where possible targets and measures should align with existing targets. Where further engagement with partners indicates a need for additional measures approval for setting any additional targets should first be agreed by the IJB and in line with IJB strategic priorities.

Level 3 Indicators will provide monthly progress reports via Change boards to the Strategic Planning Group and where indicated will report against Delivery Plan Performance Indicators on a six-monthly basis to both the SPG and the IJB through a formal mid-year or end-of-year Report.

5. Making Best Use of Data

The East Lothian Health and Social Care Partnership Data Group aims to support the best use of Data to drive local improvements and ensure robust performance monitoring. Group membership includes representation from Planning and Performance, Public Health, and the Lothian Analytical Service. The group will help build capacity for the partnership to be able to integrate robust methodology which drives local improvement.

Current areas of work include:

- Building local capacity including greater awareness of data landscape and ensuring robust approaches in data collection, analysis and presentation
- Development of local operational dashboards and tools which integrate health and social care data locally, and facilitate more robust performance management of the Core Management Team
- Prioritisation of analytical resources based on identified priority areas as defined in the IJB Strategic Plan 2019-22
- Collaboration with Lothian Analytical Services (LAS), the Local Intelligence Support Team (LIST) and Public Health Scotland to make best use of resources
- Linking with Community Planning Partners to agree key performance indicators
- Development of an agreed set of Health Inequalities measures to better understand local population needs according to levels of severe and multiple deprivation over time.

Appendix 1. Level 1, 2, and 3 Performance Indicators

Level 1	Frequency and Oversight
National MSG Indicators	
Emergency Admissions Acute Unplanned Bed Days A&E Attendances Delayed Discharge Percentage of last six months of life by setting Balance of care: Percentage of population in community or institutional settings	Reported at IJB Business sessions (5x/year) and annually in the IJB Performance report.
National Core Integration Indicators	
Percentage of adults able to look after their health very well or quite well Percentage of adults supported at home who agree that they are supported to live as independently as possible Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided Percentage of adults supported at home who agree that their health and care services seemed to be well coordinated Percentage of adults receiving any care or support who rate it as excellent or good Percentage of people with positive experience of care at their GP practice Percentage of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life Percentage of carers who feel supported to continue in their caring role Percentage of adults supported at home who agree they felt safe Percentage of staff who say they would recommend their workplace as a good place to work Premature mortality rate Rate of emergency admissions for adults Rate of emergency bed days for adults Readmissions to hospital within 28 days of discharge Proportion of last 6 month of life spent at home or in community setting Falls rate per 1,000 population in over 65s	Reported in IJB Annual Performance reports (5 year comparisons)

Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections Percentae of adults with intensive needs receiving care at home Number of days people spend in hsoptial when they are ready to be discharged Percentage of total health and care spend on hospital stays where the patient was admitted in an emergency Percentage of people admitted from home to hospital during the year, who are discharged to a care home Percentage of people who are discharged from hospital within 72 hours of being ready Expenditure on end of life care	
Level 2	
Local Delivery Plan (LDP) Standards	
People newly diagnosed with dementia will be offered a minimum of one year's post-diagnostic support, coordinated by a named Link Worker 90 per cent of patients to commence Psychological Therapy based treatment within 18 weeks of referral 90 per cent of clients will wait no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery. NHS Boards to sustain and embed alcohol brief interventions in 3 priority settings (primary care, A&E, antenatal) and broaden delivery in wider settings GPs to provide 48 Hour access or advance booking to an appropriate member of the GP team for at least 90 per cent of patients NHS Boards to achieve a sickness absence rate of 4 per cent or less 95 per cent of patients to wait no longer than 4 hours from arrival to admission, discharge or transfer for A&E treatment. Boards to work towards 98 per cent	Reported via NHS Lothian to Scottish Government
Council Top 50 – Needs updated	
% of under 65 with long-term care needs receiving personal care at home % of all under 65 non-residential service users receiving care under SDS Options 1, 2 and 3 % of 65+ with long-term care needs receiving personal care at home under option 1, 2 and 3 % of all 65+ non-residential service users receiving care under SDS Options 1, 2 and 3 Number of days people spend in hospital when they are ready to be discharged (18+)	Reported to East Lothian Council annually
East Lothian Plan	
Potentially Preventable admissions rate per 1,000 Type 2 Diabetes Prevalence rates by SIMD Falls per 1,000 population aged over 65	Reported to Community Planning

Premature mortality rates fro people aged under 75 (per 100,000) % of 65+ and under 65s with long-term care needs receiving personal care at home Suicides registered in East Lothian 2014-2018 5-year standardised rolling average rate per 100,000 population Slope index for Inequality for individuals aged 15+ prescribed medication used to treat depression and anxiety	Partnership Governance Group
Local Government Benchmarking Framework	
Number of days people spend in hospital when they are ready to be discharged per 1,000 population (75+) Proportion of care services graded 'good' (4) or better in Care Inspectorate Inspections Rate of readmission to hospital within 28 days per 1,000 discharge % of people reporting 'I was supported to live as independently as possible' % of people reporting 'I had a say in how my help, care or support was provided' % of people reporting 'The help, care or support improved or maintained my quality of life' % of people reporting 'I feel supported to continue caring' Home care costs per hour for people aged 65 or over Direct Payments + Managed Personalised Budgets spend on adults 18+ as a percentage of total social work spend on adults 18+ Percentage of people aged 65 or over with long-term care needs receiving personal care at home Percentage of adults receiving any care or support who rate it as excellent or good Percentage of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life	Reported via East Lothian Council
Level 3	
Delivery Plan Key Performance Indicators	
Primary Care Change Board Cluster workplan agreed Increased % population accessing Community Treatment and Care Services Increased % population with Mental Health and Musculoskeletal input Increased No. of practices benefiting from support of pharmacist or pharmacy technician Completed Link Worker Strategy and Service Specification No. of Completed Strategic assessments Premises audit completed No. of sustainability loans provided No. of practices supported with refurbishment	Reported to IJB via 6 monthly Progress report

eHealth infrastructure in place	
Process established for IT review	
Completed Integrated Impact Assessments	
Updated GP Transport service specification	
Fully costed Diabetes transformation plan	
Carers Change Board	
Establish baseline for No. of carers known to ELHSCP and carer organisations	
Establish baseline for No. of carers receiving support as identified in Cared for person's support plan	
Increase in No. of individual carer budgets	
Increase in No. of Adult Carer Support Plans	
Increase in No. of Young Carer Support Plans	
Development of Outcomes Framework completed	
Shifting the Balance of Care Change Board	
Reduced average No. of days client waits for assessment of need	
Reduced No. of days awaiting care following assessment	
Increased % of clients reviewed every 6 months	
Completed Day services report to IJB	
No. of individuals supported in pain management clinics	
Completed review of A&E attendances and admissions data	
From Baseline year -10% reduction in Delayed Discharge Occupied Bed Days to 72,086	
Increased No. of WTE AHP staff redeployed in community settings	
4% Increase from baseline year (2016/17) to 90% last 6 months of life spent in community	
Establish baseline for No. of people using palliative care beds	
Transforming Services for Older People	
Completion of hospital and wards re-located	
Financial model completed	
Phase 3 REH complete	
Project Plan finalised with HUB SE	
Completion of initial agreement for reprovisioning	
Increased % of Midlothian beds released	
Sheltered Housing report recommendations agreed and approved	

Mental Health and Substance Misuse
Publication of local plan
Agreement of service specification and business plan (Cameron Cottage)
Increase in statutory MHO duties completed on time
Positive user feedback from MHO
Establish baseline for service performance and future targets (MH teams)
Assertive in-reach evaluation complete
% of patients receiving minimum of 1 year post-diagnostic support following Dementia diagnosis
Options appraisal completed for alcohol services
% people accessing therapy within 18 weeks from referral
Reduced Third Sector MH waiting times
Increase in local psychological therapy resource
% of people accessing substance misuse services within 3 weeks
Identified HSCP link with Community Justice Partnership
Completed Community Justice Outcomes Framework
Adults with Complex Needs
Increased No. of people receiving multi-agency transition planning 14+
Completed report of young person and carers' experience of transition process
Increased No. of people receiving appropriate assessment and equipment
Increased No. of people supported by Guide communicator and Interpretation service
Full project implementation plan developed and agreed with IJB
Establish system for ongoing monitoring housing strategy developments
Policy developed to support core and cluster housing
Completed Needs Assessment to inform Learning Disability action plan
Disability hate crimes included in Public Protection report
Consultations reviewed for accessibility
Completed LD needs assessment for old age population
LD forensic service model agreed and implemented
Fairer Scotland implementation plan agreed
P&P resource agreed for respite service review
Increased No. of people receiving Shared Lives Service

Increased No. of new carers recruited	