# DEVON INTEGRATED CARE SYSTEM PERFORMANCE

## QUARTER 4 2018/19

## 1. INTRODUCTION

Public Sector organisations across the country are facing unprecedented challenges and pressures due to changes in demography, increasing complexity of need and the requirement to deliver better services with less public resource. Plymouth and Devon also face a particular financial challenge because of the local demography, the historic pattern of provision and pockets of deprivation and entrenched health inequalities.

The Integrated Care System (ICS) has been designed to deliver leadership of a shared vision for population well-being, single system plan and care model. It will look to ensure collaboration between statutory partners as well as to set a direction, framework and culture around the delivery of health and social care services. The performance outcomes framework has been designed to allow us to monitor how the ICS is delivering care to the people of Plymouth and the rest of the ICS geographical area.

## 2. BENCHMARKING

Benchmarking information provided in this report is sourced from a variety of places with national performance based on the most recently published data, the time period for this data will vary depending on the source.

## 3. TREND GRAPHS

Each indicator is accompanied by a trend graph showing where possible the latest four values, values that represent the whole of the Integrated Care System area which includes Plymouth, Devon and Torbay. Caution is required when interpreting the graphs as there is no Y axis displayed and as such the significance or flow of the change is difficult to interpret.

## 4. PLYMOUTH PERFORMANCE BY EXCEPTION

**OUTCOME: More people will be living independently in resilient communities**

### Adult Social Care User Survey

Outcome indicators relating to the safety and social isolation of users of adult social care services are based on an annual survey of service users.

The fieldwork for the 2019 survey was undertaken between February and April 2019 and in total we received 510 completed questionnaires, a total of 1,732 were sent out. This equates to a response rate of 29.4% and ensures our results are statistically robust.

There has been a decline in the percentage of service users who feel safe (66% down from 72%) and the percentage who have responded that they have as much social contact as they want (45% down from 50%). Analysis of these results is underway and an action plan is being developed to respond to some of the issues identified.

**OUTCOME: More people will be choosing to live healthy lifestyles and less people will be becoming unwell**

### Adult Smoking Prevalence

Smoking prevalence in Plymouth is significantly higher than the England average. We will continue to invest in the services and roll out Making Every Contact Count (MECC) to ensure that as many brief interventions take place as possible that encourage people to stop smoking and support them in doing so. We will continue to focus our resources on those with the most complex support needs and work with University Hospitals Plymouth to embed MECC within their organisation. We will also continue to take a system approach to tobacco control so that action takes place to disrupt and minimise the supply of illegal and illicit tobacco in the city, and to ensure that tobacco sales are appropriately restricted by age and advertising restrictions are adhered to.

### Excess weight in adults/ Fruit and Vegetable Consumption

Excess weight in Plymouth is higher than the national average. We continue to focus on giving children the best start in life, making schools health-promoting environments, managing the area around schools through fast food planning policy, and working with partners to raise awareness of the risk factors of unhealthy diets and physical inactivity through Thrive Plymouth. In April 2019, we renewed our Bronze Sustainable Food Cities award as part of our journey towards Silver. This includes promoting healthy eating and healthy weight through a range of initiatives, such as Sugar Smart, Healthy Start and working with our community and voluntary sector to tackle food poverty in the city.

### Dementia Diagnosis Rate

In April 2019 the diagnosis rate has increased to 56.3%, up from 55.7% in March. The diagnosis rate remains below the target of 67%.

Consultant capacity has been increased. Link workers are now in place with relevant care homes and a series of actions have been undertaken to reduce home visit rates via offering more appointments at Mount Gould. Reports have also been developed on length of wait for head scans leading to more efficient booking of follow up appointments

**OUTCOME: More care will be available in the community and less people will need to visit, or be admitted to hospital**

### Long term support needs of people 65+ met by admissions to residential or nursing care

Historically we have in Plymouth had a lower rate of adults who require long term adult social services delivered within a residential or nursing home. In 2018/19 the number of people admitted to homes increased from 261 to 305. The improvement in the management of patient flow in the hospital system which has improved our delayed transfers of care performance has had an impact on numbers admitted.

**OUTCOME: People will have far greater control over health services and will be equal partners in decisions about their care**

### Social Care Quality of Life

The Social Care Quality of Life indicator is another borne of the annual adult social care survey and takes into account people's responses to questions relating to control, personal care, food and nutrition, accommodation, safety, occupation and dignity. Based on our results the 2019 Social Care Quality of Life in Plymouth is 19.1, down from 19.7 in 2017/18.

### Overall Satisfaction of people who use services with their care and support

Satisfaction among long term users of adult social care services continues to be higher than the national average. In the 2019 survey the percentage of users who were either 'Extremely' or 'Very' satisfied was 70.6%, compared to an average of 63.7%. Those least satisfied are people aged 18-64 and receiving a service in either a home or in the community, the action plan to improve service user experience will reflect this.

**OUTCOME: People will go into hospital when necessary and will be discharged efficiently and safely with the right support in their community**

### Delayed Transfers of Care

The rate of DTOC in Plymouth continues to exceed national expectations, and work continues to improve hospital flow and discharge and thus reduce delayed transfers of care and length of stay. Actions include the now established escalation of care arrangements across health and social care systems and the daily review of long stay patients by integrated discharge teams. The management of patients with complex needs is working well at the hospital and the process to discharge people from hospital has remained stable despite pressure at the front door of the hospital.

# 5. OUTCOMES FRAMEWORK SCORECARD

| Devon ICS Strategic Outcomes Framework | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | STP in Context | | | Local Authorities | | | STP Localities | | | |
| Outcomes | Measures | England | Actual | Trend | STP Chart | Devon | Plymouth | Torbay | East (RDEFT) | North (NDHT) | West (PHNT) | South (TSDHT) |
| More people will be living independently in resilient communities | ASCOF 1E: Proportion of adults with learning disabilities in paid employment | 6.0% | 8.6% | ▲ | | 8.6% | 5.6% | 3.8% | | | | |
| | ASCOF 1F: Proportion of adults with mental health needs in paid employment | 7.0% | | | | 8.0% | 7.0% | 1.0% | | | | |
| | ASCOF 4A: Proportion of people who use services who feel safe | 69.7% | | | | 68.8% | 66.4% | 70.6% | | | | |
| | ASCOF 4B: Proportion of people who use services who say that those services have made them feel safe and secure | 86.5% | | | | 80.8% | 89.8% | 83.9% | | | | |
| | Fuel poverty | 11.4% | 10.9% | ▼ | | 10.9% | 11.8% | 10.8% | 10.6% | 10.9% | 11.2% | 10.7% |
| | Self-reported wellbeing (low happiness score) | 8.2% | 7.8% | ▼ | | 6.9% | 7.9% | 8.7% | | | | |
| | ASCOF 1Ii - The proportion of people who use services who reported they had as much social contact as they would like | 4580.0% | | | | 42.8% | 44.8% | 43.1% | | | | |
| | ASCOF 1Iii - Proportion of carers who reported that they had as much social contact as they would like | 35.5% | | | | 27.9% | 26.6% | 34.4% | | | | |
| More people will be choosing to live healthy lifestyles and less people will be becoming unwell | Adult smoking prevalence | 14.9% | 14.7% | ▲ | | 13.5% | 18.4% | 14.8% | 11.9% | 15.3% | 16.8% | 15.5% |
| | Alcohol-related admissions | 2224 | 1981 | ▼ | | 1711 | 2159 | 2248 | 1620 | 1904 | 1816 | 2044 |
| | Physically active adults | 66.3% | 70.7% | ▼ | | 72.8% | 68.7% | 70.7% | 76% | 69% | 70% | 70% |
| | Excess weight in adults | 62.0% | 64.7% | ▲ | | 67.2% | 67.2% | 59.8% | 57% | 66% | 62% | 64% |
| | Fruit and vegetable consumption | 54.8% | 60.1% | ▼ | | 62.3% | 57.2% | 60.7% | 60% | 64% | 62% | 62% |
| | Life expectancy at birth (males) | 79.6 | 79.4 | ▼ | | 80.4 | 79.0 | 78.7 | 80.2 | 79.5 | 80.4 | 79.7 |
| | Life expectancy at birth (females) | 83.1 | 83.1 | ▼ | | 84.2 | 82.2 | 82.8 | 84.3 | 82.9 | 83.6 | 83.8 |
| | Life expectancy gap (males) | 9.4 | | | | 5.6 | 8.5 | 9.4 | | | | |
| | Life expectancy gap (females) | 7.4 | | | | 4.5 | 6.3 | 4.3 | | | | |
| | IAF 102a: 10-11 classified overweight /obese | 33.9% | 29.9% | ▼ | | | | | 29.5% | | | 30.9% |
| | Dementia diagnosis rate | 67.9% | 59.2% | ▼ | | | | | 59.7% | | | 59.1% |
| People who do have health conditions will have the knowledge, skills and confidence to better manage them | Proportion of people who are feeling supported to manage their condition | 79% | 82.9% | ◀▶ | | 85.1% | 76.0% | 82.1% | 85.5% | 84.7% | 78.1% | 84.0% |
| | Hospital admissions for self-harm (aged 10 - 24) | 421 | 653.3 | ▼ | | 593.7 | 706.1 | 949.2 | 480.4 | 818.2422329 | 662.4 | 845.5936263 |
| | IAF 126b: Dementia post diagnostic support | 77.5% | 77.1% | ▼ | | | | | 77.2% | | | 76.8% |
| | Percentage of people that received an NHS Health Check of those offered | 46.5% | | | | 77.7% | 52.9% | 87.9% | | | | |
| | IAF 127b: Emergency admissions for ambulatory care sensitive conditions | 2408.5 | 2331.0 | ▼ | | | | | 2185.0 | | | 1996.0 |

# Devon ICS Strategic Outcomes Framework

| | | | STP in Context | | | Local Authorities | | | STP Localities | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Outcomes** | **Measures** | **England** | **Actual** | **Trend** | **STP Chart** | **Devon** | **Plymouth** | **Torbay** | **East (RDEFT)** | **North (NDHT)** | **West (PHNT)** | **South (TSDHT)** |
| The healthcare system will be equipped to intervene early, and rapidly, to avert deterioration and escalation of health problems | Cancer diagnosed at stage 1 or 2 | 52.2% | 53.4% | ▼ |  | 56.1% | 54.2% | 49.9% | 58.1% | 53.2% | 56.1% | 52.1% |
| | Mortality rate from preventable causes | 181.5 | 188.7 | ▲ |  | 161.0 | 207.3 | 197.7 | 164.2 | 180.25 | 165.7 | 178.1 |
| | Suicide rate | 9.6 | 10.8 | ▼ |  | 10.5 | 9.2 | 15.7 | 10.3 | 12.8 | 9.5 | 13.15 |
| | OIS 1.10: One-year survival from all cancers | 72.3% | | | | | | | 73.6% | | | 74.3% |
| | OIS 1.4: Myocardial infarction, stroke and stage 5 chronic kidney disease in people with diabetes | 100 | | | | | | | 89.6 | | | 112.5 |
| More care will be available in the community and less people will need to visit, or be admitted to, hospital | ASCOF 2Ai: long-term support needs of people 18-64 met by admission to residential or nursing care homes per 100,000 population (LOW IS GOOD) | 14.0 | 16.8 | ▲ |  | 17.7 | 11.7 | 22.8 | | | | |
| | ASCOF 2Aii: long-term support needs of people 65+ met by admission to residential or nursing care homes per 100,000 population (LOW IS GOOD) | 586 | 471.0 | ▼ |  | 494.3 | 637.5 | 446.9 | | | | |
| | Deaths in usual place of residence | 46.6% | 53.4% | ▼ |  | 53.2% | 54.5% | 53.4% | 53.0% | 51.8% | 55.2% | 52.9% |
| | IAF 127f: Hospital bed use following emergency admission | 498.9 | 397.0 | ▲ |  | | | | 427.5 | | | 366.7 |
| People will have far greater control over health services and will be equal partners in decisions about their care | ASCOF 1A: Social-care related quality of life | 19 | | |  | 19 | 19.7 | 19.4 | | | | |
| | ASCOF 3A: Overall satisfaction of people who use services with their care and support | 65.0% | | |  | 67.9% | 72.0% | 69.2% | | | | |
| | ASCOF 3B: Overall satisfaction of carers with social services | 39.0% | | |  | 37.6% | 33.6% | 37.9% | | | | |
| | ASCOF 1C(2A): proportion of people who use services receiving direct payments | 28.5% | 27% | ▼ |  | 33.3% | 22.4% | 26.7% | | | | |
| | IAF 128b: Patient experience of GP services | 83.8% | 88.6% | ▼ |  | | | | 89.0% | | | 87.4% |
| | OIS 2.1: Health-related quality of life for people with long-term conditions | 73.7% | 72.7% | ▼ |  | | | | 73.8% | | | 72.0% |
| | OIS 2.15: Health-related quality of life for carers, aged 18 and above | 79.7% | 79.7% | ▼ |  | | | | 80.8% | | | 79.7% |
| | OIS 2.16: Health-related quality of life for people with a long-term mental health condition | 51.9% | 52.4% | ▼ |  | | | | 52.0% | | | 49.5% |
| | OIS 2.2: Proportion of people who are feeling supported to manage their condition | 59.6 | | | | | | | 63.20 | | | 62.40 |
| People will go into hospital when necessary and will be discharged efficiently and safely with the right support in their community | ASCOF 2Bi: the proportion of people 65+ discharged from hospital who remain at home 91 days afterwards | 82.9% | 79.1% | ▼ |  | 82.6% | 80.4% | 70.7% | | | | |
| | ASCOF 2Bii: the proportion of people 65+ discharged from hospital who are offered reablement services. | 2.9% | 4.1% | ▲ |  | 1.8% | 3.9% | 6.5% | | | | |
| | ASCOF 2Ci: delayed transfers of care from hospital in year per 100,000 population | 1.3 | 17.5 | ▲ |  | 16.8 | 15.7 | 7.9 | | | | |
| | ASCOF 2Cii: delayed transfers of care from hospital in year attributable to social care per 100,000 population | 4.3 | 5.2 | ▼ |  | 4.3 | 2.1 | 1.9 | | | | |