REPORT TO: East Lothian Integration Joint Board

MEETING DATE: 23 May 2024

BY: Chief Officer

SUBJECT: East Lothian HSCP Performance Framework

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1 PURPOSE

1.1 To present the East Lothian HSCP Performance Framework to the IJB for approval.

2 RECOMMENDATIONS

2.1 The IJB is asked to:

i. Review and approve the appended ELHSCP Performance Framework.

ii. Note ongoing activity to develop key performance indicators to be presented to the IJB alongside the existing mid-year Annual Delivery Plan progress report and the Annual Performance Report (from autumn 2024).

3 BACKGROUND

3.1 An East Lothian HSCP Performance Framework has been developed to provide a detailed outline of performance monitoring and reporting across HSCP services and to identify areas for further development.

3.2 Delivery of the activities within the Performance Framework fulfils the following purposes:

- Supports the IJB in its governance role, helping to ensure that it has the information required to maintain oversight and scrutiny of HSCP activity in relation to delivery of its strategic objectives.
- Provides accountability and assurance to delivery partners East Lothian Council and NHS Lothian in relation to the delivery of HSCP services.

- Informs operational and tactical planning, management and decision making and supports improvement activity.
- Helps measure the impact of transformation / change activity.

3.3 The Performance Framework identifies four levels of performance management – Strategic; Assurance and Accountability; Operational; and Tactical and describes activity at each of these levels.

3.4 Appendix 1 of the Framework contains detail of the range of data / performance indicators currently reported to the IJB, SPG, East Lothian Council, NHS Lothian, Public Health Scotland, and the Scottish Government.

3.5 Appendix 2 maps outline indicators against the IJB Strategic Objectives, and the delivery priorities identified in the 2023/24 Annual Delivery Plan (ADP). These indicators form the basis of the IJB Annual Performance Report due for publication in late June. Work is currently underway to finalise the 2024/25 Annual Delivery Plan, and this is likely to include an update to the current ADP performance indicators.

3.6 From autumn 2024, a set of additional key performance indicators covering individual service areas will be reported alongside the mid-year Annual Delivery Plan progress update and the year-end Annual Performance Report.

4 ENGAGEMENT

4.1 Not applicable.

5 POLICY IMPLICATIONS

5.1 The Performance Framework relates to the delivery of a number of strategies, including the IJB Strategic Plan.

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 economy.

7 DIRECTIONS

7.1 No additional directions required.

8 RESOURCE IMPLICATIONS

8.1 Financial – None

8.2 Personnel – Activity detailed in the Performance Framework can be supported within existing staffing resource.

8.3 Other – None

9 BACKGROUND PAPERS

9.1 None.

Appendices:

Appendix 1 – East Lothian HSCP Performance Reporting – Table of Current Indicators.

Appendix 2 – Annual Delivery Plan 2023/24 – Performance Indicators.

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Appendix 1

East Lothian HSCP Performance Reporting – Table of Current Indicators

Notes:

1. The indicators included below are those reported for purposes of performance monitoring, assurance, and accountability, they do not include performance metrics used at operational or tactical level for performance management.

2. This list if not exhaustive – additional performance information may be reported by services to other entities – further mapping work is required in relation to this.

3. Performance reporting, primarily to the IJB / SPG, also takes place in relation to progress with the delivery of specific strategies / plans (besides the IJB Strategic Plan) and will include performance data as well as a narrative on activity – examples include the Workforce Plan, Carers Strategy and Dementia Strategy. Indicators included in this type of reporting are not included in this table.

4. Indicators currently reported to East Lothian Council are currently under review, with a view to making these more reflective of current delivery priorities.

Group 1 – Indicators reported to East Lothian Integration Joint Board / Strategic Planning Group

National Integration Indicators		**Reporting**
1.1	Percentage of adults able to look after their health very well or quite well	The National Integration Indicators are reported in the IJB Annual Performance Report (APR), published at the end of July each year. The APR reports trend data for these indicators over a minimum of 4 years (in some cases a 6 year period is covered). Comparative data at a Scottish level is also included where available. Indicators 1.1 to 1.9 are based on East Lothian residents' responses to the national Health and Care Experience (HACE) survey. This survey is only carried out every 2 years and this is reflected in reporting frequency.
1.2	Percentage of adults supported at home who agree that they are supported to live as independently as possible	
1.3	Percentage of adults supported at home who agree they had a say in how their help, care or support was provided	
1.4	Percentage of adults supported at home who agree that their health and social care services seemed to be well coordinated	
1.5	Percentage of adults receiving any care or support who rate it as 'excellent' or 'good'	
1.6	Percentage of people with positive experience of care at their GP practice	
1.7	Percentage of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life	
1.8	Percentage of carers who feel supported to continue in their caring role	
1.9	Percentage of adults supported at home who agree they felt safe	
1.10	Premature mortality rate for people aged under 75 per 100,000 persons (by calendar year)	
1.11	Emergency admission rate for adults (per 100,000 population)	
1.12	Emergency bed day rate for adults (per 100,000 population)	
1.13	Readmission to hospital within 28 days of discharge (rate per 1,000 discharges)	
1.14	Proportion of last 6 months of life spent at home or in a community setting	
1.15	Falls rates per 1,000 population aged 65+	
1.16	Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections	
1.17	Percentage of adults with intensive care needs receiving care at home	
1.18	Number of days people aged 75+ spend in hospital when they are ready to be discharged (per 1,000 population)	
1.19	Percentage of health and care resources spent on hospital stays where the patient was admitted in an emergency	

Ministerial Steering Group (MSG) Indicators		
1.20	Number of Emergency Admissions (18+)	The Ministerial Steering Group (MSG) Indicators are reported in the IJB Annual Performance Report (APR), published at the end of July each year. The APR reports trend data for these indicators over a minimum of 4 years (in some cases a 6 year period is covered). Comparative data at a Scottish level is also included where available. * MSG indicator data is available on a quarterly basis, so more regular reporting to the IJB could be considered.
1.21	Number of Unscheduled Hospital Bed Days – Acute (18+)	
1.22	Number of Unscheduled Hospital Bed Days – Geriatric Long Stay (18+)	
1.23	Number of Unscheduled Hospital Bed Days – Mental Health (18+)	
1.24	New Accident and Emergency attendances (18+)	
1.25	Total number of Bed Days lost to delays (all delays and all reasons 18+)	
1.26	Percentage of last 6 months of life spent in community setting	
1.27	Percentage of the population at home – supported and unsupported (aged 65+)	

Group 2– Indicators reported to East Lothian Council

East Lothian Council Key Performance Indicators		Reporting
2.1	Number of days people aged 75+ spend in hospital when they are ready to be discharged (per 1,000 population) (National Integration Indicator) *	Reported to East Lothian Council Policy and Performance Review Committee (PPRC). PPRC takes place quarterly, frequency of reporting depends on data availability (a number of indicators are only available annually). * Included in ELC's 'Top 50' indicators.
2.2	Percentage of people with intensive care needs receiving personal care at home (total percentage / percentage of under 65s / percentage of over 65s) *	
2.3	Percentage of non-residential service users receiving care under SDS Options 1 and 2 (total / under 65s / over 65s) *	
2.4	Percentage of carers receiving respite via a Carers Support Plan *	
2.5	Emergency / unplanned hospital admissions (per 100,000 population) (all 18+ / over 65s) *	
2.6	Falls per 1,000 population aged 65+ (National Integration Indicator) *	
2.7	Proportion of last 6 months of life spent at home or in a community setting (National Integration Indicator) *	
2.8	Percentage of adults able to look after their health very well or quite well (National Integration Indicator) *	
2.9	Number of delayed discharge patients waiting over 2 weeks	
2.10	Diversion from prosecution – reports requested versus individuals assessed as suitable (Justice Social Work)	
2.11	Community sentencing – preferred option (Community Payback Order, Drug Treatment and Testing Order, Restriction of Liberty Order) versus actual outcome (Justice Social Work)	
2.12	Community Payback Work Delivery – hours instructed versus hours delivered (Justice Social Work)	
2.13	Throughcare – sentencing – remand / sentences less than 12 months / sentences more than 12 months (Justice Social Work)	
2.14	Justice Outcome Star – distance travelled (Justice Social Work)	
Local Government Benchmarking Framework (LGBF) Indicators		
2.15	Home Care costs per hour for people 65 or over	These indicators are collated at a national level as part of the Local Government
2.16	SDS spend on adults 18+ as a % of total social work spend on adults 18+	

2.17	Percentage of people aged 65 or over with long term care needs receiving personal care at home	Benchmarking Framework. An annual report is made available to all local authorities and forms the basis of a report to PPRC.
2.18	Percentage of adults who agree that their services had an impact in improving their quality of life	
2.19	Percentage of adults who agree they are supported to live as independently as possible	
2.20	Percentage of adults supported at home who agree they had a say in how their care / support was provided	
2.21	Percentage of carers who feel supported to continue their caring role	
2.22	Residential care costs per week per resident for people aged 65 or over	
2.23	Rate of readmission to hospital within 28 days per 1,000 discharges	
2.24	Proportion of care services graded 'good' or better in Care Inspectorate inspections	
2.25	Number of days people spend in hospital when they are ready to be discharged (per 1000 population 75+)	
Service Pressure Indicators		
2.26	Number of Community Payback Orders	Reported to ELC Chief Executive on a quarterly basis (from June 2023). * Work to take place to develop a quarterly report to provide a more detailed assessment of current pressures and service performance more generally.
2.27	Packages of care – existing packages	
2.28	Packages of care – new packages (in the community)	
2.29	Packages of care – new packages (leaving hospital)	
2.30	Packages of care – packages restarted on hospital discharge	
2.31	Packages of care – unmet need – assessed and waiting for a package of care (in hospital / in the community)	
2.32	Social work assessment – new referrals to social work (community and hospital combined)	
2.33	Social work assessment – social care assessments carried out	
2.34	Social work assessment – social care assessments outstanding (waiting list)	
2.35	Mental Health Officer team – guardianship applications / renewals / intervention orders	
2.36	Mental Health Officer team – legal duties related to emergency / short term detentions / compulsory treatment orders	
East Lothian and Midlothian Public Protection Committee Annual Report		
2.37	Includes a range of indicators related to Adult Support and Protection	Published October / September annually and reported to PPRC.

East Lothian Plan Indicators (Community Planning)		
2.38	Potentially Preventable admissions rate per 1,000	Reported annually. * The East Lothian Plan is currently under review (July 2023) – these indicators may change as a result.
2.39	Type 2 Diabetes Prevalence rates by SIMD	
2.40	Falls per 1,000 population aged over 65	
2.41	Premature mortality rates for people aged under 75 (per 100,000)	
2.42	% of 65+ and under 65s with long-term care needs receiving personal care at home	
2.43	Suicides registered in East Lothian 2014-2018 5-year standardised rolling average rate per 100,000 population	
2.44	Slope index for inequality for individuals aged 15+ prescribed medication used to treat depression and anxiety	

Group 3 – Indicators reported to NHS Lothian

NHS Lothian – Quarterly Performance Report Indicators		Reporting
3.1	Care Opinion – Number of positive stories (by month over last 12 months)	These core indicators are reported on as part of a quarterly performance update to NHS Lothian. Quarterly performance reports include a narrative on indicators, assurance levels and points for escalation. Additional indicators may also be included based on activity the HSCP wishes to highlight, or in response to actions from previous meetings.
3.2	Care Opinion – Number of negative stories (by month over last 12 months)	
3.3	Care Opinion – use of word clouds to show common narrative and themes from quarter	
3.4	Complaints – number per subject over last quarter / number for previous 12 months (with comparison to overall NHS Lothian figures)	
3.5	Complaints – current number of complaint open for over 40 days	
3.6	Stage 1 Complaints – number by month over past 12 months (with comparison to overall NHS Lothian figures)	
3.7	Number of complaints upheld at Stage 1 as a % of all complaints closed at Stage 1 by last 3 reportable months	
3.8	Number of complaints partially upheld at Stage 1 as a % of all complaints closed at Stage 1 by last 3 reportable months	
3.9	Number of complaints closed at Stage 1 within 5 working days as a % of total number of Stage 1 complaints by month over the past 12 months with comparison to overall NHS Lothian figures	
3.10	Stage 2 complaints - number by month over the past 12 months with comparison to overall NHS Lothian figures.	
3.11	Number of complaints upheld at Stage 2 as a % of all complaints closed at Stage 2 by last 3 reportable months	
3.12	Number of complaints partially upheld at Stage 2 as a % of all complaints closed at Stage 2 by last 3 reportable months	
3.13	Number of complaints closed at Stage 2 within 20 working days as a % of total number of Stage 2 complaints by month over the past 12 months with comparison to overall NHS Lothian figures	
3.14	Number of complaints closed at Stage 2 over 20 working days as a % of total number of Stage 2 complaints by month over the past 12 months with comparison to overall NHS Lothian figures	
3.15	Stage 2 Complaints after escalation - number by month over the past 3 reportable months with comparison to overall NHS Lothian figures.	
3.16	Number of escalated complaints upheld at Stage 2 as a % of all escalated complaints closed at Stage 2 by last 3 reportable months	

3.17	Number of escalated complaints partially upheld at Stage 2 as a % of all escalated complaints closed at Stage 2 by last 3 reportable months	
3.18	Number of escalated complaints escalated within 20 working days over the past 3 reportable months	
3.19	SPSO - number of cases currently open at time of reporting with comparison to overall NHS Lothian figures	
3.20	SPSO - breakdown on the status of all open SPSO cases	
3.21	Number of Serious Adverse Events (SAEs) reported and closed by month over the past 24 months with comparison to overall NHS Lothian figures	
3.22	Number of SAEs with major harm/death which are open past the 6-month deadline by week over the past 20 months with comparison to overall NHS Lothian figures	
3.23	Forecast Business Unit financial position (current forecast)	
3.24	Forecast Business Unit Covid costs within current forecast	
3.25	Forecast Business Unit savings within current forecast	
3.26	Business Cases >£0.25m and <£10m - progress through governance if not yet approved/against project timescales if approved	
3.27	Business Cases >£10m - Progress through governance if not yet approved/against project timescales if approved	
3.28	NHS Staff Sickness Absence Rate - by month over the current and previous financial year	
3.29	Overall Absence Rates and Hours Lost - number by Job Family by month over the previous month	
3.30	Number of Episodes and Hours Lost by Reason - number by month by reason over the previous month	
3.31	Short Term Vs Long Term Absences - number of short- and long-term absences by month over the current and previous financial year	
3.32	Staff Leave – Percentage of Hours Lost by Reason - percentage by month by reason over the previous 12 months	
3.33	Covid-19 Absence Compared to Sickness Absence - percentage comparison by month over the previous 12 months	
3.34	Staff Turnover - number by month over the previous 12 months	
3.35	Bank WTE - number by month over the current and previous financial year	
3.36	Agency WTE - number by month over the current and previous financial year	
3.37	Excess WTE - number by month over the current and previous financial year	

3.38	Overtime WTE - number by month over the current and previous financial year	
3.39	Establishment Gap - percentage by month over the previous 12 months	
3.40	TURAS Appraisal Compliance - percentage of staff who are compliant, number of staff who are compliant and non-complaint, headcount within the Division and overall compliance percentage. Data to be presented alongside previous quarter information	
3.41	Core Mandatory Training (8) - percentage of staff with completed training for each of the 8 sessions showing progression from the last reportable month to the previous quarter	
3.42	Percentage of staff participating in iMatter (Q1 & Q2 only)	
3.43	Percentage of iMatter action plans completed (Q1 & Q2 only)	
3.44	Progress against Directorate / Division level iMatter action plans	
NHS Lothian – Annual Delivery Plan		
3.45	Safe and COVID compliant Remobilisation of Day Centres for Older People and delivery of a suite of alternative supports to support older people at home	Narrative on delivery of each priority submitted to NHS Lothian quarterly (last submission Q3 2022/23). * The development of the new Lothian Strategic Development Framework and associated Annual Delivery Plan is expected to lead to new reporting requirements.
3.46	Development of a 'Resource Coordinator' service to complement existing day supports for adults with complex needs under 65	
3.47	Reestablishment of provision and stabilisation of Care at Home services	
3.48	Increase from current care home capacity to previous levels to meet patient and service needs	
3.49	Support to carers	
3.50	Supporting patients with post-COVID/long-COVID issues	
3.51	Adoption of 'Home First' principles within the ELCH discharge avoidance and planning arrangements	
3.52	Development of alternative delivery options for Pain Management to reduce need for in person clinic attendance	
NHS Lothian – Other		
	Interim Care Home Beds – community and hospital – occupancy rate	Reported every 2 months to NHS Lothian
	Board Executive Team report	A narrative is sent to NHS Lothian quarterly identifying successes / issues / etc.

Group 4 – Indicators reported to Scottish Government / Public Health Scotland

Free Personal and Nursing Care		**Reporting**
4.1	Care Home residents by age and client group	Reported to Scottish Government quarterly.
4.2	Numbers of the above receiving FPC/FPNC	
4.3	Care at Home clients by age and client group	
4.4	Care at Home hours for the above	
4.5	Free Personal Care hours for the above	
4.6	Approximate cost of Free Personal Care hours for the above	
Justice Social Work		
4.7	Aggregate return	Reported to Scottish Government as part of Justice Social Work Annual Report.
4.9	Drug Treatment and Testing Orders	
4.10	Community Payback Orders	
4.11	Community Payback Orders – outstanding hours	
Local Delivery Plan		
4.12	People newly diagnosed with dementia will be offered a minimum of one year's post-diagnostic support, coordinated by a named Link Worker	Data related to the delivery of LDP targets reported to Scottish Government via NHS Lothian.
4.13	90 per cent of patients to commence Psychological Therapy based treatment within 18 weeks of referral	
4.14	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.	
4.15	NHS Boards to sustain and embed alcohol brief interventions in 3 priority settings (primary care, A&E, antenatal) and broaden delivery in wider settings	
4.16	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	
4.17	NHS Boards to achieve a sickness absence rate of 4 per cent or less	

4.18	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	
Unmet Need (Social Care)		
4.19	Waiting for a Social Care assessment – hospital	Reported to Public Health Scotland weekly.
4.20	Waiting for a Social Care assessment – community	
4.21	Assessed and waiting for a package of care – hospital	
4.22	Assessed and waiting for a package of care – community	
4.23	In receipt of a care package and waiting 12+ months for a Review	
4.24	Care yet to be provided for assessed individuals in hospital	
4.25	Care yet to be provided for assessed individuals in the community	
4.26	Care assessed as needed and not provided for those in receipt of a care package	
4.27	Basic demographic data on all / new clients	
4.28	All Care at Home provided in the quarter	
4.29	All Residential placements starting / finishing / current during the quarter	
4.30	All Respite services starting / finishing / current during the quarter	
4.31	Services provided through SDS during the year	
4.32	Client data including Day Services, frozen meals, SW involvement etc.	
Scottish Government / Public Health Scotland – Other		
4.33	Monthly hospital delayed discharge data	Submitted to NHS Lothian – data is submitted to Public Health Scotland.
4.34	Quarterly Complex Coded Delayed Discharge report	
4.35	Chief Social Work Officers Annual Report	Submitted to the Scottish Government in September – contains a range of social work related indicators.
4.36	MAT (Medication Assisted Treatment) standards implementation reporting	Reporting on a range of detailed indicators (details to be added).

Appendix 2 - Annual Delivery Plan 2023/24 – Performance Indicators

Strategic Objective 1 – Develop services that are sustainable and proportionate to need

Outcome	**Outcome Indicators**
Older people living in East Lothian receive high quality care and support and the right care, in the right place	• Narrative describing how services are being developed and how they respond to pressures / policy drivers Proportion of last 6 months of life spent at home or in a community setting (National Indicator) • % of adults with intensive care needs receiving personal care at home – over 65s (National Indicator) • Proportion of care services graded 'good' or better by Care Inspectorate (National Indicator)
More people benefit from the increased capacity / wider range of Intermediate Care services available	• Narrative describing range of Intermediate Care services available • Number of hours delivered per month – Hospital to Home, Hospital at Home, Care at Home • % of adults with intensive care needs receiving personal care at home – over 65s / under 65s (National Indicator) • Data from East Lothian Community First monitoring and evaluation
Care at home service capacity is sufficient to meet need	• Number of hours of Care at Home provision delivered per month – showing internal / external split • Care yet to be provided for assessed individuals in hospital • Care yet to be provided for assessed individuals in the community
People are happy with the care at home service they receive	• % of adults supported at home agreeing they are supported to live as independently as possible (National Indicator) • % of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life (National Indicator) • % of adults supported at home who agree they felt safe (National Indicator) • % of care at home services graded 'good' or better by Care Inspectorate (National Indicator)
Fewer people are admitted to hospital unnecessarily	• Emergency admission rate for adults (per 100,000 population) (National Indicator) • Emergency bed day rates for adults (per 100,000 population) (National Indicator) • Number of Unscheduled Bed Days (by Acute / Geriatric / Mental Health) (MSG Indicator) • Readmission to hospital within 28 days of discharge (rate per 1,000 discharges) (National Indicator)
People do not stay in hospital any longer than is medically necessary and benefit from timely assessment and discharge	• Number of days people aged 75+ spend in hospital when they are ready to be discharged (per 100,000 population) (National Indicator) • Total number of Bed Days lost to delays (MSG Indicator) • Monthly Delayed Discharge census figures – Standard Delays and Occupied Bed Days • Inreach project data – data set be agreed

Commissioned services are provided in a way that reflects our strategic approach and values and contributes to delivery of our strategic objectives	• Narrative on implementation of Commissioning Strategy
East Lothian residents are able to access a range of primary care services that provide the right care, at the right time in the right place	• Narrative regarding developments related to primary care services, including General Practice • GP practice data – to be agreed – currently under development • % of people with positive experience of care at their GP practice (National Indicator)
More people needing to access mental health / learning disability beds are able to remain in East Lothian	• Royal Edinburgh Hospital and St Johns acute mental health and rehab bed occupancy for East Lothian patients – total occupied bed days / length of stay

Strategic Objective 2 – Deliver new models of community provision, working collaboratively with communities

Outcome	**Outcome Indicators**
A wider range of community support services are available for people with complex needs (over and under 65)	• Narrative describing range of community support services in place
People supported by community support services: • Feel listened to, valued, and respected • Have the opportunity to pursue their interests and connect with others • Feel less isolated, more part of their local community, and have an improved sense of wellbeing • Are able to live as well and as independently as possible • Carers are supported and have improved wellbeing	• Monitoring data from EL Community First Service (to be confirmed) • Data for other community support services also be available once the personal outcomes framework is in place
People with complex needs are able to benefit from employment opportunities	• Narrative describing development of employability support • Number of people supported into employment via employability projects
People with dementia and their carers feel less isolated and have an improved sense of wellbeing	• Indicators to be developed – including data from ongoing monitoring / evaluation of meeting centres
People have the opportunity to have their say through being involved in HSCP engagement / participation opportunities	• Narrative describing engagement / participation / coproduction activities • Number of people reached in relation to specific engagement opportunities
People benefit from being supported to access physical activities as part of their care / treatment	• Indicators to be developed using data from physical activity referral service once established
People are actively involved in their local community and community cohesion is strengthened	• Number of hours of volunteering contributed (data being developed by VCEL)

The voluntary and community sectors play a key role in supporting local people and communities	• Data from VCEL on net worth of community / voluntary sectors and funding drawn down by these sectors • Narrative describing work carried out by VCEL to build capacity in these sectors, including support re developing governance arrangements – potentially to include data on level of engagement (e.g., number of organisations attending training / seeking support)

Strategic Objective 3 – Focus on prevention and early intervention

Outcome	**Outcome Indicators**
People benefit from being able to access joined up treatment / support from across range of AHP disciplines in a community-based clinic closer to where they live	• Number of clinics completed • Number of attendances at clinics • Waiting list data
People benefit from TEC being embedded across ELRS workstreams	• Narrative describing progress, with potential development of data in relation to people using TEC
People have the tools and support they need to improve their own health and wellbeing and undertake an appropriate level of self-management	• Narrative describing range of information / tools available including via the digital platform • Data re use of digital platform (website data analytics – including total page views) • Data from ELRS Patient Feedback Questionnaires • Calls handled via ELRS Single Point of Contact phoneline
ELRS uses the data it has available to inform service delivery, development, and improvement	• Narrative on development of data, range of data available and specific use of data for informing service development and improvement
Fewer people fall	• Falls rate per 1,000 population aged 65+ (National Indicator)
People are able to access support quickly and easily if they have concerns regarding their mental health / wellbeing	• Number of individuals accessing support from CWIC MH • Number (and %) of individuals self-referring to CWIC MH • Data to be identified in relation to delivery of Distress Brief Intervention (DBI) provision

With support / advice, people are able to take steps to improve their own mental health / wellbeing where appropriate	• % of CWIC MH respondents saying the practitioner was 'excellent' or 'very good' at helping them take control • Indicators to be agreed for DBI provision now service has been launched
People know where to go for advice / help regarding concerns about their own or someone else's mental health / wellbeing	• Indicator to be developed re people accessing online resources / information (e.g., traffic to Eastspace web pages) • Number (and %) of individuals self-referring to CWIC MH
People with long-term conditions have better outcomes and get the care they need and support to self-manage their conditions where appropriate	• % of adults able to look after their health very well or quite well (National Indicator) • Other indicators to be identified

Strategic Objective 4 - Enable people to have more choice and control and provide care closer to home as appropriate

Outcome	**Outcome Indicators**
People living in East Lothian are able to access a range of primary care services that provide the right care, at the right time in the right place	• Narrative regarding availability of range of primary care services (including HSCP delivered services) across local areas • Number of sessions / appointments offered by HSCP managed primary care services • Service uptake of HSCP managed primary care services • % of people with positive experience of care at their GP practice (National Indicator)
People are able to access outpatient secondary care services closer to home	• Narrative describing range of outpatient services available at East Lothian Community Hospital (& other East Lothian hospitals) • Number of outpatient sessions / appointments offered at ELCH
There are a range of services available to support people with dementia and their carers	• Narrative describing range of support available • Other indicators to potentially be developed as part of Dementia Strategy delivery
People with dementia and their carers are able to access informal support via Meeting Centres	• Number of people accessing Meeting Centres
People with a dementia diagnosis receive post-diagnostic support	• Number / % of people receiving post-diagnostic support • Number of people with complex needs receiving ongoing support more than a year after diagnosis (once new service up and running)
Carers needs are identified	• Number of Adult Carer Support Plans completed

Carers have improved health and wellbeing outcomes	• Indicators from Carers Census (to be agreed)
Carers are able to access support to help them carry out their caring role	• % of carers who feel supported to continue in their caring role (National Indicator) • % of carers receiving respite via a Carers Support Plan
More people receive end-of-life / palliative care at home or in a homely, community setting	• % of last six months of life spent at home or in a community setting (National Indicator)

Strategic Objective 5 – Further develop / embed integrated approaches and services

Outcome	**Outcome Indicators**
People benefit from health and social care service delivery being more integrated	• Narrative on development of integrated teams and approaches and the impact this is having (including data if available / appropriate) • % of adults supported at home who agree that their health and social care services seem to be well coordinated (National Indicator)
People benefit from easier access to services and better patient journeys through and between services	• Narrative describing work to review and improve patient pathways • Data to be agreed for individual services to evidence impact of any measures to improve patient access / patient journeys
Options are available for people with specific housing needs related to a variety of factors including age, health conditions, disability, and mental health issues	• Narrative describing development of housing options
Young people's transition from child to adult services is well planned and goes smoothly	• Indicator to be developed

Strategic Objective 6 – Keep people safe from harm

Outcomes	**Outcome Indicators**
People receive the right support at the right time to prevent harm and reduce the impact of harm	• Narrative on progress in delivering Adult Support and Protection Improvement Plan • Narrative on implementation of changes to ASP procedures in line with national Code of Practice • Number of HSCP staff completing Safe & Together training • Additional indicators to be agreed with ASP managers
People are able to access the support they need in relation to drug / alcohol issues	• Narrative describing any developments in support available • Data on service access / use (to be agreed) • Data related to implementation of MAT standards – to be agreed • Number of people accessing support via the MELD Contact Service • Drug and alcohol waiting times (% waiting less than 3 weeks between referral and treatment) • Potential to collate data on outcomes for individual to be explored
People engaged with Justice Social Work services have greater equality of opportunity, enabling them to lead more fulfilling lives	• Diversion from prosecution – reports requested versus individuals assessed as suitable (Justice Social Work) • Community sentencing – preferred option (Community Payback Order, Drug Treatment and Testing Order, Restriction of Liberty Order) versus actual outcome (Justice Social Work) • Community Payback Work Delivery – hours instructed versus hours delivered (Justice Social Work)

	• Throughcare – sentencing – remand / sentences less than 12 months / sentences more than 12 months (Justice Social Work) • Justice Outcome Star – distance travelled (Justice Social Work)
People are less likely to reoffend due to an increased sense of belonging and involvement in their local community	• Data re Community Payback Work • Justice Outcomes Star data in relation to individual outcomes related to Community Payback Work

Strategic Objective 7 – Address health inequalities (under development)