Agenda Item 4

Performance Overview of Delivery of Services by the Health and Social Care Partnership

Agenda Item 4

FALKIRK COUNCIL

Title: **Performance Overview of Delivery of Services by the Health and Social Care Partnership**

Meeting: **Scrutiny Committee (External)**

Date: **12 January 2017**

Submitted By: **Chief Officer, Falkirk Integration Joint Board**

1. Purpose of Report

1.1 This report provides the Scrutiny Committee (External) with performance information in respect of services delivered by the Falkirk Health and Social Care Partnership (HSCP).

2. Recommendation

2.1 **Committee is invited to:**

- **consider the overview performance information in respect of service delivery by the Health and Social Care Partnership at Appendix 1 and**

- **note the national and local development to finalise a set of performance and outcome measures for Health and Social Care Integration as detailed in Section 4 of this report.**

3. Background

3.1 On the inauguration of the Integration Joint Board (IJB) on 1st April 2016 there was a requirement to establish a performance reporting framework to reflect the lines of accountability of the newly integrated service delivery arrangements. Performance requires to be reported in the first instance for consideration by the IJB and thereafter to NHS Forth Valley and to the Council. This report was submitted to the IJB meeting on 18 November 2016 and is the first report to be submitted to the Scrutiny Committee (External) under the newly established arrangements.

3.2 Prior to the commencement of the IJB regular reports on performance were submitted to the Performance Panel across a range of social work adult services activity. Performance measures were derived from the Social Work Adult Services 2015 - 2018 Performance Plan. With the commencement of the IJB there will be a transition towards integrated reporting of performance across health and social care activity. Performance will be measured against

delivery of the strategic aims and objectives set out in the Falkirk Integrated Strategic Plan and overseen by the IJB.

3.3 In order to fulfil the legislative requirements as regards performance management and reporting of the Public Bodies (Joint Working) (Scotland) Act 2014 it is necessary to develop a performance management framework.

3.4 Integration Joint Boards (IJBs) will be responsible for effective monitoring and reporting on the delivery of services and relevant targets and measures included in the Integration Functions and as set out in Strategic Plans. The Integration Joint Board also requires to prepare and publish an Annual Performance Report, the contents of which are laid down in the Act. The report is required to be completed by the end of July 2017.

3.5 In addition, lists of the 'Integration Functions Performance Targets' and the 'Non-Integration Functions Performance Targets' require to be prepared and reviewed annually.

3.6 The Scottish Government has developed National Health and Wellbeing Outcomes detailed in regulation supported by a Core Indicator Set to provide a framework for partnerships to develop their performance management arrangements. Partnerships are expected to include additional relevant information beyond the minimum prescribed in order to build as full and accurate an assessment as possible as to how the integration of health and social care is delivering for people and communities.

3.7 This Framework has been developed by the Performance Management work stream as part of an overall programme to deliver health and social care integration in Forth Valley. It is acknowledged that the arrangements for supporting performance management, and the requirements, will evolve over time as IJBs and partnerships become more established.

3.8 In reflecting the new integration arrangements and the separate legal status of the Integration Joint Board, the scrutiny function requires to transfer to the Scrutiny Committee (External). This report presents to the Scrutiny Committee (External) an overview report, attached as Appendix 1, which was considered by the IJB on 18th November.

3.9 The Performance Framework was approved by the IJB at it's meeting of the 24th March 2016. A Forth Valley workstream has continued to support the development of the Covalent performance management system and a suite of integrated performance indicators aligned with the delivery of the Strategic Plan. The report at Appendix 1 was submitted to the Meeting of 18 November. In addition the Board receives a performance update at each meeting on Delayed Discharges. Work is continuing to finalise the integration performance reporting and will be submitted to the IJB of 3 February 2017.

4. Performance

4.1 An overview of performance is outlined in Section 3 of Appendix 1. Table 3 shows the summary of performance against national outcomes as at September 2016. Readmissions to hospital, delays in discharge and delayed discharge occupied beds days are showing at red. A range of work is underway to address these challenges, progress is reported to each meeting of the IJB.

5. Considerations

5.1 The strategic vision set out in the Falkirk Integrated Plan is 'to enable people in the Falkirk area to live full independent and positive lives within supportive communities'. The Falkirk HSCP has identified five specific outcomes for the Falkirk Strategic Plan and Integration Scheme. The outcomes, highlighted in a Strategy Map in the attached report to the IJB [page 33 Appendix 1], are:

- Self-Management: Individuals, carers and families are enabled to manage their own health, care and wellbeing
- Autonomy and Decision Making: Where formal support is needed people should be able to exercise as much control and choice as possible over what is provided
- Safe: Health and social care support systems are in place, to help keep people safe and live well for longer
- Service User Experience: People have a fair and positive experience of health and social care
- Community Based Support: Informal supports are in place, which enable people, where possible, to live well for longer at home or in homely settings within their community.

5.2 The performance framework for the Health and Social Care partnership is being built from a combination of:

- locally developed outcomes, derived from a Joint Strategic Needs Assessment (JSNA) and reflecting views of people who use services, their carers and communities.
- the high level national health and well-being outcomes,
- and a core suite of national integration indicators which are being developed by key stakeholders including COSLA.

5.3 Officers are working with the national network of Chief Officers in developing a benchmarking process to enable IJBs to assess progress using comparative measures.

5.4 Sir Harry Burns is chairing the National Targets and Indicators for Health and Social Care Expert Group. The group is reviewing targets and indicators for health and social care and is due to report by the end of March 2017.

5.5 The implementation of integration of health and social care calls for the development of new performance reporting arrangements. As part of the Performance Framework it is proposed that a balanced scorecard is developed for the IJB. Scorecards are now widely used in many organisations designed to give managers, executives and Board members a more 'balanced' view of performance. Future reports to the External Scrutiny Committee will reflect the newly developed reporting structure.

6. Implications

Financial

6.1 None.

Resources

6.2 None.

Legal

6.3 None.

Risk

6.4 Not applicable.

Equalities

6.5 Not applicable

Sustainability/Environmental Impact

6.6 Not applicable.

7. Conclusion

7.1 Overall the delivery of services continues to perform well however there are challenges in relation to managing financial and demographic pressures, prescribing, delays in discharge and readmissions to hospital.

7.2 The present report is the first step in establishing a programme of regular performance reporting to the External Scrutiny Committee. Future reports will incorporate a balanced scorecard enabling clear connections to be made between service activity and the strategic objectives of the Integrated Plan.

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CHIEF OFFICER, FALKIRK JOINT INTEGRATION BOARD
Date: 23 December 2016
Ref: SW AS Performance Panel Report – 20 December 2016
Contact Name: Patricia Cassidy, Ext: 4013

Enclosures:
Appendix 1: Performance report to IJB, 18th November, 2016

Title/Subject: **Performance Report**

Meeting: **Integration Joint Board**

Date: **18 November 2016**

Submitted By: **Head of Performance and Governance NHS Forth Valley**

Action: **For Noting**

1. INTRODUCTION

1.1 The purpose of this report is to present an overview of the Health and Social Care Partnership's (HSCP) performance in the delivery of health and social care services. Integration Joint Boards are responsible for effective monitoring and reporting on the delivery of services and relevant targets and measures included in the Integration Functions, and as set out in Strategic Plans. This first report focuses mainly on the partnership's position against the National Health and Wellbeing Outcomes, measured by the National Core Integration Indicators. Future reports will consider more local measures based on the delivery of the Strategic Plan.

2. RECOMMENDATION

The Integration Joint Board is asked to:

2.1. Note the content of the first performance report to the IJB

2.2. Note the exceptions highlighted and that appropriate action will be taken forward by the relevant NHS General Managers, in conjunction with the Chief Officer

2.3. Note the challenging timescale highlighted for the preparation of the Annual Report

2.4. Note that the performance information in this report will be considered by Falkirk Council's Scrutiny Committee (External).

3. BACKGROUND

3.1. In order for the Integration Joint Board (IJB) to fulfil the legislative requirements as regards performance management and reporting, the Integration Joint Board approved the Performance Management Framework at the March 2016 meeting. At the October 2016 meeting of the IJB, it was intimated that a Performance Report would be presented at a November 2016 meeting of the Integration Joint Board.

3.2. In developing a performance regime, partnerships are expected to include additional relevant information beyond the minimum prescribed by National Outcomes and Core Integration Indicators, in order to build as full and accurate an assessment as possible as to how the integration of health and social care is delivering for people and communities. It is acknowledged that the arrangements for supporting performance management, and the requirements, are evolving as the IJB and Partnership becomes more established. The work on Logic Modelling to deliver the Strategic Plan will also help the creation of more local measurement.

4. APPROACH

4.1. In terms of indicators and measurement, it is considered critical that the IJB is able to measure performance against the delivery of the Strategic Plan alongside the National Health & Wellbeing Outcomes and Core National Indicators developed by the Scottish Government. As previously presented to the IJB, work has been undertaken to create a 'Strategy Map', table 1 below and Appendix 1, which details the Partnership's vision, expected Local Outcomes and then maps these against the National Health & Wellbeing Outcomes and National Core Indicators.

These are very high level national indicators and, at times, it is difficult to draw firm conclusions. The data sources can date over long periods of time and hence are not as timeous as data collected more routinely. However monitoring these are a legislative role for the IJB. The next step in terms of performance reporting is to ensure that local partnership indicators are developed against the Strategic Plan to sit underneath the national indicators and grouped in such a way to make it meaningful to measure delivery of local outcomes. As Locality and delivery plans become clearer, additional key local indicators can also be mapped to the desired local outcome.

4.2. Strategy Map

The Falkirk HSCP vision is 'to enable people in the Falkirk area to live full independent and positive lives within supportive communities'.

The Falkirk HSCP has identified five specific outcomes for the Falkirk Strategic Plan and Integration Scheme which are highlighted within the Strategy Map. These are in line with the Scottish Government's *2020 Vision* and are:

- Self-Management: Individuals, carers and families are enabled to manage their own health, care and wellbeing
- Autonomy and Decision Making: Where formal support is needed people should be able to exercise as much control and choice as possible over what is provided
- Safe: Health and social care support systems are in place, to help keep people safe and live well for longer

- Service User Experience: People have a fair and positive experience of health and social care
- Community Based Support: Informal supports are in place, which enable people, where possible, to live well for longer at home or in homely settings within their community.

Table 1:

Falkirk Integration Joint Board Strategy Map **Appendix 1**

Vision	**To enable people to live full independent and positive lives within supportive communities**				
Local Outcomes	**SELF MANAGEMENT**- of Health, Care and Wellbeing.	**AUTONOMY & DECISION MAKING** –Where formal support is needed people can exercise control over choices.	**SAFETY** - H&SC support systems keep people safe and live well for longer.	**SERVICE USER EXPERIENCE** People have a fair & positive experience of health and social care.	**COMMUNITY FOCUSSED SUPPORTS** - to live well for longer at home or homely setting.
National Outcomes (9)	**1)** Healthier living **2)** Reduce Inequalities	**4)** Quality of Life	**7)** People are safe	**3)** Positive experience and outcomes **8)** Engaged work force **9)** Resources are used effectively	**2)** Independent living **6)** Carers are supported
National Indicators (23) (* Indicator under development nationally)	**1)** % of adults able to look after their health well/quite well **11)** Premature mortality rate	**7)** % of adults who agree support has impacted on improving/maintaining quality of life **12*)** Rate of Emergency admissions for adults **17)** % of care services graded 'good' (4) or better by Care Inspectorate	**9)** % of adults supported at home who felt safe **13*)** Emergency bed day rate for adults **14*)** Readmission to hospital within 28 days rate **16*)** Falls rate per 1000 population 65+yrs	**3)** % of adults who agree that they had a say in how their help/care was provided **4)** % of adults supported at home who agree their health and care services are co-ordinated **5)** % of adults receiving care and support rated as excellent or good **6)** % of people with positive GP experiences **10)** % of staff who recommend their place of work as good **19)** Rate of days people aged 75+ spend in hospital when they are ready to be discharged, **20)** % of total health and care spend on hospital stays where the patient admitted as an emergency **(22*)** % people discharged from hospital within 72 hours of being ready **23)** Expenditure on end of life care	**2)** % of adults supported at home who agree they are supported to be independent **21*)** % of people admitted to hospital from home then discharged to care home **15)** % of last 6 months of life spent at home or in community **18)** % of adults 18+yrs receiving intensive support at home **8)** % of carers who feel supported in their role *Note linkage to 'Experience'* **19)** Rate of days people aged 75+ spend in hospital when they are ready to be discharged, **(22*)** % people discharged from hospital within 72 hours of being ready
Partnership Indicators (Under development)	• ED Attendance • Life expectancy age 65+ • Deaths from Cancer/CHD	• *Dementia – post diagnostic tot. • Mental Health/Learning Disability data	• HAI • Telecare data 75+ • Adult Protection	• Local Client/patient data • Patient Experience survey • Staff Survey data • Financial and Budgetary information	• Hours of homecare for clients 65+ • Respite hours provided • Em/Admission 65+75+ per 100,000

4.3. The Local Outcomes come directly from the Strategic Plan and were created to address the key challenges highlighted in the Joint Strategic Needs Assessment (JSNA) with the outcomes consistent with the views of people who use services, their carers and communities.

4.4. The National Health and Wellbeing Outcomes are high-level statements of what health and social care partners are attempting to achieve through integration and ultimately through the pursuit of quality improvement across health and social care. By working with individuals and local communities, it is intended that HSCP's will support people to achieve these outcomes.

4.5. An associated Core Suite of National Integration Indicators was developed in partnership with NHS Scotland, COSLA and the third and independent sectors, drawing together measures that are appropriate for the whole system under integration. It should be noted that the indicators will develop and improve over time, and that some of them still require data development nationally.

4.6. It is important to highlight that the Scottish Government has prescribed which National Health & Wellbeing Outcome relates to which National Core Indicator, and these have been aligned with the Strategic Plan Local Outcomes.

5. REPORT STRUCTURE

5.1. Section 1 of this report considers key exceptions for further focus. Section 2 provides a performance overview of key performance in respect of the National Integration Indicators and some local partnership indicators, specifically around Community Based Supports as agreed at the last IJB. Section 3 - Summary of Key Performance provides a detailed report, under the five local outcome headings identified by the Falkirk partnership as described above. Appendix 2 describes some relevant indicators for the IJB to review prior to presentation to the Falkirk Council Scrutiny Committee (External).

The Covalent performance reporting system has been used to prepare this report. Within that system a variance range is required to be set for all indicators. This defines the acceptable or tolerable spread between numbers in a data set for red, amber and green (RAG) statuses.

5.2. Balanced Scorecard

As part of the Performance Framework it is proposed that a balanced scorecard is developed for the IJB. Scorecards are now widely used in many organisations designed to give managers, executives and Board members a more 'balanced' view of performance.

A format for the scorecard will be presented to the next IJB. Agreeing targets and tolerance levels for performance will also be a key task moving forward.

5.3. Finance and Performance

In order to ensure a sound basis for decision making and prioritisation, performance information should be read alongside financial reports to give a rounded view of the overall performance and financial sustainability of the partnership. Additionally, the triangulation of key performance indicators, measureable progress in delivering the priorities of the Strategic Plan and financial performance should be regarded as forming the cornerstone of demonstrating best value. Moving forward greater linkage will be made between the reports in preparation for the formulation of the Annual Report.

6. ANNUAL REPORT

Section 42 of the Public Bodies (Joint Working) (Scotland) Act 2014 states: ‘Each Integration Authority must prepare a performance report for the reporting year’ and this must be published before the expiry of the period of 4 months beginning with the end of the reporting year – by 31st July 2017.

This timeline will prove challenging for the Integration Authority to meet as it relies on:

- Final financial accounts information

- The publication of the National Core Suite of Integration Indicators – which Information Statistics Division is publishing on behalf of all Partnerships.

This situation is being discussed across a variety of fora nationally. Annual Performance Report Workshops have been held with all participants providing feedback regarding the timescale challenge to the Scottish Government.

An outline template, including the regulation requirements can be found in Appendix 3.

7. CONCLUSION

Integration Joint Boards are responsible for effective monitoring and reporting on the delivery of services and relevant targets and measures included in the Integration Functions, and as set out in Strategic Plans. This report represents the first formal performance report to the Board.

Resource Implications
The management of performance is critical to managing the overall budget of the IJB. The resource requirements to ensure effective performance management and performance reporting are under review.

Impact on IJB Outcomes and Priorities
Only by managing performance can the delivery of the IJB outcomes and priorities be truly assessed providing a sound basis from which to make decisions regarding investment and service change.

Legal & Risk Implications
Performance management is a legal requirement as defined in the IJB's Integration Scheme.

Consultation
The approach has been defined in the approved Performance Management Framework and further developed through the Performance Management Workstream with all parties represented.

Equalities Assessment
Not required

Approved for Submission by: Patricia Cassidy, Chief Officer
Author – Elaine Vanhegan, Head of Performance and Governance
Date: 9 November 2016

List of Background Papers:
IJB Performance Management Framework – Approved March 2016

Section 1 Exception Report

As described, this report details the most up to date available information against the National Outcomes; Core Indicator Suite as published by ISD, and local data in respect of indicators relevant to Community Based Supports.

In respect of this report, key areas for further review are:

1. Delayed discharges
2. Readmissions

1. Delayed Discharges - Status: Red

The IJB is familiar with the challenges presented by Delayed Discharges. Data presented in this report is based on the September census. The target is zero delays over 2 weeks. A total of 29 delays were reported across the partnership in October. Delayed discharges present a significant challenge to the partnership particularly at this time of year. When the total delays are considered, including those under 2 weeks (17) and those under Guardianships (7) and Code 9(6), the total for September was 59. Future performance reports will provide further detail on performance and specific actions being taken.

2. Readmissions - Status: Red

Readmission rate per 1,000 to hospital within 28 days of discharge. The readmission rate reflects several aspects of integrated health and care service, including discharge arrangements and co-ordination of follow up care underpinned by good communication between partners. The 28 day follow-up was selected nationally, as this is the time that the initial support on leaving hospital, including medicines safety, could have a negative impact and result in readmission. Based on the SMR01 acute hospital activity data, this rate is calculated from the number of re-admissions to an acute hospital within 28 days of discharge per 1,000 population.

Falkirk has a greater rate of readmission than the national average, with the position increasing year on year since 2010/11 to 2014/15. Further review of more up to date data is underway and future reports will consider this in more detail.

SECTION 2 - Overview

Table 2 - National Integration Indicators – Overview September 2016 data

	Indicator	Title	Period	Current Score	Scotland
Outcome indicators	NI - 1	Percentage of adults able to look after their health very well or quite well	2015/16	93%	94%
	NI - 2	Percentage of adults supported at home who agreed that they are supported to live as independently as possible	2015/16	86%	84%
	NI - 3	Percentage of adults supported at home who agreed that they had a say in how their help, care, or support was provided	2015/16	79%	79%
	NI - 4	Percentage of adults supported at home who agreed that their health and social care services seemed to be well co-ordinated	2015/16	81%	76%
	NI - 5	Total % of adults receiving any care or support who rated it as excellent or good	2015/16	82%	82%
	NI - 6	Percentage of people with positive experience of the care provided by their GP practice	2015/16	86%	87%
	NI - 7	Percentage of adults supported at home who agree that their services and support had an impact on improving or maintaining their quality of life	2015/16	84%	85%
	NI - 8	Percentage of carers who feel supported to continue in their caring role	2015/16	45%	43%
	NI - 9	Percentage of adults supported at home who agreed they felt safe	2015/16	87%	85%
	NI - 10	Percentage of staff who say they would recommend their workplace as a good place to work	2015/16	NA	NA
Data indicators	NI - 11	Premature mortality rate per 100,000 persons	National data is not available at this time		
	NI - 12	Emergency admission rate (per 100,000 population)	2014/15	11,742	11,865
	NI - 13	Emergency bed day rate (per 100,000 population)	2014/15	124,198	112,091
	NI - 14	Readmission to hospital within 28 days (per 1,000 population)	2014/15	118	94
	NI - 15	Proportion of last 6 months of life spent at home or in a community setting	2014/15	85%	86%
	NI - 16	Falls rate per 1,000 population aged 65+	2014/15	19	20
	NI - 17	Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections	2014/15	NA	NA
	NI - 18	Percentage of adults with intensive care needs receiving care at home	2014/15	64%	61%
	NI - 19	Number of days people spend in hospital when they are ready to be discharged (per 1,000 population)	2014/15	943	1,044
	NI - 20	Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency	2014/15	23%	22%
	NI - 21	Percentage of people admitted to hospital from home during the year, who are discharged to a care home	National data is not available at this time		
	NI - 22	Percentage of people who are discharged from hospital within 72 hours of being ready	National data is not available at this time		
	NI - 23	Expenditure on end of life care, cost in last 6 months per death	National data is not available at this time		

Table 3 – Falkirk Health and Social Care Partnership National Outcome Summary Performance (as at September 16)

National Outcome	National Indicators		RAG*
1. Healthier Living	NI 1	% of adults able to look after their health very well or quite well	Green
2. Independent Living	NI 2	% of adults supported at home who agree that they are supported to live as independently as possible	Green
	NI 15	Proportion of last 6 months of life spent at home or in a community setting	Green
	NI 18	% adults with intensive care needs receiving care at home age 18+	Green
	NI 21	% of people admitted to hospital from home during the year, who are discharged to a care home	No data available
3. Positive Experience & Outcomes	NI 3	% of adults supported at home who agreed that they had a say in how their help, care, or support was provided	Green
	NI 5	% of adults receiving any care or support who rated it as excellent or good	Green
	NI 6	% of people with positive experience of the care provided by their GP practice	Green
	NI 23	Expenditure on end of life care, cost in last 6 months per death	No data available
4. Quality of Life	NI 7	% of adults supported at home who agree that their services & support had an impact on improving/maintaining their quality of life	Green
	NI 12	Emergency admission rate per 100,000 population	Green
	NI 17	Proportion of care services graded 'good' or better in Care Inspectorate inspections	Green
5. Reduce Inequalities	NI 11	Premature mortality rate per 100,000 population	Green
6. Carers are Supported	NI 8	%of carers who feel supported to continue in their caring role	Green
7. People are Safe	NI 9	% of adults supported at home who agreed they felt safe	Green
	NI 13	Emergency bed day rate per 100,000 population	Amber
	NI 14	Readmission to hospital within 28 days rate per 1,000 population	Red
	NI 16	Falls rate per 1,000 population age 65+	Green
8. Engaged Workforce	NI 10	% of staff who say they would recommend their workplace as a good place to work	No data available
9. Resources are Used Effectively	NI 4	% of adults supported at home who agreed that their health and social care services seemed to be well co-ordinated	Green
	NI 19	Rate of days people spend in hospital when they are ready to be discharged per 1,000 population	Green
	NI 20	% of health and care resource spent on hospital stays where the patient was admitted in an emergency	Green
	NI 22	% of people who are discharged from hospital within 72 hours of being ready	In development

*RAG status evaluated against the national average detailed in Table 2. Green is where the data is within tolerance, the same as or better than national average. Amber is where the data is slightly lower (5%+) than national average. Red is where data is significantly lower (15%+) than national average

Table 4 - Local Sample Indicators – Overview

Indicator	Title	Period	Falkirk	Scotland
	Percentage of carers who feel supported and capable to continue in their role as a carer OR feel capable to continue with additional support	2015/16	89.3%	NA
	Older Persons (Over 65) Home Care Costs per Hour	2014/15	£16.33	NA
	Delayed Discharges Over 2 Weeks	Sep -16	29	NA
	Delayed Discharges Occupied Bed Days over 14 days	Sep -16	807	NA

SECTION 3	Summary of Key Performance

LOCAL OUTCOME Self Management – Individuals, carers and families are enabled to manage their own health, care and wellbeing.

Relevant National Indicators are:

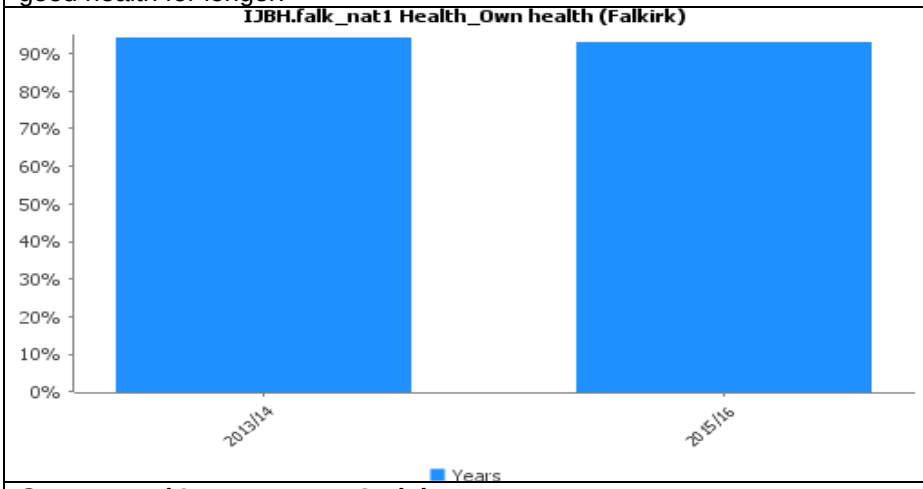
- Percentage of adults able to look after their health very well or quite well
- Premature mortality

To support delivery of these indicators a number of local indicators are being developed.

National Indicator Number 1

Title: Percentage of adults able to look after their health very well or quite well

Measure or descriptor: People are able to look after and improve their own health and wellbeing and live in good health for longer.



Date: 2015/16

Current value: 93%

National Average: 94%

Status:

Trend:
No change in performance

Context and Improvement Activity

Rationale for indicator
This indicator is intended to measure the views of local people as to whether they feel they can look after their health. This may be more difficult for people with long term conditions including mental illness or for some people with disabilities.

Integrated health and social care services can seek to influence this by the provision of appropriate information and support. They will also work with partners to improve the environmental and social factors that can act as barriers to health and wellbeing. This will involve working with individuals and communities to identify and build on their strengths.

In Scotland overall 94% of people felt they could look after their health very well or quite well. This ranged from 90% - 97% between CHP areas. Integration Authorities would be looking to maintain or improve levels on this indicator, and ideally look to increase those who say they can look after their health very well – which ranged from 51% to 64%.

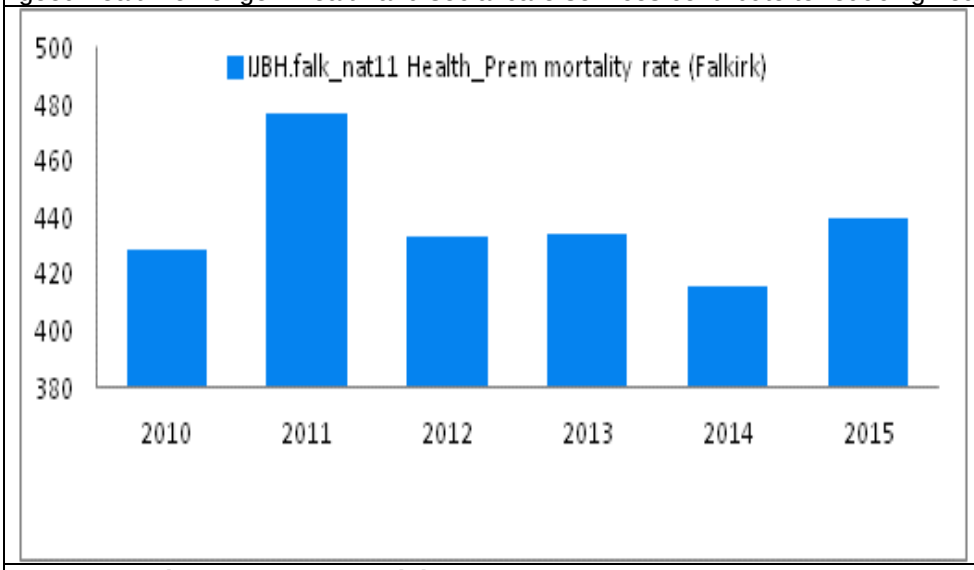
Definition and Data Source
Based on the question (Q52) in the biennial health and care experience survey: “In general, how well do you feel that you are able to look after your own health?” The number of people answering very well or quite well divided by the total number answering the question.

Current Position
The % reported for the Partnership reflects a positive position with the vast majority of those surveyed reporting that they are able to look after and improve their own health and wellbeing. In terms of self management this is an important indicator.

National Indicator Number 11

Title: Premature mortality rate per 100,000 population

Measure or descriptor: People are able to look after and improve their own health and wellbeing and live in good health for longer. Health and social care services contribute to reducing health inequalities.



Date: 2015

Current value: 440

National Average: 441

Status:

Trend:

Mortality rate increasing in comparison to previous year.

Context and Improvement Activity

Rationale for indicator

Premature mortality is an important indicator of the overall health of the population. Scotland has the highest mortality rates in the UK. Between 1997 and 2013, the rate of mortality amongst those aged under 75 years decreased by 33%. Despite these decreases, more than 20,000 people aged under 75 still die each year. Deaths in this age group are more common in deprived areas, and so this indicator reflects health inequalities. In 2012, deaths in the most deprived areas were more than three times as common as deaths in the least deprived.

Delivering significant and sustainable improvements in health requires a focus on the underlying causes of poor health and inequalities. Poor health is not simply due to diet, smoking or other life style choices, but also the result of other factors such as people's aspirations, sense of control and cultural factors. Tackling poverty, reducing unemployment, promoting mental wellbeing, increasing educational attainment and improving poor physical and social environments will, therefore, all contribute to reducing premature mortality. This needs to be complemented by specific action on the "big killer" diseases, such as cardiovascular disease and cancer where some of the risk factors, such as smoking, are strongly linked
to deprivation, as well as addressing drug

Definition

European Age-Standardised mortality rate per 100,000 for people aged under 75 in Scotland.

Current Position

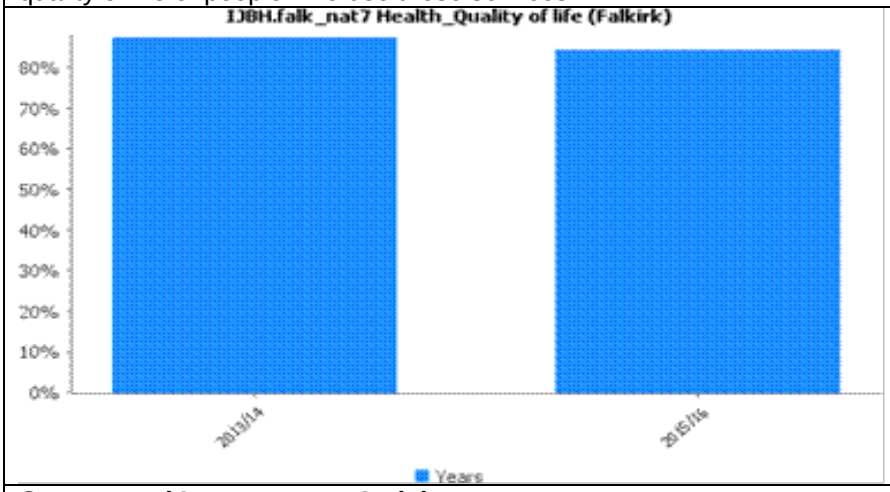
The number of deaths have increased in the reporting period. From a public health perspective, it is important to note however, that no conclusions can be drawn from variation on an annual basis and trends need consideration over a minimum of 5 years. As deprivation and inequalities are key to this indicator, this is clearly a focus for the Partnership and wider Community Planning Partnership through the SOLD Plan.

LOCAL OUTCOME Autonomy and Decision Making - Where formal support is needed people should be able to exercise as much control and choice as possible over what is provided.

Relevant National Indicators are:

- Percentage of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life.
- Rate of emergency admissions for adults
- Proportion of care and care at home services rated as 'good' or better in Care Inspectorate Inspections

To support delivery of these indicators a number of local indicators are being developed.

National Indicator Number 7	
Title: Percentage of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life	
Measure or descriptor: Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.	
	**Date: 2015/16** **Current value: 84%** **National Average: 85%** **Status:** **Trend:** Downward trend as lower than previous year

Context and Improvement Activity

Rationale for indicator
This indicator reflects the aggregate impact of local person centred work to improve personal outcomes, focusing on what is important for individuals' quality of life. It emphasises the increasing focus on personalisation of services, including the use of personal outcomes approaches.

In Scotland overall, 86% of people agreed that the services maintained or improved their quality of life in 2013/14. This varied between CHP areas from 73% to 98%. It would be expected that local areas scoring low in this should investigate the underlying issues and seek to improve.

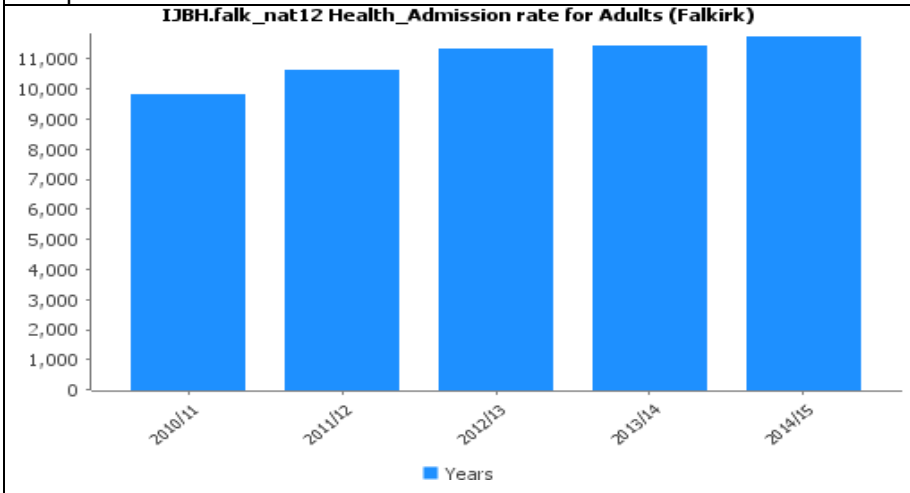
Definition and Data Source
Based on agreement with the statement (Q36h) in the biennial health and care experience survey: "The help, care or support improved or maintained my quality of life". The number of people who agree or strongly agree divided by the total number answering.

Current Position
Partnership performance is in line with the national average. This remains a core indicator moving forward.

National Indicator Number 12

Title: Rate per 100,000 of emergency admissions for adults

Measure or descriptor: People are able to look after and improve their own health and wellbeing and live in good health for longer. Health and social care services contribute to reducing health inequalities. People, including those with disabilities or long term conditions or who are frail are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community. Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services. People who use health and social care services are safe from harm.



Date: 2014/15

Current value: 11,742

National Average: 11,865

Status:

Trend: Downward trend as higher number of admissions than previous years.

Context and Improvement Activity

Rationale for indicator

Excellent emergency services are necessary when people are at a point of crisis or suffer serious injury. But many people who come to hospitals in emergencies could potentially have been offered better support or services earlier on, which would have prevented the need for them to go to hospital, or may have involved a planned visit to hospital instead. 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. It should demonstrate the effectiveness of anticipatory care, identifying people who are at risk of emergency hospital admission, supporting people to be more confident in managing their long term conditions and providing coordinated care and support at home where safe and appropriate. Safe and suitable housing for people will also be important.

Other service aspects include: the options open to GPs in referring patients; decisions made by ambulance crews on arrival at an emergency situation; mental health service provision in the community; and for older people in particular the availability of alternatives such as short term rapid response services; and whether local systems are linked in a way that supports older people at critical times. Improvements in peoples' overall health, and reducing health inequalities should also lead to fewer emergencies (the emergency admission rate is strongly related to patient age and to deprivation).

Definition and Data Source

Rate of emergency admissions per 100,000 population for adults. This will be based on SMR01 returns for acute hospitals, and SMR04 data for psychiatric hospitals (note that some further work will be undertaken by ISD regarding this data source).

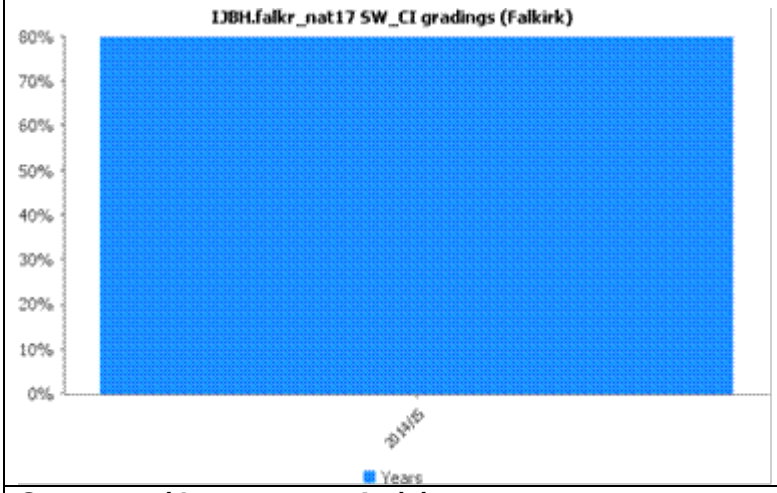
Current Position

Partnership performance is in line with the national average however with a year on year increase in the number of emergency admissions per 100,000 population, further focus will be required in line with the direction of the Strategic Plan and the Healthcare Stategy and reducing emergency admissions.

National Indicator Number 17

Title: Proportion of care and care at home services rated as 'good' or better in Care Inspectorate Inspections

Measure or descriptor: People who use health and social care services have positive experiences of those services, and have their dignity respected. Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services. People using health and social care services are safe from harm.



Date : 2014/15

Current value: 79.5%

National Average: 81.2%

Status:

Trend: No comparative data at data of compilation

Context and Improvement Activity

Rationale for indicator

This indicator is intended to provide a measure of assurance that adult care services meet a reasonable standard. It would be envisaged however that services should not just aspire to adequacy and therefore the indicator looks at those who are "good" or better on all gradings. Care services would be expected to continuously improve.

It will be important that all partners work together to improve the standards of care homes and care at home services whether provided by the Local Authority, Health Board, third sector or private sector.

Definition and data source

Care services are graded on a six point scale: 1) Unsatisfactory; 2) Weak; 3) Adequate; 4) Good; 5) Very good; 6) Excellent. The indicator will be the total number of adult care services receiving a grading of 4 or above (i.e. "good", "very good" or "excellent") on all themes as a proportion of the total number of services graded. The indicator will be updated annually and will show the latest gradings for each care service at the end of March each year

Current Position

The Partnership position is slightly below the national average. The contract monitoring arrangements that are in place support effective joint working with external care providers in the third and independent sectors to provide assurance that all social care services meet the required standards and are focused on improving the quality of their services.

Local Context

A more limited local indicator to monitor care home inspection activity has been developed. Unlike the national indicator, this local indicator includes scores across all four themes but our indicator reports the total proportion of themes rated 4 or better across the 7 care homes and not only those which scored 4 or better in all themes. On this basis, Partnership performance for care homes in 2014 – 2015 was 89% and in 2015-16 it was 93%. If only the national indicator is used the score for Falkirk Care Homes would be 71.4% for both 2014/15 & 2015/16.

The rationale to report on the proportion of themes rated 4 or better is because the themes that rate lower are generally for 'Environment', and these require major (and perhaps unlikely) renovations. It follows that it would be hard to demonstrate continuous improvement for these care homes, since the other themes which showed improvement would be hidden from the performance report.

LOCAL OUTCOME Safe - Health and social care support systems are in place, to help keep people safe and live well for longer.

Relevant National Indicators are:

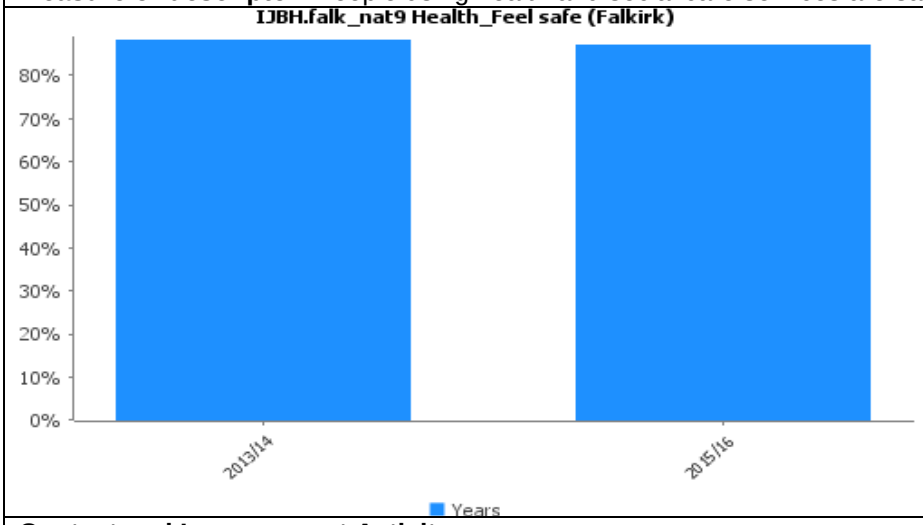
- Percentage of adults supported at home who agree they felt safe
- Rate of emergency bed day for adults
- Readmission to hospital within 28 days of discharge
- Falls rate per 1,000 population in over 65s

To support delivery of these indicators a number of local indicators are being developed.

National Indicator Number 9

Title: Percentage of adults supported at home who agree they felt safe

Measure or descriptor: People using health and social care services are safe from harm



Date: 2015/16

Current value: 87%

National Average: 85%

Status:

Trend:
Deteriorating Trend
1% Lower value than previous financial year

Context and Improvement Activity

Rationale for indicator
In carrying out their responsibilities Health Boards, Local Authorities and Integration Authorities must ensure that the planning and provision of health and social care services protects people from harm.

In Scotland overall, 86% of people agreed that they felt safe, in relation to their care and support in 2013. This varied between CHP areas from 75% to 90%. Integration Authorities would be looking to improve levels on this indicator.

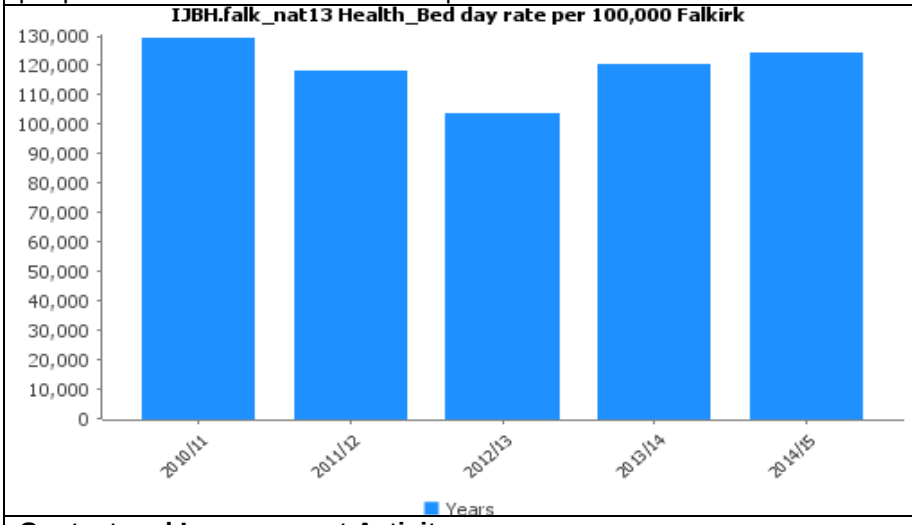
Definition and Data Source
Based on agreement with the statement (Q36g) in the biennial health and care experience survey: “I felt safe”. The number of people who agree or strongly agree divided by the total number answering.

Current Position
The percentage for the Partnership for 2015/16 is above the national average (85%). This will remain a core priority for the Partnership.

National Indicator Number 13

Title: Rate per 100,000 population of emergency bed day for adults

Measure or descriptor: People, including those with disabilities or long term conditions or who are frail are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community. Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services. People who use health and social care services are safe from harm.



Date: 2014/15

Current value: 124,198 per 100,000 population

National Average: 112,091 per 100,000 population

Status:

Trend: Downward trend - 3.38% change since previous year.

Context and Improvement Activity

Rationale for indicator

It is possible for the number of admissions to increase and bed days to reduce and vice versa, so this measure is included to ensure a balanced view. Once a hospital admission has been necessary in an emergency, it is important for people to get back home as soon as they are fit to be discharged to avoid the risk of them losing their confidence and ability to live independently.

Integration Authorities have a central role in this by providing community-based treatment and support options, “step down” care and home care packages to enable people to leave hospital quickly once they are well enough. Additionally, care homes should where appropriate be able to support people with a wider range of physical and mental frailty and needs.

Hospitals also have a role to play, by streamlining their processes and sharing best practice to ensure more people can leave hospital quickly once they are well enough. This will include improving rehabilitation and also reducing the possibility of infections, harm and injury all of which can result in longer stays.

Definition and Data Source

Rate of emergency bed days per 100,000 population for adults. This will be based on SMR01 returns for acute hospitals, and SMR04 data for psychiatric hospitals (note that some further work will be undertaken by ISD regarding this data source).

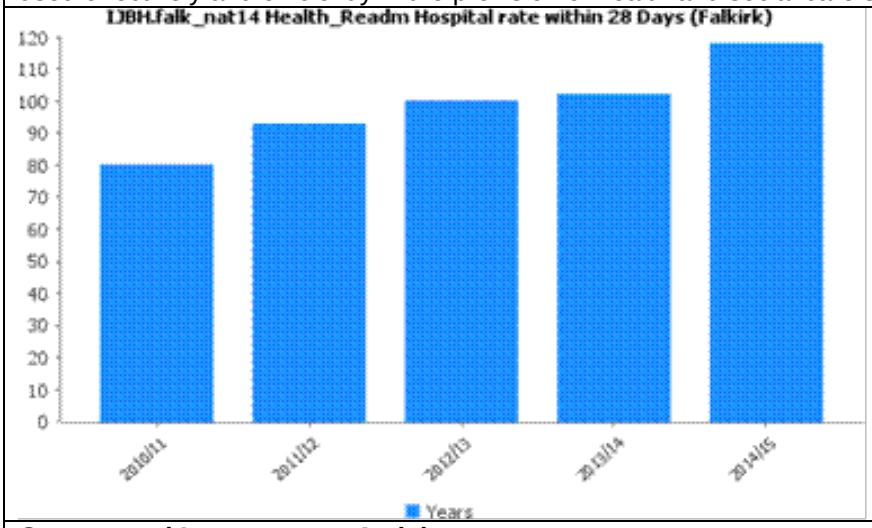
Current Position

In line with the increasing emergency admissions per 100,000 population, similar focus will be required to reverse the downward trend in beddays performance.

National Indicator Number 14

Title: Readmission rate per 1,000 to hospital within 28 days of discharge

Measure or descriptor: People, including those with disabilities or long term conditions or who are frail are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community. People who use health and social care services have positive experiences of those services, and have their dignity respected. People using health and social care services are safe from harm. Resources are used effectively and efficiently in the provision of health and social care services.



Date: 2014/15

Current value: 118 per 1000 population

National Average: 94 per 1000 population

Status:

Trend:
Downward trend
Readmissions continue to rise each year

Context and Improvement Activity

Rationale for indicator
This indicator is one of the national suite of Primary Care Indicators, and data are being made available for each General Practice in Scotland. As well as GP services, it reflects the links with other aspects of primary care in particular pharmacy and district nursing as well as social services. It will be important that Integration Authorities understand this data for their local area and identify any areas for improvement to support GP Practice efforts to improve on this.

The readmission rate reflects several aspects of integrated health and care service - including discharge arrangements and co-ordination of follow up care underpinned by good communication between partners. The 28 day follow-up was selected as this is the time that the initial support on leaving hospital, including medicines safety, could have a negative impact and result in readmission. A longer period of follow up would be more likely to include admissions that are unrelated to the initial one, whereas a shorter period (e.g. 7 days) is more likely to only pick up immediate issues linked to the hospital care.

Definition and Data Source
Based on the SMR01 acute hospital activity data, this rate is calculated from number of re-admissions to an acute hospital within 28 days of discharge per 1,000 population. The definition of the indicator is still being finalised and may be based on an average across GP practices in order to link directly into GP benchmarking.

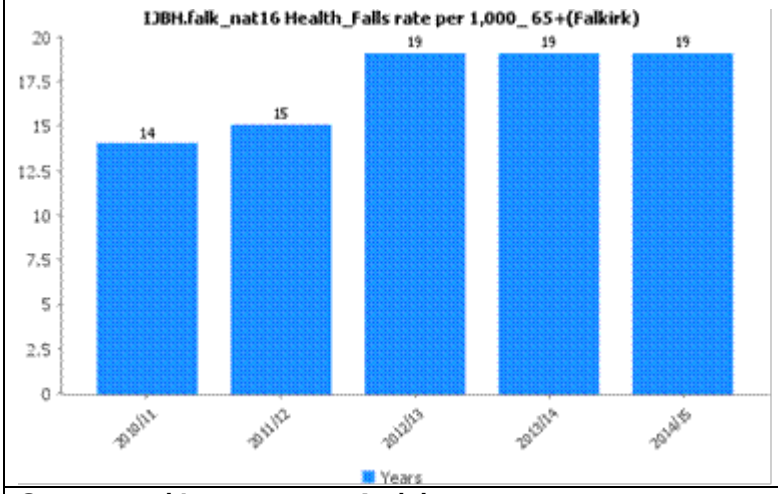
Current Position
Readmission rate per 1,000 to hospital within 28 days of discharge. The readmission rate reflects several aspects of integrated health and care service - including discharge arrangements and co-ordination of follow up care underpinned by good communication between partners. The 28 day follow-up was selected nationally as this is the time that the initial support on leaving hospital, including medicines safety, could have a negative impact and result in readmission. Based on the SMR01 acute hospital activity data, this rate is calculated from number of re-admissions to an acute hospital within 28 days of discharge per 1,000 population.

Further work is required to review up to date data and triangulate this with the higher rate of emergency admissions and beddays across the Partnership.

National Indicator Number 16

Title: Falls rate per 1,000 population in over 65s

Measure or descriptor: People, including those with disabilities or long term conditions or who are frail and able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community. People using health and social care services are safe from harm. Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services. Resources are used effectively



Date: 2014/15

Current value: 19

National Average: 20

Status:

Trend:
No change

Context and Improvement Activity

Rationale for indicator

With health and social care services striving to address the challenge of demographic change and rising demands on public services, falls among older people are a major and growing concern which are being addressed by a national improvement programme. http://www.gov.scot/Publications/2014/04/2038

Falls can have a significant impact on an older person's independence and quality of life, impeding a person's mobility and confidence. However, falls are not an inevitable consequence of old age. Well-organised services, delivering recommended and evidence based practices can prevent many falls and fractures in older people in the community setting. Rehabilitation services are also key to preventing repeat falls. In addition, the safety of a person's immediate environment as well as their prescribed medicines will be important.

Definition and Data Source

The focus of this indicator is the number of falls that occur in the population (aged 65 plus). The indicator will be measured using data gathered by Information Services Division (ISD) on the number of patients aged 65 plus who are discharged from hospital with an emergency admission code 33 - 35 and ICD10 codes W00 – W19. The intention is that there will be a development of the evidence base for this indicator, to enable a more complete picture of the prevalence of falls in the 65 plus population to be incorporated. It is recognised that the current focus on emergency admissions data is one part (albeit a very important part) of the fuller picture, and that valuable information from other sections of the health

Current Position

The Partnership is in the lowest quartile when compared nationally, and is below national average. With health and social care services striving to address the challenge of demographic change and rising demands on public services, falls among older people are a major and growing concern which are being addressed by a national improvement programme. http://www.gov.scot/Publications/2014/04/2038. This is an issue that is also being considered through the Clinical Care Governance Framework.

LOCAL OUTCOME Community Based Support – to live well for longer at home or in a homely setting within their community

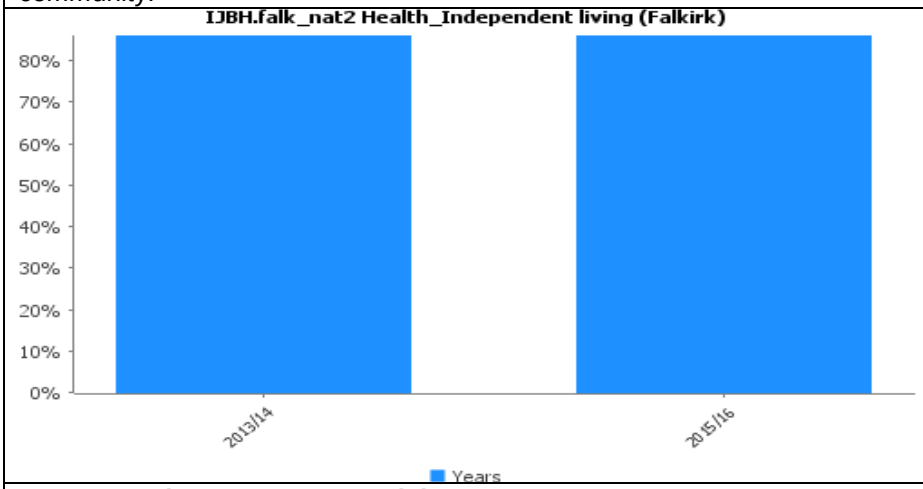
Relevant National Indicators are:

- Percentage of adults supported at home who agree that they are supported to live as independently as possible
- Percentage of carers who feel supported to continue in their caring role
- Proportion of last 6 months of life spent at home or in community setting
- Percentage of adults with intensive needs receiving care at home
- Percentage of people admitted from home to hospital during the year, who are discharged to a care home

Note linkage to 'Experience'

- Number of days people spend in hospital when they are ready to be discharged
- Percentage of people who are discharged from hospital within 72 hours of being ready

To support delivery of these indicators a number of local indicators are being developed.

National Indicator Number 2	
Title: Percentage of adults supported at home who agree that they are supported to live as independently as possible	
Measure or descriptor: People, including those with disabilities or long term conditions or who are frail are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.	
	**Date:** 2015/16 **Current value:** 86% **National Average:** 84% **Status:** **Trend:** No change from 86% 2013/14

Context and Improvement Activity

Rationale for indicator

This indicator reflects whether people who need support feel that it helps them maintain their independence as much as possible. Integration Authorities will need to provide community based services that focus on enablement, prevention and anticipatory care that mitigate increasing dependence on care and support. Housing services also have a critical role in delivering on this outcome, and there will be links to other areas such as transport. Health and social care services will need to work with partners and with communities to support social connectedness.

In Scotland overall, 84% of people agreed that they felt supported to live as independently as possible. This varied between CHP areas from 68% to 90%. Integration Authorities should seek to improve levels on this indicator.

Definition and Data Source

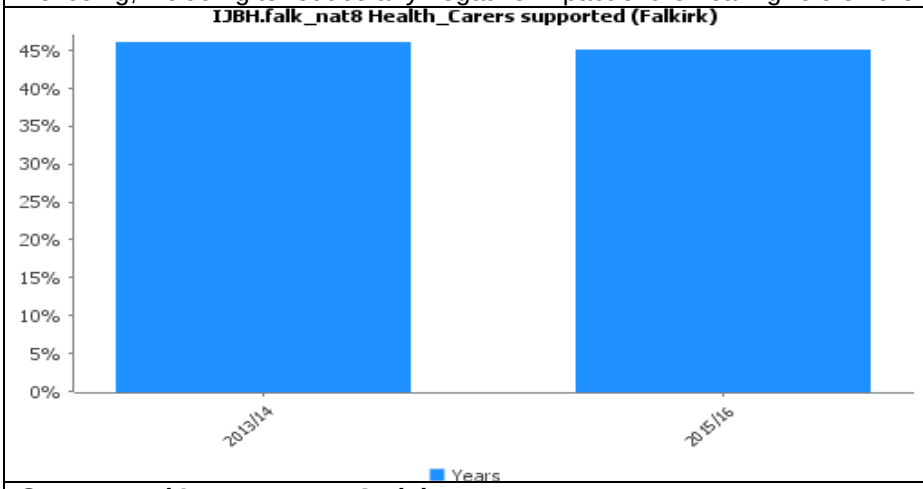
Based on agreement with the statement (Q36f) in the biennial health and care experience survey: I was supported to live as independently as possible". The number of people who agree or strongly agree divided by the total number answering.

Current Position
The Partnership position remains above the Scottish average.

National Indicator Number 8

Title: Percentage of carers who feel supported to continue in their caring role

Measure or descriptor: People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and wellbeing.



Date: 2015/16

Current value: 45%

National Average: 43%

Status:

Trend:
Downward trend
Of 1% from 2013/14

Context and Improvement Activity

Rationale for indicator
This indicator reflects the fact that health and social care services need to be planned and delivered with a strong focus on the wellbeing of unpaid carers.

In Scotland in 2013/14, 44% of carers agreed that they felt supported to continue caring.
This varied between CHP areas from 34% to 54%. Integration Authorities would be looking to increase this over time.

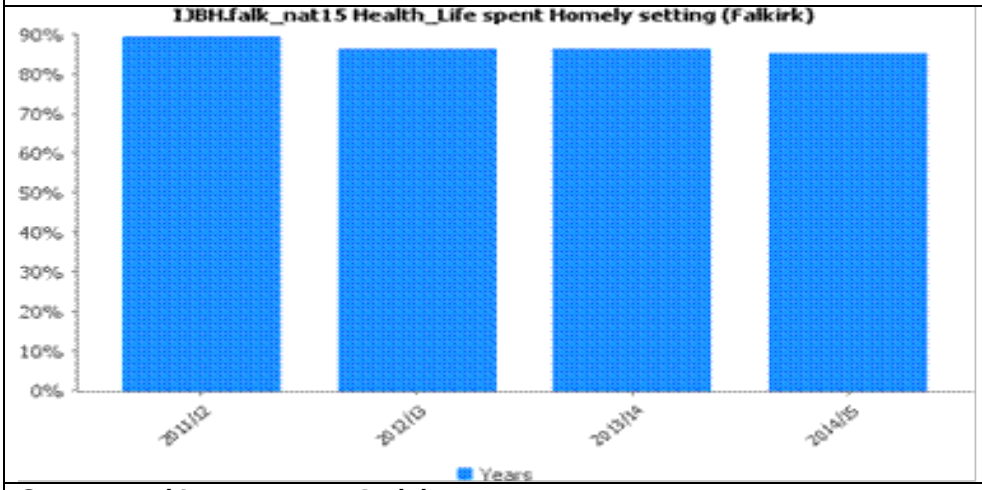
Definition and Data Source
Based on the agreement with the statement (Q45f) in the biennial health and care experience survey: “I feel supported to continue caring”. The number of people who agree or strongly agree divided by the total number answering.

Current Position
The Partnership remains above the Scottish average. This indicator is supported by local measures, some of which are detailed in the local partnership indicators section and the Adult Social Work Services Performance Report (Appendix 2) and will be incorporated into future reports as appropriate.

National Indicator Number 15

Title: Proportion of last 6 months of life spent at home or in community setting

Measure or descriptor: People, including those with disabilities or long term conditions or who are frail are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community. People who use health and social care services have positive experiences of those services and have their dignity respected. Resources are used effectively and efficiently in the provision of health and social care services.



Date: 2014/15

Current value: 85%

National Average: 86%

Status:

Trend:
Downward Trend from 86% 2013/14 & reduction since 2011/12

Context and Improvement Activity

Rationale for indicator

It is now possible to predict the progress of many diseases, enabling a planned approach to palliative and end of life care in ways which reflect best practice and which, as far as is practicable, in accordance with the needs and wishes of patients, carers and their families. Integration Authorities will be able to influence this by commissioning high quality end of life services, and working with communities, families and staff to enable discussion about planning for end of life. As more people have anticipatory care plans and as electronic palliative care summaries are rolled out throughout the country, then we should see a gradual increase in this measure in the medium to long term.

The indicator should ideally represent the wishes and choices for patients and their carers and also demonstrate the effectiveness of having a planned approach to end of life care. For an individual, the preferred place of care can change as their condition and/or family circumstances change over time, making this very difficult to measure and track. Therefore this indicator has been chosen as an alternative. The last six months of life was chosen as this is the period when most hospital admissions occur, and the period when clinicians would tend to plan end life care if the patient was not expected to live longer than 6 months. The figure has remained at just over 90% for the last few years. Across partnership areas, the proportion of the last six months of life spent at home or in a community setting in 2012-13 varied between 88.1% and 94.7%.

Definition and Data Source

This indicator measures the percentage of time spent by people in the last 6 months of life at home or in a community setting. It is derived by linking recorded deaths data with acute hospital bed day data to calculate the percentage of time spent outside acute hospitals in the 6 months at the end of people's lives. Accidental deaths are excluded.

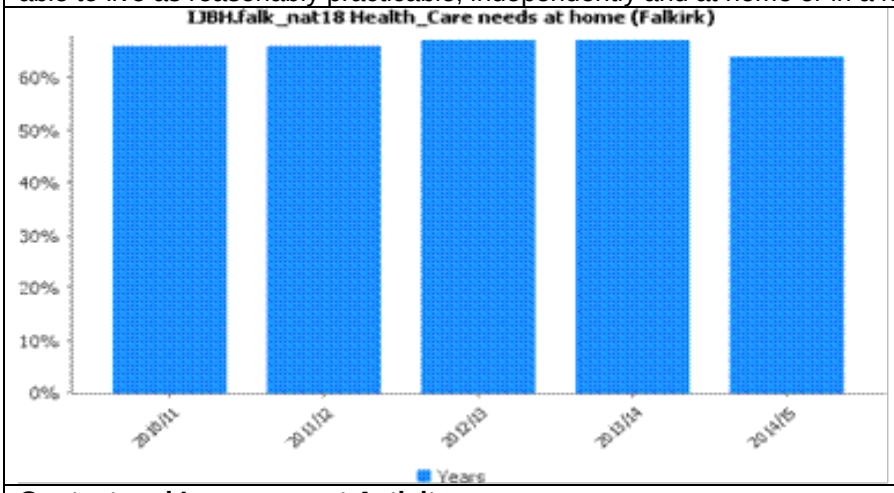
Current Position

Performance is in line with the national average. The Partnership will continue to prioritise supporting people to leave hospital wherever possible, to be cared for in their own homes or homely settings in line the Strategic Plan. This is a core priority for future planning in conjunction with independent and third sector organisations.

National Indicator Number 18

Title: Percentage of adults with intensive needs receiving care at home

Measure or descriptor: People, including those with disabilities or long term conditions or who are frail are able to live as reasonably practicable, independently and at home or in a homely setting in their community.



Date: 2014/15

Current value: 64%

National Average: 61%

Status:

Trend:

Downward trend from 67% 2013/14

Context and Improvement Activity

Rationale for indicator

People want to stay at home as long as possible. Not only is this understandable from their personal perspective, there is also significant evidence that this helps them remain more independent for longer. This makes it a priority to ensure that home care and support for people is available, particularly those with high levels of care needs. As the population ages, and the number of people with complex care needs increases, the need to provide appropriate care and support becomes even more important. Innovative approaches such as re-ablement, 'telecare' and 'telehealth', which use new technology to support people at home, have an increasing part to play. The place where people are cared for is influenced by a number of factors, above all their needs and their level of dependency. But local availability of appropriate care services, and accommodation is also important. Personal factors include: individuals' dependency levels; whether they live alone; and whether they have a carer. The importance of enabling carers to continue their caring role cannot be overstated.

This can be achieved through moving services closer to people's own homes, developing more joined up home care services and ensuring that people have their needs for care properly assessed through, for example, single shared assessments. Jointly commissioned flexible care will become increasingly important through the integration of health and social care. There has been an increase in recent years in the percentage of people receiving personal care at home, rather than in a care home or hospital. The latest figure of 61.9% for 2013 shows an increase of 1.5 percentage points compared to 60.4% in 2012 and 57.1% in 2008. It is expected that Integration Authorities will be able to continue to make progress on this.

Definition and Data Source

The number of adults (18+) receiving personal care at home or direct payments for personal care, as a percentage of the total number of adults needing care.

Current Position

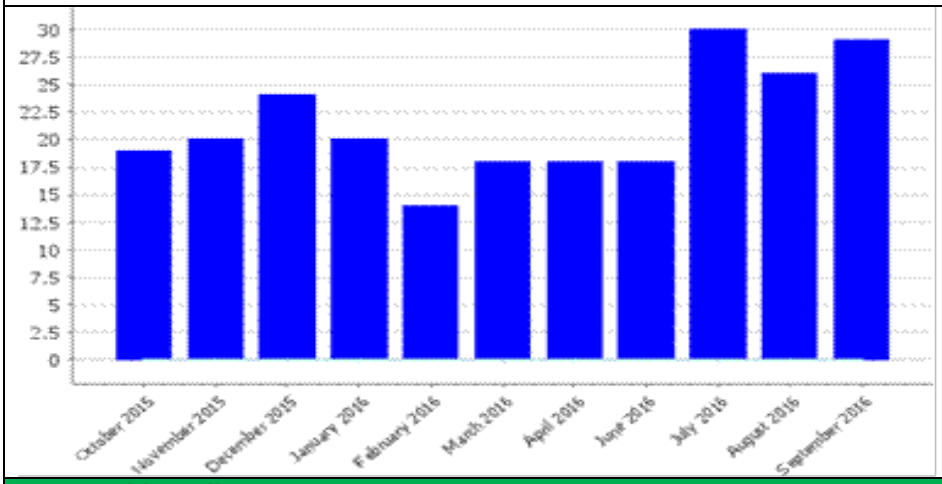
The reported performance *for 2014/15* is higher than the Scottish average. It is a priority to continue to maintain and improve performance in this area taking into account the data in the Strategic Needs Assessment and the increased demand for care at home services. Further development of integrated care provision at a Locality level and, for example, technology enabled care across the Partnership will be used to make best use of the resources available to the Partnership to support people with long term conditions and disabilities to remain in their own homes or homely settings.

LOCAL PARTNERSHIP INDICATORS

Partnership Indicator 1

Title: Delayed Discharges over 14 days

Measure or descriptor: Number of patients waiting more than 14 days to be discharged from hospital into a more appropriate care setting, once treatment is complete



Date: September 2016

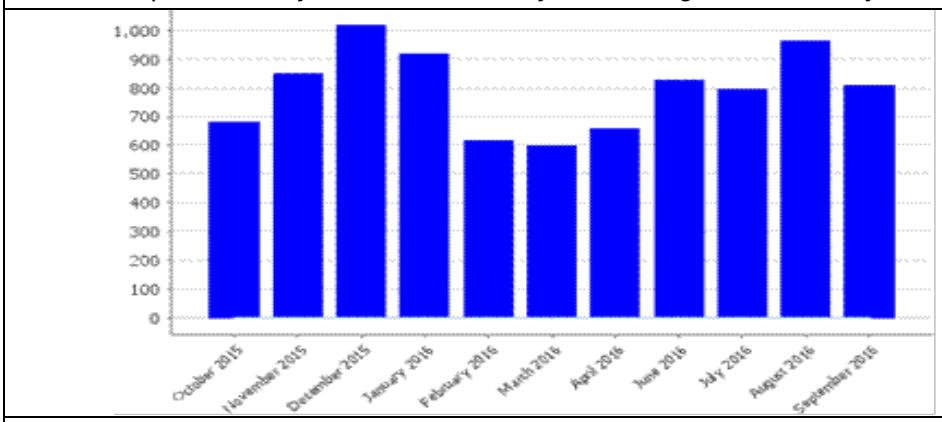
Current value:
29 delays over 14 days

Status:

Trend:
Deteriorating Trend from 26 in August 2016

Partnership Indicator 2

Title: Occupied Bed Days Attributed to Delayed Discharges Over 14 Days



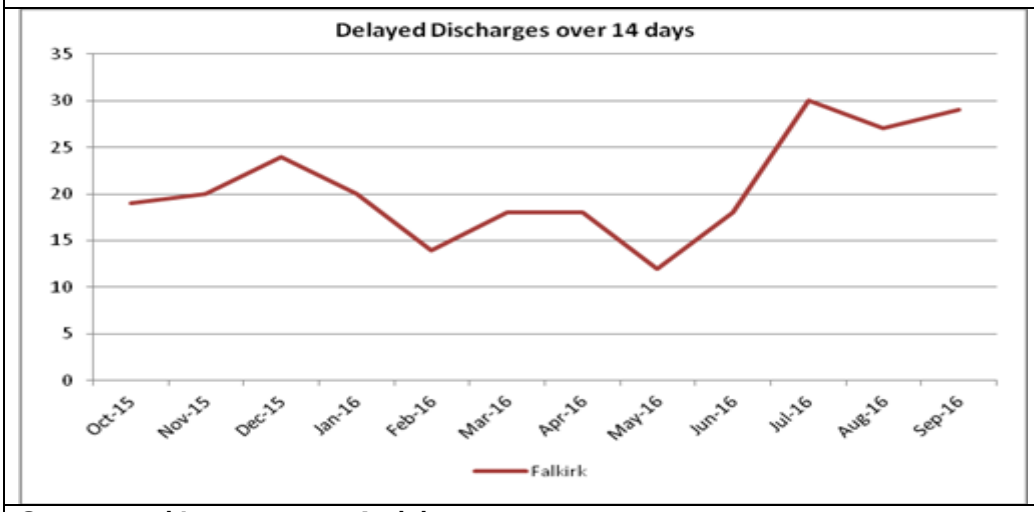
Date: September 2016

Current Value: 807

Status:

Trend:
Improving Trend
From 965 in August 2016

Delayed Discharges Monthly Overview of Local Authority from October 15_September 16



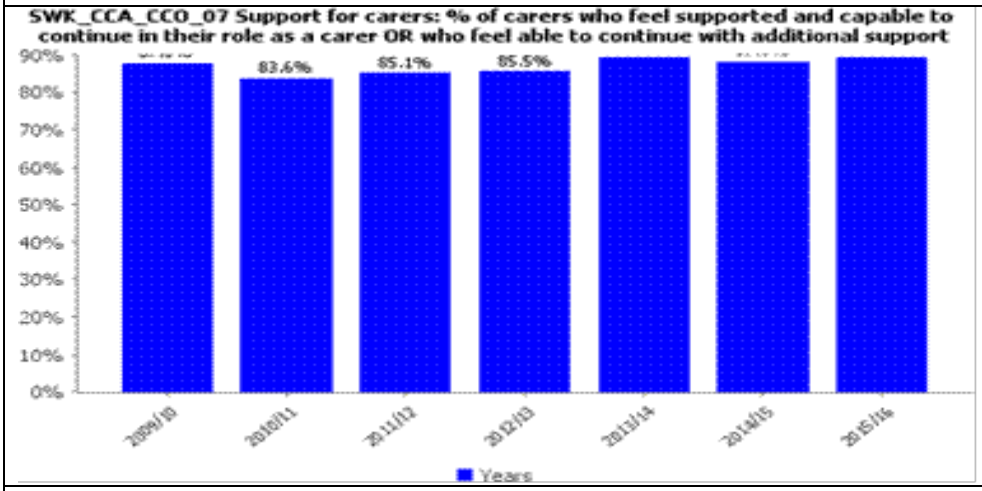
Context and Improvement Activity

The IJB is familiar with the challenges presented by Delayed Discharges. Data presented in this report is based on the September census broken down by Local Authority. The target is zero delays over 2 weeks. A total of 29 delays were reported across the partnership in September. Delayed discharges present a significant challenge to the partnership when the total delays are considered, including those under 2 weeks and those under Guardianships and Code 9, particularly at this time of year. Future performance reports will provide further detail on performance and specific actions being taken. As can be seen from the graph above the numbers are higher than this time last year.

Partnership Local Indicator 3

Title: Percentage of carers who feel supported and capable to continue in their role as a carer OR feel capable to continue with additional support.

Measure or descriptor:



Date: 2015/16

Current value: 89%

Status:

Target: No Target Assigned

Trend: Improving trend from 87.9% in 2014/15

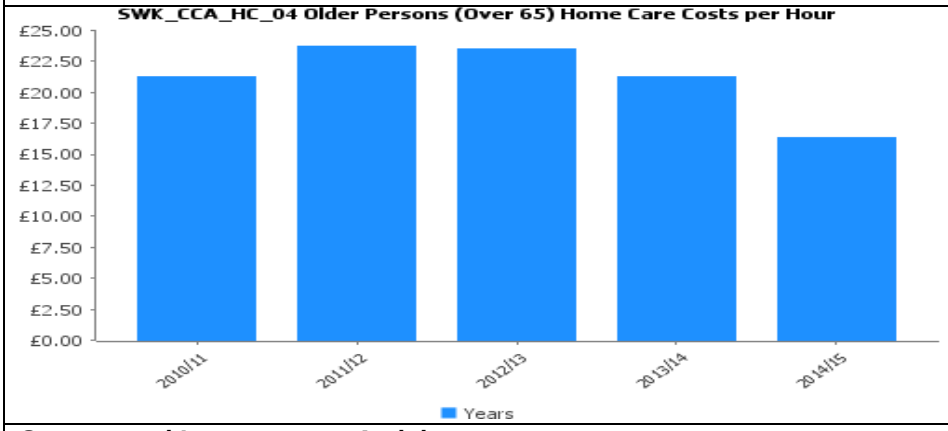
Context and Improvement Activity

- The source of this data is assessment data from SWIS. The indicator was developed under the National Outcomes Framework for Community Care,
- The performance score has increased from 86% in 2013-14 to 89% in 2015-16.

Partnership Local Indicator 4

Title: Older Persons (Over 65) Home Care Costs per Hour

Measure or descriptor: LGBF SW1 - Older Persons (Over 65) Home Care Costs per Hour



Date: 2014/15

Current value: £16.33

Status: No Target Assigned

Trend:

Improving trend as costs down from £21.23 in 2013/14

Context and Improvement Activity

Local Government Benchmarking Indicators: 2014-15
(2015-16 data is not yet available)

- Home care is one of the largest expenditures in Social Work and plays a significant part in supporting people to remain in their own home for as long as possible. The costs include in-house and externally purchased home care and this is linked to the volume and complexity of care required. However, it is important to note that the home care hours used to calculate these costs are based on a single snapshot week, and the costs included in the calculation of this indicator are not always assigned consistently across all councils. The hourly costs range from £12.79 per hour to £31.18, in 2014-15 so comparison across councils is not necessarily reliable.

- The latest data published for this indicator: SW 1: Older Persons (Over65) Home Care Costs per Hour was for 2014-15. The hourly cost in Falkirk was reported as £16.33 per hour, a reduction from 2013/14. This compares well to the Scottish average of £20.18 per hour for 2014-15.

LOCAL OUTCOME Service User Experience - People have a fair and positive experience of health and social care.

Relevant National Indicators are:

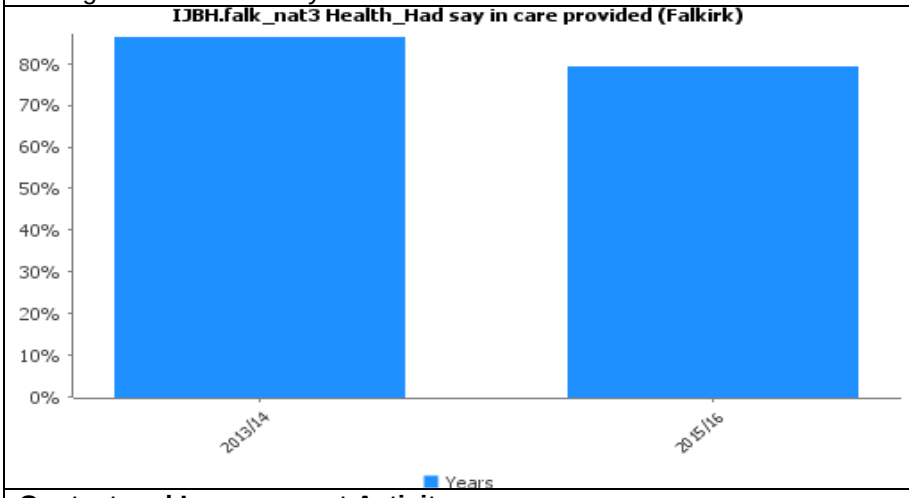
- Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided
- Percentage of adults supported at home who agree that their health and care services seemed to be well co-ordinated
- Percentage of adults receiving any care or support who rate it as excellent or good
- Percentage of people with positive experience of their GP practice
- Percentage of staff who say they would recommend their workplace as a good place to work
- Number of days people spend in hospital when they are ready to be discharged
- Percentage of total health and care spend on hospital stays where the patient admitted as an emergency
- Percentage of people who are discharged from hospital within 72 hours of being ready
- Expenditure on end of life care

To support delivery of these indicators a number of local indicators are being developed.

National Indicator Number 3

Title: Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided

Measure or descriptor: People who use health and social care services have positive experiences of those services, and have their dignity respected. People, including those with disabilities or long term conditions or who are frail are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.



Date: 2015/16

Current value: 79%

National Average: 79%

Status:

Trend:
Downward trend as results down from 86% in 2013/14

Context and Improvement Activity

Rationale for indicator
Too many people receiving care and support, choice and control over how their services are provided is very important. The increasing use of Self Directed Support should mean that more people feel that they have more control over the type of support they get.

In Scotland overall, 84% of people agreed that they had a say in how their care and support was provided. This varied between CHP areas from 73% to 90%. Integration Authorities should seek to improve levels on this indicator.

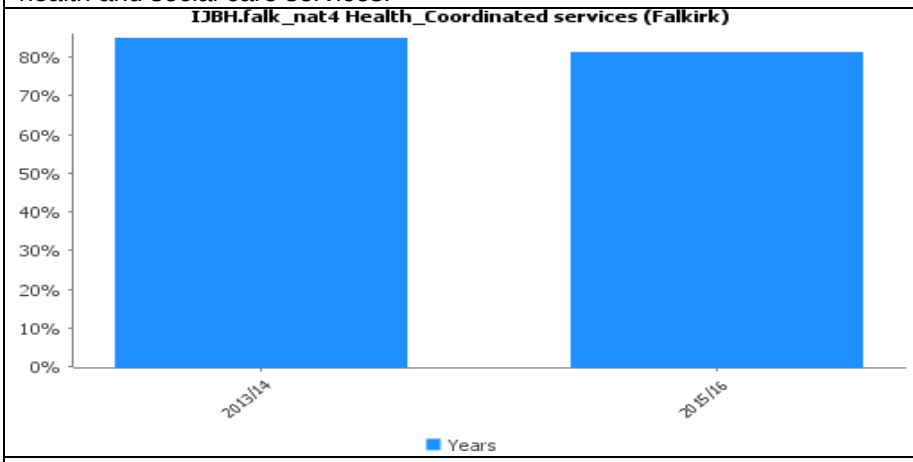
Definition and Data Source
Based on agreement with the statement (Q36b) in the biennial health and care experience survey: "I had a say I how my help, care or support was provided". The number of people who agree or strongly agree divided by the total number answering.

Current Position
The Partnership is in line with the national average however there is a downward trend to that previously reported performance and focus will continue. Local performance data presented in Appendix 2 presents a more positive picture. Relevant data will be incorporated into this report moving forward.

National Indicator Number 4

Title: Percentage of adults supported at home who agree that their health and care services seemed to be well co-ordinated

Measure or descriptor: People who use health and social care services have positive experiences of those services, and have their dignity respected. Resources are used effectively and efficiently in the provision of health and social care services.



Date: 2015/16

Current value: 81%

National Average: 76%

Status:

Trend:
Downward trend as reduced from 85% inn 2013/14

Context and Improvement Activity

Rationale for indicator
Person centred planning and delivery of services will ensure that people receive the right service at the right time, in the right place, and services are planned for and delivered for the benefit of people who use the service. This also reflects the resources outcome, as uncoordinated care is also likely to be inefficient and less effective.

In Scotland overall, 80% of people agreed that the services seemed to be well coordinated in 2013/14. This varied between CHP areas from 64% to 89%. It is expected that an increase should be seen in this indicator in future if integration of health and social care is having the desired impact.

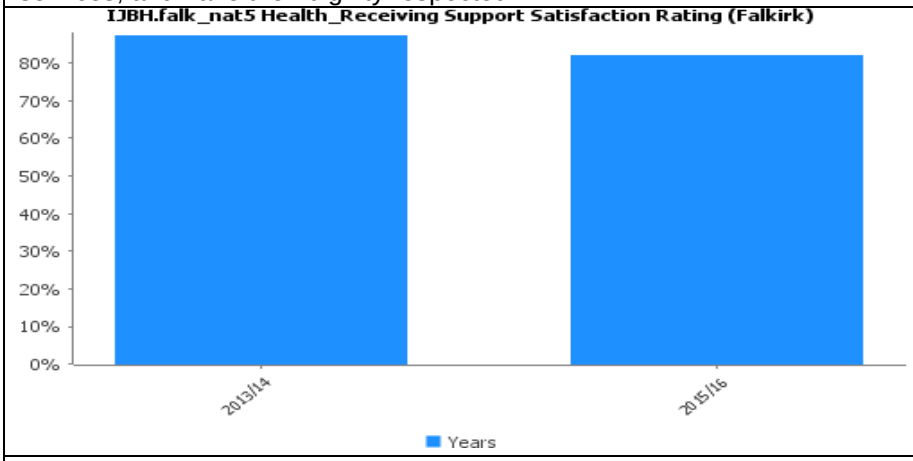
Definition and Data Source
Based on agreement with the statement (Q36e) in the biennial health and care experience survey: “My health and care services seemed to be well co-ordinated”. The number of people who agree or strongly agree divided by the total number answering.

Current Position
Partnership performance is above the national average.

National Indicator Number 5

Title: Percentage of adults receiving any care or support who rate it as excellent or good

Measure or descriptor: People who use health and social care services have positive experiences of those services, and have their dignity respected.



Date: 2015/16

Current value: 82%

National Average: 82%

Status:

Trend:
Downward Trend reduced from 87% in 2013/14

Context and Improvement Activity

Rationale for indicator
For people who use care and support services, their experience of those services should be positive and be continuously improving.

In Scotland overall, 84% of people rated their help, care or support services as excellent or good in 2013/14. This varied between CHP areas from 74% to 92%. The overall rating of care and support represents users' overviews across many aspects of service provision, which Integration Authorities will need to understand and work to improve by seeking and acting on feedback from users and their carers.

This indicator is related to the indicator on co-ordination of care, as well as the indicator on impact of services on quality of life, but provides an overview of service quality from the patient point of view – which will incorporate other factors about the service such as how well they were treated.

Definition and Data Source
Based on the question (Q37) in the biennial health and care experience survey: "Overall, how would you rate your help, care or support services?" The number of people answering excellent or good, divided by the total number answering the question.

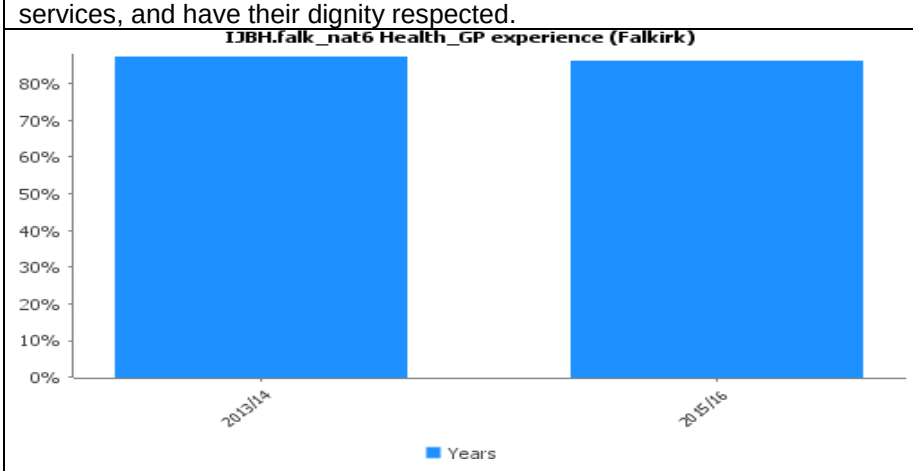
Current Position
In Scotland overall, 82% of people rated their help, care or support services as excellent or good in 2015/16. The Partnership is in line with the national average however a downward trend is noted.

This is a core priority for all service areas. Qualitative information e.g. feedback from individuals, complaints data is used to identify themes and specific areas for improvement. This is used to inform actions plans, learning and development plans for staff groups and teams.

National Indicator Number 6

Title: Percentage of people with positive experience of their GP practice

Measure or descriptor: People who use health and social care services have positive experiences of those services, and have their dignity respected.



Date: 2015/16

Current value: 86%

National Average: 87%

Status:

Trend: Downward Trend compared to 87% in 2013/14

Context and Improvement Activity

Rationale for indicator

GP services are central to health and care services so it is important that Integration Authorities work with GP practices to ensure they work with partners to contribute to patient outcomes.

While GP practices will contribute to other indicators for example, co-ordination of care, overall rating of care and people's ability to look after their own health, GPs directly provide a wide range of care and treatment a large proportion of the population. In Scotland, 87 % of patients rated their GP practice as good or excellent in 2013/14, with a range of 79% to 97% across CHP areas.

Definition and Data Source

Based on the question (Q27) in the biennial health and care experience survey: "Overall how would you rate the care provided by your GP practice?" The number of people answering excellent or good, divided by the total number answering the question.

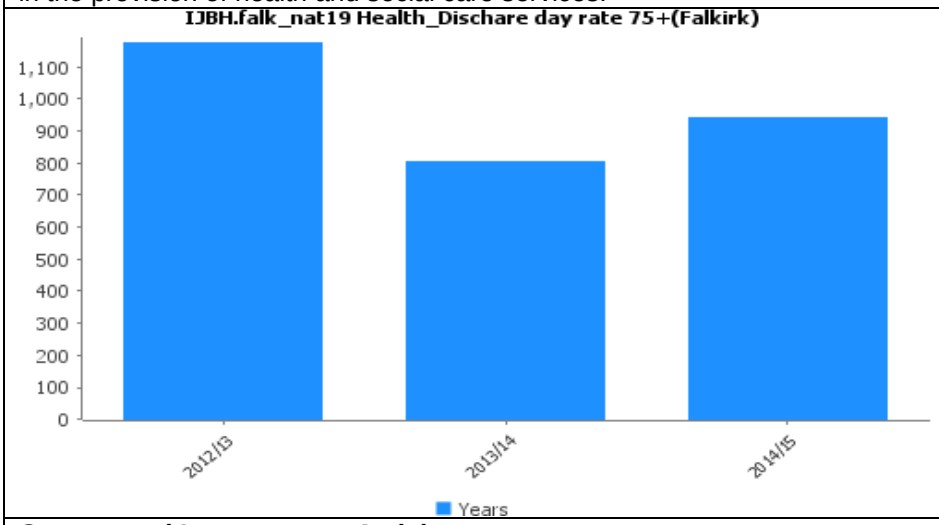
Current Position

The Partnership is in line with the national average.

National Indicator Number 19

Title: Number of days people + 75 spend in hospital when they are ready to be discharged (per 1000,000 population)

Measure or descriptor: People, including those with disabilities or long term conditions or who are frail are able to live as far as reasonably practicable, independently and at home or in a homely setting in their community. People who use health and social care services have positive experiences of those services and have their dignity respected. Health and social care services are centred on helping to maintain or improve the quality of life of people who people who use those services. Resources are used effectively and efficiently in the provision of health and social care services.



Date: 2014/15

Current value: 943

National Average: 1,044

Status:

Trend:
Downward trend from 804.9 in 2013/14, long term improvement from 1,172.1
In 2012/13

Context and Improvement Activity

Rationale for indicator
People should not have to wait unnecessarily for more appropriate care to be provided after treatment in hospital. Waiting unnecessarily in hospital is a poor outcome for the individual, is an ineffective use of scarce resource and potentially denies an NHS bed for someone else who might need it. Older people admitted to hospital are more likely to be delayed there once their treatment is complete. This, in turn, is particularly bad for their health and independence.

The indicator on its own however does not tell us about the outcomes, as people need to be discharged to an appropriate setting that is best for their reablement. Focusing on discharging patients quickly at the expense of this is not desirable, and improvements need to be achieved by better joint working and use of resources.

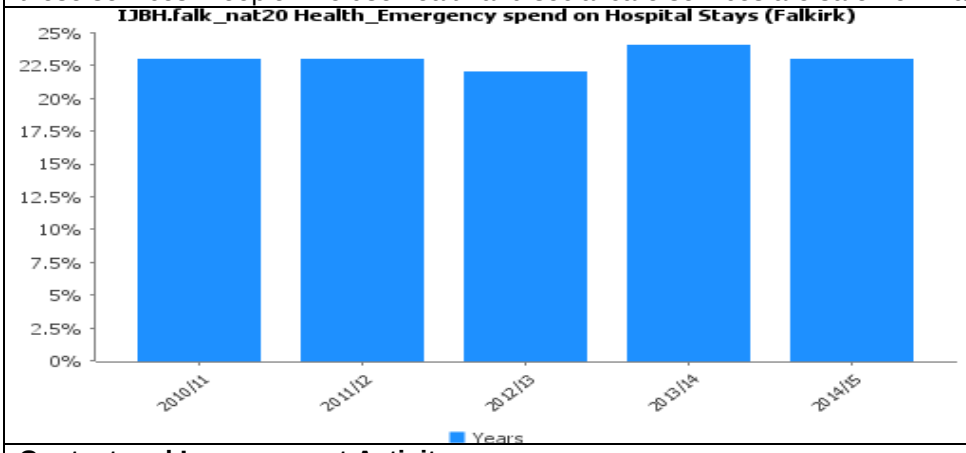
Definition and Data Source
The number of bed days due to delayed discharge that have been recorded for people resident within the Local Authority area, per 1,000 population in the area.

Current Position
The Partnership is below the national average however has seen an increase since 2013/14.

National Indicator Number 20

Title: Percentage of total health and care spend on hospital stays where the patient admitted as an emergency

Measure or descriptor: Resources are used effectively and efficiently in the provision of health and social care services. People, including those with disabilities or long term conditions or who are frail are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community. Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services. People who use health and social care services are safe from harm.



Date: 2014/15

Current value: 23%

National Average: 22%

Status:

Trend:
Downward Trend of 1% 2013/14

Context and Improvement Activity

Rationale for indicator

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. For people aged over 65, almost one third of spend (NHS and LA) in Scotland is on emergency hospital stays, and for the whole population the figure is 22%. It would be desirable to see this reducing over time.

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. This is already happening in some places in Scotland, through for example intermediate care, anticipatory and preventative care. This ensures that emergency non elective resources (staff, beds, equipment) are used for those who need acute medical and trauma care.

Definition and Data Source

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. ISD have linked all health activity and resource data that is currently available at individual level (around 70% of health expenditure). This data is available by age, by speciality, by location of care etc., so partnerships can understand emergency admissions for their population or a specific cohort.

Current Position

The Partnership is in line with the national average. In line with the Strategic Plan work is beginning to focus to reduce emergency admissions through a variety of interventions including; discharge to assess, use of intermediate care beds and supported by the use of the ALFY line, Frailty Clinics and Closer to Home.

Falkirk Integration Joint Board Strategy Map **Appendix 1**

Vision	**To enable people to live full independent and positive lives within supportive communities**				
Local Outcomes	**SELF MANAGEMENT**- of Health, Care and Wellbeing.	**AUTONOMY & DECISION MAKING** –Where formal support is needed people can exercise control over choices.	**SAFETY** - H&SC support systems keep people safe and live well for longer.	**SERVICE USER EXPERIENCE** People have a fair & positive experience of health and social care.	**COMMUNITY FOCUSSED SUPPORTS** - to live well for longer at home or homely setting.
National Outcomes (9)	**1)** Healthier living **2)** Reduce Inequalities	**4)** Quality of Life	**7)** People are safe	**3)** Positive experience and outcomes **8)** Engaged work force **9)** Resources are used effectively	**2)** Independent living **6)** Carers are supported
National Indicators (23) **(* Indicator under development nationally)**	**1)** % of adults able to look after their health well/quite well **11)** Premature mortality rate	**7)** % of adults who agree support has impacted on improving/maintaining quality of life **12*)** Rate of Emergency admissions for adults **17)** % of care services graded 'good' (4) or better by Care Inspectorate	**9)** % of adults supported at home who felt safe **13*)** Emergency bed day rate for adults **14*)** Readmission to hospital within 28 days rate **16*)** Falls rate per 1000 population 65+yrs	**3)** % of adults who agree that they had a say in how their help/care was provided **4)** % of adults supported at home who agree their health and care services are co-ordinated **5)** % of adults receiving care and support rated as excellent or good **6)** % of people with positive GP experiences **10)** % of staff who recommend their place of work as good **19)** Rate of days people aged 75+ spend in hospital when they are ready to be discharged, **20)** % of total health and care spend on hospital stays where the patient admitted as an emergency **(22*)** % people discharged from hospital within 72 hours of being ready **23)** Expenditure on end of life care	**2)** % of adults supported at home who agree they are supported to be independent **8)** % of carers who feel supported in their role **15)** % of last 6 months of life spent at home or in community **18)** % of adults 18+yrs receiving intensive support at home **21*)** % of people admitted to hospital from home then discharged to care home *Note linkage to 'Experience'* **19)** Rate of days people aged 75+ spend in hospital when they are ready to be discharged, **(22*)** % people discharged from hospital within 72 hours of being ready
Partnership Indicators (Under development)	• ED Attendance • Life expectancy age 65+ • Deaths from Cancer/CHD	• *Dementia – post diagnostic tgt, • Mental Health/Learning Disability data	• HAI • Telecare data 75+ • Adult Protection	• Local Client/patient data • Patient Experience survey • Staff Survey data • Financial and Budgetary information	• Hours of homecare for clients 65+ • Respite hours provided • Em/Admission 65+75+ per 100,000

Adult Social Care Indicators

Important Indicators on Target (16) 

Appendix 2

	2013/14	2014/15	2015/16	Target	Benchmark	Comment
	Value	Value	Value			
1. Percentage of Rehab At Home service users who attained independence after 6 weeks	Data not available	74.5%	77.4%	60%	No benchmark - target locally determined	Indicators 1 and 2 support monitoring of rehab at Home and Crisis Care prevent hospital admission and reduce delayed discharges.
2. Percentage of Crisis Care service users who are retained in the community when service ends	Data not available	74.4%	63.7%	60%	No benchmark - target locally determined	
3. The number of people aged 65+ receiving Home Care	1,905	1,826	1,867	Maintain level	No benchmark - target locally determined	The Home Care indicators (4 - 7) show improving levels of provision in 2015-16. It is worth noting that each year's data is a snapshot of provision in a single reporting week.
4. The number of Home Care hours per 1,000 population aged 65+	526.6	483.6	512.2	>=483.9	No benchmarks - targets locally determined based on quarterly figures from previous year	
5. The proportion of Home Care service users aged 65+ receiving personal care	91.6%	90.9%	91.6%	>=90.4%		
6. The proportion of Home Care service users aged 65+ receiving a service during evenings/overnight	42.4%	41.6%	49.3%	>=41.6%		
7. The proportion of Home Care service users aged 65+ receiving a service at weekends	77.7%	77.9%	79.9%	>=77.8%		
8. The number of people who had a community care assessment completed	9,575	9,505	9,571	Maintain level	No benchmark - target locally determined	The number of people receiving Community Care assessments is being maintained.
9. The total number of people with community alarms at end of the period	4,546	4,484	4,526	Maintain level	No benchmark - target locally determined	The number of people with community alarms is being maintained.

	2013/14	2014/15	2015/16	Target	Benchmark	Comment
	Value	Value	Value			
10. Number of new Telecare service users 65+	123	124	142	Increase	No benchmark - target locally determined	The number of new Telecare users has increased since 2014-15.
11. The number of new adaptations provided during the reporting year	1,786	1,666	1605	Maintain level of service	No benchmark – target locally determined	This trend needs to be reviewed.
12. Experience measures and support for carers from the National Community Care Outcomes Framework:						
a) percentage of community care service users feeling safe	88%	89%	90%	Increase	No benchmark – target locally determined	Indicators 12a to 12e show consistently high levels of satisfaction with support for service users and carers. (Source SWIS assessments)
b) percentage of service users satisfied with their involvement in the design of their care package	99%	98%	98%			
c) percentage of carers satisfied with their involvement in the design of care package	90%	92%	92%			
d) percentage of service users satisfied with opportunities for social interaction	93%	94%	93%			
e) percentage of carers who feel supported and capable to continue in their role as a carer OR feel able to continue with additional support	86%	88%	89%			
13. The proportion of Community Care services complaints completed within 20 days	66.4%	73.8%	73.4%	>70%	Council standard	Performance on complaints are now meeting the Council standard set.
14. Older Persons (65+) Home Care Costs per Hour and rank nationally	£21.23 (22nd)					
15. Percentage of Adults satisfied with social care or social work services, and rank nationally	69% (7th)					

	2013/14	2014/15	2015/16	Target	Benchmark	Comment
	Value	Value	Value			
16. Average weekly cost per local authority care home resident, and rank nationally	£302 (4th)					

	2013/14	2014/15	2015/16	Target	Benchmark
15. Older Persons (65+) Home Care Costs per Hour and rank nationally	£21.23 (22nd)	£16.33 (9th)	£16.42	Below Scottish average	Improvement Service indicator(LGBF) Scottish average 2014/15 = £20.02
16. Self Directed Support Spend on Adults 18+ as a % of Total spend on Adults 18+, and rank nationally	1.0% (30th)	1.9% (29th)	2.6%	Move towards Scottish average	Improvement Service indicator(LGBF) Scottish average 2014/15= 6.9%
18. Average weekly cost per local authority care home resident, and rank nationally	£302 (4th)	£325 (6th)	£376	Maintain	Improvement Service indicator(LGBF) Scottish average 2014/15 = £372

Item 15- Cost per LFR-3, hours based on final week of June 2016.
Item 16- per LFR-3 , SDS option 1+ option 2 vs total adult expenditure
Item 18- NCHC Residential rate £524 - average client contribution (£148)

Important Indicators slightly below target (8) 

	2013/14	2014/15	2015/16	Target	Benchmark	Comment
17. Self Directed Support Spend on Adults 18+ as a % of Total spend on Adults 18+, and rank nationally	1.0% (30th)	1.9% (29th)	Data not yet available	Move towards Scottish average	Improvement Service indicator(LGBF) Scottish average 2014/15= 6.9%	Data recording processes are not yet fully established for SDS and national data is not necessarily comparable.
18. The total overnight respite weeks provided to older people aged 65+	837.9	938.1	741.9	Maintain level of service (@938 weeks)	Scottish Government Concordat 2010/11 – 859.0	The total volume of respite care for 65+ has declined slightly in 2015-16 and needs to be monitored. The balance is also shifting from overnight to more daytime respite provision.
19. The total daytime respite weeks provided to older people aged 65+	895.3	774.0	961.9	Maintain level of service (@774 weeks)	Scottish Government Concordat 2010/11 – 862.1	
20. The total overnight respite weeks provided to other adults aged 18-64	500.1	545.9	520.1	Maintain level of service (@546 weeks)	Scottish Government Concordat 2010/11 – 538.6	The volume of respite care for 18-64 has declined in 2015-16 and needs to be monitored.
21. The total daytime respite weeks provided to other adults aged 18-64	179.4	306.0	204.4	Maintain level of service (@306 weeks)	Scottish Government Concordat 2010/11 – 243.5	
22. The number of Carers' Assessments carried out	1,883	2,139	1,936	>=2,139	No benchmark - target locally determined	This is a Joint Inspection improvement action and the Numbers need to be monitored in this service area.

	2013/14	2014/15	2015/16	Target	Benchmark	Comment
23. Percentage of older people aged 65+ with intensive care needs receiving services at home	32.0%	29.8%	Continuing care hospital data not available	Increase	Scottish average 2014/15 – 35.4%	NHS Data was not available to calculate this indicator for 2015-16. But work is also needed to review the factors involved in the reduction of people receiving 10+ hours of home care and to improve targeting of the service towards those service users with higher levels of need.
24. The number of 'OT' equipment items provided by the Joint Loan Equipment Scheme during the year	6,540	6,052	5,451	Maintain level	No benchmark - target locally determined	We are reviewing trends here as a higher proportion of JLES equipment is being issued by NHS FV NH in recent years.

Important Indicators significantly below target (3)

	2013/14	2014/15	2015/16	Target	Benchmark	Comment
25. The number of months during the reporting period that the target was achieved of no delayed discharge patients waiting 2 weeks or more	3 months (4 weeks or more)	1 month (4 weeks or more)	0 months	12	Stirling & Clacks together (~1/2 Forth Valley pop) have achieved in 1 month to 2015/16	The delayed discharge target continues to be challenging.
25. The number of overdue 'OT' pending assessments at end of the period	378 (240 assessments 138 reviews)	496 (292 assessments 204 reviews)	573 (356 assessments 217 reviews)	Decrease	No benchmark - target locally determined	The demand for OT assessments and reviews continue to grow, but reducing waiting lists are now being tackled.
27. Sickness Absence in Social Work Adult Services	7.85%	8.32%	7.91%	5.5%	Falkirk Council to 2015/16 Q2 – 4.08%	Social Work Adult Services include those engaged in Home Care and Residential Care, which are recognised nationally as physically demanding and stressful occupations.

Important Indicators – Data Only (2) 

	2013/14	2014/15	2015/16	Target	Benchmark	Comment
	Value	Value	Value			
28. The number of adult protection referrals, investigations undertaken and the number of adult protection plans in place at the end of the reporting period	477 114 17	519 79 14	579 45 12	Target not appropriate	No benchmark	The volume of ASP referrals continues to increase year on year.
29. The number and proportions of service users receiving Self Directed Support Options 1-4	Data not available	Option 1 39 (2%); Option 2 27 (1%); Option 3 - 1,788 (95%); Option 4 24 (1%)	Option 1 40 (1.6%); Option 2 46 (1.9%); Option 3 2,296 (93.8%); Option 4 65 (2.7%)	Target not appropriate	No benchmark	The number of people taking up SDS Options 1,2 and 4 show modest increases. The *number* of people choosing option 3 is growing, but reducing as a *proportion* of all SDS Options.

Appendix 3

Annual Performance Report – Draft Outline Template

Foreword

TBC

Executive Summary

TBC

Contents Page

TBC

Background & Context

TBC

Introduction

TBC

Service planning

Suggested content from The Public Bodies (Joint Working) (Content of Performance Reports) (Scotland) Regulations 2014

A performance report must include—

a) *an assessment of performance in relation to the national health and wellbeing outcomes, including—*
    i. *a description of the extent to which the arrangements set out in the strategic plan and the expenditure allocated in the financial statement have achieved, or contributed to achieving, the national health and wellbeing outcomes;*
    ii. *information about the integration authority's performance against key indicators or measures in relation to the national health and wellbeing outcomes; and in respect of the information included in the performance report by virtue of subparagraph (ii), a comparison between the reporting year and the 5 preceding reporting years (or, where there have been fewer than 5 reporting years, all preceding reporting years, if any);*

b) *an assessment of performance in relation to the integration delivery principles including information about the way in which the arrangements set out in the strategic plan, and expenditure allocated in the financial statement, have contributed to the provision of services in pursuance of integration functions in accordance with the integration delivery principles; and*

c) *an assessment of performance in relation to strategic planning including, where applicable, information about the number of significant decisions that have been made by the integration authority to which section 36 of the Act (significant decisions outside strategic plan: public involvement) applies and the reasons for making each such decision.*

Financial planning and performance

Suggested content from The Public Bodies (Joint Working) (Content of Performance Reports) (Scotland) Regulations 2014

A performance report must include information about financial performance including—

a) *the total amount spent by, or under the direction of, the integration authority on each of the matters listed in paragraph (2);*
b) *the proportion of the total amount paid to or set aside for use by the integration authority spent on each matter listed in paragraph (2); and*
c) *if there has been an underspend or overspend against the planned spending set out in the annual financial statement, the amount of underspend or overspend and an assessment of the reasons for this.*

The matters referred to in paragraphs (1)(a) and (1)(b) are—

a) *health care services provided in pursuance of integration functions to hospital inpatients;*
b) *health care services provided in pursuance of integration functions other than those provided to hospital inpatients;*
c) *social care services provided in pursuance of integration functions to service users who are provided with a care home service or adult placement service;*
d) *social care services provided in pursuance of integration functions to support unpaid carers in relation to needs arising from their caring role;*
e) *social care services provided in pursuance of integration functions not mentioned in subparagraphs (c) or (d); and*
f) *where one or more key care group has been identified in relation to the local authority area, health care services and social care services provided in pursuance of integration functions to service users within each of those key care groups.*

A performance report must include, in respect of the information which is included in the report by virtue of paragraph (1)(b) and (c), a comparison between the reporting year and at least the 5 preceding reporting years (or, where there have been fewer than 5 reporting years, all preceding reporting years, if any).

Best value in planning and carrying out integration functions

Suggested content from The Public Bodies (Joint Working) (Content of Performance Reports) (Scotland) Regulations 2014

A performance report must include an assessment of performance in relation to best value, including information about how the planning and delivery of services in pursuance of integration functions have contributed to securing best value.

In paragraph (1), the reference to 'securing best value' is a reference to—

a) *the duty to which that integration authority is subject by virtue of Part 1 of the Local Government in Scotland Act 2003(**a**); or*
b) *any similar duty contained in guidance issued by the Scottish Ministers, on which the auditor may make findings in respect of the accounts of that integration authority by virtue of section 22(1)(c) of the Public Finance and Accountability (Scotland) Act 2000(**b**), as the case may be.*

Performance in respect of localities

Suggested content from The Public Bodies (Joint Working) (Content of Performance Reports) (Scotland) Regulations 2014

A performance report must include an assessment of performance in planning and carrying out functions in localities, including—

a) *a description of the arrangements made for the consultation and involvement of groups in decisions about localities to which section 41 of the Act (carrying out of integration functions: localities) applies; and*
b) *an assessment of how the arrangements described in sub-paragraph (a) have contributed to provision of services in pursuance of integration functions in accordance with the integration delivery principles in each locality.*

A performance report must set out, for of each locality identified in the strategic plan, the proportion of the total amount paid to, or set aside for use by, the integration authority spent during the reporting year in relation to the locality.

A performance report must include, in respect of the information which is included in the report by virtue of paragraph (2), a comparison between the reporting year and the 5 preceding reporting years (or, where there have been fewer than 5 reporting years, all preceding reporting years, if any).

Inspection of services

Suggested content from The Public Bodies (Joint Working) (Content of Performance Reports) (Scotland) Regulations 2014

If during the reporting year a scrutiny body has made recommendations as a result of carrying out an inspection of the planning or delivery of a service provided in pursuance of integration functions in the area of the local authority, the performance report must include

a) *a list of the recommendations; and*
b) *in relation to each recommendation, details of the action taken by the integration authority to implement the recommendation.*

Review of strategic plan

Suggested content from The Public Bodies (Joint Working) (Content of Performance Reports) (Scotland) Regulations 2014

If during the reporting year the integration authority has carried out a review of the strategic plan, the performance report must include—

a) *a statement of the reasons for carrying out the review;*
b) *a statement as to whether, following the review, a revised strategic plan was prepared by the integration authority; and*
c) *where a revised strategic plan was prepared, a description of the changes made in revising the strategic plan.*

Further provision

Suggested content from The Public Bodies (Joint Working) (Content of Performance Reports) (Scotland) Regulations 2014

A performance report may include such other information related to assessing performance during the reporting year in planning and carrying out integration functions as the integration authority thinks fit.