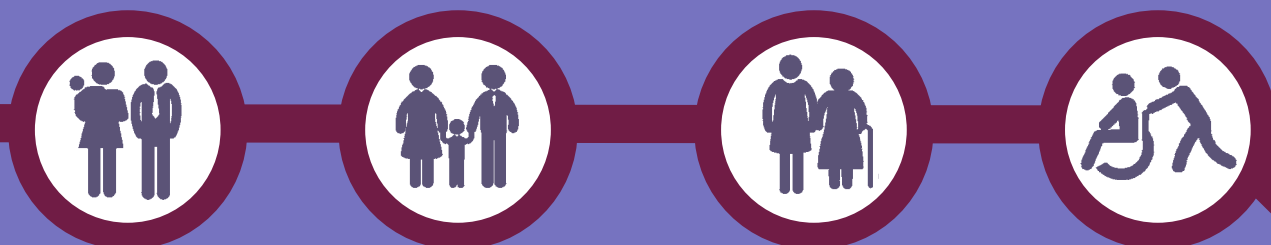




The Scottish
Government
Riaghaltas na h-Alba

Core Suite of Integration Indicators

This suite of core indicators draw together measures that are appropriate for the whole system under integration



1. Context

The National Health and Wellbeing Outcomes provide a strategic framework for the planning and delivery of health and social care services. They focus on the experiences and quality of services for people using those services, carers and their families. More information about the outcomes is available at:

<http://www.gov.scot/Publications/2015/02/9966/downloads>

Integration Authorities will be responsible for planning and delivering a wide range of health and social care services, and will be accountable for delivering the National Health and Wellbeing Outcomes. Each Integration Authority will be required to publish an annual performance report¹, which will set out how they are improving the National Health and Wellbeing Outcomes. These reports will all need to include information about the core suite of indicators, supported by local measures and contextualising data to provide a broader picture of local performance.

This paper outlines the core suite of indicators, summarising the rationale for inclusion and information on the proposed definition and data source for each indicator in section 3. Several of the indicators will measure progress towards more than one of the National Health and Wellbeing Outcomes. All of the outcomes and indicators are considered as important as each other, and so the suite needs to be considered as a package and not a set of individual unrelated indicators.

2. Core Suite of Indicators - Introduction

This core suite of indicators should be used in conjunction with the Public Bodies (Joint Working) (National Health and Wellbeing Outcomes) (Scotland) Regulations 2014 which is available at: <http://www.legislation.gov.uk/ssi/2014/343/contents/made>

The indicators have been developed in consultation with a wide range of stakeholders across all sectors, and with significant input from COSLA, and have been agreed by the Ministerial Steering Group. They remain to be tested in practice, however, and will need to be tested out with partnerships to understand their usefulness both for reporting progress and identifying areas for improvement to help with strategic planning. It should be noted that the indicators will develop and improve over time, and that some of them still require data development.

¹ <http://www.legislation.gov.uk/ssi/2014/326/contents/made>

The indicators have been, or will be, developed from national data sources so that the measurement approach is consistent across all areas. They can be grouped into two types of complementary measures:

Outcome indicators based on survey feedback, to emphasise the importance of a personal outcomes approach and the key role of user feedback in improving quality. While national user feedback will only be available every 2 years, it is expected that Integration Authorities' performance reports will be supplemented each year with related information that is collected more often.

1. [Percentage of adults able to look after their health very well or quite well.](#)
2. [Percentage of adults supported at home who agree that they are supported to live as independently as possible.](#)
3. [Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided.](#)
4. [Percentage of adults supported at home who agree that their health and care services seemed to be well co-ordinated.](#)
5. [Percentage of adults receiving any care or support who rate it as excellent or good](#)
6. [Percentage of people with positive experience of care at their GP practice.](#)
7. [Percentage of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life.](#)
8. [Percentage of carers who feel supported to continue in their caring role.](#)
9. [Percentage of adults supported at home who agree they felt safe.](#)
10. [Percentage of staff who say they would recommend their workplace as a good place to work.*](#)

Indicators derived from organisational/system data primarily collected for other reasons. These indicators will be available annually or more often.

11. [Premature mortality rate.](#)
12. [Rate of emergency admissions for adults.*](#)
13. [Rate of emergency bed days for adults.*](#)
14. [Readmissions to hospital within 28 days of discharge.*](#)
15. [Proportion of last 6 months of life spent at home or in community setting.](#)
16. [Falls rate per 1,000 population in over 65s.*](#)
17. [Proportion of care services graded 'good' \(4\) or better in Care Inspectorate Inspections.](#)
18. [Percentage of adults with intensive needs receiving care at home.](#)
19. [Number of days people spend in hospital when they are ready to be discharged.](#)
20. [Percentage of total health and care spend on hospital stays where the patient was admitted in an emergency.](#)
21. [Percentage of people admitted from home to hospital during the year, who are discharged to a care home.*](#)
22. [Percentage of people who are discharged from hospital within 72 hours of being ready.*](#)
23. [Expenditure on end of life care.*](#)

* Indicator under development

Frequency of availability of measurement or level of perceived direct influence on the data should not lead to prioritisation of one indicator at the expense of others. The indicators are designed to allow comparison between areas and to look at improvement over time – some relatively long term. It has been agreed that these indicators will not be subject to targets although local areas may wish to set improvement aims where appropriate.

The core suite of indicators should of course be considered within the wider context of health and social care measurement. While they will provide an indication of progress towards the outcomes, that can be compared across partnerships and described at Scotland level, they will not provide the full picture. Local partnerships will need to collect and understand a wide range of data and feedback that helps understand the system at locality level, and manage and improve services.

Some suggested resources can be found in the draft information framework here: <http://www.gov.scot/Topics/Health/Policy/Adult-Health-SocialCare-Integration/Implementation/ImplementationGuidance/OutcomesFramework>. In future, if there is demand, we will look at developing this into a web resource, and as such we would very much appreciate feedback on this prototype. Please send comments to irc@scotland.gsi.gov.uk.

3. Core Suite of Indicators – background information

1. Percentage of adults able to look after their health very well or quite well

National Health and Wellbeing Outcome:

People are able to look after and improve their own health and wellbeing and live in good health for longer

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.

Link to source:

<http://www.gov.scot/Topics/Statistics/Browse/Health/GPPatientExperienceSurvey>

Individual Local Authority/CHP reports can be found here:

<http://www.healthcareexperienceresults.org/>

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2. Percentage of adults supported at home who agree that they are supported to live as independently as possible

National Health and Wellbeing Outcome:

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.

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.

Link to source:

<http://www.gov.scot/Topics/Statistics/Browse/Health/GPPatientExperienceSurvey>

Individual Local Authority/CHP reports can be found here:

<http://www.healthcareexperienceresults.org/>

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

National Health and Wellbeing Outcomes:

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.

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.

Link to source:

<http://www.gov.scot/Topics/Statistics/Browse/Health/GPPatientExperienceSurvey>

Individual Local Authority/CHP reports can be found here:

<http://www.healthcareexperienceresults.org/>

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

National Health and Wellbeing Outcomes:

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.

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.

Link to source:

<http://www.gov.scot/Topics/Statistics/Browse/Health/GPPatientExperienceSurvey>

Individual Local Authority/ CHP reports can be found here:

<http://www.healthcareexperiencesresults.org/>

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5. Percentage of adults receiving any care or support who rate it as excellent or good

National Health and Wellbeing Outcome:

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

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.

Link to source:

<http://www.gov.scot/Topics/Statistics/Browse/Health/GPPatientExperienceSurvey>

Individual Local Authority/ CHP reports can be found here:

<http://www.healthcareexperiencesresults.org/>

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6. Percentage of people with positive experience of the care provided by their GP practice

National Health and Wellbeing Outcome:

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

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.

Link to source:

<http://www.gov.scot/Topics/Statistics/Browse/Health/GPPatientExperienceSurvey>

Individual Local Authority/ CHP reports can be found here:
<http://www.healthcareexperienceresults.org/>

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7. Percentage of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life.

National Health and Wellbeing Outcome:

Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.

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.

Link to source:

<http://www.gov.scot/Topics/Statistics/Browse/Health/GPPatientExperienceSurvey>

Individual Local Authority/ CHP reports can be found here:
<http://www.healthcareexperienceresults.org/>

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8. Percentage of carers who feel supported to continue in their caring role

National Health and Wellbeing Outcome:

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.

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.

Link to source:

<http://www.gov.scot/Topics/Statistics/Browse/Health/GPPatientExperienceSurvey>

Individual Local Authority/ CHP reports can be found here:

<http://www.healthcareexperiencesresults.org/>

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9. Percentage of adults supported at home who agree they felt safe

National Health and Wellbeing Outcome:

People using health and social care services are safe from harm.

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.

Link to source:

<http://www.gov.scot/Topics/Statistics/Browse/Health/GPPatientExperienceSurvey>

Individual Local Authority/ CHP reports can be found here:

<http://www.healthcareexperiencesresults.org/>

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10. Percentage of staff who say they would recommend their workplace as a good place to work

National Health and Wellbeing Outcome:

People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.

Rationale for Indicator

This indicator is a proxy for staff engagement. It is a question that was agreed could be asked of people working in various organisations relating to the provision of health and social care.

The evidence that staff engagement and positive staff experience are integral to high quality care is strong:

- There is a positive relationship between staff experience and patient experience.
- Lack of “trust” in an organisation has been found to be a factor in high-profile lapses of care.
- There is a relationship between caring, supportive behaviour in staff and better outcomes for patients, as well as satisfaction for staff themselves.
- Commitments to learning, clear leadership and empowerment of staff have been shown to lead to better care experiences.
- High-quality appraisal and management systems improve safety.
- Stress and dysfunctional teams have also been shown to be associated with poorer care.

Definition and Data Source

Based on agreement with the statement “I would recommend my workplace as a good place to work” in staff surveys. (Annual for Health Boards and Local Authorities).

It has been agreed that NHSScotland Staff Survey, and all Local Authorities will incorporate the question, and in future will spread to third and private sectors. The NHS data is not currently presented at partnership level and work needs to be undertaken to provide it in a meaningful way. For example, staff in hospitals will provide care for a range of geographic areas not one specific partnership. The sample of those working in community settings will also have to be considered.

Work has begun to explore if the survey question can also be extended to the majority of social care staff who work in the third and independent sectors. This will involve a number of providers of care and will be more complicated to collect. The mechanisms for collating and calculating this information is work in progress

Link to source:

NHS Staff survey national report

<http://www.scotland.gov.uk/Publications/2014/12/8893/0>

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11. Premature mortality rate

National Health and Wellbeing Outcome:

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.

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 and alcohol problems and links to violence that affect younger men in particular.

Definition and data source

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

Link to source:

[Latest results published by National Records for Scotland](#) (Refer to Table 4: Under 75s age-standardised death rates for all causes, administrative areas 2006 to 2012.)

European Age-Standardised mortality rates are calculated by applying the age-specific rates for Scotland to the European Standard Population and expressed per 100,000 persons per year.

The calculation follows a standard methodology which was updated in 2013, allowing for comparisons between countries and over time. Figures under the new 2013 European Standard Population are not comparable with those calculated under the 1976 European Standard Population, but trend data have been backdated to allow comparisons over time to be made using the new methodology. Further information on the ESP methodology is available on the [National Records of Scotland website](#).

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12. Emergency admission rate

National Health and Wellbeing Outcomes:

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.

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 deprivation²).

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).

Link to source:

<http://www.isdscotland.org/Health-Topics/Hospital-Care/Inpatient-and-Day-Case-Activity/> provides data on emergency admission rates to acute hospitals. It is expected that the SMR04 component of the indicator will be available within the next 6-12 months.

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² Rates rise with increasing age group, with patients aged 75+ having nearly 7 times more emergency admissions per 100,000 than 15 to 29 year olds and 4 times more than 45 to 59 year olds.

13. Emergency bed day rate

National Health and Wellbeing Outcomes:

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.

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).

Link to source:

<http://www.isdscotland.org/Health-Topics/Hospital-Care/Inpatient-and-Day-Case-Activity/> provides data on emergency admission rates to acute hospitals. It is expected that the SMR04 component of the indicator will be available within the next 6-12 months.

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14. Readmission to hospital within 28 days

National Health and Wellbeing Outcomes:

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.

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 services – 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.

Link to source:

The GP practice indicators data is available on a password protected database. Local Authority level data will be available this summer.

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15. Proportion of last 6 months of life spent at home or in a community setting

National Health and Wellbeing Outcomes:

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.

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.

Link to source:

<http://www.isdscotland.org/Health-Topics/Health-and-Social-Community-Care/End-of-Life-Care/>

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16. Falls rate per 1,000 population aged 65+

National Health and Wellbeing Outcomes:

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 and efficiently in the provision of health and social care services.

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.

A recently published economic evaluation provided an estimate of the cost to health and social care services in Scotland of managing the consequences of falls: in excess of £470 million (<http://www.ncbi.nlm.nih.gov/pubmed/24215036>) and without intervention is set to rise over the next decade as our population ages and the proportion with multi-morbidity and polypharmacy grows.

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 and social care system should be incorporated as it becomes available.

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17. Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections

National Health and Wellbeing Outcomes:

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.

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 included in this indicator are:

- Care Homes for adults and older people
- Housing Support Services
- Support Services including Care at Home and adult Daycare
- Adult placements
- Nurse Agency

The Care Inspectorate grades care services on the following themes:

- Quality of Care and Support
- Quality of Environment (Care Homes only)
- Quality of Staffing
- Quality of Management and Leadership

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.

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18. Percentage of adults with intensive care needs receiving care at home

National Health and Wellbeing Outcome:

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.

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.

Link to source:

<http://www.gov.scot/Topics/Statistics/Browse/Health/Data/CommunityCareOutcomes> - this indicator can be found in table 5.

More details on sources that feed into indicator can be found here:

<http://www.gov.scot/About/Performance/scotPerforms/TechNotes/careneeds>

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19. Number of days people spend in hospital when they are ready to be discharged, per 1,000 population

National Health and Wellbeing Outcome:

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 use those services.

Resources are used effectively and efficiently in the provision of health and social care services.

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.

Link to data source:

<http://www.isdscotland.org/Health-Topics/Health-and-Social-Community-Care/Delayed-Discharges/>

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20. Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency

National Health and Wellbeing Outcome:

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.

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.

Link to data source:

This is not yet published by Local Authority area although it is available to partnerships. National data are available here:

<http://www.isdscotland.org/Products-and-Services/Health-and-Social-Care-Integration/Analytical-Outputs/Standard-Outputs/>

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21. Percentage of people admitted to hospital from home during the year, who are discharged to a care home

National Health and Wellbeing Outcome:

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.

Rationale for Indicator

This indicator represents the fact that the policy direction is to reduce the occurrence of people being placed directly into care homes from hospital without due consideration being given to more appropriate alternatives that suit the needs of individuals.

In addition, it was proposed as a balancing measure to check for unintended consequences of the focus on delayed discharges, in that it would be easy to demonstrate progress on delayed discharge by filling care homes rather than focusing on returning people to independence through re-ablement at home and/or intermediate care.

We know that balance between care homes and home care varies quite markedly across Scotland, as do pathways into care homes, and that a number of partnerships are trying to rebalance in favour of support at home through a re-ablement model based on 72 hour discharge.

Note that this proposed indicator does not speak to the appropriateness of discharges to care homes, nor whether the care home stays were for intermediate care, for a short stay or as a long-stay resident. Interpretation will need to be supported by local understanding of pathways of care.

Definition and Data Source

The data would come from SMR01, which contains fields on where people were admitted to hospital from and where they are discharged to. The information is not currently considered of usable quality, so data improvement work will be required by ISD working with NHS Boards before this indicator can be used.

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22. Percentage of people who are discharged from hospital within 72 hours of being ready

National Health and Wellbeing Outcome:

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.

Rationale for Indicator

The Delayed Discharge Task Force has recommended that Integration Authorities should report their performance on this indicator, along with delayed bed days (indicator 19).

There is evidence that people waiting for more than 72 hours have worse outcomes than those who go home sooner. Previous approaches to reducing delays have been to focus on a target – first 6 weeks, then 4 and then 2, but the Task Force agreed that in future, focussing on increasing the % who can be discharged as soon as possible while allowing for the fact that there will be individual reasons that this is not appropriate will result in greater improvement.

Two weeks is not ambitious enough for the majority of people who should be able to return home with simple community support - generally within 72 hours of being ready for discharge. As staff often work to targets, a universal target of 2 weeks could increase the delays for this group at a time when services need to accelerate discharge processes to improve capacity and flow.

People with complex support needs will take longer, and it would be wrong to drive premature decision making about future care. Many people with complex care and support needs will have experienced delirium and / or lost confidence and independence in hospital but may have potential for further recovery even at two weeks from the date deemed ready for discharge. Decisions made at the wrong time and in the wrong setting will increase the rate of placements in long term residential care and compound the issue of capacity and resources for partnerships.

Definition and Data Source

The development of this indicator by ISD is being led by the Delayed Discharge Task Force. It requires NHS Boards to set up new methods of recording and collecting the required information, and changes to administrative systems, which is expected to take up to twelve months.

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23. Expenditure on end of life care

National Health and Wellbeing Outcomes:

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.

Rationale for Indicator

To complement the indicator on % of last 6 months of life spent in the community, it will be important for Integration Authorities to look at the opportunity costs of providing a more 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. Invasive, painful, and costly treatment in acute hospital is not always the best course of action – and better discussions and recording of individual patients' needs and wishes should allow resource to be spent on more suitable end of life care and management of the patient's needs.

Definition and Data Source

The final definition for this indicator still needs to be worked out, and will need to ensure it complements the end of life activity indicator, and to ensure this is a meaningful indicator for Integration Authorities and the public. This activity and resource analysis for this indicator builds on analytical outputs the partnerships already get from the Integrated Resource Framework.

The data will be sourced from costed health activity data as described above under indicator 20. The file also includes death records so it is possible to work backwards from date of death and examine people's pathway of activity and resource in the time before death. For 2015, the indicator will cost the last six months of life in an acute inpatient setting, this can be broken down by age, location of treatment, speciality level and by health and social care partnership.

As individual data is also currently available for other hospital based costs (accident and emergency, outpatients, mental health, geriatric long stay), it will be possible to build on the indicator and look at a wider range of hospital based and prescribing resource use in the last six months of life. In time as community health and social care data becomes available at individual level it will be possible to add in this data to examine end of life activity and resource (broken down as detailed above but also by main care type, hospital, community health, social care or a mixture of these).

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