A: Budget setting process

Performance budgeting

1. Which of the following performance frameworks has the most influence on your budget decisions:
   - National Performance Framework;
   - Quality Measurement Framework (including HEAT targets) Yes;
   - Other (please specify)

Performance frameworks are only one factor influencing budget decisions. Pay, price, pension or tax rises are covered. A rising proportion of the budget is being used to introduce new drugs as expected by national policy. Ensuring safe and sustainable services, complying with legislation or guidance, ensuring fit for purpose facilities, reflecting any change in patient flows and meeting the Board’s share of agreed national or regional developments are some of the other drivers in budget decisions.

2. Please describe how information on performance influences your budget decisions:

The case for further investment will be considered where:
   - Current performance is below target and cannot be raised to target without investment;
   - Current performance although acceptable has been underpinned by temporary funding and cannot be sustained without that level of funding;
   - An increase in demand for the service cannot be managed through redesign or productivity and performance will deteriorate unacceptably without investment.

The most significant areas in the 2015/16 financial plan where performance information has influenced investment is in relation to TTG and unscheduled care access targets.

The investment sought to maintain or improve performance against targets has to be considered alongside other demands for funding to ensure services are sustainable, safe and compliant with relevant guidance.

3. Do you consider the performance framework(s) to reflect priorities in your area?

There is a broad match between national and local priorities however in recognition that the communities that we serve (10 recognised localities in Lanarkshire) are not homogenous then we agree Local Improvement Targets to ensure that the specific needs of each locality can best be met. These
Local Improvement targets are also linked to the Single Outcome Agreements prepared on behalf of community planning partners by Local Authorities.

4. Where allocations are made in relation to specific targets, are you able to spend this effectively in the required areas? (please provide examples where relevant)

A good example of this is on substance misuse services where agreed budgets from both Councils and the NHS are linked to the ring-fenced funding provided by Scottish Government. This joint resource is then used to fund the agreed delivery plans designed to tackle the key issues that are set out in the national alcohol and drug strategies and those that are identified within local communities. The delivery plan has clear performance targets for each area of spend.

Examples of where it is harder to spend ringfenced money effectively are where;

a) Allocations are issued well into the year – the earlier the notification the better the planning and ability to organise staff and resources for maximum benefit.

b) Allocations are issued as non recurring with uncertainty about how long they will really be continued for – recruiting on fixed term contracts or secondments limits the field of applicants, as the first potential end date approaches without confirmation of extension, staff will be seeking more guaranteed alternatives resulting in loss of experience. After a period of time, even if recruited originally for a fixed term, staff have employment rights and the sudden withdrawal of funding leaves the Board with cost pressures and HR issues.

Integration of health and social care

5. Please set out, as per your integration plans/schemes with each of your partner local authorities, the method under which funding for the joint boards will be determined?

The resources in the first year of the Joint Integration Board will be based on the due diligence process carried out during the shadow year. The due diligence process will be based on the existing financial plans (including planned efficiencies, savings and uplifts) and performance of the Health Board and the Local Authority during the shadow period and financial performance in recent years.

In subsequent years, the Chief Officer and Chief Financial Officer will develop a case for the integrated budget based on the Strategic Plan and present it to the both Parties for consideration as part of both of their annual budget setting processes. The Parties will evaluate the case for the Integrated Budget against their other priorities and will agree their respective contributions accordingly. The outcome of this work will be presented to the IJB.
Following on from the budget process, the Chief Officer and the IJB Chief Financial Officer will prepare a financial plan supporting the Strategic plan.

The budget will be evidenced based with transparency of assumptions including, but not limited to Pay Award, Contractual Uplift, Savings Requirements etc.

The method for determining the amount set aside for hospital services will follow guidance issued by the Integrated Resources Advisory Group and be based initially on the notional direct costs of the relevant populations use of in scope hospital services as provided by ISD Scotland.

6. What functions will be delegated via the integration plan/scheme? Please explain the rationale for these decisions

The functions required to be delegated by the Public Bodies (Joint Working) (Prescribed Health Board Functions) (Scotland) Regulations 2014 will be delegated. Some pan Lanarkshire health services will be hosted by one Joint Integration Board on behalf of the other so that there can be consistency and effective use of shared resources. The NHS Board will also delegate community and hospital paediatrics to the North Joint Integrated Board to be hosted on behalf of both North and South as children’s services are currently managed by the North CHP which will cease to exist.

The Chief Officer of the Joint integrated Board will form part of both the NHS and social services management teams and will have direct operational responsibility for the services previously managed by the CHPs which includes both community and hospital mental health services. The large acute hospitals provide both in scope and out of scope services to more than one integration authority. They will be managed by the NHS as cohesive physical units. The Joint integration Board will strategically plan the in scope large hospital services and will monitor performance against plan and outcome measures.

For ease of reference, the functions delegated are listed below:

The Hospital services noted below will be delegated in respect of adults and children.

Accident and emergency services provided in a hospital;

Inpatient hospital services relating to the following branches of medicine:

General medicine;
Geriatric medicine;
Rehabilitation medicine;
Respiratory medicine;
Palliative care services provided in a hospital;
Paediatrics; (North only)
Psychiatry of learning disability;
Inpatient hospital services provided by general medical practitioners; Services provided in a hospital in relation to an addiction or dependence on any substance; Mental health services provided in a hospital, except secure forensic mental health services.

Community Health Services

The Community Health Services noted below will be delegated in respect of adults and children.

District nursing services; Health Visiting; Addiction services; Allied health professionals in an outpatient department, clinic, or outwith a hospital; Public dental services; Primary medical services; General dental services; Ophthalmic services; Pharmaceutical services; Primary care out-of-hours; Geriatric medicine; Palliative care; Community learning disability services; Mental Health and Learning Disability services; Continence services; Kidney dialysis services; Services provided by health professionals that aim to promote public health; Community Paediatrics. (North only)

The following services, which are currently planned and delivered on a pan Lanarkshire basis, will be included and will be hosted in North Lanarkshire:

a) Care Home Liaison;  
b) Community Children’s Services;  
c) Dietetics;  
d) Psychology;  
e) Podiatry;  
f) Sexual and Reproductive Health and Blood Borne Viruses;  
g) Speech & Language Therapy;  
h) Prisoner Health Care.

The following services, which are currently planned and delivered on a pan Lanarkshire basis will be included, and will be hosted in South Lanarkshire:

a) Community Dental Services;  
b) Diabetes Services;  
c) Health & Homelessness;
NHS Lanarkshire

d) Primary Care Administration;
e) Palliative Care;
f) Physiotherapy;
g) GP Out of Hours;
h) Traumatic Brain injury;
i) Occupational Therapy.

Social work services for adults and older people delegated by North Lanarkshire Council

a) Services and support for all adults with disabilities and long term conditions;
b) Mental health services;
c) Addiction services;
d) Adult protection;
e) Carers’ services;
f) Community care assessment and planning services;
g) Support services provided by contracted services;
h) Care home services;
i) Intermediate Care Services;
j) Health and wellbeing improvement services;
k) Aspects of housing support, including provision of equipment and adaptations to disabled people’s homes;
l) Day opportunities and day services;
m) Homecare Services;
n) Supported Living Services;
o) Respite Support;
p) Occupational therapy services;
q) Re-ablement services;
r) Smart technology, equipment and telecare.

Social work services for adults and older people delegated by South Lanarkshire Council

• Social work services for adults and older people
• Services and support for adults with physical disabilities and learning disabilities
• Mental health services
• Drug and alcohol services
• Adult protection and domestic abuse
• Carers support services
• Community care assessment teams
• Support services
• Care home services
• Adult placement services
• Health improvement services
• Aspects of housing support, including aids and adaptations
• Day services
• Local area co-ordination
• Respite provision
NHS Lanarkshire

- Occupational therapy services
- Re-ablement services, equipment and telecare

7. How much is being allocated to the Integration Joint Board for 2015-16?
   a. by the health board
   b. by local authority partners?

   The shadow budget has still to be confirmed. A due diligence process looking at the 3 previous years’ budget and expenditure is underway. The Health Financial plan was approved on the 25th of March and its high level provisions will now be translated into delegated budgets.

8. Please provide any further comments on budgetary issues associated with integration:

   When health services were managed on a unified basis across the Health Board areas there was scope each year for balancing higher than expected costs in one area with underspends in areas which were experiencing more favourable conditions and thus maintain both service and financial stability. After integration the Health Budget will be broken into 3 separate pools increasing the risk that one body may find itself in deficit whilst another sits with a surplus.

Specific challenges

9. Please provide details of any specific challenges facing your board in 2015-16 in respect of your budget:

   B: Increase the proportion of babies with a healthy birth weight

   Indicator measure: The proportion of new born babies with a weight appropriate for gestational age

   1. How does performance in your area compare with the national performance?

<table>
<thead>
<tr>
<th></th>
<th>% of new born babies with a weight appropriate for gestational age</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Board</td>
</tr>
<tr>
<td>2009</td>
<td>89.7%</td>
</tr>
<tr>
<td>2010</td>
<td>89.4%</td>
</tr>
<tr>
<td>2011</td>
<td>89.6%</td>
</tr>
<tr>
<td>2012</td>
<td>89.5%</td>
</tr>
<tr>
<td>2013</td>
<td>90.0%</td>
</tr>
</tbody>
</table>

   Source: [http://www.scotland.gov.uk/About/Performance/scotPerforms/indicator/birthweight](http://www.scotland.gov.uk/About/Performance/scotPerforms/indicator/birthweight)
2. What factors can help to explain any observed differences in performance?

Performance is in line with the national average. However, we are aware that deprivation, maternal age and other risk factors such as poor nutrition, smoking, and alcohol and drug use can impact on healthy birthweight.

3. How does performance against this indicator influence budget decisions?

NHS Lanarkshire has performed consistently well against this indicator over time. However, the risk factors associated with birthweight out with a healthy range are given due budgetary consideration in terms of prevention and early intervention. Board level data by deprivation may be helpful in further targeting of resources.

4. Do you consider this to be a useful performance indicator? (If not, what alternatives would you suggest?)

Yes, this is a useful indication of positive pregnancy outcome and performance against tackling common risk factors such as smoking in pregnancy, maternal nutrition and weight, and alcohol and drug use.

5. What programmes or services are specifically aimed at improving performance against this indicator? Please provide details for the three main areas of activity in the table below.

<table>
<thead>
<tr>
<th>Programme/service area</th>
<th>Expenditure 2014-15 £’000</th>
<th>Planned expenditure 2015-16 £’000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antenatal Access HEAT Target</td>
<td>£22,000</td>
<td>£0- will be part of overall Maternity funding.</td>
</tr>
<tr>
<td>Family Nurse Partnership</td>
<td>Not specified but is a proportion of global FNP funding - £780,000 for total programme.</td>
<td>As previous</td>
</tr>
<tr>
<td>Healthy pregnancies:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Maternal nutrition and weight management</td>
<td>£11,742</td>
<td>£11,800</td>
</tr>
<tr>
<td>• Smoking cessation dedicated during pregnancy stage alone</td>
<td>£30,000</td>
<td>£ 52,000</td>
</tr>
<tr>
<td>• Lanarkshire Additional Midwifery Service</td>
<td>£31,719</td>
<td>£32,036</td>
</tr>
</tbody>
</table>
6. What statutory partners or other partners (if any) contribute towards performance in this area?

NHS Lanarkshire, North and South Lanakshire Local Authorities, including Early Years Collaboratives, Alcohol and Drug Partnerships.

7. Please provide any further comments on this indicator e.g. other areas of activity that contribute to performance

No further comments

C: Improve end of life care

Indicator measure: Percentage of the last 6 months of life which are spent at home or in a community setting

1. How does performance in your area compare with the national performance?

<table>
<thead>
<tr>
<th>Year</th>
<th>% of last 6 months of life which are spent at home or in a community setting</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Board</td>
</tr>
<tr>
<td>2008-09</td>
<td>89.5</td>
</tr>
<tr>
<td>2009-10</td>
<td>89.5</td>
</tr>
<tr>
<td>2010-11</td>
<td>89.6</td>
</tr>
<tr>
<td>2011-12</td>
<td>90.0</td>
</tr>
<tr>
<td>2012-13</td>
<td>90.6</td>
</tr>
</tbody>
</table>

Source: [http://www.scotland.gov.uk/About/Performance/scotPerforms/indicator/endoflifecare](http://www.scotland.gov.uk/About/Performance/scotPerforms/indicator/endoflifecare)

2. What factors can help to explain any observed differences in performance?

- In relation to the national comparator, having three acute hospitals means that the majority of people in Lanarkshire have similar access as large urban populations. Easier access to hospital can make admission easier to consider where with longer distances there are more factors supporting a background desire to stay at home.
- In relation to the Lanarkshire increase over time, a number of factors are at play, for example:
  - The increase from 2011 onwards will be affected by the start of Reshaping Care for Older People, although the impact is greatest in 2012-13 as the different initiatives became more effective;
  - Anticipatory prescribing via ‘Just in Case’ boxes was rolled out in 2012 and the first 180 boxes used helped to avoid 84 hospital admissions.

Anticipatory care plans (ACP) require cultural and behavioural change, a process which takes time to fully embed in practice. Overall benefits are:
Better health related-quality of-life for those with complex or long-term conditions;
Reductions in potentially avoidable acute hospital admissions and length of stay;
Reductions in service use and resource impact (acute/primary care);
Enabling more people to remain independent in their own homes for as long as possible, with appropriate self management strategies and the relevant support.

Data to the end of February suggests 57% of Lanarkshire Care Home residents had an active ACP in place. 347 patients on the community Nursing Case Load have ACP in place and 13,046 ACPs have been shared via electronic systems. From January 2014 to February 2015, 385 Care Home residents with an ACP remained in their preferred place of care following a change in health.

3. How does performance against this indicator influence budget decisions?
As more patients are supported at home or homely settings additional resources are required – equipment, Community Nursing, Community Hospital nursing, Home Care Services, Macmillan Team and Marie Curie Nursing. (A recently commenced weekend service by Macmillan team is a practical example.) The skill mix must be appropriate to facilitate management of complex patients in terms of symptom control and pain management.

The development of Integrated Community Support Teams provides access for patients and carers to a 24 hour nursing team which incorporates AHPs (OT and Physio) and is aligned to home care and S/W services. Carers can access support at any time using a single number.

Additional posts are currently being recruited to support Specialist Palliative Care Nurses on acute sites and they are now delivering a Link Nurse Education Programme to various wards across each site.

4. Do you consider this to be a useful performance indicator? (If not, what alternatives would you suggest?)
This indicator has some usefulness as a global measure, but it masks levels of variation that are worthy of fuller exploration. Since some people wish or need to be in hospital at the end of their life, we also review place of death. This has shown a decrease in the proportion of people dying in hospital from 52.8% in 2008 to 50.3% in 2011 (source IM&T Dept, NHS Lanarkshire).
5. What programmes or services are specifically aimed at improving performance against this indicator? Please provide details for the three main areas of activity in the table below.

<table>
<thead>
<tr>
<th>Programme/service area</th>
<th>Expenditure 2014-15 £’000</th>
<th>Planned expenditure 2015-16 £’000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Training in <em>Addressing the Great Taboo</em> to encourage staff to be comfortable talking about death, dying and bereavement. This is a fundamental pre-requisite</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(initial investment now self-sustaining)</td>
</tr>
<tr>
<td>Increased availability of specialist palliative care advice at weekends for symptom management and support. Pilot work evidenced 13% of contacts avoided hospital admission</td>
<td>1.86WTE specialist nurses</td>
<td></td>
</tr>
<tr>
<td>Support for a variety of initiatives that demonstrated admission avoidance in the <em>Reshaping Care for Older People</em> evaluation and will continue to do so for the Joint Integration Boards</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

6. What statutory partners or other partners (if any) contribute towards performance in this area?

Patients/carers, health, local authorities, third & independent sectors

7. Please provide any further comments on this indicator e.g. other areas of activity that contribute to performance

• NHS Lanarkshire was one of the national palliative care pilot sites working with the Institute of Healthcare Improvement. We concentrated the Ceiling of Treatment (CoT) communication tool which records which interventions should be undertaken and which would be futile, burdensome or contrary to the patient’s wishes. Such interventions may be the only reason for remaining in hospital towards the end of life. CoT continues to be rolled out across Lanarkshire;

• In addition to being a member of the national Good Life, Good Death, Good Grief initiative, local education programmes include ‘What Matters to Me’ sessions. These encourage staff to identify patient outcomes / goals, including preferred place of care;

• GP involvement with Anticipatory Care Planning via eKIS (sahred electronic system) has increased awareness of recorded patient wishes that may include hospital admission avoidance.
Palliative care and hospice funding

8. Please provide an estimate of spending on palliative care services (as defined by the Scottish Partnership for Palliative Care, here)

<table>
<thead>
<tr>
<th></th>
<th>Expenditure 2014-15 £’000</th>
<th>Planned expenditure 2015-16 £’000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialist palliative care services</td>
<td>4,011</td>
<td>4,080</td>
</tr>
<tr>
<td>General palliative care services</td>
<td>1,897</td>
<td>1,989</td>
</tr>
</tbody>
</table>

In May 2012, the Scottish Government published new guidance for NHS Boards and independent adult hospices on establishing long-term commissioning arrangements. It stated that funding of agreed specialist palliative and end-of-life care (PELC) should be reached by NHS Boards and independent adult hospices on a 50% calculation of agreed costs. Funding should be agreed for a 3 year period, though this could be longer if appropriate. In addition it indicated intent for NHS Boards and local authorities to jointly meet 25% of the running costs of the independent children’s hospices which provide specialist palliative care and respite services for children with life-limiting conditions.

9. Please provide details of funding agreed by your Board for hospices:

<table>
<thead>
<tr>
<th></th>
<th>2014-15</th>
<th>2015-16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agreed funding for hospice running costs for specialist PELC (£’000)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>£’000</td>
<td>2,778</td>
<td>2,824</td>
</tr>
<tr>
<td>As % of total hospice funding</td>
<td>52.7%</td>
<td>52.7%</td>
</tr>
<tr>
<td>Agreed funding for running costs of independent children’s hospices (including local authority funding where relevant)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>£’000</td>
<td>82</td>
<td>84</td>
</tr>
<tr>
<td>As % of total independent children’s hospice running costs</td>
<td>12.5%</td>
<td>12.5%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>2014-15</th>
<th>2015-16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amounts shown are for the whole of NHS Scotland (Note 1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Agreed funding for running costs of independent children's hospices (including local authority funding where relevant) (Note 4)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>£000s (Note 3)</td>
<td>928</td>
<td>970</td>
</tr>
<tr>
<td>As % of total CHAS charitable activities (Note 2)</td>
<td>9.5%</td>
<td>9.4%</td>
</tr>
</tbody>
</table>

Notes:
1. There is only one independent children’s hospice organisation in Scotland, Children’s Hospice Association Scotland (CHAS). In order to avoid
bureaucracy Health Boards agreed that Tayside Health Board would be the lead funder of CHAS on behalf of NHS Scotland. The figures shown are therefore for the whole of NHS Scotland. CHAS operates two hospice facilities, Rachel House in Kinross and Robin House in Balloch.

2. The requirement for Health Boards is to fund 12.5% of hospice running costs. It is not possible to clearly identify the running costs of the hospices themselves, on which the required funding level of 12.5% is calculated. In order to simplify matters and avoid bureaucracy an agreed funding baseline was established in 2009/10, which has been uplifted each year using Health Board percentage uplifts. CHAS management have been content with this pragmatic approach.

CHAS has provided the total “charitable activities” amount from its accounts as follows:

<table>
<thead>
<tr>
<th></th>
<th>2014-15</th>
<th>2015-16</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHAS total charitable activities</td>
<td>9,739</td>
<td>10,336</td>
</tr>
</tbody>
</table>

CHAS total charitable activities include not only hospice running costs, but also other charitable activities.

3. The analysis of NHS funding paid and payable to CHAS is as follows:

<table>
<thead>
<tr>
<th></th>
<th>2014-15</th>
<th>2015-16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amounts shown are for the whole of NHS Scotland</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Funding from Territorial Boards</td>
<td>672</td>
<td>691</td>
</tr>
<tr>
<td>Funding from Scottish Government (Diana nurse funding)</td>
<td>256</td>
<td>279</td>
</tr>
<tr>
<td>Totals</td>
<td>928</td>
<td>970</td>
</tr>
</tbody>
</table>

4. Health Boards do not have knowledge of the funding provided by Local Authorities.

10. Please provide any further comments on palliative care / hospice funding that you consider to be relevant:

The adult funding above relates specifically to the Lanarkshire based Hospice. Additional funding is made available to other hospices in surrounding Board areas via cross boundary flow payment to the respective Boards, i.e. GG&C and FV.
D: Reduce emergency admissions

Indicator measure: Emergency admissions rate (per 100,000 population)

1. How does performance in your area compare with the national performance?

<table>
<thead>
<tr>
<th>Year</th>
<th>NHS Lanarkshire Health Board</th>
<th>Scotland</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009-10</td>
<td>10,665</td>
<td>9,849</td>
</tr>
<tr>
<td>2010-11</td>
<td>10,551</td>
<td>9,874</td>
</tr>
<tr>
<td>2011-12</td>
<td>11,148</td>
<td>10,090</td>
</tr>
<tr>
<td>2012-13</td>
<td>11,458</td>
<td>10,130</td>
</tr>
<tr>
<td>2013-14 (p)</td>
<td>11,570</td>
<td>10,188</td>
</tr>
</tbody>
</table>

Source: [http://www.scotland.gov.uk/About/Performance/scotPerforms/indicator/admissions](http://www.scotland.gov.uk/About/Performance/scotPerforms/indicator/admissions)

2. What factors can help to explain any observed differences in performance?

It is worth noting that Lanarkshire’s emergency admission rate is above the Scottish average, however, our emergency bed day rate is below the national average.

It is likely that this is linked to deprivation and morbidity. Availability of alternatives to hospital admission is recognised on a key development agenda for the Board and work is ongoing to implement hospital at home and improve the range of social care provision within our communities. We anticipate that the increase in self directed support will contribute to this agenda.

3. How does performance against this indicator influence budget decisions?

The integrated care fund resource is specifically targeted at reducing emergency admissions by providing community based alternatives as outlined in Question 2.

4. Do you consider this to be a useful performance indicator? (If not, what alternatives would you suggest?)

This indicator is valuable as one of a suite of indicators to operationally manage services eg alongside delayed discharge data on to strategically plan services alongside morbidity and mortality trends and resource profiles of community services.
5. What programmes or services are specifically aimed at improving performance against this indicator? Please provide details for the three main areas of activity in the table below.

### North Lanarkshire Partnership

<table>
<thead>
<tr>
<th>Programme/service area</th>
<th>Expenditure 2014-15 £’000</th>
<th>Planned expenditure 2015-16 £’000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Locality Modelling</td>
<td>£1,064,000</td>
<td>£1,850,000</td>
</tr>
<tr>
<td>Falls Prevention</td>
<td>£134,000</td>
<td>£117,000</td>
</tr>
<tr>
<td>SDS/AnCP</td>
<td>£109,000</td>
<td>£109,000</td>
</tr>
<tr>
<td>SDS (joint packages)</td>
<td>£0</td>
<td>£333,000</td>
</tr>
</tbody>
</table>

### South Lanarkshire Partnership

<table>
<thead>
<tr>
<th>Programme/service area</th>
<th>Expenditure 2014-15 £’000</th>
<th>Planned expenditure 2015-16 £’000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Integrated Community Support Model</td>
<td>£ 919,000</td>
<td>£1,417,338</td>
</tr>
<tr>
<td>Increased homecare provision</td>
<td>£2,183,000</td>
<td>£2,546,000</td>
</tr>
<tr>
<td>Voluntary/Third sector</td>
<td>£120,000</td>
<td>£650,000</td>
</tr>
</tbody>
</table>

6. What statutory partners or other partners (if any) contribute towards performance in this area?


7. Please provide any further comments on this indicator e.g. other areas of activity that contribute to performance

No further comments