**ITEM No …4……..**

**REPORT TO:** **PERFORMANCE AND AUDIT COMMITTEE – 12 FEBRUARY 2019**

**REPORT ON:** **MEASURING PERFORMANCE UNDER INTEGRATION 2019/20 SUBMISSION**

**REPORT BY:** **CHIEF FINANCE OFFICER**

**REPORT NO:** **PAC1-2019**

## 1.0 PURPOSE OF REPORT

The purpose of this report is to seek approval of the 2019/20 submission made by the Partnership to the Ministerial Strategic Group for Health and Community Care (MSG) as part of the Measuring Performance under Integration work stream.

## 2.0 RECOMMENDATIONS

It is recommended that the Performance and Audit Committee (PAC):

2.1 Endorses the 2019/20 submission to the MSG (appendix 3).

2.2 Notes the methodology used to develop proposed targets for submission to the Ministerial Strategic Group (sections 4.2.1, appendix 1 and appendix 2).

2.3 Notes that 2019/20 targets will remain in draft until such times as the IJB budget for 2019/20 has been confirmed (section 4.2.2).

## 3.0 FINANCIAL IMPLICATIONS

None.

## 4.0 BACKGROUND

### 4.1 Previous Measuring Performance under Integration Submissions

4.1.1 In mid-January 2017 the Scottish Government and COSLA, on behalf of the MSG, wrote to all Health and Social Care Partnerships to invite them to set out local objectives, trajectories and performance targets for 2017/18 under the following six key service delivery areas:

- Unplanned admissions;
- Occupied bed days for unscheduled care;
- A&E performance;
- Delayed discharges;
- End of Life care: and,
- The balance of spend across institutional and community services.

4.1.2 In February 2017 the Dundee Partnership provided an initial response to the Scottish Government for consideration by the MSG, setting out targets in each service delivery area for 2017/18. At this time the Scottish Government asked that targets be submitted for indicators across all age groups. Article X of the minute of the meeting of the Integration Joint Board held on 28 February 2017 provides detailed information regarding the request and response submitted. The submission from Dundee was identified by MSG as a particularly high quality submission.

4.1.3 In January 2018 a further submission was made to the Scottish Government setting targets in the six service delivery areas for 2018/19. At this time the Scottish Government amended its approach to allow Partnerships to submit targets for indicators for the 18+ age group only if the Partnership has not been delegated responsibility for children's services functions. Article XII of the minute of the meeting of the Integration Joint Board held on 27 February 2018 provides detailed information regarding the request and response submitted.

4.1.4 Since 2017/18 the Scottish Government, via National Services Scotland Information Service Division, has provided a quarterly Measuring Performance under Integration dataset to all Partnerships for each of the indicators within the MSG submission for which data is available. To date information has been provided up to October 2018.

4.1.5 At a local level performance against targets set out in the 2018/19 submission has been reported as part of the regular Quarterly Performance Reports submitted to PAC. Report PAC2-2019 (on this agenda) includes the position in Dundee at end of quarter 2 2018/19. In summary, there has been positive performance against 2018/19 interim targets; three areas have exceeded interim targets for the period (unplanned admissions, occupied bed days for unscheduled care and delayed discharges) and A&E performance partially met the interim target. For two areas (end of life care and the balance of spend) data is not available monthly or quarterly to allow for performance monitoring due to time lags associated with the production and provision of datasets to National Services Scotland, Information Services Division from external sources. Emergency admissions as a rate of A&E attendances have consistently not met the interim target.

**4.2 Measuring Performance under Integration – 2019/20 Request and Submission**

4.2.1 As in previous years the Health and Community Care Operational Management Team have been closely supported by the Strategy and Performance Team to develop targets for each service areas for the 2019/20 submission. The following information was utilised in preparation of the current submission (see appendix 1 and 2):

- 15/16 baseline data;
- 15/16 based projections for 17/18 and 18/19 and 19/20;
- Trajectories / targets previously submitted in the February 2017 and January 2018;
- Actual data from 1 April 18 – 31 October 18 and estimated data from 1 November 18 – 31 March 19 to estimate the 18/19 position; and
- 19/20 trajectories / targets based on the 18/19 estimated position (at city wide and, for some indicators, Local Community Planning Partnership level.)

Where special cause variation, for example improvement work to reduce delayed discharges, caused extraordinary data results, subsequent year targets were adjusted so that the same rate of increase or decrease was not expected in subsequent years. 19/20 targets for delayed discharge were adjusted for these reasons.

Appendix 3 contains the template provided by the Scottish Government. This has been completed and will form the entire Dundee submission.

4.2.2 A submission will be made to the Scottish Government to meet the 28 February 2019 deadline set in communication to Chief Officers (see appendix 4), following consideration at the IJB on 26 February 2019. At this time it will be highlighted that the targets contained within the submission for 2019/20 cannot be confirmed until such times as the 2019/20 IJB budget has been finalised and an assessment made of the adequacy of resources to deliver planned improvement actions factored into the calculation of targets.

4.2.3 Performance against targets (for both 2018/19 and 2019/20) will continue to be reported as part of the quarterly performance reports submitted to PAC.

**5.0 POLICY IMPLICATIONS**

This report has been screened for any policy implications in respect of Equality Impact Assessment. There are no major issues.

## 6.0 RISK ASSESSMENT

| | |
|---|---|
| **Risk 1 Description** | The risk of not meeting targets against Measuring Performance under Integration service areas could affect; outcomes for individuals and their carers, and spend associated with poor performance. |
| **Risk Category** | Financial, Governance, Political |
| **Inherent Risk Level** | Likelihood 3 x Impact 5 = Risk Scoring 15 (Extreme Risk) |
| **Mitigating Actions** (including timescales and resources ) | - Continue to develop a reporting framework which identifies performance against Measuring Performance under Integration targets.<br>- Continue to report data quarterly to the PAC to highlight areas of poor performance.<br>- Continue to support operational managers by providing in depth analysis regarding areas of poor performance, such as complex delayed discharges.<br>- Continue to ensure that data informs operational practices and improvements and also that operational activities and priorities are used to interpret trends shown by the data. |
| **Residual Risk Level** | Likelihood 3 x Impact 3 = Risk Scoring 9 (High Risk) |
| **Planned Risk Level** | Likelihood 2 x Impact 3 = Risk Scoring 6 (Moderate Risk) |
| **Approval recommendation** | Given the moderate level of planned risk, this risk is deemed to be manageable. |

## 7.0 CONSULTATIONS

The Chief Officer and the Clerk were consulted in the preparation of this report.

## 8.0 BACKGROUND PAPERS

None.

Dave Berry
Chief Finance Officer

**DATE**: 4 February 2019

Clare Harper
Principal Information Development Manager

Stephen Halcrow
Principal Information Analyst

Kathryn Sharp
Senior Manager

**Appendix 1**

| | | | 15/16 baseline | 17/18 Projection (15/16 based) | 17/18 Trajectory agreed Feb 17 | 17/18 Actual and Estimated | 18/19 Trajectory agreed Jan 18 | 18/19 Actual and Estimated | 19/20 Proposed Trajectory Jan 19 | %Change (15/16 baseline to 19/20 trajectory) |
|---|---|---|---|---|---|---|---|---|---|---|
| **Unplanned admissions** | | | | | | | | | | |
| 1. | Number of emergency admissions | submitted | 14,125 | 15,168 | 15,153 | 15,122 | 15,464 | 15,225 | 15,225 | 7.8% |
| 2. | Number of emergency admissions from A+E | submitted | 6,483 | 7,345 | 6,797 | 7,616 | 7,616 | 7,440 | 7,440 | 14.8% |
| 3. | A+E conversion rate (%) | to be developed | | | | | | | | |
| **Occupied bed days for unscheduled care** | | | | | | | | | | |
| 4. | Number of emergency bed days | submitted | 120,989 | 115,305 | 114,132 | 111,893 | 108,129 | 102,844 | 96,674 | -20.6% |
| 5. | Number of emergency bed days; geriatric long stay | to be developed | | | | | | | | |
| 6. | Number of emergency bed days; mental health specialities | to be developed | | | | | | | | |
| **A+E Performance** | | | | | | | | | | |
| 7. | Number of A+E attendances | submitted | 23,437 | 23,336 | 22,686 | 26,562 | 26,562 | 24,680 | 24,680 | 5.3% |
| 8. | A+E % seen within 4 hours | to be developed | | | | | | | | |

| | | | 15/16 baseline | 17/18 Projection (15/16 based) | 17/18 Trajectory agreed Feb 17 | 17/18 Actual and Estimated | 18/19 Trajectory agreed Jan 18 | 18/19 Actual and Estimated | 19/20 Trajectory Jan 18 | % Change (15/16 baseline to 19/20 trajectory |
|---|---|---|---|---|---|---|---|---|---|---|
| **Delayed Discharges** | | | | | | | | | | |
| 9. | Number of bed days lost – standard and code 9 | submitted | 15,050 | 14,502 | 14,042 | 12,480 | 11,856 | 7,860 | 6,105 | -59.4% |
| 10. | Number of bed days lost – code 9 | Not submitted | 6,668 | 7,740 | 7,740 | 6,273 | 6,461 | 5,046 | 3,785 | -43.2% |
| 11. | Number of bed days lost – Health and Social Care Reasons | No data provided from ISD | | | | | | | | |
| 12. | Number of bed days lost – Patients/Carer/Family related reasons | No data provided from ISD | | | | | | | 2,320 | |
| **End of Life Care (*based on 16/17 deaths but will change in 17/18 and 18/19 as % proportions are applied to the total number of deaths in each year)** | | | | | | | | | | |
| 13. | % of last 6 months of life in community | submitted | 86.9% | | 88% | | 89% | | +2% | 88.9% |
| 14. | % of last 6 months of life in hospice / palliative care unit | submitted | 1.4% | | 2% | | 3% | | -5.0% | |
| 15. | % of last 6 months of life in community hospital | Not applicable | | | | | | | | |
| 16. | % of last 6 months of life in large hospital | submitted | 11.7% | | 10% | | 8% | | -4.0% | |
| 17. | Number of days of last 6 months of life in community | submitted | 252,351 | | 252,275* | | 255,143* | | n/a as no. of deaths each year varies | |
| 18. | Number of days of last 6 months of life in hospice / palliative care unit | submitted | 3,965 | | 5,733* | | 8,600* | | n/a as no. of deaths each year varies | |
| 19. | Number of days of last 6 months of life in community hospital | not applicable | | | | | | | | |
| 20. | Number of days of last 6 months of life in large hospital | submitted | 34,042 | | 28,668* | | 22,934* | | n/a as no. of deaths each year varies | |

| | | | 15/16 baseline | 17/18 Projection (15/16 based) | 17/18 Trajectory agreed Feb 17 | 17/18 Actual and Estimated | 18/19 Trajectory agreed Jan 18 | 18/19 Actual and Estimated | 19/20 Trajectory Jan 18 | % Change (15/16 baseline to 19/20 trajectory |
|---|---|---|---|---|---|---|---|---|---|---|
| **Balance of Care** | | | | | | | | | | |
| **21.** | **% of population living at home (unsupported) – All ages** | **submitted** | **97.7%** | | **2** | | | | | |
| **22.** | **% of population living at home (supported) – All ages** | **submitted** | **1.3%** | | **1.5%** | | | | | |
| **23.** | **% of population living in a care home – All ages** | **submitted** | **0.7%** | | **0.5%** | | | | | |
| **24.** | **% of population living in hospice / palliative care unit – All ages** | **to be developed** | | | | | | | | |
| **25.** | **% of population living in community hospital – All ages** | **submitted** | **0%** | | **0%** | | | | | |
| **26.** | **% of population living in large hospital – All ages** | **submitted** | **0.4%** | | **0.4%** | | | | | |
| **27.** | **% of population living at home (unsupported) – 75+** | **submitted** | **79.8%** | | **80%** | | | | | |
| **28.** | **% of population living at home (supported) – 75+** | **submitted** | **11.3%** | | **11.6%** | | | | | |
| **29.** | **% of population living in a care home – 75+** | **submitted** | **6.8%** | | **6.7%** | | | | | |
| **30.** | **% of population living in hospice / palliative care unit – 75+** | **to be developed** | | | | | | | | |
| **31.** | **% of population living in community hospital – 75+** | **submitted** | **0%** | | **0%** | | | | | |
| **32.** | **% of population living in large hospital – 75+** | **submitted** | **2%** | | **1.7%** | | | | | |

**Appendix 2**

# Measuring Performance Under Integration

# Charts and Methodologies

# 2019/20

**Introduction**

This report provides key information to assist with the interpretation of the Dundee submission to the Ministerial Strategic Group regarding 'Measuring Performance under Integration'.

Under each of the six high level service delivery areas are charts which illustrate:

- 'Projected Actual' for 2018/19 is a combination of actual data (up to August 2018) taken from ISD's MSG Integration Integrators Report and estimated data (September 2018 to March 2019) taken from ARIMA modelling. (Data points on charts).

- 'Projected Actual' for 2019/20 – this is calculated in January 2019 using an autoregressive integrated moving average (ARIMA) model based on historical data between November 2014 and August 2018[1]. Historical seasonal variation and overall trends are taken into account when modelling projections. Projections for 2019/20 assume that services will continue as they did in 2018/19, including sustaining the same rate of improvement, and that no further changes which either accelerate or decelerate the rate of improvement will be made – this helps the partnership to set their trajectories by estimating what impact changes to services will make on the projections. (Blue data points on charts).

- '2018/19 Trajectory' is the trajectory submitted in January 2018 for 2018/19 which is the projection plus / minus the target applied to each year. This illustrates the improvement or deterioration which was envisaged from 2015/16 onwards. (Red line on charts).

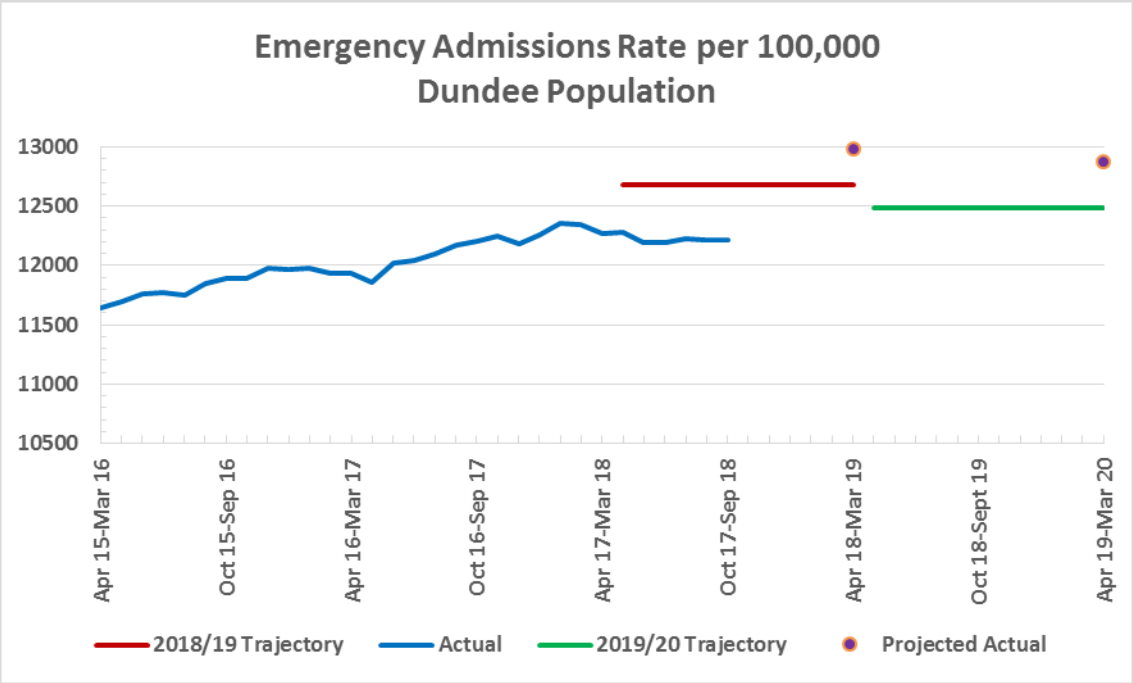
- '2019/20 Trajectory' is the trajectory proposed in January 2019 for 2019/20. Both the 'Projected Actual' for 2018/19 and 2019/20 are used as a baseline to help determine the '2019/20 Trajectory' figure. (Green line on charts).

- 'Actual' shows the actual performance of the Partnership up until September 17 to August 18. (Blue line on charts).

[1] Please note the projections for end of life care are not calculated using the ARIMA model, but instead are based on linear regression using historical annual data. In addition, projections produced through the ARIMA model for delayed discharge have been adjusted to take account of special cause variation associated with steep improvement gradients experienced over the last 3 years.

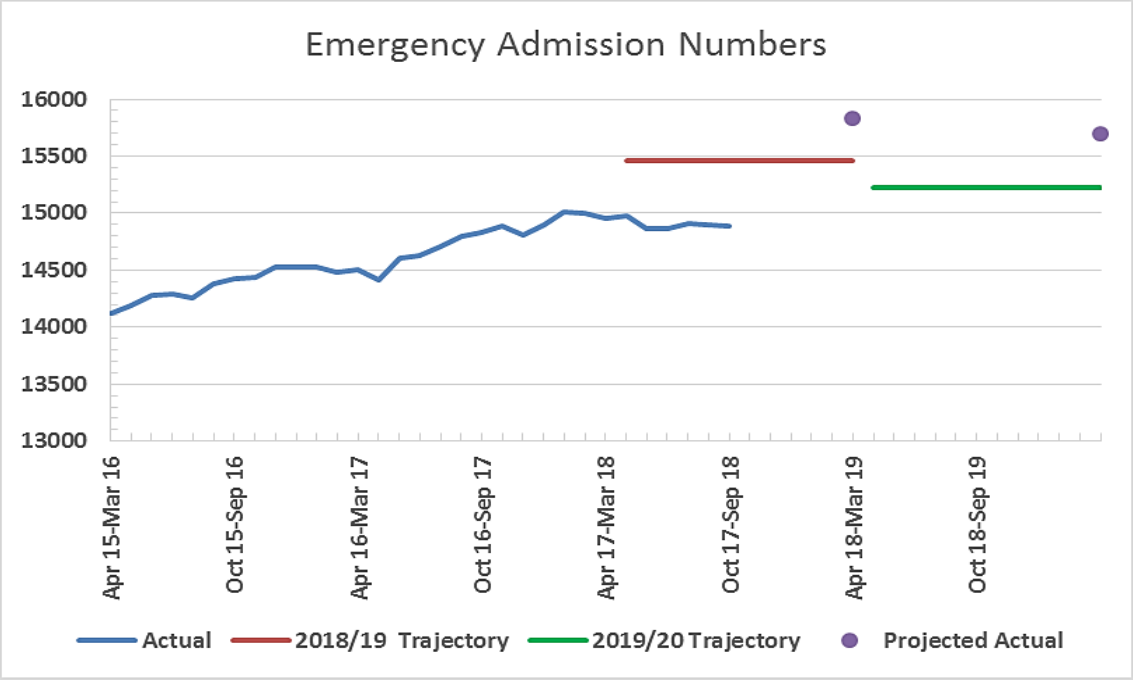
# Emergency Admissions

**Management Information - Chart 1: Emergency Admissions as a Rate per 100,000 Population in Dundee 18+**




Source: ISD LIST management information (not official statistics)

**Management Information - Chart 2: Emergency Admission Numbers 18+**




Source: ISD LIST management information (not official statistics)

**What is the data telling us?**

For Emergency Admission Numbers:

- 18/19 estimated and actual performance (15,225) is better than the projection for 18/19 (15,827) and the 18/19 trajectory (15,464) set in January 18.
- Emergency admission numbers were projected to increase in 18/19 to 15,827 from the actual 2017/18 total (14,950) and the trajectory set in January 18 for 18/19 was for emergency admissions to increase slightly less than the projection (15,464).
- The actual and estimated data for 18/19 shows that Dundee is likely to perform better than predicted and there will be approximately 15,225 emergency admissions. This is a further improvement of 239 emergency admissions compared with the 18/19 trajectory set in January 18.

**The 19/20 target**

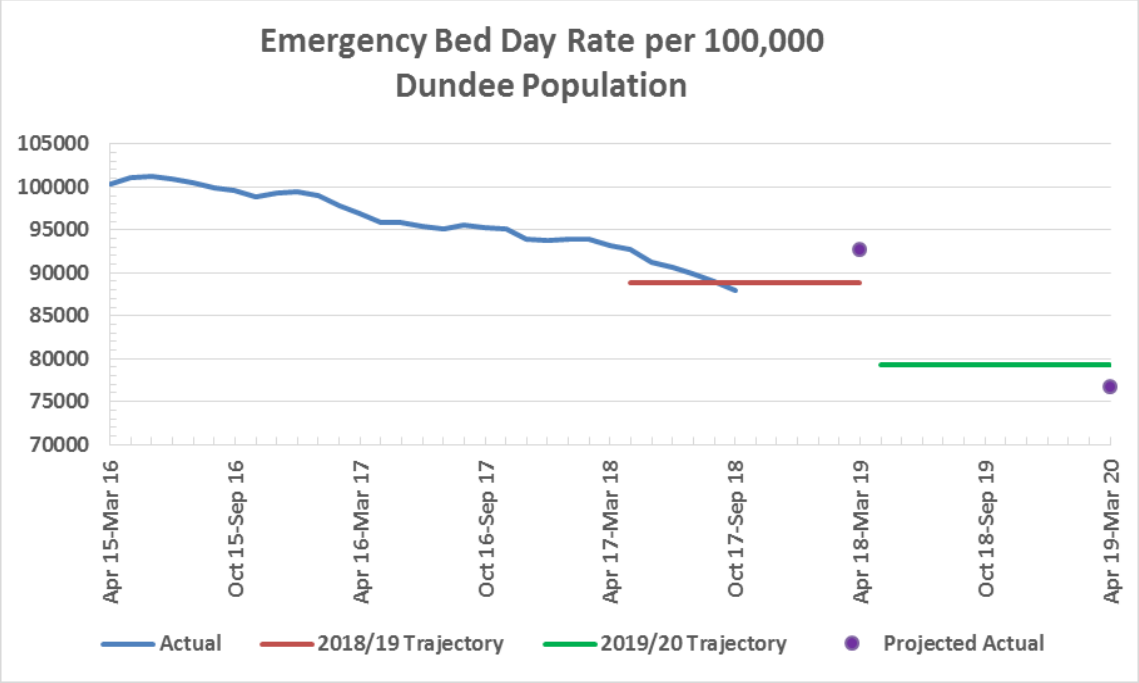
- The 19/20 target number of emergency admissions is 15,225. This is 3.0 % lower than the projected 19/20 number (15,695). This equates to a decrease of 470 in the number of emergency admissions.
- The 19/20 target is to maintain the number of emergency admissions at the 2018/19 actual and estimated figure (15,225).

**How will trajectories agreed in Jan 19 for 19/20 be achieved?**

- Roll out development of Enhanced Community Support, including acute.
- Implement 7 day targeted working (EA5-USC).
- Increased awareness and use of anticipatory care plans for all Adults where a plan would be of benefit.
- Implement an improvement plan relating to re-admission to hospital within 28 days of discharge analysis and improvement plan.
- Implement the Tayside Falls Prevention and Management Framework (2017-20) and refresh DHSCP falls pathway.
- Transformation of work with primary care and the implementation of the new GP contract.
- Development of locality based out- patient clinics.
- Progression of Reshaping Non-acute Care Redesign Programme.
- Implement Home and Hospital Discharge Plan.
- Implement Tayside Unscheduled Care Improvement Plan.
- Implement Tayside Winter Pressures Plan.

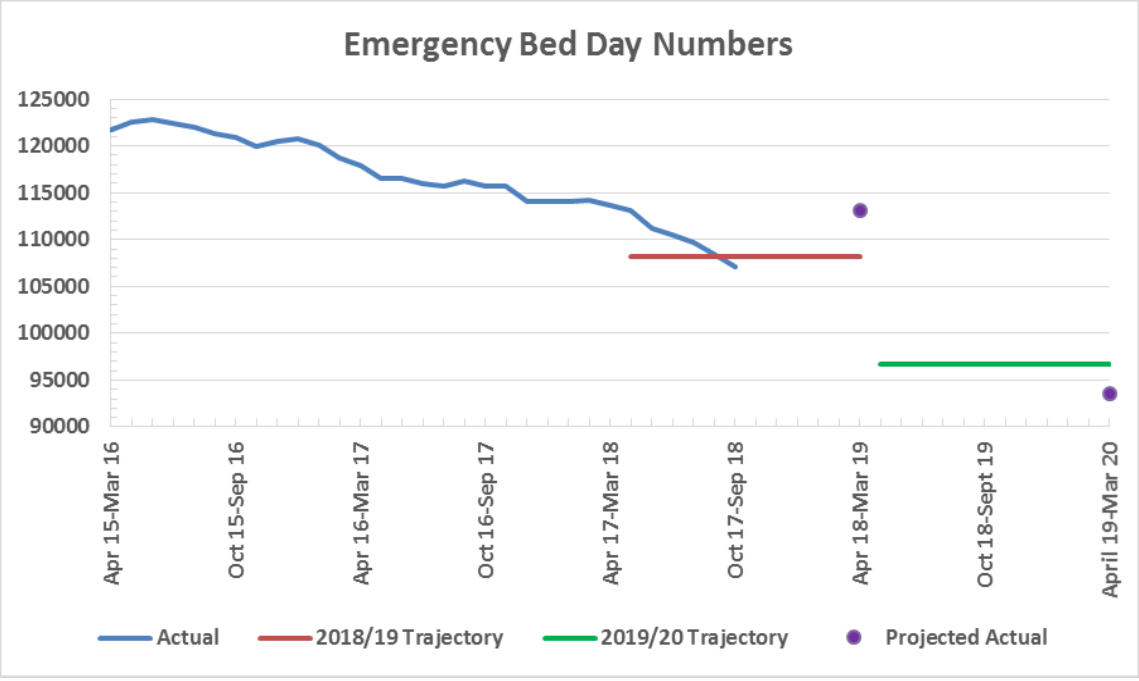
## Emergency Bed Days

**Management Information - Chart 3: Emergency Bed Days in Acute specialties as a Rate per 100,000 Population in Dundee 18+**



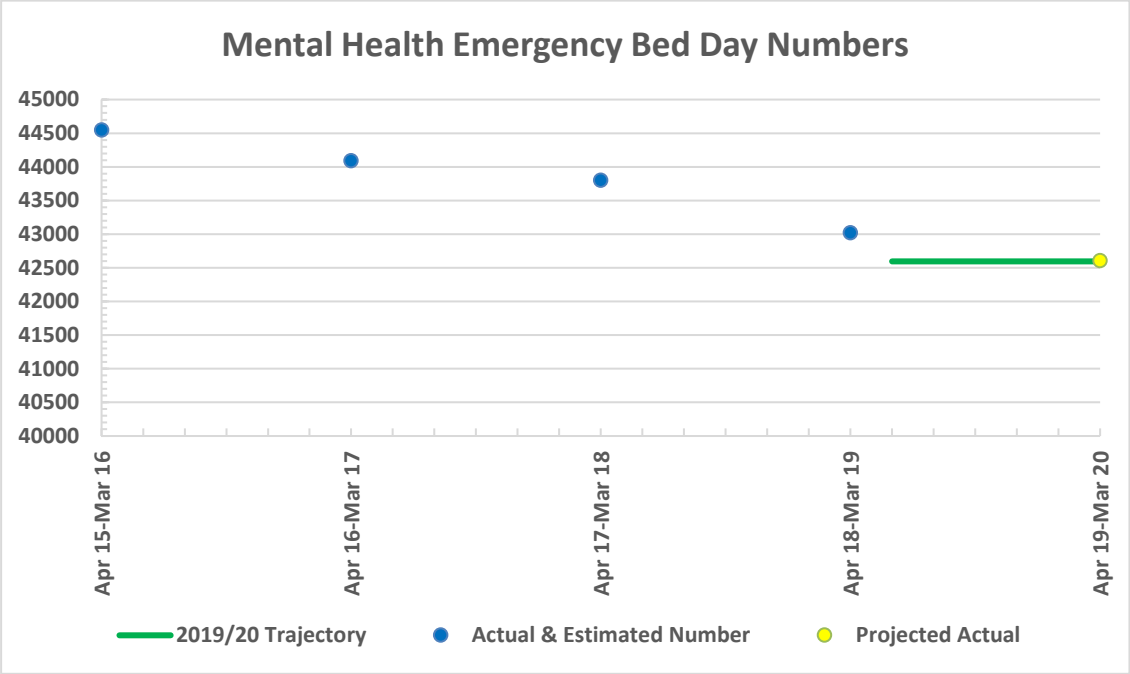

Source: ISD LIST management information (not official statistics)

**Management Information - Chart 4: Emergency Bed Day Numbers in Acute specialties 18+**




Source: ISD LIST management information (not official statistics)

**Management Information - Chart 5: Mental Health Emergency Bed Day Numbers 18+**




Source: ISD LIST management information (not official statistics)

**What is the data telling us?**

For Emergency Bed Day Numbers in Acute specialties:

- 18/19 estimated and actual performance (102,844) is better than the projection for 18/19 (113,085) and the 18/19 trajectory (108,129) set in January 18.
- Emergency bed day numbers were projected to decrease in 18/19 to 113,085 and the trajectory set in January 18 for 18/19 was for emergency bed day numbers to decrease further than the projection (108,129).
- The actual and estimated data for 18/19 shows that Dundee is likely to perform even better and there will be approximately 102,844 emergency bed days. This is a further improvement of 5,285 bed days compared with the 18/19 trajectory set in January 18.

For Mental Health Emergency Bed Day Numbers:

- There was no trajectory set in January 18 for 18/19.
- The actual and estimated number of bed days has been decreasing year on year since 15/16, and is projected to decrease again by 1% during 19/20 to 42,611 from the actual and estimated number for 18/19 (43,025).

**The 19/20 target**

For Emergency Bed Day Numbers in Acute specialties:

- The 19/20 target number of emergency bed days is 96,674 for Acute specialties. This is 3.3% higher than the projected 19/20 number (93,593). This equates to an increase of 3,081 in the number of emergency bed days.
- The 19/20 target is to reduce emergency bed days from the 18/19 actual and estimated number (102,844) by 6 % to 96,674 emergency bed days.

For Mental Health Emergency Bed Day Numbers:

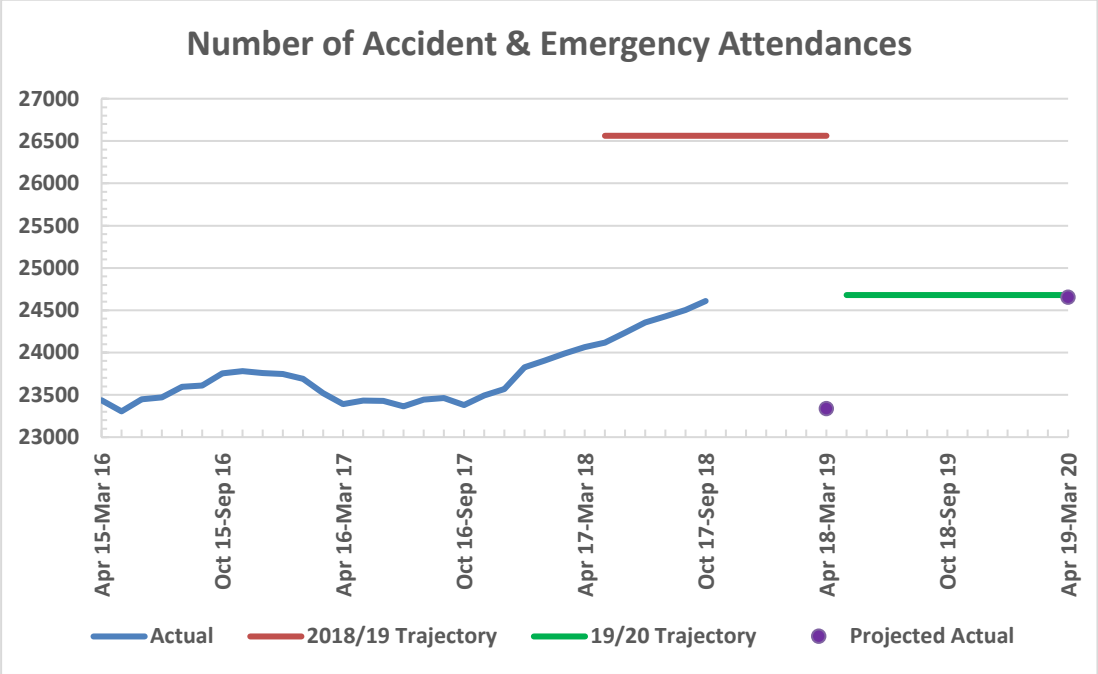
- The 19/20 target number of emergency bed days is 42,595 for Mental Health specialties. This is slightly lower than the projected 19/20 number (42,611).
- The 19/20 target is to reduce emergency bed days from the 18/19 actual and estimated number (43,025) by 1 % to 42,595 emergency bed days.

**How will trajectories agreed in Jan 19 for 19/20 be achieved?**

- Continue to review in patient models in line with community change.
- Further implement planned date of discharge model.
- Further develop discharge planning arrangements for adults with a learning disability and / or autism, mental ill-health, physical disability and acquired brain injury.
- Increase investment in intermediate forms of care.
- Co-locate the Learning Disability Acute Liaison Service within the Hospital Discharge Team base at Ninewells Hospital.
- Further develop resources which support assessment for 24 hour care taking place at home or home like settings.
- Implement a pathway for people with substance misuse problems and who have multiple morbidities.
- Hold Power of Attorney local campaigns.
- Earlier identification of requirement for measures under Adults with Incapacity (Scotland) Act 2016.
- Integrated pathways are being developed across care home teams, ortho-geriatrics and older people psychiatry.
- Remodel AHP services within acute settings to improve pathways.
- Further remodel integrated discharge hubs which will improve joint working arrangements.
- Progression of Reshaping Non-acute Care Redesign Programme.
- Implement Home and Hospital Discharge Plan.
- Implement Tayside Unscheduled Care Improvement Plan.
- Implement Tayside Winter Pressures Plan.

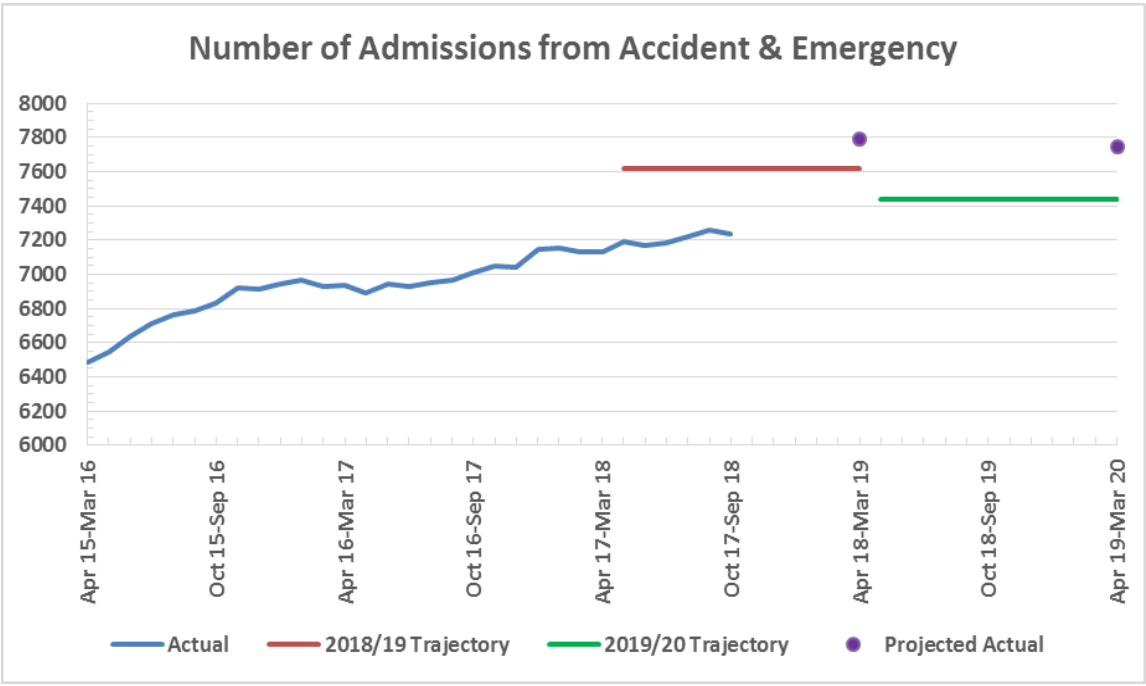
## Accident & Emergency

**Management Information - Chart 6: Number of Attendances at A+E**




Source: ISD LIST management information (not official statistics)

**Management Information - Chart 7: Number of 18+ Admissions from A+E**




Source: ISD LIST management information (not official statistics)

**What is the data telling us?**

For Accident & Emergency Attendances:

- 18/19 estimated and actual performance (24,680) is poorer than the projection for 18/19 (23,336) but better than the 18/19 trajectory (26,562) set in January 18.
- Accident & Emergency attendances were projected to decrease in 18/19 to 23,336 from the actual 2017/18 total (24,063) and the trajectory set in January 18 for 18/19 (26,562) was for A&E attendances to increase more than the projection (23,336).
- Note: the 18/19 projection was for there to be zero change from 17/18 and because the number of A&E attendances in 17/18 was higher than predicted due to the flu epidemics and falls caused by adverse weather, this meant that the 2018/19 trajectory set in January 2018 was set higher than otherwise may have been expected.

For Admissions from A&E:

- 18/19 estimated and actual performance (7,440) is better than the projection for 18/19 (7,792) and would indicate an improvement of 176 admissions on the 18/19 trajectory (7,616) set in January 18.
- Admissions from Accident & Emergency were projected to increase in 18/19 to 7,792 from the actual 2017/18 total (7,131) and the trajectory set in January 18 for 18/19 (7,616) was for A&E admissions to be less than the projection (7,792).

**The 19/20 target**

For Accident & Emergency Attendances:

- The 19/20 target for A&E Attendances is 24,680. This is 0.1% higher than the projected 19/20 number (24,656). This equates to an increase of 24 in the number of A&E attendances.
- The 19/20 target is to maintain the number of A&E attendances at the 2018/19 actual and estimated figure (24,680).

For Admissions from A&E:

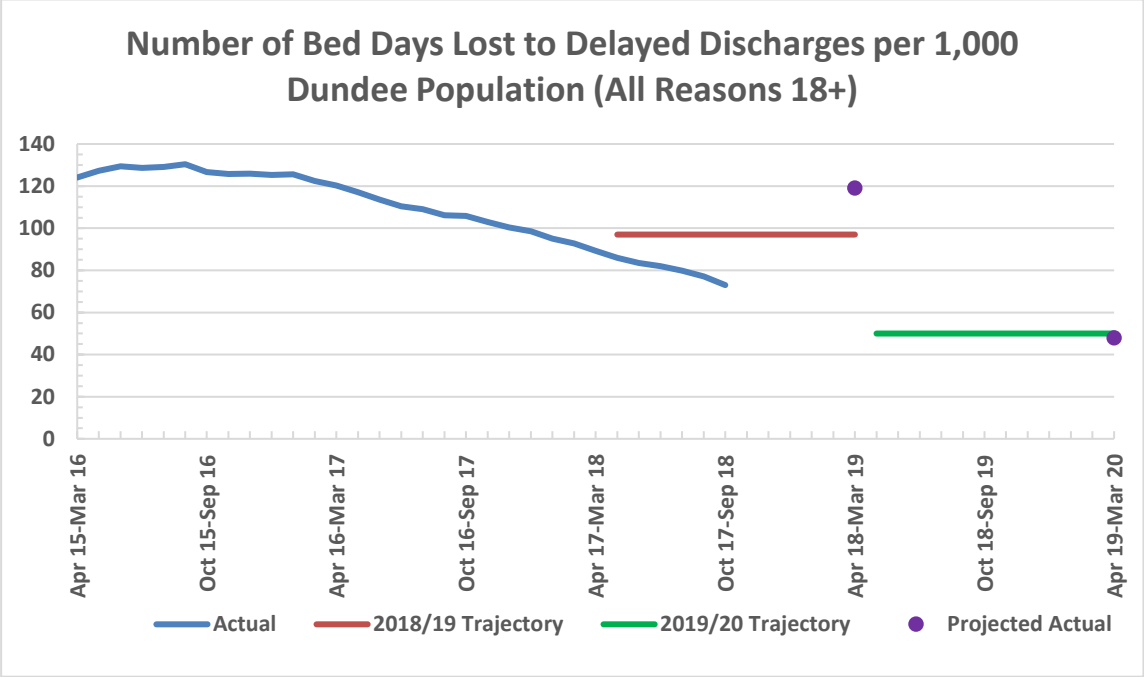
- The 19/20 target for Admissions from A&E is 7,440. This is 3.9% lower than the projected 19/20 number (7,743). This equates to a decrease of 303 in the number of admissions from A&E.
- The 19/20 target is to maintain the number of admissions from A&E at the 2018/19 actual and estimated figure (7,440).

**How will trajectories agreed in Jan 19 for 19/20 be achieved?**

- Further development of Enhanced Community Support, including acute.
- Increased awareness and use of anticipatory care plans for all Adults where a plan would be of benefit.
- Implement an improvement plan relating to re-admission to hospital within 28 days of discharge analysis and improvement plan.
- Implement the Tayside Falls Prevention and Management Framework (2017-20) and refresh DHSCP falls pathway.
- Implement a pathway for people with substance misuse problems and who have multiple morbidities.
- Transformation of work with primary care and the implementation of the new GP contract.
- Remodelling of polypharmacy.
- Further remodel integrated discharge hubs which will improve joint working arrangements.
- Progression of Reshaping Non-acute Care Redesign Programme.

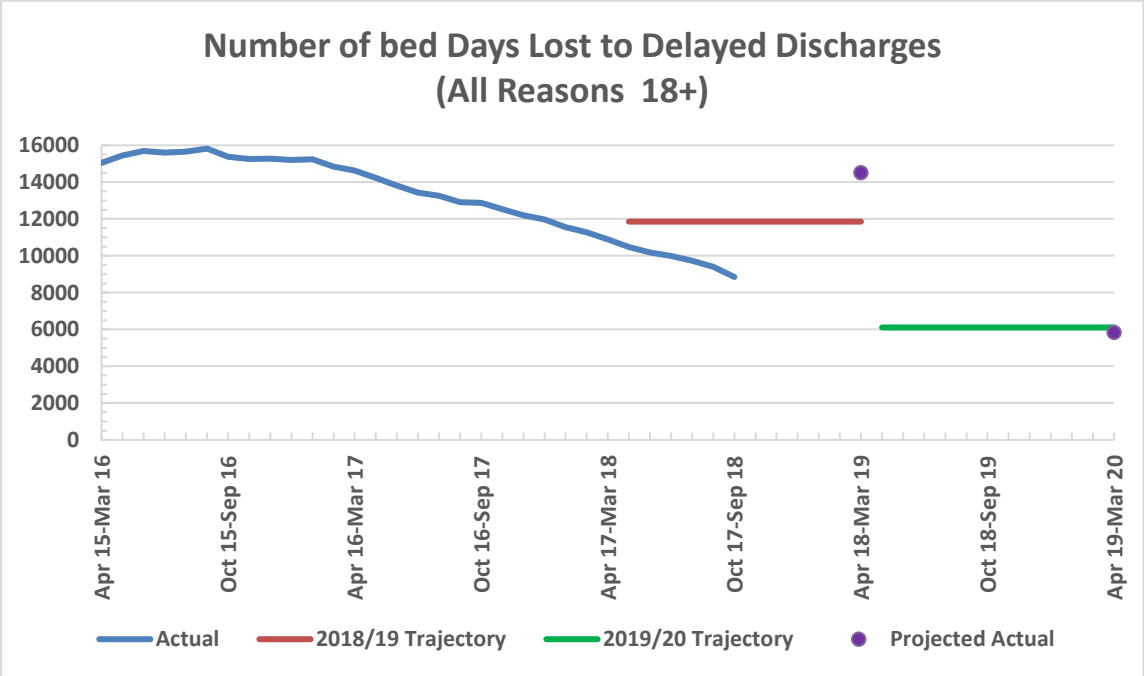
## Delayed Discharges

**Management Information - Chart 8: Bed Days Lost to Delayed Discharge 18+ as a Rate per 1,000 Population in Dundee**




Source: ISD LIST management information (not official statistics)

**Management Information - Chart 9: Number of Bed Days Lost to Delayed Discharges 18+**




Source: ISD LIST management information (not official statistics)

**What is the data telling us?**

For Number of bed Days Lost to Delayed Discharges (All Reasons):

- 18/19 estimated and actual performance (7,960) is better than the projection for 18/19 (14,502) and the 18/19 trajectory (11,856) set in January 18.
- Bed days lost to delayed discharge were projected to decrease in 18/19 to 14,502 and the trajectory set in January 18 for 18/19 was for bed days lost to delayed discharges to decrease further than the projection (11,856).
- The actual and estimated data for 18/19 shows that Dundee is likely to perform even better and there will be approximately 7,960 bed days lost. This is a further improvement of 3,896 bed days compared with the 18/19 trajectory set in January 18.

**The 19/20 target**

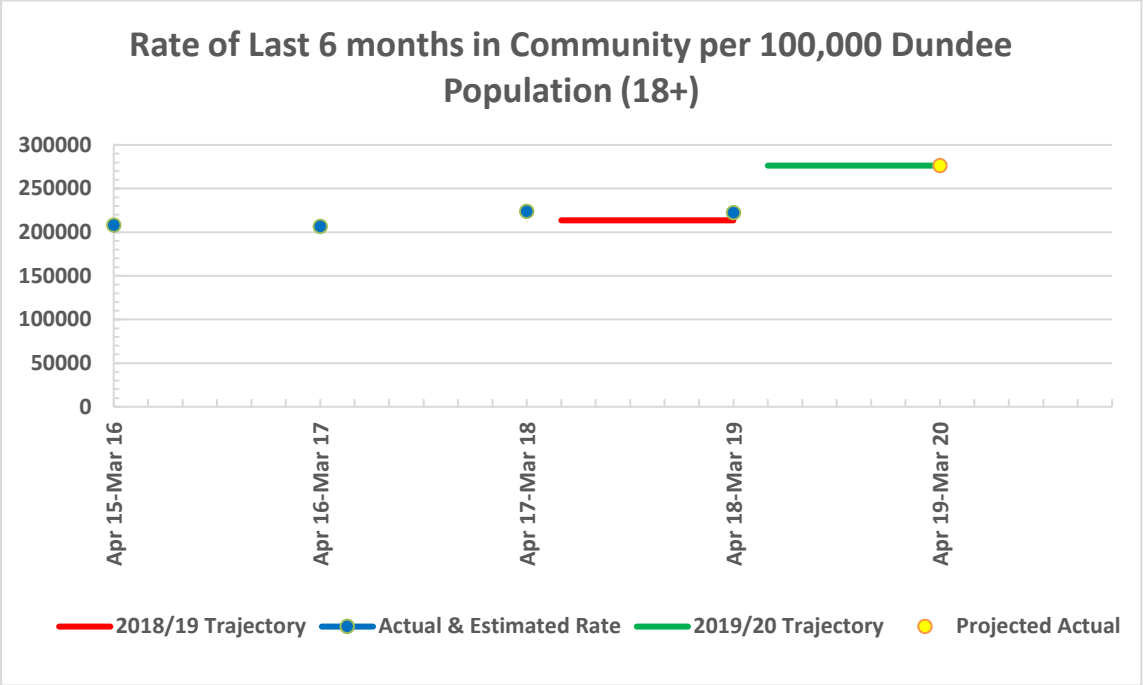
- The 19/20 target number of bed days lost is 6,105. This is 4.7 % higher than the projected 19/20 number (5,832). This equates to an increase of 273 bed days lost due to delayed discharges.
- The 19/20 target is to further reduce bed days lost from the 18/19 actual and estimated (7,960) by 20 % for Standard Delays and 25 % for Code 9 Delays to 6,105 bed days lost.

**How will trajectories agreed in Jan 19 for 19/20 be achieved?**

- Further develop intermediate forms of care.
- Further develop and remodel social care services to increase capacity and provide more flexible responses
- Further development of Community Rehabilitation and enablement.
- Review discharge pathways and corresponding procedures and guidance.
- Develop a statement and pathway for involving carers in discharge planning process.
- Extend the range of third sector supports for adults transitioning from hospital back to the community.
- Extend the step down and assessment model for residential care.
- Hold Power of Attorney local campaigns.
- Earlier identification of requirement for measures under Adults with Incapacity (Scotland) Act 2016.
- Establish an integrated model of support for people with a learning disability and / or autism who also have extremely complex health and care support needs.
- Progression of Reshaping Non-acute Care Redesign Programme.
- Implement Home and Hospital Discharge Plan.
- Implement Tayside Unscheduled Care Improvement Plan
- Implement Tayside Winter Pressures Plan

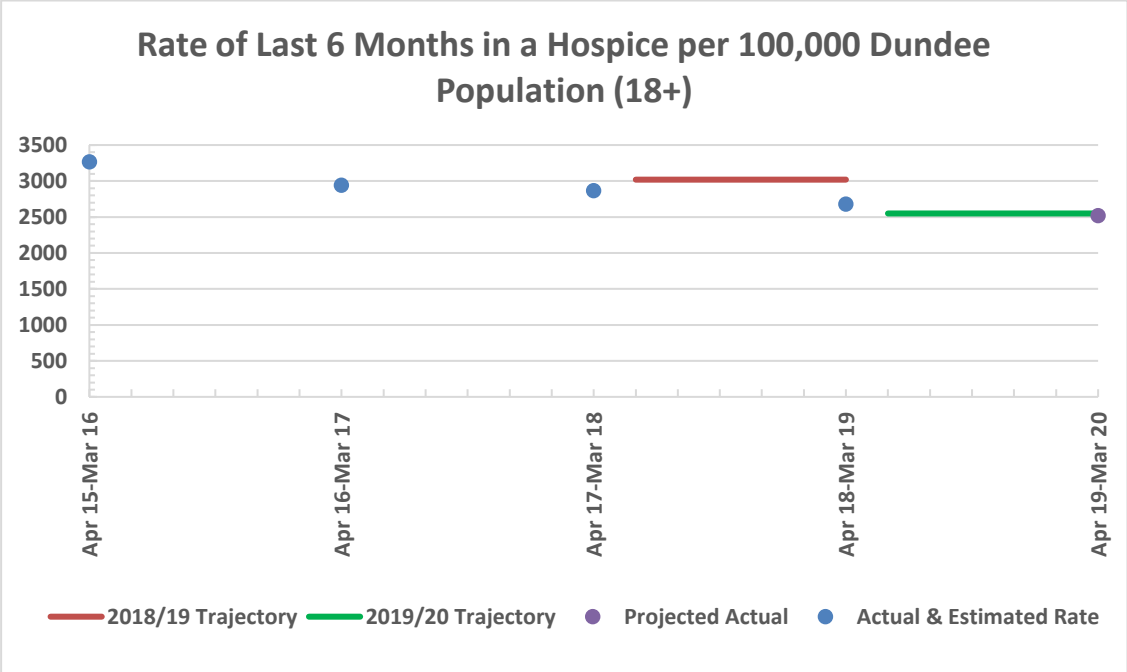
## Last 6 Months of Life

**Management Information - Chart 10: Last 6 months in community**



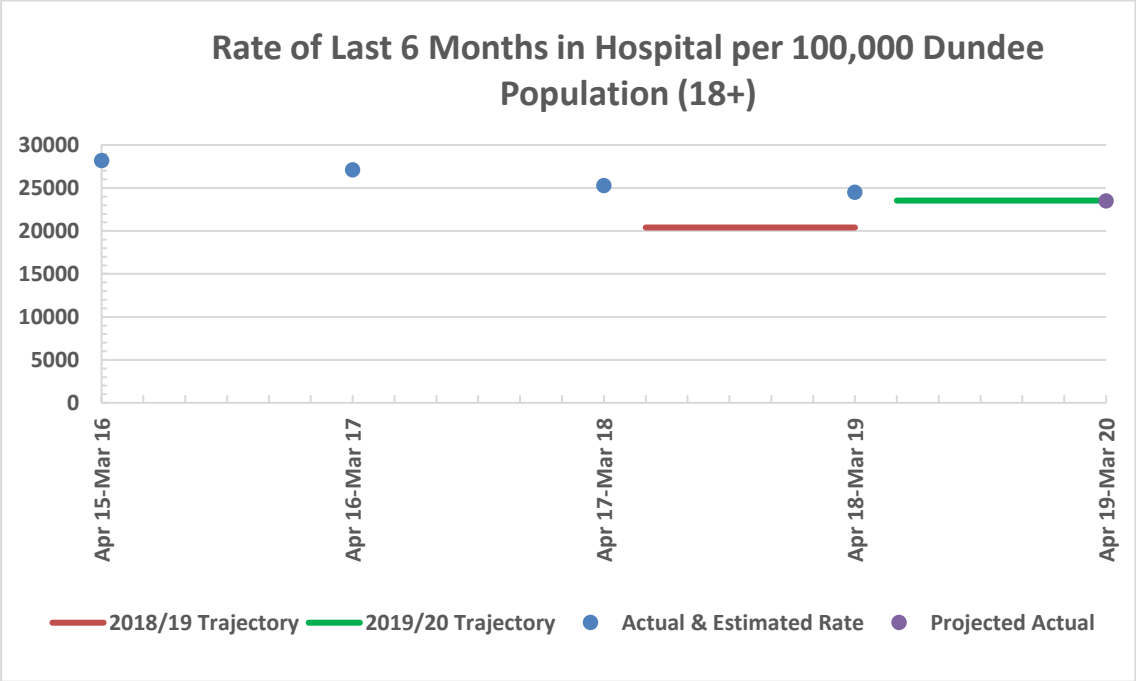

Source: ISD LIST management information (not official statistics)

**Management Information - Chart 11: Last 6 months in hospice**




Source: ISD LIST management information (not official statistics)

**Management Information - Chart 12: Last 6 months in hospital rate per 100,000 18+**




Source: ISD LIST management information (not official statistics)

**What is the data telling us?**

- There has been a year on year decrease since 15/16 in the actual and estimated numbers of people spending the last 6 months of their life in either a hospice or a hospital. The 18/19 actual and estimated number of people spending their last 6 months of life in a hospice (3,270) is well below the 18/19 trajectory (3,680) while the 18/19 actual and estimated number of people spending their last 6 months of life in a hospital (29,894) is above the 18/19 trajectory (24,878).
- Between 16/17 and 17/18 there was an 8.7% increase in the number of people spending the last 6 months of their life in the community, from 250,880 to 272,735. The 18/19 actual and estimated number of people spending their last 6 months of life in the community is 270,897 while the projected number for 19/20 is 276,204 (an increase of 2.0%).

**The 19/20 targets**

For last 6 months spent in the community:

- The 19/20 target number of bed days for last 6 months spent in the community is 276,314, with a rate of 226,660 bed days per 100,000 Dundee population - as shown in chart 10. This is 0.01 % higher than the projected 19/20 rate (226,569). This equates to an increase in the rate of 31 beds spent in the community during the last 6 months of life.
- The 19/20 target is to increase bed days from the 18/19 actual and estimated number (270,897) by 2 % to 276,314 bed days.

For last 6 months spent in a hospice / palliative care unit:

- The 19/20 target number of bed days for last 6 months spent in a hospice is 3,107, with a rate of 2,549 bed days per 100,000 Dundee population - as shown in chart 11. This is 1.2 % higher than the projected 19/20 rate (2519). This equates to an increase in the rate of 30 beds spent in a hospice during the last 6 months of life.
- The 19/20 target is to decrease bed days from the 18/19 actual and estimated number (3,270) by 5 % to 3107 bed days.

For last 6 months spent in a hospital:

- The 19/20 target number of bed days for last 6 months spent in a hospital is 28,698, with a rate of 23,541 bed days per 100,000 Dundee population - as shown in chart 12. This is 0.2% higher than the projected 19/20 rate (23,507). This equates to an increase in the rate of 34 beds spent in a hospital during the last 6 months of life.
- The 19/20 target is to decrease bed days from the 18/19 actual and estimated number (29,894) by 4 % to 28,698 bed days.

When interpreting this data it became apparent that the % change is determined by the total number of deaths in a year and if the number of deaths is less than the baseline year then targets may not be met. Common sense tells us that reduced numbers of deaths cannot be regarded as negative.

**How will trajectories agreed in Jan 19 for 19/20 be achieved?**

- PEOLC test site for dementia.
- Expand the use of Palliative Care Tool Bundle and Response Standards in use across community based health and social care services.
- Fully implement the Macmillan Improving the Cancer Project.
- PEOLC Managed Clinical Network in place, to focus on non-specialist palliative care.
- Increased availability of Key Information Summaries and ACPs.
- Develop a community Palliative Care Strategy to further progress support for people dying at home.
- Progression of Reshaping Non-acute Care Redesign Programme.

## Balance of Care

Data to measure performance against the 18/19 targets is not currently available from NSS ISD therefore it is not currently possible to measure performance. The 2017/18 figures used to set the targets are provisional.

**The 19/20 targets**

For Care Homes:

- All Ages: 0.7% of the population living in care homes. (0.5% target set in January 18)
- Aged 75+ : 7.1% of the population living in care homes. (6.7% target set in January 18)

For Large Hospitals:

- All Ages: 0.3% of the population in large hospital. (0.4% target set in January 18)
- Aged 75+ : 1.8% of the population living in large hospital. (1.7% target set in January 18)

For Supported At Home:

- All Ages: 1.5% of the population supported at home.
- Aged 75+ : 11.6% of the population supported at home

For Unsupported At Home:

- All Ages: 97.6% of the population unsupported at home.
- Aged 75+ : 80% of the population unsupported at home.

**How will trajectories agreed in Jan 19 for 19/20 be achieved?**

- Further develop Enhanced Community Support, including acute.
- Develop a model of support for carers in line with the Carers Act.
- Continue to review in patient models in line with community change.
- Further develop models that support adults within their own homes.
- Further develop and remodel social care services to increase capacity and provide more flexible responses.
- Continue to develop step down to assess model.
- Increase the range of accommodation with support for people with complex needs.
- Further develop social prescribing model for Dundee and improve self-care.
- Further develop accommodation with support models in the community for adults.
- Further remodel the stroke pathway.
- Further develop short breaks and respite opportunities.
- Progression of Reshaping Non-acute Care Redesign Programme.

## General

1. All Partnerships are invited to provide objectives for the six MSG indicators for 2019/20. A separate tab has been created for any Partnerships who wish to provide updated 2018/19 objectives athough this is **optional.**
2. If Partnerships wish to return narrative/commentary in relation to actual data versus 2018/19 objectives for their area then this can be recorded in the **Notes** section of the 2018/19 objectives tab. This can be done regardless of whether 2018/19 objectives have been updated.
3. Objectives should relate to the data provided in the monthly spreadsheets and not locally sourced information. **Please note that although the latest spreadsheet will show the most recent data available, it is likely that indicator 2 in particular will be affected by completeness issues and also by patients who are yet to be discharged. The impact of this will vary depending on the area in question and so it is important to assess this locally before deciding which time period objectives can be reliably based upon.**
4. To help complete this template, annual figures from 2014/15 to 2017/18 can be founds in the "Annual Data" tab. This is based on the spreadsheet *Integration-performance-indicators-v1.12* . Please note that completeness issues may still exist for unplanned bed days in 2017/18; see the Completeness tab for more information.
5. As a minimum Partnerships should provide objectives for the age groups delegated to them under integration but can submit for other age groups if they wish. Consequently, for indicators 1 to 3:
   - All Partnerships should provide objectives for 18+ but those responsible for all ages should also submit for <18.
   - For 18+, more detailed age groups can be used if preferred as long as overall 18+ figures can be derived e.g. objectives for 18-64 and 65+.
6. All Partnerships should provide:
   - 18+ only for indicator 4.
   - All ages for indicator 5.
   - 65+ only for indicator 6.
7. Hovering over certain cells in the template will display help text with information about what should be entered. More detailed notes can be found below.

## Objective

1. Each objective requires four pieces of information per indicator:
   - *Baseline year* : the year against which your objective is measured.
   - *Baseline total* : the total annual figure/percentage within the baseline year.
   - *% change/percentage point change* : this is the change expected in 2019/20 compared to the baseline and could be an increase, decrease or the same as the baseline.
   - *Expected 2019/20 total* : the total actual number or percentage expected within this financial year.
2. To clarify, the expected 2019/20 total should be based on the expected percentage change compared to the overall baseline year figure i.e. the percentage should not relate to month on month reductions, whereby a different number could be obtained.
3. For indicator 2, an objective is required from all Partnerships for acute specialties. Separate objectives for Geriatric Long Stay and Mental Health specialties should also be provided by Partnerships where this is relevant.
4. For indicator 4, the row relating to "all reasons" should be completed. The breakdowns for the more specific reasons are **optional.**
5. Details reagrding how each indicator is defined can be found within the footnotes of the monthly spreadsheet *Integration-performance-indicators-v1.11* . In particular, when considering objectives for indicators 5 and 6 please note:
   - How "community" is defined for indicator 5.
   - How "supported at home" and "unsupported at home" are defined for indicator 6.

   More detailed location breakdowns for indicators 5 and 6 are available in the spreadsheet *Integration-performance-indicators-v1.11* . If preferred, Patnerships are welcome to provide information by each of these location types.
6. The way in which indicators 5 and 6 are derived will only provide estimates. These indicators will be more robust in the future due to the Source social care data collection and the availability of more complete information regarding care home and care at home activity.

## How will it be achieved

1. A brief summary should be provided explaning how each objective will be achieved and may include specific programmes of work which are planned or have already been implemented. Hyperlinks to specific policies can be included.
2. Each Partnership is welcome to submit more detailed information separate to the template if they wish.

## Notes

1. Covers any information or background notes which are important to highlight in relation to the objectives provided.
2. May offer some form of context to the objectives or to help explain some of the nuances around local data collection. For example, issues around data completeness or what is/isn't included within bed days figures.
3. Any other local context which may be important to note. More detail can be provided separately to the template if preferred.

## MSG Indicators - Annual Data Summary

The data within these tables are taken from the monthly spreadsheet ***Integration-performance-indicators-v1.12***. For details explaining how each of these indicators have been derived, please see either the footnotes within that spreadsheet or the technical document named ***MSG indicators - technical document***.

Select Partnership: Dundee City

### 1. Number of emergency admissions

Partnership: Dundee City

| Age Group | 2014/15 | 2015/16 | 2016/17 | 2017/18 |
|---|---|---|---|---|
| Under 18 | 2,564 | 2,664 | 2,833 | 2,964 |
| 18+ | 14,015 | 14,127 | 14,506 | 14,950 |

### 2a. Number of unscheduled hospital bed days; acute specialties

Partnership: Dundee City

| Age Group | 2014/15 | 2015/16 | 2016/17 | 2017/18 |
|---|---|---|---|---|
| Under 18 | 3,286 | 3,255 | 3,680 | 3,517 |
| 18+ | 119,182 | 121,683 | 117,848 | 113,587 |

### 2b. Number of unscheduled hospital bed days; geriatric long stay specialties

Partnership: Dundee City

| Age Group | 2014/15 | 2015/16 | 2016/17 | 2017/18 |
|---|---|---|---|---|
| 18+ | 10,143 | 9,787 | 8,689 | 1,159 |

### 2c. Number of unscheduled hospital bed days; mental health specialties

Partnership: Dundee City

| Age Group | 2014/15 | 2015/16 | 2016/17 | 2017/18 |
|---|---|---|---|---|
| Under 18 | 1,003 | 727 | 312 | 1,004 |
| 18+ | 41,467 | 44,552 | 44,092 | 43,657 |

### 3. Number of A&E attendances

Partnership: Dundee City

| Age Group | 2014/15 | 2015/16 | 2016/17 | 2017/18 |
|---|---|---|---|---|
| Under 18 | 6,369 | 6,225 | 6,564 | 6,416 |
| 18+ | 23,423 | 23,437 | 23,389 | 24,063 |

### 4. Delayed discharge bed days

Partnership: Dundee City

| Age Group | 2014/15 | 2015/16 | 2016/17 | 2017/18 |
|---|---|---|---|---|
| 18+ | 12,239 | 15,050 | 14,627 | 10,893 |

### 5. Percentage of last six months of life spent in the community

Partnership: Dundee City

| Age Group | 2014/15 | 2015/16 | 2016/17 | 2017/18[p] |
|---|---|---|---|---|
| All Ages | 86.7% | 86.9% | 87.3% | 88.8% |

### 6. Percentage of 65+ population living at home (supported or unsupported)

Partnership: Dundee City
Setting: Home unsupported & supported

| Age Group | 2014/15 | 2015/16 | 2016/17 | 2017/18[p] |
|---|---|---|---|---|
| 65+ | 95.0% | 95.0% | 94.9% | 95.0% |

## Template for MSG 2019/20 objectives

**Health and Social Care Partnership:** Dundee City

**Age Group for indicators 1 to 3:** 18+

| | 1. Emergency admissions | | | | 2. Unplanned bed days | | | | | 3. A&E attendances | | | | 4. Delayed discharge bed days (18+) | | | | | 5. Percentage of last 6 months of life spent in community (all ages) | | | | 6. Proportion of 65+ population living at home (supported and unsupported) | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Objective** | *Baseline year* | *Baseline total* | *% change* | *Expected 2019/20 total* | Acute | *Baseline year* | *Baseline total* | *% change* | *Expected 2019/20 total* | *Baseline year* | *Baseline total* | *% change* | *Expected 2019/20 total* | All reasons | *Baseline year* | *Baseline total* | *% change* | *Expected 2019/20 total* | *Baseline year* | *Baseline percentage* | *Percentage point change* | *Expected 2019/20 %* | *Baseline year* | *Baseline percentage* | *Percentage point change* | *Expected 2019/20 %* |
| | 2015/16 | 14,127 | 7.8 | 15,225 | | 2015/16 | 121,683 | -20.6 | 96,674 | 2015/16 | 23,437 | 5.3 | 24,680 | | 2015/16 | 15,050 | -59.4 | 6,105 | 2015/16 | 86.9% | 2 | 88.9% | 2015/16 | 1.3% | | |
| | | | | | Geriatric Long Stay | *Baseline year* | *Baseline total* | *% change* | *Expected 2019/20 total* | | | | | H&SC/patient and family related reasons | *Baseline year* | *Baseline total* | *% change* | *Expected 2019/20 total* | | | | | | | | |
| | | | | | | | | | | | | | | | 2015/16 | | | 2,320 | | | | | | | | |
| | | | | | Mental Health | *Baseline year* | *Baseline total* | *% change* | *Expected 2019/20 total* | | | | | Code 9 | *Baseline year* | *Baseline total* | *% change* | *Expected 2019/20 total* | | | | | | | | |
| | | | | | | 2015/16 | 44,552 | -4.4 | 42,595 | | | | | | 2015/16 | 6,668 | -43.2 | 3,785 | | | | | | | | |
| **How will it be achieved** | • Roll out development of Enhanced Community Support, including acute. • Implement 7 day targeted working (EA5-USC).<br>• Increased awareness and use of anticipatory care plans for all Adults where a plan would be of benefit.<br>• Implement an improvement plan relating to re-admission to hospital within 28 days of discharge analysis and improvement plan.<br>• Implement the Tayside Falls Prevention and Management Framework (2017-20) and refresh DHSCP falls pathway.<br>• Transformation of work with primary care and the implementation of the new GP contract.<br>• Development of locality based out- patient clinics.<br>• Progression of Reshaping Non-acute Care Redesign Programme.<br>• Implement Home and Hospital Discharge Plan.<br>• Implement Tayside Unscheduled Care Improvement Plan.<br>• Implement Tayside Winter Pressures Plan. | | | | • Continue to review in patient models in line with community change.<br>• Further implement planned date of discharge model.<br>• Further develop discharge planning arrangements for adults with a learning disability and / or autism, mental ill-health, physical disability and acquired brain injury.<br>• Increase investment in intermediate forms of care.<br>• Co-locate the Learning Disability Acute Liaison Service within the Hospital Discharge Team base at Ninewells Hospital.<br>• Further develop resources which support assessment for 24 hour care taking place at home or home like settings.<br>• Implement a pathway for people with substance misuse problems and who have multiple morbidities.<br>• Hold Power of Attorney local campaigns.<br>• Earlier identification of requirement for measures under Adults with Incapacity (Scotland) Act 2016.<br>• Integrated pathways are being developed across care home teams, ortho geriatrics and older people psychiatry.<br>• Remodel AHP services within acute settings to improve pathways.<br>• Further remodel integrated discharge hubs which will improve joint working arrangements.<br>• Progression of Reshaping Non-acute Care Redesign Programme.<br>• Implement Home and Hospital Discharge Plan.<br>• Implement Tayside Unscheduled Care Improvement Plan.<br>• Implement Tayside Winter Pressures Plan. | | | | • Further development of Enhanced Community Support, including acute.<br>• Increased awareness and use of anticipatory care plans for all Adults where a plan would be of benefit.<br>• Implement an improvement plan relating to re-admission to hospital within 28 days of discharge analysis and improvement plan.<br>• Implement the Tayside Falls Prevention and Management Framework (2017-20) and refresh DHSCP falls pathway.<br>• Implement a pathway for people with substance misuse problems and who have multiple morbidities.<br>• Transformation of work with primary care and the implementation of the new GP contract.<br>• Remodelling of polypharmacy.<br>• Further remodel integrated discharge hubs which will improve joint working arrangements.<br>• Progression of Reshaping Non-acute Care Redesign Programme. | | | | • Further develop intermediate forms of care.<br>• Further develop and remodel social care services to increase capacity and provide more flexible responses.<br>• Further development of Community Rehabilitation and enablement.<br>• Review discharge pathways and corresponding procedures and guidance.<br>• Develop a statement and pathway for involving carers in discharge planning process.<br>• Extend the range of third sector supports for adults transitioning from hospital back to the community.<br>• Extend the step down and assessment model for residential care.<br>• Hold Power of Attorney local campaigns.<br>• Earlier identification of requirement for measures under Adults with Incapacity (Scotland) Act 2016.<br>• Establish an integrated model of support for people with a learning disability and / or autism who also have extremely complex health and care support needs.<br>• Progression of Reshaping Non-acute Care Redesign Programme.<br>• Implement Home and Hospital Discharge Plan.<br>• Implement Tayside Unscheduled Care Improvement Plan.<br>• Implement Tayside Winter Pressures Plan. | | | | • PEOLC test site for dementia.<br>• Expand the use of Palliative Care Tool Bundle and Response Standards in use across community based health and social care services.<br>• Fully implement the Macmillan Improving the Cancer Project.<br>• PEOLC Managed Clinical Network in place, to focus on non-specialist palliative care.<br>• Increased availability of Key Information Summaries and ACPs.<br>• Develop a community Palliative Care Strategy to further progress support for people dying at home.<br>• Progression of Reshaping Non-acute Care Redesign Programme. | | | | • Further develop Enhanced Community Support, including acute.<br>• Develop a model of support for carers in line with the Carers Act.<br>• Continue to review in patient models in line with community change.<br>• Further develop models that support adults within their own homes.<br>• Further develop and remodel social care services to increase capacity and provide more flexible responses.<br>• Continue to develop step down to assess model.<br>• Increase the range of accommodation with support for people with complex needs.<br>• Further develop social prescribing model for Dundee and improve self-care.<br>• Further develop accommodation with support models in the community for adults.<br>• Further remodel the stroke pathway.<br>• Further develop short breaks and respite opportunities.<br>• Progression of Reshaping Non-acute Care Redesign Programme. | | | |
| **Notes** | | | | | | | | | | | | | | | | | | | | | | | | | | |

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**Health and Social Care Partnership:** Dundee City

**Age Group for indicators 1 to 3:** < 18

| | 1. Emergency admissions | | | | 2. Unplanned bed days | | | | | 3. A&E attendances | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Objective** | *Baseline year* | *Baseline total* | *% change* | *Expected 2019/20 total* | Acute | *Baseline year* | *Baseline total* | *% change* | *Expected 2019/20 total* | *Baseline year* | *Baseline total* | *% change* | *Expected 2019/20 total* |
| | | | | | | | | | | | | | |
| | | | | | Menal Health | *Baseline year* | *Baseline total* | *% change* | *Expected 2019/20 total* | | | | |
| | | | | | | | | | | | | | |
| **How will it be achieved** | | | | | | | | | | | | | |
| **Notes** | | | | | | | | | | | | | |

## Template for MSG 2018/19 objectives

**Health and Social Care Partnership:** Dundee City

**Age Group for indicators 1 to 3:** 18+

| | 1. Emergency admissions | | | | 2. Unplanned bed days | | | | | 3. A&E attendances | | | | 4. Delayed discharge bed days (18+) | | | | | 5. Percentage of last 6 months of life spent in community (all ages) | | | | 6. Proportion of 65+ population living at home (supported and unsupported) | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Objective** | *Baseline year* | *Baseline total* | *% change* | *Expected 2018/19 total* | Acute | *Baseline year* | *Baseline total* | *% change* | *Expected 2018/19 total* | *Baseline year* | *Baseline total* | *% change* | *Expected 2018/19 total* | All reasons | *Baseline year* | *Baseline total* | *% change* | *Expected 2018/19 total* | *Baseline year* | *Baseline percentage* | *Percentage point change* | *Expected 2018/19 %* | *Baseline year* | *Baseline percentage* | *Percentage point change* | *Expected 2018/19 %* |
| | 2015/16 | 14,125 | 9.5 | 15,464 | | 2015/16 | 120,989 | -10.6 | 108,129 | 2015/16 | 23,437 | 13.3 | 26,562 | | 2015/16 | 15,050 | -21.2 | 11,856 | 2015/16 | 86.9% | 2.1 | 89.0% | 2015/16 | 1.3% | | |
| | | | | | Geriatric Long Stay | *Baseline year* | *Baseline total* | *% change* | *Expected 2018/19 total* | | | | | H&SC/patient and family related reasons | *Baseline year* | *Baseline total* | *% change* | *Expected 2018/19 total* | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | Mental Health | *Baseline year* | *Baseline total* | *% change* | *Expected 2018/19 total* | | | | | Code 9 | *Baseline year* | *Baseline total* | *% change* | *Expected 2018/19 total* | | | | | | | | |
| | | | | | | | | | | | | | | | 2015/16 | 6,668 | -3.1 | 6,461 | | | | | | | | |
| **How will it be achieved** | • Further development of Enhanced Community Support, including acute.<br>• Implement 7 day targeted working (EA5-USC)<br>• Increased awareness and use of anticipatory care plans for all Adults where a plan would be of benefit.<br>• Implement an improvement plan relating to re-admission to hospital within 28 days of discharge analysis and improvement plan.<br>• Implement the Tayside Falls Prevention and Management Framework (2017-20) and refresh DHSCP falls pathway.<br>• Transformation of work with primary care and the implementation of the new GP contract.<br>• Development of locality based out- patient clinics.<br>• Development of integrated care homes. | | | | • Continue to review in patient models in line with community change.<br>• Further implement planned date of discharge model.<br>• Further develop discharge planning arrangements for adults with a learning disability and / or autism, mental ill-health, physical disability and acquired brain injury.<br>• Increase investment in intermediate forms of care.<br>• Co-locate the Learning Disability Acute Liaison Service within the Hospital Discharge Team base at Ninewells Hospital<br>• Increase investment in resources which support assessment for 24 hour care taking place at home or home like settings.<br>• Implement a pathway for people with substance misuse problems and who have multiple morbidities.<br>• Hold Power of Attorney local campaigns.<br>• Earlier identification of requirement for measures under Adults with Incapacity (Scotland) Act 2016.<br>• Integrated pathways are being developed across care home teams, ortho geriatrics and older people psychiatry.<br>• Remodel AHP services within acute settings to improve pathways.<br>• Further remodel integrated discharge hubs which will improve joint working arrangements. | | | | | • Further development of Enhanced Community Support, including acute<br>• Implement 7 day targeted working (EA5-USC)<br>• Increased awareness and use of anticipatory care plans for all Adults where a plan would be of benefit.<br>• Implement an improvement plan relating to re-admission to hospital within 28 days of discharge analysis and improvement plan.<br>• Implement the Tayside Falls Prevention and Management Framework (2017-20) and refresh DHSCP falls pathway.<br>• Implement a pathway for people with substance misuse problems and who have multiple morbidities.<br>• Transformation of work with primary care and the implementation of the new GP contract.<br>• Remodelling of polypharmacy.<br>• Further remodel integrated discharge hubs which will improve joint working arrangements. | | | | | • Increased investment in intermediate forms of care.<br>• Remodel care at home services and provide more flexible responses.<br>• Further invest in social care infrastructure, including consolidating current tests of change through third sector partnerships.<br>• Further development of Community Rehabilitation.<br>• Review discharge management procedures and guidance.<br>• Develop a statement and pathway for involving carers in discharge planning process.<br>• Extend the range of third sector supports for adults transitioning from hospital back to the community.<br>• Develop a step down and assessment model for residential care.<br>• Hold Power of Attorney local campaigns.<br>• Earlier identification of requirement for measures under Adults with Incapacity (Scotland) Act 2016.<br>• Establish an integrated model of support for people with a learning disability and / or autism who also have extremely complex health and care support needs.<br>• -Implement home and hospital discharge plan. | | | | | • PEOLC test site for dementia<br>• Expand the use of Palliative Care Tool Bundle and Response Standards in use across community based health and social care services.<br>• Fully implement the Macmillan Improving the Cancer Project.<br>• PEOLC Managed Clinical Network in place, to focus on non-specialist palliative care.<br>• Increased availability of Key Information Summaries and ACPs.<br>• Learning disability community nursing team will work with MacMillan nurses to improve methods of communication. | | | | • Further develop Enhanced Community Support, including acute.<br>• Develop a model of support for carers in line with the Carers Act.<br>• Continue to review in patient models in line with community change.<br>• Increase investment in models that support adults within their own homes.<br>• Increase investment and improve capacity in social care.<br>• Continue to develop step down to assess model.<br>• Increase the range of accommodation with support for people with complex needs.<br>• Increase social prescribing and improve self-care.<br>• Further develop accommodation with support models in the community for adults.<br>• Remodel the stroke pathway.<br>• Further develop short breaks and respite opportunities. | | | |
| **Notes** | | | | | | | | | | | | | | | | | | | | | | | % above is for living at home supported. | | | |

**Health and Social Care Partnership:** Dundee City

**Age Group for indicators 1 to 3:** < 18

| | 1. Emergency admissions | | | | 2. Unplanned bed days | | | | | 3. A&E attendances | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Objective** | *Baseline year* | *Baseline total* | *% change* | *Expected 2018/19 total* | Acute | *Baseline year* | *Baseline total* | *% change* | *Expected 2018/19 total* | *Baseline year* | *Baseline total* | *% change* | *Expected 2018/19 total* |
| | | | | | | | | | | | | | |
| | | | | | Menal Health | *Baseline year* | *Baseline total* | *% change* | *Expected 2018/19 total* | | | | |
| | | | | | | | | | | | | | |
| **How will it be achieved** | | | | | | | | | | | | | |
| **Notes** | | | | | | | | | | | | | |

## Template for MSG 2019/20 objectives (completed example)

**Health and Social Care Partnership:** Partnership A
**Age Group for indicators 1 to 3:** 18+

| | 1. Emergency admissions | | | | 2. Unplanned bed days | | | | | 3. A&E attendances | | | | 4. Delayed discharge bed days (18+) | | | | | 5. Percentage of last 6 months of life spent in community (all ages) | | | | 6. Proportion of 65+ population living at home (supported and unsupported) | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Objective** | *Baseline year* | *Baseline total* | *% change* | *Expected 2019/20 total* | Acute | *Baseline year* | *Baseline total* | *% change* | *Expected 2019/20 total* | *Baseline year* | *Baseline total* | *% change* | *Expected 2019/20 total* | All reasons | *Baseline year* | *Baseline total* | *% change* | *Expected 2019/20 total* | *Baseline year* | *Baseline percentage* | *Percentage point change* | *Expected 2019/20 %* | *Baseline year* | *Baseline percentage* | *Percentage point change* | *Expected 2019/20 %* |
| | 2015/16 | 12,634 | 2% decrease | 12,381 | | 2015/16 | 143,872 | 4.4% decrease | 137,542 | 2015/16 | 34,100 | 2% decrease | 33,418 | | 2015/16 | 18,765 | 3.06% decrease | 18,191 | 2015/16 | 85.6% | 0.8 increase | 86.4% | 2015/16 | 83.2% | 1.3 increase | 84.5% |
| | | | | | Geriatric Long Stay | *Baseline year* | *Baseline total* | *% change* | *Expected 2019/20 total* | | | | | H&SC/patient and family related reasons | *Baseline year* | *Baseline total* | *% change* | *Expected 2019/20 total* | | | | | | | | |
| | | | | | | 2015/16 | 8,985 | 1% increase | 9,075 | | | | | | 2015/16 | 15,000 | 3.5% decrease | 14,475 | | | | | | | | |
| | | | | | Mental Health | *Baseline year* | *Baseline total* | *% change* | *Expected 2019/20 total* | | | | | Code 9 | *Baseline year* | *Baseline total* | *% change* | *Expected 2019/20 total* | | | | | | | | |
| | | | | | | 2015/16 | 21,638 | Maintain | 21,638 | | | | | | 2015/16 | 3,765 | 1.3% decrease | 3,716 | | | | | | | | |
| **How will it be achieved** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Notes** | | | | | | | | | | | | | | | | | | | | | | | | | | |

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**Health and Social Care Partnership:** Partnership A
**Age Group for indicators 1 to 3:** < 18

| | 1. Emergency admissions | | | | 2. Unplanned bed days | | | | | 3. A&E attendances | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Objective** | *Baseline year* | *Baseline total* | *% change* | *Expected 2019/20 total* | Acute | *Baseline year* | *Baseline total* | *% change* | *Expected 2019/20 total* | *Baseline year* | *Baseline total* | *% change* | *Expected 2019/20 total* |
| | 2015/16 | 2,683 | 1% reduction | 2,656 | | 2015/16 | 32,300 | 1.1% increase | 32,623 | 2015/16 | 4,387 | 0.5% increase | 4,606 |
| | | | | | Menal Health | *Baseline year* | *Baseline total* | *% change* | *Expected 2019/20 total* | | | | |
| | | | | | | Not applicable | Not applicable | Not applicable | Not applicable | | | | |
| **How will it be achieved** | | | | | | | | | | | | | |
| **Notes** | | | | | | | | | | | | | |

Health and Social Care Integration Directorate
Integration Division

Scottish Government
Riaghaltas na h-Alba
gov.scot

E: alison.taylor@gov.scot
E: johnw@cosla.gov.uk

**To: Chief Officers Integration Authorities**

COSLA

12 December 2018

Dear Colleagues

**UNDERSTANDING PROGRESS UNDER INTEGRATION**

We are writing to provide you with an update on our work to share progress updates on integration with the Ministerial Strategic Group for Health and Community Care (MSG).

Firstly, we would like to thank you for sharing your local objectives for 2018-19 on the initial six indicators earlier this year. This information has been used to provide MSG with a summary overview of Integration Authority ambitions around these indicators and quarterly progress updates. As with last year, MSG appreciated the time taken to develop and share these objectives and have found the information very helpful in supporting them in their role to provide political leadership for, and oversight of, integration.

The framework continues as agreed, with a view to reviewing and expanding when additional appropriate information, such as the inclusion of social care data in Source, becomes available.

The small MSG Data Working Group established in 2017 continues to meet and has been particularly helpful in developing the reporting framework, especially in terms of tightening links with other networks such as the Integration Authority Chief Finance Officers. The partnership approach has enhanced understanding of progress across the system of the purpose and requirements of the exercise of gathering updated objectives, which has in turn improved the process and quality of submissions. We will continue to work with the MSG Data Working Group and Chief Officers to expand the range of indicators used going forward.

Updates to MSG have included an outline of progress made in collating and sharing data and a short summary of Integration Authorities' improvement plans in March 2018, quarterly updates on progress against the six key framework indicators in June and September 2018, an update on the new single social care data collection in June 2018 and a summary of Integration Authority annual performance reports in September 2018.

MSG have welcomed these updates and have requested for future meetings that we continue to provide such updates, incorporating narrative to explain the data and also to include local experiences of leading improvement, such as that presented to MSG in March by Aberdeen City on their approach to continuous improvement.

You are invited to share your updated objectives for 2019/20. We recognise that you will want to engage with a range of partners in this process.To support the process we have reviewed and updated the guidance notes and format for sharing your objectoves. This has all been developed with advice from the MSG Data Working Group, ISD and others. The intention has been to simplify the task locally and provide consistency across the information shared. As with previous years, we anticipate that there will be local support for developing objectives from the LIST team and other local analysts drawing on collective advice on best practice around developing objectives.

We would be grateful if you would provide your updated 2019/20 local objectives for MSG by 28 February 2019. These should be sent to NSS.Source@nhs.net. We recognise that you will want to agree these objectives with your IJB, so if that is not possible within the timescale, we would be happy to accept interim objectives. We also welcome any feedback on this approach and the guidance – please contact Charlie Hogg Charlie.hogg@gov.scot or 0131 244 2493.

Yours faithfully,

Alison Taylor

Alison Taylor
Head of Integration
Scottish Government

John Wood
Chief Officer Health and Social Care
COSLA