REPORT TO ABERDEENSHIRE INTEGRATION JOINT BOARD - 27 FEBRUARY 2019

UNDERSTANDING PROGRESS UNDER INTEGRATION – ABERDEENSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP (HSCP) RESPONSE TO MINISTERIAL STRATEGIC GROUP FOR HEALTH AND COMMUNITY CARE

1 Recommendation

It is recommended that the IJB:

1.1 Acknowledge the content of the proposed Aberdeenshire HSCP response (Appendix 1); and

1.2 Agree proposed local objectives against the six indicators.

2 Risk

2.1 IJB risk 1 (Sufficiency and Affordability of Resource). Risk of failing to modernize services to improve outcomes.

IJB risk 8 (Risk of failure to deliver standards of care expected by the people of Aberdeenshire in the right place at the right time). Risk of failure to work closely cross-system to improve care for the people of Aberdeenshire.

2.2 Performance management reporting is a legislative requirement under section 42 of the Public Bodies (Joint Working) (Scotland) Act 2014.

3 Background

3.1 The purpose of this report is to inform the Integration Joint Board (IJB) of the proposed Aberdeenshire response to the request for information on behalf of the Ministerial Strategic Group for Health and Community Care (MSG).

3.2 The Integration Division of the Scottish Government and COSLA have written jointly to all Integration Authorities (as of 12 December 2018) requesting updated objectives for 2019/20 in relation to the six previously agreed indicators of:

1. Number of emergency admissions into Acute (SMR01) specialties.
2. Number of unscheduled hospital bed days.
3. Number of A&E attendances and the percentage of patients seen within 4 hours.
4. Number of delayed discharge bed days.
5. Percentage of last 6 months of life spent in the community.
6. Percentage of population residing in non-hospital setting for all adults and 65+.

3.3 All Integration Authorities have been asked to provide updated objectives against each of the six indicators by 28 February 2019. Appendix 1 provides Aberdeenshire's proposed objectives against the six indicators in the template format requested (see attached).

3.4 Guidance on preparing and sharing 2019/20 local objectives with MSG was issued on 20 November 2018. This guidance stipulated that objectives should relate to the data provided in the monthly spreadsheets from ISD and not locally sourced information. The objectives set for 2018/19 had been set using a local (Aberdeenshire) dataset, however based on this new guidance the 2019/20 objectives have been set using data from ISD.

3.5 The reporting year 2015/16 has been set as the baseline year against which five of the six objectives for 2019/10 have been set. This was the reporting year in which ISD commenced providing monthly data in relation to these objectives to HSCPs. For Delayed Discharge Bed Days the year 2017/18 has been set as the baseline. Due to substantial improvements in data quality and improvement work to reduce Delayed Discharge since 2014/15, the reporting year 2017/18 is a more appropriate baseline against which to set an objective.

3.6 It is anticipated that our gains against our performance objectives may be more marginal in future not least because our population of 65+ years is growing so significantly. Accordingly, in terms of objectives it is proposed that a reasonable and indeed challenging target will be to maintain the baseline position against projected population growth.

3.7 Performance against the MSG indicators will be incorporated into the performance framework and reporting timetable. A performance report for the 2019/20 objectives will be submitted to the IJB in line with availability of final year data.

4 Equalities, Staffing and Financial Implications

4.1 An Equality Impact Assessment is not required for the response because its purpose is to underpin the strategic direction for the service and there will be no differential impact, as a result of the report, on people with protected characteristics.

4.2 There are no specific staffing implications arising from this report.

4.3 The Chief Officer, along with the Chief Finance Officer and the Legal Monitoring Officer within Business Services of the Council have been consulted in the preparation of this report and their comments have been incorporated within the report.

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Guidance for completing MSG 2019/20 objectives

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: Aberdeenshire

1. Number of emergency admissions

Partnership: Aberdeenshire

Age Group	2014/15	2015/16	2016/17	2017/18
Under 18	3,066	3,287	3,334	2,951
18+	17,178	16,714	16,573	16,712

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

Partnership: Aberdeenshire

Age Group	2014/15	2015/16	2016/17	2017/18
Under 18	4,499	5,044	4,769	4,189
18+	157,039	144,766	148,739	145,604

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

Partnership: Aberdeenshire

Age Group	2014/15	2015/16	2016/17	2017/18
18+	303	92	191	101

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

Partnership: Aberdeenshire

Age Group	2014/15	2015/16	2016/17	2017/18
Under 18	184	1,111	968	992
18+	37,223	34,620	35,637	31,608

3. Number of A&E attendances

Partnership: Aberdeenshire

Age Group	2014/15	2015/16	2016/17	2017/18
Under 18	8,405	7,909	7,707	7,246
18+	19,224	18,984	19,616	20,234

4. Delayed discharge bed days

Partnership:	Aberdeenshire			
Age Group	2014/15	2015/16	2016/17	2017/18
18+	33,956	28,293	18,176	16,334

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

Partnership:	Aberdeenshire			
Age Group	2014/15	2015/16	2016/17	2017/18[p]
All Ages	88.8%	89.1%	89.3%	89.9%

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

Partnership:	Aberdeenshire			
Setting:	Home unsupported & supported			
Age Group	2014/15	2015/16	2016/17	2017/18[p]
65+	95.8%	95.8%	96.0%	96.2%

Template for MSG 2019/20 objectives

Health and Social Care Partnership: Aberdeenshire

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	16,714	Maintain	16,714		2015/16	144,766	Maintain	144,766	2015/16	18,984	Maintain	18,984		**2017/18**	**16,334**	Maintain	16,334	2015/16	89.1%	Maintain	89.1%	2015/16	95.8%	Maintain	95.8%
					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	92	See notes							**2017/18**	**13,695**	Maintain	13,695								
					Mental Health	*Baseline year*	*Baseline total*	*% change*	*Expected 2019/20 total*					Code 9	*Baseline year*	*Baseline total*	*% change*	*Expected 2019/20 total*								
						2015/16	34,620	Maintain	34,620						**2017/18**	**2,639**	Maintain	2,639								
How will it be achieved	• Implementation of Reshaping Care programme including Virtual Community Ward model (integrated team approach to providing rapid response and extra care around patients at risk of hospital admission). • Implementation of Enabling Health & Wellbeing Programme, including community hospital and anticipatory care planning projects. • Early implementation of Let's Think Ahead.				• Implementation of Enabling Health & Wellbeing Programme, including community hospital and anticipatory care planning projects (linking with Let's Think Ahead). • Implementation of Reshaping Care programme.					• Continued delivery of Virtual Community Ward model. • Minor Injuries Unit provision across Aberdeenshire community hospitals, development of enhanced diagnostic testing in the community and other work streams to support primary care access and minimise unnecessary admissions to ED.					• Implementation of Reshaping Care Programme. • Delivery of continuous improvement programme to develop processes and infrastructure to optimise person-centred discharge planning.					• Implementation of Enabling Health and Wellbeing programme including 'Improving the experience of end of life care' project. • Early implementation of Let's Think Ahead. • Dedicated palliative care beds within community hospitals to support provision of planned end of life care within the community (akin to hospice setting as opposed to acute hospital setting).				• Implementation of Reshaping Care programme.			
Notes	Maintain baseline number of unplanned admissions against projected growth in 65+ population. Between 2018 and 2019, the 65 + population is projected to increase by 2.3%. Between 2019-2020 the increase will be 2%. By the year 2035, it is forecast that the 65 + population of Aberdeenshire will increase by 65%. (National Records of Scotland)				Maintain the number of Unplanned Bed Days against the projected growth in the 65+ population. Geriatric Long Stay beds - no objective identified as no GLS beds in Aberdeenshire (reported figures presumed to be data error or Aberdeenshire resident activity within a GLS facility outwith Aberdeenshire). Psychiatric assessment beds currently managed by community psychiatrists.					Maintain the baseline number against projected growth in 65+ population.					Maintain the baseline number against projected growth in 65+ population.					Maintain a figure above the Scottish Average of 86% (Marie Curie Dying to Care)				Maintain current percentage of population in community setting against projected population growth.			

Aberdeenshire