MINISTERIAL STRATEGIC GROUP FOR HEALTH AND COMMUNITY CARE

Paper no: MSGHCC/118/2019
Meeting date: 29 May 2019
Agenda item: 4

Purpose: FOR DECISION

Title:	**MSG data review**

Key Issues:	This paper: • Provides an overview of the range of existing data available to partnerships to support integration. • Identifies gaps in available data and work in hand to address these, and proposes better use of data in future to support the MSG's governance role with respect to integration.

Action Required:	The MSG is invited to note the extent of health and social care data, and analytical support, now available to partnerships along with plans for improvement already underway across the system, and to discuss the Group's experience over the last two years of engaging with data to assist it in its governance role for integration. The MSG is also invited to agree two specific proposals: a) Officials should develop a revised set of measures for regular consideration, based on proposed data improvements and recognising ongoing gaps and challenges. b) As part of wider work to increase the pace of integration, receive an update on how local systems are using data to redesign services, manage risk, explore variation and spread good practice.

Author: Paul Leak, Integration Division **Date: May 2019**	

Purpose

1.   The MSG has previously received regular papers and presentations using partnership data, which have tended to report on performance against the MSG indicators and, less frequently, patterns of service use (e.g. variation and high resource individuals), and patient/client experience. The current indicators are weighted towards secondary care and therefore provide a limited view of the health and care journey as a whole.

2.   The publication of the MSG review and the Audit Scotland report, together with developments in data availability, present an opportunity to review the data reported to MSG. This paper notes the extent of data available to partnerships and practices and serves to frame a discussion for the Group to consider its data needs, both to carry out its responsibilities and also to oversee implementation of the integration review proposals.

Background

3.   The role of the MSG is to provide oversight and leadership of transformational change across the health and social care system. Its responsibilities can be grouped under three broad categories: assurance and risk; monitoring delivery; and improvement and good practice.

4.   Integration Authorities, GP clusters and GP practices currently have access to a considerable range of national and local data as a basis for planning and improvement. In addition they have access to analytical support through Scottish Government funded LIST analysts.

5.   LIST makes use of data from the SOURCE platform and local datasets, and works in collaboration with local expertise to produce analyses to support planning and improvement. Wherever possible, work is shared with other LIST analysts on a 'once for Scotland basis' so that analyses produced for one partnership may be replicated in others if required. Joint working with other national organisations is common with, for example, with NHS Health Scotland and NHS Healthcare improvement Scotland (HIS).

Currently Available Data

6.   The main data in use by LIST analysts is from the SOURCE platform, supplemented with local data. SOURCE is a large (and growing) set of linked person-level data, managed nationally by ISD, together with a secure platform that presents a range of standard analyses for partnerships and other stakeholders.

7.   The range of data incorporates national health datasets covering inpatient and day cases, outpatients, A&E attendances, community prescribing, death records, GP out of hours and delayed discharge. Increasingly, it is encompassing formal social care activity at person level, including personal budgets. This data is available at individual level for approximately 70% of delegated services, with the balance available at various aggregate levels.

8.   Crucially, as well as being linked at individual level, the data is longitudinal, which allows process mining software to be used to map individual care journeys and also aggregate level journeys for groups of interest (e.g. by care group, age, diagnosis, geography etc.). This data also allows analysis of pre and post intervention activity. MSG has seen this information previously.

9.   In addition there are a series of standard analyses available through the platform for each partnership (and also at locality and practice level).

10.   The ongoing development of SOURCE is overseen by a reference group with membership drawn from all sectors. Current information governance arrangements restrict access to the SOURCE platform for Integration Authorities, Health Boards and Local Authorities to their own partnership data and so they are unable to view data for other partnerships. This situation inhibits benchmarking and sharing good practice and in light of the integration review recommendations the reference group has agreed to develop arrangements with data controllers to allow partnerships reciprocal access to data; and at the same time to widen access to other strategic planning stakeholders and improvement bodies. The intention is that in due course all of the SOURCE outputs will be available to the general public (subject only to being non-disclosing) under the SG open data policy.

11.   In addition to SOURCE and local datasets, partnerships and practices have access to a range of other data sources, including:

- Population health profiles: available on the ScotPHO website these include data on health behaviour, inequalities, the influence of life circumstances on health and health profiles for local populations and for groups of interest.

- SPIRE: The **S**cottish **P**rimary Care **I**nformation **Re**source allows practices to access information about their patients and will allow NSS ISD to collect and analyse bespoke data extracts nationally. In addition, practices are already able to compare variation with other practices in measures based on other data such as prescribing and secondary care, via Primary Care Information (PCI) dashboards.

- Social care support: there are several national data collections covering home care, care homes, adult support and protection, carers, free personal and nursing care, waiting times for social care post assessment, and high level social service expenditure data. There is also comprehensive data on the social services formal care workforce.

- Patient Outcomes: The Scottish Government Health and Care Experience survey provides national and local information on the quality of health and care services from the service user perspective and allow local health and care providers to compare with other areas of Scotland and to track progress in improving the experiences of people using their services.

- The Scottish Health Survey (SHeS): SHeS provides a detailed picture of the health of the Scottish population in private households that cannot be obtained from other sources and makes a major contribution to the monitoring of health at local and national level.

12. In summary, partnerships and GP clusters have access to a significant range of data and to analytical support with which to understand the needs and service use of their populations, as a basis for planning and improvement. However, it is not yet fully comprehensive and there remains a considerable range of services for which individual level data is currently not available. It is important for a full understanding of care journeys that these data are also linked to SOURCE.

Data Gaps and ongoing work to address

13. ***Community nursing/wider community care***: collection of District Nursing activity data is currently the most advanced data collection in this area. Data is available and linked within SOURCE analysis files for just under half of partnerships. The ISD data management team is working with data controllers to increase coverage and extend the collection to data for other community activities (such as mental health and health visiting). Challenges remain in capturing complete and consistent data e.g. as NHS Boards change/develop relevant IT systems.

14. ***Primary Care***: there is rich data about GP activity kept on local practice data systems but this has not in the past routinely been made available in its own right or linked to other data. There is also historically a lack of routine data availability on the GP practice workforce (although the Primary Care Workforce Survey has filled some of the gap), income and expenses, and the GP estate.

15. The new 2018 GP contract has a key focus on improving the availability and quality of data in primary care, on activity, workforce, and finance. The need for better workforce data was also highlighted in the National Workforce Plan Part 3 – Primary Care. Several initiatives are underway to address those objectives, including the development of a national data set under the new contract.

16. Implementation of the SPIRE system has been slower and more complex than originally envisaged, and we are not yet seeing the types of national product emerge that would be desirable in steering and informing national policy direction.

17. In the medium to long term, however, information obtained through SPIRE will be linked to SOURCE and will be an extremely important component of understanding activity in primary care and beyond, both routinely-gathered data and data gathered in response to ad hoc requests.

18. ***Intermediate care*** typically provides care closer to home or at home and avoids or shortens the need for secondary care. As with community healthcare it is essential that this type of care is captured and linked to other data.

19. At present intermediate care data is recorded under other definitions (e.g. GP beds) and as a consequence is not visible in analysis of pathways of care. A

prototype national minimum dataset that will allow this care to be recorded as intermediate care has been designed and tested but not yet implemented.

20.   The **third sector** provides a range of care and support services but service data is currently not linked routinely to SOURCE. A short life working group with representatives from the third sector, ISD and SG was established to determine ways that third sector organisations might contribute to SOURCE nationally, but proved unfruitful. The main reasons for this include an absence of common standards for information collection across bodies, variation in organisational capacity across and very limited and variable IT/information.

21.   The LIST team have engaged in a number of projects with local third sector organisations in the last two years and it may be that a local approach co-ordinated by Integration Authority Strategic Planning Groups offers the most promising route to bringing data together.

22.   **Independent sector** care that is funded by Local Authorities is included in the SOURCE file, but privately funded care is not and as a consequence analysis of care journeys for these individuals would not include this care. This will be considered as part of the work to examine social care support data and measurement. In the medium term, the reform of adult social care is expected to address this (see below) and in the interim SG is in discussion with Scottish Care and NSS ISD to identify indirect measures of activity.

23.   ISD collects data from the **Scottish Ambulance Service** but this is currently not linked to the SOURCE file. However arrangements are in train for this to happen routinely in 2019/20; in the meantime a pilot analysis will be carried out for a small group of partnerships to demonstrate the potential of linking this data. In addition SAS is developing aggregate level key data summaries which will be used to inform a programme of engagement with each partnership.

Other Developments

24.   In addition to the above work addressing data gaps there are a number of initiatives underway that are aimed at improving the range and quality of analysis.

25.   The **Mental Health** Strategy (2017 to 2027) aims to achieve parity between mental and physical health. In order to achieve this we need to be able to observe and measure data across a wide range of services and dimensions such as access to care and treatment, quality of care and reporting of outcomes.

26.   The Mental Health Quality Indicator Profile (30 indicators) is intended to illustrate the quality of services and was launched in September 2018. Eight indicators from the profile were published on 5 February, and it is expected that further indicators will be released during the year as they become ready.

27.   The Mental Health Population Framework provides an accessible overview for those seeking to understand Scotland's mental health and wellbeing at the

population level. The Mental Health Population Framework largely draws on existing surveys, although data for some indicators are not yet currently available.

28.   The development of individual level data on those waiting for Child and adolescent Mental Health Services (CAMHS) and Psychological Therapies is progressing. Currently NHS Boards provide aggregate information on waiting times. The move to individual level data will enable improved analysis by gender, age, treatment etc. and help to inform service redesign and improved outcomes. It will also allow data linkage.

29.   In parallel with the **adult social care** reform agenda there is a suite of work underway to consider data and measurement. This includes mapping current national data collections to what it is measuring (context, process, intermediate outcomes, outcomes). This is leading to efforts on what current data can be utilised to capture demand and volume but also crucially to measure quality, peoples experience and outcomes. While most of the currently collected social care data can be analysed at both national and local level it is heavily focused on process rather than quality and outcomes.

30.   There will also be work to understand what data is collected locally that could potentially feed into a national measurement framework.

31.   Pathways in and out of social care and the relative balance of care and resources is also important and as outlined, further development of SOURCE will allow this analysis to happen routinely. The profiles of those receiving social care support will be able to be compared around Scotland focusing on deprived areas and where cohorts with similar profiles are and are not receiving social care support.

32.   Data for people registered as **homeless** has been collected by ISD from Local Authorities but has not been linked routinely to the SOURCE file. Linkage would allow partnerships to understand how homeless people use services as a basis for redesign and improve outcomes. A preliminary analysis is being carried out for the reference group which will be shared with the Integration Strategic Commissioning and Improvement managers network to inform the best way to proceed.

Reporting to the MSG

33.   Overall, data reports can assist the MSG in three broad areas of responsibility: monitoring delivery, assurance and risk, and improvement and good practice: monitoring delivery; assurance and risk; and improvement and good practice.

34.   *Monitoring delivery:* The current set of six indicators reported to MSG originated from the Health and Social Care Delivery Plan published in December 2016 and are currently biased towards hospital care. The measures are; emergency admissions to hospital, unplanned hospital bed days, A&E attendances, delayed discharge bed days, proportion of last six months spent in the community and proportion of 65+ population living at home.

35. Although it is implicit with these indicators that performance is predicated on integrated care, it is inconsistent that there are no measures explicitly addressing other parts of the care and support journey.

36. While it is likely to be an iterative process, the work to address data gaps and developments noted above will expand the range of data available to inform the MSG indicators and allow the opportunity to consider how the balance of the indicators can be improved.

37. It is therefore proposed that officials seek to increase the pace of these improvements and provide further advice on developing and incorporating additional measures that reflect the whole system. A balance will need to be achieved between national indicators that are available frequently and are therefore process based but potentially indicative of change, pace and quality in the system and those that are available less frequently and outcome based.

38. ***Assurance and risk***: The MSG will need assurance that Integration Authorities have access to suitable data and analysis to enable strategic planning, improvement, benchmarking and sharing of good practice. The information on current data and analytical support above is intended to provide initial evidence for this. In addition, the MSG will require on-going assurance on progress with addressing data gaps and with data development and in widening access to SOURCE outputs.

39. ***Improvement and good practice***: There is material variation in rates and patterns of care across partnerships and GP clusters which is indicative of the potential for improvement. Work must be focused at a local level on eliminating unwarranted variation. Integration Division has recently seconded an analyst from ISD to better support co-ordination of data and analysis at a national level. In addition, we are looking to develop a specific team with a coherent focus on performance and data, and which will support Integration Authorities to improve performance and lessen variation. The MSG will have an interest in being briefed on these opportunities and on cases where improvement has been achieved.

Recommendations

40. MSG is invited to consider whether it agrees that:

a) Officials should develop a revised set of measures for the MSG's regular consideration, based on the above data improvements and recognising ongoing gaps and challenges.

b) As part of wider work to increase the pace of integration, receive an update on how local systems are using data to redesign services, manage risk, explore variation and spread good practice.

Integration Division
May 2019