East Lothian
Integration Joint Board

REPORT TO: East Lothian Integration Joint Board

MEETING DATE: 22 March 2018

BY: Chief Officer

SUBJECT: Measuring Performance under Integration – MSG Indicators - Progress in 2017 and Objectives for 2018/19

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1 PURPOSE

1.1 To inform the Integration Joint Board of progress in delivering the Ministerial Strategic Group for Health and Community Care (MSG) objectives in 2017/18 and the proposed objectives for 2018/19.

2 RECOMMENDATIONS

The IJB is asked to:

2.1 Note attainment to date by East Lothian Health and Social Care Partnership against the 2017/18 MSG Integration objectives (Table 2).

2.2 Note that Strategic Planning Group members were informed of the HSCP's performance for 2017/18 and agreed to the proposed MSG Integration objectives for the 2018/19 period (appendix 4).

2.3 Agree to adopt the proposed targets for the 2018/19 period (appendix 4) and for these to be formally communicated to the MSG.

3 BACKGROUND

3.1 In January 2017 a joint Scottish Government and COSLA letter (appendix 1) on behalf of the Ministerial Strategic Group for Health and Community Care (MSG) announced the intention to track performance by Integration Authorities in delivering integration through the monitoring of 6 initial measures through 2017/18 as follows:

(1) unplanned admissions;
(2) occupied bed days for unscheduled care;
(3) A&E performance;
(4) delayed discharges;
(5) end of life care; and

(6) the balance of spend across institutional and community services.

3.2 Feedback to the Scottish Government noted the indicators were very health focussed and would not capture the important role of social care in improving patient outcomes. Following discussions it was agreed that other, more social care focussed measures would be developed in due course.

3.3 ISD (Information Services Division) is currently consulting on the merger of the Scottish Government Social Care Survey and ISD's 'Source' Team social care data collection.

3.4 Source is currently working on development of data items, definitions and guidance for a revised dataset to include social care.

3.5 At the time of the MSG measures being introduced each of the four IJBs in Lothian agreed on their local targets for the six measures. East Lothian's 2017/18 targets supplied to the Scottish Government are shown in table 1.

Table 1 – East Lothian MSG Targets for 2017/18

Unplanned Admissions	Unplanned bed days	A&E performance	Delayed discharges	End of Life Care	Balance of care
Reduce emergency admissions by 5% by 2018.	Reduce unscheduled bed days by 10% in 2018 compared to 2017.	Maintain 95% 4 hour compliance target from March 2018.	Reduce delayed discharges bed days by 50% in period July – Dec 2017 compared to same 2016 period. Also target to reduce number of delayed discharges by 50% by Dec 2017 compared to Dec 2016.	No more than 10.5% of L6M spent in large hospital by 2018/19.	98% of over 75s to be supported in non-acute setting

3.6 Through 2017/18 ISD issued regular data updates for each of the indicators. This information was processed by the Local Intelligence Support Team (LIST) colleagues attached to East Lothian HSCP and supported monitoring and reporting of progress in East Lothian.

3.7 By September 2017 the trend for A&E attendances continued to show rising activity along with those seen within 4 hours (with wide fluctuations in the over 65s). However, the trend for admissions from A&E was downward, unscheduled hospital bed days continued to fall, along with delayed discharge bed days (with between year and in year fluctuations).

3.8 Data for end of life care and balance of care proved more difficult for ISD to accurately capture and validate, meaning only 4 of the 6 measures (unplanned admissions / occupied bed days for unscheduled care / A&E

performance / delayed discharges) could be looked at with any confidence at that time. Data gathering for these last two measures has improved.

3.9 In November 2017 a further joint Scottish Government and COSLA letter (appendix 2) was issued. This asked for Integration Authorities to report back on their agreed objectives for 2018/19 by the 31st January 2018, to allow for reporting to the 21st March MSG meeting.

3.10 As many IJBs (East Lothian included) did not have business meeting dates to suit this deadline the MSG Secretariat requested instead that draft objectives were provided, with final objectives to be shared with the MSG after IJB agreement. The draft 2018/19 objectives for East Lothian have been shared as requested with Scottish Government colleagues who have been informed that the approved objectives will be issued following the 22 March Integration Joint Board meeting.

3.11 East Lothian's draft objectives for 2018/19 are given in appendix 4. This document also reflects on attainment to date for 2017/18. This is summarised in table 2 which presents the latest data covering the period April 2017 to October 2017.

Table 2 - Attainment (April to October 2017) against the 2017/18 MSG Indicators

Unplanned Admissions	Unplanned bed days	A&E performance	Delayed discharges	End of Life Care	Balance of care
11% reduction in overall total compared to same period in 2016. **TARGET – 5% reduction**	0.9% increase in unplanned bed days (acute specialties) compared to same period in 2016. 10.8% reduction in mental health specialties compared with same period in 2016. 43.3% reduction in GLS bed days compared with same period in 2016. **TARGET – 10% reduction**	0.9% increase in overall total attendances compared to same period in 2016. Average A&E compliance 93.9% seen within 4 hours compared to 93.5% for same period in 2016. **TARGET - maintain 95%**	33.1% reduction in all reason delayed bed days, compared to same period in 2016 37.8% reduction in H&SC+P/C/F reasons compared to same period in 2016 73.9% increase in Code 9 reasons compared to same period 2016. **TARGET – 50% reduction in delayed discharge bed days and 50% reduction in delayed discharges.**	Community: 85.7% Palliative: 0.9% Community Hospital: 1.7% Large Hospital: 11.7% For 2016/17 11.7% of care in the last 6 months of life was in a large hospital **TARGET - No more than 10.5% of L6M spent in large hospital**	Acute Setting: 1.5% Community Hospital: 0.3% Hospice: 0.0% Care Home: 5.2% Home: 9.7% (supported) Home: 83.3% (unsupported) In 2016/17 total being supported out of acute settings was 98.5% **TARGET - 98% of over 75s to be supported in non-acute setting**

4 ENGAGEMENT

4.1 No specific engagement activities are planned in the course of agreeing and delivering the proposed 2018/19 MSG Objectives.

5 POLICY IMPLICATIONS

5.1 The proposed objectives are supportive of the MSG's requirements, and principles and priorities in the East Lothian Health and Social Care Partnership Strategic Plan. As the 2017/18 objectives were supported by associated Directions, it is intended that this will apply for the 2018/19 Directions which are in development.

6 INTEGRATED IMPACT ASSESSMENT

6.1 The recommendations within this paper have not been the subject of an Integrated Impact Assessment as any necessary change to any aspect of service delivery which arises from the proposed MSG objectives will be assessed as necessary at an appropriate stage in the year.

7 RESOURCE IMPLICATIONS

7.1 Financial – there are not thought to be any financial implications associated with the recommendations as delivery of the objectives will be a direct outcome of existing service delivery.

7.2 Personnel – there are no personnel implications arising from the proposed objectives.

8 BACKGROUND PAPERS

8.1 Ministerial Steering Group letters:

Appendix 1 - Joint Scottish Government/COSLA Letter of January 2017

Appendix 2 - Joint Scottish Government/COSLA Letter of January 2017

Appendix 3 - MSG Guidance on Objectives Preparation

8.2 Proposed objectives for 2018/19

Appendix 4 - MSG Indicators – Progress in 2017 and Objectives for 2018/19

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Appendix 1 - Joint Scottish Government/COSLA Letter of January 2017

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COSLA

To: Chief Officers – Integration Authorities

19 January 2017

Dear Colleagues

MEASURING PERFORMANCE UNDER INTEGRATION

The Ministerial Strategic Group for Health and Community Care (MSG) discussed how to measure progress under integration at its meetings on 16 November and 21 December.

At the meeting on 21 December MSG agreed that for 2017/18 we will track across Integration Authorities:

(1) unplanned admissions;
(2) occupied bed days for unscheduled care;
(3) A&E performance;
(4) delayed discharges;
(5) end of life care; and
(6) the balance of spend across institutional and community services.

You are each invited to set out your local objectives for each of the indicators for 2017/18 by the end of February. MSG has agreed that it will receive a quarterly overview on progress across the whole system and you are asked to produce your objectives on that basis. We are meeting with the Executive Group of Chief Officers on Friday and will discuss what national support you would want us to offer for this process. Our objective will be to adapt and use existing data collection methodologies where possible and to establish a clear process for the work.

When we met on 16 December we had indicated that as a minimum we would provide data for each partnership covering each of the indicators. The data would show the position for all partnerships to enable individual Integration Authorities to understand the shape and

nature of their service relative to others. We are still working on the structure and format of that data. For now, we attach high level data covering a number of the areas (**Annex A**). Again we would intend to use the conversation on Friday to discuss the structure and format of the data with the intention of writing shortly after to all Chief Officers with the necessary material.

MSG noted that the approach for future years may change as a consequence of the Review into Targets and Indicators being undertaken by Sir Harry Burns and also as data sources for particular areas of service delivery improvement. It also noted that most key service delivery areas under integration have a direct impact on these higher level system indicators. In particular, it is important that we are able to understand both the contribution of social care and primary care services to these higher level system indicators, but also how they support important outcomes in respect of independent living and the protection and maintenance of health.

Local partnerships are already using a wide range of data to support their commissioning and delivery activity and will continue to operate under the duties in the 2014 Act in respect of public reporting. This process is not intended to duplicate or substitute for that process.

The Local Delivery Plan (LDP) Guidance for 2017/18 has been issued to NHS Chief Executives and sets the expectation that Boards and regional planning partnerships ensure that their objectives and plans are consistent with Integration Authority plans. Similarly, given the interaction with the hospital system you will need to ensure that your objectives and plans are consistent with NHS Board and regional plans for 2017/18.

Yours sincerely

GEOFF HUGGINS
Scottish Government

PAULA McLEAY
COSLA

Appendix 2 – Joint Scottish Government/COSLA Letter of November 2017

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COSLA

To: Chief Officers Integration Authorities

22 November 2017

Dear Colleagues

UNDERSTANDING PROGRESS UNDER INTEGRATION

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

We wanted firstly to thank you for sharing your local objectives on the initial six indicators in February. As you know, we used this information to provide MSG with a summary overview of Integration Authority ambitions around these indicators, progress to date and some of the challenges facing Integration Authorities in delivering on their objectives. MSG appreciated the time you took in developing and sharing your local objectives to support them in their role in providing political leadership for, and oversight of, integration.

Since then we have been considering how best to provide regular progress updates to MSG. With the agreement of the Chief Officer network, we established a small working group comprising lead officers for strategic commissioning and performance in Integration Authorities, Chief Finance Officers, data analysts and SG officials. The group has met three times to discuss possible approaches and suggested a potential framework for providing future updates to the MSG. This framework is outlined below.

During our discussions, we've reflected in some detail on a number of issues, for instance, how best to balance the presentation of a manageable number of common data points for all areas with more bespoke narrative insights that can help to draw out the richness of local variation; how to explore specific themes such as end of life care; how to explore the quality of service user experience; how best to recognise normal fluctuations in performance, particularly between frequent reporting dates. We've also shared experiences on setting local objectives.

Based on the these discussions, the working group has suggested the following outline framework for sharing regular progress updates with MSG based on four key elements:

a) Quarterly data on the six indicators but in time building on these indicators for example to reflect the contribution of primary and social care.
b) Comparison between progress in Integration Authorities and projections set out in local plans, and also with the likely result had no changes been made
c) Overarching narrative summary, drawing out emerging themes from across Integration Authorities
d) Local illustrations, inviting individual Integration Authorities to contextualise their progress with a presentation to the group and opportunity for discussion. Over time we aim to involve a wide range of Integration Authorities depending on the purpose / theme of the MSG meeting.

Taking account of the proposed framework, we have agreed with the working group and Chief Officers that we will co-produce a paper providing an update on progress for the next MSG meeting on 13 December, drawing on the recent annual performance reports, and will invite one or two partnerships to present at the meeting.

Beyond this meeting, we have agreed with the working group and Chief Officers that it would be helpful to provide MSG with an updated overview of local objectives and ambitions relating to the six indicators. We are aware that some Integration Authorities will have reviewed and updated their objectives since sharing them in February. You are therefore each invited to share your updated objectives for 2018/19 by 31 January 2018, following which we will provide an overview, with input and support from the working group and partnerships, for MSG for their meeting on 21 March 2018. We recognise that, as before, you will want to engage a range of partners in this process.

To support the process, we have developed draft guidance and a suggested format for sharing objectives with advice from the working group, ISD and others. This should help to simplify the task locally and will provide consistency across information shared. As before we would anticipate that there would 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 will work with the working group and Chief Officers to expand the range of indicators used going forward. In view of the move to a single national social care dataset, we have agreed with the working group that we should feed in views around about the social care data collected to ensure that it provides intelligence which supports the planning and delivery of integrated services.

We would be grateful if you would provide your updated 2018/19 local objectives for MSG by 31 January 2018 to 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 would welcome any feedback on this approach and the guidance – please contact my colleague Fee Hodgkiss fiona.hodgkiss@gov.scot or 0131 244 5429.

Yours faithfully

Alison Taylor Paula McLeay

Alison Taylor
Deputy Director
Integration Division

Paula McLeay
Chief Officer Health and Social Care
COSLA

Appendix 3 - MSG Guidance on Objectives Preparation

1.1 Guidance on preparing and sharing local objectives around six indicators for MSG

1.2 Introduction

This document provides guidance on preparing and sharing local objectives around the six indicators agreed with the Ministerial Strategic Group for Health and Community Care (MSG). We have developed this document with the advice of the MSG data working group comprising representatives from Partnerships. The objectives will be used to produce trajectories for each individual Partnership and returned by ISD on a quarterly basis alongside baseline figures and data submitted during the previous quarter e.g. SMR information.

As well as helping to illustrate the progress of Health and Social Care Integration, it is important that the indicators and the data outputs meet the needs of local areas and so feedback around this is welcomed. It is likely that, with consultation, further indicators will be included in the future but these six will allow initial analysis to be undertaken of expected future trends.

1.3 Assistance

Excel outputs containing figures for each of the indicators will continue to be sent by ISD on a monthly basis. The footnotes attached to these tables explain how the indicators have been defined. As before, and if desired, we would anticipate that there would be local support available from the LIST team and other local analysts, drawing on collective advice on best practice for developing objectives. These various forms of assistance may be of particular benefit to those Partnerships who did not provide objectives previously.

1.4 Format for sharing objectives

In order to help summarise planned objectives for each of the 6 main indicators, we have provided a suggested format in Appendix A for Partnerships to use to share their updated objectives. This should help to simplify the task locally and will provide consistency across information shared by Partnerships, as well as making it possible to create standard outputs for all Partnerships. The attached table provides a standard format for each Partnership to share key pieces of information but is intended to act as a summary only, with more detailed plans/objectives contained within the main body of the Partnership plan.

It is understood that some areas may set different objectives for adults (18+) and children and, where that is the case, two tables should be completed. Where all objectives are the same for both adults and children, only one table is required. If preferred, objectives can also be provided separately for 18-74 and 75+.

The information below contains guidance on how to complete each section of the table with an illustrative example available in Appendix B (this is not based on real data). This guidance does not provide an exhaustive list of ways in which the table should be completed but it does outline the type of information required to ensure accurate trajectories can be calculated. If there are no updates to plans/objectives previously provided then Partnerships can simply reattach these but they are asked to complete the table following the guidance provided in this document.

1.5 Indicator descriptions

Objectives should be returned for each of the following indicators:

1. Number of emergency admissions into Acute (SMR01) specialties.

2. Number of unscheduled hospital bed days, with separate objectives for Acute (SMR01), Geriatric Long Stay (SMR01E) and Mental Health (SMR04) specialties.
3. Number of A&E attendances **and** the percentage of patients seen within 4 hours.
4. Number of delayed discharge bed days. An objective can be provided to cover all reasons for delay or separate objectives for each reason type i.e. Health and Social Care, Patient/Carer/Family-related, Code 9.
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 75+. A suggested further breakdown would be: care home, at home (supported) and at home (unsupported).

For details on how figures are derived for each of these indicators, please see the footnotes beneath the tables in the accompanying spreadsheet *Integration-performance-indicators-v0.9*. A further update to this spreadsheet will be made available at the end of November. For those Partnerships wishing to provide monthly projections, space will be made in that spreadsheet which can be returned along with the summary table in Appendix A.

1.6 Baseline

Within the baseline section, Partnerships should provide a brief summary of recent trends in the data; this should be based on the monthly Excel spreadsheets sent by ISD. It should take into account the last 1 to 3 years and will offer some context for the objectives provided in the next section. It is expected that the baseline for most Partnerships will be the year prior to Health and Social Care Integration (2015/16), but this may not be the case for all areas.

1.7 Objective

Each Partnership is requested to share details of how they expect activity to change in the future, focussing up until the end of 2018/19 as a minimum. In order to calculate meaningful trajectories, the following information is required:

1. **Expected change (increase/decrease/remain the same).** This could be a percentage change or an actual number e.g. reduce by 5%/reduce by 1,500, as long as the measure is clear
2. **The baseline period the change is based on.** For example, a 3% reduction in overall unscheduled bed day figures in 2017/18 *compared to 2015/16*. It is important to note whether the baseline refers to calendar or financial year and that the baseline and change measures are comparable
3. **Expected figures.** As a result of parts 1 and 2 above, this will be the final total figures expected during the period in question. For example, 310,000 unscheduled bed days are expected during 2018/19. Providing this figure will make it easier to see the expected final outcome.

Further examples of how this could be presented (including the change and the baseline it relates to) are:

- Month to month percentage changes in emergency admissions during 17/18 and 18/19 will match those seen during 15/16. Please see attached spreadsheet for monthly breakdowns.

- Compared to 2017 calendar year, gradually reduce overall delayed discharge bed days by 10% by 2019 calendar year's end.
- Gradually increase percentage of care delivered in community to 88.5% in 2019/20.

The more detail provided in this section should reduce the need to make assumptions and increase the accuracy of the planned trajectories. Please see Appendix B for further detailed examples.

1.8 Information on how objectives will be achieved

Each Partnership is asked to provide a brief summary of specific programmes, which are planned or have already been implemented that will help to achieve these objectives. It is expected that further detail will need to be included in the main body of the Partnership plan and, if helpful, hyperlinks can be added to these sections within the table.

1.9 Progress

This section will be completed by ISD/LIST analysts and returned to Partnerships on a quarterly basis. As much as possible, it will focus on the same baseline as the objective, highlighting how the data has changed over the course of the last quarter(s). It will also refer to the objective to assess whether or not the desired progress has been made. Presenting this information will be reliant on receiving objectives in the appropriate format, as described in the Objective section.

Notes

Please include any information or background notes which are important to highlight in relation to the objectives provided. This might be to offer some form of context to the objectives or to help explain some of the nuances around local data collection. The following list contains several specific examples but Partnerships are asked to provide any information they believe to be relevant:

- SMR completeness issues due to a new IT system being implemented which affect the baseline data between September-December 2016
- Step-up and step-down beds included within the bed days figures
- Ward attenders or patients attending Combined Assessment Units included within emergency admission figures

Again, if more detail is provided in the main body of the Partnership plan then hyperlinks can be provided to those sections and a simple summary included within the table.

1.10 Next steps

The next update to the Excel spreadsheets will be sent by ISD at the end of November and will contain data up to September 2017; this data should be used to help develop objectives. Please look at the "Completeness" tab for information around the completeness of SMR data within each Health Board.

We would be grateful if you could share your objectives by 31 January 2018. Please send to NSS.Source@nhs.net. If you have any questions about the process, please get in touch with your local LIST analyst or contact Martin McKenna in ISD NSS.Source@nhs.net

Appendix A – Table

MSG Improvement Objectives – summary of objectives for Adults and Children

East Lothian	Unplanned admissions	Unplanned bed days	A&E attendances	Delayed discharge bed days	Last 6 months of life	Balance of Care
Baseline						
Objective						
How will it be achieved?						
Progress (updated by ISD)						
Notes						

Appendix B – Example

MSG Improvement Objectives – summary of objectives for Adults and Children

Partnership A	Unplanned admissions	Unplanned bed days	A&E attendances	Delayed discharge bed days	Last 6 months of life	Balance of Care
Baseline	2016/17 change: 1% decrease in overall total compared to 2015/16	2016/17 change: 2% decrease in overall total compared to 2015/16	2016/17 change: 2% increase in overall total compared to 2015/16	H&SC reasons: 5% increase in 2016/17 compared to 2015/16 Patient/Carer/Family-related: 3% increase in 2016/17 compared to 2015/16 Code 9 reasons: 2% increase in 2016/17 compared to 2015/16	2016/17 change: Percentage of time spent in community in L6M increased from 86.1% in 2015/16 to 87.2% in 2016/17.	Proportion of people (all ages) living at home has gradually increased from 97.8% in 2013/14 to 99.1% in 2015/16. For the same time period for 75+, there has been an increase from 83.8% to 85.6%
Objective	2017/18 change: 4% reduction in overall total compared to 2015/16 Expected 2017/18 total: 16,320 admissions 2018/19 change: 7% reduction in overall total compared to	2017/18 acute change: 6% reduction in acute total compared to 2015/16 Expected 2017/18 acute total: 291,400 bed days 2018/19 acute change: 10% reduction in acute total compared to	2017/18 change: 4.5% reduction in overall total compared to 2015/16 Expected 2017/18 total: 31,990 attendances 2018/19 change: 6.5% reduction in overall total compared to	All reasons, 2017/18: 10% reduction in total compared to 2015/16 Expected 2017/18 total: 85,500 bed days All reasons, 2018/19: 17% reduction in total compared to 2015/16 Expected 2018/19	Increase percentage of time spent in community in L6M to 89.5% by 2018/19.	Expect to maintain 2015/16 proportion of people living at home until 2018/19.

	2015/16 Expected 2018/19 total: 15,810 admissions	2015/16 Expected 2018/19 acute total: 279,000 bed days Maintain number of bed days seen in GLS and Mental Health specialties in 2015/16 during 2017/18 and 2018/19 Expected 2017/18 GLS total: 8,000 bed days Expected 2018/19 GLS total: 8,000 bed days Expected 2017/18 Mental Health total: 52,000 bed days Expected 2018/19 Mental Health total: 52,000 bed days	2015/16 Expected 2018/19 total: 30,980 attendances Maintain average A&E % seen within 4 hours (95.3%) in 2015/16 during 2017/18 and 2018/19	total: 78,850 bed days		
How will it be achieved	Falls prevention, Care and Repair, Home Safe Initiative					
Progress (updated by ISD)	April to September 2017 update: 3% reduction in overall total compared to same period in	April to September 2017 update: 6% reduction in acute total compared to same period in	April to September 2017 update: 5% reduction in overall total compared to same period in	April to September 2017 update: 12% reduction in all delayed bed days, compared to same	Information presented annually – update will be included once data for this period	Information presented annually – update will be included once data for this period

	2015/16	2015/16 GLS and Mental Health figures similar to same quarter in 2015/16.	2015/16. Average A&E % seen within 4 hours similar to same quarter in 2015/16.	period in 2015/16	becomes available.	becomes available.
Notes	Ward attenders included within admissions	Step-up and step-down beds included within figures. See section 2.1 for details.				

Appendix 4 - MSG Indicators - Progress in 2017 and Objectives for 2018/19

MSG Improvement Objectives - Planned 2018/19 objectives for adults in East Lothian HSCP

East Lothian	Unplanned admissions	Unplanned bed days	A&E attendances	Delayed discharge bed days	Last 6 months of life	Balance of Care
Baseline	**2016/17 change** 3.8% reduction in overall total compared to 2015/16	**2016/17 change** 3.3% increase in overall emergency bed days(acute specialties) compared to 2015/16 7.5% increase in unplanned bed days within mental health compared to 2015/16 40.1% reduction in Geriatric Long Stay unplanned bed days	**2016/17 change** 2.8% increase in A&E attendances compared to 2015/16 Average % seen within 4 hours improved to 93.1% compared to 2015/16 average of 91.7%	**2016/17 change** All Delay Reasons 6.7% reduction compared to 2015/16 H&SC + Patient/Carer/Family-related reasons 4.9% reduction in 2016/17 compared to 2015/16 Code 9 reasons 34.2% reduction in 2016/17 compared to 2015/16	**2016/17 change** Percentage of time spent in community in L6M increased from 83.5% in 2013/14 to 85.7% in 2016/17 Percentage of time spent in large hospital in L6M decreased from 13.3%% in 2013/14 to 11.7% in 2016/17	**2016/17 change** Proportion of people (all ages) living at home (supported and unsupported) has slightly increased from 99.1% in 2013/14 to 99.2% in 2016/17. For the same time period for those 75+, there has been an increase from 92.3% to 93.0%
Objectives in 2017/18	1. *Unplanned admissions* Reduce unplanned admissions by 5%.	2. *Occupied bed days for unscheduled care* Reduce by 10% occupied bed days for unscheduled care.	3. *A&E* Maintain 95% 4 hour compliance target in accident and emergency from March 2018.	4a & 4b *Delayed Discharges (including those delayed due to Adults With Incapacity)* 4a. Reduce delayed discharge bed days by 50% in period Jul – Dec 2017 compared to same 2016 period. 4b. Reduce number of delayed discharges by 50% by Dec 2017 compared to Dec 2016.	5. *End of Life Care (e.g. proportion of last 6 months of life spent at home or in a community setting)* No more than 10% of last 6 months of life spent in a large hospital by 2018/19.	6. *Balance of care spend across institutional and community care services* 98% of over 75s to be supported in non-acute setting

Progress (updated by ISD)	**April to October 2017 update:** 11% reduction in overall total compared to same period in 2016. (remaining data for 2017/18 is awaited)	**April to September 2017 update:** 0.9% increase in unplanned bed days (acute specialties) compared to same period in 2016. 10.8% reduction in mental health specialties compared with same period in 2016. 43.3% reduction in GLS bed days compared with same period in 2016. (remaining data for 2017/18 is awaited)	**April to October 2017 update:** 0.9% increase in overall total attendances compared to same period in 2016. Average A&E compliance 93.9% seen within 4 hours compared to 93.5% for same period in 2016.	**July to November 2017 update:** 33.1% reduction in all reason delayed bed days, compared to same period in 2016 37.8% reduction in H&SC+P/C/F reasons compared to same period in 2016 73.9% increase in Code 9 reasons compared to same period 2016.	**In 2016/17 location of care in the last 6 months of life was:** Community: 85.7% Palliative: 0.9% Community Hospital: 1.7% Large Hospital: 11.7% For 2016/17 11.7% of care in the last 6 months of life was in a large hospital (2017/18 data is awaited)	**In 2016/17 care for the over 75s was delivered in:** Acute Setting: 1.5% Community Hospital: 0.3% Hospice: 0.0% Care Home: 5.2% Home: 9.7% (supported) Home: 83.3% (unsupported) In 2016/17 total being supported out of acute settings was 98.5% (2017/18 data is awaited)
Notes	Based on provisional data up to Nov 2017.	Based on provisional data up to Nov 2017.	This illustrates progress since 2012/13 Progress for 2017/18 was adversely affected by high winter pressures on A&E.	Progress is being made towards the target	Indicators 5 & 6 are only updated annually. Performance for full year 2017/18 will not be available until later in 2018. This is an improvement on the 2013/14 performance of 13.3%	Progress is being made towards the target

Proposed Objectives for 2018/19

Proposed 2018/19 Objectives	1. *Unplanned admissions* Reduce unplanned admissions by a further 5% in 2018/19.	2. *Occupied bed days for unscheduled care* Reduce by 10% in 2018/19 occupied bed days across all areas of unscheduled care.	3. *A&E* Reach 4 hour compliance of 95% in Accident and Emergency in 2018/19.	4a & 4b *Delayed Discharges (including those delayed due to Adults With Incapacity)* 4a. Continue progress towards delivering a 50% reduction in delayed discharge bed days in 2018/19 compared to 2016/17. 4b. Continue work to deliver a 50% reduction in the number of all cause delayed discharges by end of 2018/19 compared to end of 2016/17.	5. *End of Life Care (e.g. proportion of last 6 months of life spent at home or in a community setting)* Achieve and maintain performance of no more than 10% of last 6 months of life spent in a large hospital by end 2018/19.	6. *Balance of care spend across institutional and community care services* Maintain performance of 98% of over 75s being supported in non-acute settings through 2018/19.
How will it be achieved?	Through co-ordinated actions of: Primary Care Teams Community Teams Hospital at Home Team Care Home Team Hospital to Home Team taking a proactive role	Through co-ordinated actions of: Primary Care Teams Community Teams Hospital to Home Team	Through co-ordinated actions of: A&E Team Acute Team	Through co-ordinated actions of: Primary Care Teams Community Teams Hospital at Home Team Care Home Team maintaining clients in their care home whilst unwell and not admitting to acute District Nursing Team intervening early to support patients	Through co-ordinated actions of: Palliative Care Team Hospital at Home Team Care Home Team	Through co-ordinated actions of: Care of Elderly Team Primary Care Teams Community Teams Hospital to Home Team Hospital at Home Team