Care Home Data Review: Workshop Summary

This report provides a summary of the discussion from the Care Home Data Review Workshop, held online on 14 March 2023. The aim of the workshop was to discuss the experiences of providers and users of care home data, looking across all national care home data collections.

The workshop

The majority of the workshop consisted of interactive sessions intended to capture data uses, issues, potential improvements and prioritisation. The topics covered in these sessions were:

> Session 1 - How can we improve the accessibility and insight from the care home data currently available?
> Session 2 - What are the most important questions that need to be answered relating to care homes and do we have the data to answer these?
> Session 3 - How do we prioritise changes/improvements to both reduce the number of collections & ensure maximum benefit for data users & providers?
> Session 4 - What are the needs of care homes/service providers with regard to data for planning and delivering good quality care?

Workshop participants

The workshop had over 110 people in attendance, both data providers and users, from a range of organisations:

- of the 94 participants who answered the question "What type of organisation do you work for or represent?", 35 (37%) worked for a Health and Social Care Partnership (HSCP); 19 (20%) worked for one of the following 3 main public sector organisations in Scotland (Scottish Government, Care Inspectorate and Public Health Scotland), while 16 (17%) worked for a care home or care home organisation
- of the 126 people who signed up, 31% were data users, 20% data providers, and 46% both provided and used data. (3% did not answer this question)
- a majority of participants came from the Central Belt, although there were a few from Aberdeenshire, Dumfries and Galloway and the Highlands and Islands

This document

This document summarises the comments provided & issues raised in the workshop, together with possible solutions suggested by participants. These issues and suggested solutions are quotes or paraphrases of workshop participants' views, so do not necessarily reflect the views of the Scottish Government or our delivery partners, nor are they an indication of practicality. Please note that this list of issues and solutions may not be complete, but simply reflects the views we heard on the day.

In summarising, we have pulled comments together under eight key themes. In some cases, a comment may cover a number of themes, but to avoid duplication will only be listed once.

We have mostly not indicated who made each comment, so the issues discussed below are a reflection of the collective challenges faced by a number of different data providers and users. It should be noted, however, that there will be variation of experience even among data providers & users (e.g. the issues faced by a care home may be very different to those faced by an HSCP).

Finally, by its very nature, the document only focusses on challenges and possible solutions; it does not reflect areas where the systems currently work well for data providers and users.

Contents

Issues raised at the workshop affecting mainly data providers

Volume of requests

It was noted that issues of time, staffing and volume of requests are all intertwined. Data providers face a balancing act between capacity (resource / staffing / available time) and demand (volume of requests). Currently many providers find their capacity does not meet demand, making providing data difficult to cope with.

(limited) Capacity can be broken down into:

- limited staffing and staff time
- not having admin support
- only some staff having access and/or knowledge to input data

(high) Demand can be broken down into:

- volume of requests
    - number of individual returns
    - length of returns
    - multiple agencies collecting similar / identical data
    - time taken to complete returns and pull together information (see also 'data input process / systems')
- limited guidance (mainly see 'Guidance / support with providing data')
- tight deadlines, often with little notice given

> *"Data and information required is overwhelming. All the reporting mechanisms and systems in place make it like a full time job"*

Linking to volume of requests, workshop attendees mentioned the:

Need for rationalisation of returns
Suggestions from the workshop of opportunities for rationalisation are shown below.

Data not bringing value to data providers
Some data providers felt the data they provided didn't bring them or their organisation any apparent benefits, but was purely for the benefit and use of the person or organisation requesting it.

Concerns about providing data that isn't used
People commented that it felt a waste of time filling in data returns that weren't looked at or used – data going into a 'black hole'. Related to this, see Little or no feedback on why data is collected or how it is used.

Suggested solutions to volume of requests

Suggested solutions related to capacity

It was mentioned that data providers would like 'incentives for providing data'.

See also 'Suggested improvements to data input process / systems'.

Suggested solutions related to demand

Many solutions suggested at the workshop related to reducing the demand on data providers through data rationalisation:

- Reducing overlap and duplication between data returns (see specific rationalisation suggestions below)
- Following consultation, stopping collecting data which are never used
- Reducing the frequency of data returns to only that which is needed (e.g. potentially stopping daily reporting)

> *"Only collect the data that is needed, and only as often as is necessary"*

An alternative suggestion was that Turas[1] could ask for more detailed context from Care Homes to prevent further questioning. This is a similar idea to working towards a single data return – it is better to complete one long return, than 10 short ones.

- **Give more notice and stop last minute requests**

To help reduce the burden from unpredictable, sporadic returns with tight deadlines, more notice could be given to data providers, with agreed time frames.

> *"Be respectful of our time and give us adequate lead time"*

- **Single, standardised data return**

Longer term suggestions related to combining data collections into a single standard data return and potentially linking with hospital/GP data.

Specific suggestions for rationalisation (e.g. combining datasets/reducing overlap)

Combining data collections with Source social care data & removing data from Source that is collected elsewhere:

- *Free Personal and Nursing Care / SG Quarterly Monitoring Return*
  Several suggestions related to combining PHS Source with the Scottish Government's Quarterly Monitoring Return/ Free Personal and Nursing Care. Currently, submission timescales are slightly different but there is a large overlap in questions.

- *Scottish Care Home Census*
  Another suggestion was to stop the separate Scottish Care Home Census data collection, and instead extract this data from Source returns.

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[1] The platform run by NHS Education for Scotland which hosts the Safety Huddle Tool.

- *Financial data (LFR 03)*
  There is overlap of financial data between LFR 03[2] and PHS Source[3]. Suggestions included excluding a financial data item from the Care Home section of the Source return or moving financial data collection from LFR **to** Source.

- *Care Inspectorate / Free Personal & Nursing Care / Delayed Discharge*
  Suggestion to combine regulatory and statutory indicators e.g. Source, Free Personal & Nursing Care, delayed discharges and those collected by Care Inspectorate.

Reporting the death of a resident.

Currently this has to be reported multiple times to different organisations.

Suggestions for how it could be done

- *Start a working group to lead rationalisation work*

  > *"Have a working group to explore, lead and champion the rationalisation work"*

  Work would include both looking at what information is never used, and finding overlapping variables, and removing these from data collections.

- *Have a formal process for approving new collections*
  Ensure all new data asks are sense checked against existing data collections. One suggestion was to start a Data Steering Group to consider new data asks. This should include data providers. Another was that a politician or senior manager of a Scotland-wide governmental organisation should give justification for a request.

- *The eventual aim of all this work:*
  A total review of the data items requested (at variable level) – with full justification of why they are needed, how they are used and who by.

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[2] The Local Financial Returns (LFRs) are a suite of annual returns collecting expenditure and income information from Local Authorities around Scotland. LFR 03 contains data on social work expenditure and income.
[3] Public Health Scotland collects a range of Social Care data in their 'Source' dataset, published annually in their 'Insights in Social Care' publication and associated dashboards.

Data input process / systems

Need to go to multiple sources to collate information before submission

Pulling information together from a number of sources ready to be submitted is time and labour intensive, particularly in care homes which still use paper-based records. This process also increases the risk of errors.

Lack of standardisation of systems for inputting data

Providers commented that they need to go to a different website/tool to input data for each data collection, taking up extra time they do not have. Care homes each have different internal data systems.

Issues with access to systems

Digital infrastructure

Digital infrastructure questions pose a particular problem in relation to the built environment of care home stock (which can be very old).

> "Care homes require digital infrastructure / digital care planning to enable data to be used to inform care. This will support earlier intervention ensuring residents receive the right care"

Suggested improvements to data input process / systems

Single system to submit returns

Overlaps with the suggestion for a 'Single, standardised data return'.

All (or most) data could be fed into a single system or tool – a 'one stop shop' for data collection. This could be linked to existing systems to reduce manual input needed. Data could then be extracted from this central system by data producers rather than going directly to care homes / other providers.

Integrate systems

If we're unable to get a single system, it was suggested that second best would be to 'connect' and 'integrate' the multitude of different systems currently in use to allow data to flow between them.

Increase automation of returns process and improve existing systems

Increase automation of the return generation process, leaving care home staff with more time for looking after residents.

> *"A return which links with existing info systems for ease of production, rather than having to generate each time"*

This is an example of the broader suggestion to help support care homes to improve their IT systems to make it easier for them to submit data.

Issues raised at the workshop affecting both providers and users

Lack of standardisation

Non-standardised and/or ambiguous definitions and terminology

Data definitions are often unclear or ambiguous, so can be interpreted in different ways, often with localised interpretations.

Definitions for the same concept are also often subtly different between organisations. This contributes to the number of overlapping data collections (increasing provider burden) and makes it difficult for data users to find clear, unique answers to questions.

Overlapping data collections and duplication – need for a Core Minimum Dataset (CMDS)

Sometimes the same data is available in more than one place. This has led to a cluttered and confused data landscape, which many people don't understand, and also increases provider burden. Many comments from the workshop mentioned the advantages of a core minimum dataset (CMDS), both from provider and user viewpoints.

"No one joining the dots between different collections"

Non-standardised systems

Mainly covered under 'data input process / systems'.

People commented on the number of different systems in place, made worse by the fact they 'don't speak to each other'.

Local systems and collections overlapping with national ones

Health and Social Care Partnerships (HSCPs) and Local Authorities (LAs) often send their own requests to care homes, in addition to the national returns they have to fill in. An example was given of an HSCP which brought in an online form for reporting incidents. Care homes in this HSCP now need to complete this local return as well as the national Care Inspectorate return for incidents.

Uneven timescales

Different returns covering the same/similar time periods do not always have the same submission dates (or exactly same time range).

Datasets not aligned with national indicators

It was noted that the data being collected can be inconsistent with existing indicators for measuring performance.

Suggested solutions to lack of standardisation

"The data strategy for health and social care and the development of the shared health and care record should introduce common data standards for across the sector"

"We need to make sure that the information standards that are developed work for the care home sector"

Standardised definitions

Agree clear, consistent definitions between organisations, particularly before starting any new collections or changing existing collections.

Other suggestions relating to standardisation

- have a review of data collection timetables across returns. "Align reporting timescales for returns covering same reporting periods"
- "align datasets with ministerial steering group indicators and develop minimum IJB dataset"
- "use APIs/data interoperability to link TURAS and Social Care Systems and NHS apps"
- standardise collection processes and methods

Data sharing issues

There were general concerns that the data people needed was not always accessible to them, or systems were not accessible. The lack of data sharing contributes to this, together with timeliness of what data sharing is currently in place. Delays with data sharing can mean that by the time data systems are accessed, the point at which you can achieve a meaningful outcome has passed.

The frustration with the current lack of sharing was clear:

"Data to be shared rather than telling 3 folk how many beds are available in 3 different forms - phone, email and online"

"Collect once and reuse many times"

By agreeing questions and definitions between organisations / data collections, and sharing data between them, the number of data returns could be significantly reduced. Eventually, there could be just one place of data input.

Suggested improvements to data sharing

- improved information governance procedures to allow data sharing between organisations working towards the same cause. "Robust data sharing agreements"
- sharing data back with those who provided it
- linking systems to ease data sharing (& collecting)
- providing care homes with access to social work & health info on people using services 'would be transformative on outcomes'

Communication issues

Guidance / support with providing data

Some questions lack clarity, so different areas or even teams will often interpret requests differently. (A specific concern raised was the need for clarity on which residents receive Self Directed Support (SDS)). There is limited guidance on completing returns, and a lack of clarity on reporting deadlines.

Little or no feedback on why data is collected or how it is used

Providers often felt they were providing data into a 'black hole', with no communication about where (or even if) their data was published or what it was used for. They said they wanted to know the purpose and the benefits of each data collection, and to have data shared back, so they could understand the difference their data is making.

"There has to be value for care homes in data capture"

Suggested improvements to communication

- regularly update data providers with reasons for each data collection, giving clarity about the purpose of each return and explaining what will be done with data
- set up data providers networks to provide clarity on what is being asked for and to agree guidance & timescales
- publish an annual list of all data collections across the sector, together with their collection dates
- 'to have data feel useful' would be a great incentive for data providers, so this could lead to higher response rates/engagement
- 'provide an overview of the key themes from returns' to help data users

Issues raised at the workshop affecting mainly data users

Quality / completeness of existing data

Timeliness of publication

"Data is often out of date by time of publication"

Providers raised concerns both with annual publications being published a while after the data they refer to was collected, and shorter term 'near real-time' datasets (like the Safety Huddle Tool) not refreshing quickly enough.

Short term / live data collections

There was concern with systems such as Turas not being nimble enough to keep up with the constantly changing nature of care homes, so data was out of date as soon as it was released. HSCPs commented that they had to phone care homes directly to get the latest vacancy data, increasing the burden both on them, and on care homes.

"…can fill in a form and it can change a few hours later. Information is a snapshot and this needs to be kept in mind"

Quarterly / annual publications

The delay between quarterly / annual returns being submitted and the data and accompanying reports & executive summaries being published limits their usefulness to management. This delay is often of the order of months – a year. For example, it was noted that workforce data from Care Inspectorate (CI) / Scottish Social Services Council (SSSC) is a year out of date at publication.

Other concerns about timeliness

Social work assessments are often out of date when received. One of the underlying issues contributing to this is that data providers need to wait for systems to update before preparing returns data.

Concerns about data coverage, accuracy & completeness

Geographic coverage

Data is not always available at a low enough level (e.g. individual level) to answer questions, but is instead aggregated by board. Resident level data is either not available or not accurate.

Inconsistent coverage

Some datasets (e.g. PHS Source social care) only cover Local Authority funded individuals, rather than all residents in a care home.

Poor response rates…

…on particular variables and datasets. Missing data is often estimated, lowering data quality. One example is the Care Home Census, where only 67% of care homes open anytime during 2021/22 submitted data (so Public Health Scotland had to estimate one-third of the data for some of the data items).

Pre-population of data fields potentially lowering data quality

In the care home census some data fields are pre-populated with the previous year's residents' data to save providers time. However, some of these residents will have died or moved on and if the discharge date or date of death is not provided then this will reduce data quality.

Inconsistency across datasets diminishing confidence in data

Participants commented how duplication raises concerns about quality and accuracy, as there are apparent conflicts of data when data about the same thing show different values in different datasets.

Specific examples of poor data quality

Specific examples were given in the workshop of poor data quality, with lots of overlap with gaps in data, below. We have noted all these concerns together in gaps in data.

Suggested improvements to quality / completeness of data

Timeliness

"Provide data in as close to real time as possible"

Geographic coverage level

Some attendees noted the need for individual level data, to allow more cuts of data to be possible.

Low completeness rates

- incentivise completion by making useful data available to data providers
- improve guidance to make it easier to complete returns
- make data collection mandatory. "Data much less useful if not 100% complete"
- feedback on how data is used and the difference it is making (see Communication)
- leave data collections open throughout the whole year, making it easier to update details as and when they change (e.g. recording discharges in the care home census)

Creation of a Core Minimum Dataset (CMDS) / reduction of duplication

"Get gardening! Throw some data to the compost heap to allow other data to grow"

Many comments mentioned the advantages of a core minimum dataset (CMDS), increased standardisation and reduced duplication to help move away from current data landscape and enable collection of data collectively agreed as important. This would free up resource to focus on additional requirements.

Gaps in data

Variable gaps

There was discussion around specific variables that are needed but not collected (or of such poor quality in their current state that they are not of any use).

Staffing and workforce

- timely and accurate data is needed on staff recruitment, turnover & retention. This is needed to determine safe levels of staffing to meet the needs of residents (it was noted that there is data on turnover and retention available relative to other social care sectors)
- poor data on movement of staff
- there is currently a poor response rate on data relating to staff leaving Social Care (e.g. the type of employment people move to)
- data needed on use of agency staff, the ratio of permanent staff : agency staff, and the impact of agency staff on quality of care
- staffing numbers in relation to occupancy are needed (i.e. headcount per resident)
- data needed to help with the safer staffing legislation
- more data needed on staffing and workforce patterns and trends
- real time data on staffing cover is needed (together with qualification & skills levels)
- data on staffing absence have been removed from Turas - would be helpful to have these back

Vacancies (as in bed vacancies, not staffing vacancies) and bed occupancy

- real time occupancy levels are needed, but data is often affected by poor timeliness
- reasons for vacancies (in placements and care homes)
- status of beds. 'Beds pending' , 'beds held for assessment', available beds, occupied beds, total beds, temp closed beds etc.
- need for data on 'viable vacancies', not just empty rooms that can't be used
- occupancy and availability trends
- a single number is not enough, but staff need more context behind bed vacancies. Some care homes have many vacancies but don't have the staff to admit to these, or care homes limit the number of admissions per day
- interim and respite care availability
- data split by care home / placement category (i.e. residential / nursing / etc.)

Resident data

Participants commented that there was a need for 'more resident focussed data'.

- *Resident needs*
  Information on resident needs is not currently captured. Data on the level of need people have and the support they require, both before and after they are admitted. The ability to track how quickly resident needs change from point of admission (i.e. residential to nursing care) would also be helpful.

  Data on dependency and high levels of care is required, especially if acute. This would help ascertain safe levels of staffing to meet resident needs.

- *Types of bed*
  Data on the numbers of residents in different types of bed (e.g. specialist beds) is needed.

- *Types of care / placement types*
  Data is needed on the types of care required, provided and received . Also more data is needed on placement types.

- *Resident health conditions, wellbeing & complexity*
  Accurate data is needed on the number of residents with specific health conditions and complexity:

  o *Dementia*
    Particularly mentioned was the need for accurate data on dementia. The care home census has dementia status but this is just a snap shot. Both the Care Home census and PHS Source social care data collection under-report the expected numbers based on prevalence. More detailed data is also needed – by severity and giving information on how long residents with dementia stay in a care home.

  o *Medication levels*

  o *Resident wellbeing*
    Details around residents' wellbeing are needed, to flag early concerns around Adult Support & Protection (ASP) and provide support to care homes. Other specific data needed include:

      ▪ *falls trends*
      ▪ *prevalence of pressure ulcers (in particular "pressure acquired wounds above grade 2")*
      ▪ *catheter-associated urinary tract infections (CAUTI)*
      ▪ *dysphagia*

- *Home address of residents*
  To determine home LA area, and give data on the number of "out of area residents" in local care homes. There's a need for a national picture of out of area placements by HSCP to HSCP

- *Outcomes and experience data*
  Both resident and care provider experience

- *Funding*
  o *Types of funding (self-funding, non-self-funding)*
  o *Who is on contract rate*
  o *Details of the charges made to self-funders*

- *Demographic data*
  For example, understanding the changing demography of care home residents.

- *Other more detailed resident data*
  o *Are people living in care homes (and the staff that care for them) receiving the support that they need from healthcare teams (e.g. GPs, Nurses, Allied Health Professionals)?*
  o *How many people have / have not had the opportunity to develop an Anticipatory Care Plan?*

Finance

Lack of robust finance data (e.g. expenditure by client group is no longer classed as a national statistic). Data has to be apportioned, as it is not available directly from LAs' ledgers.

Data is needed on sustainability – Care Home costs vs income from funded places. It was noted that "sustainability info is being gathered at a local level by HSCPs".

Discharge data

Discharge data is very patchy - wasting time contacting GP and hospital trying to verify sparse information. This is worse on rushed discharges.

A&E attendance

There is poor recording of Accident & Emergency (A&E) attendance codes. Difficult to identify any pattern of A&E attendance by care home residents. The reason for A&E attendance is particularly hard to determine. A&E data only records injury type, not reason.

Health / outbreak data & reasons for care home closure

There is a need for better data on outbreaks (including, but not limited to covid, i.e. flu, norovirus etc.), including those causing care home closure. Currently there's only data on lab-confirmed cases, so – especially now that testing is becoming less common – it's hard to determine the true size of an outbreak. There is a need for data on symptomatic residents.

Other variable gaps

- How many different GP practices are providing care to a single care home?
- Data on volunteers in care homes
- Data on access and completion rates of staff training/Continuing Professional Development (CPD, e.g. e-learning). The ability to track the impact of this training and development on quality of care.

Forecasts and predictions

Data currently used is retrospective. Several participants said that it would be useful to know the predicted future demand for Care Homes and for what purpose (e.g. residential, interim, respite etc.)".

Longitudinal / care pathway data and outcomes

Useful to have data on each client's care pathway. This would include records of the services they received before they were admitted to hospital or care home (e.g. home care and/or telecare); where people were admitted from (e.g. community or health), and the type of admission (planned / emergency). Linking this to data on the services received after admission; how long they stay; and where they are discharged to will give a much fuller picture of the full experience of a client through the care system. There is currently limited ability for addressing key questions about client outcomes.

A comment suggesting this would be possible:

> *"Scotland has excellent and developing systems to enable data linkage. Potential to use linked data for longitudinal studies… Also to understand how geography and social circumstances influence outcomes - for example through Research Data Scotland"*

Timeseries data

There was discussion around wanting to know how care home usage is 'changing over time'. Current challenges include changing definitions over time (meaning data is not comparable year to year), low data quality, and lack of specific variables focussing on care home usage are all possible reasons.

Suggested solutions to data gaps

Specific variable gaps

Solutions follow on from the variable gaps detailed above.

Data linkage

Many of the suggested solutions here relate to data linkage, including:

- linking PHS Source social care data to Hospital and Primary Care data
- linking individual resident data to dementia registers (via CHI numbers[4])
  - date stamping dementia data to facilitate pathway analysis
  - there has been a previous (one off) exercise to link the dementia register to Source social care data and the Care Home Census. It would be good if this was done more regularly and with data on severity
- linkage between residents' profiles, medical records, hospital admission/discharge
- "dataset easily linkable to the new Adult Support and Protection (ASP) dataset"
- regular collection at an individual level and linked to other service use data enables pathways analysis

In order to do this:

- "include CHI with all data returns to allow linkage and analysis"
- add a flag to other datasets to indicate that a person is in a care home. This will enable care home records to be linked to other data - linkage to hospital records for example
- "a robust online platform is required to link data. This will reduce cost and time to access and process data. This will also reduce data duplicity and redundancy problem"

The solution to aspire to is a "shared health and care record".

Lack of insight

Finding data

There were many concerns about how data is stored on a number of different systems. It is difficult to understand where data is stored, and then to navigate these systems to find a specific piece of data. Data suppliers are rarely told where the data they have supplied is published (assuming it is published at all), making it difficult for them to trace where their data has ended up.

It was also noted that not enough is known about local internal systems in care homes. There is a lot of variation between care homes, so it is hard to understand what is out there.

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[4] Community Health Index numbers - a unique identifier for each patient, used throughout NHS Scotland.

Access limitations (including information governance)

See also data sharing issues.

People commented on the difficulties of 'complex and bureaucratic data access processes', often meaning they don't have access to the necessary systems to view the data they need, or have permission to view data. There is seen to be variation both between HSCPs and even within an individual HSCPs.

- *Specific issue of accessing data from NHS and HSCPs*
  It is difficult for care homes to get accurate and quality data on service users from the NHS and HSCPs (such as hospital discharge letters and social work case files). Reasons behind this include General Data Protection Regulation (GDPR) barriers and not qualifying as next of kin.

These access difficulties lead to care homes being asked for the same data multiple times.

> "*not easy to access so care homes end up being asked for same info multiple times*"

Practical access issues

Wi-Fi is not available in all care homes (or is often limited to a single office).

Context needed

Participants commented that data often lacked context, and there was a need for 'narrative analysis' and 'qualitative stories behind the data' to help understand residents' experiences. A more detailed breakdown of figures could give better context of the data submitted (mainly vacancies and staff in TURAS).

It was noted that the data available does not provide a coherent/compelling picture of what is happening in care homes.

Cause and effect

Contributing to this, someone commented on the need for more understanding of the reasons for trends.

> "*if there has been an improvement, what action resulted in the improvement?*"

Resources to maximise use of data

Some smaller organisations don't have the resources to maximise the use of data.

Data not providing value to end users

- publications don't answer questions people have locally (e.g. types of bed), so they can't compare with other HSCPs. See quality / completeness of existing data and gaps in data
- "people are only collecting portions of data at a time so overall picture not complete"

Suggested solutions to lack of insight

Finding and accessing data

People were very keen to see the range of different sources of care home data consolidated. There were two main suggestions of how this could be done. Many participants asked for a "single source of data to support effective planning". This centralised system could be directly accessed by data users, allowing them to access, analyse and download data in the format most useful to them (dashboard, creating reports, csv files etc.).

Another idea was a "'one stop shop' for data, with links to the various sources and an easy guide of what to find where".

Points relating to data access and information governance included:

- providing care homes with restricted access to social work case files for residents, meaning they have access to data at an early point
- HSCPs / PHS to routinely publish SOURCE datasets to local Care Home Sector

Data providing value to end users

- data users asked for "support to understand what the data is telling us"

Consolidation/ timeliness

- real time data synchronization among different tools - for example, a tool to group different dashboards by different providers

Learning

- develop analytical skills across the boards
- map of work that is going on to make sure work is not duplicated

"Learn what is being done internationally"

Examples to learn from

Scotland

- Fife – Care at Home Collaborative supports sharing of data between providers and HSCP to help with delivery of services
- Dumfries & Galloway – Clinical data being shared between partners at a local level. Nationally, there is need to look at how personal data can be shared and accessed
- another area uses local data to look at Emergency Department admissions and link in with the Care Home teams to see if they had relevant support prior to admission, the pathway taken, and if that could be improved
- a participant gave an example of how they speak post Discharge to identify if discharge was the best possible. This discussion covers handover, Care home transfer document, meds, DNA returned etc.
- Perth & Kinross – uses the 'Care Opinion' platform for reviewing partnership services. The public can see comments too

International

- New Zealand and Canada – national social care datasets using Resident Assessment Instrument–Home Care (RAI-HC) – tracks all with long term conditions, whether in the community or in care homes, used for clinical and admin

If you have any questions about the contents of this document, please contact the Care Home Data Review team at SWStat@gov.scot