ITEM No …5……..

REPORT TO: **PERFORMANCE & AUDIT COMMITTEE – 17 JANUARY 2017**

REPORT ON: **DUNDEE HEALTH AND SOCIAL CARE PARTNERSHIP PERFORMANCE REPORT**

REPORT BY: **CHIEF FINANCE OFFICER**

REPORT NO: **PAC3-2017**

1.0 PURPOSE OF REPORT

The purpose of the report is to update the Performance and Audit Committee on progress in implementing the Partnership's performance framework. The report also brings forward the Quarter 2 Performance Report for 2016/17 for consideration by the Committee.

2.0 RECOMMENDATIONS

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

2.1 Notes the progress that has been made in further developing and implementing the performance framework, and supporting structures and systems, since the last update was provided to the Integration Joint Board (IJB) in August 2016.

2.2 Notes the intention to establish an Outcomes and Performance Co-ordination Group to support the further development and production of annual and quarterly performance reports.

2.3 Notes the performance of Dundee Health and Social Care Partnership as outlined in Appendix 1.

2.4 Remits the Chief Finance Officer to further develop the appended performance report into a performance improvement plan, including timescales for delivery and appropriate links to the Partnership risk register.

3.0 FINANCIAL IMPLICATIONS

3.1 None.

4.0 MAIN TEXT

4.1 Performance Framework

4.1.1 At the meeting of the IJB on 23 February 2016 the Board approved an outline performance framework and reporting cycle (see report DIJB10-2016). An update report was provided to the IJB on 30 August 2016 (see report DIJB37-2016) detailing progress to date in implementing the agreed framework, bringing forward an exemplar section of the first annual performance report (due July 2017) and an exemplar quarterly performance report against a single strategic priority.

4.1.2 The IJB meeting on 30 August 2016 agreed to the establishment of an Outcomes and Performance Co-ordination Group to support the PAC. The full terms of reference of the Outcomes and Performance Co-ordination Group, including membership, will be developed following the first PAC. However, the overall remit of the group will be to support the further

development and production of annual and quarterly performance reports, with the intention that such reports are considered in detail by the PAC prior to submission to the IJB.

4.1.3 The Strategy and Performance Team is continuing to work with the wider Partnership to develop a suite of local integration indicators for each service area which will measure Strategic Shifts. A development event was held during September and the Strategy and Performance Team is supporting teams to finalise these indicators. The aim is for all service areas to begin reporting their suite of indicators for the 2017/18 financial year. Finalising these indicators will allow a full set of performance indicators across all levels of the multi-tiered performance framework for the Partnership to be confirmed for use in the 2017/18 financial year, supporting continuous improvement across the Partnership.

4.1.4 Covalent is the tool which will be used by lead officers across the Partnership, to input data and narrative around the national and local indicators. It will also be used to provide updates towards the agreed actions reported in the Strategic and Commissioning Plan. The administrative exercise to enter all actions onto Covalent is nearing completion and a training session was provided to key leads during November 2016 which demonstrated how to upload information. Further training will be provided as required.

4.1.5 Version 1 of the Strategic Needs Assessment accompanied the publication of the Strategic and Commissioning Plan. Work has now commenced to update data and make necessary improvements to Version 1. Version 2 will continue to focus on variation between localities and provide further neighbourhood analysis. It is anticipated that Version 2 will be completed by the end of the 2016/17 financial year.

4.1.6 The Information Officers within the Strategy and Performance Team are continuing to work with their counterparts in Angus and Perth and Kinross Partnerships to develop a subset of the Dundee Performance Framework which will be reported consistently across Tayside. This will allow for accurate regional benchmarking which will assist with continuous improvements and sharing good practice.

4.1.7 Dundee City Council are currently developing a new corporate approach to Performance Management. Through discussion with the Chief Officer it has been agreed that the interface between the Partnership and this new corporate approach will take the form of submission of the IJB quarterly performance reports to Council Committee alongside the Council's own performance reports.

4.1.8 The development and implementation of Dundee and Tayside wide datasets is in part reliant on up-to-date and accurate output from NHS information systems managed by the NHS Tayside Business Support Unit. Partnerships currently receive an IJB Performance Pack (previously the Community Health Partnership Performance Pack). Data within the Performance Pack requires to be revised and further developed to more meaningfully inform performance reporting and subsequent improvement activity, including providing data at locality level.

4.1.9 The National Services Scotland, Information Services Division (NSS ISD) LIST team consists of analysts who are seconded to partnerships to assist with the production and analysis of NHS data required for performance reporting and strategic commissioning. The production of NHS data for all reporting, including Strategic Needs Assessments and Performance Reports is currently completed by the LIST analyst seconded to Dundee for 2.5 days per week. At present this resource is available to the Partnership until 31st March 2017 and NSS ISD are currently discussing with Partnerships their requirements beyond this.

4.1.10 NSS ISD also compile the SOURCE data set which brings together service user level health and social care data. All Partnerships are required to submit defined data, for the past 5 years if possible. Dundee has now provided 5 years data for all but one area of the data set. The final area, Respite, is currently being worked on. The submission of SOURCE data supports the Partnership to link individual social care data with health data (currently secondary care) and to link individual data with unit cost financial information to allow tracking of costs per service user in order to inform improvement to services. This type of analysis will further support the Partnership to identify good practice and improvement activities that will impact positively on outcomes for individuals and communities.

4.1.11 The new Social Work client record system (Mosaic) went live in November 2016. The Information Team is leading on the development of Crystal Reports which will be used to report from Mosaic on some national and local indicators, statutory Scottish Government Returns and national information sharing and linking work streams (such as SOURCE). These reports will also be used to assist operational teams deliver services and monitor operational activity and performance and support improvements in outcomes for individuals and communities. The demand on the Partnership resource with regard to this workstream is significant and will have an impact on available resources until at least the end of this financial year.

4.1.12 Following recent recruitment activity the Information Team is now operating at its full staff compliment. Whilst this will assist with the additional demands brought by integration and the implementation of Mosaic significant pressure still remains. Ways of improving efficiencies, streamlining resources and aligning individual and team work plans to strategic plans are being explored across the wider Strategy and Performance Team. This includes considering how additional resources available to the partnership from NHS Tayside, Dundee City Council, NSS ISD and national improvement agencies can be further utilised. This will allow any remaining resource deficit to be assessed and solutions sought in due course in order that the Team can continue to support performance improvement activity that delivers improvement outcomes for service users.

4.2 Quarter 2 Performance Report 2016/17

4.2.1 Previous performance reports presented to Dundee IJB have focussed on trends in performance within the partnership over time and have, in part, been based on historical reporting indicators used within Dundee City Council and NHS Tayside. The performance report in Appendix 1 sets out performance benchmarked against national data. This outward looking approach highlights the fundamental reasons for the introduction of integrated health and social care services and draws out a range of key areas the Partnership needs to focus on to improve outcomes for individuals and communities in the future. The National Indicators which form the basis of this report focus on key drivers for health and wellbeing within our communities. Performance reflects the social and demographic profile of Dundee and the issues of inequality for people living in poverty, as recently highlighted through the publication of Dundee's Fairness Commission. As such, this performance report is imperative in supporting the partnership's commitment to continuous improvement in order to achieve our vision that each citizen of Dundee will have access to the information and support that they need to live a fulfilled life.

4.2.2 The Quarter 2 Performance Report covers local performance against National Indicators 11-23. Under each of these indicators there is a summary of current and planned improvement actions. Indicators 1-10 are reported from The Health and Social Care Experience Survey administered by the Scottish Government which is conducted biennially and the results from the 2015/16 survey were presented to the IJB in August 2016. Local indicators are currently under development and will be reported on in future performance reports (see 4.1.3), as will progress in implementing strategic shifts and associated actions within the Partnership Strategic and Commissioning Plan (see 4.1.4).

4.2.3 Committee members will note that the availability of data varies across the national indicators in relation to geographic focus. Health data provided by NSS ISD is not always provided at a locality level.

4.2.4 National indicators relating to delayed discharge and the quality of care services, as assessed by the Care Inspectorate, show that Dundee is performing better than the Scottish rate in 2015/16. Report PAC1-2017also being presented to the Committee today highlights examples of the high quality of care provided by Partnership services. Two indicators show that Dundee is performing at the Scottish rate and in 6 of the indicators Dundee is amongst the most poorly performing partnerships in Scotland.

4.2.5 As at 2015/16, Dundee had the 3rd highest death rate in Scotland, the 5th highest emergency bed day rates, the 1st highest re-admission rate within 28 days, the 2nd highest falls rate, the 2nd lowest percentage of adults with intensive needs receiving care at home and the 4th highest proportion of health and social care resource spent on hospital emergency bed days.

4.2.6 The National Indicator quarterly data is currently only available for 4 national indicators – emergency bed day rate for adults, emergency admissions rate for adults, falls rate for 65+ and

delayed discharges for 75+. Between the baseline year 2015/16 and 2016/17 Q2 Dundee has seen an improvement in three out of these four indicators. Emergency bed day rates for all adults have decreased by 3%; with a greater than 5% decrease in Maryfield, West End, East End and North East. Falls rate for 65+ have decreased by 2%, with the Ferry showing the greatest improvement with a 16% decrease. Bed days lost to delayed discharges for 75+ have decreased by 4%; the West End and Coldside have seen the biggest improvements with a 26% and 15% reduction respectively.

4.2.7 Analysis by deprivation supports previous findings in the Strategic Needs Assessment that there is a strong correlation between deprivation and poor health outcomes. East End, Coldside and Lochee are the 3 localities where performance against the National Indicators is poorest. The Strategic Needs Assessment and future performance reports will continue to present analysis by locality and neighbourhood to support strategic planning in these areas. The implementation of the Locality Manager Model will also enhance capacity to analyse and respond to performance in targeted localities.

4.2.8 In addition to the National Indicators, additional analysis around potentially preventable emergency admissions (charts 5 and 6) and dementia (charts 20 and 21) have been included. These are areas that, if targeted, could improve performance across many of the National Indicators.

5.0 POLICY IMPLICATIONS

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

6.0 CONSULTATIONS

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

7.0 BACKGROUND PAPERS

None.

Dave Berry
Chief Finance Officer

DATE: 22 December 2016

Appendix 1

Dundee Local Community Planning Partnership Performance Report 2016/17 Q2 and the National Position for National Indicators 11-23 as at 2015/16

Executive Summary

- This report sets out performance benchmarked against national data. This outward looking approach highlights the fundamental reasons for the introduction of integrated health and social care services and draws out a range of key areas the Partnership needs to focus on to improve outcomes for individuals and communities in the future. As such, this report is imperative in supporting the Partnership's commitment to continuous improvement in order to achieve our vision that each citizen of Dundee will have access to the information and support that they need to live a fulfilled life.

- The National Indicators which form the basis of this report focus on key drivers for health and wellbeing within our communities. Performance reflects the social and demographic profile of Dundee and the issues of inequality for people living in poverty, as recently highlighted through the publication of Dundee's Fairness Commission.

- National indicators relating to delayed discharge and the quality of care services, as assessed by the Care Inspectorate, show that Dundee is performing better than the Scottish rate in 2015/16. Two indictors show that Dundee is performing at the Scottish rate and in 6 of the indicators Dundee is amongst the most poorly performing partnerships in Scotland.

- As at 2015/16, Dundee has the 3rd highest death rates in Scotland, the 5th highest emergency bed day rates, the 1st highest re-admission rates within 28 days, the 2nd highest falls rate, the 2nd lowest percentage of adults with intensive needs receiving care at home and the 4th highest proportion of health and social care resource spent on hospital emergency bed days.

- Between the baseline year 2015/16 and 2016/17 Q2 Dundee has seen a decrease in rates (improvement) in 3 out of 4 indicators; emergency bed day rates for all adults, falls rate for 65+ and bed days lost to delayed discharges for 75+.

- Emergency admission rates have increased slightly by 2% for Dundee since 2015/16 and only Strathmartine and the Ferry have seen a decrease over this period. The East End continues to have the highest emergency admission rate in Dundee.

- Emergency bed day rates since 2015/16 have decreased by 3% for Dundee and only Lochee has shown a noticeable increase. The biggest improvements were seen in Maryfield, West End, East End and North East of which all showed greater than a 5% decrease in bed day rates.

- Falls rates since 2015/16 have decreased by 2% for Dundee with the Ferry showing the greatest improvement with a 16% decrease. The North East has deteriorated the most by a 14% increase.

- Bed days lost to delayed discharges as a rate of the 75+ population have fallen by 4% in Dundee since 2015/16. The West End and Coldside have seen the biggest improvements with a 26% and 15% reduction respectively. The East End and Maryfield have seen the biggest increases with 17% and 14% respectively.

Purpose

The purpose of the quarterly performance report is to monitor trajectories and inform action plans throughout the year, in advance of the statutory annual performance report. The first statutory annual performance report will be available in June 2017.

Data is presented by locality where possible in order to identify variation and share best practice / improvements.

Demographic Background

Dundee is one of the most economically deprived cities in Scotland with 28.6% of the population living in 15% of the most deprived areas of Scotland. Life expectancy is low and many people are diagnosed with morbidities and multi-morbidities earlier in life than in more affluent areas. The current demographic situation poses challenges to health and social care services and these remain a focus of strategic planning within the Health and Social Care Partnership.

Dundee's Ranked Performance between 2010/11 and 2015/16

Where 1st is the best performing partnership and 32nd is the most poorly performing partnership

Dundee is better than the average Scottish performance

All tables and charts under the heading 'Management Information' are not official statistics as they have been produced by the Dundee Health and Social Care Partnership Information Team rather than by a UK statistics authority (UKSA) accredited organisations. As such, whilst every effort has been made to ensure its accuracy and consistency with NSS ISD (National Services Scotland, Information Service Division) methodology, all management information at locality level data should be treated with some caution until their general release by ISD.

Dundee is performing similar to the average Scottish performance

Dundee is below the average Scottish performance

Table 1: Dundee Ranked Performance as between 2010/11 and 2015/16

National Indicators	2011/12	2012/13	2013/14	2014/15	2015/16
11. Premature Mortality	30th	28th	29th	30th	30th
12. Admissions	19th	20th	17th	21st	19th
13. Bed Days	27th	28th	27th	28th	28th
14. Re-admissions	32nd	31st	30th	31st	32nd
15. Last 6 months	10th	12th	19th	17th	15th
16. Falls	18th	29th	30th	30th	31st
17. Care Inspectorate	N/A	N/A	N/A	6th	6th
18. Intensive Needs	30th	32nd	32nd	31st	31st
19. Delayed Discharges	N/A	18th	15th	13th	19th
20. Spend on emergencies	31st	30th	29th	29th	29th

Performance in 2016/17 Quarter 2 rolling year against baseline year 2015/16

Table 2: Performance in 2016/17 Quarter 2 (Q2) rolling year against baseline year 2015/16

National Indicator	Dundee	Coldside	East End	Lochee	Maryfield	North East	Strath martine	The Ferry	West End
12.Admissions	+2.0%	+2.0%	+0.3 %	+4.3%	+4.1%	+5.7%	-1.5%	-0.6%	+4%

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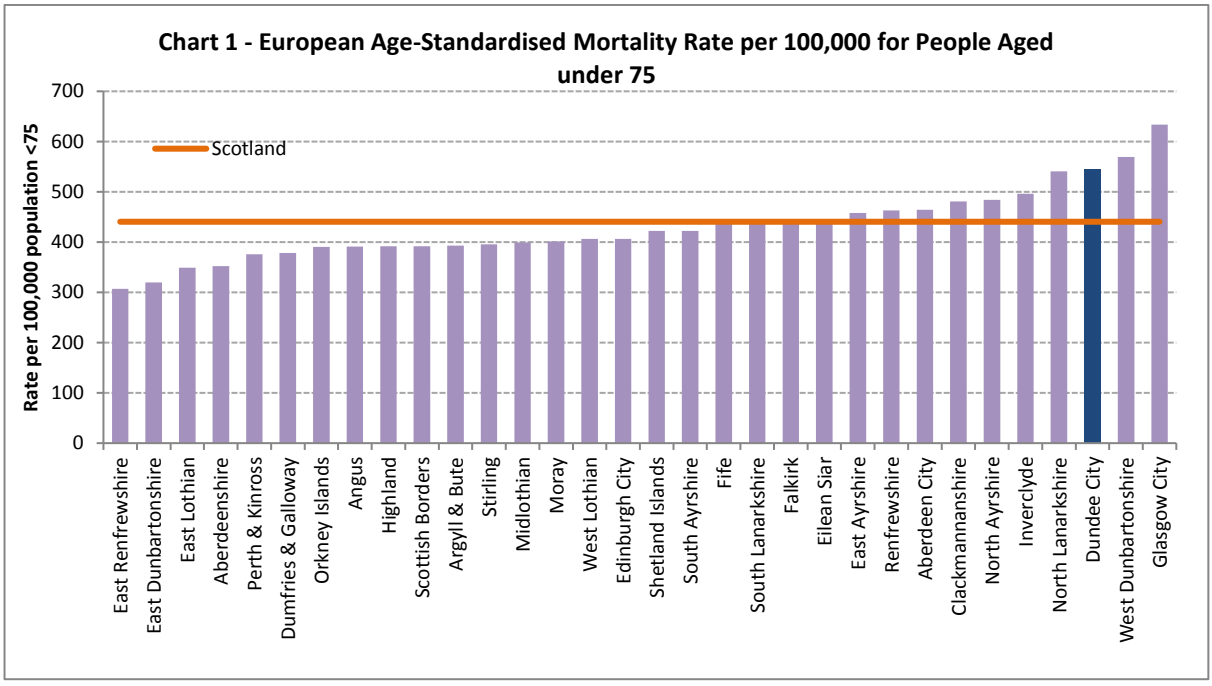
13. Bed Days	-2.6%	+0.4%	-5.2%	+2.3%	-7.2%	-5.9%	-1.1%	-1.6%	-5.8%
16. Falls	-1.7%	-2.8%	+6%	-6.1%	+1.9%	+13.6 %	+4.4%	-16%	-1.4%
19. Delayed Discharge	-3.4%	-15.2%	+17%	+1.2%	+14.1%	-4.5%	-9.7%	+0.9%	-26%

Note: 2016/17 Q2 is an annual rolling year i.e. 2016/17 Q2 is Oct 15 to Sep 16

National Indicator 11 - Premature Mortality Rate

Latest National Position as at Calendar Year 2015



Source: ISD Scotland

As at 2015 Dundee has the 3rd highest premature mortality rate in Scotland with 546 unexpected deaths per 100,000 population of under 75s.

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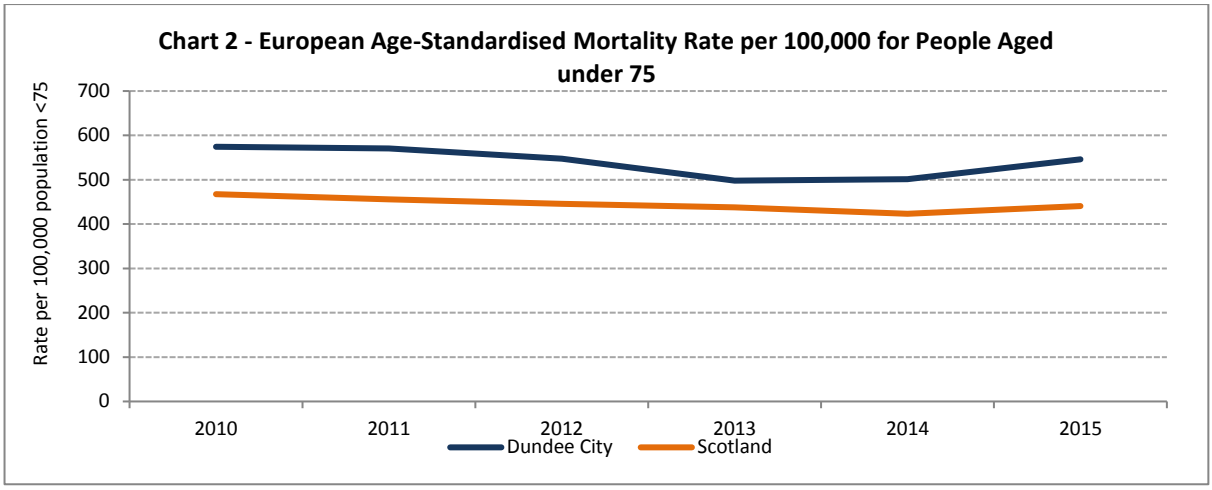
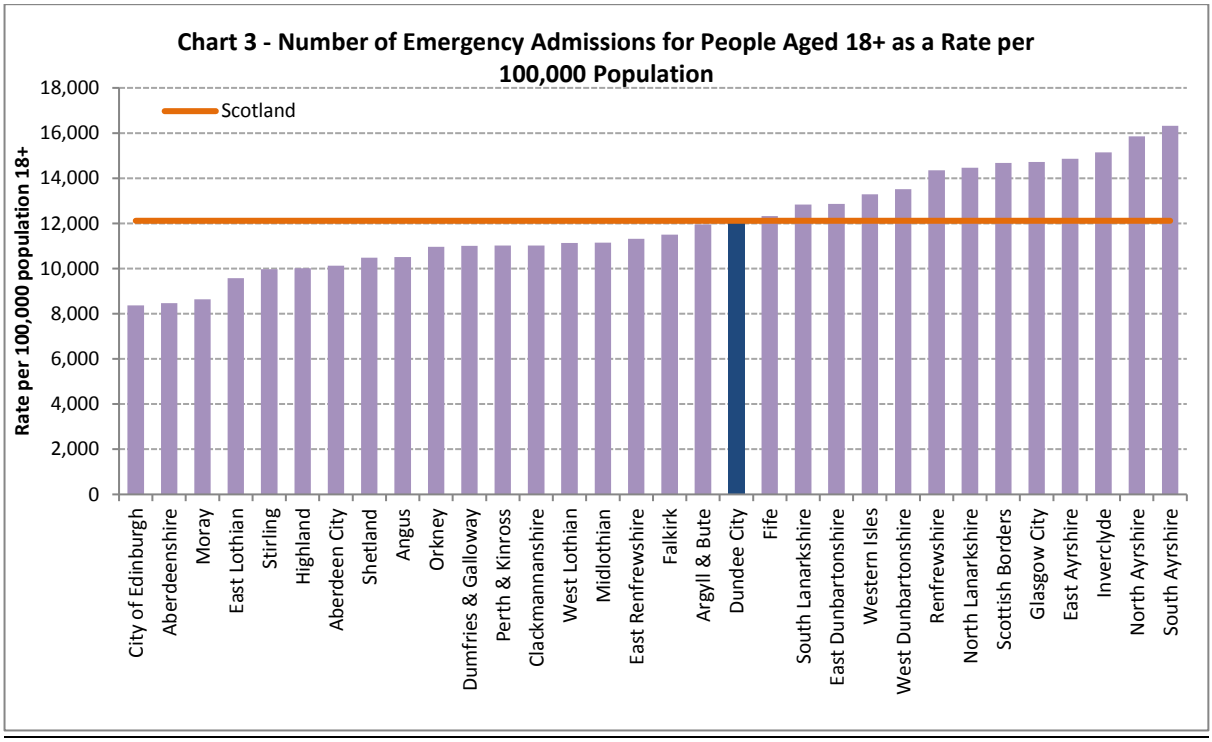


Source: ISD Scotland

Historically, Dundee has always had a higher premature mortality rate than the Scottish rate and although the Dundee rate was decreasing between 2010 and 2014 it has begun to increase thereafter.

National Indicator 12 - Rate of Emergency Admissions for Adults

Latest National Position as at 2015/16



Source: ISD Scotland

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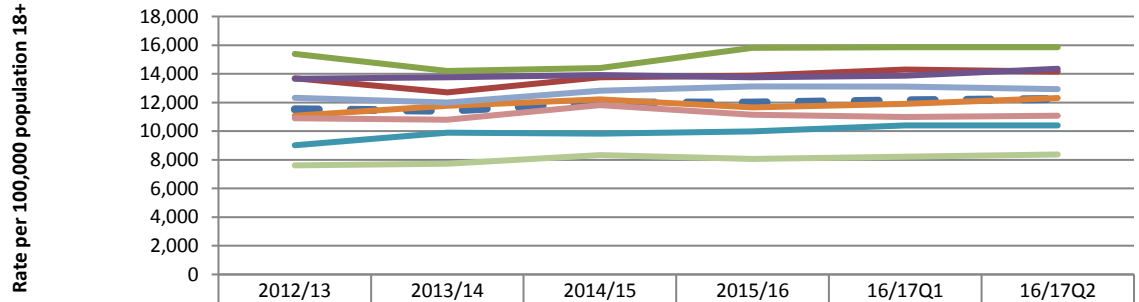
Dundee currently is performing at the Scottish average with 12,000 emergency admissions per 100,000 population

Management Information at Locality Level for 2016/17 Q2

Chart 4 - Rate per 100,000 Population of All Emergency Admissions for People Aged 18+ by Locality and Financial Year



	2012/13	2013/14	2014/15	2015/16	16/17Q1	16/17Q2
Dundee	11,523.1	11,424.0	11,985.5	11,996.2	12,148.7	12,241.8
Coldside	13,696.1	12,704.6	13,750.7	13,876.3	14,296.5	14,152.2
East End	15,375.3	14,199.5	14,414.2	15,806.4	15,854.5	15,854.5
Lochee	13,655.3	13,746.4	13,909.9	13,766.4	13,858.4	14,351.5
Maryfield	9,012.9	9,896.3	9,825.0	9,989.3	10,397.2	10,397.2
North East	11,074.3	11,757.7	12,204.9	11,648.9	11,893.9	12,307.8
Strathmartine	12,332.2	11,995.0	12,815.3	13,116.9	13,097.3	12,920.5
The Ferry	10,898.3	10,795.1	11,814.7	11,136.5	10,992.2	11,070.4
West End	7,610.7	7,731.4	8,325.0	8,054.8	8,226.6	8,370.8

Source: SMR01/SMR50/SMR04 Datasets (management information)
Note: 2016/17 Q1 and Q2 are annual rolling years i.e. 2016/17 Q2 is Oct 15 to Sep 16

The rate for Dundee has generally been increasing from 11,500 per 100,000 in 2012/13 to 12,200 per 100,000 in 2016/17 Q2. All Local Community Planning Partnerships (LCPPs) since 2012/13 have seen increases in their rates with the East End experiencing the highest rates in every financial year. The West End, the Ferry and Maryfield have the lowest rates in Dundee (the West End rate is almost 50% less than the East End rate).

Through the Home and Hospital Transition Group, the high rate of emergency admissions and re-admissions was recognised when reviewing our performance in regards to this area. A Home & Hospital Transition Plan was developed and ratified by the Integration Joint Board at their meeting on 30 August 2016.

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A commitment was made within this plan to review reasons for emergency admission and re-admission across hospital settings to establish a clear benchmark and then identify and agree improvement actions which will contribute to a reduction in emergency admission to hospital.

What we have achieved to date:

- The demographic makeup up Dundee's population is increasingly putting pressure on health and care services. Dundee has an ageing population and due to the effects of deprivation many people are developing morbidities and multi-morbidities earlier in life than in more affluent areas. Despite all efforts to provide preventative and anticipatory care and support, the health complexities which many people are experiencing mean that a hospital stay is often unavoidable.
- In order to reduce admissions and to support people to live independently at home, the following improvements, have been made
  - The continued expansion of the Enhanced Community Support service, which is aligned to GP clusters and supports those most at risk of admission.
  - Enhanced the nursing input to homeless people and hard to reach people through a further development of the Parish Nurse approach. Tested a peer volunteer model.

- Reviewed and consolidated existing health inequalities work to identify priorities and explored how this will be addressed at a locality basis. From this we have established the Health Inequalities Strategic Planning Group and are developing a Health Inequalities Commissioning Statement. Keep Well continues to engage people around their health via health checks with the community team delivering 286 health checks to "at risk " groups including those who are homeless, offenders, or carers, in Q1 and 354 in Q2, with 1170 Keep well checks over the 2 quarters including those seen in general practice based on living in a deprived area. There are also improved links and referrals from Tayside Substance Misuse Service (TSMS) to consider wider health issues. The Equally Well team host health and wellbeing network meetings across the city to support joint working in localities.

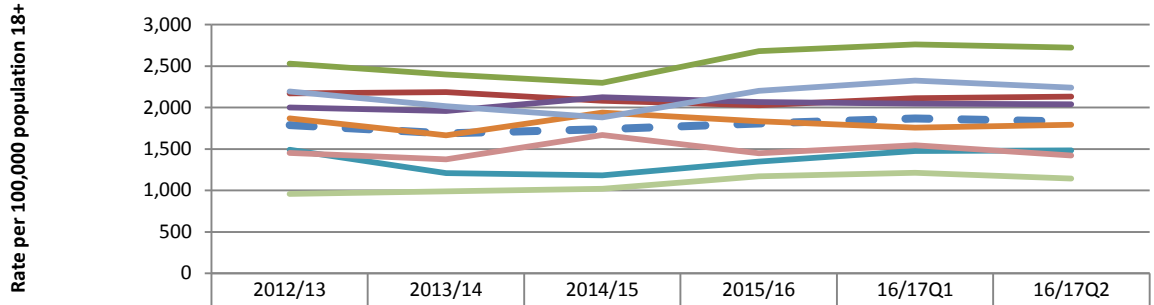
What we plan to do:

- Redesign Stroke patient services.
- Redesign the Tayside Neurological Rehabilitation services.
- Lead a review, with partners, of the current Learning Disability acute liaison service and develop future model.
- Increase our investment in intermediate forms of care such as step up/down accommodation and support for all adults.
- Develop further work to support reducing health inequalities and prevention, including developing social prescribing models to support individuals around improving their health and wellbeing.
- Review reasons for emergency admission across hospital settings to establish a clear benchmark and then identify and agree improvement actions which will contribute to a reduction in emergency admission to hospital.
- Further develop use of technology enabled care as a means of enabling people to live independently and look after their own health.
- Further develop awareness and use of anticipatory care plans for all Adults where a plan would be of benefit to the Adult.
- Embed health checks as a means to engage people in the health and wellbeing agenda, to increase self-care, and avoid longer term ill health.

The following management information, charts 5 and 6, on Potentially Preventable Admissions is supplementary to National Indicator 12 "Rate of Emergency Admissions".

Management Information at Locality Level for 2016/17 Q2

Chart 5 - Rate per 100,000 Population of Potentially Preventable Admissions by LCPP for People Aged 18+



	2012/13	2013/14	2014/15	2015/16	16/17Q1	16/17Q2
Dundee	1,788.8	1,688.1	1,736.9	1,805.7	1,867.5	1,830.4
Coldside	2,169.1	2,184.9	2,080.6	2,025.3	2,113.1	2,131.9
East End	2,528.9	2,398.8	2,296.6	2,681.2	2,761.5	2,721.4
Lochee	1,998.8	1,957.1	2,124.3	2,064.3	2,044.6	2,038.0
Maryfield	1,491.5	1,209.2	1,181.5	1,349.1	1,474.6	1,480.8
North East	1,869.8	1,663.8	1,936.5	1,833.1	1,757.1	1,790.8
Strathmartine	2,192.7	2,016.7	1,878.6	2,199.2	2,323.6	2,238.5
The Ferry	1,451.9	1,376.1	1,667.9	1,449.2	1,545.4	1,419.1
West End	958.7	988.7	1,018.5	1,169.7	1,214.0	1,142.0

Source: SMR01/SMR50/SMR04 Datasets (management information)
Note: 2016/17 Q1 and Q2 are annual rolling years i.e. 2016/17 Q2 is Oct 15 to Sep 16

The rate of potentially preventable admissions (PPAs) for people aged 18+ in Dundee has been increasing slightly since 2012/13. The East End has the highest rates of PPAs with 2,720 per 100,000 population aged 18+ as at 2016/17 Q2. This is more than twice the rate of the West End of 1,140 per 100,000 population aged 18+.

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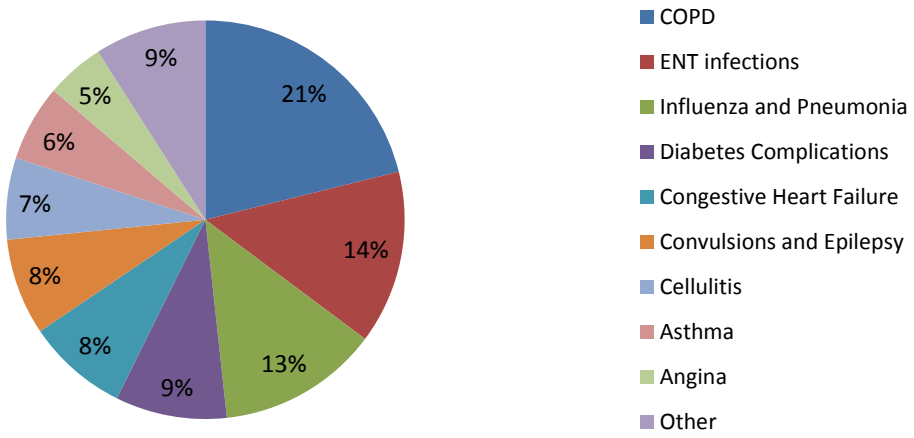
Chart 6 - Percentage of Total Potentially Preventable Admissions split by Conditions in 2016/17 Q2



Source: SMR01/SMR50/SMR04 Datasets (management information)
Note: 2016/17 Q2 is an annual rolling year i.e. 2016/17 Q2 is Oct 15 to Sep 16

One in five potentially preventable admissions (PPAs) in 2016/17 Q2 were COPD (chronic obstructive pulmonary disease) related. Almost half of the PPAs were made up of only 3 conditions; COPD, ENT infections (ear, nose and throat infections) and influenza and pneumonia.

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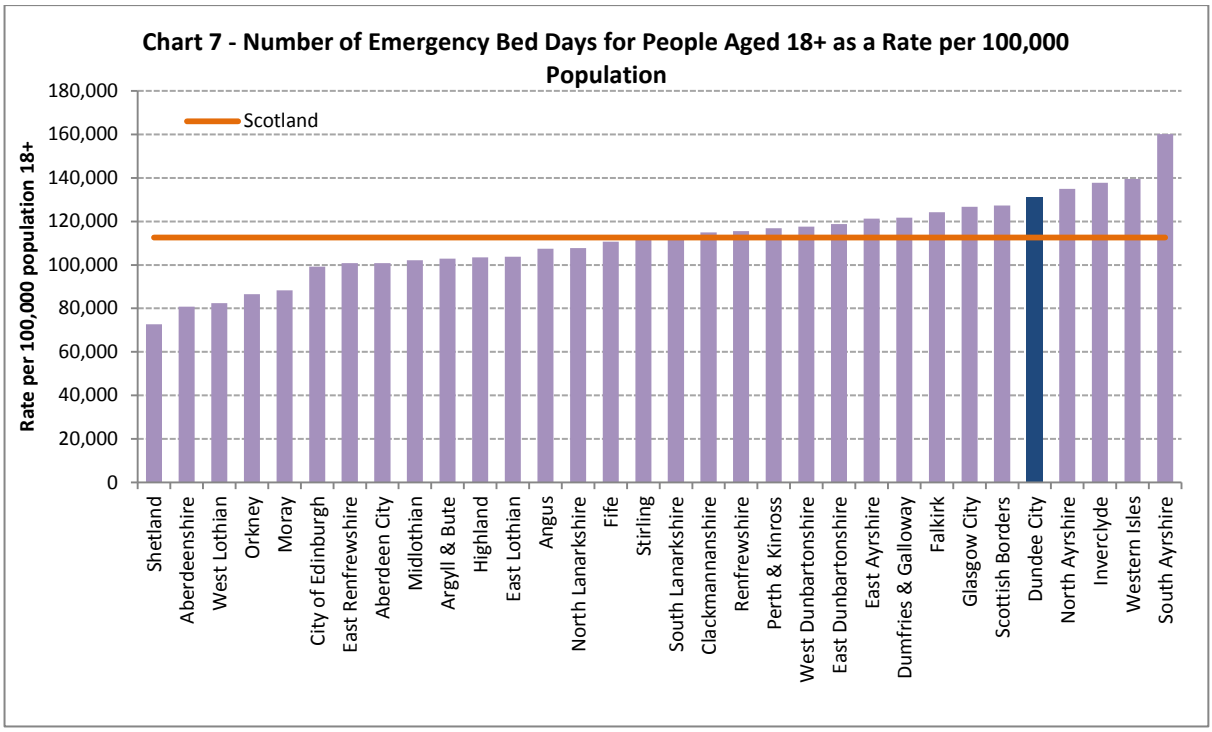
National Indicator 13 - Rate of Emergency Bed Days for Adults

Latest National Position as at 2015/16



Source: ISD Scotland

Dundee currently has the 5th highest emergency bed day rates in Scotland with a rate of 131,000 per 100,000 population for people aged 18+.

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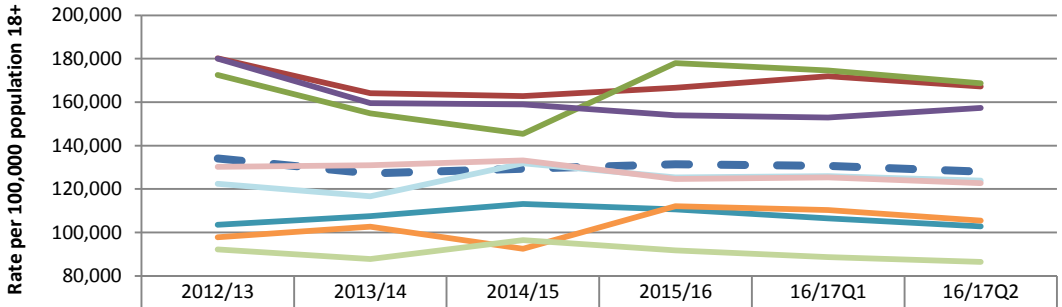
Management Information at Locality Level for 2016/17 Q2

Chart 8 - Rate per 100,000 Population of All Emergency Bed Days for People Aged 18+ by Locality and Financial Year



	2012/13	2013/14	2014/15	2015/16	16/17Q1	16/17Q2
Dundee	134,081.8	127,207.4	129,420.2	131,474.9	130,680.4	128,091.8
Coldside	180,267.7	164,151.9	162,853.2	166,698.0	171,896.2	167,300.0
East End	172,537.8	154,833.8	145,434.8	178,028.4	174,608.7	168,716.4
Lochee	180,097.6	159,590.0	158,974.0	153,901.8	152,935.4	157,373.0
Maryfield	103,565.5	107,497.0	113,154.7	110,704.6	106,519.4	102,760.9
North East	97,747.7	102,670.6	92,534.4	112,130.4	110,356.5	105,533.0
Strathmartine	122,478.4	116,648.0	131,811.6	125,330.5	125,913.1	123,890.6
The Ferry	130,248.4	131,021.4	133,248.4	124,708.4	125,393.9	122,693.9
West End	92,184.6	87,784.3	96,490.6	91,762.3	88,735.5	86,401.7

Source: SMR01/SMR50/SMR04 Datasets (management information)
Note: 2016/17 Q1 and Q2 are annual rolling years i.e. 2016/17 Q2 is Oct 15 to Sep 16

The emergency bed day rates for Dundee have slightly decreased from 134,000 per 100,000 population in 2012/13 to 128,000 per 100,000 population for people aged 18+ in 2016/17 Q2. Like the emergency admission rates, the East End has the highest bed day rates and the West End has the lowest bed day rates in Dundee. All localities except Lochee have seen a decrease in 2016/17 Q2.

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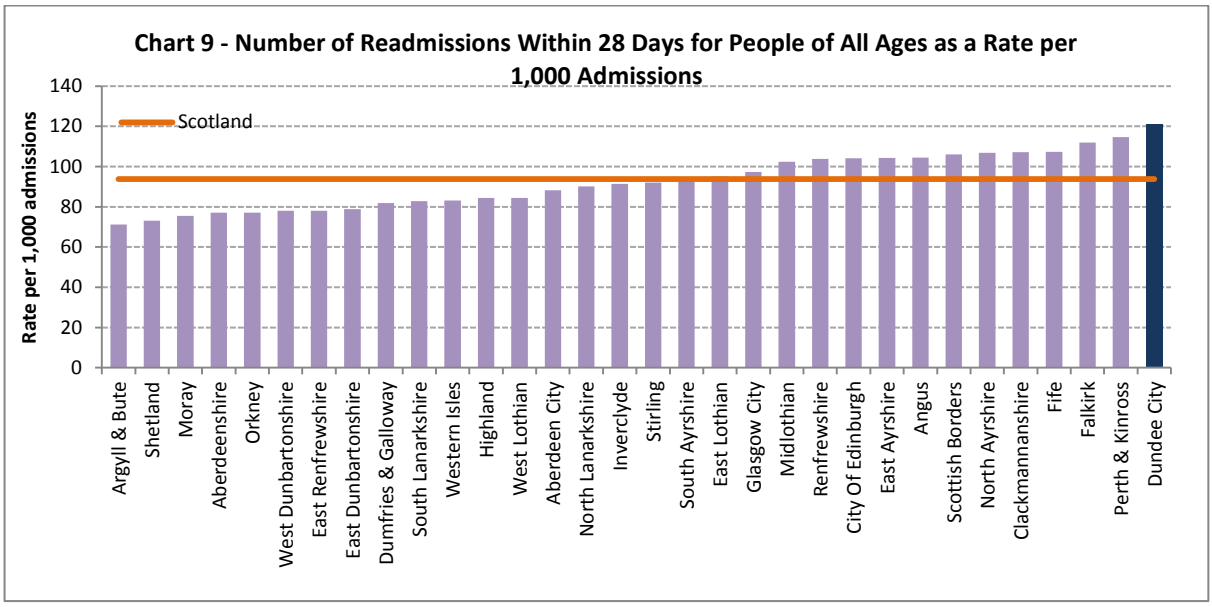
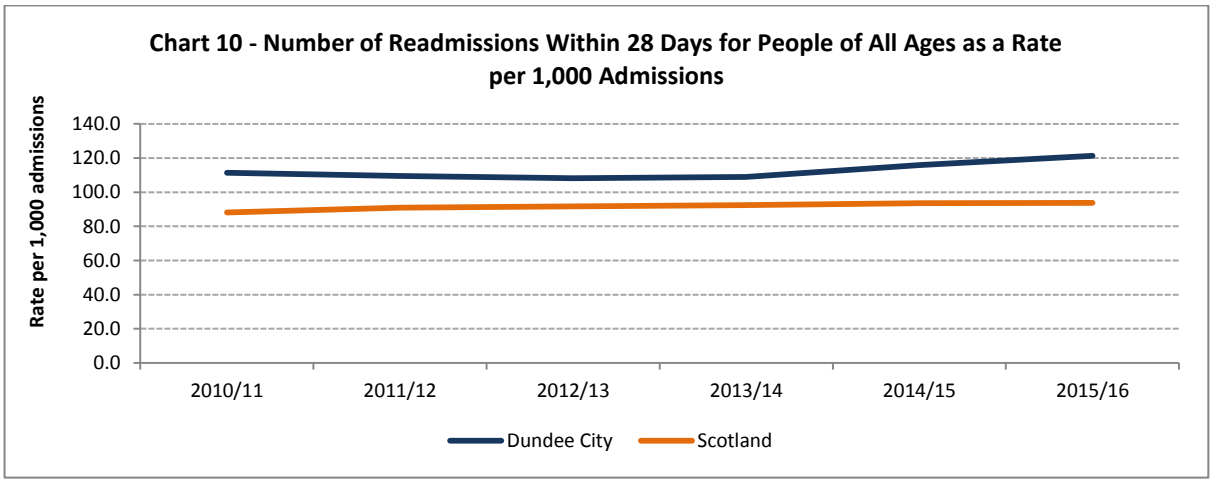
National Indicator 14 - Re-admissions to Hospital within 28 Days of Discharge

Latest National Position as at 2015/16



Source: ISD Scotland

Dundee currently has the highest readmission rates within 28 days in Scotland with a rate of 121 per 1,000 admissions for people of all ages.



Source: ISD Scotland

Dundee has consistently had higher readmission rates within 28 days than Scotland since 2010/11 and although there was a decrease between 2010/11 and 2013/14, the rates have been increasing between 2013/14 and 2015/16.

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What we have achieved to date:

- Discharged from hospital. (80% seen with 5 days of discharge/83% seen within 4 days of referral). 65% received additional support to meet their clinical needs, and data suggest that there is a reduction in re-admission rates (respiratory infection). Introduced Healthcare Support Workers to create capacity to support more complex patients, including those who have frequent readmissions.
- Expanded the Enhanced Community Support, including the testing of multidisciplinary assessment meetings at GP Practice level; and the further roll out of the model to additional practices across the 4 cluster areas. Introduced a locality nurse role in each locality to coordinate assessments and reviews and support anticipatory care planning and carer assessments. Demonstrated reduced length of hospital stay and emergency admissions through the initial test site, reduced waiting times for comprehensive geriatric assessments and a falls assessment, increased diagnostics through day hospital sessions. The work has supported Medicine for Elderly Consultant Teams linked to GP practices.
- Developed step down beds within a local authority adult care respite unit to support transition from the Acquired Brain Injury Unit. Testing project with two patients.
- Step Down (Gourdie Place) – testing of a step down housing model to support early, safe discharge from hospital. This support enables adults awaiting specialist or adapted housing to move from a hospital setting while awaiting allocation of a new home. The model commenced part year and has been in use. Two further step down housing options to commence in this financial year.
- Introduced medication reviews and employed a pharmacy technician as part of the social care enablement teams.
- Invest in resources which support assessment for 24 hour care taking place at home or home like settings.

What we plan to do:

- Review reasons for re-admission to hospital within 28 days of discharge across hospital settings to establish a clear benchmark and then identify and agree improvement actions which will continue to contribute to a reduction in re-admission to hospital.
- Further develop post-discharge support to people with long term conditions in order to contribute to a reduction in emergency hospital admission and re-admission to hospital.

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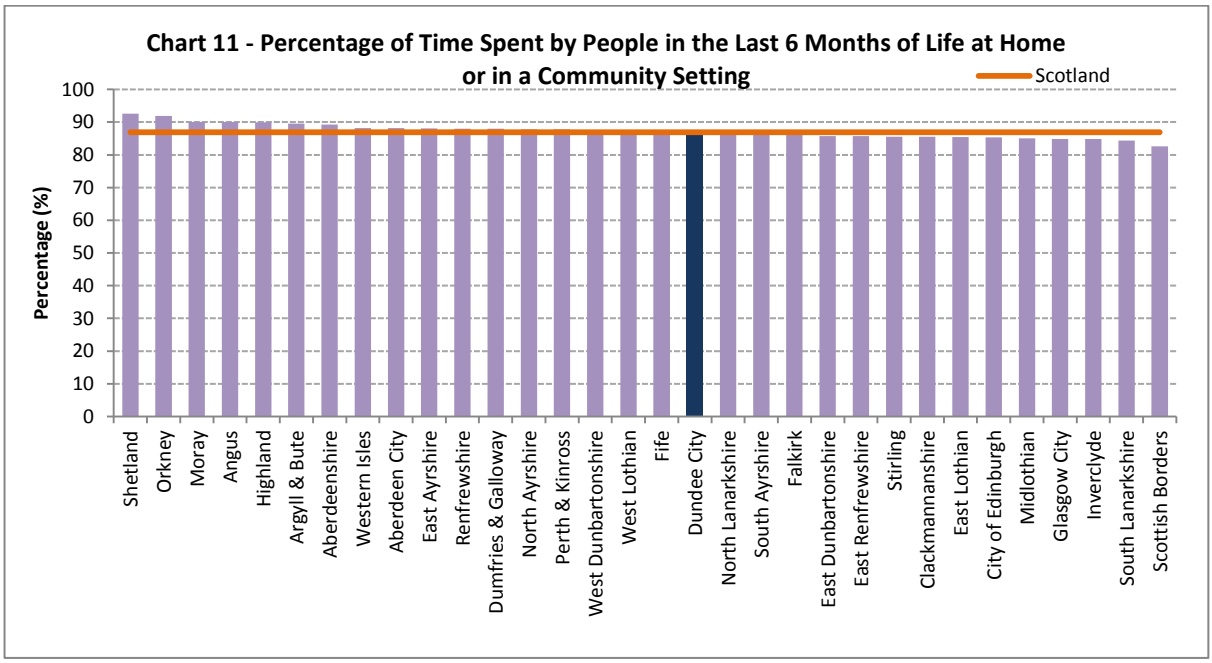
- Further implement the planned date of discharge model so that patients and their carers are involved in a well-planned discharge and have co-ordinated follow up care where required upon discharge.
- Support more people to be assessed at home rather than in hospital by completing and evaluating the 'Moving Assessment into the Community' project for older people and resource the proposed change.
- Expand the 'Moving Assessment into the Community' project to specialist areas and test pathways.
- Further develop discharge planning arrangements for adults with mental ill-health, physical disability and acquired brain injury.

National Indicator 15 - Proportion of last 6 months of life spent at home or in a community setting

Latest National Position as at 2015/16



Source: ISD Scotland

Dundee is performing at the Scottish average with 87% of time in the last 6 months of life spent at home.

What we have achieved to date:

Dundee partnership entered into the second Macmillan Local Authority Partnership in Scotland to work with people living with cancer.

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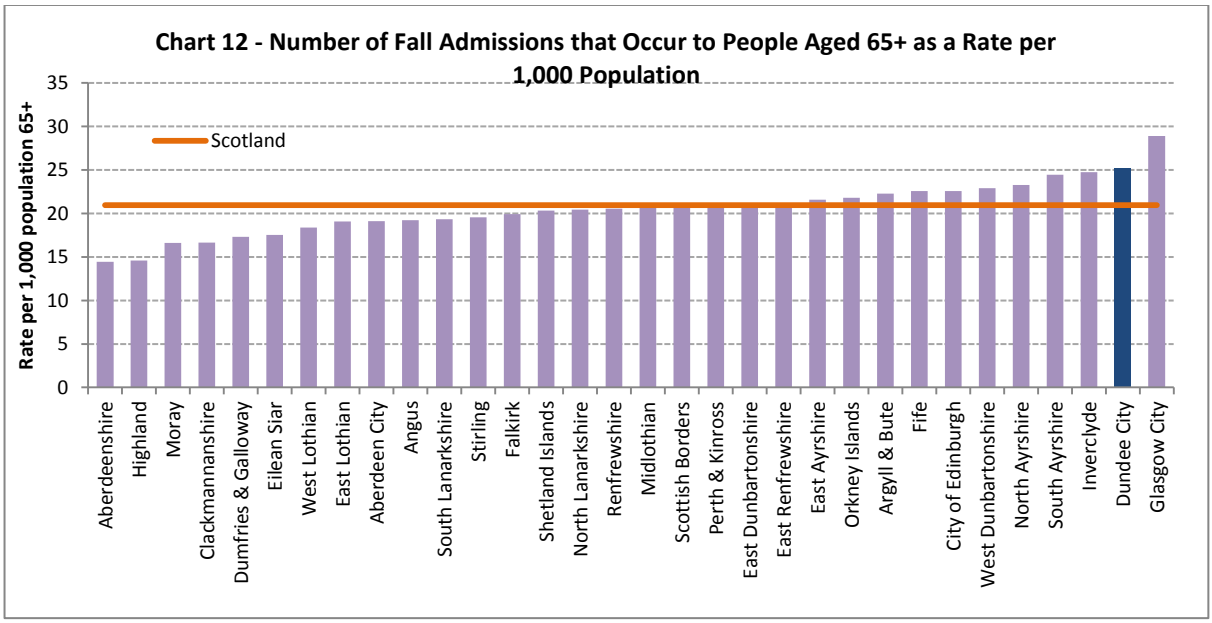
What we plan to do:

The Palliative Care Tool Bundle and Response Standards will be used across community based health and social care services in Dundee to enable staff to identify, assess, plan and evaluate care for any person with palliative and end of life care needs regardless of diagnosis.

The aim of this project is to give the person the best appropriate care through an individualised care and support plan which suits that person's needs and wishes. It would provide clear, consistent communication between secondary and primary care and reduce delays in starting treatments, or highlight where treatments/investigations would not be beneficial.

National Indicator 16 - Falls rate per 1,000 population in over 65s

Latest National Position as at 2015/16



Source: ISD Scotland

Dundee is the second poorest performing partnership in Scotland with a falls rate of 25 per 1,000 population for people aged 65+.

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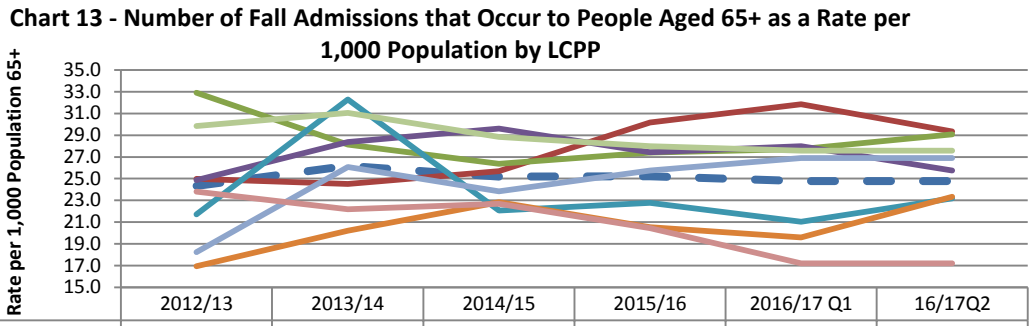
Management Information at Locality Level for 2016/17 Q2



	2012/13	2013/14	2014/15	2015/16	2016/17 Q1	16/17Q2
Dundee	24.3	26.2	25.2	25.2	24.8	24.8
Coldside	25.0	24.5	25.7	30.2	31.8	29.3
East End	32.9	28.1	26.4	27.4	27.7	29.1
Lochee	24.9	28.4	29.6	27.4	28.0	25.7
Maryfield	21.7	32.3	22.1	22.8	21.0	23.2
North East	16.9	20.2	22.8	20.5	19.6	23.3
Strathmartine	18.2	26.1	23.8	25.7	26.9	26.9
The Ferry	23.8	22.2	22.7	20.4	17.2	17.2
West End	29.8	31.0	28.9	28.0	27.6	27.6

Source: SMR01 Dataset (management information)
Note: 2016/17 Q1 and Q2 are annual rolling years i.e. 2016/17 Q2 is Oct 15 to Sep 16

Coldside and the East End have the highest rates of falls in Dundee with 29 per 1,000 population for people aged 65+. The North East had the lowest rates in 2012/13 but they have seen a sharp rise in falls in 2014/15 and again in 2016/17 Q2 to 23 per 1,000 population. The Ferry has seen a continual decrease in their falls rate and now have the lowest rates with 17 per 1,000 population. The West End, surprisingly, has one of the highest falls rates in Dundee with 28 per 1,000 population as at 2016/17 Q2.

What we have achieved to date:

- Developed a draft equipment prescribers learning framework supported by e-learning and a mentoring programme. Piloted an e-learning module.
- Expanded on the falls service to ensure Patients aged over 65 years are routinely screened by Allied Health Professional (AHP) staff if presenting with a fall and follow up interventions put in place; offered a single point of referral, triage takes place and information shared.
- Introduced falls prevention care home education resulting in a reduction in falls in care homes.
- Otago falls classes now well established in community venues showing clear improvements in clinical outcomes. Introduced self-referrals to Community Rehabilitation Team to improve access.

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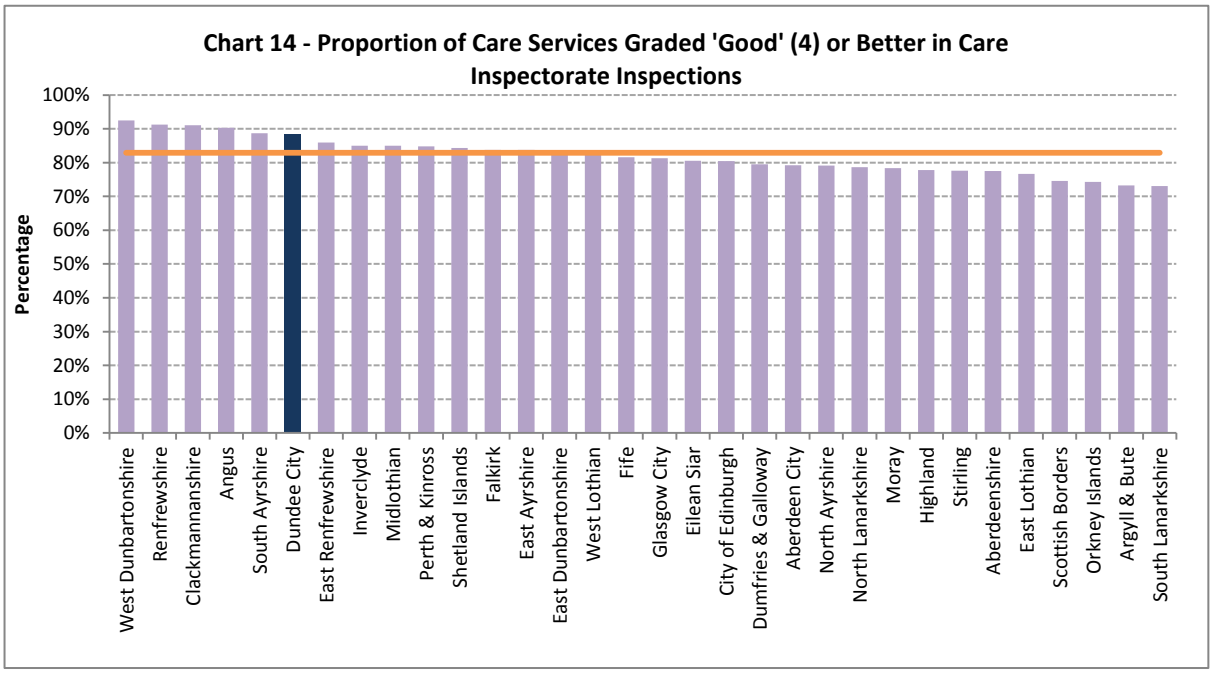
What we plan to do:

- Rolling classes with an educational component. This will prevent patients from waiting too long before they start a class and hopefully help to prevent as many drop outs.
- In discussions with Dundee College to start a project were students are trained in Otago and then with Community Rehabilitation Team support are able to implement it within care homes.
- Home based Otago project following the Otago research for patients that are unable to come to the class.
- In development of an Otago based maintenance class within the community to try and prevent re-referrals and re current falls. Based on the pulmonary rehab model.

National Indicator 17 - Proportion of care and care services rated good or better in care inspectorate inspections

Latest National Position as at 2015/16



Source: ISD Scotland

Dundee currently has the 6th highest proportion of care services rated as good or better in Scotland with 88%.

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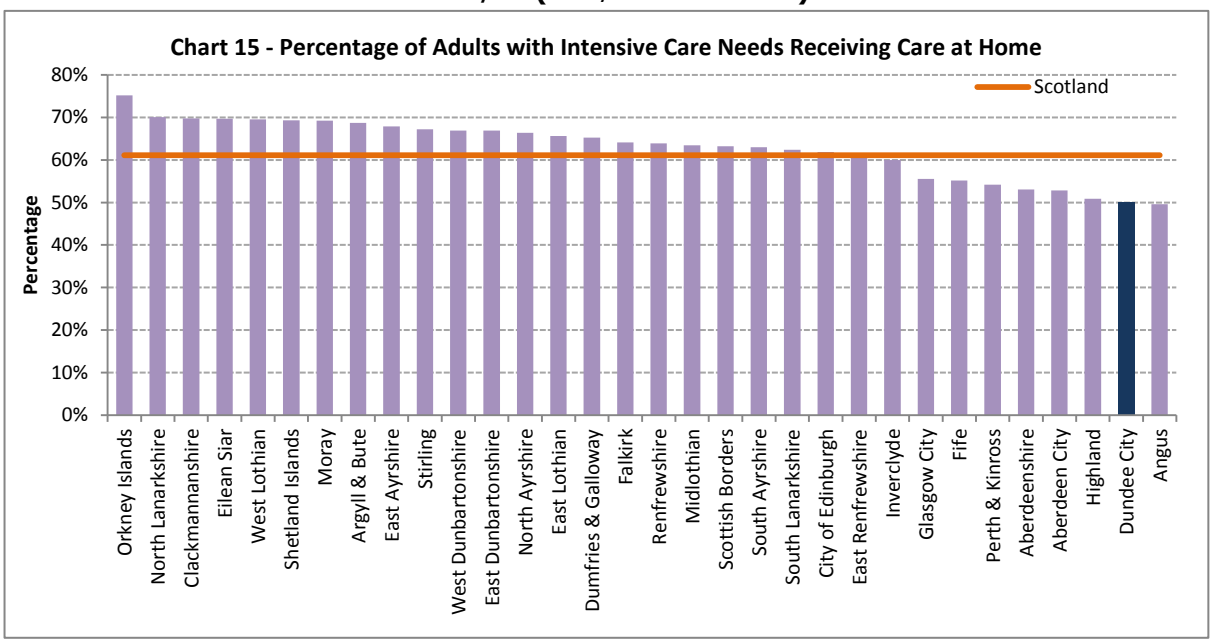
National Indicator 18 - Percentage of adults with intensive needs receiving care at home

Latest National Position as at 2014/15 (2015/16 not available)



Source: ISD Scotland

Dundee is the 2nd poorest performing partnership in Scotland with only 50% of adults receiving personal care at home (which includes Direct Payments) as a proportion of those receiving personal care at home or as part of a continuing care or long stay care home care package.

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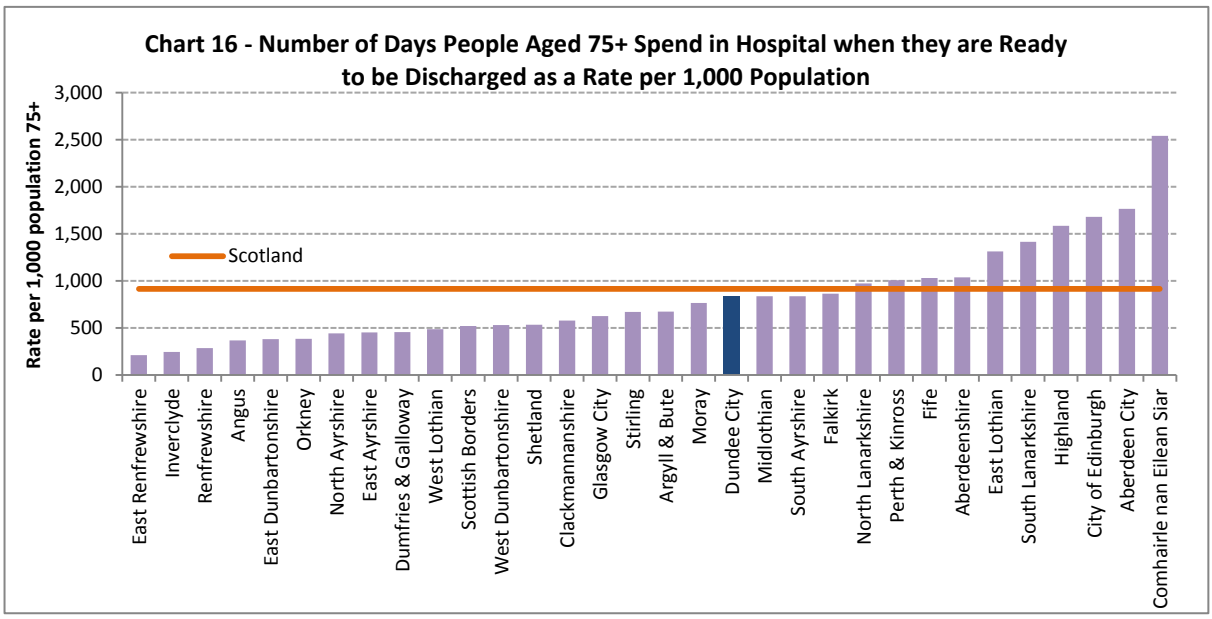
National Indicator 19 - Number of days people aged 75+ spend in hospital when they are ready to be discharged

Latest National Position as at 2015/16



Source: ISD Scotland

Dundee is currently performing below the Scottish average of bed days lost to delayed discharges for people aged 75+ with a rate of 832 per 1,000 population.

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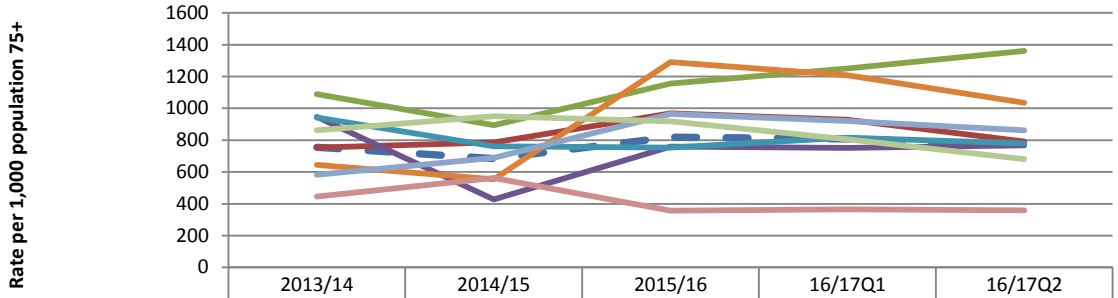
Management Information at Locality Level for 2016/17 Q2

Chart 17 - Number of Days People Aged 75+ Spend in Hospital when they are Ready to be Discharged as a Rate per 1,000 Population by LCPP Areas



	2013/14	2014/15	2015/16	16/17Q1	16/17Q2
Dundee	756.0	684.0	818.8	808.1	768.1
Coldside	752.9	785.3	967.9	928.0	792.0
East End	1089.2	894.8	1155.9	1249.8	1361.5
Lochee	947.2	426.9	758.9	750.9	766.8
Maryfield	943.0	760.9	752.7	816.1	779.3
North East	644.8	553.7	1290.9	1208.7	1034.6
Strathmartine	581.2	688.0	963.8	920.4	862.0
The Ferry	445.4	562.5	357.1	364.8	358.2
West End	861.4	951.2	917.8	805.0	680.1

Source: Edison (excludes codes 100, 42T, ESDS and ICF)
Note: 2016/17 Q1 and Q2 are annual rolling years i.e. 2016/17 Q2 is Oct 15 to Sep 16

The East End has consistently been one of the poorest performing LCPP areas for this indicator and as at 16/17 Q2 it has the highest number of bed days lost to delayed discharges for people aged 75+ and is one of only two LCPP areas to have seen an increase between 16/17 Q1 and Q2. The North East saw a big increase from 554 per 1,000 population in 2014/15 to 1,290 per 1,000 population in 2015/16 (an increase of 132%). As at 16/17 Q2, the Ferry has the lowest rates in Dundee with 358 per 1,000 population; the East End rates are approximately 280% more than the Ferry's.

What we have achieved to date:

- A Home and Hospital Transition Plan was developed which aims to ensure that citizens of Dundee are supported at home, but when people do have to go to hospital they are only there as long as they need to be. The plan was ratified at the Integration Joint Board meeting on 30 August 2016 and is currently being implemented.
- There are currently 2 step down housing options which are working very well. An example of this is a 'Smart Flat' which uses a range of Technology Enabled

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Care to support people who are waiting for housing adaptations of a new home and who are delayed in hospital. A third step down housing option will be introduced during 2016/17.

- The capacity within the Mental Health Officer team has been enhanced and Dundee City has joined a Power of Attorney Campaign to support the discharge of people who are delayed in hospital as a result of a legal issue around guardianships.
- Pathways from hospital have been reviewed and assessment services have been aligned to more locality based working.
- We have mainstreamed a number of Reshaping Care for Older People projects and fully embedded them into models of working. An example is the development of a community pharmacy technician within the enablement service. This post supports people to be discharged from hospital by dealing with medicine complications which would otherwise have caused delays.

What we plan to do:

- Implement actions identified in the Home & Hospital Transition Plan and monitor progress of that plan through the Home and Hospital Transition Group.
- Increase our investment in intermediate forms of care such as step up/step down accommodation and support for all adults.
- Further develop discharge planning arrangements for adults with mental ill-health, physical disability and acquired brain injury.
- Invest in resources which support assessment for 24 hour care taking place at home or home like settings.
- Promote Power of Attorney through local campaigns as a means of increasing number of Power of Attorneys so that Adults are not waiting in hospital settings for decisions about their care upon discharge.
- Further develop earlier identification of requirement for measures under Adults With Incapacity (Scotland) Act 2016 so that people are not waiting for completion of formal measures within a hospital setting.
- Embed within care group strategic commissioning plans the development of a range of community resources and supports which facilitate community based assessment, enable people to remain in their own home and be discharged from hospital when they are ready.
- Review and remodel care at home services to provide more flexible responses.

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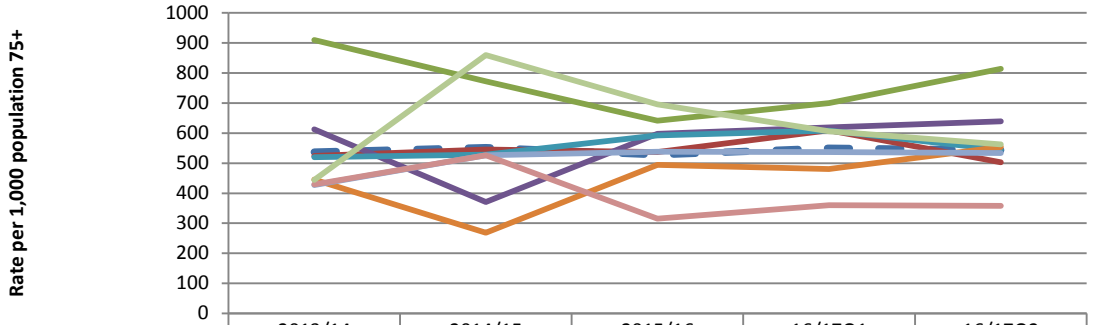
- Further develop models of Community Rehabilitation to support transitions between home and hospital.
- Develop and implement discharge management procedures and guidance to promote consistency in practice in relation to discharge management and use of planned date of discharge.
- Implement a statement and pathway for involving Carers in discharge planning process in line with section 28 of the Carers (Scotland) Act 2016 in partnership with Carers and Carers Organisations.
- Implement a fully Integrated Discharge Management Team to increase capacity of the service and enhance and further develop opportunity for discharge assessment for all patients at Ninewells.
- The Enhanced Community Support Service is working with people to identify increased support needs, particularly around requirements for care home placements at an earlier stage. It is anticipated that this proactive planning will have the positive effect of minimising the number of applications for care homes and also Power of Attorney which often happen as a crisis response when the person is in hospital.
- Extend the range of supports for adults transitioning from hospital back to the community.
- Continue to focus on those service users delayed as a result of complex needs who result in the most bed days lost per individual.
- The development of a step down and assessment model for residential care is planned for the future.

Management Information at Locality Level for 2016/17 Q2

Chart 18 - Number of Days People Aged 75+ Spend in Hospital as a Standard Delay per 1,000 Population by LCPP Areas



	2013/14	2014/15	2015/16	16/17Q1	16/17Q2
Dundee	537.4	551.7	528.0	550.0	543.2
Coldside	524.7	545.6	537.5	608.9	502.8
East End	910.0	772.6	640.9	699.9	813.8
Lochee	612.1	370.7	597.3	619.1	639.2
Maryfield	520.1	528.3	591.8	608.4	544.1
North East	445.1	268.0	494.7	481.0	553.6
Strathmartine	427.2	526.3	538.2	536.9	533.5
The Ferry	429.7	526.3	315.5	360.0	358.2
West End	443.8	859.2	696.2	605.9	562.4

Source: Edison (excludes codes 100, 42T, Early Supported Discharge Service and Integrated Care Fund)

Note: 2016/17 Q1 and Q2 are annual rolling years i.e. 2016/17 Q2 is Oct 15 to Sep 16

As at 16/17 Q2, the East End has the highest rate of bed days lost to standard delayed discharges for people aged 75+ with 814 per 1,000 population. Lochee is the second worst performing LCPP area with 639 per 1,000 population as at 16/17 Q2. The West End also performs poorly in this indicator as since 2014/15 its rate has always been above the Dundee rate.

Standard delays tend to be associated with higher volume of people who are inpatients. This is mainly due to our activity in relation to streamlining processes, planned date of discharge work and changes to social care packages taken forward.

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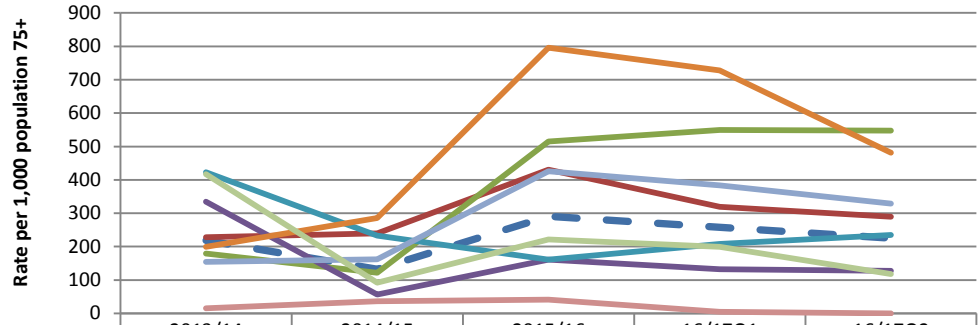
Management Information at Locality Level for 2016/17 Q2

Chart 19 - Number of Days People Aged 75+ Spend in Hospital as a Code 9 Delay per 1,000 Population by LCPP Areas



	2013/14	2014/15	2015/16	16/17Q1	16/17Q2
Dundee	218.6	132.3	290.8	258.0	224.9
Coldside	228.2	239.7	430.4	319.1	289.2
East End	179.2	122.2	515.0	549.9	547.7
Lochee	335.1	56.3	161.5	131.9	127.6
Maryfield	423.0	232.7	160.8	207.7	235.3
North East	199.7	285.7	796.2	727.7	481.0
Strathmartine	154.1	161.7	425.6	383.5	328.5
The Ferry	15.6	36.2	41.6	4.8	0.0
West End	417.5	92.0	221.6	199.0	117.6

Source: Edison (excludes codes 100, 42T, Early Supported Discharge Service and Integrated Care Fund)

Note: 2016/17 Q1 and Q2 are annual rolling years i.e. 2016/17 Q2 is Oct 15 to Sep 16

Dundee saw a significant increase in the rate of bed days, per 1,000 population for people aged 75+, lost to Code 9 delayed discharges in 2015/16 and in particular LCPP areas such as the East End, the North East and Strathmartine saw the biggest increases. Since then, most LCPP areas have seen a decrease in bed days lost to Code 9 delays with the notable exception of the East End. The Ferry had 0 bed days lost to code 9 delays in 16/17 Q2.

The reason for the increase is mainly due to a change in recording practice, as a result of improvement work, within specialist hospitals where recording of delays has increased as a result of these now being reported.

It was agreed within the Discharge Management Group that each care group strategic planning group would incorporate consideration in relation to complex care packages and specialist facilities within their strategic commissioning statements to support a strategic focus in relation to bed delays for patients with more complex needs.

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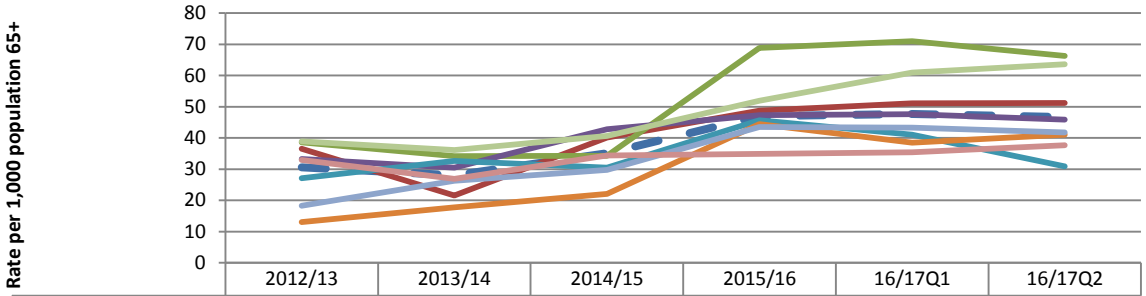
The following management information, charts 20 and 21, on dementia is supplementary to National Indicator 19 "Number of days people spend in hospital when they are ready to be discharged".

Management Information at Locality Level for 2016/17 Q2

Chart 20 - Number of Emergency Admissions with a Dementia Diagnosis in any Position for People aged 65+ as a Rate per 1,000 Population



	2012/13	2013/14	2014/15	2015/16	16/17Q1	16/17Q2
Dundee	30.6	28.0	35.2	47.0	47.7	46.7
Coldside	36.5	21.6	40.2	48.8	51.1	51.2
East End	38.6	34.2	34.3	68.8	71.0	66.3
Lochee	33.3	30.5	42.8	47.3	47.6	45.9
Maryfield	27.1	32.6	30.5	45.7	41.1	30.9
North East	13.1	17.7	22.1	44.4	38.5	41.1
Strathmartine	18.3	26.3	29.8	43.6	43.3	41.8
The Ferry	32.9	26.9	34.4	34.9	35.5	37.7
West End	38.9	36.1	40.6	51.9	61.0	63.7

Source: SMR01 Datasets (management information)
Note: 2016/17 Q1 and Q2 are annual rolling years i.e. 2016/17 Q2 is Oct 15 to Sep 16

The chart above might help explain why there was a significant increase in bed days lost to Code 9 delays as at rate per 1,000 population in 2015/16. The East End, the North East and Strathmartine all saw significant increases in emergency admission rates for dementia (aged 65+) from 2014/15 to 2015/16. Maryfield has the lowest number of emergency admission rates for dementia with 31 per 1,000 population aged 65+ and the Ferry has the second lowest rates with 64 per 1,000 population aged 65+ as at 2016/17 Q2.

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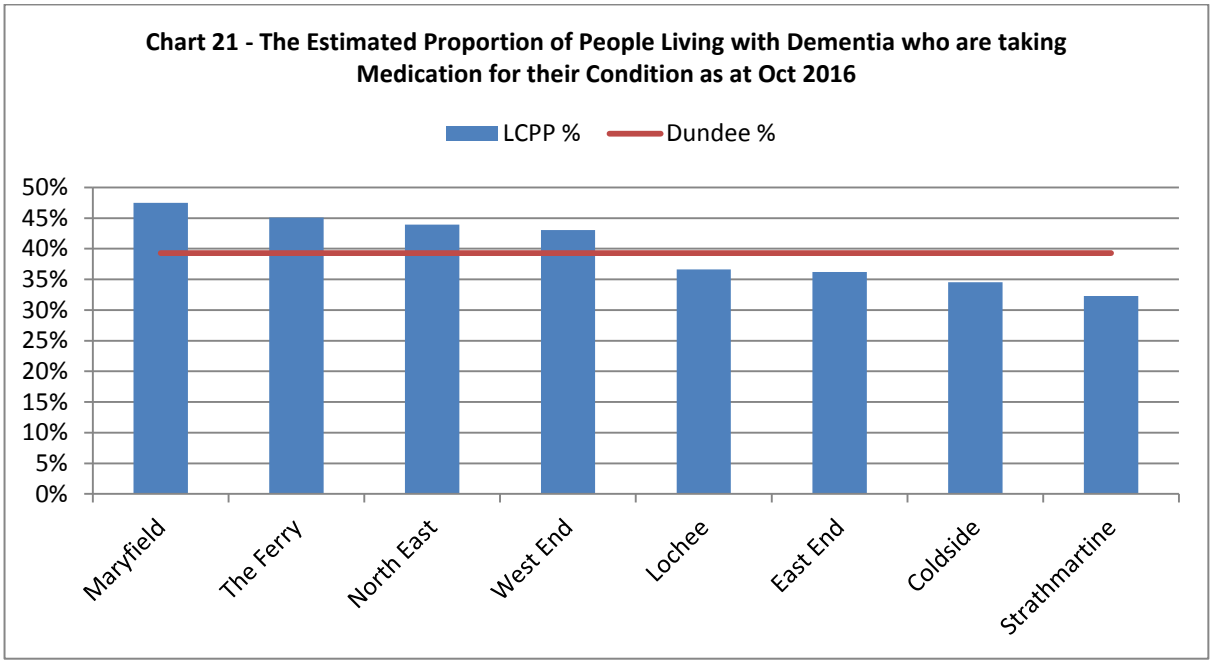

Source: PIS Dataset (management information) and EURODEM dementia prevalence estimates

** Note: Only records with a completed CHI (Community Health Index) were used for this analysis. Approximately two-thirds of the prescribing information comes from GP practices and one-third come from clinics. The information from clinics are poorly captured as only 20% of CHIs are recorded whereas GP practices capture between 95-99% of CHI records. This means that the number of prescriptions for dementia is only likely to be around 72% complete.

The estimated proportion of people living with dementia who are taking medication for their condition is highest in Maryfield, the Ferry and the North East. Interestingly, these three areas have the lowest number of emergency admissions for dementia in any diagnostic position for people aged 65+ as a rate per 1,000 population.

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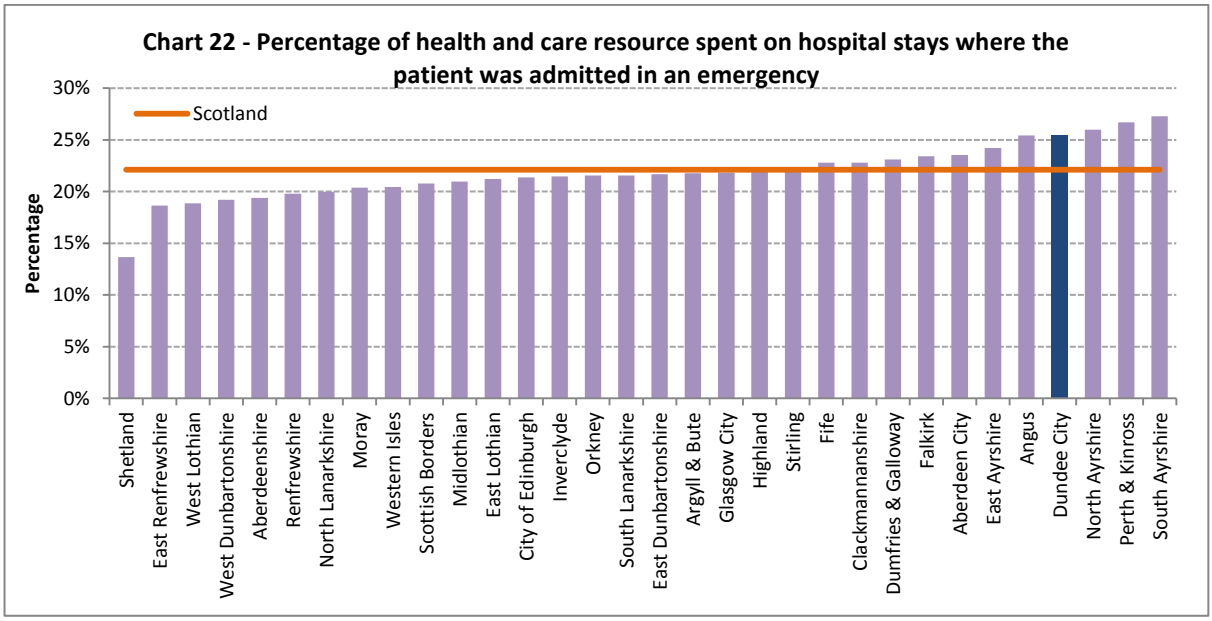
National Indicator 20 - Percentage of total health and care spend on hospital stays where the patient was admitted in an emergency

Latest National Position as at 2015/16



Source: ISD Scotland

In 2015/16 26% of Dundee's health and care budget was spent on hospital stays. This puts Dundee as the 4th highest spenders on hospital stays as a proportion of their budget with Perth & Kinross and Angus also spending above the Scottish average.

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Background to the National Indicators

All of the 23 indicators have been developed in consultation between National Services Scotland, Information Services Division (ISD) and a wide range of stakeholders across all sectors, and with significant input from COSLA, and agreed by the Ministerial Steering Group. It should be noted that the indicators will develop and improve over time, and that some of them still require data development.

Core indicators 1-10 are qualitative measures that are based on survey feedback and questionnaires, such as the Social Care Survey carried out every two years. Core indicators 11-23 are quantitative measures and are derived from organisational/system data and these will be centrally available at ISD every quarter from January 2017. Only indicators 11 – 23 will be provided quarterly at partnership level.

Indicators 11 – 23 are:

11. Premature mortality rate (*not available for 2016 or at locality level*)
12. Rate of emergency admissions for adults
13. Rate of emergency bed days for adults
14. Readmissions to hospital within 28 days of discharge
15. Proportion of last 6 months of life spent at home or in a community setting (*not available at locality level*)
16. Falls rate per 1,000 population in over 65s
17. Proportion of care and care services rated good or better in care inspectorate inspections (*not available at locality level*)
18. Percentage of adults with intensive needs receiving care at home (*not available for 2015/16 or at locality level*)
19. Number of days people spend in hospital when they are ready to be discharged
20. Percentage of total health and care spend on hospital stays where the patient was admitted in an emergency (*not available at locality level*)
21. Percentage of people admitted from home to hospital during the year, who are discharged to a care home (*still under development*)
22. Percentage of people who are discharged from hospital within 72 hours of being ready (*still under development*)
23. Expenditure on end of life care (*still under development*)

Definitions for all of the indicators can be accessed at:
http://www.gov.scot/Resource/0047/00473516.pdf

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