ITEM No …7………..

REPORT TO:	**PERFORMANCE & AUDIT COMMITTEE – 29 MAY 2018**
REPORT ON:	**DUNDEE HEALTH AND SOCIAL CARE PARTNERSHIP PERFORMANCE REPORT (QUARTER 4)**
REPORT BY:	**CHIEF FINANCE OFFICER**
REPORT NO:	**PAC30-2018**

1.0 PURPOSE OF REPORT

The purpose of the report is to update the Performance and Audit Committee on Quarter 4 (Q4) performance against the National Health and Wellbeing Indicators and Measuring Performance Under Integration interim targets.

2.0 RECOMMENDATIONS

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

2.1 Notes the content of this report.

2.2 Notes the performance of Dundee Health and Social Care Partnership against the Measuring Performance Under Integration interim targets as outlined in section 5 of this report and Appendix 1.

2.3 Notes the performance of Dundee Health and Social Care Partnership against the National Health and Wellbeing Indicators as outlined in section 6 of this report and Appendix 2.

3.0 FINANCIAL IMPLICATIONS

None.

4.0 BACKGROUND

4.1 The performance report in Appendix 1 assesses performance against targets set in the Measuring Performance Under Integration submission (Article XII of the minute of meeting of the Dundee IJB held on 27 February 2018 refers) for six high level service delivery areas – emergency admissions, emergency bed days, accident and emergency, delayed discharges, balance of care and end of life.

4.2 The performance report in Appendix 2 sets out performance against the National Health and Wellbeing Indicators at quarter 4, 2017/18. It was agreed at the PAC held on 19 July 2017 (Article VIII of the minute of the meeting refers) that local data, provided by the NHS Tayside Business Unit would be used to produce more timeous quarterly performance reports. NHS Tayside Business Unit provided data for emergency admissions, emergency bed days, readmissions and delayed discharges. Falls data is not available for Q4.

4.3 Data provided by NHS Tayside differs from data provided by National Services Scotland Information Services Division (NSS ISD); the main difference being that NHS Tayside uses ‘board of treatment’ and NSS uses ‘board of residence’. Differences in data were investigated although the two data sources were not identical, NSS data accuracy remains within an acceptable tolerance and trends are reliable for service planning and performance improvement purposes.

4.4 It was agreed at the PAC held on 19 July 2017 (Article VIII of the minute of the meeting refers) that national benchmarking data would be presented one quarter in arrears due to the time lag associated with collating and validating national data. This means that the Q4 performance report includes Q3 benchmarking data provided by NSS ISD. Recent guidance from NSS ISD has meant that other Partnerships can no longer be identified when benchmarking, until data has been formally published. Other Partnerships are numbered 1-32, however partnerships in the same family group as Dundee have been highlighted.

4.5 The performance report in Appendix 2 sets out performance for Dundee and also shows performance in each of the eight Local Community Planning Partnerships (LCPP). LCPP level data continues to be used to compile profiles to support dialogue with stakeholders regarding needs in individual LCPPs.

4.6 The Q4 Performance Report covers local performance against National Indicators 1-23. Under 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 recently published results from the 2017/18 survey are included.

4.7 Data is currently not available for eight out of the 13 National Indicators. The Scottish Government and NSS ISD are currently working on the development of definitions and datasets to calculate these indicators nationally.

5.0 MEASURING PERFORMANCE UNDER INTEGRATION INTERIM TARGETS

5.1 National data is provided to all partnerships to assist with monitoring against targets, however this data includes all ages, which cannot be used to measure against the 18+ targets agreed in February 2018. Charts for aged 18+ have been provided by the NSS ISD LIST team showing rolling monthly performance for emergency admissions, emergency admissions from accident and emergency, accident and emergency attendances, emergency bed days and age 75+ for delayed discharges.

5.2 In 2017/18 performance exceeded Measuring Performance Under Integration targets for emergency admissions (age 18+), emergency bed days (age 18+) and delayed discharges (age 75+). Targets were not met for accident and emergency attendances and the number of emergency admissions from accident and emergency. 2018/19 trajectories show that the number of accident and emergency attendances and the number of emergency admissions from accident and emergency will continue to rise.

6.0 QUARTER 4 PERFORMANCE 2017/18

6.1 Between the baseline year 2015/16 and 2017/18 Q4 there was an improvement in the rate of bed days lost to delayed discharges for people aged 75+ and the emergency bed day rate for people aged 18+.

6.2 Emergency bed day rates since 2015/16 have decreased by 9% for Dundee, which is an improvement. Every LCPP showed an improvement in Q4 compared with 2015/16 and the biggest improvements were seen in East End, Coldside, West End and Maryfield, all of which showed a greater than 10% decrease in bed day rates.

6.3 The rate of bed days lost to delayed discharges for people aged 75+ has decreased by 59% in Dundee since 2015/16, which is an improvement. In Q4 there were decreases across all LCPP areas and the decrease in the rate ranged from 30% in The Ferry to 73% in Strathmartine.

6.4 Emergency admission rates have increased by 9% for Dundee since 2015/16 and there were increases in every LCPP. The lowest increase was in East End (2% increase) and the highest increase was in Lochee (17% increase).

6.5 The rate of readmissions has increased by 2.4% since 2015/16. The rate increased in four LCPPs (Lochee, The Ferry, Coldside and West End) and decreased in four LCPPs (North East, Maryfield, East End and Strathmartine) The greatest decrease was in Maryfied (10% decrease) and the greatest increase was in Lochee (18% increase).

7.0 POLICY IMPLICATIONS

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

8.0 RISK ASSESSMENT

Risk 1 Description	The risk of not meeting targets against national indicators could affect outcomes for individuals and their carers and not make the best use of resources.
Risk Category	Financial, Governance, Political
Inherent Risk Level	Likelihood 3 x Impact 5 = Risk Scoring 15
Mitigating Actions (including timescales and resources)	- Continue to develop a reporting framework which identifies performance against national and local indicators. - Continue to report data quarterly to the PAC to highlight areas of poor performance. - Continue to support operational managers by providing in depth analysis regarding areas of poor performance, such as around readmissions to hospital and falls related hospital admissions. - Continue to ensure that data informs operational practices and improvements and also that operational activities and priorities are used to interpret trends shown by the data.
Residual Risk Level	Likelihood 3 x Impact 3 = Risk Scoring 9
Planned Risk Level	Likelihood 2 x Impact 3 = Risk Scoring 6
Approval recommendation	Given the moderate level of planned risk, this risk is deemed to be manageable.

9.0 CONSULTATIONS

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

10.0 BACKGROUND PAPERS

None.

Dave Berry
Chief Finance Officer

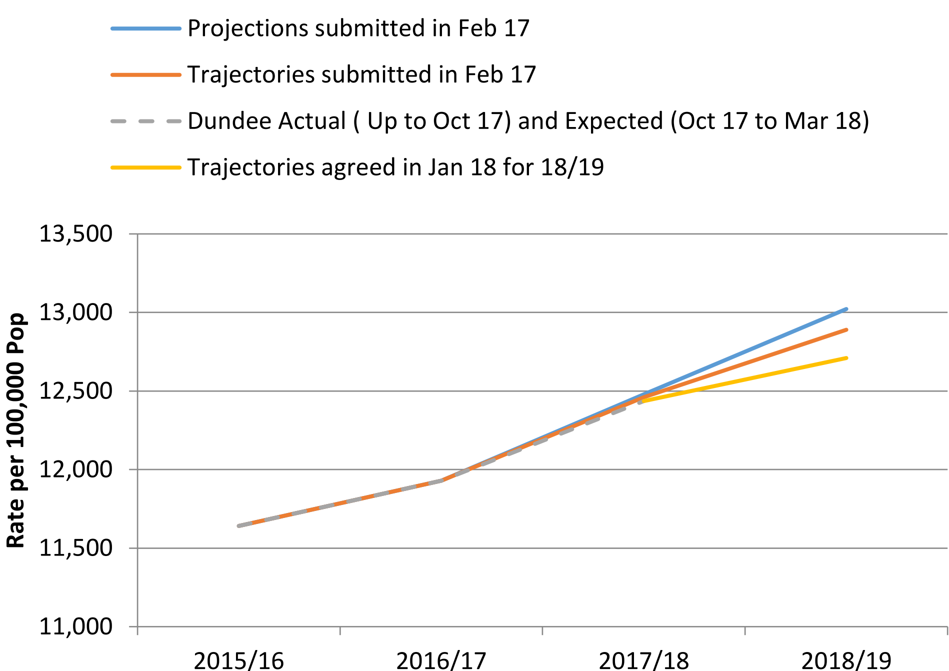
DATE: 7 May 2018

Lynsey Webster
Senior Officer

Appendix 1 - Measuring Performance under Integration Update

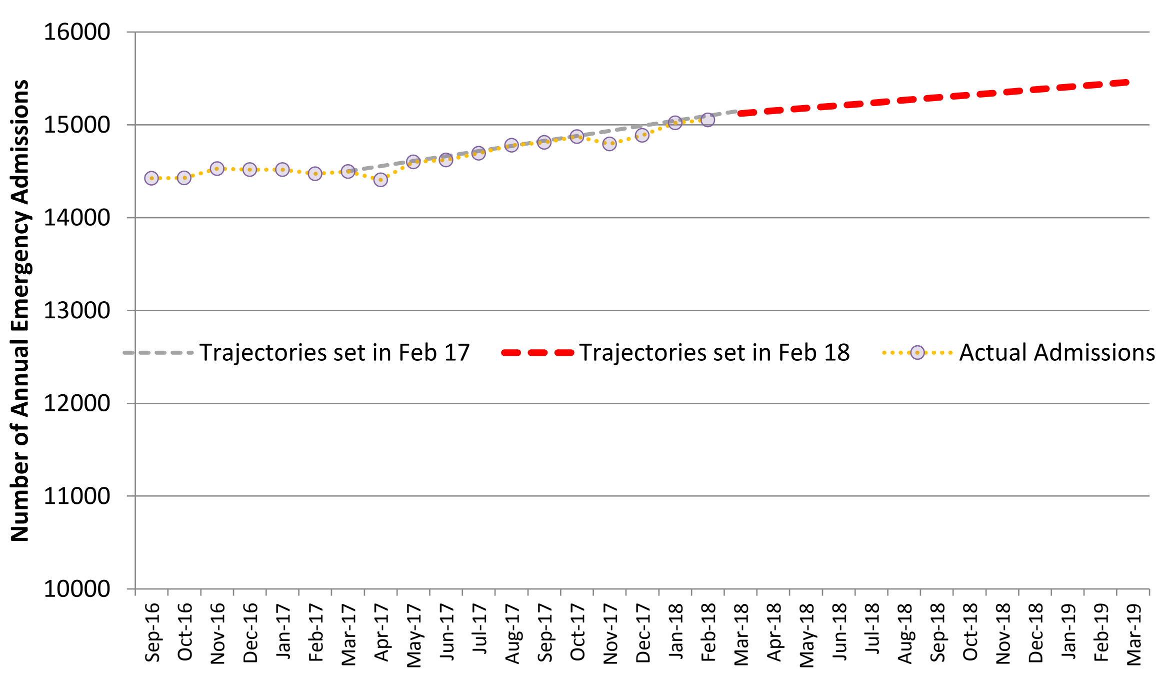
Service Delivery Area - Emergency Admissions

Chart 1: Emergency Admission Rate per 100,000 Population (18+)- Annual



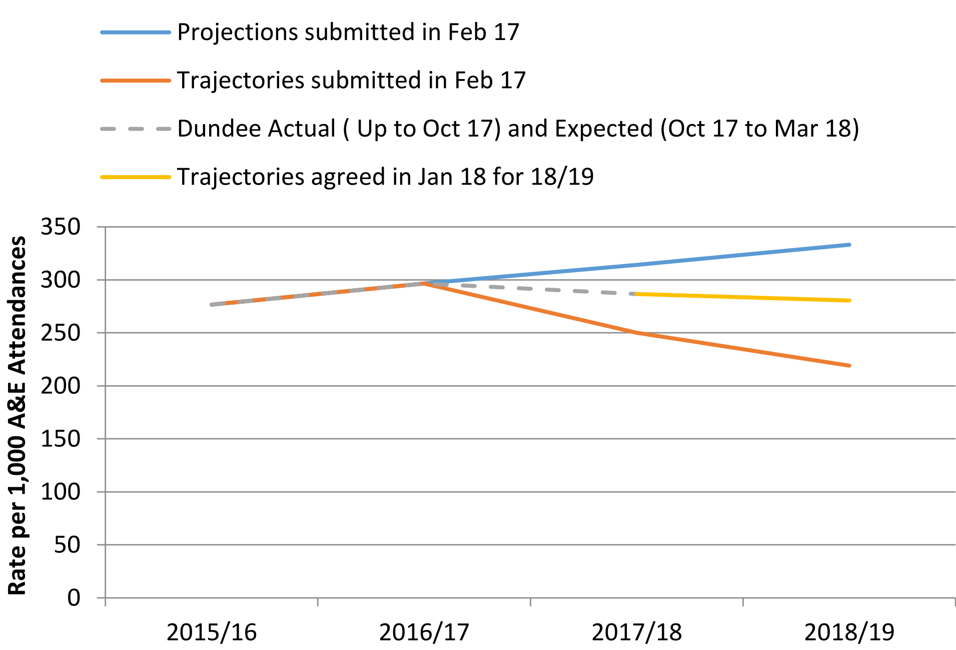
- Expected increase by 7.04% from 11,641 in 2015/16 to 12,461 in 2017/18
- The actual increase was 6.83% (12,436 emergency admissions per 100,000 population in 17/18)

Chart 2: Number of Emergency Admissions (18+)



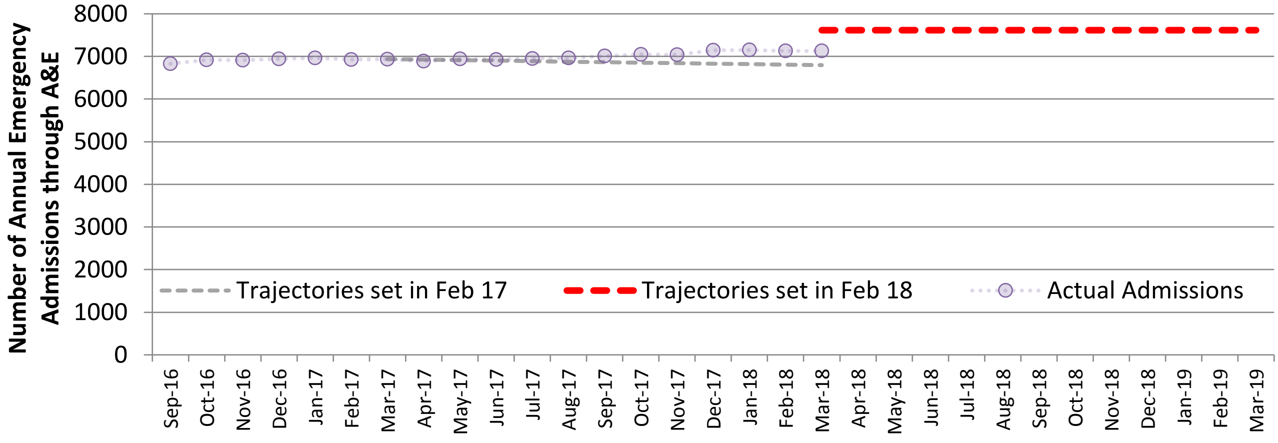
- Shows rolling annual data per month
- Actual performance each month between April 17 and March 18 was the same as or less than the trajectory set in February 2017. The trajectory from March 18 – March 19 shows that the number of emergency admissions will continue to rise.

Chart 3: Emergency Admissions as a Rate per 1,000 of All Accident and Emergency Attendances (18+)- Annual



- Expected increase in the number of emergency admissions from accident and emergency by 4.84% from 6,483 in 2015/16 to 6,797 in 2017/18.
- The actual increase was 17.48% (7,616 emergency admissions from A+E in 17/18).

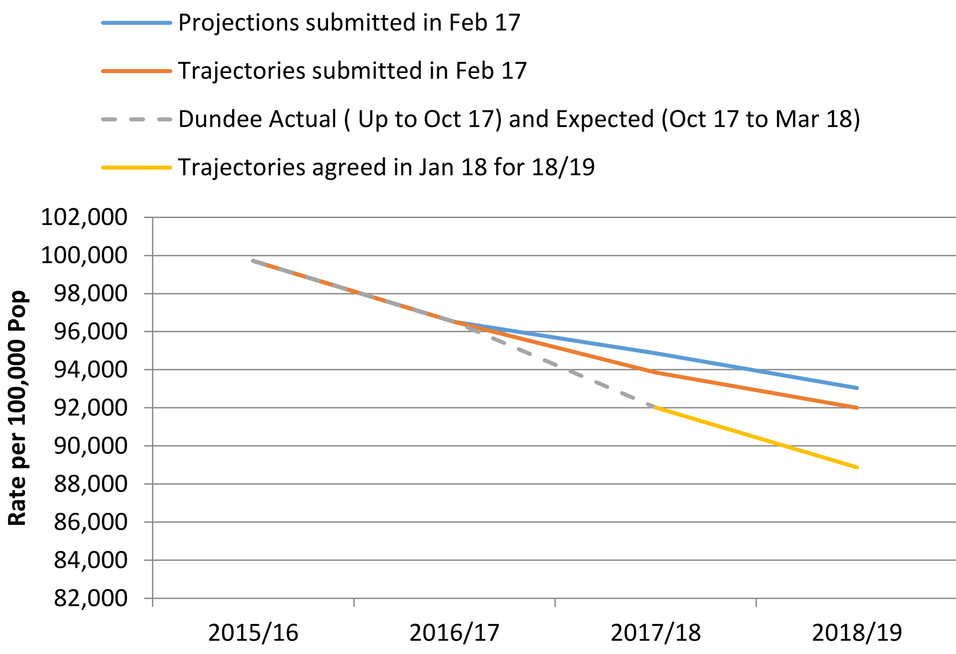
Chart 4: Number of emergency admissions from Accident and Emergency (18+)



- Actual performance was greater than the trajectory between August 2017 and March 2018. The trajectory from March 18 – March 19 shows that the number of emergency admissions from A+E will continue to rise.

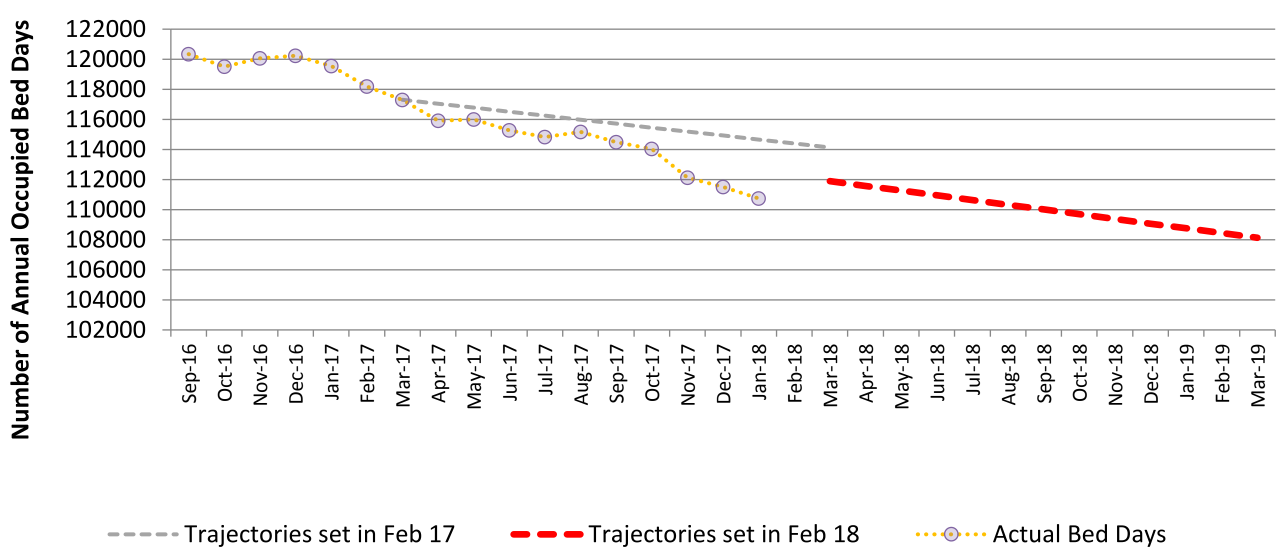
Service delivery area – Emergency Bed Days

Chart 5: Emergency Bed Day Rate per 100,000 Population (18+) – Annual



- Expected decrease by 5.87% from 99,712 in 2015/16 to 93,859 in 2017/18
- The actual decrease was 7.72% (92,018 emergency bed days per 100,000 population in 2017/18)

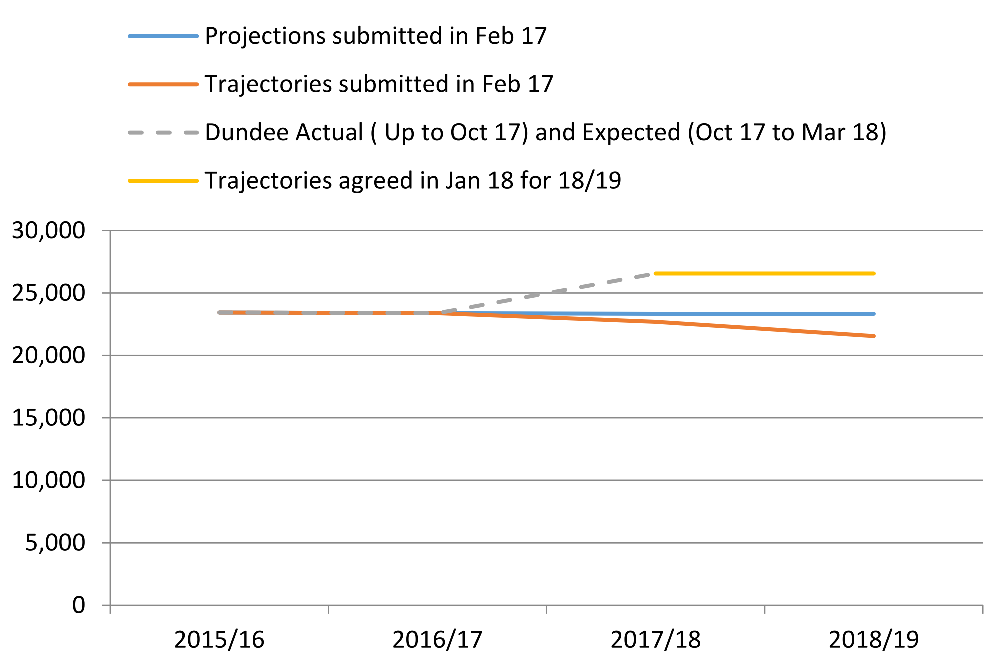
Chart 6: Emergency Bed Days (18+)



- Actual performance was less than the trajectory between April 17 and January 2018. The trajectory from March18 to March 2019 shows a further reduction in bed days.

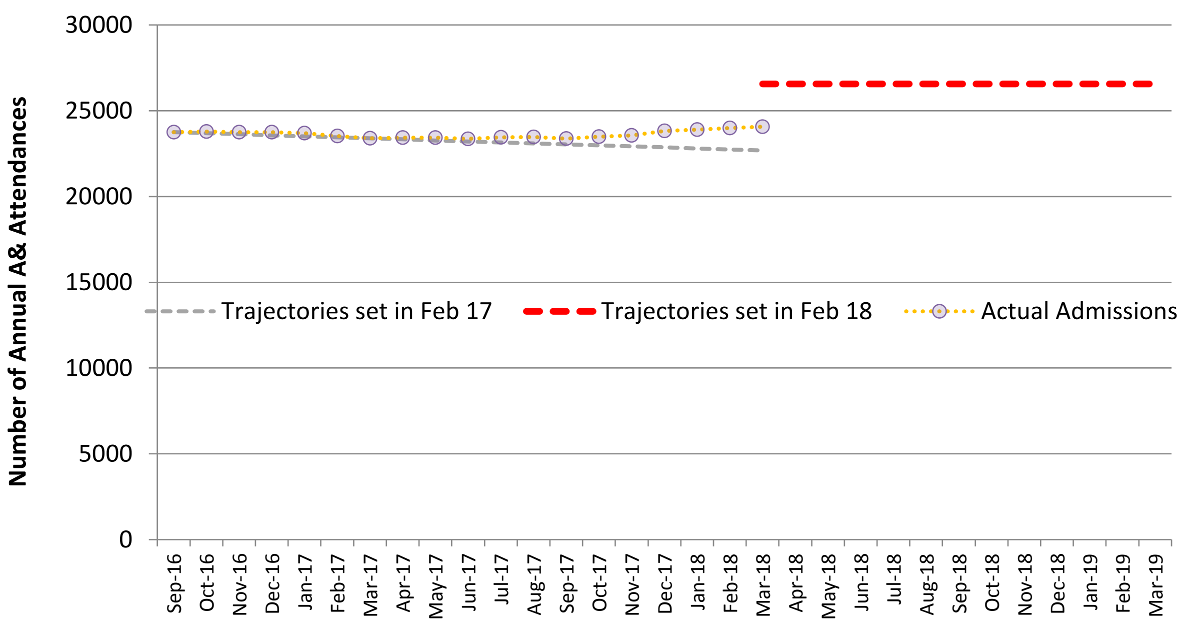
Service delivery area – Accident and Emergency

Chart 7: Accident and Emergency Attendances - Annual



- Expected decrease by 3.20% from 23,437 in 2015/16 to 22,686 in 2017/18
- The actual increase was 13.33% (26,562 accident and emergency attendances in 2017/18)

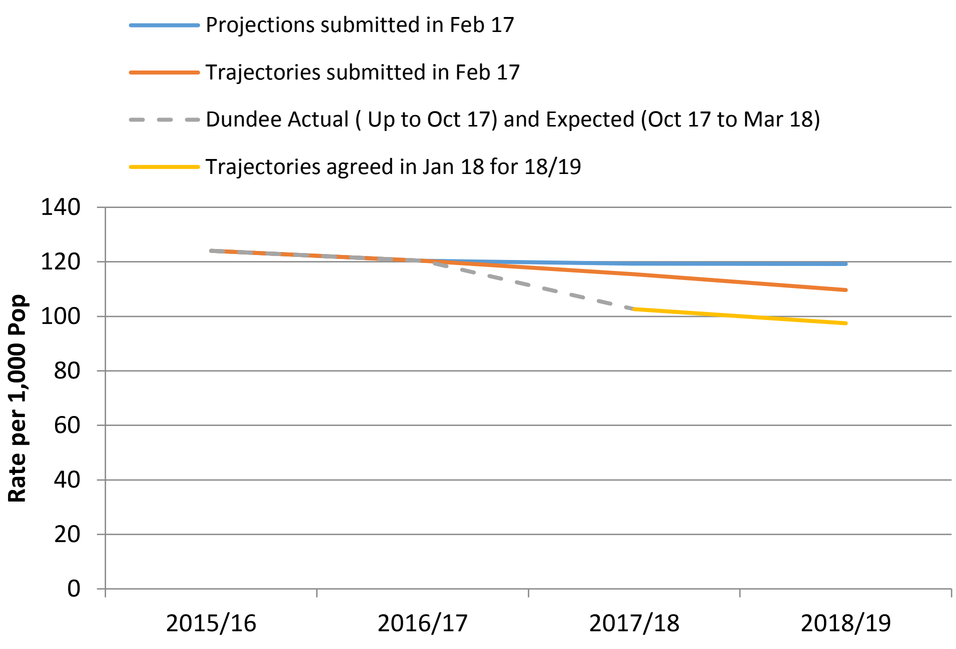
Chart 8: Accident and Emergency Attendances



- Actual performance was greater than the trajectory between June 2017 and March 2018. The trajectory from March 18 – March 19 shows that the number of accident and emergency attendances will continue to rise.

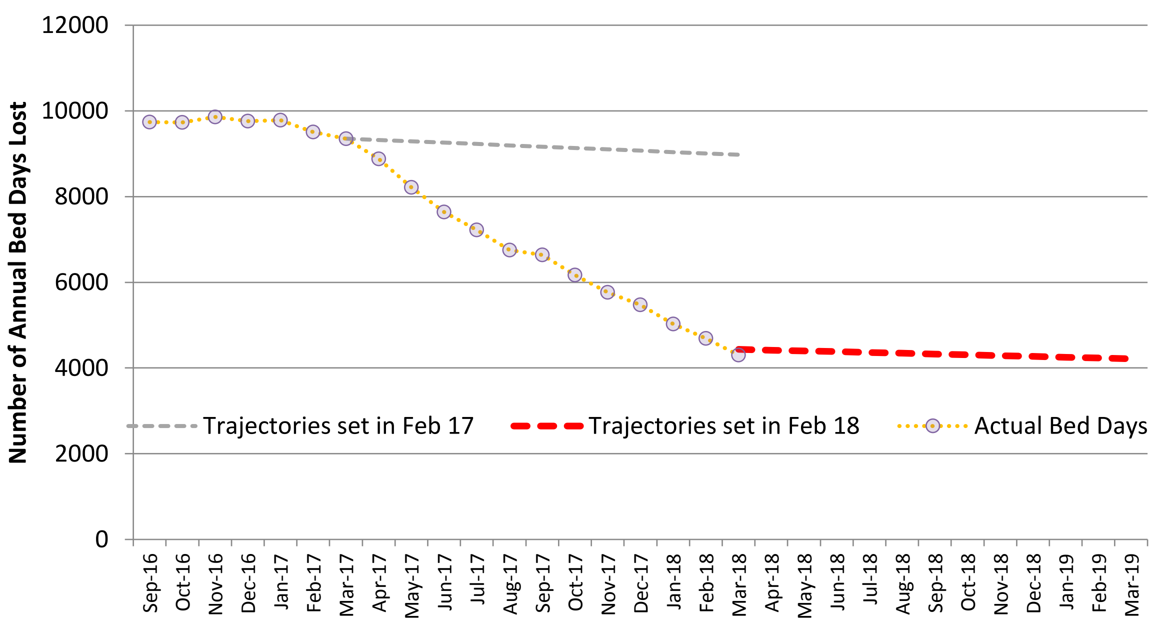
Service delivery area – Delayed Discharges

Chart 9: Rate of Bed Days Lost to Delayed Discharges (All Reasons) for Dundee 75+ - Annual



- Expected decrease by 6.70% from 15,050 in 2015/16 to 14,042 in 2017/18.
- Actual decrease of 17.08% (12,480 bed days lost in 2017/18).

Chart 10: Bed Days Lost Delayed Discharge (All reasons) 75+



- Actual performance was less than the trajectory between April 17 and March 2018. The trajectory from March 2018 to March 2019 shows a further reduction in bed days lost to delayed discharge.

APPENDIX 2

Dundee LCPP Performance Report 2017/18 Q4

Executive Summary

- The quarter 4 performance report assesses performance against the National Health and Wellbeing Indicators. 9 of these indicators are reported biannially from the Health and Care Experience Survey conducted by the Scottish Government. 5 of these indicators are health and wellbeing performance indicators which are monitored quarterly (emergency admissions, emergency bed days, readmissions, falls admissions and delayed discharge bed days lost). It also provides a benchmarking analysis against other Partnerships, including Family Groups.

- In order for quarterly data to be compared with financial years rolling quarterly data is presented for each quarter. This means that data for quarter 4 shows the previous 12 months of data including the current quarter. Quarter 4 data includes data from 1 April 2017 to 31 March 2018.

- Q4 data regarding the 5 national health and wellbeing performance indicators was provided by the NHS Tayside Business Unit, except for data regarding falls admissions which was not available. Data provided by NHS Tayside differs from data provided by NSS ISD; the main difference being that NHS Tayside uses 'board of treatment' and NSS uses 'board of residence'. Differences in data were investigated although the two data sources are not identical, NSS data accuracy remains within an acceptable tolerance and trends are reliable for service planning and performance improvement purposes.

- This report should be assessed with regard to the demographic and socio economic context of Dundee; high rates of deprivation, an ageing population, frailty and age associated conditions being diagnosed earlier in life than in more affluent Partnerships and deprivation associated mental health illnesses and substance misuse problems which impact on concentrations of people in particular neighbourhoods across the city.

- LCPP level data continues to be used to compile profiles to support dialogue with stakeholders regarding needs in these areas.

- Between the baseline year 2015/16 and 2017/18 Q4 there was an improvement in the rate of bed days lost to delayed discharges for people aged 75+ and the emergency bed day rate for people aged 18+.

- Emergency bed day rates since 2015/16 have decreased by 9% for Dundee, which is an improvement. Every LCPP showed an improvement in Q4 compared with 2015/16 and the biggest improvements were seen in East End, Coldside, West End and Maryfield, all of which showed a greater than 10% decrease in bed day rates.

- The rate of bed days lost to delayed discharges for people aged 75+ has decreased by 59% in Dundee since 2015/16, which is an improvement. In Q4 there were decreases across all LCPP areas and the decrease in the rate ranged from 30% in The Ferry to 73% in Strathmartine.

- Emergency admission rates have increased by 9% for Dundee since 2015/16 and there were increases in every LCPP. The lowest increase was in East End (2% increase) and the highest increase was in Lochee (17% increase).

- The rate of readmissions has increased by 2.4% since 2015/16. The rate increased in four LCPPs (Lochee, The Ferry, West End and Coldside) and decreased in four LCPPs (North East, Maryfield, East End and Strathmartine) The biggest decrease was in Maryfied (10% decrease) and the greatest increase was in Lochee (18% increase).

Performance in Dundee's LCPPs

Table 1: Performance in 2017/18 Q4 (falls Q3 as Q4 not yet available) and comparison between performance in LCPPs and the Dundee average

Deprivation Scale

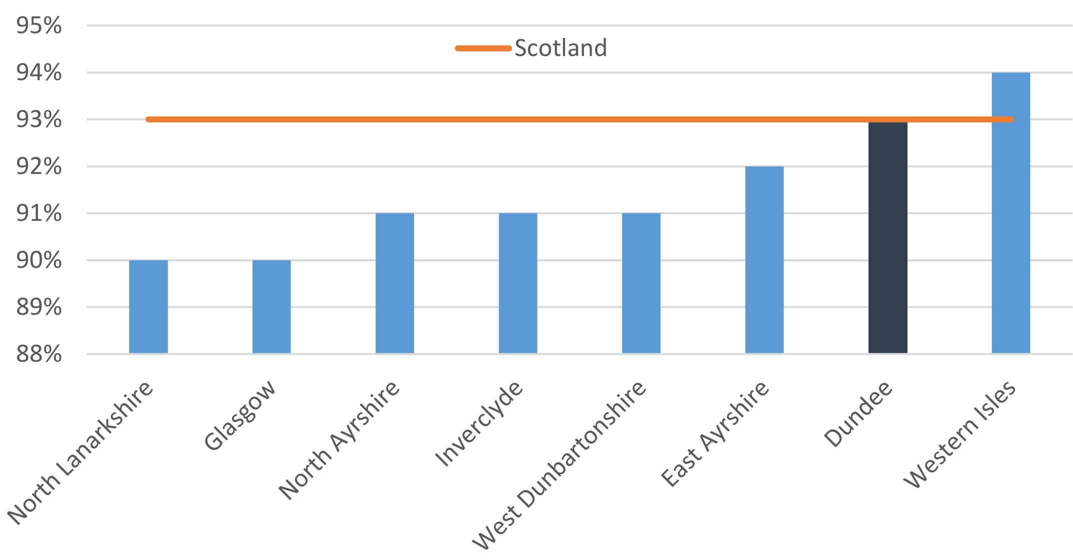
National Indicator	Dundee	Lochee	East End	Coldside	North East	Strath martine	Mary field	West End	The Ferry
Admissions rate per 100,000 18+	12,994	16,130	16,139	14,840	12,818	13,454	10,467	9,058	12,426
Bed days rate per 100,000 18+	118,610	156,544	139,266	141,128	105,178	114,869	93,490	84,974	120,719
Readmissions rate per 1,000 All Ages	114	123	120	121	110	108	110	105	112
Falls rate per 1,000 18+ (Q3)	27.7	27.1	35.4	31.1	23.0	21.3	28.6	35.7	23.2
Delayed Discharge bed days lost rate per 1,000 75+	335.3	460.4	326.9	381.8	567.6	258.0	252.1	408.7	201.5

Table 2: % change in 2017/18 Q4 (falls Q3 as Q4 not yet available) against baseline year 2015/16

National Indicator	Dundee	Lochee	East End	Cold side	North East	Strathm artine	Mary field	West End	The Ferry
Admissions rate per 100,000 18+	+8.9%	+17.2%	+2.0%	+8.2%	+10.2%	+2.8%	+5.6%	+13.2%	+12.7%
Bed days rate per 100,000 18+	-8.7%	-3.4%	-23.6	-13.4	-6.7	-7.3	-12.3	-13.4	-4.4
Readmissions rate per 1,000 All Ages	+2.4%	+18.4%	-2.8%	+5.6%	-0.2%	-7.0%	-9.6%	+2.0%	+13.7%
Falls rate per 1,000 18+ (Q3)	+10.9%	+2.1%	+29.3%	+4.1%	+12.1%	-15.3%	+23.2 %	+29.4%	+14.5%
Delayed Discharge bed days lost rate per 1,000 75+	-59.1%	-41.2	-72.2%	-61.7%	-54.0%	-72.6%	-66.8%	-54.5%	-43.2%

National Health and Wellbeing Indicator 1 - Percentage of adults able to look after their health very well or quite well.

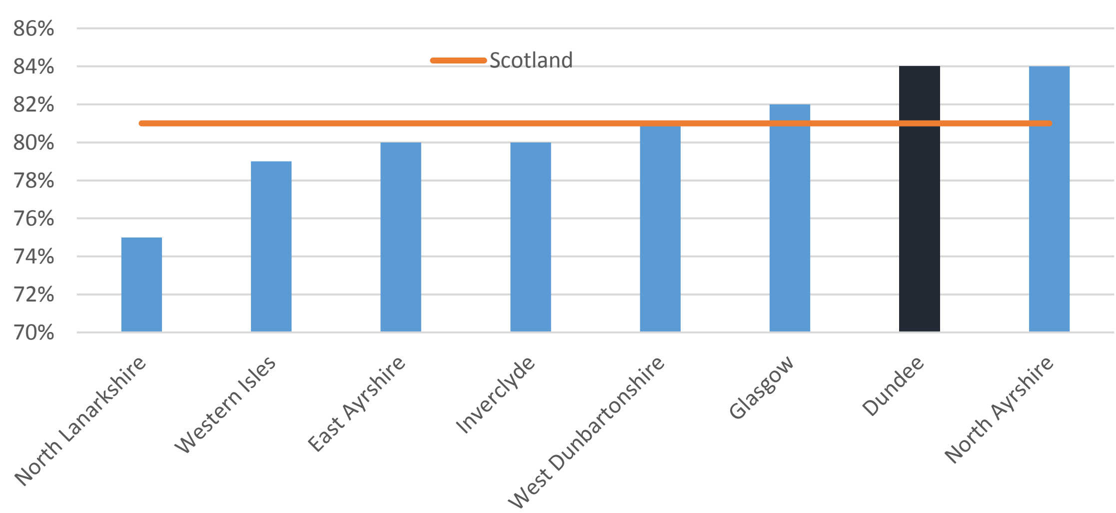
Chart 1



- 93% of respondents stated that they were able to look after their health very well or quite well.
- Results for Dundee are the same as the Scottish average and better than 6 of the other 7 family group partnerships.

National Health and Wellbeing Indicator 2 - Percentage of adults supported at home who agree that they are supported to live as independently as possible.

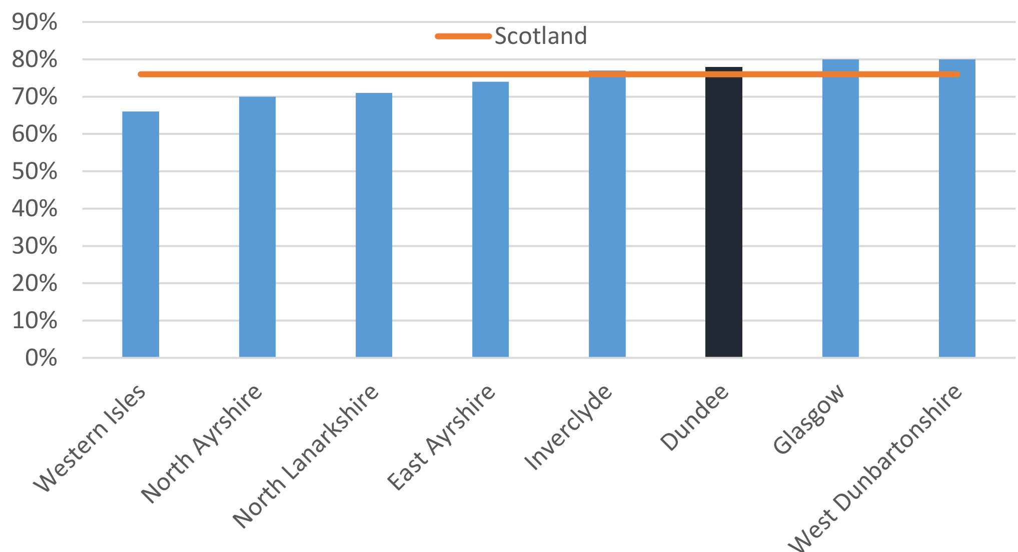
Chart 2



- 84% of respondents, who were supported at home, agreed that they were supported to live as independently as possible.
- Results for Dundee are 3% higher than the Scottish average of 81% and better than 6 of the other 7 family group partnerships.

National Health and Wellbeing Indicator 3 - Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided.

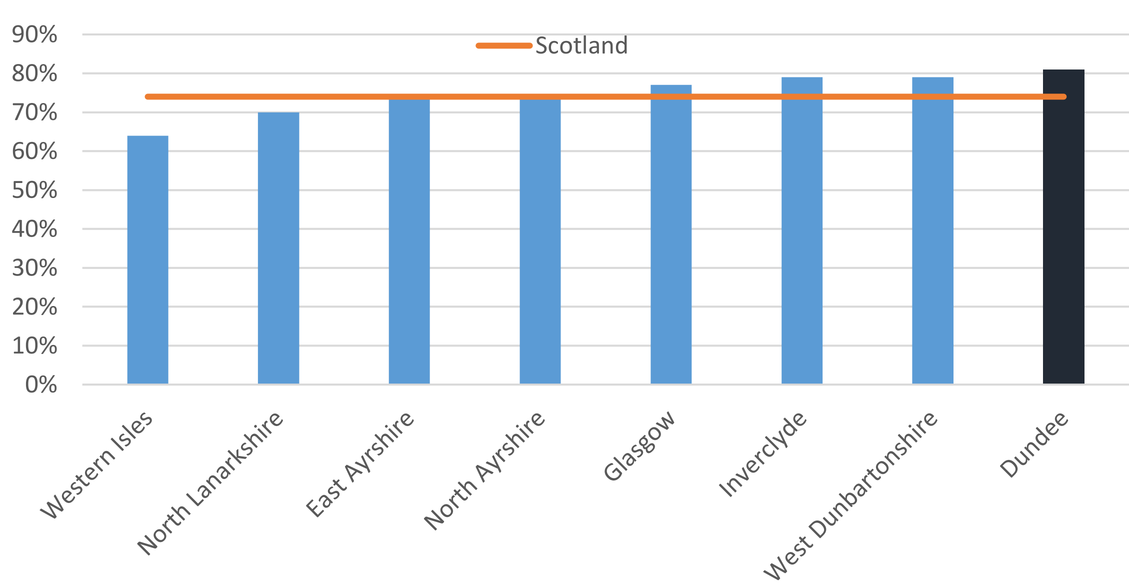
Chart 3



- 78% of adults supported at home agreed that they had a say in how their help, care or support was provided.
- Results for Dundee are 2% higher than the Scottish average and better than 5 of the other 7 family group partnerships

National Health and Wellbeing Indicator 4 - Percentage of adults supported at home who agree that their health and care services seemed to be well co-ordinated

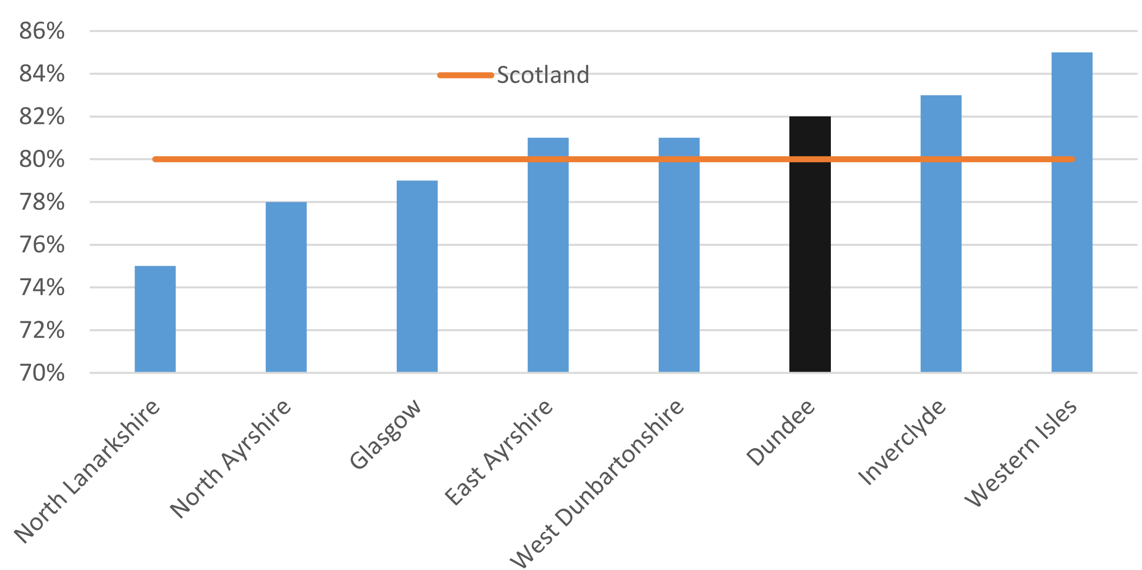
Chart 4



- 81% of adults supported at home agreed that their health and care services seemed to be well co-ordinated.
- Results for Dundee are 7% higher than the Scotland average of 74% and better than all 7 other family group partnerships.

National Health and Wellbeing Indicator 5 - Percentage of adults receiving any care or support who rate it as excellent or good

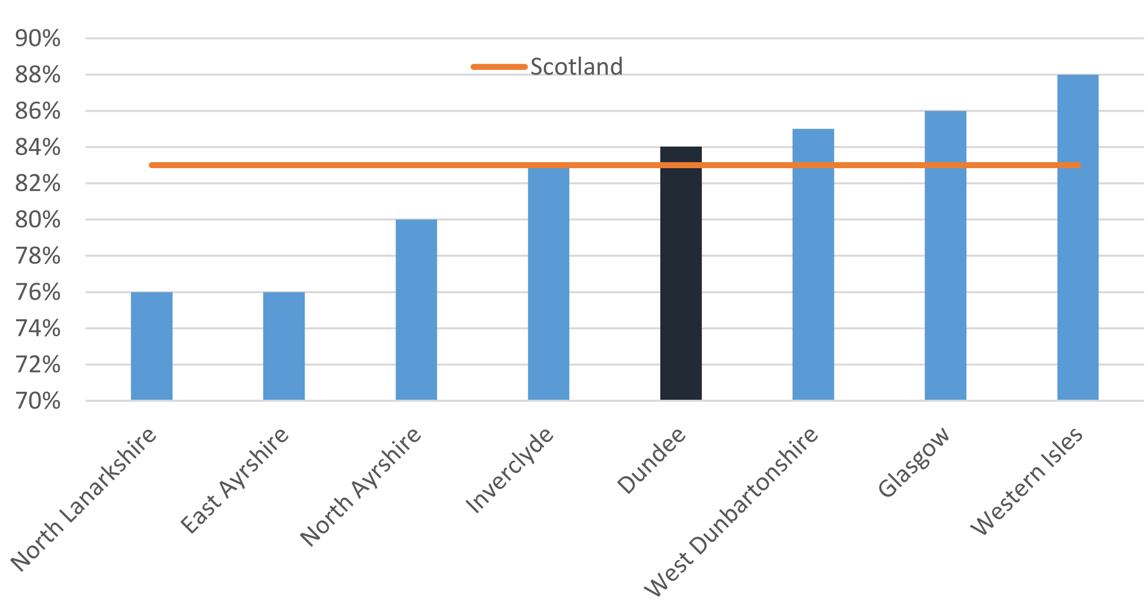
Chart 5



- 82% of adults receiving care or support rated their support as excellent or good.
- Results for Dundee are 2% higher than the Scottish average of 80% and better than 5 of the other 7 family group partnerships.

National Health and Wellbeing Indicator 6 - Percentage of people with positive experience of the care provided by their GP Practice

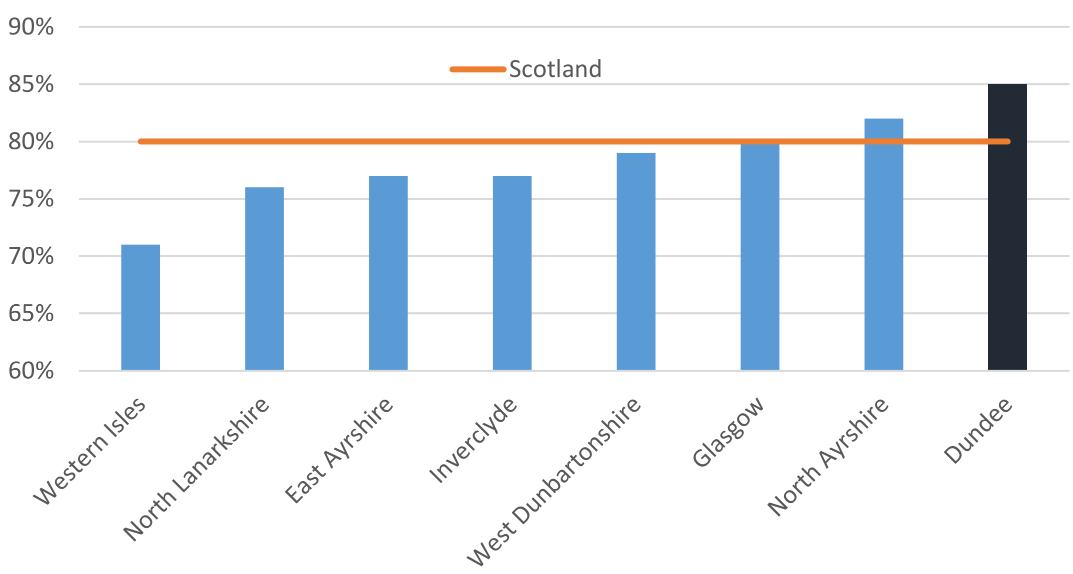
Chart 6



- 84% of respondents rated their experience of care, provided by their GP Practice as positive.
- Results for Dundee are 1% higher than the Scottish average of 83% and better than 4 of the other 7 family group partnerships.

National Health and Wellbeing Indicator 7 - Percentage of adults supported at home who agree that their services and support had an impact on improving or maintaining their quality of life.

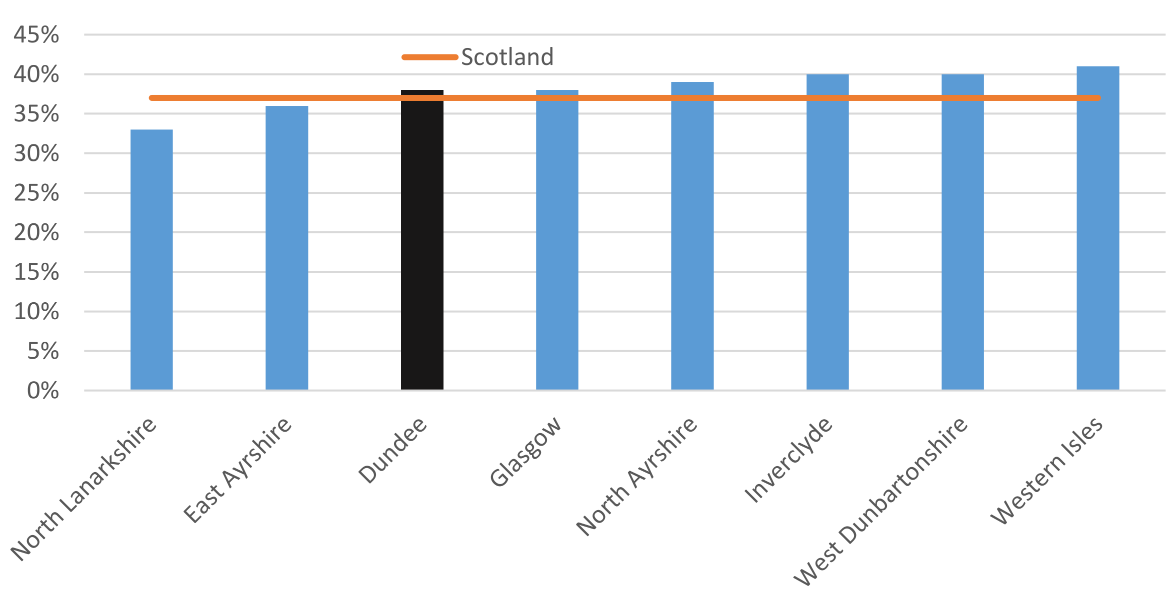
Chart 7



- 85% of adults supported at home agreed that their services and support had an impact on improving or maintaining their quality of life.
- Results for Dundee are 5% higher than the Scottish average of 80% and better than all other 7 family group partnerships.

National Health and Wellbeing Indicator 8 - Percentage of carers who feel supported to continue in their caring role

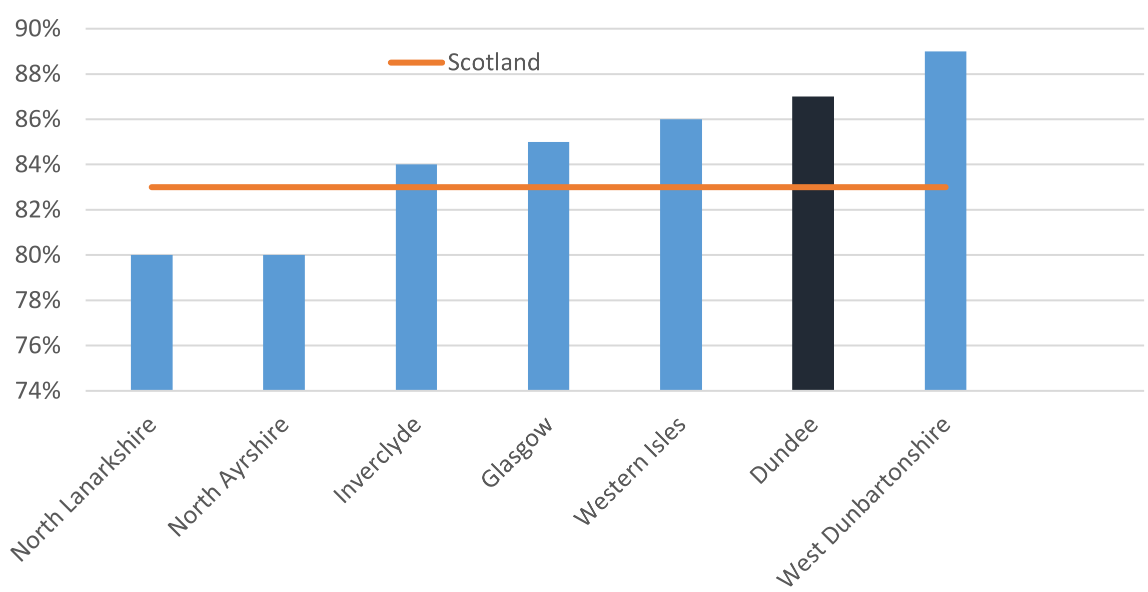
Chart 8



- 38% of carers felt supported to continue their caring role.
- Results for Dundee are 1% higher than the Scottish average of 37% and worse than 5 of the 7 family group partnerships.

National Health and Wellbeing Indicator 9 - Percentage of adults supported at home who agree they felt safe

Chart 9



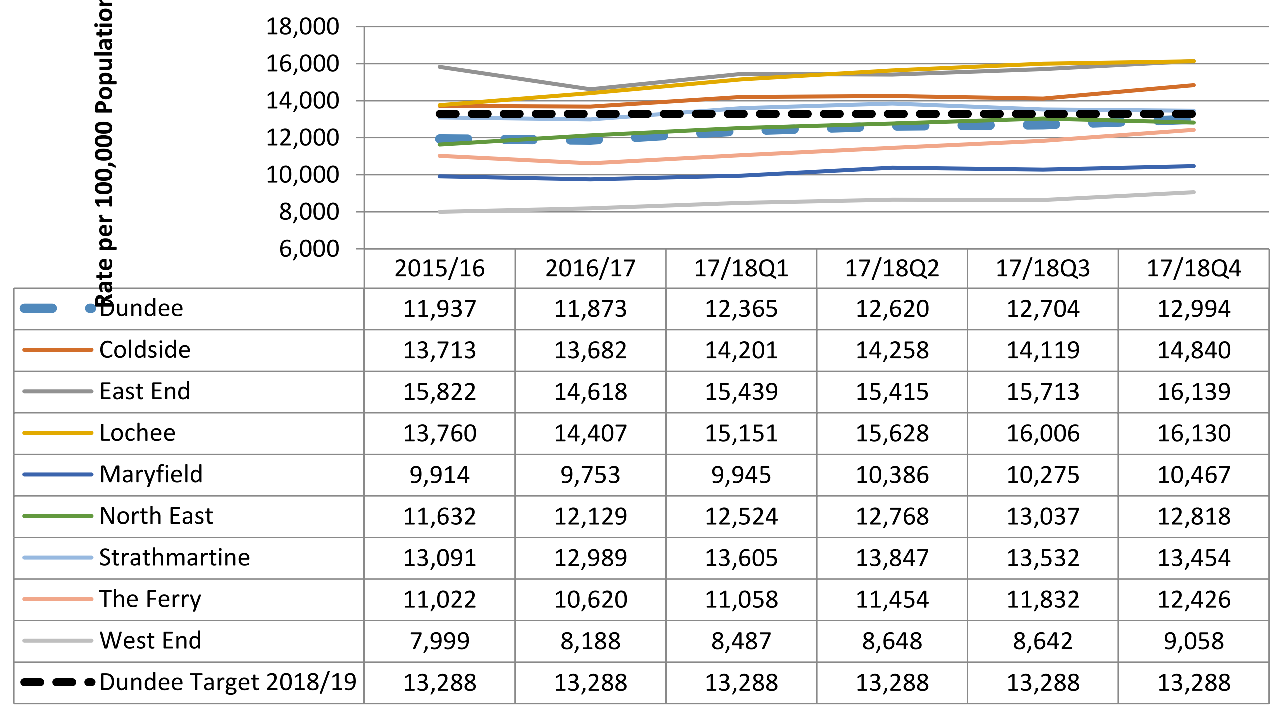
- 87% of adults supported at home agreed they felt safe.
- Results for Dundee are 4% higher than the Scottish average of 83% and better than 5 of the 7 family group partnerships.

National Health and Wellbeing Indicator 12 – Emergency Admissions

Chart 10: Rate of Emergency Admissions for Adults 18+ per 100,000 population Q3 - Benchmarked

- Scottish rate data is not currently available as the data for some partnerships is incomplete. The rate of emergency admissions was higher in Dundee than the Scottish rate in both quarters 1 and 2.
- The Dundee rate increased from 12,583 in Q1 to 12,722 in Q3.
- Dundee dropped a rank in Q2, from 13th highest in Q1 to 12th highest in Q2, however increased to 10th highest in Q3.
- Dundee performed better than all but one family group Partnerships.

Chart 11: Rate of Emergency Admissions for Adults 18+ per 100,000 population Q4 by Locality and Financial Year



	2015/16	2016/17	17/18Q1	17/18Q2	17/18Q3	17/18Q4
Dundee	11,937	11,873	12,365	12,620	12,704	12,994
Coldside	13,713	13,682	14,201	14,258	14,119	14,840
East End	15,822	14,618	15,439	15,415	15,713	16,139
Lochee	13,760	14,407	15,151	15,628	16,006	16,130
Maryfield	9,914	9,753	9,945	10,386	10,275	10,467
North East	11,632	12,129	12,524	12,768	13,037	12,818
Strathmartine	13,091	12,989	13,605	13,847	13,532	13,454
The Ferry	11,022	10,620	11,058	11,454	11,832	12,426
West End	7,999	8,188	8,487	8,648	8,642	9,058
Dundee Target 2018/19	13,288	13,288	13,288	13,288	13,288	13,288

Source: NHS Tayside BSU

Q4 17/18 Analysis

- The rate for Dundee has generally been increasing from 11,937 per 100,000 in 2015/16 to 12,994 per 100,000 in 2017/08 Q4.
- West End had the lowest rate with 9,058 emergency admissions per 100,000 people in 2017/08 Q4, followed by Maryfield and The Ferry. The West End rate was approximately 75% less than the East End rate.
- In Q4 17/18 East End had the highest rate with a rate of 16,139.
- All 8 LCPPs have seen increase es in their rates since the 2015/1a6 baseline year. The lowest increase was in East End (2% increase) and the highest increase was in Lochee (17% increase).
- The target for 2018/19 is 13,288, therefore based on rolling Q4 data, Dundee is on course to meet or exceed this target.
- During Q4 1718, performance exceeded the 2018/19 target in 4 LCPPs – Maryfield, North East, The Ferry and West End.

What we have achieved to date:
A three tiered system of support exists in Dundee which ensures that services and supports are delivered at the point of need.

Highest Tier – Caring for people with frailty / complex needs at home

- Integration of care home teams.
- Commencement of Delphi process to look at pathway improvements.
- Start of Dundee Enhanced Community Support Acute (DECSA) pilot.
- Acute Frailty Team is now a 7 day service.
- Ongoing development of joint medicine for the elderly / psychiatry of old age work.
- The Care home Liaison team, which consists of a team of four nurses who are supported by medical colleagues has contributed to many positive outcomes for residents and families, including a reduction in hospital admissions. In this period the admission rate from care homes to Kingsway Care Centre dropped from 28 to seven. Colleagues who work in care homes have found many benefits from having a specific link nurse and prearranged times to visit each area. This provides a consistent and dependable service which allows planning. Further developments within the team include; collaborative training with care homes, peripatetic services and older people review officer and enhancing knowledge in the essentials in psychological care.
- Significant shifts in the balance of care have been achieved in Medicine for the Elderly and Psychiatry of Old Age services which has resulted in the closure of acute beds and the planned closure of an entire ward by the end of 2017. The multi-disciplinary team is working effectively and successes include; the development of an acute frailty team, the completion of Anticipatory Care Plans and recording on eKIS, and creating links between the Medicine for the Elderly and Psychiatry of Old Age Teams. The polypharmacy stream has reduced harm, waste and variation by allocating resources in both enablement and care home services. Housing with care has been further expanded with the development of 2 new sites. Day services have been remodelled which has increased the number of day opportunities in the community, opposed to within traditional day centres. The resource released from the reduction of acute beds has been reinvested in expanding the Enhanced Community Support (ECS) service. This included 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. A locality nurse role has been established in each locality to co-ordinate assessments and reviews and support anticipatory care planning and carer assessments. This has directly reduced length of hospital stay and emergency admissions.

- Introduced medication reviews for people in care homes, and employed pharmacy technicians as part of the social care enablement teams.

Middle Tier – Rehabilitation

- Development of range of step down options.

- Development of assessment at home service.

- Development of a respite development worker post.

- Supported and rehabilitative transitions from the Centre for Brain Injury Rehabilitation into the community is being provided by the Mackinnon Centre. The project set out a number of key aims to be tested over a period of twelve/eighteen months. These are summarised below:
  - upskill the workforce at the Mackinnon Respite service
  - redesign the care pathway for those in patients receiving rehabilitation services through the acquired brain injury service at Royal Victoria Hospital
  - explore, through a test of change, whether the resource at the Mackinnon service could effectively support individuals in the latter stages of their rehabilitation pathway.
  - support earlier discharge from CBIR
  - increase in earlier access to CBIR from Ninewells.

- Creative Engagement, through the arts, is a developing non-medical therapeutic intervention option that can operate alongside existing treatments by addressing psychosocial benefits (mood, confidence, self-esteem…) associated with positive health and well being. Tayside Healthcare Arts Trust (THAT) has been at the forefront of its development locally across a wide range of Long Term Conditions (LTCs). Its nationally recognised work with stroke (ST/ART Project and ACES research) has earned recurring funding from NHS Tayside and partnership support from Dundee Contemporary Arts and others. THAT has for some years been demonstrating the applicability of this approach for other LTCs, particularly Dementia, COPD, Parkinson's and MS and continues to seek additional recurring funding to embed this work. Opportunities for further developments around other health inequality targets could be explored with innovative test of change work.

- Successful delivery of Post Diagnostic Support for people diagnosed with dementia across Dundee. Analysis of care plans identified excellent compliance with PDS monitoring – there was a 100% rate of referral and *98%* of patients had either 1 or more pillars recorded as met.

  Additionally 84% of people who responded to the survey were either satisfied or very satisfied.

  Patient and carer feedback included the following comments:

  "We would like to thank the service for making mum feel safe and comfortable"
  "As a carer it's good to know there is somebody at the end of a phone "
  "Information and help was very much appreciated"
  "Service provided by my worker was excellent"
  "Extremely professional but also down to earth"

Lowest Tier – Prevention

- Expansion of community companion project.

- The *Reshaping Care Capacity Building Programme* is led by Voluntary Gateway Dundee and aims to build the capacity of communities to ensure people are able to look after and improve their own health and wellbeing and live in good health for longer. The Reshaping Care Team work in local communities to build their capacity and implement a co-productive model in the planning and implementation of service that meet the needs of each community. Through the Reshaping Care Network we share information and improve connections between third sector organisations that provide health and social care services and supports in the City, Some areas of work include:

- Community Companion Project – aimed at adults living in Dundee who are either experiencing or have the potential to experience social isolation. Each service user is matched up to a community companion based on personality, hobbies and interests and general living experiences. Community companions visit people in their own homes, accompany them to social activities or shopping trips or even a visit to the local cafe.

- Men's Sheds – provide a place for men to gather and participate in a variety of activities whilst supporting each other in a relaxed environment. The team is supporting the development of Men's Sheds in the East End, Lochee and Maryfield.

- Building on existing Equally Well training sessions (including positive sensitive practice and Mind Yer Heid Plus) the new Dundee Partnership Prevention framework includes a useful toolkit for staff to assess the extent to which they are using social prescribing as a route to improving service user outcomes and help them consider what more they could be doing to provide early interventions for those most at risk.

- Developments within Keep Well to increase the partnership working, particularly with the Carers Centre, to support carers health needs are having a positive impact with an increasing number of people engaging with the Keep Well team. Similarly, although the number of people with a substance misuse issue engaged in Q1 decreased the closer link with Addaction is starting to increase those supported. The team continue to support health needs identified in the DD4 networks. Data and IT issues have led to a reduction in overall numbers but solutions are being sought to this. The increasing number of people being supported around a wide range of health and social issues by the associate practitioners is also having a positive impact, both for the individuals involved, and increasing referrals with the recognition by professionals as so the wider benefits of the teams input. The Health and Homeless Outreach Team (HHOT) have become integrated with the Keep Well team and other inequalities teams. The expertise in the team will enhance the skills of the wider team, and ensure we support health needs and prevention across vulnerable groups who often have a complex range of health and social issues impacting on their health and wellbeing.

- Dundee Healthy Living Initiatives (DHLI) work with individuals living in deprived areas of the city to identify issues impacting on their health and supports communities to develop and implement interventions to address these. Examples of activities include accredited cooking skills and health issues in the community courses, volunteer led walking programme and community based health checks and relaxation sessions. In addition the DHLI supports local groups to become formally constituted and gain independent funding for activities.

- The Listening Service "Do You Need To Talk?" was developed in 2012 in two sites in Dundee. In 2017 it received additional funding and is now available at over 18 sites in the City. The service is provided within local general practices, and uses an asset based approach, building individual resilience and supporting a sense of well being. A third of people using the listening service talk about bereavement issues, with others talking about relationships, stress, depression, ill health, fear/anxiety and a range of other issues.

  "I came away with a feeling of optimism. I have since taken positive steps to make some changes in my life, which have improved my mental and emotional wellbeing."

  The approach is evidence based, and makes use of a National Training Program funded by Scottish Government.

What we plan to do:

Models of Support, Pathways of Care

- A range of stakeholders across NHS Tayside and the 3 Partnerships are involved in a Delphi process which will give a better understanding of pathways. This involves a survey which is completed by health and social care professionals to gather information regarding critical processes in a pathway. This will be used to improve outcomes for people and system efficiencies.

- Frail people who are acutely unwell may need at times to be in hospital. They are supported there by a highly effective Acute Frailty team. This includes in reach into a number of other in patient areas. Where people do need to go to hospital this is only for the length of time they need to be in hospital and they will be able to step down as quickly as possible using a range of supports and resources such as an Assessment at Home service and an Intermediate Care unit. This ensures that assessment is undertaken at home or in a homelike setting rather than an acute hospital. This is supported by a multidisciplinary Discharge Hub

- We have commissioned Red Cross domiciliary care provider to carry out a test of change which enables social care assessment to be completed in the person's own home with intensive round the clock social care support tailored to meet the person's changing needs on a daily basis. This has supported us to address National Indicators 19 and 22, by ensuring people are discharged more efficiently from a hospital setting, and has improved patient outcomes with a 26% reduction in care home placement. This test has contributed to the reduction in bed days lost for standard delays over 17/18.

- We recognise that one group with particularly complex needs are those who live in care homes and we are in the process of developing an integrated Care Home team. This builds on the work that has taken place over the past few years to support care homes.

- A primary care improvement plan to implement the new GP contract is in development. There are 6 priority areas – urgent care, mental health, musculoskeletal, community treatment centres, immunisation, pharmacy.

- Further development of discharge planning arrangements for adults with mental ill-health, physical disability, acquired brain injury, learning disabilities and autism is also being progressed. Following a review of the hosted acute liaison service for people with learning disabilities, a further nursing post is in the process of being recruited to. This will ensure smoother transitions to and from acute care, strengthen interfaces between community / acute services and provide support and awareness raising activity within the acute sector.

- An IJB report is being prepared for the June meeting which is focussing on models of care within psychiatry of old age, to allow people to remain in the community.

- There is an understanding of the '6 essential actions for unscheduled care' and the Unscheduled Care Board is focussing on developing 7 day services to reduce variation in weekend and out of hours working and also in providing care closer to home.

- There is now a Mental Health Officer post established within the Integrated Discharge Hub which supports improved decision making around the use of Adults with Incapacity and Section 13Z(A) of the Social Work (Scotland) Act. This has significantly reduced the episodes of Code 9 delays, as well as the bed days lost for each individual patient.

Person Centred Care and Support

- Data has identified that respiratory, gastro and general surgery are priority areas for the Unscheduled Care Board. Do date initiatives have worked well for older people but need to be rolled out to younger age groups.

- The COPD team continues to work closely with the population of Dundee and those that provide support to manage this condition across the spectrum of self management, primary and secondary care. A variety of initiatives support this including the COPD discharge service which provides support to patients following necessary hospital admission to prevent readmission. Also the use of health care support workers help individuals to self manage. This is all being further supported by the Managed Care Network which will include pathway development.

- A group has been convened to improve how anticipatory care information can be shared with the appropriate professionals and is available when required.

Building Capacity

- Work has commenced to train a range of people (including homecare workers and district nurses) to identify when people are deteriorating (including delirium).

- An asset based approach is being used in Dundee to support people to be healthier and independent for longer in their own community. This involves working in partnership to co-design services with the statutory, third and independent sectors and with individuals, families and communities. Key to the success of these models is the ability to work in localities, to identify people at an early stage of their journey where things do go wrong and provide comprehensive assessment, early intervention and anticipatory care. This is done through our Enhanced Community Support and Post Diagnostic Support teams. Where people do start to deteriorate, a range of services will be provided to allow them to maximise their recovery and independence in their own home. This includes a Dundee Enhanced Community Support Acute service.

Early Intervention / Prevention

- We have implemented a Power of Attorney Campaign in partnership with Angus and Perth and Kinross Health and Social Care Partnerships, which will now take place annually. The campaign was supported by additional local awareness raising events in Dundee to help to promote Power of Attorney, reduce the need for guardianship and enable people to be discharged from hospital when they are well. Initial data gathering indicates an increase in Power of Attorneys and this will continue to be monitored over coming years.

- A number of priority areas have been agreed to reduce hospital admissions due to a fall. These include a focus on a preventative approach which will support active ageing, health improvement and self management to reduce the risk of falls.

- A partnership approach to supporting people experiencing distress is being taken to develop a range of supports. These include; a safe place (accommodation with the right support at right time), agreed pathway for timeous access to support, out of hours support and peer support.

- Increase the availability of high intensity, psychological interventions within Community Mental Health Teams (CMHT) whilst also decreasing the need for high intensity psychological interventions by enabling more mental health staff to provide appropriate low intensity psychology interventions and support at earlier stages of the patient journey.

- There has been a development around the creation and sharing of a palliative scorecard which allows an assessment of need to be identified and shared across both health and social care teams.

Localities and Engaging with Communities

- Building on the potential strengths of developing communities within the locality concept, we are looking at developing Care and Treatment Centres that will be based for communities to access within their own areas for a range of treatments. This will build on our successful model developed by the district nursing service for the treatment of leg ulcers and expanding on the number and type of treatments that will be available.

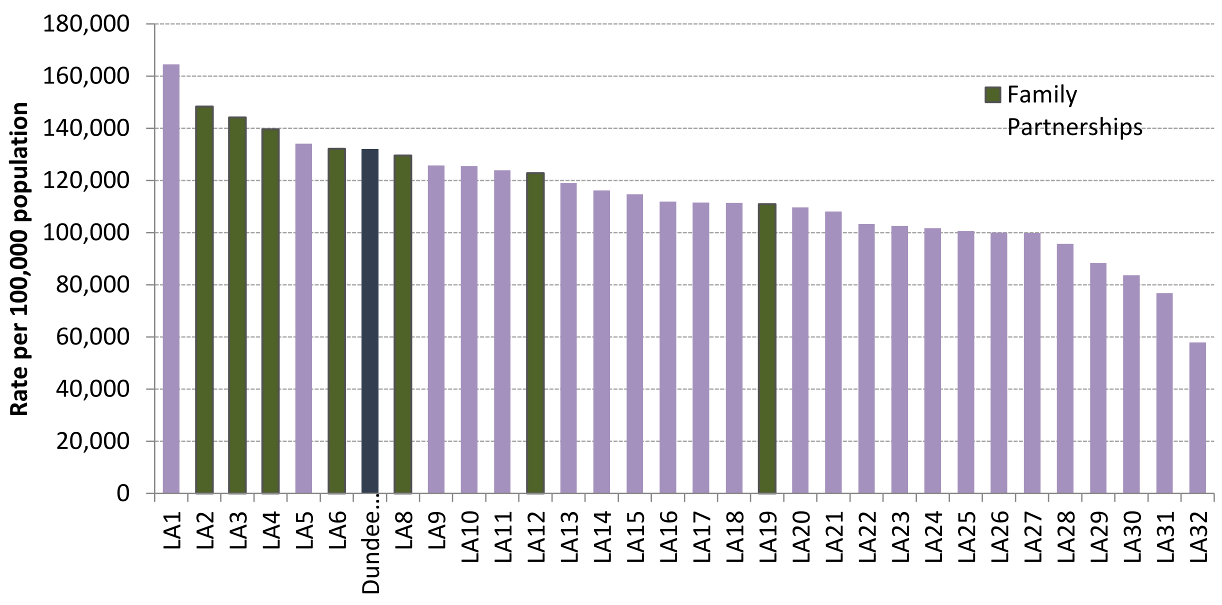
- Increase overall capacity within the Psychological Therapy service to:

  - Increase the availability of a range of specialist psychological therapies
  - Support the skill development of the wider workforce within Mental Health Services (cross sector) to ensure the best use of resources

- Plans are underway to enhance community mental health services. This will include quicker access to the right kind of support 24/7 through the development of stronger pathways between acute / community and primary services. The flexible use of available social care resources across a number of providers in the city has in recent years led to quicker response times, including where people are at risk of unnecessary hospital admission or where they require support on discharge.

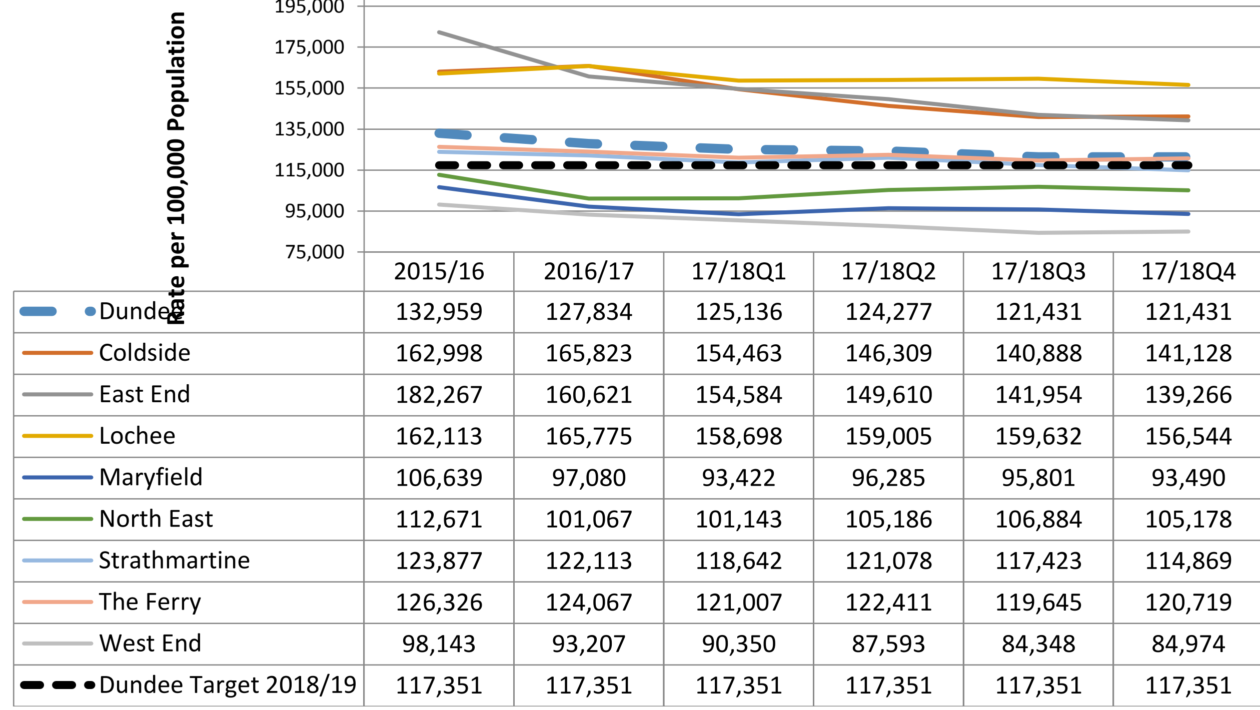
National Health and Wellbeing Indicator 13 – Emergency Bed Days

Chart 12: Rate of Emergency Bed Days for Adults 18+ Q3



- Scottish rate data is not currently available as the data for some partnerships is incomplete. The rate of emergency admissions in Dundee was higher than the Scottish rate in both quarters 1 and 2.
- The Dundee rate decreased from 138,206 in Q1 to 132,029 in Q3.
- Despite this decrease Dundee dropped two positions in Q2, from 8th highest in Q1 to 6th highest in Q2, however increased to 7th in Q3.
- Dundee performed better than 4 of the other 7 family group Partnerships.

Chart 13: Rate of Emergency Bed Days for Adults 18+ by Locality and Financial Year



	2015/16	2016/17	17/18Q1	17/18Q2	17/18Q3	17/18Q4
Dundee	132,959	127,834	125,136	124,277	121,431	121,431
Coldside	162,998	165,823	154,463	146,309	140,888	141,128
East End	182,267	160,621	154,584	149,610	141,954	139,266
Lochee	162,113	165,775	158,698	159,005	159,632	156,544
Maryfield	106,639	97,080	93,422	96,285	95,801	93,490
North East	112,671	101,067	101,143	105,186	106,884	105,178
Strathmartine	123,877	122,113	118,642	121,078	117,423	114,869
The Ferry	126,326	124,067	121,007	122,411	119,645	120,719
West End	98,143	93,207	90,350	87,593	84,348	84,974
Dundee Target 2018/19	117,351	117,351	117,351	117,351	117,351	117,351

Source: NHS Tayside BSU

Q4 17/18 Analysis

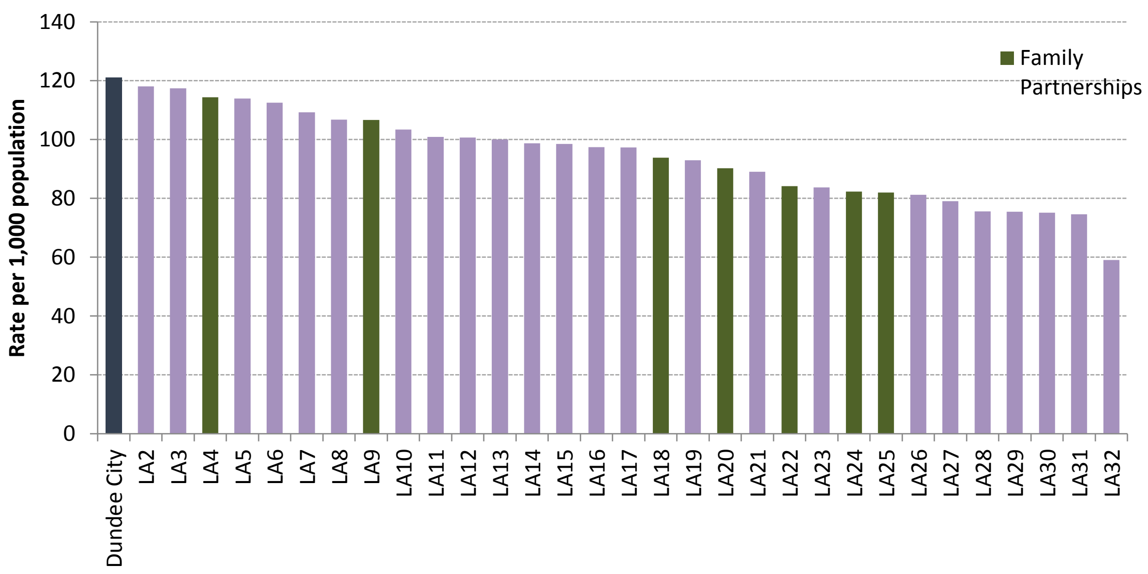
- The emergency bed day rate for people aged 18+ has reduced steadily since the 15/16 baseline year and was at a rate of 121,431 bed days per 100,000 emergency admissions in Q4 17/18.
- In Q4 17/18 Lochee had the highest bed day rate (156,544) and the West End has the lowest bed day rate (84,974). Five LCPPs have seen a decrease in the last quarter. There were increases in three LCPPs between Q3 1718 and Q4 1718 (Coldside, The Ferry and West End)
- The target for 2018/19 is 117,351, therefore based on rolling Q4 data, Dundee is not currently on course to meet or exceed this target.
- During Q4 1718, performance exceeded the 2018/19 target in 4 LCPPs – Maryfield, North East, Strathmartine and West End.

What we have achieved to date:

- We intend to pilot Enhanced Community Support in Lochee.

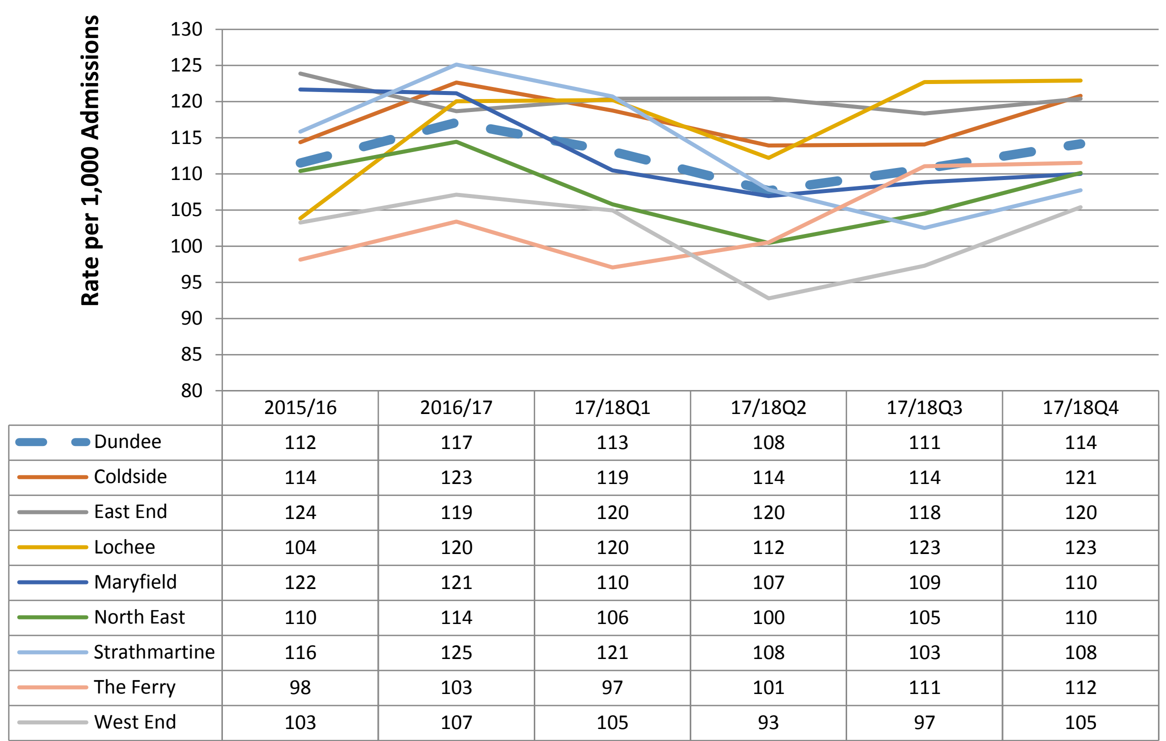
National Health and Wellbeing Indicator 14 – Readmissions

Chart 14 Readmission to hospital within 28 days of discharge per 1,000 admissions Q3 benchmarking



- Scottish rate data is not currently available as the data for some partnerships is incomplete. The rate of emergency bed days was higher in Dundee than the Scottish rate in both quarters 1 and 2 and is likely to also be higher in Q3.
- Dundee was the poorest performing partnership.
- The gap between Dundee and the 2nd poorest performing partnership closed slightly from 9 readmissions per 1,000 admissions in Q1 to 7 readmissions per 1,000 admissions in Q2 then to 3 readmissions per 1,000 in Q3.

Chart 15: Readmissions within 28 days of discharge as a rate per 1,000 admissions, all ages by LCPP



	2015/16	2016/17	17/18Q1	17/18Q2	17/18Q3	17/18Q4
Dundee	112	117	113	108	111	114
Coldside	114	123	119	114	114	121
East End	124	119	120	120	118	120
Lochee	104	120	120	112	123	123
Maryfield	122	121	110	107	109	110
North East	110	114	106	100	105	110
Strathmartine	116	125	121	108	103	108
The Ferry	98	103	97	101	111	112
West End	103	107	105	93	97	105

Source: NHS Tayside BSU

Q4 17/18 Analysis

- The rate of readmissions within 28 days has fluctuated since 2015/16 however at Q4 1718 it was higher than the 1516 baseline (112 in 1516 and 114 in Q4 1718)
- The highest readmission rate was in Lochee (123) and the lowest was West End (105).
- Over the last quarter the rate increased from 111 to 114 with rates increasing in all but 1 LCPP (Lochee), the rate in Lochee stayed the same between Q3 1718 and Q4 1718.
- Between the baseline year 15/16 and Q4 17/18 the rate decreased in 3 LCPPs (East End, Strathmartine, Maryfield), stayed the same in North East and increased in 4 LCPPs (Lochee by 15%, The Ferry by 12%, Coldside by 6% and West End by 2%).

What we have achieved to date:

This issue has been identified as a priority by the Tayside Unscheduled Care Board. Further work will be carried out during this financial year and this, added to local analysis, will lead to agreed improvement actions across Tayside.

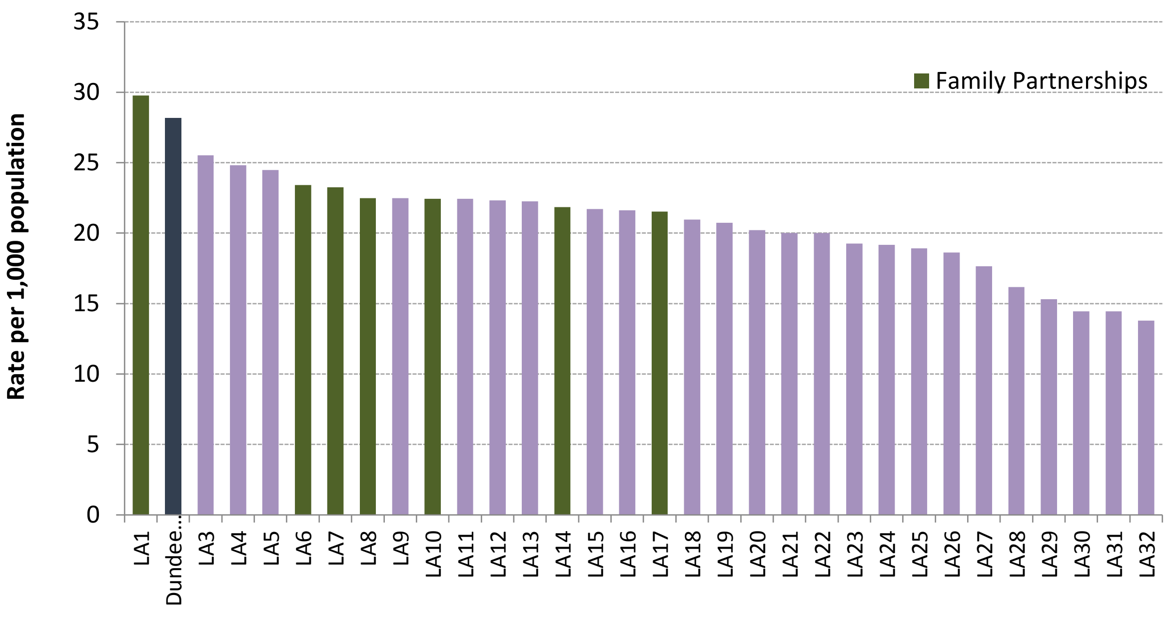
What we plan to do:

- Further analysis of reasons for readmission. We are about to do a Delphi process which will give a better understanding of pathways. This involves a survey which is completed by health and social care professionals to gather information regarding critical processes in a pathway. This is used to improve outcomes for people and also system efficiencies.
- 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.

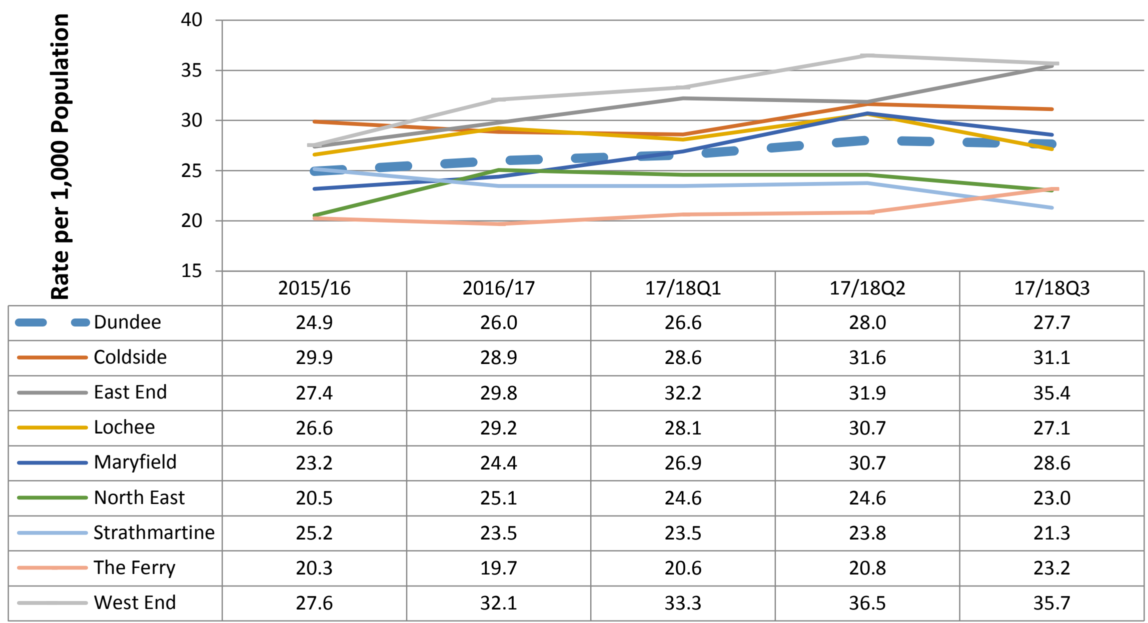
National Health and Wellbeing Indicator 14 – Falls

Chart 16: Falls rate per 1,000 population aged 65+ Q3 benchmarking



- Scottish rate data is not currently available as the data for some partnerships is incomplete. The rate of hospital admissions due to a fall in Dundee was higher than the Scottish rate in both quarters 1 and 2 and is likely to also be higher in Q3.
- At Q3 Dundee was the 2nd poorest performing partnership and poorer than 6 of the other 7 family group partnerships.
- The gap between Dundee and the 2nd poorest performing partnership closed slightly from 4 admissions per 1,000 admissions in Q1 to 2 admissions per 1,000 admissions in Q2 to 1 admission per 1,000 admissions in Q3.

Chart 17: Rate per 1,000 Population of Fall Admissions for People aged 65+ Q3 data as Q4 not available



	2015/16	2016/17	17/18Q1	17/18Q2	17/18Q3
Dundee	24.9	26.0	26.6	28.0	27.7
Coldside	29.9	28.9	28.6	31.6	31.1
East End	27.4	29.8	32.2	31.9	35.4
Lochee	26.6	29.2	28.1	30.7	27.1
Maryfield	23.2	24.4	26.9	30.7	28.6
North East	20.5	25.1	24.6	24.6	23.0
Strathmartine	25.2	23.5	23.5	23.8	21.3
The Ferry	20.3	19.7	20.6	20.8	23.2
West End	27.6	32.1	33.3	36.5	35.7

Source: NSS ISD

Note: Due to incompleteness of 2017/18 Q2 data, the SMR01 data was extrapolated for the month of December 2017 using an ARIMA model. 2017/18 Q3 should be treated provisionally until such time that SMR01 returns from NHS Tayside are 99%- 100% complete. This level of completeness is expected 6-8 weeks after 31st December 2017.

Q3 17/18 Analysis

- West End had the highest rate of falls in Dundee with 35.7 falls related hospital admissions per 1,000 population. Strathmartine had the lowest rate with 21.3 falls related hospital admissions per 1,000 population.
- The rate of falls related hospital admissions decreased in six LCPPs between Q2 17/18 and Q3 17/18 (North East, Coldside, Lochee, Maryfield. Strathmartine and West End). The rate in two LCPPs increased between Q2 17/18 and Q3 17/18 (East End and The Ferry).
- Since the baseline year 2015/16 the rate has increased from 24.9 to 27.7. There have been increases in seven LCPPs (Lochee, East End, North East, Maryfield, Coldside, The Ferry and West End) and a decrease in Strathmartine (by 15%). The highest increases were in East End and West End (both 29% increases)

What we have achieved to date:

- Falls Classes
  There are currently 6 fall prevention classes held each week in three locations – Mackinnon Centre, Kings Cross Hospital and Royal Victoria Hospital and these classes accept both self, carer and professional referrals. These classes are organised and run by the community rehabilitation and falls team. It is intended that the location of falls classes will be reviewed in line with locality plans and neighbourhood level data about falls. These classes are supported by physiotherapists and support workers and are aimed at people who have fallen or who have a fear of falling. The classes improve strength, balance, confidence and function. Education is also provided to participants on reducing the risk of falls in the future. The evidence base behind providing classes to prevent falling states that balance and strength must be challenged in order for improvements to be seen. For this reason there are 3 levels which are aimed at different levels of ability and frailty. There is also an Otago based maintenance class within the community, to prevent re-referrals and recurrent falls. The current waiting list is approximately 15 weeks from referral, however following an initial assessment people are offered advice and basic exercises to prevent falls while they await their place at the class.

- Education and falls prevention roadshows are being rolled out to established groups in the community in collaboration with other services within the Dundee Health and Social Care Partnership. In addition to this training has been provided to physiotherapy community staff, ambulance crews, social care response workers, medical students and care home staff.

- Support in Care Homes
  The community rehabilitation team provided support to care home employees, particularly regarding the OTAGO Falls Programme. All care homes in Dundee that expressed interest in receiving support have been provided with training to employees. There was a high uptake in training in the care homes located in Broughty Ferry. The care homes are expected to roll out training and the quality of the approach to prevent falling in care homes is expected to vary. Further work is required to ensure a sustainable model is in place across Dundee Care Homes.

- Emergency Department (ED)
  On a daily bases the falls team receives a list of people who attended the ED following a fall. The team contacts each person by telephone and then signposts to information and refers to services which can support underlying issues such as balance, substance misuse, polypharmacy and sensory impairment. The musculoskeletal and community rehabilitation physiotherapy teams provides support to people with dischargeable injuries, such as a shoulder rotator cuff tear, or stable fracture. In addition to a telephone call, people receive a pack in the post which includes a cover letter, falls prevention booklet, self / professional / carer referral form for the falls service and also the exercise classes. The pack also includes information about DIAL – OP service which signposts to all services and classes in Dundee. This includes a range of voluntary sector supports including a morning call service to check a person is safe and well.

- In Patients and Out Patients
  On a daily basis (Monday to Friday) Physiotherapy Services identify from referred patients aged 65+ who have either fallen twice in the last 12 months or who are at risk of a fall. They undertake balance, gait and strength assessments to reduce the risk of future falls. Patients are provided with strength and balance exercises, a falls booklet and referred to either the community rehabilitation team or the falls service.

- Referral Pathway Redesign
  GP referrals into Medicine for the Elderly services are now screened by the Falls Service instead of by medical teams. Patients are then signposted to the most appropriate clinic (physiotherapy, OT, nurse) or medical. This has reduced the time patients wait to be seen by the most appropriate person. Previously there was a waiting time of up to 16 weeks to access the medical clinic and then referred to the multidisciplinary team. This has been reduced to 4-6 weeks for the medical clinic and 1-2 weeks for the multidisciplinary team.

- Community Equipment Loan Service
  Dundee and Angus Health and Social Care Partnerships launched a new shared community equipment loan service for people with disabilities living in Dundee and Angus. The new venture is based at the Dundee Independent Living and Community Equipment Centre in Dundee and provides, delivers, installs, repairs, maintains and recycles a range of equipment to help people of all ages living in Dundee to live independently. It also provides a technical advice service and carries out risk assessments with medical and care professionals, both in-store and in people's homes.

- Collaborative Working with Scottish Ambulance Service and Other Stakeholders
  Services worked together to develop a pathway for use by the Scottish Ambulance Service and this has recently been implemented to help avoid the conveyance of service users that have fallen, but are uninjured, to hospital. This involves referring directly to the falls service and the first contact, out of hours and social care response teams. Work is currently being undertaken to further develop cross-sector working and promote the importance of all these services, recognising potential falls risk to the service user and referring for assessment as appropriate. An educational falls pack has been developed for service users. The Social Care Response Team is looking at IT systems to identify patients who have increased frequency of falling and refer to the Falls Service. Scottish Ambulance Service, the Social Care Response Team and patients can now refer directly to the Falls Service. This has improved the identification of people at risk of a fall.

What we plan to do:

- The Tayside Falls Prevention and Management Framework 2018-2022 has recently been developed and is currently out for consultation. This provides the infrastructure to monitor progress in the community, hospital and care homes towards preventing the incidence of falls and reducing the negative effect of falling on people who fall and their carers. The Framework is organised under 4 stages
  Stage 1 – Supporting active ageing, health improvement and self management to reduce the risk of falls
  Stage 2 – Identifying individuals at risk of falls and / or fragility fractures.
  Stage 3 – Responding to an individual who has just fallen and requires immediate assistance.
  Stage 4 – Co-ordinated management including specialist assessments

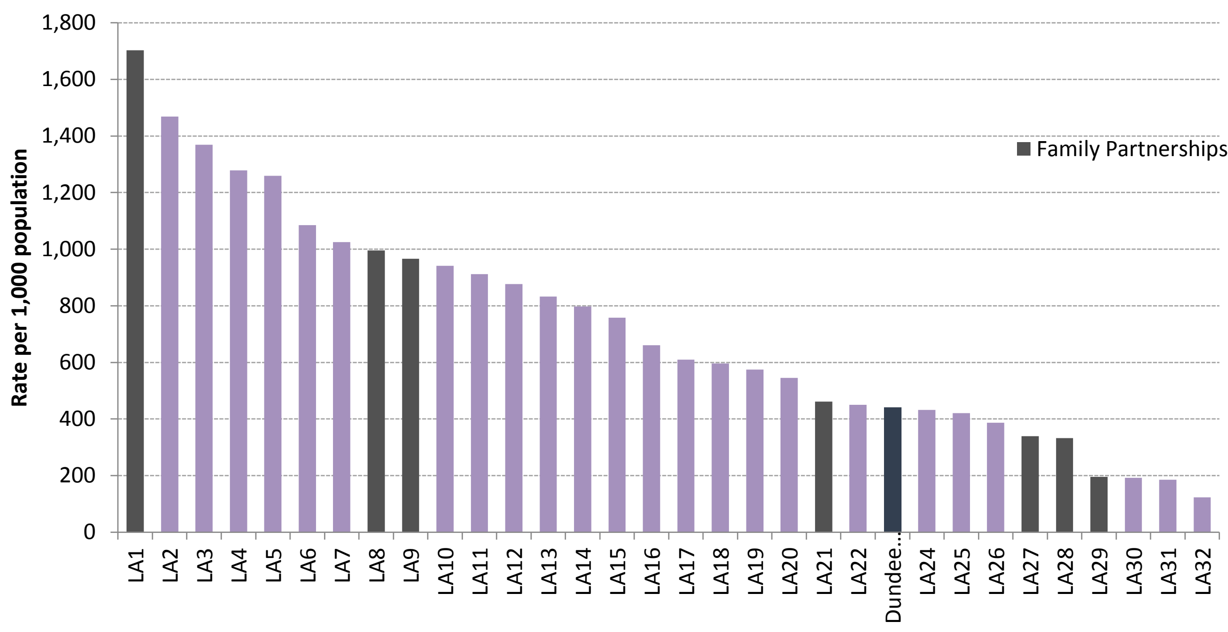
  This framework will be implement in Dundee and stage 1 will be prioritised.

- In addition to the Tayside Framework, there is recognition that more still needs to be achieved at a Dundee and locality level and the following actions have been prioritised:

  - recognising the need to work more efficiently within existing resources including the strengthening of links with community / voluntary groups and broader stakeholders.
  - discussions with Dundee College to start a project where students are trained in Otago and then with CRT support are able to implement it within care homes.
  - the implementation of a home based Otago project for patients who are unable to attend the class.

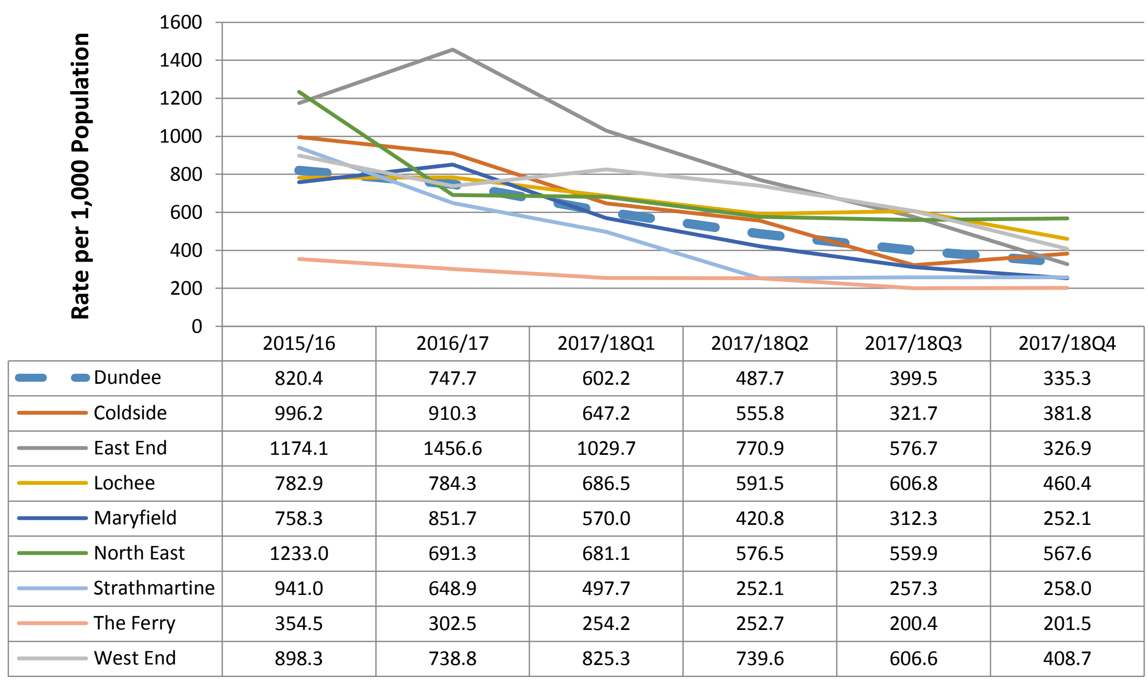
National Health and Wellbeing Indicator 19 – Bed Days Lost

Chart 18: Number of days people aged 75+ spend in hospital when they are ready to be discharged, per 1,000 population Q3 benchmarking



- Scottish rate data is not currently available as the data for some partnerships is incomplete. The rate of bed days lost due to a delayed discharge in Dundee was lower than the Scottish rate in both quarters 1 and 2 and is likely to also be lower in Q3.
- The Dundee rate decreased from 617 in Q1 to 536 in Q2 to 441 in Q3.
- Dundee performed better than 4 of the other 7 family group Partnerships.

Chart 19: 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



	2015/16	2016/17	2017/18Q1	2017/18Q2	2017/18Q3	2017/18Q4
Dundee	820.4	747.7	602.2	487.7	399.5	335.3
Coldside	996.2	910.3	647.2	555.8	321.7	381.8
East End	1174.1	1456.6	1029.7	770.9	576.7	326.9
Lochee	782.9	784.3	686.5	591.5	606.8	460.4
Maryfield	758.3	851.7	570.0	420.8	312.3	252.1
North East	1233.0	691.3	681.1	576.5	559.9	567.6
Strathmartine	941.0	648.9	497.7	252.1	257.3	258.0
The Ferry	354.5	302.5	254.2	252.7	200.4	201.5
West End	898.3	738.8	825.3	739.6	606.6	408.7

Source: Edison (excludes codes 100, 42T, ESDS and ICF)

Q4 17/18 Analysis

- The rate of bed days lost to delayed discharge for people aged 75+ dropped considerably in Q4 17/18.
- The rate is now the lowest it has been in over 3 years, having dropped from 820 in 15/16 to 335 in Q4 17/18
- The rate in 4 LCPP areas increased between Q3 17/18 and Q4 17/18. (Coldside, North East, Strathmartine and The Ferry)
- The East End was historically one of the poorest performing LCPP areas for this indicator although the Q4 figure shows a considerable improvement since the baseline year in 2015/16 from 1,174 in 15/16 to 327 in Q4 17/18. The rates in the North East and Lochee are more than double the rate in The Ferry which has the lowest rate of 202.

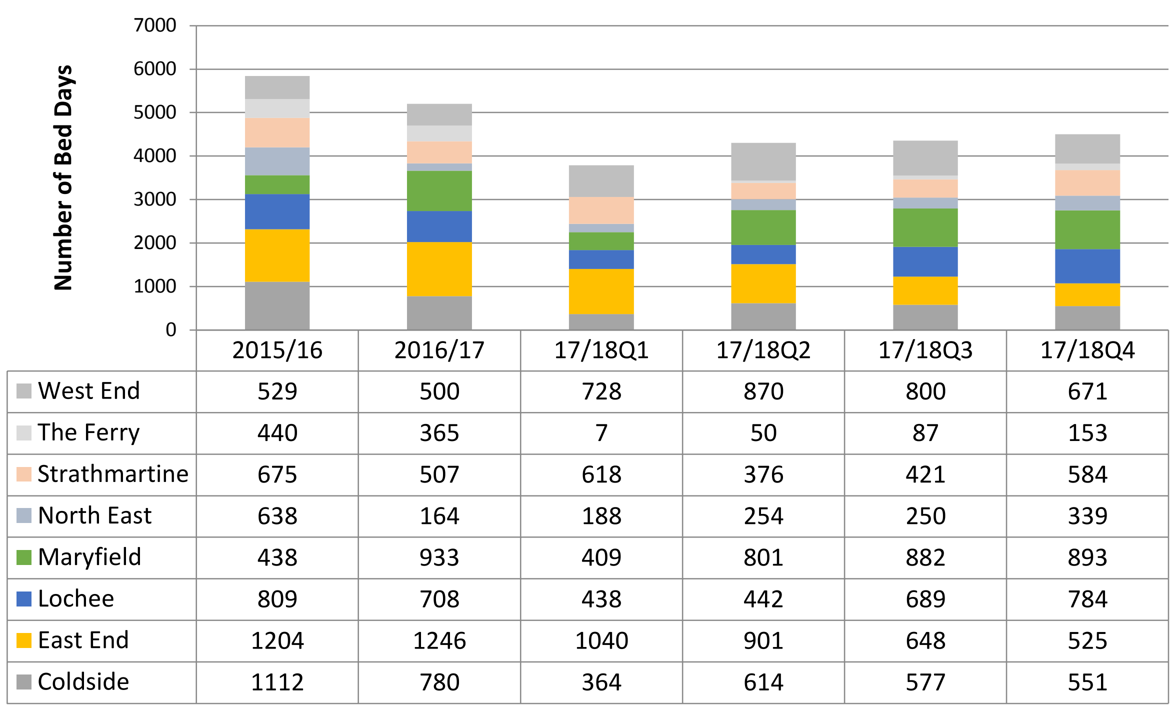
What we have achieved to date:

- There are currently two step down housing options which are working very well. An example of this is a 'Smart Flat' which uses a range of Technology Enabled Care to support people who are waiting for housing adaptations of a new home and who are delayed in hospital.
- 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:

- 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.
- Review and refresh the Delayed Discharge Improvement Plan.
- 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.

Chart 20: Number of Bed Days Lost to Complex Delayed Discharges for People of all Ages in Dundee by Locality and Financial Year



	2015/16	2016/17	17/18Q1	17/18Q2	17/18Q3	17/18Q4
West End	529	500	728	870	800	671
The Ferry	440	365	7	50	87	153
Strathmartine	675	507	618	376	421	584
North East	638	164	188	254	250	339
Maryfield	438	933	409	801	882	893
Lochee	809	708	438	442	689	784
East End	1204	1246	1040	901	648	525
Coldside	1112	780	364	614	577	551

Source: Edison (excludes codes 100, 42T, ESDS and ICF)

Q4 17/18 analysis

- The number of bed days lost to a delayed discharges for complex reasons has decreased since 2015/16 from 5,845 to 4,500 in Q4 17/18.
- The number of bed days lost to delayed discharges for complex reasons increased in five of the eight LCPPs between Q3 17/18 and Q4 (Lochee, Mayfield, North East, Strathmartine and The Ferry). The number of bed days lost decreased in two LCPPS (Coldside, East End).