ITEM No …9……..

REPORT TO: **HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD – 30 AUGUST 2016**

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

REPORT BY: **CHIEF OFFICER**

REPORT NO: **DIJB37-2016**

1.0 PURPOSE OF REPORT

The purpose of this report is to update the Integration Joint Board (IJB) on progress in implementing the Partnership's performance framework. The report also brings forward exemplars of sections of the annual and quarterly performance reports for consideration by the IJB, and sets out plans for their continued development.

2.0 RECOMMENDATIONS

It is recommended that the IJB:

2.1 Note the progress that has been made in further developing and implementing the performance framework since it was approved by the IJB in February 2016 (attached as Appendix 1).

2.2 Consider the proposed approach in Section 4.2 to reporting against the national health and wellbeing outcomes and indicators within the context of an annual performance report.

2.3 Note that work is currently being undertaken to improve the availability of data at a locality/neighbourhood level from national partners, including the Scottish Government and NHS National Services Scotland, Information Services Division.

2.4 Agree that the Information Team, working with the wider Partnership and under the direction of the proposed Performance and Audit Committee, should continue to develop exemplar formats for other sections of the annual performance report and bring these forward for consideration as they become available.

2.5 Consider the proposed approach in Section 4.3 to reporting progress against strategic priorities and shifts within the Partnership Strategic and Commissioning Plan.

2.6 Agree that the Information Team, working with the wider Partnership and under the direction of the proposed Performance and Audit Committee, should continue to develop the exemplar approach across all strategic priorities and shifts as the basis for future quarterly performance reports.

2.7 Agree that further discussion and development should take place, under the direction of the proposed Performance and Audit Committee, to enable the integration of financial performance and information into the quarterly performance report in the medium-term.

3.0 FINANCIAL IMPLICATIONS

There are additional workload demands being made on the Information Team within the Strategy and Performance Service and the NHS Tayside Business Support Unit related to data collection, analysis and reporting requirements which accompany the integration of health and social care, including annual and quarterly performance reports. Discussion with NHS Tayside and Dundee City Council have been initiated with a view to identifying how they plan to support the increase in demand.

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). This described a model of data collection, analysis and reporting that would meet statutory requirements, as well as enable the IJB to drive and track performance towards the delivery of the Partnership's vision, strategic priorities and shifts and planned outcomes for the people of Dundee.

4.1.2 The Information Team within the Strategy and Performance Service are continuing to work with the wider Partnership, NHS Tayside Business Unit and the Angus and Perth & Kinross Partnerships to develop a suite of local integration indicators and a common reporting platform to support the reporting requirements within the framework.

4.1.3 The Team are also progressing arrangements for conducting the local Health and Social Care Experience Survey before the end of 2016/17. This is a replication of the national survey, commissioned by the Scottish Government, which is carried out biennially (last conducted in 2015/16). The survey asks about people's experiences of accessing and using primary care services, as well as aspects of care, support and caring. It provides the data required to report against national health and wellbeing indicators one to nine and supports Partnerships to improve the quality of health and care services in their area.

4.1.4 Work is also ongoing to populate the Council's Corporate Performance Management Tool (Covalent) with the national and (draft) local outcomes and indicators, as well as actions from the Strategic and Commissioning Plan. This is a significant administrative task but once complete will allow performance data and information to be gathered, analysed and reported in a format that will be accessible to the IJB, wider Partnership and the public.

4.1.5 Proposals regarding the establishment of the Performance and Audit Committee have been considered under a separate report (DIJB36-2016). Following consideration of this report action will be taken as appropriate to establish the Outcomes and Performance Reporting Co-ordination Group. The Co-ordination Group will support the further development and production of the annual and quarterly performance reports, with the intention that such reports are considered in detail by the proposed Performance and Audit Committee prior to submission to the IJB.

4.2 Annual Performance Report

4.2.1 Section 42 of the Public Bodies (Joint Working) (Scotland) Act 2014 states that Integration Authorities must prepare an annual report for each reporting year. The first reporting year being 2016/17. A performance report is described as a report which sets out an assessment of performance in planning and carrying out integration functions, including performance against national outcomes and indicators. It must be published within four months of the end of the reporting year (meaning the first report must be published by 31 July 2017).

4.2.2 Guidance published by the Scottish Government in March 2016 ('Guidance for Health and Social Care Integration Partnership Performance Reports') provides further detail regarding the minimum expectations in terms of the required content of performance reports as set out in The Public Bodies (Joint Working) (Content of Performance Reports) (Scotland) Regulations 2014. The Partnership is required to have regard to this guidance in preparing the annual performance report under section 53 of the 2014 Act.

4.2.3 The annual performance report must assess the Partnership's performance in relation to:

- progress against the national health and wellbeing outcomes.
- the carrying out of the integration functions in accordance with the integration delivery principles.
- the planning and carrying out of functions in localities.
- best value in planning and carrying out integration functions.
- financial planning and performance.
- actions in response to any scrutiny and inspection of services.
- actions taken to review the Plan.

4.2.4 Whilst the first annual performance report is not required until July 2017, the Information Team has begun the process of developing an appropriate format and approach. In the first instance the Team has focused on developing an exemplar of the section of the annual performance report addressing performance against the national health and wellbeing outcomes based on 2015/16 data (attached as Appendix 2). As well as reporting data against the core suite of national indicators it provides a rationale for local performance.

4.2.5 The Regulations require that annual performance reports provide a comparison between the reporting year and the preceding five years (or, where there have been fewer than five preceding reporting years, all preceding reporting years). Therefore the minimum requirement for the first reporting year (2016/17) is to report only data for that year. There is no national template for the presentation of Annual Performance Reports, therefore the Information Team will continue to consult with the wider Partnership, NHS Tayside Business Support Unit and the Angus and Perth & Kinross Partnerships to develop consistent and comparable formats. The Information Team will also consult with the Chief Officer, Chief Finance Officer, proposed Performance and Audit Committee and Outcomes and Performance Reporting Co-ordination Group regarding content and presentation of the Annual Performance Report.

4.2.6 IJB members will note that the availability of data varies across the national indicators both in relation to geographic focus and reporting years. These variations relate to data sources; for example, the Health and Social Care Experience Survey administered by the Scottish Government (see section 4.1.3 of this report) does not currently collect postcode data and therefore results cannot be reported at a locality or neighbourhood level. The survey has also only been conducted biennially up until 2015/16 so no data is available for 2014/15. In addition, health data provided by NHS National Services Scotland Information Services Division (NSS ISD) is not always provided at locality level. The Information Team will continue to work with national partners to address the availability of locality data.

4.2.7 The Information Team plan to continue to develop formats for other sections of the annual performance report in collaboration with the wider Partnership and under the direction of the proposed Performance and Audit Committee. Financial information will also develop to meet the requirements of the regulations in relation to the Annual Performance Report. This report will include financial information on the amount spent on achieving the national health and wellbeing outcomes and the amount spent on care groups, localities and service type. In addition, partnerships are required to publish an Annual Financial Statement on the resources that they plan to spend in implementing their Strategic and Commissioning Plan and shown against these same categories. Further consideration will also be given to requirements to report on aspects of clinical and care governance

4.3 Quarterly Performance Reports

4.3.1 At the meeting of the IJB on 23 February 2016 the Board agreed that the annual report will be supported by quarterly performance reports. There was agreement that quarterly reports should:

- Compare data with any previous quarters for that financial year, as well as the same quarter during the previous financial year.
- Present data at whole population, care group, LCPP and neighbourhood level, where possible.

4.3.2 In February an illustrative example was provided to the IJB of how data from across the three levels of the local performance framework will be used to assure the IJB that the Partnership is making progress in terms of the strategic shifts contained within the Strategic and

Commissioning Plan. This approach has been further developed to provide an exemplar of the proposed approach to reporting progress towards the strategic shifts within the Partnership Strategic and Commissioning Plan on a quarterly basis (attached as Appendix 3).

4.3.3 The Information Team plan to continue to develop this format across all strategic shifts, as well as to consider other aspects of performance that should be addressed within quarterly performance reports, such as progress in implementing the actions identified within the Strategic and Commissioning plan.

4.3.4 The quarterly performance report is organised under strategic priorities and strategic shifts as reported in the Strategic and Commissioning Plan. The quarterly report uses one example of a strategic priority and organises draft outcomes and indicators under each corresponding strategic shift. Upon compiling the quarterly report it became apparent that the level and breadth of information which is necessary to fully measure each strategic shift means that the quarterly performance report will be very lengthy.

4.3.5 IJB members should note that the availability of data for quarterly reports is similarly affected by the issues set out in section 4.2.6 of this report.

4.3.6 The NHS Tayside Business Support Team has agreed to consider the production of admissions and discharge data at locality level, which would be extracted using QlikView. The Business Support Unit has agreed to respond regarding the feasibility of producing this data by mid August.

4.3.7 Financial monitoring reports will be presented to the IJB throughout the financial year as an essential part of financial governance. While this will initially focus on a cost centre/service basis, as the budget evolves this will also reflect the shifts in resources required to support the delivery of the IJB's Strategic and Commissioning Plan. Further consideration requires to be given to integrating financial performance data and clinical and care governance data into quarterly performance reports in line with the performance framework agreed by the IJB in February.

4.4 Multi-Tiered Performance Reporting

4.4.1 There are a number of options for performance reporting which the IJB is asked to consider:

Exceptions Report
This would be an extract of the full quarterly performance report and would detail top achievements and challenges for the quarter. The proposed Performance and Audit Committee would receive a performance report quarterly and this would be either a full report or a more in depth themed report which may incorporate two or three strategic priorities per report.

National Quality Outcome Indicators
The IJB may be satisfied that the Performance and Audit Committee can fully scrutinise the quarterly performance reports. In which case, the IJB may wish to receive the (statutory) annual performance report and on a quarterly basis the IJB may wish to receive the national outcome indicators reported quarterly and at a locality level where possible.

4.4.2 Once the proposed Performance and Audit Committee arrangements are finalised it will become clearer as to which option would be most beneficial. The IJB is requested to consider these options and discuss any further reporting structures that would assist them to fully understand performance against Strategic Priorities, Strategic Shifts and National and Local Outcome Indicators.

5.0 POLICY IMPLICATIONS

This report has been screened for any policy implications in respect of Equality Impact Assessment and Risk Management. No major issues have been identified.

6.0 CONSULTATIONS

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

7.0 BACKGROUND PAPERS

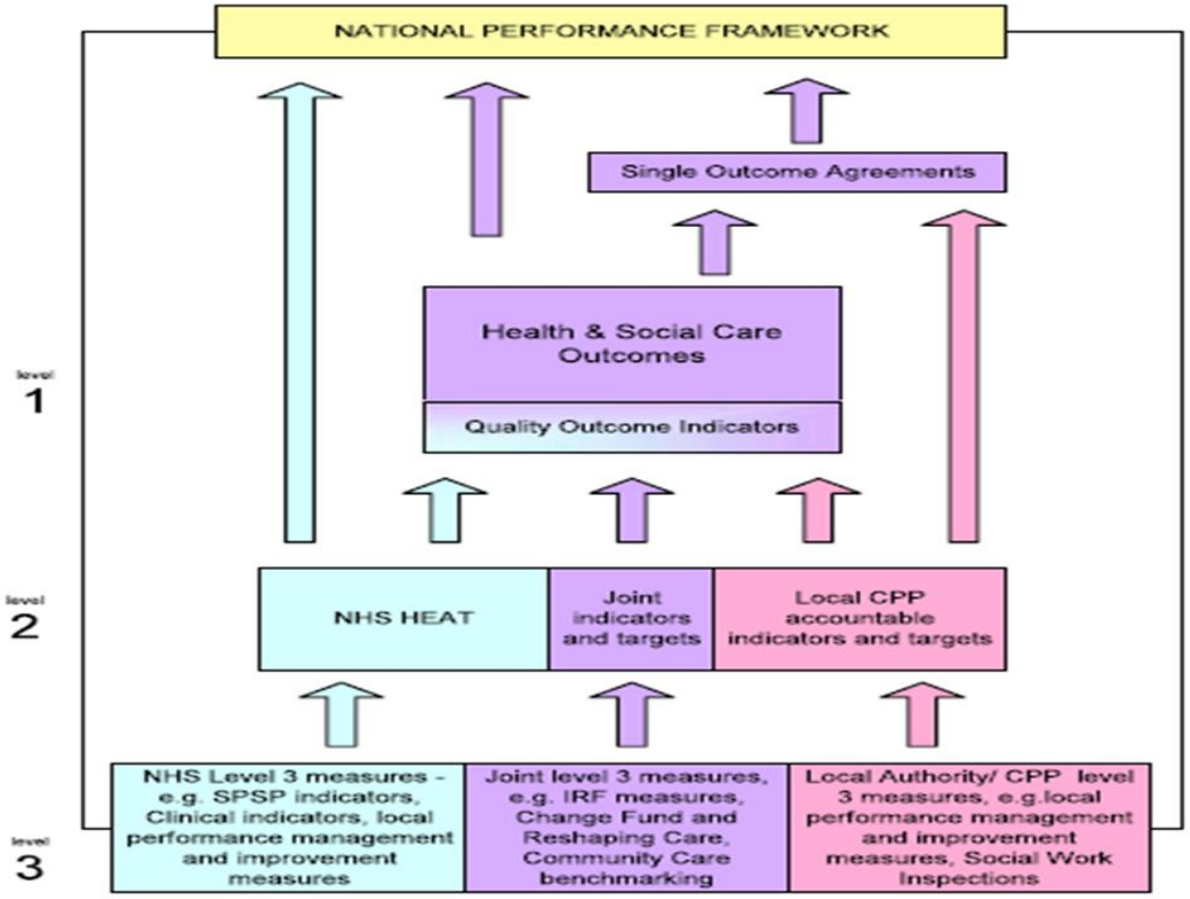
None.

David W Lynch
Chief Officer

DATE: 9 August 2016

APPENDIX 1

Health and Social Care Quality Improvement Framework



a) Level 1

High level outcomes used to drive health and social care quality. These are now represented by the nine National Health and Wellbeing Outcomes and the core suite of 23 statutory integration indicators referred to in Section 4 of this Plan.

b) Level 2

Publicly accountable indicators and targets for Health Boards, Community Planning Partnerships and Health and Social Care Partnerships/Integration Authorities used to drive short to medium term improvement and agreed to impact significantly and positively on the Level 1 outcomes.

c) Level 3

Extensive range of indicators/measures used for local improvement and performance management, including core sets of specific indicators for national programmes. This will also include information from self-evaluation and external scrutiny activity.

ITEM No …9……..

Appendix 2

Dundee Health and Social Care Partnership

Performance Report 2015/16

National Outcome 1 - Healthier Living

People are able to look after and improve their own health and wellbeing and live in good health for longer.

AND

National Outcome 5 – Reduce Health Inequalities

Health and Social Care Services contribute to reducing health inequalities

The data and narrative for National Outcomes 1 and 5 are the same therefore these outcomes have been presented together.

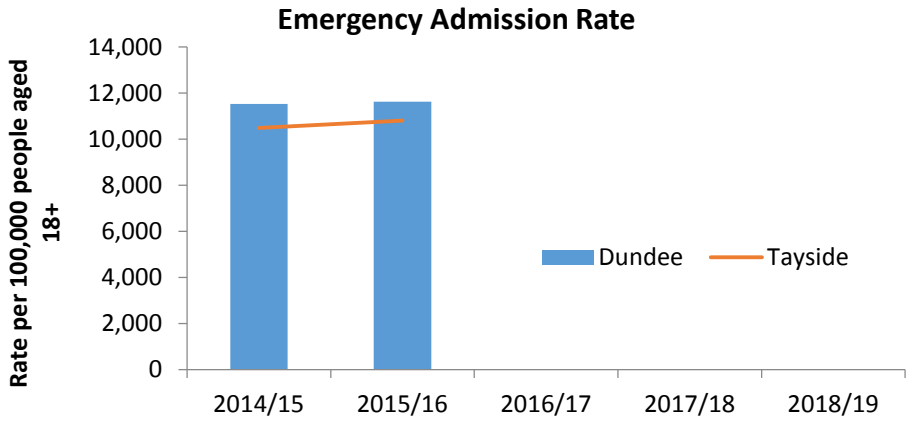
(National Outcome 5 also links to National Indicator 9 – % of adults supported at home who agree they felt safe, however the data for National Indicator 9 is presented under National Outcome 7)

National Indicator 2: % of adults supported at home who agree they are supported to live as independently as possible			
	2013/14	**2015/16**	**Direction of Travel**
Dundee	94.2%	93.9%	maintained within 5%
Scotland	93.9%	92.9%	maintained within 5%
Highest Dundee	99.1% Grove (113)*	98.3% Muirhead (115)**	
Lowest Dundee	85.4% Whitfield (96)*	86.5% Lochee (109)	
What we have achieved to date	*Total number of respondents in brackets ** Further discussion to take place regarding the inclusion of Muirhead Stroke Life Style Self Management Course materials developed and 2 cohorts of training progressed. Peer support introduced as part of this package. Model of support for young adults at risk of homelessness developed. 122 referrals received with good outcomes which included; 70 young people remaining at home through conflict resolution, 52 supported to alternative safe accommodation and 93 achieving or maintaining vocational placements. Community Companionship project has recruited 14 volunteers and received 45 referrals. Applicants are also signposted to other agencies. Participants reported reduction in social isolation and improved physical health, wellbeing, confidence and independence. Expanded the Small Grants Fund to support local organisations to develop community resources and held a range of community surgeries to promote the fund and follow up on initial enquiries. This fund is managed through the Third Sector and awarded funds to 42 projects including exercise equipment, arts and crafts resources, developed a Muslim Elders group, intergenerational groups and educational community projects. One new club, Roll and a Bowl attracts 40 – 50 people per session and provides nutritional meals to those who attend as well as reducing social isolation. Expanded the STEP Community Capacity project to approximately 200 adults. Project delivered 150 hours of volunteer time. Both qualitative and outcomes data identified that participants enjoyed the programmes and increased wellbeing, confidence and self care management. It has had positive results for both the individuals and their family/carers. Purchased universal training programmes for the management of malnutrition in the community. Dundee Healthy Living initiatives work with individuals living in more deprived areas of the		

	City to identify issues impacting on their health and works with 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, training sessions such as First Aid, Heartstart and FAST, and community based health checks and relaxation sessions. In 2014/15, the DHLI offered over 70 activities per week with over 5,000 contacts from individuals. In addition the DHLI supports local groups to become formally constituted and gain independent funding for activities. Sources of Support (SOS) social prescribing scheme is part of Dundee's Equally Well initiative and operates in 4 General Practices in the City. The scheme is funded through NHS Tayside and the Scottish Government national link worker and links patients from General practice with sources of support within the community. It provides GPs with a non-medical referral option that can operate alongside existing treatments to improve health and well-being. Three SOS link workers support patients with poor mental health and wellbeing to identify the causes and consequences of their condition and access a wide range of services and activities that can help. Keep Well uses anticipatory health checks to engage those falling within targeted populations who are at higher risk of health inequalities. The targeted population includes, those aged between 40-64 who live within defined postcode areas, (i.e. those who live in the 20% most deprived postcodes according to SIMD), and those who fall within a number of vulnerable groups including carers, offenders, the BME population, those who are homeless, gypsy/travellers, and those who have a substance misuse issue (drugs or alcohol). A wide range of partners, in general practice and the third sector, as well as within NHS, are involved in engaging individuals from these key groups, and in supporting individuals with a wide range of health, lifestyle and social issues after the health check. Evaluation demonstrates that this range of medical interventions, ongoing support and lifestyle changes are having an impact. Keep Well may be contributing to the considerable reductions being seen in admissions to hospital where Coronary Heart Disease is identified as the main diagnosis. There has been a similar decrease in the number of occupied bed days where Coronary Heart Disease is the main diagnosis. Qualitative evaluation demonstrates the positive impact this approach has on individuals. Equally partners have recognised the benefits they see both for their service and their clients. A Partnership Suicide Prevention Steering Group has been established. A training programme has been developed for the coming year, which key staff have been trained to deliver. A local Choose Life Co-ordinator has been recruited.
What we plan to do	Review existing health inequalities focussed work to: Ensure that they are targeting health inequalities effectively. Identify areas of commonality and uniqueness. Develop an integrated service delivery model with appropriate care and clinical governance support frameworks. Clearly identify priorities. Clearly identify any remaining gaps in service delivery and develop proposals for how these gaps can be met. Support services to identify areas where take up of health initiatives are low and support approaches to improve access and take-up. Provide leadership, expertise, knowledge and skills around suicide prevention. Work towards creating suicide safer communities where people will be more confident to support those at risk of suicide. To achieve this we will offer relevant suicide prevention training.

	Pilot a community based support model for prevention of suicide Support and encourage staff across the Partnership to adopt a social prescribing approach to support individuals.
Data Source	Health and Care Experience Survey

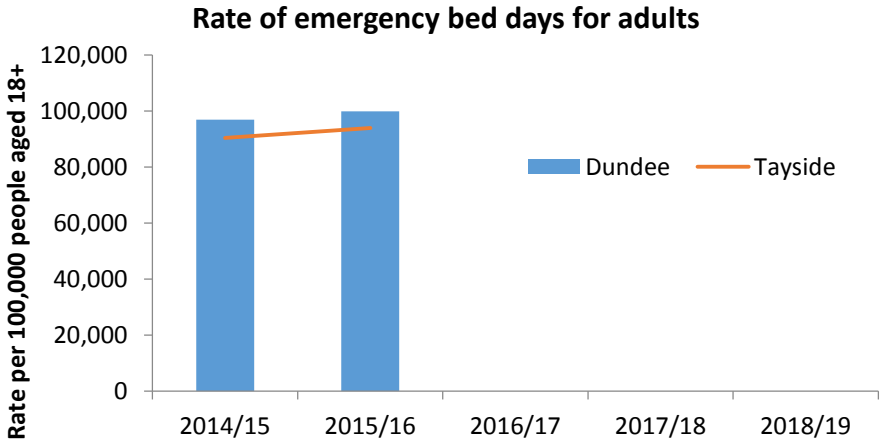
National Indicator 12: Emergency Admission Rate (per 100,000 people aged 18+)			
	2014/15	**2015/16**	**Direction of Travel**
Dundee	11,535	11,631	maintained within 5%
Tayside	10,489	10,806	maintained within 5%



What we have achieved to date	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 we are developing a Health Inequalities Commissioning Statement. Improvements include 875 Keep well community team health checks, improved links and referrals from TSMS to consider wider health issues, hosting health and wellbeing network meeting across the city to support targeted outreach through the equally well programme.
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.
Data Source	ISD Linked Catalogue

National Indicator 13: Rate of emergency bed days for adults (per 100,000 people aged 18+)			
	2014/15	**2015/16**	**Direction of Travel**
Dundee	96,971	99,918	maintained within 5%

Tayside	90,430	94,005	maintained within 5%



What we have achieved to date	Remodelled the COPD Discharge Service to support more adults 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 (exacerbation of COPD). Introduced Healthcare Support Workers to free up nurse time. 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 MfE 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. Invested in resources which support assessment for 24 hour care taking place at home or home like settings. Reviewed patient pathways between Carseview and the community.
What we plan to do	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
Data Source	ISD Linked Catalogue

National Outcome 2 – Independent Living

People, including those with disabilities, long term conditions, or who are frail are able to live, as far as reasonably practicable, independently and at home or in a homely setting in the community

(National Indicator 12 – Emergency Admission Rate also links to National Outcome 2, however the data is presented under National Outcome 1)

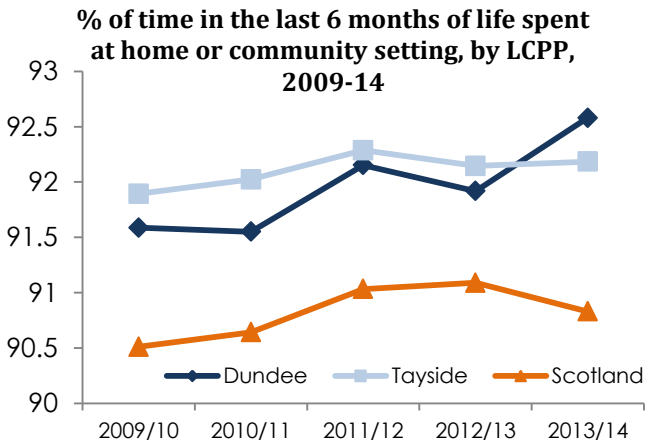
National Indicator 2: % of adults supported at home who agree they are supported to live as independently as possible			
	2013/14	**2015/16**	**Direction of Travel**
Dundee	85%	88%	maintained within 5%
Scotland	84%	84%	maintained within 5%
Highest Dundee	100% Coldside (10), Taybank 2 (11), Hillbank (13), Lochee (6), Nethergate (6)*	100% Grove (11), Taybank (6), Ryehill (7), Terra Nova (13), Ancrum (8)*	
Lowest Dundee	50% Stobswell (4)*	67% Muirhead (6)* and **	
What we have achieved to date	*Total number of respondents in brackets ** Discussion to take place regarding the inclusion of Muirhead There are a number of services and supports currently available which support this measurement: The enablement service is a rehabilitative service for new service users and people being discharged from hospital. Service users are assessed at the beginning and end of the service. The % of people who require reduced homecare following enablement is high (77%). We are looking to review the profile of our workforce. This is being supported by reorganising teams and realigning them around localities. The Introduction of a driving team has improved support across the city as this team can move around the city as required. Retendering of Care at Home services, aligned with localities, has recently concluded. There is now a social care input into the Enhanced Community Support Team in order to support people at an early stage. Service improvement and design is focusing on innovative and preventative models of care and support. Examples are the Enablement and Enhanced Community Support Teams. Welfare Reform Support and Connect Team provided support to service users and members of the public to manage and mitigate the impact of welfare reform. Volunteer Social Prescribing expanded to support service users to connect and engage in local community services. Success stories demonstrated improved health and wellbeing, reduced social isolation and a reduction in reliance on statutory services and supports and improved life chances. In 2014 NHS Tayside was selected as one of two pilot sites for Scottish Government Health and Welfare Reform development funding, and a number of community-based tests of change were carried out within Dundee. Key pieces of work carried out locally include: ○ Development of a mobile device application - Money Crisis? And associated promotional materials to signpost individuals to appropriate local finance		

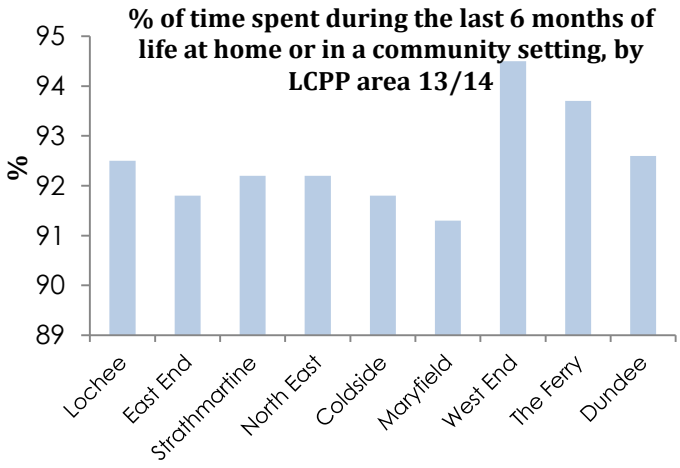
	supports ○ Development of a welfare reform Learn-Pro e-learning module for staff ○ Improved links with the CONNECT team ○ Welfare Rights advice service located within several GP surgeries in the City to support both the GP Practice team and vulnerable patients to maximise their incomes. ○ Development of a financial inclusion triage service within the Ninewells Concourse ○ Fit for Work and Working Health Services both continue to provide support for the working age population who are in work but have health issues impacting on their ability to work, including those who may have short term absence, to support them back to work
What we plan to do	We will continue to review the models of care and support and increase the number of alternatives to traditional homecare such as Housing with Care and more preventative measures which enable people to remain at home for longer. Self Directed Support will continue to encourage alternatives to traditional homecare services and work will continue to develop a market place to support social enterprise and self-employed carers in order to improve choice to people when using all Self Directed Support options. Remodel Housing Support services to ensure equity of access based on need. Implement the proposals for accommodation with care for adults in line with the Strategic Housing Investment Plan. Implement relevant key actions and commitments linked to the outcomes detailed in the Dundee Housing Contribution Statement 2016. Develop a Strategic Commissioning Statement for technological care and implement actions alongside partnership agencies. Increase the range of technological supports. Secure capital funding for developing wheelchair housing. Review the current models of residential care for older people in line with future of residential care. Disinvest in residential forms of care for older people and increase investment in accommodation with support. Evaluate the impact of co-location of welfare rights staff within GP surgeries and health centres and make recommendations for further roll-out
Data Source	Health and Care Experience Survey

National Indicator 18: % of adults with intensive care needs receiving care at home			
	2014	**2015**	**Direction of Travel**
Dundee	50.4%	49.9%	maintained within 5%

Scotland	56.2%	51.1%	maintained within 5%
What we have achieved to date	More people with complex needs are using direct payments. There has been a significant amount of work with staff to develop procedures and Self Directed Support guidance. There has been training for all staff on Self Directed Support and Direct Payments.		
What we plan to do	Continual focus to increase the number of people utilising Self Directed Support Options. Plan to increase the number of Housing with Care and Accommodation with Support options. Remodel respite services to assist carers to support people with complex needs at home.		
Data Source	ISD Tableau		

National Indicator 15: Proportion of last 6 months of life spent at home or in a community setting						
	2009/10	**2010/11**	**2011/12**	**2012/13**	**2013/14**	**Direction of Travel**
Dundee	91.6%	91.6%	92.2%	92.0%	92.6%	maintained within 5%
Tayside	91.9%	92.0%	92.3%	92.1%	92.2%	maintained within 5%
Scotland	90.5%	90.6%	91.0%	91.1%	90.8%	maintained within 5%

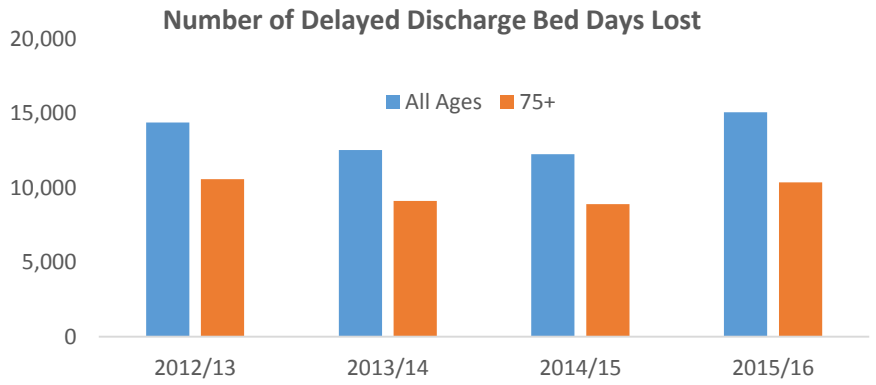




Narrative	This above chart shows that between the years 2009 and 2014 there was a gradual increase in the amount of time people in Dundee spent at home or in a community setting during the last 6 months of life. In 2013/14, 92.6% of time for people in Dundee was spent at home or in a community setting. This figure is slightly higher than the percentage for Tayside and Scotland as a whole. There is slight variation shown between the most deprived LCPP areas and the most affluent LCPP areas. The West End had the highest percentage of time spent by people at home or in a community setting during their last 6 months of life. The West End is one of the most affluent LCPP areas. From the information and figures available it is not possible to determine whether the proportion of time people in Dundee spent at home in their last 6 months of life, or the location of death for those involved, would have accorded with their personal preferences or choice.
What we have achieved to date	Developed resources to support safe palliative care in the community/care homes. Developed and tested response standards in 2 community nursing zones. Older people supported through end of life and palliative care.
What we plan to do	We are seeking funding to develop the palliative care tool bundle and response standards across community based health and social care services.

	We are contributing to a partnership with MacMillan to build supports and services for people living with cancer. As lead for hosted palliative care services we will seek to review our models of service delivery across Tayside.
Data Source	ISD Scotland Publications

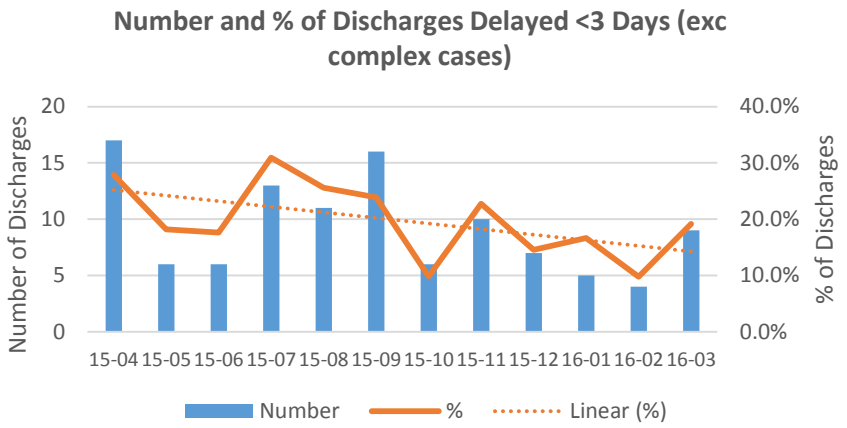
National Indicator 19: Number of days people spend in hospital when they are ready to be discharged					
All Ages	**2012/13**	**2013/14**	**2014/15**	**2015/16**	**Direction of Travel**
Dundee	14,363	12,533	12,239	15,050	deteriorated
Tayside	39,666	41,473	38,969	43,646	deteriorated
75+					
Dundee	10,569	9,113	8,889	10,351	deteriorated
Tayside	31,711	32,691	29,839	31,437	deteriorated



What we have achieved to date	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 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 from hospital by dealing with medicine complications which would otherwise have caused delays in discharge.
What we plan to do	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.
Data Source	ISD Scotland Publications 'Bed Days Occupied Tables'

National Indicator 22: % of people discharged from hospital within 72 hours of being ready					
	Q1 14/15	**Q2 14/15**	**Q3 14/15**	**Q4 14/15**	**Direction of**

					Travel
Dundee	29	40	23	18	Improved



Note that NSS ISD have not yet finalise the definition of this measure yet. For the purpose of this report local data from Edisson has been used and the definition has been assumed to be the % of people delayed <3 days, of all delays. This is not all discharges from hospital – only the discharges which were delayed >1 day.
This data includes all delays and therefore is not snapshot census data.

What we have achieved to date	The Enhanced Community Support Service is contributing to the reduction in delays in hospital due to the transition to residential / nursing care. Processes are being started sooner, in the community and reducing the reactive / emergency solutions required once a person is admitted to hospital in a crisis situation.
What we plan to do	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, particularly where 24 hour care is being considered. Expand the 'Moving Assessment into the Community' project to specialist areas and test pathways. 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. Redesign services to ensure rapid access to palliative services. Review patient pathways between Carseview Hospital and the community. Embed within strategic commissioning plans the development of a range of community resources which enable people to remain in their own home and be discharged from hospital when they are ready. 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. 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. Review and remodel care at home services to provide more flexible responses. Further develop models of Community Rehabilitation to support transitions between home and hospital
Data Source	Edisson – Supplied by The Business Support Unit NHS Tayside

National Outcome 3 – Positive Experiences and Outcomes

People who use health and care services have positive experiences of those services and have their dignity respected

(National Indicator 22 – % of people discharged within 72 hours of being ready also links to National Outcome 3, however the data is presented under National Outcome 2

National Indicator 15 – proportion of last 6 months of life spent at home or in a community setting also links to National Outcome 3, however the data is presented under National Outcome 2

National Indicator 4: % of adults supported at home who agree their health and care services seem to be well co-ordinated			
	2013/14	**2015/16**	**Direction of Travel**
Dundee	82%	76%	deteriorated
Scotland	79%	75%	maintained within 5%
Highest Dundee	100% Taybank 2 (11), Stobswell (3), Whitfield (8)*	100% Taybank (5)*	
Lowest Dundee	50% Grove (4)*	50% Muirhead (6)* and **	
What we have achieved to date	*Total number of responses in brackets ** Discussion to take place regarding the inclusion of Muirhead Established a community based Catheter Change Clinic. The model will be rolled out across the city and will incorporate other health interventions (wound care) freeing up GP practice nurse time to support other early interventions. Increase in attendance. Expanded the Enhanced Community Support service, including the testing of multidisciplinary assessment meetings at GP practice level. Improved the alignment between GPs and Geriatric Consultants. Tested delivering Welfare Rights within 2 GP practices. In the initial test £390,560 of benefits were generated. Expanded volunteer social prescribing to support service users to connect and engage in local community services.		
What we plan to do	Shift the balance of building based to non-building based day opportunities. Redesign non-acute services for older people (MfE/POA) and develop more community supports. Remodel and further develop multidisciplinary team approach with General Practice at the centre. Roll out of the Welfare Rights service within GP practices Develop the 'House of Care' Model for care and support planning, ensuring this links with partners' approaches to person centred care, for those with a long term condition.		
Data Source	Health and Care Experience Survey		

National Indicator 5: % of adults receiving any care or support who rate it as excellent or good			
	2013/14	**2015/16**	**Direction of Travel**
Dundee	89%	94%	improved

Scotland	84%	92%	improved
Highest Dundee	100% Taybank 2 (11), Hawkhill (6), Hillbank (13), Muirhead (7)**, Nethergate (6), Ryehill (9), Westgate (9), Whitfield (9)*	100% Invergowrie (5), Lochee (16), Westgate (12), Taybank (6), Park Ave (12)*	
Lowest Dundee	66.7% Downfield (9)*	66.7% Muirhead (6)*, Coldside (9)*, Princes Street (9)*	
What we have achieved to date	*Total number of responses in brackets ** Discussion to take place regarding the inclusion of Muirhead The achievements which contribute to the improved performance of this indicator are a combination of the outcomes of most of the achievements already reported, therefore they have not been duplicated.		
What we plan to do	We are rolling out outcome focussed assessments across health and social care services. This will allow us to monitor and evaluate outcomes for people and take action as required. We will start to build evaluation processes which assess the impact of change on service user experience as we further develop our services. The analysis from this data at aggregate level will inform the development of new services and practices across health and social care integration.		
Data Source	Health and Care Experience Survey		

National Indicator 6: % of people with positive experience of accessing their GP practice			
	2013/14	**2015/16**	**Direction of Travel**
Dundee	88%	90%	maintained within 5%
Scotland	87%	87%	maintained within 5%
Highest Dundee	100% Muirhead (130)**, Whitfield (87)*	awaiting data at GP practice level	
Lowest Dundee	72.7% Family (77)*	awaiting data at GP practice level	
What we have achieved to date	*Total number of responses in brackets ** Discussion to take place regarding the inclusion of Muirhead Tested delivering Welfare Rights from within 2 GP Practices. In the initial test 216 patients were seen and £390,560 of benefits generated. 88% of appointments were kept, with the service demonstrating a shift from reactive longer term work (tribunals) to more proactive preventative work. The service is in the progress of expanding the number of practices it provides the service in. Over the last year we have aligned services to GP practices, including the alignment of Geriatrics to GPs, social prescribing, welfare rights and the enhanced community support service.		
What we plan to do	Address local challenges to General Practice boundaries and changing workforce and		

	remodel in partnership with GPs. Test improved and more efficient models of service delivery in partnership with General Practice, focusing initially on long-term conditions and older people. Support new models of General Practice care and Out of Hours urgent care in line with Sir Lewis Ritchie's 2015 review.
Data Source	Health and Care Experience Survey

National Indicator 17: Proportion of care services graded 'good' or above in Care Inspectorate Reports			
	2013/14	**2015/16**	**Direction of Travel**
Care Homes	40%	66.5%	Improved
Other Adult Services	Data not available	68%	
Narrative	The following narrative is a summary from the report about Adult Services (exc Care Homes) which was presented to the IJB during May 2016. There will be a separate report about Care Home inspections in due course. The Care Inspectorate is responsible for the inspection and regulation of all registered care services in Scotland. The regulatory authority ensures that care service providers meet their respective National Care Standards and that in doing so they provide quality care services. The Care Inspectorate use a six point grading scale, against which certain key themes are graded. Of the 63 registered services listed in the Performance Report, 119 inspections were undertaken. One service, the White Top Adult Respite Centre, was graded 6 'excellent' for all four quality themes in their last inspection. Rose Lodge, a Care at Home and Housing Support Service, were graded 6 'excellent' in their last two inspections in all quality themes assessed. Another service, Gowrie Care College Support Services, was graded 6 'excellent' for Quality of Care & Support, Quality of Staffing and Quality of Management & Leadership (Quality of Environment was not assessed). A further two Care at Home and Housing Support providers, namely Gowrie Care and Turning Point Scotland were graded 6 'excellent' in all quality themes assessed for a number of their Dundee services at their last inspections. Of the 63 establishments inspected, there was a 25% improvement in grades for Quality of Care and Support, 3% improvement for Quality of Environment, 25% improvement in Quality of Staffing and 25% improvement in Quality of Management and Leadership. Of the 63 establishments inspected 11% of services were downgraded for Quality of Care and Support, no services downgraded for Quality of Environment, 5% downgraded for Quality of Staffing and 10% downgraded for Quality of Management and Leadership. One inspection, Dudhope Villa, resulted in grade 2 'weak' for Quality of Care and Support and Quality of Environment and grade 1 'unsatisfactory' for Quality of Management and Leadership. A full review of this service is currently being undertaken in partnership with the service provider to support improvement in the quality of services provided to service users. Partnership representatives undertaking the review are liaising closely with Care Inspectors to ensure a collaborative approach is being taken to service improvement. During the period of each service's previous two inspections, requirements were placed on 14 of the 63 services covering a range of issues relating to the health, welfare and safety of service users. Action plans were drawn up setting out the actions the services would take in response to these requirements. During the same period, there were 11 complaints to the Care Inspectorate relating to 10 of the		

	63 care services in Dundee. No enforcement action has been required to be taken in respect of services reported upon, either directly by the Care Inspectorate or by Dundee City Council taking a decision to suspend any referrals to services. In some cases a service may decide not to receive referrals themselves over a period to allow a period of improvement and consolidation to take place.
What we plan to do	The introduction of the Social Care (Self Directed Support) Act 2013 will progress personalised models of care further and meet the demand for more aspirational day supports. A review of available types of accommodation to ensure there is adequate access to appropriate housing stock, tailored to specific needs of individuals, available for now and in the future.
Sources	IJB Paper 4th May 2016 – Dundee Registered Service for Adults (exc Care Homes) Care Inspectorate Information Request

National Outcome 4 – Quality of Life

Health and Social Care Services are centred on helping to maintain or improve the quality of life of service users. Everyone should receive the same quality of service no matter where they live

National Indicator 7: Percentage of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life			
	2013/14	**2015/16**	**Direction of Travel**
Dundee	88%	88%	maintained
Scotland	85%	84%	
Highest Dundee	100% Muirhead (6), Grove (4), Taybank 2 (10), Hillbank (13), Ancrum 2 (9), Nethergate (5), Lochee (6), Whitfield (7)*	100% Park Ave (11), Taybank (6), Westgate (11), Broughty (12), Ryehill (5)*	
Lowest Dundee	66.7% Erskine (12), Stobswell (3), Invergowrie (6)*	66.7% Stobswell (9)*	
What we have achieved to date	*Total number of responses in brackets 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.		
What we plan to do	Increase the use of volunteers to support adults and older people in their lifestyle choices. Contribute to the outcome of the Steps to Better Healthcare review of Learning Disability		

	in-patient services and increase the provision of community health supports whilst reducing the bed base. Continue to increase opportunities for adults with a Learning Disability and/or Autism to receive more personalised support in leisure, recreational and social activities, including in the evening and at weekends. We are rolling out outcome focussed assessments across health and social care services. This will allow us to monitor and evaluate outcomes for people and take action as required. We will increase the number of housing with care and accommodation with support. We will roll out the welfare rights service within GP practices. Explore and develop opportunities to embed creative engagement through the Arts within mainstream service and support delivery
Data Source	Health and Care Experience Survey

National Outcome 6 – Carers are Supported

People who provide unpaid care are supported to look after their own health and wellbeing. This includes reducing any negative impact of their caring role on their own health and wellbeing.

(National Indicator 18 – % of adults with intensive needs receiving care at home links to Outcome 6, however the data is presented under Outcome 2)

National Indicator 8: % of carers who feel supported to continue in their caring role			
	2013/14	**2015/16**	**Direction of Travel**
Dundee	43%	44%	improved
Scotland	44%	41%	
Highest Dundee	70.6% Terra Nova (17)*	71.4% Taycourt (14)*	
Lowest Dundee	10% Grove (10)*	21% Family (14)*	
What we have achieved to date	*Total number of responses in brackets The Public Social Partnership is a co-productive arrangement involving service users and carers in designing and delivering services for people with mental health problems and their carers. A short breaks bureau has been established to support carers and the people they care for to arrange all aspects of planning a short break. There has been a reduction in transitional respite beds for adults as some beds, previously used for traditional respite are now being used for step down brain injury. Developed a co-designed flexible inquiry approach to explore new ways of engaging with carers in two localities. This will support the sharing of experiences of caring and support the development of the Carer's Strategic Commissioning Statement. Developed a Carers Media campaign which was launched in Carers Week. Established a Short Breaks Service supported by a brokerage service. Approximately 172 carers have accessed or are accessing the service. Of those who have accessed a short break service 1005 reported a range of improvements in caring role, health and life balance. These positive outcomes are also reflected by those who received respite at home. The brokerage service has also supported carers to access a range of services which support wellbeing		

	(education, therapies, etc.) Tested a model of supported respite within the independent sector and with one service user/provider and agreed two further tests of change within different care providers.
What we plan to do	We will continue to build on research and use this evidence base to inform the commissioning of services across all service areas. We will continue to invest in partnership arrangements. We will continue to expand the types of support for carers and focus on ongoing support which will reduce the need for a crisis response. Examples of these are Time for You. We will review the Public Social Partnership and based on this we will roll out alternative models.
Data Source	Health and Care Experience Survey

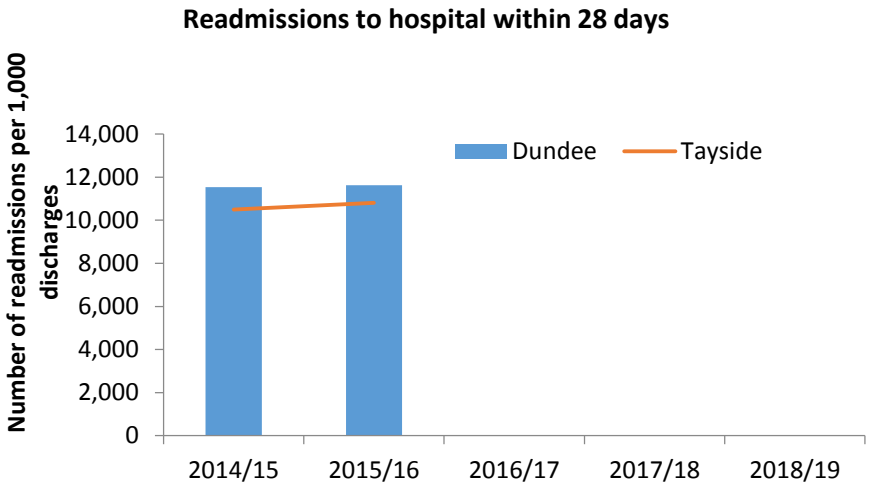
National Outcome 7 – People are Safe

People who use health and social care services are safe from harm

National Indicator 9: % of adults supported at home who agree they felt safe			
	2013/14	**2015/16**	**Direction of Travel**
Dundee	90%	85%	deteriorated
Scotland	85%	84%	maintained within 5%
Highest Dundee	100% Coldside (10 respondents), Taybank 2 (11), Grove (3), Hawkhill (6), Lochee (6), Muirhead (7), Nethergate (6), Whitfield (8)*	100% Taybank (6 respondents), Westgate (11), The Mill (6), Whitfield (6)*	
Lowest Dundee	66.7% Stobswell (3)*	60% Muirhead (5)*and **	
What we have achieved to date	*Total number of responses in brackets ** Discussions are taking place regarding the inclusion of Muirhead Safe zone/place working groups established. Staff and volunteers trained. Safe Zone Bus launched and active every Friday and Saturday night. Close working partnership across health, social work, police, red cross and pastoral services. Service users diverted from A&E services and police services.		
What we plan to do	Implement the recommendations within the Adult Support and Protection Committee Biennial Report (2014-2016) when published. Prevent and eradicate Violence Against Women (including Domestic Abuse) - Introduce the Caledonian Programme to work with perpetrators of domestic abuse - Introduce the Safe & Together model for working with families affected by domestic abuse - Deliver awareness sessions on Harmful Practices (including FGM, Forced Marriages and 'honour' based violence) to professionals across the city. Work in partnership to address the issue of domestic abuse by identifying high risk victims. We will prevent further incidences of abuse against them by using the Multi Agency Risk		

	Assessment Case Conferencing process to enhance the safety of victims of domestic abuse.
Data Source	Health and Care Experience Survey

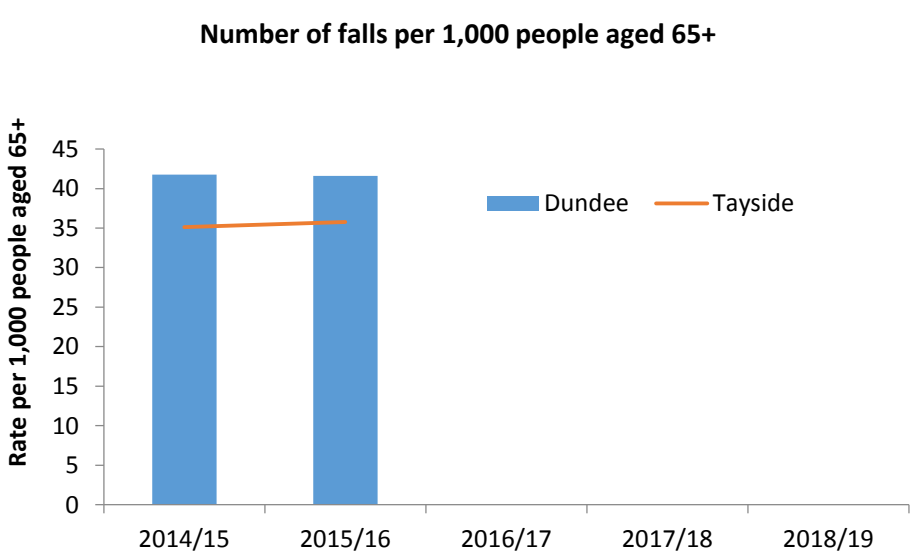
National Indicator 14: readmission to hospital within 28 days (rate per 1,000 discharges)			
	2014/15	**2015/16**	**Direction of Travel**
Dundee	11,535	11,631	maintained within 5%
Tayside	10,489	10,806	maintained within 5%



What we have achieved to date	We have remodelled the COPD Discharge service to support more adults discharged from hospital. We have expanded the Enhanced Community Support service, including the testing of multidisciplinary assessment meetings at GP practice level.
What we plan to do	Extend the range of supports for adults transitioning from hospital back to the community. Continue to roll out the Enhanced Community Support service. Reviewing models of service and care for AHP services, which includes the remodelling of OT services.
Data Source	ISD Linked Catalogue

National Indicator 16: Falls rate per 1,000 population in over 65's			
	2014/15	**2015/16**	**Direction of Travel**

Dundee	42	42	maintained within 5%
Tayside	35	35	maintained within 5%



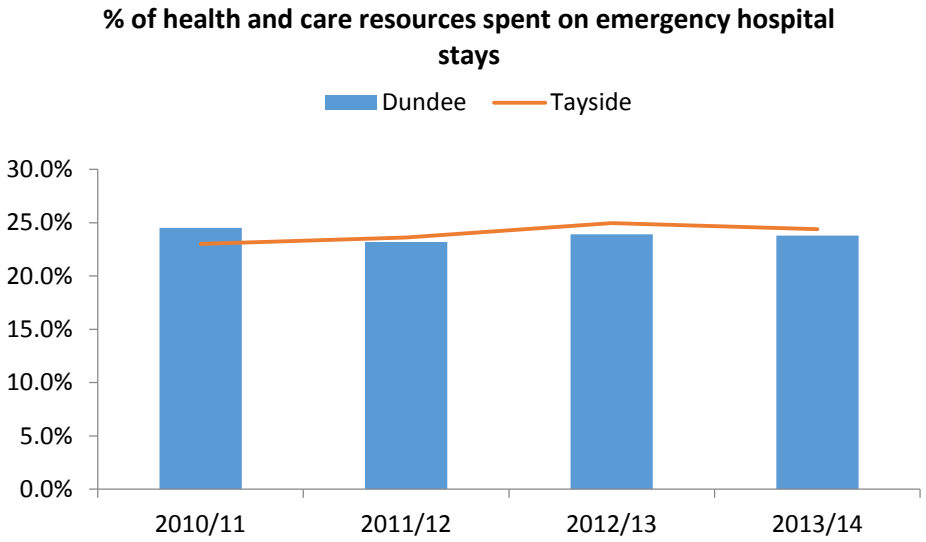
What we have achieved to date	Developed a draft equipment prescribers learning framework supported by e-learning and a mentoring programme. Piloted an e-learning module. Expanded on the falls service to ensure Patients aged over 65 years are routinely screened by AHP staff if presenting with a fall and 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. Octago falls classes now well established in community venues showing clear improvements in clinical outcomes. Introduced self referrals to CRT to improve access.
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 CRT 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.
Data Source	Adapted from an ISD Information Request (IR2015-02169)

<u>National Outcome 9 – Resources are used Efficiently and Effectively.</u>

To deliver Best Value and ensure scarce resources are used effectively and efficiently in the provision of health and social care services

(National Indicator 12 – rate of emergency admissions for adults links to National Outcome 9, however the data is

National Indicator 20: % of health and care resources spent on hospital stays where the patient was admitted in an emergency					
	2010/11	**2011/12**	**2012/13**	**2013/14**	**Direction of Travel**
Dundee	24.5%	23.2%	23.9%	23.8%	maintained within 5%
Tayside	23.0%	23.6%	25.0%	24.4%	maintained within 5%



What we have achieved to date	We have remodelled the COPD Discharge service to support more adults discharged from hospital. We have expanded the Enhanced Community Support service, including the testing of multidisciplinary assessment meetings at GP practice level.
What we plan to do	Extend the range of supports for adults transitioning from hospital back to the community. Continue to roll out the Enhanced Community Support service. Reviewing models of service and care for AHP services, which includes the remodelling of OT services.
Data Source	Tableau Health and Social Care - Expenditure Overview

ITEM No …9……

Appendix 3

Dundee Health and Social Care Partnership

Q1 Performance Report 2016/17

The Strategic Commissioning Plan presented a Case for Change which will only be achieved if strategic shifts in the way services are prioritised, accessed, organised and delivered, take place. This will involve a process of investment towards some areas of service and disinvestment in others, with resources deployed towards a more preventative and integrated community based approach. Taking account of our vision, our strategic needs assessment, the Case for Change, the views of our citizens and partners and our desired outcomes, eight priority areas were identified which will underpin the delivery of this Plan. These are:

1. Health Inequalities
2. Early Intervention/Prevention
3. Person Centred Care and Support
4. Carers
5. Localities and Engaging with Communities
6. Building Capacity
7. **Models of Support/Pathways of Care**
8. Managing our Resources Effectively

Under each of these eight priorities there are a range of strategic shifts that have been identified. It is recognised that all of these priorities, and their associated strategic shifts, are 'cross cutting' and will impact on each other. For the purposes of clarity, however, the following are the strategic shifts which are most strongly related to each of the eight priorities identified. The first 2, highlighted in bold have been reported against.

7. Models of Support/Pathways of Care

- **Investing in tests of change/remodelling of services which are designed to improve capacity and flow between large hospitals and the community**
- **Redesign models of non-acute hospital based services and re-invest in community based services**
- Remodelling local authority residential care to provide more targeted and specialist resources
- Remodel General Practice in line with G.P. cluster model, the changes to the GMS contract and the opportunities afforded through integration
- Investing in the transformation of community nursing services to deliver the Tayside District Nursing vision and model, improving outcomes for adults and older people
- Remodelling and investing in the development of, and increase in, accommodation with support
- Remodelling and investing in the development of day opportunities for adults and older people
- Investing in and expanding the range of telehealth and telecare supports
- Re-model and prioritise mainstream and specialist services to ensure a rapid and effective response to protecting people concerns

Strategic Shift	**Investing in tests of change/remodelling of services which are designed to improve capacity and flow between large hospitals and the community**
Local Indicators (Draft)	**Number of Bed Days Lost in hospital when person is awaiting discharge** **% of delays where person discharged within 72 hours** **% of people requiring reduced homecare following enablement** **Number of patients who were discharged from the ward then readmitted as an emergency to any NHS Tayside location within 28 days of discharge. Presented by the month of initial discharge along with the rate for readmissions per 1000 discharges** **Emergency admission rates per 100,000 people**

Number of Delays in hospital where person is awaiting to go home

Table A All Delays (Bed Days)

All Ages	2012/13	2013/14	2014/15	2015/16	Direction of Travel
Dundee	14,363	12,533	12,239	15,050	deteriorated
Tayside	39,666	41,473	38,969	43,646	deteriorated
75+					
Dundee	10,569	9,113	8,889	10,351	deteriorated
Tayside	31,711	32,691	29,839	31,437	deteriorated

Table B Standard Delays (Bed Days)

All Ages	2012/13	2013/14	2014/15	2015/16	Direction of Travel
Dundee	9911	8050	9050	8382	Improving
Tayside	33205	34026	31 322	31, 744	deteriorated
75+					
Dundee	7,962	6,288	7,136	6661	Improving
Tayside	27,610	27,878	25,535	25, 105	Improving

Table C Code 9 Bed Delays (Bed Days)

All Ages	2012/13	2013/14	2014/15	2015/16	Direction of Travel
Dundee	4,452	4,483	3,189	6,668	deteriorated
Tayside	6,461	7,447	7,647	11,902	deteriorated
75+					
Dundee	2,607	2,825	1,753	3,690	deteriorated
Tayside	4,101	4,813	4,304	6,332	deteriorated

Discharge Data Types

Standard delays are defined by ISD Scotland as delays where the standard maximum delay period applies. This includes patients delayed due to awaiting assessment, housing, equipment, care home or nursing placements.

Code 9 delays are used by ISD Scotland to describe delays where the standard maximum delay is not applicable. This is in recognition that there are some patients whose discharge will take longer to arrange and would include patients delayed due to awaiting place availability in a high level needs specialist facility and where an interim option is not appropriate, patients for whom an interim move is deemed unreasonable or where an adult may lack capacity under adults with incapacity legislation.

Discharge Data Information (Bed Delays)

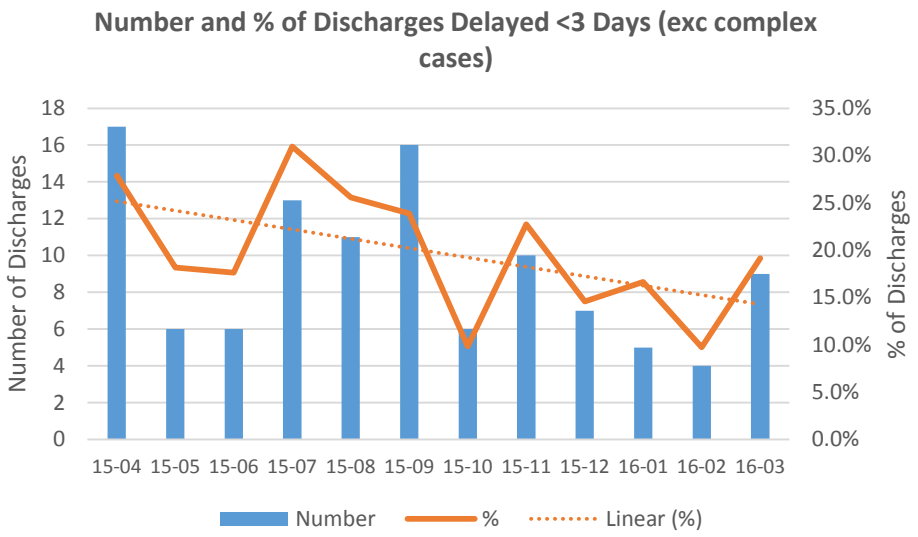
Standard delays tend to be associated with higher volume of people who are inpatients. This is mainly due to our activity in relation to streamlining processes, PDD work and changes to social care packages taken forward.

However, where we have seen a decrease in our performance against bed delays is in relation to code 9 delays as demonstrated in Table C. Code 9 delays tend to be reflective of lower number of patients in line with our weekly reporting. This decrease affects the overall totals as demonstrated in Table A. 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.

What we have achieved to date	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 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	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.

% of people discharged from hospital within 72 hours of being ready					
	Q1 14/15	**Q2 14/15**	**Q3 14/15**	**Q4 14/15**	**Direction of Travel**
Dundee	29	40	23	18	Improved

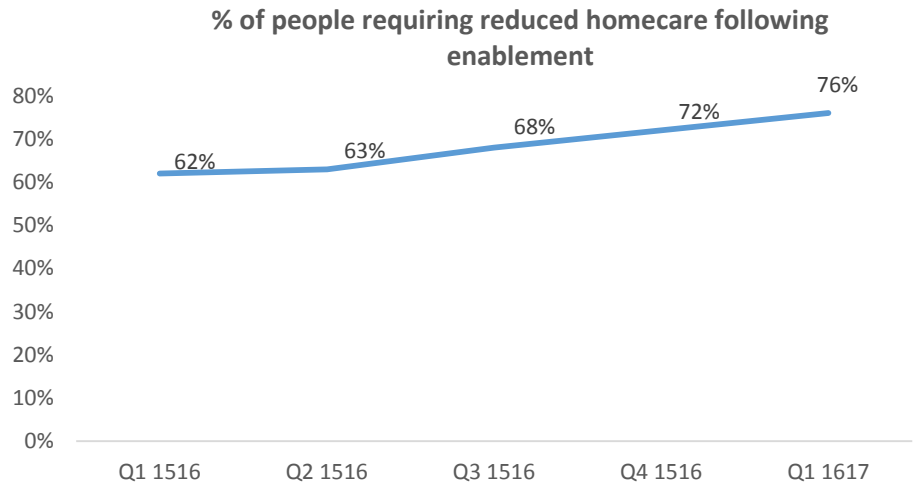


Note that NSS ISD have not yet finalise the definition of this measure yet. For the purpose of this report local data from Edisson has been used and the definition has been assumed to be the % of people delayed <3 days, of all delays. This is not all discharges from hospital – only the discharges which were delayed >1 day.
This data includes all delays and therefore is not snapshot census data.

What we have achieved to date	The Enhanced Community Support Service is contributing to the reduction in delays in hospital due to the transition to residential / nursing care. Processes are being started sooner, in the community and reducing the reactive / emergency solutions required once a person is admitted to hospital in a crisis situation.
What we plan to do	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, particularly where 24 hour care is being considered. Expand the 'Moving Assessment into the Community' project to specialist areas and test pathways. 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. Redesign services to ensure rapid access to palliative services. Review patient pathways between Carseview Hospital and the community. Embed within strategic commissioning plans the development of a range of community resources which enable people to remain in their own home and be discharged from hospital when they are ready. 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. 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. Review and remodel care at home services to provide more flexible responses. Further develop models of Community Rehabilitation to support transitions between home and hospital
Data Source	Edisson – Supplied by The Business Support Unit NHS Tayside

% of people requiring reduced homecare following enablement						
	Q1 1516	**Q2 1516**	**Q3 1516**	**Q4 1516**	**Q1 1617**	**Direction of Travel**
Dundee	62%	63%	68%	69%	76%	improved

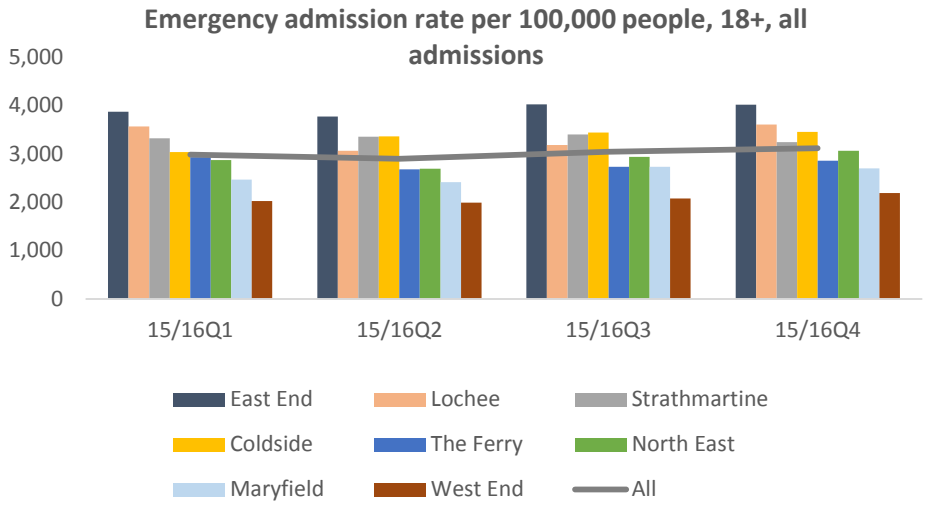


What we have achieved to date	Expanded the Enhanced Community Support, including the testing of multidisciplinary assessment meetings at GP Practice level; and the further roll out of the model to additional practices across the 4 cluster areas. Introduced a locality nurse role in each locality to coordinate 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 MfE Consultant Teams linked to GP practices. Introduced medication reviews and employed a pharmacy technician as part of the social care enablement teams. Service improvement and design is focusing on innovative and preventative models of care and support. Examples are the Enablement and Enhanced Community Support Teams.
What we plan to do	Increase our investment in intermediate forms of care such as step up/down accommodation and support for all adults. We will continue to review the models of care and support and increase the number of alternatives to traditional homecare such as Housing with Care and more preventative measures which enable people to remain at home for longer. Self Directed Support will continue to encourage alternatives to traditional homecare services and work will continue to develop a market place to support social enterprise and self-employed carers in order to improve choice to people when using all Self Directed Support options. Remodel Housing Support services to ensure equity of access based on need. Implement the proposals for accommodation with care for adults in line with the Strategic Housing Investment Plan. Implement relevant key actions and commitments linked to the outcomes detailed in the Dundee

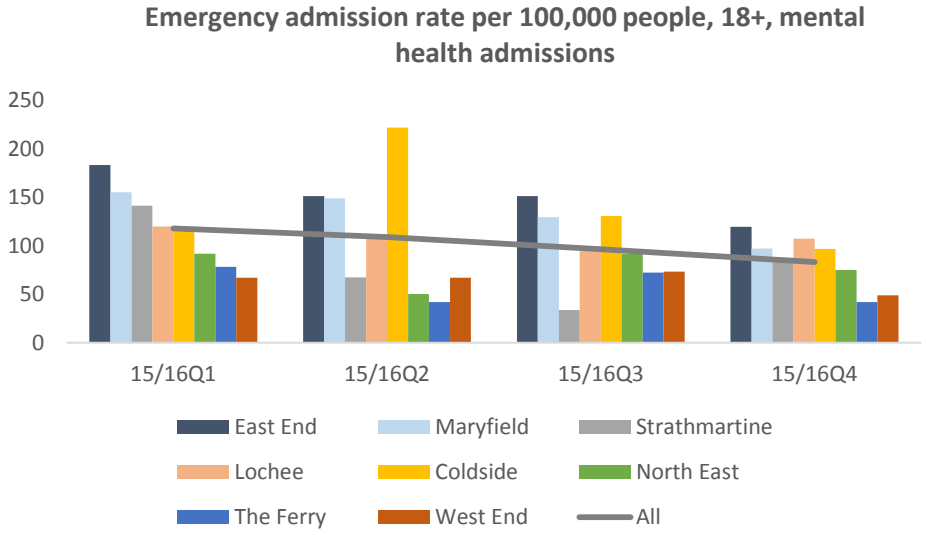
	Housing Contribution Statement 2016 Develop a Strategic Commissioning Statement for technological care and implement actions alongside partnership agencies. Increase the range of technological supports.
Data Source	Enablement Service User Register

Number of patients who were discharged from the ward then readmitted as an emergency to any NHS Tayside location 28 days of discharge. Presented by the month of initial discharge along with the rate for readmissions per 1000 discharges.					
	Q1	**Q2**	**Q3**	**Q4**	**Direction of Travel**
Bluebell ICU	125	79.4	196.7	244.9	deteriorated
RVH Hospital (Wards 1, 2, 3, 6 Rox Hse East and Rox Hse West)	87	83.3	80.5	133.3	deteriorated
Kingsway Care Centre	0	147.1	173.9	0	improved
What we have achieved to date	Remodelled the COPD Discharge Service to support more adults 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 free up nurse time. 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 MfE 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 so	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				
Data Source	Qlikview, Inpatient Activity App - Readmissions Within 28 Days				

Emergency admission rates per 100,000 people					
	15/16Q1	15/16Q2	15/16Q3	15/16Q4	Direction of Travel
Dundee	**2,984**	**2,897**	**3,039**	**3,115**	maintained within 5%
Coldside	3,032	3,357	3,436	3,453	maintained within 5%
East End	3,869	3,765	4,020	4,012	maintained within 5%
Lochee	3,562	3,063	3,183	3,600	deteriorated (13%)
Maryfield	2,468	2,416	2,734	2,695	maintained within 5%
North East	2,867	2,692	2,934	3,059	maintained within 5%
Strathmartine	3,318	3,352	3,399	3,237	maintained within 5%
The Ferry	2,927	2,680	2,728	2,855	maintained within 5%



- Q1 16/17 complete data is not currently available.
- East End has the highest emergency admission rate. This is consistent across all quarters and the rate peaked at Q4 15/16.
- The West End had the lowest emergency admission rate across all quarters.
- There is a correlation between emergency admission rates and age and deprivation.



- Q1 16/17 complete data is not currently available.
- In all, except for 1 quarter, coldside had the highest emergency admission rate due to mental health.
- During Q2 15/16 there was a significant peak in the emergency admission rate due to mental health in Coldside.

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. Improvements include 286 Keep Well community team health checks (Q1 16/17), improved links and referrals from TSMS to consider wider health issues, hosting health and wellbeing network meeting across the city to support targeted outreach through the equally well programme.
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.
Data Source	Source: ISD Linked Catalogue (SMR01, SMR50 and SMR04)

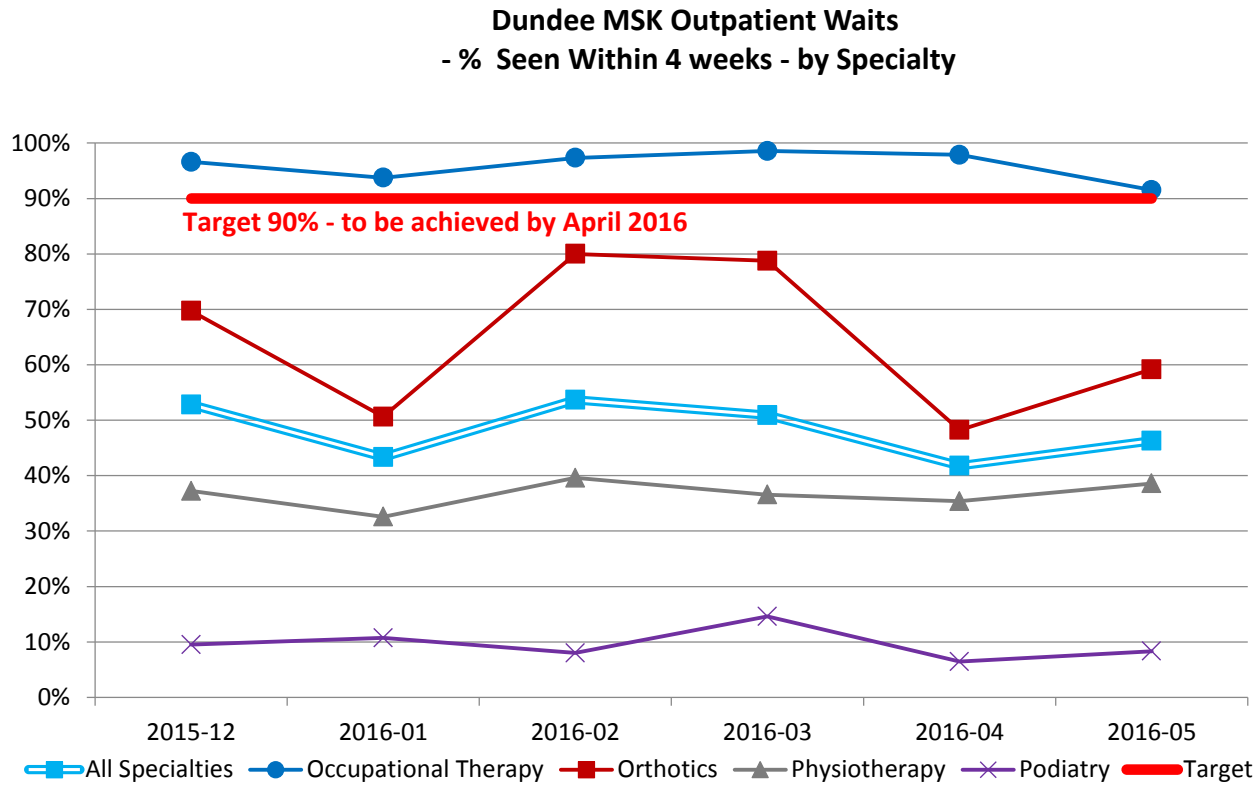
Strategic Shift	**Redesign models of non-acute hospital based services and re-invest in community based services**

Local Indicators (Draft)	**£ saving from Hospital to Home – Step Down Resource – Blackwood Housing Partnership** **New MSK Waiting Times - Completed waits (4 week target)** **Proportion of last 6 months of life spent at home or in a community setting** **Falls rate per 1,000 people aged 65+** **COPD Discharge Service** - **% of people seen within 5 days of service** - **% of people seen within 4 days of referral** - **% of people who received additional support needs to meet their clinical needs**

£ saving from Hospital to Home - Step Down Resource – Blackwood Housing Partnership					
	Q1	**Q2**	**Q3**	**Q4**	**Direction of Travel**
Dundee	£24,638				
What we have done to date	The outcome for this test of change was to determine whether a relatively modest investment could support and improve capacity and flow between Ninewells and CBIR and the community. This approach also contributes to moving assessment from hospital base to home and the added value of this model is that the commissioning of care packages is much better defined. Funding from the Integrated Care Fund was approved in the second half of the financial year 2015/16 in response to the availability of a suitably accessible property. Full year funding for the property costs are: 2016 -17 £11,000 2017 -18 £11,000 The number of days, to date, that the step down property has been occupied is 150 days. The care package to support the current individual is £675 per week as opposed to £290 per night in CBIR. If the person remained in CBIR then this would have cost approximately £43,500, whereas the cost at the step down property was approximately £14,512. There are ongoing costs associated with CBIR, such as facilities and staff costs which cannot be reduced, therefore it is assumed that 10% of the CBIR cost remains, this means that the CBIR cost of the 150 days being utilised at the step down property is £4,350. The total cost of the step down property for 150 days was (£4,350+£14,512) £18,862 which was an approximate saving of £24,638, during the 150 period for 1 individual.				
What we plan to do	The step down facility has already demonstrated that in both personal outcome terms and financial terms this test of change has been hugely successful with the current tenant due to move to their newly adapted property within the next two weeks. A third person currently transitioning through the rehabilitation pathway between CBRI and the Mackinnon Centre will be moving to the step down property as soon as it is vacated as they are awaiting on adaptations to their own property before they can return home.				

New MSK Waiting Times - Completed waits (4 week target)

	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Direction of Travel
All Specialties	53%	43%	54%	51%	42%	46%	maintained within 5%
OT	97%	94%	97%	99%	98%	90%	maintained within 5%
Orthotics	70%	51%	80%	79%	48%	59%	improved
Physiotherapy	37%	33%	40%	37%	35%	39%	maintained within 5%
Podiatry	10%	11%	8%	15%	6%	8%	maintained within 5%



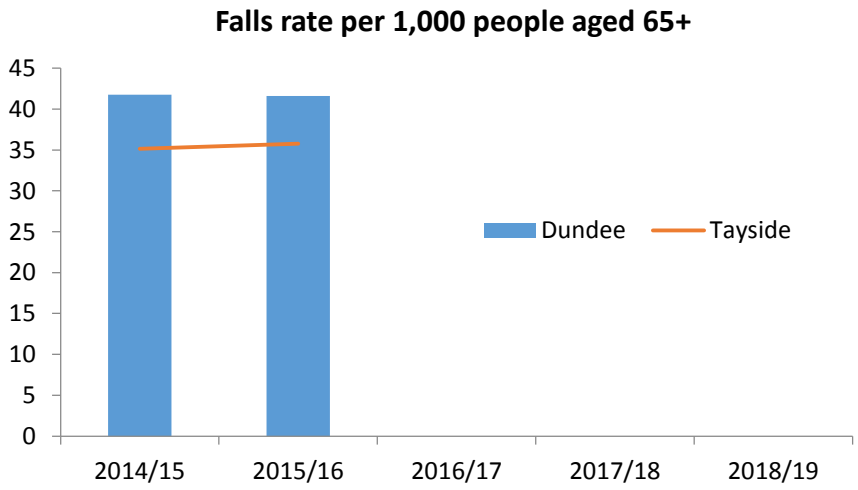
What we have achieved to date	MSK pathway has been redesigned and implemented across Tayside. AHPs can be first point of contact and have access to diagnostics and can refer directly to secondary care when indicated. Patients can have fast access to information via NHS Inform and receive triage and advice via MATS (musculoskeletal advice and triage service) to ensure therapy can begin as early as possible thereby potentially reducing the need for intervention from therapy services. Decision support tool developed to support primary care staff directing patients to most appropriate services (developed in Tayside and adapted as national tool). DCAQ workshops held for AHP staff. Standardisation of AHP services across Tayside. Implementation of telephone assessment, telephone review, email review models. Developed multidisciplinary triaging across hand/plastics service to ensure appropriate/early referral to correct clinical team.
What we plan to do	Ongoing DCAQ workshops to ensure sustainability and spread of good practice across Tayside. Foot and ankle pathway being reviewed and new model being piloted with focus on multidisciplinary triaging and clinics. Ongoing review of clinic models exploring the possibility of 'open' clinics to allow immediate access to therapy.

Proportion of last 6 months of life spent at home or in a community setting

	13/14				Direction of Travel
Dundee	92.58%				
Tayside	92.2%				
Scotland	90.8%				
Lochee	92.5%				
East End	91.8%				
Strathmartine	92.2%				
North East	92.2%				
Coldside	91.8%				
Maryfield	91.3%				
West End	94.5%				
The Ferry	93.7%				
What we have achieved to date	Entered into the second Macmillan Local Authority Partnership in Scotland to work with people living with cancer.				
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.				
Data Source	NSS ISD				

Falls rate per 1,000 people aged 65+					
	2014/15	**2015/16**			**Direction of Travel**

Dundee	42	42			maintained within 5%
Tayside	35	36			maintained within 5%
% of care home residents *Tinetti scores which improved following Falls Exercise Class					
Dundee	91%	90%			maintained within 5%



What we have achieved to date	* The **Tinetti** Assessment Tool is a test that measures a resident's gait and balance. The test is **scored** on the resident's ability to perform specific tasks. 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 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. Octago falls classes now well established in community venues showing clear improvements in clinical outcomes. Introduced self referrals to CRT to improve access.
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 CRT 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.
Data Source	Adapted from an ISD Information Request (IR2015-02169) NHS Tayside Physiotherapy and Community Therapy Team

COPD Discharge Service

- **% of people seen within 5 days of service***

- **% of people seen within 4 days of referral****
- **% of people who received additional support needs to meet their clinical needs***

***Data for illustrative purposes only. From a stand alone study and data will not be available quarterly.**
****This is the proposed measure for this service although data reported in this report from a stand alone study. Processes will be developed to enable this measure to be reported quarterly going forward.**

	Nov 13 – March 14				**Direction of Travel**
% of people seen within 5 days of service	80%				
% of people seen within 4 days of referral	83%				
% of people who received additional support needs to meet their clinical needs	65%				
What we have done to date	Remodelled the COPD Discharge Service to support more adults discharged from hospital. Data suggest that there is a reduction in re-admission rates (COPD exasperation). Introduced a health care support worker role to increase capacity to support more complex COPD patients, as well as those being supported after discharge from hospital. We have undertaken questionnaires with the COPD team, patients and their carers, and general practice colleagues to assess the impact of the service. Of a sample of 30 patients who undertook a telephone questionnaire in Jan/Feb 16 - 93% rated the service as very good or excellent - 93% felt the timing of the visit after discharge was just right - 79% said they understood their condition better as a result of the service - 97% of this sample were seen within 4 days of referral				
What we plan to do	We are looking at how we can proactively identify patients with COPD who would benefit from additional support to improve quality of life, and keep the patient in a homely setting where possible. We are also planning further work to assess the impact of the developments on patients.				