ITEM No …8……….

REPORT TO: PERFORMANCE & AUDIT COMMITTEE – 19 JULY 2017

REPORT ON: DUNDEE HEALTH AND SOCIAL CARE PARTNERSHIP PERFORMANCE REPORT (QUARTERS 3 & 4)

REPORT BY: CHIEF FINANCE OFFICER

REPORT NO: PAC15-2017

1.0 PURPOSE OF REPORT

The purpose of the report is to update the Performance and Audit Committee on progress in implementing the Partnership's performance framework. The report also brings forward the combined Quarter 3 and Quarter 4 Performance Report for 2016/17 for consideration by the Committee.

2.0 RECOMMENDATIONS

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

2.1 Notes the progress that has been made in further developing and implementing the performance framework, and supporting structures and systems, since the last update was provided to the Integration Joint Board (IJB) in January 2017 (section 4.1).

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

2.3 Notes the progress that has been made to develop information from the quarterly performance reports and Ministerial Strategic Group (MSG) submission into a Partnership Delivery Plan for 2017/18 with a focus on improvement in identified areas (section 4.1.3).

2.4 Approves the proposed approach to Quarterly Performance Reports for 2017/18 (section 4.3).

2.4 Notes the progress that has been made in developing links between the Quarterly Performance Report and risk register (section 4.3.4).

3.0 FINANCIAL IMPLICATIONS

None.

4.0 MAIN TEXT

4.1 Performance Framework

4.1.1 The Strategy and Performance Team is continuing to work with the wider Partnership to develop a suite of local integration indicators for each service area which will measure Strategic Shifts. Draft indicators have now been developed for psychiatry of old age inpatient and community teams, the Chronic Obstructive Pulmonary Disease (COPD) community team, the palliative care team and teams aligned to health inequalities work streams. Other service areas are continuing their work to identify appropriate indicators. In addition the Strategy and Performance Team has supported the development of draft indicators and targets for the Health, Care and Wellbeing section of the Local Outcomes Improvement Plan in which the Partnership plays a key role alongside other community planning partners.

4.1.2 Version 1 of the Strategic Needs Assessment accompanied the publication of the Strategic and Commissioning Plan. Work is ongoing to update data and make necessary improvements to form Version 2 which will continue to focus on variation between localities and provide further neighbourhood analysis. It had originally been anticipated that Version 2 would be completed by the end of the 2016/17 financial year, however the significant pressure within the Information Officer capacity created by the transition to the new social work client record system (Mosaic) and statutory returns (see section 4.1.8) has meant this has not been possible. Revised sections describing the city profile, demographics, life expectancy, deprivation, benefits claims, employment support, substance misuse, sexual and reproductive health, teenage pregnancies, adult support and protection, violence against women, criminal justice court reports, care homes, learning disabilities services and the mental health officer service are now complete, with further sections being prioritised where available resource allows. Completed sections are being made available to relevant staff for the purposes of planning and strategic commissioning.

4.1.3 Work is progressing to develop a Partnership Delivery Plan for 2017/18. Initially this plan will focus on the six key areas of performance included within the MSG submission (unplanned admission, occupied bed days for unscheduled care, delayed discharge, balance of care, end of life care and accident and emergency) but will be further expanded to cover other priority areas of performance. As well as setting out key deliverables for 2017/18 under each area of performance the plan will describe the expected impact of activities in relation to MSG targets (set through the MSG submission), as well as national health and wellbeing indicator, national delivery plan and 'best in class' targets (currently being developed from benchmarking data).

4.1.4 Dundee City Council (DCC) is currently developing a new corporate approach to Performance Management. Through discussion with the Chief Officer it has been agreed that as well as the submission of the Integration Joint Board (IJB) quarterly performance reports to Council Committee that the Partnership will agree a Health and Social Care Scorecard for inclusion in DCC Corporate Performance Reports. The scorecard is currently in draft and contains a range of process, outcome and satisfaction measures drawn from the suite of national indicators, MSG indicators and local government indicators for which benchmarking information is available.

4.1.5 The development and implementation of Dundee and Tayside-wide datasets is in part reliant on up-to-date and accurate output from NHS information systems managed by the NHS Tayside Business Support Unit. Throughout 2016/17 the Partnership has been reliant on the NHS National Services for Scotland, Information and Statistics Division (NSS ISD) local information team (LIST) analyst seconded to the partnership for the production of NHS data for all reporting, including Quarterly Performance Reports. More recently significant progress has been made in arrangements for provision of local performance data from NHS Tayside Business Unit, meaning that from 2017/18 onwards data will be available directly from the Business Unit, releasing LIST analyst capacity for other areas of work focused on data analysis to inform performance improvement.

4.1.6 At present NSS ISD second a senior analyst through the LIST project to Dundee on a 0.5 FTE basis. Further investment in LIST at a national level has resulted in additional capacity of approximately 0.4 FTE being allocated to the Partnership from 23 August. Additional analytical capacity will be utilised to continue LIST support to the partnership but it will also be used to support the clusters in Dundee.

4.1.7 NSS ISD also compile the SOURCE data set which brings together service user level health and social care data. A full update on Partnership participation in SOURCE was provided to the Committee in March (see PAC8-2017). Since this time work has progressed with regards to refreshing CHI seeding of Partnership records with final information governance arrangements currently being made. The March update report highlighted that 'maintaining the submission of data on a quarterly basis is challenging within the context of the significant pressures within the Partnership's Information Team'; these pressures have increased significantly over the last quarter due to Mosaic transition and the statutory return period (see 4.1.8).

4.1.8 The new Social Work client record system (Mosaic) went live in November 2016. The Information Team is leading on the development of Crystal Reports which will be used to report from Mosaic on some national and local indicators, statutory Scottish Government Returns and national information sharing and linking work streams (such as SOURCE). These reports will also be used to assist operational teams deliver services and monitor operational activity and performance as well as support improvements in outcomes for individuals and communities.

The impact of Mosaic transition on the resource required to prepare statutory returns, as well as on the quality of data available within the system, has been very significant. The need to prioritise Mosaic transition work given that it is crucial to the future availability of social care data and that returns are a statutory requirement, alongside the resource required to prepare the Partnership's annual performance report, has led to slowed progress in a number of other areas (see 4.1.1., 4.1.2 and 4.1.7). It is anticipated that Mosaic transition will continue to significantly impact upon available resources until at least the end of this financial year. The Senior Management Team are considering proposals for the management of these pressures.

4.2 Quarter 3 and Quarter 4 Performance Report 2016/17

4.2.1 The performance report in Appendix 1 sets out performance benchmarked against national data. This outward looking approach highlights the fundamental reasons for the introduction of integrated health and social care services and draws out a range of key areas the Partnership needs to focus on to improve outcomes for individuals and communities in the future. Performance continues to reflect the social and demographic profile of Dundee and the issues of inequality for people living in poverty. As such, this performance report is imperative in supporting the partnership's commitment to continuous improvement in order to achieve our vision that each citizen of Dundee will have access to the information and support that they need to live a fulfilled life.

4.2.2 The Quarters 3/4 Performance Report covers local performance against National Indicators 11-23. Under each of these indicators there is a summary of current and planned improvement actions. Indicators 1-10 are reported from The Health and Social Care Experience Survey administered by the Scottish Government which is conducted biennially and the results from the 2015/16 survey were presented to the IJB in August 2016.

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

4.2.4 Out of the eight indicators, where 2016/17 is available, two show that Dundee is performing better than the Scottish rate: bed days lost to delayed discharge for 75+ (improved by 9.2% between baseline year 2015/16 and 2016/17) and registered services graded good or excellent by the Care Inspectorate.

4.2.5 Two indictors show that Dundee is performing at the Scottish rate and in four of the indicators Dundee is amongst the most poorly performing partnerships in Scotland. As at 2016/17 Dundee has the 5th highest emergency bed day rates, the 1st highest re-admission rate within 28 days, the 2nd highest falls rate and the 4th highest proportion of health and social care resource spent on hospital emergency bed days.

4.2.6 Between the baseline year 2015/16 and 2016/17, Dundee has seen an improvement in bed days lost to delayed discharges for people aged 75 and over. Bed days lost to delayed discharges as a rate of the 75+ population have fallen by 9.2% in Dundee since 2015/16. North East and Strathmartine have seen the biggest improvements with a 41% and 29% reduction respectively. The East End and Maryfield are the only Local Community Planning Partnerships (LCPPs) where there were increases by 20% and 9% respectively.

4.2.7 Emergency bed day rates since 2015/16 have decreased by 4% for Dundee and Coldside, Lochee and Strathmartine have shown small increases. The biggest improvements were seen in Maryfield, West End and East End of which all showed greater than a 5% decrease in bed day rates.

4.2.8 Emergency admission rates have increased slightly by 1.8% for Dundee since 2015/16, however four out of eight LCPPs saw a decrease over this period. There were increases in emergency admission rates in Coldside (1.3%), Lochee (8.4%), North East (7.3%) and West End (7.3%). The East End continues to have the highest emergency admission rate in Dundee.

4.3 Future Quarterly Performance Reports

4.3.1 As described at section 4.1.5 local performance data that forms the basis of Quarterly Performance Reports will, from Quarter 1 of 2017/18, be available directly by NHS Tayside

Business Unit. Work with the Business Unit over the last quarter has confirmed that data provided directly is of a sufficiently high quality and accuracy to form the basis of Partnership performance reports. Utilising locally provided data will significantly reduce the time lags that have been experienced during 2016/17 between quarter ends and the availability of validated data at a national level, meaning the PAC (and other stakeholders) will receive local performance reports more timeously throughout 2017/18. However it should be noted that the data received from the Business Unit is based upon treatment data rather than residence (which nationally validated and published data is) and is not able to be benchmarked against performance in other Partnerships. Testing of local data against national data has confirmed that despite data being based on treatment rather than residence that accuracy remains within an acceptable tolerance and that trends in local data are reliable for service planning and performance improvement purposes.

4.3.2 From Quarter 1 of 2017/18 it is also intended that progress towards targets contained within the MSG submission will form part of quarterly performance reports. Monthly update data is provided to Partnerships via NSS ISD, however this data is not complete (for example, data relating to bed days has a significant time lag as records continue to be passed from local Boards to NSS) and has not been validated. Again, this means that information is not suitable for benchmarking, but is reliable for the purposes of tracking trends and progress within the partnership.

4.3.3 Given the availability of data to the partnership it is proposed that Quarterly Performance Reports are submitted to the PAC as follows:

	Local Performance Report	Benchmarking Report
12 September 2017	Quarter 1	
27 November 2017	Quarter 2	Quarter 1
As soon as possible after end of Quarter 3	Quarter 3	Quarter 2
As soon as possible after end of Quarter 4	Quarter 4	Quarter 3 and Quarter 4

Exact timescales for submission of reports will be set out once 2018 Committee dates are available.

4.3.4 The PAC has previously requested that work be undertaken to ensure appropriate links are made between performance reports and the Partnership risk register. On 27 June the IJB approved a revised approach to the assessment of policy implications and risk management within Board/Committee reports (see Agenda item 20 – agenda note). Following on from this the framework agreed will be applied to future Quarterly Performance Reports, with risks identified being addressed through the Partnership Delivery Plan, risk register or other appropriate identified approaches.

5.0 POLICY IMPLICATIONS

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

6.0 CONSULTATIONS

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

7.0 BACKGROUND PAPERS

None.

Dave Berry
Chief Finance Officer

DATE: 3 July 2017

Appendix 1

Dundee LCPP Performance Report 2016/17 Q3 and 4 and the National Position for National Indicators 11-23 as at 2016/17

Executive Summary

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

- 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.

- Out of the 8 indicators, where 2016/17 is available, only two show that Dundee is performing better than the Scottish rate. Two indicators show that Dundee is performing at the Scottish rate and in 4 of the indicators Dundee is amongst the 7 most poorly performing partnerships in Scotland.

- As at 2016/17 Dundee has the 7th highest emergency bed day rates, the 1st highest re-admission rate within 28 days, the 2nd highest falls rate and the 3rd highest proportion of health and social care resource spent on hospital emergency bed days.

- Between the baseline year 2015/16 and 2016/17 Q4 Dundee has seen an improvement in bed days lost to delayed discharges for 75+.

- Emergency admission rates have increased slightly by 1.8% for Dundee since 2015/16, however 4 out of 8 LCPPS saw a decrease over this period. There were increases in emergency admission rates in Coldside (1.3%), Lochee (8.4%), North East (7.3%) and West End (7.3%). The East End continues to have the highest emergency admission rate in Dundee.

- Emergency bed day rates since 2015/16 have decreased by 4% for Dundee and Coldside, Lochee and Strathmartine have shown small increases. The biggest improvements were seen in Maryfield, West End and East End of which all showed greater than a 5% decrease in bed day rates.

- Bed days lost to delayed discharges as a rate of the 75+ population have fallen by 9.2% in Dundee since 2015/16. North East and Strathmartine have seen the biggest improvements with a 41% and 29% reduction respectively. The East End and Maryfield are the only LCPPs where there were increases by 20% and 9% respectively.

Dundee's Ranked Performance between 2010/11 and 2016/17

Where 1st is the best performing partnership and 32nd is the worst performing partnership

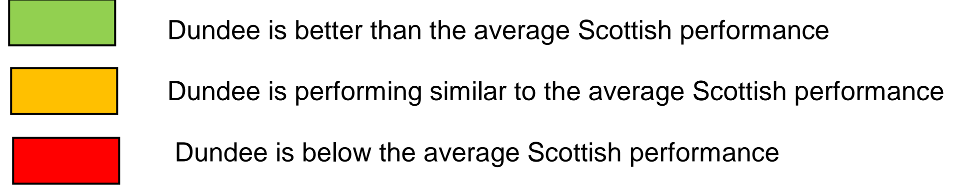


Table 1: Dundee Ranked Performance as between 2010/11 and 2016/17

National Indicators	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
11.Premature Mortality	30th	28th	29th	30th	30th	N/A
12. Admissions	19th	20th	17th	21st	19th	21st
13. Bed Days	27th	28th	27th	28th	28th	26th
14. Re-admissions	32nd	31st	30th	31st	32nd	32nd
15. Last 6 months	10th	12th	19th	17th	15th	14th
16. Falls	18th	29th	30th	30th	31st	31st
17. Care Inspectorate	N/A	N/A	N/A	6th	6th	6th
18. Intensive Needs	30th	32nd	32nd	31st	31st	N/A
19. Delayed Discharges	N/A	18th	15th	13th	19th	17th
20. Spend on emergencies	31st	30th	29th	29th	29th	30th

Performance in 2016/17 Q4 against baseline year 2015/16

Table 2: Performance in 2016/17 Q4 against baseline year 2015/16

National Indicator	Dundee	Cold side	East End	Lochee	Mary field	North East	Strath martine	The Ferry	West End
12.Admissions	+1.8%	+1.3%	-4.5%	+8.4%	-1.3%	7.3%	-0.1%	-1.9%	+7.3%
13. Bed Days	-4.1%	+2.4%	-11.5%	+2.0%	-17.8%	-4.3%	+2.9%	-1.6%	-9.4%
16. Falls	+1.1%	-1%	+1.9%	+2.1%	+1.6%	+4.6%	-1.6%	-0.7%	+4.7%
19. Delayed Discharge	-9.2%	-9.2%	+20.3 %	-1.5%	+8.9%	-41.3%	-29.3%	-14.1%	-18.1%

Premature Mortality Rate (Latest National Position as at Calendar Year 2015/16 – 2016/17 data not yet available)

Chart 1: European Age-Standardised Mortality Rate per 100,000 for People Aged under 75

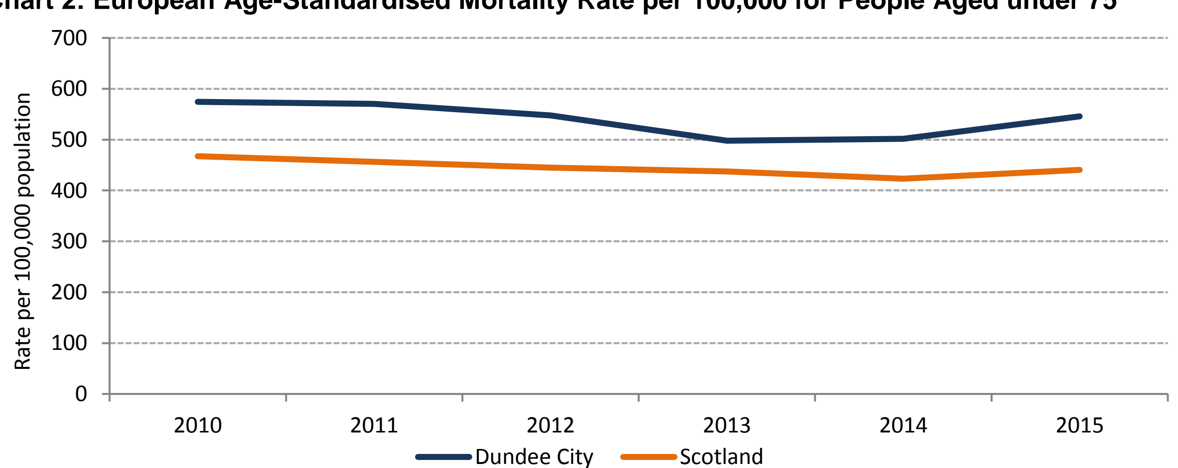
Rate per 100,000 population
700
600
500
400
300
200
100
0
Scotland
East Renfrewshire
East Dunbartonshire
East Lothian
Aberdeenshire
Perth & Kinross
Dumfries & Galloway
Orkney Islands
Angus
Highland
Scottish Borders
Argyll & Bute
Stirling
Midlothian
Moray
West Lothian
Edinburgh City
Shetland Islands
South Ayrshire
Fife
South Lanarkshire
Falkirk
Eilean Siar
East Ayrshire
Renfrewshire
Aberdeen City
Clackmannanshire
North Ayrshire
Inverclyde
North Lanarkshire
Dundee City
West Dunbartonshire
Glasgow City

Source: ISD Scotland

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

Whilst the Dundee HSCP is working very hard to reverse this national position and to reduce premature mortality it should be acknowledged that this requires continued and further partnership with stakeholders across the wider local community planning partnerships.

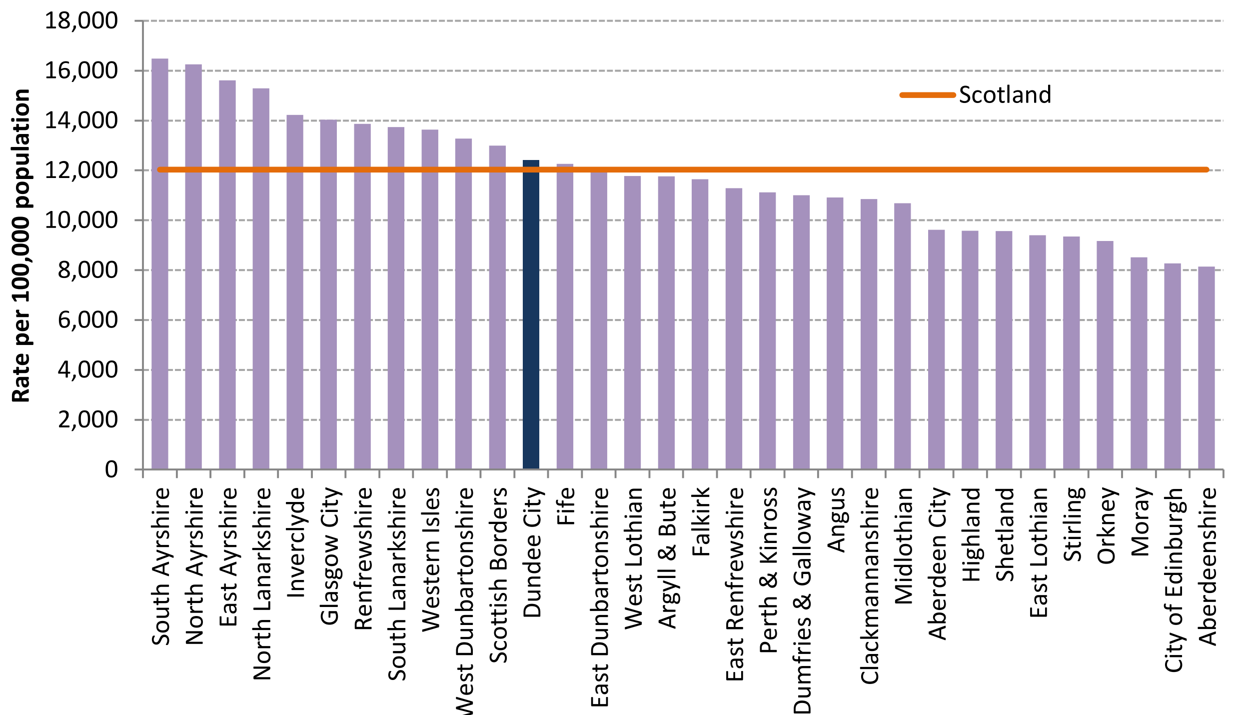
Chart 2: European Age-Standardised Mortality Rate per 100,000 for People Aged under 75



Source: ISD Scotland

As at 2015, Dundee was the 3rd highest ranked partnership for premature deaths with 548 per 100,000 population. Historically, Dundee has always had a higher premature mortality rate than the Scottish rate and although the Dundee rate was decreasing between 2010 and 2014 it began to increase thereafter.

Chart 3: Rate of Emergency Admissions for Adults (Latest National Position as at 2016/17)



Source: ISD Scotland

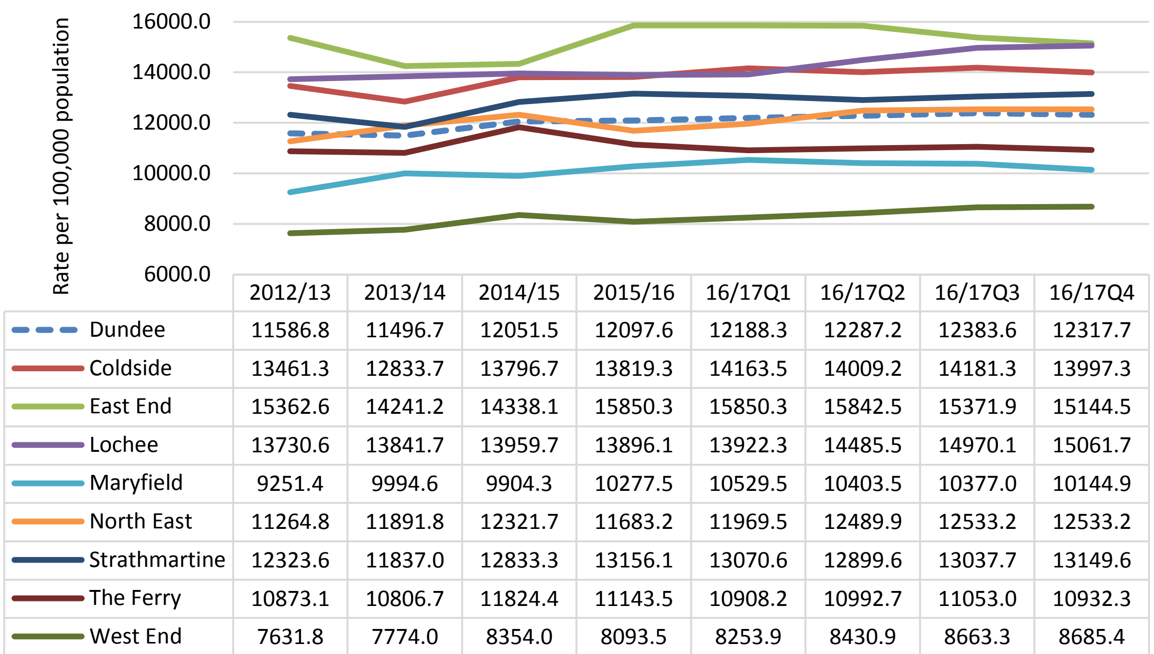
Dundee currently is performing slightly higher that the Scottish average with approximately 12,500 emergency admissions per 100,000 population, compared with the Scottish average of approximately 12,000 emergency admissions per 100,000 population.

Whilst performance appears poor compared with other Partnerships, when assessment is made alongside the other 'family group' Partnerships which Dundee is aligned to performance is more positive.

Dundee performance is better than the following 'family group' Partnerships – North Lanarkshire, Glasgow, East Ayrshire, North Ayrshire and Inverclyde and West Dunbartonshire.

Management Information at Locality Level for 2016/17 Q4

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



	2012/13	2013/14	2014/15	2015/16	16/17Q1	16/17Q2	16/17Q3	16/17Q4
Dundee	11586.8	11496.7	12051.5	12097.6	12188.3	12287.2	12383.6	12317.7
Coldside	13461.3	12833.7	13796.7	13819.3	14163.5	14009.2	14181.3	13997.3
East End	15362.6	14241.2	14338.1	15850.3	15850.3	15842.5	15371.9	15144.5
Lochee	13730.6	13841.7	13959.7	13896.1	13922.3	14485.5	14970.1	15061.7
Maryfield	9251.4	9994.6	9904.3	10277.5	10529.5	10403.5	10377.0	10144.9
North East	11264.8	11891.8	12321.7	11683.2	11969.5	12489.9	12533.2	12533.2
Strathmartine	12323.6	11837.0	12833.3	13156.1	13070.6	12899.6	13037.7	13149.6
The Ferry	10873.1	10806.7	11824.4	11143.5	10908.2	10992.7	11053.0	10932.3
West End	7631.8	7774.0	8354.0	8093.5	8253.9	8430.9	8663.3	8685.4

Source: SMR01/SMR50/SMR04 Datasets (management information)

The rate for Dundee has generally been increasing from 11,500 per 100,000 in 2012/13 to 12,300 per 100,000 in 2016/17 Q4. All LCPPs since 2012/13 have seen increases in their rates with the East End experiencing the highest rates in every financial year. West End had the lowest rate at 8,685 emergency admissions per 100,000 people in 16/17 Q4. The West End, the Ferry and Maryfield had the lowest rates in Dundee (the West End rate was almost 50% less than the East End rate).

There was also high variation within each of these localities. For example Pentland/Ancrum is a neighbourhood in West End which has an emergency admission rate of 15,640 per 100,000 people which is higher than all but one neighbourhood in East End. Linlathen is the neighbourhood in East End which has a higher rate than Pentland/Ancrum at 18,040 admissions per 100,000 people. This demonstrates the high levels of variation which exist within both localities.

A further analysis of both Pentland/Ancrum (West End) and Linlathen (East End) neighbourhoods had similar conclusions. A high number of admissions were regarding people of adult (18-64) age, however there was also a relatively high number of admissions from the older population (aged 65+). Mental ill-health was not a prominent reason for emergency admissions across both age ranges.

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

- The Care home Liaison team, which consists of a team of 4 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 two 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 four cluster areas. A locality nurse role has been established in each locality to coordinate assessments and reviews and support anticipatory care planning and carer assessments. This has directly reduced length of hospital stay and emergency admissions through the initial test site, reduced waiting times for comprehensive geriatric assessments and a falls assessment, increased diagnostics through day hospital sessions. The work has supported Medicine for the Elderly Consultant Teams linked to GP practices. Learning from ECS for older people will be applied to under 65s with complex needs.

- Introduced medication reviews and employed a pharmacy technician as part of the social care enablement teams.

Middle Tier - Rehabilitation

- 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"

- 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.

- Evaluation of Keep Well 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. There are also improved links and referrals from TSMS to consider wider health issues.

- Dundee Healthy Living Initiatives (DHLI) 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 addition the DHLI supports local groups to become formally constituted and gain independent funding for activities.

<u>Lowest Tier – Prevention</u>

- 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.

- 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 wellbeing. 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."

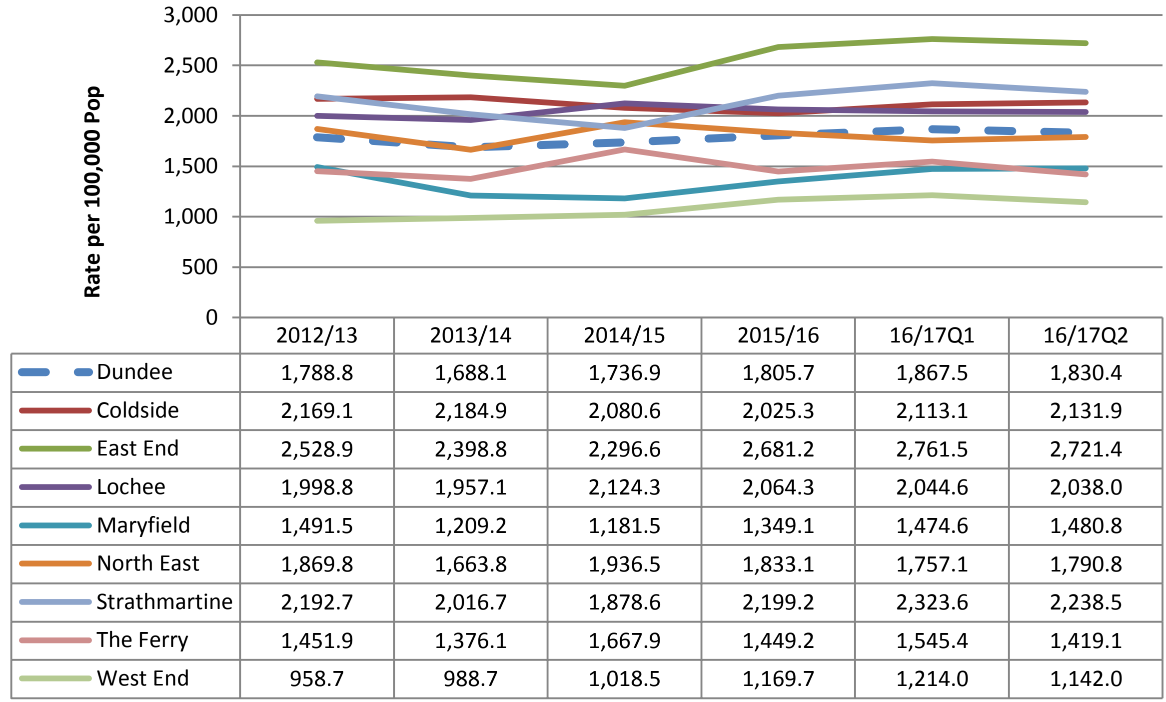
  The approach is evidence based, and makes use of a National Training Program funded by Scottish Government.

What we plan to do:

- Redesign Stroke patient services.
- Redesign the Tayside Neurological Rehabilitation services.
- Lead a review, with partners, of the current Learning Disability acute liaison service and develop future model.
- Increase our investment in intermediate forms of care such as step up/down accommodation and support for all adults.
- Develop further work to support reducing health inequalities and prevention, including developing social prescribing models to support individuals around improving their health and wellbeing.
- We are developing a Dundee Enhanced Community Support – Acute service which will work with people with acute illness in their own home.
- Continue to develop a polypharmacy service to reduce harm at home.
- Develop good practice in anticipatory care planning.

Management Information at Locality Level for 2016/17 Q2 (Q3 and Q4 data not currently available)

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



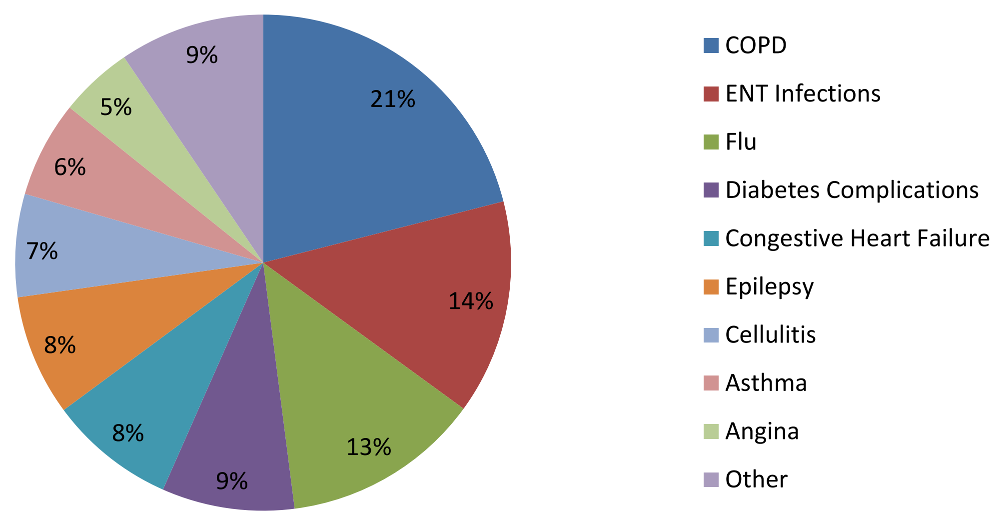
	2012/13	2013/14	2014/15	2015/16	16/17Q1	16/17Q2
Dundee	1,788.8	1,688.1	1,736.9	1,805.7	1,867.5	1,830.4
Coldside	2,169.1	2,184.9	2,080.6	2,025.3	2,113.1	2,131.9
East End	2,528.9	2,398.8	2,296.6	2,681.2	2,761.5	2,721.4
Lochee	1,998.8	1,957.1	2,124.3	2,064.3	2,044.6	2,038.0
Maryfield	1,491.5	1,209.2	1,181.5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

Source: SMR01 Dataset (management information)

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

Management Information at Locality Level for 2016/17 Q2

Chart 6: Percentage of Total PPAs by Diagnoses in 2016/17 Q2



Source: SMR01 Dataset (management information)

One in five potentially preventable admissions (PPAs) in 2016/17 Q2 were COPD related. Almost half of the PPAs were made up of only 3 conditions; COPD, ENT Infections (Ear, Nose and Throat infections) and Flu.

- We have 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 create capacity to support more complex patients, including those who have frequent readmissions.

- We are developing a Dundee Enhanced Community Support – Acute service which will work with people with acute illness in their own home.

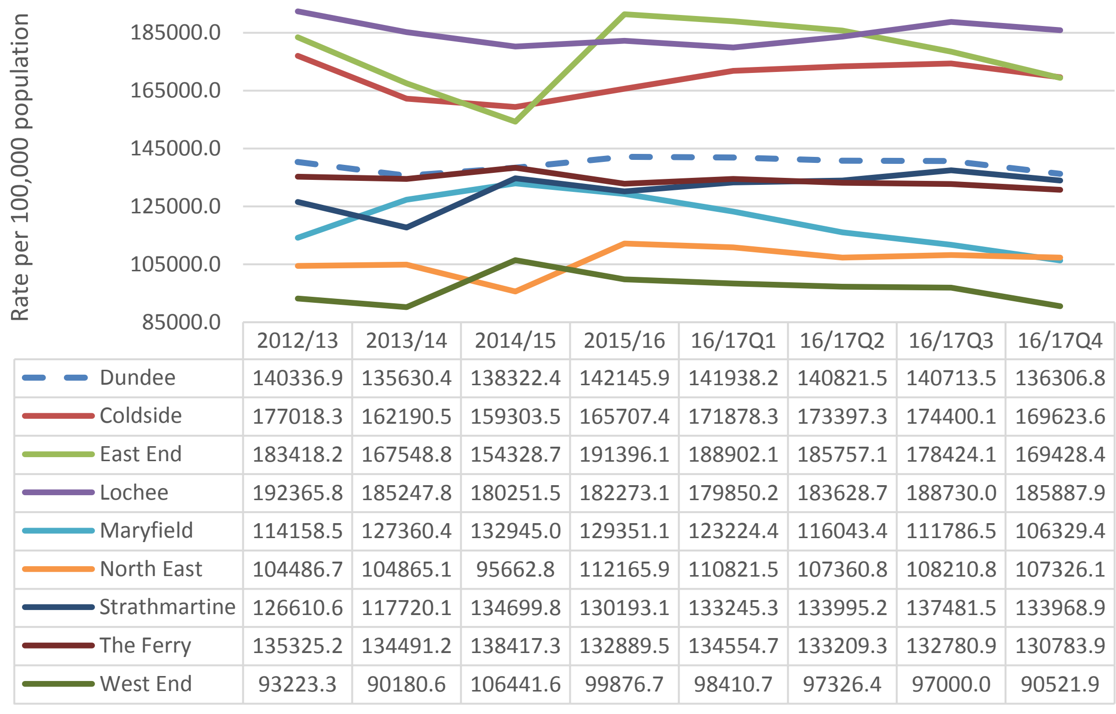
Chart 7: Rate of Emergency Bed Days for Adults (Latest National Position as at 2016/17)

Source: ISD Scotland

Dundee currently has the 7th highest emergency bed day rates in Scotland with a rate of 136,000 per 100,000 population.

Management Information at Locality Level for 2016/17 Q4

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



	2012/13	2013/14	2014/15	2015/16	16/17Q1	16/17Q2	16/17Q3	16/17Q4
Dundee	140336.9	135630.4	138322.4	142145.9	141938.2	140821.5	140713.5	136306.8
Coldside	177018.3	162190.5	159303.5	165707.4	171878.3	173397.3	174400.1	169623.6
East End	183418.2	167548.8	154328.7	191396.1	188902.1	185757.1	178424.1	169428.4
Lochee	192365.8	185247.8	180251.5	182273.1	179850.2	183628.7	188730.0	185887.9
Maryfield	114158.5	127360.4	132945.0	129351.1	123224.4	116043.4	111786.5	106329.4
North East	104486.7	104865.1	95662.8	112165.9	110821.5	107360.8	108210.8	107326.1
Strathmartine	126610.6	117720.1	134699.8	130193.1	133245.3	133995.2	137481.5	133968.9
The Ferry	135325.2	134491.2	138417.3	132889.5	134554.7	133209.3	132780.9	130783.9
West End	93223.3	90180.6	106441.6	99876.7	98410.7	97326.4	97000.0	90521.9

Source: SMR01/SMR50/SMR04 Datasets (management information)

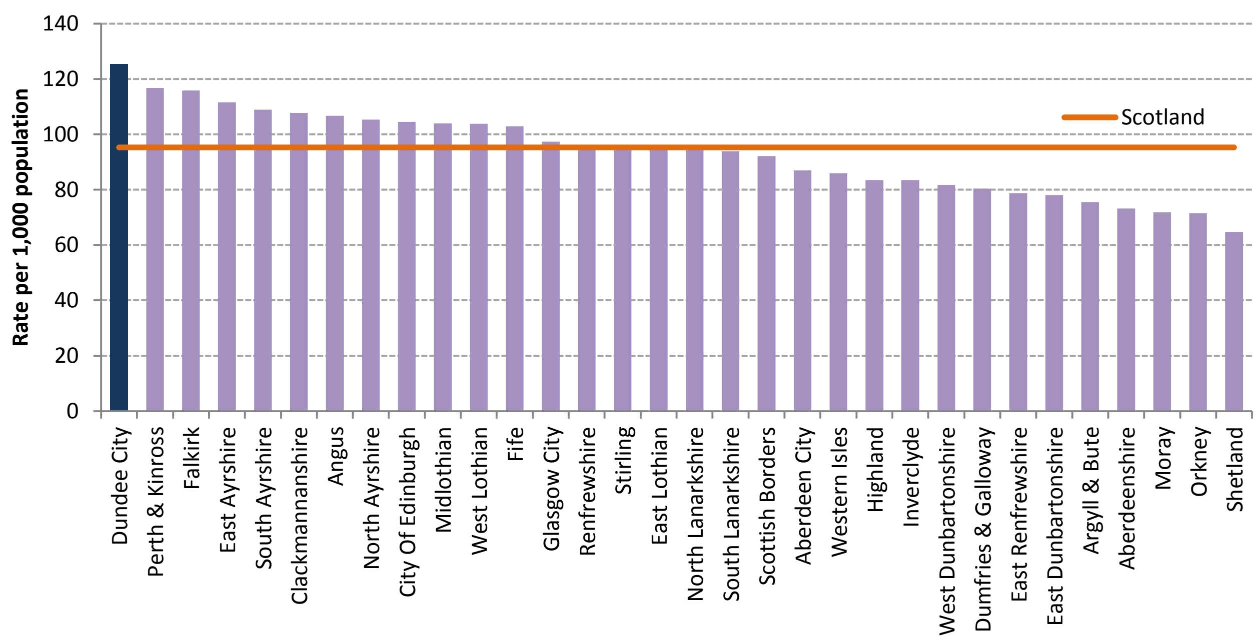
The rate for Dundee has been slightly decreasing from 140,000 per 100,000 in 2012/13 to 136,000 per 100,000 in 2016/17 Q4. Lochee has the highest bed day rate and the West End has the lowest bed day rate in Dundee. All localities have seen a decrease in the last quarter.

There is also high variation within each of these localities. For example Ninewells is a neighbourhood in West End which has an emergency bed day rate of 140,301 per 100,000 people. This is higher than many neighbourhoods in Lochee, including Gowrie Park, Lochee and Dryburgh. The variation within Lochee is particularly extreme. While there are some neighbourhoods with emergency bed day rates which are relatively low, there are neighbourhoods with extremely high rates. Beechwood has an emergency bed day rate of 832,541 bed days per 100,000 people. This is over 4 times the average rate for Lochee. The bed day rate in Beechwood has reduced over the years, however it still remains the neighbourhood with the highest rate in Dundee. This also highlights the high levels of variation within localities

A further analysis of the Beechwood bed day rate explained that a large proportion of these were regarding mental ill health of the older (65+) population.

We intend to pilot Enhanced Community Support in Lochee.

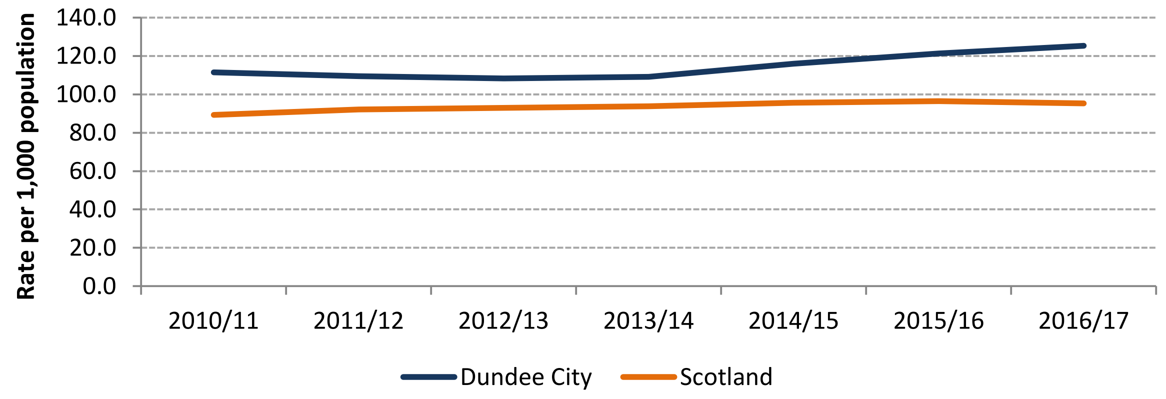
Chart 9: Readmissions to Hospital within 28 Days of Discharge (Latest National Position as at 2016/17)



Source: ISD Scotland

Dundee currently has the highest readmission rates within 28 days in Scotland with a rate of 125 per 1,000 admissions.

Chart 10: Number of Readmissions Within 28 Days for People of All Ages as a Rate per 1,000 Population



Source: ISD Scotland

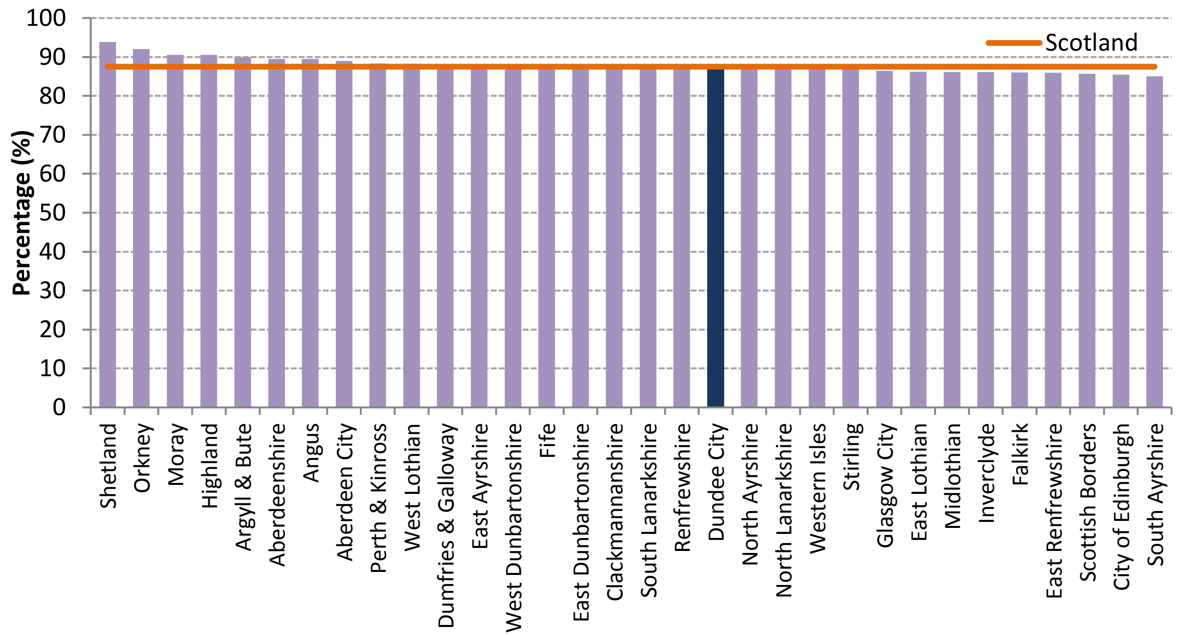
Dundee has the highest readmission within 28 day rates in Scotland (Perth and Angus are also high in the rankings). Dundee has consistently had higher readmission rates than Scotland since 2010/11 and although there was a decrease between 2010/11 and 2013/14, the rates have been increasing since 2013/14 up to 2016/17.

What we have achieved to date:
This issue has been identified as a priority by the Tayside Unscheduled Care Board. Analysis has commenced, however due to staffing resources this has been delayed. 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.

Chart 11: Proportion of last 6 months of life spent at home or in a community setting (Latest National Position as at 2016/17)



Source: ISD Scotland

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

What we have achieved to date:

- *Macmillan Cancer Support* has teamed up with partners in Dundee to form the Macmillan and Local Authority Partnership. The Partnership included Dundee City Council, Dundee Health and Social Care Partnership and Leisure and Culture Dundee working together with MacMillan to support local people who are affected by cancer. The Partnership works with local communities to try and counteract some of the ways that having a cancer diagnosis affects people's lives. We held a large stakeholder event in January to kick off the process.

- 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.

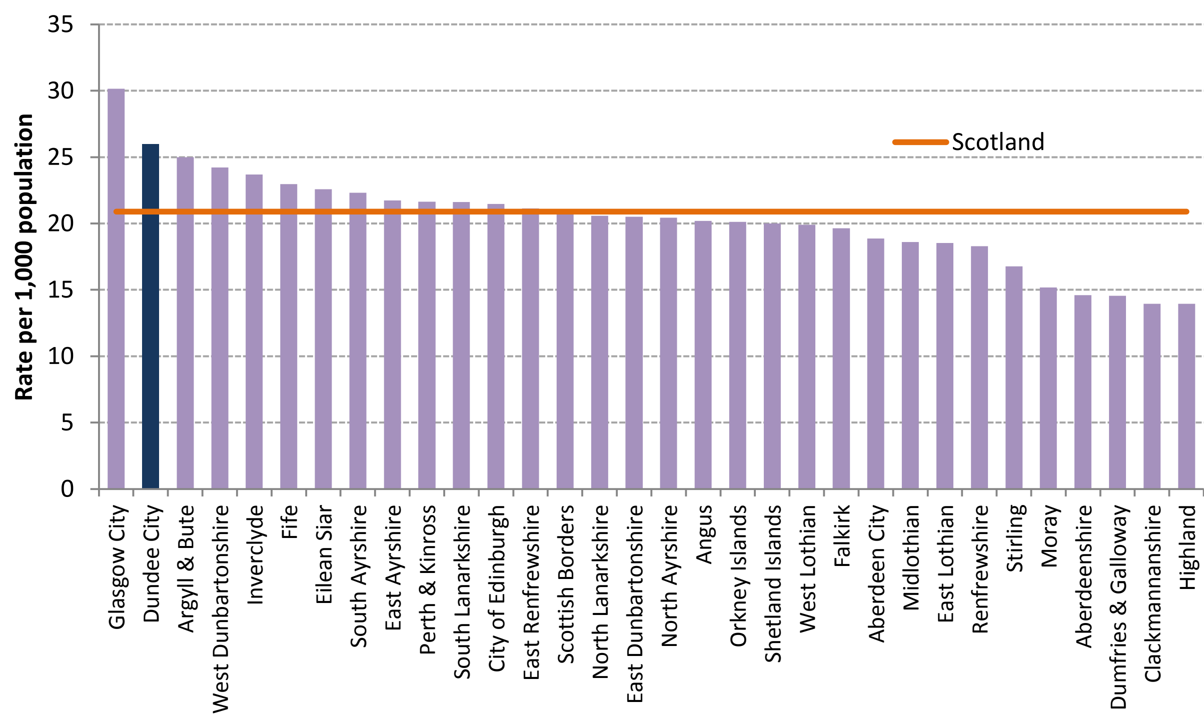
- Work is underway to improve anticipatory care planning and we have adopted the NES tool.

- The support by the District Nurse service in Dundee allows a group of people to be cared for in their own homes.

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.
- We will become the 6th site for palliative and end of life quality improvement for people with dementia who live in care homes.

Chart 12: Falls rate per 1,000 population in over 65s (Latest National Position as at 2016/17)



Source: ISD Scotland

Dundee was the second poorest performing partnership in Scotland with a falls rate of 26 per 1,000 population aged 65+.

***Management Information** at Locality Level for 2016/17 Q4*

Chart 13: Rate per 1,000 Population of Fall Admissions for People aged 65+

	2015/16	16/17Q1	16/17Q2	16/17Q3	16/17Q4
Dundee	24.9	24.6	24.5	25.5	26.0
Coldside	29.9	30.9	28.4	30.1	28.9
East End	27.4	28.3	28.6	26.6	29.3
Lochee	26.6	27.6	25.4	28.1	28.7
Maryfield	23.2	21.4	22.2	24.4	24.8
North East	20.5	20.0	23.7	23.2	25.1
Strathmartine	25.2	26.5	26.5	23.1	23.6
The Ferry	20.3	17.3	17.2	19.8	19.6
West End	27.6	26.7	27.9	32.3	32.3

Source: SMR01 Dataset (management information)

West End had the highest rate of falls in Dundee with 32 per 1,000 population. The North East had the lowest rates in 2012/13 but they have seen a sharp rise in falls in 2014/15 and again in 2016/17 Q4 to 25 per 1,000 population. The Ferry has seen a continual decrease in their falls rate and now have the lowest rates with 19 per 1,000 population. The West End, has one of the highest falls rates in Dundee with 32 per 1,000 population as at 2016/17 Q4.

There was a high variation in falls rates within West End in 16/17 Q4. The neighbourhood with the highest rate of falls is Logie / Blackness (29 emergency admissions which equates to 38 emergency admissions per 1,000 population) followed by West End Residential (36 emergency admissions which equates to 36 emergency admissions per 1,000 population). There were also neighbourhoods in West End where there were low numbers and rates of emergency admissions due to a fall. In Q4 16/17 there was only 1 emergency admission from Pentland/Ancrum (4 per 1000 population) and 7 (19 per 1000 population) rom Perth Road/Nethergate.

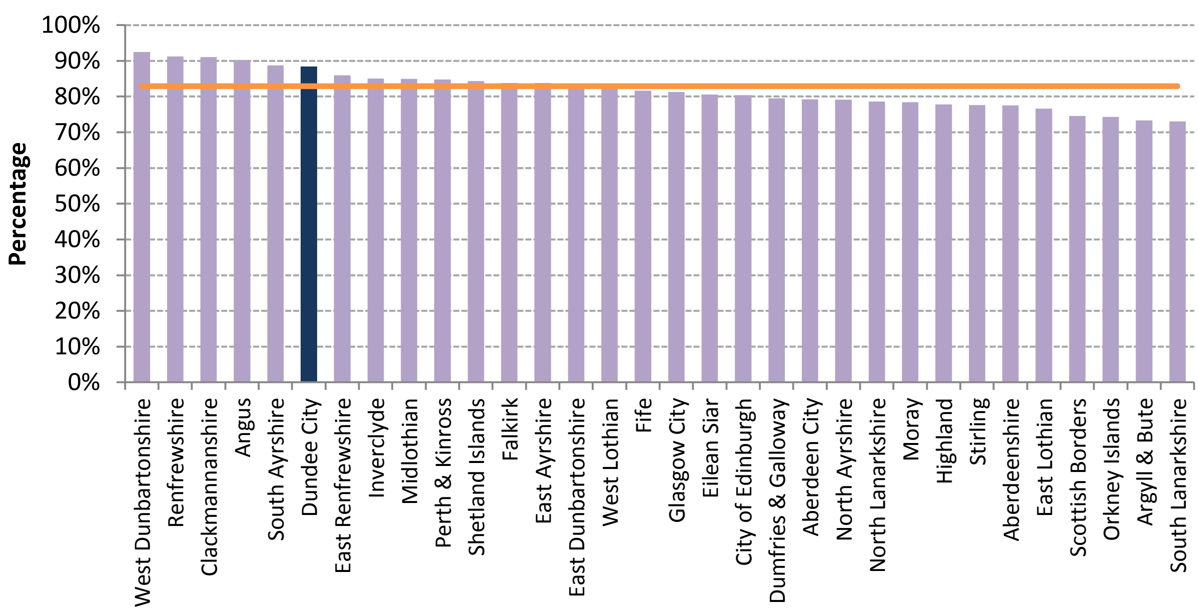
<u>What we have achieved to date:</u>

- 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.
- Otago falls classes now well established in community venues showing clear improvements in clinical outcomes. Introduced self-referrals to CRT to improve access.
- Dundee and Angus Health and Social Care Partnerships launched a new shared community equipment loan service for people with disabilities living in the areas. 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.

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.

Chart 14: Proportion of care and care services rated good or better in care inspectorate inspections (Latest National Position as at 2015/16, 16/17 not yet available)



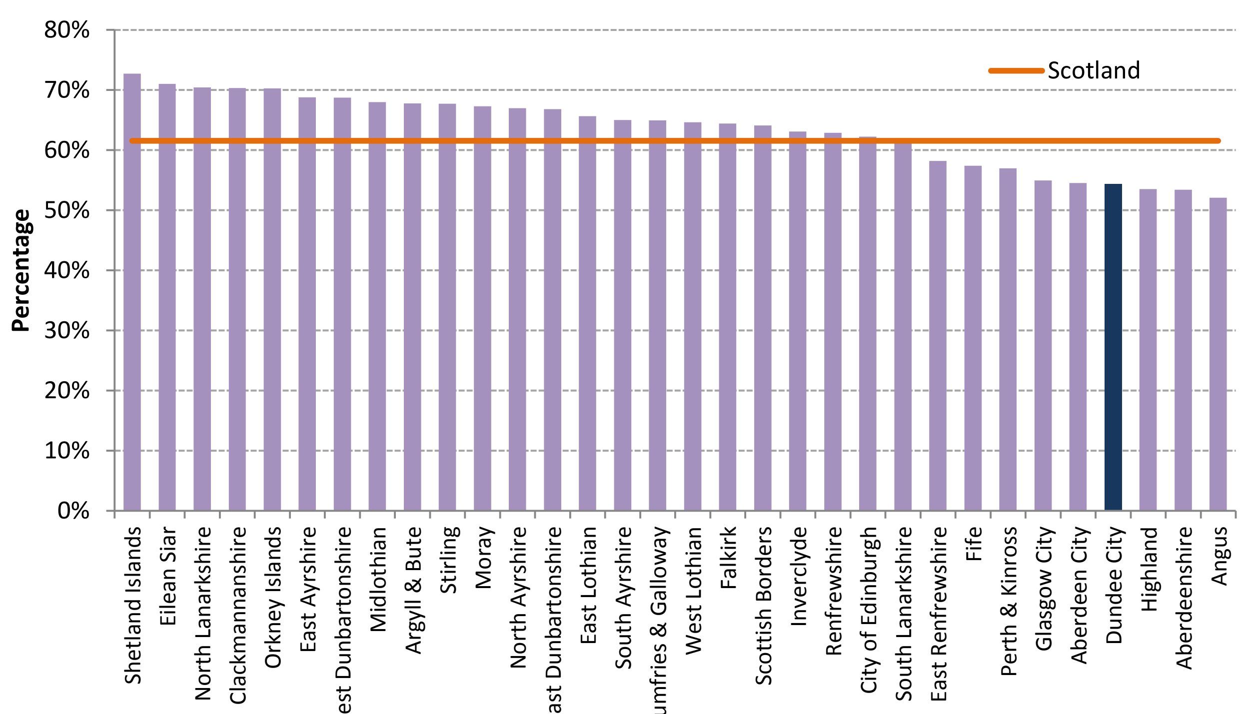
Source: ISD Scotland

Dundee had the 6th highest proportion of care services rated as good or better in Scotland (88%).

What we have achieved to date:

- There are various fora including the care home providers forum and care at home providers forum. We have developed a number of teams that support care homes including the peripatetic team, the older people's review team. We have an advanced nurse practitioner working with care homes. We hold regular improvement events and we developed the early indicators of concern procedures.
- We will integrate the teams supporting care homes into an integrated service. We are developing the early indicators of concern procedures for care at home providers.

Chart 15: Percentage of adults with intensive needs receiving care at home (Latest National Position as at 2015/16, 2016/17 not yet available)



Source: ISD Scotland

Dundee was the 4th poorest performing partnership in Scotland with only 54% of adults with intensive needs receiving personal care at home.

Although in comparison with other partnerships, performance in Dundee is poor, there has been improvement since 2014/15 when Dundee was 2nd poorest and had a performance of 50%.

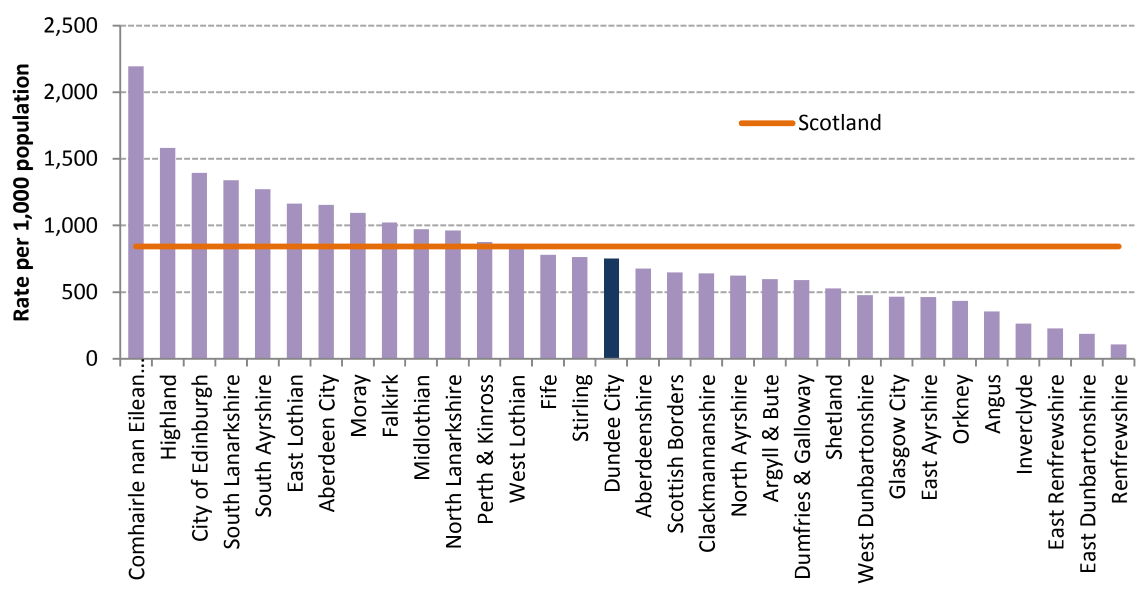
What we have achieved to date:

- Invested in resources which support assessment for 24 hour care taking place at home or home like settings.
- 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.
- Closed 2 wards in RVH due to a reduction in demand.
- Reduced the number of continuing care patients in RVH to 0.
- Increased Housing With Care – an additional 20 units.

What we plan to do:

- Continue to develop step down options.
- Continue to develop Housing With Care
- Close a further ward in RVH, in order to reinvest resources in the community.

Chart 16: Number of days people aged 75+ spend in hospital when they are ready to be discharged (Latest National Position as at 2016/17)

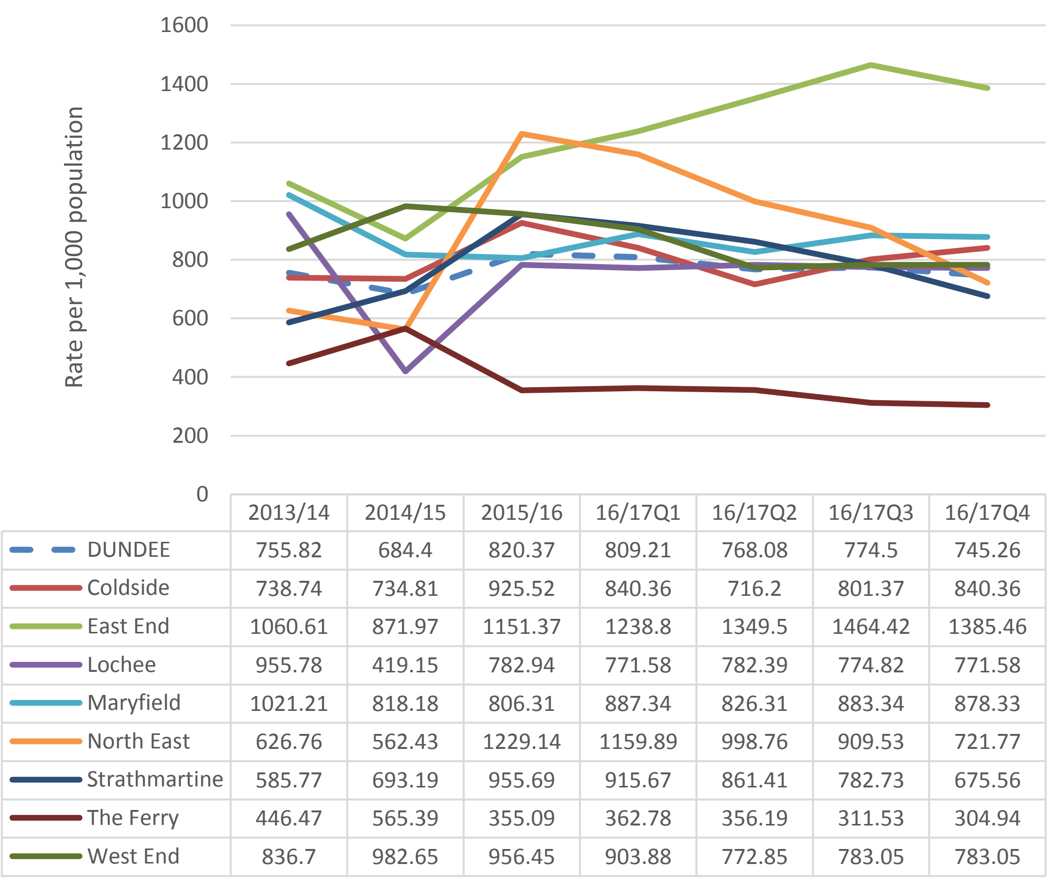


Source: ISD Scotland

Dundee is currently performing better than the Scottish average of bed days lost to delayed discharges for 75+ with a rate of 755 per 1,000 population. This is an improvement from 2015/16 when the rate was 832 per 1,000 population.

Management Information at Locality Level for 2016/17 Q4

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



	2013/14	2014/15	2015/16	16/17Q1	16/17Q2	16/17Q3	16/17Q4
DUNDEE	755.82	684.4	820.37	809.21	768.08	774.5	745.26
Coldside	738.74	734.81	925.52	840.36	716.2	801.37	840.36
East End	1060.61	871.97	1151.37	1238.8	1349.5	1464.42	1385.46
Lochee	955.78	419.15	782.94	771.58	782.39	774.82	771.58
Maryfield	1021.21	818.18	806.31	887.34	826.31	883.34	878.33
North East	626.76	562.43	1229.14	1159.89	998.76	909.53	721.77
Strathmartine	585.77	693.19	955.69	915.67	861.41	782.73	675.56
The Ferry	446.47	565.39	355.09	362.78	356.19	311.53	304.94
West End	836.7	982.65	956.45	903.88	772.85	783.05	783.05

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

The East End has consistently been one of the poorest performing LCPP areas for this indicator although the Q4 figure shows an improvement since Q3. Coldside is the only LCPP where performance worsened between Q3 and Q4. The North East saw a big increase from 562 per 1,000 population in 2014/15 to 1,229 per 1,000 population in 2015/16, however performance has improved and is following a downward trajectory towards what performance looked like in 2014/15. As at 16/17 Q4, the Ferry had the lowest rates in Dundee with 305 per 1,000 population; the East End rates are approximately 4 times higher than the Ferry's.

What we have achieved to date:

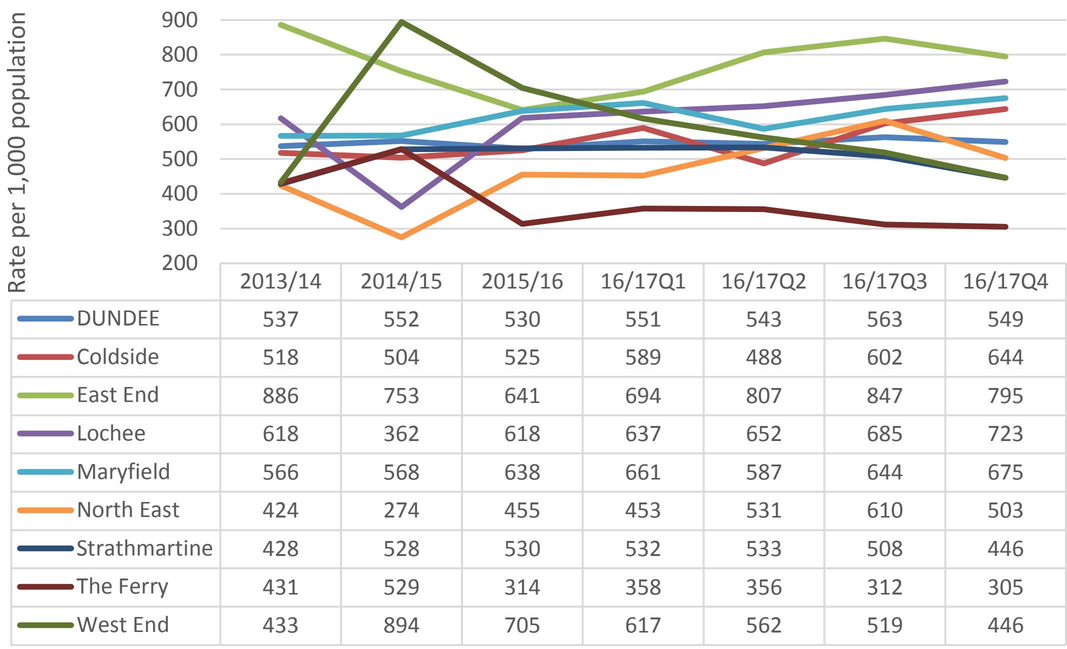
- There are currently 2 step down housing options which are working very well. An example of this is a 'Smart Flat' which uses a range of Technology Enabled Care to support people who are waiting for housing adaptations of a new home and who are delayed in hospital. A third step down housing option will 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.

***Management Information** at Locality Level for 2016/17 Q4*

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



	2013/14	2014/15	2015/16	16/17Q1	16/17Q2	16/17Q3	16/17Q4
DUNDEE	537	552	530	551	543	563	549
Coldside	518	504	525	589	488	602	644
East End	886	753	641	694	807	847	795
Lochee	618	362	618	637	652	685	723
Maryfield	566	568	638	661	587	644	675
North East	424	274	455	453	531	610	503
Strathmartine	428	528	530	532	533	508	446
The Ferry	431	529	314	358	356	312	305
West End	433	894	705	617	562	519	446

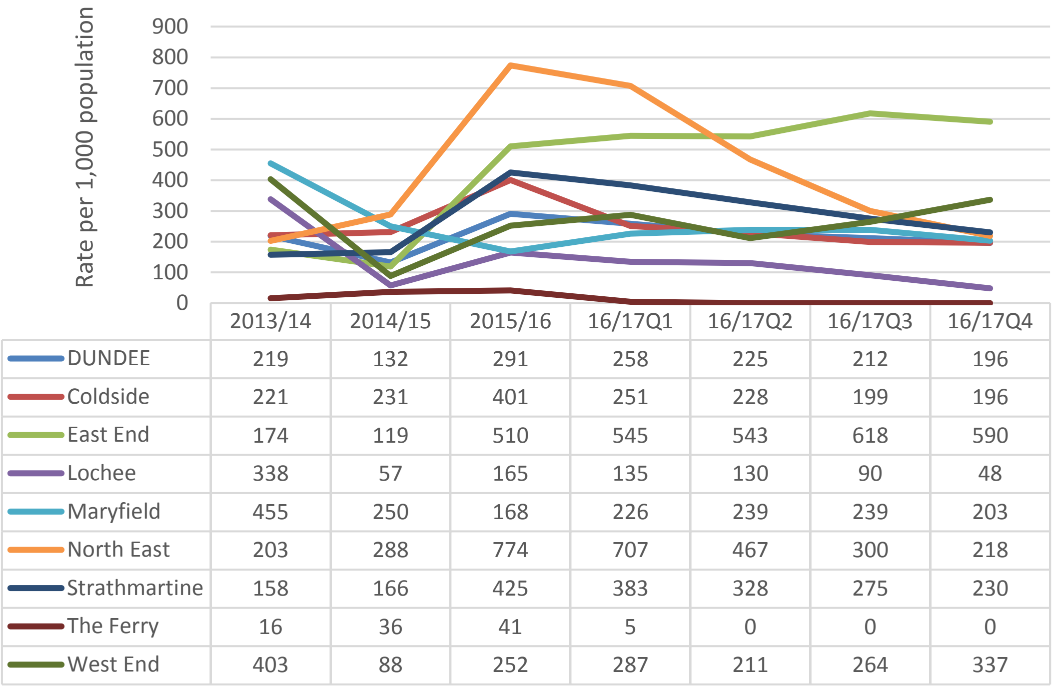
Source: Edison (excludes codes 100, 42T, ESDS and ICF)

As at 16/17 Q4, the East End had the highest rate of bed days lost to standard delayed discharges for people aged 75+ with 795 per 1,000 population. Lochee is the second worst performing LCPP area with 723 per 1,000 population as at 16/17 Q4. The Q2 report highlighted the higher than average performance in West End, however this has improved and is now the second lowest in Dundee.

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.

***Management Information** at Locality Level for 2016/17 Q4*

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



	2013/14	2014/15	2015/16	16/17Q1	16/17Q2	16/17Q3	16/17Q4
DUNDEE	219	132	291	258	225	212	196
Coldside	221	231	401	251	228	199	196
East End	174	119	510	545	543	618	590
Lochee	338	57	165	135	130	90	48
Maryfield	455	250	168	226	239	239	203
North East	203	288	774	707	467	300	218
Strathmartine	158	166	425	383	328	275	230
The Ferry	16	36	41	5	0	0	0
West End	403	88	252	287	211	264	337

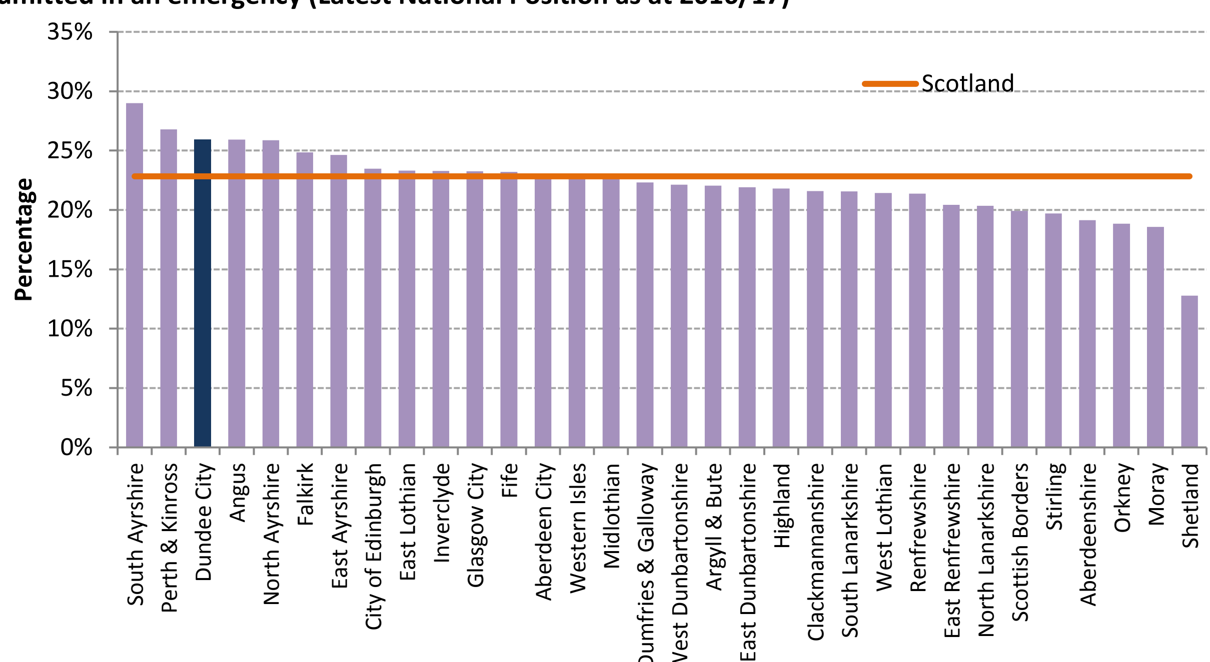
Source: Edison (excludes codes 100, 42T, ESDS and ICF)

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

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

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

Chart 20: Percentage of total health and care spend on hospital stays where the patient was admitted in an emergency (Latest National Position as at 2016/17)



Source: ISD Scotland

In 2016/17 26% of Dundee's health and care budget was spent on hospital stays. This puts Dundee as the 3rd highest spenders (up from 4th on 205/16) on hospital stays as a proportion of their budget with Perth & Kinross and Angus also spending above the Scottish average.

What we have achieved to date:

- Closed 2 wards at RVH
- Reduced the bed base in Kingsway Care centre down to 49.
- Develop joint Psychiatry of Old Age and Medicine for the Elderly services across Dundee and Angus.
- Further develop the Enhanced Community Support model.