Clerk and Standards Officer:
Roger Mennie
Head of Democratic and Legal Services
Dundee City Council

City Chambers
DUNDEE
DD1 3BY

16th May, 2023

TO: ALL MEMBERS, ELECTED MEMBERS AND OFFICER REPRESENTATIVES OF THE PERFORMANCE AND AUDIT COMMITTEE OF DUNDEE CITY HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD
(See Distribution List attached)

Dear Colleague

PERFORMANCE AND AUDIT COMMITTEE

I would like to invite you to attend a meeting of the above Committee which is to be held remotely on Wednesday, 24th May, 2023 at 10.00am.

Members of the Press or Public wishing to join the meeting should contact Committee Services on telephone (01382) 434818 or by email at committee.services@dundeecity.gov.uk by no later than 12 noon on Monday 22nd May, 2023.

Apologies for absence should be intimated to Arlene Hay, Committee Services Officer, on telephone 01382 434818 or by e-mail arlene.hay@dundeecity.gov.uk.

Yours faithfully

VICKY IRONS

Chief Officer

A G E N D A

1 APOLOGIES FOR ABSENCE

2 DECLARATION OF INTEREST

Members are reminded that, in terms of the Integration Joint Board's Code of Conduct, it is their responsibility to make decisions about whether to declare an interest in any item on this Agenda and whether to take part in any discussions or voting.

3 MINUTE OF PREVIOUS MEETING AND ACTION TRACKER

(a) MINUTE **- Page 1**

The minute of previous meeting of the Committee held on 1st February, 2023 is attached for approval.

(b) ACTION TRACKER **- Page 5**

The Action Tracker (PAC14-2023) for meetings of the Performance and Audit Committee is attached for noting and updating accordingly.

4 ANALYTICAL REVIEW OF EMERGENCY READMISSION RATES – UPDATE – (PAC16-2023)

Unscheduled hospital care is one of the biggest demands on Partnership resources. Whilst significant improvements have been made in some aspects of unscheduled care, performance in relation to repeat emergency admissions remains an area requiring further understanding and improvement. The Performance and Audit Committee has received a series of in-depth analytical reports for unscheduled care, including readmissions (Article VIII of the minute of the Dundee PAC on 29th May 2018, Article IV of the minute of the Dundee PAC on 25th March 2019 and Article XIV of the minute of the Dundee PAC on 22nd September 2020 refer). At the end of 2021 further analytical work was being planned (Article VII of the minute of the Dundee PAC on 24th November 2021 refers), however this was suspended as local data for readmissions was not available from Q1 2021/22 as NHS Tayside Business Unit (NHST BSU) were undertaking investigation and improvement of coding and recording to ensure greater parity when benchmarking performance across Partnerships (Article XI of the minute of the Dundee PAC on 20th July 2022 refers).

Following completion of the work by NHST BSU reporting of readmissions data has recommenced as at Q3 2022/23 (please see report PACX-2023).

Since February 2023 a short-life working group has been meeting to consider readmissions data. This group includes NHST BSU, NHST Public Health Directorate, Public Health Scotland LIST and both data and intelligence and operational staff from the Dundee Health and Social Care Partnership. To date the work of the group has focused on developing a robust understanding of local readmissions data and ensuring that local calculation of the readmissions indicator is consistent with the technical definition of the national readmissions indicator. The group has now reached the stage of having as high a level of confidence as is proportionate, given limited analytical resources, in the local data and local calculation methodology. This provides the foundation for moving forward with further work in two areas: data definitions and quality and, analysis to inform improvement.

In relation to data definitions and quality, the immediate focus is on addressing remaining recording and coding issues that have been identified through the process already undertaken by the working group. The group has also opened up channels of communication with Public Health Scotland regarding the technical definition of the national readmissions indicator and are advocating for changes to the methodology to align this with modern pathways of care.

Work to develop a robust understanding of local readmissions data and indicator calculation has also helped the working group to identify specific areas for further analysis, with a view to this informing future improvement activity:

- Further analysis of data by Scottish Index of Multiple Deprivation (SIMD), gender and age;
- Analysis of the readmission ratio, which is the number of readmissions observed over the expected readmissions;
- Further analysis of short stay admissions and readmissions (0 days and 1-3 days);
- Analysis of readmissions activity based on admission routes, including admissions made by GPs;
- Analysis of admissions and readmissions by diagnosis, with a focus on instances where initial admissions and subsequent readmissions are for the same diagnosis;

- Analysis of instances where there have been a significant number of multiple readmissions;
- Confirmation of specialities with highest readmission rates and further analysis of data for each of these specialities; and,
- Working with operational colleagues to contextualise readmissions activity as part of the pathway of unscheduled care and articulate the impact of wider improvement activity on a broader suite of indicators that provide a more holistic overview of unscheduled care performance and quality.

The working group anticipate submitting a full analytical report to the Performance and Audit Committee on 27th September 2023.

The Performance and Audit Committee is asked to note the updated position.

5 DUNDEE HEALTH AND SOCIAL CARE PARTNERSHIP PERFORMANCE REPORT – 2022/2023 QUARTER 3 - Page 11

(Report No PAC17-2023 by the Chief Finance Officer, copy attached).

6 MENTAL HEALTH PERFORMANCE - Page 35

(Report No PAC20-2023 by the Chief Finance Officer, copy attached).

7 DUNDEE HEALTH & SOCIAL CARE PARTNERSHIP CLINICAL, CARE & PROFESSIONAL GOVERNANCE ASSURANCE REPORT - Page 65

(Report No PAC15-2023 by the Clinical Director, copy attached).

8 QUARTERLY COMPLAINTS PERFORMANCE – 4TH QUARTER 2022/23 - Page 87

(Report No PAC18-2023 by the Chief Finance Officer, copy attached).

9 DUNDEE HEALTH AND SOCIAL CARE PARTNERSHIP STRATEGIC RISK REGISTER UPDATE - Page 97

(Report No PAC19-2023 by the Chief Finance Officer, copy attached).

10 DUNDEE INTEGRATION JOINT BOARD INTERNAL AUDIT REPORT – GOVERNANCE ACTION PLAN - Page 107

(Report No PAC10-2023 by the Chief Finance Officer, copy attached).

11 GOVERNANCE ACTION PLAN PROGRESS REPORT - Page 119

(Report No PAC12-2023 by the Chief Finance Officer, copy attached).

12 DUNDEE INTEGRATION JOINT BOARD INTERNAL AUDIT PLAN PROGRESS REPORT - Page 127

(Report No PAC13-2023 by the Chief Finance Officer, copy attached).

13 ATTENDANCE LIST - Page 135

(A copy of the Attendance Return (PAC21-2023) for meetings of the Performance and Audit Committee held over 2023 is attached for information and record purposes).

14 DATE OF NEXT MEETING

The next meeting of the Committee will be held remotely on Wednesday 27th September, 2023 at 10.00am.

PERFORMANCE AND AUDIT COMMITTEE
CONTACT LIST

(a) CONTACTS – PERFORMANCE AND AUDIT COMMITTEE

(* - DENOTES VOTING MEMBER)

Role	Recipient
Elected Member (Chair)	Councillor Ken Lynn *
Elected Member	Councillor Dorothy McHugh *
NHS Non Executive Member	Anne Buchanan *
NHS Non Executive Member	Sam Riddell *
Chief Officer	Vicky Irons
Chief Finance Officer	Dave Berry
Registered medical practitioner employed by the Health Board and not providing primary medical services	James Cotton
Chief Social Work Officer	Diane McCulloch
Chief Internal Auditor	Tony Gaskin
Staff Partnership Representative	Raymond Marshall
Person providing unpaid care in the area of the local authority	Martyn Sloan

(b) DISTRIBUTION – FOR INFORMATION ONLY

Organisation	Recipient
Dundee City Council (Chief Executive)	Greg Colgan
Elected Member – Proxy	Councillor Lynne Short
Elected Member – Proxy	Councillor Roisin Smith
Elected Member – Proxy	Bailie Helen Wright
Dundee City Council (Executive Director of Corporate Services)	Robert Emmott
Dundee City Council (Head of Democratic and Legal Services)	Roger Mennie
NHS Tayside (Chief Executive)	Grant Archibald
NHS Non Executive Member – Proxy	Donald Macpherson
NHS Non Executive Member – Proxy	Jenny Alexander
NHS Tayside (Director of Finance)	Stuart Lyall
Dundee City Council (Members' Support)	Jayne McConnachie
Dundee City Council (Members' Support)	Dawn Clarke
Dundee City Council (Members' Support)	Elaine Holmes
Dundee City Council (Members' Support)	Sharron Wright
Dundee City Council (Communications rep)	Steven Bell
Dundee Health and Social Care Partnership	Kathryn Sharp
NHS Tayside (Communications rep)	Jane Duncan
NHS Tayside (Communications rep)	Anna Michie
NHS Fife (Internal Audit) (Principal Auditor)	Judith Triebs
NHS (PA to Tony Gaskin)	Carolyn Martin
Audit Scotland (Audit Manager)	Richard Smith
Dundee Health and Social Care Partnership	Christine Jones
Dundee City Council (Communications rep)	Katie Alexander
Dundee City Council (Communications rep)	Mike Boyle
Dundee City Council (Communications rep)	Lewis Thomson
Dundee Health and Social Care Partnership	Jenny Hill

UPDATED: 25th January 2023

Organisation	Recipient
Dundee Health and Social Care Partnership	Lynsey Webster
Dundee City Council (Legal Manager)	Kenny McKaig
Dundee City Council (Legal rep)	Maureen Moran
Dundee Health and Social Care Partnership	Matthew Kendall
Audit Scotland	Mary O'Connor

ITEM No …3(a)……..

Dundee Health & Social Care Partnership

At a MEETING of the **PERFORMANCE AND AUDIT COMMITTEE OF THE DUNDEE CITY HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** held remotely on 1st February, 2023.

Present:-

Members	Role
Ken LYNN (Chairperson)	Nominated by Dundee City Council (Elected Member)
Dorothy MCHUGH	Nominated by Dundee City Council (Elected Member)
Anne BUCHANAN	Nominated by Health Board (Non Executive Member)
Sam RIDDELL	Nominated by Health Board (Non Executive Member)
Dave BERRY	Chief Finance Officer
Tony GASKIN	Chief Internal Auditor
Vicky IRONS	Chief Officer
Martyn SLOAN	Person providing unpaid care in the area of the local authority

Non-members in attendance at the request of the Chief Finance Officer:-

Linda GRAHAM	Health and Social Care Partnership
Jenny HILL	Health and Social Care Partnership
Christine JONES	Health and Social Care Partnership
Matthew KENDALL	Health and Social Care Partnership
Shona HYMAN	Health and Social Care Partnership
Clare LEWIS-ROBERTSON	Health and Social Care Partnership
Mary O'CONNOR	Audit Scotland
Kathryn SHARP	Health and Social Care Partnership
David SHAW	Heath and Social Care Partnership
Richard SMITH	Audit Scotland
Lynsey WEBSTER	Health and Social Care Partnership

Ken LYNN, Chairperson, in the Chair.

I APOLOGIES FOR ABSENCE

There were apologies for absence submitted on behalf of:-

James Cotton	NHS Tayside
Diane McCulloch	Health and Social Care Partnership
Raymond Marshall	NHS Tayside

II DECLARATION OF INTEREST

There were no declarations of interest.

III MINUTE OF PREVIOUS MEETING AND ACTION TRACKER

(a) MINUTE

The minute of meeting of the Committee held on 23rd November, 2022 was submitted and approved.

(b) ACTION TRACKER

There was submitted the Action Tracker (PAC6-2022) for meetings of the Performance and Audit Committee. Dave Berry reported that work was underway to close off some of the older actions

The Committee agreed to note the content of the Action Tracker.

IV DUNDEE HEALTH AND SOCIAL CARE PARTNERSHIP PERFORMANCE REPORT – 2022-23 QUARTER 2

There was submitted Report No PAC1-2023 by the Chief Finance Officer updating the Performance and Audit Committee on 2022-23 Quarter 2 performance against the National Health and Wellbeing Indicators and 'Measuring Performance Under Integration' indicators. For the first time, the published Social Care – Demand for Care at Home services had been summarised and included in the report.

The Committee agreed:-

(i) to note the content of the summary report;

(ii) to note the performance of Dundee Health and Social Care Partnership, at both Dundee and Local Community Planning Partnership (LCPP) levels, against the National Health and Wellbeing Indicators as summarised in Appendix 1 (tables 1, 2 and 3);

(iii) to note the performance of Dundee Health and Social Care Partnership against the 'Measuring Performance Under Integration' indicators as summarised in Appendix 1 (table 3); and

(iv) to note the number of people waiting for social care assessment and care at home package and associated hours of care yet to be provided in Appendix 2.

Following questions and answers the Committee further agreed:-

(v) that Lynsey Webster would check why there was a red line (Number of People waiting in the community for a social care assessment) on the legend on the graph on page 31 but there was no line red detailed in the content of the graph; and

(vi) to note that data about the length of time people were waiting for a care at home package would be incorporated into the Performance Report at an appropriate time.

V MENTAL HEALTH SERVICES INDICATORS

There was submitted Report No PAC2-2023 by the Chief Finance Officer seeking approval of a proposed suite of indicators summarising performance in delegated Mental Health services for scrutiny and assurance that would form the basis of future six-monthly performance reports to the Performance and Audit Committee.

The Committee agreed:-

(i) to note and approve the proposed suite of indicators outlined in section 5 and Appendix 1; and

(ii) to note the intention to further develop the proposed suite of indicators into a full 6-monthly performance report for submission to PAC on an ongoing basis, in-line with arrangements already in place for Discharge Management and under development for Drug and Alcohol Services (as outlined in section 5.4 of the report).

VI DUNDEE HEALTH AND SOCIAL CARE PARTNERSHIP CLINICAL, CARE AND PROFESSIONAL GOVERNANCE ASSURANCE REPORT

There was submitted Report No PAC4-2023 by the Clinical Director providing assurance regarding matters of Government policy directives and legal requirements. This aligned to the safe, effective and person centred quality ambitions of NHS Scotland.

The report was brought to the Committee to provide assurance on the clinical and care governance activities and arrangements across the Partnership as outlined in the Getting It Right For Everyone (GIRFE) Framework in accordance with the Partnership Integration Scheme. Clinical Governance was a statutory requirement to report, at Board level, from Scottish Government as per NHS MEL (1998) 75. The Performance and Audit Committee was asked to provide their view on the level of assurance the report provided in regard to clinical and care governance within the Partnership. The timescale for the data within the report was to November, 2022.

The Committee agreed:-

(i) to note the Exception Report for the Dundee Health & Social Care Partnership Clinical, Care & Professional Governance Group as detailed in Section 4 of the report; and

(ii) to note that the authors were recommending that the report provided reasonable assurance.

Following questions and answers the Committee further agreed:-

(iii) that Matthew Kendall would ensure that the section of the report on page 56 containing Xs would be removed; and

(iv) that Matthew would ensure that embedded documents would be included as appendices to the report in future.

VII DUNDEE HEALTH AND SOCIAL CARE PARTNERSHIP STRATEGIC RISK REGISTER UPDATE

There was submitted Report No PAC5-2023 by the Chief Finance Officer updating the Performance and Audit Committee in relation to the Strategic Risk Register and on strategic risk management activities in Dundee Health and Social Care Partnership.

The Committee agreed:-

(i) to note the content of the Strategic Risk Register Update report;

(ii) to note the extract from the Strategic Risk register attached as Appendix 1 of the report; and

(iii) to note the recent work and future work on the Pentana Risk Management System in Section 7 of the report.

VIII GOVERNANCE ACTION PLAN PROGRESS REPORT

There was submitted Report No PAC3-2023 by the Chief Finance Officer providing the Performance and Audit Committee with an update on the progress of the actions set out in the Governance Action Plan.

The Committee agreed to note the content of the report and the progress made in relation to the actions set out in the Governance Action Plan as outlined in Appendix 1 of the report.

IX DUNDEE INTEGRATION JOINT BOARD INTERNAL AUDIT PLAN PROGRESS REPORT

There was submitted Report No PAC8-2023 by the Chief Finance Officer providing the Performance and Audit Committee (PAC) with an update on the substantive completion of the previous years' internal audit plans as well as progress against the 2022/2023 plan. The report also included internal audit reports that were commissioned by the partner Audit and Risk Committees, where the outputs were considered relevant for assurance purposes to Dundee Integration Joint Board.

The Committee agreed to note the continuing delivery of the audit plans and related reviews as outlined in the report.

X INTERNAL AUDIT REPORT – SUSTAINABILITY OF PRIMARY CARE

There was submitted Report No PAC9-2023 by the Chief Finance Officer presenting the findings of the internal audit review of the Sustainability of Primary Care.

The Committee agreed:-

(i) to note the content and findings of the internal audit report which provided Limited Assurance (which was attached as Appendix 1 to the report);

(ii) to note that progress with implementation of the agreed actions would be monitored by the organisations which commissioned the review; and

(iii) to instruct the Chief Officer to provide a further report on progress made in relation to both Tayside wide and local actions by September 2023.

XI ATTENDANCE LIST

There was submitted Agenda Note PAC7-2023 providing attendance returns for meetings of the Performance and Audit Committee held over 2022.

The Committee agreed to note the position as outlined.

XII DATE OF NEXT MEETING

The Committee agreed to note that the next meeting of the Committee would be held on Wednesday, 24th May, 2023 at 10.00 am.

Ken LYNN, Chairperson.

ITEM No …3(b)……...

PAC14-2023

PERFORMANCE AND AUDIT COMMITTEE – ACTION TRACKER – 24th MAY 2023

No	Meeting	Minute Ref	Heading	Action Point	Responsibility	Timeframe	Status
1.	26/05/21	III(ii)	MINUTE OF PREVIOUS MEETING – 3RD FEBRUARY 2021	The Partnership to progress public information being placed on the website including information on Voluntary Action Exercise Group.	Chief Finance Officer	(Sept 2021) Sept 2023	In progress. Further initiatives around sharing of information on range of services / activities available continue to be developed
2.	26/05/21	V(vii)	DUNDEE HEALTH AND SOCIAL CARE PARTNERSHIP PERFORMANCE REPORT – 2020/2021 QUARTER 3 SUMMARY	Kathryn Sharp to undertake further analysis of the position in relation to the figures for the North East area to establish what learning could be achieved for the benefit of the other areas in Dundee.	Strategy and Performance Manager	(June 2022) June 2023	Completion of this analysis is not able to be prioritised within existing resources at the present time due to other competing demands associated with statutory requirements and other analytical requests from the PAC and operational services.

No	Meeting	Minute Ref	Heading	Action Point	Responsibility	Timeframe	Status
3.	26/05/21	VI (iv)	DISCHARGE MANAGEMENT PERFORMANCE UPDATE ON COMPLEX AND STANDARD DELAYS	Jenny Hill to prepare a one page outline document showing an organisational graph of the Partnership for circulation to the full Committee.	Head of Health and Community Care	(Sep 2021) May 2023	In progress – deferred until HSCP restructure confirmed. Expected by May 2023 PAC meeting
4.	26/05/21	VIII(vi)	DUNDEE HEALTH AND SOCIAL CARE PARTNERSHIP CLINICAL, CARE AND PROFESSIONAL GOVERNANCE ASSURANCE REPORT	Dave Berry to take forward the provision of information on Equality Impact Assessment in New Member Induction Training and the possibility of training not being confined to new members but offered as a refresher for the full membership with Tony Gaskin.	Chief Finance Officer/Chief Internal Auditor	(June 2022) February 2023	Complete – briefing provided to all IJB members on Public Sector Equality Duties, including IIAs, in February 2023.
5.	29/09/21	VIII(iii)	DUNDEE INTEGRATION JOINT BOARD INTERNAL AUDIT PLAN PROGRESS REPORT	to note following enquiry from Bailie Wright the explanation from Tony Gaskin in relation to what was meant by Viability as indicated in the report and that a report on Key Risk Viability would be submitted to the February meeting.	Chief Internal Auditor	(February 2022) September 2023	In progress – Deadline to move to coincide with planned completion of Internal Audit Report on provider sustainability – expected September 2023
6.	24/11/21	VII(iv)	DUNDEE HEALTH AND SOCIAL CARE PARTNERSHIP PERFORMANCE	to instruct the Chief Finance Officer to submit a further in-depth analysis of readmissions data, which should include analysis of the data for the	Chief Finance Officer	(March 2022)	In progress - deferred due to data availability. Agenda note submitted to July 2022

No	Meeting	Minute Ref	Heading	Action Point	Responsibility	Timeframe	Status
			REPORT – QUARTER 1	specialty with the highest readmission rate (excluding where reasons for poor performance were due to coding) no later than 31st March, 2022 (sections 5.4 and 6 of the report).		May 2023	meeting and May 2023 meetings. Data reporting has now recommenced as part of Q3 2022/23 reporting. Further analytical report planned for submission in September 2023.
7.	20/07/22	VI(vi)	DUNDEE HEALTH AND SOCIAL CARE PARTNERSHIP PERFORMANCE REPORT 2021/2022 - QUARTER 4	that, at request of Councillor McHugh, information would be provided on the support available to care staff.	Chief Officer	(October 2022) May 2023	In progress.
8.	20/07/22	VII(vi)	DUNDEE HEALTH AND SOCIAL CARE PARTNERSHIP STRATEGIC RISK REGISTER UPDATE	that a date for a development session on risk would be arranged.	Chief Finance Officer	(December 2022) June 2023	In progress. Deferred until June due to increased number of other development sessions for IJB members planned

No	Meeting	Minute Ref	Heading	Action Point	Responsibility	Timeframe	Status
9.	20/07/22	XIII(vi)	DUNDEE HEALTH AND SOCIAL CARE PARTNERSHIP CLINICAL, CARE AND PROFESSIONAL GOVERNANCE ASSURANCE REPORT	that updates would be provided to the next Committee on the Community Mental Health Service Activity and MAT Standards.	Head of Health and Community Care	(November 2022) February 2023	Complete – indicator sets for drugs and alcohol and mental health have been agreed by PAC. Mental health data reporting commences to PAC in May 2023 and drug and alcohol data is now being reported on a six monthly basis.
10.	28/09/22	III(b)(iii)	ACTION TRACKER	that consideration would be given by the Management Team to noting the briefing notes, that were issued inbetween PAC meetings, at the next available meeting of the PAC.	Chief Officer	(December 2022) September 2023	In progress – Discussions held with Head of Legal and Democratic Services of Dundee City Council as advisor to the IJB/PAC
11.	28/09/22	IV(vi)	DUNDEE HEALTH AND SOCIAL CARE PARTNERSHIP PERFORMANCE REPORT 2022/23 – QUARTER 1	that consideration would be given to using more nuanced colour coding in the report.	Service Manager, Strategy and Performance	(March 2023) September 2023	Ongoing – being considered as part of production of next quarterly performance report.
12.	23/11/22	VII	DISCHARGE MANAGEMENT PERFORMANCE UPDATE ON	that arrangements would be made to show actual numbers in the chart, where possible, in future reports.	Senior Officer - Information	June 2023	Ongoing – being considered as part of the production of the next six-monthly

No	Meeting	Minute Ref	Heading	Action Point	Responsibility	Timeframe	Status
			COMPLEX AND STANDARD DELAYS				discharge management report.
13.	23/11/22	VII	DISCHARGE MANAGEMENT PERFORMANCE UPDATE ON COMPLEX AND STANDARD DELAYS	that Lynne Morman would check if the data on the number of patients being discharged without care packages was being tracked.	Associate Locality Manager, Acute and Urgent Care	February 2023	Complete – information manually recorded by Discharge Team of outcomes for patients on discharge
14.	01/02/23	IV	DUNDEE HEALTH AND SOCIAL CARE PARTNERSHIP PERFORMANCE REPORT – 2022-23 QUARTER 2	that Lynsey Webster would check why there was a red line (Number of People waiting in the community for a social care assessment) on the legend on the graph on page 31 but there was no line red detailed in the content of the graph.	Senior Officer - Information	May 2023	Complete – this has been checked and corrected for future reports.

REPORT TO: **PERFORMANCE & AUDIT COMMITTEE – 24 MAY 2023**

REPORT ON: **DUNDEE HEALTH AND SOCIAL CARE PARTNERSHIP PERFORMANCE REPORT – 2022-23 QUARTER 3**

REPORT BY: **CHIEF FINANCE OFFICER**

REPORT NO: **PAC17-2023**

1.0 PURPOSE OF REPORT

1.1 The purpose of this report is to update the Performance and Audit Committee on 2022-23 Quarter 3 performance against the National Health and Wellbeing Indicators and 'Measuring Performance Under Integration' indicators. Data is also provided in relation to Social Care – Demand for Care at Home services.

2.0 RECOMMENDATIONS

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

2.1 Note the content of this summary report.

2.2 Note the performance of Dundee Health and Social Care Partnership, at both Dundee and Local Community Planning Partnership (LCPP) levels, against the National Health and Wellbeing Indicators as summarised in Appendix 1 (tables 1, 2 and 3).

2.3 Note the performance of Dundee Health and Social Care Partnership against the 'Measuring Performance Under Integration' indicators as summarised in Appendix 1 (table 3).

2.4 Note the number of people waiting for social care assessment and care at home package and associated hours of care yet to be provided in Appendix 2.

3.0 FINANCIAL IMPLICATIONS

3.1 None.

4.0 BACKGROUND INFORMATION

4.1 Since the last reporting period, work has been completed to review the usefulness of providing Statistical Process Control (SPC) charts to identify special cause variation in performance (i.e. variations in performance that sit outwith the expected normal range). The findings were that whilst SPC is a useful method, it is most beneficial when focused on weekly or daily data trends and when used to support improvement activity at an operational level. When SPC was applied to the quarterly available National Indicators the reduced activity and subsequent increase following remobilisation due the Pandemic were identified as special cause variation, however data was not detailed enough to identify other variation. Additionally the National Indicators are related to very wide and complex systems and therefore SPC variation could be attributed to several reasons. Limiting the usefulness of the analysis for improvement purposes. For this reason, the use of SPC within quarterly performance reports will not be pursued any further.

4.2 Quarterly and locality data for readmissions within 28 days, has been included for the first time since Q1 2021/22. A Short Life Working Group has now reached the stage of having as high a level of confidence as is proportionate, given limited analytical resources, in the local data and local calculation methodology. This provides the foundation for moving forward with further work in two areas: data definitions and quality and, analysis to inform improvement. The working group anticipate submitting a full analytical report to the Performance and Audit Committee on 27 September 2023. A detailed explaination is available in report PAC16-2023.

5.0 QUARTER 3 PERFORMANCE 2022-23 – KEY ANALYTICAL MESSAGES

5.1 Key analytical messages for the Quarter 3 2022/23 period are:

- Significant variation by Local Community Planning Partnership (LCPP) is still apparent, with poorest performance for many of the National Indicators in the most deprived LCPPs.

- Performance poorer than the 2015/16 baseline for rate of emergency admissions 18+, hospital admissions due to a fall 65+, A+E attendances 18+, emergency admission numbers from A+E 18+, emergency admissions as a rate of all A+E attendances 18+, 28 day readmissions, % care services graded good, standard bed days lost to delayed discharges 75+.

- Despite having a deteriorating rate of emergency admissions 18+, with performance across most LCPPs being poorer than the 2015/16 baseline, performance is 2nd best out of the 8 family group partnerships. Although performance is poorest out of the 3 Tayside Partnerships.

- The number of emergency admissions from A+E has increased over the last 4 quarters and particularly between Q2 (7880) and Q3 (8134) although the number of emergency admissions as a rate per 1,000 of all A+E attendances has decreased over the last 4 quarters (both are higher than the 2015/16 baseline).

- The rate of emergency bed days 18+ has reduced since 2015/16, which is an improvement although the rate has increased (deteriorated) in Maryfield by 5.5% and Strathmartine (6.8%). Performance is best in the family group but 3rd out of the 3 Tayside Partnerships.

- The rate of readmissions within 28 days of discharge increased by 4.9% from the 15/16 baseline although has maintained a stable rate since 2018/19, sitting between 139 and 140 each year. There is variation by LCPP with rates ranging from 114 in The Ferry to 167 in Coldside. A Short Life Working Group is completing further analysis by Scottish Index of Multiple Deprivation (SIMD), gender and age in order to further understand this variation

- 91.7% of the last 6 months of life was spent at home or in a community setting and this is higher than the 2015/16 baseline of 86.6% (improvement) and although performance across Scotland is similar, it is 5th out of the 8 family group partnership and is 3rd out of the 3 Tayside partnerships.

- Rate of hospital admissions due to a fall for aged 65+ is 36% higher than the 2015/16 baseline and is higher in every LCPP. Dundee is the 2nd poorest (behind Glasgow) of the 8 family group partnerships and poorest out of the 3 Tayside partnerships. The Falls Data Group continues to meet to understand and ultimately improve this performance.

- % care services graded 'good' (4) or better in Care Inspectorate inspections has deteriorated since the 2015/16 baseline.

- Rate of bed days lost to a standard delayed discharge for age 75+ is 35% more than the 2015/16 baseline and performance deteriorated in The Ferry (by 101%), East End (by 85%), North East (by 49%), Lochee (by 41%), Strathmartine (by 35%) and Coldside (by

5%). However, therehas been a decrease since Q1. At Q3 the LCPP with the highest rate was East End (1205) and the LCPP with the lowest rate was Maryfield (517).

- Rate of bed days lost to complex (code 9) delayed discharge for age 75+ is 45% less than the 2015/16 baseline, with increases across 2 LCPPs (Maryfield and The Ferry). Performance has deteriorated over the last 4 quarters. The Discharge Management report which provides indepth analysis regarding delays, along with an operational and strategic update will be available at the next PAC (September 2023).

5.2 Public Health Scotland publishes a four week snapshot of the demand for Care at Home services provided by Health and Social Care Partnerships across Scotland. The information in Appendix 2 shows the number of people waiting for an assessment for a package of care to allow them to live at home or in the community and also the number of hours of care that has been assessed but not yet delivered. The information is presented by people waiting in hospital or waiting at home / in the community for the care at home service to be delivered. In Dundee, as at 20 March 2023:

- 0 people waited in hospital and 57 people waited in the community for a social care assessment. This is an overall decrease over the previous 4 weeks from 41 people waiting in the community at 13 February 2024.

- 0 people have have waited in hospital each week since 24 October 2022.

- 51 people were assessed and were waiting in hospital for a care at home package and is the lowest it was been in the previous 6 weeks.

- 174 people were assessed and were waiting in the community for a care at home package and is the lowest it has been in the last 15 weeks.

- 51 people were assessed and waiting for a care at home package in hospital (858 hours yet to be provided). This is the lowest number of hours waiting to be provided in the last 7 weeks.

- 174 people were assessed and waiting for a care at home package in the community (1,367 hours yet to be provided). This is the lowest number of hours waiting to be provided in the last 16 weeks.

- For those already in receipt of a care at home package 378 additional hours were required and not provided. This is the lowest number of hours waiting to be provided in the last 10 weeks.

The Integration Joint Board has recently received a report regarding the management of demand for social care supports (Article X of the minute of the meeting of the Dundee Integration Joint Board held on 14 December 2022 refers), with PAC having received a detailed report on discharge management (including delays associated with social care assessment and provision) in November 2022 (Article VII of the minute of the meeting of Dundee IJB Performance and Audit Committee refers). The next report wil be available at to PAC when they meet in September 2023.

6.0 POLICY IMPLICATIONS

6.1 This report has been subject to the Pre-IIA Screening Tool and does not make any recommendations for change to strategy, policy, procedures, services or funding and so has not been subject to an Integrated Impact Assessment. An appropriate senior manager has reviewed and agreed with this assessment.

7.0 RISK ASSESSMENT

Risk 1 Description	Poor performance against national indicators could affect outcomes for individuals and their carers, spend associated with poor performance and the ability of the IJB to deliver fully commitments set out in the Strategic and Commissioning Plan.
Risk Category	Financial, Governance, Political
Inherent Risk Level	Likelihood 3 x Impact 5 = Risk Scoring 15 (which is an Extreme Risk Level)
Mitigating Actions (including timescales and resources)	- Continue to develop a reporting framework which identifies performance against national and local indicators. - Continue to report data quarterly to the PAC to highlight areas of exceptional performance (poor and excellent). - Continue to support operational managers by providing in depth analysis regarding areas of poor performance, such as around readmissions to hospital and falls related hospital admissions. - Continue to ensure that data informs operational practices and improvements and also that operational activities and priorities are used to interpret trends shown by the data. - Work with operational managers, through a recommencement of the Performance and Finance Group, to identify areas of poor performance that result in operational risk and undertake additional analysis as required.
Residual Risk Level	Likelihood 3 x Impact 3 = Risk Scoring 9 (which is a Moderate Level)
Planned Risk Level	Likelihood 2 x Impact 3 = Risk Scoring 6 (which is a Moderate Risk Level)
Approval recommendation	Given the moderate level of planned risk, this risk is deemed to be manageable.

8.0 CONSULTATIONS

8.1 The Chief Officer, Heads of Service, Health and Community Care and the Clerk were consulted in the preparation of this report.

9.0 BACKGROUND PAPERS

9.1 None.

Dave Berry
Chief Finance Officer

DATE: 25 April 2023

Lynsey Webster
Senior Officer, Strategy and Performance

APPENDIX 1 – Performance Summary

Table 1: Performance in Dundee's LCPPs - % change in Q3 2022-23 against baseline year 2015/16

National Indicator	Dundee	Lochee	East End	Coldside	North East	Strathmartine	Maryfield	West End	The Ferry
Emer Admissions rate per 100,000 18	+6.7%	+2.2%	+2.3%	+13.1%	+2.6%	+11.7%	+8.9%	+14.2%	-1.1%
Emer Bed Days rate per 100,000 18+	-5.5%	-16.1%	-3.7%	-4.2%	-10.3%	+6.8%	+5.5%	-2.7%	-18.5%
28 Day Readmissions rate per 1,000 Admissions	+6%	-7.5%	+13.2%	+4.8%	+1.3%	+19.6%	-4.6%	+18%	+2.3%
Hospital admissions due to falls rate per 1,000 65+	+34%	+44%	+40%	+33%	+29%	+5%	+47%	+26%	+51%
Delayed Discharge Bed Days Lost rate per 1,000 75+ (Standard)	+35%	+41%	+85%	+5%	+49%	+35%	-13%	-13%	+101%
Delayed Discharge Bed Days Lost rate per 1,000 75+ (Code 9)	-45%	-28%	-69%	-29%	-89%	-79%	+204%	-76%	+33%

Table 2: Performance in Dundee's LCPPs - LCPP Performance in Q3 2022-23 compared to Dundee

National Indicator	Dundee	Lochee	East End	Coldside	North East	Strath martine	Mary field	West End	The Ferry
Emer Admissions rate per 100,000 18+	12,742	14,056	16,193	15,515	11,936	14,616	10,796	9,132	10,896
Emer Bed days rate per 100,000 18+	125,628	135,938	175,546	156,219	101,052	132,244	112,524	80,035	122,906
28 Day Readmissions rate per 1,000 Admissions	139	136	143	167	119	144	128	160	114
Hospital admissions due to falls rate per 1,000 65+	33.5	38.3	38.2	39.9	26.5	26.5	34.1	34.9	30.6
Delayed Discharge bed days lost rate per 1,000 75+ (standard)	710	859	1205	580	706	665	517	590	629
Delayed Discharge bed days lost rate per 1,000 75+ (Code 9)	162	118	161	317	85	86	493	52	74

Source: NHS Tayside data

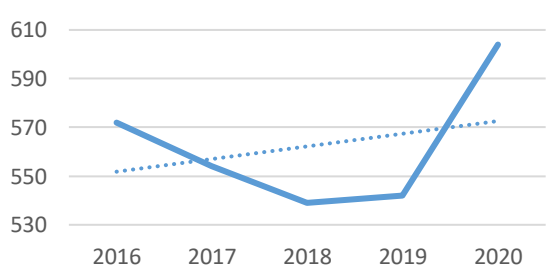
Key: Improved/Better Stayed the same Declined/Worse

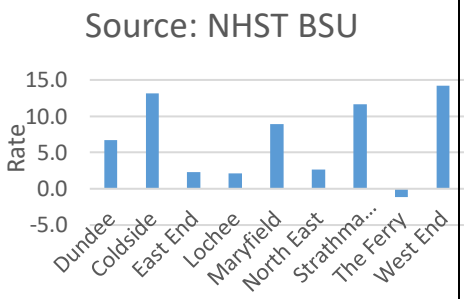
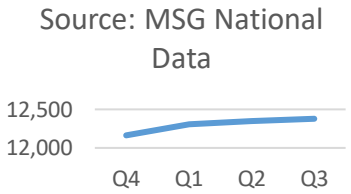
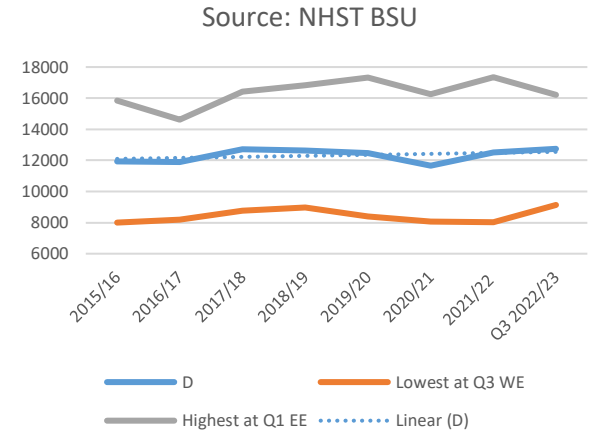
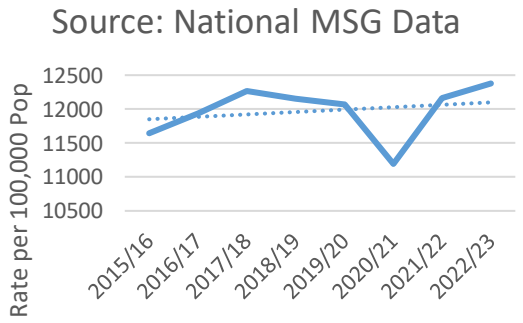
Table 3: Performance in Dundee's LCPPs - LCPP Performance in Q3 2022-23 compared to Dundee

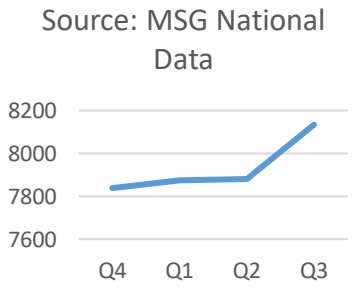
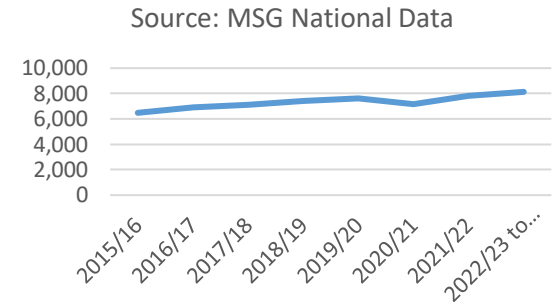
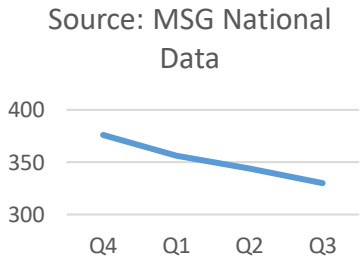
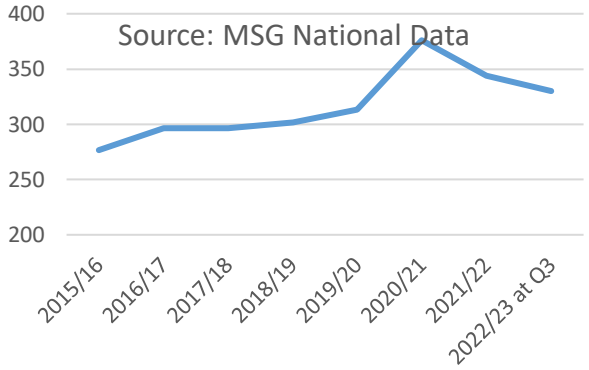
Dundee = D	East End = EE	Coldside = C	West End = WE
Strathmartine = S	North East = NE	Lochee = L	The Ferry = TF

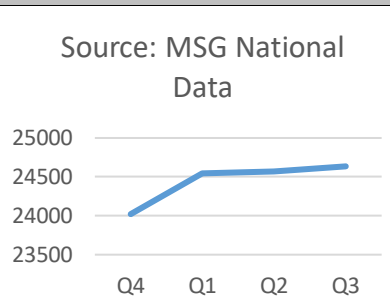
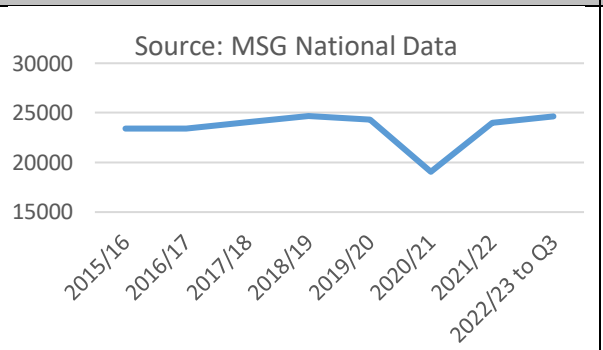
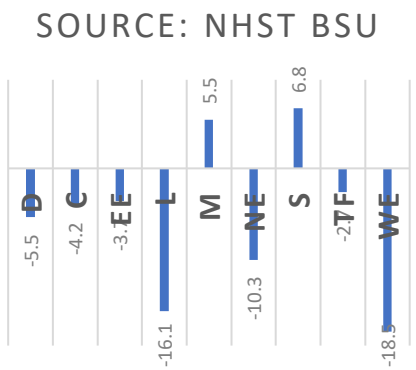
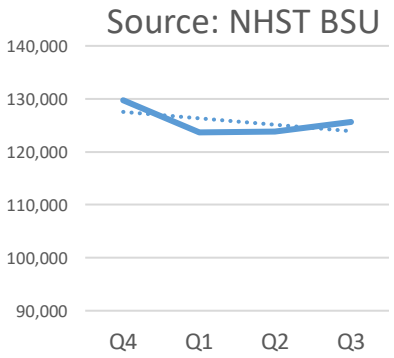
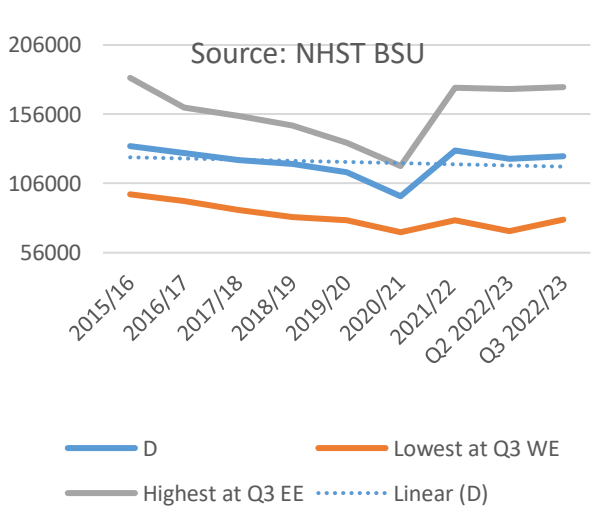
Please note that indicators 1-9 are reported from a biennial national survey – therefore short-term trends are not available. Longitudinal trends are also not available due to changes in suvrey methodology since 2015/16.

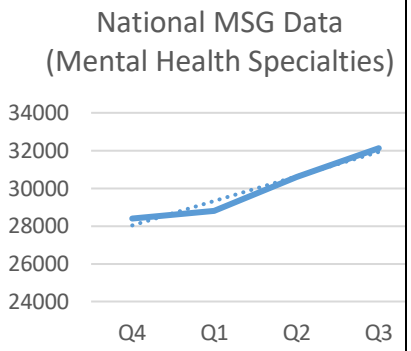
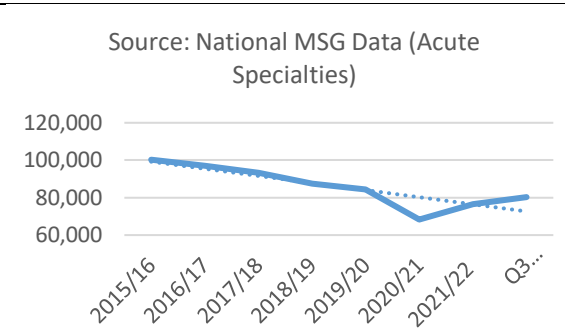
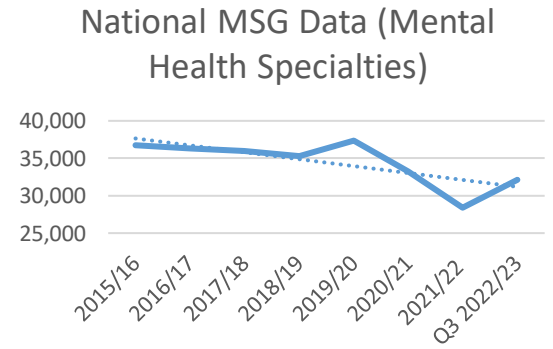
National Indicator	Difference From 15/16 Baseline	Dundee Short Term Trend (last 4 quarters)	Long Term Trend	Scotland Position 1= best, 32 = worst	Family Group Position 1= best, 8 = worst	Tayside Group Position 1= best, 3 = worst
1.% of adults able to look after their health very well or quite well*				30th	5th (89%)	3rd
2.% of adults supported at home who agreed that they are supported to live as independently as possible*				5th	1st (84%)	1st
3.% of adults supported at home who agreed that they had a say in how their help, care, or support was provided*				7th	2nd (75%)	2nd
4. % of adults supported at home who agree that their health and social care services seem to be well co-ordinated*				2nd	2nd (76%)	2nd
5.% of adults receiving any care or support who rate it as excellent or good*				2nd	2nd (84%)	1st
6.% of people with positive experience of care at their GP practice*				16th	3rd (67%)	3rd

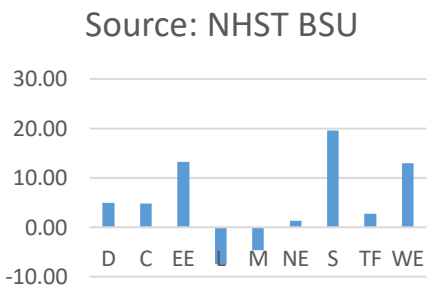
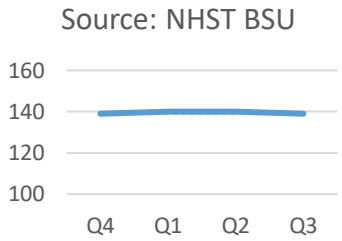
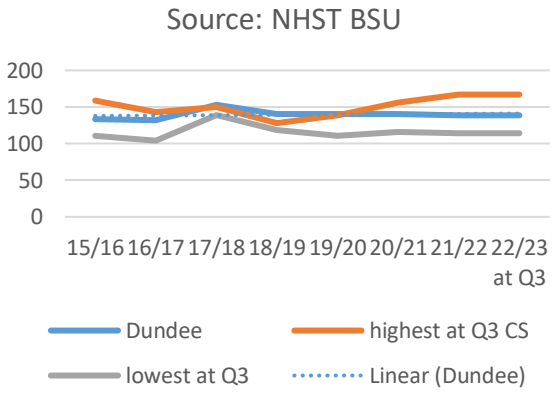
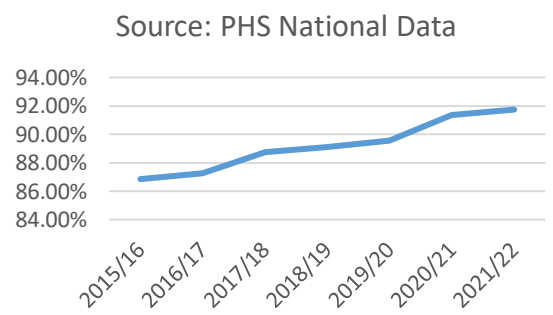
National Indicator	Difference From 15/16 Baseline	Dundee Short Term Trend (last 4 quarters)	Long Term Trend	Scotland Position 1= best, 32 = worst	Family Group Position 1= best, 8 = worst	Tayside Group Position 1= best, 3 = worst
7.% of adults supported at home who agree that their services and support had an impact on improving or maintaining their quality of life*				29th	8th (72%)	3rd
8.% of carers who feel supported to continue in their caring role*				26th	7th (27%)	3rd
9.% of adults supported at home who agreed they felt safe*				20th	7th (77%)	3rd
10. % staff who say they would recommend their workplace as a good place to work	Not Available Nationally	Not Available Nationally	Not Available Nationally			
11. Premature mortality rate per 100,000 persons	6% less in 20/21 than 15/16 (improved)	Not Available		29th	7th	3rd

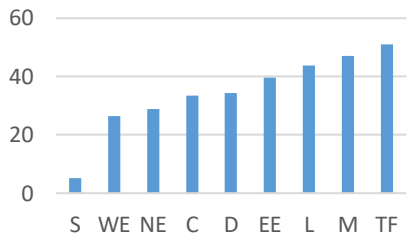
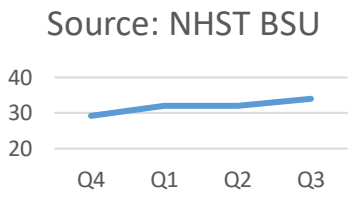
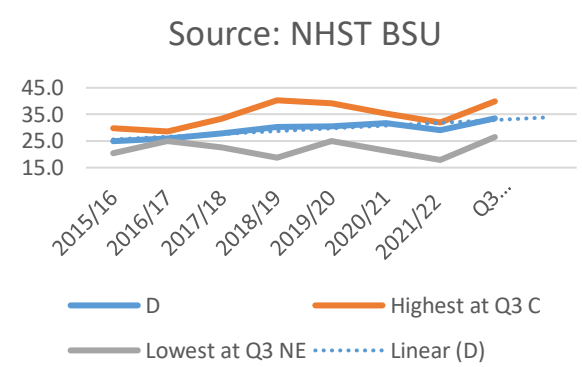
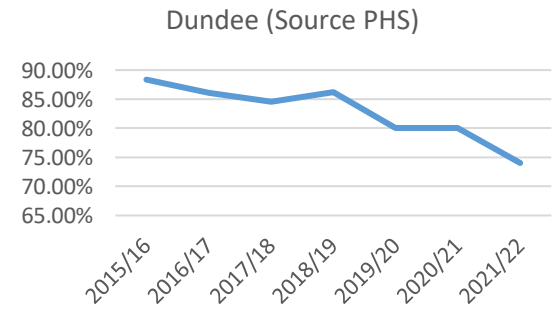
National Indicator	Difference From 15/16 Baseline	Dundee Short Term Trend (last 4 quarters)	Long Term Trend	Scotland Position 1= best, 32 = worst	Family Group Position 1= best, 8 = worst	Tayside Group Position 1= best, 3 = worst
12. Emer Admissions rate per 100,000 18+	6.1% (874 admissions) more in Q3 22/23 than 2015/16 (deterioration) (source: MSG) 		 	22nd	2nd	3rd

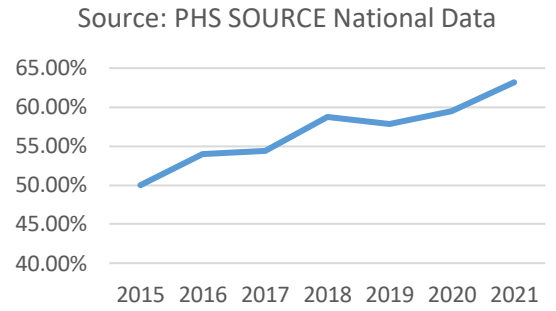
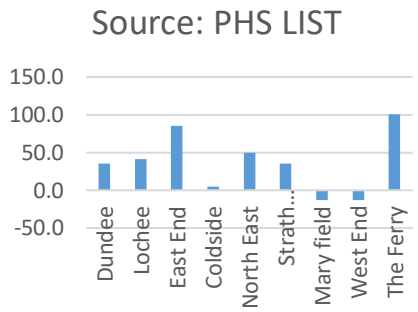
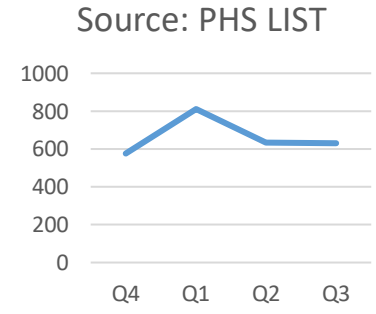
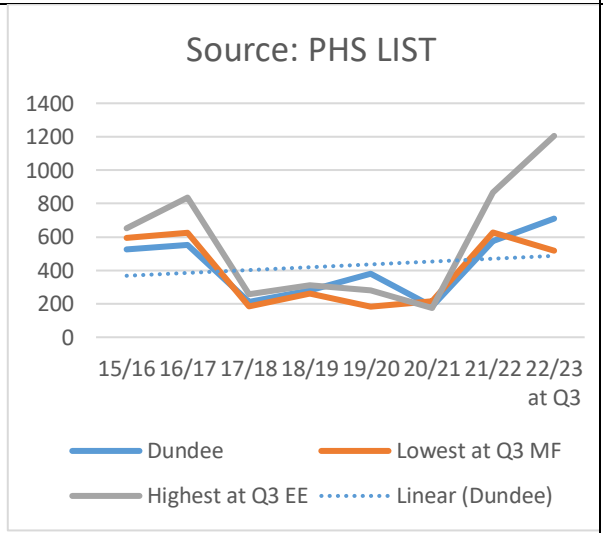
National Indicator	Difference From 15/16 Baseline	Dundee Short Term Trend (last 4 quarters)	Long Term Trend	Scotland Position 1= best, 32 = worst	Family Group Position 1= best, 8 = worst	Tayside Group Position 1= best, 3 = worst
Emergency Admissions Numbers from A&E (MSG)	1,651 more attendances in Q3 22/23 than 2015/16			NA as number and not rate	NA as number and not rate	NA as number and not rate
Emergency Admissions as a Rate per 1,000 of all Accident &Emergency Attendances (MSG)	53 higher at Q3 2022/23 than 2015/16	 Although rate remains higher than in 20215/16, it was decreased (improved) over the last 4 quarters.		Not Avail	Not Avail	Not Avail

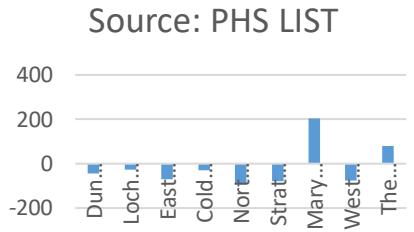
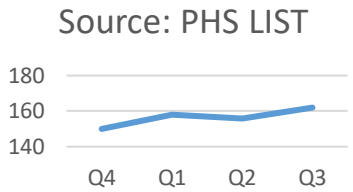
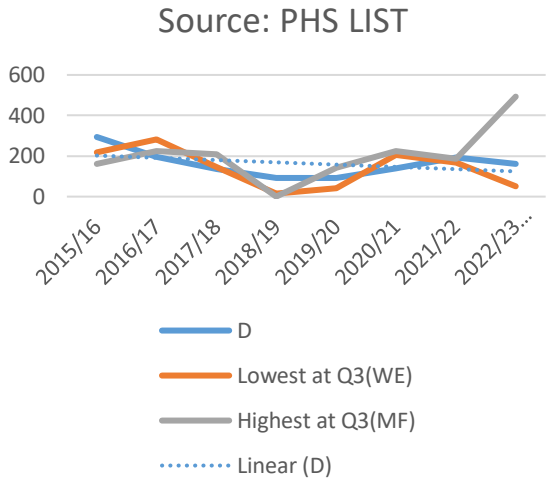
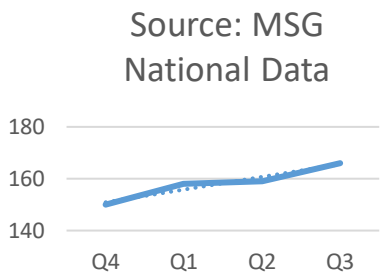
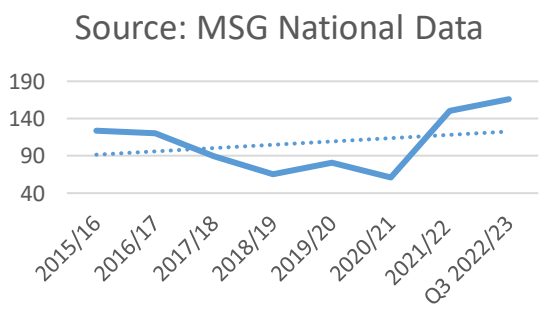
National Indicator	Difference From 15/16 Baseline	Dundee Short Term Trend (last 4 quarters)	Long Term Trend	Scotland Position 1= best, 32 = worst	Family Group Position 1= best, 8 = worst	Tayside Group Position 1= best, 3 = worst
Accident & Emergency Attendances (MSG)	1,198 more in Q3 2022/23 than 2015/16			NA as number and not rate	NA as number and not rate	NA as number and not rate
13.Emer Bed days rate per 100,000 18+	 7,331 (5.5%) less acute bed days in Q3 2022/23 than 2015/16 (improved) (source: NHST BSU)	 Q3 rate is higher than Q4 21/22 however has been rising since Q1 22/23		19th	1st	3rd

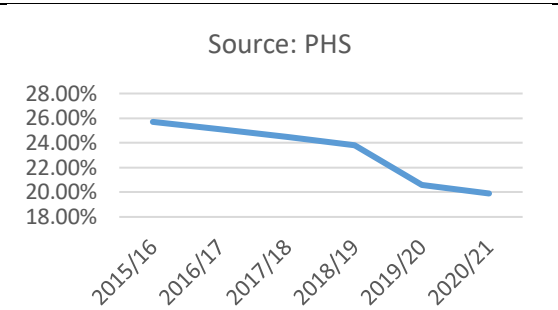
	5,387 (12%) less mental health bed days in Q3 2022/23 than 2015/16 (improved) (source: MSG)		 			

National Indicator	Difference From 15/16 Baseline	Dundee Short Term Trend (last 4 quarters)	Long Term Trend	Scotland Position 1= best, 32 = worst	Family Group Position 1= best, 8 = worst	Tayside Group Position 1= best, 3 = worst
14.Readmissions rate per 1,000 Admissions All Ages*	 4.9% more in Q3 22/23 that 15/16 (deterioration). Variation ranges from -7.5% in Lochee to +19.6% in Strathmartine.			29th	8th	3rd
15. % of last 6 months of life spent at home or in a community setting	Up from 86.8% in 2015/16 to 91.7% in 2021/22 (improvement)	Not Available		15th	5th	3rd

National Indicator	Difference From 15/16 Baseline	Dundee Short Term Trend (last 4 quarters)	Long Term Trend	Scotland Position 1= best, 32 = worst	Family Group Position 1= best, 8 = worst	Tayside Group Position 1= best, 3 = worst
16. Hospital admissions due to falls rate per 1,000 65+	 36% (234 falls admissions) more in Q3 2022/23 than 2015/16 (deterioration). Greatest increase (deterioration) was in The Ferry with 51% increase (deterioration).	 All LCPPs deteriorated between Q2 and Q3.		31st	7th	3rd
17. % care services graded 'good' (4) or better in Care Inspectorate inspections	Dropped from 88.4% in 2015/16 to 74% in 2021/22 (deterioration)	Not Available		28th	8th	3rd

National Indicator	Difference From 15/16 Baseline	Dundee Short Term Trend (last 4 quarters)	Long Term Trend	Scotland Position 1= best, 32 = worst	Family Group Position 1= best, 8 = worst	Tayside Group Position 1= best, 3 = worst
18. % adults with intensive care needs receiving care at home	9.2% (115 people) more in 2021 than 2016 (improvement) (note calendar year)	Not Available		23rd	8th	2nd
19.1 Delayed Discharge bed days lost rate per 1,000 75+ (standard)	 35.1% increase (deterioration) since 2015/16.	 Improvement since Q1		NA	NA	NA

National Indicator	Difference From 15/16 Baseline	Dundee Short Term Trend (last 4 quarters)	Long Term Trend	Scotland Position 1= best, 32 = worst	Family Group Position 1= best, 8 = worst	Tayside Group Position 1= best, 3 = worst
19.2 Delayed Discharge bed days lost rate per 1,000 75+ (Code 9)	 Overall 45% improvement since 2015/16 although increase (deterioration) in The Ferry 81%, and Maryfield 204%.	 Deterioration since Q4		NA	NA	NA
Delayed Discharge bed days lost rate per 1,000 18+ (All Reasons) (MSG)	5,189 more bed days lost in Q3 2022/23 than 2015/16 (deterioration)			NA	NA	NA

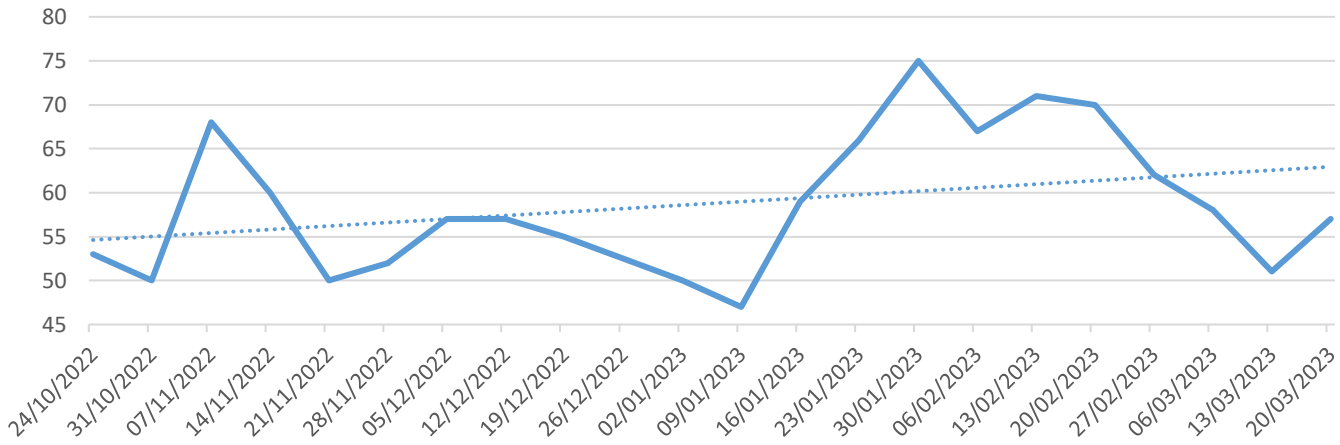
20. % of health and social care resource spent on hospital stays where the patient was admitted as an emergency	5.8% less in 2020/21* than 2015/16 (improvemement) *latest data available	Not Available		18th	3rd	3rd

APPENDIX 2 SUMMARY OF SOCIAL CARE – DEMAND FOR CARE AT HOME SERVICES DUNDEE

This report is an assessment of the demand for Care at Home services provided by Health and Social Care Partnerships. The information shows the number of people waiting for an assessment for a package of care to allow them to live at home or in the community and also the number of hours of care that has been assessed but not yet delivered. The information is presented by people waiting in hospital or waiting at home/community for the care at home service to be delivered.

The data included in this publication is management information which Health and Social Care partnerships began submitting in August 2021. This data collection is still under development and requires further work on the consistency of the recording of the information across Health and Social Care Partnerships.

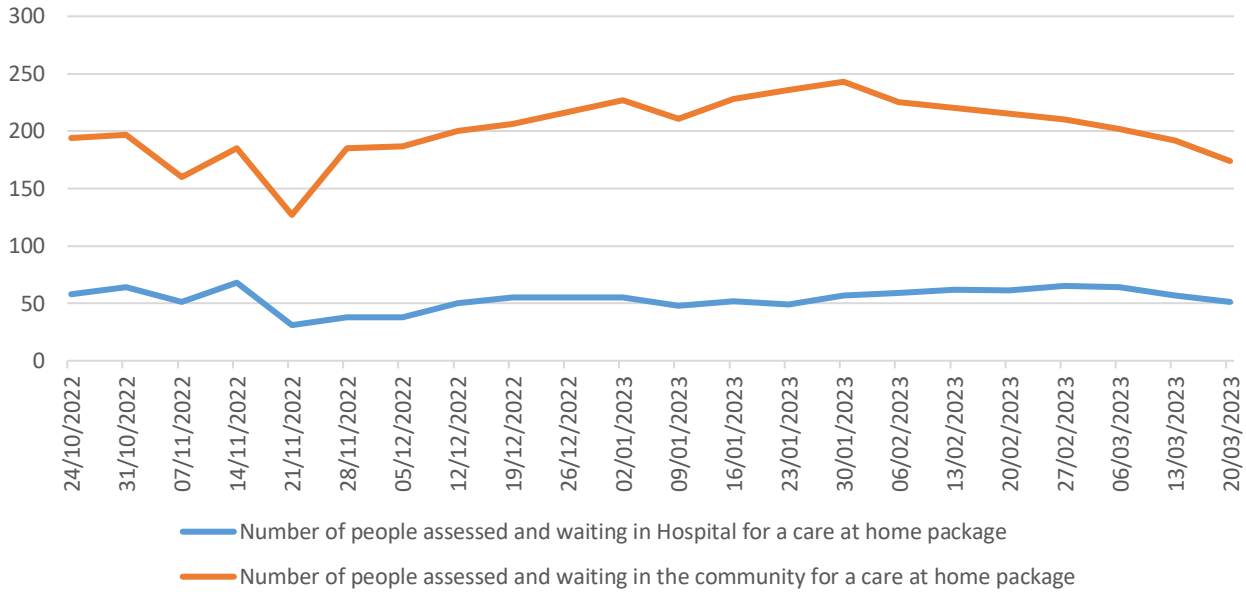
Chart 1 Number of people waiting for social care assessment



In Dundee as at 20th March 2023

- 0 people waited in hospital and 57 people waited in the community for a social care assessment. This is an overall decrease over the previous 4 weeks from 41 people waiting in the community at 13 February 2024.
- 0 people have have waited in hospital each week since 24 October 2022

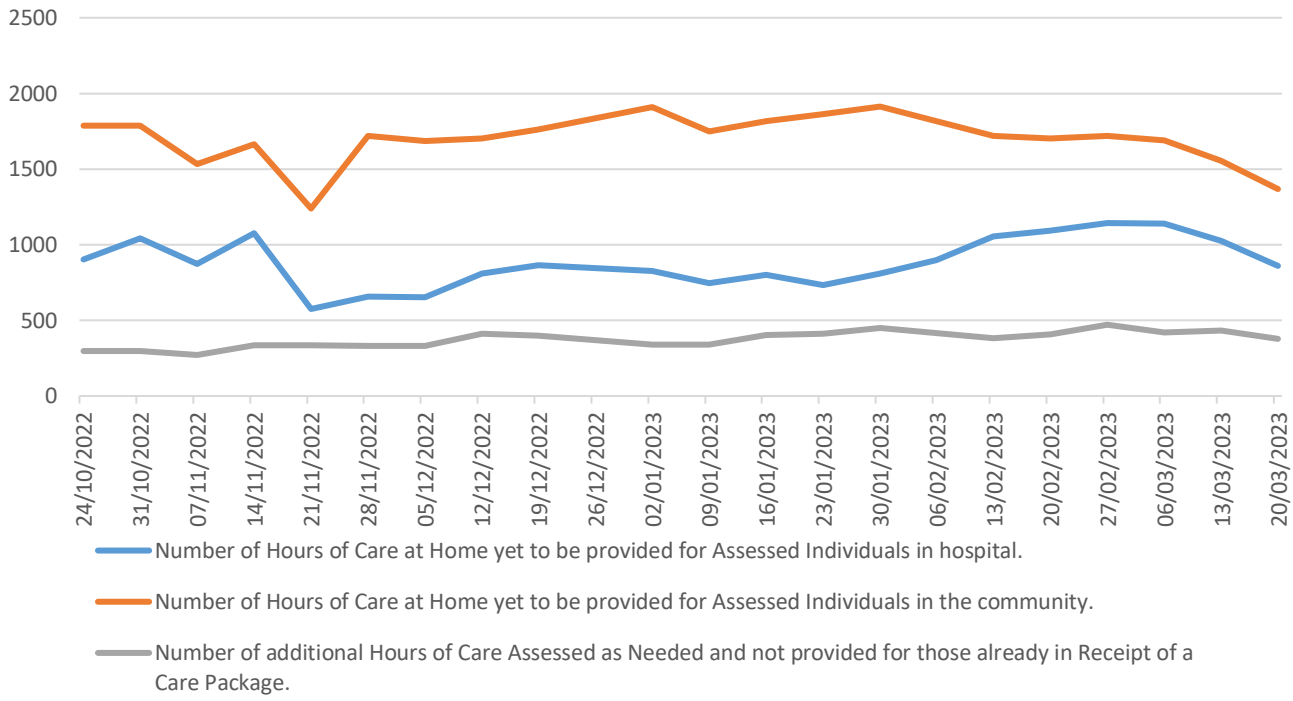
Chart 2 Number of people assessed and waiting for a Care at Home Package



In Dundee as at 20th March 2023

- 51 people were assessed and were waiting in hospital for a care at home package and is the lowest it was been in the previous 6 weeks.
- 174 people were assessed and were waiting in the community for a care at home package and is the lowest it has been in the last 15 weeks.

Chart 3 Number of hours of care at home yet to be provided



- 51 people were assessed and waiting for a care at home package in hospital (858 hours yet to be provided). This is the lowest number of hours waiting to be provided in the last 7 weeks.
- 174 people were assessed and waiting for a care at home package in the community (1,367 hours yet to be provided). This is the lowest number of hours waiting to be provided in the last 16 weeks.
- For those already in receipt of a care at home package 378 additional hours were required and not provided. This is the lowest number of hours waiting to be provided in the last 10 weeks.

APPENDIX 3 – DATA SOURCES USED FOR MEASURING PERFORMANCE

The Quarterly Performance Report analyses performance against National Health and Wellbeing Indicators 1-23 and Measuring Performance Under Integration (MPUI) indicators. 5 of the 23 National Health and Wellbeing Indicators are monitored quarterly (emergency admissions, emergency bed days, readmissions, falls admissions and delayed discharge bed days lost. Data is provided both at Dundee and Local Community Planning Partnership (LCPP) level (where available). Data is currently not available for eight out of the 13 National Indicators which are not reported using The Health and Social Care Experience Survey (see section 4.3). The Scottish Government and Public Health Scotland are working on the development of definitions and datasets to calculate these indicators nationally.

The National Health and Wellbeing Indicators 1-9 are reported from The Health and Social Care Experience Survey administered by the Scottish Government which is conducted biennially. Full details were provided to the PAC in February 2021 (Article V of the minute of the Dundee Performance and Audit Committee held on 3 February 2021 refers). The Scottish Government changed the methodology used to filter responses to reflect people who receive services from the Partnership and therefore it is not possible to longitudinally compare results for National Indicators 1-7 and 9.

The quarterly performance report also summarises performance against indicators in the Measuring Performance Under Integration (MPUI) suite of indicators for four out of six high level service delivery areas – emergency admissions, emergency bed days, accident and emergency and delayed discharges, end of life and balance of care. In November 2020 the Performance and Audit Committee agreed that targets should not be set for 2020/21 for these indicators, however that the indicators should continue to be monitored in quarterly performance reports submitted to the PAC (Article VI of the minute of the Dundee Performance and Audit Committee held on 24 November 2020 refers).

National data is provided to all partnerships, by Public Health Scotland. This data shows rolling[1] monthly performance for emergency admissions, emergency admissions from accident and emergency, accident and emergency attendances, emergency bed days and delayed discharges. Previously Public Health Scotland were only able to provide data for all ages, however following feedback from Dundee and other Partnerships they have now provided data for people age 18+.

It was agreed at the PAC held on 19 July 2017 (Article VIII of the minute of the meeting refers) that local data, provided by the NHS Tayside Business Unit will be used to produce more timeous quarterly performance reports against the National Health and Wellbeing Indicators. NHS Tayside Business Unit has provided data for emergency admissions, emergency bed days, readmissions, delayed discharges and falls. From quarter 1 2020/21 the NHS Tayside Business Unit has been providing breakdowns of covid and non covid admission reasons for emergency admissions and emergency bed days.

Data provided by NHS Tayside differs from data provided by Public Health Scotland (PHS); the main differences being that NHS Tayside uses 'board of treatment' and PHS uses 'board of residence' and NHS Tayside uses an admissions based dataset whereas PHS uses a discharge based dataset (NHS Tayside records are more complete but less accurate as PHS data goes through a validation process). As PHS data is discharge based, numbers for one quarter will have been updated the following quarter as records get submitted for those admitted one quarter and discharged a subsequent quarter. By the time PHS release their data, records are (in most cases) 99% complete. The data provided by NHS Tayside Business Unit is provisional and figures should be treated with caution.

[1] Rolling data is used so that quarterly data can be compared with financial years. This means that data for Quarter 3 shows the previous 12 months of data including the current quarter. Therefore, Quarter 3 data includes data from 1 January 2022 to 31 December 2022.

Dundee Integration Joint Board Integrated Impact Assessment

Part 1 - Pre-Integrated Impact Assessment Screening.
NB For Dundee City Council Committees the Citrix Firm Step Process must be used.
This word document can be completed and information transferred to Firm Step if required.

Title of Report/Project/Strategy	Dundee Health And Social Care Partnership Performance Report – 2022-23 Quarter 3
Lead Officer for Report/Project/Strategy (Name and Job Title)	Kathryn Sharp, Service Manager
Name and email of Officer Completing the Screening Tool	Kathryn Sharp, Service Manager
List of colleagues contributing information for Screening and IIA	-
Screening Completion Date	25/04/23
Name and Email of Senior Officer to be Notified when Screening complete	Vicky Irons, Chief Officer

Is there a clear indication that an IIA is needed? Mark one box only		
	YES	Proceed to IIA
X	**NO**	*Continue with Screening Process*

Is the purpose of the Committee document the approval of any of the following Mark one box either **Yes** or **No**
NB When yes to any of the following proceed to IIA document.

	Yes		**No**	
A major Strategy/Plan, Policy or Action Plan		*Proceed directly to IIA*	X	*Continue with Screening Process*
An area or partnership-wide Plan		*Proceed directly to IIA*	X	*Continue with Screening Process*
A Plan, programme or Strategy that sets the framework for future development consents		*Proceed directly to IIA*	X	*Continue with Screening Process*
The setting up of a body such as a Commission or Working Group		*Proceed directly to IIA*	X	*Continue with Screening Process*
An update to a Plan		*Proceed directly to IIA*	X	*Continue with Screening Process*

There a number of reports which do not automatically require an IIA. If your report does not automatically require an IIA you should consider if an IIA is needed by completing the checklist on following page.

These include: An annual report or progress report on an existing plan **/** A service redesign. **/** A report on a survey, or stating the results of research. / Minutes, e.g. of Sub-Committees. / A minor contract that does not impact on the wellbeing of the public. / An appointment, e.g. councillors to outside bodies, Senior officers, or independent chairs. / Ongoing Revenue expenditure monitoring. / Notification of proposed tenders. / Noting of a report or decision made by another Committee including noting of strategy, policies and plans approved elsewhere.

Only complete the checklist on the following page whenever your report does not automatically require an Integrated Impact Assessment otherwise delete the page prior to proceeding to IIA.

Dundee Integration Joint Board Integrated Impact Assessment

Part 1 (continued) Pre-Integrated Impact Assessment Screening.

Screening Checklist for IIA Completion. When yes to any of the following proceed to IIA document.

Mark one box only either Yes or No.

Will the recommendations in the report impact on anyone in relation to any of the Protected Characteristics? *Age; Disability; Gender Reassignment; Marriage & Civil Partnerships; Pregnancy & Maternity; Race / Ethnicity; Religion or Belief; Sex; Sexual Orientation*.			
X	**No** Continue Screening Process		**Yes. Proceed to IIA.**
Will the recommendations in the report impact on People's Human Rights? *For more information on Human Rights visit: https://www.scottishhumanrights.com*			
X	**No** Continue Screening Process		**Yes. Proceed to IIA.**
Will the recommendations in the report impact on anyone residing in a Community Regeneration Area (CRA)? *Within the 15% most deprived areas in Scotland according to the 2020 Scottish Index of Multiple Deprivation*.			
X	**No** Continue Screening Process		**Yes. Proceed to IIA.**
Will the recommendations in the report impact on anyone in more vulnerable types of households? *Lone parent families (especially single female parents); households with a greater number of children and/or young children; pensioner households (single or couple)*			
X	**No** Continue Screening Process		**Yes. Proceed to IIA.**
Will the recommendations in the report impact on anyone experiencing the following issues? *Unskilled or unemployed and of working age; serious and enduring mental health; homelessness (potential homelessness); drug and/or alcohol.*			
X	**No** Continue Screening Process		**Yes. Proceed to IIA.**
Will the recommendations in the report impact on anyone in the following more vulnerable groups? *Offenders and ex-offenders; looked after children and care leavers; carers.*			
X	**No** Continue Screening Process		**Yes. Proceed to IIA.**
Will the recommendations in the report impact on any of the following? *Employment; education & skills; benefit advice / income maximisation; childcare; affordability and accessibility of services.*			
X	**No** Continue Screening Process		**Yes. Proceed to IIA.**
Will the recommendations in the report on Climate Change or Resource Use? *Mitigating greenhouse gases; adapting to the effects of climate change. or Energy efficiency & consumption; prevention, reduction, re-use, recovery or recycling waste; sustainable procurement.*			
X	**No** Continue Screening Process		**Yes. Proceed to IIA.**
Will the recommendations in the report impact on Transport? *Accessible transport provision; sustainable modes of transport.*			
X	**No** Continue Screening Process		**Yes. Proceed to IIA.**
Will the recommendations in the report impact on the Natural Environment? *Air, land or water quality; biodiversity; open and green spaces.*			
X	**No** Continue Screening Process		**Yes. Proceed to IIA.**
Will the recommendations in the report impact on the Built Environment? *Built heritage; housing.*			
X	**No** Continue Screening Process		**Yes. Proceed to IIA.**

When no to everything in the above screening process you must contact 'Senior Officer to be Notified on Completion' and present a copy of this Screening tool with IJB Report.
Otherwise proceed to IIA.

* Transfer information into the Firm Step Process when report is progressing to Council Committee.

The following document includes all questions in DCC IIA- The Dundee City Council IIA Guidance document can be found here.

REPORT TO: **PERFORMANCE & AUDIT COMMITTEE – 24 MAY 2023**

REPORT ON: **MENTAL HEALTH PERFORMANCE**

REPORT BY: **CHIEF FINANCE OFFICER**

REPORT NO: **PAC20-2023**

1.0 PURPOSE OF REPORT

1.1 The purpose of this report is to report a suite if measurement relating to the activity of Mental Health services for scrutiny and assurance.

2.0 RECOMMENDATIONS

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

2.1 Note the content of this report.

2.2 Discuss any further areas for development in the content and presentation of this report.

2.3 Note the operational and strategic supporting narrative in the context of the trends in performance and activity.

3.0 FINANCIAL IMPLICATIONS

3.1 None.

4.0 BACKGROUND INFORMATION

4.1 The suite of mental health measures (Appendix 1) for Dundee is intended to provide assurance and allow for scrutiny of mental health services delegated to Dundee IJB. The indicators have been developed in tandem with a suite of substance use measures being developed for the purpose of presenting information regarding performance within NHS Tayside functions. The suite of indicators is dynamic and can be improved and enhanced following discussions.

4.2 In all data reports with public accessibility, content and disaggregation has been reviewed in order to comply with General Data Protection Regulation and ultimately to ensure that individuals can not be identified.

5.0 LOCAL CONTEXT

5.1 Dundee has the 5th highest rate in Scotland of adults (aged 16-64) who reported in the 2011 Census that they lived with a mental health condition. Dundee has a rate of 64 people per 1,000 population compared to 54 for Scotland. Dundee also has 6319 people in the 16-64 age group who identified themselves as having mental health conditions; this is 6.4% of the 16 to 64 population. The gender balance for mental health conditions is similar to the Scottish average. There is a higher prevalence of females (57% females : 43% males) and also a higher prevalence in the 35-64 age group.

5.2 There is a higher rate of people with mental health conditions living in Lochee, East End and Coldside. East End has more than double the rate of people with a mental health condition, compared with The Ferry.

5.3 In the 2011 Census 31% of people with mental health conditions in Dundee rated their health as bad or very bad. There is variation between LCPP areas in terms of self-reported mental health conditions, ranging from 35% in the East End to 25% in the West End, of people who rated their health as bad or very bad.

5.4 In Dundee life expectancy is ten years lower for people with a mental health condition (66.8 years) compared with the general Dundee population (76.8 years).

5.5 It is estimated from Scottish Survey data that around a third (33%) of all adults age 16+ in Dundee have a limiting long-term physical or mental health condition. Results from the Scottish Burden of Disease study suggest that the population of Dundee experiences a higher rate of burden of disease (a combined effect of early deaths, and years impacted by living with a health condition) compared with Scotland, for a number of health conditions, including cardiovascular disease, COPD, Mental Health and Substance Use disorders, and diabetes.

5.6 The effects of COVID-19 on the population has further widened the social and health inequalities gap and many people are finding it more difficult than ever to cope across many aspects of their life. Engage Dundee reported the most common difficulties reported by respondents during the pandemic were regarding mental health (37%),

5.7 The Kings Fund review of long-term conditions and mental health reported that those with long-term conditions and co-morbid mental health problems disproportionately lived in deprived areas with access to fewer resources.

5.8 Dundee on average has around 70 children on the child protection register at any one time and around one third are placed on the register due parental mental illness.

5.9 Dundee's five-year rate of suicide per 100,000 people stands at 23.9 compared to an average across Scotland of 14.1.

6.0 WHAT THE DATA IS TELLING US

6.1 The rate of Mental Health admissions and beds has decreased across all and emergency admissions. However there is substantial variation by LCPP, with the most deprived localities having the highest rate of admissions and bed days across both the 18-64 and 65+ populations.

6.2 When benchmarked across the 8 Family Group Partnerships and compared with Scotland, Dundee has the 2nd highest rate of emergency bed days for ages 18-64 and the highest rate of emergency bed days for ages 65+.

6.3 The number of new referrals of psychological therapies has increased with most new referrals coming from Strathmartine. It may be of interest to note that Strathmartine has the lowest rate of ALL mental health bed days and the 3rd lowest of emergency mental health bed days for age 65+. Also, Strathmartine has the 4th highest rate rate of ALL mental health bed days and the 3rd highest of emergency mental health bed days for age 18-64.

6.4 The % of patients referred to psychological therapies who commenced their treatment within 18 weeks of referral (completed waits) has risen from 45% of Q1 21/22 to 72% in Q4 22/23 (to Feb 23).

6.5 The number of community based mental health appointments from Dundee Crisis Team has decreased, where as the number from Dundee Community Mental Health West Team has increased. The number from Dundee Community Mental Health East Team has remained constant

over the reporting time period. The number of people discharged without bening seen follows the same pattern.

6.6 The number of community based mental health return appointments for every new patient seen is currently an average of 14.The number of new referrals to Psychiatry of Old Age dipped to Q1 22/23 and has since increased to around the same as Q1 21/22. The % of referrals accepted followed a similar pattern. At Q4, the highest number of new referrals came from The Ferry and the lowest number came from Maryfield. The average number of return appointments for every patient seen is 6.

6.7 The number of new referrals to Learning Disabilities services has increased from 211 in Q1 21/22 to 283 in Q4 22/23 (to Feb 23). The highest number of new referrals was from Coldside and the lowest number was from The Ferry. The % of referrals accepted increased from 66% at Q1 21/22 to 74% at Q4 22/23. The average number of return appointments for every new patient seen at Q4 22/23 (to Feb 23) was 13.5 which has decreased from 18 in Q1 21/22.

6.8 The number of new referrals to the Social Work Mental Health Officer Team and the Community Mental Health Teams (younger and older age groups, social work) has decreased durining the reporting period.

6.9 The number of local authority guardian applications were 40 during Q4 22/23 (to Feb 23) and the number of Private Guardianship applications increased from 53 in Q1 21/22 to 63 in Q4 22/23 (to Feb 23).

7.0 POLICY IMPLICATIONS

7.1 This report has been subject to an Integrated Impact Assessment to identify impacts on Equality and Diversity, Fairness and Poverty, Environment and Corporate Risk. No impacts on these issues, positive or negative, were identified. An appropriate senior manager has checked and agreed with this assessment. A copy of the Integrated Impact Assessment is included as an Appendix to this report.

8.0 RISK ASSESSMENT

Risk 1 Description	Poor performance could affect outcomes for individuals and their carers, spend associated with poor performance and the ability of the IJB to deliver fully commitments set out in the Strategic and Commissioning Plan.
Risk Category	Financial, Governance, Political
Inherent Risk Level	Likelihood 3 x Impact 5 = Risk Scoring 15 (which is an Extreme Risk Level)
Mitigating Actions (including timescales and resources)	- Continue to develop a reporting framework which identifies performance and activity - Continue to report data quarterly to the PAC to highlight performance and activity - Support operational managers by providing in depth analysis regarding areas of poor performance, such as around readmissions to hospital and falls related hospital admissions. - Ensure that data informs operational practices and improvements and also that operational activities and priorities are used to interpret trends shown by the data.
Residual Risk Level	Likelihood 3 x Impact 3 = Risk Scoring 9 (which is a Moderate Level)
Planned Risk Level	Likelihood 2 x Impact 3 = Risk Scoring 6 (which is a Moderate Risk Level)
Approval recommendation	Given the moderate level of planned risk, this risk is deemed to be manageable.

9.0 CONSULTATIONS

9.1 The Chief Officer, Heads of Service, Health and Community Care and the Clerk were consulted in the preparation of this report.

10.0 BACKGROUND PAPERS

10.1 None.

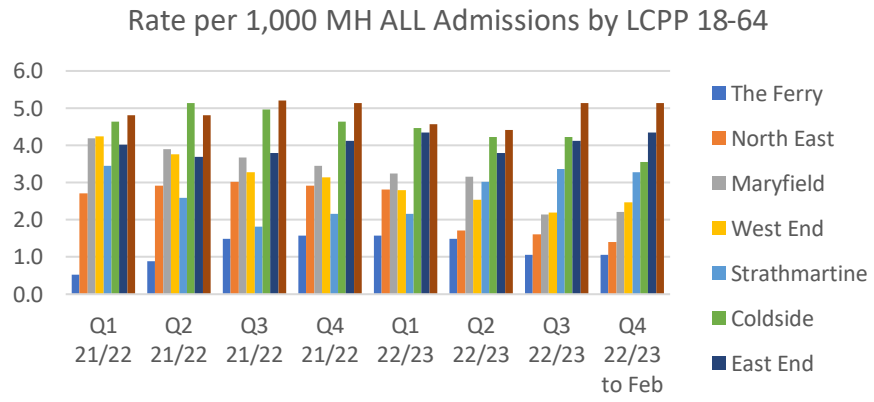
Dave Berry
Chief Finance Officer

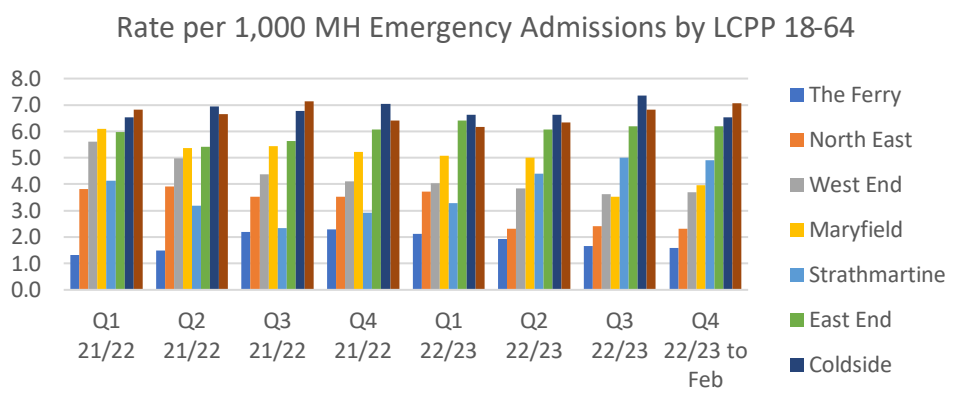
DATE: 1 May 2023

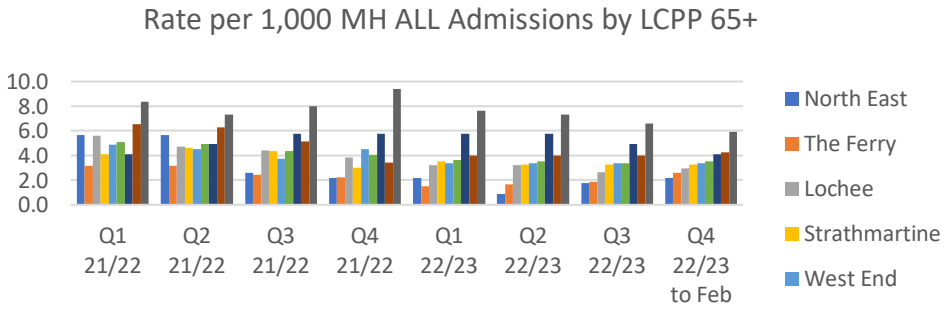
Lynsey Webster
Senior Officer, Strategy and Performance

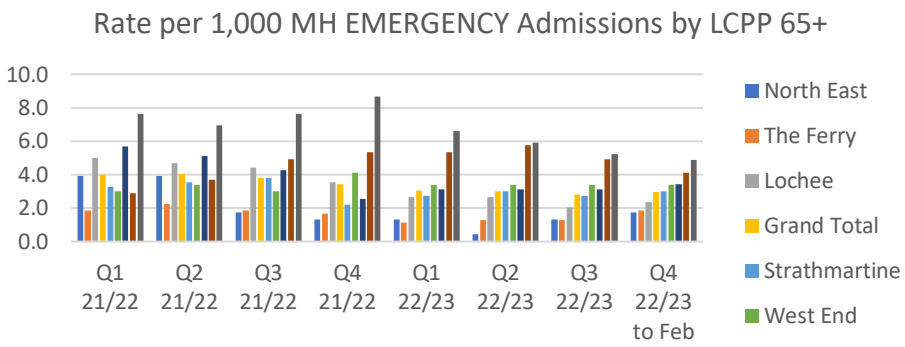
Linda Graham
Clinical Lead for Mental Health and Learning Disabilities

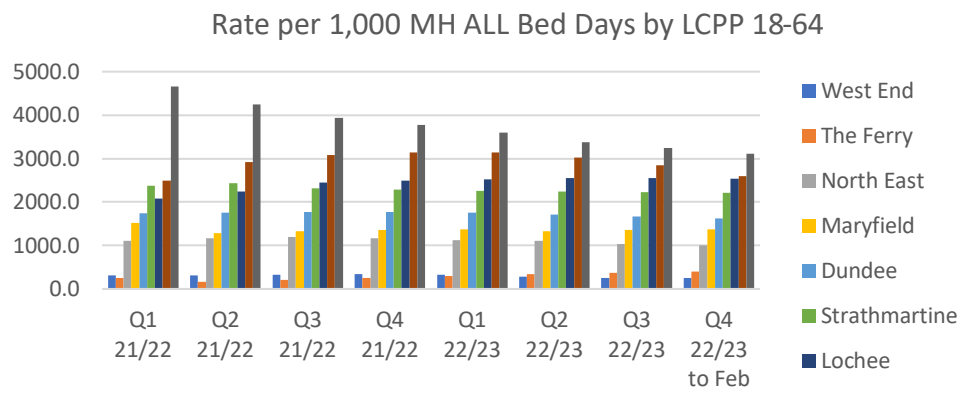
Indicator	Rolling 21/22 Q1	Rolling 21/22 Q2	Rolling 21/22 Q3	Rolling 21/22 Q4	Rolling 22/23Q1	Rolling 22/23Q2	Rolling 22/23Q3	Rolling 22/23Q4 (To Feb)	Comments/Analysis
Unscheduled Care									
Number of Mental Health ALL Admissions for people aged 18-64	485	456	448	447	443	435	433	430	Downward trend
Number of Mental Health EMERGENCY Admissions for people aged 18-64	345	333	326	323	307	290	281	277	Downward trend
Rate per 1,000 Mental Health ALL Admissions for people aged 18-64	5.1	4.8	4.7	4.7	4.7	4.6	4.6	4.5	- Downward trend -Variation by LCPP although note that rates are not standardised. -Highest rates in Lochee, followed by East End and lowest rates in The Ferry

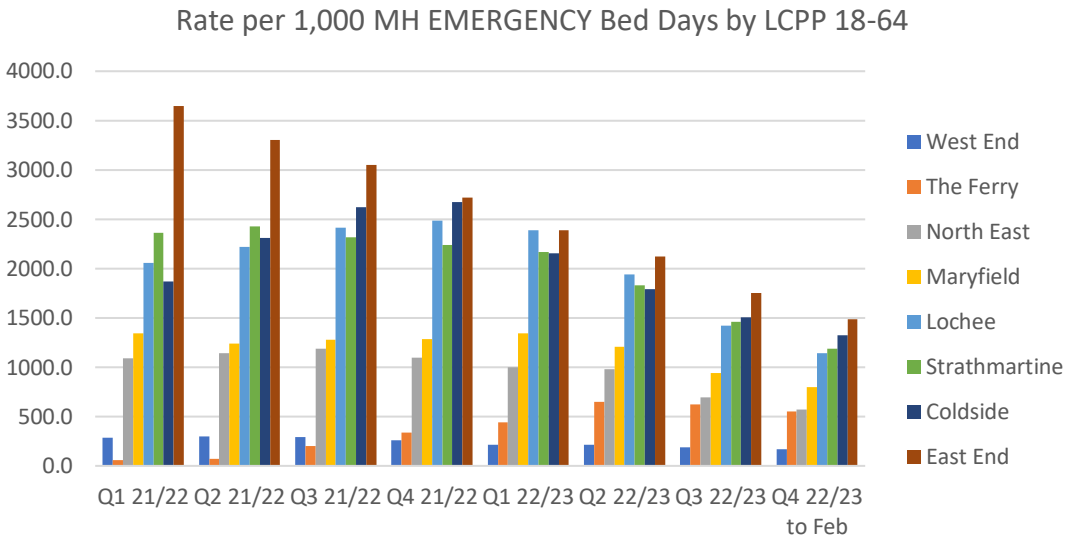
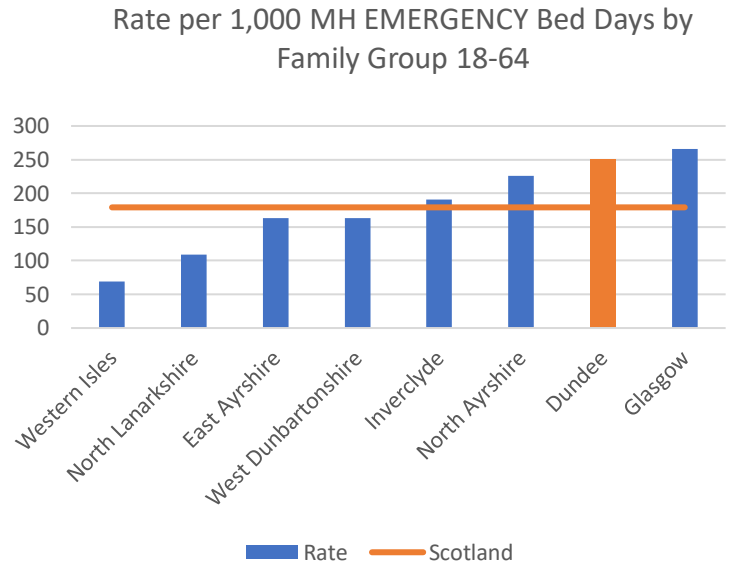


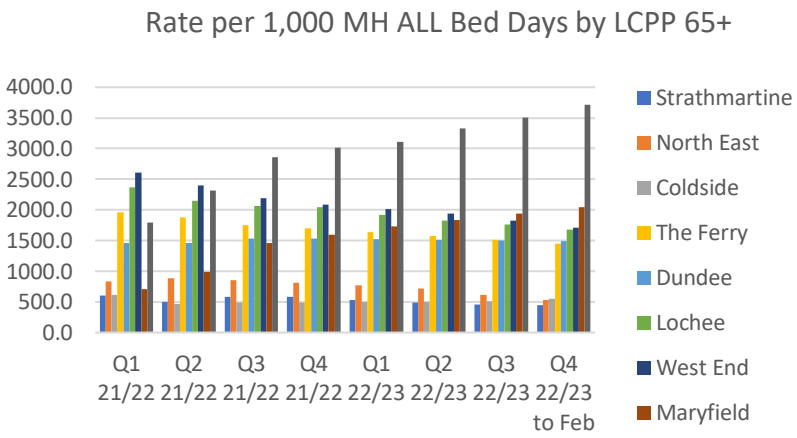
Indicator	Rolling 21/22 Q1	Rolling 21/22 Q2	Rolling 21/22 Q3	Rolling 21/22 Q4	Rolling 22/23Q1	Rolling 22/23Q2	Rolling 22/23Q3	Rolling 22/23Q4 (To Feb)	Comments/Analysis
Rate per 1,000 Mental Health EMERGENCY Admissions for people aged 18-64	3.6	3.5	3.4	3.4	3.2	3.1	3.0	2.9	-Downward trend -Variation by LCPP although note that rates are not standardised. -Highest rates in Lochee, followed by Coldside and lowest rates in The Ferry
									
Number of Mental Health ALL Admissions for people aged 65+	134	130	115	106	96	92	89	92	Downward Trend
Number of Mental Health EMERGENCY Admissions for people aged 65+	105	106	10	90	80	79	74	78	Downward Trend

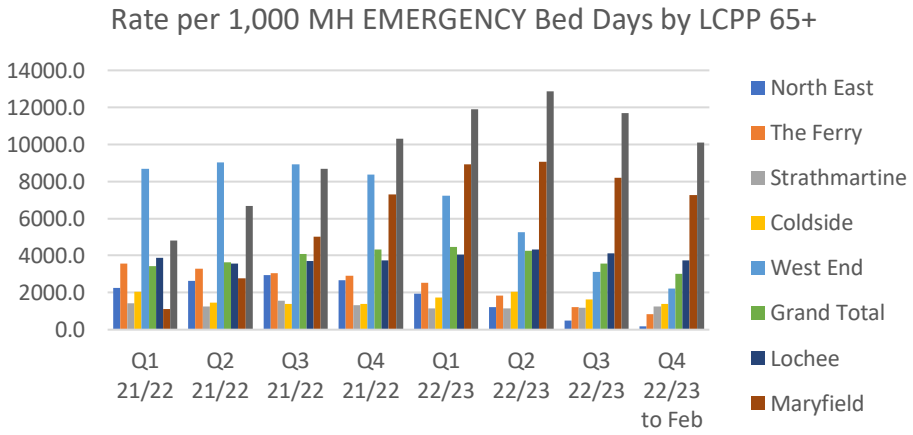
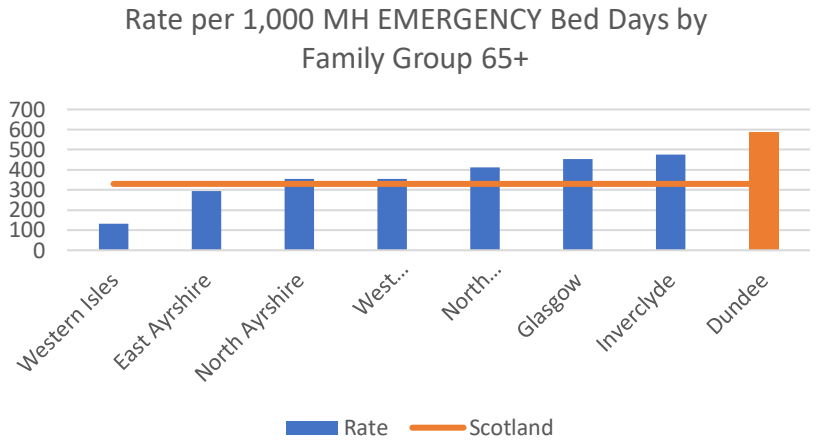
Indicator	Rolling 21/22 Q1	Rolling 21/22 Q2	Rolling 21/22 Q3	Rolling 21/22 Q4	Rolling 22/23Q1	Rolling 22/23Q2	Rolling 22/23Q3	Rolling 22/23Q4 (To Feb)	Comments/Analysis
Rate per 1,000 Mental Health ALL Admissions for people aged 65+	5.1	5.0	4.4	4.0	3.7	3.5	3.4	3.5	-Downward trend -Variation by LCPP although note that rates are not standardised. -Highest rates in East End, followed by Coldside and lowest rates in North East
									
Rate per 1,000 Mental Health EMERGENCY Admissions for people aged 65+	4.0	4.0	3.8	3.4	3.0	3.0	2.8	3.0	-Downward trend -Variation by LCPP although note that rates are not standardised. -Highest rates in East End, followed by Maryfield and lowest rates in North East

Indicator	Rolling 21/22 Q1	Rolling 21/22 Q2	Rolling 21/22 Q3	Rolling 21/22 Q4	Rolling 22/23Q1	Rolling 22/23Q2	Rolling 22/23Q3	Rolling 22/23Q4 (To Feb)	Comments/Analysis
									
Number of Mental Health ALL Bed Days for people aged 18-64	165,561	166,188	168,114	168,120	166,589	162,593	158,575	154,189	Downward Trend
Rate per 1,000 Mental Health ALL Bed Days for people aged 18-64	1743.7	1750.3	1770.6	1770.7	1754.5	1712.5	1670.1	1623.9	-Downward trend -Variation by LCPP although note that rates are not standardised. -Highest rates in East End, followed by Coldside and lowest rates in West End .

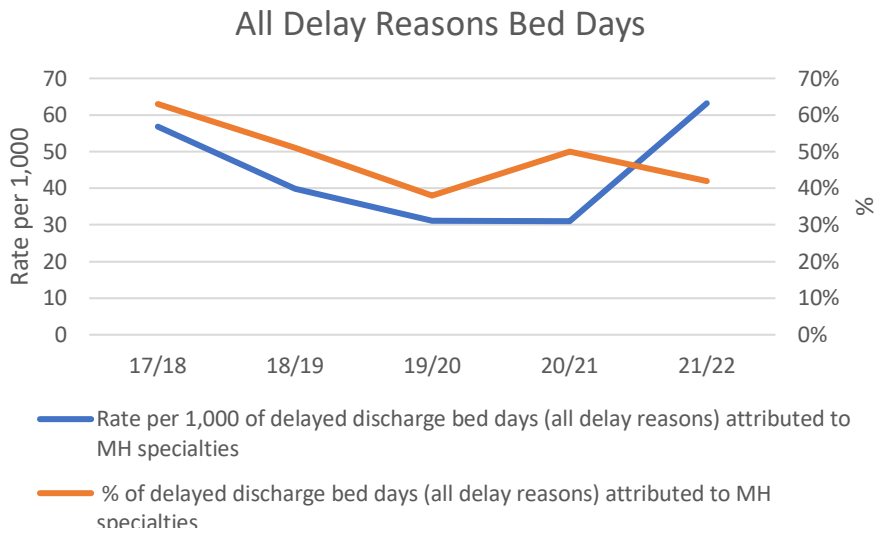
Indicator	Rolling 21/22 Q1	Rolling 21/22 Q2	Rolling 21/22 Q3	Rolling 21/22 Q4	Rolling 22/23Q1	Rolling 22/23Q2	Rolling 22/23Q3	Rolling 22/23Q4 (To Feb)	Comments/Analysis
									
Number of Mental Health EMERGENCY Bed Days for people aged 18-64	143,295	147,632	152,483	150,302	139,394	123,403	98,439	83,022	Downward Trend
Rate per 1,000 Mental Health EMERGENCY Bed Days for people aged 18-64	1509.2	1554.9	1606.0	1583.0	1468.1	1299.7	1036.8	874.4	-Downward trend -Variation by LCPP although note that rates are not standardised. -Highest rates in East End, followed by Coldside and lowest rates in West End . -Dundee has the 2nd highest rate in the Family Group and is considerably higher than the Scotland rate.

Indicator	Rolling 21/22 Q1	Rolling 21/22 Q2	Rolling 21/22 Q3	Rolling 21/22 Q4	Rolling 22/23Q1	Rolling 22/23Q2	Rolling 22/23Q3	Rolling 22/23Q4 (To Feb)	Comments/Analysis
									
Number of Mental Health ALL Bed Days for people aged 65+	138,778	138,448	145,020	145,549	144,060	143,339	142,091	141,532	Increasing trend
Rate per 1,000 Mental Health ALL Bed Days for people aged 65+	1461.6	1458.2	1527.4	1532.9	1517.3	1509.7	1496.5	1490.6	• Increasing trend • Variation by LCPP although note that rates are not standardised. • Highest rates in East End, followed by Maryfield and lowest rates in Strathmartine .

Indicator	Rolling 21/22 Q1	Rolling 21/22 Q2	Rolling 21/22 Q3	Rolling 21/22 Q4	Rolling 22/23Q1	Rolling 22/23Q2	Rolling 22/23Q3	Rolling 22/23Q4 (To Feb)	Comments/Analysis
									
Number of Mental Health EMERGENCY Bed Days for people aged 65+	89,783	95,559	107,267	113,938	117,480	111,945	93,723	79,553	Downward trend
Rate per 1,000 Mental Health EMERGENCY Bed Days for people aged 65+	3421.2	3641.3	4087.5	4341.7	4476.6	4265.7	3571.4	3031.4	-Downward trend -Variation by LCPP although note that rates are not standardised. -Highest rates in East End, followed by Maryfield and lowest rates in North East . -Dundee has the highest rate in the Family Group and is considerably higher than the Scotland rate.

Indicator	Rolling 21/22 Q1	Rolling 21/22 Q2	Rolling 21/22 Q3	Rolling 21/22 Q4	Rolling 22/23Q1	Rolling 22/23Q2	Rolling 22/23Q3	Rolling 22/23Q4 (To Feb)	Comments/Analysis
									
Number of A+E attendances with psychiatry diagnosis	N/A	N/A	N/A	1792	1755	1673	1650	1674	Downward trend, 118 less attendances in Q4 22/23 than Q4 21/22.
Number of people who have received support from a Navigator									In progress
Number of avoided emergency admissions supported by the paramedic response vehicle.									In progress

Indicator	Rolling 21/22 Q1	Rolling 21/22 Q2	Rolling 21/22 Q3	Rolling 21/22 Q4	Rolling 22/23Q1	Rolling 22/23Q2	Rolling 22/23Q3	Rolling 22/23Q4 (To Feb)	Comments/Analysis
Delayed Discharges									
Rate of standard delayed discharge from general psychiatry specialty									Indicator in development
Rate of standard delayed discharge from psychiatry of old age specialty									Indicator in development
Rate of complex delayed discharge from general psychiatry specialty									Indicator in development
Rate of complex delayed discharge from psychiatry of old age specialty									Indicator in development



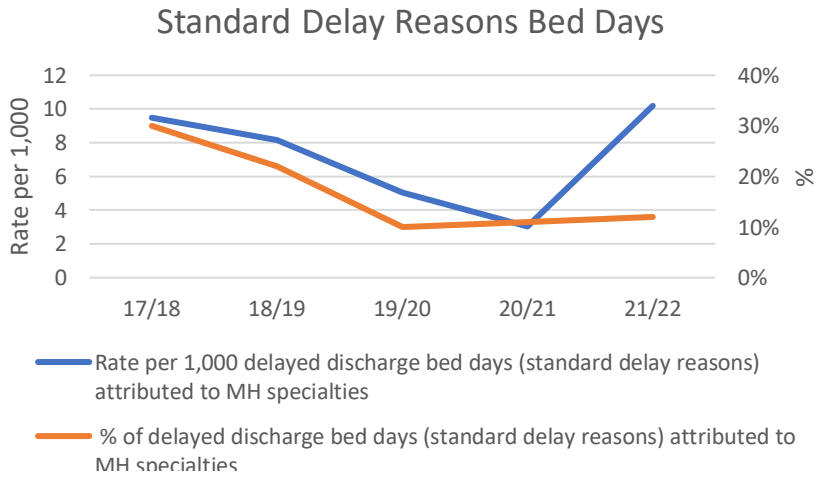
-not available at LCPP level

-not available by quarter

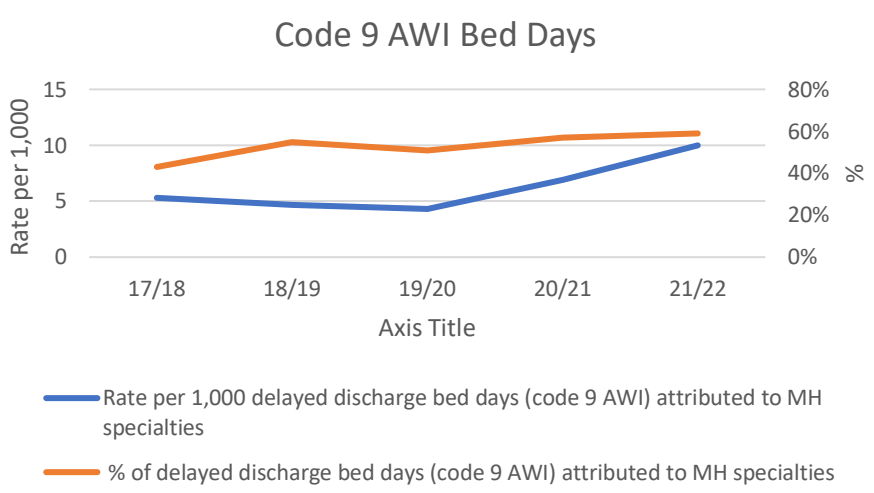
- Rate per 1,000 delayed discharge bed days (all reasons) attributed to MH specialties increased between 2021/22 and was higher than the 17/18 rate

-% of delayed discharge bed days (all reasons) attributed to MH specialties increased between 20/21 and 21/22 and was 63% at 21/22

Source: PHS Publication December 2022



-not available at LCPP level
-not available by quarter
- Rate per 1,000 delayed discharge bed days (standard delay reasons) attributed to MH specialties increased between 2021/22 and was higher than the 17/18 rate
-% of delayed discharge bed days (standard delay reasons) attributed to MH specialties decreased from 30% in 17/18 to 10% in 19/20 and between 19/20 and 21/22 increased to 12%.
Source: PHS Publication December 2022



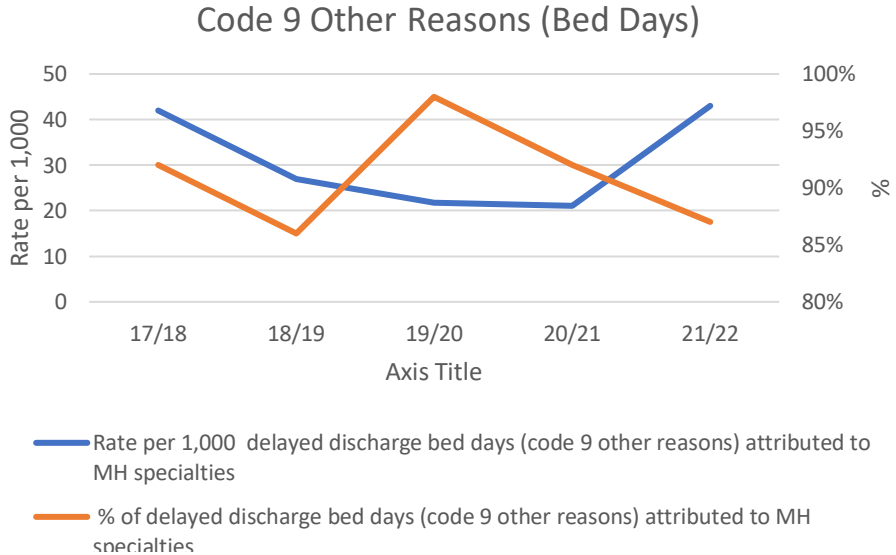
-not available at LCPP level

-not available by quarter

- Rate per 1,000 delayed discharge bed days (code 9 AWI) attributed to MH specialties decreased from 5 in 17/18 to 4 in 19/20 and between 19/20 and 21/22 increased to 10.

-% of delayed discharge bed days (code 9 AWi) attributed to MH specialties increased from 43% in 17/18 to 59% in 21/22

Source: PHS Publication December 2022



-not available at LCPP level

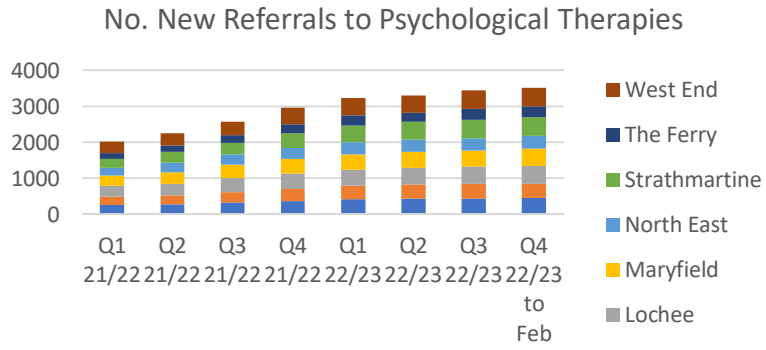
-not available by quarter

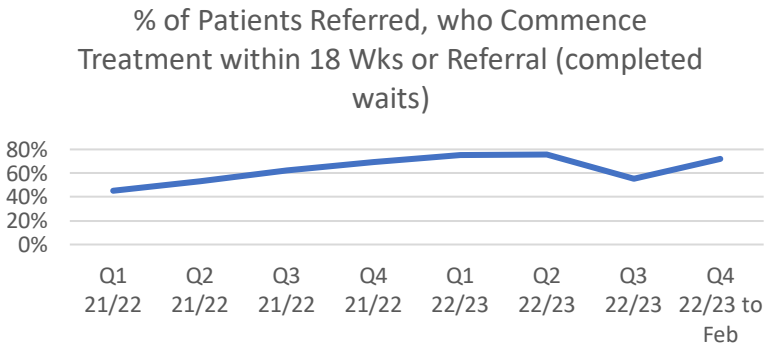
- Rate per 1,000 delayed discharge bed days (code 9 other reasons) attributed to MH specialties decreased from 42 in 17/18 to 21 in 20/21 and increased to 43 in 21/22.

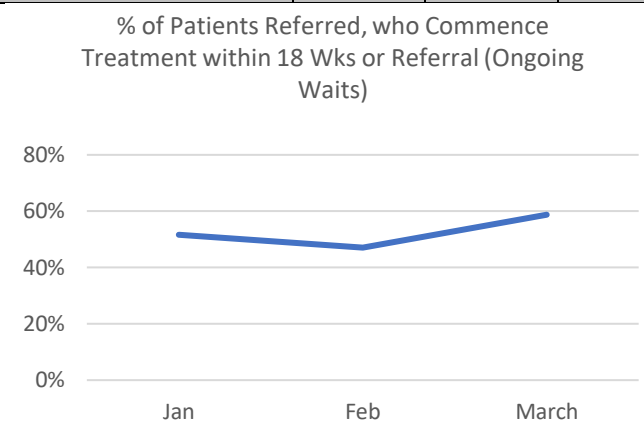
-% of delayed discharge bed days (code 9 other reasons) attributed to MH specialties decreased from 98% in 19/20 to 87% in 21/22.

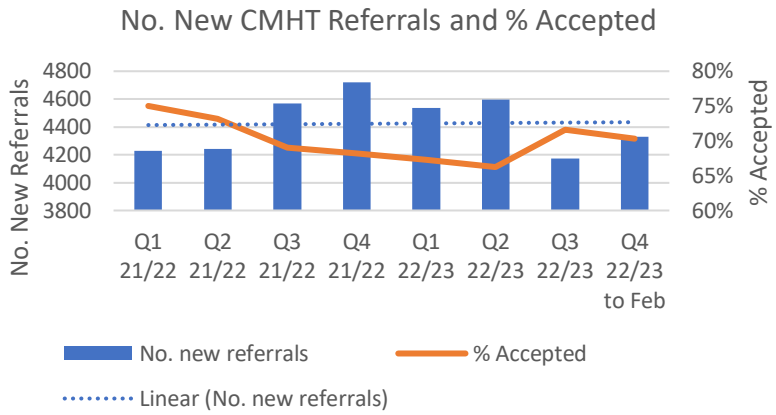
Source: PHS Publication December 2022

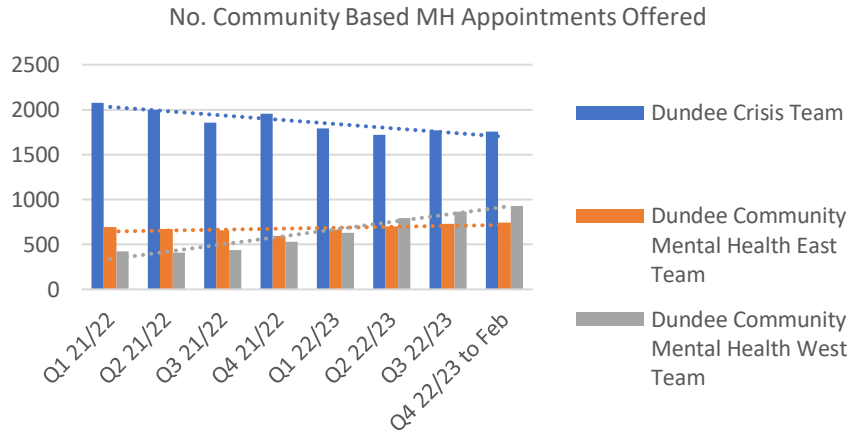
Indicator	Rolling 21/22 Q1	Rolling 21/22 Q2	Rolling 21/22 Q3	Rolling 21/22 Q4	Rolling 22/23Q1	Rolling 22/23Q2	Rolling 22/23Q3	Rolling 22/23Q4 (To Feb)	Comments/Analysis
Psychological Therapies									
Number of NEW referrals to psychological therapies (ALL)	2010	2249	2572	2954	3217	3299	3442	3500	• Increasing trend • Most new referrals are from Strathmartine (526 at Q4 22/23). • Strathmartine has the lowest rate of ALL mental health bed days and the 3rd lowest of emergency mental health bed days for age 65+. • Strathmartine has the 4th highest rate rate of ALL mental health bed days and the 3rd highest of emergency mental health bed days for age 18-64.

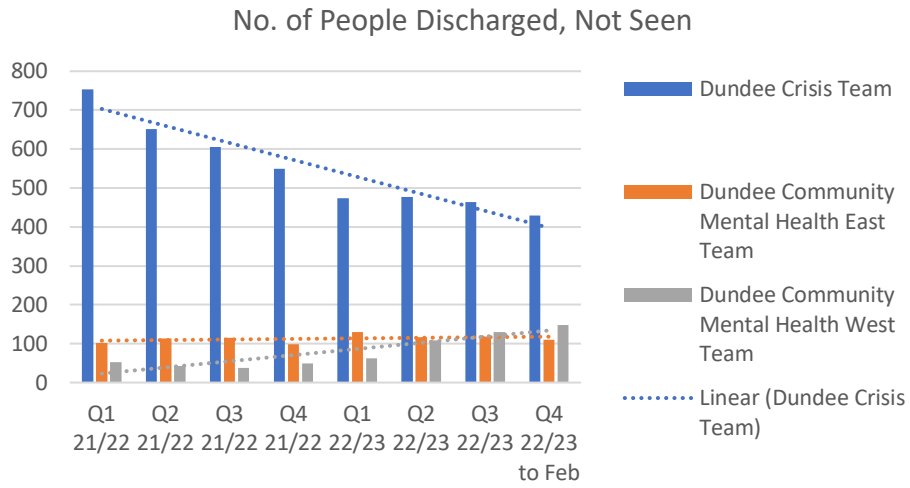


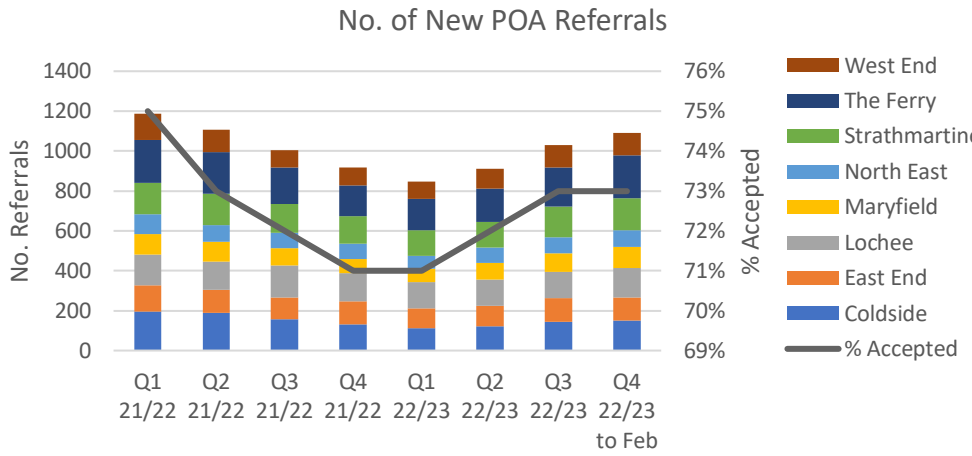
Indicator	Rolling 21/22 Q1	Rolling 21/22 Q2	Rolling 21/22 Q3	Rolling 21/22 Q4	Rolling 22/23Q1	Rolling 22/23Q2	Rolling 22/23Q3	Rolling 22/23Q4 (To Feb)	Comments/Analysis
% of patients referred to psychological therapies who commences their treatment within 18 weeks of referral (completed waits)	45%	53%	62%	69%	75%	76%	55%	72%	Increasing trend.
									
% of patients referred to psychological therapies who commences their treatment within 18 weeks of referral (ongoing waits)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	52%	Data prior to Jan 2022 not available.

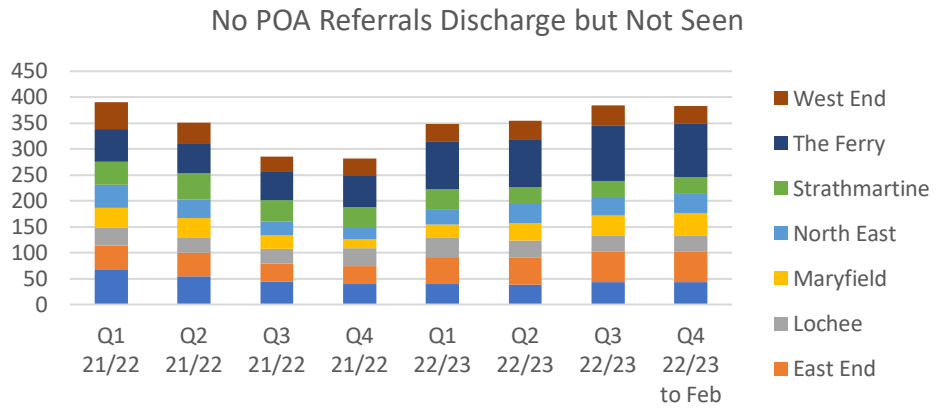
Indicator	Rolling 21/22 Q1	Rolling 21/22 Q2	Rolling 21/22 Q3	Rolling 21/22 Q4	Rolling 22/23Q1	Rolling 22/23Q2	Rolling 22/23Q3	Rolling 22/23Q4 (To Feb)	Comments/Analysis
									
Community Mental Health Team									
Number of new referrals to CMHT (and % accepted)	4227 (75%)	4244 (73%)	4568 (69%)	4719 (68%)	4536 (67%)	4597 (66%)	4171 (72%)	4328 (70%)	-The number of referrals peaked at Q4 21/22 but has since returned to around Q1/Q2 21/22 levels. -The % accepted has fluctuated between 66% and 75%

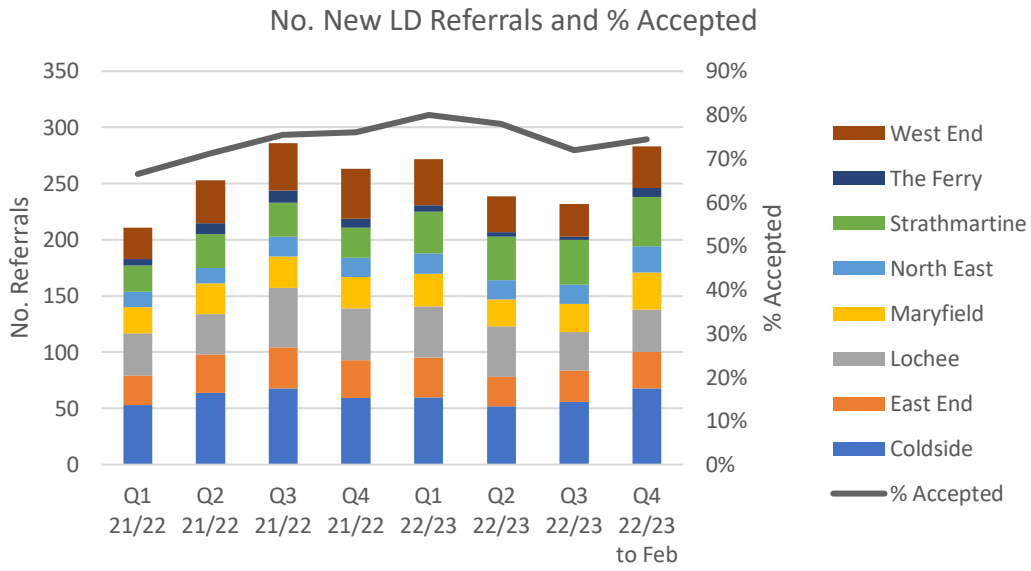
Indicator	Rolling 21/22 Q1	Rolling 21/22 Q2	Rolling 21/22 Q3	Rolling 21/22 Q4	Rolling 22/23Q1	Rolling 22/23Q2	Rolling 22/23Q3	Rolling 22/23Q4 (To Feb)	Comments/Analysis
									
% of discharged psychiatric in patients followed up by CMHT services within 7 calendar days									Requires further development as not currently possible using the current EMIS system.
Number of community based mental health appointments offered	3194	3077	2942	3077	3083	3213	3361	3428	-Slight reduction in number of appointments offered from Dundee Crisis Team. -The number of appointments offered from Dundee Community Mental Health East Team has remained fairly stable. -There has been an increase in the number of appointments offered from Dundee Community Mental Health West Team.

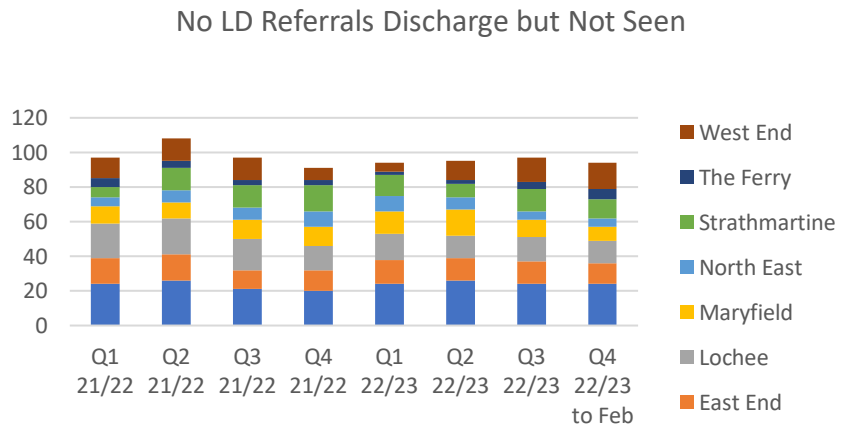
Indicator	Rolling 21/22 Q1	Rolling 21/22 Q2	Rolling 21/22 Q3	Rolling 21/22 Q4	Rolling 22/23Q1	Rolling 22/23Q2	Rolling 22/23Q3	Rolling 22/23Q4 (To Feb)	Comments/Analysis
									
No. of return appointments for every new patient seen.	16	17	19	18	18	17	15	14	Reduced from 16 appointments to 14.
Number of people discharged without being seen	3203	3086	2950	3085	3091	3221	3370	3436	-Slight reduction in number of people discharged without being seen from Dundee Crisis Team. -The no. of people discharged without being seen from Dundee Community Mental Health East Team has remained fairly stable. -There has been an increase in the number of people discharged without being seen from Dundee Community Mental Health West Team.

Indicator	Rolling 21/22 Q1	Rolling 21/22 Q2	Rolling 21/22 Q3	Rolling 21/22 Q4	Rolling 22/23Q1	Rolling 22/23Q2	Rolling 22/23Q3	Rolling 22/23Q4 (To Feb)	Comments/Analysis
									
Waiting time indicator in development									Data quality exercise being undertaken and data expected Q1 23/24
Psychiatry of Old Age									
Number of new referrals to Psychiatry of Old Age (and % accepted)	1186 (75%)	1108 (73%)	1004 (72%)	918 (71%)	846 (71%)	911 (72%)	1030 (73%)	1092 (73%)	-The number of new referrals dipped to Q1 22/23 and has since increased to around the same as Q1 21/22. The % accepted followed a similar pattern. -At Q4, the highest number of new referrals came from The Ferry and the lowest number came from Maryfield.

Indicator	Rolling 21/22 Q1	Rolling 21/22 Q2	Rolling 21/22 Q3	Rolling 21/22 Q4	Rolling 22/23Q1	Rolling 22/23Q2	Rolling 22/23Q3	Rolling 22/23Q4 (To Feb)	Comments/Analysis
									
Number of return appointments for every new patient seen.	7	6	6	6	6	6	5	6	Reduced from 7 to 6.
Number of people discharged without being seen	390	351	285	282	348	355	384	383	• Slight dip Q4 21/22 but the number increased to Q4 to similar number as Q1 21/22. • The largest number of people discharged without being seen are from The Ferry (also highest number of new referrals) and the lowest number are from Lochee.

Indicator	Rolling 21/22 Q1	Rolling 21/22 Q2	Rolling 21/22 Q3	Rolling 21/22 Q4	Rolling 22/23Q1	Rolling 22/23Q2	Rolling 22/23Q3	Rolling 22/23Q4 (To Feb)	Comments/Analysis
									
% of those referred for post diagnostic support who received a minimum 12 months of support.									Published data only available to 20/21 (Published Dec 22). At that point Dundee was at 93.4%
Learning Disabilities									
Number of new referrals to LD (and % accepted)	211 (66%)	253 (71%)	286 (76%)	263 (76%)	272 (80%)	239 (78%)	232 (72%)	283 (74%)	-Q4 22/23 is the highest of the previous 7 rolling 12 month periods. -Highest number of new referrals was from Coldside and the lowest number was from The Ferry. -% accepted increased from 66% at Q1 21/22 to 74% at Q4 22/23.

Indicator	Rolling 21/22 Q1	Rolling 21/22 Q2	Rolling 21/22 Q3	Rolling 21/22 Q4	Rolling 22/23Q1	Rolling 22/23Q2	Rolling 22/23Q3	Rolling 22/23Q4 (To Feb)	Comments/Analysis
									
Number of return appointments for every new patient seen.	18.1	16.8	15.5	15.1	14.4	13.8	14.0	13.5	Reduced from 18 to 13.5
Number of people discharged without being seen	97	108	97	91	94	95	97	94	Has been fairly consistent over the previous 4 rolling quarters and at Q4 22/23 was 94.

Indicator	Rolling 21/22 Q1	Rolling 21/22 Q2	Rolling 21/22 Q3	Rolling 21/22 Q4	Rolling 22/23Q1	Rolling 22/23Q2	Rolling 22/23Q3	Rolling 22/23Q4 (To Feb)	Comments/Analysis
									
Mental Health Officer Team									
MHO new referrals and Assessment	325	342	329	339	337	321	298	292	Downward trend.
CMHT (SW team) new referrals	158	159	166	167	149	136	151	145	Downward trend.
CMHT older people (SW team)	195	171	156	131	136	140	159	165	Downward trend.
LA Guardianship applications	39	37	34	47	41	48	49	40	Stable trend.

Indicator	Rolling 21/22 Q1	Rolling 21/22 Q2	Rolling 21/22 Q3	Rolling 21/22 Q4	Rolling 22/23Q1	Rolling 22/23Q2	Rolling 22/23Q3	Rolling 22/23Q4 (To Feb)	Comments/Analysis
Private Guardianship application	53	64	71	65	58	59	64	63	Fluctuating between 53 and 71, however 63 at Q4 22/23.
Emergency detention in hospital (up to 72 hours) (s36)	91	96	84	97	102	103	107	95	Increased at Q1 22/23 but decreased Q4 22/23/
Short term detention in hospital (up to 28 days) (s44)	156	170	157	167	164	166	169	169	Stable trend
Compulsory Treatment Orders (s64)	47	54	49	46	52	47	52	55	Increasing trend.
No. of S44 with Social Circumstance report was considered	81	83	65	67	56	51	52	56	Downward trend.
No. of SCR that were prepared	59	60	47	50	41	35	34	32	Downward trend.
MHO team caseload at period end	225	243	272	263	265	251	265	273	Increasing trend.
MHO unallocated at end of quarter	29	41	56	47	49	46	53	44	Increasing trend.
% MHO unallocated out of all cases	13%	17%	21%	18%	18%	18%	20%	16%	Stable trend.

Indicator	Rolling 21/22 Q1	Rolling 21/22 Q2	Rolling 21/22 Q3	Rolling 21/22 Q4	Rolling 22/23Q1	Rolling 22/23Q2	Rolling 22/23Q3	Rolling 22/23Q4 (To Feb)	Comments/Analysis
CMHT (SW team) caseloads at period end	446	457	462	485	456	412	410	429	Downward trend.
CMHT (SW teams) unallocated at end of quarter	5	5	5	4	4	0	2	11	Increasing trend.
% CMHT (SW teams) unallocated out of all cases	1%	1%	1%	1%	1%	0%	0%	3%	Very low % unallocated.
CMHT older people (SW team) caseloads at period end	259	255	258	259	269	254	262	253	Stable trend.
CMHT older people (SW team) unallocated at end of quarter	1	0	0	0	0	0	0	0	Very low / zero unallocated. .
% CMHT older people (SW team) unallocated out of all cases	0%	0%	0%	0%	0%	0%	0%	0%	Zero

Dundee Integration Joint Board Integrated Impact Assessment

Part 1 - Pre-Integrated Impact Assessment Screening.
NB For Dundee City Council Committees the Citrix Firm Step Process must be used.
This word document can be completed and information transferred to Firm Step if required.

Title of Report/Project/Strategy	Dundee Health And Social Care Partnership Mental Health Performance Report
Lead Officer for Report/Project/Strategy (Name and Job Title)	Kathryn Sharp, Service Manager
Name and email of Officer Completing the Screening Tool	Kathryn Sharp, Service Manager
List of colleagues contributing information for Screening and IIA	-
Screening Completion Date	28/04/23
Name and Email of Senior Officer to be Notified when Screening complete	Vicky Irons, Chief Officer

Is there a clear indication that an IIA is needed? Mark one box only		
	YES	Proceed to IIA
X	**NO**	*Continue with Screening Process*

Is the purpose of the Committee document the approval of any of the following Mark one box either **Yes** or **No**
NB When yes to any of the following proceed to IIA document.

	Yes		**No**	
A major Strategy/Plan, Policy or Action Plan		*Proceed directly to IIA*	X	*Continue with Screening Process*
An area or partnership-wide Plan		*Proceed directly to IIA*	X	*Continue with Screening Process*
A Plan, programme or Strategy that sets the framework for future development consents		*Proceed directly to IIA*	X	*Continue with Screening Process*
The setting up of a body such as a Commission or Working Group		*Proceed directly to IIA*	X	*Continue with Screening Process*
An update to a Plan		*Proceed directly to IIA*	X	*Continue with Screening Process*

There a number of reports which do not automatically require an IIA. If your report does not automatically require an IIA you should consider if an IIA is needed by completing the checklist on following page.

These include: An annual report or progress report on an existing plan **/** A service redesign. **/** A report on a survey, or stating the results of research. / Minutes, e.g. of Sub-Committees. / A minor contract that does not impact on the wellbeing of the public. / An appointment, e.g. councillors to outside bodies, Senior officers, or independent chairs. / Ongoing Revenue expenditure monitoring. / Notification of proposed tenders. / Noting of a report or decision made by another Committee including noting of strategy, policies and plans approved elsewhere.

Only complete the checklist on the following page whenever your report does not automatically require an Integrated Impact Assessment otherwise delete the page prior to proceeding to IIA.

Dundee Integration Joint Board Integrated Impact Assessment

Part 1 (continued) Pre-Integrated Impact Assessment Screening.

Screening Checklist for IIA Completion. When yes to any of the following proceed to IIA document.

Mark one box only either Yes or No.

Will the recommendations in the report impact on anyone in relation to any of the Protected Characteristics? *Age; Disability; Gender Reassignment; Marriage & Civil Partnerships; Pregnancy & Maternity; Race / Ethnicity; Religion or Belief; Sex; Sexual Orientation*.			
X	**No** Continue Screening Process		**Yes. Proceed to IIA.**
Will the recommendations in the report impact on People's Human Rights? *For more information on Human Rights visit: https://www.scottishhumanrights.com*			
X	**No** Continue Screening Process		**Yes. Proceed to IIA.**
Will the recommendations in the report impact on anyone residing in a Community Regeneration Area (CRA)? *Within the 15% most deprived areas in Scotland according to the 2020 Scottish Index of Multiple Deprivation*.			
X	**No** Continue Screening Process		**Yes. Proceed to IIA.**
Will the recommendations in the report impact on anyone in more vulnerable types of households? *Lone parent families (especially single female parents); households with a greater number of children and/or young children; pensioner households (single or couple)*			
X	**No** Continue Screening Process		**Yes. Proceed to IIA.**
Will the recommendations in the report impact on anyone experiencing the following issues? *Unskilled or unemployed and of working age; serious and enduring mental health; homelessness (potential homelessness); drug and/or alcohol.*			
X	**No** Continue Screening Process		**Yes. Proceed to IIA.**
Will the recommendations in the report impact on anyone in the following more vulnerable groups? *Offenders and ex-offenders; looked after children and care leavers; carers.*			
X	**No** Continue Screening Process		**Yes. Proceed to IIA.**
Will the recommendations in the report impact on any of the following? *Employment; education & skills; benefit advice / income maximisation; childcare; affordability and accessibility of services.*			
X	**No** Continue Screening Process		**Yes. Proceed to IIA.**
Will the recommendations in the report on Climate Change or Resource Use? *Mitigating greenhouse gases; adapting to the effects of climate change. or Energy efficiency & consumption; prevention, reduction, re-use, recovery or recycling waste; sustainable procurement.*			
X	**No** Continue Screening Process		**Yes. Proceed to IIA.**
Will the recommendations in the report impact on Transport? *Accessible transport provision; sustainable modes of transport.*			
X	**No** Continue Screening Process		**Yes. Proceed to IIA.**
Will the recommendations in the report impact on the Natural Environment? *Air, land or water quality; biodiversity; open and green spaces.*			
X	**No** Continue Screening Process		**Yes. Proceed to IIA.**
Will the recommendations in the report impact on the Built Environment? *Built heritage; housing.*			
X	**No** Continue Screening Process		**Yes. Proceed to IIA.**

When no to everything in the above screening process you must contact 'Senior Officer to be Notified on Completion' and present a copy of this Screening tool with IJB Report.
Otherwise proceed to IIA.

* Transfer information into the Firm Step Process when report is progressing to Council Committee.

The following document includes all questions in DCC IIA- The Dundee City Council IIA Guidance document can be found here.

ITEM No …7……..

REPORT TO: **PERFORMANCE & AUDIT COMMITTEE – 24 MAY 2023**

REPORT ON: **DUNDEE HEALTH & SOCIAL CARE PARTNERSHIP CLINICAL, CARE & PROFESSIONAL GOVERNANCE ASSURANCE REPORT**

REPORT BY: **CLINICAL DIRECTOR**

REPORT NO: **PAC15-2023**

1.0 PURPOSE OF REPORT

1.1 This is presented to the Committee for:

- **Assurance**

This report relates to:

- Government policy/directive
- Legal requirement

This aligns to the following NHS Scotland quality ambition(s):

- Safe
- Effective
- Person-centred

This report is being brought to the Committee to provide assurance on the clinical and care governance activities and arrangements across the Partnership as outlined in the Getting It Right For Everyone (GIRFE) Framework in accordance with the Partnership integration scheme. Clinical Governance is a statutory requirement to report on, at Board level, from Scottish Government as per NHS MEL(1998)75. The Performance and Audit Committee is being asked to provide their view on the level of assurance this report provides and therefore the level of assurance regards clinical and care governance within the Partnership. The timescale for the data within this report is to 31 January 2023.

2.0 RECOMMENDATIONS

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

2.1 Note the Exception Report for the Dundee Health & Social Care Partnership Clinical, Care & Professional Governance Group as detailed in Section 4.

2.2 This report is being presented for:

- **Assurance**

As Lead Officer for Dundee Health & Social Care Partnership (DHSCP) I would suggest that the level of assurance provided is: Reasonable; due to the following factors:

- There is evidence of a sound system of governance throughout the HSCP.
- The identification of risk and subsequent management of risk is articulated well throughout the majority of services.

- There is ongoing scope for improvement across a range of services, in relation to the governance processes, although this is inextricably linked to the ongoing difficulties with recruitment and retention of staff.
- There is evidence of non-compliance relating to a fully comprehensive governance system across some teams, i.e. contemporary management of adverse events and risks.

3.0 FINANCIAL IMPLICATIONS

3.1 None.

4.0 MAIN TEXT

4.1 Background

The role of the Dundee HSCP Clinical, Care & Professional Governance Group (CCPG Group) is to provide assurance to the Dundee Integration Joint Board (IJB), NHS Tayside Board (through the Care Governance Committee) and Dundee City Council, that there are effective and embedded systems for Clinical, Care and Professional Governance in all services within Dundee HSCP.

4.2 The GIRFE Framework is an agreed tool used by all three HSCPs to ensure consistency of approach between Local Authorities, Tayside NHS Board and the IJBs for the three HSCPs; quality assurance is assessed against an agreed, prioritised common data set for each of the governance domains as detailed below. A GIRFE Steering Group has been established and continues to meet, with representatives from each of the three Partnerships, and part of its remit is to support additional common assurance measures and this template.

4.3 The six domains continue to evolve over time and must be adaptable and responsive to the changes in legislation and external support and monitoring. The domains reflect the principles set out in the Health and Social Care Standards, My support, My life; Scottish Government, 2018 and the Quality of Care Approach, HIS and Care Inspectorate, September 2018. The domains are:

Information Governance
Professional Regulation and Workforce Development
Patient / Service User / Carer and Staff Safety
Patient / Service User / Carer and Staff Experience
Quality and Effectiveness of Care
Promotion of Equality and Social Justice

5.0 ASSESSMENT

5.1 Clinical and Care Risk Management

a.1 The table below shows the top six risks in the Dundee HSCP.

Title of Risk		Inherent Risk Score (without controls)	Current Risk Score (with current controls in place)
Increasing patient demand in excess of resources – DDARS		15	25
Risk that current funding would be insufficient to undertake the service redesign of the DDARS		20	20
Insufficient number of		25	16

DDARS staff with prescribing competencies			
Lack of resource to deliver the benzodiazepine dependence pathway compliant with guidelines		20	16
Negative media reporting increasing reputational, clinical and safeguarding risk		25	25
Cornhill Macmillan Centre Registered Nursing Workforce Sustainability		25	20

a.2 Five of the top six risks sit with the Dundee Drug and Alcohol Recovery Service (DDARS). There are ongoing service pressures due to staff turnover that affect all of the key risks identified.

a.3 One of these risks continues to show a current risk score in excess of the inherent risk score. This is primarily due to ongoing challenges relating to recruitment and retention into the DDARS service combined with the increased referral rates throughout and beyond the pandemic.

A senior service manager role has now been appointed to enhance the local leadership for this team and provide support to the two managers currently in post. They are due to commence in role in March 2023. Nursing staffing is showing an improving picture for recruitment and retention at the time of writing this report. This will be closely monitored as this has been highly variable over the past 18 months. One locum consultant now in post and anticipation that there will be a slight improvement in return of substantial medical staff in April.

This has impacted on the ability to provide mental health assessments, increased pressure related to the requirements for same day prescribing, along with reduced availability for support for nursing staff, urgent and batch prescription signing, mentorship for non medical prescribers and advanced nurse practitioners and support and supervision for medical trainees, GPs with special interest and the specialty doctor. This also has an impact on the work to achieve the medication assisted treatment standards (MATS) which are currently reported monthly to the Scottish Government.

a.4 The benzodiazepine dependence pathway is currently being considered via a National Taskforce who are considering the possible models of practice.

<u>New Risks</u>
<u>Cornhill In-Patient Unit Nursing Workforce Sustainability</u>

b.1 As a result of increasing registered nursing vacancies there is a significantly depleted workforce that has the potential to be unable to deliver safe and effective care. A number of measures have been established to manage this risk including daily safety huddle meetings, weekly contingency meetings, managers supporting clinical shifts (those who have previously and recently worked in palliative care), exploring the use of tier 3 agency staff, linking with human resources for any staff who may be able to support via the redeployment register and the mutual aid of staff from Roxburghe House, Dundee.

A new charge nurse has been appointed who is building a very positive culture within the unit with early reports of enhanced retention of staff.

<u>Occupational Therapy Workforce Sustainability – Ninewells Hospital</u>

b.2 As a result of a vacancy rate above 30% (with additional medium term sick leave), Occupational Therapy care delivery is being compromised as the team need to prioritise input to discharges and front door areas of Ninewells Hospital. This has the potential to impact on

patient care across the teams, staff stress and dissatisfaction and this contributes to reduced retention of staff.

b.3 The team have a number of actions in place to mitigate this risk:

- Rolling adverts on Jobtrain
- Service-wide priorities considered daily across teams and sites
- Exploring opportunities for international recruitment
- Escalation plans in place for each team and across Tayside
- Nurse bank health care support workers recruited to assist with routine occupational therapy tasks
- Flexible working options open to staff to support wellbeing and care delivery

Staff Resource

b.4 The sustainability of staffing continues to be a significant pressure across a wide range of teams and professions within the HSCP. Within the new risks listed above, both nursing staff and occupational therapy staff are highlighted as areas of particular concern. This is managed well on a day to day basis and support is provided between teams, between HSCPs and across professional boundaries as required. This is not sustainable in the long term and staff continue to report fatigue and impacts on their wellbeing. This links to strategic risk HSCR00b1 which describes the risk across a range of staff groups and the control measures including the development of new models of care, organisational development strategy, service redesign and the ongoing development of the workforce plan.

b.5 A number of measures have been put into place to try and support teams to meet the increasing demands being placed on them across all areas of the HSCP due to the reduction in available staff and also the increase in new levels of demand. Digital solutions have been implemented to support some pathways and also support the principles of 'active waiting' when patients are on our waiting lists. Work is prioritised on a daily basis to ensure the most acutely unwell and vulnerable are well supported. Various methods to support recruitment have been explored; international recruits, recruitment micro sites, role development and work with wider partners to support more routine work. Management are taking a supportive and flexible approach to requests for additional hours although this will become more challenging into the next financial year.

5.2 Clinical & Care Governance Arrangements

c.1 The arrangements for clinical, care & professional governance (CCPG) in the Dundee HSCP are outlined in Appendix 1: Dundee HSCP Governance Structure.

During this reporting period exception reports were presented to the CCPG Group from the following services:

- Nutrition and Dietetics
- Acute and Urgent Care
- Care Homes
- Community Services
- Drug and Alcohol Recovery Service
- Inpatient and Day Care
- Health Inequalities
- Psychological Therapies
- Psychiatry of Old Age
- Primary Care

Examples from the exception reports presented include:

c.2 Psychological Therapies reported on the national work they are involved with exploring additional ways to increase the number of candidates applying for posts. They also reported

on the internal opportunities being developed for existing staff to gain experience in difficult to recruit to specialities.

c.3 The Care Home report provided a comprehensive overview of the oversight measures that continue to operate following their development through the pandemic. The report provided an excellent overview of the current status for care homes and where any issues were identified, where any emerging issues were noted and where new developments were implemented. The report described a range of forums and opportunities for engagement and collaborative working including the planning for care homes with the Listening Service and a study in conjunction with University of St Andrews around adaptive interaction techniques.

c.4 The Psychiatry of Old Age Inpatient team reported ongoing concerns with regard to sustainability of registered mental health nurses on overnight shifts. This is currently being explored via a Tayside short life working group and a framework for band 4 staff development. The team are also building enhanced links with advocacy and carers' centres within Kingsway Care Centre including the development of drop in sessions for carers and a touchdown desk being made available to advocacy and carers' link workers.

c.5 The Nutrition and Dietetic Service reported that the Adult Weight Management waiting times have reduced from over 100 weeks to 48 weeks with the redesigned service and additional staff supporting this improvement.
They also reported on a series of adverse events relating to enteral feeding and the processes around this. Following review, training packages and enhanced communication have been established to support ongoing care.

c.6 The Dundee Drug and Alcohol Recovery Service (DDARS) reported on the recent flood at Constitution House, the team worked hard to maintain services during this period across the City and the restoration work was completed in February, allowing a return to Constitution House from 20 February 2023.

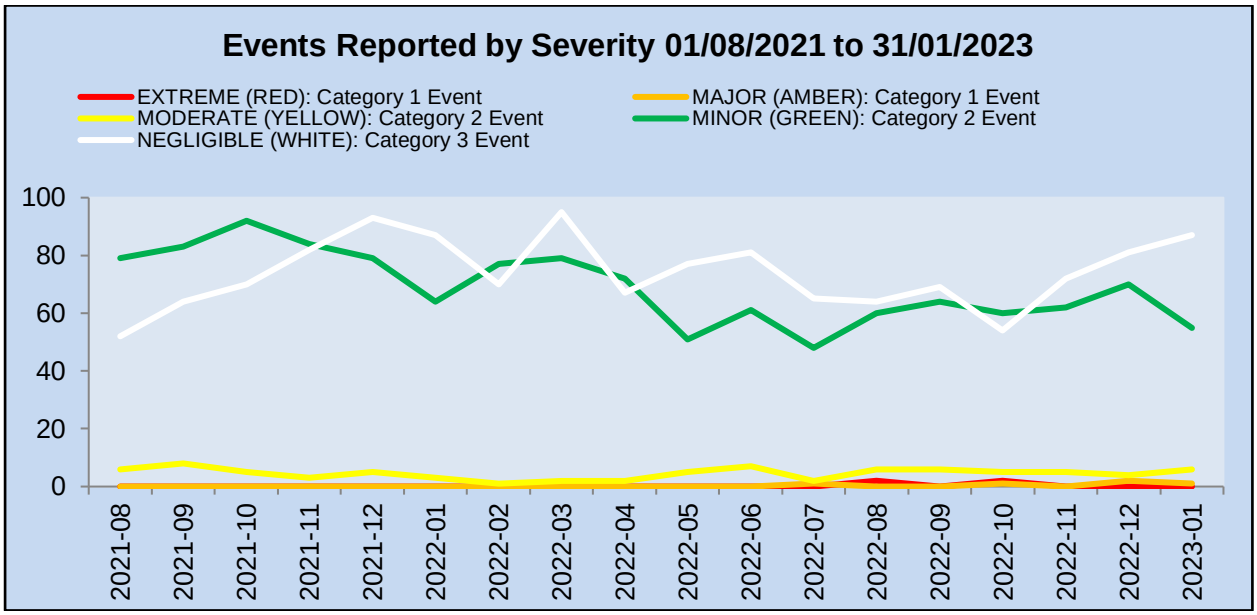
c.7 DDARS also reported the current position for their MAT Standards with Standards 1-5 all reported at Amber. Work continues on standards 6-10 in readiness for formal reporting to the Scottish Government.

Significant updates across the standards include:

- The multi-disciplinary, direct access drop in clinics (and planned requested appointments) now operate over four days of the week.
- All those currently on waiting lists were written to to advise about the new direct access and planned requested appointments and the service now has a very low historical waiting list.
- Database for those at high risk of harm is developed with data being populated and reported.
- NFOD Co-ordinator role has been successfully appointed to with a start date of 13 March 2023.
- Business case for immunisation service is currently delayed due to staff capacity (Although it should be noted this is not required for initial compliance with MAT 4).
- Work continues to identify and move patients to the shared care model. Third sector organisations are supporting DDARS to identify those who may be suitable.
- The Dundee team have pulled together and expanded a number of the national resources, developed by NHS Education Scotland, into local toolkits.

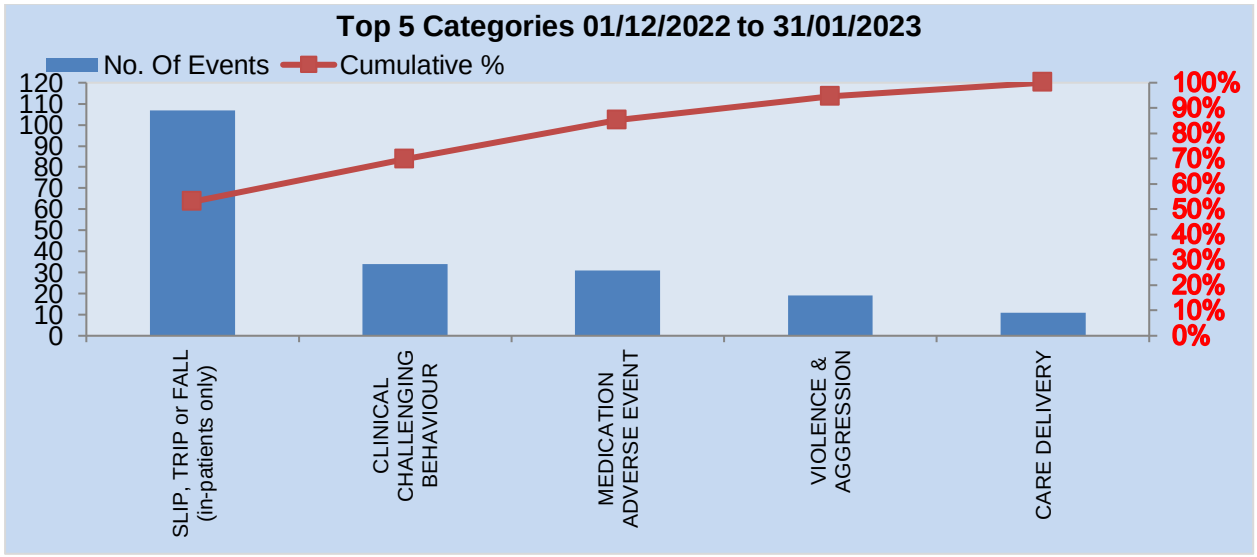
5.3 Adverse Event Management

d.1 The following graph shows the impact of the reported adverse events by month over the past 18 months.



The ratio of events with harm to events with no harm is 1 to 4. This shows a static position from the previous report. There has been an increase in the number of negligible events in this reporting period.

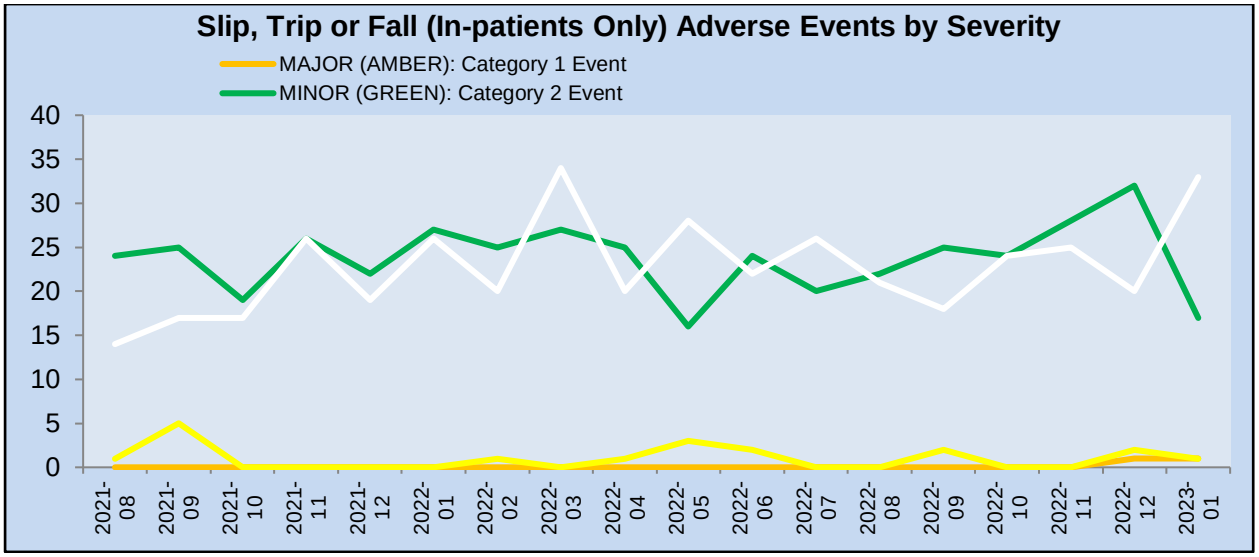
d.2 The following graph shows the Top 5 categories reported between 01/12/2022 and 31/01/2023.



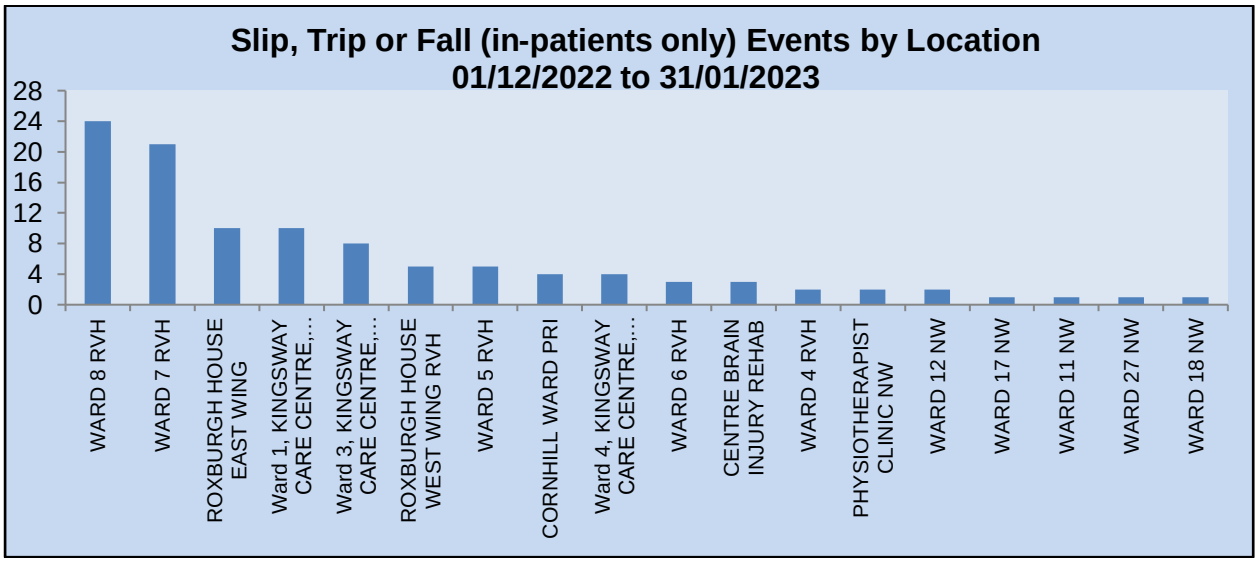
These categories account for 202 of the 306 events (72%) reported within the time period.

Slips, Trips and Falls

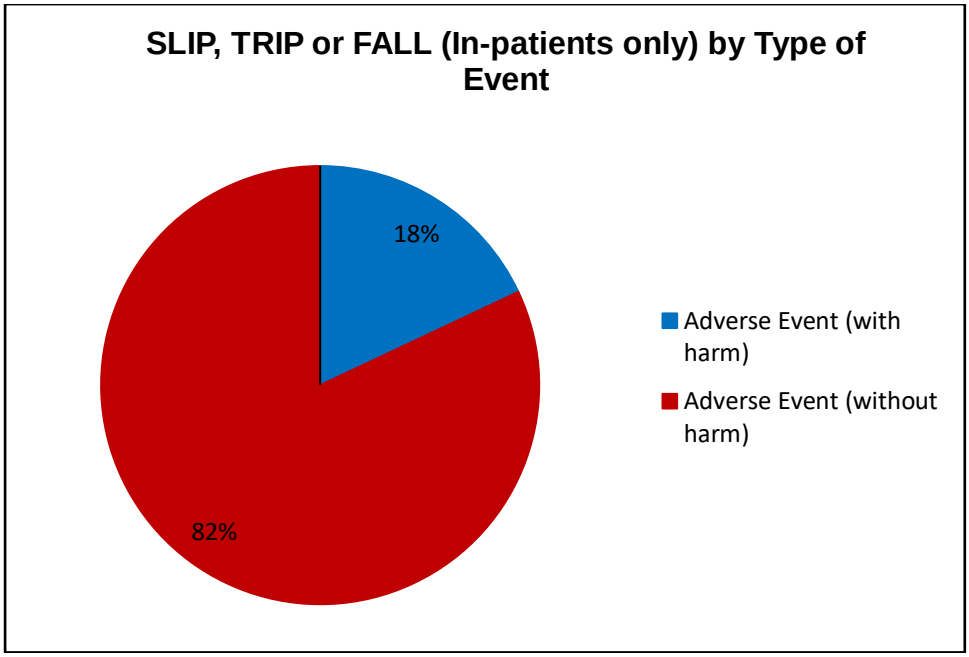
d.3 There were 107 events reported between 01/12/2022 and 31/01/2023. The following table shows slips, trips and falls by severity over the past 18 months.



d.4 There were 107 events reported between 01/12/2022 and 31/01/2023. The areas with the highest number of falls were Ward 8 RVH (24) and Ward 7 RVH (21).



d.5 The chart below shows the type of events reported. 88 of the events are reported as adverse events (without harm), 19 are reported as adverse events (with harm).



These tables show a slight increase in slips, trips and falls over this reporting period. We can see that where the majority of falls occur, there are patients with dementia and/or delirium.

These figures also include patients who have slipped out of a chair or out of their bed.

18% of patients were harmed as a result of their fall. A review of this data shows low levels of harm for patients (bruising, skin flaps, soreness) with no cases needing escalation of care through the Emergency Department or secondary care wards or departments.

A review is undertaken after each fall with falls plans being updated as required. There are no themes or patterns identified following review that require further investigation. The teams continue to monitor at a local level to ensure falls plans are developed and are in place for all patients across inpatient settings.

The Patient Safety Team is currently working with the Falls Group to support further falls management across the HSCP.

Clinical Challenging Behaviour and Violence and Aggression

d.6 Work is ongoing to support accurate reporting of these incident types. There have been good improvements across Psychiatry of Old Age and Medicine for the Elderly services and while this is variable, there are signs that this is becoming more reflective and accurate.

Frequency and levels of harm remain low (10 in this reporting period) and reviews are conducted after each adverse event to ensure staff and patient wellbeing.

Teams report increasing challenges in regard to patients being younger, fitter and stronger than previously. The teams are working closely with the violence and aggression training teams for ongoing support and education.

Medication Adverse Events

d.7 There were 31 events reported between 01/12/2022 and 31/01/2023. Within this there were 14 separate subcategories reported across ten different clinical teams. There are no clear themes or patterns identified within teams or across the HSCP. The District Nursing Service had seen a positive reduction in adverse events following consistent review of their events, although this has increased from an average of three per month to five per month in this reporting period.

d.8 There has been an emergent trend within Mental Health with regard to delays in following up people who have not attended for depot medication and other aspects of depot medication management. Although numbers are small and spread over a long period of time, education events with regard to nursing responsibilities within medicines management have been designed and the processes around depot clinics are being revisited.

Care Delivery

d.9 There were 11 adverse events reported in this reporting period. The majority of these events related to poor discharge planning and implementation across a range of establishments including the Prison Service, Acute wards and Rehab wards. On all occasions there was collaboration between discharging and receiving teams to review the adverse event. This also included the use of tabletop exercises to explore scenarios in order to reduce the chance of recurrence.

Some of these events reflect care being delivered below the standard expected. On each occasion the staff have reflected on practice undertaken and training has been provided where required.

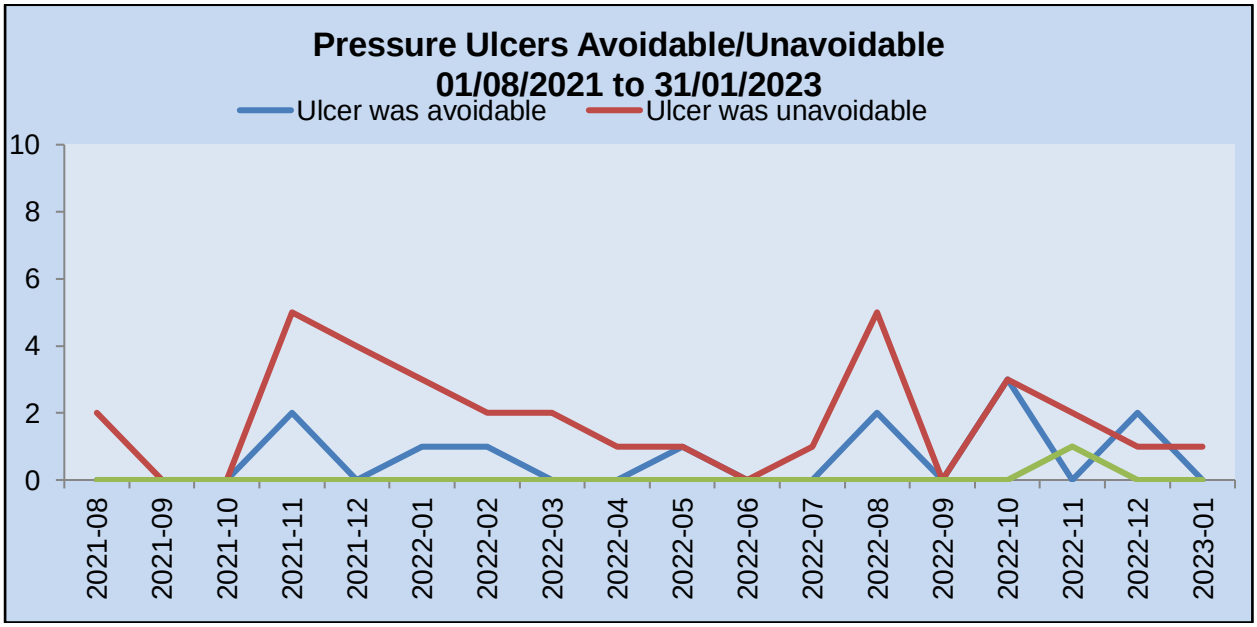
Significant Adverse Event Reviews

d.10 There is currently one significant adverse event review (SAER) commissioned in the Dundee HSCP, although this is awaiting confirmation of a Review team.

A SAER undertaken with regard to medical records management, largely pertaining to records within Mental Health & Learning Disability services is now complete. The actions arising from this, including Duty of Candour reporting, are in progress.

Pressure Ulcers

d.11 There have been four pressure ulcer events reported between 01/12/2022 and 31/01/2023, which is a reduction from the last reporting period (9). The number of pressure ulcers reported over the past 18 months is shown in the following graph, by those that were determined as avoidable and those that were determined as unavoidable.



d.12 One of the avoidable pressure ulcers was noted on admission to the ward. Feedback is given to those providing care prior to admission to support reflective practice and enhanced management of pressure ulcers. The other avoidable pressure ulcer developed under the care of Community Nursing. This complex case identified a number of factors contributing to the pressure ulcer including reduced compliance with advice given and caring staff not using the recommended equipment. The Tissue Viability Service and District Nursing Service initiated a plan of care to support.

Feedback

e.1 The table below shows the number of complaints by service area and how long they have been open:

No. of Open Cases – 7							
Clinical Care Group/Department	**Days_Band**	0-5 Days	6-10 Days	>20 Days	>40 Days	>60 Days	**Total**
Mental Health (Dundee)		1	1	1	1	-	**4**
Physiotherapy (Dundee HSCP)		-	1	-	-	-	**1**
Nutrition and Dietetics (Dundee HSCP)		-	-	-	1	-	**1**
Older People Services (Dundee)		-	-	-	-	1	**1**
Total		**1**	**2**	**1**	**2**	**1**	**7**

The total number of open cases shows a significant improvement from the last two reports (22 and 12) and with four cases open longer than 20 days, compared with 12 and 4 in the last two reports respectively. Work will continue to further improve this position.

Key themes

e.2 During this reporting period the key themes for complaints have been clinical treatment, competence and failure to follow agreed procedures, with the sub-themes including co-ordination of clinical treatment, disagreement with treatment plan and lack of continuity.

Learning from Complaints

e.3 There are a number of complaints that, following investigation, identify and confirm that high quality care is provided, that correct pathways and procedures are adhered to and correct legal processes are followed. The receipt of a complaint is an opportunity to review what we have done and how we have done it, and often the complaints are not about the technical aspects of delivering care but the manner in which the care was delivered or communicated to our patients and clients.

Every complaint is reviewed to understand what did happen, what should have happened and, where a difference exists, what measures can be taken to reduce the likelihood of a similar incident occurring again.

All teams are asked to report on their complaints through the CCPG Group and Forum to ensure the sharing of learning across the Health and Social Care Partnership.

e.4 Some examples of complaints and associated actions and learning:

- A complaint was received in relation to the provision of equipment and the policy that supports decision-making. The policy is undergoing a review to ensure it reflects current legislation. This review is ongoing with health and social care staff, the Housing Department and the local authority legal team.
- A complaint was received in relation to the timely response provided from the Direct Payments Team. A review led to the implementation of different working practices with an enhanced focus on the monitoring of work and the prioritisation and timely nature of responses.
- A complaint was received in relation to posts made by a staff member on social media. While the staff member was aware of the social media policy they have been asked to reflect on their actions and review the policy.
- A number of complaints were received in relation to standards of care and on investigation these related to a failure in communication. Teams have worked hard, in complex and challenging circumstances, to develop systems for clear, concise communication and escalation processes to ensure ongoing communication throughout care provision.
- A complaint was received regarding poor communication following the death of a patient in an inpatient setting. (The circumstances relating to the death did not form part of the complaint.) A number of outcomes were implemented following review which included:

- Verification of death training
- Oral Health education
- The development of an SBAR to support enhanced communication between medical and nursing staff.
- Review and enhancement of induction for junior doctors.
- Reflection on Conduct and Professionalism for staff involved.

e.5 Compliments

Oct 2022: "*The bit that stands out for me is nurse Jayne. Jayne was incredibly responsive to our concerns, very easy to talk to and had excellent listening skills. The DECS-A service was for my Mum, but she listened to my Dad's questions and she took the questions very seriously. My Dad certainly felt supported and he got the right care. Jayne stayed with us throughout the process until Mum and Dad were happy there were no more concerns."*

Nov 2022: "My Dad who is in his 90's took unwell and was feeling dizzy and couldn't get out of bed. We called the Dr and then had a team of community district nurses to look after Dad. They were excellent; Holly, Neil and Susan did a fantastic job and also answering all of my Mums questions too. They really couldn't have been better."

Dec 2022: *"I would like to tell how exceptional Dr Din and the nurses from Victoria Hospital were to me. Dr Din actually listened to my problems and what a difference it made! After taking blood pressure tablets for 20 years, she managed to get me off the tablets. She got me admitted for a surgery at Ninewells Hospital. The operation was to remove a hernia from my left side, it was done by Dr Moses and it was successful. Three weeks before this surgery at Ninewells Hospital, a specialist told me they cannot operate on this and discharged me without any further contact or help. My local GP prescribed me antibiotics, but my problems with the hernia were going on for 2 years at that time. I am very grateful to Dr Din in Victoria Hospital for everything she and the nurses done for me. I feel some Drs do not seem to care about the elderly, but they were wonderful with me and listened to my problems. The only thing I am disappointed about is that I can no longer go back and see Dr Din because I am already discharged from the hospital and can only go back to see my GP. There are 10 Drs in my GP and I can never see the same one. It made a world of difference that Dr Din in Victoria Hospital actually listened to me."*

External Reports & Inspections

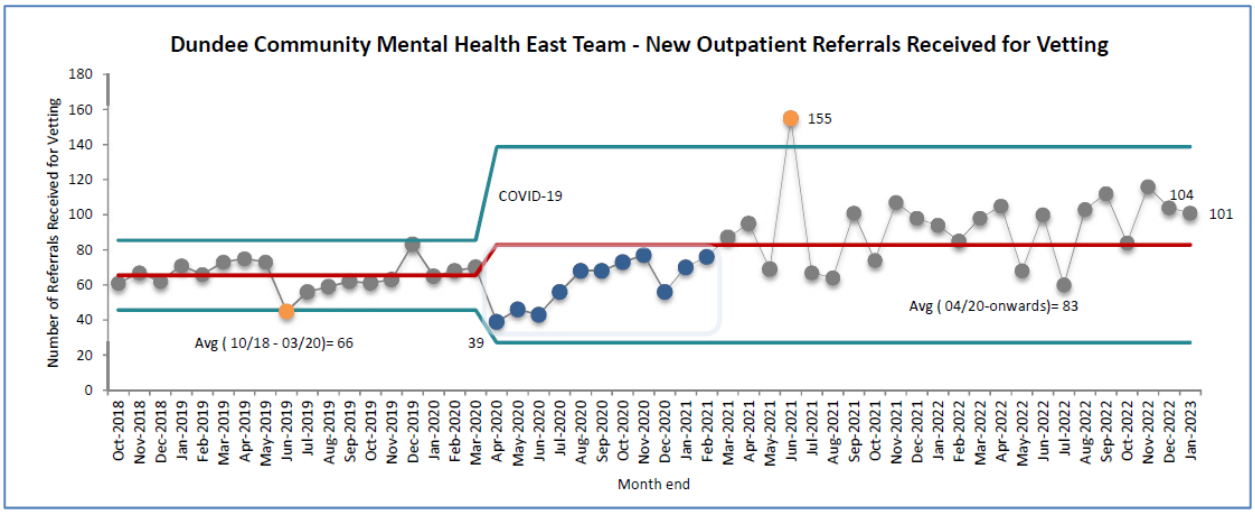
e.6 There have been no external reports or inspections for Dundee HSCP since the last assurance report.

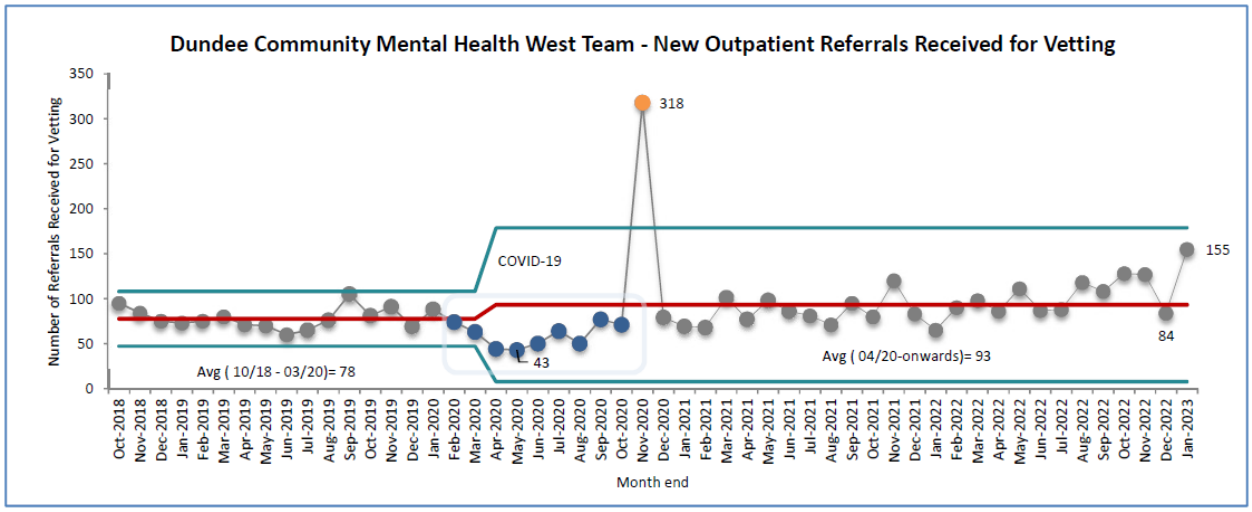
Mental Health

f.1 There are differing trends within the data below for Community Mental Health Teams (CMHT) East and West, particularly with regard to demand. CMHT West has a consistently higher level of referral than East. This same Team also has fewer Locum Consultant sessions and has been disproportionately affected by reduction in service when Locums move. The graphs outlining the numbers of people waiting indicate that three Locums per CMHT allows a 'static' position to be achieved with demand and capacity being well matched (supplemented by ANPs). Where there is fewer than this, the numbers waiting are growing month on month. There will be more detailed analysis of referrals by GP practice in coming months to determine whether the historic allocation of practices to East/West remains appropriate.

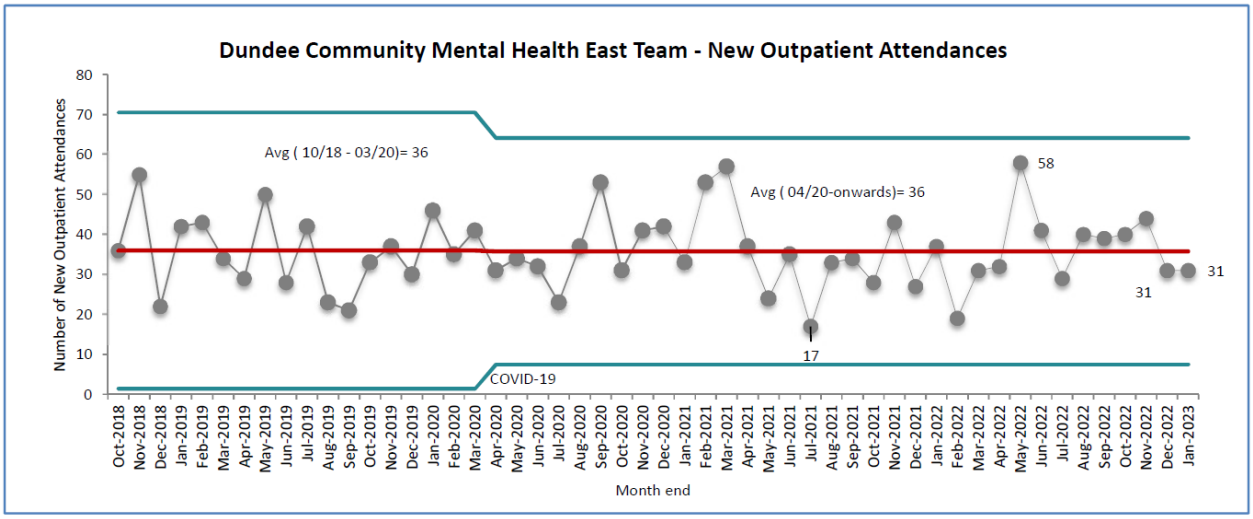
There continues to be a focus on ensuring that TrakCare data is accurate; a significant initial 'cleansing' exercise having been undertaken to ensure that incorrect or missing TrakCare codes were not resulting in wrongly inflated waiting numbers. This work continues month-on-month.

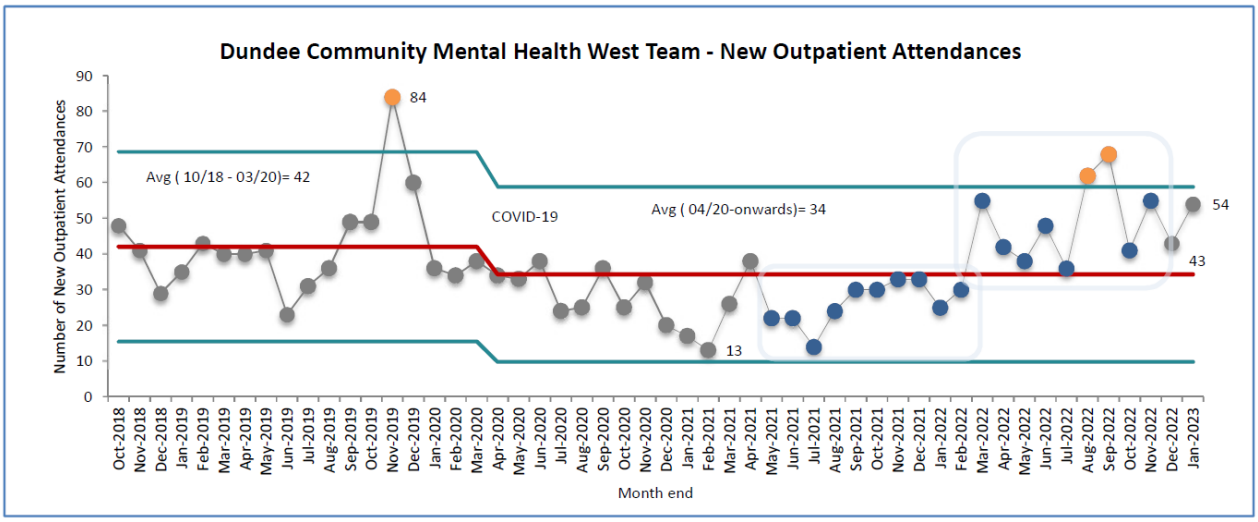
f.2 Volume of referrals received for vetting, including those vetted and returned, grouped by referral received month:



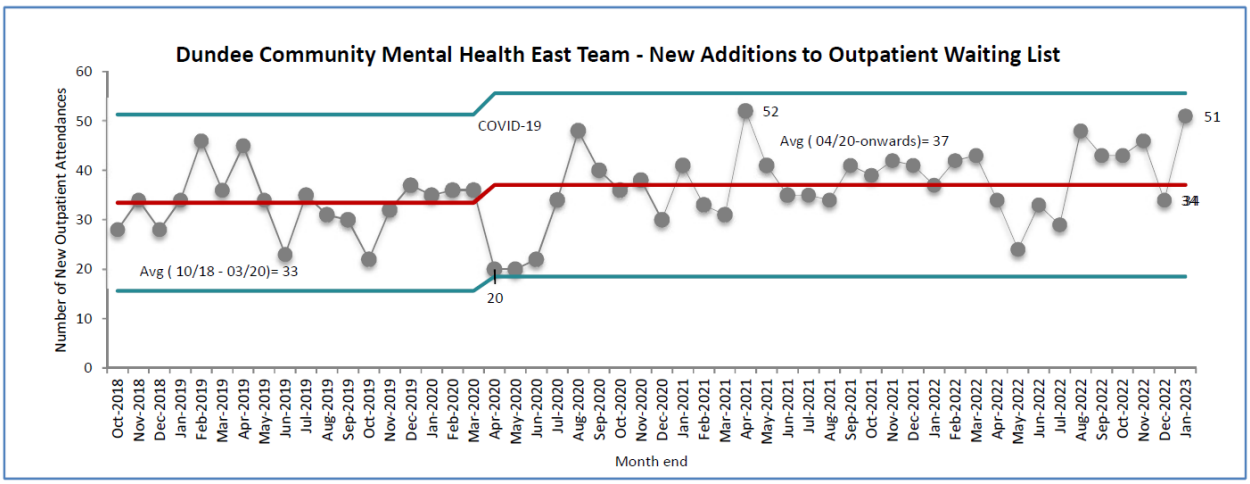


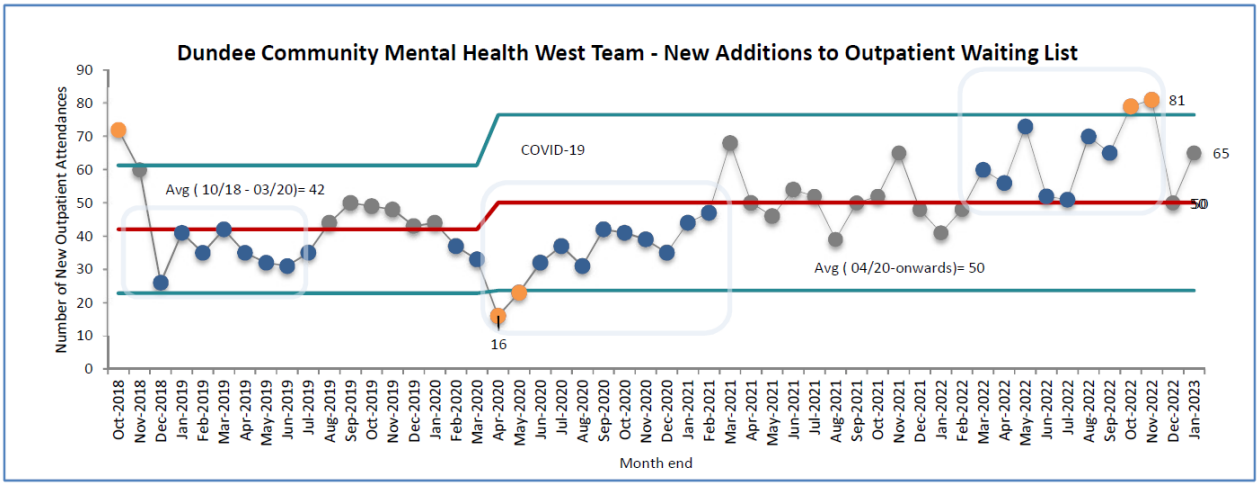
f.3 Volume of new outpatient attendances, excluding did not attends, grouped by attendance month:



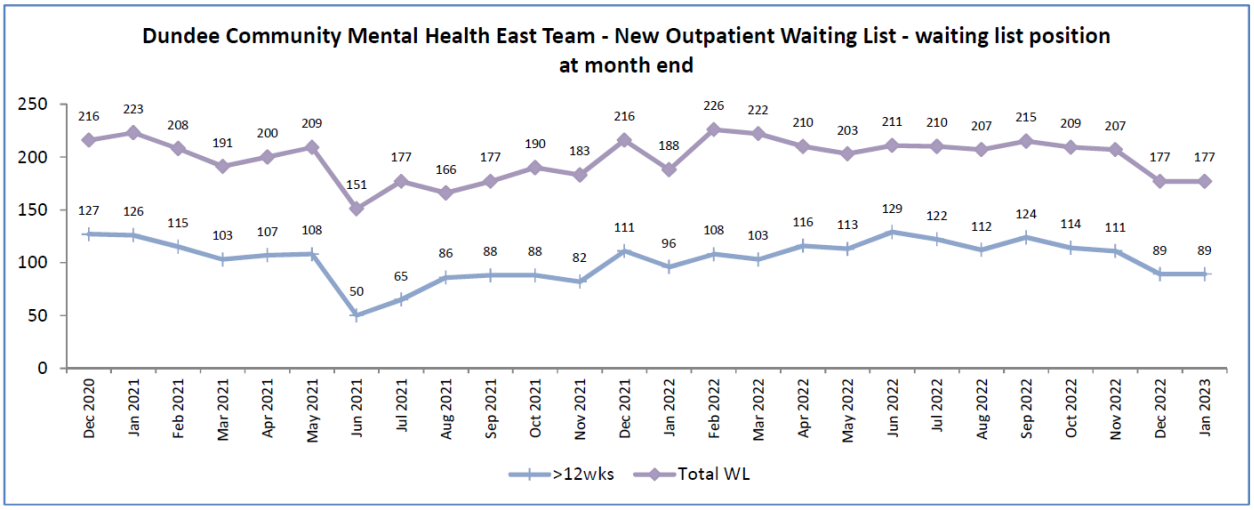


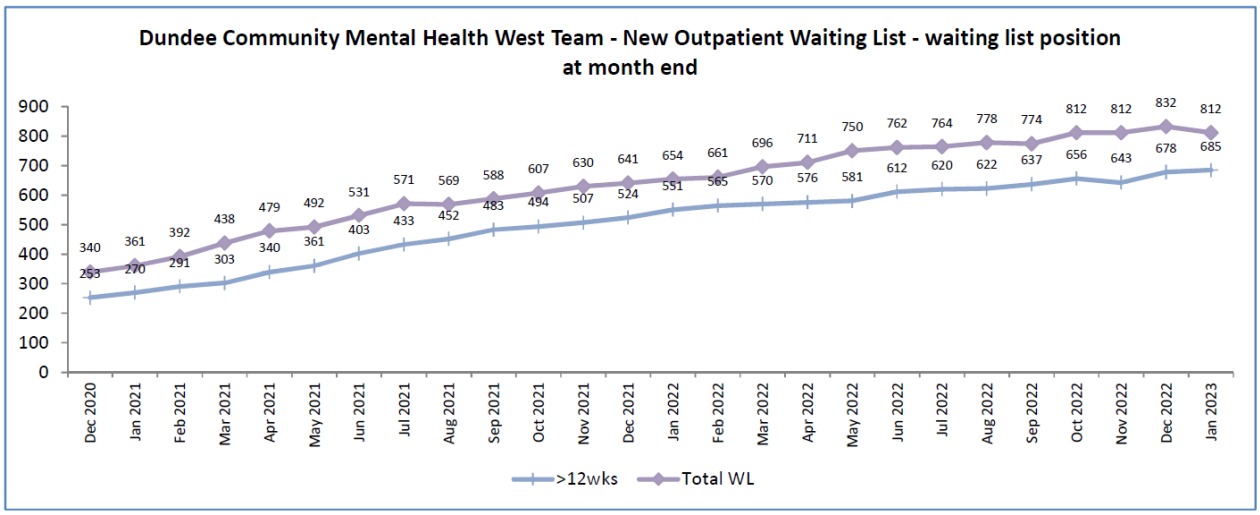
f.4 Volume of referrals added to the waiting list for a new appointment, grouped by referral month:





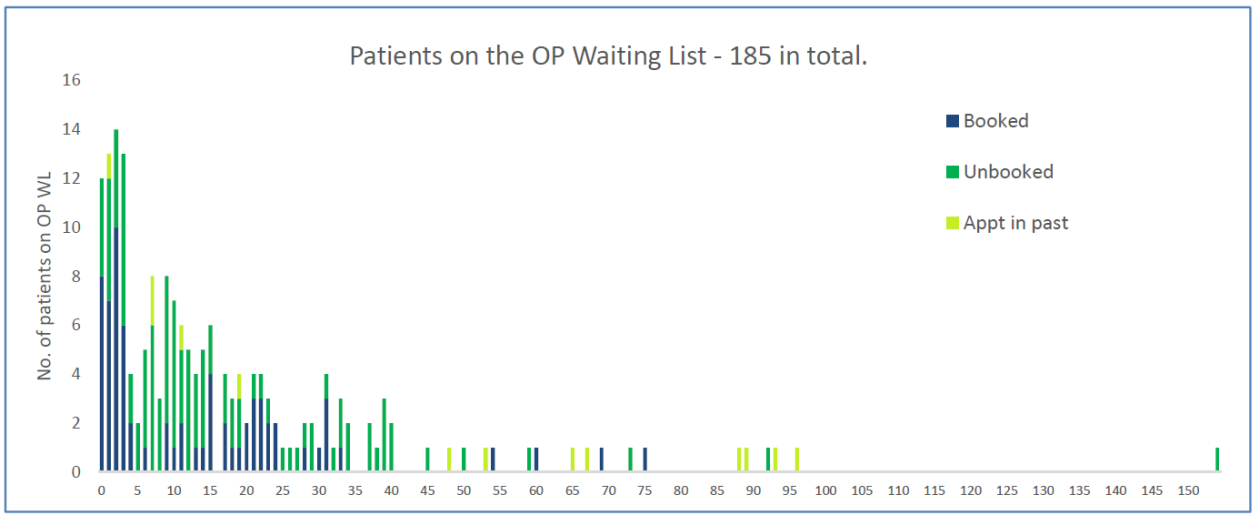
f.5 Snapshot of waiting list position at month end; total volume on waiting list and volume waiting over 12 weeks:



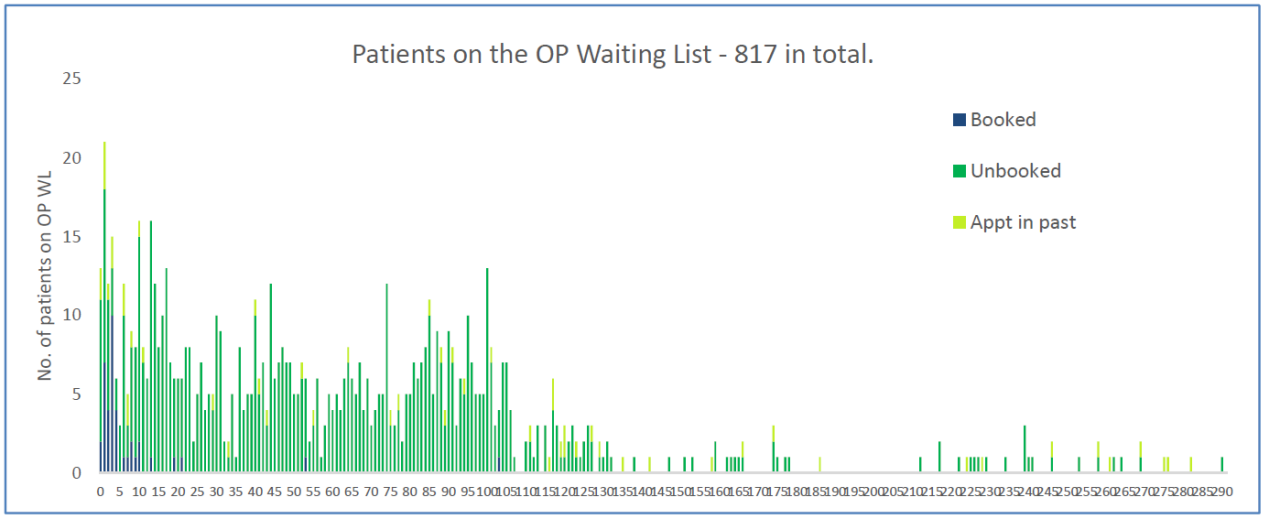


f.6 Snapshot waiting list distribution by weeks waiting at a point in time (05/02/2023) – Waiting List Type – True WL

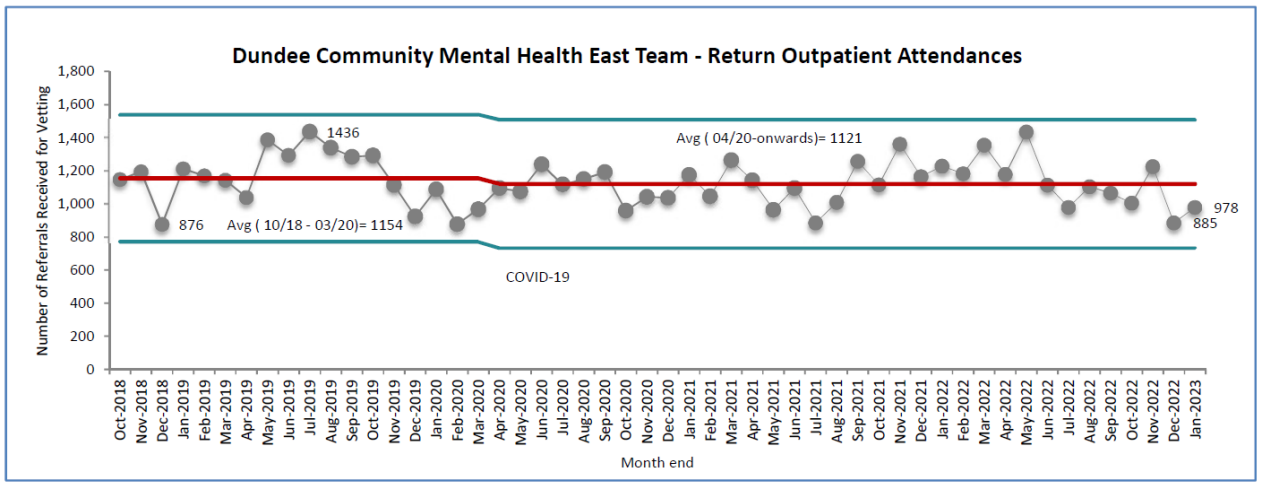
CMHT(East)

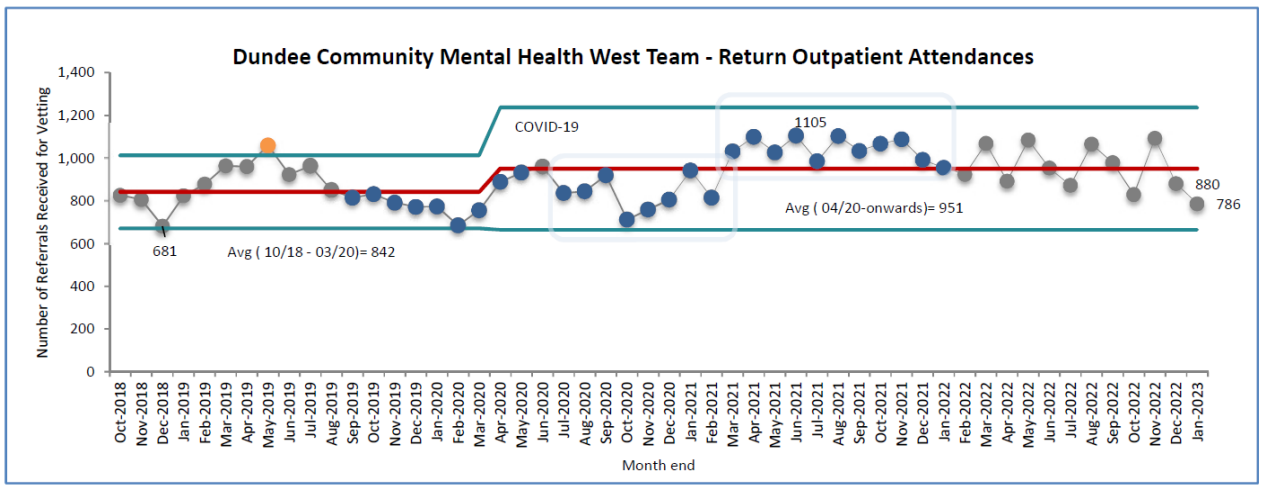


CMHT (West)



f.7 Volume of outpatient attendances, excluding did not attends, grouped by attendance month:





6.0 POLICY IMPLICATIONS

6.1 This report has been subject to the Pre-IIA Screening Tool and does not make any recommendations for change to strategy, policy, procedures, services or funding and so has not been subject to an Integrated Impact Assessment. An appropriate senior manager has reviewed and agreed with this assessment.

7.0 RISK ASSESSMENT

Risk 1 Description	The risk of not providing sufficient assurance through governance assurance routes will reduce confidence in the ability of the HSCP to deliver safe, quality care.
Risk Category	Governance
Inherent Risk Level	Likelihood (2) x Impact (4) = Risk Scoring (8)
Mitigating Actions (including timescales and resources)	Systems in place for all operational teams to provide exception reports to the clinical, care and professional governance group. 'Getting It Right' Group established to support development of reporting framework for HSCP.
Residual Risk Level	Likelihood (2) x Impact (4) = Risk Scoring (8)
Planned Risk Level	Likelihood (1) x Impact (3) = Risk Scoring (3)
Approval recommendation	The risk level should be accepted with the expectation that the mitigating actions are taken forward.

8.0 CONSULTATIONS

8.1 The Chief Finance Officer, Chief Officer, Locality Managers and the Clerk were consulted in the preparation of this report.

9.0 BACKGROUND PAPERS

9.1 Appendix 1: Dundee HSCP Governance Structure

Dr David Shaw
Clinical Director

DATE: 25 April 2023

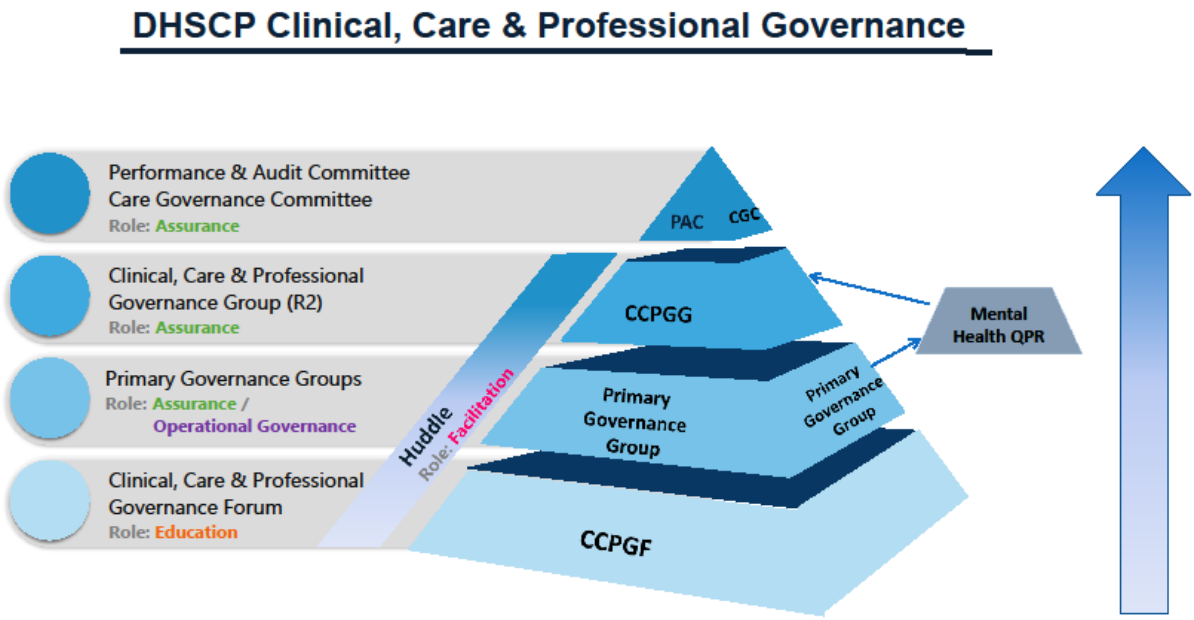
Diane McCulloch
Chief Social Work Officer / Head of Health and Community Care

Matthew Kendall
Allied Health Professions Lead

Level of Assurance		System Adequacy	Controls	✓
Substantial Assurance		A sound system of governance, risk management and control exists, with internal controls operating effectively and being consistently applied to support the achievement of objectives in the area audited	Controls are applied continuously or with only minor lapses.	
Reasonable Assurance		There is a generally sound system of governance, risk management and control in place. Some issues, non-compliance or scope for improvement were identified which may put at risk the achievement of objectives in the area audited.	Controls are applied frequently but with evidence of non-compliance.	✓
Limited Assurance		Significant gaps, weaknesses or non-compliance were identified. Improvement is required to the system of governance, risk management and control to effectively manage risks to the achievement of objectives in the area audited.	Controls are applied but with some significant lapses.	
No Assurance		Immediate action is required to address fundamental gaps, weaknesses or non-compliance identified. The system of governance, risk management and control is inadequate to effectively manage risks to the achievement of objectives in the area audited.	Significant breakdown in the application of controls.	

Dundee HSCP Governance Structure

Dundee HSCP governance structures are outlined in the diagram below. The following narrative explains how each of the aspects functions to provide assurance to NHS Tayside and the Dundee IJB.



Dundee Health and Social Care Partnership Clinical, Care and Professional Governance Group is responsible for directing, collating and monitoring governance arrangements and ensuring that there are effective and embedded systems for Clinical, Care & Professional Governance in all services within Dundee Health and Social Care Partnership. It is chaired by the Clinical Director, and membership, as referenced in the terms of reference, extends to Head of Health and Community Care Services, Associate Nurse Director, Associate Medical Director, Associate Locality Managers, Lead Allied Health Professional, Lead Nurse, Lead Pharmacist, Clinical Governance Lead, Senior Officer – Business Planning and Information Governance, NHS Business Support Representative.

Management structures across Dundee HSCP have been redesigned over the past three months and the members of the CCPG Group will be updated to reflect this and the Primary Governance Group Structure which sits beneath the CCPG Group.

At each CCPG Group meeting each Primary Governance Group will present an exception report highlighting key areas of concern across the six domains listed in GIRFE. They will also reference exceptional pieces of work undertaken, current challenges and future potential issues identified through triangulation of data reviewed through Primary Governance Group meetings.

Each Primary Governance Group will produce an annual report in line with the reporting programme.

A range of additional reports are also reviewed at the CCPG Group, which includes DHSCP Analysis Report (Adverse events and Risks), Complaints, Infection Prevention and Control and Inspection Reports.

Further assurance is sought with a range of reports/discussions relating to topics such as professional registration, GDPR, SPSO, contemporaneous issues for example Dundee Drugs Commission review and Trust and Respect Report.

Primary Governance Groups (PGG)

There are currently nine PGGs:

- In Patient Services (MfE, POA, CBIR, Palliative)
- Adult Community Services
- Acute and Urgent Care
- Mental Health
- Learning Disabilities
- Psychological Therapies
- Health Inequalities
- Nutrition and Dietetics
- Dundee Drugs and Alcohol Recovery Services

Each Primary Governance Group will meet monthly and the remit of the Primary Governance Group is to:

- Provide assurance to the Clinical, Care and Professional Governance Group on the systems and processes for clinical, care and professional governance activities.
- Develop, prioritise, implement, monitor and review the annual work plan for clinical, care and professional governance activities.
- To create the learning environment and conditions within Services by dedicating time to allow staff to share learning, tools and other resources and encourage the dissemination of good practice.
- Ensure that clinical and care leadership underpins Service assurance processes and that clinical and care leaders are supported to share tools and resources to spread good practice.
- Encourage an integrated approach to quality improvement across Services.
- Ensure appropriate actions in relation to clinical, care and professional governance and quality activities are taken in response to internal reports and external reports from bodies such as NHS Healthcare Improvement Scotland, Care Inspectorate, Audit Scotland, Mental Welfare Commission and Scottish Public Services Ombudsman.

- Ensuring that there is a robust reporting and assurance mechanism for services which are hosted within the partnership but do not solely operate within Dundee Health and Social Care Partnership.
- Undertake the management, escalation or cascading of issues/risks/concerns as appropriate.
- Collate, review and analyse core and service specific datasets to inform exception report to the CCPGG, reflecting the six domains described in the Getting It Right for Everyone – A Clinical, Care and Professional Governance Framework.
- The exception report should include, but is not limited to:

    - Emergent issues of concern identified
    - Adverse Events:
        - Recurring themes, Major and Extreme Incidents
        - Incidents that trigger Statutory Duty Of Candour
    - All Red Adverse Events
    - Adverse Event Reviews, Significant Case Reviews
    - Complaints
    - Risks
    - Inspection Reports and Outcomes
    - Changes to standards, legislation and guidelines
    - Outcomes of care
    - Adherence to standards
    - Sharing of learning

A representative from each PGG will represent the group at the Dundee HSCP CCPG Group and present and talk to the exception report and, where required, the annual report. The representative will act as a conduit between the PGG and CCPGG ensuring effective communication between groups.

Due to the recent redesign of the management structure, there have been changes in the organisation of the PGGs. The Governance team, alongside the professional leads in the HSCP are working closely with the new chairs of these PGGs to support development of these groups.

<u>Governance Huddle</u>

There is a weekly governance huddle attended by the professional leads and the governance team. A high level review of all adverse events is undertaken with the intention of identifying themes or patterns and triangulating knowledge of service pressures, governance scorecards and service data to identify services who may be struggling, who require support to manage adverse events or who may display a change in their current performance in relation to managing adverse events. This allows for early support to be provided to teams from both a governance and managerial perspective to undertake early management of developing potential risks.

The huddle is open to managers to attend to gain an enhanced overview of the governance arrangements across the HSCP. Managers can also attend to discuss specific aspects of clinical, care and professional governance as required.

The huddle will also undertake work to review risk management, complaints process and quality and any other governance-related theme as required.

Clinical, Care and Professional Governance Forum

The forum is used as an education forum for managers and lead governance staff across the HSCP. The format allows for review of scorecard data, encouraging discussion around works of excellence and challenging areas, with managers peer-reviewing one another and sharing learning across a range of themes.

Each forum will also have a dedicated educational element to improve knowledge and understanding of governance systems and processes across the HSCP. Subjects to date have included: Qlikview, Risk Management System, Datix system report building and scorecard development.

ITEM No …8……..

REPORT TO: **PERFORMANCE AND AUDIT COMMITTEE – 24 MAY 2023**

REPORT ON: **QUARTERLY COMPLAINTS PERFORMANCE – 4th QUARTER 2022/23**

REPORT BY: **CHIEF FINANCE OFFICER**

REPORT NO: **PAC18-2023**

1.0 PURPOSE OF REPORT

The purpose of this report is to summarise the complaints performance for the Health and Social Care Partnership (HSCP) in the fourth quarter of 2022/23. The complaints include complaints handled using the Dundee Health and Social Care Partnership Social Work Complaint Handling Procedure, the NHS Complaint Procedure and the Dundee City Integration Joint Board Complaint Handling Procedure.

2.0 RECOMMENDATIONS

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

2.1 Notes the complaints handling performance for health and social work complaints set out within this report.

2.2 Notes the work which has been undertaken to address outstanding complaints within the HSCP and to improve complaints handling, monitoring and report.

3.0 FINANCIAL IMPLICATIONS

None

4.0 MAIN TEXT

4.1 Since the 1st April 2017 both NHS and social work complaints follow the Scottish Public Service Ombudsman (SPSO) Model Complaint Handling Procedure. Both NHS Tayside Complaint Procedure and the Dundee Health and Social Care Partnerships Social Work Complaint Handling Procedures have been assessed as complying with the model complaint handling procedure by the SPSO.

4.2 Complaints are categorised by 2 stages: Stage 1: Frontline Resolution and Stage 2: Investigation. If a complainant remains dissatisfied with the outcome of a Stage 1: Frontline Resolution complaint, it can be escalated to a Stage 2. Complex complaints are handled as a Stage 2: Investigation complaint. If a complainant remains dissatisfied with the outcome of Stage 2: Investigation complaint they can contact the Scottish Public Services Ombudsman who will investigate the complaint, including professional decisions made. Complaints about the delivery of services are regularly presented to the Clinical, Care and Professional Governance Group to inform service improvement.

4.3 The information regarding complaints to complete the complaints monitoring report is received by the IJB from Dundee City Council and NHS Tayside. However, for quarter 4, NHS Tayside did not provide the requested information which has resulted in an incomplete report for health complaints. NHS Tayside has committed to provide access to this information for future reporting.

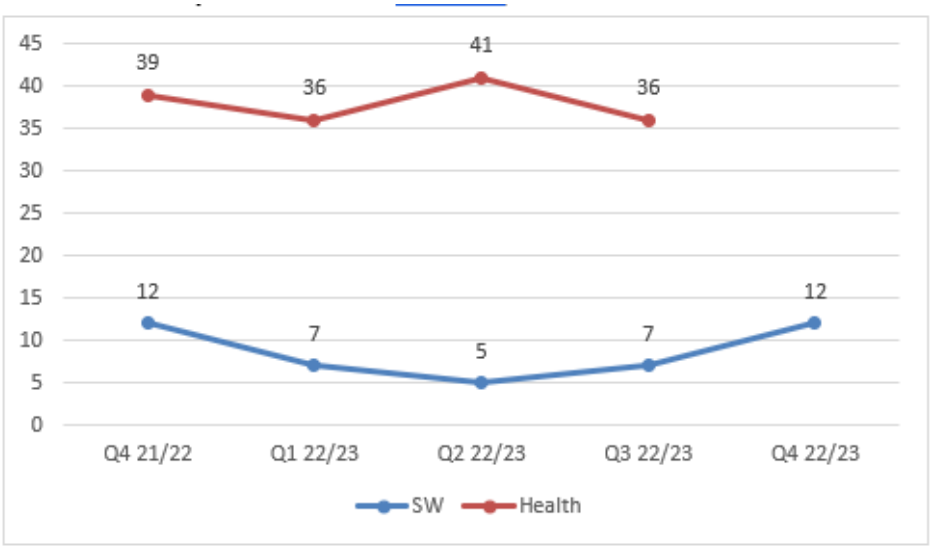
4.4 While the first graph advises the volume of complaints received during the period, this report is based upon complaints closed within the period. SPSO categories are included as appendix 1 at the end of the report. Please note that not all figures will add up to 100% due to missing data or different recordings.

4.5 Complaints Received

In the fourth quarter of 2022/23 a total of 12 complaints were received about social work or social care services.

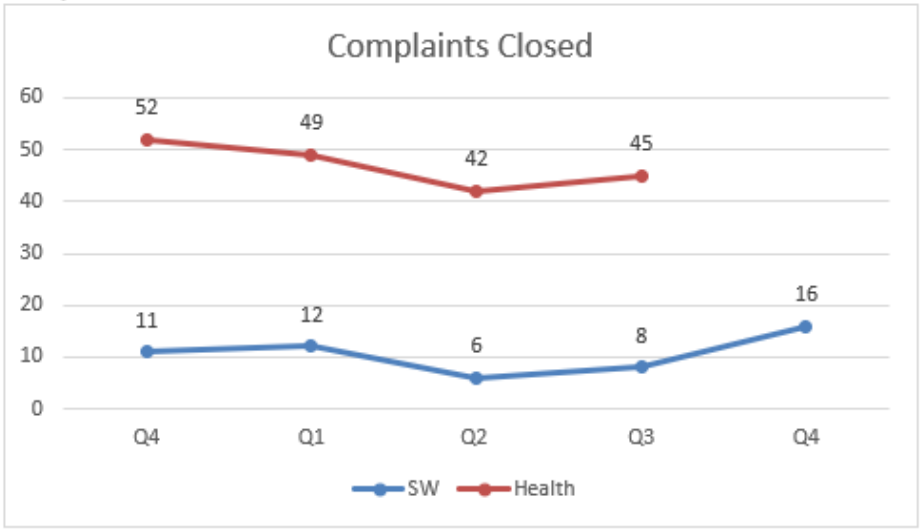
No data was received regarding Health complaints for Q4 within in the Dundee Health and Social Care Partnership. Therefore, when looking at the graphs, please note that the last reported and analysed data is from Q3 and no comparisons can be made throughout this report.

Number of complaints received quarterly



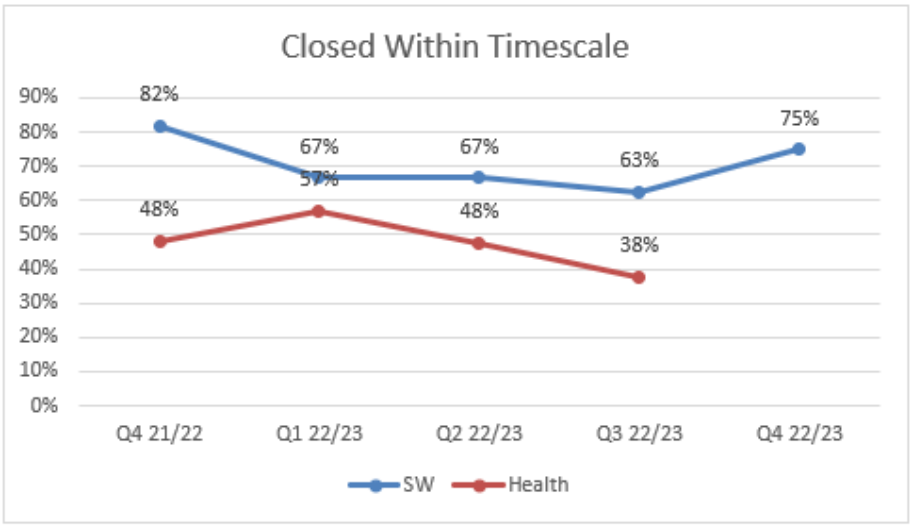
The graph shows that Social Work and Social Care Services have seen another increase in complaints received for the second quarter running.

4.6 Complaints Closed & Resolved Within Timescales



During quarter four, Social Care closed 16 complaints which is the highest within the last year.

4.7 Complaints Closed within Timescale



Out of the closed complaint Social Care closed 75% within timescale, which is an increase this quarter.

4.8 Social Work complaints by reason for concern

Complaint themes continue to be monitored for trends and looking at the table below, we can see that for the 4th quarter running Delays have been the most frustrating element for complainants making complaints.

	Q4 2021/22	Q1 2022/23	Q2 2022/23	Q3 2022/23	Q4 2022/23
Attitude, behaviour or treatment by a member of staff	2	0	2	2	2
Delay in responding to enquiries and requests	7	9	4	2	5
Dissatisfaction with our policy	0	1	0	1	3
Failure to provide a service	1	0	0	1	2
Failure to follow the proper administrative process	0	0	0	0	1
Failure to meet our service standards	2	2	0	2	3

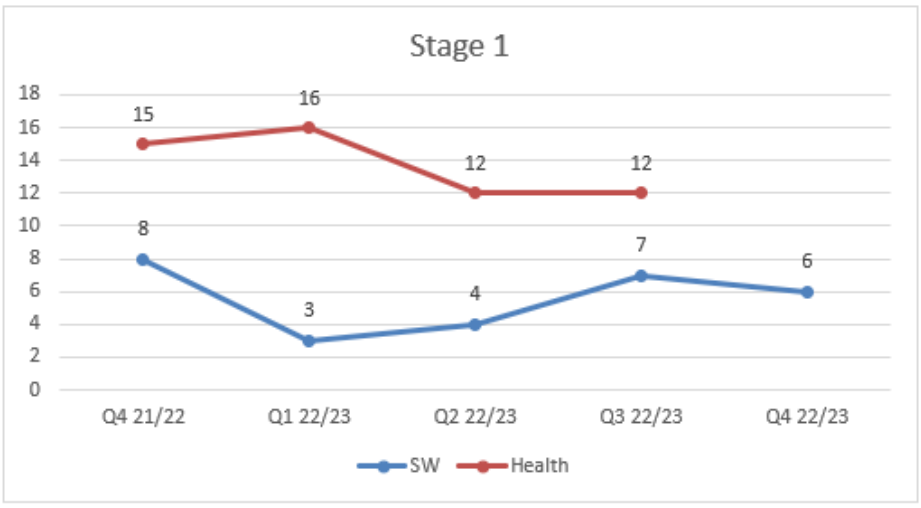
The numbers of social work complaints received this quarter are small.

4.9 Health complaints by reason for concern

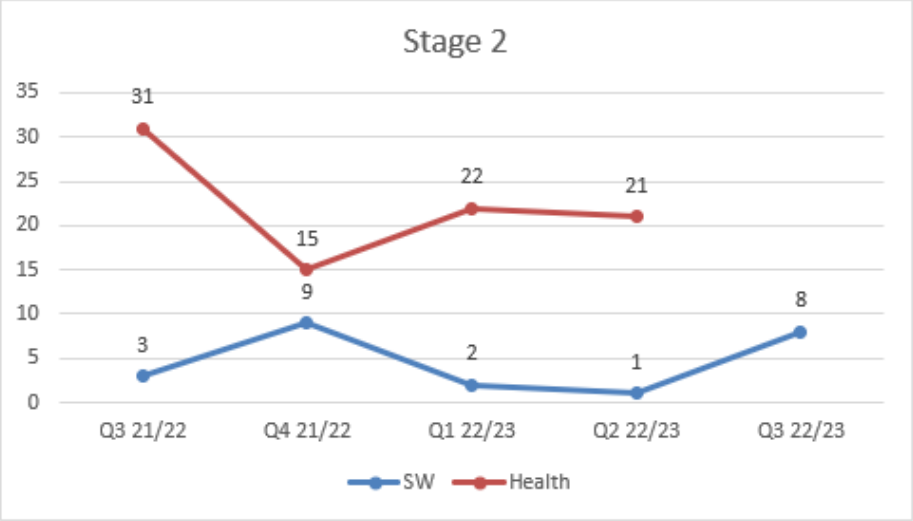
	Q1 2022/23	Q2 2022/23	Q3 2022/23
Disagreement with treatment / care plan	6	1	8
Lack of continuity	1	1	0
Letter wording	1	0	0
Problems with medication	3	1	1
Unacceptable time to wait for an appointment	8	3	4
Lack of support	6	1	2
Shortage of staff	3	0	0
Patient not being verbally told	1	0	1
Email	1	0	0
Not listening	0	1	0
Telephone	1	0	1
Error with prescription	1	0	0
Poor medical treatment	1	1	1
Poor aftercare	0	1	0
Abruptness	1	1	1
Conduct	1	1	0
Staff not trained properly	0	1	0
Waiting too long for results	0	1	1
Waiting for referral	0	1	0
Co-ordination of clinical treatment	0	3	0
Patient has been sent no communication	0	1	0
Inappropriate comments	0	1	0
Insensitive to patient needs	0	2	0
Inefficient	0	1	1
Disabled parking	0	0	1
Poor nursing care	0	0	2
Other	0	0	2
Formal	0	0	1
Face to face	0	0	1
Cancellation of appointment	0	0	1

No complaint data was provided this quarter for Health.

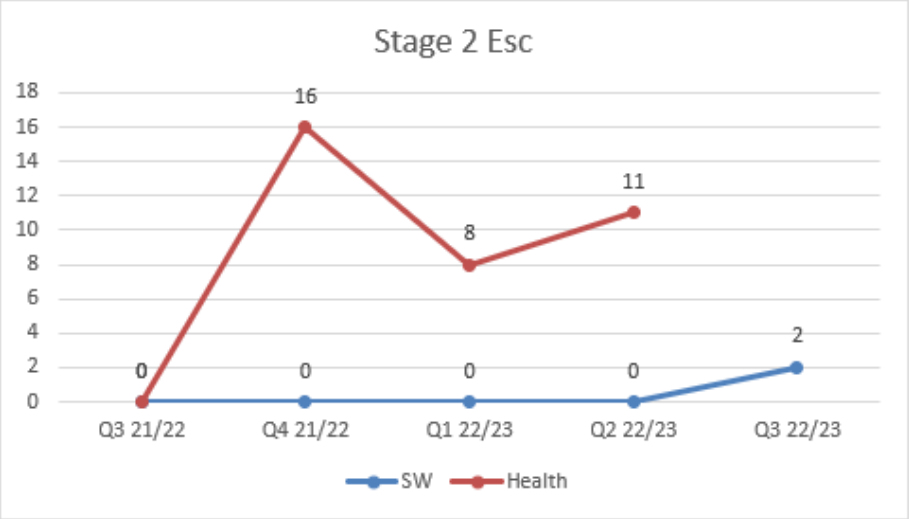
4.10 Complaints Stages



Stage 1 complaints are completed within 5 days or given a maximum extension of a further 10 days. Numbers fluctuate within Social Work between quarters.



Stage 2 complaints are completed within 20 working days and can be extended also.
Social Work stage 2 complaints have seen a substantial increase this quarter.
Stage 2 complaint data for Health has not been received.

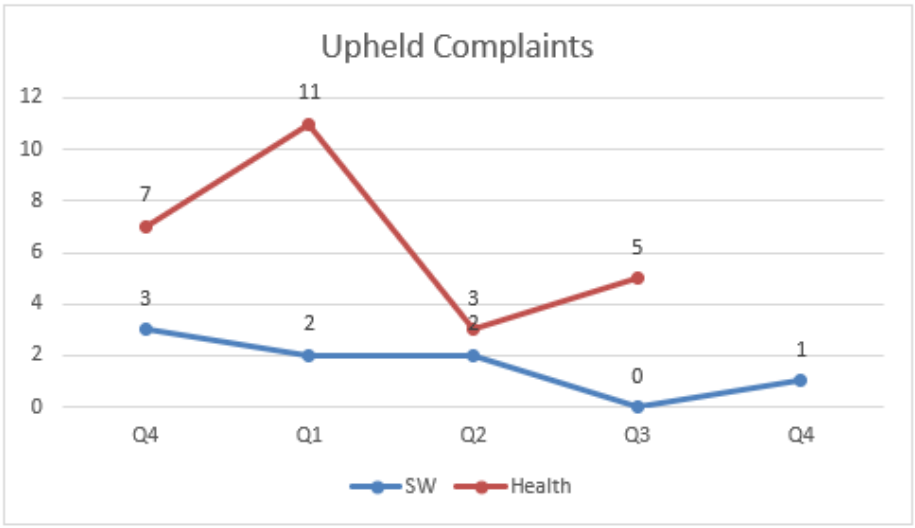


Stage 2 escalated complaints are those which are escalated from stage 1 to stage 2 after being logged and possibly responded to.
Social Work stage 2 escalated complaints have increased for the first time this year.

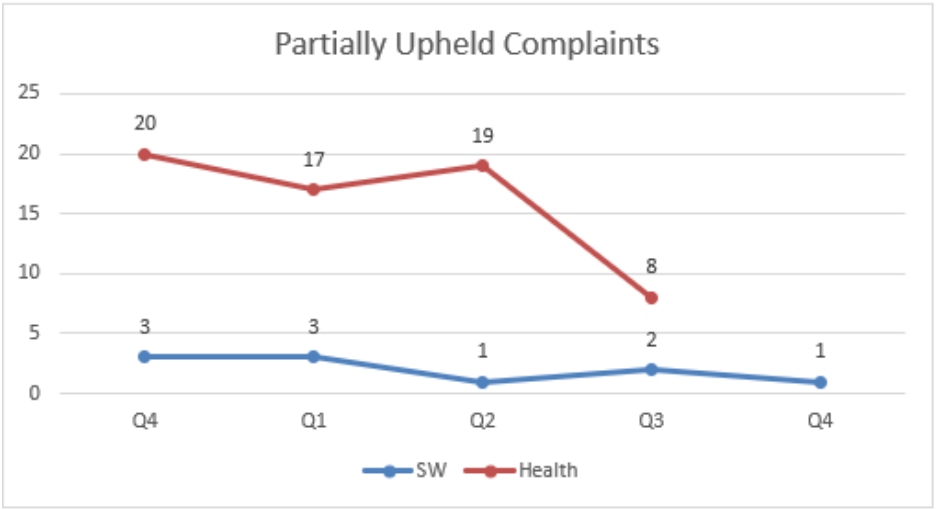
4.11 Complaint Outcomes

Partially upheld and upheld complaints receive planned service improvements logged against them by the allocated complaint investigator and these must be completed within a set timeframe.

These planned service improvements can range from process improvements or re-design to team briefings regarding staff attitude and behaviour.



Social Work upheld complaints have increased slightly this quarter.



Social Work Partially Upheld complaints have decreased slightly this quarter.

4.12 Planned Service Improvements

There were two partially upheld or upheld complaints which have all identified a cause and have service improvements planned to address these. By putting these planned service improvements in place, we look to minimises complaints of the same nature being received.

This is a reduction from last quarter of 15 complaints which had planned service improvements put in place but only includes Social Work due to not receiving Health complaints data.

4.13 Open Complaints

	Total Open	20 days or less	21-39 days	40-99 days	100 days +	180 days +	Average Days
SW	1	1	1	0	0	0	16
Health	-	-	-	-	-	-	-

4.14 Snapshot of Health open complaints across services

Data not provided

4.15 Compliments

Compliments are received by teams across Dundee Health and Social Care Partnership. Here is an extract from compliments received about the Dundee Enhanced Support Acute Team.

Jan 2023: I was taken to the A & E department recently after coming round lying on the floor and having no idea of what had happened or how I got there. After having tests, x-rays and a scan, the diagnosis was a severe chest infection and I was told I would be allowed home, but, as I live alone the Dundee Enhanced Support Acute Team (DECS-A) would come in and take over my care. I was happy with this, although I had never heard of this team before. A nurse and doctor arrived the following morning and they were very kind and explained that they would take over my medical care until they were happy that I was fully fit again. The nurse arranged to collect my prescription and she brought it back for me that afternoon and she came in every day until my antibiotics were finished and she was happy I was fully recovered. I can never thank that team enough for what they did for me. I hadn't even realised I was unwell and they just stepped in and helped me. A service like that, provided by such a professional team of medically qualified people, is worth its weight in gold, and must surely mean that people, who would otherwise have to stay in hospital, may be able to be cared for at home, and that's where most of us would rather be.

Mar 2023: Instead of my elderly mum going into hospital she received excellent care from this team. We also felt supported and reassured. She received daily visits as long as they were required. Can't thank them enough.

5.0 IJB Complaints

No complaints about the Integration Joint Board have been received.

6.0 POLICY IMPLICATIONS

This report has been subject to the Pre-IIA Screening Tool and does not make any recommendations for change to strategy, policy, procedures, services or funding and so has not been subject to an Integrated Impact Assessment. An appropriate senior manager has reviewed and agreed with this assessment.

7.0 RISK ASSESSMENT

This report has not been subject to a risk assessment as it is provided for information and does not require a policy decision from the PAC.

8.0 CONSULTATIONS

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

9.0 BACKGROUND PAPERS

None

Dave Berry
Chief Finance Officer

DATE: 24 April 2023

APPENDIX 1

SPSO Categories

	Social Work				Health			
	Q1	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
1a: the total number of complaints received per 1,000 population	0.06	0.04	0.06	0.10	0.30	0.34	0.30	NA
1b: the total number of complaints closed per 1,000 population	0.10	0.05	0.07	0.13	0.40	0.34	0.37	NA
2a: the number of complaints closed at stage 1 as % all complaints closed	25%	67%	88%	38%	33%	29%	27%	NA
2b: the number of complaints closed at stage 2 as % all complaints closed	75%	33%	13%	50%	31%	52%	69%	NA
2c: the number of complaints closed after escalation as % all complaints closed	0%	0%	0%	13%	33%	19%	24%	NA
3a: the number of complaints upheld at stage 1 as % of all complaints closed in full at stage 1	33%	25%	0%	17%	44%	25%	33%	NA
3b: the number of complaints not upheld at stage 1 as % of all complaints closed in full at stage 1	33%	50%	43%	83%	13%	8%	25%	NA
3c: the number of complaints partially upheld at stage 1 as % of all complaints closed in full at stage 1	0%	25%	29%	0%	44%	67%	33%	NA
3d: the number of complaints upheld at stage 2 as % of all complaints closed in full at stage 2	11%	50%	0%	0%	20%	0%	3%	NA
3e: the number of complaints not upheld at stage 2 as % of all complaints closed in full at stage 2	56%	0%	100%	75%	47%	59%	45%	NA
3f: the number of complaints partially upheld at stage 2 as % of all complaints closed in full at stage 2	33%	0%	0%	0%	33%	41%	13%	NA
3g: the number of escalated complaints upheld at stage 2 as % of all escalated complaints closed in full at stage 2	0%	0%	0%	0%	6%	0%	0%	NA
3h: the number of escalated complaints not upheld at stage 2 as % of all escalated complaints closed in full at stage 2	0%	0%	0%	50%	56%	63%	100%	NA
3i: the number of escalated complaints partially upheld at stage 2 as % of all escalated complaints closed in full at stage 2	0%	0%	0%	50%	31%	25%	0%	NA
4a: the average time in working days for a full response to complaints at stage 1	31	19	15	35	10	19	13	NA
4b: the average time in working days for a full response to complaints at stage 2	50	28	69	45	31	26	41	NA
4c: the average time in working days for a full respond to complaints after escalation	0	0	0	57	39	35	36	NA
5a: the number of complaints closed at stage 1 within 5 working days as % of total number of stage 1 complaints	0%	50%	57%	50%	6%	83%	83%	NA
5b: the number of complaints closed at stage 2 within 20 working days as % of total number of stage 2 complaints	22%	0%	100%	50%	33%	36%	24%	NA

5c: the number of complaints closed after escalation within 20 working days as % of total number of escalated complaints	0%	0%	0%	0%	25%	25%	45%	NA
6a: number of complaints closed at stage 1 where extension was authorised as % of all complaints at stage 1	33%	50%	29%	33%	6%	8%	0%	NA
6b: number of complaints closed at stage 2 where extension was authorised as % of all complaints at stage 2	78%	100%	100%	38%	0%	9%	5%	NA
6c: number of complaints closed after escalated where extension was authorised as % of all complaints escalated	0%	0%	0%	50%	19%	25%	27%	NA

**Please note all categories add up to 100% due to missing data, the use of resolved outcomes and other categories to close complaints.

***Please note that no data was received from NHS to complete Health Q4 data

REPORT TO: **PERFORMANCE & AUDIT COMMITTEE – 24 MAY 2023**

REPORT ON: **DUNDEE HEALTH AND SOCIAL CARE PARTNERSHIP STRATEGIC RISK REGISTER UPDATE**

REPORT BY: **CHIEF FINANCE OFFICER**

REPORT NO: **PAC19-2023**

1.0 PURPOSE OF REPORT

1.1 The purpose of this report is to update the Performance and Audit Committee in relation to the Strategic Risk Register and on strategic risk management activities in Dundee Health and Social Care Partnership.

2.0 RECOMMENDATIONS

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

2.1 Note the content of this Strategic Risk Register Update report.

2.2 Note the extract from the Strategic Risk register attached at Appendix 1 to this report.

2.3 Note the recent work and future work on the Pentana Risk Management System in Section 7 of this report.

3.0 FINANCIAL IMPLICATIONS

3.1 None.

4.0 BACKGROUND

4.1 The Dundee HSCP Strategic Risk Register is regularly presented to the NHS Tayside Strategic Risk Management Group and is available to Dundee City Council Risk and Assurance Board through the Pentana system.

4.2 Operational Risks are reviewed by the Clinical Care and Professional Governance forum with any significant areas of concern which may impact on the ability of the IJB to deliver its Strategic and Commissioning Plan reported to the PAC through the Clinical Care and Professional Governance Group's Chairs Assurance Report.

4.3 Operational Risks which should be escalated are identified through Senior Management meetings, the Clinical Care and Professional Governance forum and through reports to the IJB and PAC.

5.0 STRATEGIC RISK REGISTER UPDATE

5.1 The three highest scoring risks on the Strategic Risk Register have changed since the last update in February. They are now: Staff Resource - Clinical; the National Care Service; Restrictions on Public Sector Funding, Staff Resource – Planned Performance Management and Primary Care.

5.2 The Strategic Risk Register extract details the most recent updates and a brief description of the mitigating control factors identified.

5.3 All strategic risks are reviewed regularly and mitigating actions recorded and scored. Further development work is underway to link risk with performance as recommended in the Internal Audit Report on Performance Management presented to the PAC at its meeting on 24th March 2021 (Item VI of the minute refers).

5.4 Work has been underway by members of the Clinical Care and Professional Governance forum to ensure that the escalation of operation risks to strategic risks is given adequate scrutiny during all relevant meetings.

6 RISKS

6.1 There has been movement of risks since the last Strategic Risk Register update.

6.2 The Dundee Drug and Alcohol Recovery Service has decreased from the maximum risk to 4 x 4 (16) risk. This is due to several actions being taken and is evidenced by progress made on the MAT Standards.

6.3 A new risk around Data Quality has been entered on the Strategic Risk Register. This is around capacity to ensure accurate data is recorded on social care systems and ensuring statutory returns are accurate.

7.0 PENTANA RISK MANAGEMENT SYSTEM

7.1 Following on Risk Development Sessions with the Integration Joint Board members, development work on the Pentana Risk Management System is being undertaken.

7.2 Developments include linking the risks to the individual Actions in the current Strategic and Commissioning Plan Actions, and Performance Indicators where appropriate.

7.3 Documents will be added as links to the risks where they are part of the Control Factor. For example we plan to add the link to the Workforce Strategy document to the Staff Resource risk.

7.4 The inherent risks will be revisited to take into account external events which have meant that current scores are higher than previous inherent scores.

7.5 The target risk scores will be revisited following planned Risk Appetite sessions for the recent development work around risk appetite.

8.0 POLICY IMPLICATIONS

8.1 This report has been subject to the Pre-IIA Screening Tool and does not make any recommendations for change to strategy, policy, procedures, services or funding and so has not been subject to an Integrated Impact Assessment. An appropriate senior manager has reviewed and agreed with this assessment.

9.0 RISK ASSESSMENT

9.1 This report has not been subject to a risk assessment as it provides the IJB with an overview of the IJBs Strategic Risks.

10.0 CONSULTATIONS

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

11.0 BACKGROUND PAPERS

11.1 None.

Dave Berry
Chief Finance Officer

DATE: 27 April 2023

Clare Lewis-Robertson
Senior Officer, Strategy and Performance

DUNDEE HEALTH AND SOCIAL CARE PARTNERSHIP – STRATEGIC RISK PROFILE APRIL 2023 PAC Appendix 1

Description	Lead Director/Owner	Current Assessment			Status	Control Factors	Date Last Reviewed
		L	C	Exp			
Staff Resource Post Covid recruitment challenges continue to exist in a range of roles including social care and nursing. Recruitment for Consultants and Doctors in specific areas such as Mental Health, and Substance Misuse has meant that there are significant difficulties in filling posts, with posts remaining vacant. These risks are detailed in Operational Risk Registers and have been escalated as risks for the Strategic Risk Register. The IJB has approved the Workforce Strategy	Dundee HSCP Chief Officer	**5**	**5**	**25**	→	• Developments of new models of care • Organisational development strategy • Service redesign • Workforce Strategy approved	27/04/2023
National Care Service The National Care Service risk continues to pose a risk to the IJB's future existence and its ability to carry out the Strategic Plan. Political changes and expected delays in the implementation of the NCS also mean that partner bodies may be reluctant to investment in HSCP projects due to uncertainty.	Dundee HSCP Chief Officer	**5**	**5**	**25**	→	• Change Management • Engagement with consultation process	27/04/2023
Restrictions on Public Sector Funding Additional interventions by Scottish Government to seek the use of IJB's reserves has the potential to de-stabilise agreed investment plans eg Primary Care Improvement Funding.	Dundee HSCP Chief Finance Officer	**5**	**4**	**20**	→	• Additional Scot Gov funding • Budgeting arrangements • MSG and external audit recommendations • Savings and Transformation Plan	27/04/2023
Primary Care Challenges continue to present within Primary Care services, including the recent closure of Ryehill Medical Practice. Progress around development of Primary Care Improvement Plan has been impacted by	Dundee HSCP Chief Officer	**4**	**5**	**20**	→	• Maximise skills mix. • Longer term national work to increase undergraduate training • Test of change for IT infrastructure	27/04/2023

the Scottish Governement's changed stance on funding for 2022/23 by restricting overall funding available.						• Other funding sources identified as opportunities arise	
Staff resource is insufficient to address planned performance management improvements in addition to core reporting requirements and business critical work. Pressures still remain, however restructure and enhancement to service planned for over coming months. This risk was highlighted further in recent IJB reports around the the development of the IJB Strategic and Commissioning Plan.	Dundee HSCP Chief Officer	**5**	**4**	**20**	→	• Planned restructure and enhancement	27/04/2023
Dundee Drug and Alcohol Recovery Service There has been a reduction in risk that is evidenced by the progress made in Dundee on the MAT standards . A vital role in the progress is also feedback we have had from the people that use our services. This dialogue with those who have lived experience and those who care for them is at an early stage, but this will be a primary driving force throughout all the work we are doing to improve and reduce risk of harm from drug and/or alcohol use There continue to be improvements that are required due to the level of drug death being higher than anyone would hope or expect. Figures show there has been some reduction but it's too early to confirm that has been due to steps we have taken so far. It is hoped that by sustaining the progress on MAT standards 1-5 and now starting major work on Standards 6-10 we will continue to see progress and a downward trend of risk and drug deaths.	Dundee HSCP Chief Officer	4	**4**	16	↓	• ADP Residential Rehab Pathway • Service Restructure • ADP Risk Register	27/04/2023
Unable to maintain IJB Spend Most recent financial projections note that the IJB is likely to be in financial balance at the end of the current financial year	Dundee HSCP Chief Finance Officer	**4`**	**4**	**16**	→	• Financial monitoring system • Increase in reserves	27/04/2023

						• Management of vacancies and discretionary spend • MSG and external audit recommendations • Savings and transformation plan	
Lack of Capital Investment in Community Facilities (including Primary Care) Restrictions in access to capital funding from the statutory partner bodies and Scottish Government to invest in existing and potential new developments to enhance community based health and social care services. This could potentially be exacerbated by the transitional period until the establishment of a National Care Service due to the uncertainty of funding and ownership of assets by the local authority and Health Board.	Dundee HSCP Chief Officer and Chief Finance Officer	**4**	**4**	**16**	→	• To be developed	27/04/2023
Cost of Living Crisis The cost of living and inflation will impact on both service users and staff , in addition to the economic consequences on availability of financial resources. The uncertainty of the fuel cost crisis is yet to be fully felt.	Dundee HSCP Chief Officer and Chief Finance Officer	**4**	**4**	**16**	→	• To be developed	27/04/2023
Viability of External Providers Previous assessments have been affected by the Covid Pandemic, however the increase in energy prices in addition to fuel costs for staff travel in addition to staff pay pressures is already impacting this sector with concerns that a number will not be able to sustain their activities.	Dundee HSCP Chief Officer	**4**	**4**	**16**	→	• Maintain regular communication with third sector essential service providers	27/04/2023
Mental Health Services Tayside Mental Health Strategy continues to make progress, developments such as the Community Wellbeing Centre will enhance community supports for people with mental health issues.	Dundee HSCP Chief Officer	**4**	**4**	**16**	→	• Community Wellbeing Centre development • Tayside Mental Health Strategy	27/04/2023
Capacity of Leadership Team	Dundee HSCP Chief Officer	**3**	**4**	**12**	→	• Restructure	27/04/2023

Leadership team continue to be impacted by workload pressures of the wider workforce recruitment challenges. This is likely to be exacerbated as preparations for the intro of the NCS develop over the coming period.						• Sharing of Management Team duties	
Data Quality Capacity to ensure accurate data is recorded on social care systems and ensuring statutory returns are accurate.	Chief Finance Officer	**3**	**4**	**12**	↑	• Analysis of data inadequacies • Support by business support • Changes to Mosaic	27/04/2023
Impact of Covid 19 DHSCP continue to experience difficulties in delivering services due to significantly higher rates of sickness absence due to long term covid or other related covid illnesses. In addition some services which were paused due to Covid have still not been able to be resumed .	Dundee HSCP Chief Officer	**4**	3	12	↓	• Remobilisation plans	27/04/2023
Governance Arrangements being Established fail to Discharge Duties Further progress made on ensuring actions on Governance Action Plan have been completed. External audit plan for 2021/22 noted a reduction in the key areas of assessment due to reduced risk associated with governance. Futher refinement of the Governance Action Plan is being undertaken to reduce duplication of actions.	Dundee HSCP Chief Officer	**3**	**4**	**12**	→	• Implementation of Governance Action Plan	09/01/2023
Increased Bureaucracy Potential for additional bureaucracy through Scot Gov Covid enquiry and National Care Service development.	Dundee HSCP Chief Officer	**3**	**3**	**9**	→	• Support and roles	09/01/2023
Category One Responder The Category One Responder Action Plan was presented to and approved by the IJB on the 26th October 2022.	Dundee HSCP Chief Officer	2	**4**	**8**	→	• 4 actions	09/01/2023

Archived

No risks have been archived since the last Risk Register update.							

Risk Status	
↑	Increased level of risk exposure
→	Same level of risk exposure
↓	Reduction in level of risk exposure
x	Treated/Archived or Closed

ITEM No …10……..

REPORT TO: **PERFORMANCE & AUDIT COMMITTEE – 24 MAY 2023**

REPORT ON: **DUNDEE INTEGRATION JOINT BOARD INTERNAL AUDIT REPORT – GOVERNANCE ACTION PLAN**

REPORT BY: **CHIEF FINANCE OFFICER**

REPORT NO: **PAC10-2023**

1.0 PURPOSE OF REPORT

1.1 This paper presents the findings of the Internal Audit Review of the Governance Action Plan which is presented to each meeting of the Performance and Audit Committee

2.0 RECOMMENDATIONS

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

2.1 Notes the content and recommendations of the Internal Audit Review of the Governance Action Plan as set out in Appendix 1 to this report.

2.2 Instructs the Chief Finance Officer to implement the recommendations of the report and provide an update on progress at the next meeting of the PAC.

3.0 FINANCIAL IMPLICATIONS

3.1 None.

4.0 MAIN TEXT

4.1 The Governance Action Plan was first presented to the Performance and Audit Committee in March 2019. When first developed, the Governance Action Plan reflected the complicated range of governance arrangements required to be implemented for the IJB as an emerging organisation within a new integrated legislative framework for which there was no previous model to follow. The range of actions continued to be added to at each stage a review on particular aspects of governance was undertaken, including internal and external audit reports and national governance directions.

4.2 Given the complexity of the governance arrangements around integration and through embedding governance processes across a wide range of areas, duplication of actions started to become a theme in the plan. Although an exercise was carried out to combine a number of actions, the plan remains to be complex in nature. As part of the IJB's Annual Internal Audit Plan, a review of the Governance Action Plan has been carried out by Internal Audit. Appendix 1 to this report sets out the findings and recommendations of the report. The assessment of risk is rated as significant i.e. requires action to avoid exposure to significant risks to achieving the objectives for area under review.

4.3 The recommendations of the report have been agreed by management who have committed to streamline the approach.

5.0 POLICY IMPLICATIONS

5.1 This report has been subject to the Pre-11A Screening Tool and does not make any recommendations for change to strategy, policy, procedures, services or funding and so has not been subject to an Integrated Impact Assessment. An appropriate senior manager has reviewed and agreed with this assessment.

6.0 RISK ASSESSMENT

6.1 This report has not been subject to a risk assessment as it a status update and does not require any policy or financial decisions at this time.

7.0 CONSULTATIONS

7.1 The Chief Finance Officer, Regional Audit Manager, Chief Internal Auditor and the Clerk were consulted in the preparation of this report.

8.0 BACKGROUND PAPERS

8.1 None.

Dave Berry
Chief Finance Officer

Date: 28/04/23

FTF Internal Audit Service

Governance Action Plan

Report No. D06/21

Issued To: V Irons, Chief Officer
D Berry, Chief Finance Officer

Dundee City Integration Joint Board
External Audit

C Wyllie, Senior Manager – Internal Audit, DCC
D Vernon, Principal Internal Auditor- Internal Audit, DCC

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Draft Report Issued	27 February 2023
Management Responses Received	24 April 2023
Target Audit & Risk Committee Date	24 May 2023
Final Report Issued	**25 April 2023**

CONTEXT AND SCOPE

1. Good practice guidance, as laid out in the Audit Committee Handbook, emphasises the importance of effective follow up processes to ensure that the actions agreed by management to address control weaknesses identified by the work of Internal and External Audit are actually implemented. The remit of the Performance & Audit Committee (PAC) requires the PAC '*to receive reports, monitor the implementation of agreed actions on audit recommendations and reporting to the IJB as appropriate'*.

2. A Governance Action Plan was first presented and approved at the PAC meeting in March 2019 in response to a recommendation within our Annual Internal Audit Report 2017/18. Since then, our annual reports noted that a number of longstanding complex issues have remained incomplete for a number of years and continue to feature in the IJBs Governance Statement as well as Governance Action Plans. The Governance Action Plan was escalated to the October 2020 meeting of Dundee City IJB who *'instructed the Chief Officer and Chief Finance Officer to ensure these initiatives are implemented in order to strengthen the governance arrangements in place within the Integration Joint Boards governance framework*'.

3. Work was undertaken to produce an integrated Governance Action Plan which was then presented to the PAC in September 2021.

4. Our audit will evaluate the design and operation of the Governance Action Plan and will specifically consider whether:

    - The Governance Action Plan provides a complete record of all governance actions, taking account of all relevant sources;
    - The Governance Action Plan as reported to the Performance & Audit Committee provides an accurate picture of the status of each action;
    - There is no unnecessary duplication, and similar action points aimed at the same outcomes have been appropriately amalgamated with a clear audit trail where actions have been closed off as no longer relevant;
    - Internal Audit can provide enhancements to the format and content of the Governance Action Plan to the Performance & Audit Committee;
    - Internal Audit can provide any additional support in progressing outstanding actions.

AUDIT OPINION

5. We reviewed Dundee City IJB systems and processes for producing a Governance Action Plan and compared current practice against other FTF clients, in order to share good practice. A grade is therefore not provided for this review.

6. Descriptions of assessment of risks are given in Section 3 of this report.

Executive Summary

7. Following an internal audit recommendation, the first Governance Action Plan (GAP) was presented to the Performance & Audit Committee (PAC) in March 2019 to monitor progress in implementing internal and external audit action points. Subsequent annual internal audit reports reference the crossover duplication with improvement actions arising from the Ministerial Steering Group (MSG) report as well as areas identified for development in the annual Governance Statement. A recommendation was then made as part of the 2028/29 Annual Internal Audit Report to consider establishing a separate Audit Follow Up process for audit recommendations as distinct from the more high level governance improvement actions.

8. Whist we note the background to producing one overarching GAP, we now consider this approach to be over complicated and difficult to follow. We recommend that separate reports are maintained and reported to the PAC as follows:
    - Internal Audit Report recommendations including those arising from Annual Internal Audit Reports (each meeting)
    - External Audit Recommendations
    - External review recommendations, for example MSG report (as needed/ minimum annually)
    - Governance Statement Improvement Actions
9. Since the introduction of the Action Tracker in November 2021, actions arising from agenda item discussions should be reported within the action points update agenda item.
10. An update to the Terms of Reference for the PAC will be required to reflect the reporting arrangements. To support each report, we recommend that protocols are set up and agreed by the PAC to ensure clarity on the processes and roles for the production of each report. For example, an Audit Follow Up protocol could set out how completion of actions will be validated to provide assurance that the audit recommendations are having the required impact on the original control weakness.

Completeness of the current Governance Action Plan (GAP)

11. The Governance Action Plan as currently used was initially created based on a review of agenda items discussed by the Performance & Audit Committee (PAC) rather than directly on the actions noted in final internal audit reports or reports by other organisations. We noted that it also includes actions agreed as part of discussions by the PAC which should now be monitored through the Action Tracker for the Committee which has been used since November 2021.
12. In terms of completeness, it also means that reports where governance actions are agreed; but which were taken to the IJB rather than the PAC; are not included, for example the Annual Internal Audit Reports for 2020/21 and 2021/22. Other areas not included which we would have expected to see on the Governance Action Plan are the improvement areas identified in the Governance Statement(s). We have also previously commented in our Annual Internal Audit Reports on the lack of monitoring of actions agreed in response to the MSG report.

Accuracy of Status of Actions in the current GAP

13. We reviewed the actions (these included action points update and audit report recommendations) noted as complete on a GAP report from the Pentana system on 5 July 2022, and based on our knowledge we can provide assurance that they accurately reflect their status as completed.

Duplication of Actions in the current GAP

14. A number of themes have emerged and been mirrored across different reports, including several Internal Audit and External Audit annual reports, the MSG report action plan and the improvement actions noted as part of Dundee City IJB's Annual Governance Statement.

15. Whilst duplication of themes across different assurance provider reports is inevitable, to ensure completeness moving forward, Internal Audit are of the opinion that separate reports relevant to each assurance provider (see para 8) should be provided and reported to the PAC. Cross references maybe made within these reports. The issues identified above with regards to completeness require an exercise to be undertaken to organise the actions to be followed up and reported within the respective reports recommended by Internal Audit, which may present the opportunity for consolidation or cross reference.

Future enhancements to the format of the current GAP report to PAC

16. We reviewed the current format of reporting to assess whether it provides robust assurance over the implementation of agreed actions and allows the PAC to fulfil its remit.

17. As set out above, actions are currently referenced by the agenda item PAC reference number rather than the name or reference of the report they arose from. In addition, actions are grouped by the degree of progress that has been made. It is therefore not possible to use the GAP as a basis for easily assessing progress against one report or area of governance. Consideration should be given to reporting by source as listed in paragraph 8.

18. To ensure meaningful and adequate scrutiny of progress with governance actions, there is scope within each report suggested in paragraph 8 to include the following which will enhance and provide clearer assurance on the status of governance related actions :

    - Chart showing total number of action points due broken down into complete, in progress, due date extended, no longer relevant
    - Link to risk (and/or area of governance) –updates should clearly identify risks of non-delivery of actions and these should be summarised in the risk assessment section of the cover paper, which should link to relevant strategic risks.
    - a RAG rating for outstanding actions
    - the drafting of protocols which clarify roles and responsibilities, monitoring and escalation arrangements over each process.

ACTION

19. The action plan at Section 2 of this report has been agreed with management to address the identified weaknesses. A follow-up of implementation of the agreed actions will be undertaken in accordance with the audit reporting protocol.

ACKNOWLEDGEMENT

20. We would like to thank all members of staff for the help and co-operation received during the course of the audit.

Barry Hudson BAcc CA
Regional Audit Manager

Action Point Reference 1

Finding:

The current GAP does not make it easy to identify if all the recommendations from a specific report/source have been completed. Whist we note the background to produce one overarching GAP, we now consider this approach to be over complicated and difficult to follow.

Audit Recommendation:

An exercise, facilitated by Internal Audit, including reprioritisation of outstanding recommendations is undertaken to ensure completeness of actions to be followed up within the respective reports recommended by Internal Audit, which may present the opportunity for consolidation or cross reference.

We recommend that separate reports are maintained and reported to the PAC as follows:

- Internal Audit Report and Annual Report recommendations
- External Audit Recommendations
- External review recommendations, for example MSG report
- Governance Statement Improvement Actions
- Actions from agenda item discussions to be reported within the standard agenda item – Action Tracker

Areas of enhancement to the reporting could include:

- Chart showing total number of action points due broken down into complete, in progress, due date extended, no longer relevant
- Link to risk (and/or area of governance) –updates should clearly identify risks of non-delivery of actions and these should be summarised in the risk assessment section of the cover paper, which should link to relevant strategic risks.
- a RAG rating for outstanding actions

Consider drafting a Follow Up Protocol to clarify roles and responsibilities, monitoring and escalation arrangements over the process. The PAC Terms of Reference will require updating to reflect the arrangements going forward, along with related protocols.

Assessment of Risk:

Significant		Weaknesses in design or implementation of key controls i.e. those which individually reduce the risk scores. **Requires action to avoid exposure to significant risks to achieving the objectives for area under review.**

Management Response/Action:	
When first developed, the Governance Action Plan reflected the complicated range of governance arrangements required to be implemented for the IJB as an emerging organisation within a new integrated legislative framework for which there was no previous model to follow. The range of actions continued to be added to at each stage a review on particular aspects of governance was undertaken. It is agreed by management that this has now become overly complicated to manage in a single plan and management agrees that this can now be streamlined against the categories outlined in the report. Management will develop future reporting to the PAC to be consistent with the recommendations.	
Action by:	**Date of expected completion:**
Chief Finance Officer	**September 2023**

Assessment of Risk

To assist management in assessing each audit finding and recommendation, we have assessed the risk of each of the weaknesses identified and categorised each finding according to the following criteria:

Risk Assessment		Definition	Total
Fundamental		Non Compliance with key controls or evidence of material loss or error. **Action is imperative to ensure that the objectives for the area under review are met.**	None
Significant		Weaknesses in design or implementation of key controls i.e. those which individually reduce the risk scores. **Requires action to avoid exposure to significant risks to achieving the objectives for area under review.**	One
Moderate		Weaknesses in design or implementation of controls which contribute to risk mitigation. **Requires action to avoid exposure to moderate risks to achieving the objectives for area under review.**	None
Merits attention		There are generally areas of good practice. **Action may be advised to enhance control or improve operational efficiency.**	None

ITEM No …11……..

REPORT TO: **PERFORMANCE AND AUDIT COMMITTEE – 24TH MAY 2023**

REPORT ON: **GOVERNANCE ACTION PLAN PROGRESS REPORT**

REPORT BY: **CHIEF FINANCE OFFICER**

REPORT NO: **PAC12-2023**

1.0 PURPOSE OF REPORT

1.1 The purpose of this report is to provide the Performance and Audit Committee with an update on the progress of the actions set out in the Governance Action Plan.

2.0 RECOMMENDATIONS

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

2.1 Notes the content of the report and the progress made in relation to the actions set out in the Governance Action Plan as outlined in Appendix 1.

3.0 FINANCIAL IMPLICATIONS

3.1 None.

4.0 MAIN TEXT

4.1 The Governance Action Plan was first presented and approved at the PAC meeting of the 25th March 2019 (Article VIII of the minute of the meeting refers) in response to a recommendation within Dundee Integration Joint Board's Annual Internal Audit Report 2017/18. This action plan enables the PAC to regularly monitor progress in implementing actions and understand the consequences of any non-achievement or slippage in strengthening its overall governance arrangements. The PAC remitted the Chief Finance Officer to present an update progress report to each PAC meeting.

4.2 The progress of the actions considered previously in the Governance Action Plan update, and not yet completed are noted in Appendix 1. Work is progressing to clear these outstanding actions. The completed actions previously reported to the Performance and Audit Committee have been removed from Appendix 1 to reduce the amount of information shown.

5.0 POLICY IMPLICATIONS

5.1 This report has been subject to the Pre-IIA Screening Tool and does not make any recommendations for change to strategy, policy, procedures, services or funding and so has not been subject to an Integrated Impact Assessment. An appropriate senior manager has reviewed and agreed with this assessment.

6.0 RISK ASSESSMENT

6.1 This report has not been subject to a risk assessment as it relates to the development of an action plan in line with the findings of the Annual Internal Audit Report.

7.0 CONSULTATIONS

7.1 The Chief Officer, Chief Internal Auditor and the Clerk were consulted in the preparation of this report.

8.0 BACKGROUND PAPERS

8.1 None.

Dave Berry
Chief Finance Officer

DATE: 1st May 2023

PAC12-2023 HSCP Governance Action Report

Generated on: 02 May 2023

Rows are sorted by Progress

	Action Code & Title	Progress Bar	Dates Due Date	Dates Original Due Date	Ownership Assigned To	Latest Update
	PAC7-2019-1 Clarification of deputising arrangements for the Chief Officer to be presented to the IJB.	100%	31-Aug-2022	31-Mar-2022	Dave Berry	CO advised Chief Execs formally that CFO will deputise should there be longer term absence of the CO
	PAC 13-2022-1 Category 1 Responders - Fully incorporate responder resilience arrangements into the IJB's governance structure.	90%	31-Oct-2022	31-Dec-2021	Kathryn Sharp	First annual report to be submitted to the IJB in June 2023. Working Group established to support development of annual report and review other governance arrangements, including assurance interface from NHST and DCC.
	PAC 13-2022-3 Copy of Category 1 Responders - Assurances to be provided to the IJB	90%	31-Oct-2022	31-Dec-2021	Kathryn Sharp	Report due to be submitted to the IJB in June 2023.
	PAC 36-2020-1 Status of savings proposals and transformation should be clearly and regularly reported to members. The impact from Covid-19 and delivering	90%	31-Aug-2023	31-Mar-2022	Dave Berry	New savings plan for 23/24 will feature in financial monitoring reports throughout the 23/24 financial year

	Action Code & Title	Progress Bar	Dates Due Date	Dates Original Due Date	Ownership Assigned To	Latest Update
	pandemic remobilisation plans will also need to be considered.					
	PAC7-2019-4 Development of improved Hosted Services arrangements around risk and performance management for hosted services.	80%	31-Mar-2023	31-Mar-2022	Dave Berry; Kathryn Sharp	Work continues to be progressed, including in relation to revision of strategic plans and preparation of 22/23 annual performance reports.
	PAC 36-2020-3 The Board and PAC are updated on progress in delivering against the risk maturity action plan.	75%	31-Mar-2023	31-Mar-2022	Clare Lewis-Robertson	IJB Development session on risk maturity being prepared for before end of June 2023
	PAC20-2019-1 The Transformation Programme should be recorded in an overarching document	75%	31-Mar-2023	31-Aug-2021	Dave Berry	The transformation programme will be presented to the IJB as part of the 5 Year Financial Framework in June 2023
	PAC20-2019-2 Summary reports on the progress of the Transformation Programme should be prepared and submitted to the PAC for its review. The Terms of Reference of the PAC should be updated to reflect the requirement for the TDG to report to it.	75%	31-Mar-2023	31-Aug-2021	Dave Berry	Review of terms of reference of PAC commenced. Individual reports on Mental Health, Substance Use, Primary Care and Reshaping Non- Acute care strategic frameworks and transformation presented regularly to the IJB
	PAC30-2021-4 Review and further develop the IJB's risk management policy	75%	31-Mar-2023	31-Oct-2022	Clare Lewis-Robertson	Development of IJB Risk appetite through development session will ensure the IJB makes further progress with embedding the risk management policy
	PAC 13-2022-2 Category 1 Responders - Arrangements to be put in place for assurances from partner bodies.	70%	31-Oct-2022	31-Dec-2021	Diane Mcculloch	Request to be made formally through Tayside Local Resilience Planning Group to receive appropriate resilience reports
	PAC 34-2019-4 Combine financial and	70%	31-Mar-2023	31-Dec-2021	Kathryn Sharp	IJB is in final stages of development of

	Action Code & Title	Progress Bar	Dates Due Date	Dates Original Due Date	Ownership Assigned To	Latest Update
	performance reporting to ensure that members have clear sight of the impact of variances against budget in terms of service performance.					strategic commissioning framework, due to be submitted for approval in late June 2023. Following on from this further work will be undertaking on a resources framework and performance framework – this will allow a long-term, sustainable approach to alignment of financial and performance reporting to be developed.
	PAC29-2021-1 Develop a Psychological Therapies Strategic Plan including the introduction of a pan-Tayside Strategic Commissioning Group	70%	30-Jun-2022	30-Jun-2022	Diane Mcculloch	Commissioning Group established and has met a number of times on a Tayside wide basis. Development of the plan has been delayed due to challenges of recruiting to the Director of Psychology post
	PAC7-2019-3 Development of Large Hospital Set Aside arrangements in conjunction with the Scottish Government, NHS Tayside and Angus and Perth and Kinross Integration Joint Boards.	70%	31-Mar-2023	31-Mar-2022	Dave Berry	Value of 22/23 Large Hospital Set Aside agreed for including in the IJB's Year End Accounts
	PAC7-2019-6 Further develop performance report information into a delivery plan framework	70%	31-Mar-2022	31-Dec-2021	Kathryn Sharp	This continues to be developed in line with the IJB's revised Strategic Plan and associated delivery plan
	PAC9-2018-1 Clinical and care governance across delegated services review of remits	70%	31-Mar-2023	30-Sep-2021	Matthew Kendall	Further work on this will tie in with the action on the strengthening of performance reporting for lead partner (hosted) arrangements
	PAC26-2021-1 Submit a further in-depth analysis of readmissions data	60%	31-May-2022	31-Mar-2022	Kathryn Sharp	Agenda note submitted to PAC in July 2022. Contemporary readmissions is not available for further analysis due to ongoing work by

	Action Code & Title	Progress Bar	Dates Due Date	Dates Original Due Date	Ownership Assigned To	Latest Update
						NHS Tayside Business unit on coding and recording. However Partnership information staff have planned next steps in the analytical process and will recommence activity as soon as data becomes available. An update is to be provided to PAC in November 2022.
	PAC28-2020-1 The DHSCP management team should review attendance at groups based on agreed principles	60%	31-Mar-2023	31-Mar-2022	Dave Berry	Management team continues to assess attendance at meetings based on reducing duplication of attendees, relevance and priorities
	PAC8-2018-1 Work to fully implement the actions in the Workforce and Organisational Development Strategy	60%	31-Mar-2023	31-Mar-2022	Dave Berry; Diane Mcculloch	Publication of updated IJB Workforce strategy in June 2022 further strengthens the framework to take forward a revised organisational development strategy
	PAC31-2021-2 The Finance & Performance Group, when constituted, should consider both finance and performance in the context of the IJB's strategic risks	50%	31-Mar-2023	30-Jun-2022	Dave Berry	Further work planned on completion of IJB's new Strategic Plan and associated finance and performance frameworks
	PAC31-2021-3 The IJB should monitor whether the Strategic Commissioning Plan is delivering the required outcomes	50%	31-Mar-2024	31-Mar-2024	Dave Berry	Work progressing through the Strategic Planning Advisory Group around developing the monitoring framework for the delivery plan as the "action" list from the Strategic and Commissioning Plan
	PAC31-2021-4 Develop a process to trigger further analytical reports	50%	31-Mar-2023	30-Jun-2022	Dave Berry	Further work being undertaken to scope this in line with development of performance framework associated with new Strategic Plan

	Action Code & Title	Progress Bar	Dates Due Date	Dates Original Due Date	Ownership Assigned To	Latest Update
	PAC8-2018-2 Develop a formal Service Level Agreement (SLA) detailing all key corporate support services to be provided to the DH&SCP by DCC and NHST	50%	30-Jun-2023	31-Mar-2022	Dave Berry; Kathryn Sharp	Following sign off of the Integration Scheme by the Scottish Government in November 2022, the statutory parties will be asked to take forward the development of a memorandum of understanding regarding the provision of support functions. This will consider the implications of the introduction of a National Care Service
	PAC20-2019-3 Terms of Reference documents should be developed / reviewed for all groups that impact on the transformation and service redesign arrangements of the DH&SCP, including the ISPG	40%	31-Mar-2023	31-Mar-2022	Dave Berry	As revised transformation programme develops this will become a key action to ensure consistency in approach to managing change including reducing duplication
	PAC28-2020-2 A governance mapping best practice guidance document is developed to ensure the operation of all groups conforms to the various principles detailed in the report.	40%	28-Feb-2023	31-Mar-2022	Dave Berry; Diane Mcculloch	Work to commence on this as the HSCP moves back into business as usual mode following the Covid19 pandemic
	PAC31-2021-6 The IJB should direct its partners to undertake a review of the resources required for performance management	30%	31-Mar-2023	30-Jun-2022	Dave Berry	Following sign off of the Integration Scheme by the Scottish Government in November 2022, the statutory parties will be asked to take forward the development of a memorandum of understanding regarding the provision of support functions of which performance management forms part.

Action Status	
	Cancelled
	Overdue; Neglected
	Unassigned; Check Progress
	Not Started; In Progress; Assigned
	Completed

ITEM No …12……..

Dundee Health & Social Care Partnership

REPORT TO: **PERFORMANCE & AUDIT COMMITTEE – 24 MAY 2023**

REPORT ON: **DUNDEE INTEGRATION JOINT BOARD INTERNAL AUDIT PLAN PROGRESS REPORT**

REPORT BY: **CHIEF FINANCE OFFICER**

REPORT NO: **PAC13-2023**

1.0 PURPOSE OF REPORT

1.1 This paper provides the Performance and Audit Committee (PAC) with an update on the completion of the previous years' internal audit plans as well as progress against the 2022/23 plan and work relating to 2023/24. This report also includes internal audit reports that were commissioned by the partner Audit and Risk Committees, where the outputs are considered relevant for assurance purposes to Dundee IJB.

2.0 RECOMMENDATIONS

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

2.1 Notes the completion of the 2021/22 Internal Audit Plan and work undertaken relating to 2022/23 and the commencement of the 2023/24 plan.

3.0 FINANCIAL IMPLICATIONS

3.1 None.

4.0 MAIN TEXT

4.1 The Public Sector Internal Audit Standards (PSIAS) require that the Chief Internal Auditor (CIA) reports periodically to the Audit Committee (the PAC in the case of Dundee City IJB) on activity and performance relative to the approved annual plan. We have previously set out that audit work is planned so as to allow the Chief Internal Auditor to provide the necessary assurances prior to the signing of the accounts.

4.2 There is one outstanding audit from previous years which has yet to be finalised which relates to the Financial Viability of External Providers. This will be available for the September meeting of the PAC. Working with our partners in Dundee City Council, we are committed to ensuring that internal audit assignments are reported to the target Performance & Audit Committee and work is underway to complete the outstanding 2022/23 reviews. While the 2023/24 Annual Internal Audit plan is due to be presented for approval at the next Performance & Audit Committee meeting, progress on non-discretional elements of the provisional plan is also incorporated in Appendix 1 below. Following a suggestion at the September 2021 PAC (Article VIII of the minute of meeting of this Committee of 29th September 2021 refers) the progress of each audit has been risk assessed and a RAG rating added showing an assessment of progress using the following definitions:

Risk Assessment		Definition
Green		**On track or complete**
Amber		**In progress with minor delay**
Red		**Not on track (reason to be provided)**

4.3 An update on the progress of all the IJB's Internal Audits is shown in Appendix 1. Resources to deliver these audits are provided by NHS Tayside and Dundee City Council Internal Audit Services.

4.4 In order that all parts of the system receive appropriate information on the adequacy and effectiveness of internal control within their purview, including controls operated by other bodies which impact on their control environment, an output sharing protocol was developed and approved by all partners' respective audit committees which covers the need to share internal audit outputs beyond the organisation that commissioned the work, in particular where the outputs are considered relevant for assurance purposes. The following reports are considered relevant and are summarised here for information. It should be noted that the respective Audit and Risk Committees of the commissioning bodies are responsible for scrutiny of implementation of actions.

NHS Tayside reports:

Report	Opinion	Key findings
T23/23 Workforce Planning	Limited	The audit identified that the current NHS Tayside Workforce Plan and associated action only sets out the currently employed workforce, with some associated data which were not analysed in sufficient depth beyond the broad implication for the Workforce and the service that will be required to be delivered. Significantly, it does not set out the workforce which will be required in future, nor an effective series of actions to deliver that workforce. The full report can be accessed under page 90 in the following link: https://www.nhstaysidecdn.scot.nhs.uk/NHSTaysideWeb/idcplg?IdcService=GET_SECURE_FILE&dDocName=PROD_362186&Rendition=web&RevisionSelectionMethod=LatestReleased&noSaveAs=1
T08/23 ICE	N/A	The Internal Control Evaluation (ICE) is undertaken each year to provide assurance on the overall systems of internal control that support the achievement of the Board's objectives. This review provides early warning of any significant issues that may affect the Governance Statement. This final report contains 11 recommendations, intended to embed good governance principles and to ensure coherence between Governance Structures, Performance Management, Risk Management and Assurance. NHS Tayside has successfully managed shorter term operational risks, ensuring continuation of service delivery and good performance throughout the pandemic. The focus must now be on management

		of longer term risks, most importantly the Waiting Times risk, and development of overall Strategy. The report highlights the worsening external environment and, as previously, the importance of an achievable strategy accompanied by realistic objectives and robust prioritisation. The full report can be accessed under page 40 in the following link: https://www.nhstaysidecdn.scot.nhs.uk/NHSTaysideWeb/idcplg?IdcService=GET_SECURE_FILE&dDocName=PROD_365449&Rendition=web&RevisionSelectionMethod=LatestReleased&noSaveAs=1

Dundee City Council reports:

Report	Final report Issued	Opinion	Key findings
N/A			

Other Tayside IJB reports:

Report	Final report Issued	Opinion	Key findings
N/A			

5.0 POLICY IMPLICATIONS

5.1 This report has been subject to the Pre-11A Screening Tool and does not make any recommendations for change to strategy, policy, procedures, services or funding and so has not been subject to an Integrated Impact Assessment. An appropriate senior manager has reviewed and agreed with this assessment.

6.0 RISK ASSESSMENT

6.1 This report has not been subject to a risk assessment as it a status update and does not require any policy or financial decisions at this time.

7.0 CONSULTATIONS

7.1 The Chief Finance Officer, Regional Audit Manager, Chief Internal Auditor and the Clerk were consulted in the preparation of this report.

8.0 BACKGROUND PAPERS

8.1 None.

Dave Berry
Chief Finance Officer

Date: 28/04/23

Outstanding								
Ref	**Audit**	**Indicative Scope**	**Target Audit Committee & current** **RAG status**	**Planning Commenced**	**Work in Progress**	**Draft Report**	**Completed**	**Grade**
D06-21	Audit Follow Up/ Governance Action plan	Joint exercise between Internal Audit and management to review & update and consolidate actions arising from all sources of previous recommendations as well as reprioritising using a RAG status.	Complete  See separate agenda item	✓	✓	✓	✓	N/A
D05-22	Viability of External Providers	Review the controls established to manage Strategic Risk HSCP00d1. A review of the IJB's approach to continually assess the viability of its contracted social care providers as essential partners in delivering health and social care services and the priorities set out in the IJB's Strategic and Commissioning Plan. The review will consider the steps taken to engage with providers around the IJB's strategic direction and how the IJB provides ongoing support to them, including the process invoked should there be concerns over financial or operational sustainability.	~~February 2023~~ September 2023 	✓	✓	✓		

2022/23:								
Ref	**Audit**	**Indicative Scope**	**Target Audit Committee & current RAG status**	**Planning Commenced**	**Work in Progress**	**Draft Report**	**Completed**	**Grade**
D01-23	Audit Planning	Agreeing audit universe and preparation of strategic plan	Complete 	✓	✓	✓	✓	**N/A**
D02-23	Audit Management	Liaison with management and attendance at Audit Committee	Complete 	✓	✓	✓	✓	**N/A**
D03-23	Annual Internal Audit Report (2021/22)	CIA's annual assurance statement to the IJB and review of governance self-assessment	Complete 	✓	✓	✓	✓	**N/A**
D04-23	Governance & Assurance	Ongoing advice in relation to governance and assurance arrangements to support the response to the Dundee Drugs Commission	Ongoing 	✓	✓			
D05-23	Workforce	Related risk: Staff Resource Scope: coherent, co-ordinated, adequate and effective approach to managing significant workforce risks. Strategic & operational responses across the totality of the workforce, including contracted services and 3rd sector	~~February 2023~~ September 2023* 	✓				

2022/23:								
Ref	**Audit**	**Indicative Scope**	**Target Audit Committee & current** **RAG status**	**Planning Commenced**	**Work in Progress**	**Draft Report**	**Completed**	**Grade**
D06-23	Operational planning	Related risk: All Planning and monitoring implementation of actions to deliver strategic priorities, including those arising from remobilisation and service plans	~~February 2023~~ September 2023** 	✓	✓			

* Start of work on this audit has been delayed by Internal Audit resourcing issues and completion of work on the NHS Tayside workforce audit (Shared under the output sharing protocol above).

** Whilst it has not been possible to schedule work in time for the target PAC meeting, fieldwork on this audit is now well underway.

2023/24:								
Ref	**Audit**	**Indicative Scope**	**Target Audit Committee & current** **RAG status**	**Planning Commenced**	**Work in Progress**	**Draft Report**	**Completed**	**Grade**
D01-24	Audit Planning	Agreeing audit universe and preparation of strategic plan	September 2023 	✓				
D02-24	Audit Management	Liaison with management and attendance at Audit Committee	Ongoing/ May 2024 	✓	✓			

2023/24:								
Ref	**Audit**	**Indicative Scope**	**Target Audit Committee & current RAG status**	**Planning Commenced**	**Work in Progress**	**Draft Report**	**Completed**	**Grade**
D03-24	Annual Internal Audit Report (2022/23)	CIA's annual assurance statement to the IJB and review of governance self-assessment	June 2023 (IJB) 	✓	✓			

ITEM No …13……..

PAC21-2023

PERFORMANCE AND AUDIT COMMITTEE – ATTENDANCES - JANUARY 2023 TO DECEMBER 2023

COMMITTEE MEMBERS - (* - DENOTES VOTING MEMBER – APPOINTED FROM INTEGRATION JOINT BOARD)					
Organisation	**Member**	**Meeting Dates 2023**			
		1/2	24/5	27/9	22/11
Dundee City Council (Elected Member)	Ken Lynn **	✓			
Dundee City Council (Elected Member)	Dorothy McHugh *	✓			
NHS Tayside (Non Executive Member)	Anne Buchanan *	✓			
NHS Tayside (Non Executive Member)	Sam Riddell *	✓			
Chief Officer	Vicky Irons	✓			
Chief Finance Officer	Dave Berry	✓			
NHS Tayside (Registered Medical Practitioner – not providing primary medical services)	James Cotton	A			
Dundee City Council (Chief Social Work Officer)	Diane McCulloch	A			
NHS Tayside (Staff Partnership Representative)	Raymond Marshall	A			
Carers' Representative	Martyn Sloan	✓			
Chief Internal Auditor ***	Tony Gaskin	✓			

✓ Attended

A Submitted apologies

A/S Submitted apologies and was substituted

☐ No longer a member and has been replaced / was not a member at the time

* Denotes Voting Members

** Denotes Office Bearer. Periods of appointment are on fixed terms in accordance with legislation. At meeting of the Integration Joint Board held on 27th October, 2020, Trudy McLeay was appointed as Chair (the Chair of the Committee cannot also be the Chair of the Integration Joint Board).

*** The Chief Internal Auditor is a member of the Committee and is not a member of the Integration Joint Board.

**** Audit Scotland are not formal members of the Committee and are invited to attend at least one meeting of the Committee a year.

(Note: First meeting of the Committee was held on 17th January, 2017).

(Note: Membership are all members of the Integration Joint Board (only exceptions are Chief Internal Auditor and Audit Scotland).

^ This meeting was not required to be held.