Measuring Performance Under Integration

Objectives and Targets 17/18

DRAFT – 23 February 2017

Local objectives for 2017/18 for the proposed six core indicators discussed with the Chief Officer network and the Ministerial Strategic Group for Health and Community Care.

Please note that this information is currently draft and both the targets, projections and objectives will be further developed in line with the further development of local Implementation and locality plans.

1 Emergency Admissions, acute stays

Chart 1.1: Number of Emergency Admissions for People Aged 18+ as a Rate per 100,000 Population

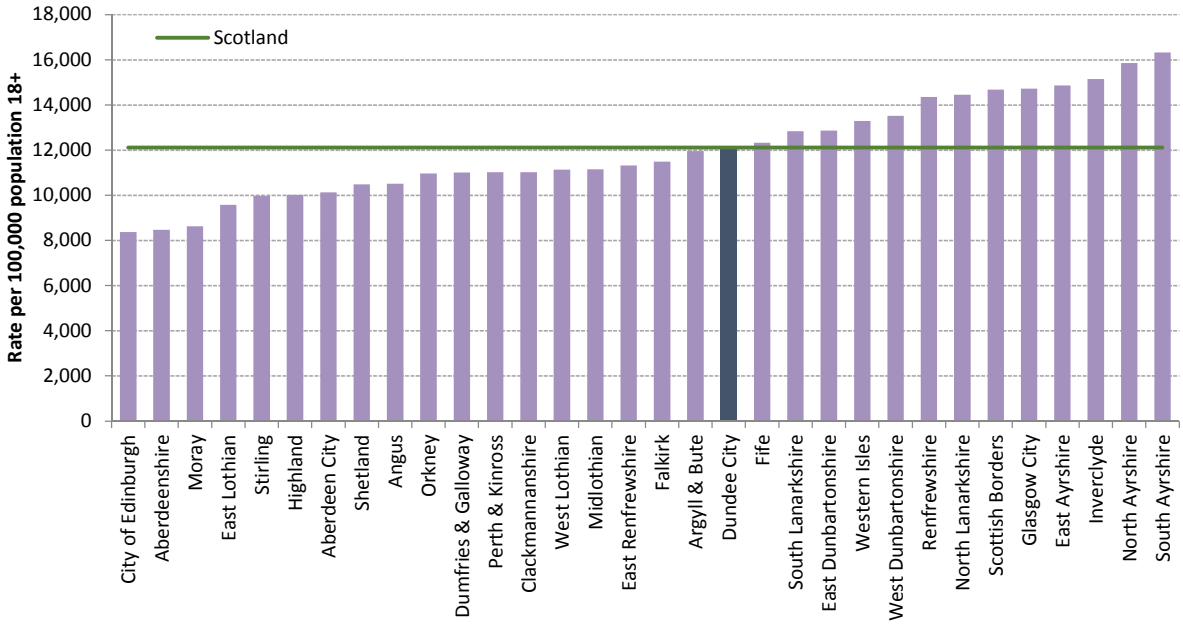
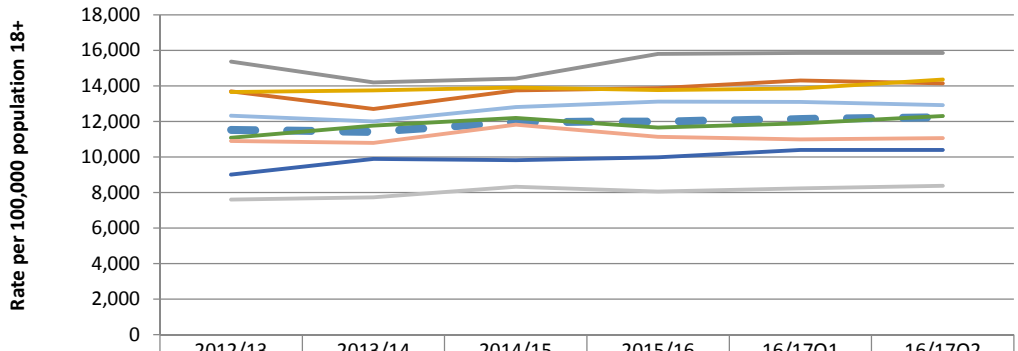


Chart 1.2 Rate per 100,000 Population of All Emergency Admissions for People Aged 18+ by Locality and Financial Year



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

What is the data telling us?

- The rate for Dundee has generally been increasing from 11,500 per 100,000 in 2012/13 to 12,200 per 100,000 in 2016/17 Q2.
- All Local Community Planning Partnerships (LCPPs) since 2012/13 have seen increases in their rates with the East End experiencing the highest rates in every financial year. The West End, the Ferry and Maryfield have the lowest rates in Dundee (the West End rate is almost 50% less than the East End rate).
- The Strategic Needs Assessment was produced to complement and inform the Strategic Commissioning Plan and this evidenced and reported on the high levels of deprivation and associated morbidity, multi morbidities and health inequalities across the city. A detailed analysis of the 54 natural 'neighbourhoods' of Dundee highlighted the higher emergency admission rates in the most deprived neighbourhoods, particularly due to substance misuse and mental health problems.

What we have achieved to date

In order to reduce emergency admissions and to support people to live independently at home, the following improvements, have been made:

- The continued expansion of the Enhanced Community Support service, which is aligned to GP clusters and supports those most at risk of admission.
- Nursing input to homeless people and hard to reach people has been enhanced through a further development of the Parish Nurse approach. A peer volunteer model has been tested.
- Existing health inequalities work has been reviewed and consolidated to identify priorities and explore how this will be addressed at a locality basis. From this a Health Inequalities Strategic Planning Group has been established which is developing a Health Inequalities Commissioning Statement. Keep Well continues to engage people around their health via health checks with the community team delivering 286 health checks to "at risk " groups including those who are homeless, offenders, or carers, in Q1 and 354 in Q2, with 1170 Keep well checks over the 2 quarters including those seen in general practice based on living in a deprived area. There are also improved links and referrals from Tayside Substance Misuse Service (TSMS) to consider wider health issues. The Equally Well team host health and wellbeing network meetings across the city to support joint working in localities.
- Remodelled care management teams to provide a locality model.
- We have reviewed all aspects the Learning Disability Acute Liaison Service and made recommendation to expand this service.
- We have assessed and confirmed the local requirement for a Primary Care Liaison Nurse to support individuals with Profound and Multiple Learning Disabilities and complex co-morbid health conditions as per recommendation 22 of the 'Keys to Life – Improving quality of life for people with learning disabilities' strategy Scottish Government (2013).

What we plan to do

The projected emergency admission target rate will be 12,168 admissions per 100,000 population. This is an expected increase of 4.5% from 2016/17 and the following actions within the Partnership will contribute to achieving this target.

- Redesign the Tayside Neurological Rehabilitation services.
- Continue to develop Enhanced Community Support.
- Develop an Assess to Admit Model.
- Expand the Acute Frailty team to a 7 day model.
- Test a rapid response care at home service.
- Look at how we respond in areas which have a high usage.

- Increase our investment in intermediate forms of care such as step up/down accommodation and support for all adults.
- Develop further work to support reducing health inequalities and prevention, including developing social prescribing models to support individuals around improving their health and wellbeing.
- Review reasons for emergency admission across hospital settings to establish a clear benchmark and then identify and agree improvement actions which will contribute to a reduction in emergency admission to hospital.
- Further develop use of technology enabled care as a means of enabling people to live independently and look after their own health.
- Further develop awareness and use of anticipatory care plans for all Adults where a plan would be of benefit to the Adult.
- Embed health checks as a means to engage people in the health and wellbeing agenda, to increase self-care, and avoid longer term ill health.
- As articulated in the Learning Disability future commissioning plan, permanently resource a Primary Care Liaison PMLD Nurse post
- Seek to increase the availability of Profound and Multiple Learning Disabilities (PMLD) nursing resources incorporating primary care liaison function

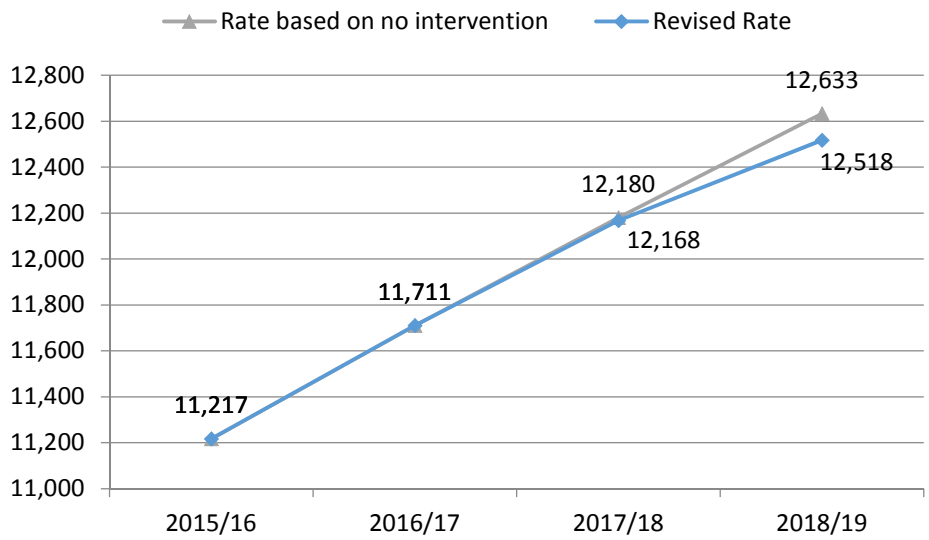
How will we measure improvement?

Historic emergency admission data has been used to project the rate based on historic increases only, if there was no intervention by Health and Social Care Partnerships.
A revised projected rate has been calculated for 2017/18 and 18/19 which takes into account the historic increasing trend but also factors in local actions to counter this increase. It is thought that local actions will have the effect of slowing down the increase in emergency admission rate.

The projected emergency admission target rate will be 12,168 admissions per 100,000 population. This is an expected increase of 4.5% from 2016/17.

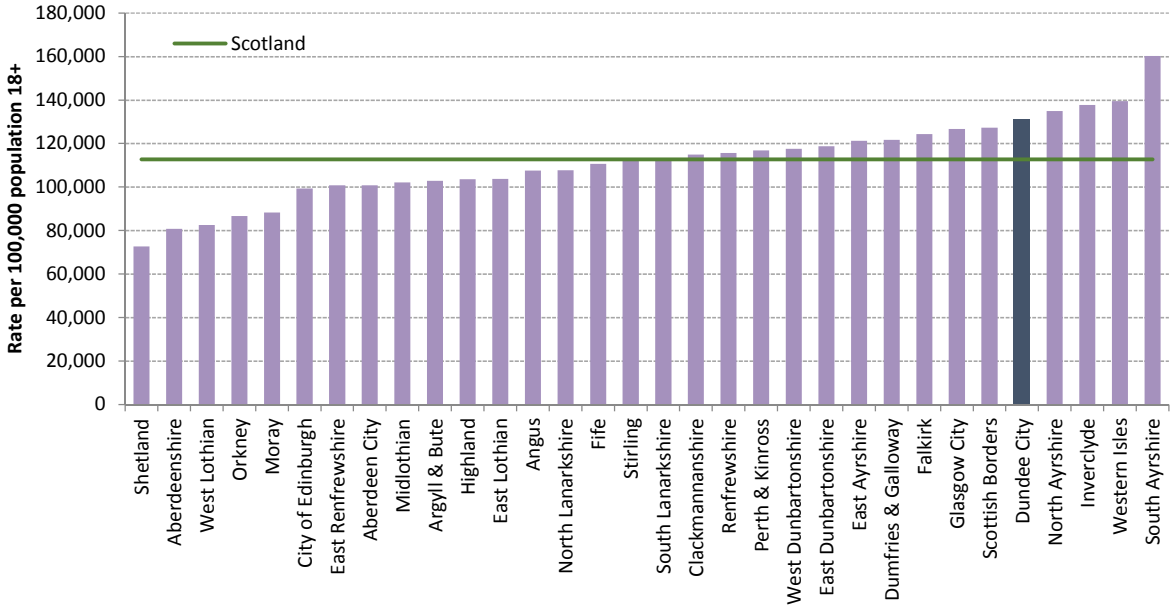
Note that the data in Chart 1.3 includes pediatric admissions, which cannot be influenced by the Dundee Health and Social Care Partnership. The next iteration will exclude pediatric admission data.

Chart 1.3: Projected Emergency Admission Target Rates per 100,000 population



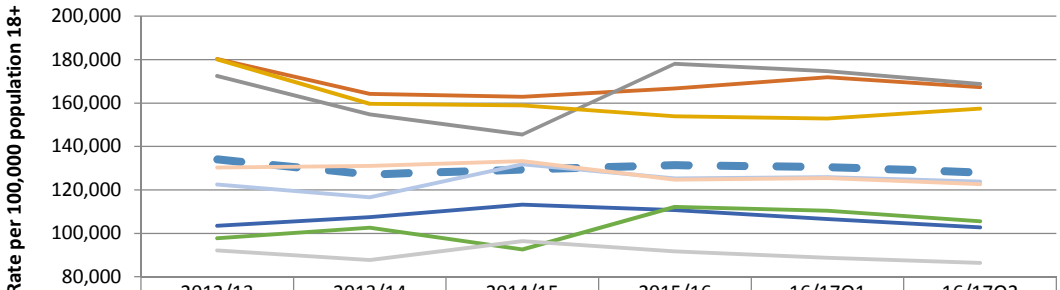
2. Occupied Bed Days, unscheduled acute stays

Chart 2.1: Number of Emergency Bed Days for People Aged 18+ as a Rate per 100,000 Population



Source: ISD Scotland

Chart 2.2: Rate per 100,000 Population of All Emergency Bed Days for People Aged 18+ by Locality and Financial Year



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

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

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

What is the data telling us?

- The emergency bed day rates for Dundee have slightly decreased from 134,000 per 100,000 population in 2012/13 to 128,000 per 100,000 population for people aged 18+ in 2016/17 Q2.
- Like the emergency admission rates, the East End has the highest bed day rates and the West End has the lowest bed day rates in Dundee. All localities except Lochee have seen a decrease in 2016/17 Q2.
- The Strategic Needs Assessment was produced to complement and inform the Strategic Commissioning Plan and this evidenced and reported on the high levels of deprivation and associated morbidity, multi morbidities and health inequalities across the city. A detailed analysis of the 54 natural 'neighbourhoods' of Dundee highlighted the higher emergency bed days in the most deprived neighbourhoods, particularly due to substance misuse and mental health problems.

What we have achieved to date

- Discharged from hospital. (80% seen within 5 days of discharge/83% seen within 4 days of referral). 65% received additional support to meet their clinical needs, and data suggest that there is a reduction in re-admission rates (respiratory infection). Introduced Healthcare Support Workers to create capacity to support more complex patients, including those who have frequent readmissions.
- Expanded the Enhanced Community Support, including the testing of multidisciplinary assessment meetings at GP Practice level; and the further roll out of the model to additional practices across the 4 cluster areas. Introduced a locality nurse role in each locality to coordinate assessments and reviews and support anticipatory care planning and carer assessments. Demonstrated reduced length of hospital stay and emergency admissions through the initial test site, reduced waiting times for comprehensive geriatric assessments and a falls assessment, increased diagnostics through day hospital sessions. The work has supported Medicine for Elderly Consultant Teams linked to GP practices.
- Developed step down beds within a local authority adult care respite unit to support transition from the Acquired Brain Injury Unit. Testing project with two patients.
- Step Down (Gourdie Place) – testing of a step down housing model to support early, safe discharge from hospital. This support enables adults awaiting specialist or adapted housing to move from a hospital setting while awaiting allocation of a new home. The model commenced part year and has been in use. Two further step down housing options to commence in this financial year.
- Through our partnership working with colleagues in neighbourhood services we have committed to a range of housing developments within the city. These form part of the Strategic Housing Investment Plan (SHIP) and will increase the availability of housing with support for adults with additional support needs within the city.
- Introduced medication reviews and employed a pharmacy technician as part of the social care enablement teams.
- Invest in resources which support assessment for 24 hour care taking place at home or home like settings including housing care home and care at home.
- Improved access to social care conference calls.
- We have strengthened the links between the Hospital Discharge Team and the Learning Disability Acute Liaison Service to improve consistency of discharge planning processes.
- We have assessed the requirement to increase the range of community based Allied Health Professional resources both locally and for hosted pan-Tayside services, this to specifically affect a reduction in unscheduled acute stays; reduced health inequalities and improvements in the long term health and wellbeing of individuals with Learning Disabilities and co-morbid health complexities.

What we plan to do

The projected emergency bed day target rate will be 78,355 admissions per 100,000 population. This is an expected decrease of 2.7% from 2016/17 and the following actions within the Partnership will contribute to achieving this target.

- Close 12 beds in RVH as part of the Medicine for the Elderly redesign
- Review reasons for re-admission to hospital within 28 days of discharge across hospital settings to establish a clear benchmark and then identify and agree improvement actions which will continue to contribute to a reduction in re-admission to hospital.
- Further develop post-discharge support to people with long term conditions in order to contribute to a reduction in emergency hospital admission and re-admission to hospital.
- Further implement the planned date of discharge model so that patients and carers are involved in a well-planned discharge and have co-ordinated follow up care where required upon discharge.
- Support more people to be assessed at home rather than in hospital by completing and evaluating the 'Moving Assessment into the Community' project for older people and resource the proposed change.
- Expand the 'Moving Assessment into the Community' project to specialist areas and test pathways.
- Further develop discharge planning arrangements for adults with a learning disability and / or autism, mental ill-health, physical disability and acquired brain injury.
- Continue collaborative work with a range of providers to increase the availability of care at home/housing support related to the housing developments committed to within the SHIP.
- Develop assess to admit model.
- Continue to develop step down step up models.
- Introduce pharmacy reviews to people in Care Homes.
- Continue through the care home learning network to support people who live in care homes
- Continue to develop Enhanced Community Support Service.
- Expand Acute Frailty Team to 7 day model.
- To move the base of the Learning Disability Acute Liaison Service to be co-located within the Hospital Discharge Team base at Ninewells Hospital.
- Planning discussions have commenced regarding contracting the acute bed base in collaboration with neighbouring Partnerships.

How will we measure improvement?

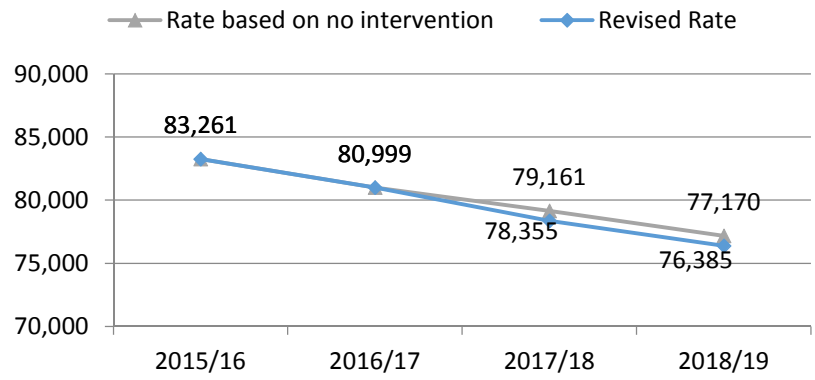
Historic emergency bed day data has been used to project the rate based on historic increases only, with no intervention by Health and Social Care Partnerships.
A revised projected rate has been calculated for 2017/18 and 18/19 which takes into account the historic increasing trend but also factors in local actions to counter this increase (including the 12 bed closures in Royal Victoria Hospital). It is thought that local actions will have the effect of further decreasing the emergency bed day rate.

Further iterations will include an analysis of Mental Health and Geriatric Long Stay bed days and targets will be agreed for these.

The projected emergency bed day target rate will be 78,355 admissions per 100,000 population. This is an expected decrease of 2.7% from 2016/17.

Note that the data in Chart 2.3 includes pediatric bed days, which cannot be influenced by the Dundee Health and Social Care Partnership.

Chart 2.3: Projected Emergency Bed Day Rate per 100,000 Population



3. Accident and Emergency Performance

Chart 3.1: New and Unplanned Return attendances to A+E

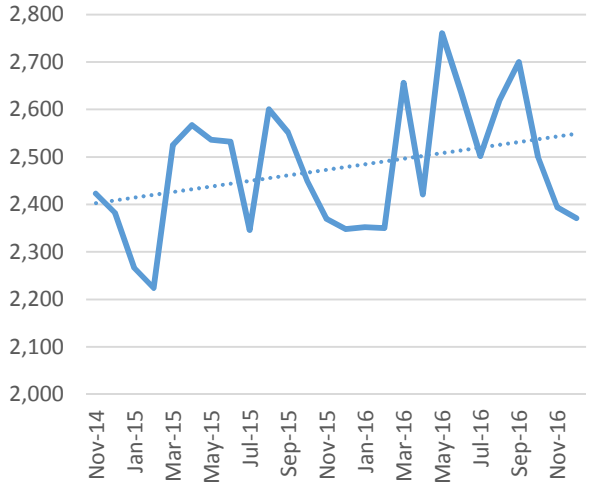
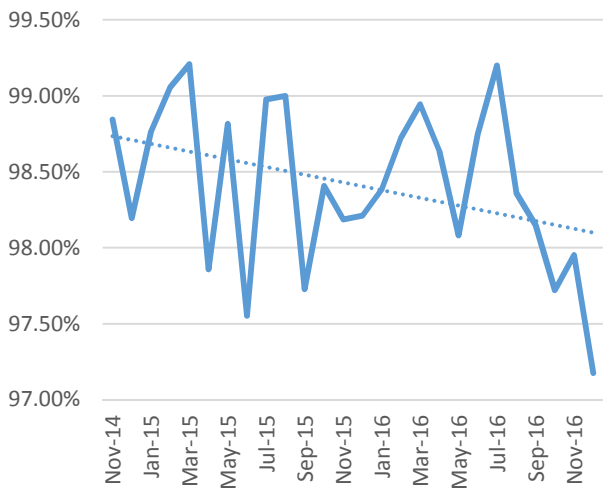
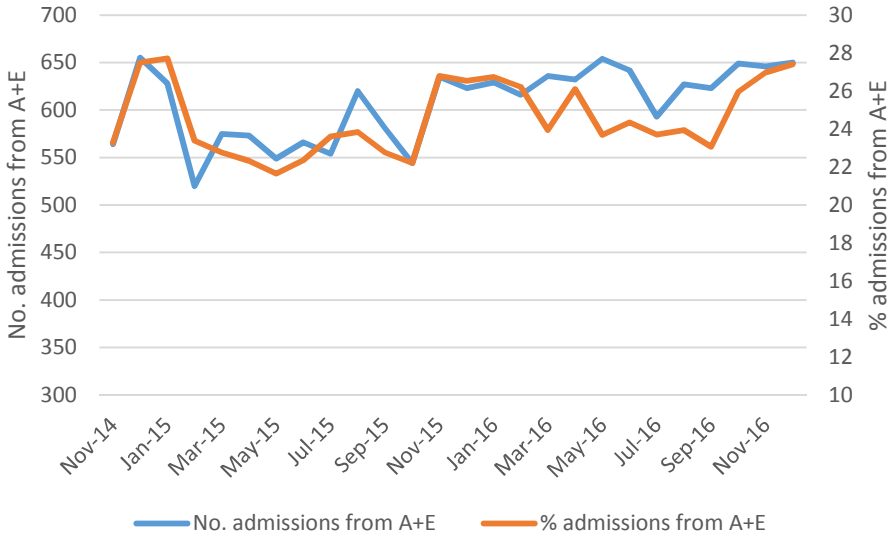


Chart 3.2: % of A+E waits within 4 hours



Source: A&E Datamart, ISD

Chart 3.3: Emergency Episodes from Accident and Emergency (A+E)



Source: A&E datamart, ISD

What is the data telling us?

- New and unplanned attendances to Accident and Emergency are increasing.
- Over 97% of attendees to Accident and Emergency are seen within 4 hours.
- A relatively low proportion of unscheduled admissions are routed from Accident and Emergency. This is mainly a result of a successful Acute Medical Unit in Dundee.

What we have achieved to date

- Introduced an Acute Medical Unit which reduces the pressure on Accident and Emergency.

What we plan to do

We will reduced the number of Accident and Emergency attendances by 3% to 29,257 in 2017/18. The following actions within the Partnership will contribute to achieving this target:

- Develop assess to admit model, to identify earlier entry to social care services prior to consideration for admission.
- Continue to develop Enhanced Community Support Service.
- Expand Acute Frailty Team to 7 day model.
- Create a training and education link to the proposed expanded Learning Disability Acute Liaison Service, and in collaboration with Speech and Language Therapy specialists, explore the creation of enhanced methods of symbolised communication formats to improve the accuracy and content of dialogue between people with a learning disability, their family and paid carers throughout the pathway, leading to accident and emergency admission. This would include out of hours GP's; Ambulance Service staff; Police services and all members of medical and nursing staff within accident and emergency units in Tayside.

How will we measure improvement?

The projected number of emergency attendances will be 29,257. This is an expected decrease of 3% from 2016/17.

Chart 3.4: Projected Accident and Emergency Attendances

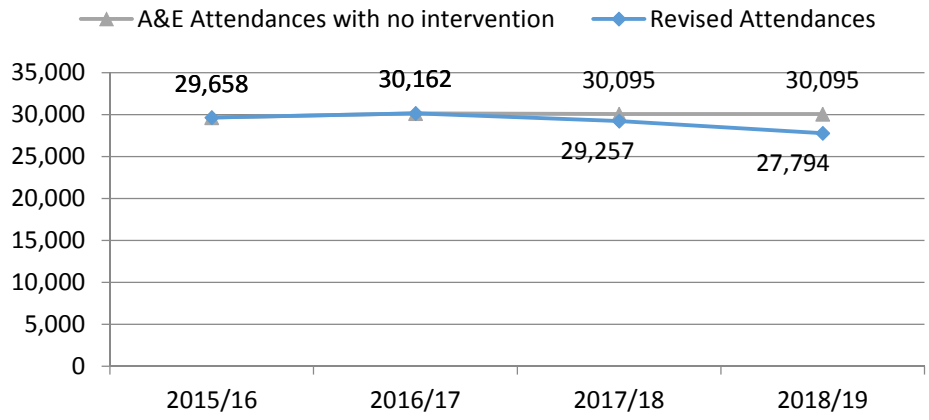
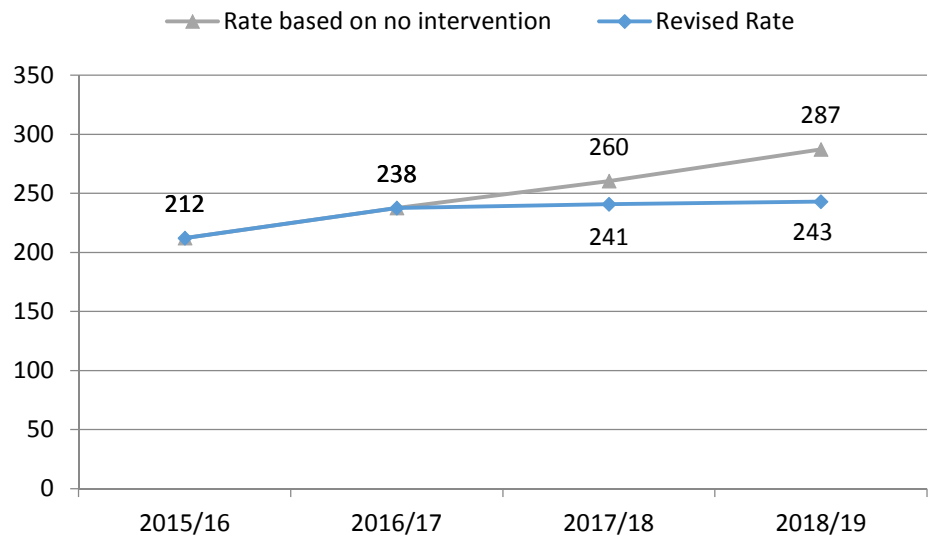
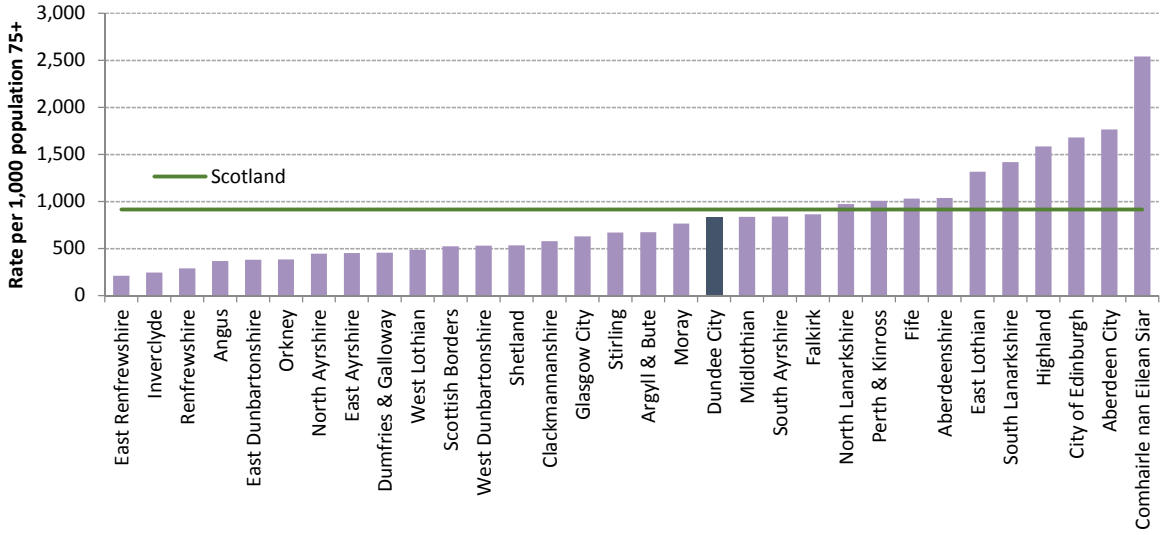


Chart 3.5: Projected Emergency Admissions as a Rate per 1,000 of all Accident and Emergency Attendances



4. Delayed discharge

Chart 4.1: Number of Days People Aged 75+ Spend in Hospital when they are ready to be Discharged as a Rate per 1,000 Population



Source: ISD Scotland

Standard and Code 9 Delays have been assessed separately

Standard Delays

Chart 4.2: Number of occupied bed days from Standard Delays

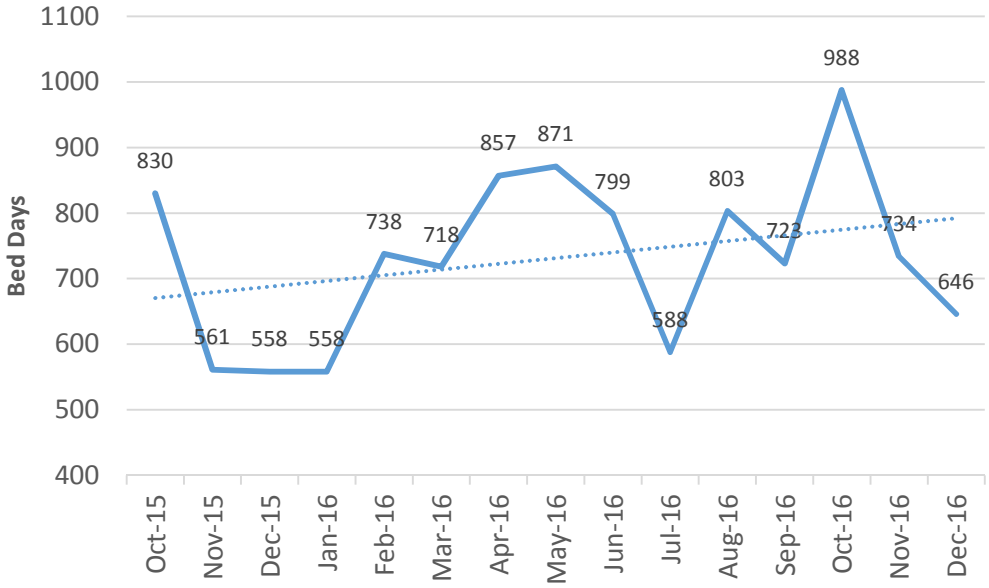
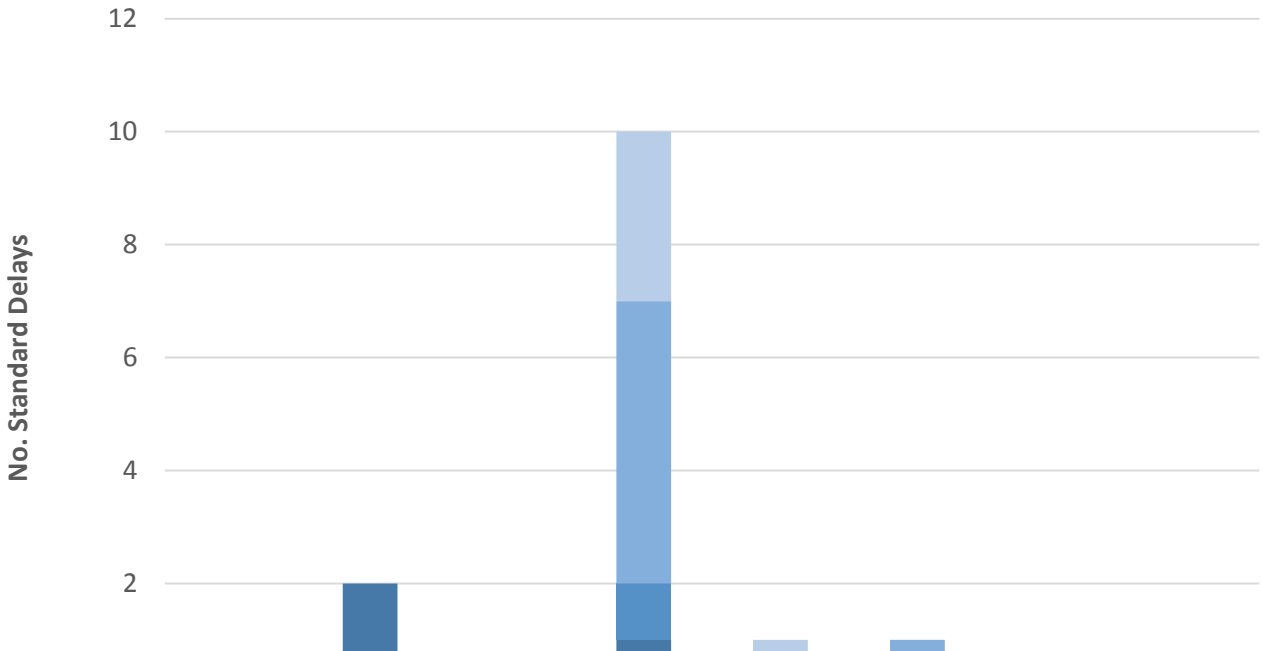
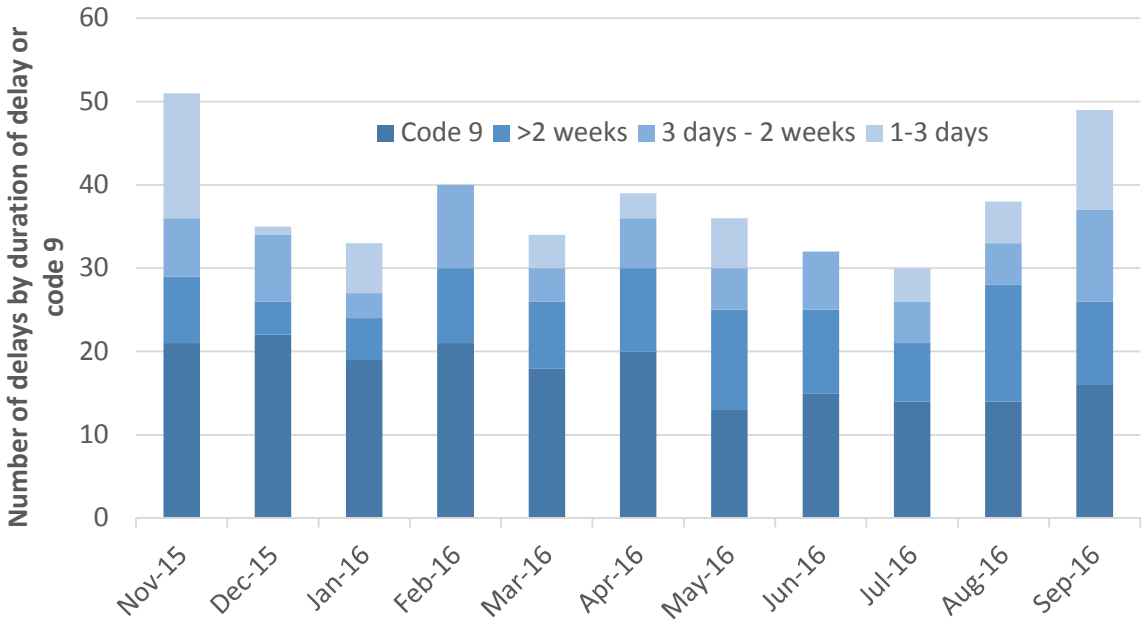


Chart 4.3: Reasons for Standard Delays by Duration of Delay November 2016



	Health and Social Care					Patient and Family		
	Assessments	Funding	Place Availability	Care Arrangements	Transport	Disagreement	Legal /Financial	Other
>6 weeks				3	1			
>4 weeks				5		1		
>2 weeks				1				
>3 days		2		1				

Chart 4.4: Delayed Discharge, Length of Delay at Census



What is the data telling us?

- Standard delays are defined by ISD Scotland as delays where the standard maximum delay period applies. This includes Patients delayed due to awaiting assessment, care packages, housing, care home or nursing placements. The standard maximum delay period is now 72 hours.
- Standard delays tend to be associated with higher volume of people who are inpatients within the acute hospital settings.
- Dundee is currently performing below the Scottish average of bed days lost to delayed discharges for people aged 75+ with a rate of 832 per 1,000 population.
- The East End has consistently been one of the poorest performing LCPP areas for this indicator and as at 16/17 Q2 it has the highest number of bed days lost to delayed discharges for people aged 75+ and is one of only two LCPP areas to have seen an increase between 16/17 Q1 and Q2. The North East saw a big increase from 554 per 1,000 population in 2014/15 to 1,290 per 1,000 population in 2015/16 (an increase of 132%). As at 16/17 Q2, the Ferry has the lowest rates in Dundee with 358 per 1,000 population; the East End rates are approximately 280% more than the Ferry's.
- As at 16/17 Q2, the East End had the highest rate of bed days lost to standard delayed discharges for people aged 75+ with 814 per 1,000 population. Lochee is the second worst performing LCPP area with 639 per 1,000 population as at 16/17 Q2. The West End also performs poorly in this indicator as since 2014/15 its rate has always been above the Dundee rate.
- We have evidenced improvement mainly due to our activity in relation to streamlining processes, planned date of discharge work and changes to social care packages taken forward over the past three years.

What we have achieved to date

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

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

- Pathways from hospital have been reviewed and assessment services have been aligned to more locality based working.
- We have mainstreamed a number of Reshaping Care for Older People projects and fully embedded them into models of working. An example is the development of a community pharmacy technician within the enablement service. This post supports people to be discharged from hospital by dealing with medicine complications which would otherwise have caused delays.

What we plan to do

We will save 403 bed days in 2017/18 and 1,136 bed days in 2018/19, compared with the baseline year 2015/16. The following actions within the Partnership will contribute to achieving this target:

- Implement actions identified in the Home & Hospital Transition Plan and monitor progress of that plan through the Home and Hospital Transition Group.
- Increase our investment in intermediate forms of care such as step up/step down accommodation and support for all adults.
- Invest in resources which support assessment for 24 hour care taking place at home or home like settings.
- Work in partnership with Neighbourhood Services colleagues to ensure a consistent standard of technology is in place for all new build developments.
- Embed within care group strategic commissioning plans the development of a range of community resources and supports which facilitate community based assessment, enable people to remain in their own home and be discharged from hospital when they are ready.
- Review and remodel care at home services to provide more flexible responses.
- Further develop models of Community Rehabilitation to support transitions between home and hospital.
- Develop and implement discharge management procedures and guidance to promote consistency in practice in relation to discharge management and use of planned date of discharge.
- Implement a statement and pathway for involving carers in discharge planning process in line with section 28 of the Carers (Scotland) Act 2016 in partnership with Carers and Carers Organisations.
- Implement a fully Integrated Discharge Management Team to increase capacity of the service and enhance and further develop opportunity for discharge assessment for all patients at Ninewells.
- The Enhanced Community Support Service is working with people to identify increased support needs, particularly around requirements for care home placements at an earlier stage. It is anticipated that this proactive planning will have the positive effect of minimising the number of applications for care homes and also Power of Attorney which often happen as a crisis response when the person is in hospital.
- Extend the range of supports for adults transitioning from hospital back to the community. .
- The development of a step down and assessment model for residential care is planned for the future.

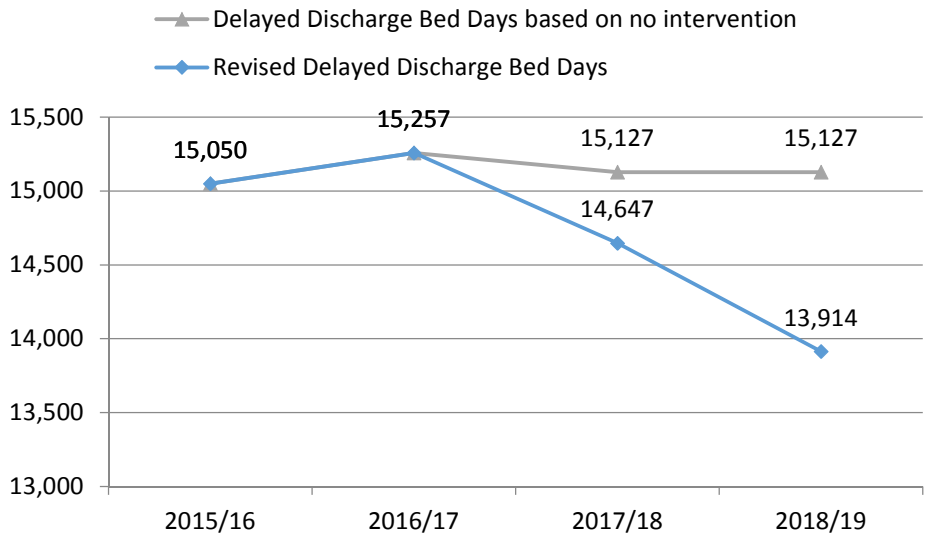
How will we measure improvement?

We have assessed bed days lost in line with the promises in the Health and Social Care Delivery Plan and Dundee Strategic Commissioning Plan and targeted local actions.

We believe that through analysis and modelling of historic and projected data that we work towards a 4% reduction in bed days lost in 2017/18 and a further 5% reduction in bed days lost on 2018/19.

This amounts to a 403 bed days saved in 2017/18 and 1,136 bed days saved in 2018/19, compared with the baseline year 2015/16.

Chart 4.4: Projected Bed Days Lost to all Delayed Discharges



Code 9 Delays

Chart 4.5: Number of Occupied Bed Days from Code 9 Delayed Discharges

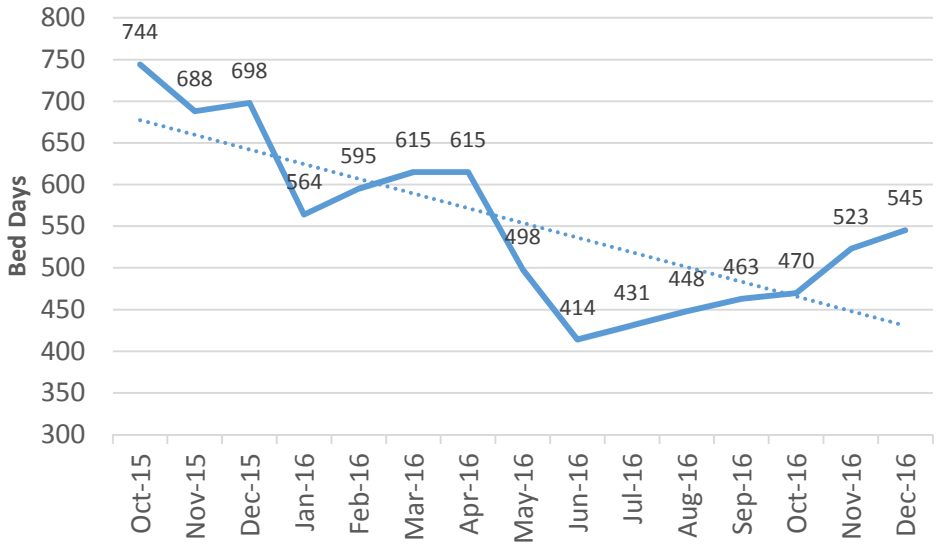
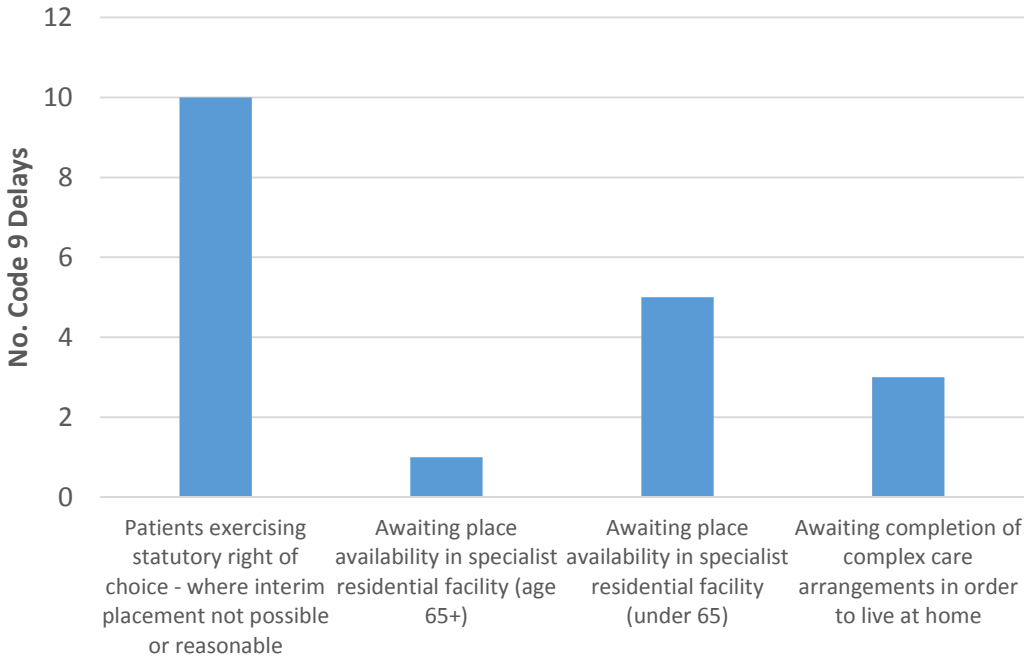


Chart 4.6: Reason for Code 9 delays at November 2016



What is the data telling us?

- Code 9 Complex delays are used by ISD Scotland to describe delays where the standard maximum delay, therefore 72 hours, is not applicable. This is in recognition that there are some Patients whose discharge will take longer to arrange and would include Patients delayed due to awaiting place availability in a high level needs specialist facility and where an interim option is not appropriate, Patients for whom an interim move is deemed unreasonable or where an adult may lack capacity under adults with incapacity legislation.
- The main reason is due to people awaiting legal process to be concluded for 0ver 75's. For under 75's arranged specialist accommodation to meet assessed needs.

- Dundee saw a significant increase in the rate of bed days, per 1,000 population for people aged 75+, lost to Code 9 delayed discharges in 2015/16 and in particular LCPP areas such as the East End, the North East and Strathmartine saw the biggest increases. Since then, most LCPP areas have seen a decrease in bed days lost to Code 9 delays with the notable exception of the East End. The Ferry had 0 bed days lost to code 9 delays in 16/17 Q2.
- The reason for the increase is mainly due to a change in recording practice, as a result of improvement work, within specialist hospitals where recording of delays has increased as a result of these now being reported.

What we have achieved to date

- A Home and Hospital Transition Plan was developed which aims to ensure that citizens of Dundee are supported at home, but when people do have to go to hospital they are only there as long as they need to be. The plan was ratified at the Integration Joint Board meeting on 30 August 2016 and is currently being implemented.
- The capacity within the Mental Health Officer team has been enhanced and Dundee City has joined a Power of Attorney Campaign to support the discharge of people who are delayed in hospital as a result of a legal issue around guardianships.
- Reviewed processes and considered needs of people with complex needs in the home & hospital transition group.
- Through our partnership working with colleagues in neighbourhood services we have committed to a range of housing developments within the city. These form part of the Strategic Housing Investment Plan (SHIP) and will increase the availability of housing with support for adults with additional support needs within the city.

What we plan to do

We will save 1,011 bed days in 2017/18 and 1,237 bed days in 2018/19 and the following actions within the Partnership will contribute to achieving this target:

- It was agreed within the Discharge Management Group that each care group strategic planning group would incorporate consideration in relation to complex care packages and specialist facilities within their strategic commissioning statements to support a strategic focus in relation to bed delays for patients with more complex needs.
- Implement actions identified in the Home & Hospital Transition Plan and monitor progress of that plan through the Home and Hospital Transition Group.
- Further develop discharge planning arrangements for adults with a learning disability and / or autism, mental ill-health, physical disability and acquired brain injury.
- Promote Power of Attorney through local campaigns as a means of increasing number of Power of Attorneys so that Adults are not waiting in hospital settings for decisions about their care upon discharge.
- Further develop earlier identification of requirement for measures under Adults with Incapacity (Scotland) Act 2016 so that people are not waiting for completion of formal measures within a hospital setting.
- Develop and implement discharge management procedures and guidance to promote consistency in practice in relation to discharge management and use of planned date of discharge.
- Implement a statement and pathway for involving carers in discharge planning process in line with section 28 of the Carers (Scotland) Act 2016 in partnership with Carers and Carers Organisations.
- Implement a fully Integrated Discharge Management Team to increase capacity of the service and enhance and further develop opportunity for discharge assessment for all patients at Ninewells.
- Extend the range of supports for adults transitioning from hospital back to the community.
- Continue collaborative work with a range of providers to increase the availability of care at home/housing support related to the housing developments committed to within the SHIP.

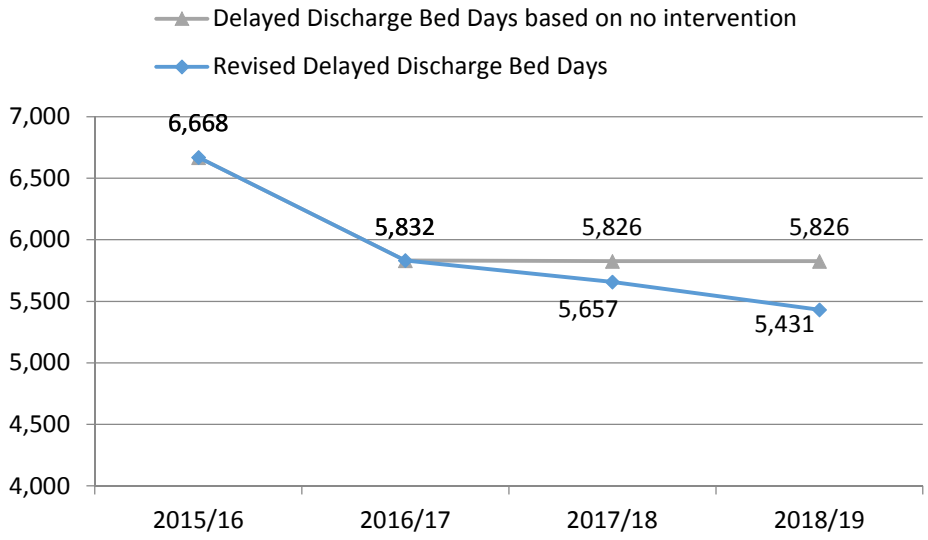
How will we measure improvement?

We have assessed bed days lost in line with the promises in the Health and Social Care Delivery Plan and Dundee Strategic Commissioning Plan and targeted local actions.

We believe that through analysis and modelling of historic and projected data that we work towards a 3% reduction in bed days lost in 2017/18 and a further 4% reduction in bed days lost on 2018/19.

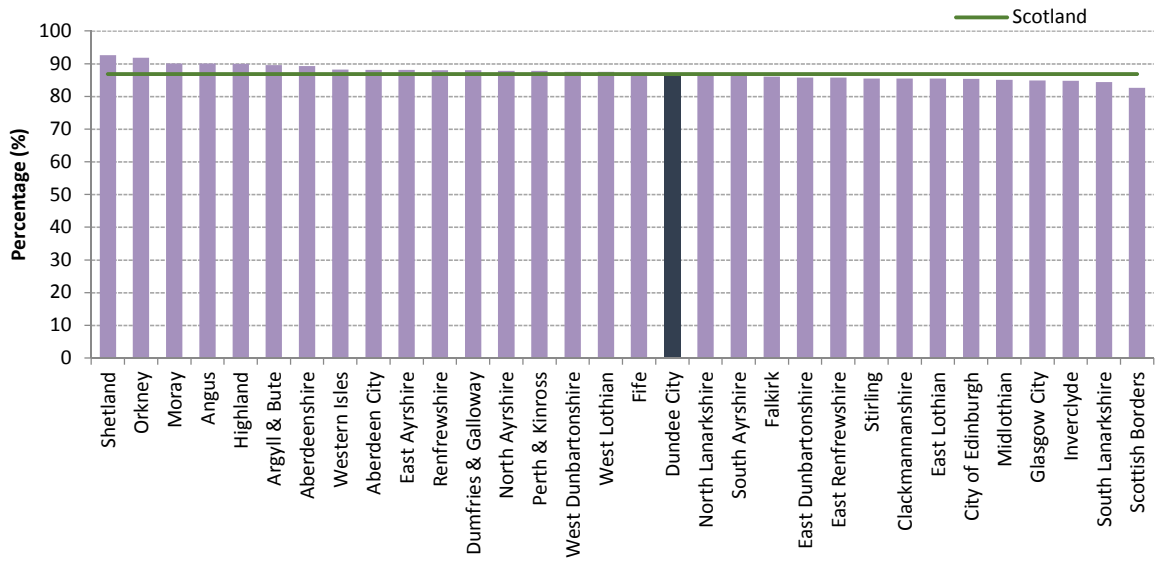
This amounts to a 1,011 bed days saved in 2017/18 and 1,237 bed days saved in 2018/19.

Chart 4.7: Projected Bed Days Lost to Delayed Discharges Code 9's as a Rate per 1,000 Population aged 75+



5. End of Life Care

Chart 5.1: Percentage of Time Spent by People in the Last 6 Months of Life at Home or in a Community Setting 2015/16



Source: ISD Scotland

What is the data telling us?

Dundee is performing at the Scottish average with 86.91% of time in the last 6 months of life spent at home.

What we have achieved to date

- Dundee partnership entered into the second Macmillan Local Authority Partnership in Scotland to work with people living with cancer.
- A project to improve the delivery of palliative care has been completed. Information which included quality markers of death across locations of death and barriers to good palliative care in acute hospitals provided useful intelligence to redesign the service. It established early specialist palliative care review for unscheduled acute medical admissions improved quality of life and quality of death outcomes, reduced length of stay in the acute setting, reduced interim ward placements and enabled more efficient hospice placement. Further work is planned in the acute setting to test the short project findings over a longer period of time.
- We are developing links with existing end of life care services to deliver training and awareness of the particular needs of people with a learning disability.

What we plan to do

We will increase the % of the last 6 month of life spent in the community from 86.91% in 2015/16 to 88.41% in 2017/18 and the following actions actions within the Partnership will contribute to achieving this target:

- The Palliative Care Tool Bundle and Response Standards will be used across community based health and social care services in Dundee to enable staff to identify, assess, plan and evaluate care for any person with palliative and end of life care needs regardless of diagnosis.
- The aim of the Palliative Care Tool Bundle Project is to give the person the best appropriate care through an individualised care and support plan which suits that person's needs and wishes. It would provide clear, consistent communication between secondary and primary care and reduce delays in starting treatments, or highlight where treatments/investigations would not be beneficial.

- We are partnered with Macmillan Cancer Care and the Scottish Partnership for Palliative Care to participate in the "Building on the Best – Scotland" project. This looks to describe and evaluate current approaches to shared decision making from a person centred perspective and identify approaches to improve this area of health and social care. This is likely to link into the palliative care tool bundle.
- A Managed Clinical Network is in development this will enable partnership approaches across health and social care to monitor, evaluate and impact on this indicator and other aspects of palliative and end of life care. It will enhance the purposeful interaction between general palliative care providers and specialist services across all settings in the health and social care system.
- In line with the promises in the National Delivery Plan for Health and Social Care, the availability of Key Information Summaries will be increased and everyone will be offered one by 2021.

How will we measure improvement?

The target is to increase the number of days spent in hospices / palliative care units by 2%, reduce the number of days spent in large hospitals by 13% and increase the number of days spent in the community by 2%.

Chart 5.2: Number of Bed Days of Last 6 Months of Life Spent in Hospice / Palliative Care Unit

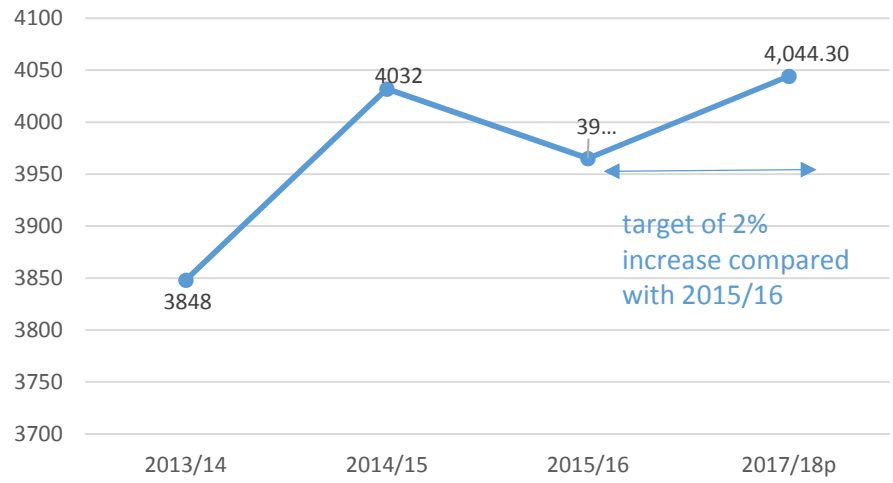


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Chart 5.3: Number of Bed Days of Last 6 Months of Life Spent in Community

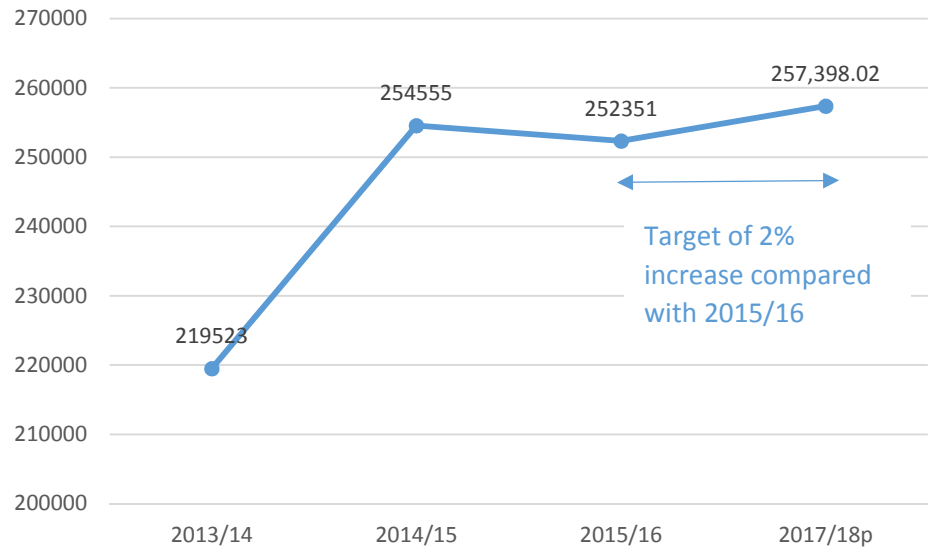

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Chart 5.4: Number of Bed Days of Last 6 Months of Life Spent in Large Hospital

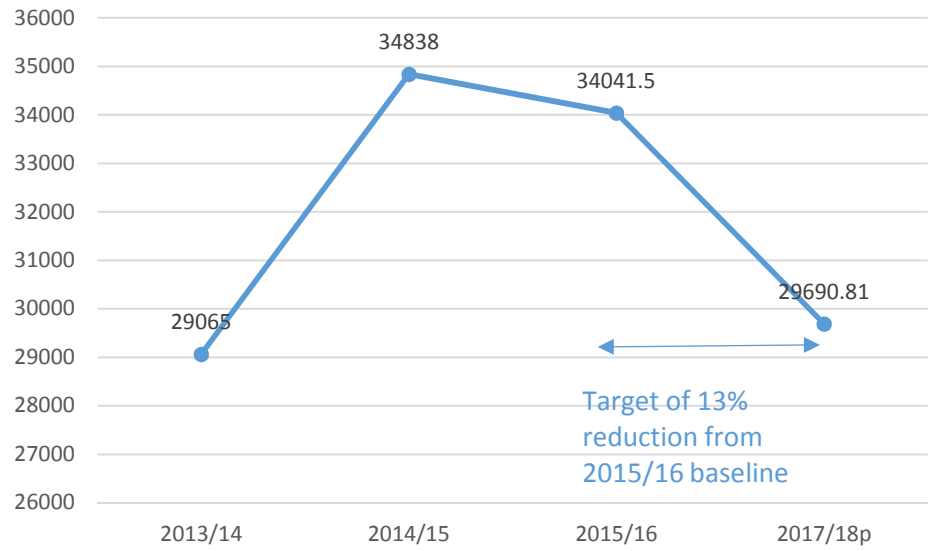

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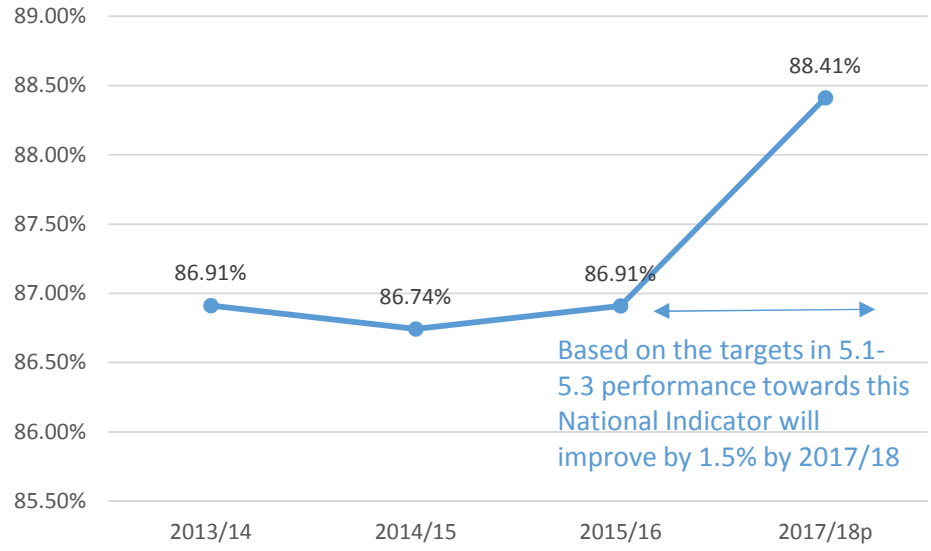
Chart 5.5: % Last 6 Months of Life Spent Living in the Community



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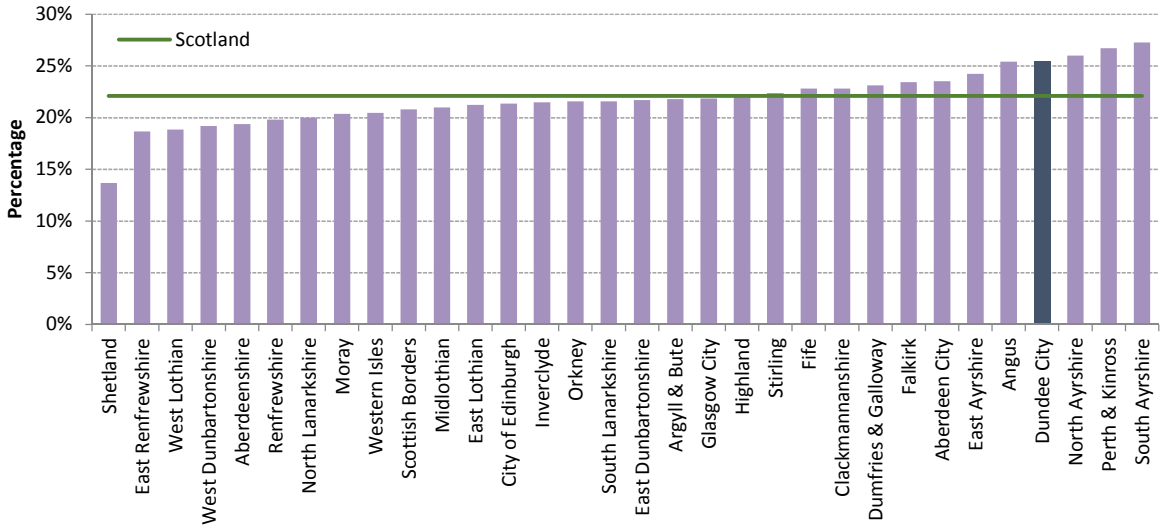
By achieving each of these targets in 5.1 to 5.3 there would be a 1.5% increase in the national indicator "% of last 6 months of life spent at home", from 86.91% in 2015/16 to 88.41% in 2017/18

6. The balance of spend across institutional and community services

Chart 6.1: Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency



What is the data telling us?

In 2015/16 26% of Dundee's health and care budget was spent on emergency hospital stays. This puts Dundee as the 4th highest spender on hospital stays as a proportion of budget, this is consistent with the position of the other 2 Tayside Partnerships.

What we have achieved to date

- Increased spend in Direct Payments, although this is an area for improvement.
- Increased the number of homecare hours and reduced the unit cost of internal provision.
- A Home and Hospital Transition Plan was developed which aims to ensure that citizens of Dundee are supported at home, but when people do have to go to hospital they are only there as long as they need to be. The plan was ratified at the Integration Joint Board meeting on 30 August 2016 and is currently being implemented.
- The capacity within the Mental Health Officer team has been enhanced and Dundee City has joined a Power of Attorney Campaign to support the discharge of people who are delayed in hospital as a result of a legal issue around guardianships.
- Reviewed processes and considered needs of people with complex needs in the home and hospital transition group.
- The continued expansion of the Enhanced Community Support service, which is aligned to GP clusters and supports those most at risk of admission.
- Remodelled Care Management Teams to provide a Locality Model.
- Developed step down beds within a local authority adult care respite unit to support transition from the Acquired Brain Injury Unit. Testing project with two patients.
- Step Down (Gourdie Place) – testing of a step down housing model to support early, safe discharge from hospital. This support enables adults awaiting specialist or adapted housing to move from a hospital setting

while awaiting allocation of a new home. The model commenced part year and has been in use. Two further step down housing options to commence in this financial year.

- Introduced medication reviews and employed a pharmacy technician as part of the social care enablement teams.
- Invested in resources which support assessment for 24 hour care taking place at home or home like settings including housing care home and care at home
- Improved access to social care conference calls.

What we plan to do

- Continue to develop Enhanced Community Support.
- Develop an Assess to Admit Model.
- Expand the Acute Frailty team to a 7 day model.
- Test a rapid response care at home service.
- Increase our investment in intermediate forms of care such as step up/down accommodation and support for all adults.
- Develop further work to support reducing health inequalities and prevention, including developing social prescribing models to support individuals around improving their health and wellbeing.
- Review reasons for emergency admission across hospital settings to establish a clear benchmark and then identify and agree improvement actions which will contribute to a reduction in emergency admission to hospital.
- Further develop use of technology enabled care as a means of enabling people to live independently and look after their own health.
- Further develop awareness and use of anticipatory care plans for all adults.
- Embed health checks as a means to engage people in the health and wellbeing agenda, to increase self-care, and avoid longer term ill health.
- Close 12 beds in RVH as part of the Medicine for the Elderly redesign.
- Review reasons for re-admission to hospital within 28 days of discharge across hospital settings to establish a clear benchmark and then identify and agree improvement actions which will continue to contribute to a reduction in re-admission to hospital.
- Further develop post-discharge support to people with long term conditions in order to contribute to a reduction in emergency hospital admission and re-admission to hospital.
- Further implement the planned date of discharge model so that patients and carers are involved in a well-planned discharge and have co-ordinated follow up care where required upon discharge.
- Support more people to be assessed at home rather than in hospital by completing and evaluating the 'Moving Assessment into the Community' project for older people and resource the proposed change.
- Expand the 'Moving Assessment into the Community' project to specialist areas and test pathways.
- Further develop discharge planning arrangements for adults with mental ill-health, physical disability and acquired brain injury.
- Continue to develop step down step up models.
- Introduce pharmacy reviews to people in Care Homes.
- Continue through the care home learning network to support people who live in care homes.
- We continue to increase investment in models that support adults within their own homes and as a result, overall, fewer younger adults now live within care homes or out of area.
- Planning discussions have commenced regarding contracting the acute bed base in collaboration with neighbouring Partnerships.

How will we measure improvement?

The balance of care between acute and community services is measured and checked across many levels within the Partnership.

For future iterations it is suggested that the data supplied to support this core indicator is revised to include only patients and service users in the denominator, rather than all citizens. This would give a truer measure of the balance of spend.

In order to shift the balance of spend there needs to be increased spend to support people to live at home and reduced spent in acute hospitals. The targets for these are stated below.

Chart 6.2: % of People Supported at Home

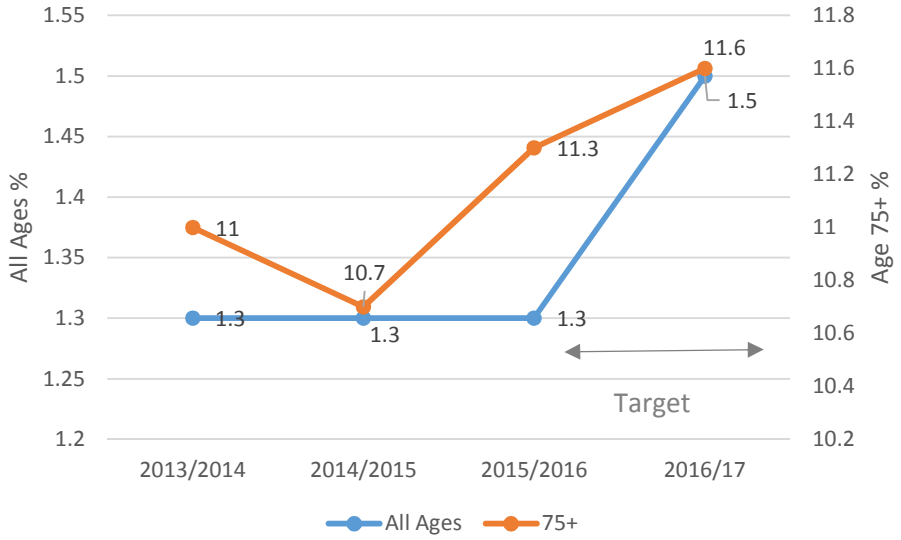


Chart 6.3: % of People Unsupported at Home

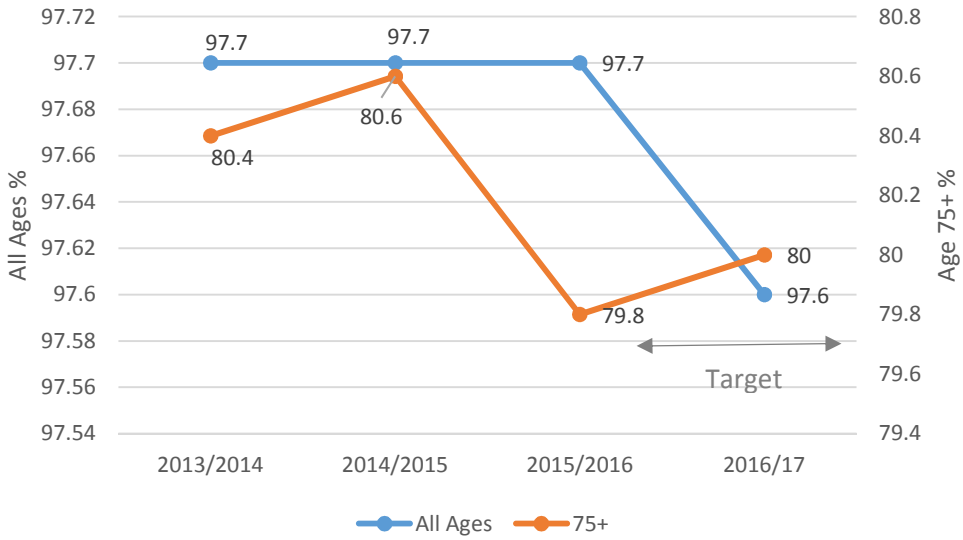


Chart 6.4: % of People living in Care Homes

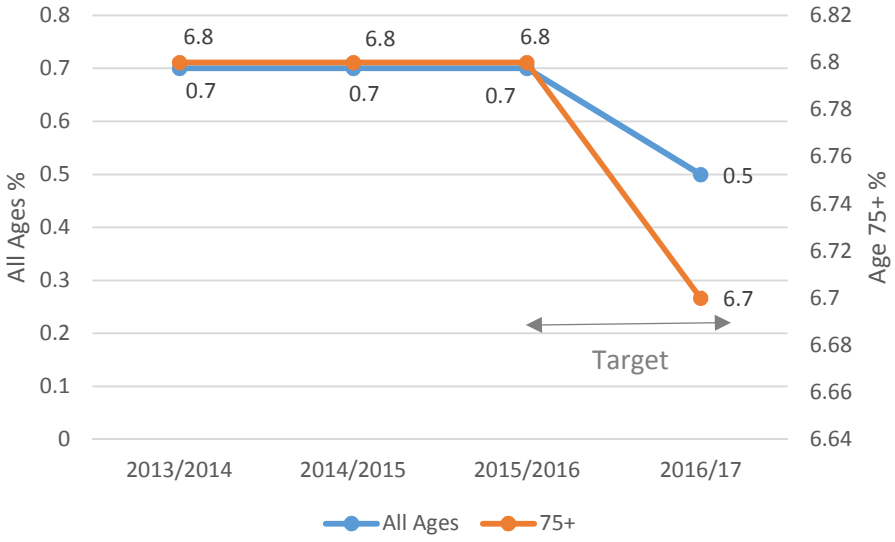


Chart 6.5: % of People in Large Hospital