NATIONAL GOALS OF THE DANISH HEALTHCARE SYSTEM

2018

CONTINUITY FOR THE PATIENT

The National Goals ensure a shared, ambitious direction for healthcare development, for the benefit of the patients. This is a key focal point for a new management of our healthcare system, with focus on quality, continuity of care, and patient safety. Since our collaboration on the eight national goals for the Danish healthcare system, as part of the Danish Healthcare Quality Programme in 2016, municipalities and regions have been making targeted efforts to implement and embed these goals in specific actions for healthcare personnel.

These goals mark a shift from process and registration requirements to a greater focus on more professional and meaningful goals and results, which will improve the quality of services. The development of national goal indicators must be an ongoing process, to underpin the intended progression of the healthcare system, and to highlight the values that the healthcare system creates for each individual patient. This year's status for the national goals has had a special focus on local anchoring of quality and improvement measures for psychiatric services. New indicators have also been developed for targeted measures in general practice.

The regions are utilising the national goals in management information and in hospitals in their efforts to improve quality and efficiency. The municipalities are also working to implement the national goals and indicators in healthcare services, and to integrate quality improvements in practice.

We must continue to bolster efforts to gain a strong foothold in local policies, including local healthcare services. It is therefore essential that positive experiences are carried forward in the continued work on securing national goals through locally defined goals and measures in both regions and municipalities, and in the interaction between municipalities, general practices and hospitals. Through communication of knowledge, use of data and transparency, we will continue to ensure that these goals are supported by local measures. These goals will become guidelines for quality improvement measures in the Danish healthcare system, e.g. in hospital wards, municipal health and care services, and for the benefit of the patients.

Ellen Trane Nørby
Minister of Health

Jacob Bundsgaard
Chairman of KL
(Local Government Denmark)

Stephanie Lose
Chairman of Danish Regions

THE DANISH HEALTHCARE QUALITY PROGRAMME IS PART OF A BROADER RESTRUCTURING OF QUALITY IMPROVEMENT MEASURES

The essence of the new Danish Healthcare Quality programme is to create greater value for the patient. The programme is meant to facilitate the development of the healthcare system, and deliver higher quality treatment and rehabilitation, with emphasis on results that have relevance for patients. The programme will also help to ensure cost efficient healthcare.

Securing national goals at the local level is only one element of the Danish Healthcare Quality Programme, which also consists of many other initiatives.

A network of learning and quality teams has been established, consisting of clinicians and leaders from relevant departments and units, and an expert group to ensure quality improvement in certain areas where quality has been unsatisfactory, or where changes are needed. Thus far, learning and quality teams have been established for palliation (care and treatment of the terminally ill), apoplexy, upper femur hip fractures, and the rational use of antibiotics. These three learning and quality teams aim to ensure that positive experiences with quality improvement measures are rapidly communicated between healthcare professionals (or staff) to the benefit of the patient. Several more learning and quality teams are being planned, including teams that also involve the municipalities, with emphasis on inter-sectoral cooperation. This will ensure coherence and continued progression of quality in patient pathways across sectors, so that patients receive continuity of care throughout the system.

National management programme
Daily operations are the best testing ground for strategic measures, where management will have an impact. This is where the measures will be anchored, to ensure lasting and meaningful improvements. This is the reason for implementing a national management programme. Its purpose is to enhance the competency of local operations managers with regard to quality and improvement efforts. A focus on management is therefore essential for continued improvement, for the benefit of the patients.

The first group of 40 managers from municipalities and regions completed the management programme in February 2018. The aim is for managers to act as spearheads in the implementation of quality programmes in the daily operations of hospitals and municipalities. The second group in the national management programme began their training in March 2018.

Systematic patient involvement
Work is being carried out at both a national and local level, with a stronger focus on systematic patient involvement and the collection of data on patients' own experiences (PRO) from their treatment and rehabilitation pathways.

The Danish government, KL (Local Government Denmark) and Danish Regions collaborated on the "Strategy for Digital Health 2018-2022", to establish a framework for cross-cutting digital technology in the field of healthcare, aimed at bolstering the eight national goals. The parties have specified national goals for each of the Strategy's five focus areas, which can be attained through shared digital solutions and new technology. The strategy involves better opportunities for patients to actively participate in their own treatment pathways, by providing them with greater insight into their own medical and health information, and to ensure a more flexible contact with the healthcare system, including services provided in the patient's own home.

Measures are also underway to ensure a more active use of health data, through a National Health Data program and through local initiatives in regions and municipalities. This includes the development of Danish Clinical Registries (RKKP), which will support activity and quality data in real time for hospital staff, municipal health measures, and patients. New management and billing models are being tested in all regions based on value-based management, where effective, high quality treatment for the patient is key. All for the benefit of the patients.

NATIONAL GOALS: BETTER QUALITY, CONTINUITY OF CARE, AND GEOGRAPHICAL EQUALITY IN THE HEALTHCARE SYSTEM

BETTER CONTINUITY OF PATIENT CARE IN CLINICAL PATHWAYS	STRONGER MEASURES FOR CHRONICALLY ILL AND ELDERLY PATIENTS	HIGHER SURVIVAL RATE AND IMPROVED PATIENT SAFETY	HIGH QUALITY TREATMENT	QUICK ASSESSMENT AND TREATMENT	GREATER PATIENT INVOLVEMENT	ADDITIONAL HEALTHY LIFE YEARS	MORE EFFICIENT HEALTHCARE SYSTEM
INDICATORS							
ACUTE SOMATIC/ PSYCHIATRIC READMISSIONS WITHIN 30 DAYS WAITING TIME FOR REHABILITATION NUMBER OF HOSPITAL DAYS AFTER COMPLETION OF SOMATIC/ PSYCHIATRIC TREATMENTS UPDATED MEDICINE INFORMATION (GENERAL PRACTI-TIONER) ACCESS TO THE WORKFORCE (FOR SOMATIC AND PSYCHIATRIC PATIENTS) ACCESS TO EDUCATIONAL SERVICES FOR YOUNG PEOPLE WITH MENTAL ILLNESS*, **	ACUTE HOSPITAL ADMISSIONS PER COPD/DIABETES PATIENT PREVENTABLE ADMISSIONS AMONG ELDERLY PATIENTS USE OF ANTI-PSYCHOTIC MEDICATION FOR PATIENTS WITH DEMENTIA OVER-OCCUPANCY IN MEDICAL DEPARTMENTS	5-YEAR SURIVIVAL RATE AFTER CANCER CARDIOVASCULAR MORTALITY MENTAL ILLNESS AND EXCESS MORTALITY* HOSPITAL-ACQUIRED INFECTIONS SURVIVAL AFTER SUDDEN CARDIAC ARREST DISPENSED PRESCRIPTIONS FOR ANTIBIOTICS IN GENERAL PRACTICE*	ATTAINMENT OF QUALITY GOALS IN CLINICAL QUALITY DATABASES USE OF BELT RESTRAINTS ON PATIENTS ADMITTED TO PSYCHIATRIC WARDS	WAITING TIME FOR PLANNED HOSPITAL SURGERY, AND FOR PSYCHIATRIC CARE SOMATIC/ PSYCHIATRIC PATIENTS ASSESSED WITHIN 30 DAYS CANCER PATHWAY PACKAGE COMPLETED WITHIN THE PREDETERMINED TIME FRAME	PATIENT SATISFACTION (SOMATIC AND PSYCHIATRIC CARE) PATIENT EXPERIENCE OF INVOLVEMENT (SOMATIC AND PSYCHIATRIC CARE)	AVERAGE LIFE EXPECTANCY DAILY SMOKERS IN THE POPULATION	AVERAGE LENGHT OF STAY PER HOSPITAL ADMISSION HOSPITAL PRODUC-TIVITY
REGIONAL / MUNICIPAL LOCAL INTERMEDIATE GOALS							

* Indicator presented without figures. **Possible links to the workforce indicator will be explored.

A DYNAMIC HEALTHCARE SYSTEM – CONTINUED WORK ON NEW INDICATORS

Indicators for the national goals must be continuously developed, to ensure that they reflect the desired direction for the healthcare system and value for each individual patient, e.g. in terms of the entire care pathway and better continuity of care between specialists, initiatives and sectors. Some indicators may have a shorter time frame, and can therefore be adjusted to accommodate new focus areas and higher quality data. However, it is important to have a manageable number of indicators, to ensure better consistency and continuity of the healthcare system.

Since the previous status report, the aim has been to develop indicators that encompass trends in general practice, as well as indicators intended for psychiatric services. The present status report has therefore included the following new indicators:

- Patient satisfaction among patients in psychiatric care
- Patient-experienced involvement among patients in psychiatric care
- Number of days in hospital for patients in psychiatric care
- Psychiatric readmissions

In the coming year, work will continue on the development of the following indicators for psychiatric services and general practice:

- Excess mortality among citizens with mental illness
- Access to educational services for young people with mental illness (possible link to the workforce indicator will be explored.)

- Dispensed prescriptions for antibiotics in general practice
- At least one additional indicator for general practice

A potential indicator for physical health and somatic assessment for citizens with mental illness will also be explored.

The 2019 regional financial agreement introduces a new governance model for the healthcare system, intended to enhance coherence for patients. In the coming year, there will be efforts to create greater coherence between the national goals and future local financing.

Additional indicators aimed at municipalities will be developed as data technology improves.

An updated definition for "Acute somatic readmission within 30 days":

The previous definition of readmission has come into question, due to organisational changes and revised registrations with the establishment of joint urgent care centres. As a result of these changes, the indicator underestimated the rate of readmissions and comparability over time and between regions and municipalities was impacted. A new definition has therefore been developed, which is more accurate and should improve comparability. These indicators are methodically different, and data from the two methods cannot be compared. More detailed information on the new definition can be found at: http://esundhed.dk/sundhedsaktivitet/sundhedsaftaler/Sider/SUA01.aspx

DEVELOPMENT OF GOALS AND INDICATORS

We are following the development of the national goals. This will be done using traffic light markers which signify the status of each region or municipality with regard to the eight different national goals. The colour of the traffic light indicates the progress of the healthcare system.

When viewing the overall development in comparison to the previous year, it is clear that progress has been made for several of the goals. For instance, waiting time has been reduced in both the regions and the municipalities, and survival rates for cancer and heart disease have improved. Nevertheless, there is still room for improvement, e.g. compliance with the right to a medical examination, and access to the workforce.

In order to support improvement measures in the regions, Danish Regions has prepared a version of the key figures for national goals, which will enable each region to follow the ongoing development. This version can be found here.[1]

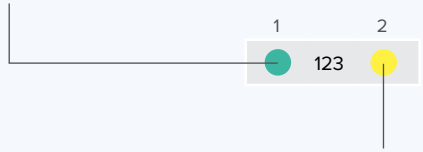
Pages 13-16 present a nuanced picture of the trends of certain indicators.

The colours signify the progress of regions and municipalities since the previous year, and how they rank when compared to the national average. The intent is for both regions and municipalities to follow these indicators and learn from best practice.

WHAT THE MARKERS SIGNIFY:

The colour markers to the left of the number indicates the development from 2016 to 2017 for each region and municipality.

- Positive development
- No change in development
- Negative development



The colour markers to the right of the number indicate the status as compared to the national average.

- Better than the national average
- Same as the national average
- Worse than the national average

The yellow marker is used to indicate a change of +/- 1 percent. This means that if the development is plus or minus 1 percent, there has been no change in the development, and if the deviation from the national average is plus or minus 1 percent, it is assumed that the region or municipality is the same as the national average

1. http://www.regioner.dk/sundhed/kvalitet-og-styring/loebende-noegletal-for-de-nationale-maal-for-sundhedsvaesenet

TABLE 1 Overview of indicator colour markers

GOALS	INDICATORS	ENTIRE COUNTRY	NORTH DENMARK	CENTRAL DENMARK	SOUTH DENMARK	CAPITAL	ZEALAND
BETTER CONTINUITY OF PATIENT CARE IN CLINICAL PATHWAYS	Acute somatic readmissions within 30 days, pct. [1,2]	11.6	10.8	11.9	11.1	12.0	12.3
	Acute psychiatric readmissions within 30 days, pct. [3]	22.3	15.4	23.2	22.1	23.7	19.9
	Waiting time for rehabilitation, days [2,4]	12	13	13	13	13	10
	Number of hospital days after completion of somatic treatment, days [2,5]	3.6	1.7	2.1	2.3	6.4	3.2
	Number of hospital days after completion of psychiatric treatment, days [3]	4.1	3.8	4.8	1.6	4.9	5.2
	Updated medicine information (March 2018), pct. [6]	16.4	20.5	18.7	14.7	13.1	18.2
	Retention of somatic patients in the workforce in 2016, pct. [7]	80.9	77.7	79.4	79.6	83.2	81.0
	Retention of psychiatric patients in the workforce in 2016, pct.	47.4	45.3	45.0	48.9	47.8	48.2
	Access to educational services for young people with mental illness (in development - possible link to the workforce indicator will be explored)	–	–	–	–	–	–
STRONGER MEASURES FOR CHRONICALLY ILL AND ELDERLY PATIENTS	Acute hospital admissions per 1,000 COPD patients [2,8]	547.2	469.0	531.8	450.6	641.6	595.4
	Acute hospital admission per 1,000 type 2 diabetes patients [2,8]	356.7	301.4	355.7	291.4	410.5	390.0
	Preventable admissions per 1,000 elderly patients (65+) [2,8]	59.0	50.8	54.5	48.4	71.3	64.7
	Over-occupancy rates in medical departments of public hospitals, pct. [9]	0.59	0.83	0.78	0.49	0.41	0.68
	Share of citizens with dementia that have purchased antipsychotic medication, pct.	19.2	14.5	19.4	19.0	22.1	16.1
HIGHER SURVIVAL RATE AND IMPROVED PATIENT SAFETY	5-year survival rate after cancer (2012-2014), pct. [10]	63	62	63	64	65	61
	Cardiovascular mortality (2014-2015), deaths per 100,000 patients	126	126	123	122	130	131
	Excess mortality among citizens with mental illness (under development)	–	–	–	–	–	–
	Hospital-acquired infections – number of bacteraemias per 10,000 patient days at risk [2]	8.2	6.7	6.7	9.8	8.8	8.0
	Hospital-acquired infections – clostridium difficile, number per 100,000 patients	59	49	48	53	70	67
	Share of patients surviving at least 30 days after sudden cardiac arrest, pct. [*13]	27	28	35	26	25	23
	Dispensed prescriptions for antibiotics in general practice (under development)	–	–	–	–	–	–

Development from 2016 to 2017 — 123 — Status as compared to the national average

Continued

GOALS	INDICATORS	ENTIRE COUNTRY	NORTH DENMARK	CENTRAL DENMARK	SOUTH DENMARK	CAPITAL	ZEALAND
HIGH QUALITY TREATMENT	Fulfilment of quality goals in clinical quality databases, pct.*	57.5	57.6	66.1	57.3	48.8	53.4
	Persons admitted to psychiatric wards with belt restraints, pct. [3]	5.4	6.6	8.7	4.8	3.9	5.2
QUICK ASSESSMENT AND TREATMENT	Average experienced waiting time for hospital surgeries, days [2]	42	51	33	43	46	40
	Average experienced waiting time for child psychiatric care, days [3]	22	34	14	20	27	21
	Average experienced waiting time for adult psychiatric care, days [3]	19	24	18	19	18	22
	Somatic assessment trajectory, where the right to assessment is upheld, percentage of all assessment trajectories (4th quarter 2017), pct. [2]	78	94	84	79	61	76
	Psychiatric assessment trajectories (child and adolescent), where the right to assessment is upheld, percentage of all assessment trajectories (4th quarter 2017), pct. [3]	90	91	97	99	47	95
	Psychiatric assessment trajectories (adults), where the right to assessment is upheld, percentage of all assessment trajectories (4th quarter 2017), pct. [3]	94	93	95	97	91	87
	Package pathways carried out within predetermined standard trajectory times for cancer, pct. [2]	77	77	75	82	76	73
GREATER PATIENT INVOLVEMENT	Patient-experienced satisfaction - patients in somatic care (average score 1-5)**	4.25	4.32	4.33	4.26	4.16	4.18
	Patient-experienced satisfaction - patients in psychiatric care children and adolescents (average score 1-5)**[11]	4.02	3.96	4.06	4.05	3.90	4.09
	Patient-experienced satisfaction - patients in psychiatric care, adults (average score 1-5)**[11]	4.22	4.18	4.22	4.30	4.19	4.15
	Patient-experienced involvement - patients in somatic care (average score 1-5)**	3.76	3.82	3.90	3.72	3.66	3.65
	Patient-experienced involvement - patients in psychiatric care. children and adolescents (average score 1-5)**[11]	4.23	4.32	4.09	4.38	4.01	3.93
	Patient-experienced involvement - patients in psychiatric care. adults (average score 1-5)**[11]	4.56	4.53	4.59	4.62	4.53	4.49

Development from 2016 to 2017 — 123 — Status as compared to the national average

Continued

GOALS	INDICATORS	ENTIRE COUNTRY	NORTH DENMARK	CENTRAL DENMARK	SOUTH DENMARK	CAPITAL	ZEALAND
ADDITIONAL HEALTHY LIFE YEARS	Life expectancy, years***	80.9	80.7	81.5	81.0	80.8	80.1
	Daily smokers, percent (2013)****[11]	16.9	16.9	15.7	18.7	15.9	18.4
MORE EFFICIENT HEALTHCARE SYSTEM	Average length of stay per admission, days	3.3	3.9	3.1	3.6	3.3	3.0
	Hospital productivity, index: entire country = 100 (2016)	100	96	99	102	100	102

Sources: Danish Health Data Authority. *Danish Regions **National Danish Survey of Patient Experiences ***Statistics Denmark ****Danish National Health Profile.

Comments:
A project has now been initiated, as part of the National Health Data Programme, to provide a better presentation of the indicators included in the National Goals for Healthcare Services. This project involves an extensive review and technical restructuring of the indicators, which may potentially uncover discrepancies in the data. Through the management of these, indicator values may be revised and altered.

The colour markers are based on the number of decimals given in the overview.

1. New definition of indicator, cf. box page 7
2. Implementation of the Healthcare Platform in the Capital Region in May 2016, and in the Zealand Region in November 2017 may also have influenced the data.
3. Implementation of the Healthcare Platform in the Capital Region in May 2017, and in the Zealand Region in November 2017 may also have influenced the data.
4. It has been determined municipalities have experienced challenges in reporting due to poor data delivery from the system provider. The determined waiting time must therefore be interpreted with caution. This is especially true at the municipal level.
5. The 2016 figures for the Capital Region and its municipalities must be interpreted with great caution, as the number of days in hospital per patient were not reported by Herlev and Gentofte hospitals for June and July 2016, due to the implementation of the Healthcare Platform. The report rate for August 2016 was also very low.
6. This rate is relatively low and reflects limited updates from several general practices.
7. The implementation of the Healthcare Platform in the Capital Region in May 2016 may have influenced the data.
8. The introduction of the joint urgent care centres has resulted in a continuous restructuring of registrations, where patients who are admitted to and treated at urgent care centres are reported to the Danish National Patient Registry as acute ambulatory contacts, and are therefore not included in the indicator data. This could indicate an underestimation of the number of admissions, which would affect opportunities for comparison over time and between regions or municipalities.
9. The colour markers are solely based on the development from 2016 to 2017.
10. The Danish Cancer Registry was revised after the most recent update of the National Goals of the Danish Healthcare System.
11. There is a gap in the data between 2016 and 2017 due to a revision of the questions.
12. Development from 2013 to 2017
13. The Capital Region first began reporting to the database in 2017.

Development from 2016 to 2017 — 123 — Status as compared to the national average

FOCUS AREAS

The government, KL (Local Government Denmark) and Danish Regions all agree that a safe and efficient healthcare system is a pillar of our welfare society. We must continue to improve our efforts across the country, and build on the results.

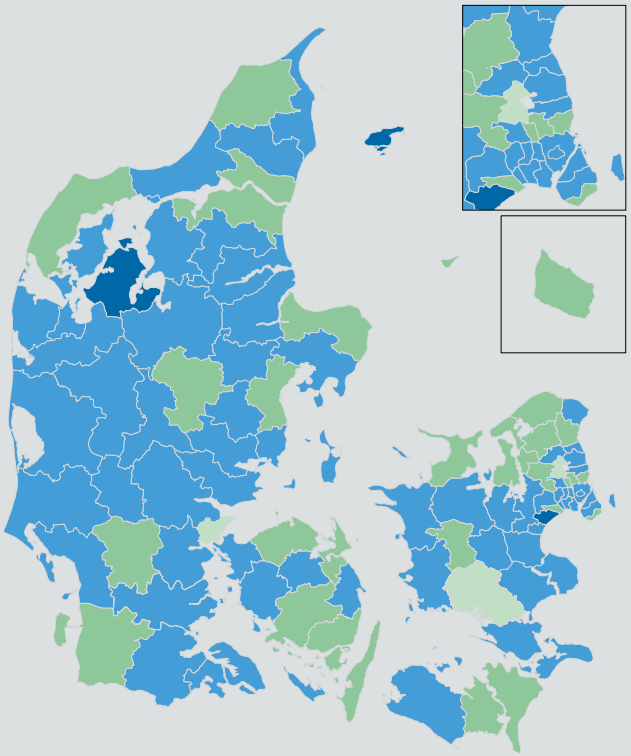
The healthcare system must be structured such that it is able to deal with future challenges. A healthcare system with focus on high quality, coherence across sectors, and patient experiences and involvement. Together, we will ensure the highest possible level of quality healthcare and value. This goal should reflect the way in which we organise our healthcare system. This is one of the reasons we must ensure that all areas of healthcare services emphasise coherence and prevention, to enhance local continuity of care for each citizen.

A coherent healthcare system is a focal point for the future generation of healthcare agreements. We have highlighted local continuity of care in the government's mini proposal "Healthcare where you live" (follow-up of recommendations by the Committee for local and coherent healthcare systems), Danish Region's proposal "Health for All - vision of a sustainable healthcare system", as well as the mini proposal by KL (Local Government Denmark), "Strengthen the local healthcare system!".

The national goals reflect our common direction for the development of the healthcare system.

EXAMPLES OF INDCATORS

FIGURE 1
Trends in the number of acute somatic hospital readmissions within 30 days, by percentage, 2016-2017

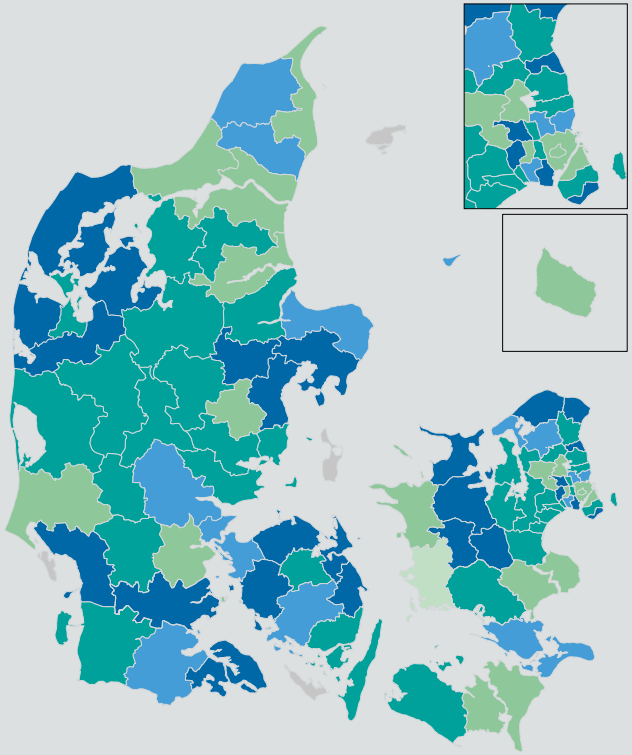


- Significant positive trend (Below -2 pct points)
- Positive trend (-0.01 to -2 pct. points)
- Neutral trend (0 pct. point)
- Negative development (0.01% to -2.5 pct. points)
- Significant negative trend (Above 2 pct. points)

Note:
Implementation of the Healthcare Platform in the Capital Region in May 2016, and in the Zealand Region in November 2017 may also have influenced the data.

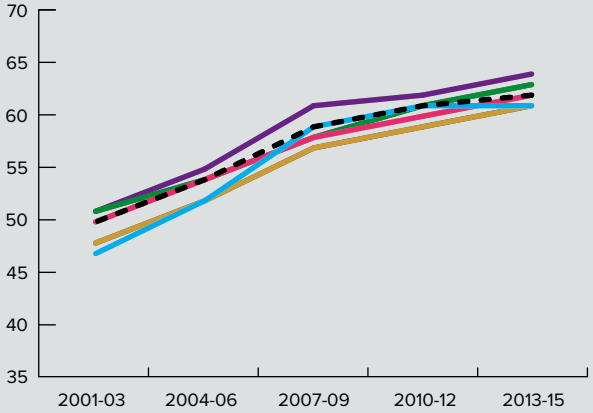
Source:
Danish National Patient Registry, Danish Health Data Authority

FIGURE 2
Trends in the number of acute psychiatric readmissions within 30 days, by pct., 2016-2017



- Significant positive trend (Below -2 pct. points)
- Positive trend (-0.01 to -2 pct. points)
- Neutral trend (0 pct. point)
- Negative trend (0.01 to 2 pct. points)
- Significant negative trend (Above 2 pct. points)
- The rate has not been determined as there are too few observations

FIGURE 3
5-year cancer survival rate, by pct., 2001-2015

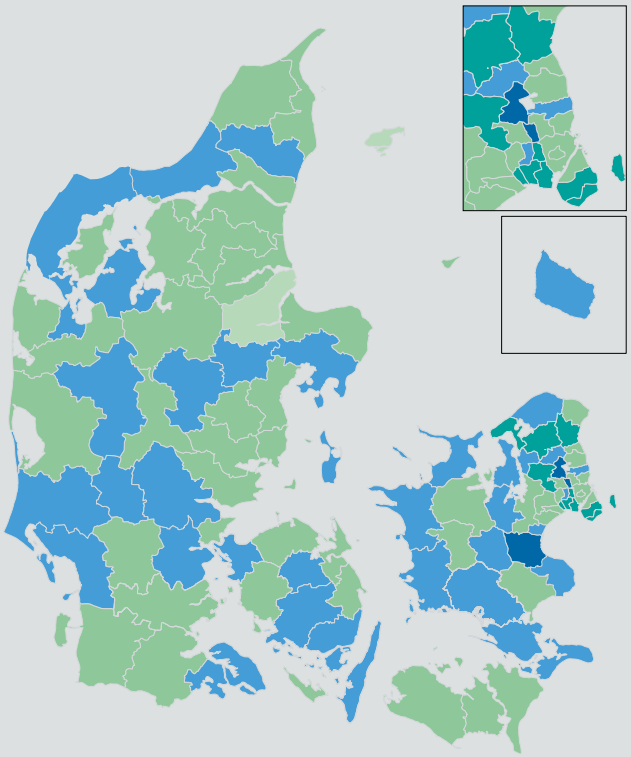


- Capital Region
- Zealand Region
- Central Denmark Region
- Southern Denmark Region
- Northern Denmark Region
- Entire country

Note.:
The only type of skin cancer included are melanomas.

Source:
Danish Cancer Registry, CPR (Danish Civil Registration System) and Danish Health Data Authority

FIGURE 4
The trend in the number of days in hospital for somatic care per 1000 citizens, 2016-2017

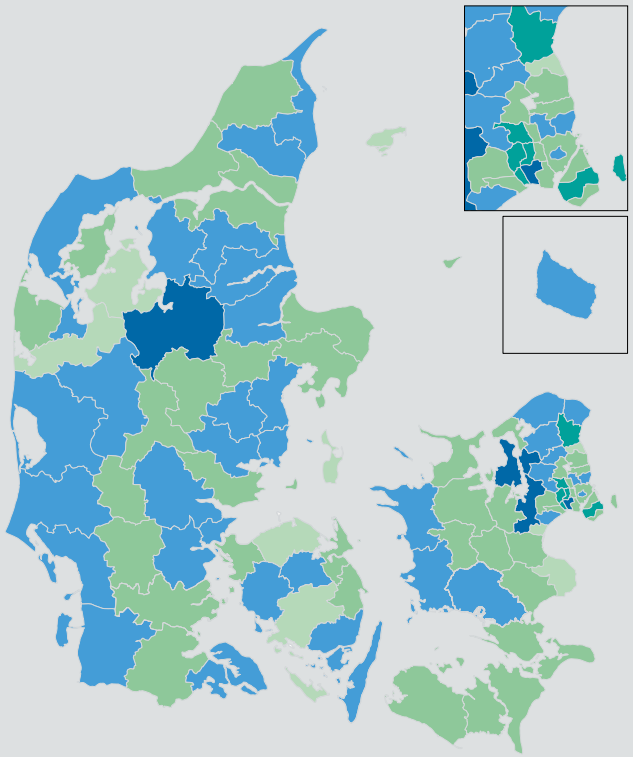


- Significant positive trend (Fewer than 5 days)
- Positive trend (-5 to -0.01 days)
- Neutral trend (0 days)
- Negative trend (0.01 to 5 days)
- Significant negative trend (More than 5 days)

Note: Implementation of the Healthcare Platform in the Capital Region in May 2016, and in the Zealand region in November 2017 may also have influenced the data.

Source: Danish National Patient Registry, Danish Health Data Authority

FIGURE 5
The trend in the number of days in hospital for psychiatric care per 1000 citizens, 2016-2017

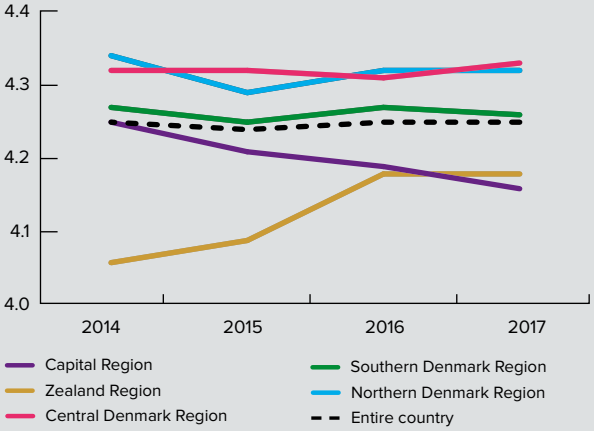


- Significant positive trend (Fewer than 5 days)
- Positive trend (-5 to -0.01 days)
- Neutral trend (0 days)
- Negative trend (0.01 to 5 days)
- Significant negative trend (More than 5 days)

Note: Implementation of the Healthcare Platform in the Capital Region in May 2017, and in the Zealand Region in November 2017 may also have influenced the data.

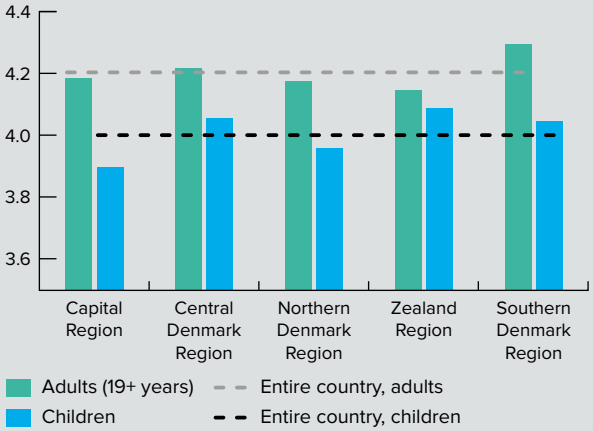
Source: Danish National Patient Registry, Danish Health Data Authority.

FIGURE 6
Patient-experienced satisfaction – patients in somatic care (average score 1-5), 2015-2017



Source: Nationwide Study of Patient Experiences (LUP)

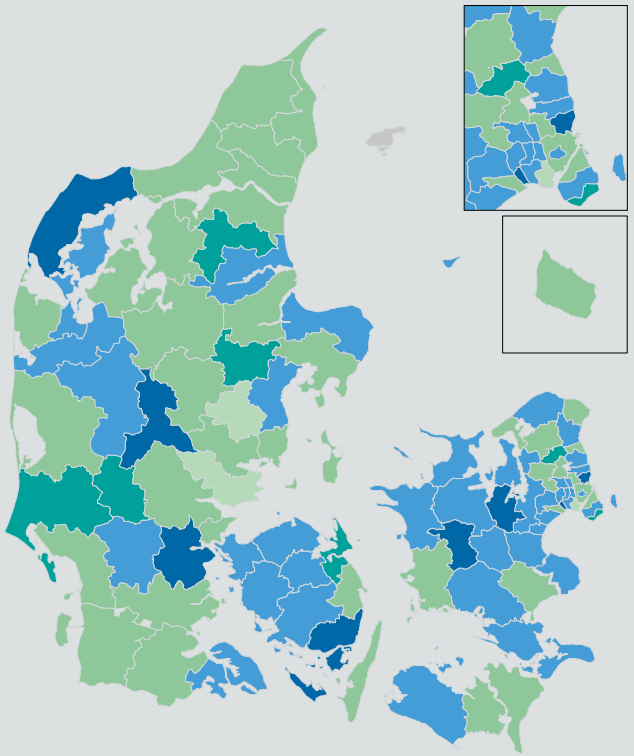
FIGURE 7
Patient-experienced satisfaction - patients in psychiatric care (average score 1-5), 2017



Note: There is a gap in the data between 2016 and 2017 due to a revision of the questions.

Source: Nationwide Study of Patient Experiences (LUP)

FIGURE 8
Trends in the retention of somatic care patients in the workforce, pct., 2015-2016

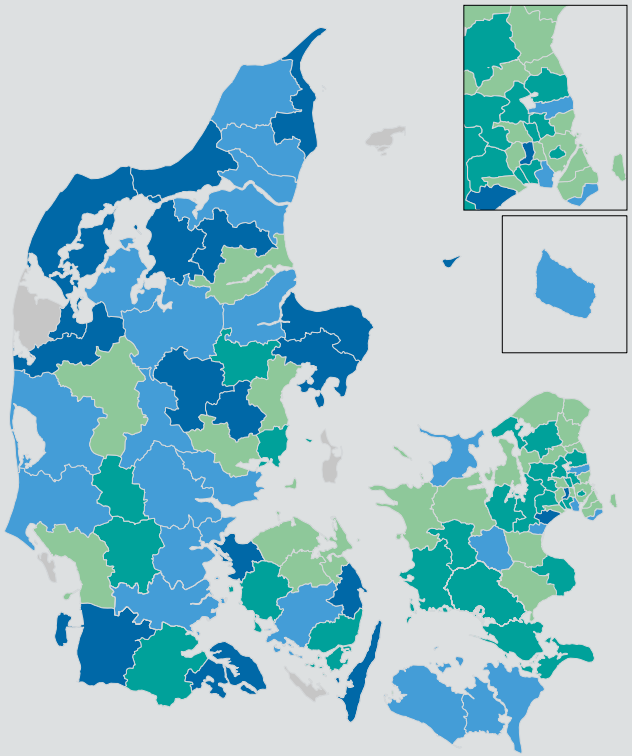


- Significant positive trend (Above 2.5 pct. points)
- Positive trend (0.01 to 2.5 pct. points)
- Neutral trend (0 pct. points)
- Negative trend (-0.01 to -2.5 pct. points)
- Significant negative trend (Below -2.5 pct. points)
- The rate has not been determined as there are too few observations

Note: Implementation of the Healthcare Platform in the Capital Region in May 2016 may also have influenced the data.

Source: Danish National Patient Registry and DREAM (Danish Institute for Economic Modelling and Forecasting), Danish Health Data Authority

FIGURE 9
Retention of psychiatric patients in the workforce in 2016, compared to the national average percentage.

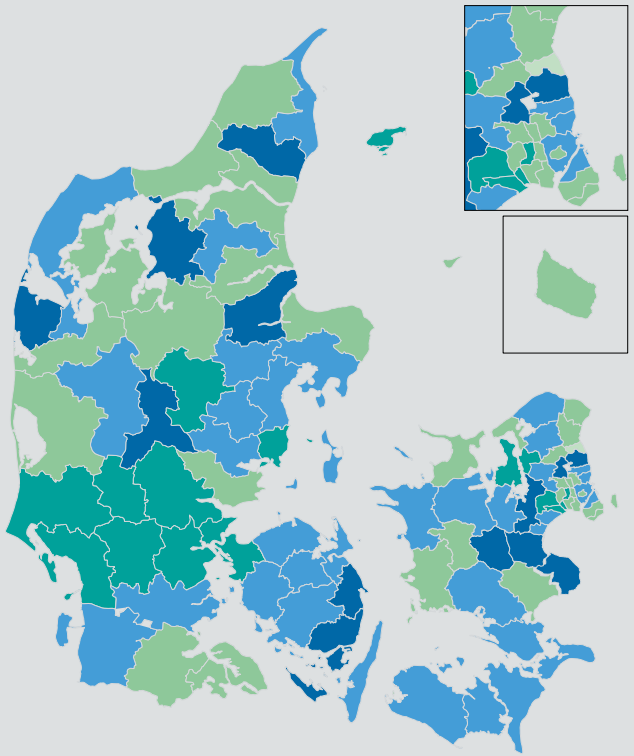


- Significant positive trend (Above 5 pct. points)
- Positive trend (0.01 to 5 pct. points)
- Neutral trend (0 pct. points)
- Negative trend (-0.01 to -5 pct. points)
- Significant negative trend (Below -5 pct. points)
- The rate has not been determined as there are too few observations

Note: The rates are given as 4-year rates due to few observations, 2013-2016

Source: Danish National Patient Registry and DREAM (Danish Institute for Economic Modelling and Forecasting), Danish Health Data Authority

FIGURE 10
Trends in the number of preventable admissions among 1000 elderly citizens, by number, 2016-2017

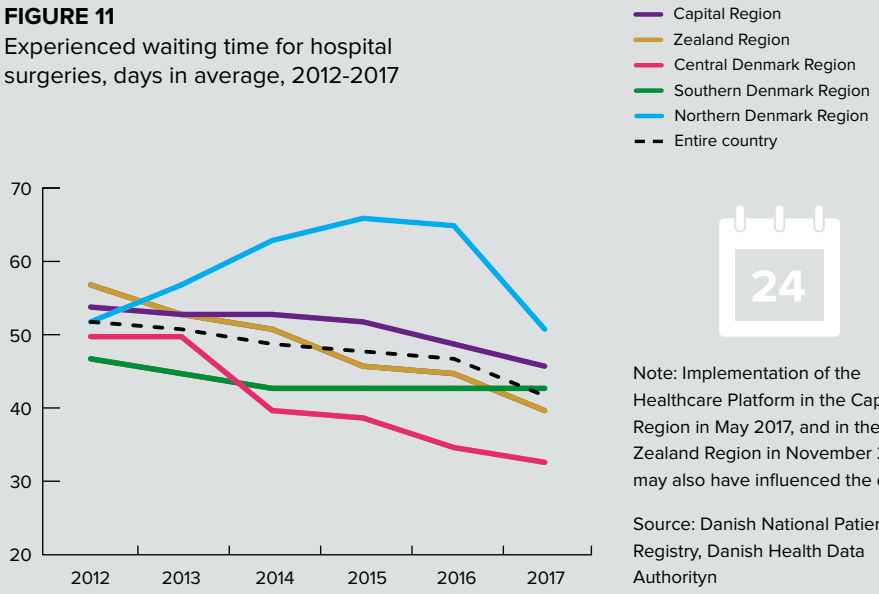


- Significant positive trend (Below -10 pct.)
- Positive trend (-10 pct. to -0.01 pct.)
- Neutral trend (0 pct.)
- Negative trend (0.01 pct. to 10 pct.)
- Significant negative trend (Above 10 pct.)

Note: The introduction of the joint urgent care centres has resulted in a continuous restructuring of registrations, where patients who are admitted to and treated at urgent care centres are reported to the Danish National Patient Registry as acute ambulatory contacts, and are therefore not included in the indicator data. This could indicate an underestimation of the number of admissions, which would affect opportunities for comparison over time and between regions or municipalities.

Source: Danish National Patient Registry, Danish Health Data Authority

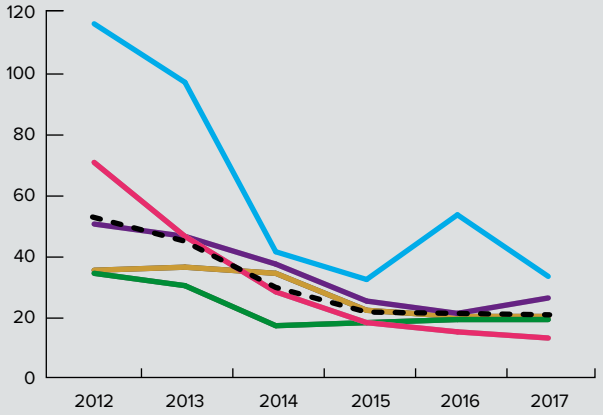
FIGURE 11
Experienced waiting time for hospital surgeries, days in average, 2012-2017



Note: Implementation of the Healthcare Platform in the Capital Region in May 2017, and in the Zealand Region in November 2017 may also have influenced the data.

Source: Danish National Patient Registry, Danish Health Data Authorityn

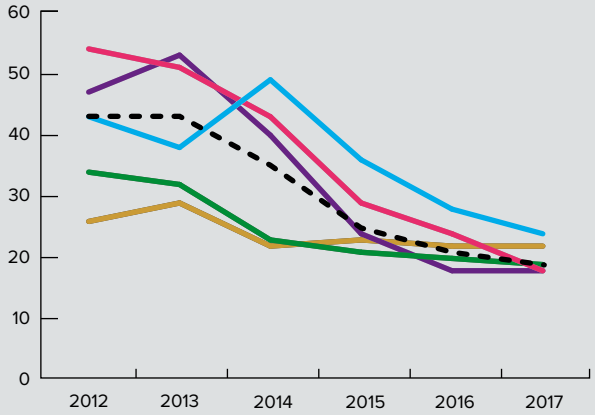
FIGURE 12
Experienced waiting time for child psychiatric care, days in average, 2012-2017



Note: Implementation of the Healthcare Platform in the Capital Region in May 2017, and in the Zealand Region in November 2017 may also have influenced the data.

Source: Danish National Patient Registry, Danish Health Data Authority

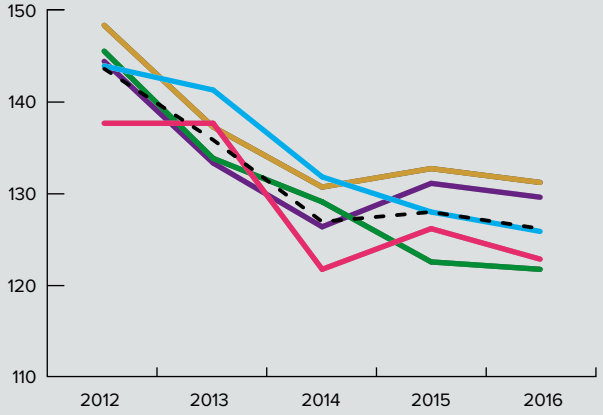
FIGURE 13
Experienced waiting time for adult psychiatric care, days in average, 2012-2017



Note: Implementation of the Healthcare Platform in the Capital Region in May 2017, and in the Zealand Region in November 2017 may also have influenced the data.

Source: Danish National Patient Registry, Danish Health Data Authority

FIGURE 14
Cardiovascular mortality, death per 100,000, 2012-2016



Source: Cause of Death Registry, Danish Health Data Authority

BROAD ANCHORING AND LOCAL OWNERSHIP

Securing goals at a local level in various hospital departments, municipal heath measures, and the medical practice sector are essential for achieving improved quality for patients. Here the national goals will be converted to local intermediate goals and initiatives, so that they become relevant and are an integrated part of the work performed by healthcare staff.

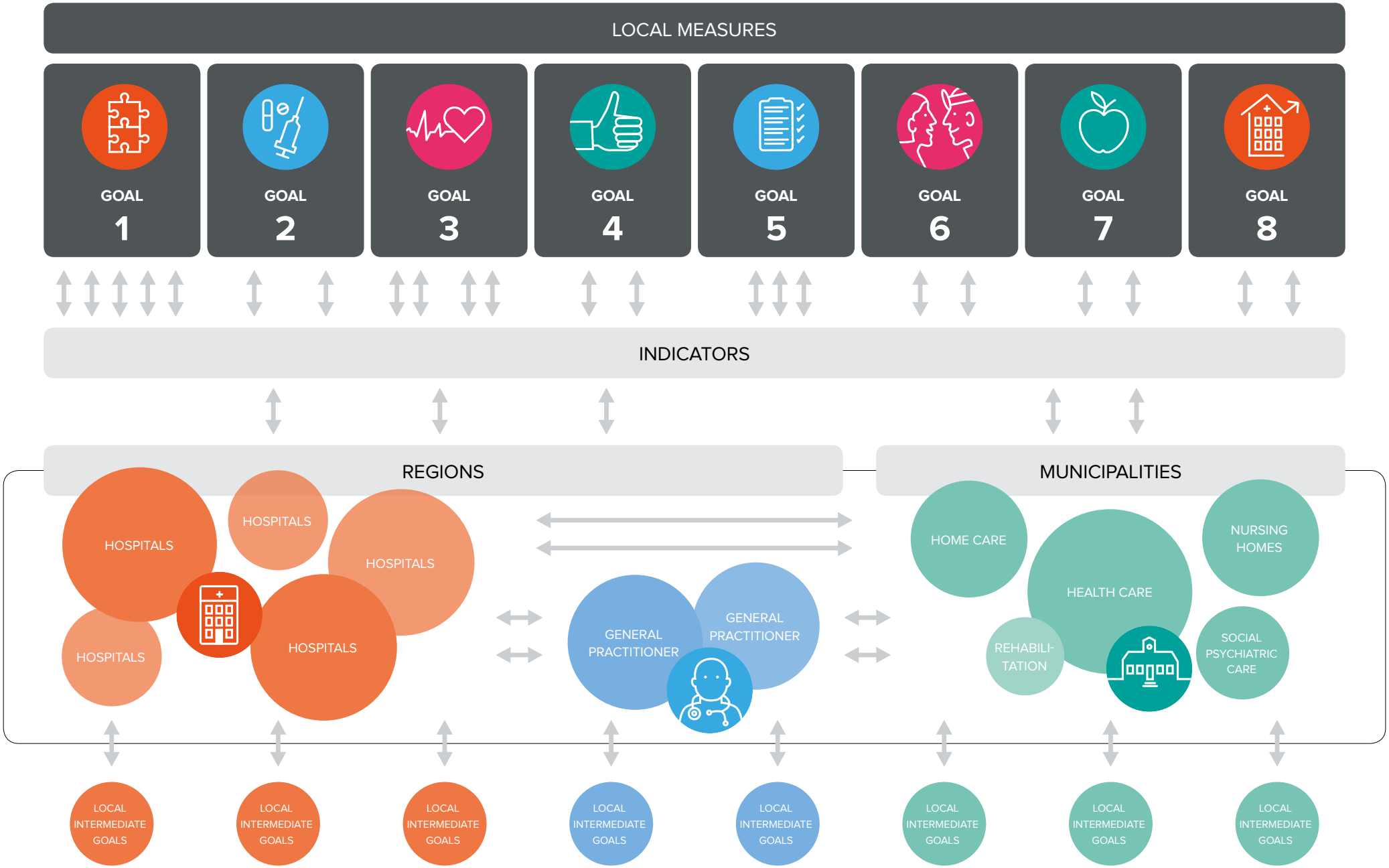
In this manner, healthcare personnel will have greater freedom to identify measures that can improve quality for their patients based on accreditation by the Danish Quality Model. The national goals and the active use of data creates greater visibility and transparency across regions and municipalities, and form a basis for benchmarking and mutual learning, for the benefit of patients. This requires a political focus, as well as management and collegial efforts.

Local anchoring is a key focal point for work with national goals. It is therefore crucial to maintain a strong emphasis on integrating quality improvement efforts in the daily tasks of hospital departments, in municipal healthcare activities, etc.

The Healthcare Quality Programme Dialogue Panel[2] – which includes relevant stakeholders, i.e. the Danish Medical Association, the Danish Nurses Organisation, patient organisations, etc., have pointed out the importance making healthcare staff aware of the national goals and initiatives aimed at improving the quality of local challenges.

The following section lists several examples of regional and municipal work on national goals in local settings over the past few years, and how these have led to improvements in quality for the patients.

2. Read more about the Quality Programme's Dialogue Panel here:
https://www.sum.dk/Sundhed/Sundhedskvalitet/Ny-tilgang-til-kvalitetsarbejdet/Dialogpanelet-for-kvalitetsprogrammet.aspx


LOCAL MEASURES
GOAL 1
GOAL 2
GOAL 3
GOAL 4
GOAL 5
GOAL 6
GOAL 7
GOAL 8
INDICATORS
REGIONS
MUNICIPALITIES
HOSPITALS
HOSPITALS
HOSPITALS
HOSPITALS
HOSPITALS
GENERAL PRACTITIONER
GENERAL PRACTITIONER
HOME CARE
HEALTH CARE
NURSING HOMES
REHABILI-TATION
SOCIAL PSYCHIATRIC CARE
LOCAL INTERMEDIATE GOALS
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LOCAL INTERMEDIATE GOALS

DEVELOPMENT IS FOLLOWED CROSS-REGIONALLY

The board of Danish Regions has decided to discuss development and results each quarter. One aim of securing this development at a political level, is to discover whether there are opportunities for learning between regions, and to focus on how different regions can help each other to achieve better results or to attain their goals, e.g. by focusing on the density of physicians in the country.

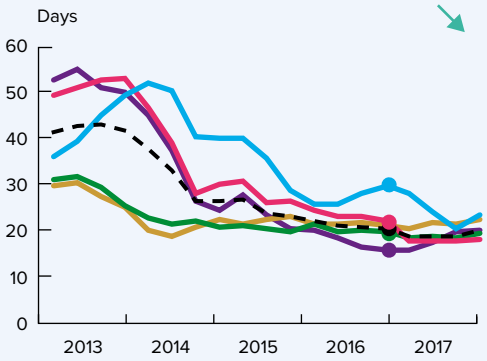
Each region has incorporated national goal indicators in their management information, which are used for follow-up at both political and administrative levels in the region, and at the hospitals and their departments.

All regions work with data-driven improvement measures, which means that hospitals and departments have access to information regarding development and results. An important part of this is management information, which hospital can use to determine action. There has been special emphasis on upholding patient rights and maintaining cancer trajectory packages, e.g. through monitoring, "early warning" systems, etc.

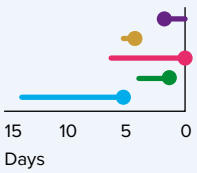
Early warning systems provide an overview of patients who are waiting for assessment, where red indicates that the waiting time has been exceeded, yellow means that patient has waited longer than 15 days, and green indicates that the patient has waited fewer than 15 days.

FACTS
All quality indicators are followed across regions according to this KPI concept.

Waiting time for adult psychiatric care



Rank from best



Latest measurement

Capital Region	20 ↗
Zealand Region	23 ↗
Central Denmark Region	28 ↘
Southern Denmark Region	23 ↘
Northern Denmark Region	24 ↘
The entire country	20 ↘

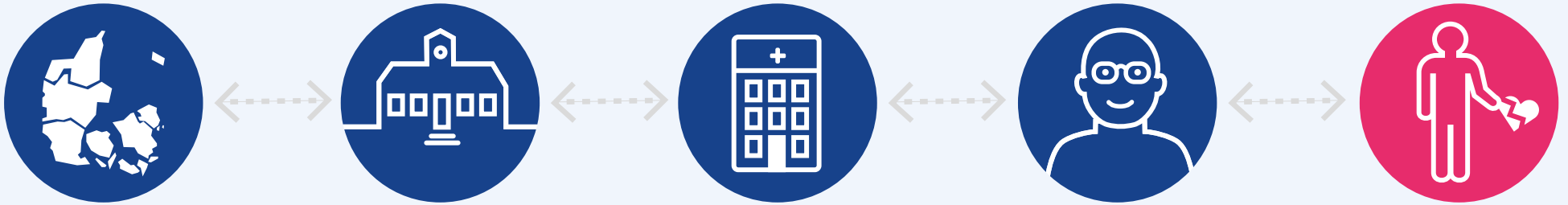
Green: Desired direction
Distance between top and bottom ●

MUNICIPALITIES ARE WORKING TO ATTAIN NATIONAL GOALS FOR THE HEALTHCARE SYSTEM AND ITS INDICATORS

Each municipality is actively working to implement the national goals and quality improvement measures in home care services, nursing homes, etc. To support this work, and to ensure a common direction and shared knowledge across sectors, KL (Local Government Denmark) has also appointed a quality assurance group for the healthcare field. KL (Local Government Denmark) and RKKP (Danish Clinical Registries) have also begun cooperative efforts to develop cross-sectoral quality databases.

KL and the municipalities are working to improve statistics for the health and treatment of the Danish population. This is essential for the continued efforts toward data-driven quality improvement. The municipalities and KL are therefore working to organise and categorise documentation from home care, home health services, and rehabilitation, in addition to prevention measures for patients with chronic illnesses. This is being done across municipalities, and will mean that data can be more easily shared and used for indicators, management information and quality improvement. Through a shared management information system, available by 2019, municipalities will be able to benchmark themselves in the healthcare field, using indicators based on the national goals.

PSYCHIATRIC SERVICES - LOCAL ANCHORING AND COHERENCE



Patients with mental illness, like all other patients, must be offered high quality continuity of care. Local anchoring of national goals and the development of coherence indicators for psychiatric care will be an essential element in the ongoing efforts to improve quality, for the benefit of patients with mental illness.

This is why we must continue to have a strong political, management and personnel focus on quality improvements in local healthcare practices.

Last year's status report proposed the development of specific indicators, targeting psychiatric care and emphasising better continuity of care across sectors, for the benefit of psychiatric patients. The present status report therefore includes several more indicators targeting psychiatric care than the previous year. With these new indicators, psychiatric care is now on more equal footing with somatic care, and there is greater focus on continuity of care across sectors. This should help to ensure greater visibility and transparency in practices in different hospital departments, municipal services and across the general practice sector, and will enable us to identify measures that can improve quality of psychiatric care services.

The next few pages provide examples of how local services in regions and municipalities are working to to attain national goals in the field of psychiatric care services. These examples show the local anchoring of national goals in psychiatric hospital wards and municipal healthcare measures for people with mental illness, and how this work is being carried out across municipalities and regions.

STRATEGY ON THE BOARD

Overarching goals must be converted into specific, concrete goals down through the organisational line. These goals are followed with the aid of charts and whiteboards with data.

Northern Denmark Region Psychiatric and Clinical services management has simplified and adapted national and regional goals to create specific goals for management teams down through the organisational line. Clinical personnel are involved in adapting these goals, and there is also focus on considerations for local differences. This is to ensure that the selected methods will actually solve the problems. A problem solved by one method in Aalborg may have to be solved using different method in Thisted.

Goals are followed up with the aid of charts and data that are reviewed at whiteboard meetings. Whiteboards with data help to specify strategy efforts.

Management follows the results of selected indicators, and data-driven management assists in evaluating whether psychiatric care services are moving in the right direction, in accordance with national and regional goals. In this manner, data information helps to maintain focus on the most important factors.

For instance:

One of the efforts to attain the national goal of a more efficient healthcare system, is a regional goal to reduce the number of no-shows and cancellations.

In psychiatric care services, this means that no-shows and cancellations must be reduced from X% to Y%.

At a clinical level, certain departments have been selected to test various measures aimed reducing no-shows and cancellations to Y%.

In these departments, this involves working with no-shows from the first consultation and cancellations by patients with a long history of treatment.

FROM GOAL TO BUILDING BLOCK

“Psykiatriens Hus”, a psychiatric care facility in Aarhus will assist in creating better continuity of care for patient pathways by improving the coordination of services between the region and municipalities.

The Central Denmark Region is working with the national goal “Better coherence in patient pathways”, by establishing Psykiatriens Hus, a psychiatric care facility in Aarhus, in cooperation with Aarhus municipality.

The intent is to strengthen local psychiatric care services by ensuring coordinated regional and municipal services, and by establishing high quality psychiatric services for future patients. These measures will support patient recovery processes.

Construction of the psychiatric facility in Aarhus will be carried out in several stages. The first stage is expected to be in operation by early December 2018, with the following services:

- Joint management
- Acute ambulatory team with 8 regional inpatient beds
- Municipal inpatient beds
- Psychoeducation
- Peer support
- User-controlled services

The psychiatric facility in Aarhus is located in the MarselisborgCentret, which would enable cooperation with other municipal and private actors for development of rehabilitation services.

2018 Annual Plan for Psychiatric Care in the Central Denmark Region

Goal: Better coherence in patient pathways

RESTRAINT-FREE DEPARTMENT

A strong focus on management and continuing education for healthcare personnel has aided in avoiding the use of restraint belts in Aabenraa psychiatric services.

Based on the national goal of ensuring high quality treatment, the Southern Denmark Region has made intensive efforts over the past three years to avoid the use of restraint belts in psychiatric care. As a result, one psychiatric ward in Aabenraa has not had a single patient in restraint belts for one and a half years, and the adult psychiatric ward in Aabenraa now has restraint-free access. These results were achieved through a major focus on management and continuing education for personnel.

Working to achieve restraint-free access requires a strong focus on management and continuing education for personnel. And patients are very pleased by the amount of effort being put into this work. The target group for the project includes all patients in the catchment area, ages 20 to 69, with all types of psychiatric disorders needing hospital admission. Restraint-free treatment also involves a reduction of other types of coercion, such as coercive detention and the involuntary immobilisation with sedation.

MEASUREMENT OF THE EFFECT OF TREATMENT IN PSYCHIATRIC CARE PATHWAYS

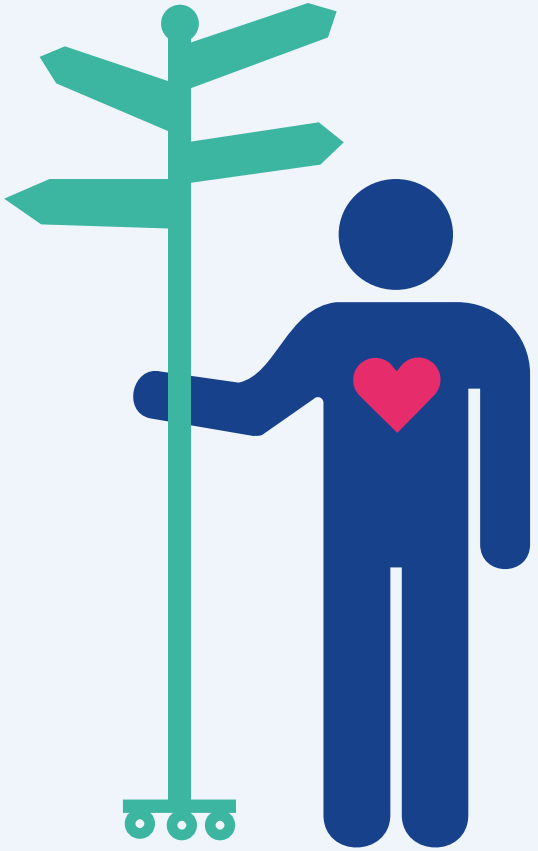
The Capital Region is working to develop a model for measuring the effect of treatment in psychiatric care pathways, which would be included in dialogue with the patient, and as part of quality and goal management.

Several of the national goals focus on ensuring effective treatment for the patient. The Capital Region has therefore been working to determine how to measure treatment efficacy, and how this measurement can be included in the dialogue with the patient with respect to treatment progress, and as a part of quality and goal management.

The region is now developing a model to measure the effect of treatment in psychiatric care pathways. This means that the patient is systematically involved in evaluating the effect of treatment with the aid of questionnaires. These contain questions regarding a number of factors relevant to the patient's illness, health and quality of life. Patients become more aware of their own wishes for treatment, and its effect or its lack of effect.

The treatment offered to individual patient groups will then become more targeted in the future. There will also be greater focus on potential problems with efficacy and on patient needs. Data acquired from the model will later help to clarify the prognosis for the patient and provide decision support for treatment planning.

Data results from the measurement of treatment effect will be incorporated into management information systems for psychiatric care services by 2018, and will therefore be included in quality and operational goal management.



RAPID RESPONSE TREATMENT FOR PATIENTS IN ACUTE CRISES

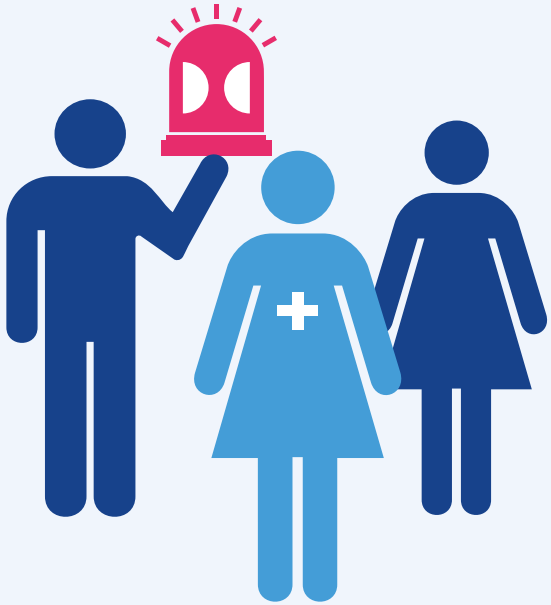
An ambulatory acute care team in Vordingborg is a measure that contri butes to better continuity of care for patients, and also aids in preventing readmissions.

One of the national goals is to develop better coherence in patient pathways and to prevent readmissions. The ambulatory acute care team in Vordingborg is a measure that can help to attain this goal.

The ambulatory acute care team in Vordingborg covers the entire catchment area of Psychiatry South (Næstved, Vordingborg, Guldborgsund and Lolland municipalities). The team is staffed with 3 nurses, one specialist psychologist and a specialist physician.

The team provides rapid response assistance for adults seeking help at the Psychiatric Emergency Clinic due to acute crisis, recurrence or exacerbation of symptoms. This intensive treatment consists of home visits and outpatient consultations as a substitute for hospital admission through the Psychiatric Emergency Clinic or inpatient psychiatric ward. The acute care team also offers acute care follow-up services for patients who are discharged from the Psychiatric Emergency Clinic and inpatient wards, for a period of 6 weeks following their discharge. The intent is to provide greater security for patients during this vulnerable period.

These services started up in 2015 as a social financing project, and have been proven successful. Both patients and healthcare personnel have expressed satisfaction with these services, which have resulted in fewer admissions through the Psychiatric Emergency Clinic and therefore fewer intrusive measures for patients. The opportunity for inpatient wards to discharge patients to the care of the acute care team also means that the transition and waiting time for psychiatric outpatient services is not as abrupt. These services fill a gap which may sometimes occur in the transition between hospitalisation and outpatient treatment. The ambulatory acute care team has now become a regular part of outpatient services.



Case

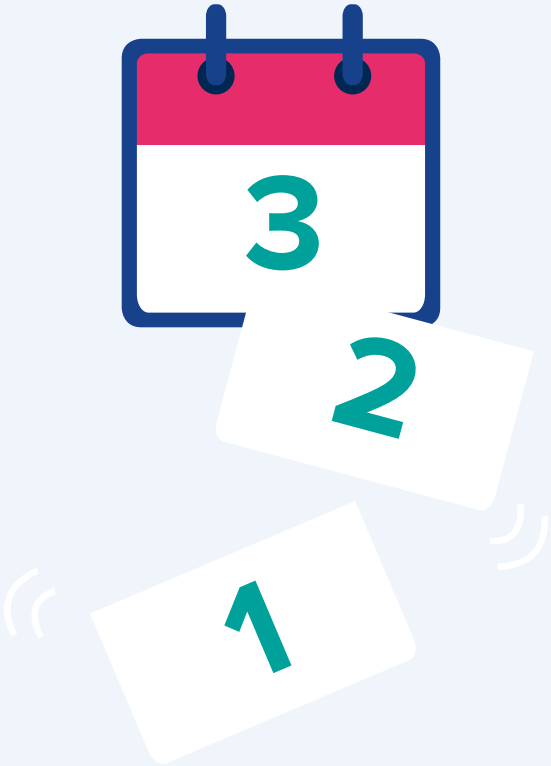
ACCELERATED CASE ASSESSMENT AT A PSYCHIATRIC HOSPITAL IN ROSKILDE

Roskilde municipal health visits for patient service assessments have been moved to the psychiatric department in order to reduce the number of days in hospital for each patient.

Over the past three years, Roskilde municipal health visitors have gradually moved their assessment visits to the psychiatric department. Here, they do rounds in the wards with the staff and meet Roskilde citizens who have been admitted. Together with the patients, they assess whether there is a need for municipal services following discharge. These visits include assessments of everything from practical assistance to nursing care, home support or housing services. Support may be provided while the patient is still in hospital, so that the patient feels more secure upon discharge. Coordinated action plans have proven useful when coordinating continued psychiatric treatment and municipal services.

Accelerated case assessments are typically limited to a two-hour visit per week at a psychiatric hospital, followed by a certain number of hours for case assessment. Even when the case assessment is accelerated, the task remains the same, and changes in practice remain within the existing financial framework.

Roskilde Municipality has noted a significant reduction in the number of days in hospital for patients in the target group. Case assessment time has also been shortened for admitted patients. It is also determined that some of these patients would have had trouble seeking help on their own, and accelerated case assessment gives patients easier access. Cooperation across sectors for each individual patient has also been significantly strengthened due to continuous contact between health visitors and clinicians.



Case

BETTER CONTINUITY OF CARE – SINGLE INTAKE FOR CITIZENS WITH MENTAL ILLNESS

Municipal and regional personnel work at the same location in Næstved Municipality to create greater continuity of care in patient pathways.

In recent years, there have been efforts in several parts of the country to strengthen intersectoral cooperation on psychiatric services to ensure greater continuity of care for citizens across treatment and rehabilitation sectors.

One example is Næstved Municipality and the Zealand Region, which collaborated in 2015 on the establishment of "Psykiatriens Hus" (a psychiatric facility) in Næstved, which offers treatment, care, housing, rehabilitation and re-entry to the workforce for people with mental illness, all at the same location.

The innovative aspect of this collaboration is the idea of a single intake for people with mental illness, since both the municipal and regional staff are working in the same building. This physical structuring ensures coordination of services provided by the various sectors, so that these systems are able to work in the same direction and find the optimal solution together with the service user.

Psychiatry Zealand includes:

– Psychiatric Clinic – Næstved and
– District Psychiatric Services– Næstved

Næstved Municipality includes units from:

– Job Centre
– Counselling for substance abuse
– Social psychiatry services and Health Visitation Assessment

There are 101 citizens registered in Integrated Psychiatric Services and 66 of these cases have now been closed. The conclusion by the staff is that this joint organisation of district psychiatric services, social psychiatry services and Job Centre, all located in the same building has shown positive results, in the form of high service-user satisfaction, and greater expectations for possible employment or education in the long term. Næstved has now begun to see the first signs of this success.

IN SAFE HANDS FOR SOCIAL PSYCHIATRY

The project “In Safe Hands” is intended to reduce pressure sores, medication errors, falls and infections in the municipalities.

18 municipalities are participating in the improvement programme “In Safe Hands” for the Danish Society for Patient Safety. The municipalities are working to reduce pressure sores, medication errors, falls and infections. In 2013, the municipalities of Frederiksberg, Lolland, Sønderborg, Viborg and Thisted began its work on all six target areas, and have now eradicated pressure sores and serious medication errors. They have systematised the involvement of patients and family members, and have established a new form of management.

Based on these results, another 13 municipalities, (Allerød, Billund, Brøndby, Greve, Helsingør, Hillerød, Kerteminde, Mariagerfjord, Silkeborg, Syddjurs, Varde, Aabenraa and Aarhus), began using methods of this project from 2016. The 13 new municipalities are focusing exclusively on pressure sores and medication errors, in addition to the two organisational measures (management of improvement efforts, and patient and family cooperation).

Since 2013, Thisted Municipality has been working with “In Safe Hands” and the model for improvement, and has also launched the model for municipal social psychiatry services. Implementation and competency enhancement of personnel and management for these services has been conducted several times and is now being applied to services for disabilities and psychiatric care.

Measures have been implemented to improve quality and security of medical services, patient involvement, and the reduction of errors through quality checks and systematic work procedures.

All services dealing with medication now have educational personnel and health professionals in charge of medicines, with the intent to ensure greater security. Thisted Municipality has focus on management, organisation and network formation to ensure that its goals and quality improvement measures are maintained. The municipality has set a goal of 300 days without medication errors. Results show that many of the municipal services have achieved this goal, and some have reached 900 days.

Case

GOOD COOPERATION BETWEEN HEALTHCARE PERSONNEL AND THE PUBLIC IS ESSENTIAL FOR ACHIEVING GOOD RESULTS FROM SOCIAL PSYCHIATRIC MEASURES

Lyngby-Tårbæk Municipality is making targeted efforts to support recovery, based on the assumption that people with mental illness can recover.

One essential factor for good results from social psychiatric measures is cooperation with the individual service user. This has been a strong focal point for municipalities, using a variety of approaches, such as Open Dialogue and Recovery-based access.

The social psychiatric service, "Slotsvænget" in Lyngby-Tårbæk Municipality uses targeted measures to support recovery. Slotsvænget consists of several social psychiatric services in Lyngby-Tårbæk Municipality for people with mental illness. Services are provided for adults of all ages, who have been diagnosed with schizophrenia, bipolar disorder, personality disorders or psychoses. Residents of Slotsvænget housing services have severe and complex disorders, and some are struggling with heavy substance abuse. Slotsvænget housing services also have a café, a voluntary meal service, and the opportunity to work at a sheltered workshop through the "Flyver Team".

Slotsvænget uses a recovery-based approach, that emphasises the individual's potential for recovery from mental illness. It has therefore developed a number of competencies that support recovery, e.g. through the project "Manage your life" which involves the use of tools and pathways for getting better. This process is known as person-centred planning. In this process, strategies are based on the wishes, dreams and hopes of the resident, helping them develop tools for reaching their goals. The process also requires an understanding of the resident's current needs, as well as their perspectives and experiences.

Phenomena such as auditory hallucinations and self-harm are explored based on the resident's perceptions of them and experiences with them. Efforts are made to create meaning and to help residents to gain as much control as possible.

TABLE 2 An overview of municipal results for selected indicators

CAPITAL REGION	ACUTE SOMATIC READMISSIONS WITHIN 30 DAYS, PCT. [1,2]	ACUTE PSYCHIATRIC READMISSIONS WITHIN 30 DAYS, PCT. [1,4,5,6]	WAITING TIME FOR REHABILITATION, DAYS [2,7,8]	NUMBER OF HOSPITAL DAYS AFTER COMPLETION OF SOMATIC TREATMENT, DAYS [2,9]	NUMBER OF HOSPITAL DAYS AFTER COMPLETION OF PSYCHIATRIC TREATMENT, DAYS [3]	RETENTION OF PHYSICALLY ILL EMPLOYEES IN THE WORKFORCE, PCT. [10]	RETENTION OF MENTALLY ILL EMPLOYEES IN THE WORKFORCE, PCT. [4,6,11]	ACCESS TO EDUCATIONAL SERVICES FOR YOUNG PEOPLE WITH MENTAL ILLNESS [12]	ACUTE HOSPITAL ADMISSIONS PER 1 000 COPD PATIENTS [2,13]	ACUTE HOSPITAL ADMISSIONS PER 1 000 TYPE 2 DIABETES PATIENT [2,13]	PREVENTABLE ADMISSIONS PER 1 000 ELDERLY PATIENTES (65+) [2,13]	SHARE OF CITIZENS WITH DEMENTIA THAT HAVE PURCHASED ANTIPSYCHOTIC MEDICATION, PCT. [6,14]	LIFE EXPECTANCY [*15]	DAILY SMOKERS, PCT. [**16]
ALBERTSLUND	12.8	21.3	18	0.8	0.0	82.0	47.7	-	667.1	420.5	62.2	32.3	80.5	19.2
ALLERØD	10.0	15.8	10	4.8	1.4	87.3	49.7	-	529.6	353.1	53.7	25.6	82.8	9.1
BALLERUP	11.2	31.3	13	0.7	2.9	81.9	51.5	-	622.8	377.1	69.0	22.7	80.2	17.3
BORNHOLM	10.1	18.8	13	0.9	2.9	79.8	46.7	-	483.2	336.4	64.1	29.8	79.5	20.2
BRØNDBY	12.5	26.2	15	42.2	11.0	82.6	55.2	-	684.2	420.1	77.9	24.1	79.5	18.5
DRAGØR	10.5	15.6	13	2.6	1.5	84.9	43.2	-	518.1	360.2	70.7	25.2	81.5	12.2
EGEDAL	10.3	27.0	24	7.5	1.0	83.8	55.3	-	550.7	337.7	50.0	18.4	81.9	12.1
FREDENSBORG	11.7	21.7	14	1.8	0.0	84.8	52.3	-	603.9	420.1	58.8	27.0	81.8	13.5
FREDERIKSBERG	12.0	18.0	5	0.4	1.9	85.1	58.5	-	670.5	444.6	84.7	23.4	80.9	12.6
FREDERIKS-SUND	12.7	21.1	12	3.8	7.2	82.4	52.0	-	705.2	436.8	76.6	24.7	80.1	17.4
FURESØ	10.5	14.8	8	15.0	2.9	85.2	52.8	-	530.7	361.2	58.8	14.0	82.4	13.1
GENTOFTE	9.9	26.8	12	2.7	2.5	83.6	50.6	-	488.2	336.4	60.8	23.1	83.1	11.1
GLADSAXE	11.2	29.1	15	2.7	1.6	85.1	54.0	-	641.9	370.9	70.7	17.9	80.0	16.1
GLOSTRUP	13.0	24.7	12	7.1	0.2	81.3	38.5	-	680.4	424.7	58.3	29.8	80.4	17.3
GRIBSKOV	11.6	19.5	10	14.9	2.6	82.4	51.2	-	631.3	440.3	73.2	27.1	80.6	17.3
HALSNÆS	12.0	21.9	13	5.9	0.1	83.9	53.0	-	709.4	436.4	75.5	24.8	78.9	20.0
HELSINGØR	12.3	27.2	14	4.6	8.0	84.2	49.9	-	593.2	406.7	64.6	25.2	80.4	19.7
HERLEV	11.4	21.8	-	22.6	2.6	83.9	54.4	-	658.2	405.7	75.1	15.9	79.7	15.8
HILLERØD	11.4	26.1	16	7.7	8.5	85.4	57.1	-	646.4	453.7	74.1	20.2	81.5	13.9
HVIDOVRE	13.2	17.0	10	0.8	2.4	83.3	47.2	-	704.2	448.2	83.4	16.2	80.5	16.4
HØJE-TAASTRUP	12.8	26.1	15	5.6	1.9	81.7	61.1	-	716.1	404.8	54.4	21.9	80.1	18.2
HØRSHOLM	11.1	27.3	8	0.2	0.0	86.4	48.1	-	516.0	354.5	53.9	24.8	82.6	9.6
ISHØJ	13.4	17.1	14	1.0	3.3	79.9	49.3	-	718.4	396.4	70.1	21.6	79.5	19.7
KØBENHAVN	12.6	24.2	13	7.2	9.0	82.5	51.9	-	697.9	445.7	88.5	20.3	78.6	17.3
LYNGBY-TAARBÆK	11.6	28.8	12	2.9	0.2	83.7	44.6	-	667.5	368.4	59.9	17.6	82.2	12.3
RUDERSDAL	11.4	23.4	14	0.3	0.3	84.5	53.8	-	479.6	342.1	52.5	21.2	83.1	11.2
RØDOVRE	11.9	14.7	15	16.3	0.8	79.9	49.0	-	601.5	412.7	75.5	24.8	80.0	17.1
TÅRNBY	13.5	19.6	14	11.1	7.1	81.1	52.4	-	611.2	431.4	74.7	21.5	80.0	17.0
VALLENSBÆK	12.2	25.2	14	0.2	0.0	81.3	55.1	-	773.3	444.5	55.7	26.9	81.4	12.2

Development from 2016 to 2017 — 123 — Status as compared to the national average

Continued

CENTRAL DENMARK REGION	ACUTE SOMATIC READMISSIONS WITHIN 30 DAYS, PCT. [1,2]	ACUTE PSYCHIATRIC READMISSIONS WITHIN 30 DAYS, PCT. [1,4,5,6]	WAITING TIME FOR REHABILITATION, DAYS [2,7,8]	NUMBER OF HOSPITAL DAYS AFTER COMPLETION OF SOMATIC TREATMENT, DAYS [2,9]	NUMBER OF HOSPITAL DAYS AFTER COMPLETION OF PSYCHIATRIC TREATMENT, DAYS [3]	RETENTION OF PHYSICALLY ILL EMPLOYEES IN THE WORKFORCE, PCT. [10]	RETENTION OF MENTALLY ILL EMPLOYEES IN THE WORKFORCE, PCT. [4,6,11]	ACCESS TO EDUCATIONAL SERVICES FOR YOUNG PEOPLE WITH MENTAL ILLNESS [12]	ACUTE HOSPITAL ADMISSIONS PER 1 000 TYPE 2 DIABETES PATIENT [2,13]	ACUTE HOSPITAL ADMISSIONS PER 1 000 COPD PATIENTS [2,13]	PREVENTABLE ADMISSIONS PER 1 000 ELDERLY PATIENTES (65+) [2,13]	SHARE OF CITIZENS WITH DEMENTIA THAT HAVE PURCHASED ANTIPSYCHOTIC MEDICATION, PCT. [6,14]	LIFE EXPECTANCY [*15]	DAILY SMOKERS, PCT. [**16]
FAVRSKOV	11.8	25.8	9	0.9	0.0	84.2	57.1	-	510.8	386.7	49.6	23.9	81.7	14.5
HEDENSTED	11.2	15.3	11	0.2	0.0	81.9	44.8	-	504.2	336.3	59.1	18.4	81.3	17.6
HERNING	12.2	15.8	10	3.7	2.9	78.0	50.1	-	455.7	308.9	51.1	20.9	81.1	15.7
HOLSTEBRO	12.7	22.4	14	0.1	1.5	80.0	38.5	-	563.9	334.5	63.0	25.4	81.1	14.8
HORSENS	12.6	26.0	14	0.8	3.8	79.4	48.8	-	644.0	398.2	75.4	15.1	81.0	19.6
IKAST-BRANDE	12.2	15.9	13	0.7	0.0	73.2	44.3	-	463.3	350.7	60.3	18.0	81.2	17.2
LEMVIG	12.9	19.1	9	0.5	0.0	77.7	-	-	494.2	331.8	57.0	26.0	80.5	18.0
NORDDJURS	11.7	23.4	13	0.0	0.2	76.5	39.7	-	506.8	381.9	46.1	20.8	79.5	19.7
ODDER	11.1	10.3	13	2.4	3.5	81.0	55.1	-	568.0	356.7	56.7	19.3	81.6	16.0
RANDERS	12.6	18.8	12	0.2	5.8	79.1	45.7	-	608.2	425.7	59.3	20.0	79.8	17.8
RINGKØBING-SKJERN	11.9	8.3	11	1.5	0.0	79.0	43.4	-	477.9	320.5	44.8	23.2	81.2	17.1
SAMSØ	8.4	-	10	3.2	0.0	77.4	-	-	454.1	417.9	42.6	- 18.8	-	18.1
SILKEBORG	11.7	17.2	12	1.2	0.6	79.6	38.7	-	573.5	379.8	49.1	18.2	81.3	15.5
SKANDERBORG	11.2	13.0	13	0.5	1.6	80.7	39.2	-	473.4	326.0	63.1	13.7	82.1	13.3
SKIVE	14.3	14.7	14	0.4	0.0	79.8	44.5	-	590.8	415.4	35.6	20.1	80.7	17.6
STRUER	12.8	20.0	12	4.9	3.8	78.1	24.2	-	459.0	378.4	54.9	22.5	81.1	16.7
SYDDJURS	12.0	16.9	11	1.4	0.4	78.8	40.2	-	495.4	339.7	50.5	21.5	81.3	17.8
VIBORG	13.5	24.9	14	0.3	11.4	81.3	46.2	-	620.5	417.6	35.9	19.6	81.5	16.6
AARHUS	10.5	31.4	15	5.3	10.7	79.4	47.9	-	484.6	312.6	60.3	17.6	81.2	12.8

Development from 2016 to 2017 — 123 — Status as compared to the national average

Continued

SOUTHERN DENMARK REGION	ACUTE SOMATIC READMISSIONS WITHIN 30 DAYS, PCT. [1,2]	ACUTE PSYCHIATRIC READMISSIONS WITHIN 30 DAYS, PCT. [1,4,5,6]	WAITING TIME FOR REHABILITATION, DAYS [2,7,8]	NUMBER OF HOSPITAL DAYS AFTER COMPLETION OF SOMATIC TREATMENT, DAYS [2,9]	NUMBER OF HOSPITAL DAYS AFTER COMPLETION OF PSYCHIATRIC TREATMENT, DAYS [3]	RETENTION OF PHYSICALLY ILL EMPLOYEES IN THE WORKFORCE, PCT. [10]	RETENTION OF MENTALLY ILL EMPLOYEES IN THE WORKFORCE, PCT. [4,6,11]	ACCESS TO EDUCATIONAL SERVICES FOR YOUNG PEOPLE WITH MENTAL ILLNESS [12]	ACUTE HOSPITAL ADMISSIONS PER 1 000 TYPE 2 DIABETES PATIENT [2,13]	ACUTE HOSPITAL ADMISSIONS PER 1 000 COPD PATIENTS [2,13]	PREVENTABLE ADMISSIONS PER 1 000 ELDERLY PATIENTES (65+) [2,13]	SHARE OF CITIZENS WITH DEMENTIA THAT HAVE PURCHASED ANTIPSYCHOTIC MEDICATION, PCT. [6,14]	LIFE EXPECTANCY [*15]	DAILY SMOKERS, PCT. [**16]
ASSENS	10.5	21.2	12	7.0	0.5	76.1	57.6	-	364.0	230.0	53.5	12.6	80.8	20.5
BILLUND	10.5	13.7	17	1.4	0.0	82.4	57.4	-	465.9	293.8	48.4	16.0	80.9	18.0
ESBJERG	12.1	25.2	13	5.1	2.5	81.5	49.2	-	507.1	315.9	46.0	19.4	80.2	19.0
FANØ	13.3	-	13	0.6	0.6	78.5	-	-	408.7	221.2	58.4	-	-	17.0
FREDERICIA	11.6	25.6	13	0.2	0.1	82.0	42.6	-	460.2	321.1	38.7	15.4	80.3	20.1
FAABORG-MIDTFYN	9.8	21.7	13	3.1	0.1	76.6	46.9	-	401.2	237.4	45.5	13.9	80.7	18.0
HADERSLEV	11.1	23.4	12	3.4	4.7	79.3	47.0	-	493.3	334.3	54.4	24.2	81.2	21.8
KERTEMINDE	9.2	30.5	13	2.6	0.0	84.8	52.2	-	449.7	332.8	50.2	16.9	81.4	20.6
KOLDING	11.8	20.7	12	0.8	1.2	77.6	45.2	-	474.2	347.9	30.8	16.2	80.7	18.0
LANGELAND	9.2	15.5	17	2.9	2.8	79.7	33.7	-	385.3	270.4	56.7	16.4	79.8	23.8
MIDDELFART	10.7	24.8	16	1.1	1.9	77.2	41.1	-	469.3	294.1	33.3	14.9	80.7	18.5
NORDFYNS	9.8	21.5	14	1.0	0.0	75.7	50.1	-	377.0	229.8	53.9	15.0	80.6	20.0
NYBORG	11.1	22.4	5	7.9	0.2	78.3	41.3	-	366.0	261.0	54.2	11.7	80.6	20.2
ODENSE	10.3	21.4	14	0.7	1.0	78.3	50.7	-	396.4	243.9	55.9	16.7	80.6	16.7
SVENDBORG	10.1	25.4	14	5.6	5.8	75.6	54.8	-	398.1	288.3	54.4	24.2	80.9	18.5
SØNDERBORG	11.7	25.7	11	1.6	2.8	80.8	41.8	-	495.0	325.2	58.1	25.8	81	18.5
TØNDER	10.2	14.3	21	1.5	2.4	75.9	30.7	-	436.2	279.7	51.4	34.2	80.4	20.1
VARDE	10.8	15.3	10	1.7	2.1	80.4	43.8	-	389.4	264.0	32.1	20.4	81.8	18.5
VEJEN	10.4	15.2	11	0.0	0.2	78.1	57.1	-	461.0	306.3	32.6	18.8	81.1	20.7
VEJLE	11.0	25.7	20	1.4	0.8	83.0	44.4	-	522.1	322.6	51.1	14.5	80.8	16.5
ÆRØ	10.2	-	7	0.5	0.0	71.1	-	-	517.1	277.8	57.2	15.9	-	23.7
AABENRAA	12.3	16.0	15	3.0	0.8	81.5	62.5	-	567.6	312.2	51.5	30.4	80.4	19.3

Continued

ZEALAND REGION	ACUTE SOMATIC READMISSIONS WITHIN 30 DAYS, PCT. [1,2]	ACUTE PSYCHIATRIC READMISSIONS WITHIN 30 DAYS, PCT. [1,4,5,6]	WAITING TIME FOR REHABILITATION, DAYS [2,7,8]	NUMBER OF HOSPITAL DAYS AFTER COMPLETION OF SOMATIC TREATMENT, DAYS [2,9]	NUMBER OF HOSPITAL DAYS AFTER COMPLETION OF PSYCHIATRIC TREATMENT, DAYS [3]	RETENTION OF PHYSICALLY ILL EMPLOYEES IN THE WORKFORCE, PCT. [10]	RETENTION OF MENTALLY ILL EMPLOYEES IN THE WORKFORCE, PCT. [4,6,11]	ACCESS TO EDUCATIONAL SERVICES FOR YOUNG PEOPLE WITH MENTAL ILLNESS [12]	ACUTE HOSPITAL ADMISSIONS PER 1 000 COPD PATIENTS [2,13]	ACUTE HOSPITAL ADMISSIONS PER 1 000 TYPE 2 DIABETES PATIENT [2,13]	PREVENTABLE ADMISSIONS PER 1 000 ELDERLY PATIENTES (65+) [2,13]	SHARE OF CITIZENS WITH DEMENTIA THAT HAVE PURCHASED ANTIPSYCHOTIC MEDICATION, PCT. [6,14]	LIFE EXPECTANCY [*15]	DAILY SMOKERS, PCT. [**16]
FAXE	12.0	22.7	6	1.0	1.0	81.8	48.5	-	564.6	413.2	57.8	16.3	79.8	18.2
GREVE	13.2	13.5	11	2.4	0.9	82.9	38.9	-	601.8	354.4	61.1	13.7	81.1	14.8
GULDBORG-SUND	12.2	16.9	11	2.2	2.7	79.7	46.2	-	606.4	426.1	61.4	15.7	78.9	21.0
HOLBÆK	11.8	22.7	8	4.5	3.2	81.4	48.3	-	577.4	394.0	69.6	15.5	80.5	18.6
KALUNDBORG	11.0	16.1	10	1.9	5.0	81.4	51.3	-	613.6	360.2	64.3	18.9	79.9	21.6
KØGE	11.5	16.4	8	13.3	0.6	82.7	48.5	-	568.1	368.0	70.5	18.0	80.7	15.0
LEJRE	10.4	11.0	9	2.1	3.2	80.3	54.8	-	626.7	353.0	64.0	11.4	81.8	13.5
LOLLAND	12.7	17.6	12	0.9	0.1	77.5	45.8	-	662.7	407.8	67.8	19.4	77.4	22.8
NÆSTVED	11.9	18.1	12	1.4	0.8	81.0	53.1	-	628.6	411.6	68.5	15.8	79.8	16.5
ODSHERRED	11.3	21.8	16	4.4	3.0	79.9	46.6	-	532.9	365.6	68.0	15.4	79.2	22.5
RINGSTED	13.0	11.6	7	0.9	1.1	79.6	46.6	-	536.3	386.9	64.2	24.1	80.1	18.5
ROSKILDE	11.7	23.9	10	0.4	27.7	82.5	53.5	-	591.7	387.7	68.9	10.1	81.0	15.3
SLAGELSE	12.9	18.0	-	3.4	9.9	81.1	57.3	-	630.3	424.8	65.6	17.9	79.2	20.8
SOLRØD	10.6	10.7	8	4.7	0.0	82.9	42.9	-	531.4	321.4	56.1	11.4	81.7	13.2
SORØ	11.0	30.7	12	0.8	0.3	77.7	53.0	-	636.5	402.7	60.0	19.0	79.3	17.7
STEVNS	11.7	19.0	14	4.4	0.0	81.6	67.9	-	509.8	384.4	62.4	16.5	80.6	20.3
VORDINGBORG	12.6	26.6	8	5.2	1.7	79.5	53.7	-	585.1	391.8	56.5	17.1	78.7	20.7

Development from 2016 to 2017 — 123 — Status as compared to the national average

Continued

NOTHERN DENMARK REGION	ACUTE SOMATIC READMISSIONS WITHIN 30 DAYS, PCT. [1,2]	ACUTE PSYCHIATRIC READMISSIONS WITHIN 30 DAYS, PCT. [1,4,5,6]	WAITING TIME FOR REHABILITATION, DAYS [2,7,8]	NUMBER OF HOSPITAL DAYS AFTER COMPLETION OF SOMATIC TREATMENT, DAYS [2,9]	NUMBER OF HOSPITAL DAYS AFTER COMPLETION OF PSYCHIATRIC TREATMENT, DAYS [3]	RETENTION OF PHYSICALLY ILL EMPLOYEES IN THE WORKFORCE, PCT. [10]	RETENTION OF MENTALLY ILL EMPLOYEES IN THE WORKFORCE, PCT. [4,6,11]	ACCESS TO EDUCATIONAL SERVICES FOR YOUNG PEOPLE WITH MENTAL ILLNESS [12]	ACUTE HOSPITAL ADMISSIONS PER 1 000 COPD PATIENTS [2,13]	ACUTE HOSPITAL ADMISSIONS PER 1 000 TYPE 2 DIABETES PATIENT [2,13]	PREVENTABLE ADMISSIONS PER 1 000 ELDERLY PATIENTES (65+) [2,13]	SHARE OF CITIZENS WITH DEMENTIA THAT HAVE PURCHASED ANTIPSYCHOTIC MEDICATION, PCT. [6,14]	LIFE EXPECTANCY [*15]	DAILY SMOKERS, PCT. [**16]
BRØNDERSLEV	11.9	12.7	13	3.9	2.3	77.4	44.2	-	462.8	263.8	53.5	10.0	80.6	17.6
FREDERIKSHAVN	10.8	14.2	11	0.1	2.1	76.6	42.1	-	428.0	298.8	58.0	18.9	80.0	19.4
HJØRRING	11.3	13.3	6	1.0	4.9	78.9	47.0	-	460.6	293.5	56.4	13.7	81.2	17.1
JAMMERBUGT	10.5	15.7	20	7.3	0.5	77.8	29.6	-	516.9	302.3	57.8	17.9	80.7	18.4
LÆSØ	11.2	-	5	0.0	0.0	49.6	-	-	373.7	212.6	28.8	-	-	20.4
MARIAGERFJORD	10.5	15.2	12	1.9	4.1	77.9	49.9	-	482.5	285.8	42.3	17.1	80.1	17.6
MORSØ	10.8	27.5	17	0.4	0.0	77.8	27.9	-	602.0	360.6	69.9	12.6	79.8	19.1
REBILD	10.6	6.6	7	0.6	4.7	81.5	27.4	-	518.3	313.8	45.0	12.7	80.8	14.7
THISTED	11.1	16.1	14	0.0	2.0	78.4	28.9	-	626.8	426.9	82.4	15.1	79.8	17.1
VESTHIMMERLANDS	11.2	13.7	9	0.4	1.1	77.1	41.5	-	426.3	305.3	40.6	15.4	80.6	17.3
AALBORG	10.2	15.8	16	1.7	6.0	77.2	47.1	-	422.2	276.1	37.9	12.9	80.5	15.6
HELE LANDET	11.6	22.3	12	3.6	4.1	80.9	49.9	-	547.2	356.7	59.0	19.2	80.6	16.9

Source: Sundhedsdatastyrelsen. *Danmarks Statistik **Den Nationale Sundhedsprofil.

Comments:
The National Health Data Programme has initiated a project to develop a better presentation of the indicators included in the National Goals for Healthcare Services. This project involves an extensive review and technical restructuring of the indicators, which may potentially uncover discrepancies in the data. Through their management, the indicator values may be revised and altered.

The colour markers are based on number of decimates given in the overview.

1. New definition of indicator, cf. box, page 7..
2. Implementation of the Healthcare Platform in the Capital Region in May 2016, and in the Zealand Region in November 2017 may also have influenced the data.
3. Implementation of the Healthcare Platform in the Capital Region in May 2017, and in the Zealand Region in November 2017 may also have influenced the data.
4. If there are fewer than 20 observations in the indicator, or fewer than 5 observations in the counter, the rate is not counted.
5. These figures are not standardised, as there are too few observations.
6. These figures are generally associated with a relatively high statistical uncertainty.
7. It has been noted that municipalities have experienced challenges in reporting due to poor data delivery from the system provider. The determined waiting time must therefore be interpreted with caution. This is especially true at the municipal level.
8. Waiting time for municipalities with fewer than 20 rehabilitation trajectories are not given due to statistical uncertainty.
9. The 2016 figures for the Capital Region and its municipalities must be interpreted with great caution, as the number of days in hospital per patient were not reported by Herlev and Gentofte hospitals for June and July 2016, due to the implementation of the Healthcare Platform. The report rate for August 2016 was also very low.
10. Implementation of the Healthcare Platform in the Capital Region in May 2016 may also have influenced the data.
11. The rates are given as 4-year rates as there were few observations, (2013-2016)
12. Under development - possible links to the workforce indicator will be explored.
13. The introduction of the joint urgent care centres has resulted in a continuous restructuring of registrations, where patients who are admitted to and treated at urgent care centres are reported to the Danish National Patient Registry as acute ambulatory contacts, and are therefore not included in the indicator data. This could indicate an underestimation of the number of admissions, which would affect opportunities for comparison over time and between regions or municipalities.
14. Figures for municipalities with fewer than 20 citizens with dementia, or fewer than 5 citizens that have been dispensed antipsychotic medications are not given, due to statistical uncertainty.
15. Average life expectancy for 0-year olds in Ærø, Samsø, Fanø and Læsø municipalities are not given in the table, as the statistics are too uncertain due to the size of the municipalities.
16. Trend from 2013 to 2017.

Development from 2016 to 2017 — 123 — Status as compared to the national average

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