Appendix 1

ANGUS
Health & Social Care
Partnership

ANGUS HEALTH AND SOCIAL CARE PARTNERSHIP

PERFORMANCE REPORT

2016/17 Quarter 3 Performance Report

April 2017

Angus Health and Social Care Partnership

Performance Report 2016/17 Quarter 3

Introduction

The purpose of this Quarter 3 2016/17 performance report is to show progress against the four priorities set out in the Angus Health and Social Care Partnership's strategic plan and three performance areas. These are:

Priority 1	Improving health, wellbeing and independence	Page 5
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Priority 3	Developing integrated and enhanced primary care and community responses	Page 22
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The information aims to set out what has been achieved in relation to delivery of the strategic plan; what is to be delivered next and how the delivery of the strategic plan is impacted on the performance of the organisation. Performance is shown by locality where possible in order that locality improvement groups can focus on addressing variance in performance and continuous improvement.

Demographic change is beginning to be felt in some indicators. The total number of people over 65 living in Angus has not changed over the last 5 years. However, the number of people aged 75+ has increased by over 1,000 and the number of people between 65 and 74 has decreased by over 1,000. This, in part, contributes to some of the increase in hospital activity as a rate of the adult population.

Data explanatory note: where health information has been extracted from a different source other than the ISD Source team there are some minor discrepancies between the ISD published and non-ISD published health information. All non-published information, such as health information shown by localities, should therefore be treated with caution. Social care information has been extracted from Care First, there have been some data anomalies and data quality issues which are being addressed to improve the quality of the performance information.

Overall Locality Performance

- Most improved locality for the majority of national core indicators is the South East, both in terms of its position across a number of performance indicators and in overall performance against 2015/16 (see table 2).

- Only West Dunbartonshire, Renfrewshire and Clackmannanshire have a higher proportion than Angus of all its care services (Care Homes, Care at Home, Day Care etc) graded as good or better by the Care inspectorate in Scotland as at 2015/16.

- Angus performs well nationally in relation to premature mortality rates; emergency admission rates; emergency bed day rate;, last 6 months of life spent at home or in a community setting; falls leading to an emergency admission and delayed discharges. The good performance in relation to these indicators shows the progress the partnership has made in addressing timely discharge and shifting the balance of care to more community based and responsive services.

- Angus performs above the Scottish average in relation to the percentage of time that people spend at home or in a community setting in the last 6 months. At 90% this is an improved performance area against previous years.

- Progress has been made in addressing hospital bed occupancy as Angus has seen a continuing decrease in the bed day rates.

- Enhanced Community Support (ECS), managing delays in timely discharge and increasing levels of personal care have contributed to a reduction in bed days lost to delayed discharges for people aged 75+.

- Readmissions within 28 days of discharge have increased for Angus as a whole; this increasing readmission rate contributes to the increase in all emergency admissions. The largest increase in readmissions is in the South West locality. The North East has also seen increasing readmissions for the first time in quarter 3 of 2016/17. North West and South East continue to see improvements in their rates of readmissions.

- A high proportion (89%) of users of care, rate the services as excellent or good.

- Targets for further improvement have been established in relation to:

    - Attendance at A and E
    - Admissions from A and E
    - Hospital bed day rate
    - Rate of bed days lost due to delays in discharge
    - Rate of bed days lost due to complex delays in discharge (code 9)

  These targets are shown in this performance report as a trajectory over time against the current expected projection for that same period. Given the changes in the proportion of older people in the community a trajectory which follows exactly the projection, based on the current population, may be challenging to meet. The trajectories are the first attempt to set targets based on the data that has been developed. It is anticipated that the trajectories will be refined and improved as data availability continues to improve.

Angus' Ranked Performance in 2015/16

The tables below show the summary of Angus performance in relation to the Scottish performance across a range of national indicators.

G	Angus is performing well against the Scottish average
A	Angus rate is approximately the same as the Scottish average
R	Angus has greater room for improvement against the Scottish average

Table 1: Angus' Ranked Performance for national indicators 2015/16

National Indicators	2015/16
11. Premature mortality	G
12. Emergency Admissions	G
13. Emergency Bed Days	G
14. Re-admissions after 28 days	R
15. Last 6 months of life at home	G
16. Falls ending in admission	G
17. Care Inspectorate grades	G
18. Intensive Needs at home*	R
19. Delayed Discharges	G
20. Spend on emergency admissions	R

* definition of indicator is changing

National data for 2016/17 is not available yet

Locality Performance in 2016/17 Quarter 3 against baseline year 2015/16

< 0%	2016/17 Quarter 3 performance has improved against baseline 15/16 rate
< +1%	2016/17 Quarter 3 performance is approximately the same as the baseline 15/16 rate
> +1%	2016/17 Quarter 3 performance has declined against the baseline 15/16 rate

Table 2: Percentage change in 2016/17 Quarter 3 against 15/16

National Indicator	Angus	North East	North West	South East	South West
12.EmergencyAdmissions	+3.9%	+5.0%	+3.2%	+2.1%	+5.7%
13.Emergency Bed Days	-3.0%	-1.0%	-3.6%	-7.7%	+0.9%
14. Re-admissions after 28 days	+1.2%	+2.3%	-2.5%	-9.4%	+18.9%
16. Falls ending in admission	+0.6%	+12.4%	+6.0%	-2.3%	-12.1%
19. Delayed Discharges	-2.5%	-22.6%	+20.3%	+37.3%	-36.3%

Priority 1: Improving Health, Wellbeing and Independence

The aim of the Angus Health and Social Care Partnership's strategic plan is to progress approaches that support individuals to live longer and healthier lives. This includes having access to information and natural supports within communities. AHSCP's focus is on health improvement and disease prevention including addressing health inequalities; building capacity within our communities; supporting carers and supporting the self-management of long term conditions. There are health inequalities in Angus which were identified in the Joint Strategic Needs Assessment. We are working with public health to determine appropriate measures which provide evidence in relation to health equity and the impact of services across Angus. This will include ensuring that data from primary providers is available so that we can see performance in the most and least deprived areas of Angus against the Angus average performance. Addressing performance variation will go some way to begin to address health inequalities.

1.1 What we have achieved to date

- Delivered a programme to support self-management of long term conditions
- Developed peer support groups for long term conditions
- Progressed a review of out of hours services, this has identified and proposed an outline plan for transforming unscheduled care and a new model of service provision based in line with national transformation plans.
- Developed a primary care transformation programme
- Increased uptake of community alarm services and the range of peripherals available
- Supported Voluntary Action Angus and other third sector organisations financially to develop and deliver community based services to support adults with health and social care needs. Each locality has a Voluntary sector single point of contact officer supporting and signposting communities. These officers also work within multi-disciplinary teams supporting options for social prescribing.
- Developed ALISS, a web based community information system. Progress has been made in making information available about the range of opportunities for voluntary support in Angus. Information on most organisations can now be found on ALISS (a local information system for Scotland).
- Provided resources to Angus Carers Association to develop a carers support worker in each locality. This worker works within the multi-disciplinary teams to identify carers and provide advice and support. A range of supports are put in place following an assessment of carers needs, this includes daytime short breaks and overnight breaks.
- Addressed drug and alcohol use through the Angus Alcohol and Drug Partnership.
- Developed Independent Living Angus, a web based self-referral and assessment tool to support access to information and advice on equipment to support daily living. This is also used by the first contact service to support

individuals to access some equipment from the equipment store without the need for assessment by occupational therapy.

1.2 What we plan to do next

- Plans around the use of technology enabled care to support self-management of long term conditions and people with multi-morbidities are testing telehealth opportunities to support people to live at home for as long as possible.

- Further develop the application of Independent Living Angus as part of the review of first contact arrangements. This will include consideration of how to provide advice and support for self-management of long term conditions through Independent Living Angus

- Develop an improvement plan to address the falls admission rate in Angus. Supported by public health, the improvement plan is identifying areas of best practice across Scotland and will incorporate a review of the Angus falls services.

- Continue to roll out programmes to support self-management of long term conditions

- Develop new arrangements for respite for people with learning disabilities

1.3 How we monitor progress

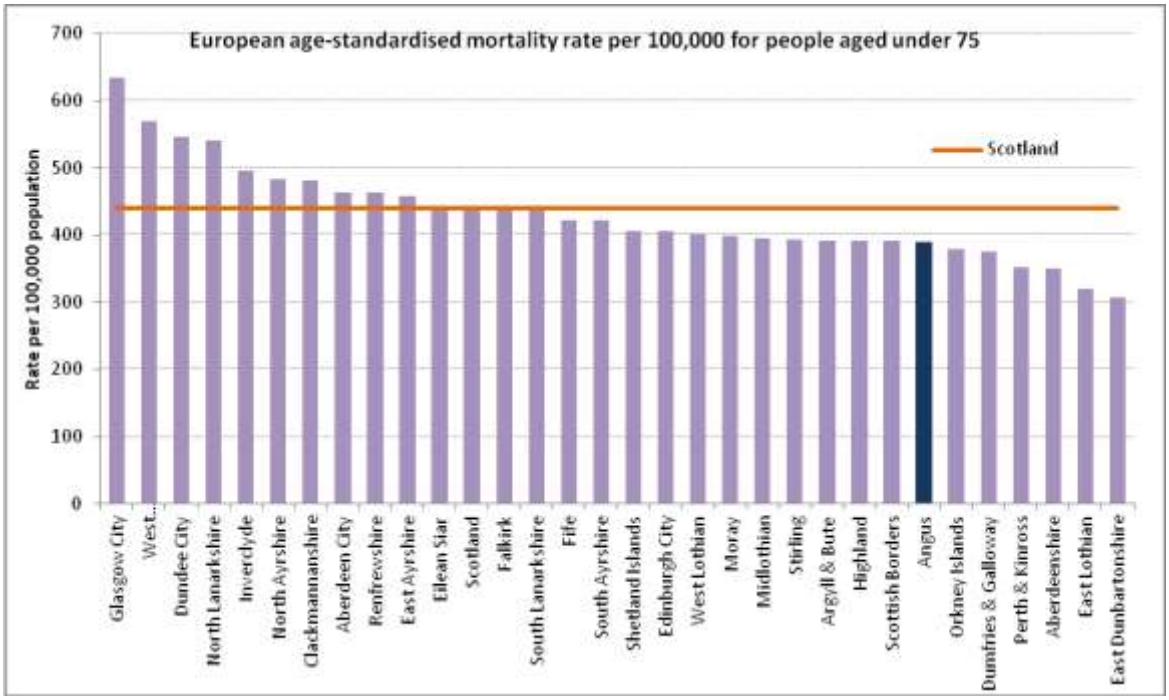
Progress is monitored through the following national and local performance measures:

Premature mortality

1.3.1 Angus is consistently below the Scottish average in relation to premature mortality rates. As at 2015, Angus is the 7th lowest ranked partnership for premature deaths with 391 per 100,000 population.

Graph 1 National Indicator 11: Premature Mortality Rate

Latest National Position as at Calendar Year 2015



Source: Source (ISD Scotland)

Volunteering

1.3.2 Angus continues to have high levels of volunteering. Voluntary Action Angus are supporting the development of voluntary organisations and volunteering across Angus. The capacity of communities to care is a focus of the work. In 2015/16 there were 902 voluntary organisations working and supporting communities in Angus. There were 6,017 adults volunteering in Angus, a volunteering rate of 65.5 adults per 1,000 adult populations. As yet this cannot be benchmarked nationally.

Carers

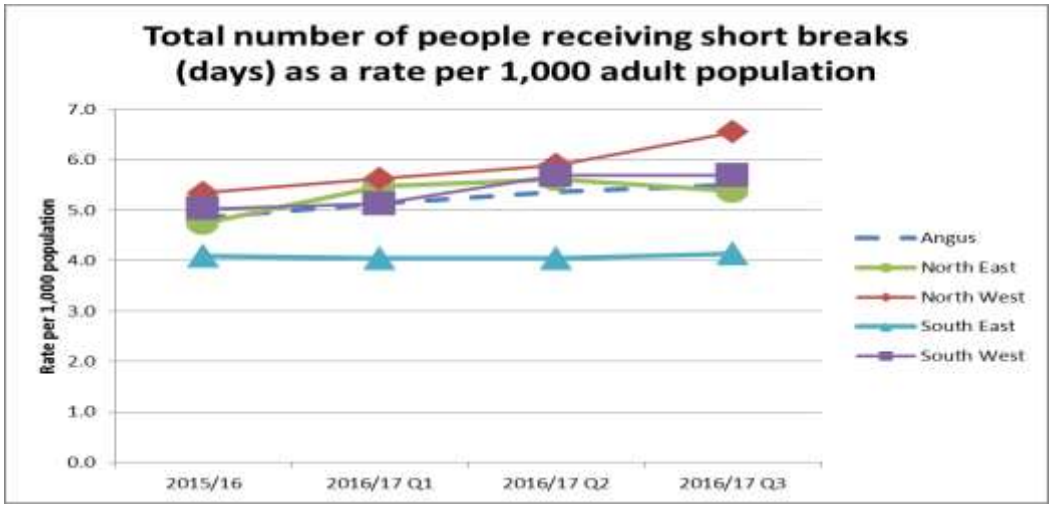
1.3.3 Angus performance in relation to carers feeling supported to continue their caring role is marginally less than the Scottish average. There is an improving picture of the number of carers that have been identified in Angus and the number of carers support plans that have been put in place. In 2015/16, Angus Carers:

- provided 1,621 carers with one to one support,
- developed 178 new carers support plans and 81 reviews with carers aged over 50 years old
- achieved a total of 363 support plans in place with carers aged over 50 years

1.3.4 There is an increase in the number of carers accessing short breaks. This is related to the development of a carers assessment which then offers the self-directed support options providing carers with greater flexibility about what

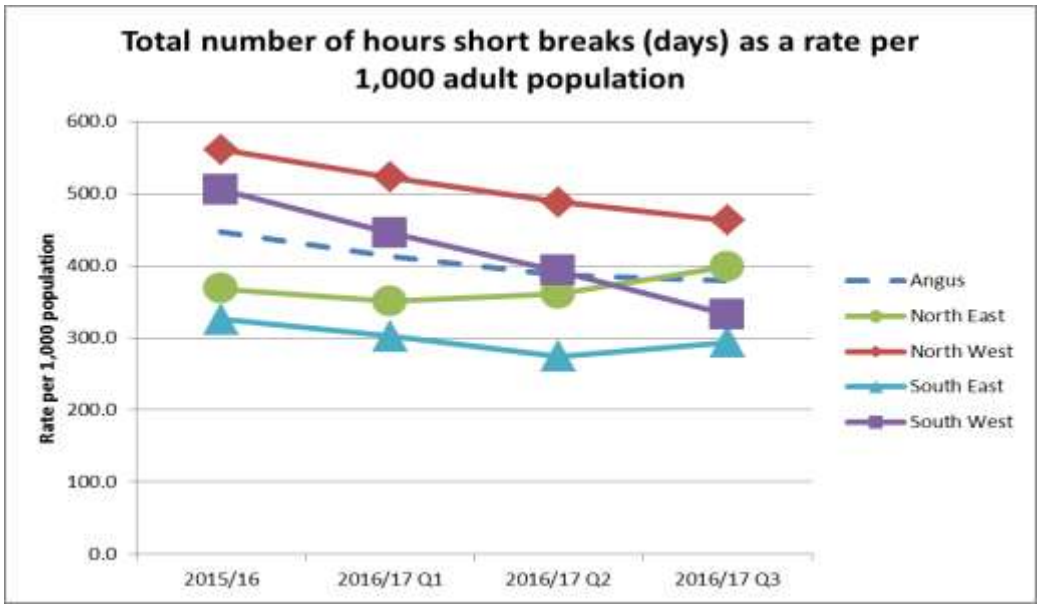
types of services they choose and how they are delivered. Following the introduction of self-directed support there has been a shift away from the use of day care with carers using shorter breaks at home rather than day care to support their respite needs. Total day respite hours have therefore reduced. There is a wide variation in day time respite between localities with the North West supporting the most people with day time respite and the most number of hours

Graph 2: Management Information at Locality Level - Rate of people using short breaks



Source: Care First (Angus Council)

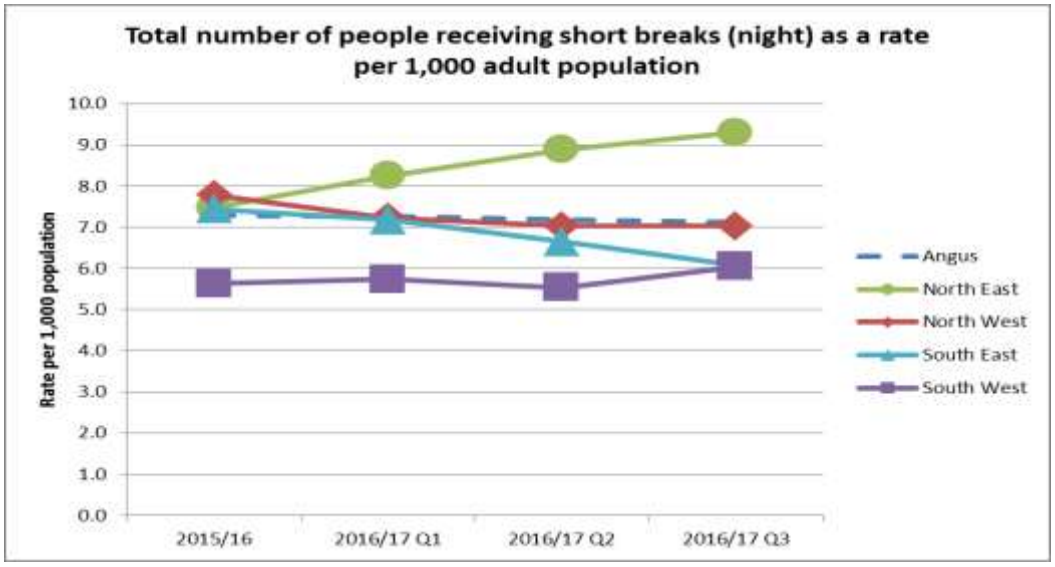
Graph 3: Management Information at Locality - Rate of short breaks (daytime hours)



Source: Care First (Angus Council)

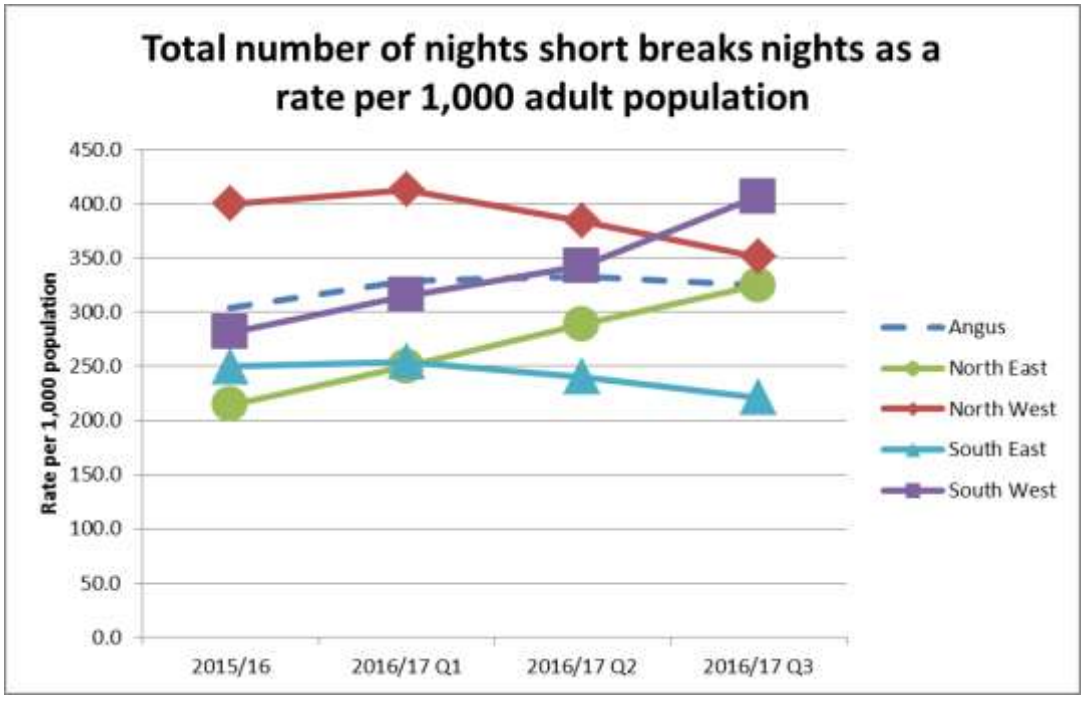
1.3.5 There continues to be a similar rate of provision for short break nights and number of carers accessing this support although variation between localities is increasing, with North East locality supporting more people with respite and providing more nights respite .

Graph 4: Management Information at Locality Level - Rate of people using short breaks (nights)



Source: Care First(Angus Council)

Graph 5: Management Information at Locality Level - Rate of short breaks nights

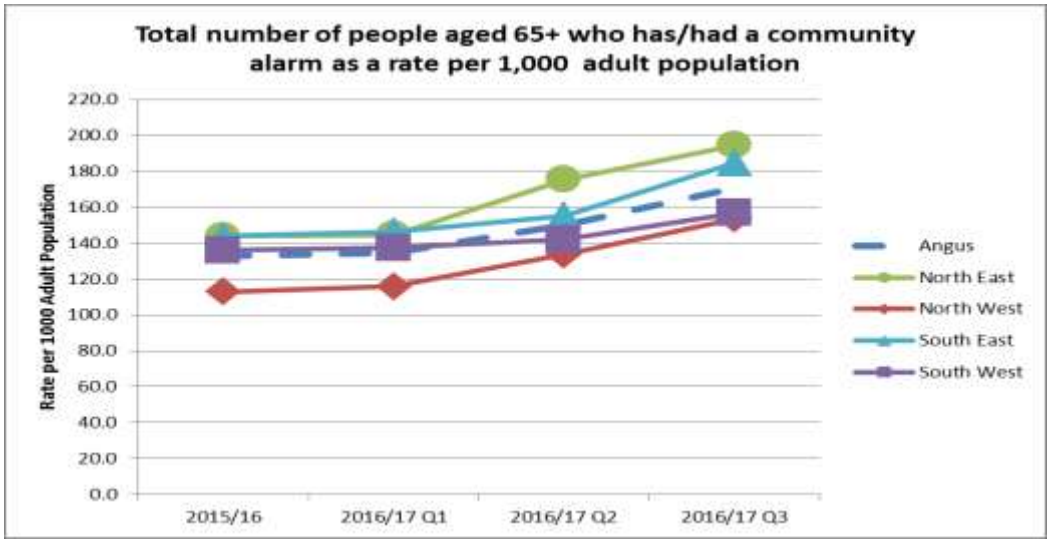


Source: Care First(Angus Council)

Community Alarm

1.3.6 Installation of community alarms has risen since 2015/16. This shows the progress in our aim to improve tele-enabled care. The range of available peripherals to the system has also increased e.g. GPS monitors, Tru-call, call blocking system.

Graph 6: Management Information at Locality Level - Rate of community alarm use



Source: Care First(Angus Council)

Enablement

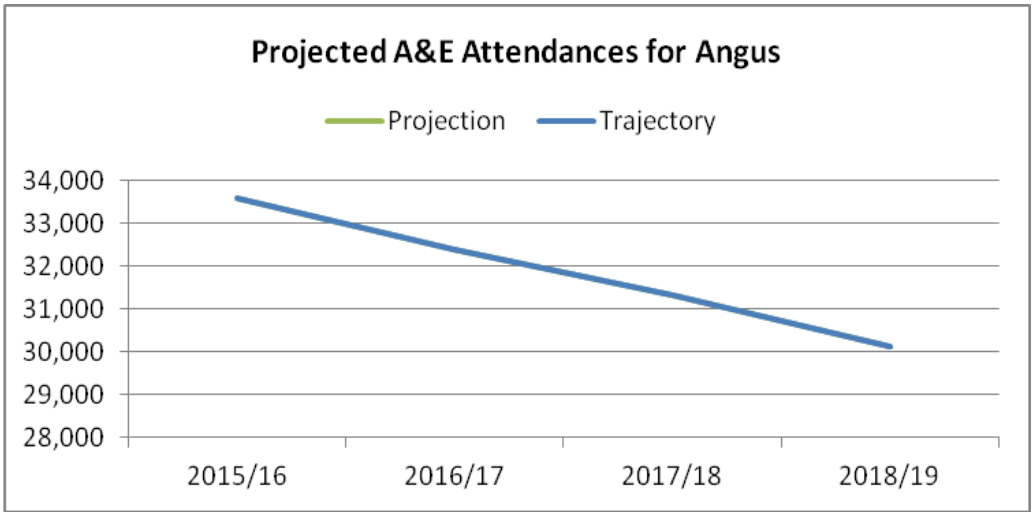
1.3.7 All new referrals for a social care service, where eligible needs exist, are supported by a period of enablement lasting between four to six weeks. Enablement services have been successful in returning individuals to full independence. Currently 52% of people who are over 65 years require no further services following a period of enablement. The success rate has reduced over the past 3 years, partly due to individuals having repeated enablement referrals. Individuals using enablement in 2015/16 are much more likely to have had previous successful enablement contacts. There are people who require ongoing services but cannot be discharged from enablement due to a shortage of long term personal care services in all localities. This is being addressed through the Help to Live at Home programme. Due to changes in operational procedures we are currently unable to show enablement performance into 2016/17.

Accident and Emergency

1.3.8 An Accident and Emergency Performance indicator is not included in the national core data set for integration therefore we have not developed locality information in this area. The Scottish Government have asked for projected performance in this area. We do know that there has been a deceasing trend in the Angus population in relation to attendance at A & E. We expect this trend to continue. Following an attendance at A & E the proportion of people who require to be admitted is increasing; we expect this trend to continue as people use emergency departments and minor injuries units (MIUs). There is a planned approach to reviewing the future provision of MIIU services in Angus. An option appraisal will be developed in consultation with localities.

1.3.9 The aim is to continue to reduce A&E attendances in line with the current projection. In the graph below the projection is therefore the same as the trajectory.

Graph 7: Projected A&E Attendances



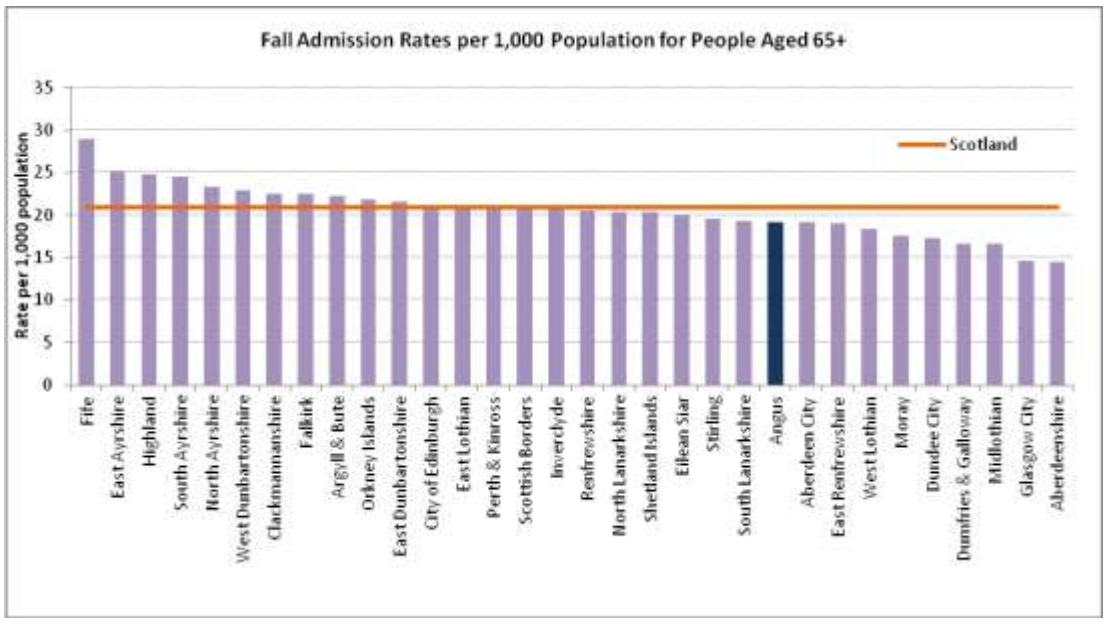
Source: Angus Trajectories for Developing Local Improvement Plans

Admissions following a fall

1.3.10 In 2015/16 the rate of fall admissions in Angus is 19.2 per 1,000 population which is just below the Scottish rate of 21 per 1,000 population. The level of falls in our community do contribute to hospital admissions and place ongoing pressure on services as individuals are more likely to need ongoing health and social care support.

Graph 8: National Indictor 16 – Fall admission rates per 1,000 population in over 65s

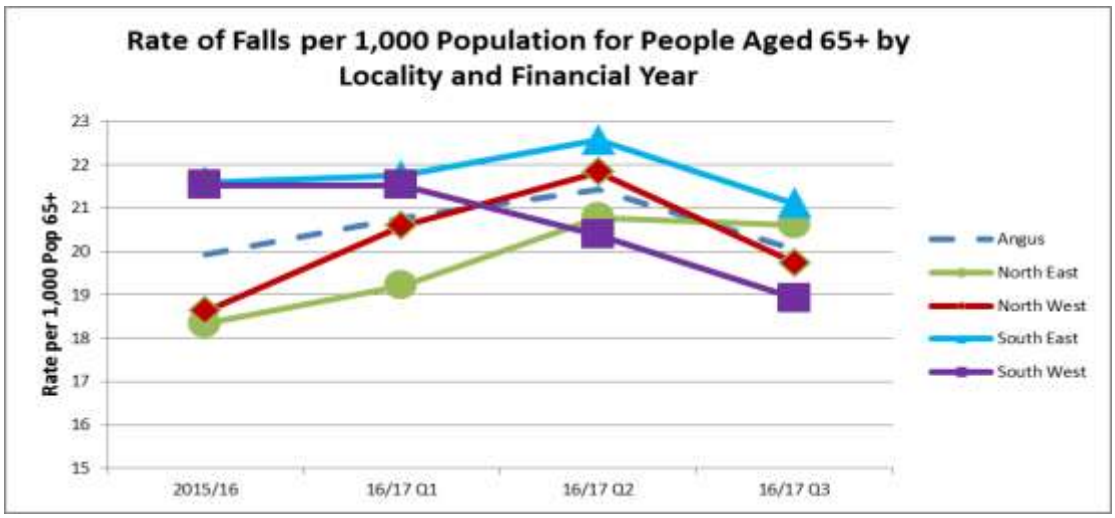
Latest National Position as at 2015/16



Source: Source (ISD Scotland)

1.3.11 In quarter 3 of 2016/17 the rate of fall admissions per 1,000 population aged 65+ are highest in the South East and North East. The South West saw the biggest decrease between 2015/16 and quarter 3 in 2016/17. The reason for this recent improvement in the South West is not known and requires to be reviewed in order that any improvement opportunities can be shared across Angus.

Graph 9: Management Information at Locality Level - Rate of fall admissions per 1,000 population for people aged 65+



Source: SMRA Inpatient Dataset (for management information purposes and are not national statistics)

Priority 2: Supporting care needs at Home

The Joint Strategic Needs Assessment identifies that the population of Angus is growing older and that the population of Angus will continue to age for the next 20 years. It is anticipated that this change in demographics will place a further increase in demand on services if they continue to be delivered in the same way. The strategic plan aims to address demographic change by changing the way that services are provided. The focus of the strategic plan is to support care needs at home by enhancing opportunities for technology enabled care; further progressing self-directed support, and; delivering change in care at home services through the Help to Live at Home project.

2.1 What we have achieved to date

- The development of Enhanced Community Support (ECS) wraps responsive services around GP practices; proactively assessing older people with frailty that are at risk of an unplanned admission; ECS responds to escalations in health needs and it is delivered through the development of a multi-disciplinary team. The ECS model is well established in the South West and South East localities. It is currently being rolled out to the localities in the North. ECS delivery in the South has led to the ability to close beds at Little Cairnie and also within Arbroath Infirmary.

- One of the recorded reasons for delays in timely discharge is the lack of capacity in personal care services. The Help to Live at Home programme has seen an improvement in availability of personal care with greater choice and control for individuals in how their support is delivered. More personal care is being delivered in our localities. The Help to Live at Home project has made progress in addressing this. More of that care is being delivered by the independent sector.

- Delivered support through Voluntary Action Angus to support people to get home and be at home through volunteer post hospital support programmes

- Developed a next steps to home project which supports people with enablement based respite while care at home arrangements are established

- Reviewed and implemented timely discharge processes including direct referral from discharge coordinators to early supported discharge and enablement teams

- Provided additional resource for the discharge team at Ninewells

- Provided access to social care IT systems for discharge staff working in Ninewells

- Developed an accommodation overview and priorities for people with learning disabilities

- Increased the number of people with a power of attorney in place in Angus through our involvement in a campaign to improve uptake.

- Developed a social enterprise model 'Care about Angus' which supports people at home

2.2 What we plan to do

- Through the Help to Live at Home programme review and redesign enablement and early support discharge and prevention of admission services.
- Develop a neighbourhood care model using the principles of Burtzog
- Embed ECS in practice in the North localities.
- Work with housing to ensure the availability of community based accommodation for people with mental ill health and learning disability
- Although palliative care services are hosted by the Dundee Partnership we believe it important to develop a locally based approach to palliative care. Lippen Care has agreed to fund a project worker for a year to bring together local professionals and communities to agree our local approach to palliative and end of life care.
- Continue to improve on the number of anticipatory care plans in place
- 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.
- Implement the recommendations of the care home review once approved by the IJB.
- Replace The Gables Care Home with supported accommodation for the current residents

2.3 How we monitor progress

Progress is monitored through the following national and local performance measures:

Self-directed support

2.3.1 Access to long term support requires an assessment of need with an individual making choices about what services would meet their personal outcomes, how and when those supports will be delivered/accessed and who will provide them. Self-directed support is the mechanism by which these choices are provided. The options available are:

Option 1 - direct payment
Option 2 - person directs the available support
Option 3 - local authority arranges the support
Option 4 - mix of the above

Option 2 was not available before the introduction of the Social Care (Self-Directed Support) (Scotland) Act 2013 and has therefore seen a noticeable rise. Most people in Angus continue to access option 3, continuing to ask Partnership staff to organise support on their behalf. As yet there is very little shift from traditional models of support provision with most resources continuing to be spent on personal care. Table 3 below identifies the relative uptake of the self-directed support options.

Table 3 Self-Directed Support Uptake of Options

Indicator	2015/16 Value
Percentage of people who access SDS (Option 1)	4%
Percentage of people who access SDS (Option 2)	13%
Percentage of people who access SDS (Option 3)	79%
Percentage of people who access SDS (Option 4)	4%

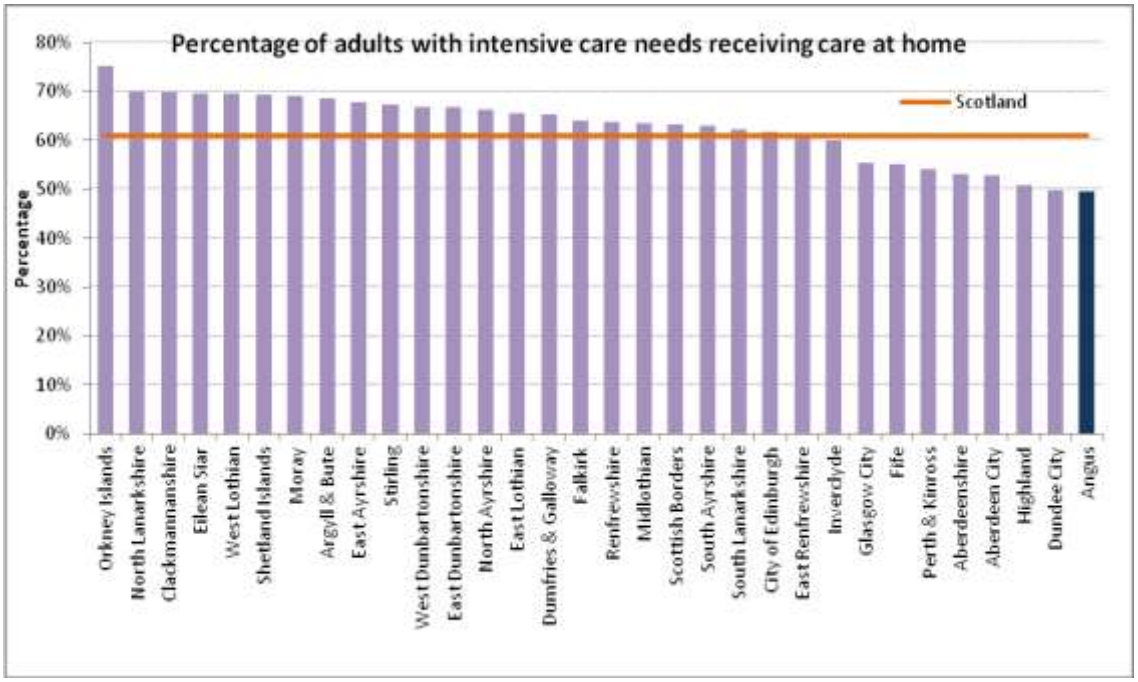
Source Care First (Angus Council)

Care at home including personal care

2.3.2 The percentage of adults with intensive care needs receiving care at home in Angus in 2015/16 was 52%. This is below the Scottish average of 62%. This indicator is been based on the percentage of people receiving any form of home care (personal care, housing support, community alarm, community laundry and community meals) who are receiving 10 hours or more of personal care. Angus has provided less intensive care packages than the national average since this indicator was introduced. Angus also commissions higher levels of care home provision(3.3.12) than the Scottish average which suggests that the balance of social care provision in Angus needs to be addressed.

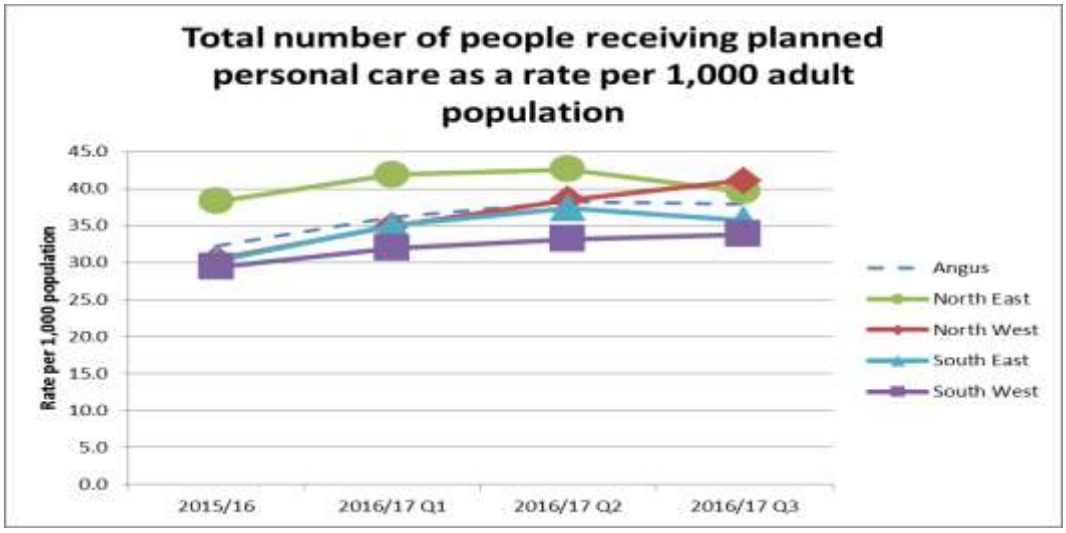
Graph 10: National Indicator 18 - Percentage of adults with intensive needs receiving care at home

Latest National Position as at 2015/16



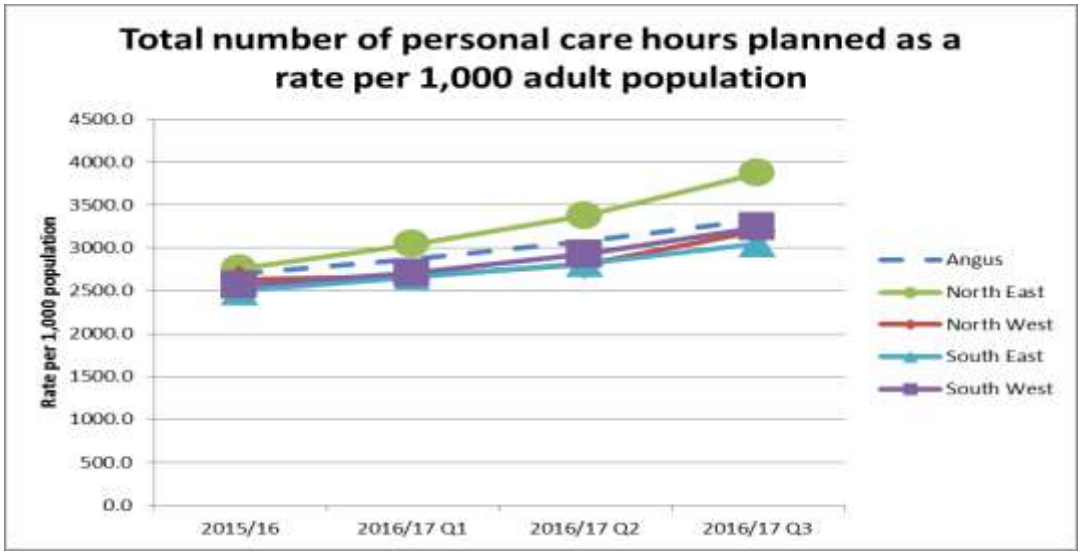
Source: Source (ISD Scotland)

Graph 11: Management Information at Locality level - Rate of Personal Care Hours



Source Care First (Angus Council)

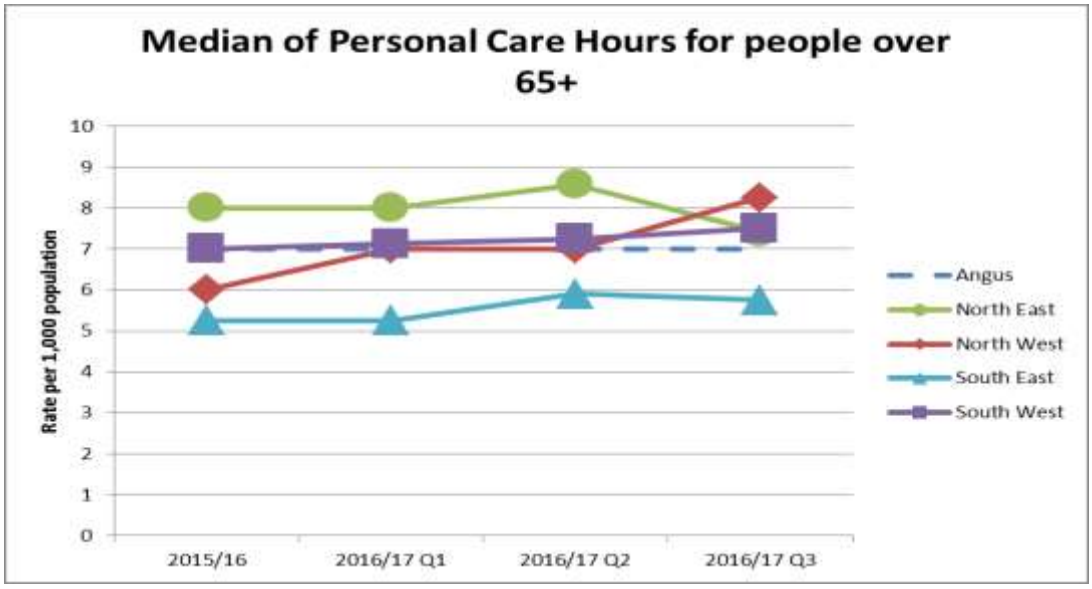
Graph 12: Management Information at Locality level - Rate of Personal Care Hours



Source: Care First (Angus Council)

2.3.3 The rate of personal care hours is increasing and the average size of a personal care support package has levelled. There is variation in the typical size of a personal care package across localities with the North West providing the largest personal care support package to the most individuals.

Graph 13: Management Information at Locality level - Personal care support package per week (Hours)



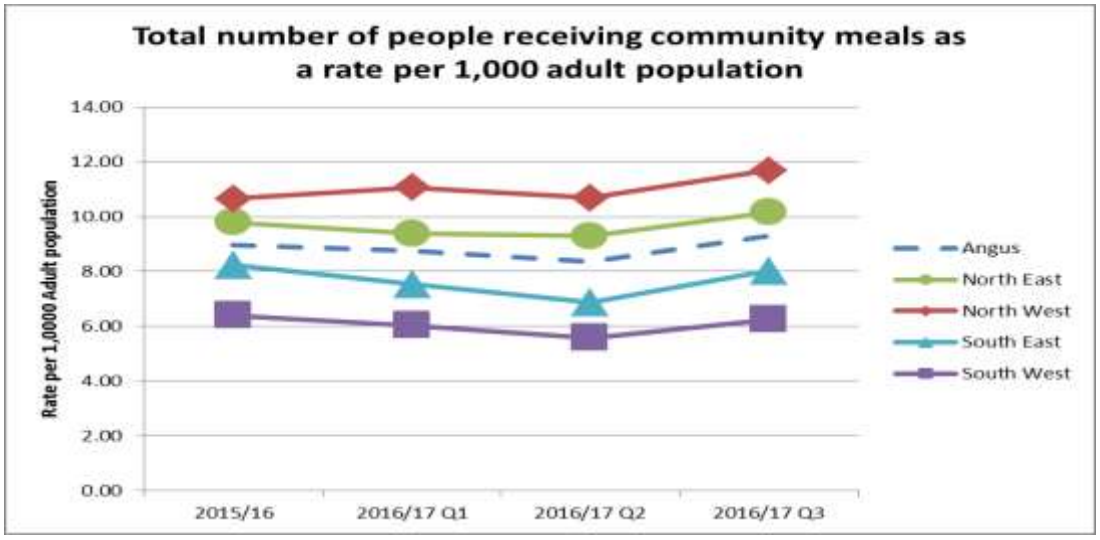
Source: Care First (Angus Council)

2.3.4 Social Care in Angus is not focused solely on personal care. There are a range of different types of supports available, including community meals, day care community alarm, and volunteer arrangements for transport and befriending. The rate of uptake of community meals declined following the withdrawal of the tea time hot service but has now started to recover.

Community Meals

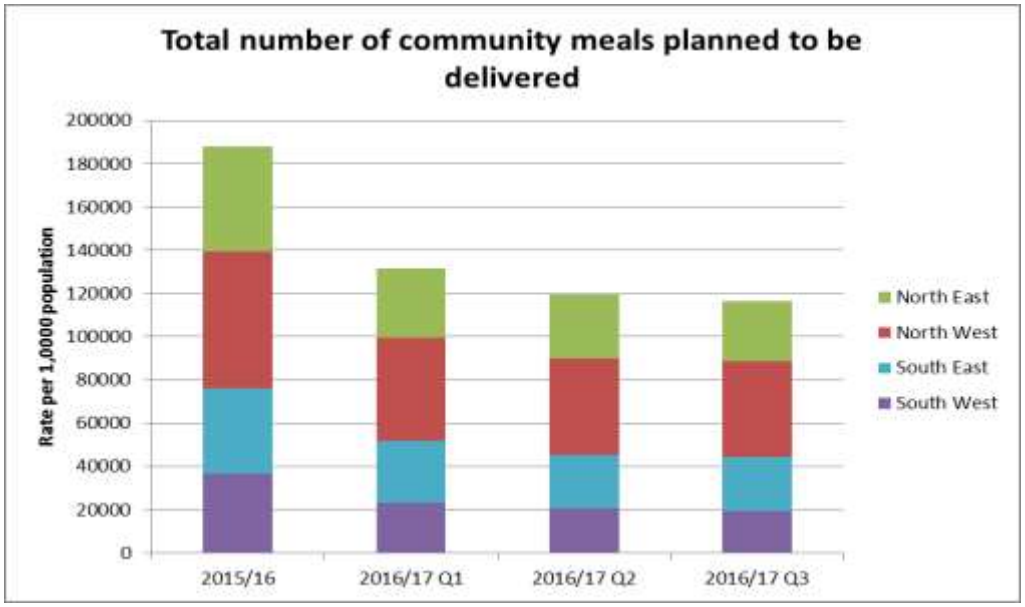
2.3.5 The number of people receiving community meals has increased within that number however the number of people using the tea time sandwich service, delivered along with a hot lunch has declined. This appears as an overall reduction in the number of meals provided.

Graph 14: Management Information at Locality level rate of Community Meals provision



Source: Care First (Angus Council)

Graph 15: Management Information at locality level Community Meals Delivered



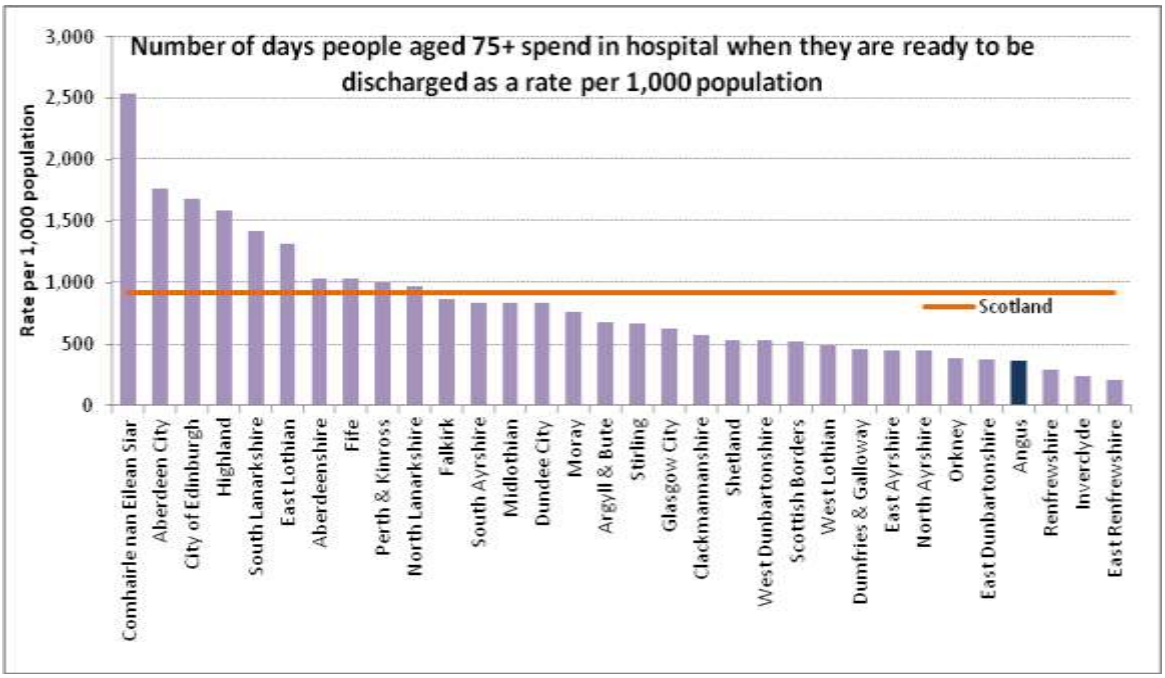
Source: Care First (Angus Council)

Timely discharge

2.3.6 As at 2015/16 the number of days people spend in hospital when they are ready to be discharged as a rate per 1,000 population, is 368 per 1,000 in Angus. This is below the Scottish rate of 915 per 1,000 population. This places Angus as the 4th best performing partnership in Scotland.

Graph 16: National Indicator 19 - Number of days people aged 75+ spend in hospital when they are ready to be discharged

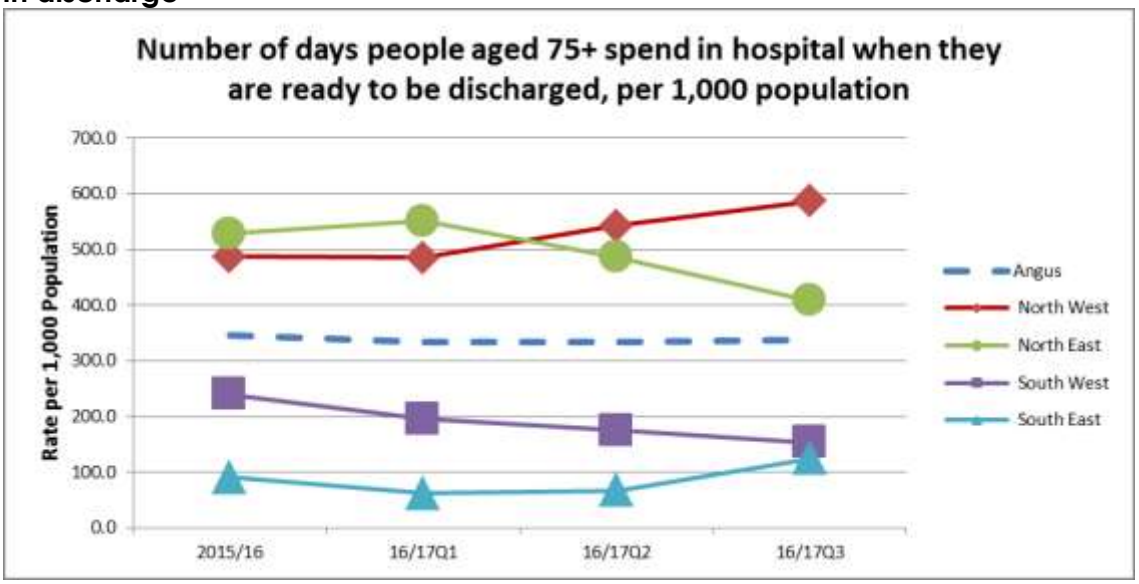
Latest National Position as at 2015/16



Source: Source (ISD Scotland)

2.3.7 The rate of all bed days lost to delayed discharges for people aged 75+ has remained level between 2015/16 and quarter 3 in 2016/17, although there has been an increase in the North West and South East. The South East has the lowest delayed discharge bed day rate in Angus as at quarter 3 of 2016/17. The variance in bed days lost to delayed discharges between the northern and southern localities suggests that there is still room for improvement in the north.

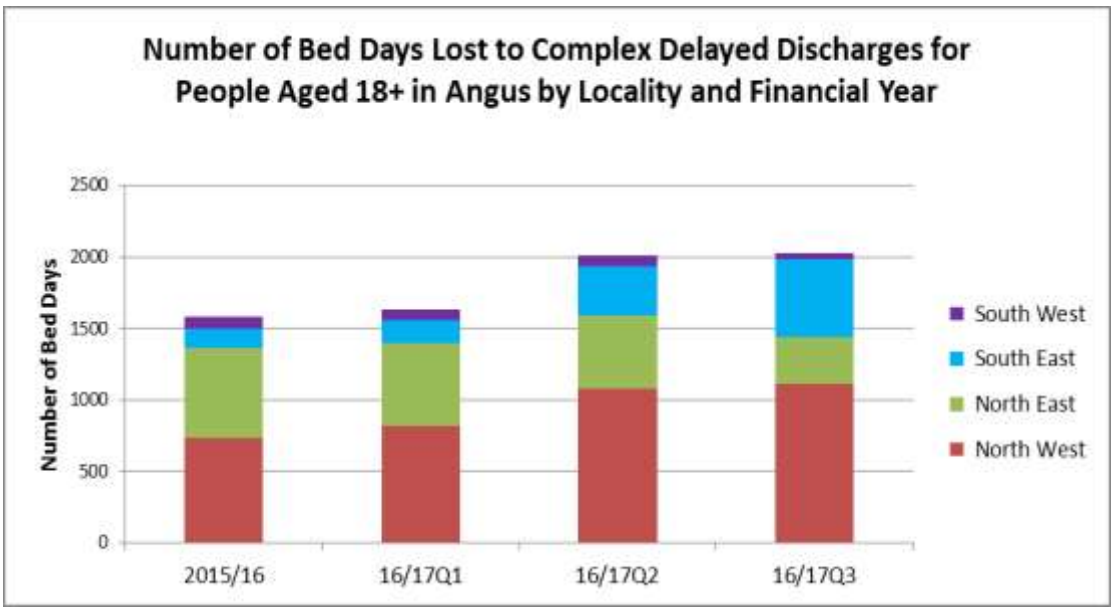
Graph 17: Management Information at Locality Level -Bed days lost to delays in discharge



Source: Edison (for management information purposes and are not national statistics)

2.3.8 In relation to complex (code 90 delays the main reason for delay is people awaiting legal process to be concluded for over 75s (guardianship). For under 75s, delays mostly relate to the provision of specialist accommodation to meet assessed needs.

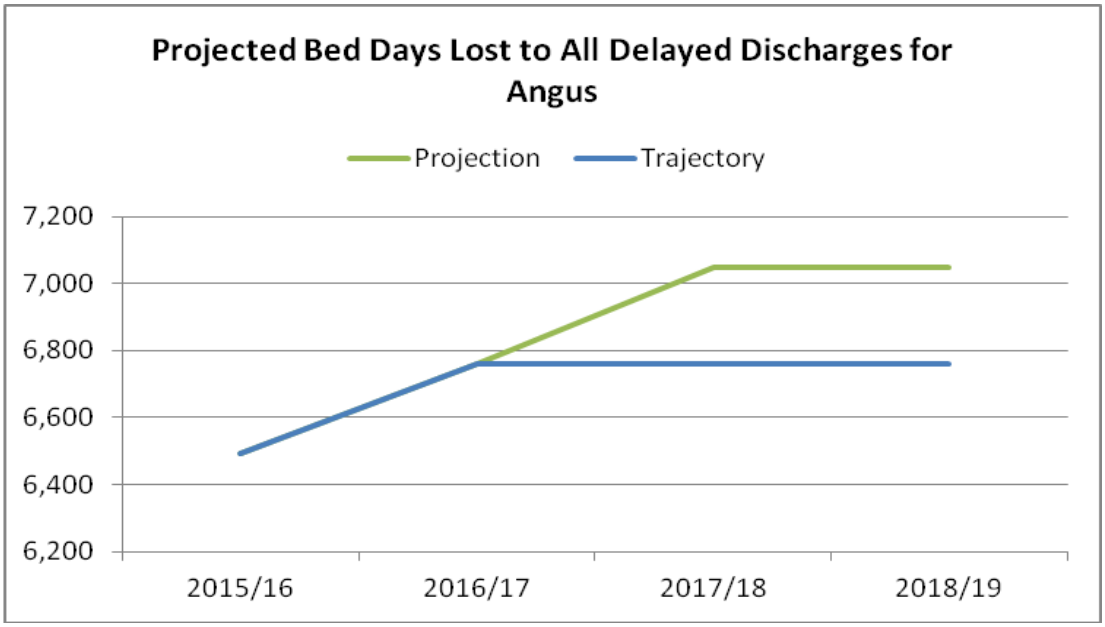
Graph 18: Management Information at Locality Level -Bed days lost to complex delays in discharge



Source: Edison (for management information purposes and are not national statistics)

2.3.9 The roll out of ECS in North Angus and the continued development of Help to Live at Home is expected to have a reducing effect on patient delays in hospital. However, it is anticipated that the improvements being made in response to the strategic plan will have stabilising effect despite the increasing proportion of older people in Angus

Graph 19: Projected bed days lost to delayed discharge



Source: Angus Trajectories for Developing Local Improvement Plans

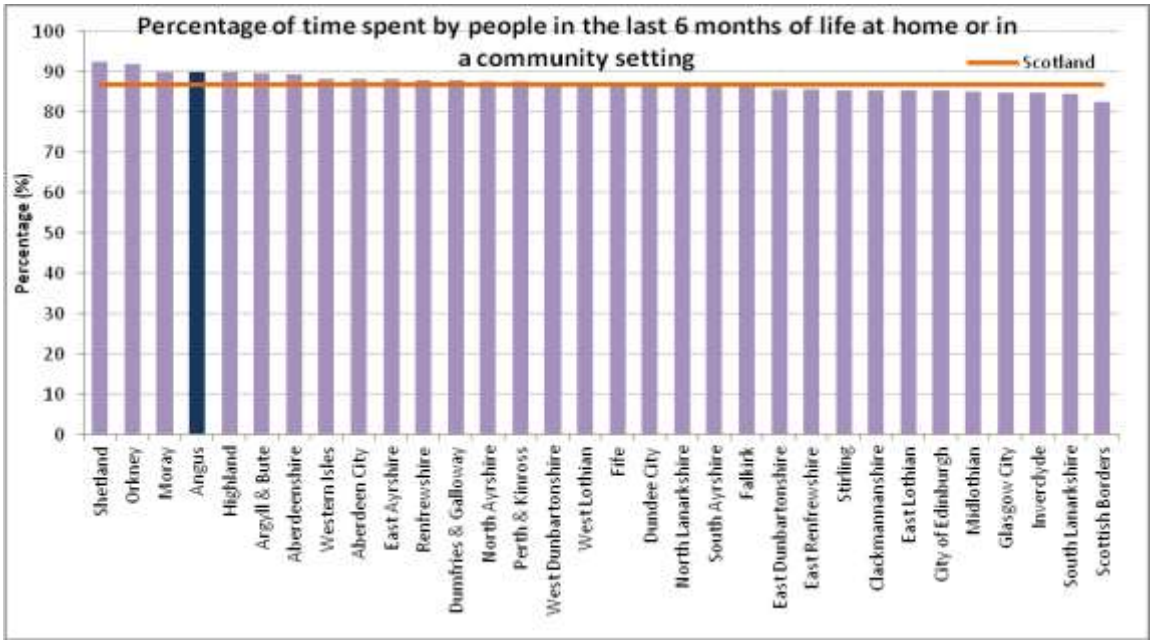
2.3.10 Campaigns to increase awareness and uptake of power of attorney are expected to have some effect on complex delays. The delivery of the learning disability accommodation priorities and work in mental health services with Housing is also expected to deliver improvements in complex delays. It is recognised that new build accommodation solutions take time.

Last 6 months of life

2.3.11 We are currently developing locality information around end of life care. Angus performs well in relation to end of life care. The percentage of time that people spend at home or in a community setting in the last 6 months of their life in Angus is 90%.

Graph 20: National Indicator 15 - Proportion of last 6 months of life spent at home or in a community setting

Latest National Position as at 2015/16



Source: Source (ISD Scotland)

2.3.12 We know we need to develop locality based information on end of life care including gaining a greater understanding of place of death and the type of support that requires to be in place to continue to shift the balance from large hospital to community based supports. Once information is available this will be included in the quarterly performance report for the IJB.

Priority 3: Developing integrated and enhanced primary care and community responses

Over the next three years AHSCP aims to deliver performance that meets the aspirations of Angus communities. The aspiration is to support individuals to stay at home when appropriate; if a hospital admission is necessary then to ensure a timely discharge plan with relevant support available at home or in localities is important. In Priority 3 we consider the impact of improvements on the unplanned use of hospital beds.

3.1 What we have achieved to date

- The development of ECS wraps responsive services around GP practices; proactively assessing older people with frailty that are at risk of an unplanned admission; ECS responds to escalations in health needs and it is delivered through the development of multi-disciplinary team. ECS has contributed to the success of supporting shorter hospital stays and thereby reducing bed day rates in the South localities. This service has not yet commenced in the North West and it is currently being implemented in the North East. ECS delivery in the South has led to the ability to close beds at Little Cairnie and also within Arbroath Infirmary.
- The Help to Live at Home programme has seen an improvement in availability for personal care
- Embedded a planned date of discharge approach in discharge planning
- Increased the number of anticipatory care plans in place
- Located care management within community hospitals

3.2 What we plan to do next

- Opportunities for improving performance in this area need to be identified.
- 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.
- Review what social care packages were in place for people who experienced a readmission within 28 days
- Analyse the information available which will help us identify potential service and support solutions that can be developed through our localities.
- Fully implement ECS in the North Localities with the expectation that this will lead to a requirement for a reduction in in-patient beds in keeping with the Scottish Government's Health and Social Care Delivery Plan (December 2016).
- A review of out of hours services is being progressed, this has identified and proposed an outline plan for transforming unscheduled care and a new model of service provision based in line with national transformation plans.

- A review of the care home model in Angus is due to report to the IJB in June.
- Plans around the use of technology enabled care to support self-management of long term conditions and people with multi-morbidities are testing telehealth opportunities to support people to live at home for as long as possible.
- Develop an improvement plan to address the increasing falls rate in Angus. Supported by public health, the improvement plan is identifying areas of best practice across Scotland and this will incorporate a review of the Angus falls services.
- Address the variance in length of stay between our localities through ECS.
- Further develop discharge planning arrangements for adults with mental ill-health, learning disability, physical disability

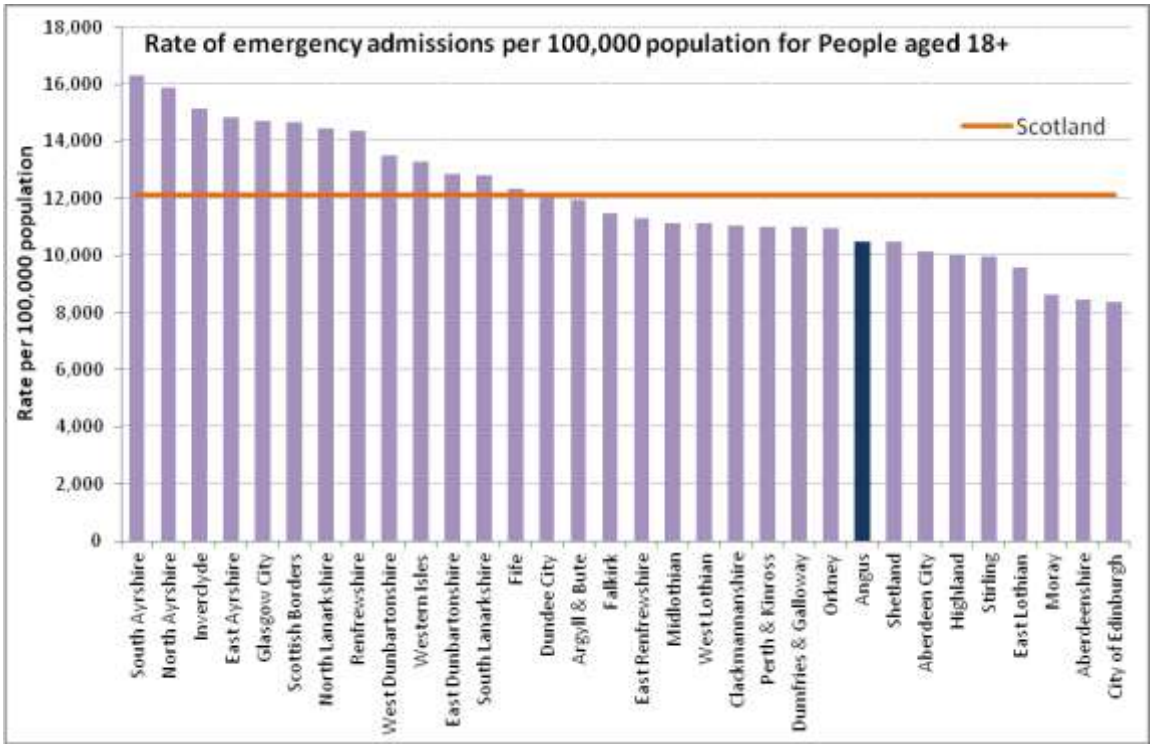
3.3 How we monitor progress

Progress is monitored through the following national and local performance measures:

Emergency admissions

Graph 21: National indicator 12 - Rate of Emergency Admissions for Adults

Latest National Position as at 2015/16

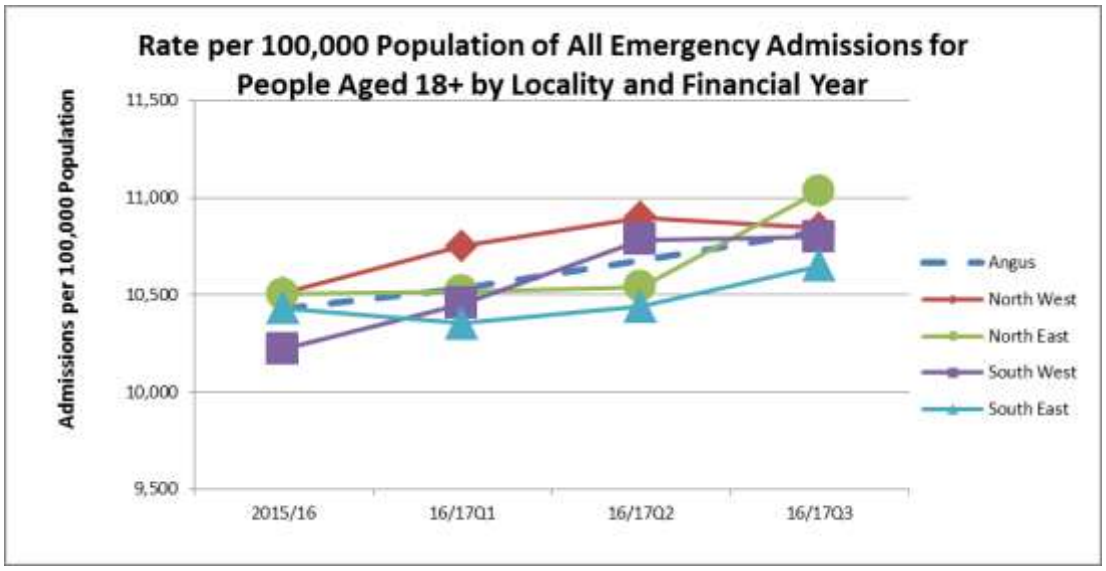


Source: Source (ISD Scotland)

3.3.1 Angus continues to perform well against the national picture and as at 2015/16 it is the 9th best performing partnership in Scotland.

3.3.2 Since 2015/16 all localities have seen an increase in emergency admission rates. As at quarter 3 in 2016/17, the South East has the lowest emergency admission rates and the North East has the highest emergency admission rates for people aged over 18 in Angus. The increase in the South West could be driven by the increase in readmissions (see graph 31).

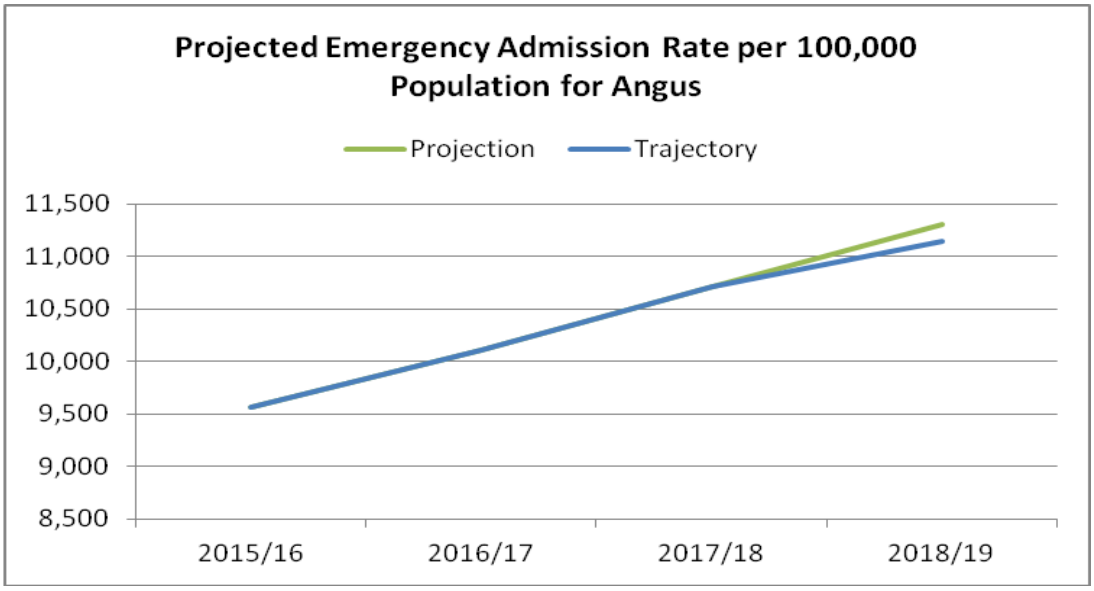
Graph 22: Management Information at Locality Level - Rate of Emergency Admissions for Adults



Source: SMRA Inpatient Dataset (for management information purposes and are not national statistics)

3.3.3 Although the rate of emergency admissions has increased, Angus continues to perform well against the national picture as admission rates are increasing across Scotland. It is anticipated that further improvements delivered through the strategic plan will lead to a reduction in the projected rate of admissions.

Graph 23: Projected Rate of Emergency Admissions



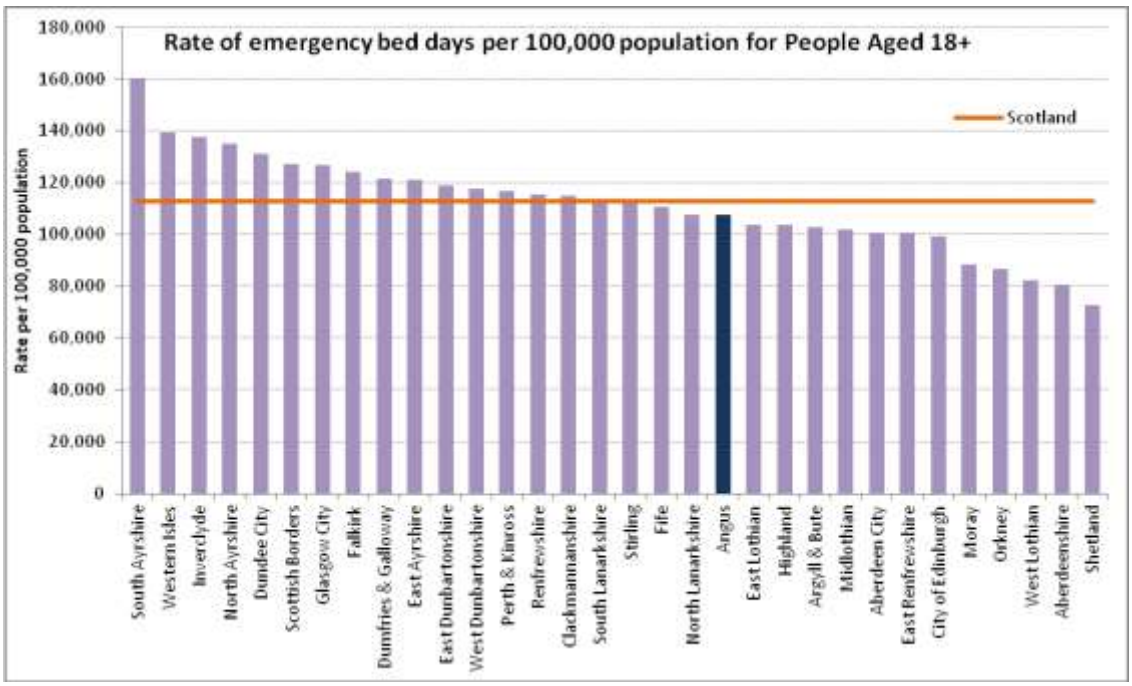
Source: Angus Trajectories for Developing Local Improvement Plans

Hospital Bed days used following an emergency admission

3.3.4 As at 2015/16, Angus has a slightly lower emergency bed day rate than the Scottish average at 107,489 per 100,000 population.

Graph 24: National Indicator 13 - Rate of Emergency Bed Days for Adults

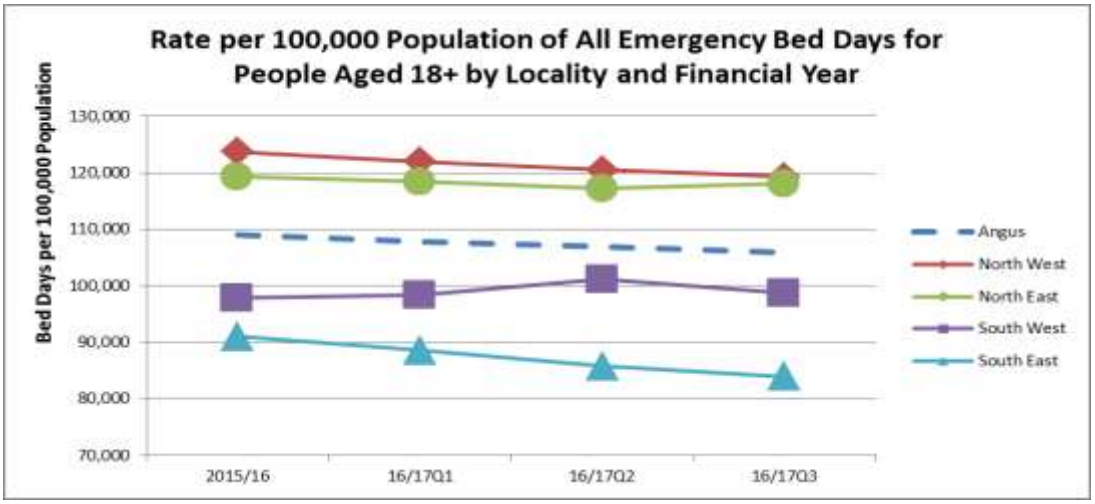
Latest National Position as at 2015/16



Source: Source (ISD Scotland)

3.3.5 Although emergency admission rates have been increasing, emergency bed day rates in Angus have been steadily decreasing since 2015/16 from 109,097 to 105,861 per 100,000 population in quarter 3 of 2016/17 (a decrease of 3%). The lowest bed day rates are in the South East.

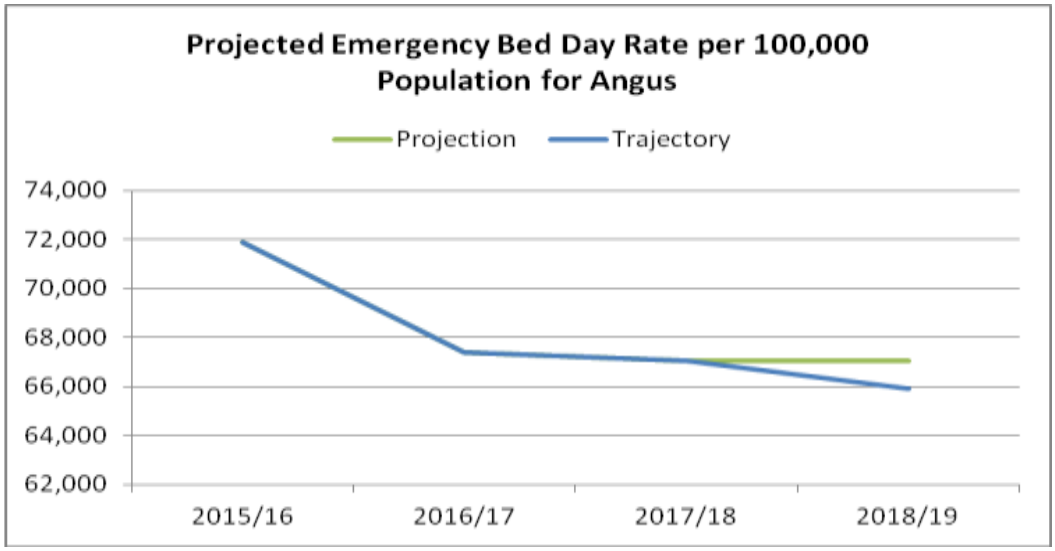
Graph 25: Management Information at Locality Level - Rate of Emergency Bed Days for Adults



Source: SMRA Inpatient Dataset (for management information purposes and are not national statistics)

3.3.6 Following the implementation of ECS across all localities the variation in the bed day rate is expected to narrow. This means that the trajectory for Angus is expected to improve against the projection.

Graph 26: Projected Emergency Bed Day Rate

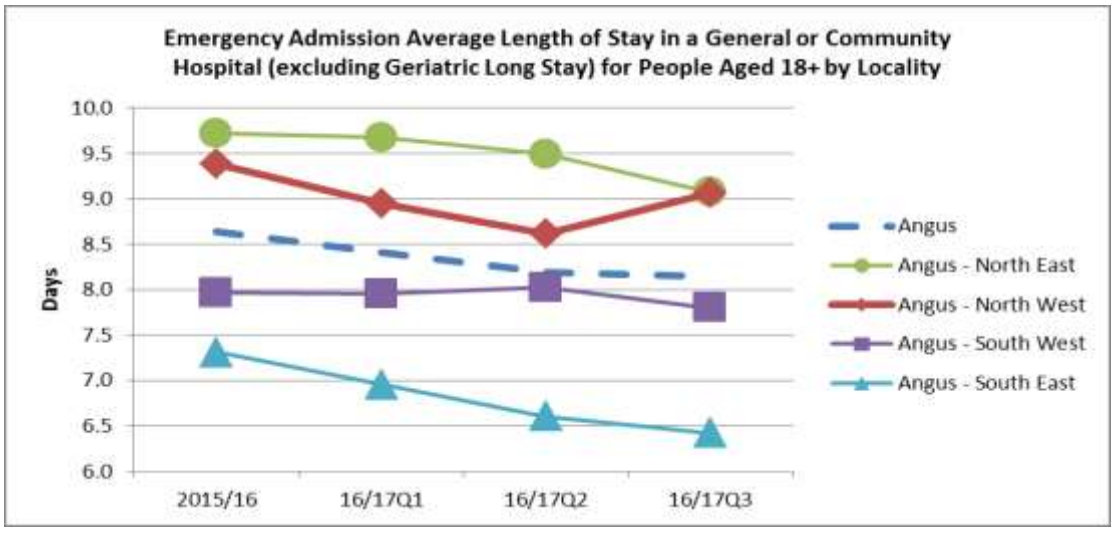


Source: Angus Trajectories for Developing Local Improvement Plans

Length of hospital stay following an emergency admission

3.3.7 The overall emergency bed day rate in Angus has reduced due to improvements in average length of stay following an emergency admission. Average length of stay continues to improve in all of the 4 localities. There is room for further improvement as there is a difference of almost 3 days between the northern localities and the South East.

Graph 27: Management Information at Locality Level– Average Length of Stay for Emergency Admissions for Adults



Source: SMRA Inpatient Dataset (for management information purposes and are not national statistics)

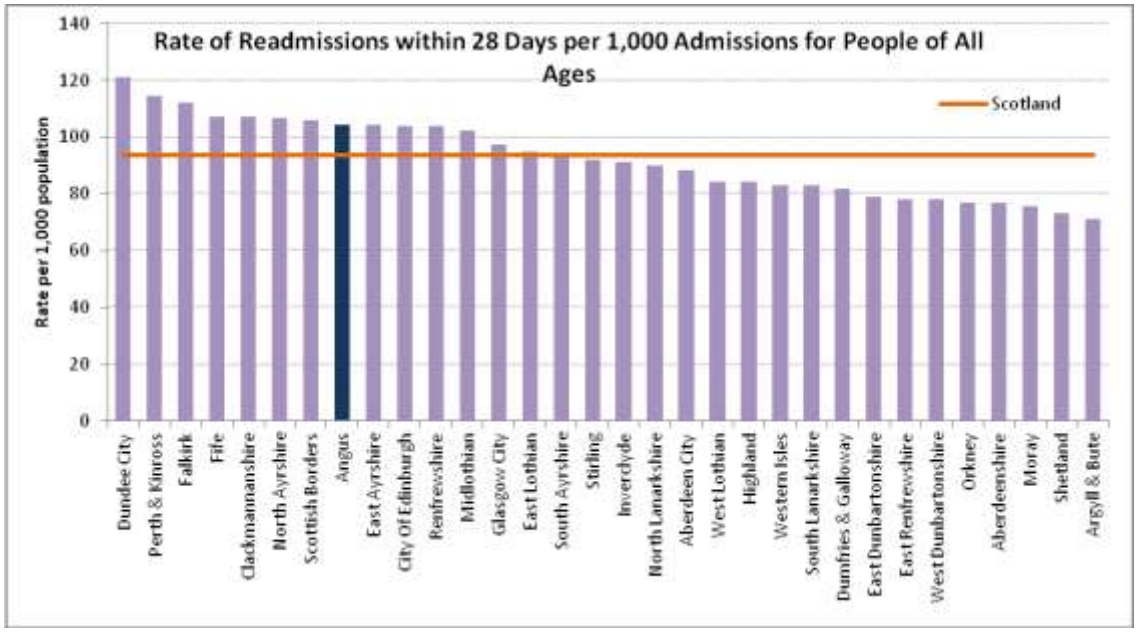
3.3.8 Angus performs well against the Scottish average for bed use but there remains significant room for improvement. It is anticipated that the roll out of ECS and improvements in availability of personal care through Help to Live at Home in the North will reduce the emergency bed day rate.

Readmissions to hospital

3.3.9 The readmission rate for Angus is 104 per 1,000 admissions. This is above the Scottish readmission rate and ranks Angus as the 8th highest partnership in Scotland.

Graph 28: National Indicator 14 - Readmissions to Hospital within 28 Days of Discharge

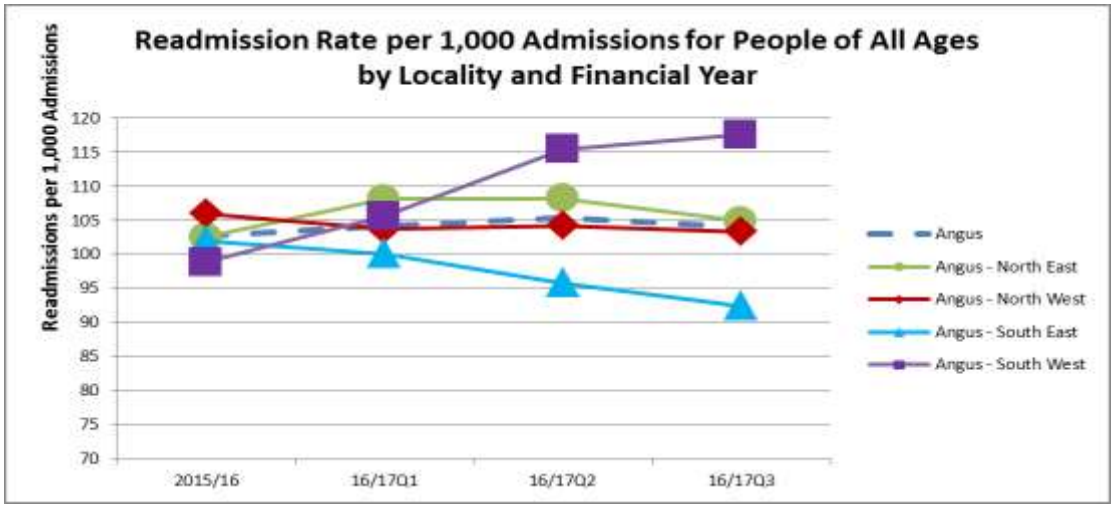
Latest National Position as at 2015/16



Source (ISD Scotland)

3.3.10 Readmission rates in Angus for quarter 3 of 2016/17 are similar to 2015/16. The South West locality has seen the biggest increase in readmission rates between 2015/16 and quarter 3 of 2016/17. A greater understanding of readmission data is required to understand how community responses might reduce readmissions to hospital.

Graph 29: Management Information at Locality Level– Emergency Readmission Rates within 28 days



Source: SMRA Inpatient Dataset (for management information purposes and are not national statistics)

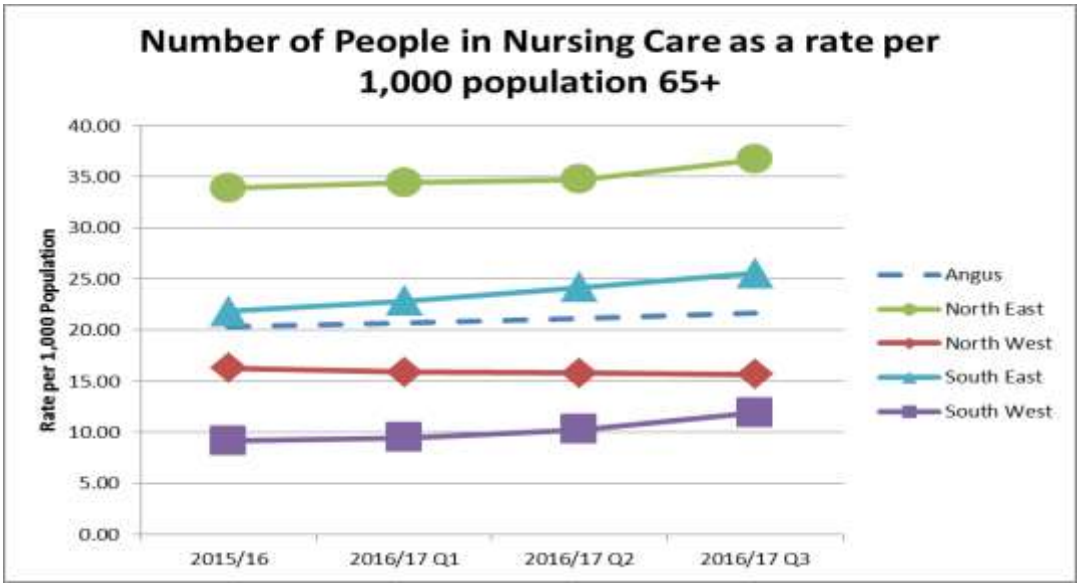
Residential and Nursing Care

3.3.11 The average age of a person placed in a care home in Angus is approximately 84. The number of people aged over 75 in Angus has increased by 1000 over the past 5 years. If care home placements are considered as a rate for the 75+ population the Angus average rate of 63.5 and is higher than the Scottish rate of 41.1. Angus, historically, provides the lowest level of intensive personal care packages in Scotland.

3.3.12 The North West has the lowest number of placements and utilises more care at home and respite. The South East locality makes high levels of placements but uses less personal care and other community services. The North East make the most placements and also use very high levels of personal care and other community based services. The South West make few placements but also use less personal care and other community based service.

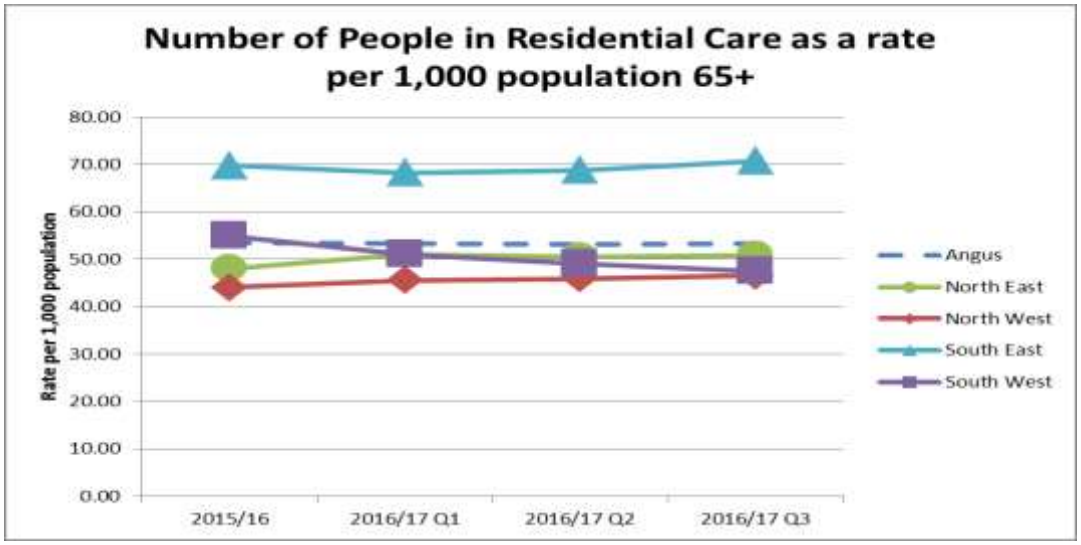
3.3.13 Patterns of care provision are inconsistent across Angus and the variation in the pattern of service uptake cannot be explained by variation in the proportion of over 85s in the population, the level of owner occupiers (who, anecdotally, are more reluctant to move into care) or older people living alone (who are more likely to be considered at risk and more likely to take up a care home placement). Commissioning of care home placements does relate more closely to the rate of bed provision within the locality.

Graph 30: Management Information at Locality Level - Nursing Care Placement Rate



Source: Care First (Angus Council)

Graph 31: Management Information at Locality Level - Residential Care Placement Rate



Source: Care First (Angus Council)

Priority 4: Improving integrated care pathways for priorities in care

Health and Social Care services are available to support all adults in need. There are some more complex needs that require additional support. This includes specialist needs such as mental health, learning disability and substance misuse. Services may wholly or in part be hosted by another partnership. Angus Health & Social Care Partnership is working with other partnerships and with housing to develop responses to services in this area.

4.1 What we have achieved to date:

- A housing contribution statement has been agreed with Angus Council Housing services which set out how specialist housing needs will be supported;
- An Angus Autism Strategy has been developed and approved. An implementation plan is being progressed;
- An older people's mental health strategy is being developed;
- The development of a Carers strategy is being progressed in line with the New Carers (Scotland) Act 2016. Commencement for this new legislation is April 2018;
- A learning disability accommodation overview has been produced with three priorities agreed by the IJB;
- Progressed the delivery of new supported accommodation in Forfar for people with a learning disability;
- A strategy has been published by the Alcohol and Drugs Partnership and a delivery plan implemented;
- Worked with Perth and Kinross HSCP (host IJB) on issues facing in-patient adult mental health services;
- Successfully tested the delivery of mental health and wellbeing services within one GP practice.

4.2 What we plan to do next

- Undertake a review of supported accommodation for older people;
- Undertake a review of supported accommodation for people with learning disabilities;
- Undertake a review of supported accommodation for people with adult mental health problems;
- Address sleep over arrangements in line with Scottish Living wage and working time directives;
- Fully implement the Carers (Scotland) Act 2016 ensuring that a state of readiness evaluation is completed and eligibility criteria are developed in consultation with carers by 31 March 2018.

4.3 How we monitor progress

Angus Health & Social Care Partnership is working with housing, learning disability, adult mental health and other services to identify appropriate measures.

Performance Area 1: Workforce

The employing organisations, Angus Council and NHS Tayside, measure sickness absence differently.

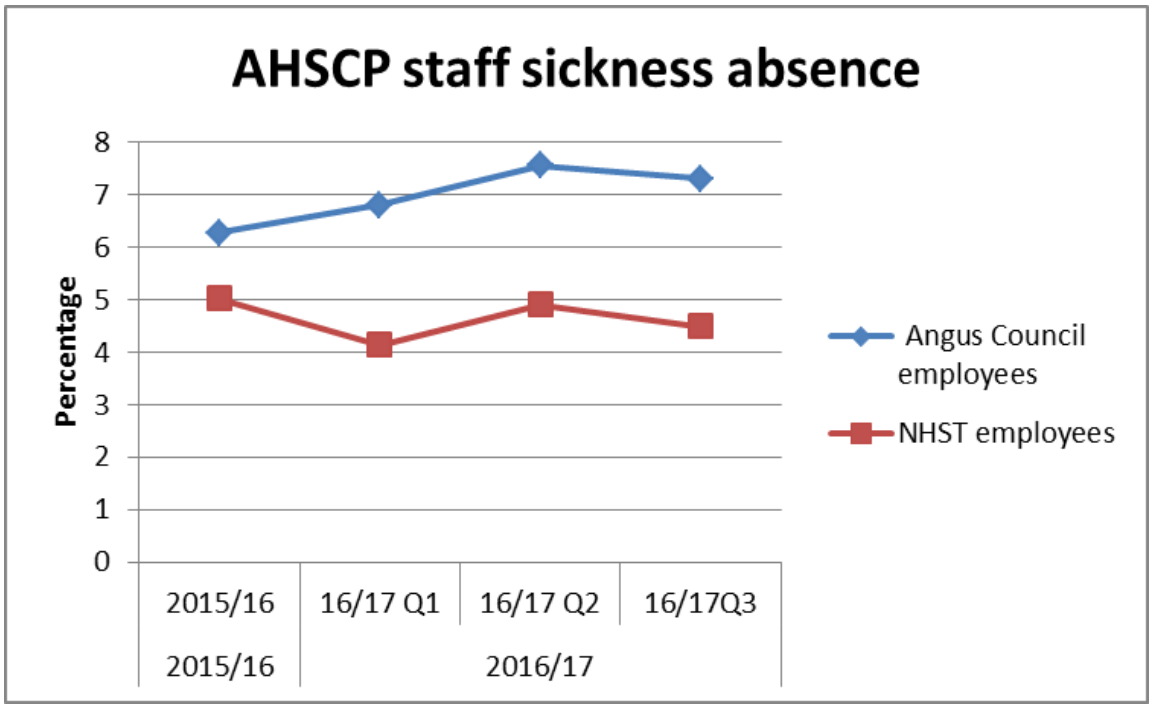
Angus Health & Social Care Partnership is working to improve the comparability of the data and present information in a consistent way.

Sickness Absence

Sickness absence amongst Angus NHS staff increased by 0.42% in February 2017 against the same period in 2016 and increased by 0.21% on absence in January 2017. This was due to long term sickness absence.

The percentage absence by Council staff working in Angus Health and Social care Partnership is much higher than the percentage for all Angus Council staff (4.66%) and has been increasing over time. There has been a slight improvement in figures for quarter 3.

Graph 32 Management Information Percentage Staff sickness absence



source: Angus Council and NHST epayroll

Performance Area 2: Clinical, Care and Professional Governance

Clinical, Care and Professional Governance is overseen through a governance group (R2) established under the agreed Clinical and Care Governance Framework. The group are actively developing systems using an exception reporting approach which will allow any governance issues to be raised through services. All reporting approaches will use the 6 domains of assurance set out in the clinical and care governance framework. The R2 has identified a service reporting framework though exception reporting to begin to understand any clinical and care governance issues and good performance. Some arrangements in relation to data gathering have to be addressed. These areas will be highlighted in each domain.

6.1 Domain 1 - Information Governance

Angus Council Internal Audit has completed an audit of data security. The objectives of the audit were to review the controls in place to manage the following business risks:

- The Council has not put in place appropriate arrangements for the physical and environmental security of information and data including when transferring data to third parties.
- Staff and approved users of Angus Council's information are not aware of or do not understand policy and procedures relating to information security resulting in non- compliance.
- The Council is subject to fines from the Information Commissioner due to staff and users not complying with existing policies and processes.

The results from the audit testing demonstrate that the objectives of the audit have not been met in full in adult services. A number of areas have been identified where improvements could be made to strengthen the control environment and ensure compliance with existing guidance. The most material recommendations are:

- Managers ensure that the data security e-learning module is completed by all of their staff in compliance with the reminder issued by the Strategic Director (People) in June 2015 and that guidance is issued to staff to ensure that work data is not transferred to personal email accounts.
- Management review the security of archive filing at Bruce House to ensure that unauthorised access is restricted and that storage arrangements are appropriate.
- Managers ensure that the clear desk policy at Bruce House is adhered to and all confidential files are locked away when not in use.

Whilst all actions have been completed consideration is being given to how to better monitor the uptake of the information governance e-learning module through the e-learning system. An information governance group has been established in order to develop an internal information governance plan which complies with policy. No breaches in information governance have been reported during Q2.

6.2 Domain 2 - Professional Regulation and Workforce Development

No breaches in registration have been recorded in respect of health staff working in the Partnership.

6.3 Domain 3 - Patient, Service User and Staff Safety

Adult Protection

New indicators are being developed in relation to adult protection.

Adverse events

Approaches to care that encourage rehabilitation and enablement carry a greater risk of falls as greater mobilisation is part of the rehabilitation. This likely accounts for the higher levels of falls which are category 3 (green event/ negligible impact)) and all falls in designated rehab facilities. The available information does not include the number of individuals who have fallen. One person may account for multiple recorded falls. Given the number of individuals who pass through premises each year, the falls rate is low. All falls are investigated and any required action is taken.

6.4 Domain 4 - Patient, Service User and Staff Experience

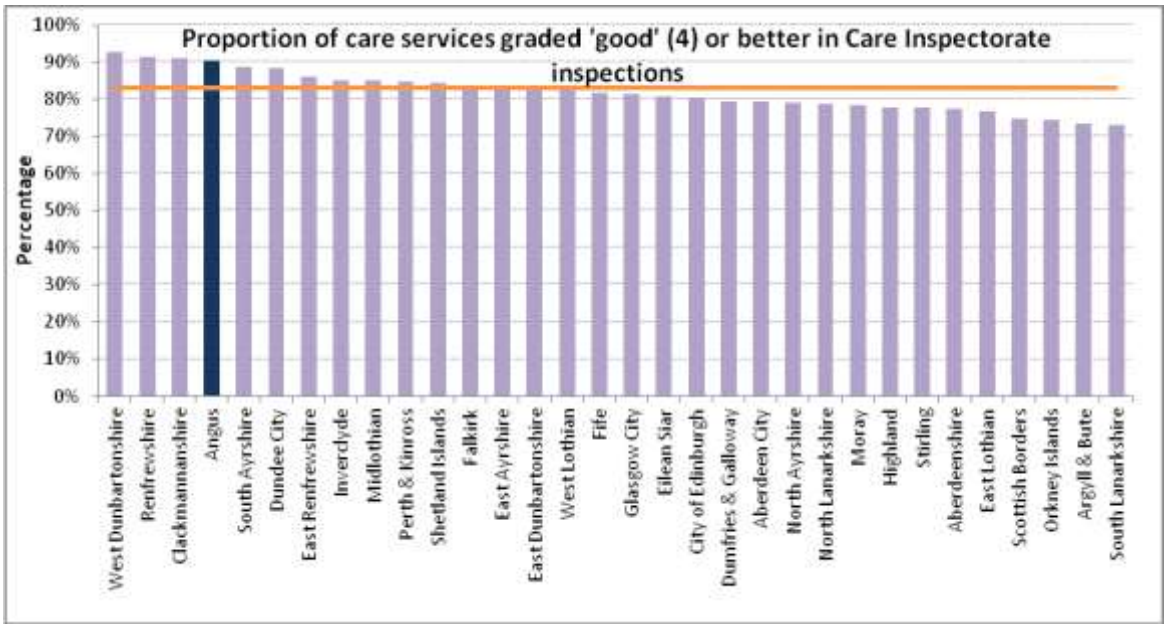
As at 2013/14, 89% of Angus adults care/support users rates their care as excellent or good. (Source: Biennial Health and Care Experience Survey 2013/14).

6.5 Domain 5 - Regulation of Quality and Effectiveness of Care

Quality of registered social care services

Graph 33: National Indicator 17 - Proportion of care and care services rated good or better in care inspectorate inspections

Latest National Position as at 2015/16



Source: Source (ISD Scotland)

The proportion of care services graded good or better in Care Inspectorate inspections in Angus is 90% which is above the Scottish rate of 83%. This ranks Angus as the 4th best performing partnership for this indicator. Care services includes all registration categories: for example care home, day care, care at home.

Complaints

In quarter 3 of 2016/17, 13 complaints were received by the Partnership in respect of Angus services. Nine of those complaints were responded to within 20 working days.

6.6 Domain 6 - Promotion of Equality and Social Justice

The IJB approved a set of equality outcomes and mainstreaming report in May 2016. Indicators which show how services and outcomes vary between the most and least deprived communities in Angus are being developed.

Performance Area 3: Resources

Detailed reports on finance are submitted by the Chief Finance Officer. The aim of our strategic plan is to evidence a shift in resources from health to social care provision and from institutional based care to community based support within our localities. We are working with Information Services Division (ISD) on the development of Source. This is a system which matches health and social care data and generates information from spend on individuals to demonstrate the split between health and social care spend and between spend on institutions and community based services. We are working with ISD to improve the information we submit to the Source project and to work towards accessing the analysed data more quickly.

7.1 What we have achieved to date

- Minimal usage of agency staff in Angus Community hospitals
- Developing community services which support people to stay at home has resulted in less reliance on inpatient beds.
- The rate of use of care home beds has been reduced with commensurate improvements in the uptake and availability of care at home

7.2 What we plan to do next

- Continue to move resources into the community as the roll out of our community based programmes become effective
- Work with secondary care to better understand the higher costs in relation to emergency admissions for Angus patients and to develop models of care which allow a shift in the balance of care with resource to the community

7.3 How we monitor progress

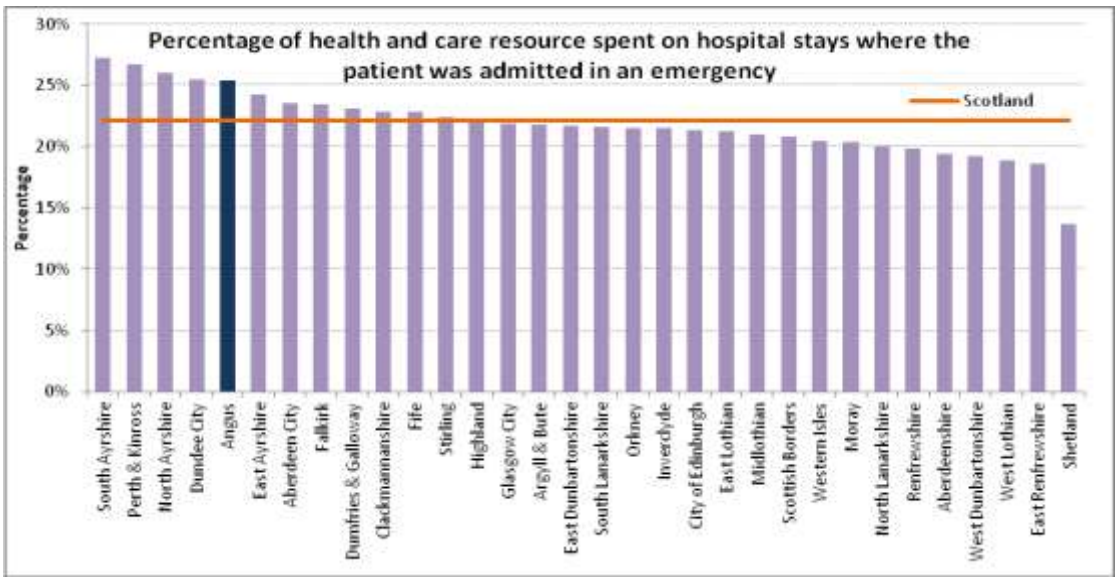
We will report on this measure in the annual performance report and financial statement. We will work with Voluntary Action Angus to identify information on the contribution of the voluntary sector to our partnership. We will continue to work with the Source team at the Information services Division (ISD) to improve the provision of social care information in order to develop measures relating to the balance of care between health and social care and the balance of care between community and institutional expenditure.

Spend on hospital stays following emergency admission

7.3.1 Angus has one of the biggest percentages of total health and care spend on hospital stays where the patient was admitted as an emergency. This is not directly in the control of the IJB as most admissions are of an acute nature and are to Ninewells Hospital.

Graph 34: National Indicator 20 - Percentage of total health and care spend on hospital stays where the patient was admitted in an emergency

Latest National Position as at 2015/16



Source: Source (ISD Scotland)