ANGUS HEALTH AND SOCIAL CARE INTEGRATION PARTNERSHIP

Locality Development Events September 2015

South East Angus

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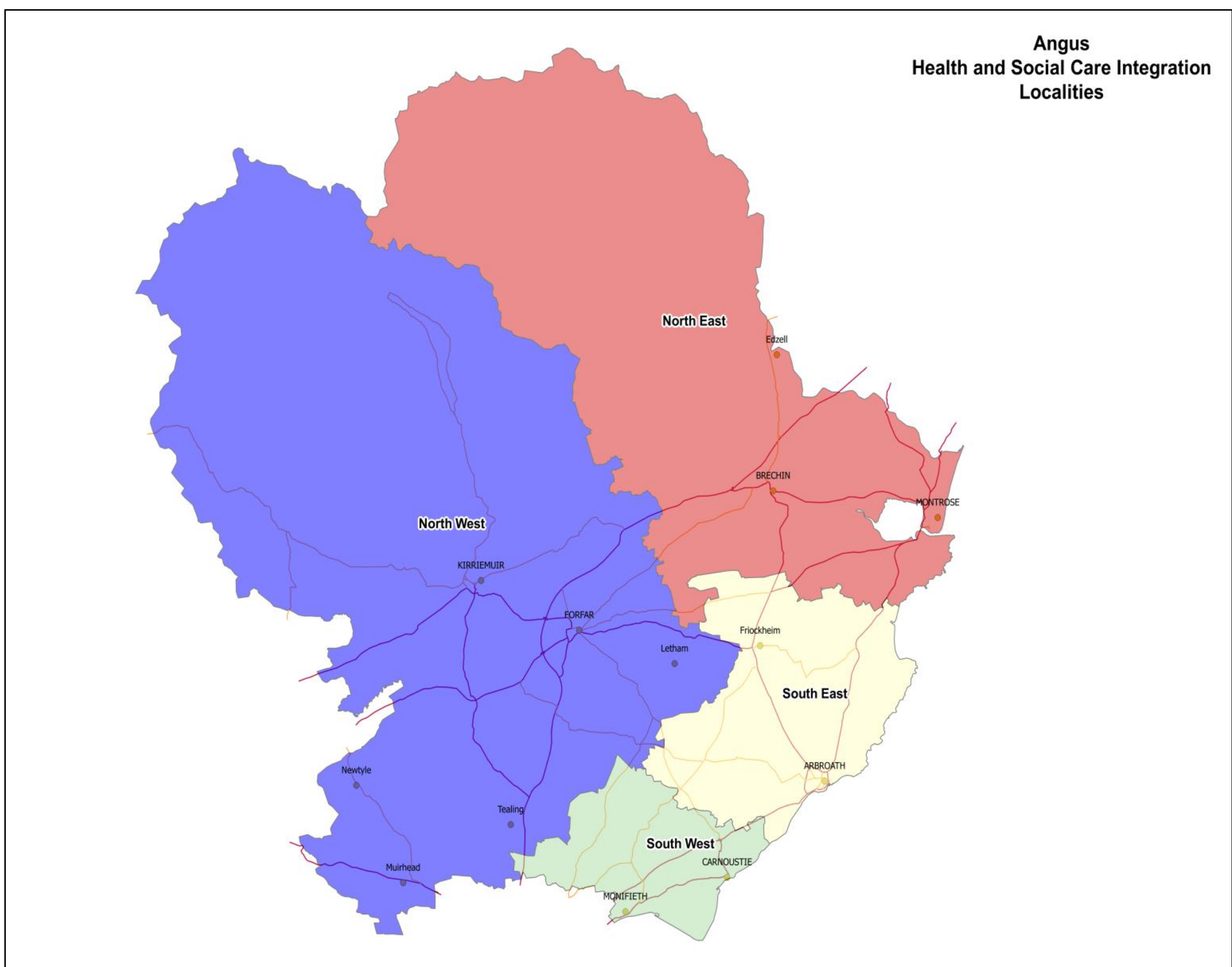
1. Introduction

This feedback report aims to take locality commissioning a little further forward from the development events. The information required to deliver a locality plan is not fully complete. This feedback is based on information provided at the events with some additional information that has become available. This will be used by the Locality Development Group to identify local priorities.

The evaluation of the locality events was very positive. There was a recognition of the value of multidisciplinary working and we have begun to identify how to present data and information in a way that will support wider understanding.

Angus Localities will deliver:

- A range of core services;
- Local leadership;
- Partnership with the voluntary sector/independent sector;
- Relevant local commissioning;
- Local access to support.



2. Understanding South East Angus

During the development event, we had the opportunity to look at a range of information about Angus. This is a summary of what it tells us. We are currently working on a full needs assessment profile that we will be able to provide in a few weeks.

- Population is 29,437, 25.3% of the total population of Angus.

- Population has grown by 1,732 people over the past 10 years (6.25%).

- Over the last 10 years the population age distribution has changed, people aged over 65 have increased from 17.9% to 19.9% of the population, people aged over 85 which have increased by more than 30%, population of children and young people under 18 have decreased by 5.4% and the working age population has increased by 5%.

- In the next 20 years in Angus as a whole the overall size of the population is not expected to change significantly. The age distribution of the Angus population is expected to continue to change with reductions in the population of children and young people and working age people but a significant increase in the proportion of the population who are over 65 with, again, the most significant increase being in relation to people who are over 85 years.

- Average life expectancy in Angus is greater than the Scottish average at 78.3 for men and 81.6 for women. Life expectancy across Angus varies depending on a number of factors which include deprivation. Life expectancy in South East Angus is lower than the Angus average with a range, for men, of 70.6 (Arbroath Harbour) to 79.9 (Friockheim) and for women, of 77.9 (Arbroath Harbour) to 85.4 (Friockheim).

- Around 300 births each year, there has been a slight decline in the past 10 years. The birth rate amongst women aged 15 to 44 is 59.2/1,000, this is the second highest birth rate in the Angus localities and below the Angus average.
- Around 370 deaths each year with a rate of 12.6/1,000 residents. This is the highest death rate in Angus and is below the Angus average.

- 51% of Angus' 10% most deprived areas are in South East Angus. These include Arbroath Warddykes, Arbroath Clifburn, Arbroath Harbour, Arbroath Kirkton.

- 13,607 household spaces in South East Angus, 96.3% of those are occupied. 57.8% are owner occupied properties.

- 4461 people live alone, 40.7% are over 65 years. This accounts for 35.3% of all over 65 households.
- 37.4% working age population is in full time employment, 14.5% in part time employment and 7.6% are self-employed.

- 5.6% (1188 people) of the working age population is unemployed.

- 5808 (20%) people say that their activities are limited due to health or long term conditions.

- 1494 describe their health as bad or very bad.
- 1470 people are on ESA, incapacity or disability benefits.
- 742 people describe themselves as providing 49 hours or more of care yet only 305 people are in receipt of carers allowance.
- 10.9% of the population are obese.
- 26.6% smoke.
- Population estimates suggest that 7235 people will have 2 or more long term conditions

Pharmacy data has now been broken down to localities. We are showing just one part of it here.

Prescribing information tells us that:

- 13 patients prescribed 10+ distinct BNF chapters (no high risk) (8 patients over the age of 65 years)
- 424 patients prescribed 10+ distinct BNF chapters (high risk) (277 patients over the age of 65 years)
- 988 patients prescribed 5+ distinct BNF chapters (no high risk) (303 patients over the age of 65 years)
- 5,462 patients prescribed 5+ distinct BNF chapters (high risk) (2,530 patients over the age of 65 years)

The 5 GP practices in South East Angus provide services for people who live in adjoining localities, equating to 102.7% of the South East population (30,245 people). 19,983 people used pharmacies in the past 12 months and presented 2 or more prescriptions. Information from the practices and pharmacies tells us that:

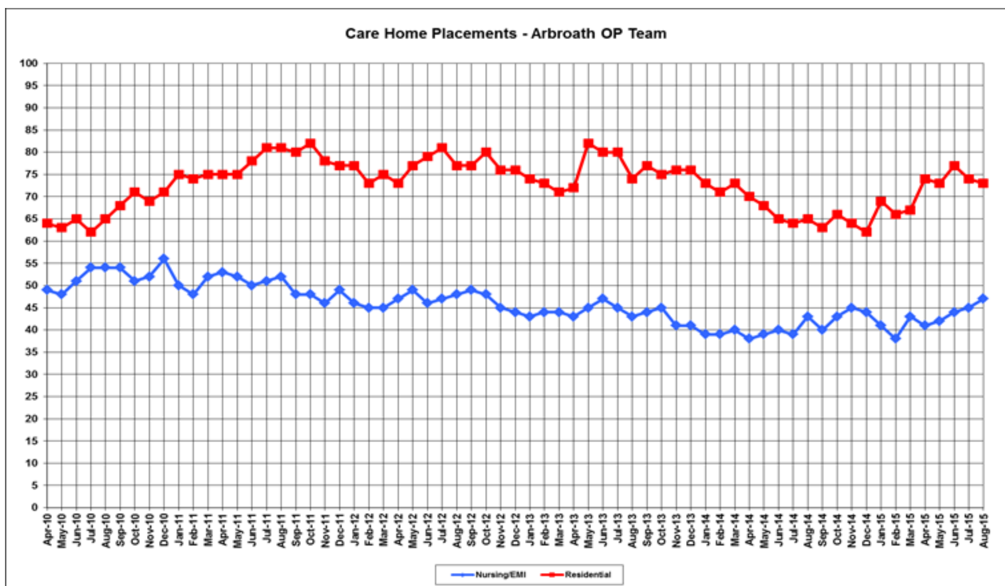
Diagnosis	Number of people	Prescriptions	unique patient identifiers
Depression	971	Anti- depressants	3717
dementia	315		
diabetes	1664		
Learning disability	156		
Mental health	254		
Osteoporosis	74		
cancer	690	Breast cancer Prostate cancer	108 59
Palliative care	66		
Stroke/TIA	751		

We do know that the mental health foundation suggests that 2.6% of the population have depression, 4.7% anxiety and 9.7% depression and anxiety. We need to consider what the Quality & Outcomes Framework (QOF) and pharmacy data is telling us and how this relates to the level of services provided for mental health.

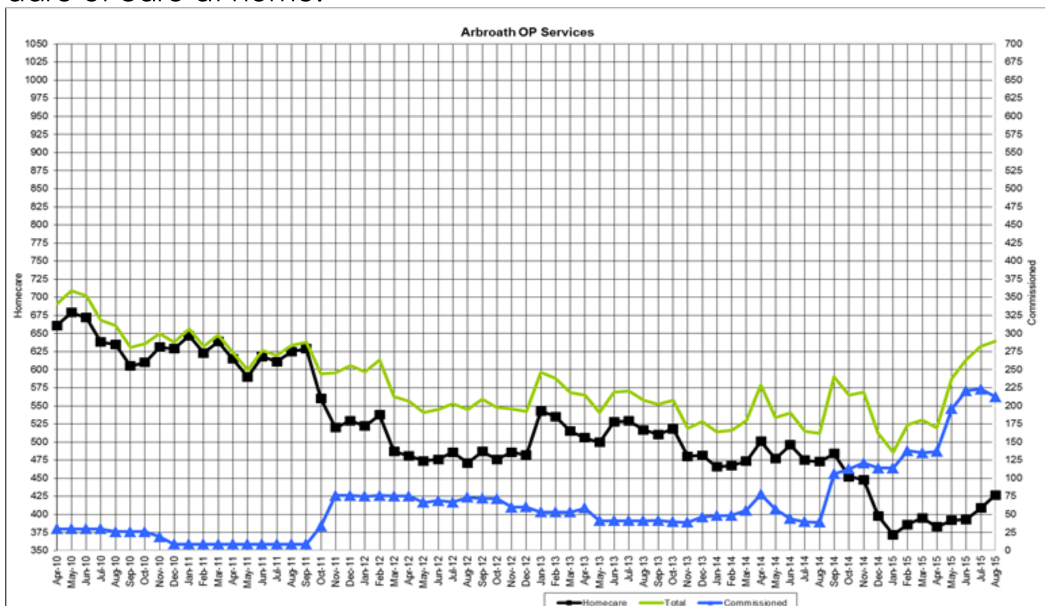
3. Current Performance

We are working on the development of a performance framework. We need to be able to provide all performance information at a locality level. Some information in relation to Angus wide services is not yet available at locality level. Other information is gathered at team level so new systems need to be put in place to deliver locality based information. Information included in this report therefore requires to be reviewed to reflect locality information. Only part locality information is described here. This includes information on drug and alcohol use and services, adult mental health services and learning disability services.

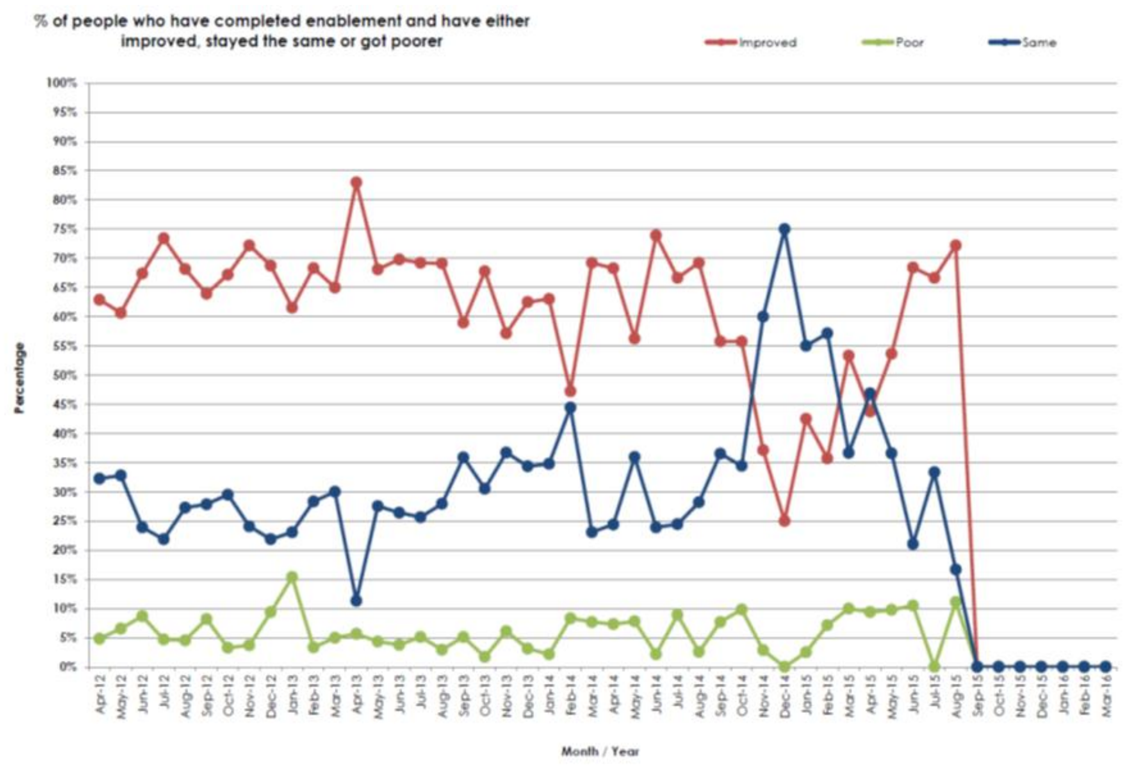
Care home placements for older people have been reducing over the past 5 years. The age at which people move into a care home has been increasing and the length of stay reducing. There are 260 care home beds provided through 6 care homes. Vacancy rates are low. Angus Council supports approximately 50 nursing home and 74 residential home placements for older people alone in this locality.



The amount of personal care provided to older people in the South East has increased in the past few months. The independent sector is providing an increasing dare of care at home:



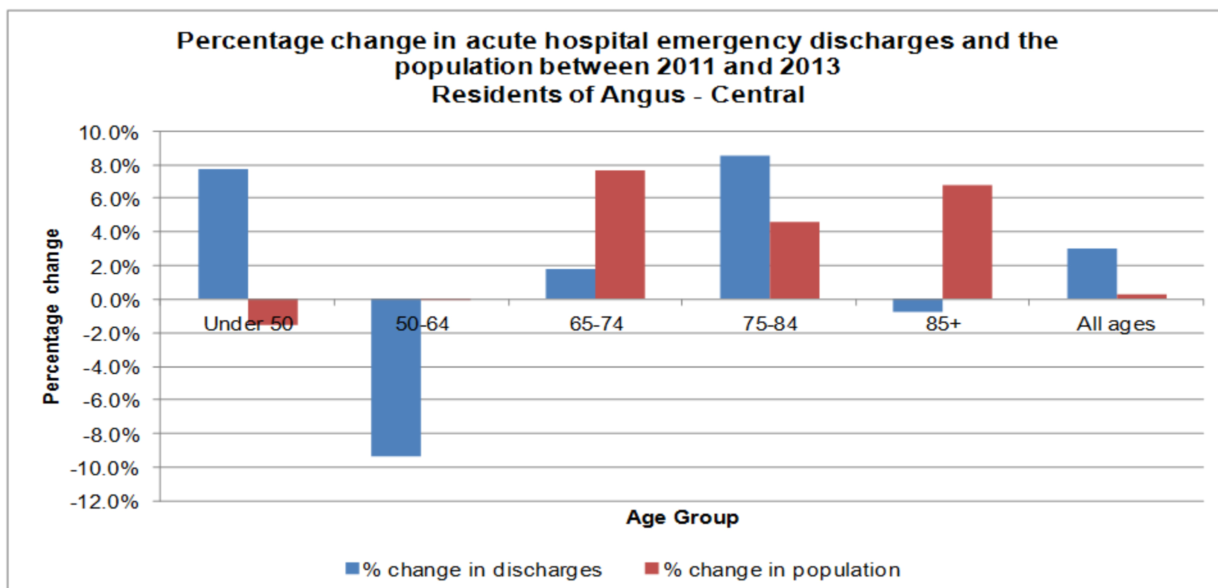
Enablement services delivered for the first 4 to 6 weeks following a social care referral continue to support people to greater independence and reduce reliance on social care services especially housing support and community meals services.



The rate of emergency admissions fluctuates year on year. The rate in the South East is the second lowest rate in Angus. The number of people admitted following a fall is increasing especially among over 85s:

	2011/12	2012/13	2013/14
Number of discharges	2,526	2,513	2,603
Crude rate per 100,000 population	8,604.7	8,570.9	8,842.6

Whilst the introduction of enhanced community support appears to have had an impact on emergency admissions in relation to those aged 75 and over, we need to ensure that this approach also supports adults under 75 with multi-morbidities especially those under 50. We need to understand how people aged 50-64 have been supported in this locality especially the 50-64 age group where emergency admissions have reduced although the population is relatively constant:



South East has the lowest rate of emergency admissions for over 65s in Angus

Angus patients (aged 65+) with multiple (2+) emergency hospitalisations
Age standardised rate per 100,000 popn

Locality	2007-2009	2008-2010	2009-2011	2010-2012	2011-2013
Angus - North East	4,582.7	4,056.0	3,867.8	3,668.1	3,971.6
Angus - North West	4,317.8	4,387.4	4,144.4	4,005.6	3,810.0
Angus - South East	**3,837.6**	**4,195.9**	**3,943.7**	**3,867.4**	**3,801.5**
Angus - South West	4,176.9	4,212.4	4,215.0	4,085.6	4,024.4
Angus	4,261.4	4,252.4	4,073.6	3,929.0	3,907.0

The number days lost to delayed discharge is reducing.

Number of days people spend in hospital when they are ready to be discharged

Locality	2010/11	2011/12	2012/13	2013/14	2014/15
North East	1,504	2,127	3,246	2,817	2,313
North West	4,348	3,526	3,527	3,146	2,037
South East	**3,010**	**1,989**	**2,597**	**1,530**	**1,446**
South West	1,947	1,765	1,644	1,415	1,195
ANGUS TOTAL	10,809	9,407	11,014	8,908	6,991

4. Current Improvement activity

Four priorities for improvement will be taken forward through the Angus Health and Social Care Partnership Strategic Commissioning Plan. These improvement priorities are already being delivered in South East Angus through the following activity:

1. Improving health, wellbeing and independence

- Self management of long term conditions
- ALISS development
- Third sector single point of contact officer
- Carer development worker
- Carer befriending / sitting / voucher scheme

2. Supporting care needs at home

- ADL smartcare development
- Integration of occupational therapy services
- Enablement
- Help to live at home project
- Self directed support

3. Developing integrated and enhanced primary care and community responses

- Enhanced community support
- Hospital discharge pathway
- Physiotherapy and generic rehabilitation and falls
- Poly pharmacy
- Orthopaedic pathway

4. Improving integrated care pathways for priorities in care

- Housing solutions for adult mental health and learning disability
- Dementia diagnosis and support

5. Developing specific priorities for the South East

Looking at a range of case studies provided an opportunity to consider and identify opportunities for development specific to South East Angus.

Case studies: Alex, Brian, Morag and Pete (Mental Health, Drugs & Alcohol & Learning Disability)

What already exists in the community?

- A lot of resources already in the locality – but not everybody knows how to access these.

What supports are missing?

- One point of contact
- Better support for children with parental mental health problems

Case studies: James and family (Long Term Conditions)

What already exists in the community?

- A lot of resources already in the locality

What supports are missing?

-

Case studies: William, Jimmy, Mary & Yvonne (Older Person)

What already exists in the community?

- A lot of resources in the locality

What supports are missing?

- Telehealth
- Skype/iPad service to help people stay in touch with family
- Bereavement support
- Men's shed
- Better transport links

Focusing specifically on change, groups identified:

A. Positive attributes of locality:

- Established MDT working and enhanced community support
- Wide range of supports available
- Plethora of voluntary organisations

Arbroath

- Arbroath Infirmary and links with community care

Friockheim

- Small community where people know each other
- Church is a hub for social activities

B. Areas for development

- Lots going on but it is not joined up
- Community hubs signposting people to local information
- Intergenerational working e.g. cooking clubs
- Alternatives to admission

Arbroath

- Greater mix of clinical capacity required e.g. GPs and Advanced Nurse Practitioners
- Services come to local groups e.g. chiropody, podiatry, O.T.
- Reduce duplication of deliverable community/social services

Friockheim

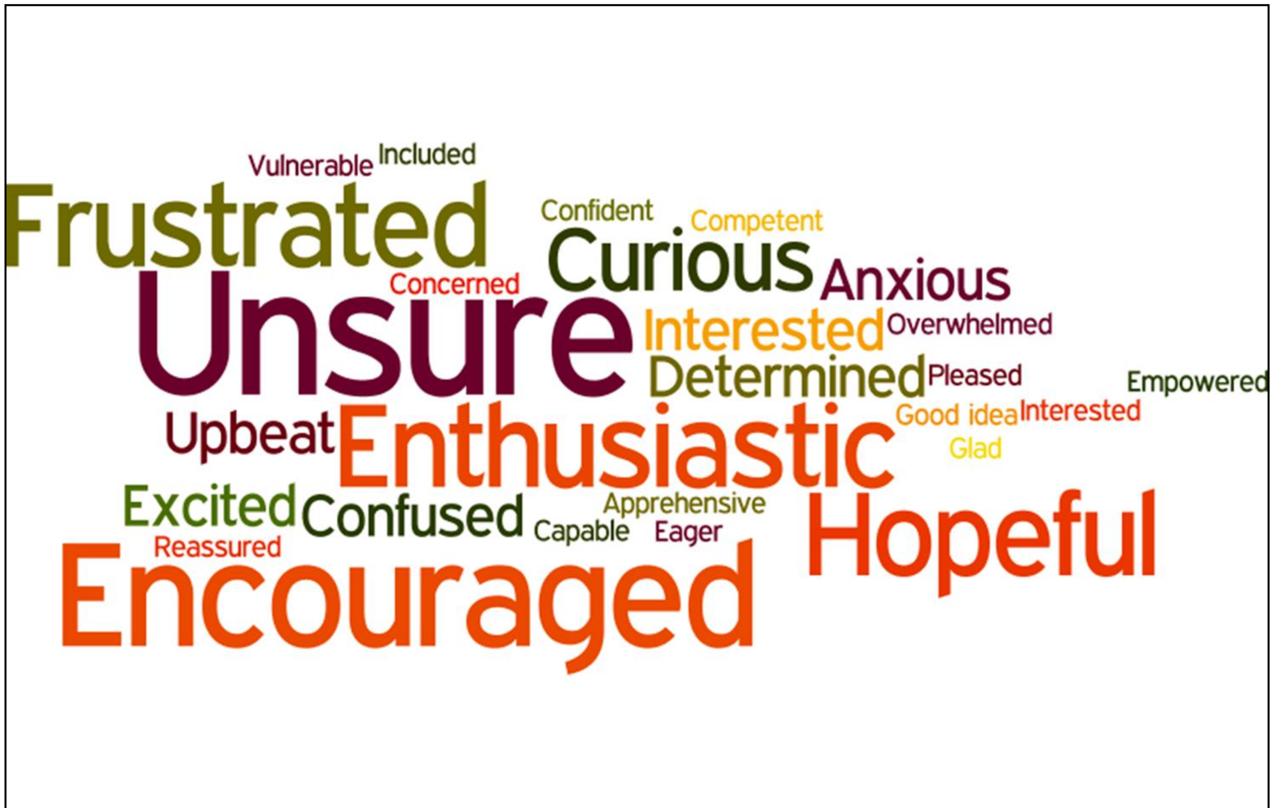
- Set up a 'wellbeing café/lunch club/dementia café

C. Wild card suggestions

- Combined befriending and meal service
- Adopt whole family approach
- Named person to check on an older person every 1-2 weeks for medications, shopping, wellbeing

6. Next Steps

At the end of the event you expressed how you felt about integrated working in your locality:



You agreed the most important message is:

Timeline for Strategic Commissioning Plan

Date	Milestone
Early September	Locality commissioning events
October 2015	High level strategic aims and priorities published
October 2015	Strategic Needs Assessment completed
November 2015	Baseline performance information
December 2015	Locality commissioning priorities identified
February 2016	Draft Strategic Commissioning Plan for public consultation Draft locality plans
March 2016	Market facilitation plan set out
April 2016	Delivery of strategy following delegation of powers to IJB

Each locality has a Locality Improvement Group which will progress the development of the Locality Improvement Plan.

How will you work together, in this locality, to identify what, in addition to the Angus improvement priorities, you need to deliver and how improvement can be delivered?

7. Attendees

NAME	REPRESENTING
Susan Anderson	Carers
Fiona Anderson-Peacock	Council
Allyson Angus	Health
Dr Sarah-Jane Baldwin	Health
David Barrowman	Public
Donna Bennett	Public
Vanessa Black	Carers
Ann Bowdler	Health
George Bowie	Council
Jan Brodie	Health
Claire Cosans	Carers
Dr Greg Cox	Health
Ashleigh Crawford	Third Sector
Linda Cruickshank	Council
Donna Cuthill	Independent Sector
Mhairi Dickson	Council
Jenny Donald	Council
Sandra Dow	Public
Dr Alex Duncan	Health
Jackie Duncan	Third Sector
Kay Erskine	Health
Maureen Fagan	Health
Ann Findlay	Independent Sector
Scott Fleming (School)	Secondary Schools
Drew Gillespie	Council
Margaret Hagan	Carers
Linda Hamilton	Health
Nicola Hay	Health
Alan Ingram	Independent Sector

NAME	REPRESENTING
Susan Jackson	Council
Linda Kennedy	Council
Susan Kidd	Council
Dr Douglas Lowdon	Health
Andrea Lowe	Council
Dr Duncan MacDonald	Health
David Mackenzie	Public
Sharon McFadyen	Health
Cait Mcintosh	Council
Shauna McLeod	Council
Jacqui McNeill	Council
Alice Menmuir	Independent Sector
Patricia Millar	Public
Gillian Milne	Carers
Elizabeth Montgomery-Fox	Public
Liz Murray	Health
Emma Petrie	Health
Jed Roberts	Third Sector
Jane Skene	Council
Carrie-Anne Stephen	Health
Holly Stephen (School)	Secondary Schools
Ian Stillwell	Council
Ann Strachan	Council
Jane Swan	Independent Sector
Barry Thomson	Third Sector
Gordon Walker	Health
Dr Allan Ward	Health
Kristy Whitton	Health
Nicky Worrall	Council