AGENDA ITEM NO 8

REPORT NO. IJB 42/18

ANGUS HEALTH AND SOCIAL CARE

INTEGRATION JOINT BOARD – 27 JUNE 2018

ANNUAL STRATEGIC PROGRESS AND PERFORMANCE REPORT

REPORT BY VICKY IRONS, CHIEF OFFICER

ABSTRACT

The purpose of this report is to update the Integration Joint Board (IJB) on the progress made in delivering the strategic plan and the effect of our activity on performance during 2017/18. This report builds on previous quarterly performance reports presented to the IJB. The report demonstrates the level of improvement activity being delivered across the partnership and shows how that is driving progress towards the delivery of the Partnership's vision, strategic shifts and planned outcomes for the people of Angus.

1. RECOMMENDATIONS

It is recommended that the Integration Joint Board (IJB):

(i) approve the 2017/18 Strategic Progress and Performance Report for Angus (Appendix 1);

(ii) recognise the progress that has been made by staff in delivering the aims of the strategic plan;

(iii) approve the recommendation of the Strategic Planning Group to retain the four priorities for the development of the Strategic Plan 2019-2022

(iv) ask the Chief Officer to ensure that updated performance reports are provided to the IJB biannually.

2. THE ANNUAL STRATEGIC PROGRESS AND PERFORMANCE REPORT

2.1 The IJB have agreed previous reports related to the development of the Partnership's performance framework.

2.2 This 2017/18 Strategic Progress and Performance Report aims to set out the strategic level performance described in the partnership's performance framework. This includes the national core indicators which demonstrate progress against the national outcomes.

2.3 The report also summarises the position of the Strategic Planning Group in relation to reviewing the Strategic Plan 2016-2019 and the consensus that the four priorities of the Strategic Plan 2016-2019 remain fit for the future and should be retained as the focus of the strategic plan for 2019-2022.

2.4 Strategic activity during 2017/18 and a number of additional local indicators have been developed to show progress and performance in relation to the four strategic priorities:

Priority 1	Improving health, wellbeing and independence
Priority 2	Supporting care needs at home
Priority 3	Developing integrated and enhanced primary care and community responses
Priority 4	Improving integrated care pathways for priorities in care

2.5 The report also provides both progress and performance information on a further three performance areas:

Performance area 1	Clinical and care governance
Performance area 2	Staff
Performance area 3	Resources

2.6 The 2017/18 Strategic Progress and Performance Report (Appendix 1) provides evidence of progress in line with the requirements for the annual performance report set out in regulations.

2.7 In setting out strategic progress and performance the report highlights that:

- ✓ Angus performs well nationally in relation to most national core indicators. This good performance shows the progress the partnership has made in shifting the balance of care to more community based and responsive services and addressing the average length of stay in hospital following an emergency admission.

- ✓ We have developed the Angus Care Model. This has improved the pathway for people through services in and out of hospital. It is enabling the delivery of change in the inpatient bed model across Angus, the care home model, minor injury and illness services, care and treatment services to support GP practice and timely discharge. Through this we gained public recognition that typically having 37 unoccupied hospital beds was not sustainable or desirable and gained acceptance of the need for change.

- ✓ Progress has been made in addressing hospital bed occupancy. Angus has seen a continuing decrease in the bed day rates although admissions continue to increase. We have extended Enhanced Community Support (ECS) into the North East locality. ECS is an approach to integrated multi-disciplinary team working around GP practice and facilitates Medicine for the Elderly Consultant follow through from hospital to community and Advanced Nurse Practitioner support. ECS has delivered improvements in admissions and average length of stay for people over 75.

- ✓ We have completed the delivery of Help to Live at Home. The outsourcing of personal care and housing support services has ensured that we have been able to increase the level of personal care available within our communities by 47% over the last 2 years. Recognising that care providers along with Angus Health & Social Care Partnership are all partners in supporting the needs in our communities, we have developed a new contractual framework including delivering a fair cost of care with providers. After a delay in delivery, we have delivered the integration of enablement and community alarm services into Enablement Response Teams providing enablement and short term support to increase independence, prevent admission and ensure support at discharge from hospital. We are supporting people in the community with greater levels of need for longer.

- ✓ We can demonstrate that people are moving into care homes later in life for a shorter period of time and with higher levels of need.

- ✓ We have developed opportunities that will enable the integration of Occupational Therapy services and introduced advice on ‘Life Curve’ as part of a new approach to self-management. This has included the delivery of self-assessment for some equipment including community alarm. Self-assessment can be accessed anytime through Independent Living Angus.

- ✓ We continue to improve Involvement and Engagement approaches through locality improvement groups, care home improvement groups, GP clusters and GP clinical partnership, provider’s forums and the locality conversation programme.

- ✓ We are improving the relationship with community planning and development of locality Outcome and Improvement Plans.

- ✓ We have supported improvement in medication management in care homes. A new process developed by the care home improvement group with GPs and pharmacy has led to zero medication waste in care homes.

- ✓ We have introduced Mental Health and Wellbeing nurses to support GP practice reducing demand on GP appointments and supporting people with non-medication alternatives to managing mental wellbeing.

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Appendices

Appendix 1 – 2017/18 Strategic Progress and Performance Report