ANGUS
Health & Social Care
Partnership

Strategic Progress & Performance Report

April 2017-March 2018

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Introduction

The Angus Health and Social Care Partnership (AHSCP) set out the vision for change and improvement in its strategic plan 2016-19. The purpose of this Annual Strategic Progress and 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 further performance areas.

The four priorities of our strategic plan aim to deliver the nine national health and wellbeing outcomes. Our performance in relation to the national outcomes will be set out in relation to our four strategic priorities and three performance areas (Figure 1). The relationship between our strategic priorities, the national outcomes and the national core indicators is set out in Table 2. This report also sets out our plans for the coming year. Throughout the report, performance is shown by locality, where possible. This allows locality improvement groups to focus on addressing variance in performance and continuous improvement. The report does not cover hosted services. Discussions are ongoing with other Partnerships about how we create and deliver a shared approach to reporting on those services.

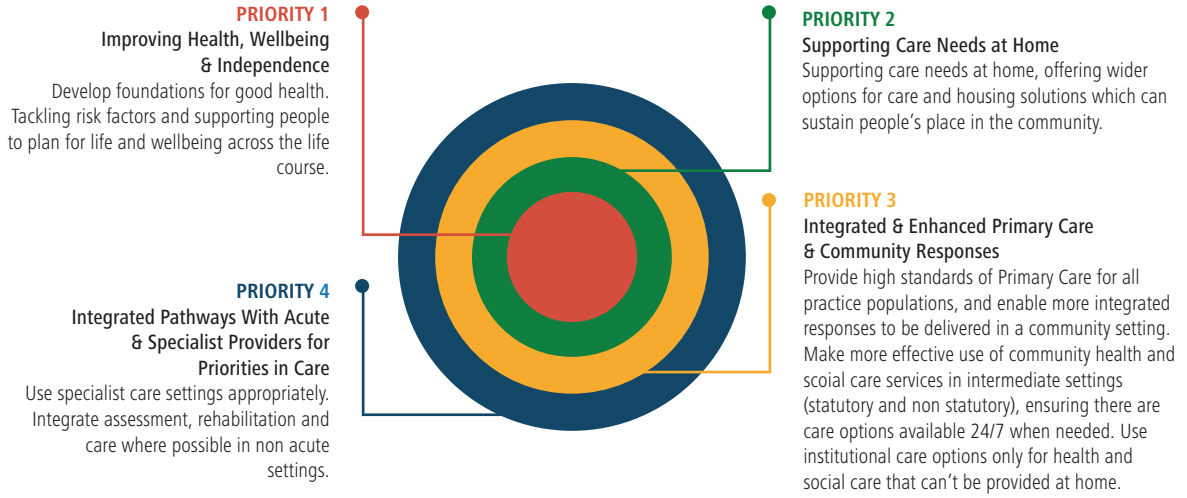
The Strategic Priorities

Angus Health and Social Care Partnership (AHSCP) is committed to placing individuals and communities at the centre of service planning and delivery in order to deliver person-centred outcomes. The Partnership is focused upon improving the long term health of its population, providing timely health and social care interventions when needed, and ensuring that such interventions give the best outcomes for our service users and their carers. The Angus Strategic Plan makes a commitment to shifting the balance of care from institution-based care to care at home; it calls for health and social care to extend beyond the traditional setting of hospitals and care homes to reach more effectively into a person's own home and community. The strategic plan sets out this ambition through four strategic priorities.

There is a growing demand for care provision. People are living longer with multiple and complex care needs that require more support from health and social care services. Local people have told us they want to access care closer to home, and care which helps to maintain their independence and the support of their own community.

Resource management is becoming more challenging because of increasing levels of demand. Year on year we face a growing requirement to manage the resources of the Integration Joint Board (IJB) in line with increased demand. Using the current resource framework as efficiently and effectively as possible is essential. The strategic plan identifies a number of areas of efficiency, and the shift in the balance of care required.

Figure 1: The Strategic Plan - Transforming Health & Social Care in Angus



Review of the Strategic Plan

The strategic plan continues to be progressed by the delivery of a range of improvement activity across services. This includes integrating teams, delivering services differently and developing new types of service models. The Annual Performance Report sets out progress and improvement against each of the strategic themes. As we progress delivering improvement in our services we continue to learn more about how to progress change in a challenging financial and strategic environment. A delivery plan was established in 2017 to focus our efforts on key areas of improvement from our strategic plan. Ongoing progress has been reported to the IJB in a number of reports. What we have achieved in 2017/18 in relation to the delivery plan is outlined against each strategic priority in this report.

Each locality has developed a locality improvement plan which includes an action plan showing how Angus wide improvement projects are impacting on that locality. These plans also identify a number of locality specific tests of change and improvements within localities supported by the locality improvement groups. It is anticipated that some of these tests of change will identify further improvement opportunities that can be rolled out across Angus and be included in a future version of the delivery plan. Locality progress is reported at each meeting of the strategic planning group and reflected in this report in relation to the strategic priorities.

Optimising resources and joining up health and social work services is critical to realising the ambitions of health and social care integration. Our delivery plan has begun to realise our aspirations that an integrated package of assessment, enablement, treatment, rehabilitation and support in the community, along with help for carers, can better serve the needs of Angus people and help deliver more effective deployment of the resources available to the AHSCP. This approach requires people to be central to decisions about their own needs, outcomes and support.

We continue to take every opportunity to better integrate services at all levels of our partnership. We plan to think and do things differently to support people more effectively in their own homes. As we continue to progress with change our focus must be to deliver improvements in care which will:

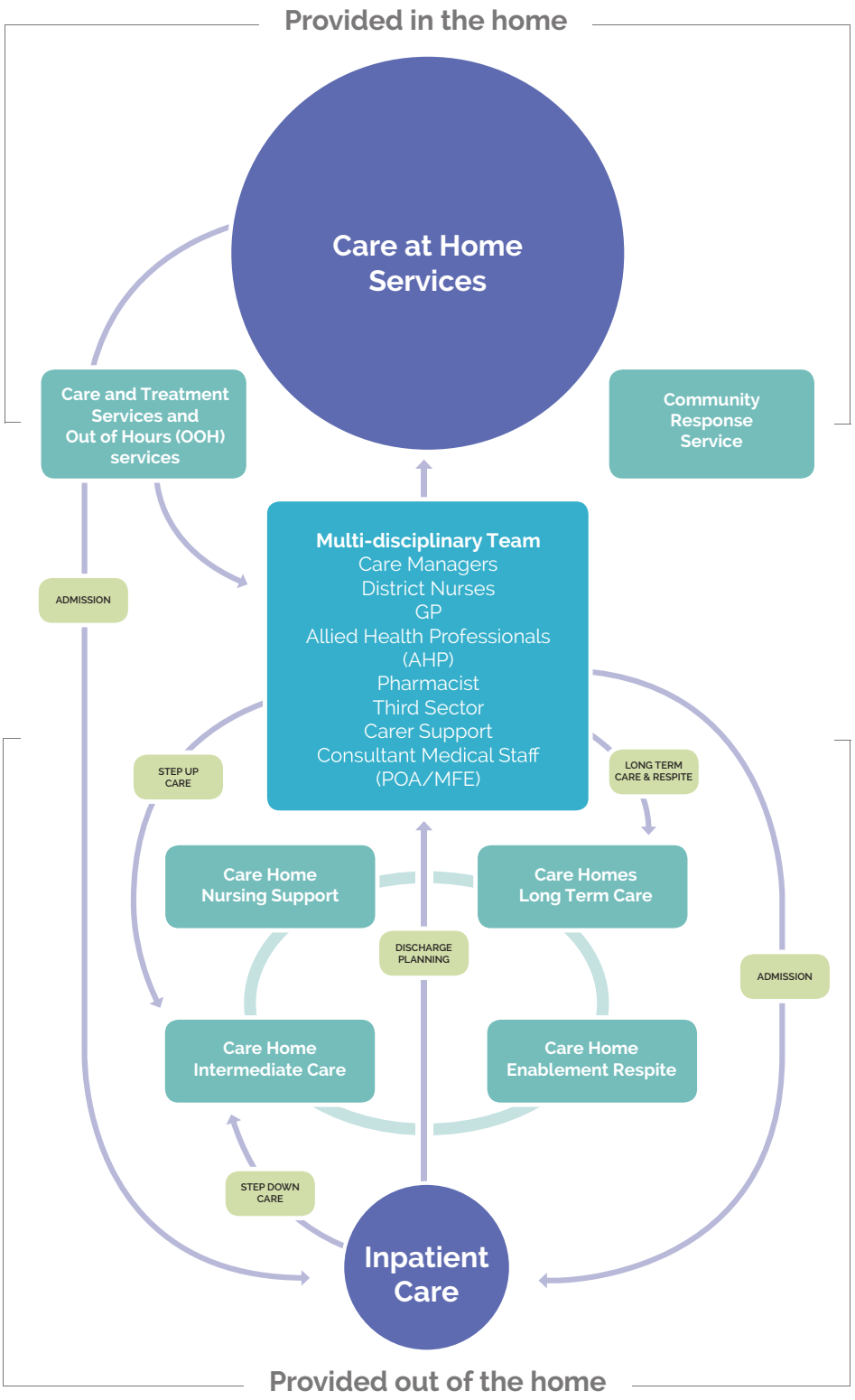
- **Rebalance** care, maximising support for people in their own homes.
- **Reconfigure** access to services delivering a workable geographic model of care outside the home.
- **Realise** a sustainable workforce delivering the right care in the right place.
- **Respond** to early warning signs and risks in the delivery of care.
- **Resource** care efficiently, making the best use of the resources available to us.

The completion of a broad series of reviews that have impacted on the way the services are designed and delivered to support delivery of the national health and wellbeing outcomes, identifying overlaps in care, support, processes and other arrangements, identified the need to bring review outcomes together. This has allowed us to create the Angus Care Model.

As we move into the final year of the current strategic plan the focus of our efforts will continue to be in strategic priority areas two and three. This will allow us to complete the delivery across the whole of Angus of Enhanced Community Support and build on that work to deliver on our vision of the Angus Care Model.

ANGUS CARE MODEL

The Angus Care Model built on a foundation of an Angus that actively cares



Our partnership will grow through working together with providers to deliver support that is focused on:

- meeting agreed outcomes with people who use services;
- flexible and responsive services that deliver enabling and practical approaches that support people to live well; and,
- delivering good quality services which are well placed to respond to new models of care and support.

Information to date suggests we are already doing well, with more than 90% of older people's care being delivered in the community, but there is still more to do for the whole adult population. Early information tells us that whilst hospital admission rates for people over 75 are declining, admission rates for people aged 50-75 are increasing. We have already delivered good work in relation to self-management but we are beginning to understand more about opportunities for improvement around potentially preventable admissions relating to people aged 50-74 with COPD, diabetes and asthma.

Delivering a Strategic Plan for 2019-2022

We continue to see the four priorities that are established in our strategic plan 2016-19 as fit for the future. We are developing new information around the health and wellbeing of the population in a new Joint Strategic Needs Assessment and improving performance information at a management level in more areas. This will allow us to create evidence to support a shift in emphasis in relation to our strategic priorities for the new strategic plan 2019-2022. We expect to continue to grow our approach to the Angus Care Model that has a much greater emphasis on creating communities that actively care including how the partnership supports prevention, early intervention and self-management whilst continuing to deliver arrangements aimed at supporting people in their own homes and communities with less dependence on hospitals. This will be supported at a national level with the introduction of new public health priorities.

Over the last year, the Scottish Government and COSLA, working with a range of partners and stakeholders, engaged widely across Scotland to develop a set of priorities for the whole system. This included drawing upon Local Outcome Improvement Plans to ensure consistency with local community planning priorities, and collaborating with a wide range of stakeholders. The priorities are summarised below:

A Scotland where…

1 We live in safe and healthy places.
2 We flourish in our early years.
3 We have good mental wellbeing.
4 We reduce the use and harm from tobacco, alcohol and other drugs.
5 We have an inclusive economy with fair share, of what we have, for all.
6 We eat well and are active.

Involvement and Engagement

We continue to be committed to engagement with stakeholders in our services. We host a range of groups and forums to deliver consensus on plans and the vision for the future. Involvement and engagement approaches include:

- Locality Improvement Groups
- Care Home Improvement Groups
- GP clusters
- GP clinical partnership groups
- Providers Forums

In addition to the above we have developed a 'Continuing the Conversation' approach in each locality to create greater 'public facing' opportunity for discussion on the narrative of change.

- During October and December 2017 and March 2018 we held 'Continuing the Conversation' events in each of our four localities when members of the public spoke to staff about health and social care in Angus. The drop in events gave people the opportunity to talk to staff and learn about improvements, see examples of current care pathways and hear why changes need to be made.
- People also had the opportunity to give their views and help shape how services will look in the future.
- The majority of people who attended the events told us that they had been given sufficient opportunity to comment and offer their opinion and had found the events helpful.
- Attendees at the March 2018 event told us that they felt encouraged, interested, hopeful and reassured about what they had seen and heard.

Angus Performance Summary

What we have achieved in 2017/18

- Angus performs well nationally in relation to most national quantitative core indicators. This 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 across Angus 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 where integrated multi-disciplinary teams work in partnership with GP practices, Medicine for the Elderly Consultants and Advanced Nurse Practitioners, following the patient pathway from hospital to community. 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 AHSCP 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. We have delivered the integration of enablement and community alarm services into Enablement and 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 keeping well and staying independent 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 any time through web based 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, providers' 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 a Locality 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.

Summary – National Indicators 2017/18

Table 1 shows the summary of Angus 2017/18 performance in relation to the Scottish (2017/18) performance across a range of national indicators. Four national indicators remain undeveloped and are therefore not included in the summary table. More detail on performance in relation to these indicators is provided throughout the Strategic Progress and Performance Report. The national indicators are reported in relation to the four strategic priorities and 3 performance areas in the manner described in Table 2 which shows the association between the national outcomes, national indicators and the four AHSCP strategic priorities.

Qualitative Indicators (NI 1-10)

The Qualitative Indicators which form part of the National Core Data Set for Health and Social Care are derived from a national survey undertaken every 2 years. The survey was originally called the GP survey but has been developed to include questions in relation to wider health and social care services delivered through Partnerships. The 2017/18 survey was issued randomly to 8,641 adults in Angus. 2,488 surveys were returned (29%). The survey includes many questions in addition to those that form the national indicators. Whilst 2,466 people responded to the question relating to NI-1, the majority of the questions were responded to by only approximately 140 people (0.15% of the population of Angus aged over 18). The measure is an aggregate of people responding positive adn very positive to the survey question. People also responed as neither positive or negative (neutral) or negative. Against most questions negative response for Scotland is equal to or worse than the Angus negative response. Locally we have undertaken 1770 reviews during 2017-18 of people who use services. The picture from responses of supported people in reviews show a very different picture to the results of the national survey.

Quantitative Indicators (NI 11-23)

The quantitative indicators aim to show shift in the balance of care from institutional services to community based services. Some of these indicators are used by a Joint Ministerial Steering Group to show progress against the Scottish Government's National Delivery Plan for Health and Social Care which was published in 2016. These indicators are:

- NI 12 Emergency admission rate for adults (per 100,000 population)
- NI 13 Emergency bed day rate for adults (per 100,000 population)
- NI 15 Proportion of last 6 months of life spent at home or in a community setting.
- NI 19 Number of days people spend in hospital when they are ready to be discharged (per 1,000 population)

In addition the Joint Ministerial Steering Group are interested in information on performance in relation to two additional indictors which are not part of the national core data set. These are:

- A&E attendances (adults)
- Balance of Care

Two local indicators in relation to personal care and care home use are also described in the summary to begin to address information in relation to balance of care.

Anonymised personal stories are used to show the impact of change and performance on people. Permission has been provided to use these stories.

For quick reference table 1 includes colours which describes Angus performance as follows:

- Angus is performing well against the Scottish average
- Angus rate is similar to the Scottish average but there is room for improvement (</=5%)
- Angus has greater room for improvement against the Scottish average

Table 1: Angus' Ranked Performance for national indicators and local indicators

Biennial Outcome Indicators 2017/18							
Indicator	**Title**	**Scotland 2015/16**	**Angus 2015/16**	**Scotland 2017/18**	**Angus 2017/18**	**Response to national survey**	**Notes from reviews of supported people in Angus in 2017/18**
NI - 1	Percentage of adults able to look after their health very well or quite well	94%	96%	93%	**95%**	2,466 responses	Page 16
NI - 2	Percentage of adults supported at home who agreed that they are supported to live as independently as possible	83%	86%	81%	**76%**	136 responses 21% neutral, 3% negative Scotland 5% negative	98% feel that services help them to stay as well as they can be (Page 47)
NI - 3	Percentage of adults supported at home who agreed that they had a say in how their help, care, or support was provided	79%	79%	76%	**71%**	144 responses 21% neutral, 8% negative Scotland 8% negative	100% feel listened to by staff (Page 47)
NI - 4	Percentage of adults supported at home who agreed that their health and social care services seemed to be well co-ordinated	75%	79%	74%	**71%**	137 responses 21% neutral, 8% negative Scotland 10% negative	99% people feel that they have a choice over the nature and timing of support (Page 47)
NI - 5	Total percentage of adults receiving any care or support who rated it as excellent or good	81%	81%	80%	**76%**	149 responses 16% neutral, 8% negative Scotland8% negative	91% people feel that staff within services are responsive to their need and wishes (Page 48)
NI - 6	Percentage of people with positive experience of the care provided by their GP practice	87%	87%	83%	**78%**	2,133 responses 16% neutral, 7% negative Scotland 5% negative	The increasing strain on General Practice nationally is reflected in a deterioration in access for patients who wish to see a GP (Page 48)
NI - 7	Percentage of adults supported at home who agree that their services and support had an impact on improving or maintaining their quality of life	83%	81%	80%	**77%**	136 responses 21% neutral, 2% negative Scotland 5% negative	98% feel that services help them to stay as well as they can be (Page 48)
NI - 8	Total combined percentage of carers who feel supported to continue in their caring role	40%	38%	37%	**34%**	321 responses 39% neutral, 27% negative Scotland 23% negative	96% carers have been offered support which has allowed them to continue in their caring role (Page 48)
NI - 9	Percentage of adults supported at home who agreed they felt safe	84%	83%	83%	**80%**	140 responses 17% neutral, 3% negative Scotland 4% negative	95% people feel that services they have in place help them feel safe (Page 48)

Quantitative Indicators 2017-18						
Indicator	**Title**	**Scotland 2015/16**	**Angus 2015/16**	**Scotland 2017/18**	**Angus 2017/18**	**Notes from reviews of supported people in Angus in 2017/18**
National Data indicators 2015/16						
NI - 11	Premature mortality rate per 100,000 persons	441	391	440	404	This shows that we need to increase efforts in relation to health improvement. (P16)
NI - 12	Emergency admission rate for adults (per 100,000 population)	12,346	10,528	11,959	10,976	The increase in admission rates has slowed in Angus mostly due to improvements in admission rates relating to people aged over 75. Admission rates in those aged 18-74 continue to increase. (P33)
NI - 13	Emergency bed day rate for adults (per 100,000 population)	127,965	116,043	115,518	107,303	Most improvement has been delivered through ECS activity with people over 75. (P34)
NI - 14	Readmission to hospital within 28 days for adults (per 1,000 population)	97	104	97	100	Readmissions are a percentage of those who have previously been admitted. Lower levels of hospital admissions experienced in Angus (NI 12) may contribute to higher levels of readmissions as admissions are most necessary. (P35)
NI - 15	Proportion of last 6 months of life spent at home or in a community setting.	87%	90%	88%	90%	Angus is amongst the best performing partnerships in Scotland in relation to this indicator. (P30)
NI - 16	Falls rate per 1,000 population aged 65+	21	19	22	21	Falls rates in Angus are increasing at a greater level than Scotland as a whole. This may be due to the over 85 population increasing in Angus at a greater rate than Scotland as a whole (P24)
NI - 17	Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections (*2015/16)	83%	90%	85%	84%	(P48)
NI - 18	Percentage of adults with intensive care needs receiving care at home	61%	52%	62%	52%	This indicator is focused on the proportion of people known to the partnership who receive personal care. The proportion of people in Angus who have community alarm is higher than the Scottish average. This indictor does not include other types of services such as day care which also support people to live independently. The years where performance is shown greater than the Scottish average are those years when day care hours were added into the personal care return. Day care does not feature in the service arrangements of many areas of Scotland. (P29)
NI - 19	Number of days people spend in hospital when they are ready to be discharged (per 1,000 population)	915	368	772	426	A separate report was provided to the IJB to explain the challenges Angus has experienced in 2017 in relation to delays in discharge. Efforts to mitigate these issues began to deliver improvement in quarter 4 2017/18. (P40)
NI - 20	Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency	24%	28%	23%	27%	Dundee and Perth & Kinross Partnerships perform at a similar level to Angus for this indicator. This indicator is influenced by the cost of hospital care in Tayside. (P55)

Quantitative Indicators 2017-18						
Indicator	**Title**	**Scotland 2015/16**	**Angus 2015/16**	**Scotland 2017/18**	**Angus 2017/18**	**Notes from reviews of supported people in Angus in 2017/18**
Local Indicators						
LI - 24	Personal care hours rate per 1,000 18+	Not available	2,697	Not available	3,924	Personal care provision has increased across all localities of Angus. (P28)
LI - 25	Care home nights rate per 1,000 65+	Not available	10,718	Not available	10,447	People are entering care homes later in life and for a shorter periods. (P36)

Table 2: The relationship between Angus Priorities, the National Health and Wellbeing Outcomes and the National Core Performance Meausures

Angus Strategic Priorities and Performance Areas National	Wellbeing outcomes	National Core performance measures
Priority 1: Improving health , wellbeing and independence	1. Healthier Living. People are able to look after and improve their own health and wellbeing and live in good health for longer. 5. Reduce Health Inequality. Health and social care services contribute to reducing health inequalities. 6. Carers are Supported. People who provide unpaid care are supported to look after their own health and wellbeing. This includes reducing any negative impact of their caring role on their own health and wellbeing.	NI-11 Premature mortality rate. NI-16 Falls rate per 1,000 population in over 65s. NI-1 Percentage of adults able to look after their health very well or quite well. NI-8 Percentage of carers who feel supported to continue in their caring role.
Priority 2: Supporting Care needs at Home	2. Independent Living. People, including those with disabilities, long term conditions, or who are frail, are able to live as far as reasonably practicable, independently at home or in a homely setting in their community.	NI-18 Percentage of adults with intensive needs receiving care at home. NI-15 Proportion of last 6 months of life spent at home or in community setting.
Priority 3: Developing integrated and enhanced primary care and community responses	3. Positive Experiences and Outcomes. People who use health and social care services have positive experiences of those services and have their dignity respected. 4. Quality of Life. Health and social care services are centred on helping to maintain or improve the quality of life of service users. Everyone should receive the same quality of service no matter where they live.	NI-6 Percentage of people with positive experience of care at their G.P. practice. NI-12 Rate of emergency admissions for adults. NI-13 Rate of emergency bed days for adults. NI-14 Readmissions to hospital within 28 days of discharge. NI-21 Percentage of people admitted from home to hospital during the year, who are discharged to a care home (data not available) NI-22 Percentage of people who are discharged from hospital within 72 hours of being ready. (data not available)
Priority 4: Improving Integrated care pathways for priorities in care		NI-19 Number of days people spend in hospital when they are ready to be discharged.

Angus Strategic Priorities and Performance Areas National	Wellbeing outcomes	National Core performance measures
Performance Area 1: Managing our workforce	8. Engaged Workforce. People who work in health and social care services are supported to continuously improve the information, support, care and treatment they provide and feel engaged with the work they do.	NI-10 Percentage of staff who say they would recommend their workplace as a good place to work.(data not available)
Performance Area 2: Clinical and Care Governance	7. People are Safe. People who use health and social care services are safe from harm.	NI-17 Proportion of care services graded 'good' (4) or better in Care Inspectorate Inspections. NI-2 Percentage of adults supported at home who agree that they are supported to live as independently as possible. NI-3 Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided. NI-4 Percentage of adults supported at home who agree that their health and care services seemed to be well co-ordinated. NI-5 Percentage of adults receiving any care or support who rate it as excellent or good. NI-7 Percentage of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life. NI-9 Percentage of adults supported at home who agree they felt safe.
Performance Area 3: Managing our resources	9. Resources are used Efficiently and Effectively. To deliver Best Value and ensure scarce resources are used effectively and efficiently in the provision of health and social care services.	NI-20 Percentage of total health and care spend on hospital stays where the patient was admitted in an emergency. NI-23 Expenditure on end of life care(data not available)

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.

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. The health inequalities in Angus 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 in order to 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 in 2017/18

- Continued to deliver a wide programme of support for self-management of long term conditions.
- Increased uptake of a wider range of peripherals with community alarm telecare range.
- Created a telecare demonstration room in the Kirriemuir Hub.
- First Health & Social Care Partnership to sign up to the National Technology Charter for people living with Dementia
- Tested, developed and extended the use of the Florence home mobile health monitoring system to nine services. This text based system supports people with home monitoring of some healthcare indicators (weight management, blood pressure monitoring, pain management, smoke free pregnancy etc).
- Developed a locality locator to support better understanding of services that cover each Angus postcode area.
- Developed a specification for an Angus Health and Social Care Partnership website and arranged for the procurement of the website.
- Provided alcohol brief interventions directly within primary care.
- Delivered training (through Tayside Council on Alcohol) for staff in older people's services with the aim of identifying individuals who may have emerging alcohol difficulties/dependence.
- Embedded the whole family approach in Angus Integrated Drug and Alcohol services.
- Supported the development of an Angus that Actively Cares as part of the Angus Care Model through the provision of funding support to the third sector across Angus.
- Accessed funding through the European NSR Interreg project which is allowing us to work with partners across Europe on digital innovation and the use of data to improve service design
- New arrangements are in place for the provision of respite care for people with learning disability with Tus Nua Care Services in Carnoustie and with HC One Finavon Care Home in Forfar.
- The Alcohol and Drugs Partnership have overseen a range of training:
    - Alcohol Focus Scotland's Rory Resource for primary schools – 28 teaching staff from across Angus trained to deliver in classrooms and cascade across colleagues.

- Overdose Awareness and Naloxone Training delivered across Angus localities by Tayside staff.
- Scottish Drug Forum Drug Awareness training delivered.
- Scottish Drugs Forum Listening and responding to children affected by substance use training delivered.
- Scottish Drugs Forum Older & Wiser (working with older drug users) training delivered.
- Scottish Drugs Forum Staying Alive in Scotland (Harm reduction/preventing drug deaths) training delivered.
- Scottish Drug Forum Introduction to trauma training delivered.
- NPS e-learning resource developed and implemented by a commissioned service.

- A review of Alcohol Screening & Brief Intervention Activity across Tayside has been completed.
- A Lead Officer Model for the three Alcohol & Drug Partnerships (ADPs) in Tayside has been implemented. This is hosted in Angus.
- The ADP strategic priorities for 2018-20 have been refined.
- Completed the implementation of the Carers (Scotland) Act 2016 with the introduction of new adult care and support plans and the establishment of local eligibility criteria.

1.2 What we plan to do next

- Review commissioning arrangements in relation to third sector organisations that provide preventative support in communities.
- Develop a new strategic commissioning plan with a greater emphasis on prevention and self-management.

1.3 How we monitor progress

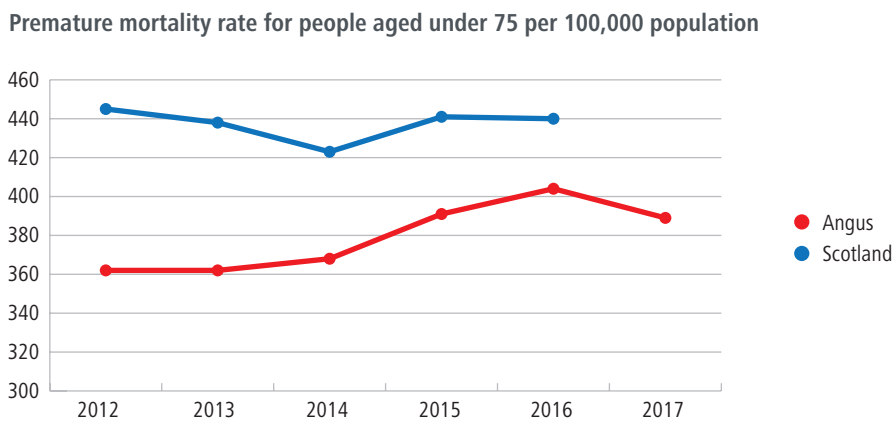
Progress is monitored through the following national and local performance measures:

Angus continues to perform well (above the Scottish average) with 95% of adults able to look after their own health (NI 1)

Premature mortality

1.3.1 Angus is consistently below the Scottish average in relation to premature mortality rates.

GRAPH 1: Management Information: Premature mortality rate for people aged under 75 per 100,000 population (NI-11)

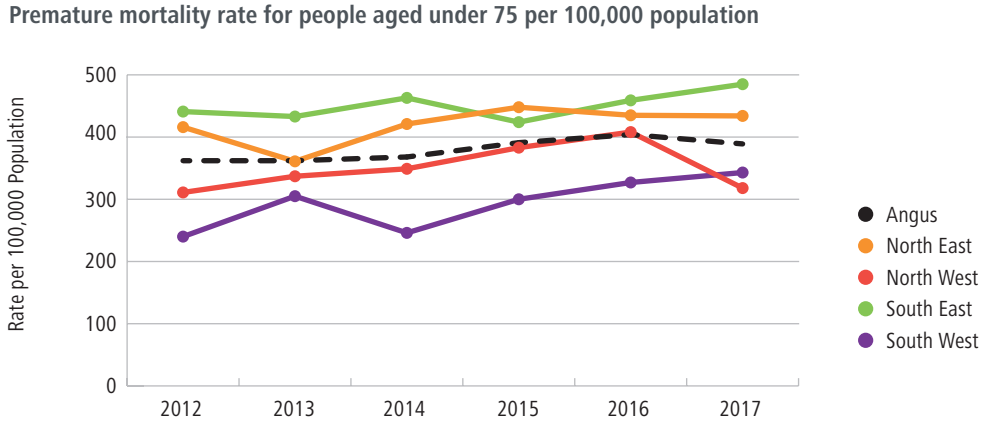


Source: National Record of Statistics (up to 2016)

Note: * 2017 rates are produced by ISD LIST and are provisional. They are not official National Records of Scotland (NRS) statistics. Official figures by NRS for 2017 will be released later in 2018.

1.3.2 There has been a decline in premature mortality in Angus following a 3 year period of increasing premature mortality rates. There is however variation between localities. This variation is consistent with areas affected by deprivation. Improving approaches to addressing health inequity continues to be a challenge for Angus.

GRAPH 2: Management Information at Locality Level: Premature mortality rate for people aged under 75 per 100,000 population



Source: ISD LIST (not official NRS statistics)

Note: Premature mortality rates at locality level are calculated by the ISD LIST team in Angus and are these are not official National Records of Scotland statistics.

1.3.3 Angus Health and Social Care Partnership is working with Community Planning Partners and through our Locality Improvement Groups to develop broader locality plans which address the causes of deprivation. Amongst that work is delivering different approaches to engage with people who do not usually use services.

Keep Well

Susan is a 32 year old woman who was referred to Keep Well by Penumbra. She experiences variations in her mood levels and frequent episodes of acute anxiety, which affects her levels of communication and relationships with others.

For her, the purpose of the Keep Well Health Check was to gain more knowledge and awareness of any health issues she was experiencing and to identify ways she could achieve a good balance of emotional and physical well-being.

Specific areas focussed on during the Keep Well Assessment were:

- Weight – Susan was finding it difficult to lose weight following the birth of her daughter two years ago. We identified that her diet primarily consisted of foods high in sugar and saturated fats
- Motivation Levels – Susan experienced low levels of motivation and lacked energy to carry out day-to-day activities, resulting in low-self esteem and isolation

A cognitive behavioural approach was used to help focus and identify factors which surrounded her diet and motivation levels. She was Referred2Exercise with the aim of reducing her weight levels and increasing her general motivation. She was provided with healthy eating information as a means of improving her diet.

A further appointment for review and examination was arranged for eight weeks following the initial assessment date, with an interim telephone conversation held between assessment and review appointment. During this, she reported that she was in contact with the Refer2Exercise Instructor regarding commencing on a 12 week Exercise Programme. She was feeling positive regarding this. She further reported that she felt less negative thinking regarding her weight levels and felt focussed in addressing it now that she has clarity of her obesity levels.

The Third Sector and Volunteering

1.3.4 Angus continues to have high levels of volunteering. Voluntary Action Angus (VAA) are supporting the development of voluntary organisations and volunteering across Angus. The capacity of communities to actively care is a focus of the work.

VAA undertakes a crucial role in delivering on the aspirations of Health and Social Care Integration, locality working and prevention. We have four full time locality workers who work in partnership with local health practices as link workers and helping people to access health improvement, community involvement, volunteering and access to clubs and groups etc.

In the last year they have supported 3126 people and helped ease the pressure on busy GP practices through developing further volunteer driving and access services. This last year has seen a significant increase in demand on the driving service which is integral to new ways of working within communities around health priorities.

Volunteers' impact on people's lives everyday

There are 46 volunteers and 38 volunteer drivers directly supporting the work of Angus Health and Social Care Partnership. They make a big difference in the lives of people in our communities every day. Here are some of their stories:

- The volunteer drivers who transport a teenage girl at 9.30pm or 10.15pm three times a week to enable her to access drama, gymnastics and young carers groups whilst her parent is in hospital.
- The elderly lady who gets transported 4 days a week to day care to give her husband some respite – she is so frail that volunteers provide assistance to get from house to car.
- The two volunteers who run a scrabble group every week for people with early dementia, supported by a further three people who get volunteer drivers to ensure that people can access the scrabble group.
- Volunteers who support a mother every week from Forfar to Glasgow for an hourly visit with her child who is being educated within a secure unit.
- For about six months volunteers transported a man to the supermarket every week so he could continue to do his own shopping until a service became available

VAA volunteering programme is founded on inclusion with a particular emphasis on helping young unemployed volunteers into a career in health. Whilst in its early stages, this has proved successful with an increase in the amount of young people volunteering as part of the national Saltire awards. VAA's role as the Third Sector Interface (TSI) is important to building new cultures of care and collaborations within the sector and across partnerships. As part of this we seek to work across sectors to develop a new health and wellbeing network through the TSI Tayside initiative. This has already been proved successful in Perth and Kinross.

The Value of Volunteering

'I am in my mid-twenties and am a single mother with a young child. I didn't enjoy school and am sure they were pleased to help me leave at 16. I then went on to college, completed the course but found it very hard to get work. Following the birth of my child I received help from my doctors who also referred me to a specialist as I was unhappy and unwell. They discovered I had Attention Deficit Hyperactivity Disorder (ADHD), continued to give me support, and prescribed me medication which has helped me a lot. I started to be more outgoing and confident and found volunteering through Voluntary Action Angus. Their support was terrific and I continue to meet my link worker from VAA.

I volunteer in my local community helping people with dementia, and through this found paid employment as a Social Care Officer. I am doing really well and found a job I'm good at and love. I can see myself having a long career in care. I'm being trained up to achieve an SVQ and continue on my journey which helped me so much - Volunteering

Carers

1.3.5 Angus Health and Social Care Partnership provide funding to Angus Carers which allows for the delivery of a comprehensive range of information, advice, develop support plans and support for carers across Angus. Angus Carers are also able to signpost carers to other resources available in the community. In addition, carers who have greater levels of need access a more complex support plan through care management which will provide access to a personal budget that can be used for respite and other support.

Angus performance in relation to carers feeling supported to continue their caring role is less than the Scottish average. Performance both in Scotland and in Angus has declined in relation to this biennial national indicator (NI 8). 34% of carers in Angus feel supported to continue in their caring role (NI 8). This indicates that we need to do more to ensure that effective supports for carers are available in our communities. We do know that 96% of carers who care for people with social care services in place have been offered support which has allowed them to continue in their caring role. The difference between the national survey and the local information may indicate that a number of carers are not known to services.

The number of carers known to Angus Carers continues to increase in Angus. Angus Carers have recorded that:

- 1404 carers aged over 55 were registered with Angus Carers on 31 March 2018, an increase of 351 registered carers aged over 55 registered at 31 March 2017.
- 2,451 hours of volunteer-led 'care free' respite has been provided in 2017/18.
- 239 new carer support plans were developed during 2016/17.
- 160 hours per year of counselling support is available but this is no longer meeting the demand for the service. Recently Angus Carers has had to close the waiting list for this service and is now aiming to identify additional funding to further develop the service.

A Carer's Journey - Angus Carers Centre

This case study demonstrates the fluctuating journey faced by this carer. From very low level information and advice initially to more structured 1:1 and peer support, access to short breaks, benefits support, advocacy support and counselling. The transition from full time carer for his wife to being a husband again is a journey that demonstrated the different levels of impact faced by Mr Frame in his caring role. Eligibility Framework thresholds have been used indicate the impact of caring role on the carer.

2008 Mr Frame is a 71 year old who cares for his wife aged 67. He was referred to Angus Carers. Mr Frame cared for his wife who had COPD, heart problems and depression. At that stage he was content to receive our quarterly newsletter and attend events/activities. Mr Frame struggles to read and write and finds some written information too complex to understand. (Low Impact).

2014 Mr Frame had a 1:1 meeting with a worker after he reported (at a 'cuppy time' event) that his wife needed more care. Mrs Frame accessed day care twice a week. This was beneficial for them both as Mrs Frame received the attention and support she needed and Mr Frame was getting a break. Mr Frame was getting increasingly worried, however about leaving Mrs Frame for any length of time. This was preventing him getting involved in activities that he enjoyed. Mr Frame agreed to accept support through our Take a Break scheme; accessing support from Sue Ryder for carer at home support (Moderate Impact) Intervention (Low Impact).

Mr Frame reported he was becoming more stressed and short tempered and this concerned him as it left him feeling guilty and sad. He agreed to participate in some relaxation techniques. He really enjoyed the session and was surprised how easy it was and how effective. Mr Frame was provided with a copy of the relaxation CD and advised to practice some of the techniques. He was also invited to participate in regular group sessions held in his locality to get some peer support and access to information via guest speakers etc. Mr Frame built up good peer friendships. (Moderate Impact) Intervention Stress Management, Peer Support Group (Low Impact).

In early 2015, Mrs Frame suffered a stroke and a home visit revealed the extent of the situation. Mrs Frame was in need of more care and this was taking its toll on Mr Frame. They were both very vulnerable at this point and had asked about the possibility of Sheltered Housing. We supported the application process and also referred them to our Short Break scheme.

Mr Frame was also struggling with health anxiety and was referred to our counsellor for support. (High Impact) Intervention, 1:1 support, Counselling, Advocacy (Low Impact). Mr Frame also engaged with our Male Carer Support Worker and enjoyed the male carer activity programme.

In June 2015, Mr and Mrs Frame moved to sheltered housing in a different town. Mr Frame wanted to have worker continuity but understood the reasons for attending a support group in his new locality. Mr Frame was happy to share his issues with the locality worker for his new area and would still be able to access 1:1 support from his original worker.

Mr Frame's mental health was beginning to deteriorate, so he was supported to access short breaks. These have been hugely important, giving him time away to rest and recharge his batteries. (Moderate Impact) Intervention funding for short break (Low Impact). Mr Frame has continued to access 1:1 and peer support.

2017 Mr Frame disclosed he was not coping well with his caring role, it was getting too much for him and his own health was deteriorating. We supported Mr Frame in discussions with his wife and the Care Manager. The worker also attended the GP with Mr Frame as he was finding it difficult to talk about his battle with his caring role and its impact on him. The GP agreed that the caring role was too much and his condition would probably improve if he no longer had the caring responsibility for Mrs Frame. (High Impact) Intervention 1:1 intensive support, Advocacy (Moderate Impact).

We supported an Attendance Allowance Claim for Mr Frame due to his own deteriorating health conditions. Standard rate was awarded, giving him an extra £55.00 a week (Improved Financial Situation).

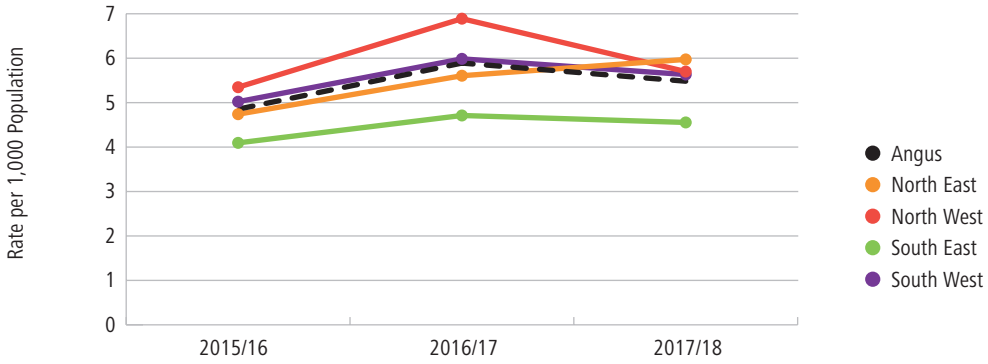
After much deliberation and intensive 1:1 support, Mr and Mrs Frame decided that Mrs Frame would move to a nearby care home. This situation has greatly improved Mrs Frame's mental health and outlook. Recently we successfully supported his application for Helping Hands Funds to arrange for his bedroom to be redecorated after his wife's hospital bed had been removed.

1.3.6 During 2017/18 work has progressed towards the implementation of The Carers (Scotland) Act 2016. Agreement has been reached on local eligibility criteria; the services commissioned from Angus Carers reviewed and a new agreement put in place. This has led to some changes in the way services are delivered and by whom.

A carer's support plan delivered by Care Management offers the self-directed support options, providing carers with greater flexibility about what types of services they choose and how they are delivered. Whilst the number of carers accessing day respite hours as part of their support plan has declined from 551 in 2016/17 to 518 in 2017/18, the number of hours has increased from 36,961 in 2016/17 to 54,047 in 2017/18, suggesting that this form of respite is being focussed on those most in need. Over the course of 2017/18 503 people have used day care. Typically in any month 165 older people and 98 people with learning disability access day care.

GRAPH 3: Management Information at Locality Level: Rate of people using short breaks

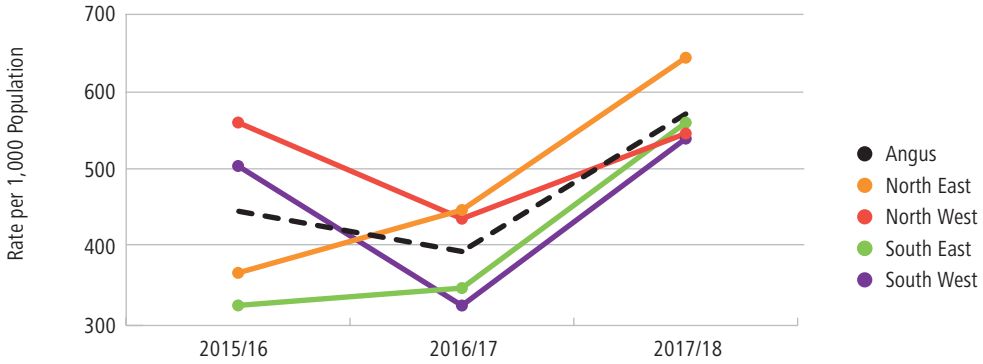
Total number of people receiving short breaks (days) as a rate per 1,000 adult population



Source: Care First (Angus Council)

GRAPH 4: Management Information at Locality Level: Rate of short breaks (daytime hours)

Total number of hours short breaks (days) as a rate per 1,000 adult population

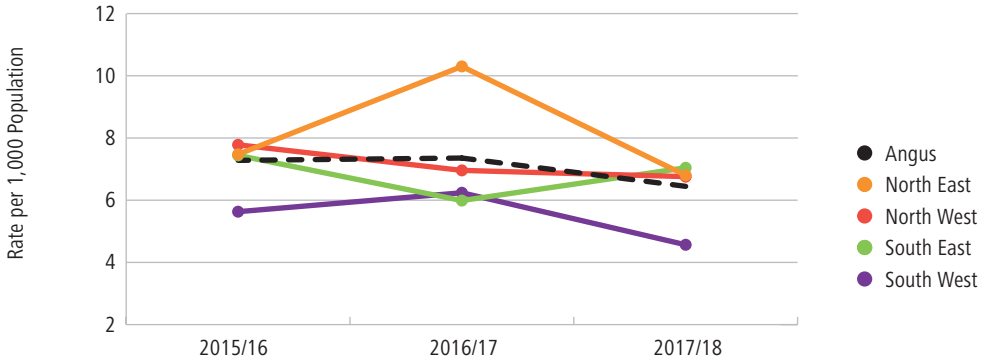


Source: Care First (Angus Council)

1.3.7 Similarly to day time respite hours, the number of people using respite care has declined but the number of nights has increased. This again demonstrates a focus on those most in need of support and the success of more community based arrangements in supporting carers.

Graph 5: Management Information at Locality Level: Rate of people using short breaks (nights)

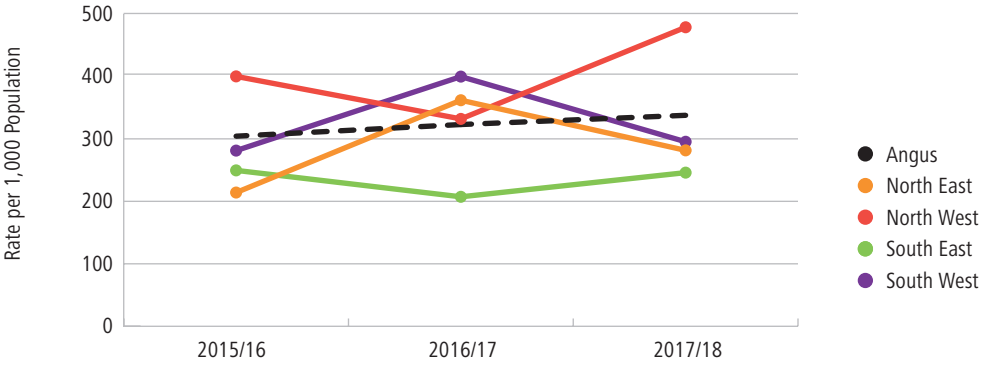
Total number of people receiving short breaks (nights) as a rate per 1,000 adult population



Source: Care First (Angus Council)

Graph 6: Management Information at Locality Level: Rate of short breaks nights

Total number of nights short breaks (nights) as a rate per 1,000 adult population



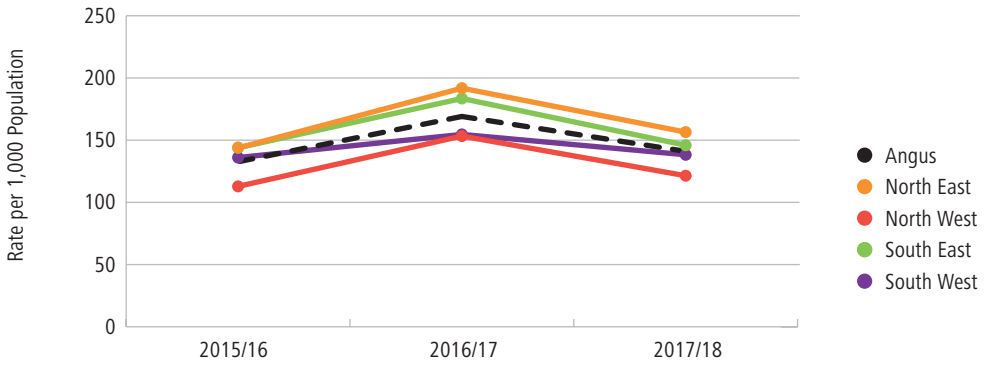
Source: Care First (Angus Council)

Community Alarm

1.3.8 Installation of community alarms has risen since 2015/16. Community alarm now support 3735 people across Angus. This is an increase from 3438 in 2015/16 (8% increase). This is in line with our aim to improve technology enabled care. The range of available equipment and sensors has also increased e.g. GPS monitors, Truecall the call blocking system. There is variation between Angus localities in the uptake of community alarm. In 2016/17 arrangements for sheltered housing changed. The changeover accounts for some double counting of community alarms during that period reflected in Graph 7 below.

Graph 7: Management Information at Locality Level: Rate of community alarm use

Total number of people aged 65+ who has/had a community alarm as a rate per 1,000 65+ population



Source: Care First (Angus Council)

Enablement

1.3.9 The new internal Enablement and Response Team (ERT) became operational in late November 2017. The role of this service is to provide short-term intervention for people in crisis or transition; to provide an enablement service to reduce dependence; and to provide a response service for people with community alarms. During the first months a number of service users remained with the ERT while alternative services were arranged. This reduced the capacity of the new service to deliver what it was designed for, particularly in the South localities where there was simultaneously upheaval in the independent care market. This contributed to increase in delays in discharge (page 40). The service is now approaching its required capacity.

Forfar ERT

Charles was admitted to hospital with reduced mobility and increased confusion. He was keen to return home but there were concerns in his ability to cope with his daily living tasks due to the deterioration in his memory. Support for an enablement assessment was requested from the Enablement & Response Team (ERT). There was also a conflict of concerns from his family as to how he would cope at home.

Charles came home and onto the ERT service for an assessment period. His support commenced with four times a day visits and he was also referred for a Community Alarm and Telecare Equipment that included door contacts. His Alarm and Telecare devices were installed on his discharge.

The ERT social care officers supported Charles back into his daily routine. During his assessment it was clear that Charles required support in the form of Community Meals and these were put in place to support him. Social Care Officers continued to support Charles and he progressed very well, regaining his independence within five weeks of his discharge. ERT monitored Charles, reducing his support first by carrying out check visits, then by telephone calls to Charles and also linking in with his son to ensure Charles was managing. Charles successfully regained his independence and remained at home with no further support required other than Community Meals and Telecare Equipment and is managing well.

Carnoustie ERT

Violet was in Independent Intermediate Care in a Nursing Home for rehabilitation. Following her assessment it was clear that she would require ongoing support in the morning and pm and there were still concerns whether she would manage her meals independently at home. It was felt that she would fail with this if discharged home and would require ongoing support 4 times a day. Violet was keen to return home and try. She was discharged home with support from the ERT for up to four weeks to support her back into her meal preparation routine. Once home, Violet quickly regained her independence and routine with her meal preparation, and her support assessment successfully ended within a week of discharge as she was fully independent with her meal preparation and intake. Violet remained at home managing well, with ongoing am & pm support only instead of the four times a day anticipated.

Arbroath ERT

Barbara was admitted to hospital for a knee replacement. Although keen to return home, both Barbara and her daughter were very anxious about her managing with her daily living routines. Support was discussed in the format of the ERT, to which she agreed, and a request for an enablement assessment from the ERT was made. Barbara was discharged home with support from ERT 4 times a day as requested to enable her to regain her independence with her daily living tasks.

On discharge Barbara struggled with showering, dressing/undressing her lower half of clothing, and with her meal preparation. Social Care Officers and Occupational Therapists worked jointly, encouraging and supporting Barbara in using various Occupational Therapy aids to help with her meal preparation and dressing tasks. Barbara made great progress and built great confidence in her abilities, and her support was gradually reduced the more independent she became. Barbara was keen to regain her independence and worked well with both Social Care Officer Staff and Occupational Therapy staff. She improved greatly, regaining her full independence within three weeks. Barbara is managing well at home independently with no support and improved confidence.

Accident and Emergency

1.3.10 An Accident and Emergency (A&E) Performance indicator is not included in the national core data set for integration therefore we have not developed locality information in this area. Angus wide data has been produced to support evidence to the Joint Ministerial Steering Group. In 2016/17 national data indicated

that Angus attendance at A&E for major issues was the second lowest in Scotland (in Angus attendance rate is 43.7/1,000 compared to 125.1/1,000 for Scotland). For minor issues (which includes attendance at minor injury and illness units), attendance was the highest in Scotland (234.2/1,000 population attendances compared with 125.1/1,000 for Scotland). This confirms that some attendances at MIIU services in Angus are inappropriate. We do know that there has been a decreasing trend in the Angus population in relation to attendance at A&E. We expect this trend to continue as the MIIU aspects of the Angus Care Model are embedded in practice including the development of new care and treatment services. The new arrangements will aim to divert unnecessary attendance at A&E (including MIIU) to more appropriate services.

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 and illness units (MIIUs) and emerging care and treatment services more appropriately.

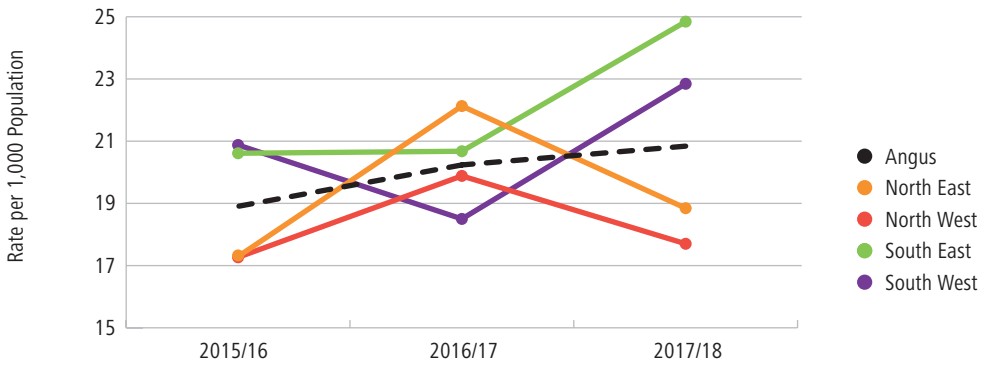
1.3.11 The aim is to continue to reduce A&E attendances in line with the current projection. The attendance trajectories include response to the unusually high flu virus epidemic which was prevalent in Tayside severely over the autumn/winter of 2017/18. There was also a noted increase in fractures. The admission rates appear better than expected in part due to the higher than projected number of attendances

Admissions following a Fall

1.3.12 In 2017/18 the rate of falls admissions in Angus is 20.8 per 1,000 population. This Angus falls rate is a 10% increase on the 2015/16 level of 19.2 per 1,000 population and 3% increase on 2106/17. The Angus rate of admissions following a fall continues to be below the Scottish average rate. The level of falls in our community does contribute to hospital admissions and places ongoing pressure on services as individuals are more likely to need ongoing health and social care support. It should be noted, however, that admissions following a fall only account for 5% of all admissions in an emergency (552 admissions). Much of the increase occurred during quarter 3 and related to some very poor weather where there was an increase in A&E attendances relating to falls on ice.

1.3.13 There is a continued upward trend in the rate of falls leading to an admission in Angus. This upward trend is most pronounced in the South East locality which has seen a 20% increase since 2015/16.

Graph 8: Management Information at Locality Level: Rate of fall admissions per 1,000 population for people aged 65+ (NI-16)



Source: ISD LIST management information (not official ISD statistics)

Note: * 2017/18 rates are provisional and are not official ISD statistics. Official figures for 2017/18 will be released later in 2018.

1.3.14 A review of the falls pathway and public health issues to be addressed to reduce falls is currently being conducted and is expected to conclude in September 2018. This will aim to identify the reasons for the variation in falls, and in particular consider the differences between performance in the North and South localities.

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.

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 in 2017/18

- Increased the number of personal care hours available to support people in our communities.
- Increased the number of community meals available in our communities.
- Expanded the uptake of the Florence home mobile health monitoring system across a range of services to support people with monitoring and self-management of long term conditions.
- Introduced the Enablement Response Team that brings together community alarm, early supported discharge, prevention of admission and enablement together into an integrated, flexible and responsive service.
- Delivered an improved framework arrangement with the independent sector for the delivery of long term personal care at home. This includes the development of a fair cost of care to ensure that services can be accessed equally in rural and remote areas of Angus.
- Extended Enhanced Community Support arrangements into the North East Locality.

Using Florence (Flo) for Oral Nutritional Support

Adam lives with cystic fibrosis and like most cystic fibrosis patients has to work hard to keep up his calorie intake to get the right nutrients and maintain a healthy weight. Just as he was about to turn 16, Adam was introduced to Adult CF Specialist Dietitian, Alison. Alison worked closely with Adam to get his weight up to the point where he would no longer need to rely on his gastrostomy feeding tube.

"The ideal place for Adam health wise was to have a BMI (Body Mass Index) of 23" said Alison "but a cystic fibrosis patient won't always find it easy to eat as much as they need to so the gastrostomy tube can make a big difference in terms of nutrition." However Adam was still at school and naturally wanted to be able to take part in different activities such as swimming which would be more difficult to do with a feeding tube. He wanted to do the same as everyone else his own age, but still wanted to maintain his weight.

With the aim of no longer being dependent on the gastrostomy tube, both Adam and Alison worked on increasing his oral nutrition and supplements whilst decreasing the use of the tube, and within the space of six months made good progress. It was around this time that Alison asked Adam if he'd like to try Flo to help him with this. "I didn't really have a system for managing my diet." said Adam. "I would just eat whatever I wanted to and tried to remember to eat snacks in between meals. I would also just try to remember tips from my dietitian such as adding cream to my

milkshakes in the morning. I also never weighed myself at home. My dietitian asked me if I wanted to try (Flo) and I said yes because there's no harm in trying something that might help."

Flo helped Adam embed these strategies into his daily life by sending regular messages and asking Adam to record his weight periodically too. "I've been using Flo to give me tips on how to put on weight, remind me to eat snacks and also to monitor how much weight I'm putting on and I have found it fairly helpful - I now remember much better to eat my snacks and also have a broad range of tips for putting on extra weight." In addition to the messages Flo sends, Adam also used Flo's ideas and methods to set up extra prompts and reminders of his own to help him even more.

Adam says "I have managed to achieve a significant weight increase which led to the removal of my gastrostomy tube in my stomach which I was wanting desperately." Adam is now busy completing an internship with a national utilities company and Alison is still able to log into Flo to send a message to Adam now and then to make sure he is still on track. Flo still maintains her 'Bossie Flossie' image however as Adam says "Sometimes the texts could get a bit annoying and if you didn't send in your weight it would send it a couple of times which got a bit annoying." However this didn't put Adam off at all as he says "it was a great help!"

2.2 What we plan to do next

- Bring together the range of digital work into a consolidated improvement plan that reflects the recently published Scottish Health and Social Care Digital Strategy.
- Further extend the reach of Enhanced Community Support arrangements into the North West locality.
- Deliver a palliative and end of life care plan for Angus in conjunction with Lippen Care.
- Continue to improve on the number of anticipatory care plans in place.
- Review the commissioning arrangements for day care services for older people.
- 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.
- Following national action learning sets supported by the Scottish Government, a local solution to support during the night in supported accommodation is being developed.
- Develop an Angus plan for palliative and end of life care.

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

There has been a shift towards greater choice and control with a greater proportion of supported people accessing direct payments (option 1) and directing the available support (option 2). Option 2 was not available before the introduction of the Social Care (Self-Directed Support) (Scotland) Act 2013 and uptake continues to rise. Most people in Angus continue to access option 3, asking Partnership staff to organise support on their behalf although the proportion of people using option 3 has decreased. 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. A new framework contract has been put in place for 2018/19 to meet demand for option 3. It is anticipated that the impact of this will be to reduce the proportion of option 2 uptake in 2018/19 as the focus on quality and flexibility is delivered through this contract for option 3 services.

Table 3 Self-Directed Support Uptake of Options

Indicator	2015/16	2016/17	2017/18
Percentage of people who access SDS (Option 1)	4%	8%	6%
Percentage of people who access SDS (Option 2)	13%	15%	22%
Percentage of people who access SDS (Option 3)	79%	73%	67%
Percentage of people who access SDS (Option 4)	4%	4%	5%

Source Care First (Angus Council)

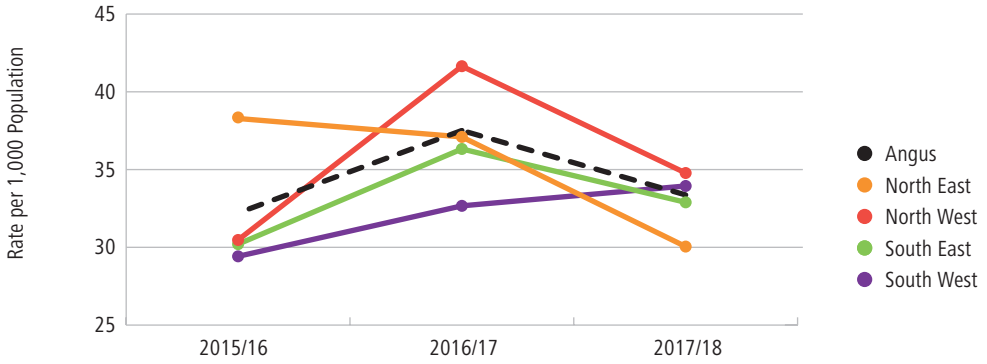
Care at home including personal care

2.3.2 Improvement in the provision of information and data to operational managers in older people's services has allowed them to focus on the variation in use of personal care across Angus. The impact has been a narrowing of variation between localities.

2.3.3 In 2017/18 the number of people receiving personal care has decreased compared to 2016/17 but this was still an overall increase on the benchmarking year of 2015/16. The number of hours has continued to rise. This suggests that personal care is being targeted at those with higher levels of need. In 2017/18 3150 people received personal care every week, a decrease of 10% on 2016/17 but an increase of 4.5% on 2015/16. 370,852 hours of personal care were delivered in 2017/18, an increase of 47% (an additional 118,543 hours) on 2015/16 and10% on 2016/17. The availability of support in communities provided through the third sector is increasing and is making a difference to those with lower levels of need. This includes the home support services offered by the social enterprise Care about Angus as well as an increasing range of third sector and volunteering support. Access to this type of support is offered through ECS through the involvement of the Single Point of Contact Officers working as part of the multi-disciplinary team.

Graph 9: Management Information at Locality Level: Rate of personal care hours

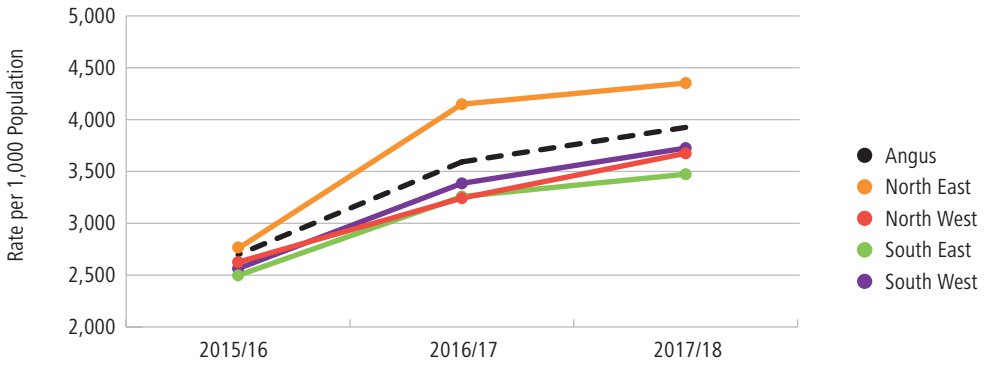
Total number of people receiving planned personal care as a rate per 1,000 adult population



Source Care First (Angus Council)

Graph 10: Management Information at Locality Level: Rate of personal care hours (LI 24)

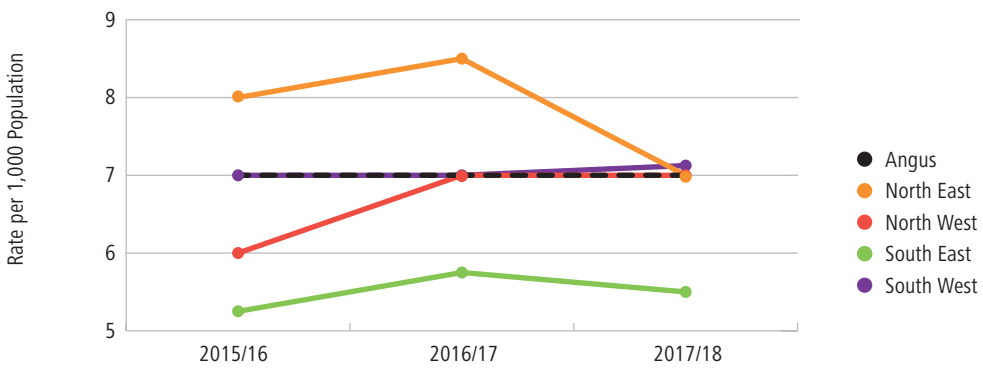
Total number of personal care hours planned as a rate per 1,000 adult population



Source: Care First (Angus Council)

2.3.4 In 2017/18 the typical (median) size of a personal care package in Angus continues to be 7 hours. The variation between the localities is decreasing and all but South East have a typical personal care support package at 7 hours. More people are receiving this level of personal care and this has contributed to the average (mean) personal care package increasing from 4.91 hours per week in 2016/17 to 4.95 hours per week in 2017/18.

Graph 11: Management Information at Locality Level: Personal care support package per week (hours)



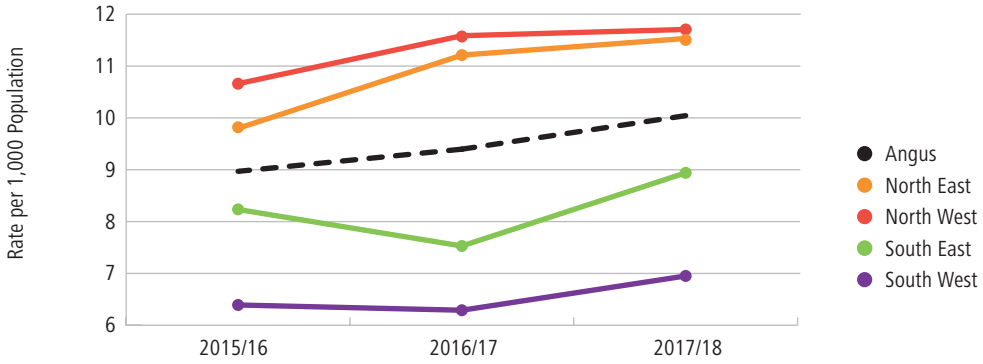
Source: Care First (Angus Council)

2.3.5 52% of adults with intensive needs are supported at home (NI 18), this is below the Scottish average. This indicator is solely focused on personal care support in relation to the total number of people known. The number of people known includes all community alarm users. Angus provides more community alarm services than many other areas of Scotland so a smaller proportion receiving personal care is more likely. Personal care data does not include information on other types of social care offered in Angus. There are a range of different types of supports available including community meals, day care, community alarm, and volunteer arrangements for transport and befriending which combine with personal care provision to support people to live at home for as long as possible.

Community Meals

2.3.6 The number of people receiving community meals has increased from 839 in 2015/16 to 949 in 2017/18. The number of people using the tea time sandwich service, delivered along with a hot lunch, has declined. This appeared as an overall reduction in the number of meals provided from 119662 in 2015/16 to 115744 in 2016/17. The take up of hot lunches has grown and the total number of meals delivered, whilst still lower than 2015/16, has increased by 2.5% on 2016/17 to 118,579.

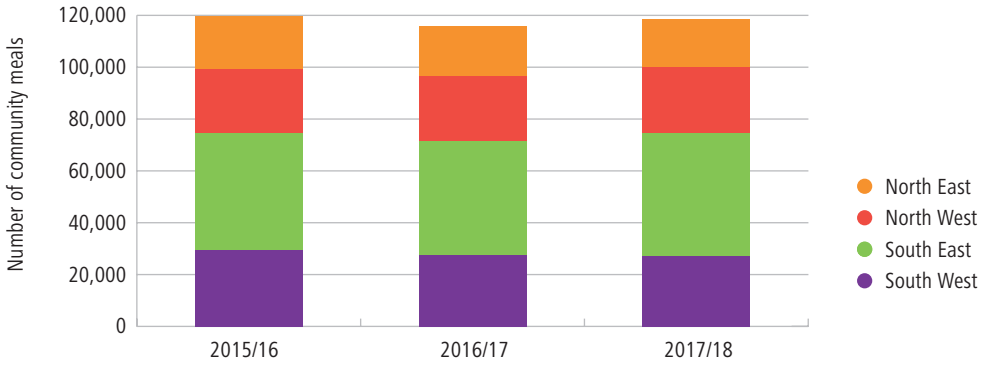
Graph 12: Management Information at Locality Level: Rate of community meals provision



Source: Care First (Angus Council)

Graph 13: Management Information at locality level: Community Meals Delivered

Total number of community meals planned to be delivered



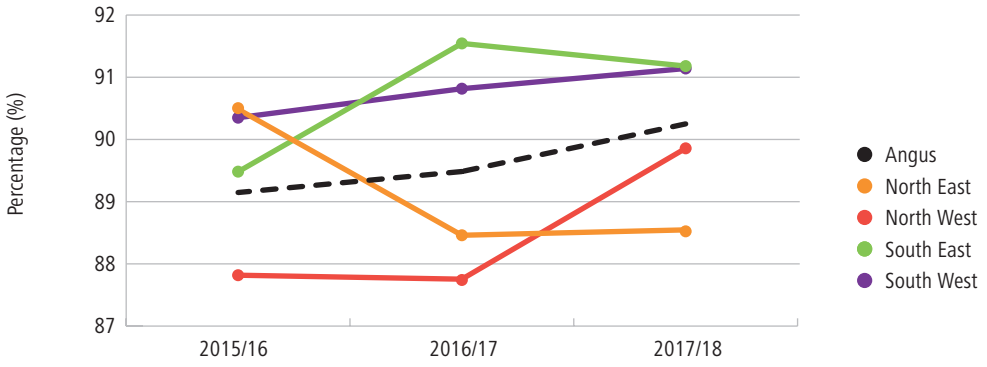
Source: Care First (Angus Council)

Last 6 months of life

2.3.7 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 89.5% (2017/18). Angus performs better than the Scottish average, where 87.6% of people spend the last 6 months of life at home or in a community setting. There is variation across localities with the South localities supporting more people to live at home or in a community setting during the last 6 months of life than the North localities. It is anticipated that the roll-out of enhanced community support in the North localities and the delivery of the new inpatient bed model will support improvements in this area of performance.

Graph 14: Management Information at Locality Level: Proportion of last 6 months spent at home or in a community setting (NI 15)

Proportion of last 6 months of life spent at home or in a community setting



Source: ISD LIST management information (not official ISD statistics)

2.3.8 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. During 2018/19 a plan for palliative and end of life care in Angus will be developed.

Priority 3

Developing integrated and enhanced primary care and community responses

AHSCP aims to deliver performance that meets the aspirations of Angus communities. This includes supporting 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 around our GP practices and in the community on the unplanned use of hospital beds.

3.1 What we have achieved to date

- Developed the Angus Care Model which shows how multi- disciplinary team working is at the centre of our service arrangements and how services work together to reduce reliance on hospital beds and deliver services for our communities in our communities.
- Enhanced Community Support has now been implemented in the North East locality and is currently being developed in the North West locality with the early implementation of aspects of ECS in preparation for full roll-out in 2018/19. Multi-disciplinary team working is at the centre of the Angus Care Model.
- The successful implementation of ECS in North East locality has led to a reduction in demand for hospital beds. This led to typically 37 empty hospital beds across Angus on a daily basis. Successfully supporting people at home who may otherwise have gone to hospital through ECS has led to the withdrawal of inpatient services at Brechin and Montrose Infirmaries.
- The development of new inpatient care arrangements as part of the Angus Care Model.
- The development of new approaches to Minor Injuries and care and treatment services as part of the Angus Care Model.
- Addressed short term challenges in approaches to timely discharge.
- Increased the number of anticipatory care plans in place.
- Commissioned three ‘step up’ independent intermediate care beds to support prevention of admission in North East locality.

3.2 What we plan to do next

- Complete the implementation of ECS in the North West Locality.
- Create opportunities for co-location of the multi-disciplinary team to improve operational delivery.
- Reutilise hospital care management capacity in the North East locality to work closely with the Advanced Nurse Practitioner for Medicine for the Elderly to focus on opportunity for prevention of admission.
- Contribute to work with other Health and Social Care Partnerships and the iHub across the North Region in relation to frailty. The Angus focus will be with people aged 50-74.
- Deliver efficiencies in the local authority care homes as part of the Angus Care Model.
- Deliver new approaches to care home provision, particularly in relation to nursing support, as part of the Angus Care Model.

Delivering ECS

My name is 'Mrs Mary Smith', I am 91 years old and until recently I have lived alone independently with support from my daughter 'Jennifer' and some carers who visit 3 days a week to help me have a shower.

My GP came to see me recently after I had a fall. I hurt my hip and I am still in pain and can't move about very well. To be honest I have had back pain for a while and was struggling a little bit but know I don't feel safe walking around and have just been staying in bed. I know that isn't good for me and the toilet is downstairs so that is a problem as well.

My GP has passed my details on to the people at something called Enhanced Community Support who will hopefully help me get around more.

The outcome of working together was that Mary:

- was assessed promptly by the primary care team and the efficient referral to Occupational Therapy/Physiotherapy initiated a rapid response. This enabled her to safely stay in her own home with the equipment and support to facilitate this.
- decided it would be best to move her bed downstairs so she could live on one level without the need to risk using the stairs.
- made great progress with physiotherapy and occupational therapy and managed to return back to her previous level of mobility. This meant she could walk to the kitchen to make her own meals and drinks and this meant that the social care officers were no longer needed at meal times.
- is now able to administer her medications independently from the compliance aid.
- pain has improved and her painkillers have been reduced which has reduced the risk of side effects.
- now doesn't have to rely on carers to get her in and out of bed which continues to promote her independence, and has not needed to use her community alarm since the equipment was installed.
- has met her befriender and is now enjoying a weekly visit or outing with her new friend. Jennifer is still thinking about contacting the Carers Centre.

3.3 How we monitor progress

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

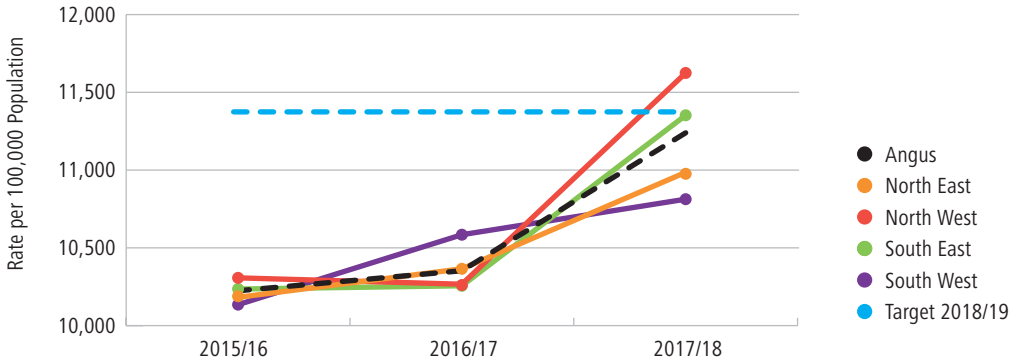
Emergency admissions

3.3.1 Admission rates in Angus continue to increase in relation to the adult population, driven by increases in admission relating to people under 75 years. Angus continues to perform well against the national picture with Angus adult admissions around 11% lower than the Scottish average. The gap between Angus performance and Scotland as a whole is narrowing as Scottish admission rates have declined. Admission rates in Angus for people aged 75+ have declined. At the end of Quarter 3, 2015/16 admission rates in Angus for people aged 75+ were 383/1,000 people. By Quarter 3 2017/18 this had declined to 304/1,000 compared to 363/1,000 for Scotland. (2017/18 data is not available yet). The delivery of ECS has had a particular impact on performance in relation to the 75+ population. It is anticipated that, as ECS roll-out is completed in the North localities, performance for Angus as a whole in relation to 75+ will improve further.

3.3.2 Since 2015/16 all localities have seen an increase in emergency admission rates. This increase is driven by increasing admission rates in the 18-74 population. The main areas that have seen increases in admission rates are geriatric medicine, respiratory medicine and admissions from A&E.

Graph 15: Management Information at Locality Level: Rate of emergency admissions for adults (NI 12)

Rate per 100,000 population of all emergency admissions for people age 18+



Source: ISD LIST management information (not official ISD statistics)

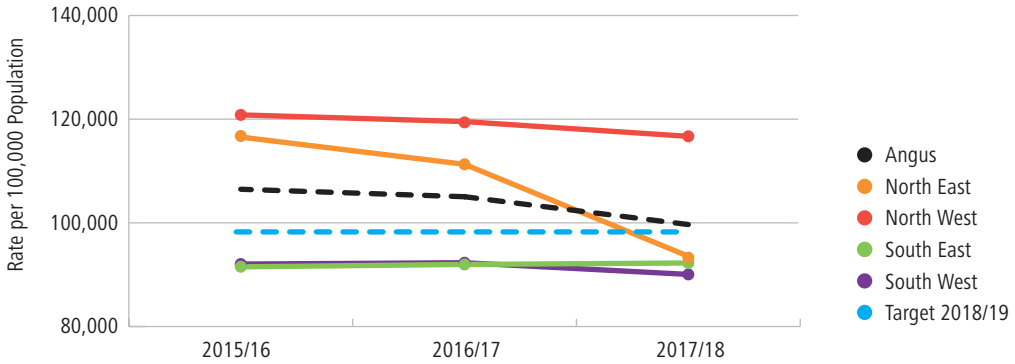
3.3.3 Angus has continued to manage admission rates within the locally set target however there is variation between localities and the target has been exceeded in North West. This target had taken into account the national picture of increasing admissions and expected Angus admissions to increase in a similar way. We know that since 2015/16 there has been an increase in potentially preventable admissions in Angus. Potentially preventable admissions in Angus have grown faster than the Scottish increase although they continue to be below the Scottish average. Over the coming months we will work with the other partnerships in the North Region of Scotland and the iHub to explore approaches to reducing admissions of people aged 18-74. Our initial focus will be to work with ECS teams on those potentially preventable admissions, to begin to understand what support is required in our communities to prevent similar potentially preventable admissions in future. There is room for improvement in admissions in relation to COPD and diabetes.

Hospital Bed days used following an emergency admission

3.3.4 The bed day rate for all adults in Angus continues to decline in Angus however this masks an increase in bed day rate for 18-74 age group where there has been an increase. There continues to be a reduction in bed day use in relation to the 75+ age group. This mirrors performance in relation to admissions and is delivering reductions in average length of stay for people aged 75+.

Graph 16: Management Information at Locality Level: Rate of emergency bed days for adults (NI 13)

Rate per 100,000 population of all emergency bed days for people age 18+



Source: NHS Tayside Business Unit (not official ISD statistics)

3.3.5 The number of bed days used following an emergency admission in 2017/18 in Angus was 94,177, a decrease of 5.1% on 2016/17 and 6.3% on 2015/16. The lowest bed day rates are in the South West. The overall emergency bed day rate in Angus has improved due to reductions in average length of stay following an emergency admission.

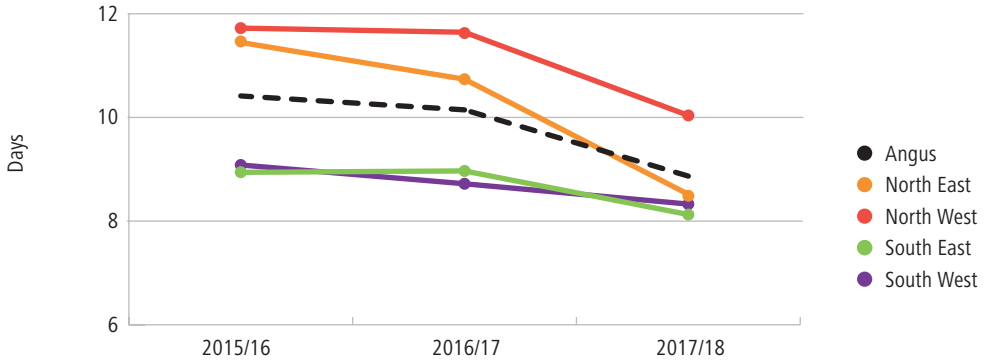
3.3.6 Following the implementation of ECS across all localities the variation in the bed day rate is expected to narrow. The target for improvement in bed days has been adjusted to reflect this.

Length of hospital stay following an emergency admission

3.3.7 Although emergency admission rates have been increasing, emergency bed day rates in Angus have been decreasing. This is reflected in improvement in the average length of stay. We know that the average length of stay for adults admitted in an emergency in Angus is higher than the Scottish average. We also know that the gap between Angus performance and Scotland performance is declining. This Angus improvement has been driven by improvements in length of stay for people aged 75+ where Angus performs better than the Scottish average. In Quarter 3 2015/16, average length of stay for people aged 75+ was 13.1 days. This was above the Scottish average of 12.6 days at that time. In Quarter 2 217/18, average length of stay for people aged 75+ was 12 days compared to 12.6 for Scotland. The average length of stay for people aged 18-74 is above the Scottish average. We need to investigate this further to understand which specialities could be the focus of improvement. The variation between localities has also narrowed due to the progress being made with the delivery of ECS and ECS Lite in the North localities.

Graph 17: Management Information at Locality Level: Average length of stay for emergency admissions for adults

Average length of stay for people aged 18+ who were admitted as an emergency inpatient



Source: ISD LIST management information (not official ISD statistics)

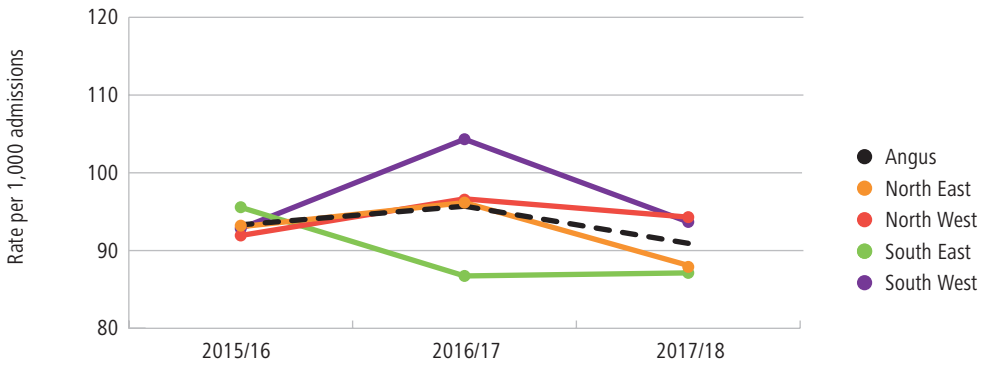
Readmissions to hospital

3.3.8 Angus readmission rates are lower than the Scottish average but, when considered as a percentage of admissions, are above the Scottish average. This may indicate that a high proportion of Angus readmissions relate to a group of people with the most complex and challenging health issues. Readmissions as a percentage of all admissions for people aged 75+ are now below the Scottish average. In Quarter 3 2015/16, readmissions for people aged 75+ in Angus were 18.3% compared to 16.7% for Scotland. By Quarter 3 2017/18, Angus readmission rates for people aged 75+ had improved to 12.1% compared to 12.6% for Scotland. This suggests that ECS makes an impact on supporting people at home most effectively after a first admission. Admission rates as a percentage of admissions for people aged 18-74 in Angus are higher than the Scottish average. This again suggests that there is a need to focus effort on improvement in relation to this younger age group.

3.3.9 Readmission rates in Angus increased in 2016/17 with a broad variation between localities. During 2017/18, localities through ECS have aimed to improve readmission rates and this has led to both a reduction in rates and a narrowing in the variance between localities.

Graph 18: Management Information at Locality Level: Emergency readmission rates within 28 days (NI 14)

Rate per 1,000 Admissions of Readmissions within 28 days for people of all ages



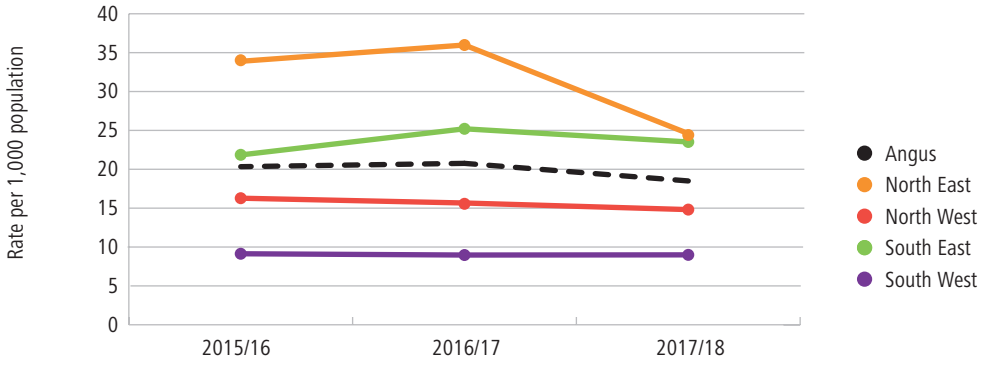
Source: ISD LIST management information (not official ISD statistics)

Residential and Nursing Care

3.3.10 The number of older people placed in residential and nursing care at any one time has reduced from around 770 to 730. This is likely due to the improvements in availability of personal care in communities. The total number of people in placements during 2017/18 was 2,066, an increase of 7.8% (1915 placements) on 2015/16 and 4% (1985 placements) on 2016/17. At the same time the number of placed nights decreased by 0.4% from 277,782 in 2015/16 to 276,736 in 2017/18. This demonstrates improvements in the targeting of care home placements to those most in need. This is supported by the increasing age of people living in care homes and the reductions in length of stay. The average age of a person placed in a care home in Angus is approximately 84.9 years, an increase from 84 years in 2015/16. The average length of stay has continued to decrease from 18 months in 2015/16 to 17.3 months in 2017/18. We are seeing an increase in the number of people placed for very short periods of time towards the end of life.

Graph 19: Management Information at Locality Level: Nursing care placement rate

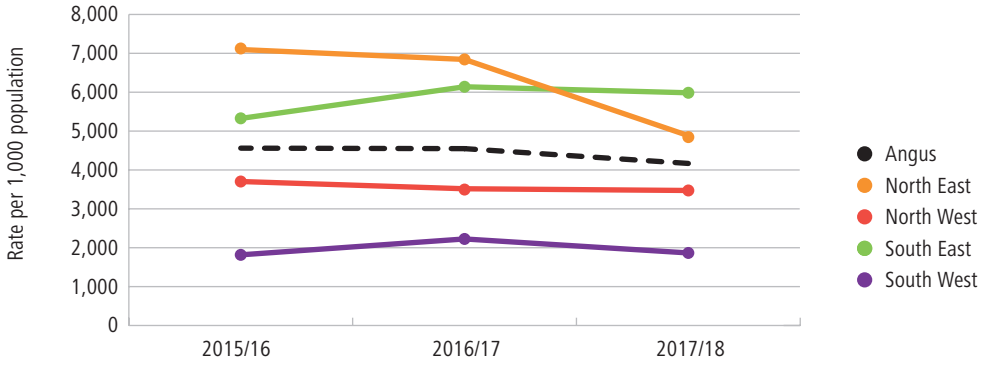
Number of people in nursing care as a rate per 1,000 population 65+



Source: Care First (Angus Council)

Graph 20: Management Information at Locality Level: Nursing care nights rate

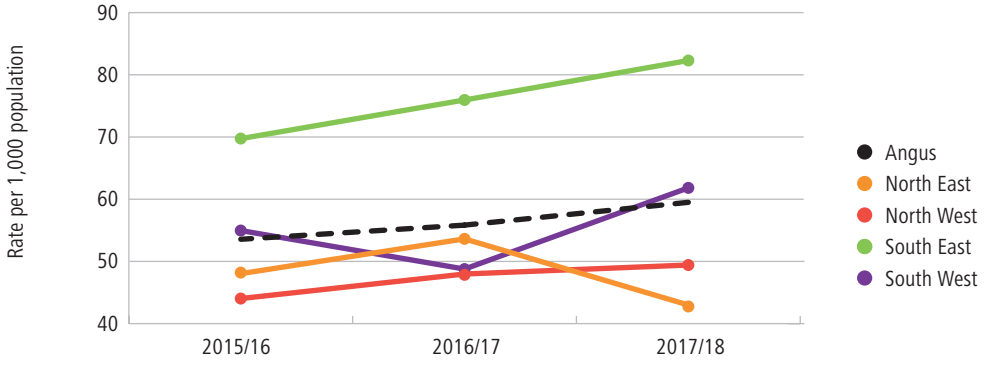
Total number of nights in permanent nursing care as a rate per 1,000 population 65+



Source: Care First (Angus Council)

Graph 21: Management Information at Locality Level: Residential care placement rate

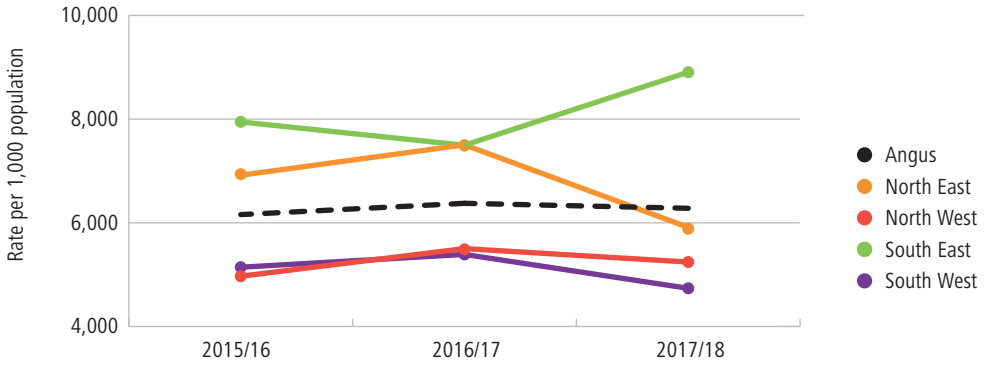
Number of people in residential care as a rate per 1,000 population 65+



Source: Care First (Angus Council)

Graph 22: Management Information at Locality Level: Nursing care placement rate

Total number of nights in permanent residential care as a rate per 1,000 population 65+



Source: Care First (Angus Council)

3.3.11 There continues to be some variation between localities in placement rates in both residential and nursing home care. The variation in the rate is more marked in relation to people with frailty. Placement rates in relation to people with dementia are very similar across Angus. There has been a marked reduction in placements in the North East. This corresponds with an increase in the rate of personal care hours used in this locality. Overall the South East Locality continues to use more care home placements and have lower levels of personal care hours than the other localities. More consideration needs to be given to issues such as deprivation and life expectancy to see if these are having an impact on placement patterns or whether care management practice is different in this locality.

3.3.12 Patterns of care provision continue to be inconsistent across Angus and the variation in the pattern of service uptake cannot be explained by variation in the proportion of people aged 85+ 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 that locality. There are more beds in South East than elsewhere in Angus and more placements. We have improved the performance information available to teams in order that they can address the variation.

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

- Developed the Angus Care Model as a focus for the care pathway in and out of hospital.
- Addressed the increasing delays in discharge during 2016/17 by:
  - giving the highest priority in allocation in the Enablement and Response Team (ERT) to delays in Ninewells;
  - providing additional resource to the matching process between cases and private providers/ERT;
  - subsiding respite provision to allow "step down" to residential care to take place more quickly;
  - providing an enhanced payment to providers to allow for additional uptake in hard-pressed areas, for example to assist with recruitment of additional staff;
  - inviting staff in ERT to work additional hours to cover the increase in demand and staff sickness, and there was a positive response to this;
  - introducing daily teleconferences between the consultant for MFE, lead clinician for Angus, heads of service and operational managers to manage throughput and prioritisation. These connected with three times daily teleconferences at Ninewells.
- Increased the number of people in Angus with a Power of Attorney in place through our involvement in a national campaign to improve uptake.
- Worked with Perth and Kinross HSCP (host IJB) on issues facing in-patient adult mental health services.
- Started to grow the delivery of mental health and wellbeing services within GP practice following the successful test in Brechin and subsequent roll-out to Montrose.
- Developed plans for the replacement of the Gables Care Home for people with learning disabilities. The building work is expected to start in autumn 2018 and last around 12 months.
- Withdrew provision of inpatient care in Montrose and Brechin Infirmaries following improvements in the Angus Care Model.

4.2 What we plan to do next

- Develop a new housing contribution statement alongside the development of the new strategic plan.
- Deliver step up Intermediate Care beds in Montrose.
- AHSCP is developing local Angus Statutory and Third sector services to improve access and promote a more comprehensive and integrated community service. It allows NHS Tayside and the HSCP to consider the workforce as a whole.

- The rationale and need for Enhanced Home Treatment (EHT) is well documented in research. EHT supports early discharge from hospital, reduces hospital admission and re-admission rates, increases choice, and improves patient experience.
- Angus HSCP has set out plans to expand the existing Monday to Friday Community Mental Health Teams to deliver EHT to support people, who may require daily visits by professional staff in their own homes to manage an acute mental health episode, seven days per week, 52 weeks per year. Seven day working in the community will be supported by a 24/7 multi-disciplinary Crisis Assessment Service based at the Carseview Centre, Dundee.
- Feedback from the Mental Health consultation events in Angus strongly calls for an investment in its community services to provide a seven day model to ensure the people of Angus have the same level of service to those in other parts of Tayside.
- The Angus service would be delivered within existing community mental health teams.
- The Head of Mental Health Services, following consultation with clinical colleagues, service users and other key stakeholders, proposes that a shift of resources equivalent to 7 WTE nurses is made to ensure that the key messages of safe, sustainable and clinically viable community services can be delivered in the Angus community.

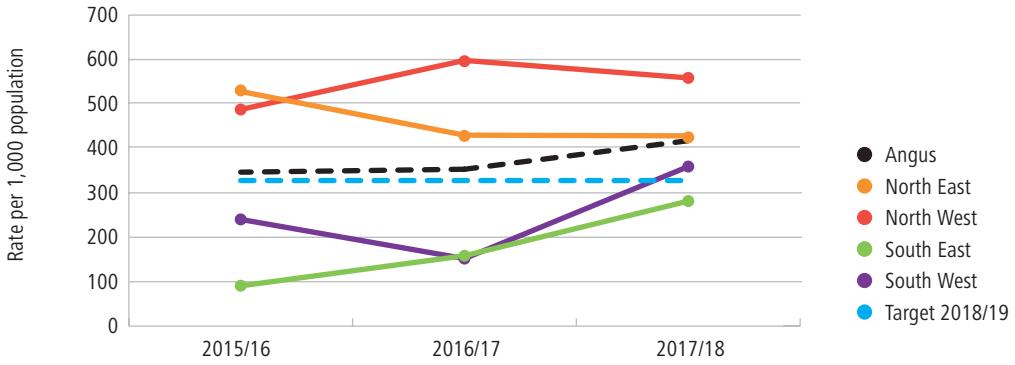
4.3 How we monitor progress

Angus Health & Social Care Partnership is working with housing, learning disability, adult mental health and other services to identify appropriate measures. We measure pathways in and out of secondary care, in part through our work on admissions and readmissions. These are all reported on in relation to Priority 3.

Timely discharge

4.3.1 The number of delayed discharges for people aged 75+ in Angus remains relatively small compared to the overall position in Scotland. The rate of all bed days lost to delayed discharges in Angus for people aged 75+ has increased to 4909 from 4153 (18% increase) in 2016/17 and 4042 (21.4) in 2015/16. A total of 309 people aged 75+ were affected by a delay in their discharge arrangements. Most of the increase in delays can be attributed to standard delays in relation to people aged 75+. This rose to 295 people during 2017/18 from 232 in 2016/17 and 257 in 2015/16. During 2017/18 the average length of stay for someone affected by a delay increased reduced from 17 days to 15.4 days. The poorest performance in relation to people aged 75+ affected by a delay was experienced in 2017/18 Quarter 3. There are signs of recovery in performance during Quarter 4.

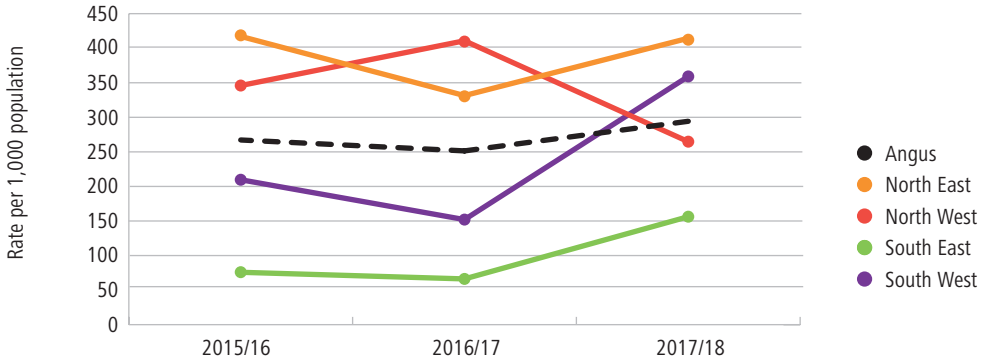
Graph 23: Management Information at Locality Level: Bed days lost to delays in discharge (NI 19)



Source: ISD LIST management information (not official ISD statistics)

Graph 24: Management Information at Locality Level: Bed days lost to standard delays in discharge for people aged 75+

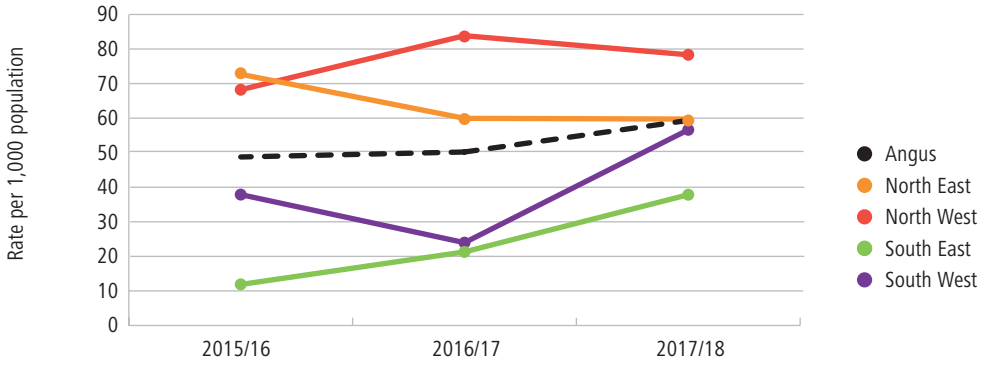
Rate per 1,000 population of the number of days people aged 75+ spend in hospital as a standard delay when they are ready to be discharged



Source: ISD LIST management information (not official ISD statistics)

Graph 25: Management Information at Locality Level: Bed days lost to delays in discharge for people aged 18-74

Rate per 1,000 population of the number of days people aged 18-74 spend in hospital when they are ready to be discharged



Source: ISD LIST management information (not official ISD statistics)

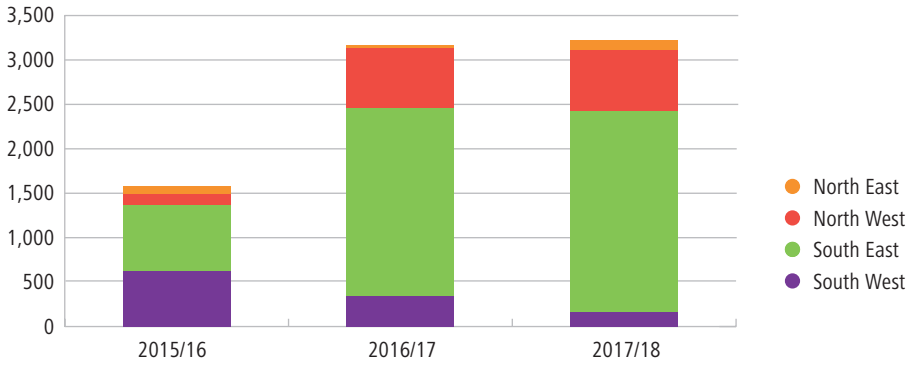
4.3.2 In 2016/17 there were challenges with maintaining Angus' very good performance in relation to timely discharge. A full review was undertaken and a number of additional measures were put in place to address specific challenges. A specific performance report on effective discharge was presented to the IJB. A number of contributing factors were identified including:

- Freezing weather led to a high number of hospital admissions due to falls and resultant injuries.
- An outbreak of influenza occurred in Angus, adversely affecting our vulnerable service users (e.g. people with COPD), and led to increased hospital admissions.
- The new Enablement and Response Team (ERT), delayed by five months, commenced on 27 November 2018, bringing it nearer to the winter surge period than would have been the case had its introduction gone to plan. Not surprisingly with a new service, it encountered a number of teething problems in operational delivery. These have been addressed.
- The ERT suffered from reduced capacity due to a backlog of long term cases which had not yet moved across to private providers, and because of flu amongst staff leading to sickness absence, particularly in Arbroath and Carnoustie. This occurred at a time of peak demand for discharge.
- The tendering process for developing the new home care framework was under way at this time. It meant that providers were unlikely to invest in a particular geographical area until it was clear that they would be one of the approved providers following the tender exercise. This led to some difficulties accessing new provision for emerging discharge cases.

4.3.3 The number of bed days lost to complex delayed discharge doubled between 2015/16 and 2016/17. 3227 bed days were lost due to complex delays in 2017/18. The poorest performance was experienced during 2017/18 Quarter 3, with signs of recovery happening in Quarter 4. The main reason for delay is people awaiting legal process to be concluded for over 75s (guardianship). For under 75s, complex delays mostly relate to the provision of specialist accommodation to meet assessed needs. A range of measures were put in place to improve the pathway for those with complex delays.

Graph 26: Management Information at Locality Level: Bed days lost to complex delays in discharge

Number of bed days lost to complex delayed discharges for people of all ages in Angus by locality and financial year



Source: ISD LIST management information (not official ISD statistics)

Performance Area 1

Workforce

One of the key drivers of health and social care integration is maximising the workforce capacity, capability and developing new opportunities.

Angus HSCP is committed to providing high quality integrated care to patients, service users, families and carers who use the services. To maximise the benefits of our Partnership, our workforce is on a journey of change that will challenge us to develop new ways of commissioning, managing and delivering services.

5.1 What we have achieved to date

- We have produced a workforce plan which set outs a strategic focus that will:
  - Ensure all our models of care are built on a sustainable workforce
  - Recruit new and younger staff
  - Maintain and enhance careers for older staff
  - Provide opportunities for existing staff
- iMatter, the Staff Experience Continuous Improvement Model, was rolled out across integrated teams during the summer of 2017.
- Delivered improvements in NHS staff sickness absence

5.2 What we plan to do next

We have set out a series of ambitions in our workforce plan:

Ambition	Action
We will increase the number of staff aged under 20 years in the HSCP to at least 2% by 2020. (currently 1 out of 882 or 0.1% NHS)	A Modern Apprenticeships in Care programme will be launched by the HSCP.
We will plan, analyse and manage our workforce resource and skills to meet our demand issues	We need to utilise local and national workforce tools across health and social care to manage and plan.
All employees will report via iMatter that they feel motivated, supported and cared for at work	We need a workforce development plan covering statutory, third and independent sectors to ensure career development pathways and plans are inherent to enable staff to develop appropriate skills, knowledge and experience to meet the future needs of the service.
Increase Volunteering Opportunities	In collaboration with VAA, implement Volunteering plans.
Increase work placements	Expand Angus Works into care environments.
Implement 'Grow our own nurses Scheme'	Discuss with University of Dundee and NHST Nursing Directorate.
Streamline staff's ability to move from substantive posts to bank	Raise with NHS Tayside
Increase attractiveness of working in Angus	Contribute to NHS Tayside and Angus Council's recruitment processes

5.3 How we monitor progress

Quantitative Data regarding staff sickness and vacancies will be complemented by qualitative feedback from the iMatter team action plans. These have been reviewed by the appropriate management groups. Progress is monitored through the following national and local performance measures:

Angus as a good place to work

National Indicator 10: Percentage of staff who say they would recommend their workplace as a good place to work is still under development nationally and therefore cannot be reported.

1049 members of staff received a copy of the iMatter questionnaire and 708 responded (67% response rate). The questionnaire sought to identify staff feeling about:

- Staff governance and standards
- Experience as an individual
- My team/My direct line manager
- My organisation

Angus Health and Social Care Partnership is a relatively new organisation and efforts continue in relation to developing shared culture and values and organisational development as a whole. The outcome from iMatter was positive in relation to the journey we are on, and identified areas where the organisation had opportunity for further development such as feeling involved in decisions about the organisation and how performance is managed. Every team who took part in iMatter has an action plan to address opportunities for improvement. These will be progressed over the next year. The iMatter programme will be extended to all teams in 2018.

Sickness Absence

The percentage of sickness absence amongst Angus NHS staff continues to decrease. Opportunities for improving sickness absence in Angus Council staff are being developed.

Table 4: Management Information - Percentage Staff sickness absence of staff working within Angus Health and Social Care Partnership

Angus Health and Social Care Partnership	2015/16	016/17	2017/18
NHS staff	5.02	4.78	4.66
Angus Council staff	6.28	7.46	8.69

Source: Angus Council and NHST epayroll

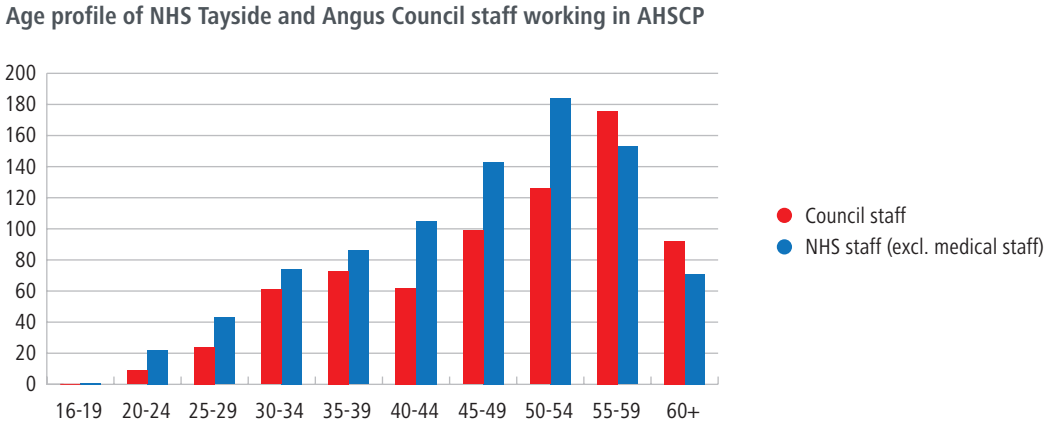
We know that our staff are delivering services and care in an increasingly complex environment and that stress related illness is amongst the main causes of absence across Angus. The approach to managing sickness absence will be standardised during 2018/19 using learning from the effective process used in the NHS.

Staff number and Age profile

There are 667 NHS Tayside staff, 99 hosted staff and 722 Angus Council staff working in AHSCP. This is a 21% reduction in Angus Council staff numbers compared to April 2016 when the Partnership was established.

The workforce is ageing. 54% Angus Council and 46% of NHS Tayside staff are over the age of 50. This is the same as in April 2016. There is no change in age distribution of NHS Tayside staff over the age of 50 but the age distribution of Angus Council staff over the age of 50 has shifted with higher proportion of staff now over 55.

Graph 27: Management Information at Angus Level: Age profile of Angus Health and Social Care Workforce



Source: Angus Council and NHS Tayside

Angus HSCP Staff Partnership Forum

The Angus Health and Social Care Partnership Staff Forum was established to ensure the ethos of partnership working is embedded. Its remit is to ensure the fair and consistent application of the employing authority's staff governance standards for all NHS Tayside and Angus Council staff working within the Partnership. The forum addresses operational issues affecting staff and services and contributes to the development and implementation of strategy and policy.

Walkabouts

The Staff Partnership Forum introduced the 'walkabout' towards the end of 2017/18. The objectives of the walkabout are to:

- Help the Forum appear more approachable by encouraging staff to enquire about the role of the forum and allow members to hear what issues affect the workforce, face to face.
- Improve communication by discussing in an unfiltered setting relevant topical issues affecting specific groups of staff e.g. proposed changes.
- Explore opportunities for specific staff groups.

The first walkabout met 4 members of staff. Main points of the discussion were:

- Staff had not heard of the Staff Partnership Forum.
- They would all recommend Angus Council as an employer.
- All appeared to be very proud of their facility and displayed a genuine warmth to their client group.
- The main issues that affected them in their day to day work was covering for staff who were off sick, rotas being changed at short notice, and questions linked to the promotion of family friendly working practices.

Actions

Feedback to service manager staff comments regarding family friendly policies with an aim to monitor compliance and increase understanding.

More walkabouts are planned.

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 which allows for multi-agency scrutiny. There is an exception reporting approach which reflects the 6 domains of assurance set out within the framework. A regular reporting calendar assures that services under the direct responsibility of the Angus IJB including hosted services, alongside voluntary reporting by the wider partnership members, occurs. The quality of performance is evaluated by regular production of performance data for consideration by the group. The risk register and any complaints are also considered. Some arrangements in relation to improving data availability and quality have still to be addressed, however progress is being made. Areas for development are highlighted in each domain.

6.1 Domain 1 - Information Governance

Arrangements for the delivery of GDPR have been progressed both within Angus Council and NHS Tayside. New Privacy Notices have been developed and staff training has been delivered and Angus Health and Social Care Partnership has recently registered with the Information Commissioner's Office in recognition of the increasing role as joint data controller with both NHS Tayside and Angus Council.

There were no breaches in information governance that required notification to the Information Commissioner's Office in any organisation. Remedial action has been put in place in relation to two near misses in adult care.

Angus Council received 97 Freedom of Information Act enquiries in relation to adult care services. NHS Tayside received 35 enquiries in relation to services within Angus Partnership. The themes included:

- A wide range of information in relation to home care services
- Charging and funding
- Procurement and contractual arrangements including contract values
- Information in relation to services including: primary care; drug and alcohol services; adult mental health services; older people services; self-directed support; continence; equipment
- Staff expenses
- Vulnerable people and violence against women
- Delayed Discharge

Plans are being developed to expand open data in relation to health and social care. Freedom of information requests give a good indication of the type of data that should be included in the plans for improving open data.

6.2 Domain 2 - Professional Regulation and Workforce Development

Professional registration and revalidation

Systems are in place to assure that Angus Council and NHS Tayside staff working within Angus Health and Social Care Partnership maintain appropriate and up-to-date registration and complete any required revalidation process. All social care staff that require registration have the correct registration in place. No breaches in registration have been recorded in respect of health staff or social care staff working in the

Partnership. 11 members of staff (care home and support workers) have registration applications in process. A further 7 care home and support workers require to register within the next 6 months.

Since April 2016, all nurses and midwives in the U.K. need to follow a Revalidation process to maintain their registration with The Nursing and Midwifery Council (NMC). This new process replaces the previous (Prep) requirements, and all nurses and midwives will have to revalidate every three years to renew their registration.

Support, Supervision and Appraisal

It has been identified that stress related illness is a significant cause of absence within Angus. Ensuring good uptake of effective, high quality appraisal that discusses performance and identifies support and development opportunities for staff will ensure staff are better supported.

Systems for appraisal have changed both for NHS and Council staff. New monitoring arrangements require to be established.

Risks

There are two amber operational risks relating to staffing issues that continue to require management and mitigation, and one amber and one red service risk which also require management and mitigation. Plans are in place to address these risks.

6.3 Domain 3 - Patient, Service User and Staff Safety

Adult Protection

A full report on adult protection is published by the Angus Adult Protection Committee.

Adverse events

Adverse events are reported routinely by health staff and are typically anything that raises a concern. 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 rehabilitation facilities. The available information does not include the number of falls attributable to or recorded against one individual. 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. Of 1662 adverse events recorded in 2016/17, 399 of those events were recorded with harm. Typically 80% of adverse events are reported within 24 hours, 70% are verified within 24 hours and 71% are verified within 90 days.

6.4 Domain 4 - Patient, Service User and Staff Experience

Outcome indicators relate to people's perception of their experience in using services. Angus performance in relation to the national indicators (NI) has declined since the last survey. This may reflect the significant change in arrangements that have taken place over the last 12 months as we have delivered parts of the Angus Care Model. We also have some concerns that the national indicators my not fully reflect the views of the population given the sample size, the overall response rate and the response rate to individual questions (see Table 1 page 11). Continuing to hold conversations with the people of Angus focused on being transparent, showing data and information about need and performance and involving people in plans for change will also make a difference. We expect performance in these qualitative indicators to improve. Our basis for this comes from the 1770 reviews undertaken over the past 12 months with people who use services. All services also undertake experience surveys with people who use those services. Feedback is generally positive but services recognise that there continues to be more work to do.

Table 5 National and Local Survey results

Indicators	National Survey - Angus performance	People who use Angus services
NI 2	76% of adults supported at home who agreed that they are supported to live as independently as possible	98% feel that services help them to stay as well as they can be
NI 3	71% of adults supported at home who agreed that they had a say in how their help, care, or support was provided	100% feel listened to by staff
NI 4	71% of adults supported at home who agreed that their health and social care services seemed to be well co-ordinated	99% people feel that they have a choice over the nature and timing of support
NI 5	76% percent of adults receiving any care or support who rated it as excellent or good	91% people feel that staff within services are responsive to their need and wishes
NI 6	78% of people with positive experience of the care provided by their GP practice	See note below
NI 7	77% of adults supported at home who agree that their services and support had an impact on improving or maintaining their quality of life	98% feel that services help them to stay as well as they can be
NI 8	34% - combined percentage of carers who feel supported to continue in their caring role	96% carers have been offered support which has allowed them to continue in their caring role
NI 9	80% of adults supported at home who agreed they felt safe	95% people feel that services they have in place help them feel safe

(Source: Biennial Health and Care Experience Survey 2017/18 ISD and Talking points reviews Care first Angus Council)

Note: In respect of General Practice there is a high degree of variation between practices and lower scoring practices do tend to be those who are experiencing more recruitment difficulties. There is a high degree of GP engagement in working towards implementation of the new GP contract which is primarily aimed at reducing GP workload. Angus HSCP is working hard with practices to provide alternatives to seeing a GP, freeing up GPs to concentrate on their emerging role as expert medical generalists.

6.5 Domain 5 - Regulation of Quality and Effectiveness of Care

Quality of registered social care services

In 2015/16 the proportion of care services graded good or better in Care Inspectorate inspections in Angus was 90% which was above the Scottish rate of 83%. In 2017/18 78% of care services operating in Angus are graded as good or better against a Scottish average of 84%. This overall percentage does not take individual grades into consideration; it only reflects the lowest grade across all indicators for each provider operating in Angus. A provider could have individual grades in 3 achieving excellent but one area scoring adequate. This would result in the provider being excluded from those care services operating at good or better. Some providers operate in Angus without being part of any directly commissioning arrangement. Care services include all registration categories such as care home, day care, care at home, supported housing etc. Most change in grading has been in the care home sector where there are real challenges in staffing, particularly in relation to nurse recruitment and retention. We have developed Locality based care home improvement groups and introduced a care home forum where we are working with providers, and providers are working together to address these issues.

Service inspections

Care Inspectorate

There are 76 registered social care services supporting adults in Angus. 84% of care services in Angus are graded good (4) or better in Care Inspectorate inspections during 2017/18 (NI 17). There have been 51 annual inspections in relation to care services provided within Angus in 2017/18. There were 24 requirements made across all themes involving 6 care services. There were 86 recommendations across all themes involving 17 care services.

This is an increase in requirements but a decrease in recommendations compared to 2016/17.

Note: A requirement is a statement which sets out what a care service must do to improve outcomes for people who use services and must be linked to a breach in the Public Services Reform (Scotland) Act 2010 (the "Act"), its regulations, or orders made under the Act, or a condition of registration. Requirements are enforceable in law. Requirements are made where (a) there is evidence of poor outcomes for people

using the service or (b) there is the potential for poor outcomes which would affect people's health, safety or welfare. A recommendation is a statement that sets out actions that a care service provider should take to improve or develop the quality of the service, but where failure to do so would not directly result in enforcement. Recommendations are based on the National Care Standards, SSSC codes of practice and recognised good practice. These must also be outcomes-based and if the provider meets the recommendation this would improve outcomes for people receiving the service.

From inspection reports a number of issues are highlighted in requirements and recommendations.

Table 6: Management Information – Themes of requirements and recommendations following inspections of care services in Angus.

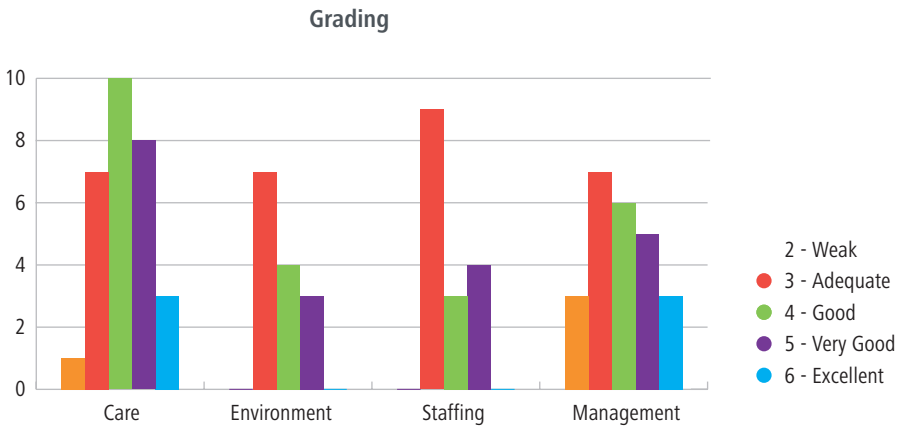
Inspection Theme	Requirement themes	Recommendation themes
Care	Medicines	Care plans; medicines; skin management; activity; health monitoring; meal time experience
Staffing	Recruitment and registration	Recruitment; training; induction; supervision; registration
Management	Audit, management of resident finances, improvement plan	Audit, appraisal
Environment	N/A	Signage; lighting; repairs

Source: Care Inspectorate data store

No enforcement action was taken by the Care Inspectorate in Angus during 2017/18.

Care Homes

Graph 28: Care Inspectorate Grading of Care Homes in Angus



Source: Care Inspectorate data store

In 2016/17 no homes received a grade of 2 or below. In 2017/18 three care homes received a grade of 2. These grades relate to the care and support theme and management and leadership theme.

Mental Welfare Commission Report on Unannounced Visit to Rowan and Willow Units, Stracathro Hospital, 24 May 2017

A positive unannounced inspection report has been received from the Mental Welfare Commission in respect of this visit, and feedback has been shared with staff.

Healthcare Environment Inspection (HEI) Unannounced Thematic Inspection – Invasive Devices (Catheter Care) NHS Tayside: Ninewells Hospital, Perth Royal Infirmary, Stracathro Hospital, 1-3 November 2017

A report has been received in relation to this unannounced visit. The report highlights:

- Staff knowledge of the processes for urinary catheter insertion and maintenance, including aseptic technique, was good.
- Where the insertion and maintenance bundle was used, insertion criteria was well recorded.

Areas for improvement

- Make sure staff document the key recommendations of insertion and maintenance of urinary catheters.
- Agree clear guidelines on the approved method of glove use for insertion of urinary catheters.

The inspection resulted in four requirements and one recommendation. An action plan has been agreed and the four requirement actions attributed to individuals have been addressed. An education/awareness plan has been formally approved to support the roll out of a Catheter Passport in tandem with the urinary catheter insertion and maintenance bundle. This has been communicated organisation-wide via a 'Vital Signs'. An NHS Tayside Urinary Catheter Care Improvement Group has been established to progress the recommendation. The assurances measures in relation to the documentation of urinary catheter care and management will be an action for this group, for completion by 30 June 2018.

Complaints

In 2017/18 there were:

Stage 1 Complaints	41	(consisting 29 Angus HSCP Health only & 12 Hosted Services)
Stage 2 Complaints	36	(consisting 19 Angus HSCP Health only & 17 Hosted Services) and 15 joint Angus involvement with NHS Tayside services

36 Stage 2 complaints were received in respect of health services directed by the Angus Health and Social Care Partnership. The aim is to respond to 68% of these complaints within 20 working days. In 2017/18, 75% of complaints were responded to within the 20 working days.

The Care Inspectorate upheld 6 complaints in this time period, involving 5 care homes. The issues raised in these complaints related to:- record keeping: healthcare: staffing levels: adult protection.

Stage 1 Complaints

It is aimed to ensure an early resolution (within 5 days) to Stage 1 complaints. Stage 1 complaints were made in relation to a range of services including inpatient services, community mental health services, continence and physiotherapy. In 2017/18 Stage 1 complaint themes included:

- The environment
- Staff attitude
- Waiting times
- Diagnosis

Stage 2 Complaints

Where it has not been possible to address a complaint early or the complainer is not satisfied with the outcome, Stage 2 complaints allow for a more in-depth investigation which is to be completed within 20 working days.

Stage 2 complaints during 2017/18 were received in relation to a number of services including inpatient services, minor injury and illness services, personal care and some integrated services. Themes included:

- Disagreement with assessment
- Complaints about individual members of staff
- Communication
- Care and treatment

6.6 Domain 6 - Promotion of Equality and Social Justice

A review of the Equalities and Mainstreaming report has been undertaken and a update was approved by the IJB in April 2018. Indicators which show how services and outcomes vary between the most and least deprived communities in Angus are being developed. These are reported on separately.

6.7 Corporate Risk Management

The Corporate Risk Management Plan is overseen by the Clinical, Care and Professional Governance Group.

Table 7 shows the risk summary at the end of 2017/18. During 2017/18 two risks were managed into their planned acceptable level of risk. These were in relation to clinical, care and professional governance, and sustainability of out of hours. A third risk was managed to a better than planned level of risk. This is in relation to implementation of the Strategic Plan. These three risks are now archived.

Angus Health & Social Care Partnership – Corporate Risk Rating Matrix

NO	Risk Title	Risk Owner	Risk Exposure – no controls	16 Jan 2017	12 April 2017	25 May 2017	9 Aug 2017	4 Oct 2017	22 Nov 2017	19 Jan 2018	14 Mar 2018	Planned Risk Exposure	
1	** Sustainability of Primary Care Services • 2c Practices	Associate Director – Primary Care	12 (4x3)	9 (3x3)	12 (4x3)	12 (4x3)	25 (5x5)	25 (5x5)	20 (5x4)	20 (5x4)	20 (5x4)	9 (3x3)	↔
	Sustainability of Out of Hours Service	Chief Officer					12 (4x3)	12 (4x3)	9 (3x3)	9 (3x3)	9 (3x3)	6 (2x3)	↔
2	GP Prescribing	Clinical Director	25 (5x5)	25 (5x5)	25 (5x5)	25 (5x5)	25 (5x5)	25 (5x5)	25 (5x5)	25 (5x5)	25 (5x5)	20 (4x5)	↔↓
3	Financial Management	Chief Officer	25 (5x5)	25 (5x5)	25 (5x5)	25 (5x5)	25 (5x5)	25 (5x5)	25 (5x5)	25 (5x5)	25 (5x5)	20 (4x5)	↔
4	Enhanced Community	Support Head of Community Health & Care Services (North Angus)	In development	6 (4x4)	16 (4x4)	16 (4x4)	16 (4x4)	16 (4x4)	16 (4x4)	16 (4x4)	16 (4x4)	4 (2x2)	↔
5	Clinical, Care & Professional Governance	Clinical Director	9 (3x3)	9 (3x3)	9 (3x3)	6 (2x3)	6 (2x3)	6 (2x3)	6 (2x3)	6 (2x3)	6 (2x3)	6 (2x3)	↔
6	Implementation of Strategic Planning Priorities	Head of Community Health & Care Services (South Angus)	16 (4x4)	16 (4x4)	12 (3x4)	12 (3x4)	8 (2x4)	8 (2x4)	3 (1x3)	3 (1x3)	3 (1x3)	8 (2x4)	↔
7	Performance Management	Head of Community Health & Care Services (North Angus)	20 (5x4)	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	9 (3x3)	8 (2x4)	↓
8	Workforce Optimisation	Head of Mental Health Services	9 (3x3)	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	12 (4x3)	6 (2x3)	↔

Risk Exposure Rating

Critical/Extreme (5)	5	10	15	20	25
Major (4)	4	8	12	16	20
Significant/Moderate (3)	3	6	9	12	15
Marginal/Minor (2)	2	4	6	8	10
Negligible (1)	1	2	3	4	5
	Very Low/Rare (1)	**Low/Unlikely (2)**	**Low to High/ Possible (3)**	**High/Likely (4)**	**Very High/Almost Certain (5)**

Key

- Controls are working effectively
- Controls require further development
- Significant controls not operating effectively
- Significant controls do not exist or have broken down

Performance Area 3

Resources

Throughout 2017/18, Finance Reports have been presented to every IJB meeting. These reports set out information regarding the annual budgets and projected financial out-turns for the financial year. At the end of the 2017/18 financial year, a year end summary report was submitted to the June 2018 IJB meeting.

Reports through the year projected in year underspends within Adult Social Care related to early delivery of savings plans including, for example, within the Help to Live at Home programme, and one-off savings for reasons including delayed social care placements. At the year end the Adult Social Care position was an underspend of £380k.

Within the IJB's local Community Health Services good progress was reported through the year on delivering in year (one-off) and recurring savings. The IJB's local Community Health Services underspent during 2017/18 and this position helped to offset Hosted Service (including Mental Health Services) and, in particular, local Primary Care prescribing overspends. The latter remains a significant challenge for Angus IJB with a year end overspend of £2.8m after non-recurring financial support of c£500k.

The IJB Finance reports also provided regular feedback to the IJB regarding progress with 2017/18 savings targets and, noting progress with the Angus Care Model, the IJB was able to confirm by February 2018 that all 2017/18 recurring savings targets (excluding Prescribing and Hosted Services) had been delivered.

Noting the materiality of Primary Care prescribing overspends to the IJB's overall position, the IJB received regular Prescribing reports setting out the work underway locally and regionally to address the local Prescribing challenges.

More detail on financial performance is provided to the IJB separately in reports on the annual accounts.

7.1 What we have achieved to date

The IJB has successfully delivered services throughout 2017/18 in line with the Integration Scheme. While the Strategic Plan and operational imperatives create a challenging and busy landscape for the IJB in terms of operational service delivery, much progress has been made including:

- The completion of further phases of the Help to Live at Home programme including completion of the Internal Service redesign, migration of services to external providers, and the development of the procurement arrangements for a revised Care at Home contractual framework from April 2018. The programme did require a reduction in staff employed through Angus Council and this was managed through a process of early retirement/voluntary redundancy. The implementation of the Internal Service redesign was completed by November 2017 and the Help to Live at Home programme is now delivering the planned efficiencies.
- Development of an Improvement and Change Programme intended to bring together the oversight and project management of a series of changes within Adult Social Care. This programme reports to the IJB half-yearly and has assisted the IJB deliver savings in 2017/18 and will assist with plans for 2018/19.
- The development of the Angus Care Model. This was first described to the IJB in October 2017 and considered the future configuration of Community Hospital services, Minor Injury and Illness Services and Residential Care Home Services. Agreement regarding future service configuration and further work was reached in January 2018.

- An increased engagement with local General Practitioners and with NHS Tayside to consider and address Primary Care Prescribing challenges within Angus.
- The further progression of accommodation developments for adults with Learning Disabilities including progression of the rehabilitation of some Strathmartine Centre patients and the progression of the replacement for The Gables residential care home. The IJB has also supported the development of new residential respite arrangements for adults with Learning Disabilities.
- Involvement with the Tayside–wide review of Mental Health Services and responding to the resultant changes. This has had a significant impact on the configuration of local services in particular due to changes in In Patient Mental Health provision.
- Undertaking the early stages of preparing for the introduction of the new 2018 General Medical Services contract. This will ultimately have far-reaching implications for local General Practices and the services that support them.
- Preparing for the implementation of the Carers (Scotland) Act 2016, including developing eligibility criteria. Further work is still required to ensure the IJB can deliver the full implementation of the Carers Act within the available resources.

The IJB has had to manage a number of challenges throughout the year including workforce issues, particularly prevalent in medical and nurse staffing. There have also been some delays in projects that the IJB had anticipated would be more developed including the integration of Occupational Therapy Services, reviews of Medication Administration arrangements, and the final phases of the roll-out of Enhanced Community Support. These issues remain under development.

It is also important to recognise the breadth of change that the Angus population have had to absorb. This has included changes within Mental Health Services inpatient provision, changes in Community Hospital provision, and changes to Minor Injury and Illness Services. These changes reflect the scale of the challenge Angus IJB faces to deliver sustainable and safe services within available financial and workforce resources.

7.2 What we plan to do next

On an annual basis, Angus IJB negotiates budget settlements with both Angus Council and NHS Tayside. Angus IJB has now agreed a budget settlement with Angus Council for 2018/19 and is working with provisional budget assumptions regarding a budget settlement from NHS Tayside for 2018/19. Subject to NHS Tayside confirmation, the budget settlements for 2018/19 will be as follows:

Budgets to be delegated from Angus Council - £44.672m
Budgets to be delegated from NHS Tayside - £126.791m
Total budgets to be devolved to the IJB - £171.463m

The budgets above include revised assumptions regarding Large Hospital Set Aside resources. This part of the IJB's resource framework remains under-developed. While this is a national issue, Angus IJB continues to develop solutions with both NHS Tayside and other local IJBs. This will be an area of significant national and local focus during 2018/19.

Both settlements present significant challenges in terms of accommodating service, demographic and inflationary type pressures. While Angus IJB regularly monitors progress being made towards delivering the required level of efficiencies to live within agreed annual budget settlements, in April 2018 Angus IJB also considered a multi-year financial framework (IJB report 25/18) that highlighted future financial challenges.

In 2018/19 we expect to deliver:

- Continue to move resources into the community through Enhanced Community Support 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 and large hospital resources generally for Angus patients, and to develop models of care which allow a shift in the balance of care with resource to the community.
- Seek to deliver a series of further operational, administrative and managerial efficiencies.
- Deliver the next stages of the Angus Care Model developments regarding Care Homes and Minor Injury and Illness Units.
- Develop reviews of Learning Disability Services.
- Develop reviews of service eligibility criteria.
- 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.

- Seek to develop locality reporting regarding resources, improve the Large Hospital Set Aside arrangements and develop financial reporting of Hosted Services.

7.3 How we monitor progress

Detailed reports on finance are submitted by the Chief Finance Officer separately. The IJB seeks to demonstrate best value through a comprehensive efficiency programme as described in Board papers and IJB financial monitoring reports.

Currently the availability of data within Tableau is dependent on our ability to upload our local data, and on ISD's progress with the development of the dashboard. In respect of financial information, the dashboard is currently providing information up to the year 2014/15. We do not see this as relevant to the performance of the Partnership and wait for improved information in Tableau as the system is further developed.

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, at 27% against a Scottish average of 23% NI 20). This is not directly in the control of the IJB as most admissions are of an acute nature and are to Ninewells Hospital.

7.4 Best Value

As is demonstrated elsewhere, the IJB has a significant programme of change under way. This ranges from completion of the Help to Live at Home Programme in 2018/19, to the initiation of the Angus Care Model in 2017/18 and the work undertaken within the Improvement and Change programme. The scale of the changes underway within Angus IJB are reflective of the scale of change required to meet the range of pressures the IJB faces - from financial pressures to demographic pressures to workforce pressures. The IJB's 2016-19 Strategic Plan set out the initial IJB intentions and this will be built upon in the next iteration of the IJB's Strategic Plan.

This scale of change means that the vast majority of the IJB's resources and services are subject to some form of service review and continuous improvement and consequently this assists the IJB demonstrate that it is, at all times, seeking to secure best value from the resources available.

Beyond accessing the corporate systems of both Angus Council and NHS Tayside as required (e.g Procurement), the IJB's own governance systems include regular financial and performance reporting that is intended to allow the IJB to make judgements regarding the effective use of resources.

In terms of core Procurement, all the IJB's Procurement activity is managed through either NHS Tayside or Angus Council, and all Procurement consequently complies with all Procurement guidance applicable within these organisations.