Appendix 1

ANGUS
Health & Social Care
Partnership

ANGUS HEALTH AND SOCIAL CARE PARTNERSHIP

ANNUAL PERFORMANCE REPORT

April 2018 to March 2019

Published June 2019

Angus Health and Social Care Partnership

Strategic Progress and Performance Report 2018/19

Contents

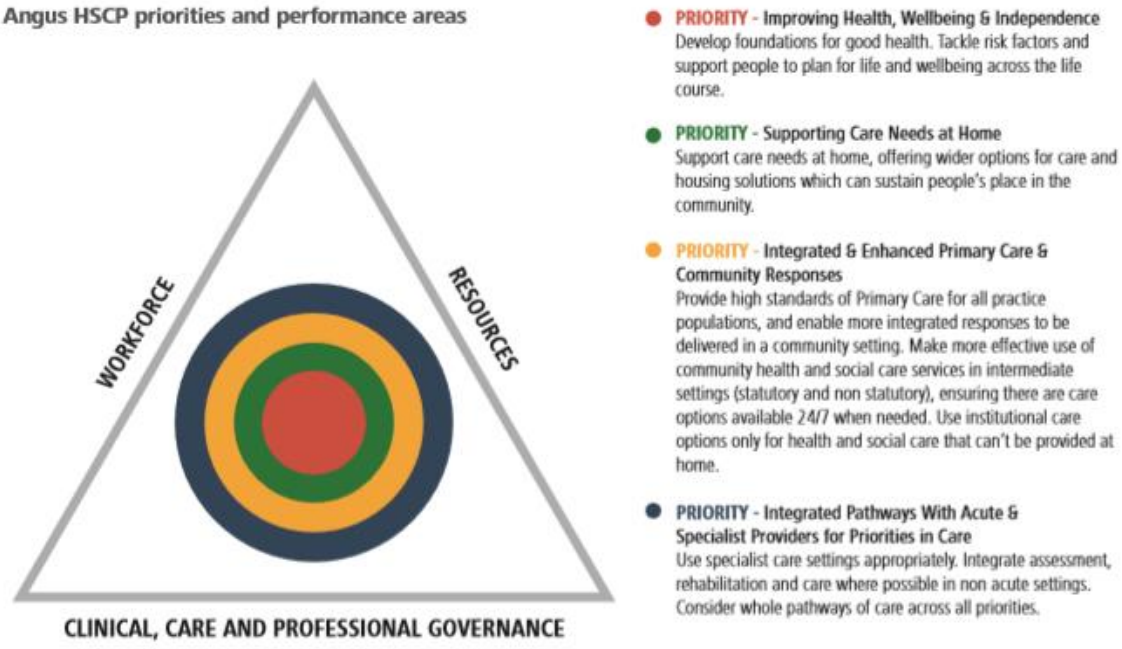
INTRODUCTION

The Angus Health and Social Care Partnership (AHSCP) set out the vision for change and improvement in its Strategic Commissioning Plan 2016-19. The purpose of this Annual Performance Report is to show progress against the four priorities set out in the Angus Health and Social Care Partnership's Strategic Commissioning Plan and three further performance areas. The four priorities of our Strategic Commissioning 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. 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 all hosted services but includes information in relation to Accident and Emergency and Adult Mental Health Inpatient 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 Commissioning Plan 2016-2019 made a commitment to shifting the balance of care from institution-based care to care at home; it called 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 Commissioning Plan set out this ambition through four strategic priorities.

Figure 1



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 IJB in line with increased demand. Using the current resource framework as efficiently and effectively as possible is essential. The Strategic Commissioning Plan identified a number of areas of efficiency, and the shift in the balance of care required.

Review of the Strategic Commissioning Plan

A review of the Strategic Commissioning Plan 2016-19 published in June 2018 acknowledged that a new plan would be developed for 2019-22. This Strategic Commissioning Plan 2019-2022 was approved by the IJB in April 2019.

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 more opportunities for discussion on the development and progress of change with the public. We have also developed a website and use social media (Facebook and Twitter) to engage with the public.

During March and October 2018 and February 2019 we continued to hold a series of continuing the Conversation Events in each locality. The events were an important opportunity for people in Angus to find out about health and social care in their locality and become involved in shaping the future vision and direction of adult health and social care as we developed our new Strategic Commissioning Plan. Members of the public had the opportunity to meet with staff and ask questions about a range of topics related to the development to the Angus Care Model.

We have asked the public to tell us more about what services should be like in the future. This is what they told us:

We are encouraging staff and the public to tell us more about how our work and their contribution is making a difference to health and social care in Angus by using the hashtag #angusmakingadifference on social media. This will help us deliver the vision for our new Strategic Commissioning Plan 2019-22

"Just wanted to say how impressed I was with all the wonderful services and passionate people there are working in the Angus Health & Social Care field. Truly made me proud to be part of a county shaping services this way." Feedback from a member of the public at a conversation event.

ANGUS PERFORMANCE SUMMARY

What we have achieved in 2018/19

- ✓ Angus performs well nationally in relation to eight of ten national quantitative core indicators particularly in relation to admissions, bed days and timely discharge. This good performance shows the progress the partnership has made in shifting the balance of care to more community based and responsive services and addressing the average length of stay in hospital following an emergency admission.

- ✓ The performance in relation to two of the national core indicators; falls admissions and percentage of adults with intensive care needs has fallen. A full review of all information in relation to falls is required to understand why the Angus performance has declined, while Scotland as a whole continues to improve.

- ✓ We have developed a new Strategic Commissioning Plan for 2019-22. We are developing new Locality Improvement Plans to support the delivery of this new Strategic Commissioning Plan.

- ✓ We have delivered training on 'Life Curve' to our Enablement Response Teams to support the staff in promoting greater independence with service users.

- ✓ We have introduced 'Just Checking', a digital monitoring system, to support the assessment of people who may need support with personal care.

- ✓ We have delivered more support in communities that means we have been able to cease Inpatient Services in Montrose Royal Infirmary. Typically there continue to be more than 20 empty hospital beds in Angus every day. This demonstrates continued progress with the delivery of the Angus Care Model, supporting people in communities

- ✓ We have introduced temporary independent intermediate care services in North East Angus to support step up care by GP's.

- ✓ We have launched the Angus HSCP website and continue to work with communities to improve and develop content.

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

- ✓ We have introduced a 'Check Tech Out' Scheme to support people to learn about digital technology before purchasing their own equipment.

- ✓ We have commenced the discussion to develop Treatment and Care services in our localities. This may include leg ulcer, wound care support, vaccine transformation, physiotherapy first and an extension to our social prescribing service.

- ✓ The new Integrated Overnight Service in Angus (IONA) commenced on 1 April. This will provide a more appropriate service enabling patients to stay at home. In addition there is still a 24 hour service based in Minor Injury Unit at in Arbroath Infirmary

- ✓ Innovative work carried out in Letham Health and Wellbeing Centre was shortlisted in the "Innovative Remote and Rural Services" category of the Annual Scottish Digital Health and Care Awards.

- ✓ Medication Management continues to improve. A local Angus GP recently won a STAR Award for his leadership around this.

- ✓ We have established a new Mental Health and Wellbeing Network with the Angus Community Planning Partnership. It's Vision is to support all agencies to work together to promote prevention and early intervention opportunities, activities and support service improvements and links to other strategic planning groups to achieve the best outcome possible for the citizens of Angus in relation to all aspects of mental health and wellbeing, specifically including suicide prevention.

Nine of our GP Practices now have Mental Health and Wellbeing Workers delivering a preventative and early intervention model. The remaining eight practices will have this service by 2021.

National and Local Indicators 2018/19

Table 1 shows the summary of Angus 2018/19 performance in relation to the Scottish (2018/19) performance across a range of national indicators. Four national indicators remain undeveloped and are therefore not included in the summary table. National Indicators 1 to 10 are only measured biennially so there is no data to report for 2018/19. 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.

Quantitative Indicators (NI 11-23)

The quantitative indicators aim to show the 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 Governments 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 day's 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 throughout this annual report 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:

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

Table 1: Angus' Performance for national indicators and local indicators (from ISD provisional data)

	Quantitative Indicators 2017-18						
	Indicator	***Title***	***Scotland 2015/16***	***Angus 2015/16***	***Scotland 2018/19***	***Angus 2018/19***	***Notes***
National Data Indicators	**NI - 11**	Premature mortality rate per 100,000 persons	*441 (2015)*	*391 (2015)*	*425 (2017)*	*384 (2017)*	We have made progress towards addressing premature mortality. The gap between premature mortality in the least and most deprived areas of Angus is also narrowing. Page 16 *Note: These rates are per calendar year rather than financial year. The latest year available from NRS is 2017. The rate for Angus for 2018 (from LIST- not official statistics) is 318.*
	NI - 12	*Emergency admission rate for adults (per 100,000 population)*	*12,281*	*10,535*	*11,492*	*10,951*	Whist admission rates have increased in Angus from 2015/16 to 2018/19 there has been a reduction, for the first time, between 2017/18 and 2018/19. Page 32
	NI - 13	*Emergency bed day rate for adults (per 100,000 population)*	*128,630*	*117,547*	*107,921*	*98,834*	Bed day rates continue to decline. Previously this has been due to improvements in average length of stay. This latest improvement is related to reductions in admissions and improvements in timely discharge. Page 34
	NI - 14	*Re-admission to hospital within 28 days for adults (per 1,000 population)*	*98*	*105*	*98*	*99*	Re-admissions are recorded as a percentage of those who have previously been admitted. Reductions in re-admissions contribute to the overall reduction in admissions experienced between 2017/18 and 2018/19. Page 36
	NI – 15	*Proportion of last 6 months of life spent at home or in a community setting.*	*87%*	*90%*	*89%*	*91%*	Angus is amongst the best performing partnerships in Scotland in relation to this indicator. Page 30
	NI – 16	*Falls admission rate per 1,000 population aged 65+*	*21.6*	*19.3*	*21.6*	*25.5*	Falls admission rates for people over 65 in Angus are increasing. In Scotland falls admission rates are falling. In Angus 45% of all fall admissions for people aged over 65 are people aged over 85 who account for 12% of the over 65 population. The percentage of people aged over 85 in our over 65 population is the same as Scotland as a whole. Falls have been identified as an area for further assessment and improvement, with a comprehensive falls action plan to be implemented. Page 25
	NI - 17	*Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections (*2015/16)*	*83%*	*90%*	*82%*	*83%*	There have been changes to inspection processes following the introduction of the National Care Standards. Comparisons between current and previous performance may therefore be against different inspection themes and standards. Page 48

	NI - 18	*Percentage of adults with intensive care needs receiving care at home*	*61%* *(2015)*	*52%* *(2015)*	*61%* *(2017)*	*51%* *(2017)*	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 a community alarm is higher than the Scottish average. This indictor does not include other types of service for example day care which also supports people to live independently. Day care does not feature in the service arrangements of many areas of Scotland. It is noted that there has been an increase in personal care in 2018/19 not accounted for in this 2018/19 national reporting which only includes data to the end of 2017. Page 29 *Note: These rates are per calendar year rather than financial year. The latest year available from NRS is 2017.*
	NI - 19	*Number of days people spend in hospital when they are ready to be discharged (per 1,000 population)*	*915*	*368*	*805*	*320*	Good progress has been made in addressing the issue that led to a reduction in performance in this area in 2017/18. Page 40
	NI - 20	*Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency*	*24%*	*28%*	*22%*	*23%*	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 as well as bed day use. Page 54
Local Indicators	***LI -24***	*Personal care hours rate per 1,000 18+*	*Not available*	*2697*	*Not available*	*4705*	Personal care provision has increased across all localities of Angus. Page 29
	LI -25	*Care home nights rate per 1,000 65+*	*Not available*	*10718*	*Not available*	*10414*	People are entering care homes later in life and for a shorter periods. Page 36

Chart 1 Angus ranked performance relative to all Scottish Partnerships

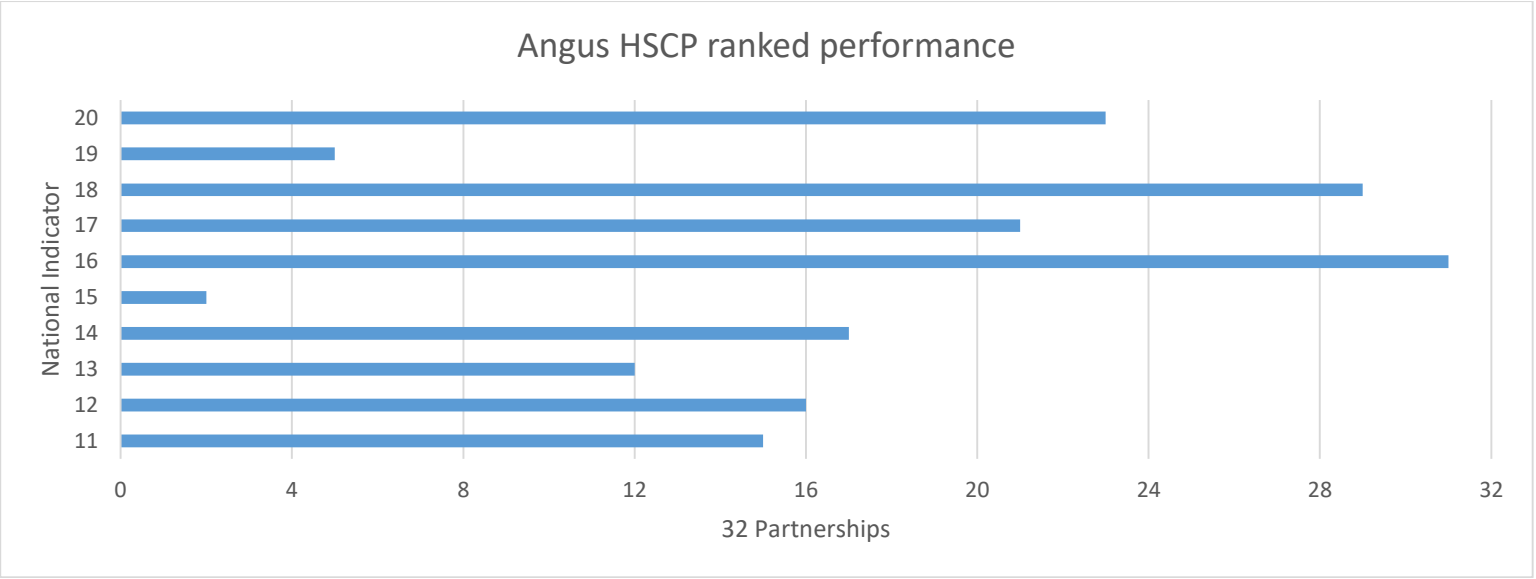


Chart 1 sets out the Angus HSCP performance ranked against all 32 areas of Scotland. National Indicators 16 (falls admissions rate for people aged over 65) and 18 (intensive social care support at home) show falling Angus performance where Angus is now ranked 31 and 29 out of 32 respectively.

Table 2 Relationship between Angus Strategic Priorities, the National Wellbeing Outcomes and the National Core Performance Indicators

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.	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 Re-admissions 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**	**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-19 Number of day's 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)

Priority: Improving Health, Wellbeing and Independence

The aim of the Angus Health and Social Care Partnership's Strategic Commissioning Plan 2016-19 has been to progress approaches that support individuals to live longer and healthier lives. This includes having access to information and natural supports within communities. Angus HSCP'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 Highlights from 2018/19

- We have developed an Angus HSCP website and used social media to share our work and promote health and wellbeing
- We have introduced Mental Health and Wellbeing Practitioners into GP practice
- Voluntary Action Angus has developed a locality locator to support better understanding of activities, groups and services that operate in each Angus postcode area.
- We have delivered a health improvement project in an Arbroath Community
- We have introduced a new Carers Support Plan
- We have delivered much more community based development through our Locality Improvement Groups

Locality Improvement Groups- making a difference –locally

North West Locality

All GP Practices within the Links Health Centre in Montrose are now certified 'Parkrun' UK practices' with patients being 'prescribed' outdoor physical activity rather than medication. The initiative aims to improve the health and wellbeing of health care staff, patients and carers, reducing the need for lifelong medication. Healthcare practitioners are signposting patients and carers to parkrun, particularly those who are the least active and have long-term health conditions.

Prior to this initiative three staff members did no exercise. Since participating in the weekly parkrun they have taken approximately 7 minutes off their best time. Family members and friends have now joined and this is all by word of mouth.

Working in partnership with Voluntary Action Angus, Family Fun sessions were organised over three weeks in East Brechin during Summer 2018. As a result parents were able to spend time with their children in a different setting and participate in games with their children and interact with other parents/carers.

Positive feedback was received from families for example; "It was good to spend time with other children and parents."
"Less screen time, more time for Mum to spend with children which is good."

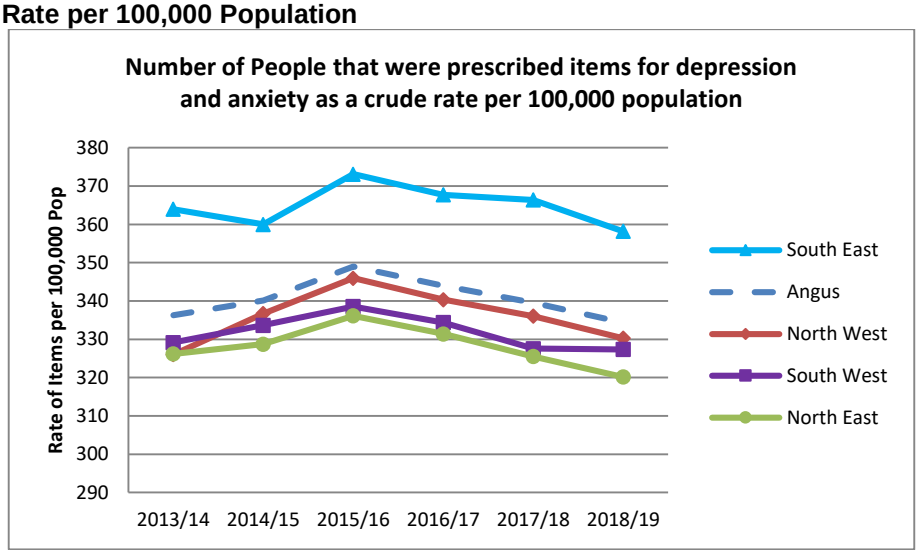
Although not formally evaluated it is anticipated that this initiative will have improved participant's mental health and wellbeing.

1.2 Making a Difference

1.2.1 We have started to identify proxy indicators that can help us understand the health and wellbeing of the population. Proxy Indicators include, for example, the use of medication for the management of depression and anxiety to help us understand mental health and wellbeing in our communities; and, hypertension and diabetes to help us understand levels of people with healthy weights in our communities. Information is available at locality level.

Mental Wellbeing

Graph 1 Number of People Prescribed Items for Depression and Anxiety in Angus as a Crude Rate per 100,000 Population



Source: PIS Dataset

1.2.2 The Strategic Commissioning Plan 2019-22 sets out an ambition to reduce the use of medications which support anxiety and depression as a proxy measure for other interventions that aim to improve the mental wellbeing of people in our communities. Enhanced Community Support Services have delivered prescribing reviews by Pharmacists and Pharmacy Technicians, this has led to reductions in prescribing generally. The testing of Mental Health and Wellbeing Practitioners in GP practice has evaluated well with evidence to suggest that alternatives to prescribing can be delivered through this model.

Promoting mental wellbeing in GP Practice

Steven, aged 21 had been seen by GP's over the last few years for low mood and anxiety symptoms and treated with various anti-depressants. After a discussion with his GP, Steven wanted a review with a Mental health and Wellbeing Practitioner to explore alternative options than just medication.

A brief mental health and wellbeing assessment allowed Steven to share the ongoing difficulties from childhood, which suggested a possible ASD (Autistic Spectrum Disorder)/Asperger's diagnosis. Steven agreed to a referral to TAACT (Tayside Adult Autism Consultancy Team) understanding that this specialist team would complete a full assessment to enable a diagnosis. The waiting times for this service are lengthy, sometimes between 9-12 months.

We also had the opportunity to discuss general wellbeing focusing on the areas in his life that were working well and the areas he wanted to work on. Steven recognised that he struggled in certain social situations, but that he also enjoyed being around others. He talked of a point in his life he felt the most happy and contented when at school and undertaking a short-course in hospitality. We looked at opportunities for volunteering and Steven agreed to meet with the social prescriber to see what opportunities were available that might suit him. Steven met with the social prescriber from Voluntary Action Angus (VAA) immediately after our discussion. We arranged to meet again.

Two weeks later the referral to TAACT had been accepted and Steven was waiting for an appointment. He had a successful meeting with VAA and had identified an area where he was going to start some volunteering work.

One year later Steven has been diagnosed with ASD and has ongoing support from TAACT in relation to this. Has been volunteering 3 days a week at a community pantry and has now enrolled on the Aspire college course.

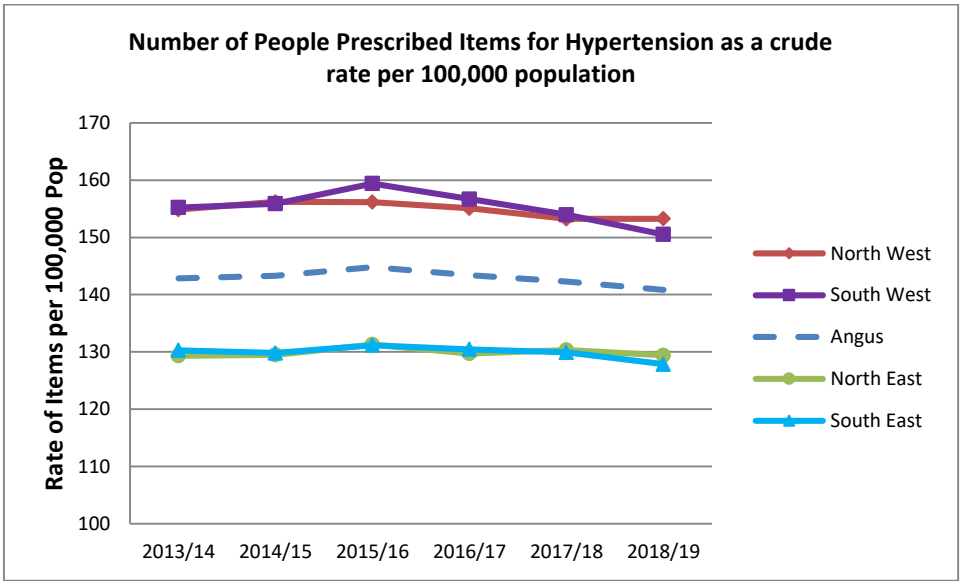
Steven is in a relationship and feeling a huge improvement to wellbeing and mood. He feels he has a better understanding of his difficulties and now feels supported with these.

Steven says that his mental wellbeing has increased also from his volunteering and what he is giving back to the community.

Healthy Weight

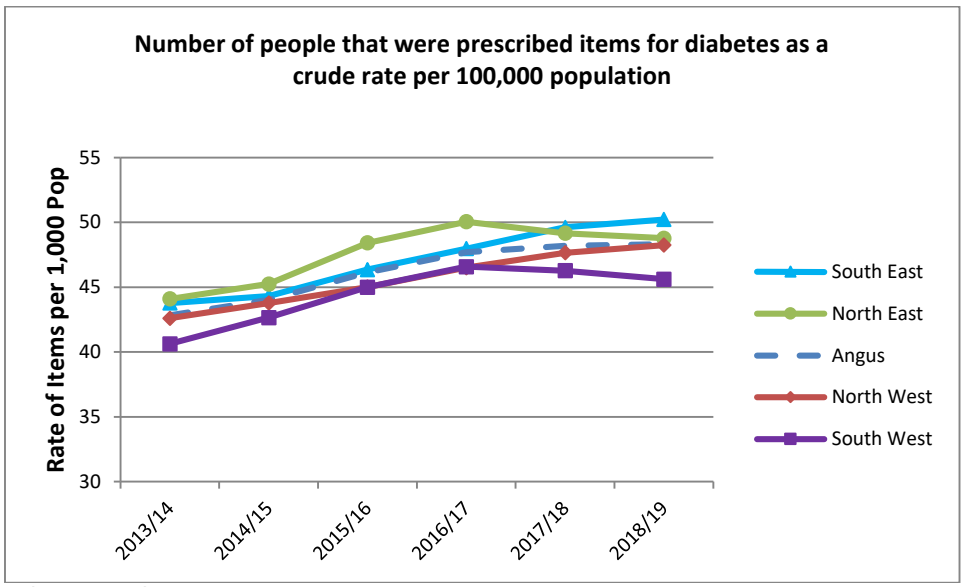
1.2.3 Hypertension and type 2 diabetes are closely associated to poor weight management, we are therefore using the prescribing of medication for the treatment of hypertension and diabetes as a means to consider the healthy weight of the population.

Graph 2 Number of People Prescribed Items for Hypertension in Angus as a Crude Rate per 100,000 Population



Source: PIS Dataset

Graph 3 Number of People that were Prescribed Items for Diabetes in Angus as a Crude Rate per 100,000 Population



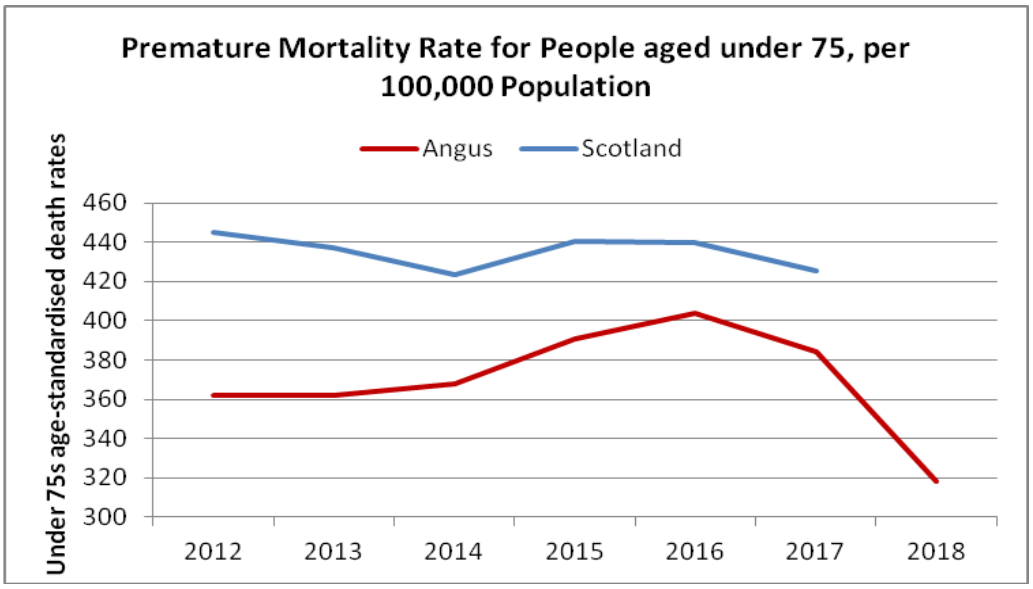
Source: PIS Dataset

1.2.3 The rate of Type 2 diabetes is increasing in Angus. The Strategic Commissioning Plan 2019-22 commits the Partnership to undertaking a whole systems approach to responding to the increase in type 2 diabetes. Locality Improvement Groups are working on a number of initiatives to improve active living and healthy weight amongst people in communities.

Premature mortality

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

Graph 4: Management Information: Premature Mortality Rate for People aged Under 75 per 100,000 Population (NI 11)

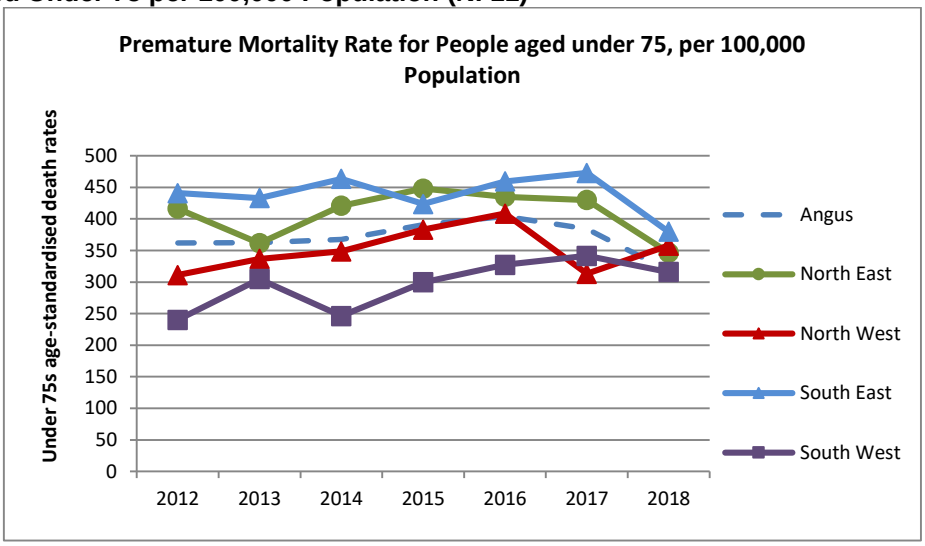


Source: National Record of Statistics (up to 2017)

Note: * 2018 rates are produced by ISD LIST and are provisional. They are not official National Records of Scotland (NRS) statistics. Official figures by NRS for 2018 will be released later in 2019.

1.2.5 The rate of premature mortality (unexpected deaths) in the under 75s has fallen for the second consecutive year, following a three year period of increasing rates of premature mortality in the under 75's. Whilst there are variations between the localities, the gap has reduced significantly in 2018.

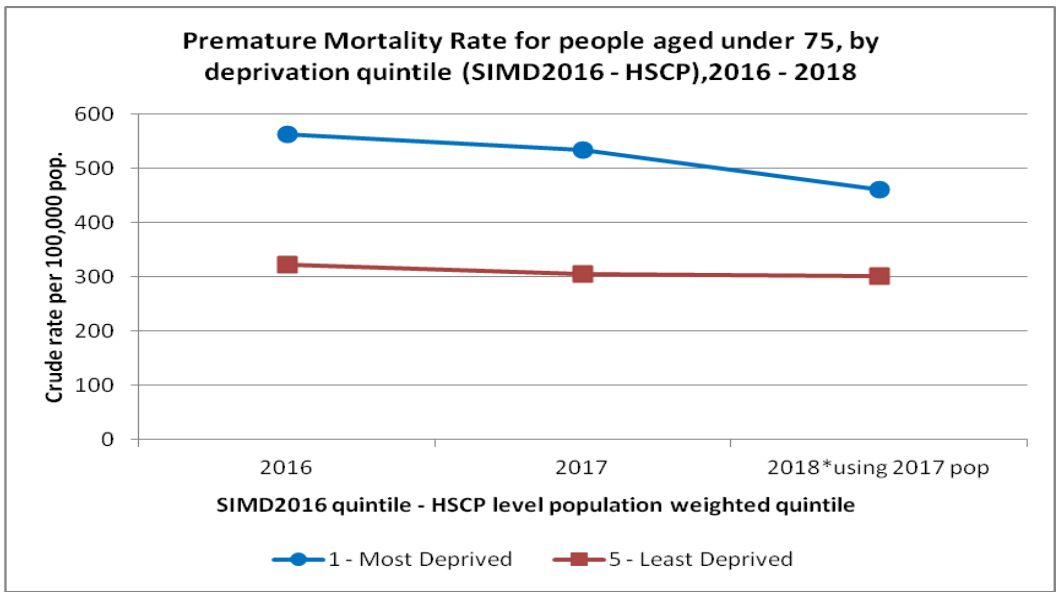
Graph 5: Management Information at Locality Level: Premature Mortality Rate for People aged Under 75 per 100,000 Population (NI 11)



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

Graph 6: Management Information at Socio-economic Level: Premature Mortality Rate for People aged Under 75 per 100,000 Population



Source: ISD LIST (not official NRS statistics)

1.2.6 The rate of improvement in premature mortality for people from the most deprived areas of Angus is greater than those from the least deprived areas. Although the correlation between deprivation and increased premature mortality remains, ongoing work by Angus Health and Social Care Partnership appears to be contributing to a reduction in the gap between the most and least deprived.

Good practice

Situation: *In Angus there have been high GP prescribing costs (greater than Scotland average) with considerable financial risk to the partnership. The reasons for this have been unclear. General Practice is under strain with many demands on GP time. This has meant that it has been challenging to engage GPs in a prescribing cost reduction approach.*

Action taken by Angus HSCP take:
We recognised that GP engagement was a priority. A GP prescribing lead was appointed to support involvement of GP practices in understanding and addressing the prescribing differences in Angus.

Practice-specific prescribing reports were produced, allowing practices to identify their own projects in order to address both patient safety and financial issues through the interpretation of their own data. Communications about the work were produced by GPs and pharmacists, for GPs and pharmacists. An Angus work plan developed on the priorities identified by pharmacy and GP leads was taken forward. Specific projects to improve prescribing approaches were tailored to individual practice needs.

GP's were supportive of conversations in localities with the public and information shared through Angus HSCP social media aimed at highlighting issues such as;

- *the importance of regular medication reviews,*
- *the importance of good self-management of long term conditions and the support available,*
- *the difference in performance and cost of some medications where alternatives existed,*
- *the level of medication waste in Angus. GPs were very supportive of public conversations on this topic.*

Practice learning time has supported engagement through clinically-focused presentations and workshops. Clinical leadership among clusters and within localities between GPs, practice pharmacists and the wider teams has enabled sharing of information within front-line teams.

***Impact** Successful projects were shared and spread across all Angus practices. This approach has led to a reduction in prescribing costs of more than £1.5million in Angus*

We want to thank the public and GP's and other staff for their efforts so far on this work. The work continues.

The Third Sector and Volunteering

1.2.7 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.

1.2.8 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. This forms part of the approach to signposting and social prescribing.

Good Practice

***Situation:** All partners were finding it difficult to identify which third sector groups and services were available within each locality. During discussions it was apparent that a lot of service users with low/moderate risk were in receipt of statutory support. Staff undertaking assessments and developing support plans did not know about third sector alternatives and what third sector activity was available in each locality that could support individuals to continue to be more independent and integrate with their communities.*

***Action taken by Angus HSCP take: Voluntary Action Angus (VAA)** created an online database called the locality locator which allows all partners and members of the public to access information about what's available in the local area. This could be anything from third sector organisations, community groups such as book clubs etc. The online system is available on VAA's website. It gives individuals the opportunity to search thematically as well as searching by locality. Once the locality locator helps identify opportunities there is also an option to leave feedback.*

The system works hand in hand with VAA locality workers and social prescribers who are based in each area. Workers also collect information about gaps in community and third sector provision and if there's a need they will assist with filling this gap. http://www.voluntaryactionangus.org.uk/localitylocator/

Impact: *All partners and public members are much more aware of what's available in regards to services and community groups. The locality locator has grown from strength to strength since its creation. Feedback from partners has been very positive. Once full publicity of the locality locator is complete we hope that the partnership will see a decrease in the amount of individuals at low/moderate risk being awarded care packages.*

1.2.9 VAA volunteering programme is founded on inclusion, with a particular emphasis on helping young unemployed volunteers into a career in health and social care. 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.

Social prescribing in practice

'Anna, the wife of a Self-employed man who has cancer and undergoing treatment came to see me (social prescriber) at the health centre. Anna doesn't work due to a range of health issues. She was visibly upset and broke down. I made her a coffee and we had a good chat. Her husband is unable to work and as he is self-employed he receives only SSP. The wife was worrying about her husband and how where they going to pay bills etc. They have two young children at school and living at home.

Anna told me the boiler has broken down and has been condemned. They no longer have mortgage protection as he has had cancer previously and received a payment for this. He could not afford the payments and it would not cover him again for cancer diagnoses.

Anna had already seen the Macmillan cancer nurses, who had already made sure the family were in receipt of all benefits that they were entitled to.

Anna said that she was now getting to the point of not answering the phone or the door as creditors keep phoning and asking for money. I gave her information about Citizen Advice Bureau (CAB, set up a meeting and gave her the income expenditure forms that she needed to complete before her meeting with them

Anna is very concerned about losing her home and told me that they had an interest only endowment mortgage and that they no longer had the endowment policy to pay it off at the end of the term. CAB would give them basic advice, however due to the amount of mortgage still outstanding she should consider speaking with her lender after meeting with CAB.

I was also able to refer them to SCARF home energy advisors who work in partnership with Angus Council and Home Energy Scotland. A visit was carried out by SCARF and it looks like that due to the benefits her husband now receives and the fact that his wife is unable to work herself due to health issues, it is highly likely they with receive a new gas boiler, two new doors and roof insolation to enable them to get out of fuel poverty.

I will continue to support Anna.

Carers

1.2.10 Angus Health and Social Care Partnership provide funding to Angus Carers Centre which allows for the delivery of a comprehensive range of information, advice, development of support plans and support for carers across Angus. Angus Carers Centre 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. Carers requiring this level of support may also continue to access support from Angus Carers Centre.

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

	2016/17	2017/18	2018/19
Registered carers	1053(31/3/17)	1404(31/3/18)	1231(30/9/18)
Volunteer 'care free' respite		2,451	2,748
New support plans established		239	128
Counselling support hours		160	128
Short breaks grant applications			97
Respitality short breaks			41
Locality care support groups			247

1.2.11 The 2018/19 Angus Carers Centre data suggests that performance has fallen in some areas. The implementation of General Data Protection Regulation (GDPR) has meant that some carers information was withdrawn for the Angus Carers Centre database. We are working with Angus carers to consider how we capture carers who are not registered but known. Angus carers provide support to all carers whether they are registered with the Centre or not. The implementation of the new Adult Carers Support Plan, (ACSP), developed as part of the implementation of the Carers (Scotland) Act 2016, was introduced by both Angus Carers Centre and Angus HSCP Care Management Teams on 1 October 2018. Both organisations have reported that the ACSP requires a more in depth conservation between the worker and the carer. This means that the ASCP was initially taking around 3 times longer to complete than the previous Carers Assessment. It is expected that as staff become more familiar with the ASCP less time will be required for completion of the ACSP alongside introduction of a less intensive screening tool. The additional time required by the ASCP has meant that of the 305 new carer referrals received between 1.4.18 and 28.2.19, (11 months) only 128 have been completed.

A Carer's Journey - Angus Carers Centre

Susan is in her 60s and cares for her husband Alan who has Motor Neurone Disease. After a few years of the MND progressing Alan's speech is now greatly affected. Susan is worried that Alan's ability to swallow will also start to decline soon. Alan has been wheelchair user for some time and requires help from carers with personal care. Susana and Alan are already in touch with the MND society.

I am a Carers Development Worker and when I meet with Susan I find that she is very emotional. Susan is worrying about the tense relationship she has with Alan which continues to be put under considerable pressure. Alan is refusing to accept more personal care recommended by his Care manager. The Care Manager also offered planned regular residential respite but this has not been put in place. Alan has in the past checked out of residential respite after a couple of days and Susan struggles to get time to herself.

Susan feels that she has to leave house throughout the day in order to get "space from him" and is very tired as a result. Susan also has her own health issues. She has arthritis and says that she needs to look after herself more.

Susan has engaged well with Angus Carers since registering in July 2017. She attends her ***local monthly support group*** *and says that she gains good support from this and from the worker who attends. Susan has also tapped into our* ***short breaks service*** *and been able to apply for breaks away from home where she has taken a friend with her.*

*Susan has attended individual **counselling sessions** and successfully completed **WRAP (Wellness Recovery Action Planning)**. This has enabled her to take more control over her own self-care and her own needs. Susan is developing strategies for coping with stresses that continually arise.*

*Susan has met with me for **1:1 support every 2-3** weeks for a few months. These sessions are her chance to be open, honest and to offload. Susan is a private person and benefits from the confidential nature of our 1:1's. She knows she is never judged for the thoughts or feelings that she expresses. We work together to problem solve situations as they arise. This is a most valuable support for her and it is something she wants to continue. Susan knows that she can contact me in between these visits.*

Recently Susan completed an Adult Carer Support Plan. She may be able to access a budget in her own right in order to maintain her health and wellbeing in relation to her caring role. Our hope is that this will allow her more respite in her own house.

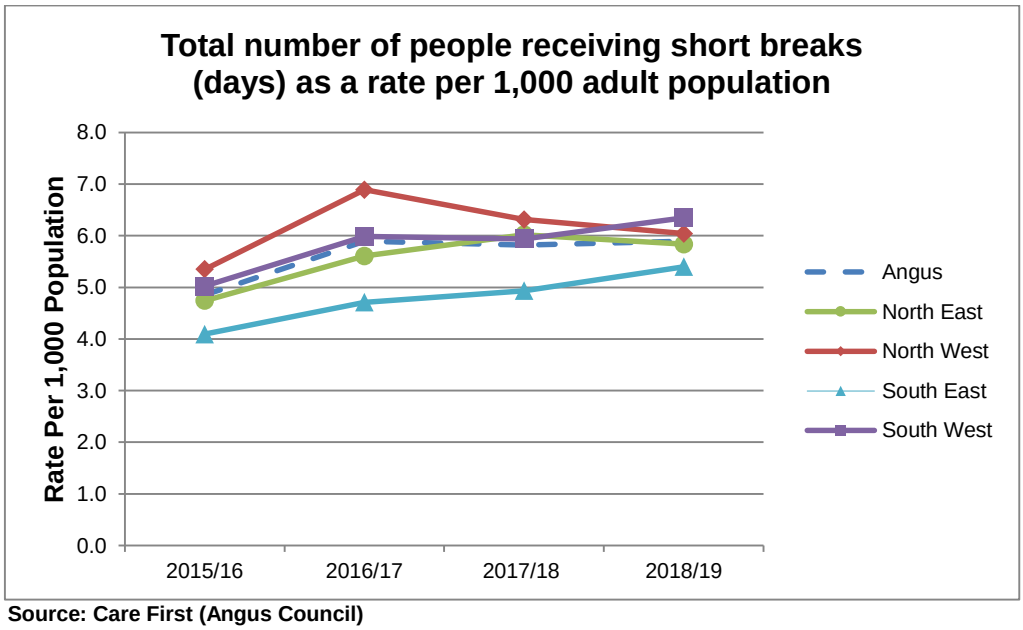
1.2.12 The Carers (Scotland) Act 2016 started to have full effect from April 2018. A new carer's support plan has been designed in conjunction with Carers. This is used by both Angus Carers and Care Management Teams. A carers' support plan establishes a potential budget that can be used to support the carer to continue in their caring role. This then offers support through the self-directed support options, providing carers with greater flexibility about what types of support they choose and how it is delivered. Through the completion of the Adult Carer Support Plan, carers are being encouraged to use their budgets in outcome-focused ways to complement other support and services which sustain them in their caring role. This includes for example support from their wider family and friends; 1:1 support from all allocated worker from Adult Services or Angus Carers Centre; peer support groups; telecare (including community alarm) and occupational therapy. This new approach to assessment and support arrangements appears to be making a difference in patterns of use of respite services.

New Carer care and support plans - making a difference

Andrew has a dual caring role for his wife and son. He recently retired and the big thing on his retirement bucket list was to build his own cello and learn to play it. His son has refused an assessment, so the family are receiving no support for his care and as a result are using most of their personal finances to pay for this.

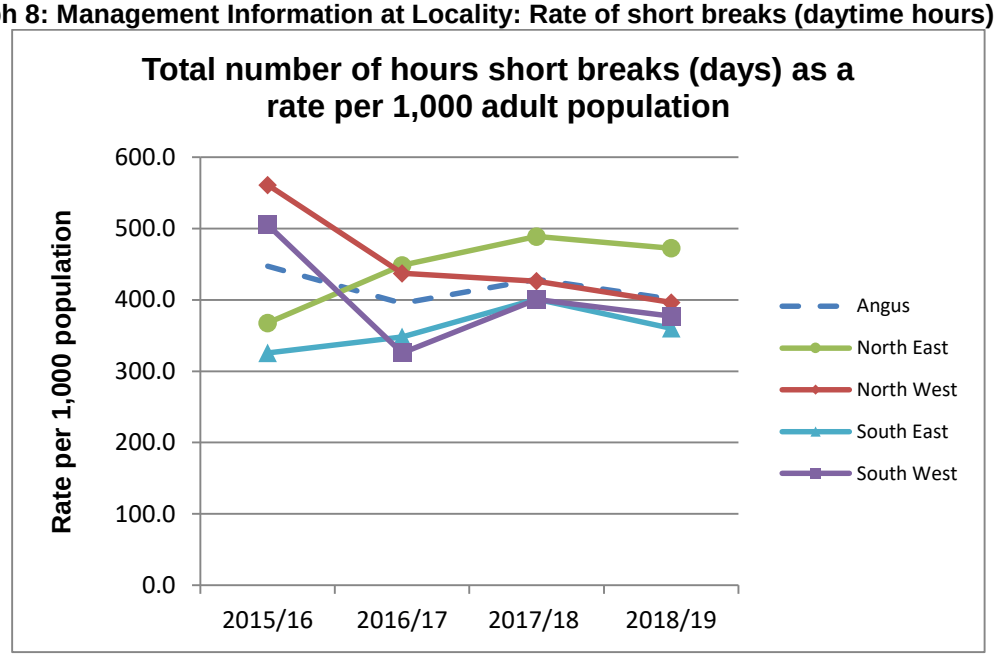
Andrew cannot leave his home/ immediate area very often because of his caring responsibilities and has little money or opportunity to do the things he wanted to do with his retirement. He had identified that using his budget to build a cello and then get cello lessons, would be the ideal way to have time to himself to relax. He also feels that this will restore some of the confidence and focus on personal goals that he has lost since his caring role increased.

Graph 7: Management Information at Locality Level: Rate of people using short breaks



Source: Care First (Angus Council)

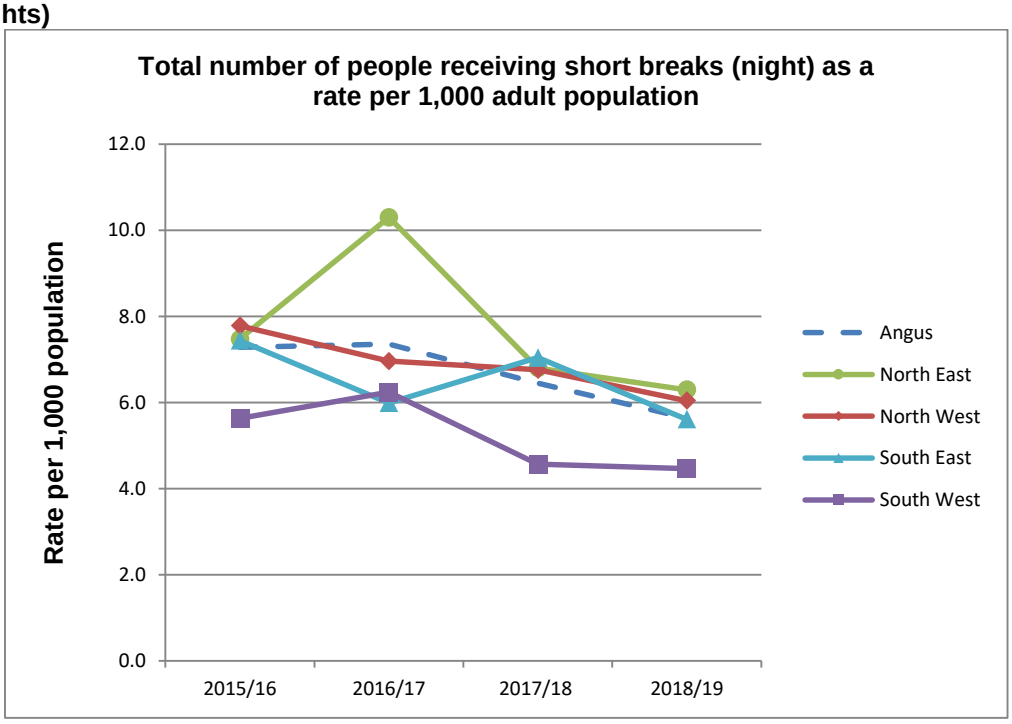
Graph 8: Management Information at Locality: Rate of short breaks (daytime hours)



Source: Care First (Angus Council)

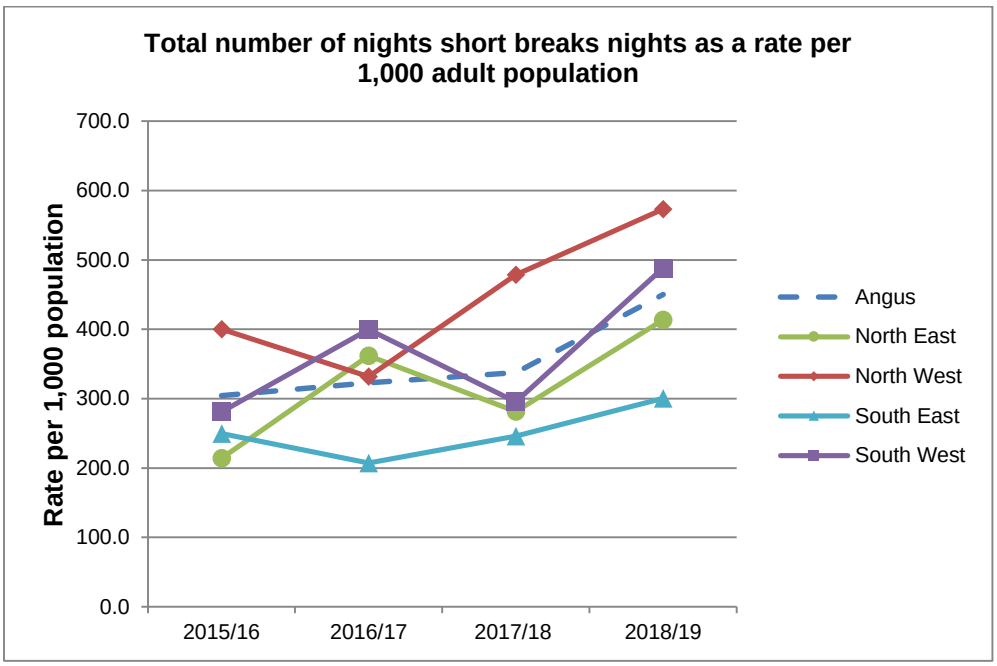
1.2.13 Typically in any month 165 older people and 98 people with learning disability access day care.The number of carers supported by day time repite has increased from 2015/16 by 22% There have been fluctuations in uptake during the last 3 years with some decline in uptake as a consequence of the implenmentation of self- directed support. There was a decline in the use of daycare following the introduction of self-directed support as people chose alternatives to day care. The decline appears to have stablised and what we see is more carers using day care but typically using only one or two days per week. The overall effect is a reduction in day time repite hours of 9.5% since 2015/16. Other support being purchased by carers using their self-directed support funds includes sitting services, domestic support and personal/ housing support to enable them to have a break and attend exercise classes, shop, catch up with friends or just have time on their own.

Graph 9: Management Information at Locality Level: Rate of people using short breaks (nights)



Source: Care First (Angus Council)

Graph 10: Management Information at Locality Level: Rate of short breaks nights



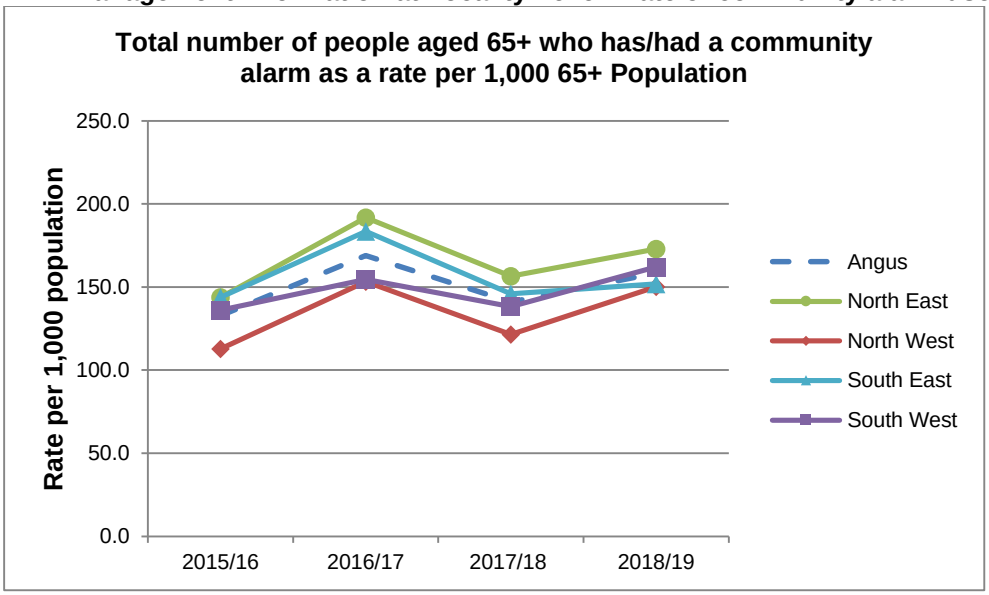
Source: Care First (Angus Council)

1.2.14 533 carers used a total of 42,546 respite nights in 2018/19. Since 2015/16 there has been a reduction in the number of carers receiving night time respite by 20% but an increase in nights by 49%. This suggests that services are supporting those with the greatest needs with more or longer periods of overnight respite. There has also been an increase in alternative use of carers support resources with individuals choosing short break holidays through direct payments which are not included in this measure

Community Alarm

1.2.15 Although there are fluctuations in the use of community alarms, uptake has grown since 2015/16 by 22% (graph 11 below). There was some double counting of community alarm installations 2016/17 due to a service changeover in sheltered housing

Graph 11: Management Information at Locality Level: Rate of community alarm use



Source: Care First (Angus Council)

1.2.16 Community alarm now supports 4195 households.

Enablement

1.2.17 Enablement services and community alarm teams have been merged into an Enablement Response Team (ERT). The aim of the team is to support people to be as independent as they can be and reduce reliance on services. The teams have mobile devices and now use the life curve approach as one of the ways of supporting people to greater independence. We have introduced 'Just Checking' a digital system that supports assessment. We have provided training to ERT staff to ensure that they can use Independent Living Angus to support people to greater independence. An evaluation of ERT has recently been completed and the final report and improvement plan is awaited.

Good Practice

Situation

There is an increasing number of the Angus population who are aged over 75. The level of frailty appears to be increasing. The rate of admissions to hospital following a fall has been increasing. The use of personal care services has been increasing suggesting that there is a need to focus on supporting people to independence through enablement.

Action taken by Angus HSCP

Funding from the Technology Enabled Care (TEC) Fund enabled the introduction of ADL Smartcare in Angus – renamed Independent Living Angus (ILA) for local use. This system is recommended as part of the Scottish Governments National Allied Health Professional Plan; Active and Independent Living Programme. https://www.independentlivingangus.org.uk/

Locally the system has been designed with input from occupational therapists who are responsible for the clinical content including the hints and tips that are provided and the decision making protocols. ILA aims to reduce demand on occupational therapy services for advice on minor equipment. Orders can be placed directly with the equipment store for certain pieces of equipment that continue to be provided free of charge. This includes self-referral for community alarm, including some peripherals.

People who are having difficulty with everyday activities will likely benefit the most from the using ILA. There are a wide range of solutions available to help people including bathing, showering and toileting equipment, bed and chair raisers, grab rails, banister rails as well as community alarm, smoke alarms and falls detectors. There are also solutions for people who have hearing and/or visual loss."

The system also operates LifeCurve (an ADL Smartcare trademark) which is a simple system offering advice for enablement and improving independence. The LifeCurve questionnaire is repeatable and can provide information on change in an individual's abilities over time. The system can be further developed to offer other forms of self-management support such a money advice, physiotherapy triage, long term conditions information. The development potential as a self-serve solution to reduce assessment demand in a number of areas is significant. Ultimately the system can deliver referrals for supports and services where eligibility criteria are met e.g. where the level of need is substantial or critical.

Impact

2,183 people accessed ILA. 44% of users are finding help through the self-assessment and LifeCurve section and people are also using the equipment catalogue and the local information section, finding help from local services and organisations embedded within the site. This may be the only help that someone needed and may be enough to prevent a call to First Contact. Using LifeCurve is already helping staff work through enablement approaches with people.

The work continues and we expect to grow ILA.

Accident and Emergency

1.2.18 In 2018/19 Angus had the same rate of attendance at A&E (including MIIU) as Scotland as a whole (284 attendances /1,000 population). We have considered this data further by looking at differences in major and minor issues as the Angus Care Model includes changes to MIIU services.

1.2.19 In 2018/19 national data indicated that Angus attendance at A&E for major issues was the third lowest in Scotland (in Angus attendance rate in 2018/19 was 47/1,000 compared to 132.1/1,000 for Scotland). There has been an increase in the rate of attendance at A&E for major issues in both Angus and Scotland from 2017/18 to 2018/19

1.2.20 For minor issues (which includes attendance at minor injury and illness units), attendance in 2018/19 in Angus continues to be the highest in Scotland (236/1,000 population attendances compared with 152/1,000 for Scotland). This suggests that some attendances at MIIU services in Angus continue to be inappropriate. The development of new Treatment and Care Services in localities will contribute to reducing the inappropriate use of minor injury services.

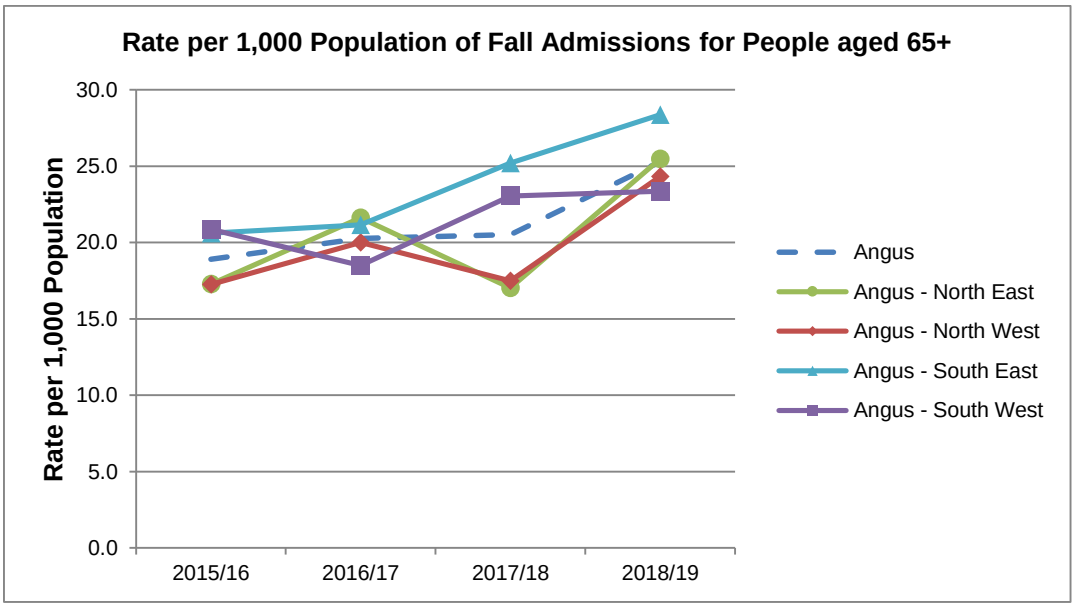
1.2.21 Following an attendance at A&E the proportion of people who require to be admitted to an inpatient bed continues to increase with more than 75% of all attendances at A&E for a major issue resulting in an admission. We do not understand whether this is more appropriate use of A&E for major issues or there continue to be some admissions that could be preventable.

1.2.22 The stated aim of Angus HSCP submitted to the Ministerial Strategic Group is to continue to reduce all A&E attendances in line with the current projection.

Admissions following a fall

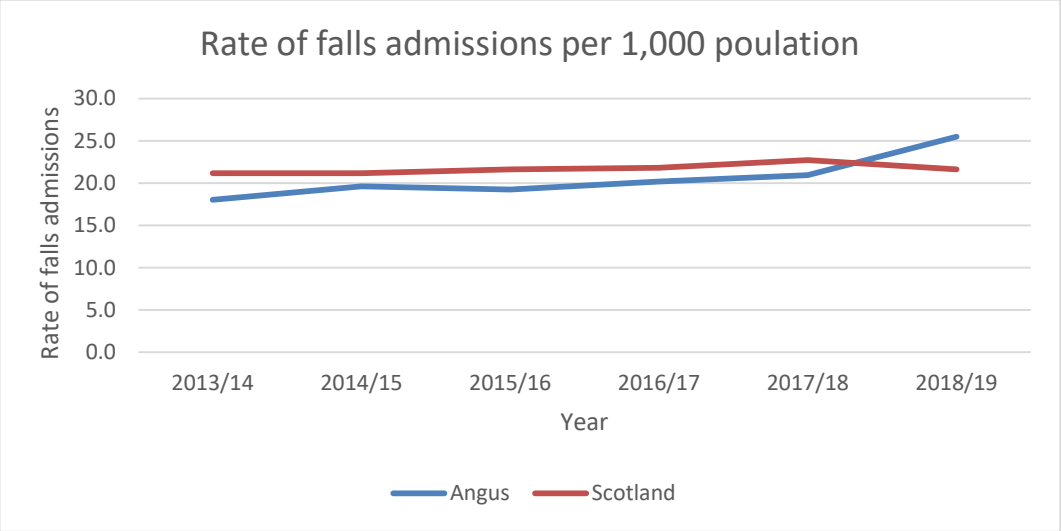
1.2.23 There were 678 admissions following a fall for people aged over 65 in Angus in 2018/19.

Graph 12: 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.

Graph 13: Angus HSCP relative performance to Scotland. Rate of fall admissions per 1,000 population for people aged 65+ (NI 16)



Source: ISD (provisional national data 2018/19)

1.2.24 During 2018/19 the rate of admissions following a fall for people aged over 65 in Angus is 25.3 per 1,000 population (graph 12). This is a 33% increase on the 2015/16 level and 23% increase on 2017/18. The rate of falls admissions in Angus is now higher than the Scottish average. The level of falls in our communities contribute to hospital admissions. They place ongoing pressure on services as individuals are more likely to need ongoing health and social care support on discharge. It should be noted, however, that admissions following a fall account for 6.6% of all admissions in an emergency and this proportion is increasing.

1.2.25 The number of admissions by month is very variable and the peak was reached in November 2018 when there were 80 admissions, this was a 30% increase in admissions for the month when compared to the two previous Novembers. The weather during November 2018 turned very cold quite suddenly from the temperatures in October. Historically temperatures in Angus are around 4-6˚C in November. In November 2018 there were many days where the temperature was below 0C and it reached -8˚C on one day. The highest levels of admissions following a fall arise in the South East locality.

1.2.26 As part of our improvement plan for falls we know that we have to improve our joint working with Scottish Ambulance Service (SAS) who are not making full use of the falls resources that are available. In November 2018 for example SAS attended 77 incidents for falls which led to 47 people being conveyed to A&E. Of the 30 not conveyed to hospital none were referred to the falls prevention service for advice and triage.

1.2.27 The Angus population who are aged over 85 accounts for only 12% of the total population over 65 in Angus. In Angus however 45% of all admissions from a fall in older people relate to people aged over 85 years. This suggests that we need to have a greater focus on understanding the causes of falls and falls prevention in people aged over 85.

1.2.28 The rate of admissions following a fall in Angus has continued to increase. 2018/19 is the first year where Angus performance is worse than the Scottish average. Performance has improved in Scotland as a whole while performance in Angus has continued to decline (graph 13 below).

Priority: 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 population demographics will place a further increase in demand on services if they continue to be delivered in the same way. The Strategic Commissioning Plan 2016-19 aimed to address demographic change by changing the way that services are provided. The focus of the Strategic Commissioning Plan 2016-19 has been 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 Highlights from 2018/19

- We have increased the number of personal care hours available to support people in our communities.
- We have introduced Mental Health and Wellbeing Practitioners in some GP practices.
- We have introduced 'Check TEC Out'.
- We have 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.
- We have delivered an improved framework contract with the independent sector personal care providers for the delivery of long term personal care at home. This has included the development of a fair cost of care to ensure that services can be accessed equally in rural and remote areas of Angus.
- We have extended Enhanced Community Support arrangements into the North East Locality.

2.2 Making a Difference

Technology Enabled Care

2.2.1 We continue to progress technology enabled care solutions offering a range of peripheral equipment along with the community alarm. Currently more than 1500 peripheral telecare devices are in use across Angus. This is slowly increasing every year.

2.2.2 Florence (Flo) is a simple, text messaging, telehealth system that supports people with self-management of their long term health conditions. Flo communicates by text to and from patients' mobile phones. The host organisation arranges to purchase 'bundles' of texts from the Flo supplier. There is no charge for this service to the patient. Clinicians agree protocols which determine the pattern of text messages sent to the patient based on the parameters for each patient's readings, which they submit by text. Clinicians can change messages that Flo sends. The clinician can access the information sent and received by Flo in order to monitor their patient. There are 345 people are now enabled to support their long term conditions through Flo. Due to the success of the system development in Angus we will be hosting scale up blood pressure monitoring programme through Flo to support Tayside GP practices.

Good Practice

We recognise that many people that we work with are not 'TEC savvy'. We also recognise that there are many pieces of digital equipment around that could support people to remain at home. To support learning and grow the use of the technology that is currently commercially available, we have developed a ***Check TEC Out*** service*. This test of change allows smaller items of digital telecare to be borrowed on a short term basis by service users supported by the Enablement Response Team. The loan items are not specialist and can be bought online or in shops. The 'Tec' includes remote control sockets, digital assistants such as Echo dot, dehydration cups, wireless motion sensing LED's, automatic LED toilet lights, and projector clocks.*

The aim is to enable people to test new innovations in their home with a view to purchasing the items after the trial. We have developed a questionnaire to capture feedback on each piece of equipment.

The project commenced in January 2019. Initial uptake has been slower than anticipated, but we continue to promote the initiative with Care Management, Community Nursing and our Inpatient Services. We have recently offered Check TEC Out to people within the Independent Intermediate Care Services and in respite facilities.

Despite the short period that the service has been operating, we are already seeing evidence of people buying their own TEC as a result of getting to try it out first.

Care Management

2.2.3 Access to long term social care support requires an assessment of need by Care Management Teams Individuals. Choices are made about what support or services would meet their needs and 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

Table 3 Self-Directed Support Uptake of Options

Indicator	2015/16	2016/17	2017/18	2018/19
Option 1	4%	8%	6%	7%
Option 2	13%	15%	22%	23%
Option 3	79%	73%	67%	65%
Option 4	4%	4%	5%	6%

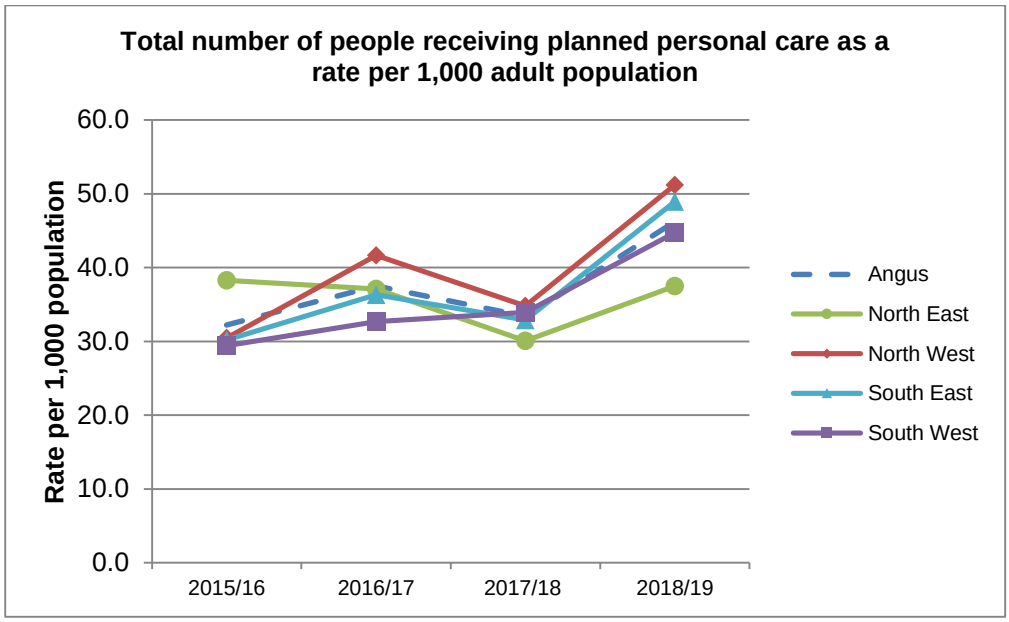
Source Care First (Angus Council)

2.2.4 3150 people have care plans in place that include support that is subject to self-directed support options. There has been a shift towards greater choice and control with a greater proportion of supported people accessing options 1, 2 and 4. Most people in Angus continue to access option 3, asking Partnership staff to organise support on their behalf. The percentage of people using option 3 alone has decreased year on year.

Care at home including personal care

2.2.5 Provision of personal care has increased across all localities

Graph 14: Management Information at Locality level: Rate of Personal Care Hours (LI 24)



Source Care First (Angus Council)

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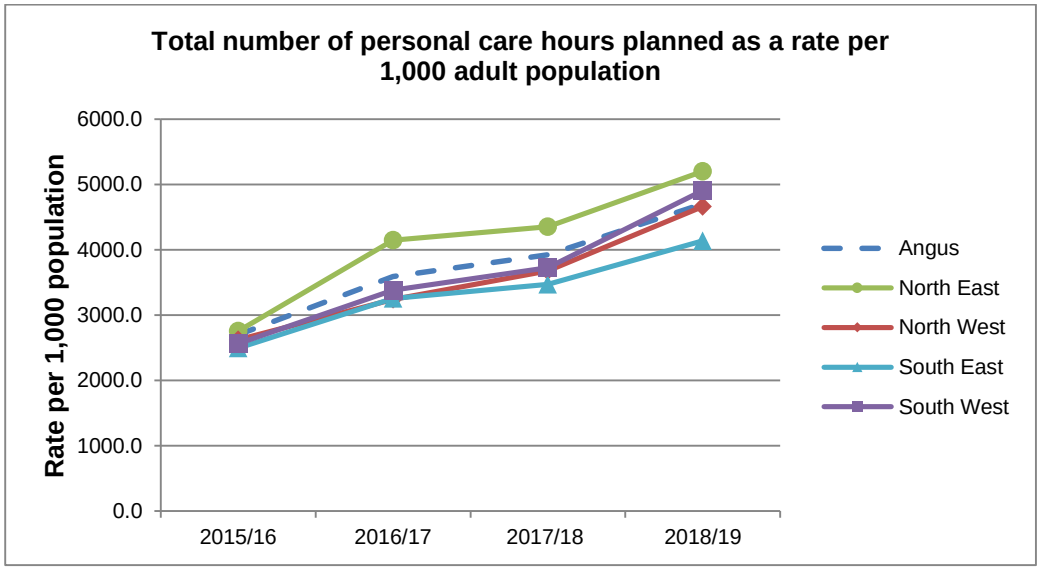
Graph 15: Management Information at Locality level: Rate of Personal Care Hours



Source: Care First (Angus Council)

2.2.6 4370 people received personal care at some point during 2018/19. This was an increase of 11.4% from 2017/18 and by 45% from 2015/16. The number of hours of personal care delivered across Angus has also continued to rise. A total of 444,620 hours of personal care were delivered in 2018/19, an increase of nearly 20% on 2018/19 and 76% on 2015/16. The increase is also seen in the rate of provision in the population.

2.2.7 The increase in the rate of personal care provision cannot be accounted for by demographic change alone. Some of the increase in rate of personal care provision is related to the delivery of the Angus Care Model, where we have seen a reduction in hospital bed day use and improvements in timely discharge. We have also seen changes to care home provision suggesting that people with higher levels of need are supported in our communities. Further work is required to investigate the increase in provision and how enablement can be used to effect a future decrease in personal care, an ambition set out in the Strategic Commissioning Plan 2019/22.

2.2.8 In 2017/18 the median size of a personal care package in Angus continues to be 7 hours (median excludes the very small and very large personal care packages to consider the average of the middle). There is now no variation between localities. The average (mean) level of personal care people receive each week has decreased suggesting that higher levels of smaller packages of personal care are being provided.

2.2.9 In Angus 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 support 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. 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 Enhanced Community Support (ECS), via the involvement of the Single Point of Contact Officers/ Social Prescribers working as part of the multi-disciplinary team

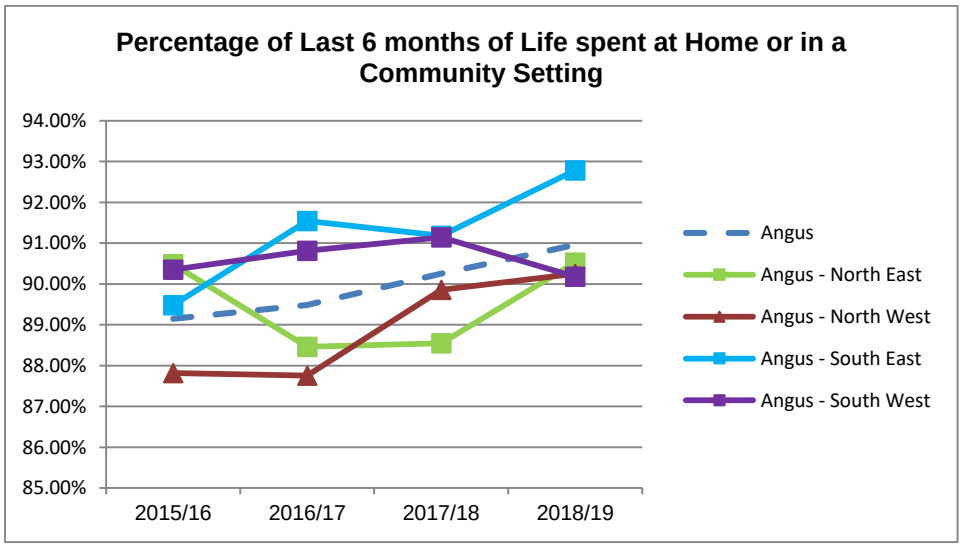
Community Meals

2.2.10 The number of people receiving community meals is limited by the capacity of the service. 869 people benefited from the service in 2018/19 and 113275 meals were delivered. This is a 4% reduction in meals delivered when compared to 2017/18. The number of people using the tea time sandwich service, delivered along with a hot lunch, has declined.

Last 6 months of life

2.2.11 Angus performs well in relation to end of life care.

Graph 16: Management Information at Locality Level: Proportion of Last 6 Months spent at Home or in a Community Setting (NI 15)



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

2.2.12 The percentage of time that people spend at home or in a community setting in the last 6 months of their life in 2018/19 in Angus was 91%. Angus performs better than the Scottish average, where 89% of the last 6 months of life is spent at home or in a homely setting in the community. There is variation across localities with the South East locality performing better than the other localities. There is also variation based on deprivation with people from the least deprived areas of Angus spending 92.44% of the last 6 months of life at home and people from the most deprived areas of Angus spending 91.62% of the last 6 months of life at home.

2.2.13 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. As part of the development of the palliative and end of life care improvement plan, an analysis of place of death of Angus citizens in 2016/17 was undertaken. This identified that 54% people die at home or in a homely environment in their community, 12% in Angus community hospitals, 6% in Roxburgh House and 28% in other hospitals (for example Ninewells).

Priority: 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 in 2018/19

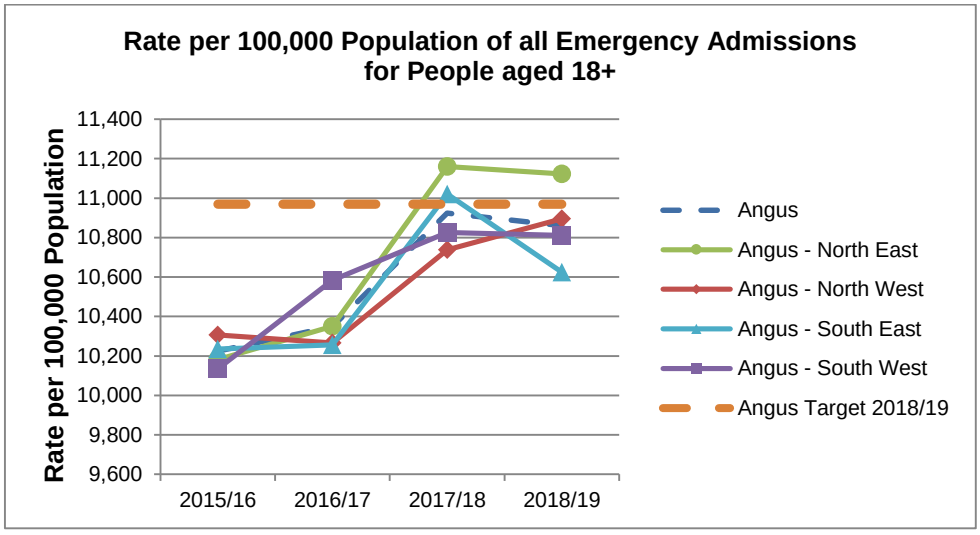
- We have further developed the Angus Care Model which shows how multi-disciplinary team working around individuals is at the centre of our service arrangements and how services work together to reduce reliance on hospital beds and deliver services for our communities, in our communities.
- We have introduced Enhanced Community Support in the North West Locality. This means our multi-disciplinary team approach is now working in all localities.
- New mealtime experiences developed in Dorward House mean that residents are more settled and their eating and hydration has improved. This good practice can be shared with all care home providers through the Care Home Locality Improvement Groups.

3.2 Making a difference

Emergency admissions

3.2.1 Angus continues to perform well against the national picture with Angus adult admissions around 10% lower than the Scottish average. Admissions to adult mental health inpatient services accounted for 4.4% of all adult admissions in 2018/19, a decrease from 5.2% of all emergency admissions in 2015/16 (page 39) Admissions following a fall in people aged over 65, account for 6.6% of all admissions(page 25), this is increasing

Graph 17: Management Information at Locality Level: Rate of Emergency Admissions for Adults (NI 12)



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

3.2.2 Admission rates in Angus have fallen for the first time in 2018/19 (graph 17). The gap between Angus performance and Scotland as a whole continues to narrow, as Scottish admissions rates have reduced at a faster rate

3.2.3 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 the North East locality. This appears to be related to the status of the implementation of Enhanced Community Support. This target had taken into account the national picture of increasing admissions and expected Angus admissions to increase in a similar way. The delivery of our whole systems approach through the Angus Care Model with integrated team working central to this, gives us cautious optimism for the future, as this has been achieved at a time when we are feeling the impact of the demographic shift in Angus towards an older population.

Good Practice

Situation

How to intervene before people deteriorate providing the right services and right staff at home with sufficient INTEGRATED support to meet their needs.

Action by the Angus HSCP

We wanted to improve integrated working between Social Work Care Management, Voluntary Action Angus, Occupational Therapy, and District Nursing to further progress the good work already achieved through Enhanced Community Support. The intention is to improve assessment and care planning and provide a seamless service for patients/service users. We want to build health and social care integration from the front line in a much more local way, responding to local needs promptly and effectively. This is our first step into developing a neighbourhood care model that will work for Angus.

To achieve this we have:

- *co-located services in the Monifieth GP practice to develop our model through a test of change in one locality,*
- *integrated team meetings*
- *introduced daily huddles to consider people who may be in need of additional support in an integrated way. The huddles include GPs and personal care at home providers.*
- *Established joint team leadership by a senior District Nurse and Social Work Team Manager.*

Impact:

Staff engagement in the development has been excellent, they have delivered Monifieth Integrated Care with enthusiasm despite their initial misgivings. The arrangements commenced in October 2018 so it is early days. All indications are that the integrated team approach is improving our assessment and care provision and building stronger relationships between professionals. The key messages from staff so far include:

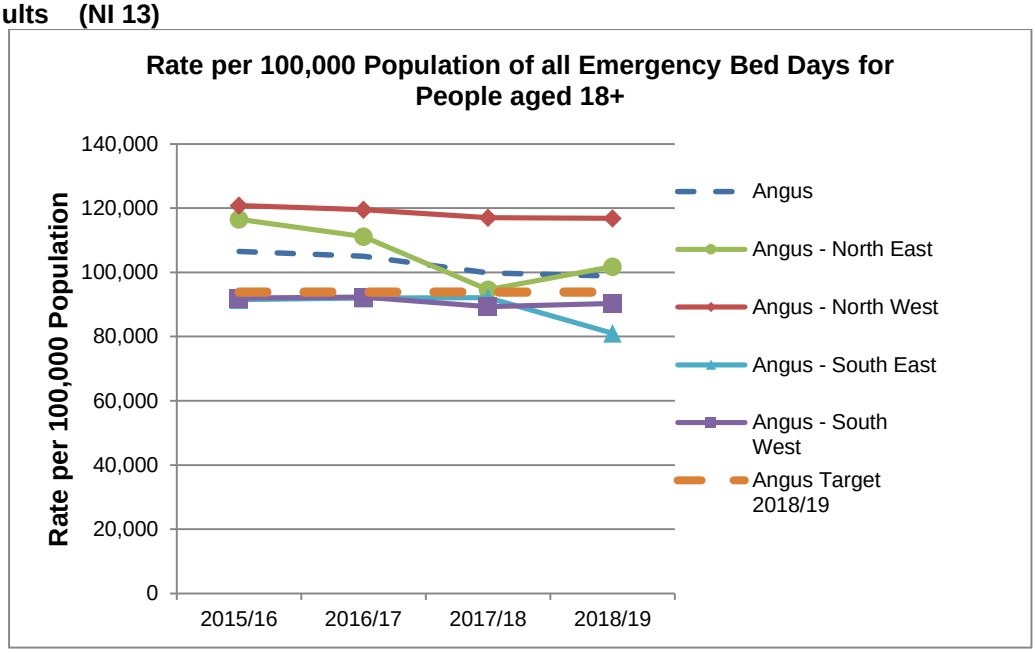
- *we are putting the person at the centre of decision making about their immediate and future care needs*
- *we can see that services are more efficient and effective through the level of coordination we have achieved*
- *there is a huge improvement in communication*
- *we can now see and engage with all available services and partners to best effect*
- *we could benefit much more if only we had integrated IT systems.*
- *We have seen a reduction in admissions in our locality for the first time!*

The work continues, our Monifieth Integrated care Neighbourhood Team is evolving……..

Hospital Bed days used following an emergency admission

3.2.4 The bed day rate for all adults in Angus continues to decline however, bed use has exceeded our target

Graph 18: Management Information at Locality Level: Rate of Emergency Bed Days for Adults (NI 13)



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

3.2.5 The number of bed days used following an emergency admission in 2018/19 in Angus was 93,263, a decrease of 1% on 2017/18 and 7.3% on 2015/16 (7,423 fewer bed days). There is variation between localities with performance in North West locality being the driver behind our failure to meet our target reduction in bed days.

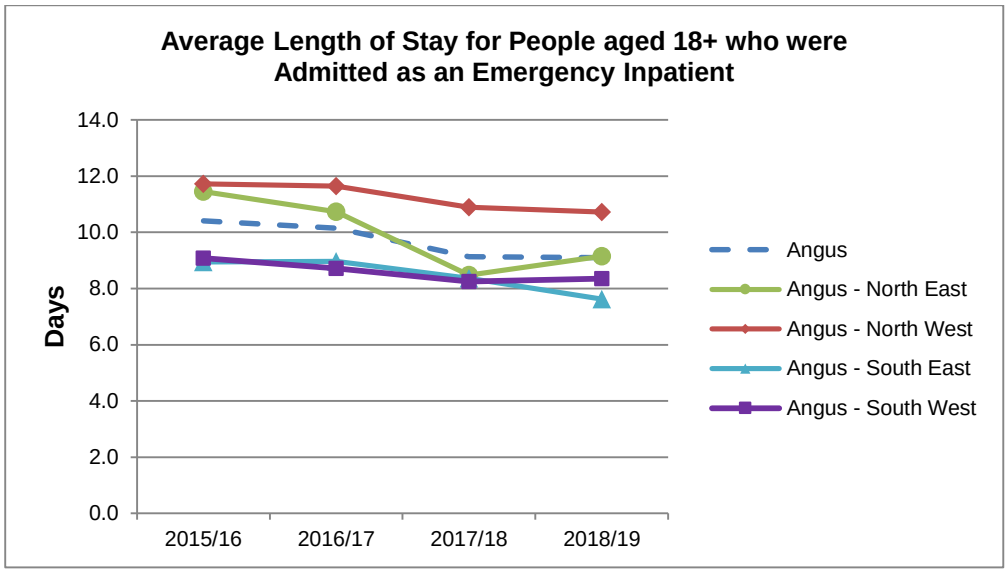
3.2.6 We know that 26% of bed days are used following a mental health admission (graph 23). The rate of mental health bed use in the North West Locality is 28% accounting for some of the higher rate of all bed days for adults in the North West Locality. The variation between the North West and the other localities is also related to the average length of stay which, in the North West is 17% longer than the Angus average and 29% longer than the average length of stay for the South East Locality (graph 19). The variation may also be related to the status of the implementation of Enhanced Community Support and the different pattern of social care provision which suggests that people with much higher levels of need are supported at home (higher levels of personal care prevision and lower levels of care home use). The North West Locality also includes the population serviced by a practice whose support is largely provided via Dundee HSCP services and who do not operate our Enhanced Community Support model. We need to consider the data differently to identify if this is a contributing factor to performance in this area.

3.2.7 The overall emergency bed day rate in Angus has improved due to the reduction in admissions that has been achieved in all localities with the exception of the North West Locality (graph 17)

Length of hospital stay following an emergency admission

3.2.8 Improvements in bed days have up to this point been driven by improvements in average length of stay. This has not been the case during 2018/19. Average length of stay in 2018/19 remains at 9.1 days as it was in 2017/18. There is some room for continued improvement in this area when we consider the performance of other partnerships.

Graph 19: Management Information at Locality Level: Average Length of Stay for Emergency Admissions for Adults



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

3.2.9 There is variation between localities with average length of stay for people from North West locality being 10.7 days, 1.6 days more than the Angus average and 3.1 days longer than in South East locality. The average length of stay in the North West Locality is strongly influenced by the average length of stay in mental health services (including learning disability). At 76 days this is 40% higher than the average Angus mental health length of stay and 76% higher than the average length of stay for mental health in the South East Locality (graph 25). While this may also be, in part, related to the status of implementation of Enhanced Community Support, it may also be related to the different pattern of social care. The lower rate of use of care home placements suggest that higher levels of dependency are supported at home. This difference is not related to delays in timely discharge.

Enhanced community support – making a difference , helping people stay at home

Mrs Munro lives with her daughter and son-in law. She has multiple long term conditions including type 2 diabetes, angina, congestive cardiac failure, bilateral leg oedema, breathlessness. Mrs Munro's mobility is also reduced and she has been having falls. There is no social care package in place. Mrs Munro had been admitted to Ninewells and recently and discharged with significant pain from a viral infection. Mrs Munro is using complex medication for the pain which has to be monitored. Her kidney function also needs to be monitored.

The ECS team discussed Mrs Munro, it was agreed that the Advanced Nurse Practitioner should undertake a review to prevent a further admission. This was supported by the full team including GP, District Nurses, Physiotherapy, Occupational Therapy, Care Manager and Medicine for the Elderly Consultant.

Mrs Munro is a very thin, frail lady who has had several falls at home. Suffering with pain from shingles despite pain killers, Mrs Munro was also found to have poor appetite and hydration, and a leg oedema (swelling) which was becoming worse. Mrs Munro and her daughter were unsure about her overall health and what medication should be taken. Both felt unsupported at home, and Mrs Munro was reluctant to accept help even though she felt unable to take care of herself. Both mother and daughter were suffering from low mood which was impacting on their relationship. A new treatment and care package was established this included:

- *Occupational therapy support and equipment to support her at home.*
- *ongoing physiotherapy support to mobilise safely and independently.*
- *a medication review and support from the Pharmacy Technician with understanding of her medication.*
- *treatment from the District Nurse to address the leg wounds and swelling.*

- *a package of enablement to help with her independence.*
- *support from Angus Carers for Mrs Munro's daughter.*

Mrs Munro's pain has now resolved, her leg wounds healed, and her overall health condition improved. She has had no further falls and is able to mobilise independently, make her own meals/drinks, and manage her medications independently. Over a short period of time, her mood improved and she has now accepted further support from care management team.

Mrs Munro now feels more able and comfortable in managing her own health and in making her own decisions and choices about her care and treatment. Mrs Munro and her daughter's mood has improved as has their relationship. They have both made plans together to go on a short break.

Mrs Munro has been able to stay at home with her daughter and son-in-law which are her wishes.

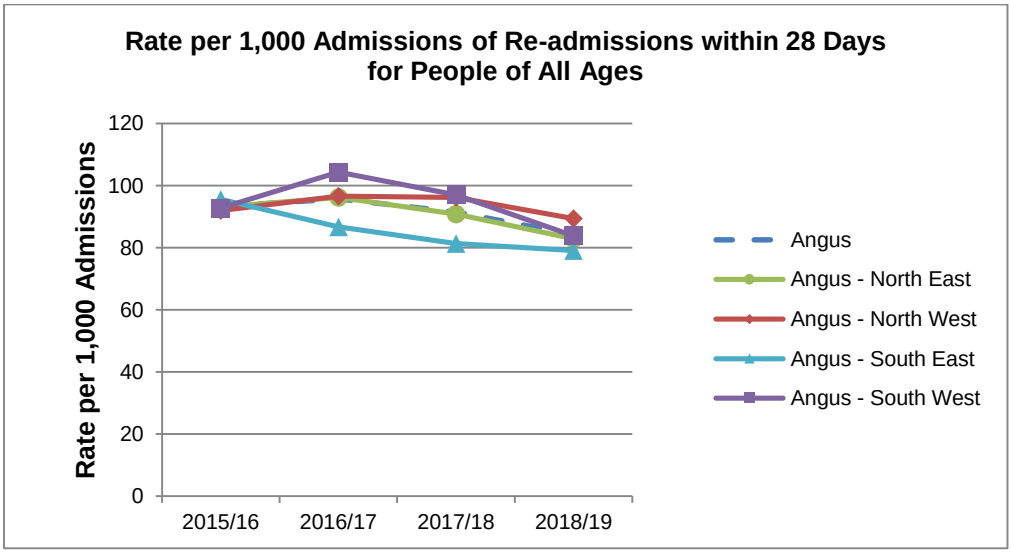
Mrs Munro said "thank you for all the attention and the lovely people who have helped me. I feel back to my old self. We are so lucky to have such a wonderful service".

Mrs Munro's daughter said "I don't know what I would have done because until the team kicked in, I felt completely unsupported and didn't know what to do. What a wonderful service we have. This has allowed my mum to stay at home".

Re-admissions to hospital

3.2.10 Angus re-admission rates are now similar to the Scottish average where previously re-admission rates had been worse than the Scottish average.

Graph 21: Management Information at Locality Level: Emergency Re-admission Rates within 28 days (NI 14)



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

3.2.11 Re-admissions within 28 days relate to all ages (including children). They are a measure of the percentage of people re-admitted following a previous admission. In 2018/19 there were 16,358 admissions from Angus including 6,108 admissions of children under 18 years. Re-admissions are decreasing in all localities (graph 20). In 2018/19 there were 1591 re-admissions relating to all ages in 2018/19, this was an 11% decrease from 2018/19.

3.2.12 Re-admission rates for children under 18 have been increasing. In 2015/16 they accounted for 11% of all re-admissions but in 2018/19 accounted for 15.5% of all re-admissions.

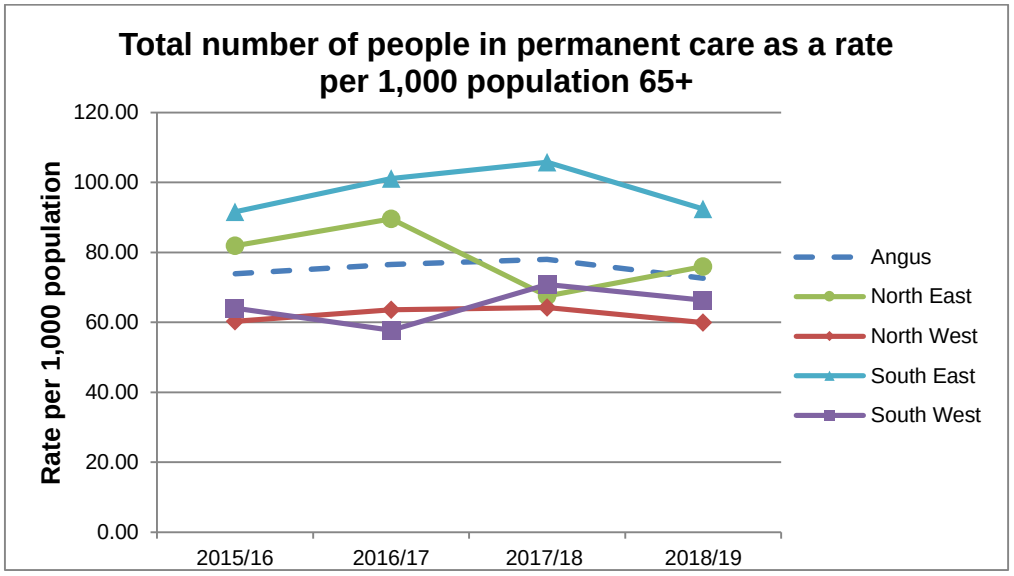
3.2.13 Re-admission rates for adults have seen an improvement in the last 2 years in all localities however this overall improvement includes an increase in re-admission rates for people aged over 75 seen in the South West and North West Localities.

3.2.14 If we consider re-admissions as a rate of the population rather than a percentage of those previously admitted there has been a reduction in the rate of admissions per 1,000 adults from 18.2 in 2015/16 to 16.6 in 2018/19. The rate of re-admission per 1,000 population over 75 has reduced from 51.2 in 2015/16 to 49.6 in 2015/16

Residential and Nursing Care

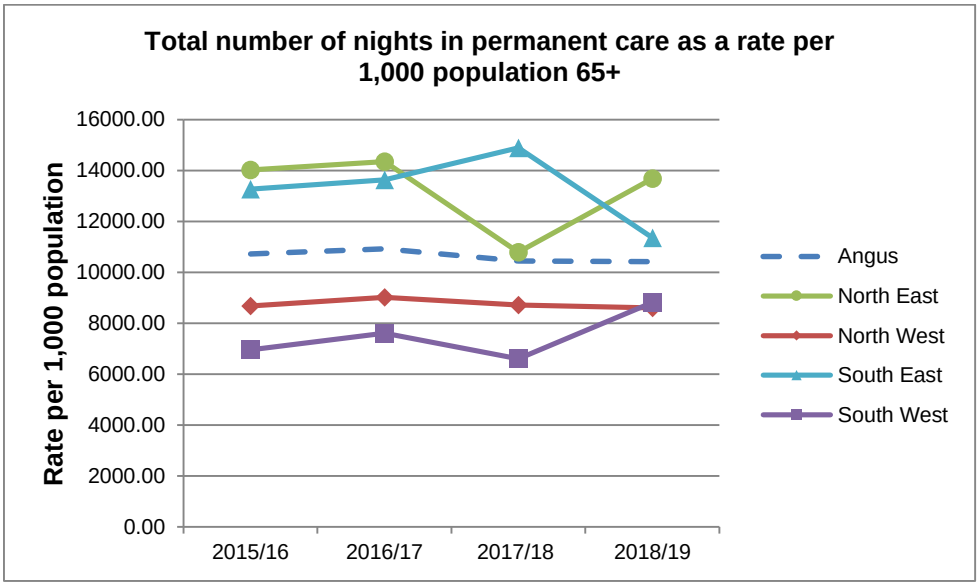
3.2.15 The number of older people placed in a care home at any one time has reduced from around 770 in 2015/16 to 690 in 2018/19. This decrease demonstrates that we are supporting people at home for longer. Around 25% of placements are for nursing care.

Graph 22: Management Information at Locality Level: Care Home Placement Rate per 1,000 people over 65



Source: Care First (Angus Council)

Graph 23: Management Information at Locality Level: Care Home Nights Rate per 1,000 people over 65



Source: Care First (Angus Council)

3.3.16 The total number of people aged over 65 in a permanent care home placements at anytime during 2018/19 was 1923, a decrease of 7% on 2017/18. At the same time the number of placed care home nights used decreased by from 276,736 to 275,853 (0.3% reduction). Fewer individuals are being placed in a care home throughout the year. This suggests that there have been improvements in the targeting of care home placements to those most in need. The average age of a person placed in a care home in Angus is approximately 85.6 years, an increase from 84 years in 2015/16. The average length of stay in a care home remains at 17.3 months as it was in 2017/18. We are seeing an increase in the number of people placed for short periods towards the end of life.

3.2.17 There continues to be some variation between localities in placement rates in both residential and nursing home care. Overall the North East Locality uses more care home placements and have higher levels of personal care hours than the other localities. 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). The rate 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. More consideration needs to be given to issues such as deprivation and life expectancy to see if these are having an impact on placement pattern.

Priority: 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:

- We have implemented the Angus Care Model giving a focus to the care pathway in and out of hospital.
- We have improved on our previous performance of delayed discharges recorded in 2017/18 by:
  - giving the highest priority in allocation in the Enablement 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.
- We have increased the number of people in Angus with a Power of Attorney in place through our involvement in a national campaign to improve uptake.
- We have worked with Perth and Kinross HSCP (host IJB) on issues facing in-patient adult mental health services.
- We have started to grow the delivery of mental health and wellbeing services within GP practices, following the successful test in Brechin and subsequent roll-out to Montrose.
- We have developed plans for the replacement of the Gables Care Home for people with learning disabilities. The building work is expected to start in September 2019 and last around 12 months.

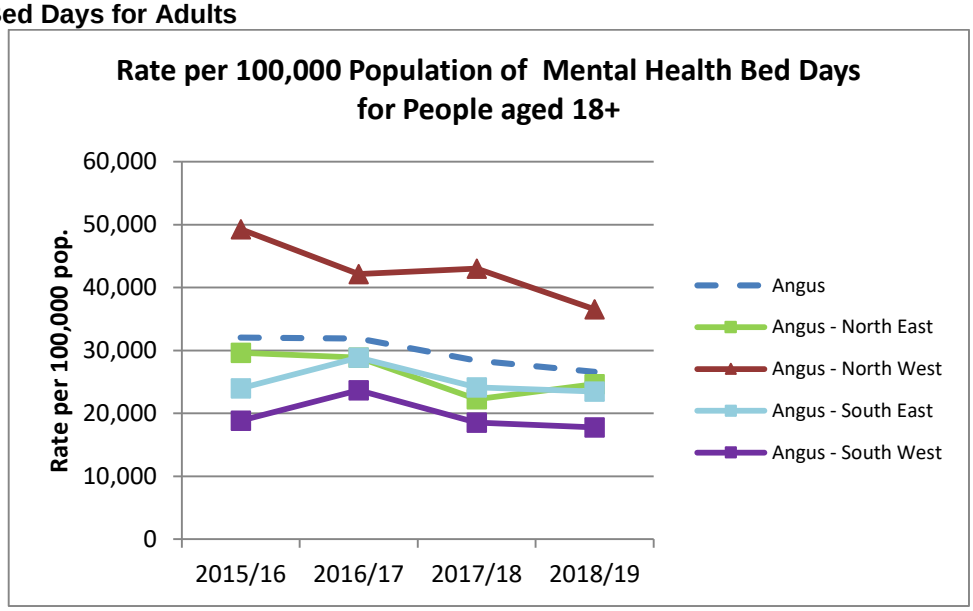
4.2 Making a difference

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 re-admissions. These are all reported on in relation to Priority: Developing integrated and enhanced primary care and community responses (page 32).

Adult Mental Health

4.2.1 The plan for mental health improvement work is establish a whole systems approach to delivering shifts in the balance of care from hospital based services to community based services; a mental health perspective on the Angus Care Model. This will be a significant focus of the work delivered by the Angus HSCP Strategic Commissioning Plan 2019-22. Mental health admission account for approximately 4.4% of all emergency admissions (graph 17). In 2018/19 there were 451 adult mental health admissions (including learning disability). This was an 11% reduction on the 512 admissions in 2015/16 but a 28% increase on the 352 admissions in 2017/18.

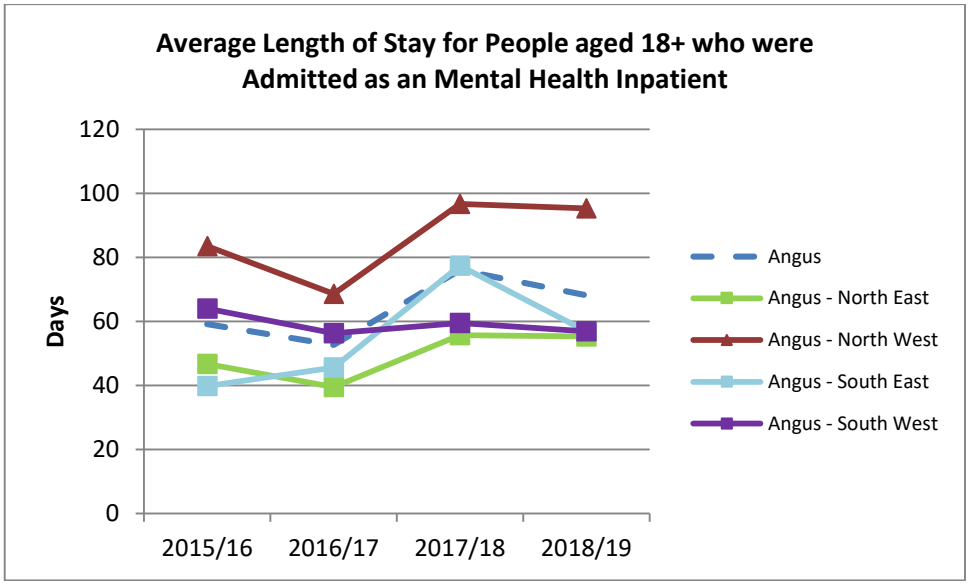
Graph 24: Management Information at Locality Level: Rate of Emergency Mental health Bed Days for Adults



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

4.2.2 Inpatient bed days for mental health admissions in 2018/19 have reduced by 17% from 2015/16 and 6% from 2017/18. Mental health bed days account for nearly 27% of all bed days used in an emergency (graph 18). The variation in the North West may be due to a very small number of lengthy admissions to learning disability inpatient services.

Graph 25: Management Information at Locality Level: Average length of Stay for Adult Mental Health inpatients



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

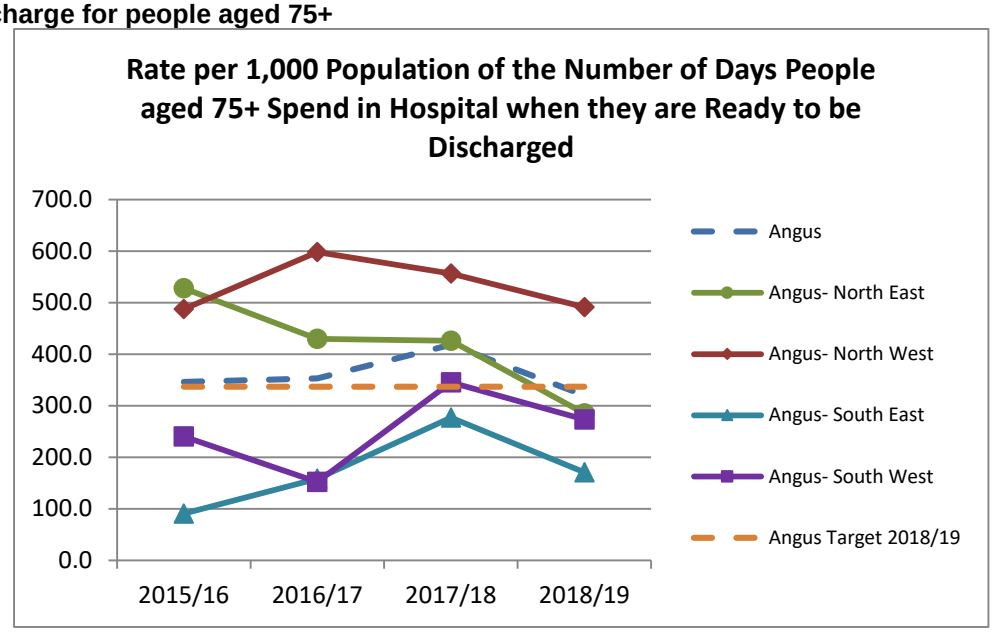
4.2.3 Average length of an inpatient stay for someone with mental health issues has started to decline. It is currently 68 days in Angus. People from North West experience the longest length of stay although this variation may be skewed by a very small number of lengthy admissions for learning disability inpatient services.

Timely discharge

4.2.4 The total number of days lost to all delays in discharge in 2018/19 was 5318 days. This was a 24% reduction from 2017/18 and a 7.6% reduction from 2015/16. Performance in 2017/18 deteriorated due to a number of service changes.

These issues have now resolved and performance is once again improving and we have met our target set in conjunction with the Ministerial Strategic Group.

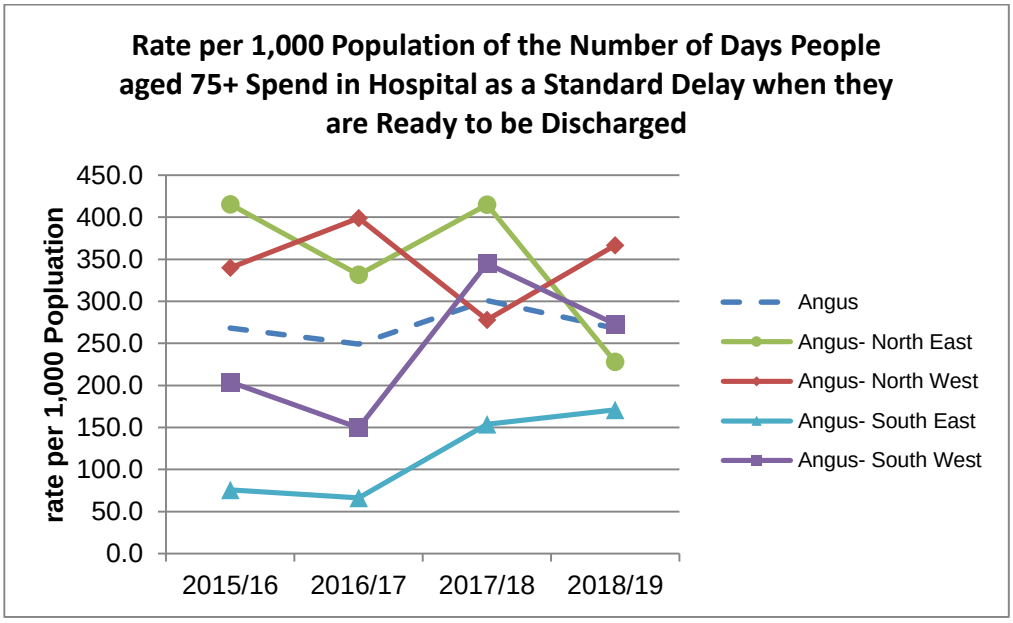
Graph 26: Management Information at Locality Level: Bed days lost to delays in discharge for people aged 75+



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

4.2.5 The number of delayed discharges for people aged 75+ in Angus remains relatively small compared to the overall position in Scotland.

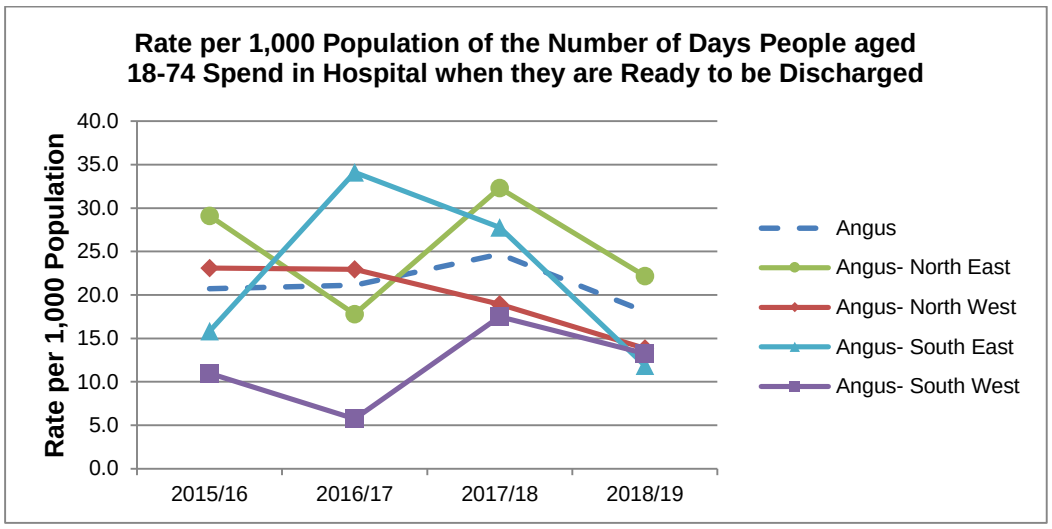
Graph 25 Management Information at Locality Level: Bed days lost to standard delays in discharge for people aged 75+



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

4.2.6 Standard delays occur when a person is not able to be discharged due to delays in undertaking an assessment, getting required care in place (care home or care at home) or for family reasons. People over 75 spent 3202 days in hospital due to delays for these reasons in 2018/19. This was a reduction of 11% on 2017/18 and a similar figure to 2015/16. On average on each census day in 2018/19 there were 9 people aged over 75 experiencing this type of delay. This is down from an average 15 people on census day each month during 2017/18.

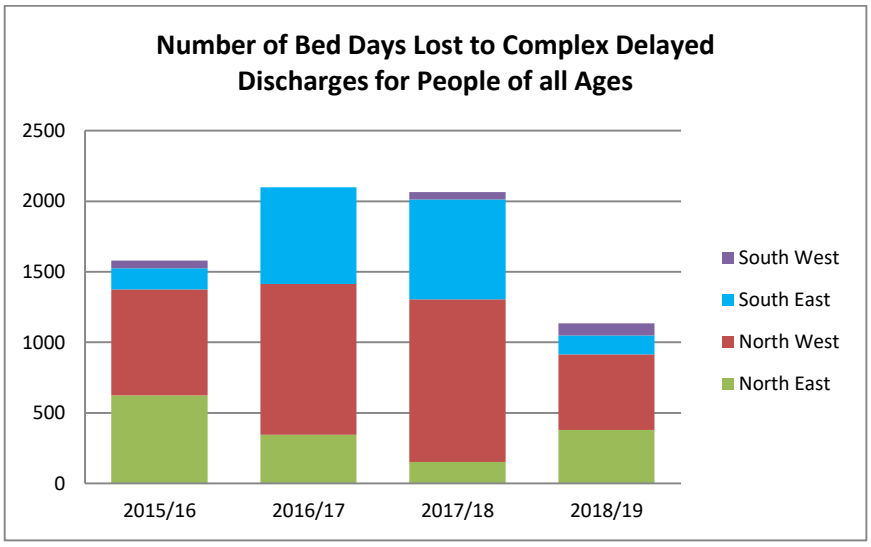
Graph 26: Management Information at Locality Level: Bed days lost to delays in discharge for people aged 18-74



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

4.2.2 Improvements have also been delivered in delays for people aged 18-74. In 2018/19 1491 days were lost to delays in discharge for people aged 18-74. This was a reduction of nearly 27% on 2017/18 and 13% on 2015/16.

Graph 27: Management Information at Locality Level: Bed days lost to complex delays in discharge



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

4.2.3 The most improved performance in relation to the management of delayed discharge is in relation to complex delays. There were on average 3 complex delays each month in 2018/19. There were 1256 bed days lost due to complex delays in 2018/19, this was a decrease of nearly 40% on 2017/18 and 20% on 2015/16. There have been improvement delivered by the Mental Health Officer Team in the management and processing of guardianship applications.

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 in 2018/19

- Ensured all our revised models of care have taken into account the workforce availability now and in the future. This has been the main driver for the Angus Care Model which resulted in a number of nursing posts transferring from hospital to community settings.
- Recruited the first three modern apprentices in health and social care. It is planned to recruit up to four each year.
- Completed a second cycle of iMatter, the Staff Experience Continuous Improvement Model, was implemented across all staff teams in 2018.
- Developed links with schools and participated in workshops promoting health and social care as a positive career choice.

5.3 Making a difference

iMatter findings are confidential to each team, therefore no qualitative data is available. The staff completion rate for iMatter fell from 67% in 2017 to 53% 2018. Of the 127 teams who completed questionnaires only 48% have completed action plans within 12 weeks. The Staff Partnership Forum have produced an action plan to improve completion rates in 2019.

Areas covered within action plans include:

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

Sickness Absence

The percentage of sickness absence amongst Angus NHS staff has increased from 2017/18 to 2018/19, this is due to increases in one service area. A report has been submitted to NHS Tayside and improvement actions agreed to address the issue in this service. Sickness absence for Angus Council staff has decreased. Sickness absence amongst Angus NHS employees is above the NHS Tayside average.

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*	*2016/17*	*2017/18*	*2018/19*
NHS staff	*5.02*	*4.78*	*4.66*	*5.15*
Angus Council staff	*6.28*	*7.46*	*8.69*	*6.73*

Source: Angus Council and NHST epayroll

Quantitative and qualitative data regarding staff sickness are presented and discussed at the Health and Social Care Staff Partnership Forum. A number of actions have been taken forward.

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

Robust joint data protection arrangements between the Partnership, Angus Council and NHS Tayside are now in place. These include agreed data breach joint management and reporting arrangements, a new framework for data sharing between the three organisations, and improved guidance for staff within the Partnership on various aspects of data protection. Specific training and advice has been provided by the Partnership's Data Protection Officer to most of the Partnership service areas. Where appropriate the training has been carried out jointly with information governance staff from NHS Tayside.

Over the period from the introduction of the new data protection legislation in May 2018 to March 2019 there have been 47 personal data breaches within the Partnership. Of these, 24 were within NHS services and 23 within Council services. In most cases the breach was a result of human error.

There were 31 breaches which were minor in nature and quickly mitigated. In the remaining 16 cases the breach did pose a risk of harm to the data subjects involved, in all cases swift action prevented any harm occurring. There were 2 breaches which were sufficiently serious to warrant reporting to the Information Commissioner, as required under the data protection legislation. Having reviewed both breaches, the Information Commissioner was satisfied with the quick and effective action taken by staff to protect the interests of the data subjects affected and the Commissioner has decided to take no further action.

The number of data breaches reported is much higher than in previous years. This is not a sign of deteriorating data protection practice, but rather reflects an increase in staff awareness of data protection issues following the introduction of the new legislation along with training and advice provided to staff over the last 12 months.

Angus Council received 93 Freedom of Information Act enquiries in relation to adult care services. NHS Tayside received 19 enquiries in relation to services within Angus Partnership. The themes included:

- A wide range of information in relation to home care services
- A wide range of information in relation to care home services
- Charging and funding
- Services for carers
- Procurement and contractual arrangements including contract values
- Adult protection and other issues related to vulnerable people
- Delayed Discharge

The Partnership has prepared a Records Management Plan and submitted it to the Keeper of the Records of Scotland for approval. Implementation of the plan will form part of a three year Information Governance Strategy which will also see developments in public access to information, Partnership IT infrastructure, information security, and digitisation of records.

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. There are 19 Angus Council employees with registration applications in process. A further 8 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. All managers monitor registration completion. There does not appear to be a system that provides us with positive assurance overall, that all staff are appropriately registered. We have a system that will tell us if someone's professional registration is breached, but this is done retrospectively. No issues have been raised through the Clinical, Care and Professional Governance Forum.

Support, Supervision and Appraisal

Angus Council have established a short life working group looking at services with high stress/anxiety related absences. Appraisal systems can be monitored with the support of NHS Tayside and Angus Council support.

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 routinely reported by health staff and are typically anything that raises a concern. Of the 1463 events recorded in 2018/19, 318 of those events were recorded with harm. During 2018/19 79% of adverse events were verified within 24 hours and 62% of events resulting in a Local Adverse Event Review (LAER), were completed within 90 days. The NHST Adverse Event Management Policy advises to complete all Local Adverse Event Reviews within 90 days, however, the high level of scrutiny required to ensure a quality review, including receiving information from third parties e.g. Police Scotland particularly around suspected drug deaths, can mean that this timescale needs to be extended.

On direction of the Clinical Care and Professional Governance Group, an Adverse Event Management Group has recently been convened. The purpose of this group is to provide assurance in relation to the quality of adverse management. This will include ensuring a quality checklist is completed on all Local Adverse Event Reviews (LAER) actions associated to the event are completed, all staff are able/equipped to participate in LAER/OAER/Reviews, identify and make recommendations to the Angus Clinical, Care & Professional Governance R2 Forum in relation to areas of practice development, training and development needs and ensure adherence to the NHS Adverse Event Management Policy (March 2019).

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 declined in 2018 from the previous national survey. There is no updated national report for 2019 as the survey is only undertaken every second year. We do however, collect feedback from reviews of people who use social care services. Feedback is generally positive but services recognise that there continues to be more work to do.

Table 5 National and Local Survey results

National Survey 2018-Angus performance	People who use Angus services 2017/18	People who use Angus services 2018/19
76% of adults supported at home who agreed that they are supported to live as independently as possible NI 2	98% feel that services help them to stay as well as they can be	98% feel that services help them to stay as well as they can be
71% of adults supported at home who agreed that they had a say in how their help, care, or support was provided NI 3	100% feel listened to by staff	99% feel listened to by staff
71% of adults supported at home who agreed that their health and social care services seemed to be well co-ordinated NI 4	99% people feel that they have a choice over the nature and timing of support	99% people feel that they have a choice over the nature and timing of support
76% percent of adults receiving any care or support who rated it as excellent or good NI 5	91% people feel that staff within services are responsive to their needs and wishes	100% people feel that staff within services are responsive to their needs and wishes
77% of adults supported at home who agree that their services and support had an impact on improving or maintaining their quality of life NI 7	98% feel that services help them to stay as well as they can be	98% feel that services help them to stay as well as they can be
34% - combined percentage of carers who feel supported to continue in their caring role NI 8	96% carers have been offered support which has allowed them to continue in their caring role.	95% carers have been offered support which has allowed them to continue in their caring role.
80% of adults supported at home who agreed they felt safe NI 9	95% people feel that services they have in place help them feel safe	99% 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, 83% of care services operating in Angus are graded as good or better against a Scottish average of 82%. There have been changes to inspection processes following the introduction of the National Care Standards. This may mean there may not be any direct comparison from this year's performance to previous performance. 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

This year has seen a major change in the grading system used by the Care Inspectorate to grade care services. The change is to reflect the implementation of the new National Care Standards. The Care Inspectorate have introduced a Quality Indicator Framework which has five domains:

- Support Person's Well Being
- Support and Care Planning
- Environment
- Staffing and Staff Team
- Leadership and Management

Services are graded 1 to 6 against each of these domains. This means that new grades may not be directly comparable to previous grades.

There are 79 registered care providers in Angus. In 2018/19, three care services received a grade of 2 in at least one area. These grades relate to the care and support theme and management and leadership theme. There were 60 inspections of adult social care services in Angus, undertaken by the Care Inspectorate in 2018/19.

There are 14 services currently carrying grades of 2 or 3 in relation to at least one domain. This includes 11 care homes and 3 support/housing support services. No enforcement action has been required, but a number of recommendations have been made in inspection reports. Themes of recommendations include:

- Informing users of the new Health and Social Care National care Standards
- Improvements to care plans
- Improvements to managing money on behalf of service users in a care home
- Consistency of staffing in support services so people can build relationships with staff
- Medication management
- Training in dementia awareness, understanding leadership, adult protection
- Recruitment practices

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

NHS inspections

Mental Welfare Commission Report on Unannounced Visit to the Prosen Unit, Whitehills Health and Community Care Centre on 16 April 2018

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. At the time of the inspection several patients were subject to compulsory measures under the Mental health (Care and Treatment) (Scotland) Act 2003. It was noted that appropriate forms were filed correctly with patient files but good practice would suggest the form should also be held with the drug prescription sheets. One recommendation was made;

'Managers should ensure that copies of the T2 or T3 forms are kept the drug prescription sheets.
Processes have been updated to ensure that forms are held with drug prescription sheets in line with this good practice.

Mental Welfare Commission Report on Unannounced Visit to Rowan and Willow Units, Stracathro Hospital, 25 June 2018

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. There was one recommendation relating to remedial work in the garden areas:

'The relevant managers should ensure that issues being raised by the service about repair work in the gardens which needs to be completed is taken forward with whoever is responsible for ground maintenance.'

The remedial work in the gardens is now complete.

Complaints

In 2018/19 there were:

Stage 1 Complaints	27	(consisting 21 Angus HSCP Health only & 67 Hosted Services)
Stage 2 Complaints	33	(consisting 22 Angus HSCP Health only & 11 Hosted Services) and 15 joint Angus involvement with NHS Tayside services

Stage 1 Complaints

It is aimed to ensure an early resolution (within 5 days) to Stage 1 complaints. 94 % complaints were responded to within 5 days stage 1 complaints were made in relation to a range of services including inpatient services, community mental health services, continence and physiotherapy. In 2018/19 Stage 1 complaint themes included:

- Care and treatment
- Staff attitude
- Waiting times
- Communication

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. 64% stage 2 complaints were responded to within 20 days.

Stage 2 complaints during 2018/19 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:

- Complaints about individual members of staff
- Communication
- Care and treatment
- Wrong diagnosis
- waiting time

6.6 Domain 6 - Promotion of Equality and Social Justice

A progress report on the equalities mainstreaming report will be provided to the IJB in September 2019. We have started to introduce some indicators in this report which show how services and outcomes vary between the most and least deprived communities in Angus. More are to be developed. .

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 2018/19. During 2018/19 two risks were managed into their planned acceptable level of risk. This shows an improving picture of risk management.

Table 7 Angus Health & Social Care Partnership – Corporate Risk Rating Matrix

Risk Exposure Rating

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

Key

Green	**Controls are working effectively**
Yellow	**Controls require further development**
Amber	**Significant controls not operating effectively**
Red	**Significant controls do not exist or have broken down**

No	Risk Title	Risk Owner	Risk Exposure – no controls	19 Jan 2018	14 Mar 2018	30 May 2018	25 July 2018	13 Sept 2018	5 Dec 2018	23 Jan 2019	13 March 2019	Status	Planned Risk Exposure
1.	Sustainability of Primary Care Services	Medical Director (JG)	25 (5x5)	20 (5x4) RED	20 (5x4) RED	25 (5x5) RED	16 (4x4) AMBER	16 (4x4) AMBER	16 (4x4) AMBER	16 (4x4) AMBER	20 (5x4) RED	↓	9 (3x3) YELLOW
2.	Prescribing Management	Clinical Director (AC)	25 (5x5) RED	25 (5x5) RED	25 (5x5) RED	25 (5x5) RED	25 (5x5) RED	25 (5x5) RED	20 (4x5) RED	20 (4x5) RED	20 (4x5) RED	↔	16 (4x4) AMBER
3.	Financial Management	Chief Officer (VI)	25 (5x5) RED	25 (5x5) RED	25 (5x5) RED	25 (5x5) RED	25 (5x5) RED	25 (5x5) RED	25 (5x5) RED	20 (4x5) RED	16 (4x4) AMBER	↔	20 (4x5) RED
4.	Enhanced Community Support	Head of Community Health & Care Services (North Angus) (GS)	ARCHIVE	16 (4x4) AMBER	16 (4x4) AMBER	16 (4x4) AMBER	16 (4x4) AMBER	16 (4x4) AMBER	16 (4x4) AMBER	12 (4x3) AMBER	3 (1x3) GREEN	↑	4 (2x2) YELLOW
7.	Performance Management	Head of Community Health & Care Services (North Angus) (GS)	20 (5x4) RED	12 (4X3) AMBER	9 (3x3) YELLOW	9 (3x3) YELLOW	9 (3x3) YELLOW	9 (3x3) YELLOW	12 (4X3) AMBER	12 (4X3) AMBER	12 (4X3) AMBER	↔	8 (2x4) YELLOW
8.	Workforce Optimisation	Head of Mental Health Services (BT)	9 (3x3) YELLOW	12 (4X3) AMBER	12 (4X3) AMBER	12 (4x3) AMBER	12 (4x3) AMBER	12 (4x3) AMBER	12 (4x3) AMBER	20 (4X5) RED	20 (4X5) RED	↔	6 (2x3) YELLOW

No	Risk Title	Risk Owner	Risk Exposure – no controls	19 Jan 2018	14 Mar 2018	30 May 2018	25 July 2018	13 Sept 2018	5 Dec 2018	23 Jan 2019	13 March 2019	Status	Planned Risk Exposure
9.	Complex and Co-existing Conditions	Clinical Director (AC)	20 (4x5) RED			20 (4x5) RED	20 (4x5) RED	20 (4x5) RED	16 (4x4) AMBER	16 (4x4) AMBER	16 (4x4) AMBER	↔	10 (2x5) AMBER
10.	Compliance with GDPR and Data Protection Act 2018	Clinical Director (AC)	20 (4x5) RED			20 (4x5) RED	20 (4x5) RED	20 (4x5) RED	16 (4x4) AMBER	16 (4x4) AMBER	9 (3x3) YELLOW	↔	4 (2x2) YELLOW
11.	Commissioned Service Provider Failure	Head of Community Health & Care Services (South Angus) (GB)	12 (3x4) AMBER						12 (3x4) AMBER	12 (3x4) AMBER	12 (3x4) AMBER	↔	8 (2x4) YELLOW
12.	European Union (EU) Withdrawal	Head of Mental Health Services (BT)	9 (3x3 YELLOW)								9 (3x3 YELLOW)		6 (3x2) YELLOW

Performance Area 3: Resources

On an annual basis, Angus IJB negotiates budget settlements with both Angus Council and NHS Tayside. The final budget delegated for 2018/19 were:

Budgets delegated from Angus Council - £44.149m

Budgets delegated from NHS Tayside - £125.272m

Total budgets to be devolved to the IJB - £169.421m.

The budgets above included 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 2019/20.

Both settlements presented 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.

Throughout 2018/19, 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 2018/19 financial year, a year end summary report was submitted to the June 2019 IJB meeting.

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

7.1 What we have achieved in 2018/19

Throughout 2018/19, a Finance Reports have been presented to IJB Board meetings. These reports set out information regarding the annual budgets and projected financial out-turns for the financial year as well as describing financial risks and reserves positions. At the end of the 2018/19 financial year, a year end summary report was submitted to the June 2019 IJB Board meeting.

Reports through the year projected in-year under spends within Adult Social Care relating to one-off underspends, the longer term containment of cost pressures and early delivery of savings plans. At the year end, the underspend increased beyond original projections resulting in an Adult Social Care position of an underspend of £1.6m.

Within the IJB's local Community Health Services good progress was reported through the year on delivering recurring savings and containing costs. This helped to offset ongoing overspends regarding Hosted Services (including Mental health Services) and local Primary Care prescribing over spends. Prescribing, while still overspending, as an area of significant improvement during 2018/19 with the IJB's cost per weighted patient dropping from 14% above the national average to less than 8% above the national average. As this overspend has been managed down, so this has directly improved the financial position during 2018/19 compared to previous years. In addition to these factors, in 2018/19, NHS Tayside devolved an additional £1.2m of non-recurring resources to the IJB. This reflected funds previously managed at NHS Tayside level on behalf of the IJB. Those resources have directly contributed to the IJB's in year financial position.

While Finance reports from mid-2018/19 on wards had forecast health under spends, these projections improved significantly in the final quarter reflecting some late adjustments, material underlying improvement in service position and the release of the non-recurring funds from NHST Tayside to support the overall IJB position. The end result, excluding under spends subsequently allocated to ear-marked reserves, was £2.5m.

The financial position for both Adult Services and Health Services has therefore improved compared to 2017/18. It does mean that, with hindsight, the IJB may have been able to make different decisions during 2018/19. However, those decisions would always have been constrained by the longer term financial picture while the improved financial position in 2018/19 also means the IJB has a better starting point for the new financial year.

The IJB Finance reports also provided regular feedback to the IJB regarding progress with 2018/19 savings targets.

Noting the materiality of Primary Care prescribing over spends 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.

7.2 Making a difference

Spend on hospital stays following emergency admission

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 23% against a Scottish average of 22% (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.

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 delivery of aspects of the Angus Care Model in 2018/19, the work on prescribing costs 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.