AGENDA ITEM NO 12

REPORT NO. IJB 84/19

ANGUS HEALTH AND SOCIAL CARE PARTNERSHIP

PERFORMANCE REPORT

Mid-Year Report 2019-20

November 2019

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1. Introduction

This mid-year Performance Report demonstrates delivery of the Angus Health and Social Care Partnership's Strategic Commissioning Plan for 2019-22 to the end of September 2019 (Q2). The range of indicators reported have been updated to reflect the agreed ambitions and the improvement priorities.

This report focuses on the four priorities of the Strategic Commissioning Plan:

- Improving health, wellbeing and independence
- Supporting care needs at home
- Developing integrated and enhanced primary care and community responses
- Improving integrated care pathways for priorities in care

These four priorities of our Strategic Commissioning Plan aim to deliver on the nine National Health and Wellbeing Outcomes (Appendix 1).

Data explanatory notes are provided (Appendix 2).

Table 1 Key National and local measures at a glance

National Indicator 12 - Emergency admission rate for adults (per 100,000 population)

2018/19	Trend	2019/20 Q2	Target	Achieving
10916	↑	10996	10,377	✓

National Indicator 13 - Emergency bed day rate for adults (per 100,000 population)

2018/19	Trend	2019/20 Q2	Target	Achieving
99266	↓	98891	94,803	✓

National Indicator 14 - Readmission to hospital within 28 days for adults

2018/19	Trend	2019/20 Q2	Target	Achieving
97.3	↑	98.9	N/A	✗

National Indicator 16 - Falls rate per 1,000 population aged 65+

2018/19	Trend	2019/20 Q2	Target	Achieving
25.4	↓	25.0	N/A	N/A

National Indicator 19 - Number of days people aged 75+ spend in hospital when they are ready to be discharged (per 1,000 75+ population)

2018/19	Trend	2019/20 Q1*	Target	Achieving
320	↓	277	303	✓

Local Indicator 24 - Personal care hours rate per 1,000 18+

2018/19	Trend	2019/20 Q2	Target	Achieving
4715	↑	5019	N/A	N/A

Local Indicator 25 - Care home nights rate per 1,000 65+

2018/19	Trend	2019/20 Q2	Target	Achieving
10414	↓	9991	No change	✓

* Latest data available

Key for Table 1

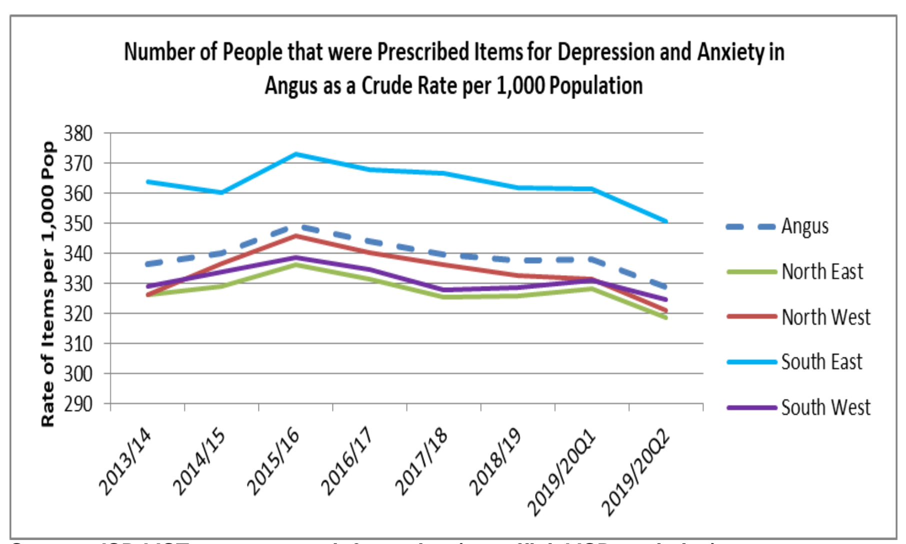
↑	Increase from previous quarter	-	No change	✓	Yes Achieving
↓	Decrease from previous quarter			✗	Not Achieving

2. Improving Health, Wellbeing and Independence

The aim of the Angus Health and Social Care Partnership (AHSCP) Strategic Commissioning Plan is to progress approaches that support individuals to live longer and healthier lives. This includes having access to information and support within communities. AHSCP's focus is on health improvement and disease prevention including addressing health inequalities; building capacity within our communities; supporting carers and supporting the self-management of long term conditions.

2.1 Promoting Wellbeing

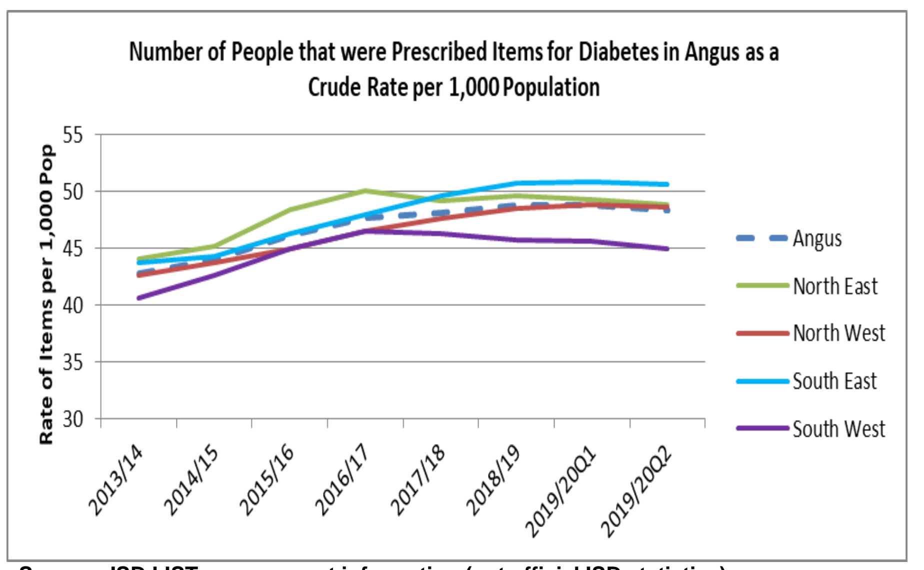
Graph 1: Number of People that were Prescribed Items for Hypertension in Angus as a Crude Rate per 1,000 Population



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

The AHSCP Strategic Commissioning Plan set an ambition of a 3% reduction in hypertension prescribing by 2022. The rate of people who were prescribed items for hypertension in Angus compared to 2017/18 has reduced by 1.4%.

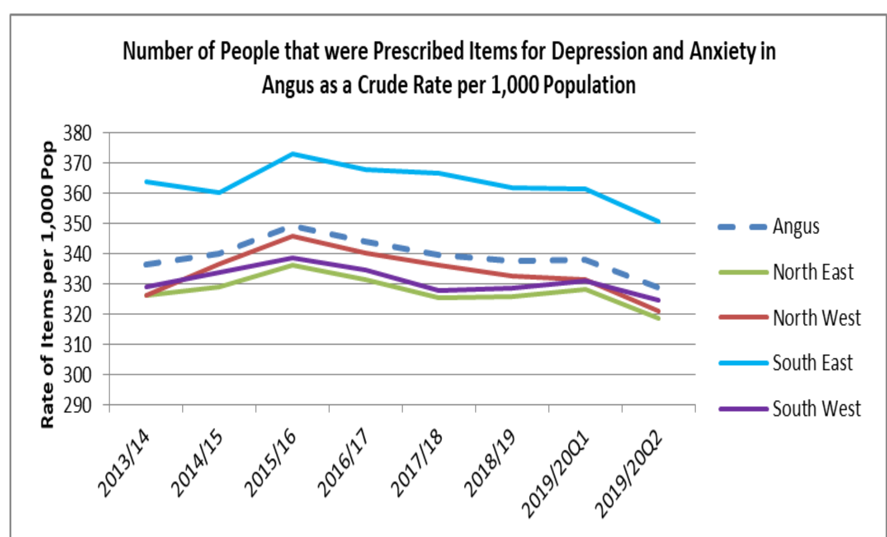
Graph 2: Number of People that were Prescribed Items for Diabetes in Angus as a Crude Rate per 1,000 Population



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

The rate of people prescribed items for diabetes in Angus has remained consistent with 2017/18

Graph 3: Number of People that were Prescribed Items for Depression and Anxiety in Angus as a Crude Rate per 1,000 Population



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

The rate of people prescribed items for depression and anxiety in Angus has reduced by 3.3% compared to 2017/18.

2.2 Carers Support

New legislation to support Carers and deliver Carers Support Plans was enacted in April 2019. An individual carer's support plan will be agreed with Care Management that offers self-directed support options, providing carers with greater flexibility about what types of services they choose and how they are delivered.

A carer's census was undertaken between October 2018 and March 2019. In Angus the number of adult carers was 637.

Table 2 Number of Carers identified through Census

Carer age group	Female	Male	All
18 - 64	272	69	341
65 and over	196	100	296
Total	**468**	**169**	**637**

Source: Angus Carers Census

All 637 carers were offered an Adult Carer Support Plan, four were declined. An eligibility framework was developed by the Angus Carers Planning Group. 91% of Carers with a Support Plan were eligible for financial support.

Table 3 Number of Carers Eligible for Financial Support

Carer age group	Eligible	Not Eligible	Not Known	All
18 - 64	274	17	50	341
65 and over	252	13	31	296
Total	**526**	**30**	**81**	**637**

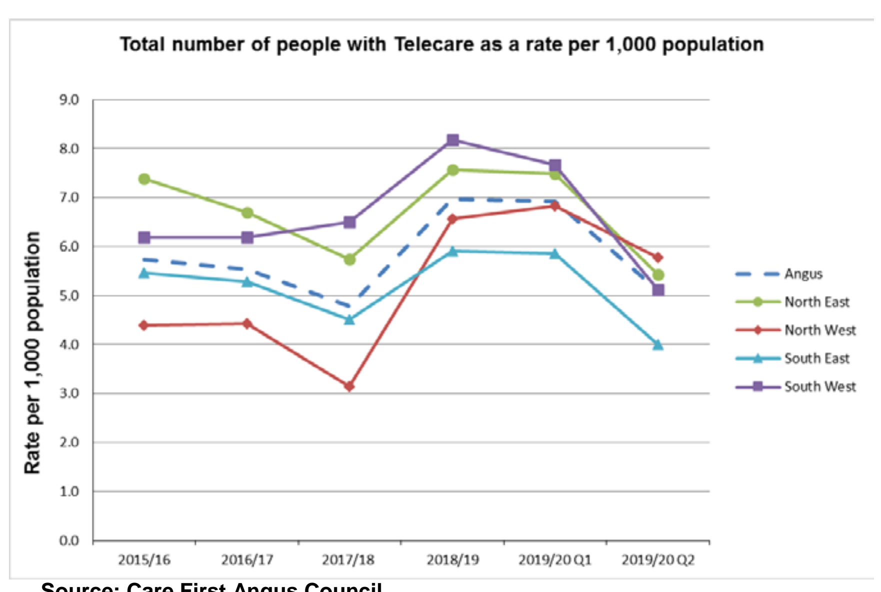
Source: Angus Carers Census

Based on the data available, the average weekly carer's budget is approximately £200.

2.3 *Community Alarm*

Community alarm supported 3471 people across Angus to the end of Quarter 2. The Strategic Commissioning Plan 2019-22 sets out plans which aim to increase the uptake and improve the use of telecare. A range of telecare products are supported through community alarm.

Graph 4 The Number of People with Telecare as rate per 1,000 population

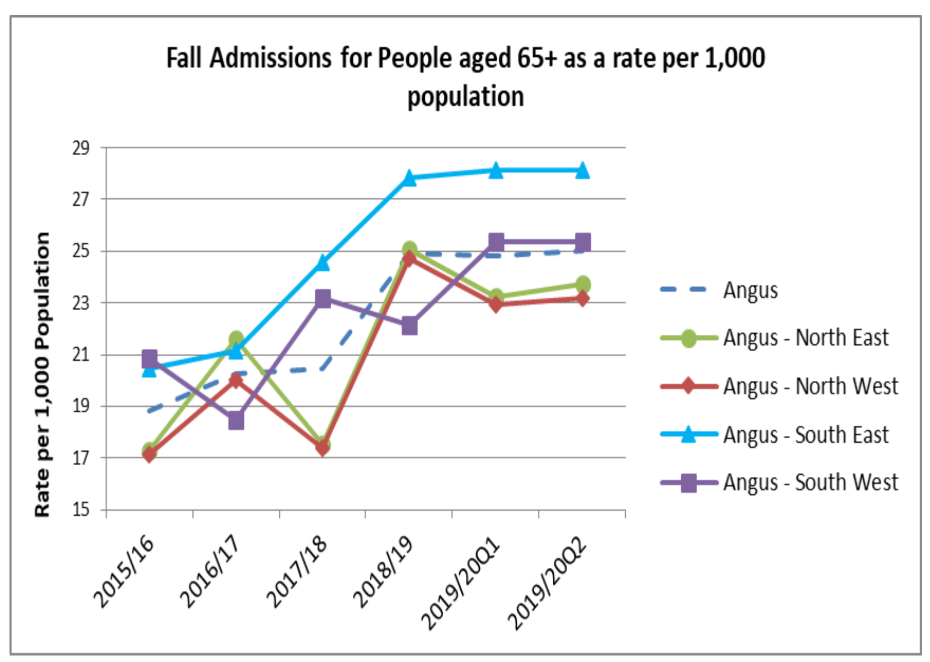


Source: Care First Angus Council

Progress was made in 2017/18 in improving the uptake of telecare. A charge for telecare equipment was introduced in April 2019. The uptake of telecare products has since declined. During the same period we have also seen an increase in the number of larger personal care packages.

2.4 Falls

Graph 5: 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)

The rate of admission following fall has increased in Angus. There is an underlying increasing trend with falls admissions that is largely due to the higher proportion of people aged over 85 living at home in Angus.

The increase in falls admissions between 2017/18 and 2018/19 appears to be related to a change in the pathway and data coding involving the Accident and Emergency (A&E) and Medicine for the Elderly, for example, if a patient transfers from A&E to a ward area for day

treatment, this is counted as a hospital admission, though they leave the department later that day. This improved pathway does ensure that older people experience a holistic assessment before returning home but it is now identified in the data coding as an admission. Previously this would not have been counted in the admission statistics as patients would have been discharged from A&E directly. This change in the patient pathway should be seen as a positive improvement aimed at delivering better outcomes for patients with direct access to Medicine for the Elderly support and review before returning home. The AHSCP Strategic Commissioning Plan 2019-2022 recognises that everyone has a right to live a long and healthy life, and if people live longer at home and become frailer, the likelihood of a fall increases.

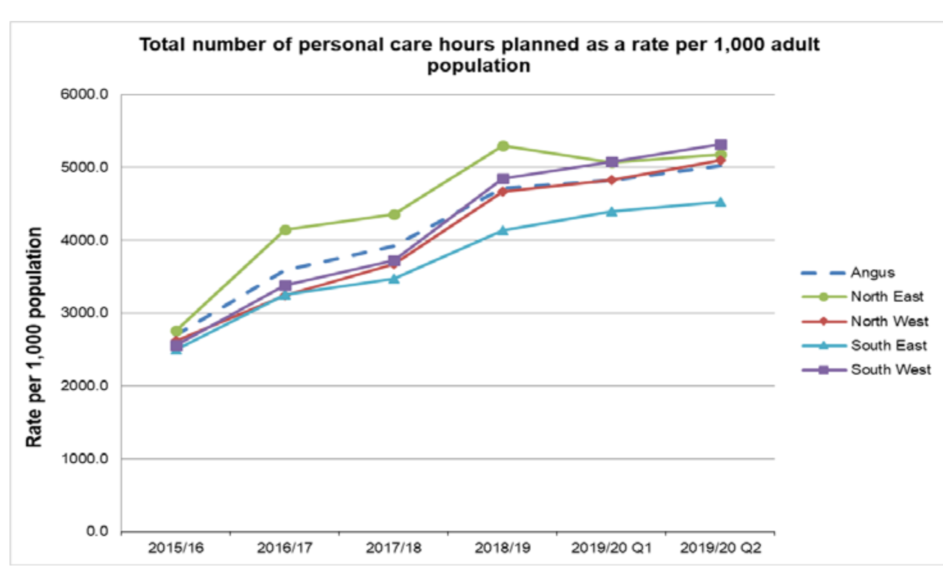
3. Supporting Care Needs at Home

The population of Angus is growing older and this will continue for the next 20 years. This change in demographics will place a further increase in demand on services. The focus is to support care needs at home by enhancing technology enabled care; further progress self-directed support; and deliver change in care at home services.

3.1 Personal Care

The provision of more personal care was essential to the delivery of AHSCP's Strategic Commissioning Plan 2016-19. Growth was experienced between 2017/18 and 2018/19. The Help to Live at Home programme delivered new ways of working with independent sector personal care providers providing opportunity to address unmet need.

Graph 6: Management Information at Locality level: People aged 18+ Receiving Personal Care Services as a Rate of 1,000 Population (LI 24)

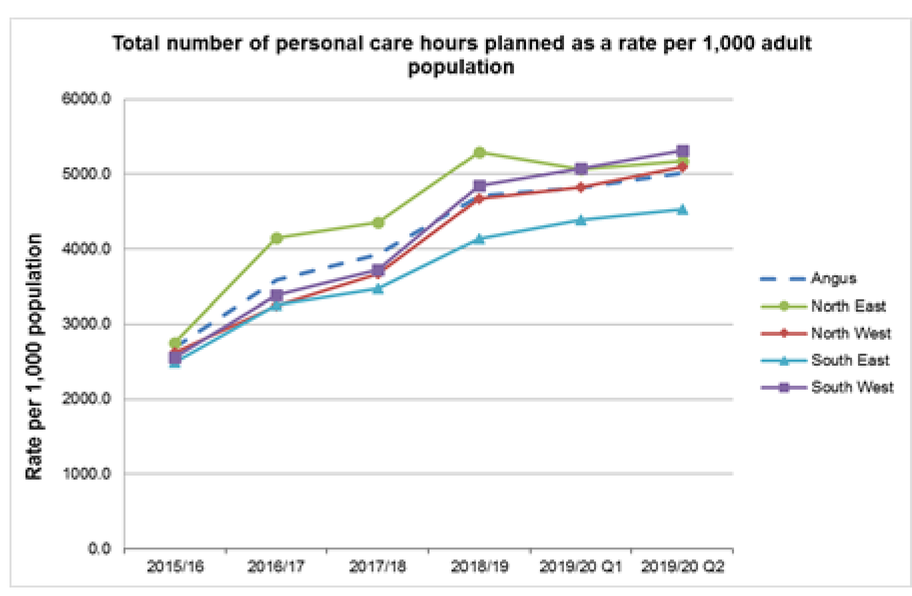


There continues to be growth in demand for personal care. Some of the additional demand is due to demographic change and the Angus Care Model. 473229 hours of personal care were delivered in Q2.

Source: Care First Angus Council

The provision of personal care to younger adults, particularly those with learning disability, has also increased. The number of people with learning disabilities accessing personal care support has grown from 10% to 16% of people receiving personal care and the proportion of personal care hours used by people with learning disability has increased to approximately 21%.

Graph 7: Management Information at Locality level: Rate of Personal Care Hours



The complexity of people being supported at home has increased. There has been growth in the number of support plans which include more than 14 hours per week.
To the end of Q2 the typical (median) size of a personal care package in Angus continued to be 7 hours.

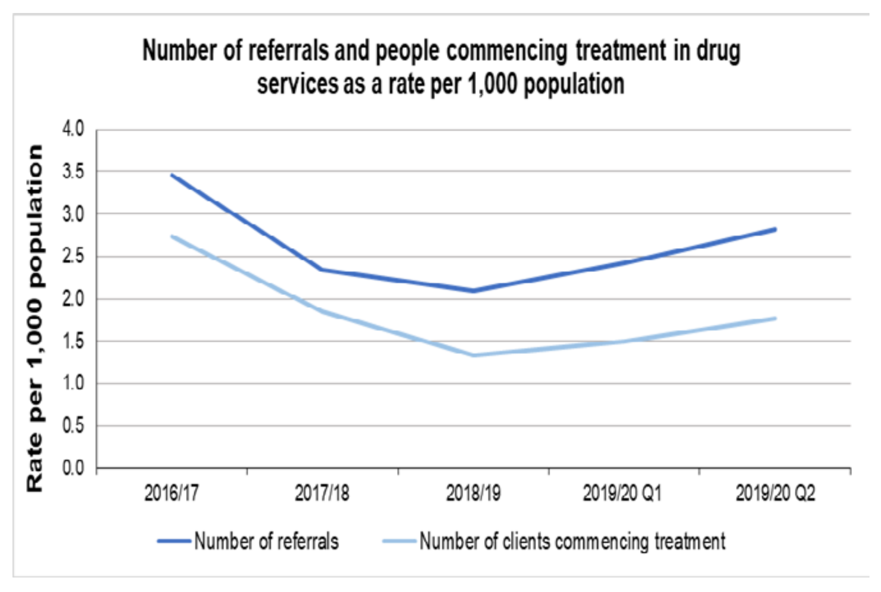
Source: Care First Angus Council

People aged over 65 use nearly 70% of all personal care hours. There is a requirement to reduce demand through enablement and other preventative services as well as low level services such as community meals so we can reduce the projected increase by 10% as agreed in the Strategic Commissioning Plan 2019-22.

3.2 Drug and Alcohol Services

The AHSCP Strategic Commissioning Plan 2019-22 set out an ambition that 90% people referred for support with Angus Integrated Drug and Alcohol Recovery Service were seen within three weeks of referral.

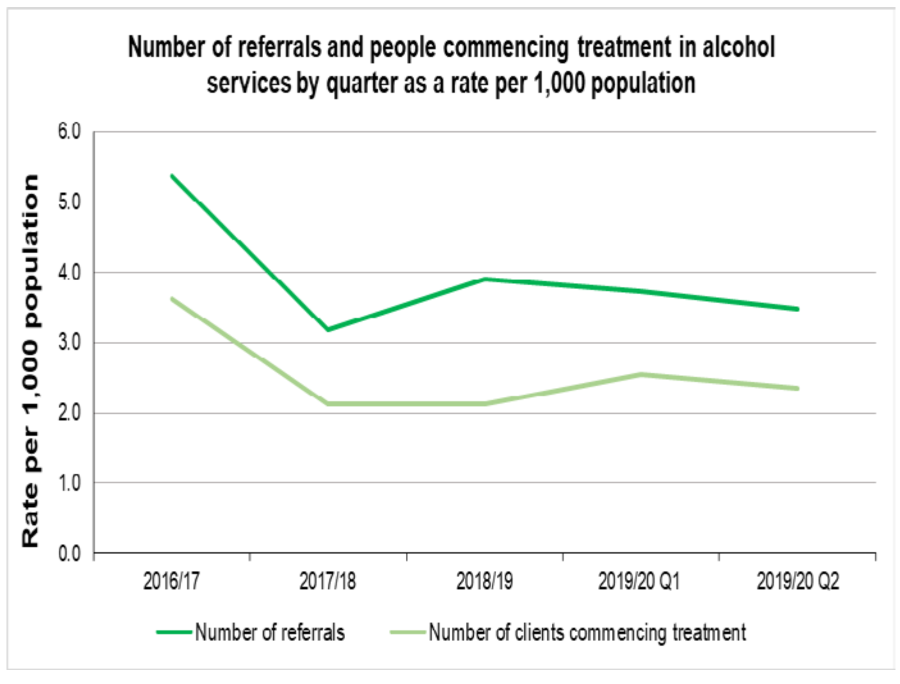
Graph 8 Number of referrals to and people commencing drug services as a rate per 1,000 population



Referrals for treatment in drug services have been increasing. There are a proportion of people referred who fail to attend appointments and do not start treatment

Source: NHS Tayside

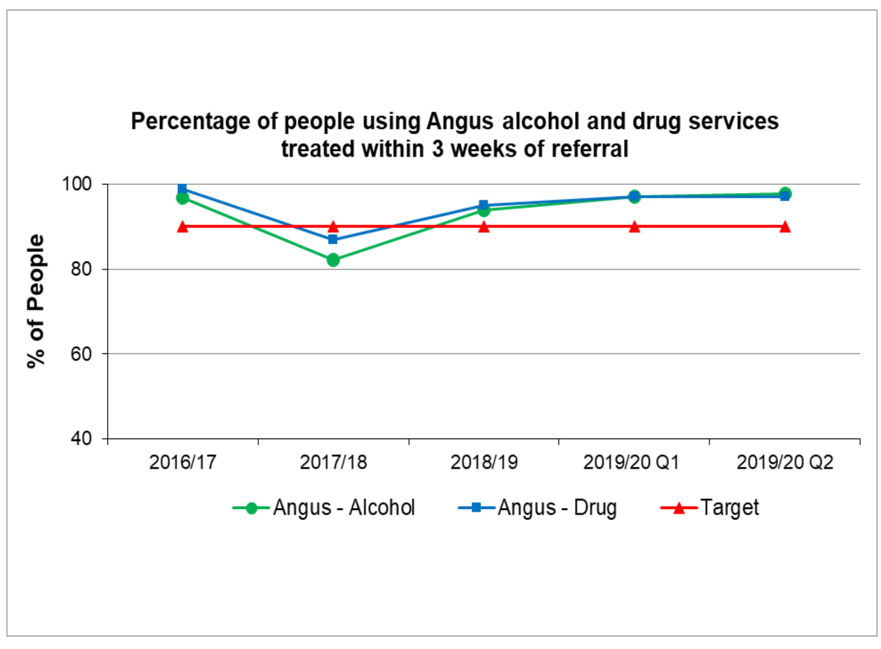
Graph 9 Number of referrals to and people commencing treatment in alcohol services as a rate per 1,000 population



Referrals for treatment in alcohol have been declining. There are a proportion of people referred who fail to attend appointmnts and do not start treatment

Source: NHS Tayside

Graph 10 Percentage of People using alcohol and drug services treated within 3 weeks of referral



Following the integration of health and social care teams to form Angus Integrated Drug and Alcohol Recovery Services, the percentage of people seen within 3 weeks of referral has improved beyond the target

Source: NHS Tayside

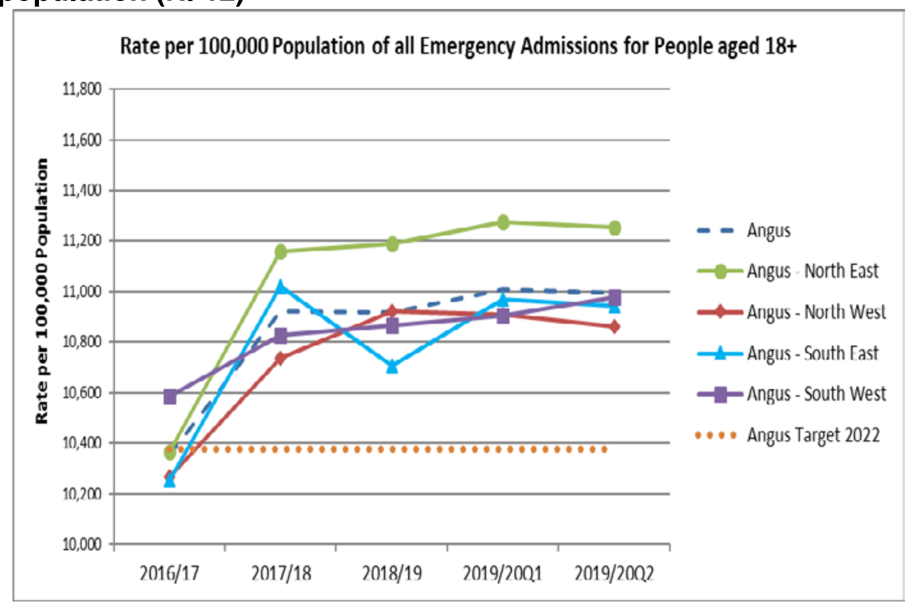
4. Developing Integrated and Enhanced Primary Care and Community Responses

AHSCP aims to support individuals to stay at home for as long as possible when it is safe to do so. If a hospital admission is necessary then ensuring a timely discharge plan with relevant support available at home or in localities is important.

4.1 Emergency admissions

Information which relates to adult admissions includes Psychiatry of Old Age, General Psychiatry Medicine for the Elderly and all other emergency admissions to Ninewells and Community Hospitals. Improvement in pathways is at different stages in each service area.

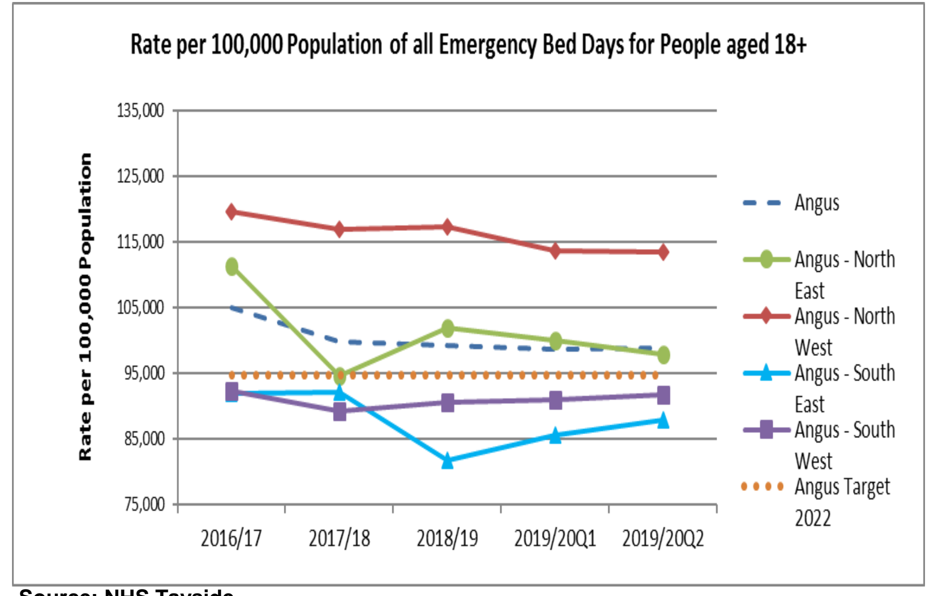
Graph 11: Management Information at Locality Level: Emergency Admissions for all Adults as a rate of 100,000 population (NI 12)



Admission rates in Angus have been maintained.

Source: NHS Tayside

Graph 12: Management Information at Locality Level: Emergency Bed Days for all Adults as a rate of 100,000 population(NI 13)



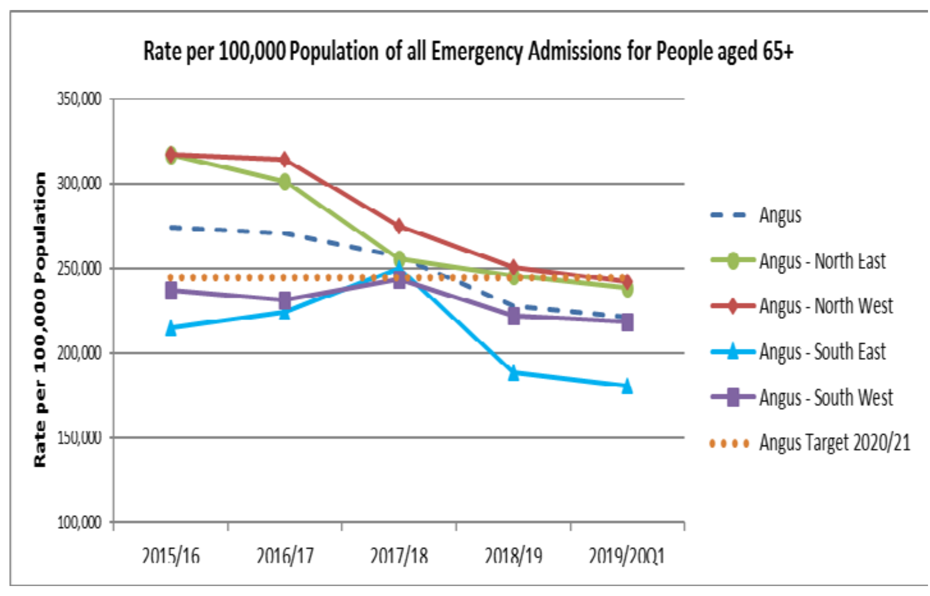
The bed day rate for all adults decreased into Q1 but increase into Q2. The average length of stay for all admissions in Q2 has remained at 9 days

The average length of stay in the North West Locality is 10.4 days accounting for the variance in all bed days. Mental health bed days are also higher in the North West (Table 5 page20)

Source: NHS Tayside

4.2 Admission of People Aged Over 65

Graph 13 Management Information at Locality Level: Emergency Admissions for People aged 65+ as a rate of 100,000 people aged 65+

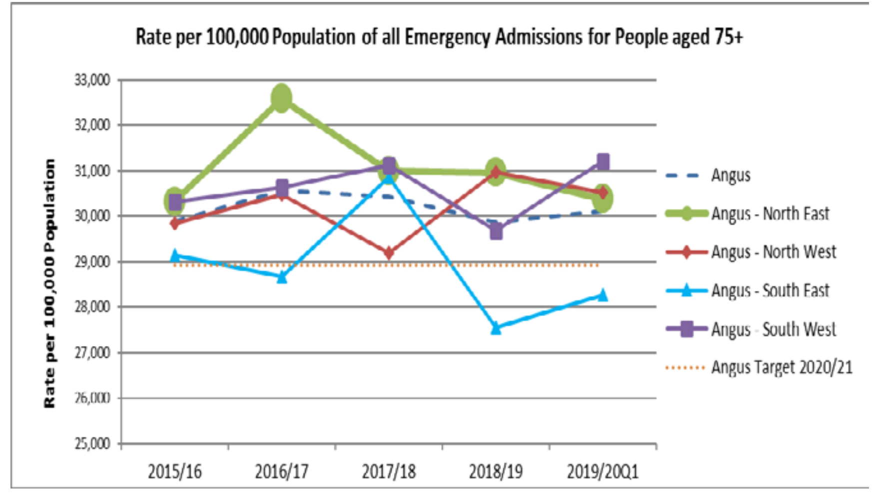


Admissions for people over 65 in an emergency continue to fall. Improvements in the North East and North West Localities suggest that Enhanced Community Support model is being embedded in practice. Data for Q2 is not available.

Source: NHS Tayside

4.3 Admission of People Aged Over 75

Graph 14 Management Information at Locality Level: Emergency Admissions for People aged 75+ as a rate per 100,000 of people aged 75+

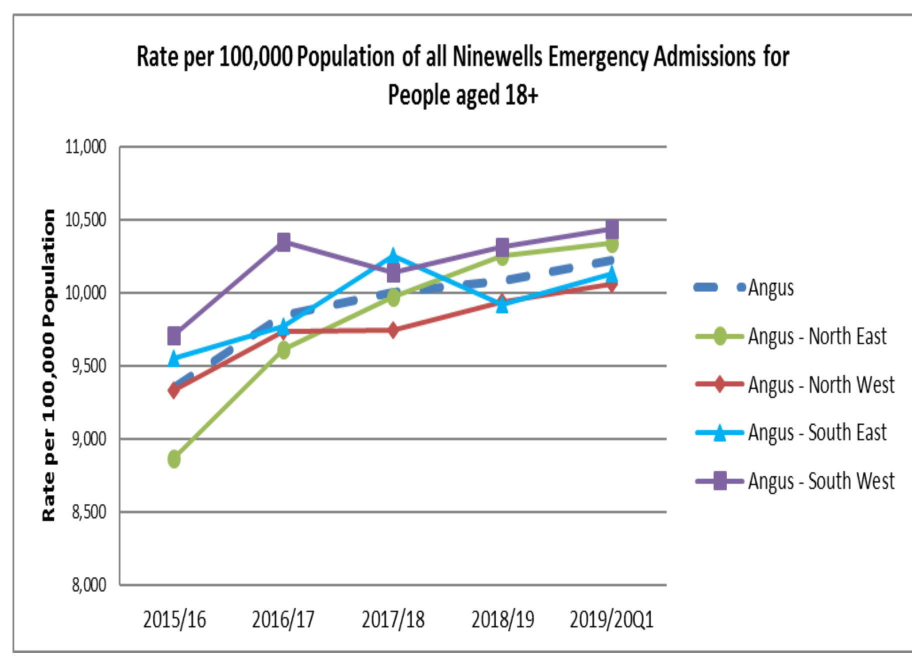


The rate of admission for people aged 75+ has increased into Quarter 2. This is associated with the increase in falls admissions which appear to be due to the improved pathway at A&E described in paragraph 2.3 falls. Data for Q2 is not available

Source: NHS Tayside

4.4 Admissions to Ninewells

Graph 15: Management Information at Locality Level: Emergency Admissions to Ninewells Hospital for Angus Adults as a rate of 100,000 population (NI 12)



Admissions to Ninewells account for 96% of all Angus admissions and are continuing to rise. An element of this increase due to the changes in the pathway from A&E described earlier. Bed day use in Ninewells continues to decline (graph 16) Data for Q2 is not available.

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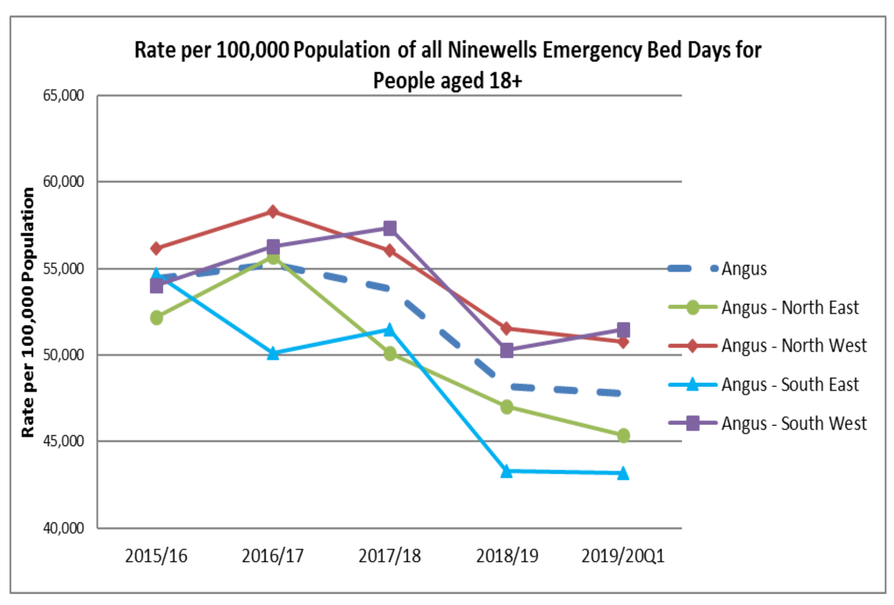
Source: NHS Tayside

If we are to achieve our ambitions for improvement set out in our Strategic Commissioning Plan 2019-22 we will have to address potentially preventable admissions to Ninewells

Graph 16: Management Information at Locality Level: Rate of Emergency Bed days in Ninewells Hospital for Angus Adults



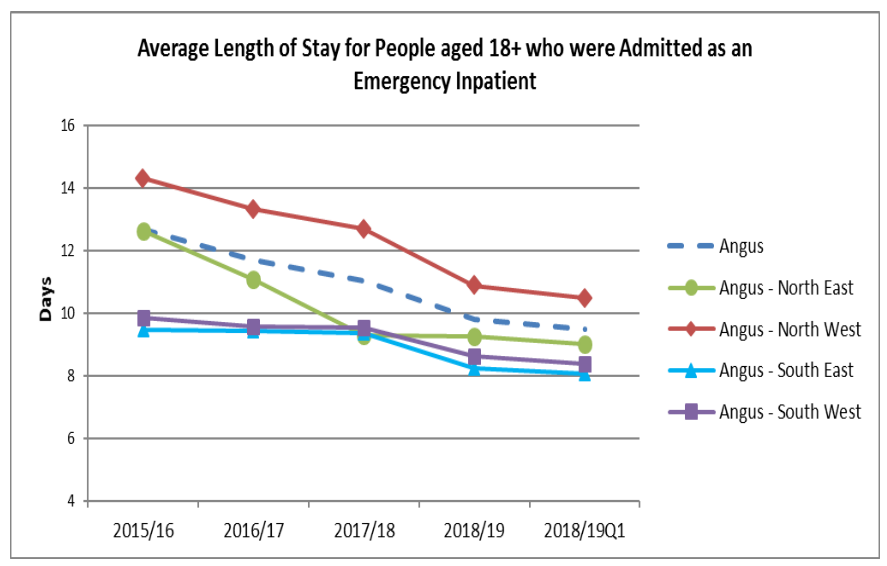
Bed days in Ninewells account for only 49.9% of bed days used by Angus residents (compared to 96% of all admissions).

Data for Q2 is not available but following encouraging decline in bed day use in Ninewells during 2017/18 and 2018/19 we have seen this level off into Q1.

Source: NHS Tayside

4.5 Length of hospital stay following an emergency admission

Graph 17: Management Information at Locality Level: Average Length of Stay for Emergency Admissions for Adults



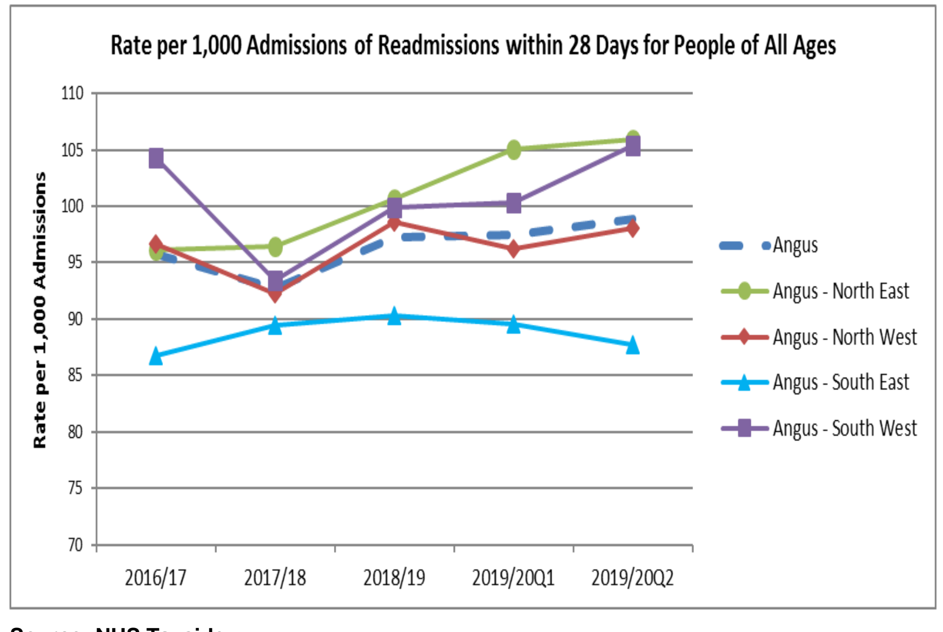
Average length of stay in hospital following an emergency admission continues to fall although the rate of decline has slowed in Q1. Data for Q2 is not available.

Source: NHS Tayside

Following an emergency admission, average length of stay in Ninewells Hospital is now 5.1 days; lower than the Angus average length of stay for all adult admissions in all hospitals which is driven by longer stays in Mental Health Services (General Psychiatry and Psychiatry of Old age).

4.6 Readmissions to hospital

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



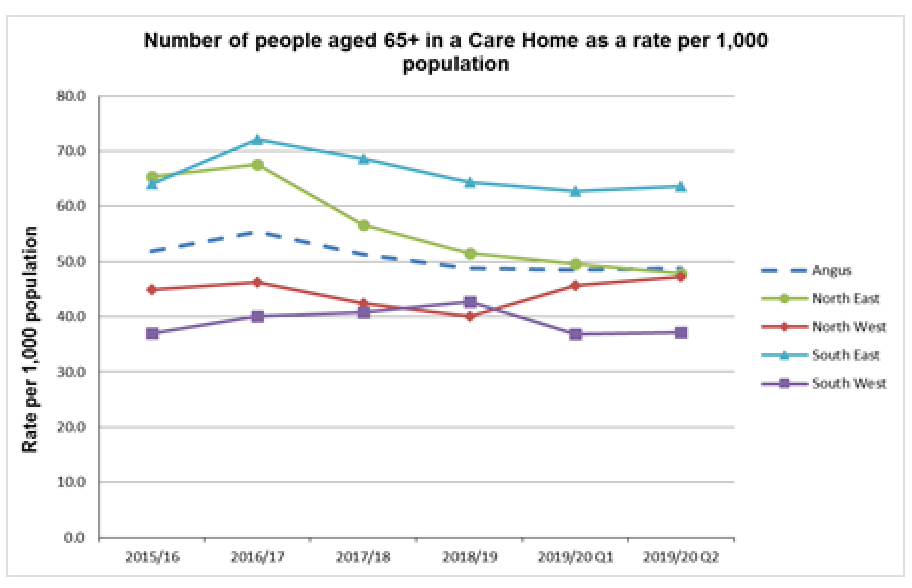
Readmission rates have increased in Angus. As admission rates have decreased this suggests that those individuals with the most complex needs require more regular hospital based support.

Source: NHS Tayside

4.7 Care Home

Care home placements form an important element of the Angus Care Model. They support people with the highest level of need and dependency.

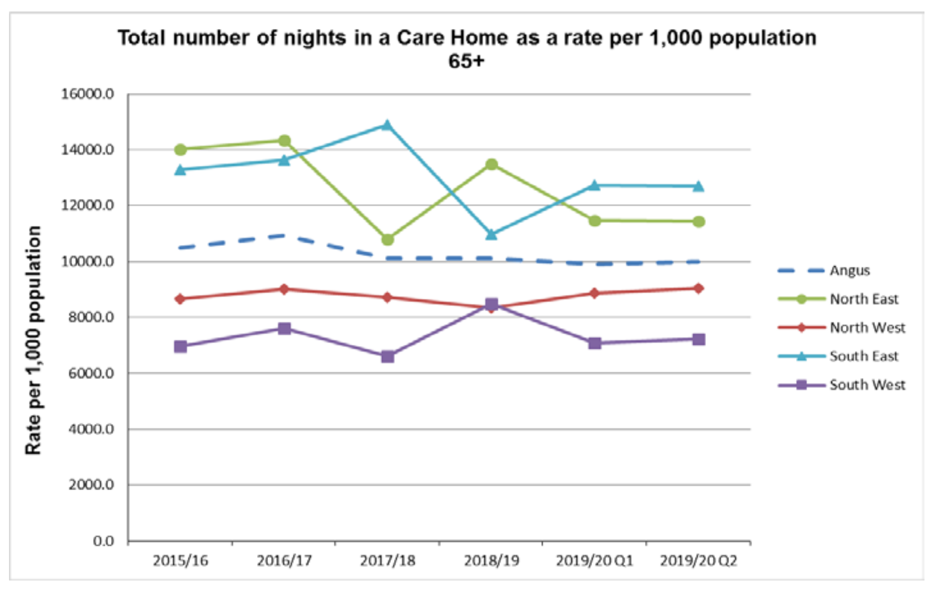
Graph 19 Number of people placed in a care home as a rate of 1,000 poulation



Care home placement levels remian fairly consistent. For older people this is around the 750 placements at any one time as agreed in the Angus Care Model.

Source: Care First Angus Council

Graph 20 Number of care home nights as a rate per 1,000 population



Older people who live in the South East locality are more likely to be placed in a Care Home than an older person from the South West locality and less likley to have a support plan which includes more than 14 hours per week personal care.

Source: Care First Angus Council

An older person from the South East will also have a longer length of stay in a care homes. There is an increase in the number of people placed for very short periods of time towards the end of life.In Angus the typical age for an older person to move into a care home is around 85 years whilst it is 80[1] years for Scotland. The average length of stay for an older person in a care home in Angus is around 17 months; it is 28 months for Scotland.

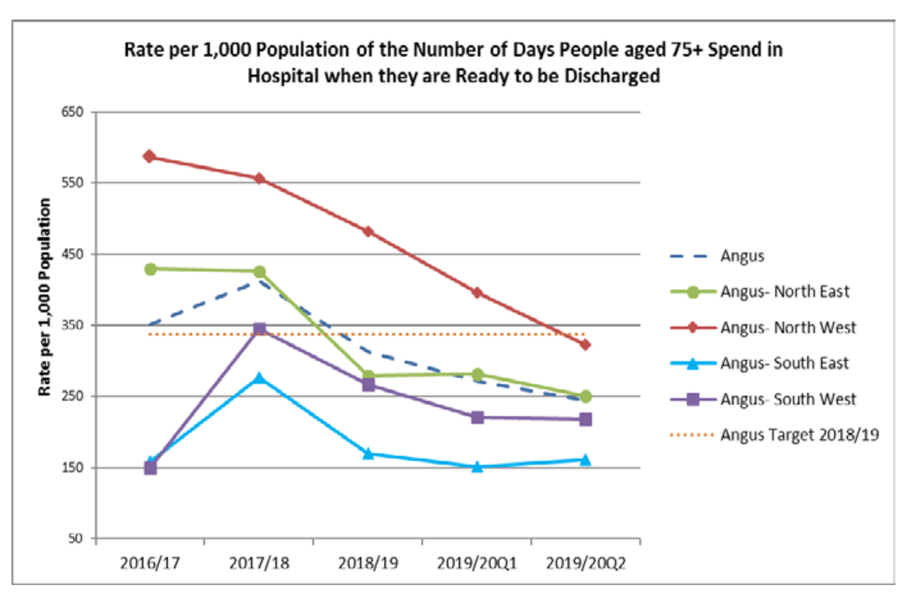
[1] Data from the Care Inspectorate

5. 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 where additional support may be required. Improvement in specific pathways including pathways in and out of acute services.

5.1 Timely Discharge

Graph 21: Management Information at Locality Level: Bed days lost to delays in discharge for people aged 75+ (NI 19)

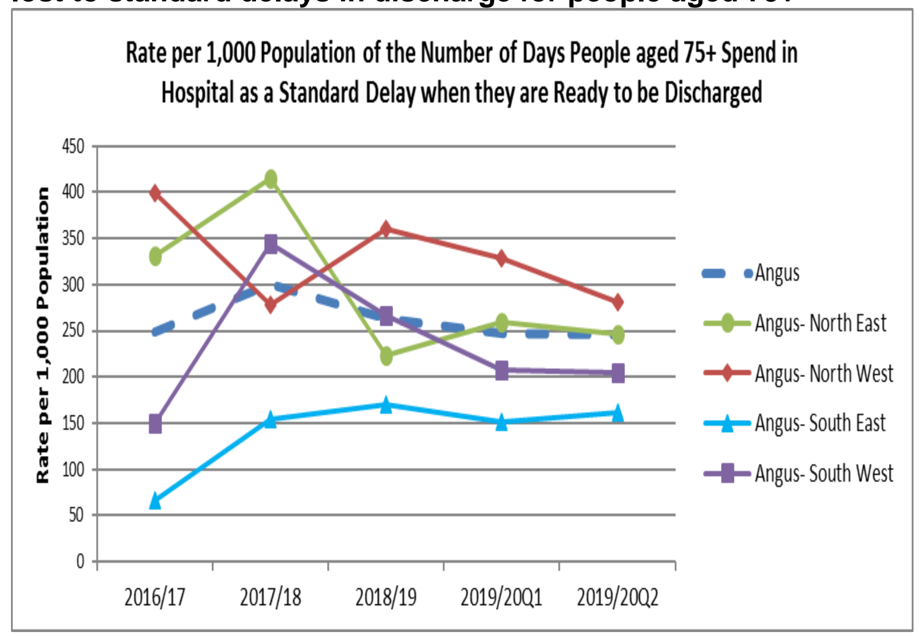


Improvements in timely discharge are driven mostly be improvements in complex delays affecting people 75+.

Delays in timely discharge are low in Angus compared to Scotland as a whole.

Source: NHS Tayside

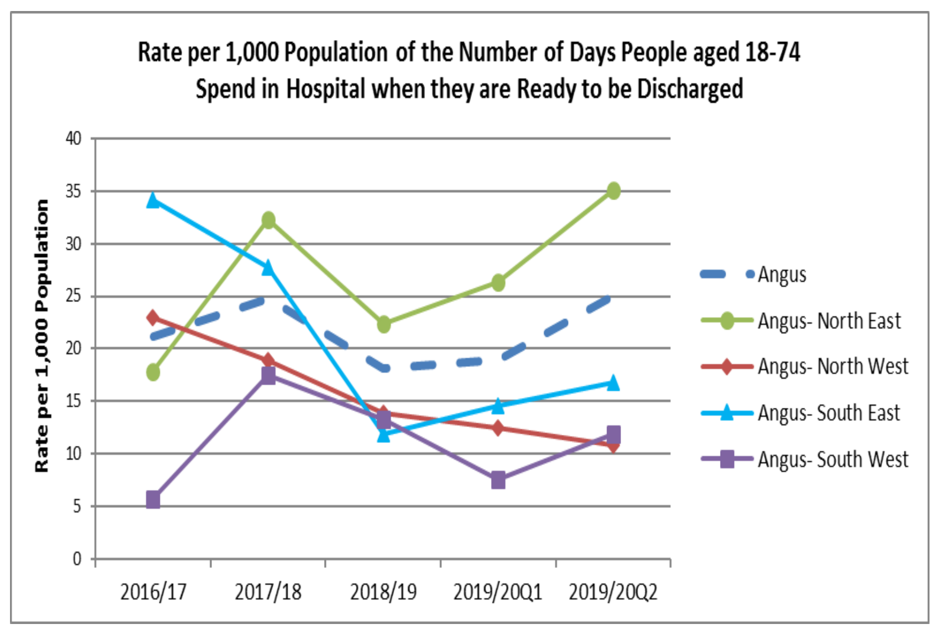
Graph 22: Management Information at Locality Level: Bed days lost to standard delays in discharge for people aged 75+



The number of bed days lost to standard delays in timely discharge affecting people 75+ has declined. The variation between localities is generally related to the availability of personal care services in these localities.

Source: NHS Tayside

Graph 23: Management Information at Locality Level: Bed days lost to delays in discharge for people aged 18-74



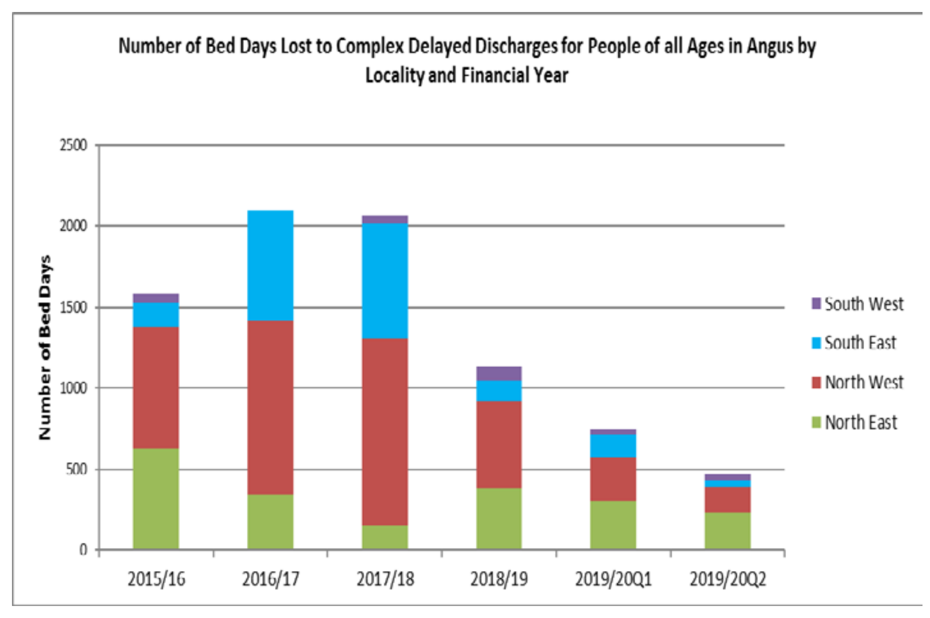
There has been an increase in bed days lost to delays in timely discharge in Q2 for people under 75. This bed day rate is 10% of the rate for people 75+.

More than half of the days lost for people aged under 75 are attributable to complex delays. It is likely that this decline in performance is related to a very small number of people aged under 75 experiencing a longer complex delay.

Source: NHS Tayside

5.2 Complex delays

Graph 24: Management Information at Locality Level: Bed days lost to complex delays in discharge



Complex delays continue to fall. This is largely driven by improvements in timescales associated with guardianship applications

Improvement relates to reductions in complex delays affecting people aged over 75.

Source: NHS Tayside

In 2018/19 15.8% of all bed days lost to delays in discharge affecting people aged over 75 were complex delays. In Q2 2019/20 only 9% of days lost to delays in discharge affecting people aged over 75 years are due to complex delays.

5.3 Mental Health

The AHSCP Strategic Commissioning Plan 2019-22 established an ambition to support people affected by mental ill health more effectively in our communities.

Table 4 Performance in Mental Health Services (all specialities)

	2018/19	2019/20 Q1	2019/20 Q2
Bed Days (number)	27163	27085	27002
Admissions (number)	436	438	410
Average Length of Stay (ALOS) (days)	62.3	61.8	65.9

Source: NHS Tayside Qlikview

Mental Health Bed days account for 29% of all bed days used in an emergency but only 4% of all admissions.

Table 5 Mental Health Bed Day Rates per 1,000 for Angus Residents split by Localities:

	2018/19	2018/19 Q1	2018/19 Q2
Angus	288	287	286
North East	312	304	295
North West	381	369	366
South East	215	234	244
South West	212	210	210

Source: NHS Tayside Qlikview

There is variation between localities with the North West using more bed days in mental health services than other localities.

Mental health specialities include Forensic psychiatry, general psychiatry, learning disability and psychiatry of old age. Each of these services is performing differently and have separate improvement plans in place.

Table 6 Mental Health Bed Day Rates per 1,000 for Angus Residents split by Specialties:

	2018/19	2018/19 Q1	2018/19 Q2
Forensic Psychiatry	20	19	19
General Psychiatry	89	94	97
Learning Disability	56	52	49
Psychiatry of Old Age	124	122	121

Source: NHS Tayside Qlikview

Appendix 1

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. 3. Positive Experiences and Outcomes. People who use health and social care services have positive experiences of those services and have their dignity respected. 4. Quality of Life. Health and social care services are centred on helping to maintain or improve the quality of life of service users. Everyone should receive the same quality of service no matter where they live.	NI-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**		NI-6 Percentage of people with positive experience of care at their G.P. practice. NI-12 Rate of emergency admissions for adults. NI-13 Rate of emergency bed days for adults. NI-14 Readmissions to hospital within 28 days of discharge. NI-21 Percentage of people admitted from home to hospital during the year, who are discharged to a care home (data not available) NI-22 Percentage of people who are discharged from hospital within 72 hours of being ready. (data not available)
Priority 4 **Improving Integrated care pathways for priorities in care**		NI-19 Number of days people spend in hospital when they are ready to be discharged.

Appendix 2

Data explanatory note:

Social care information has been extracted from Care First. ISD published data is not sufficiently up to date to provide in this mid-year report. Local NHS Tayside data for all health measures has been applied. This excludes data from admissions to hospitals outside Tayside.

2019/20 quarter definitions

Each quarter reflects the full year performance to the end of that quarter.
Quarter 1 – 1st July 2018 to 30th June 2019
Quarter 2 – 1st October 2018 to 30th September 2019

NHS Tayside have been unable to provide all the data required up to the end of Quarter 2 therefore some health data in this report relates to performance to the end of Quarter 1 only.

National and Core Local Indicators 2018/19

Table 1 shows the summary of Angus 2018/19 performance compared 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. More detail on performance in relation to these indicators is provided throughout this report. The national indicators are reported in relation to the four strategic priorities in the manner described in Appendix 1 which shows the association between the National Outcomes, National Indicators and the four AHSCP Strategic Priorities.
Qualitative Indicators (NI 1-10)
Qualitative Indicators which form part of the National Core Data Set for Health and Social Care are derived from a national survey undertaken every 2 years.
These were reported in the Annual Strategic Progress and Performance Report 2018/19 and will not be reported on again until the annual report in 2019/20.
Quantitative Indicators (NI 11-23)
All quantitative indicators are reported on an annual basis using national published data. The mid-year report and summary includes only the 5 national indicators that are subject to most direct action in our Strategic Commissioning Plan. The mid-year report uses local data. There may, therefore, be a variance between national published data and local data. Trends are the same.
Two local indicators in relation to personal care and care home nights, are also described in the summary. A range of additional indicators are reported in the narrative of the report.