ANGUS
Health & Social Care
Partnership

ANGUS HEALTH AND SOCIAL CARE PARTNERSHIP

INTERIM ANNUAL PERFORMANCE REPORT

Report 2019-20

June 2020

Contents

1 Introduction

This is a condensed annual performance report which demonstrates the progress made in 2019/20 towards delivery of the Angus Health and Social Care Partnership's Strategic Commissioning Plan for 2019-22, against a reduced set of measures. The Scottish Government, through legislation and engagement with Partnerships, agreed that publication of Annual Performance Reports from IJB's can be delayed until October 2020. The aim of this was to allow staff to concentrate on the delivery of the response to the COVID-19 pandemic.

A full report will therefore be presented in October 2020 and a list of additional measures to be included in the full report is detailed in Appendix 1.

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

2 Summary Performance Dashboard

Improving Health and Wellbeing

- **5 out of the 7 measures are on track**
- **2 out of the measures are greater than 5% variance against target/trajectory**

Number of people aged over 65 admitted to hospital following a fall as a rate per 1,000 population *(National Indicator)*

18/19		19/20	Target
680	↑	**647**	**n/a**

Number of people that were prescribed items for hypertension in Angus as a crude rate per 1,000

18/19		19/20Q3	*Target 2022*	
142	↑	141	140.5	

Number of people prescribed items for diabetes in Angus as crude rate per 1,000

18/19		19/20 Q3	*Target 2022*	
49	↔	49	***49***	

Number of people prescribed items for anxiety and depression in Angus as a crude rate per 1,000

18/19		19/20Q3	*Target 2022*	
336	↔	336	***336***	

Number of people in Angus using Telecare items as a rate per 1,000 population

18/19		19/20	*Target 2020*	
7.0	↓	5.0	***9.0***	

Number of people using short breaks as a rate of 1,000 population

18/19		19/20	*Target*
3.9	↑	4.2	***n/a***

Number of respite nights for people aged over 65 as a rate of 1,000 population

18/19		19/20	*Target*
6241	↓	5963	***n/a***

Supporting Care needs at home

- **2 out of the 5 measures are on track**
- **3 out of the 5 measures are greater than 5% variance against target/trajectory**

Percentage of people using alcohol and drug services treated within 3 weeks of referral*)*

18-19		*19-20*	*Target*	
95%	↑	*98%*	***=90%***	

Number of people receiving personal care as a rate per 1,000 population

18/19		19/20	*Target 2022*	
17.1	↓	18.2	***15.4***	

Number of personal care hours as a rate per 1,000 adult population

18/19		19/20	*Target*
47151	↓	5382	***n/a***

Average age that someone over 65 is likely to require personal care

18-19		19-20	*Target 2022*	
79.22	↑	82.49	**≥83.41 years**	

Number of personal care hours for people aged over 65 as a rate of the population aged over 65

18/19		19-20	*Target 2022*	
11, 379	↓	13,480	***11,088***	

Developing Integrated and Enhanced Primary Care and Community Responses

- **5 out of the 6 measures are on track**
- **1 out of the6 measures is greater than 5% variance against target/trajectory**

Emergency admissions for adults as a rate per 1,000 population (National Indicator)				Emergency bed days for adults as a rate per 1,000 population (National Indicator)				Emergency readmissions within 28 days of discharge as a rate of all emergency admissions (National Indicator)				
18/19		19/20	***2022 Target***	18/19		19/20	***2022 Target***	18/19		19/20	***Target***	
109	↑	108	**103**	9926	↑	9500	**9480**	97	↓	107	***100***	
Average length of stay for adults following an emergency admission				***Number of care home nights as a rate per 1,000 population over 65***				**Number of people aged over 65 placed in a care home as a rate per 1,000 population**				
18/19		19/20	***2022 Target***	18/19		19/20	***Target***	18/19		19/20	***Target***	
9.1	↑	8.8	***≤ 7.6***	10108	↑	9663	9630	***48.7***	↑	46.7	***48.7***	

Improving Integrated Care Pathways for Priorities in Care

- **2 out of the 2 measures are on track**
-

Bed days lost to delays in discharge for people aged over 75 as a rate per 1,000 population				Bed days lost to complex delays (all ages) (MSG indicator)				
18/19		19/20	***Target***	18/19		19/20 Q3	***Target***	
312	↑	228	***-5%***	1256	↑	601	***-10%***	

Key: all data derived from local management information not national statistics.			
↑	Improved performance		Meeting Target/Trajectory
↔	Static performance		Within 5 % tolerance Of Target/Trajectory
↓	Decline in performance		Greater than 5% tolerance from Target/Trajectory

3 Improving Health, Wellbeing and Independence

The aim of the Angus Health and Social Care Partnership (AHSCP) Strategic Commissioning Plan 2019-22 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.

Improving Health and Wellbeing

- **5 out of the 7 measures are on track**
- **2 out of the measures are greater than 5% variance against target/trajectory**

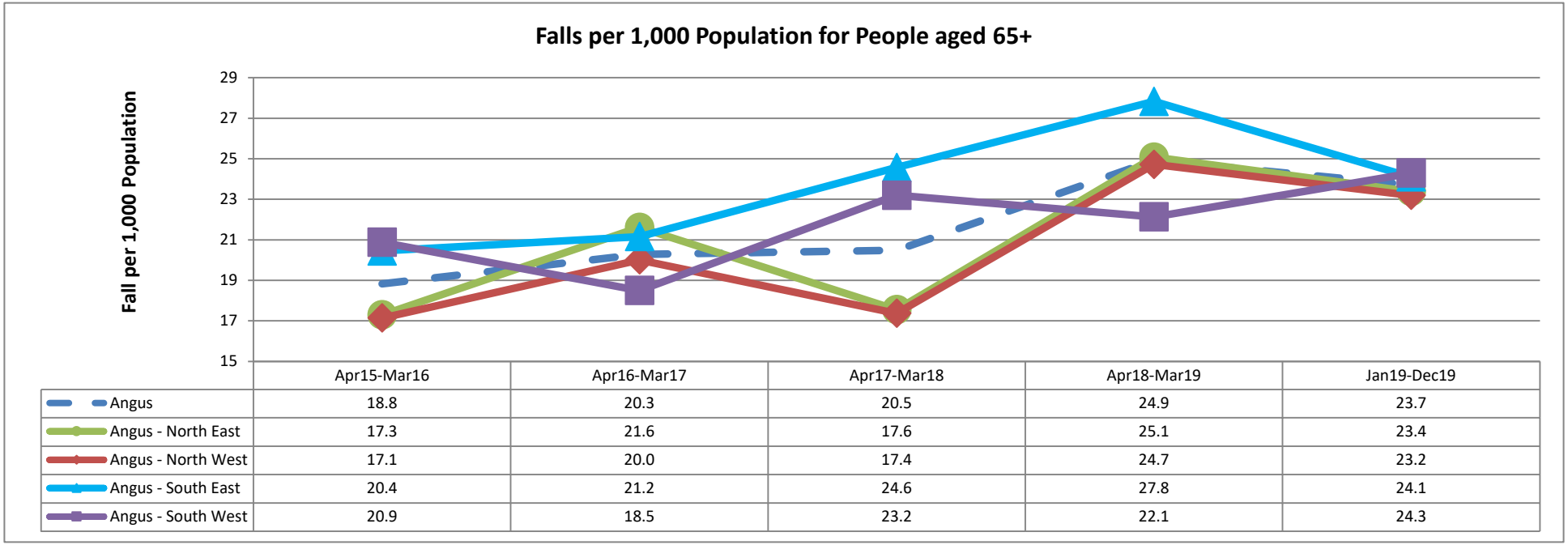
Number of people aged over 65 admitted to hospital following a fall as a rate per 1,000 population*(National Indicator)*		
18/19 **680** ↑ 19/20 **647** **Target n/a**		
Number of people that were prescribed items for hypertension in Angus as a crude rate per 1,000	**Number of people prescribed items for diabetes in Angus as crude rate per 1,000**	**Number of people prescribed items for anxiety and depression in Angus as a crude rate per 1,000**
18/19 142 ↑ 19/20Q3 141 ***Target 2022*** 140.5	18/19 ***49*** ⇔ 19/20 Q3 49 ***Target 2022 49***	18/19 336 ⇔ 19/20Q3 336 ***Target 2022 336***
Number of people in Angus using Telecare items as a rate per 1,000 population	**Number of people using short breaks as a rate of 1,000 population**	**Number of respite nights for people aged over 65 as a rate of 1,000 population**
18/19 7.0 ↓ 19/20 5.0 ***Target 2020 9.0***	18/19 **3.9** ↑ 19/20 4.2 ***Target n/a***	18/19 6241 ↓ 19/20 5963 ***Target n/a***

Falls

There has been a reduction in the number of people aged over 65 admitted to hospital following a fall and a reduction in referrals to the falls pathway. Although the reduction is small, it is assumed this, in part, can be attributed to a mild winter, elderly people remaining indoors during winter period and shielding as a result of the COVID-19 pandemic. Parallel to this there has been:

- an increase in home safety advice by ERT, Fire & Rescue and care providers;
- better balance classes were reintroduced; and
- ERT are using the LifeCurve so providing exercise advice to improve mobility from independent living Angus

The graph below shows the improvement in falls per 1,000 population for people aged 65+.



	Apr15-Mar16	Apr16-Mar17	Apr17-Mar18	Apr18-Mar19	Jan19-Dec19
Angus	18.8	20.3	20.5	24.9	23.7
Angus - North East	17.3	21.6	17.6	25.1	23.4
Angus - North West	17.1	20.0	17.4	24.7	23.2
Angus - South East	20.4	21.2	24.6	27.8	24.1
Angus - South West	20.9	18.5	23.2	22.1	24.3

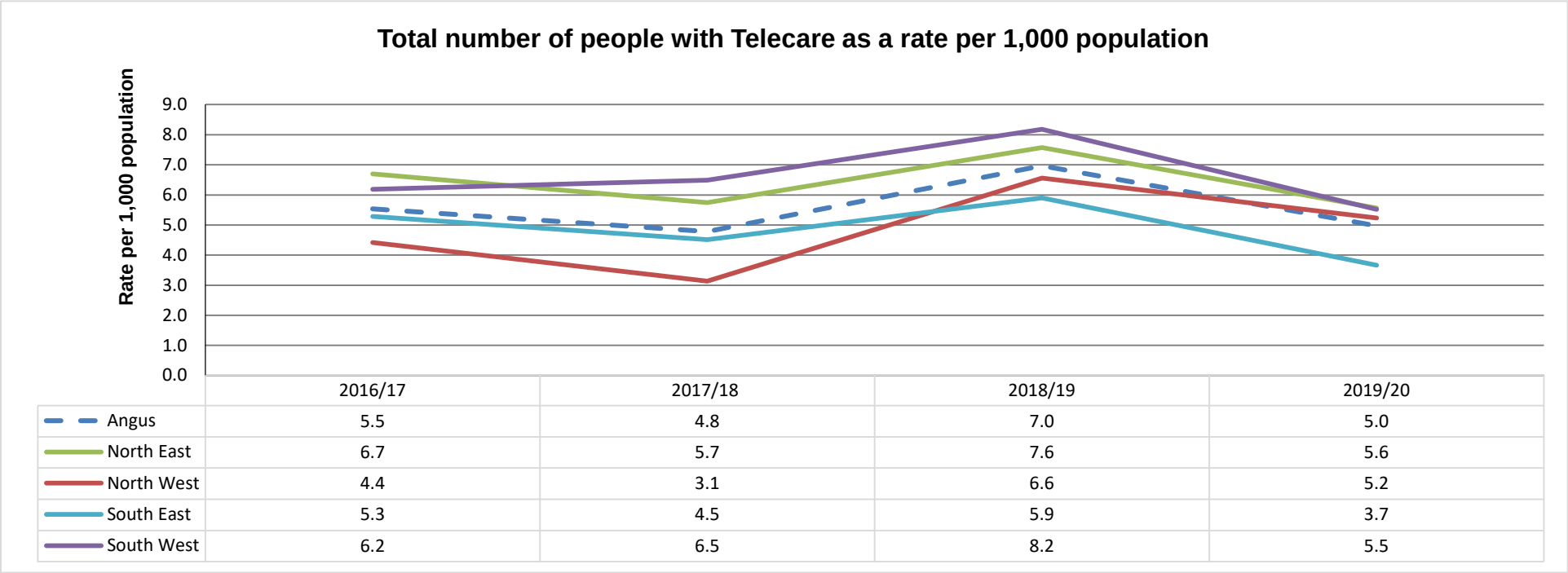
Community Health and Wellbeing

Performance against the measures of number of people prescribed medication for hypertension, diabetes and anxiety & depression, have been maintained or reduced in line with target performance set out in the Strategic Commissioning Plan 2019-22. These measures are proxy measures aimed at identifying improvements in the health and wellbeing of the community. Improvement in these measures is driven by the introduction of social prescribing, the delivery of more mental health and wellbeing practitioner services in GP practice and the focus on weight loss as a means of addressing diabetes.

Telecare

There has been an increase of 2% in people aged over 65 using community alarm. Use of Telecare equipment offered in addition to community alarm has declined from 19% to 13% of community alarm users. Whilst it is recognised that people are moving to digital alternatives that they can source themselves eg mobile phones and digital devices like Alexa, the decline in telecare use appears to follow the introduction of a charge of £1/week in June 2019 for telecare equipment in addition to the charge for community alarm.

The graph below demonstrates the use of telecare since 2016/17.

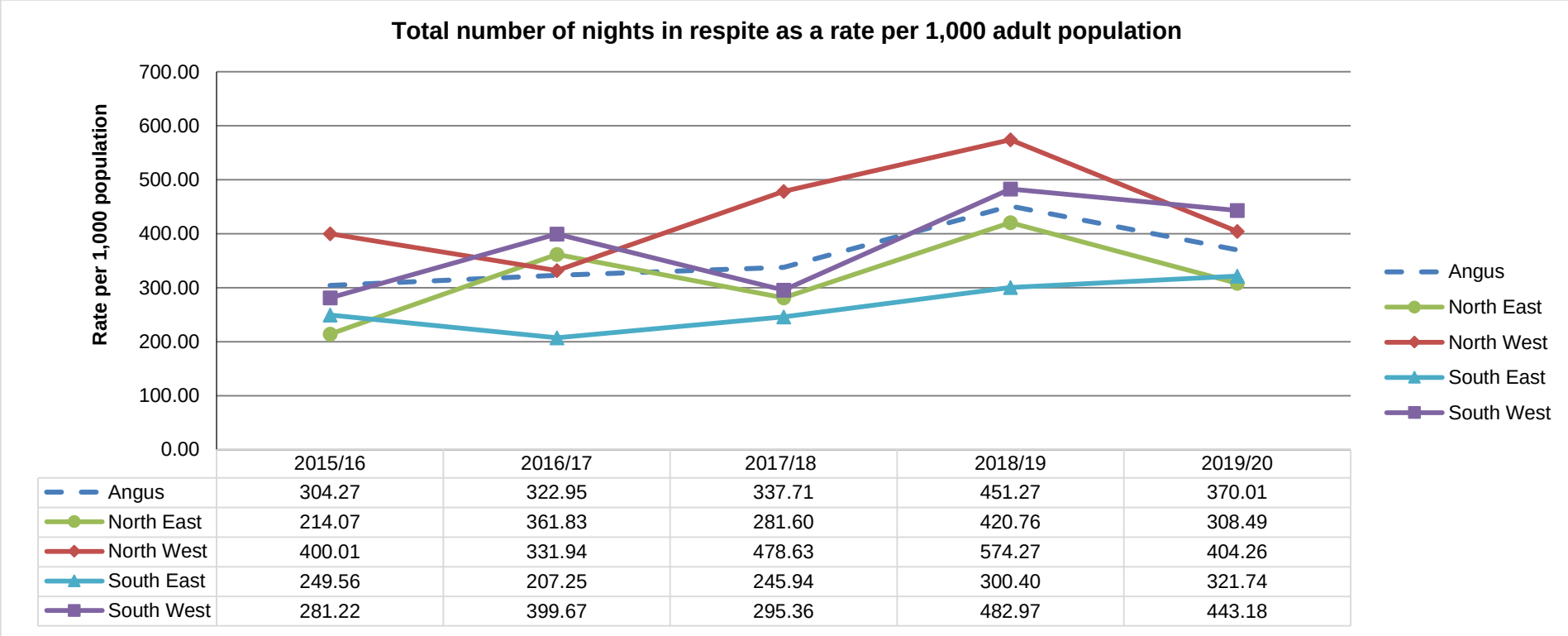


	2016/17	2017/18	2018/19	2019/20
Angus	5.5	4.8	7.0	5.0
North East	6.7	5.7	7.6	5.6
North West	4.4	3.1	6.6	5.2
South East	5.3	4.5	5.9	3.7
South West	6.2	6.5	8.2	5.5

Respite

Demand for respite is variable, planned respite is offered following the development of a carers support plan to proactively ensure that carers are supported in this role. Respite can also be offered in an emergency where the carers circumstances have changed rapidly. The volume of emergency respite offered is one reason why respite varies from year to year. In 2019/20 the use of both planned and emergency respite has reduced, this can in part be attributed to an increase in personal care and the further role out of Enhanced Community Support (ECS). Cancellation of all respite from 16 March 2020 was part of the response to the COVID-19 pandemic and will also have impacted upon the data. Some emergency respite was reintroduced at Seaton Grove by the end of March 2020.

The graph below shows the use of respite nihts since 2015/16.



	2015/16	2016/17	2017/18	2018/19	2019/20
Angus	304.27	322.95	337.71	451.27	370.01
North East	214.07	361.83	281.60	420.76	308.49
North West	400.01	331.94	478.63	574.27	404.26
South East	249.56	207.25	245.94	300.40	321.74
South West	281.22	399.67	295.36	482.97	443.18

4 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.

Supporting Care needs at home

- **2 out of the 5 measures are on track**
- **3 out of the 5 measures are greater than 5% variance against target/trajectory**

Percentage of people using alcohol and drug services treated within 3 weeks of referral)					Number of people receiving personal care as a rate per 1,000 population					Number of personal care hours as a rate per 1,000 adult population				
18-19		*19-20*	***Target***		18/19		19/20	***Target 2022***		18/19		19/20	***Target***	
95%	↑	*98%*	***=90%***		17.1	↓	18.2	***15.4***		47151	↓	5382	***n/a***	
Average age that someone over 65 is likely to require personal care					**Number of personal care hours for people aged over 65 as a rate of the population aged over 65**									
18-19		19-20	***Target 2022***		18/19		19-20	***Target 2022***						
79.22	↑	82.49	**≥83.41 years**		11, 379	↓	13,480	***11,088***						

Alcohol and Drug Services

There has been an improvement in performance against the measure for individuals accessing Alcohol and Drug services and treated within three weeks. This follows significant work to integrate the NHS and Local Authority Drug and Alcohol teams in AIDARS (Angus Integrated Drug and Alcohol Recovery Service). This has resulted in improvements in both resource use and in the pathway for service users.

Personal Care

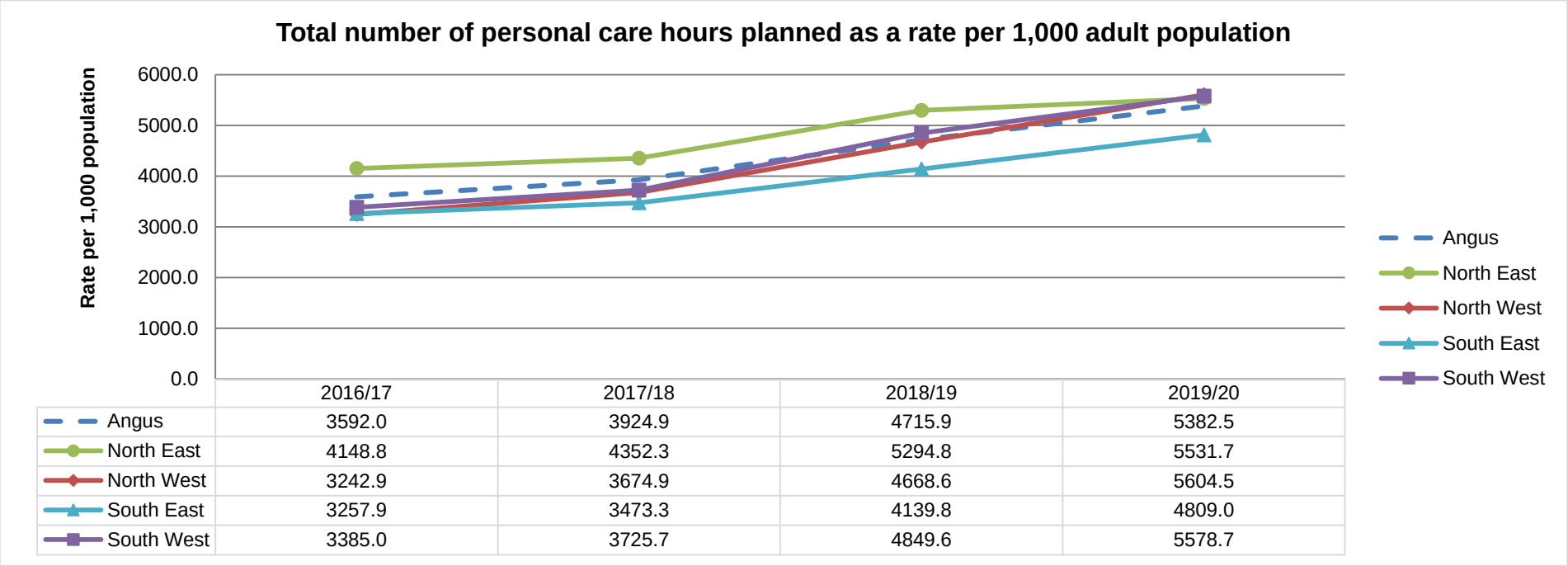
Whilst there is no target for personal care hours for all adults; there is a specific target for personal care for people aged over 65. This was agreed in IJB Report no 77/19 which focused on the impact of demographic change of services for older people and subsequently identified a number of approaches to mitigate against that change. Independent providers of personal are have worked hard to address demand and it is possible that greater availability continues to address a previously hidden demand. It is also possible the provision of greater levels of regular personal care is impacting on demand for emergency respite where we have seen a decrease in provision. The increase in all personal care is largely driven by increased demand by people aged over 65. The actions previously agreed to mitigate against further increases in demand from people aged over 65 have to be further developed in order to

address the increase. The other measures demonstrate a decline in performance and upward trend from previous year where there has been an increase in the number of people receiving personal care.

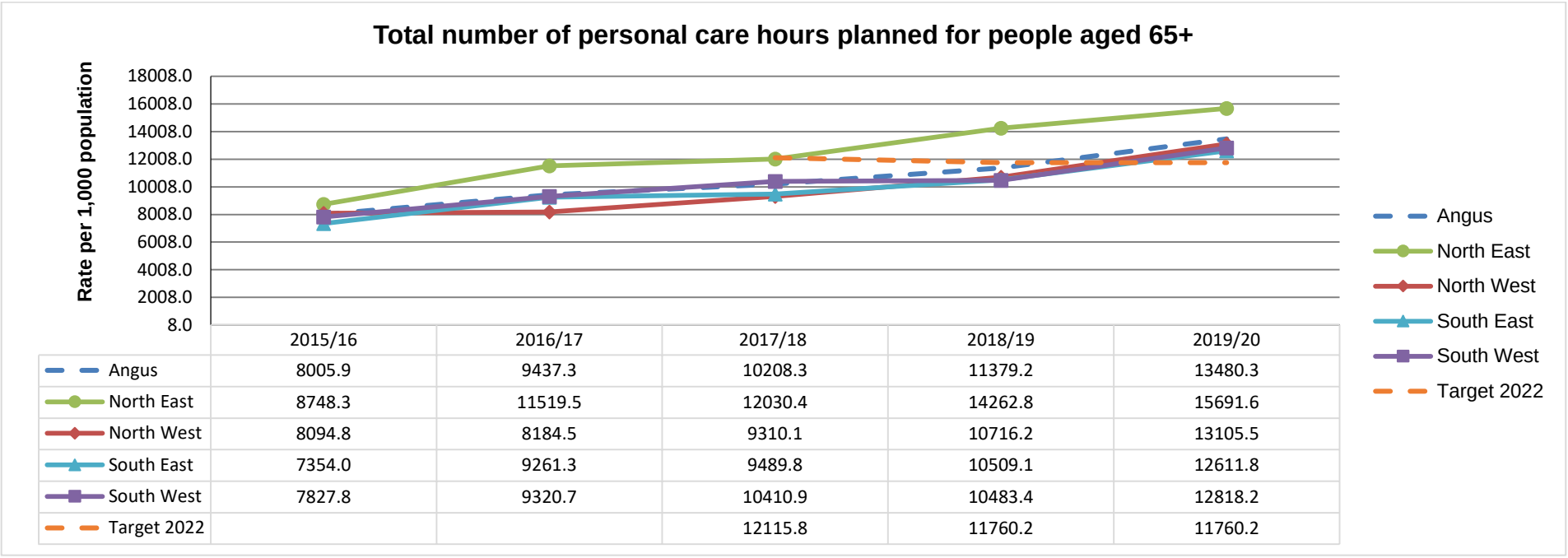
The proportion of personal care delivered to people aged over 65 has grown from 69% to 72% of all personal care hours, with an increase of 4% in personal care hours for people under 65. This was anticipated following the extension of free personal care to people under 65 in April 2019. During the same period however, there has been an increase of 18% in personal care hours for people over 65 which cannot be fully explained by demographic growth alone.

It is possible that reductions in use of telecare has impacted on increases in use of personal care for people aged over 65 as well as reductions in care home placements. Care home placements for people aged over 65 have reduced by 4% and the overall use of care home nights has also reduce by 4.5%. This could account for as much as 50% of the growth in personal care hours in 2019/20 for people aged over 65.

The graphs below show the changes in personal care hours planned from 2016/17.



	2016/17	2017/18	2018/19	2019/20
Angus	3592.0	3924.9	4715.9	5382.5
North East	4148.8	4352.3	5294.8	5531.7
North West	3242.9	3674.9	4668.6	5604.5
South East	3257.9	3473.3	4139.8	4809.0
South West	3385.0	3725.7	4849.6	5578.7



	2015/16	2016/17	2017/18	2018/19	2019/20
Angus	8005.9	9437.3	10208.3	11379.2	13480.3
North East	8748.3	11519.5	12030.4	14262.8	15691.6
North West	8094.8	8184.5	9310.1	10716.2	13105.5
South East	7354.0	9261.3	9489.8	10509.1	12611.8
South West	7827.8	9320.7	10410.9	10483.4	12818.2
Target 2022			12115.8	11760.2	11760.2

5 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.

Developing Integrated and Enhanced Primary Care and Community Responses

- **5 out of 6 measures are on track**
- **1 out of 6 measures is greater than 5% variance against target/trajectory**

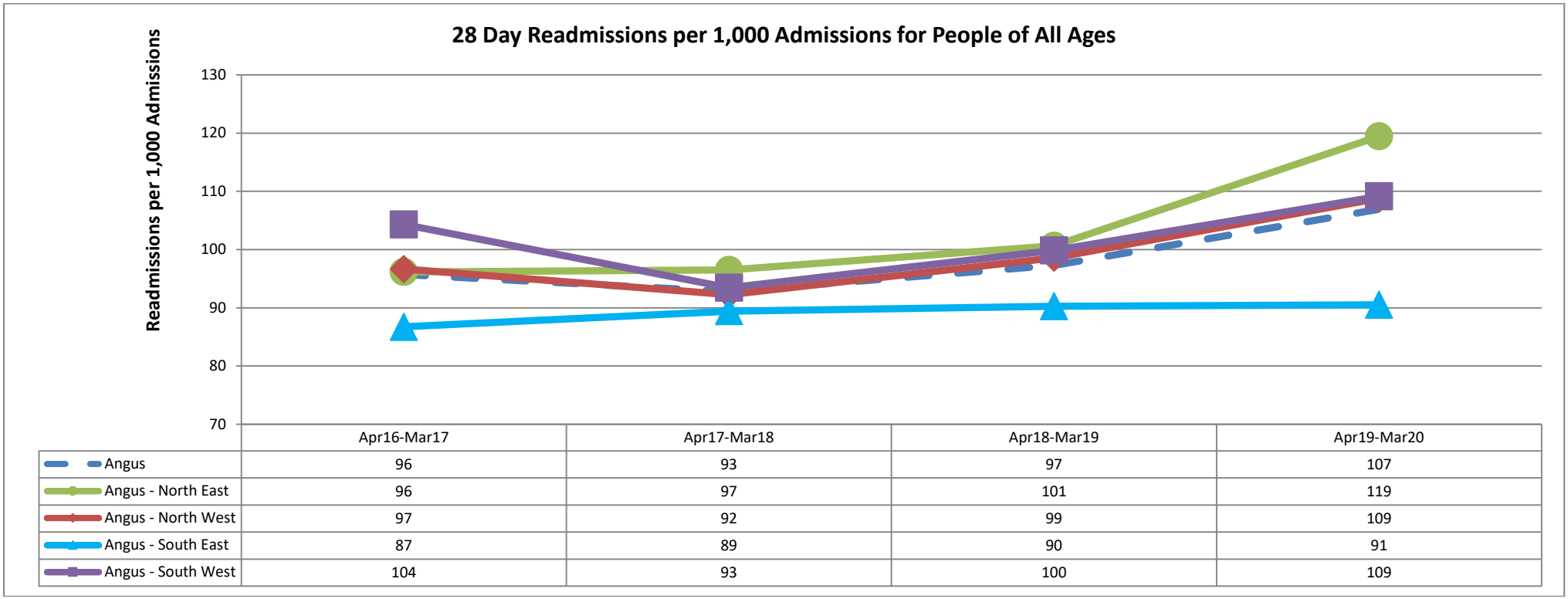
Emergency admissions for adults as a rate per 1,000 population (National Indicator)					**Emergency bed days for adults as a rate per 1,000 population (National Indicator)**					**Emergency readmissions within 28 days of discharge as a rate of all emergency admissions (National Indicator)**				
18/19		19/20	***2022 Target***		18/19		19/20	***2022 Target***		18/19		19/20	***Target***	
109	↑	108	**103**		9926	↑	9500	**9480**		97	↓	107	***100***	
Average length of stay for adults following an emergency admission					***Number of care home nights as a rate per 1,000 population over 65***					**Number of people aged over 65 placed in a care home as a rate per 1,000 population**				
18/19		19/20	***2022 Target***		18/19		19/20	***Target***		18/19		19/20	***Target***	
9.1	↑	8.8	***≤ 7.6***		10108	↑	9663	9630		***48.7***	↑	46.7	***48.7***	

AHSCP now has Enhanced Community Support (ECS) model embedded throughout all four localities which is reflected in the performance of the above outcome measures. Work has been progressing to improve unscheduled care pathways and emergency admissions from Angus. AHSCP continues to contribute to an integrated whole system approach. The benefits of this work can be seen in the data for the measures where there is an improved performance compared to 18/19 and on target to achieve the target or trajectory by 2022 with the exception of emergency readmissions.

There has been a decline in performance in relation to emergency readmissions within 28 days of discharge (as a rate of all emergency admissions). This measure is a national indicator but its definition is for both planned and unplanned admissions to hospital, whilst unplanned admissions have reduced, at this time we have no specific data about the level of planned admissions. Many planned admissions were cancelled in March as part of the NHS response to managing the COVID-19 pandemic. Small numbers of patients admitted frequently also have an impact on this indicator.

The number of unplanned admissions has decreased by 1%. The rate of readmissions continues to increase across all localities and there is variation in the rate between localities. Readmissions as a proportion of unplanned adnmissions has grown from 15% to 17%. Factors which may be contributing to the increased rate of readmissions include increasing frailty in the community, due to an ageing population, management in the community rather than care homes and an increase in age in Angus of entry to care homes, alongwith the availability of emergency respite or other forms of care in the community at short notice.

The graph below demonstrates the 28 day readmissions per 1000 admissions from 2016/17



	Apr16-Mar17	Apr17-Mar18	Apr18-Mar19	Apr19-Mar20
Angus	96	93	97	107
Angus - North East	96	97	101	119
Angus - North West	97	92	99	109
Angus - South East	87	89	90	91
Angus - South West	104	93	100	109

6 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.

Improving Integrated Care Pathways for Priorities in Care

- **2 out of 2 measures are on track**

Bed days lost to delays in discharge for people aged over 75 as a rate per 1,000 population					Bed days lost to complex delays (all ages) (MSG indicator)				
18/19		19/20	*2022 Target*		18/19		19/20 Q3	*2022 Target*	
312	↑	228	**-5%**		1256	↑	601	**-10%**	

ECS model of care has also improved performance across the above measures. Proactive care around the individual allows the anticipation of needs and the prevention of hospital admission. Where hospital admission is required, the discharge process is improved by the appropriate support mechanisms being available in the community through the ECS teams. Monifieth Integrated Care has seen the amalgamation of the Care Management and District Nursing teams. This has been positively evaluated with plans to roll out in order to support other Angus localities.

Notable improvement in relation to reductions in complex delays has been delivered through improvements in Mental Health Officer services ensuring a more speedy response and streamlined approach to guardianship applications.

7 Conclusion

The data described in this report demonstrates that the AHSCP is making progress against the ambitions set out in its Strategic Commissioning Plan 2019-22. There are, however, areas that require further work to be progressed to improve performance and work towards achieving the target or trajectory, in particular personal care provision. Improvement plans have been developed to address the areas of declining performance.

8 Improvement Plan

The table below shows a summary of the key actions planned to support improvement in the measures where there is a greater than 5% variance against target/trajectory

Improving Health and Wellbeing - George Bowie/Jillian Richmond			
Key Actions For Improvement	**Planned Benefits**	**Due By**	**Status**
Programme to promote the uptake of telecare including demonstrations for Care managers, District nurses and GP's as well as promotion in public places. This includes the development of videos that can be shared through social media	Grow the understanding of Care Managers, GP's and supported people in the value of telecare and the range of equipment available.	September 2022	In progress temporarily suspended due to Covid 19 restrictions
Review the need for a charge for the use of telecare equipment	We need to fully understand if the introduction of the charge for telecare equipment is reducing use. This was considered as part of the IJB report no 77/19	October 2020	Start date TBA
Supporting Care Needs at Home - George Bowie/Susan MacLean/Linda Kennedy/Jillian Richmond			
Key Actions For Improvement	**Planned Benefits**	**Due By**	**Status**
Re-establish emergency respite at Kinloch Care Centre	To ensure that carers can be supported in their caring role	June 2020	In progress
Re-establish planned respite	To ensure that carers can be supported in their caring role	TBA	In progress
Developing Integrated and Enhanced Primary Care and Community Care Responses - George Bowie/Susan MacLean/Linda Kennedy			

Key Actions For Improvement	Planned Benefits	Due By	Status
A range of actions aimed at mitigating against growth in personal are for people aged over 65 were set out in IJB report 77/19. These actions need to be delivered. These actions include the following:	To promote independence of people in our communities and reduce demand for personal care services	April 2021	In progress
Evaluate the effectiveness of ERT on reducing demand for personal care	Provide assurance that services are delivering on expectations	April 2021	Start date TBA
Grow the content in Independent living Angus website	Promote improvement in LifeCurve for older people. Self-assessment for simple equipment that can reduce demand for personal care. Generally defer people from referral for personal care.	April 2021	In progress
Review the application of eligibility criteria by care management	Ensure equity in access to services	April 2021	Start date TBA
Introduce new moving and handling equipment with staff training	Reduce the need for two members of staff to support personal are for people who require the use of hoists.	April 2021	Start date TBA
Review all care packages that exceed the value of residential care with an aim to introduce a maximum number of personal are visits each day	Manage demand for personal care	April 2021	Start date TBA
Support the delivery of strong third sector responses to support and sustain people to be as independent as possible	Growth of third sector support in communities reducing referrals for personal care.	April 2022	In progress
Improving Integrated Care Pathways for Priorities of Care – Jillian Galloway/Alison Clement			
Key Actions For Improvement	**Planned Benefits**	**Due By**	**Status**
Develop the Angus Care Model to focus on early intervention within primary care to maintain health during ageing and delay the onset of frailty.	Better support for people in the community who need temporary additional support but do not warrant a hospital admission	April 2021	Start date TBA
Undertake an analysis of the reasons for readmission and consider whether any were potentially preventable and what clinical pathways, services or supports need to be in place in communities to prevent the admission.	A better understanding of the reasons for readmission and the opportunities to prevent those that are potentially preventable.	April 2021	Start date TBA
Identify our expected trajectory for readmissions based on our targets for unplanned admissions.	To gain a better understanding of NHS Tayside plans in relation to planned admissions and the impact that will have on this national indicator.	April 2022	Start date TBA

9 Other Measures for the Annual Report

The following measures are not included but are under development either nationally (NI) or locally to meet annual reporting requirements:

- Percentage of adults able to look after their health very well or quite well.(NI)
- Percentage of carers who feel supported to continue in their caring role. (NI)
- Premature mortality rate(NI)
- Percentage of adults supported at home who agree that they are supported to live as independently as possible. (NI)
- Number of volunteers and community groups
- Number of Carers known to Angus Carers
- Number of people completing suicide as a arte of the population
- Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided. (NI)
- 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)
- Percentage of adults supported at home who agree they felt safe.
- Percentage of adults with intensive needs receiving care at home. (NI)
- Proportion of last 6 months of life spent at home or in community setting. (NI)
- Percentage of people admitted to hospital from home during the year, who are discharged to a care home
- Percentage of people who access SDS - Option 1
- Percentage of people who access SDS - Option 2
- Percentage of people who access SDS - Option 3
- Percentage of people who access SDS - Option 4
- Care Inspection Reports – an analysis of service user experience responses
- Percentage people who spent the last 6 months of life at home or in the community(NI)
- Number of days people spend in hospital when they are ready to be discharged. (NI)
- Percentage of total health and care spend on hospital stays where the patient was admitted in an emergency. (NI)
- Rate of potentially preventable admissions to hospital
- Percentage of staff who say they would recommend their workplace as a good place to work. (NI)
- Percentage of adults supported at home who agree that their health and care services seemed to be well co-ordinated. (NI)
- Percentage of adults receiving any care or support who rate it as excellent or good. (NI)
- Percentage of people with positive experience of care at their G.P. practice. (NI)
- Proportion of care services graded ‘good’ (4) or better in Care Inspectorate Inspections. (NI)