APPENDIX

ANNUAL PEFORMANCE DASHBOARD

2022-23

Produced June 2023 (Version 4)

Contents

Contents 2
1. Introduction 3
2. Summary Performance Dashboard 4
3. Improving Health, Wellbeing, and Independence 6
4. Supporting Care Needs at Home 10
5. Developing Integrated and Enhanced Primary Care and Community Responses 13
6. Improving Integrated Care Pathways for Priorities in Care 15
7. Conclusion 17
8. Other Measures for the Annual Report 18

1. Introduction

This annual performance dashboard demonstrates the progress made in 2022/23 towards delivery of the Angus Health and Social Care Partnership's Strategic Commissioning Plan for 2019-22, against a reduced set of measures. A full annual performance report in line with SSI 2014/326 The Public Bodies (Joint Working) (Content of Performance Reports) (Scotland) Regulations 2014 will be available in July 2023.

This report focuses on key indicators in relation to 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

The final year data for 2022/23 in relation to some indicators are not available yet. Where this is the case full year data to the end of December 2022 has been used. This is shown in the dashboards as 22/23 Q3.

2. Summary Performance Dashboard

Improving Health and Wellbeing

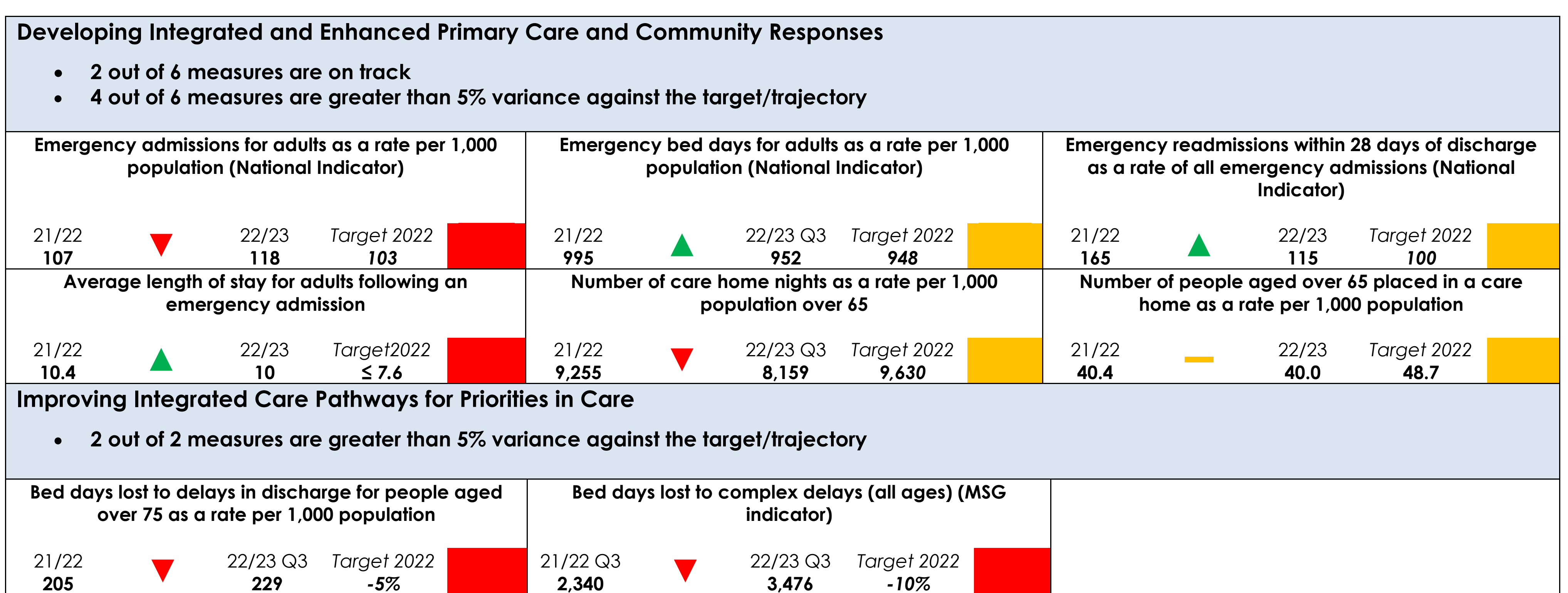
- 3 out of 4 measures are within 5% tolerance of target/trajectory
- 1 out of 4 measures are greater than 5% variance against the target/trajectory
- 3 measures do not have a target/trajectory set

Measure	21/22	Trend	Latest	Target
Number of people aged over 65 admitted to hospital following a fall as a rate per 1,000 population (National Indicator)	22.7	▼	22/23 Q3: 25.1	*Target* *n/a*
Number of people that were prescribed items for hypertension in Angus as a crude rate per 1,000	140	–	22/23 Q3: 141	*Target 2022* ***140.5***
Number of people prescribed items for diabetes in Angus as crude rate per 1,000	54	▼	22/23 Q3: 55	*Target 2022* ***49***
Number of people prescribed items for anxiety and depression in Angus as a crude rate per 1,000	220	–	22/23: 221	*Target 2022* ***207***
Number of people in Angus using Telecare items as a rate per 1,000 population	5.0	▲	22/23: 5.6	*Target 2022* ***9.0***
Number of people using short breaks as a rate of 1,000 population	3.9	–	22/23: 4.0	*Target* ***n/a***
Number of respite nights for people aged over 65 as a rate of 1,000 population	417	▼	22/23: 386	*Target* ***n/a***

Supporting Care Needs at Home

- 1 out of 4 measures are on track
- 3 out of 4 measures are within 5% tolerance of target/trajectory
- 1 out of 4 measures are greater than 5% variance against the target/trajectory
- 1 measure does not have a target/trajectory set

Measure	Previous	Trend	Latest	Target
Percentage of people using alcohol and drug services treated within 3 weeks of referral	21/22: 84.3%	▲	22/23: 93.8	*Target* ***90%***
Number of people receiving personal care as a rate per 1,000 population	21/22: 19.6	–	22/23: 20.2	*Target 2022* ***15.4***
Number of personal care hours as a rate per 1,000 adult population	21/22: 6,963 hrs	–	22/23: 6,872 hrs	*Target* ***n/a***
Average age that someone over 65 is likely to require personal care	21/22: 82.26	–	22/23: 82.50	*Target 2022* ***≥ 83.41***
Number of personal care hours for people aged over 65 as a rate of the population aged over 65	21/22: 17,420 hrs	▼	22/23: 16,313 hrs	*Target 2020* ***11,088***
Weekly hours of personal care yet to be provided (Unmet Need)	04 Apr 22: 1,100 hrs	▼	27 Mar 23: 1,573 hrs	Target n/a



Developing Integrated and Enhanced Primary Care and Community Responses

- **2 out of 6 measures are on track**
- **4 out of 6 measures are greater than 5% variance against the target/trajectory**

Measure	21/22	Trend	Current	Target	RAG
Emergency admissions for adults as a rate per 1,000 population (National Indicator)	21/22 **107**	▼	22/23 **118**	*Target 2022* ***103***	Red
Emergency bed days for adults as a rate per 1,000 population (National Indicator)	21/22 **995**	▲	22/23 Q3 **952**	*Target 2022* ***948***	Amber
Emergency readmissions within 28 days of discharge as a rate of all emergency admissions (National Indicator)	21/22 **165**	▲	22/23 **115**	*Target 2022* ***100***	Amber
Average length of stay for adults following an emergency admission	21/22 **10.4**	▲	22/23 **10**	*Target2022* ***≤ 7.6***	Red
Number of care home nights as a rate per 1,000 population over 65	21/22 **9,255**	▼	22/23 Q3 **8,159**	*Target 2022* ***9,630***	Amber
Number of people aged over 65 placed in a care home as a rate per 1,000 population	21/22 **40.4**	▬	22/23 **40.0**	*Target 2022* **48.7**	Amber

Improving Integrated Care Pathways for Priorities in Care

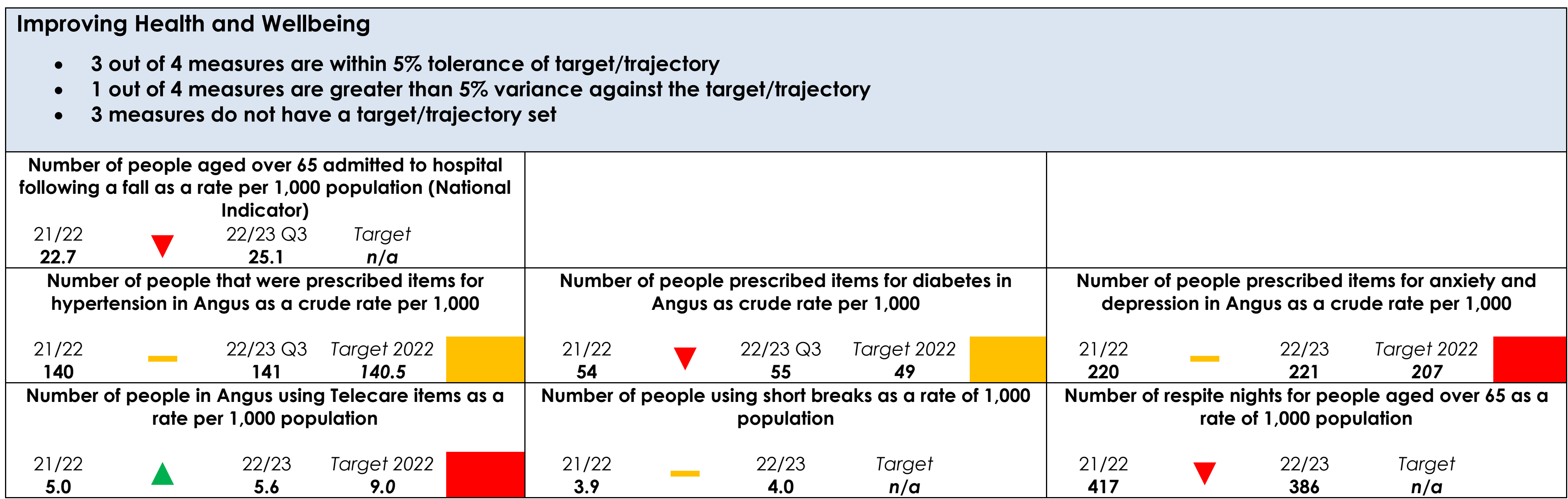
- **2 out of 2 measures are greater than 5% variance against the target/trajectory**

Measure	Baseline	Trend	Current	Target	RAG
Bed days lost to delays in discharge for people aged over 75 as a rate per 1,000 population	21/22 **205**	▼	22/23 Q3 **229**	*Target 2022* ***-5%***	Red
Bed days lost to complex delays (all ages) (MSG indicator)	21/22 Q3 **2,340**	▼	22/23 Q3 **3,476**	*Target 2022* ***-10%***	Red

Key: all data derived from local management information not national statistics.			
▲	Improved performance	Green	Meeting Target/Trajectory
▬	Static performance	Amber	Within 5% tolerance of Target/Trajectory
▼	Decline in performance	Red	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 was 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

- **3 out of 4 measures are within 5% tolerance of target/trajectory**
- **1 out of 4 measures are greater than 5% variance against the target/trajectory**
- **3 measures do not have a target/trajectory set**

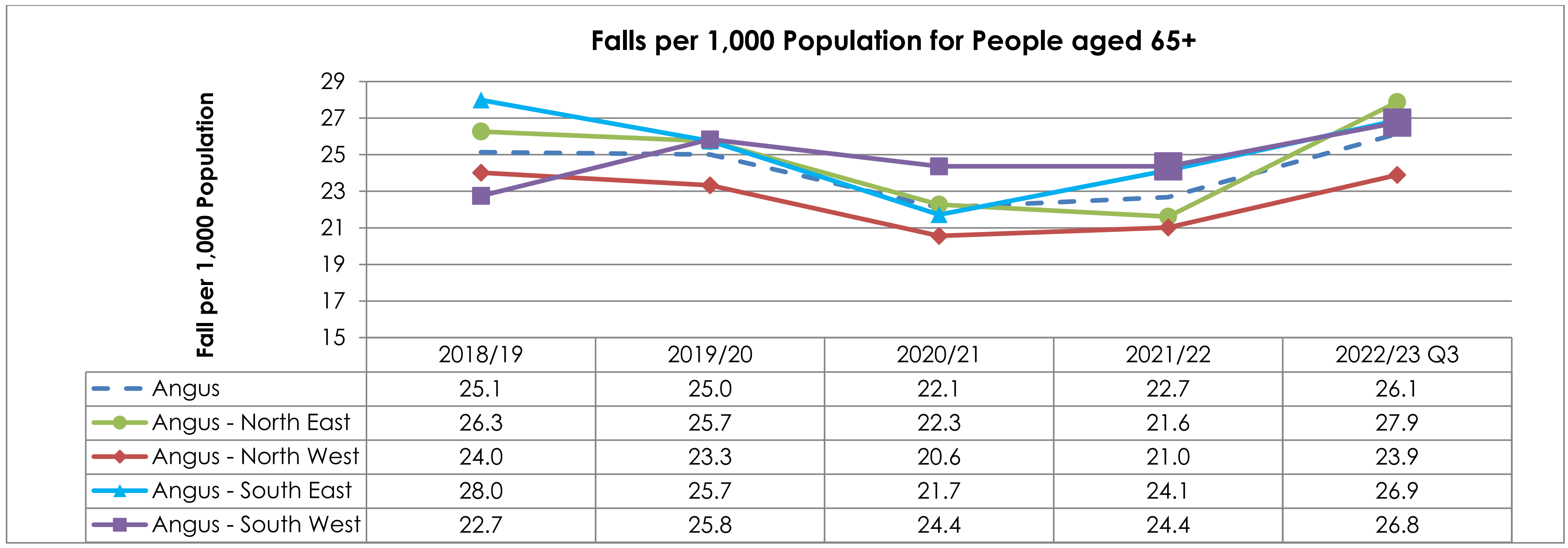
Measure	21/22	Trend	Latest	Target
Number of people aged over 65 admitted to hospital following a fall as a rate per 1,000 population (National Indicator)	**22.7**	▼	22/23 Q3 **25.1**	*Target* ***n/a***
Number of people that were prescribed items for hypertension in Angus as a crude rate per 1,000	**140**	▬	22/23 Q3 **141**	*Target 2022* ***140.5***
Number of people prescribed items for diabetes in Angus as crude rate per 1,000	**54**	▼	22/23 Q3 **55**	*Target 2022* ***49***
Number of people prescribed items for anxiety and depression in Angus as a crude rate per 1,000	**220**	▬	22/23 **221**	*Target 2022* ***207***
Number of people in Angus using Telecare items as a rate per 1,000 population	**5.0**	▲	22/23 **5.6**	*Target 2022* ***9.0***
Number of people using short breaks as a rate of 1,000 population	**3.9**	▬	22/23 **4.0**	*Target* ***n/a***
Number of respite nights for people aged over 65 as a rate of 1,000 population	**417**	▼	22/23 **386**	*Target* ***n/a***

Falls

Admissions due to a fall represent 7% of all unplanned admissions. We have seen a slight increase in the number of people aged over 65 admitted to hospital following a fall. To the end of December 2022, we saw 715 people aged over 65 admitted following a fall an increase of 36 admissions on 20/21. During this same period there were 10,720 unplanned admissions for all adults (18+).

The falls pathways will be considered within the Angus urgent care programme of work. Falls prevention is the key focus of work for the prevention and proactive care workstream which is supported within the Getting it Right for Everyone Framework. There is particular focus being given to 'better balance' classes which have a strong evidence base.

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



	2018/19	2019/20	2020/21	2021/22	2022/23 Q3
Angus	25.1	25.0	22.1	22.7	26.1
Angus - North East	26.3	25.7	22.3	21.6	27.9
Angus - North West	24.0	23.3	20.6	21.0	23.9
Angus - South East	28.0	25.7	21.7	24.1	26.9
Angus - South West	22.7	25.8	24.4	24.4	26.8

Community Health and Wellbeing

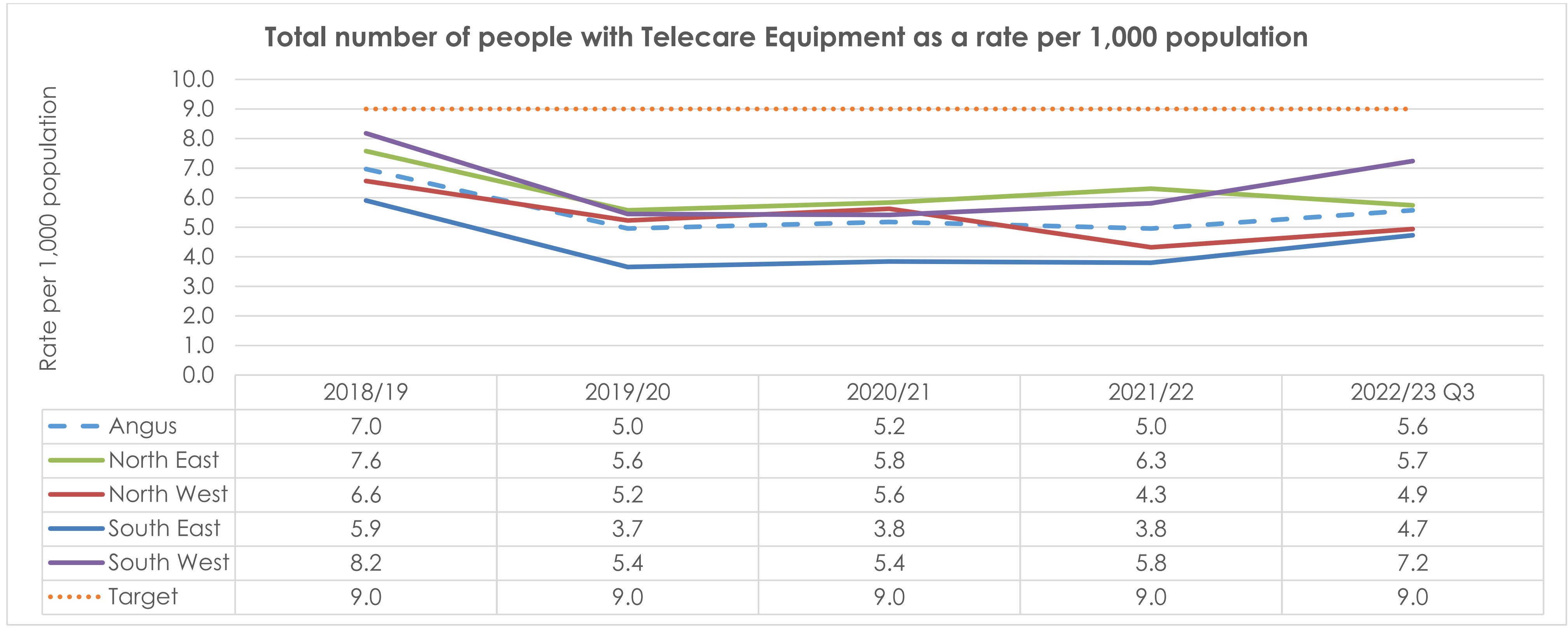
Performance against the measures of number of people prescribed medication for hypertension, diabetes, and anxiety & depression, have increased against the target performance set out in the Strategic Commissioning Plan 2019-22. These measures are proxy measures aimed at identifying improvements in the health and wellbeing of the community.

National therapeutic indicators are now available which are likely to replace previous measures within the future Angus Strategic Commissioning Plan. Polypharmacy reviews, evidence-based interventions which focus on prevention and a focus on mental health are priorities of the partnership.

Telecare

3,609 people used a community alarm during 2022/23, this is a 2% increase on the previous year and a 12% increase on 2015/16 baseline. Use of Telecare equipment offered in addition to community alarm has seen a slight increase from 13% of people in 2021/22 to 15% in 2022/23. It should be recognised that people are moving to digital alternatives that they can source themselves or recommended during our enablement period.

The graph below demonstrates the use of telecare since 2018/19.

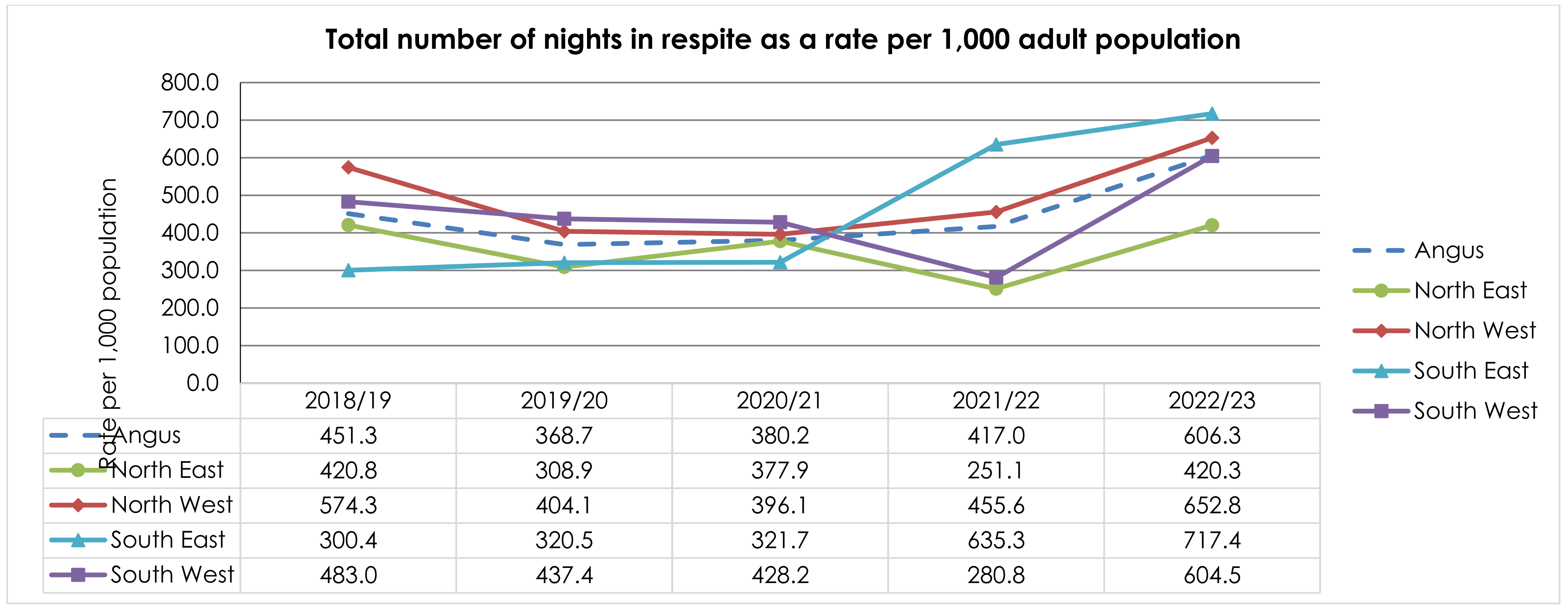


	2018/19	2019/20	2020/21	2021/22	2022/23 Q3
Angus	7.0	5.0	5.2	5.0	5.6
North East	7.6	5.6	5.8	6.3	5.7
North West	6.6	5.2	5.6	4.3	4.9
South East	5.9	3.7	3.8	3.8	4.7
South West	8.2	5.4	5.4	5.8	7.2
Target	9.0	9.0	9.0	9.0	9.0

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 and carers are no longer available to provide care. 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 reduced, this was in part be attributed to an increase in personal care and the further role out of Enhanced Community Support (ECS). In 2021/22 there has continued to be growth in the availability of care at home (both personal care and care and support). Access to residential respite in care homes was a challenge during the COVID-19 pandemic. In 2022/23, 566 people accessed 57,232 nights of residential respite. This is a 24% increase in the number of people accessing residential respite with a further 45% increase in the number of nights provided.

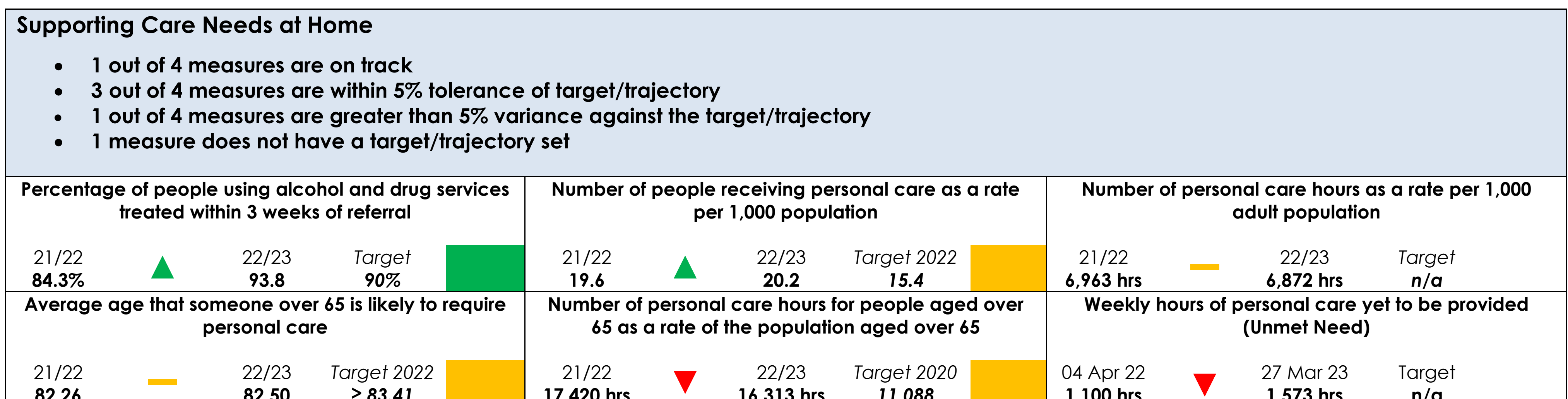
The graph below shows the use of respite nights since 2018/19.



	2018/19	2019/20	2020/21	2021/22	2022/23
Angus	451.3	368.7	380.2	417.0	606.3
North East	420.8	308.9	377.9	251.1	420.3
North West	574.3	404.1	396.1	455.6	652.8
South East	300.4	320.5	321.7	635.3	717.4
South West	483.0	437.4	428.2	280.8	604.5

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 of Angus HSCP 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

- **1 out of 4 measures are on track**
- **3 out of 4 measures are within 5% tolerance of target/trajectory**
- **1 out of 4 measures are greater than 5% variance against the target/trajectory**
- **1 measure does not have a target/trajectory set**

Measure	Earlier value	Latest value	Target
Percentage of people using alcohol and drug services treated within 3 weeks of referral	21/22 **84.3%**	22/23 **93.8**	*Target* ***90%***
Number of people receiving personal care as a rate per 1,000 population	21/22 **19.6**	22/23 **20.2**	*Target 2022* ***15.4***
Number of personal care hours as a rate per 1,000 adult population	21/22 **6,963 hrs**	22/23 **6,872 hrs**	*Target* ***n/a***
Average age that someone over 65 is likely to require personal care	21/22 **82.26**	22/23 **82.50**	*Target 2022* ***≥ 83.41***
Number of personal care hours for people aged over 65 as a rate of the population aged over 65	21/22 **17,420 hrs**	22/23 **16,313 hrs**	*Target 2020* ***11,088***
Weekly hours of personal care yet to be provided (Unmet Need)	04 Apr 22 **1,100 hrs**	27 Mar 23 **1,573 hrs**	Target **n/a**

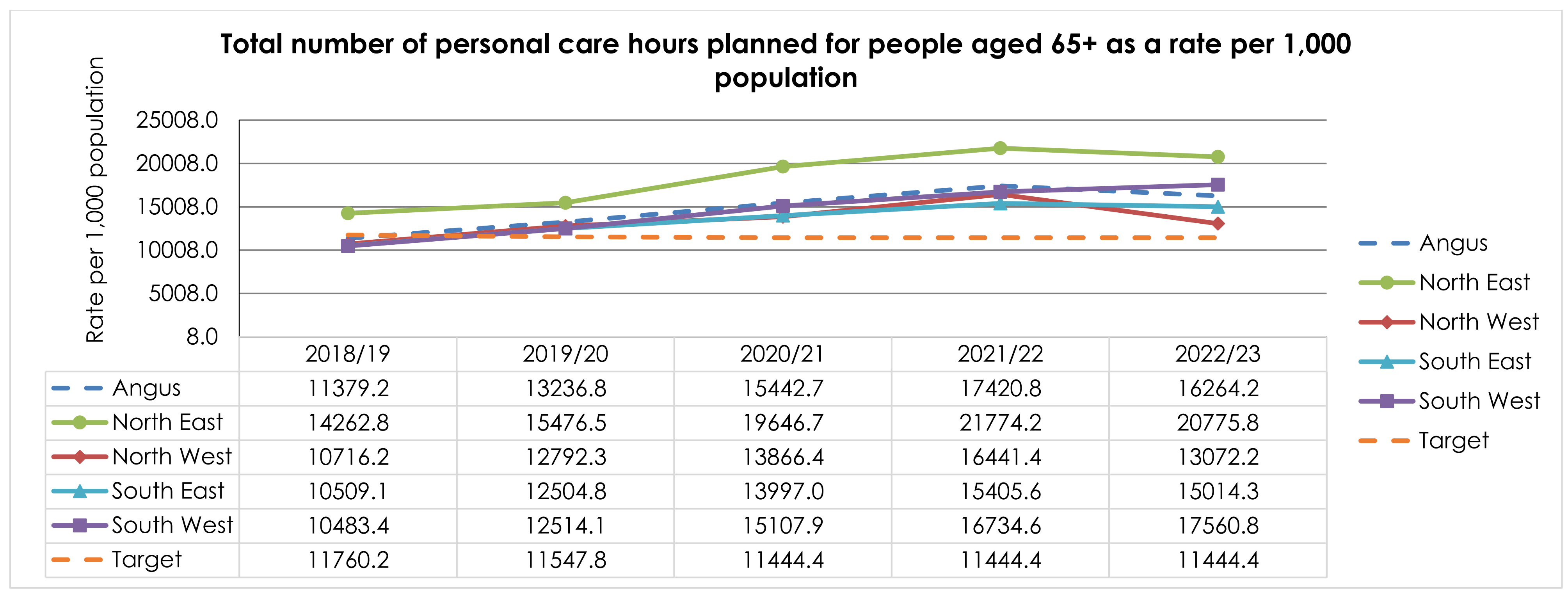
Alcohol and Drugs Services

Compared to 21/22, we have seen an increase of around 10% in relation to the measure for individuals accessing Alcohol and Drug services and treated within three weeks.

The numbers of new waits for brand new treatments are relatively small compared to other disciplines, in the latest quarter (2022/23) 8 out of 130 waits missed the target.

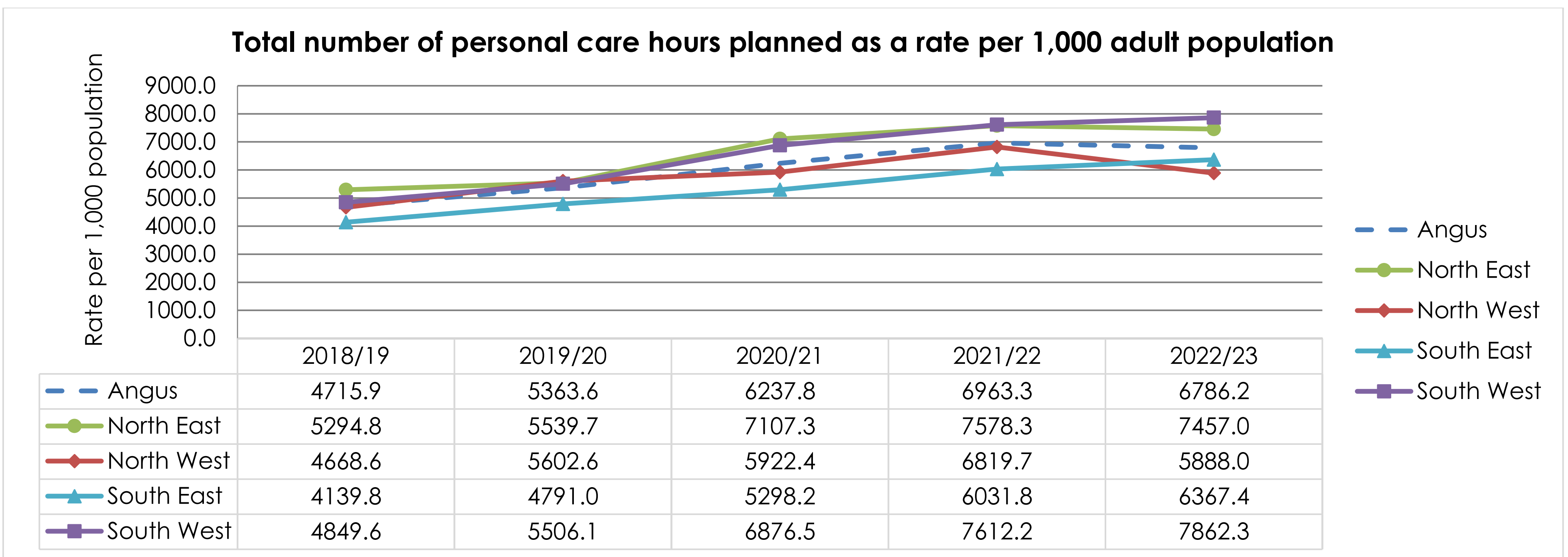
Personal Care

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 and subsequently revised in IJB report no 3/21. These reports focused on the impact of demographic change of services for older people, addressed the service cost base and also identified a number of approaches aimed at mitigating against continued growth. 456,065 hours of personal care were delivered to people aged over 65 in 2022/23, this was a decrease of -7% on the 2021/22 figures. Although a decrease, this has still exceeded the target for 2021/22 by 8%. The approaches aimed at mitigation against growth are still required to deliver in 2023/24. Work is ongoing to review current demand and further growth ending in 2023.



	2018/19	2019/20	2020/21	2021/22	2022/23
Angus	11379.2	13236.8	15442.7	17420.8	16264.2
North East	14262.8	15476.5	19646.7	21774.2	20775.8
North West	10716.2	12792.3	13866.4	16441.4	13072.2
South East	10509.1	12504.8	13997.0	15405.6	15014.3
South West	10483.4	12514.1	15107.9	16734.6	17560.8
Target	11760.2	11547.8	11444.4	11444.4	11444.4

Overall, 640,613 hours of personal care were delivered in 2022/23 this was a slight decrease of 3% in 2021/22. 1906 people use personal care services in 2020/21 which was a 3% increase in people.



	2018/19	2019/20	2020/21	2021/22	2022/23
Angus	4715.9	5363.6	6237.8	6963.3	6786.2
North East	5294.8	5539.7	7107.3	7578.3	7457.0
North West	4668.6	5602.6	5922.4	6819.7	5888.0
South East	4139.8	4791.0	5298.2	6031.8	6367.4
South West	4849.6	5506.1	6876.5	7612.2	7862.3

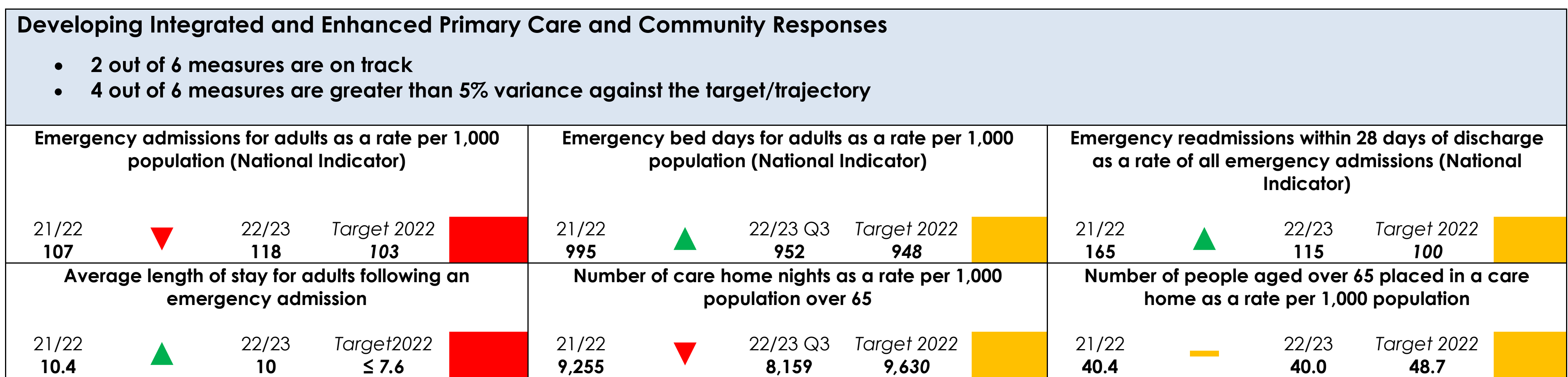
In addition, 359,139 hours of care and support (non-personal home care) were delivered in 2022/23. This was an increase of 5% on 2021/22.

Demand and capacity issues continue in relation to personal care services. Independent providers of personal care have worked hard to address demand. For week commencing 28 March 2023 there were 375 people waiting for 1573 hours compared to 281 people and 1100 hours week commencing 04 April 2022. Various initiatives have been introduced to try reducing unmet need including, a recruitment campaign working with current providers to help increase their workforce/maintain existing service delivery. 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 must be further developed to address the increase.

Following the introduction of the Carers (Scotland) Act 2016 (the Act), and the implementation of new eligibility criteria for carers, both the number of carers being assessed, and the value of the support provided have increased. In 2022/23, 264 adult carer support plans were completed, with carers being assessed as eligible for support and had a calculated budget. The purpose of the budget is in part to provide replacement care so that carers can achieve the outcomes agreed in their support plan. A proportion of the increase in care at home services will be associated with carers support plans and may be reducing the demand for emergency respite.

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

- **2 out of 6 measures are on track**
- **4 out of 6 measures are greater than 5% variance against the target/trajectory**

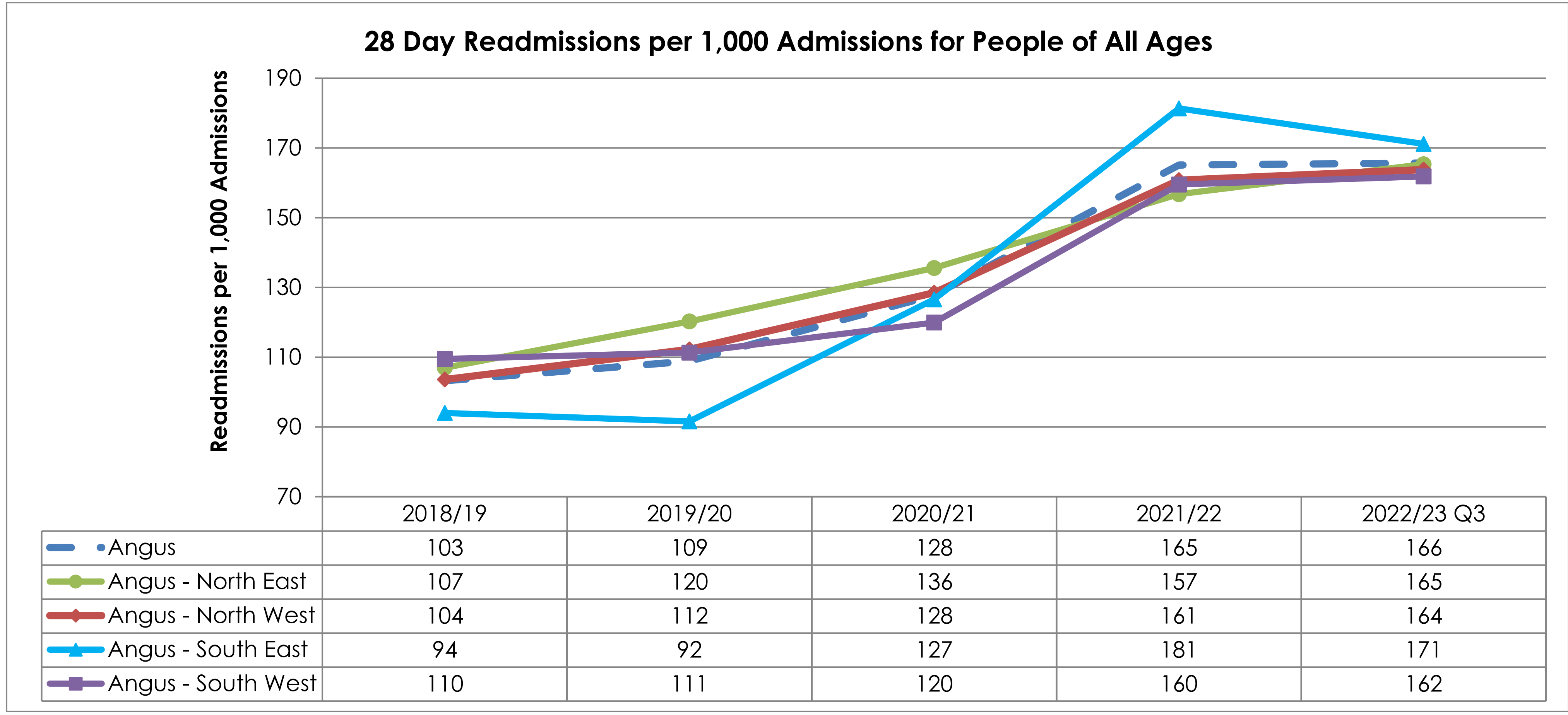
Measure	21/22	Trend	22/23	Target
Emergency admissions for adults as a rate per 1,000 population (National Indicator)	107	▼	118	Target 2022: 103
Emergency bed days for adults as a rate per 1,000 population (National Indicator)	995	▲	22/23 Q3: 952	Target 2022: 948
Emergency readmissions within 28 days of discharge as a rate of all emergency admissions (National Indicator)	165	▲	115	Target 2022: 100
Average length of stay for adults following an emergency admission	10.4	▲	10	Target2022: ≤ 7.6
Number of care home nights as a rate per 1,000 population over 65	9,255	▼	22/23 Q3: 8,159	Target 2022: 9,630
Number of people aged over 65 placed in a care home as a rate per 1,000 population	40.4	–	40.0	Target 2022: 48.7

AHSCP now has Enhanced Community Support (ECS) model embedded throughout all four localities. Monifieth Integrated Care has seen the amalgamation of the Care Management and District Nursing teams. Work is progressing to improve unscheduled care pathways with the Angus Urgent and Unscheduled Care Programme Steering Group taking forward a range of initiatives to improve the journey for people who have a physical and/or mental health need that does not require emergency care but cannot wait until a pre-planned care appointment.

There were 11,290 unplanned admissions in 2022/23, this was an increase of 9% on 2021/22. Admissions accounted for 118,674 hospital bed days a decrease of 28% on 2020/21.

There has been a continued decrease in the performance in relation to emergency readmissions within 28 days of discharge (as a rate of all emergency admissions). However, we have seen a 30% decrease in this area between 2021/22 and 2022/23. This measure is a national indicator, but its definition is for both planned and unplanned admissions to hospital. Planned admissions in 2022/23 have increased with the continued backlog after the COVID-19 pandemic. Other factors which may be contributing to the increased rate of readmissions include increasing frailty in the community, management in the community rather than care homes.

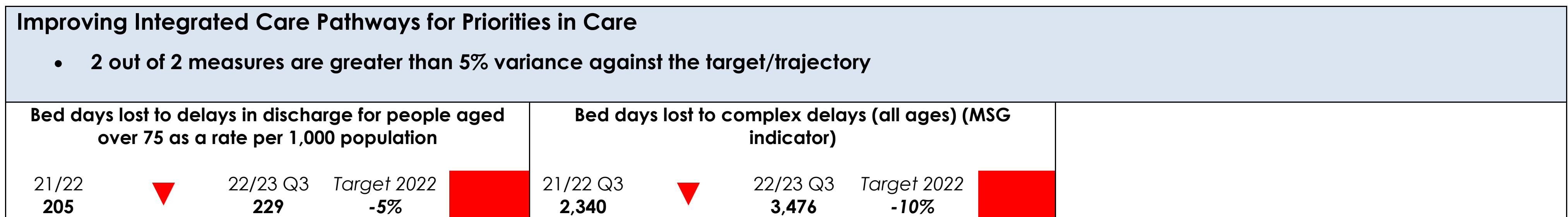
The graph below demonstrates the 28-day readmissions per 1000 admissions from 2017/18.



	2018/19	2019/20	2020/21	2021/22	2022/23 Q3
Angus	103	109	128	165	166
Angus - North East	107	120	136	157	165
Angus - North West	104	112	128	161	164
Angus - South East	94	92	127	181	171
Angus - South West	110	111	120	160	162

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.



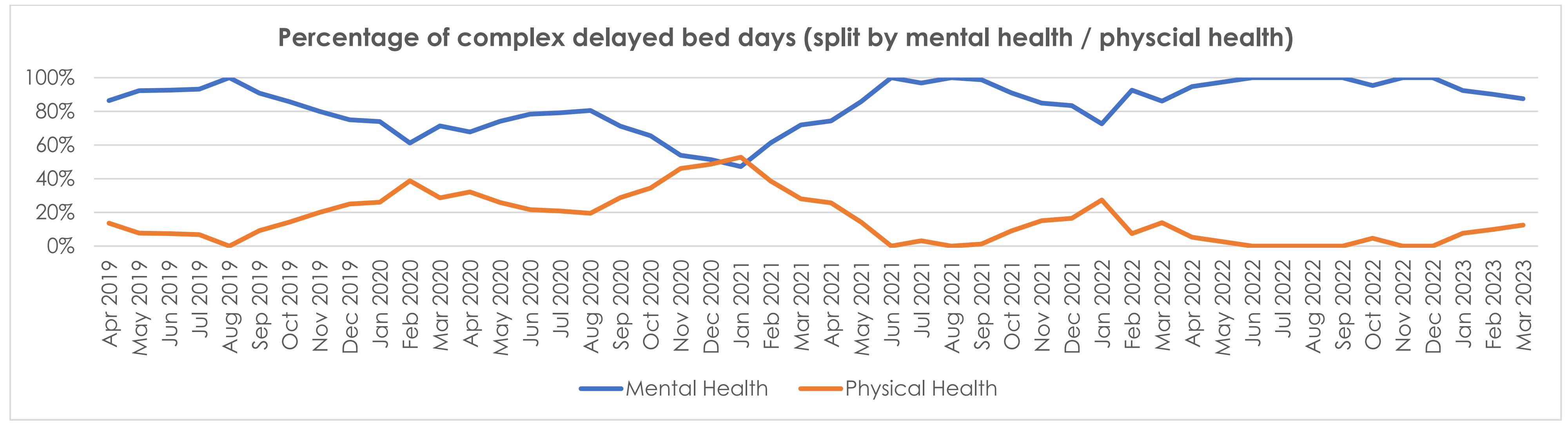
Improving Integrated Care Pathways for Priorities in Care

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

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)			
21/22 **205**	▼	22/23 Q3 **229**	*Target 2022* ***-5%***	21/22 Q3 **2,340**	▼	22/23 Q3 **3,476**	*Target 2022* ***-10%***

The final year data for these indicators is not available. The challenges around personal care delivery have impacted on our performance in relation to the timely discharge of older people. Proactive care around the individual allows the anticipation of needs and the prevention of hospital admission. 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.

The graph below uses local data to look at the split between specialities Mental Health and Physical Health in relation to complex delayed bed days. The data is taking from Trakcare via Qlikview. The data shows that Mental Health accounted for around 96% of the bed days lost.



Complex delays have increased mainly as a result of the lack of specialist care accommodation for people under 65. Guardianship applications also account for lengthy delays and although work has progressed to deal with the backlog of Guardianship applications, processing through the court system can delay people for longer than we would like.

Several initiatives are under way to improve the position regarding delays in discharge. A new social work discharge team created to be proactive and review all delayed patients both in acute and community hospital bed base plus we continue the role out of the planned date of discharge work.

7. Conclusion

Overall, the data described in this report demonstrates that AHSCP has continued to make progress against the ambitions set out in its Strategic Commissioning Plan 2019-22. Some indicators have been impacted by COVID-19, particularly those related to hospital admissions. There are areas that require further work to be progressed to improve performance and work towards achieving the target or trajectory, in particular personal care provision and prescribing.

Angus IJB approved a new Strategic Commissioning Plan (SCP) for 2023-26. This SCP includes a Strategic Delivery Plan detailing new/updated ambitions and revised indicators. These indicators will be reviewed and target/trajectories set to ensure we can delivery on the new SCP.

8. Other Measures for the Annual Report

The following measures are not included within this summary report but will be part of the full annual performance report: -

- 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 rate 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)