AGENDA ITEM NO 6
REPORT NO 276/17

ANGUS COUNCIL

SCRUTINY AND AUDIT COMMITTEE – 22 AUGUST 2017

STRATEGIC PROGRESS AND PERFORMANCE: REPORT FOR THE PERIOD 1 APRIL 2016 TO 31 MARCH 2017

REPORT BY VICKY IRONS, CHIEF OFFICER, ANGUS HEALTH AND SOCIAL CARE PARTNERSHIP

ABSTRACT

This report provides information to members with regard to the progress of Angus Health and Social Care Partnership in delivering its strategic plan. The 2016/17 Strategic Progress and Performance Report is appended for information. This was approved by Angus IJB on 28 June 2017.

1. RECOMMENDATION

The Committee is requested to note the contents of this report.

2. BACKGROUND

2.1 The Public Bodies (Joint Working) (Scotland) Act 2014 set out how health and social care services for adults would be integrated across Scotland. The legislation required Health Boards and local authorities to integrate their health and social care services under the direction of an Integrated Joint Board.

2.2 The principal ambitions of health and social care integration are to:

- Support the improvement of the quality and consistency of services for patients, carers, service-users and their families.
- Provide seamless, joined-up quality health and social care services in order to care for people in their homes or in a homely setting, where it is safe to do so.
- Ensure that resources are used effectively and efficiently to deliver services.

2.3 The Angus Integration Joint Board was fully established and assumed delegated responsibility for services from 1 April 2016. A Chief Officer was appointed by the Integration Joint Board. The services which are delegated to the Integration Joint Board are set out in an Integration Scheme approved by the Scottish Government. In Angus, services delegated by Angus Council which are identified in the Integration Scheme are all social work and social care services for adults except welfare benefits and criminal justice services.

2.4 In keeping with legislative requirements, services are delivered through four geographical localities, each of which has a multi-agency Locality Improvement Group which supports the delivery of the Strategic Plan, influences its content according to local demographics and assessed need, and oversees change to operational delivery.

3. Strategic Progress and Performance Management

3.1 Section 42 of the Public Bodies (Joint Working) (Scotland) Act 2014 states that Integration Authorities must prepare an annual performance report for each reporting

year. A performance report is described as a report which sets out an assessment of performance by each Integration Authority in planning and carrying out its integration functions. Each Integration Authority is required to report on its performance against a set of prescribed national outcomes and indicators.

3.2 The attached 2016/17 Strategic Progress and Performance Report aims to set out the strategic level performance described in the Partnership's performance framework. This includes the specified national core indicators which demonstrate progress against the national outcomes.

3.3 A number of additional local indicators have been developed to show progress and performance in relation to the four IJB strategic priorities:

Priority 1	Improving health wellbeing and independence
Priority 2	Supporting care needs at home
Priority 3	Developing integrated and enhanced primary care and community responses
Priority 4	Improving integrated care pathways for priorities in care

3.4 The report also provides progress and performance information on a further three performance areas:

Performance area 1	Clinical and care governance
Performance area 2	Staff
Performance area 3	Resources

3.5 2016/17 Strategic Progress and Performance Report (Appendix 1) provides evidence of progress in line with the requirements for the annual performance report set out in regulations.

3.6 In reviewing strategic progress and performance, the report highlights that:

- Angus performs well nationally in relation to most national core indicators. 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.
- Progress has been made in addressing hospital bed occupancy. Angus has seen a continuing decrease in the bed day rates although admissions continue to increase. Readmission rates have increased and have impacted on performance in relation to the overall rate of admission.
- Readmissions within 28 days of discharge have increased for Angus as a whole; this increasing readmission rate contributes to the increase in all emergency admissions. The largest increase in readmissions is in the South West locality. The North East has also seen increasing readmissions for the first time in 2016/17. The South East saw the most improvement through to quarter 3 but has lost ground in quarter 4 2016/17.
- Enhanced Community Support (ECS), managing timely discharge and increasing levels of personal care, has contributed to a reduction in bed days lost to delayed discharges for people aged 75+.
- There has been a 33% increase in the level of personal care being delivered within our localities. More people are being supported and more people are receiving higher levels of care.
- The North West locality has the lowest rate of total care home placements (residential and nursing combined) and utilises more care at home and respite. The South East locality makes high levels of placements by population rate but uses less personal

care and other community services. The North East locality makes the most placements by population rate and also uses very high levels of personal care and other community based services. The South West locality makes few placements but also uses less personal care and other community based services. The South West was the only locality to reduce placements by rate in 2016/17. This equated to a 10% reduction in actual placements during the year. All other localities saw an increase in the number of placements in 2016/17.

- A high proportion (89%) of users of care rate the services as excellent or good. Locally, information gathered by services also indicates high levels of satisfaction with those services.

3.7 During 2017/18 it is anticipated that further indicators will be developed as progress is made with the implementation of the performance framework, along with improvements in the availability of data and information from Angus Council, NHS Tayside and the Information Services Division (ISD) Source project.

4. REPORT AUTHOR

This report has been compiled by:

George Bowie Head of Community Health and Care Services (South)
Gail Smith Head of Community Health and Care Services (North)
Angus Health and Social Care Partnership

List of Appendices:

Appendix 1 - Angus Health and Social Care Partnership 2016/17 Strategic Progress and Performance Report

Appendix 1

ANGUS
Health & Social Care
Partnership

ANGUS HEALTH AND SOCIAL CARE PARTNERSHIP

STRATEGIC PROGRESS AND PERFORMANCE REPORT

April 2016 to March 2017

Published June 2017

Angus Health and Social Care Partnership

Strategic Progress and Performance Report 2016/17

Introduction

The purpose of this Annual Strategic Progress and Performance Report is to show progress against the four priorities set out in the Angus Health and Social Care Partnership's strategic plan and three performance areas. The four priorities of our strategic plan aim to deliver the nine national health and wellbeing outcomes. The relationship between our strategic priorities, the national outcomes and the national core indicators is set out in appendix 1. Our performance in relation to the national outcomes will be set out in relation to our four strategic priorities and three performance areas. These are:

The information included in this report aims to set out what has been achieved in relation to the delivery of the priorities set out in the strategic plan; what is to be delivered next and how the delivery of the strategic plan has impacted on the performance of Angus Health and Social Care Partnership. Throughout the report, performance is shown by locality, where possible, in order that locality improvement groups can focus on addressing variance in performance and continuous improvement. The emerging strategic delivery plan for 2017-19 is set out at appendix 2. The report does not cover hosted services. Discussions are ongoing with other Partnerships about how we create and deliver a shared approach to reporting on those services.

The total number of people over 65 living in Angus has not changed over the last 5 years. However, the number of people aged 75+ has increased by over 1,000 and the number of people between 65 and 74 has decreased by over 1,000. This, in part, contributes to some of the increase in hospital activity as a rate of the adult population. It has not been possible to adjust rates for 2016/17 to take account of demographic change as population figures are not yet published. Data has been constructed based on 2015 populations. Data is show using rolling years, this means:

- Quarter 1 16/17 (Q1) = 1 July 2015 to June 30 2016
- Quarter 2 16/17(Q2) = 1 October 2016 to 30 September 2016
- Quarter 3 16/17(Q3) = 1 January 2016 to December 31 2016
- Quarter 4 16/17(Q4) = 1 April 2016 to March 31 2017 (full year effect)

***Data explanatory note*:** where health information has been extracted from a different source other than the ISD Source team there are some minor discrepancies between the ISD published and non-ISD published health information. All non-published information, such as health information shown by localities, should therefore be treated with caution. Social care information has been extracted from Care First, there have been some data anomalies and data quality issues which are being addressed to improve the quality of the performance information. The national position for 2016/17 in relation to performance against the 23 national core indicators will not be published until September 2017 and therefore cannot be included in this report. The 2015/16 benchmark is offered to allow for some comparison.

Angus Performance Summary

Overall Locality Performance

- Angus performs well nationally in relation to most national core indicators (see Table 1) 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.

- Progress has been made in addressing hospital bed occupancy. Angus has seen a continuing decrease in the bed day rates although admissions continue to increase. Readmission rates have increased and have impacted on performance in relation to the overall rate of admission.

- Readmissions within 28 days of discharge have increased for Angus as a whole; this increasing readmission rate contributes to the increase in all emergency admissions. The largest increase in readmissions is in the South West locality. The North East has also seen increasing readmissions for the first time in 2016/17. The South East saw the most improvement through to quarter 3 but has lost ground in quarter 4 2016/17.

- Enhanced Community Support (ECS), managing timely discharge and increasing levels of personal care have contributed to a reduction in bed days lost to delayed discharges for people aged 75+.

- There has been a 33% increase in the level of personal care being delivered within our localities. More people are being supported and more people are receiving higher levels of care.

- The North West has the lowest rate of total care home placements (residential and nursing combined) and utilises more care at home and respite. The South East locality makes high levels of placements by population rate but uses less personal care and other community services. The North East makes the most placements by population rate and also uses very high levels of personal care and other community based services. The South West makes few placements but also uses less personal care and other community based service. The South West was the only locality to reduce placements by rate in 2016/17. This equated to a 10% reduction in actual placements during the year. All other localities saw an increase in the number of placements in 2016/17.

- A high proportion (89%) of users of care, rate the services as excellent or good. Locally, information gathered by services also indicates high levels of satisfaction with those services.

- Only West Dunbartonshire, Renfrewshire and Clackmannanshire have a higher proportion than Angus of all its care services (Care Homes, Care at Home, Day Care etc) graded as good or better by the Care inspectorate in Scotland during 2015/16.

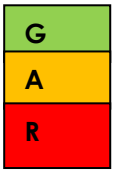
- Targets for further improvement have been established in relation to:

    - Attendance at A and E
    - Admissions from A and E
    - Hospital bed day rate
    - Rate of bed days lost due to delays in discharge

  These targets have been developed locally and will be refined over the next few months, particularly where the target for 2018 has already been achieved.

Angus Ranked Performance in 2015/16

The tables below show the summary of Angus 2016/17 performance in relation to the Scottish (2015/16) performance across a range of national indicators.



Angus is performing well against the Scottish average

Angus rate is similar to the Scottish average but there is room for improvement

Angus has greater room for improvement against the Scottish average

Table 1: Angus' Ranked Performance for national indicators

Biennial Outcome Indicators 2015/16					
	Indicator	**Title**	**Scotland 2015/16**	**Angus 2016/17**	**Ranking 2015/16**
Outcome indicators 2015/16 biennial survey	**NI - 1**	Percentage of adults able to look after their health very well or quite well	**94%**	**95%**	**13**
	NI - 2	Percentage of adults supported at home who agreed that they are supported to live as independently as possible	**84%**	**89%**	**5**
	NI - 3	Percentage of adults supported at home who agreed that they had a say in how their help, care, or support was provided	**79%**	**81%**	**11**
	NI - 4	Percentage of adults supported at home who agreed that their health and social care services seemed to be well co-ordinated	**75%**	**81%**	**8**
	NI - 5	Total percentage of adults receiving any care or support who rated it as excellent or good	**81%**	**82%**	**19**
	NI - 6	Percentage of people with positive experience of the care provided by their GP practice	**87%**	**83%**	**29**
	NI - 7	Percentage of adults supported at home who agree that their services and support had an impact on improving or maintaining their quality of life	**84%**	**84%**	**21**
	NI - 8	Total combine percentage of carers who feel supported to continue in their caring role	**41%**	**39%**	**25**
	NI - 9	Percentage of adults supported at home who agreed they felt safe	**84%**	**86%**	**12**
	NI - 10	Percentage of staff who say they would recommend their workplace as a good place to work	**NA**	**NA**	_
Quantitative Indicators – Angus 2016/17 Scotland and ranking as at 2015/16 (2016/17 information is not available)					
	Indicator	**Title**	**Scotland 2015/16**	**Angus 2016/17**	**Ranking 2015/16**
Data indicators 2015/16	**NI - 11**	Premature mortality rate per 100,000 persons	**441**	**391**	**8**
	NI - 12	Emergency admission rate (per 100,000 population)	**10480**	**10,913**	**12**
	NI - 13	Emergency bed day rate (per 100,000 population)	**106531**	**111,585**	**18**
	NI - 14	Readmission to hospital within 28 days (per 1,000 population)	**95**	**107**	**26**
	NI - 15	Proportion of last 6 months of life spent at home or in a community setting.	**87%**	**90%**	**4**
	NI - 16	Falls rate per 1,000 population aged 65+	**21**	**20**	**8**
	NI - 17	Proportion of care services graded 'good' (4) or	**81**	**90% ***	**2**

		better in Care Inspectorate inspections (*2015/16)			
	NI - 18	Percentage of adults with intensive care needs receiving care at home *(2015/16)	**62**	**52%***	**31**
	NI - 19	Number of days people spend in hospital when they are ready to be discharged (per 1,000 population)	**915**	**355**	**4**
	NI - 20	Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency	**21**	**26%**	**2**
	NI - 21	Percentage of people admitted to hospital from home during the year, who are discharged to a care home		**NA**	**-**
	NI - 22	Percentage of people who are discharged from hospital within 72 hours of being ready		**NA**	**-**
	NI - 23	Expenditure on end of life care, cost in last 6 months per death		**NA**	**-**

Note: At the time of writing, 2016/17 national ranking information has not been published and therefore cannot be included in this report.

Locality Performance in 2016/17 against baseline year 2015/16

<-3%	2016/17 performance has improved against baseline 15/16 rate
>-3 to <3%	2016/17 performance is similar the baseline 15/16 rate (- figure is improving performance, +figure is declining performance)
>3%	2016/17 performance has declined against the baseline 15/16 rate

Table 2: Percentage change in 2016/17 against baseline year 2015/16

National Indicator	Angus	North East	North West	South East	South West
12.Emergency Admissions	**1.60%**	**1.50%**	**0.70%**	**0.50%**	**4.50%**
13.Emergency Bed Days	**-1.40%**	**-5.30%**	**-0.60%**	**0.40%**	**0.20%**
14. Re-admissions after 28 days	**2.60%**	**3.30%**	**5.10%**	**-9.20%**	**12.40%**
16. Falls ending in admission [1]	**9.00%**	**26.30%**	**18.70%**	**5.60%**	**-11.70%**
19. Delayed Discharges [2]	**2.70%**	**-18.30%**	**23.40%**	**78.70%**	**-36.70%**

Footnote:

[1] Admissions resulting from a fall represented 5% (535) of all emergency admissions in 2016/17. Wider variation is likely to be seen where small numbers exist (Ref. Table 1 NI 16)

[2] In the South East, delayed discharges increased from 17 in 2015/16 to 26 in 2016/17. Wider variation is likely to be seen where small numbers exist (Ref. Table 1 NI 19)

Priority 1: Improving Health, Wellbeing and Independence

The aim of the Angus Health and Social Care Partnership's strategic plan is to progress approaches that support individuals to live longer and healthier lives. This includes having access to information and natural supports within communities. AHSCP's focus is on health improvement and disease prevention including addressing health inequalities; building capacity within our communities; supporting carers and supporting the self-management of long term conditions. The health inequalities in Angus were identified in the Joint Strategic Needs Assessment. We are working with public health to determine appropriate measures which provide evidence in relation to health equity and the impact of services across Angus. This will include ensuring that data from primary providers is available in order to see performance in the most and least deprived areas of Angus against the Angus average performance. Addressing performance variation will go some way to begin to address health inequalities.

1.1 What we have achieved to date

- Delivered a programme to support self-management of long term conditions
- Developed peer support groups for long term conditions
- Progressed a review of out of hours services; this has identified and proposed an outline plan for transforming unscheduled care and a new model of service provision based in line with national transformation plans.
- Developed a primary care transformation programme
- Increased uptake of community alarm services and the range of peripherals available
- Supported Voluntary Action Angus and other third sector organisations financially to develop and deliver community based services to support adults with health and social care needs. Each locality has a voluntary sector single point of contact officer supporting and signposting communities. These officers also work within multi-disciplinary teams supporting options for social prescribing.
- Delivered support through Voluntary Action Angus to support people to get home and be at home through volunteer post-hospital support programmes
- Developed ALISS, a web based community information system. Progress has been made in making information available about the range of opportunities to access voluntary support in Angus. Information on most organisations can now be found on ALISS (a local information system for Scotland).
- Provided resources to Angus Carers Association to provide a carers support worker in each locality. This worker works within the multi-disciplinary teams to identify carers and provide advice and support. A range of supports can be put in place following an assessment of carers needs, this includes daytime short breaks and overnight breaks.
- The Angus Alcohol and Drug Partnership completed the pilot phase of the whole family approach and produced recommendations for the future.
- A needs assessment around "chemsex" was carried out in partnership with The Terrence Higgins Trust, which provided information relating to the use of substances and subsequent impact on sexual behaviour.
- Developed Independent Living Angus, a web based self-assessment and referral tool to support access to information and advice on equipment to support daily living. This is also used by the First Contact service to support individuals to access some equipment from the equipment store without the need for assessment by occupational therapy.
- Established a working group to progress the implementation of the new Carers (Scotland) Act 2016 which places new duties on local authorities from 1 April 2018.

1.2 What we plan to do next

- Plans around the use of technology enabled care to support self-management of long term conditions and people with multi-morbidities are testing telehealth opportunities to support people to live at home for as long as possible.

- Further develop the application of Independent Living Angus as part of the review of First Contact arrangements. This will include consideration of how to provide advice and support for self-management of long term conditions through Independent Living Angus.

- Develop an improvement plan to address the falls admission rate in Angus. Supported by public health, the improvement plan is identifying areas of best practice across Scotland and will incorporate a review of the Angus falls services.

- Continue to roll out programmes to support self-management of long term conditions

- Develop new arrangements for respite for people with learning disabilities

- A study of children affected by parental substance misuse to be carried out by the Angus Alcohol and Drug Partnership (ADP)

- Planned re-design of services, in response to national ADP funding reductions.

- Fully implement the Carers (Scotland) Act 2016 ensuring that a state of readiness evaluation is completed and eligibility criteria are developed in consultation with carers by 31 March 2018.

1.3 How we monitor progress

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

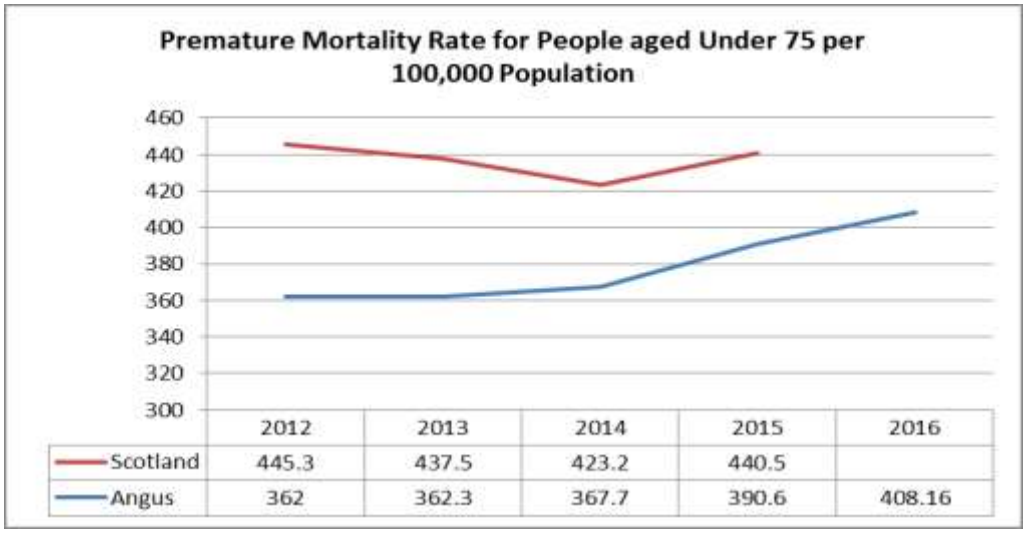
Angus continues to perform well (above the Scottish average) in relation to the proportion of individuals who are able to look after their own health (see table1)

Premature mortality

1.3.1 Angus is consistently below the Scottish average in relation to premature mortality rates. As at 2015, Angus is the 7th lowest ranked partnership for premature deaths with 391 per 100,000 population (ISD). National data tables for 2016 have not been published at the time of this report.

1.3.2 There has been an increase in premature mortality in Angus; this is a continued trend. There is variation between localities. The North East and South East have the highest premature mortality rates. These localities include areas of deprivation.

Graph 1: Management Information: Premature Mortality Rate for People aged Under 75 per 100,000 Population

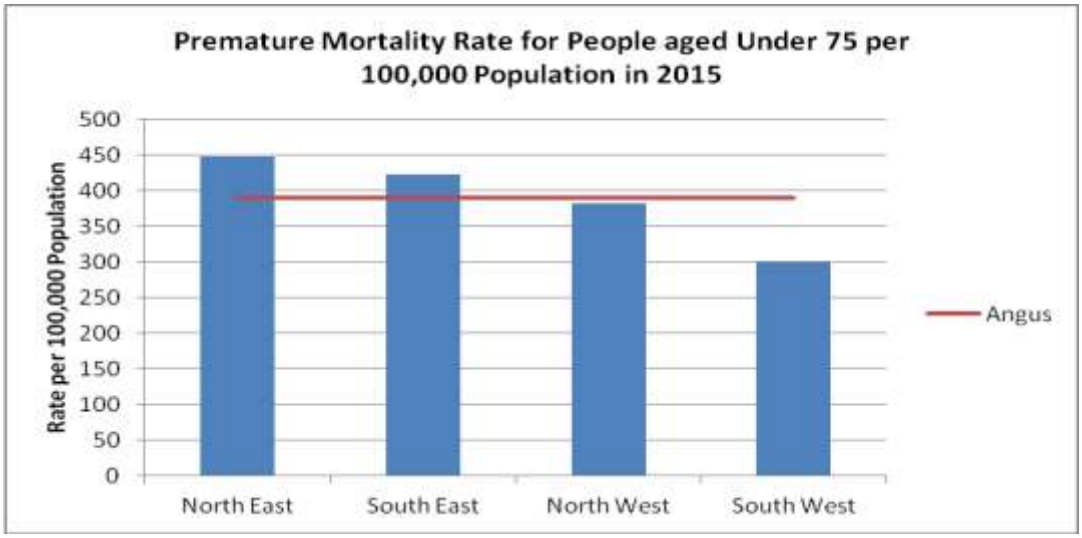


	2012	2013	2014	2015	2016
Scotland	445.3	437.5	423.2	440.5	
Angus	362	362.3	367.7	390.6	408.16

Source: National Record of Statistics (up to 2015)

Note: * 2016 rates are produced by ISD LIST and are provisional. They are not official National Records of Scotland (NRS) statistics. Official figures by NRS for 2016 will be released later in 2017.

Graph 2: Management Information at Locality Level: Premature Mortality Rate for People aged Under 75 per 100,000 Population in 2015



Source: ISD LIST (not official NRS statistics)

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

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

Keep Well

Paul is a 63 year old man from a Keep Well targeted postcode area. He has had infrequent contact with his General Practice, but has attended previously in relation to muscular/joint pain and recent urinary symptoms. He has recently retired from oil related employment.

His Keep Well Health Check revealed a raised Total Cholesterol result of 6.55mmol/L. His Cardio-vascular Disease Risk Score was 23%. His GP prescribed cholesterol lowering medication, (Simvastatin). Paul expressed some ambivalence about this, which he discontinued after 3 days as he was experiencing unpleasant side effects.

He agreed to attend follow-up appointments with the Keep Well Outreach Nurse at 3 and 6 monthly intervals, adopting a House of Care approach, to monitor and review behaviour change strategies. These were identified and agreed, in relation to his aim of reducing his cardio-vascular risk and cholesterol levels. Goals included increasing his physical activity, following a Mediterranean style diet, and reducing his intake of sugars and animal fats. His cholesterol levels were repeated at the 3 monthly review appointment with the Keep Well Outreach Nurse in December 2016, which showed a reduction on his Total Cholesterol from 6.55mmol/L to 6.04mmol/L, which contributed towards a lower Cardio-vascular Disease Risk Score of 19%.

Paul advised that he felt positive and optimistic about his ability to manage and assume control over his health, and was motivated and confident in continuing to utilise the health behavioural change strategies he had identified.

The Third Sector and Volunteering

1.3.4 Angus continues to have high levels of volunteering. Voluntary Action Angus (VAA) are supporting the development of voluntary organisations and volunteering across Angus. The capacity of communities to care is a focus of the work. The biggest capacity issue for organisations is volunteer recruitment. VAA has recruited more than 1300 volunteers who are now engaged in community and voluntary organisations in a health or care context. They have provided minibus and transport services for older people and for 216 community / voluntary organisations to make journeys. More than 130,000 miles of volunteer driving have supported our communities. 216 new volunteers have been trained and supported into volunteering opportunities in 2016/17. New volunteer agreements and hand books have been developed and implemented to support all volunteering activity.

Warm and Well project by CAB

Margaret was referred by SCARF (Save Cash and Reduce Fuel) part of Home Energy Scotland. Margaret is in her 80s and has a large energy bill due to her supplier reducing the direct debit without consent. Margaret had been in touch with her energy supplier to advise they did not want the direct debit to reduce but the energy company decreased it anyway. Margaret's complaint had not been dealt with by the energy company. The Warm and Well Fuel Poverty Worker visited Margaret and contacted the energy company to raise a further complaint. As Margaret now had an outstanding balance which she could not afford to pay an application was successfully made to the energy company's trust fund and the outstanding balance of £900.44 was cleared.

Margaret is awaiting the energy company updating meter readings and to revert Margaret's payments back to the fixed tariff she was originally on. This was the first time Margaret had ever been in debt; she had been very stressed and anxious when she was referred to the project. Client was over the moon that this debt has been cleared and is now no longer suffering from stress.

Carers

1.3.5 Angus performance in relation to carers feeling supported to continue their caring role is marginally less than the Scottish average. There is an improvement in the number of carers that have been identified in Angus and the number of carers support plans that have been put in place. In 2016/17, Angus Carers have recorded:

- 1053 carers aged over 55 were registered with Angus Carers, an increase from 413 registered carers over 55 in 2015/16. The total number of carers registered of all ages is 2033.
- 4,672 hours of volunteer-led 'care free' respite were provided
- 269 new carer support plans were developed and 34 reviews undertaken with carers aged over 50 years old
- 363 support plans in place with carers aged over 50 years

Developing a carers support plan

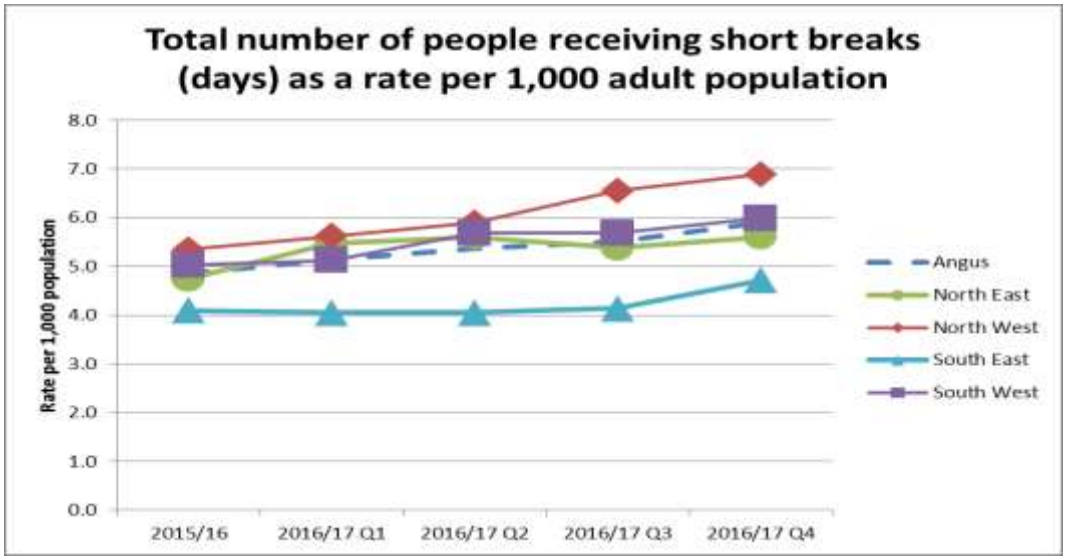
Walter is a 70 year old male who was referred to Angus Carers by an existing carer/volunteer. He had been caring for his wife for 5 years without any support and it was beginning to take its toll. Walter was reluctant to admit he was struggling initially but during the support conversation it became apparent that Walter and his wife, Susan, were finding things difficult; both were quite tearful and emotional. When I explained what kinds of support Angus Carers could offer they were both very open and admitted things had to change.

Susan was a little reticent but agreed to consider the options for befriender. I supported Walter to apply for Attendance Allowance; this was successful at High Rate and he received backdated payment of over £500.00 coming just a few days before Christmas. Walter and Susan were £82.00 a week better off. I matched Susan with a volunteer who will accompany her days out giving Walter some much needed respite. I referred to the Short Breaks and 'Respitality' service where Walter could get more support to allow some time for golf/football.

Walter is thrilled that we are supporting them and says he could not have accessed this without our help

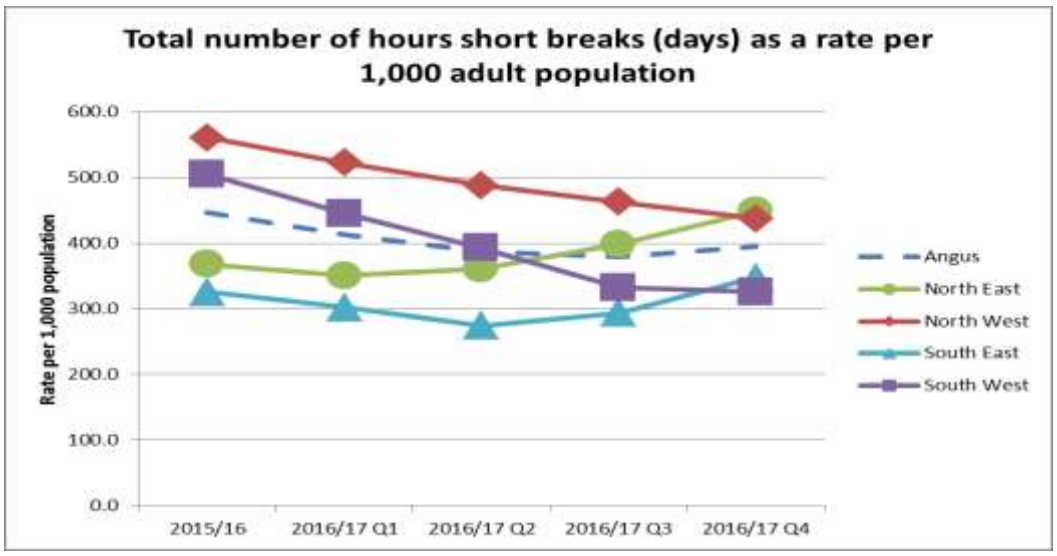
1.3.6 The number of carers accessing short breaks has risen from 454 in 2015/16 to 551 in 2016/17 (an increase of 21%). The carers assessment offers the self-directed support options, providing carers with greater flexibility about what types of services they choose and how they are delivered. Following the introduction of self-directed support there has been a shift away from the use of day care with carers using shorter breaks at home rather than day care to support their respite needs. Total day respite hours have reduced from 41810 in 2015/16 to 36961 in 2016/17 (a decrease of 11%). There is wide variation in day time respite between localities with the North West supporting the most people with day time respite and the most number of hours.

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



Source: Care First (Angus Council)

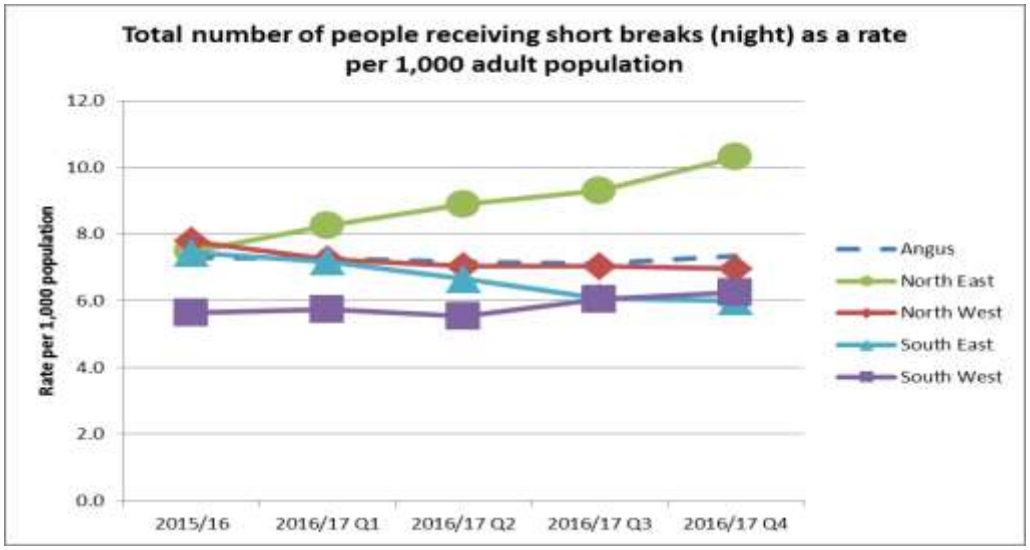
Graph 4: Management Information at Locality: Rate of short breaks (daytime hours)



Source: Care First (Angus Council)

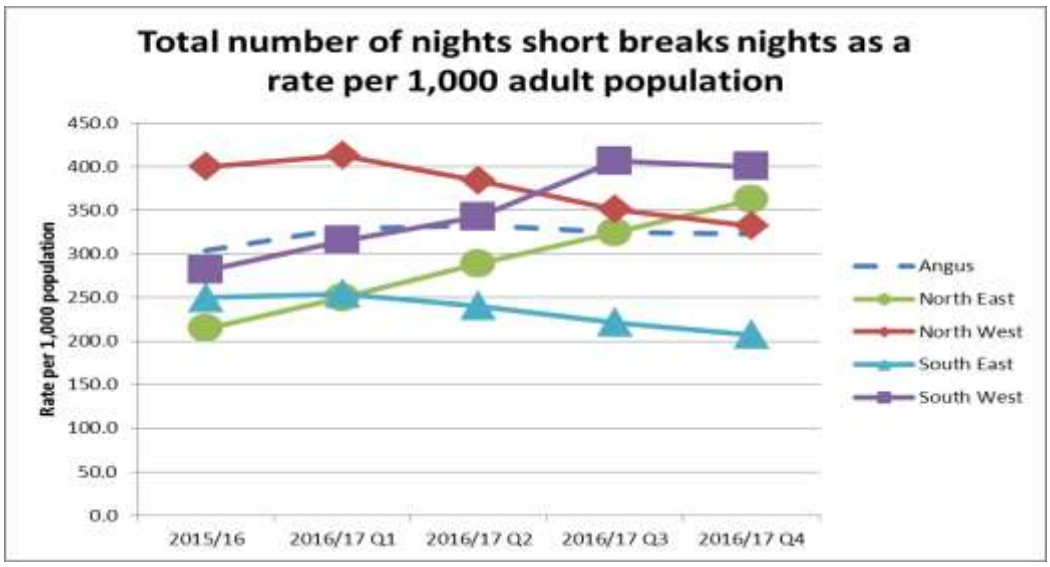
1.3.7 There continues to be a similar rate of provision for short break nights and the number of carers accessing this support. Variation between localities is increasing, with the North East locality supporting more people with respite and providing more overnight respite .

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



Source: Care First (Angus Council)

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

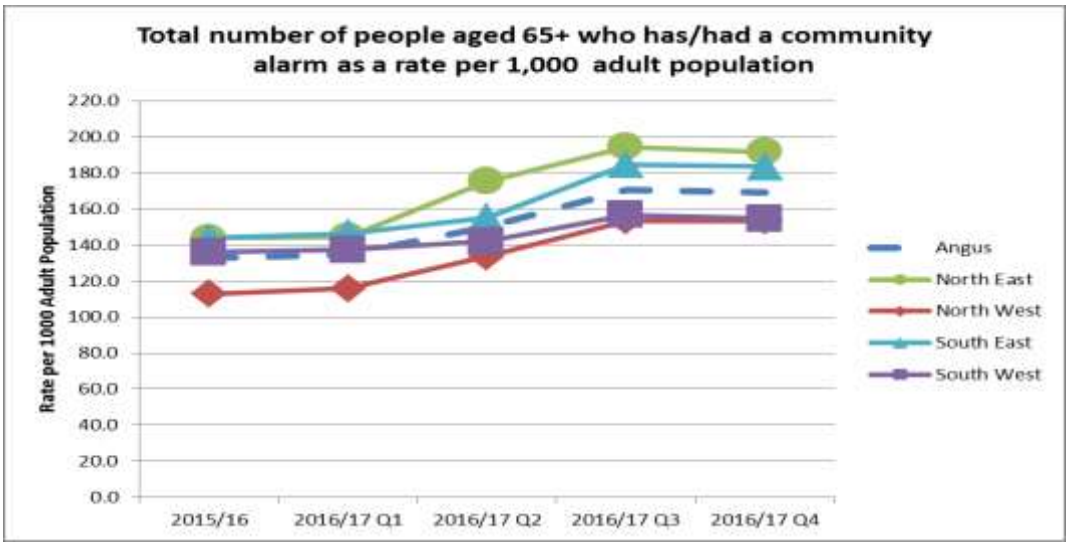


Source: Care First (Angus Council)

Community Alarm

1.3.8 Installation of community alarms has risen since 2015/16. Community alarm now support 4381 people across Angus. This is an increase from 3438 in 2015/16 (27% increase).This is in line with our aim to improve tele-enabled care. The range of available equipment and sensors has also increased e.g. GPS monitors, Tru-call, call blocking system. There is variation between Angus localities in the uptake of community alarm.

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



Source: Care First (Angus Council)

Enablement

1.3.9 All new referrals for a social care service, where eligible needs exist, are supported by a period of enablement lasting between four to six weeks. Enablement services have been successful in returning individuals to full independence. In 2015/16 52% of people who were over 65 years required no further services following a period of enablement. Individuals using enablement in 2015/16 were much more likely to have had previous successful enablement contacts. Due to changes in operational procedures we are currently unable to show enablement performance for 2016/17.

Enabling Stuart and Alan

Stuart, an older gentleman was in Montrose Infirmary The nursing staff and the occupational therapist were unsure how this man would manage at home due to memory and mobility. They were concerned that he might go home only to fail.

Stuart was keen to go home so we agreed a discharge with 4 times daily visits from the enablement service. It took a few days for Stuart to find his feet but he became independent within four weeks. The only service he now requires is assistance once a week for 5 minutes to change a catheter leg bag.

Alan is an older gentleman who had poor mobility, poor appetite, a urinary catheter and a stoma in place

He was discharged from hospital with support from the enablement service 4 times a day. Alan took a week to settle back at home. He is now independent with making his own meals and his appetite has increased. He has also become fully independent with his personal care needs and manages well with bathing equipment supplied by the occupational therapist. Initially the only ongoing assistance he required was to change his catheter leg bag, but the catheter has now been removed. Alan no longer requires social care support. He has a community alarm, just in case he needs us.

Accident and Emergency

1.3.10 An Accident and Emergency Performance indicator is not included in the national core data set for integration therefore we have not developed locality information in this area. The Scottish Ministerial Group have asked for projected performance in this area. We do know that there has been a deceasing trend in the Angus population in relation to attendance at A & E. We expect this trend to continue. Following an attendance at A & E the proportion of people who require to be admitted is increasing; we expect this trend to continue as people use emergency departments and minor injuries and illness units (MIIUs). There is a planned approach to reviewing the future provision of MIIU services in Angus. An option appraisal will be developed in consultation with localities.

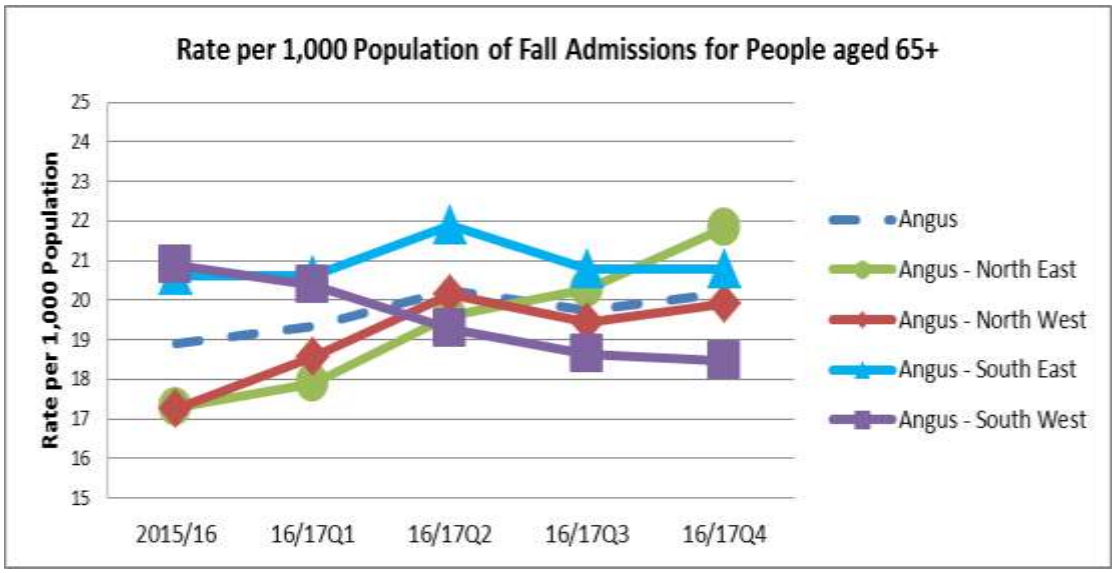
1.3.11 The aim is to continue to reduce A&E attendances in line with the current projection. This reduction is approximately 6% by 2018.

Admissions following a fall

1.3.12 In 2016/17 the rate of falls admissions in Angus is 20 per 1,000 population. This Angus falls rate is an increase on the 2015/16 level of 19.2 per 1,000 population. The Angus falls rate is just below the 2015/16 Scottish rate of 21 per 1,000 population. Angus was ranked 8 for this national indicator in 2015/16. The level of falls in our community does contribute to hospital admissions and places ongoing pressure on services as individuals are more likely to need ongoing health and social care support.

1.3.13 There is a continued upward trend in the rate of falls leading to an admission in Angus. This upward trend is most pronounced in the North East and North West localities. The South West saw the biggest decrease between 2015/16 and 2016/17. The reason for this recent improvement in the South West is unclear and requires to be investigated as part of the review of the falls pathway in order that any improvement opportunities can be shared across Angus. The increase in falls rate accounted for an additional 42 admissions due to falls in 2016/17 from 2015/16 admissions (an 8.5% increase).

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



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

Note: * 2016 rates are provisional and are not official ISD statistics. Official figures for 2016 will be released later in 2017.

Priority 2: Supporting care needs at Home

The Joint Strategic Needs Assessment identifies that the population of Angus is growing older and that the population of Angus will continue to age for the next 20 years. It is anticipated that this change in demographics will place a further increase in demand on services if they continue to be delivered in the same way. The strategic plan aims to address demographic change by changing the way that services are provided. The focus of the strategic plan is to support care needs at home by enhancing opportunities for technology enabled care; further progressing self-directed support; and delivering change in care at home services through the Help to Live at Home project.

2.1 What we have achieved to date

- Delivered a range of new support through technology enabled care such as video active, a joint venture with Angus Alive; provided new types of equipment through community alarm such as call blockers to reduce nuisance calls and scams; GPS systems to support people with dementia when they are out and about; introduced Florence (FLO) a patient reminder system to support GP, nursing and allied health professional (AHP) interventions with patients.

Using technology to support people at home

Alistair is a gentleman who lives with his daughter. He has recently been diagnosed with Alzheimer's disease. Alistair has enjoyed walking all his life but has started to get confused whilst out walking and has become distressed when he has not been able find his way home. His daughter, Alison, became concerned about her father getting lost and started following him when he was out for his walks. We have provided Alistair with a GPS tracker which has allowed Alison to monitor his movements within the town without the need to follow him. The tracker provided Alistair with an easy way to get in touch with his family if he became disorientated. Alistair is very happy that he is able to get out of the house and that his daughter is reassured. He says 'I no longer feel like a prisoner in my own home being watched all the time'.

- One of the recorded reasons for delays in timely discharge has traditionally been the lack of capacity in personal care services. The Help to Live at Home project has made significant progress in addressing this. The programme has led to an improvement in availability of personal care with greater choice and control for individuals in how their support is delivered. More personal care is being delivered in our localities than ever before. Much more of that care is now being delivered by the independent sector.

- Intervention through Voluntary Action Angus to support people to get home and remain at home through volunteer post-hospital support programmes.

- Developed a 'next steps to home' project which supports people with enablement based respite while care at home arrangements are established.

- Integrated the health and social care occupational therapy teams delivering a locality based model.

- Plans around the use of technology enabled care to support self-management of long term conditions and people with multi-morbidities are testing telehealth opportunities to support people to live at home for as long as possible.

Supporting people to get in and out of their house

Occupational therapists work with Angus Care and Repair to look at solutions for the provision of ramps quickly to support discharge or towards the end of life. Mr M had a long term progressive condition affecting his functional mobility. He required to use mobility aids both in and outwith the home environment and used a wheelchair for longer distances outdoors although his use of this will increase over time. Mr M was unable to manage the access steps to his home. He was residing wholly on the ground floor of his property and unable to get outside.

Mr M wanted to be able to enter/ exit his home independently and have more choice about when he can go into his garden/ community setting. The ramp was installed in July 2016 and removed in February 2017 following his death. The ramp improved his end of life care significantly.

Approximate cost of a permanent solution would have been £3400. Cost of temporary ramp and installation was £1712. The ramp has now been reused elsewhere.

- Developed a social enterprise model 'Care about Angus' which supports people living in sheltered accommodation.

Care About Angus is a social enterprise. It has grown considerable during 2016/2017 from an organisation employing 24 staff in April 2016 to 55 staff in March 2017. Our client base has also grown. Home Help Service April 2016 1417 hours service delivered, March 2017 1694 hours service delivered, a 19.5% increase.

The demand for Home Help services is growing with between 4 and 7 new enquiries received each week. It is not always possible to satisfy the demand immediately as there might not be available staff in the right area at the time; this situation is constantly reviewed by management and new staff recruited when possible. All staff are trained, PVG checked and are issued with a contract of employment.

Community Resource Worker service in Sheltered Housing - August 2016 330 clients, March 2017 362 clients, a 9.7% increase. The number of clients fell initially in 2016 due to some residents being excluded from the benefit system when SDS was implemented. We are also restricted in the number of new clients by the total number of housing units available in each Sheltered complex and the type of client being given accommodation.

Community Resource Workers are offering a much wider range of services to clients based on discussion with the client, their families or Care Managers and is person centred so they do not receive a stereo-type service but one based on individual needs. Staff also work closely with Community Alarm to ensure that if an emergency arises when they are on site then a rapid response is possible.

2.2 What we plan to do next

- Through the Help to Live at Home programme, deliver the redesigned enablement, early supported discharge and prevention of admission services.
- Embed ECS in practice in the North localities and review effectiveness in South localities in light of year end performance information.
- Although palliative care services are hosted by the Dundee Partnership we believe it important to develop a locally based approach to palliative care. Lippen Care has agreed to fund a project worker for a year to bring together local professionals and communities to agree our local approach to palliative and end of life care.
- Continue to improve on the number of anticipatory care plans in place.

- In line with the promises in the National Delivery Plan for Health and Social Care, the availability of Key Information Summaries will be increased and everyone will be offered one by 2021.

- Examine opportunities for greater application of telecare during night-times in residential care and supported accommodation.

- Address sleep-over arrangements in line with Scottish Living Wage and working time directives.

2.3 How we monitor progress

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

Self-directed support

2.3.1 Access to long term support requires an assessment of need with an individual making choices about what services would meet their personal outcomes, how and when those supports will be delivered/accessed and who will provide them. Self-directed support is the mechanism by which these choices are provided. The options available are:

Option 1 - direct payment
Option 2 - person directs the available support
Option 3 - local authority arranges the support
Option 4 - mix of the above

1357 people now access self-directed support options; an increase of 12% on 2015/16. There has been a shift towards greater choice and control with a greater proportion of supported people accessing direct payments (option1) and directing the available support (option 2). Option 2 was not available before the introduction of the Social Care (Self-Directed Support) (Scotland) Act 2013 and uptake continues to rise. Most people in Angus continue to access option 3, asking Partnership staff to organise support on their behalf although the proportion of people using option 3 has decreased. As yet there is very little shift from traditional models of support provision with most resources continuing to be spent on personal care. Table 3 below identifies the relative uptake of the self-directed support options.

Table 3 Self-Directed Support Uptake of Options

Indicator	2015/16 Value	2016/17 Value
Percentage of people who access SDS (Option 1)	4%	8%
Percentage of people who access SDS (Option 2)	13%	15%
Percentage of people who access SDS (Option 3)	79%	73%
Percentage of people who access SDS (Option 4)	4%	4%

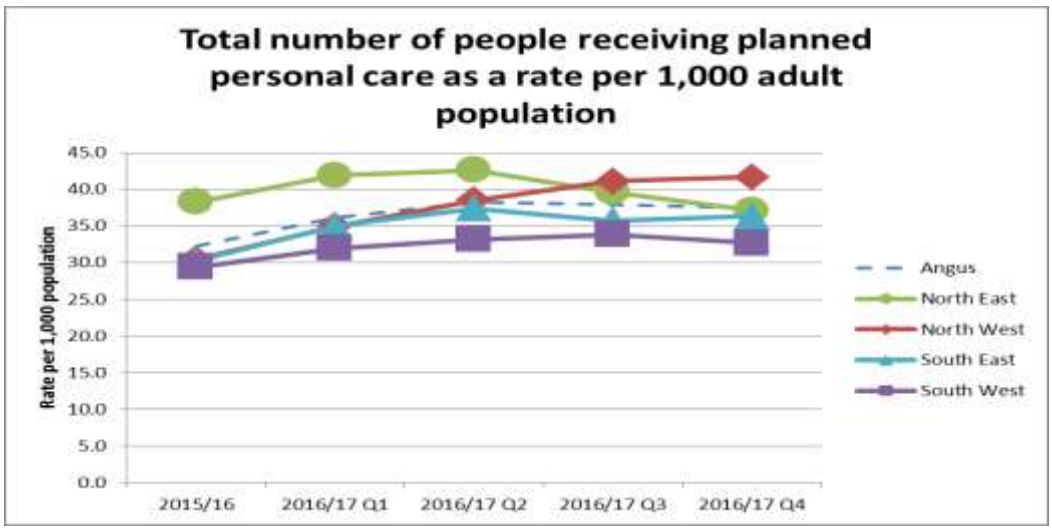
Source Care First (Angus Council)

Care at home including personal care

2.3.2 In 2015/16 Angus provided the lowest levels of intensive personal care support packages in Scotland with approximately 49% of those requiring personal care receiving 10 hours or more; the national average was 62%. Care home placement rates for people aged over 75 remain much higher than the Scottish average (paragraph 3.3.10). This suggests that the balance of social care provision in Angus requires to be addressed further.

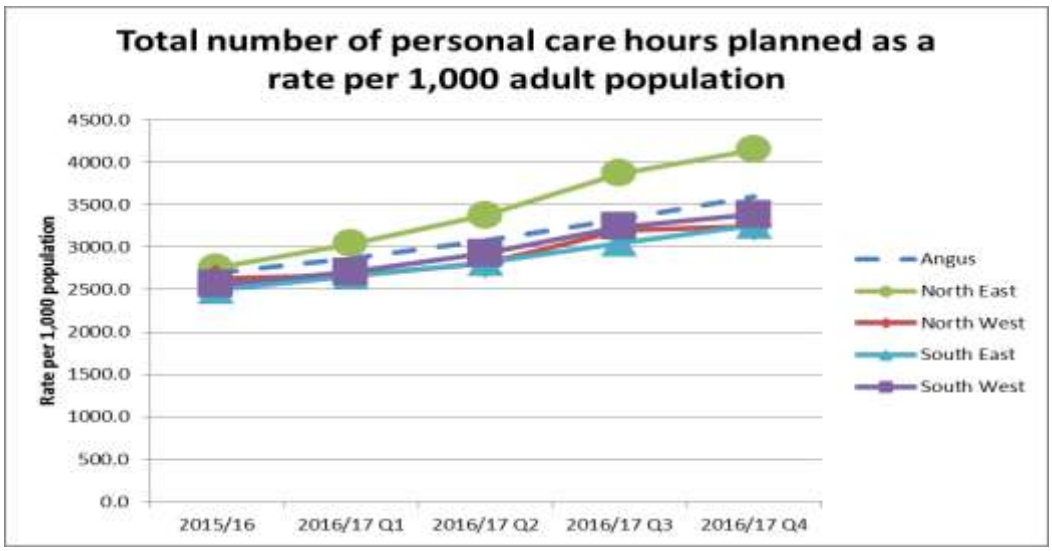
2.3.3 In 2016/17 both the number of people receiving personal care and the number of hours delivered has increased. In 2016/17 1307 people received personal care every week an increase of 5% on 2015/16. 336,000 hours of personal care were delivered in 2016/17, an increase of 33% (an additional 83,691 hours) on 2015/16.

Graph 9: Management Information at Locality level: Rate of Personal Care Hours



Source Care First (Angus Council)

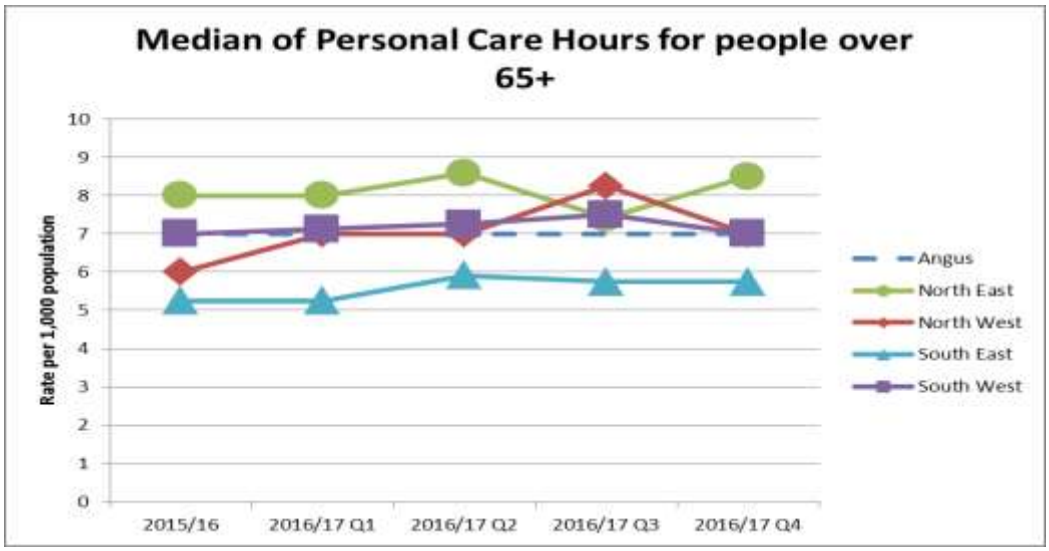
Graph 10: Management Information at Locality level: Rate of Personal Care Hours



Source: Care First (Angus Council)

2.3.4 In 2016/17 the most often offered (median) size of a personal care package in Angus was 7 hours. More people are receiving this level of personal care and this has contributed to the average (mean) personal care package increasing from 3.9 hours per week in 2015/16 to 4.9 hours per week in 2016/17.

Graph 11: Management Information at Locality level: Personal care support package per week (Hours)



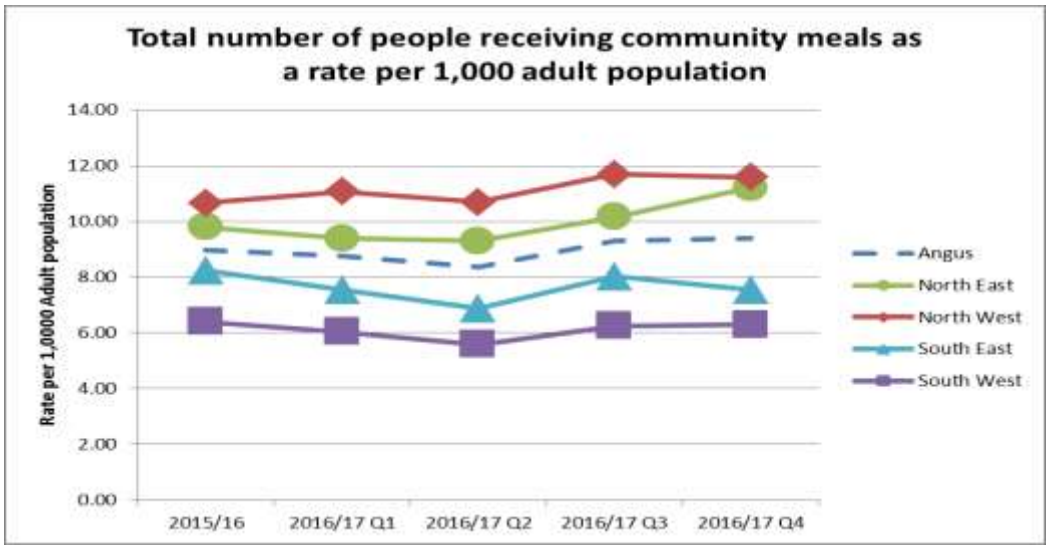
Source: Care First (Angus Council)

2.3.5 Social Care in Angus is not focused solely on personal care (2.3.2). There are a range of different types of supports available, including community meals, day care, community alarm, and volunteer arrangements for transport and befriending which combine with personal care provision to support people to live at home for as long as possible.

Community Meals

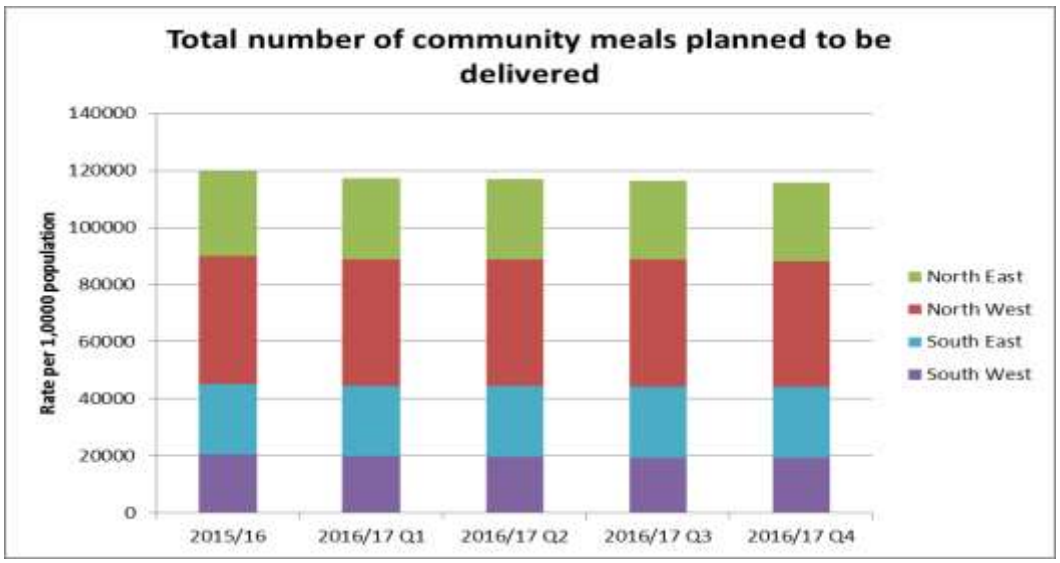
2.3.6 The number of people receiving community meals has increased from 839 in 2015/16 to 879 in 2016/17. The number of people using the tea time sandwich service, delivered along with a hot lunch, has declined. This appears as an overall reduction in the number of meals provided from 119662 to 115744.

Graph 12: Management Information at Locality level: Rate of Community Meals provision



Source: Care First (Angus Council)

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

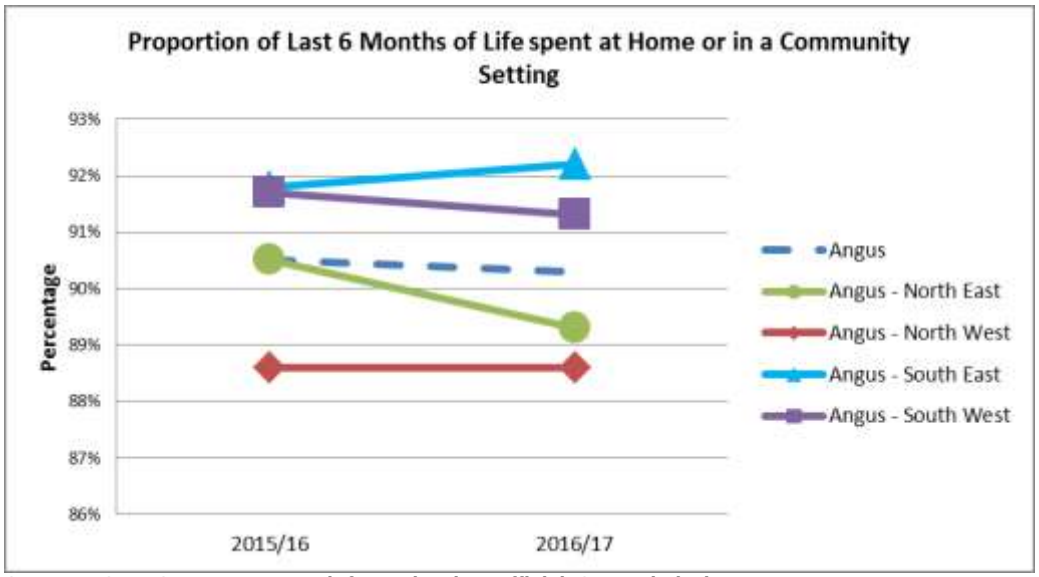


Source: Care First (Angus Council)

Last 6 months of life

2.3.7 Angus performs well in relation to end of life care. The percentage of time that people spend at home or in a community setting in the last 6 months of their life in Angus is 90%. Across Scotland as a whole 87% of people spend the last 6 months of life at home or in a community setting. There is variation across localities with the South localities supporting more people to live at home or in a community setting during the last 6 months of life than the north localities. It is anticipated that the roll out of enhanced community support in the north localities will support improvements in this area of performance.

Graph 14: Management Information at Locality Level: Proportion of Last 6 Months spent at Home or in a Community Setting



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

2.3.8 We know we need to develop locality based information on end of life care including gaining a greater understanding of place of death and the type of support that requires to be in place to continue to shift the balance from large hospital to community based supports. Once information is available this will be included in the quarterly performance report for the IJB.

Priority 3: Developing integrated and enhanced primary care and community responses

Over the next three years AHSCP aims to deliver performance that meets the aspirations of Angus communities. The aim is to support individuals to stay at home when appropriate; if a hospital admission is necessary then to ensure a timely discharge plan with relevant support available at home or in localities is important. In Priority 3 we consider the impact of improvements around our GP practices and in the community on the unplanned use of hospital beds.

3.1 What we have achieved to date

- The development of Enhanced Community Support (ECS) wraps responsive services around GP practices; proactively assessing older people with frailty that are at risk of an unplanned admission. ECS responds to escalations in health needs and it is delivered through the development of multi-disciplinary team. ECS has contributed to the success of supporting shorter hospital stays and thereby reducing bed day rates in the South localities. This service has not yet commenced in the North West and it is currently being implemented in the North East. Successfully supporting people at home who may otherwise have gone to hospital through ECS delivery in the South has led to the ability to close beds at Little Cairnie and also within Arbroath Infirmary.

Delivering ECS

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

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

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

The outcome of working together was that Mary:

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

- Increased the availability of personal care services through the Help to Live at Home programme.
- Embedded a planned date of discharge approach in discharge planning.
- Increased the number of anticipatory care plans in place.
- Located care management within community hospitals.

3.2 What we plan to do next

- Further opportunities for improving performance in this area need to be identified and implemented following further analysis of year-end figures, taking into account changes in performance information in the South localities, where ECS is the most well-established.
- Review reasons for re-admission to hospital within 28 days of discharge across hospital settings to establish a clear benchmark and then identify and agree improvement actions which will continue to contribute to a reduction in re-admission to hospital.
- Review the effectiveness of social care packages which were in place for people who experienced a readmission within 28 days, and other factors which may have contributed.
- Fully implement ECS in the North localities with the expectation that this will lead to a requirement for a reduction in in-patient beds in keeping with the Scottish Government's Health and Social Care Delivery Plan (December 2016).
- A review of out of hours services is being progressed. This has identified and proposed an outline plan for transforming unscheduled care and a new model of service provision based in line with national transformation plans.
- Develop an improvement plan to address the increasing falls rate in Angus. Supported by public health, the improvement plan is identifying areas of best practice across Scotland and this will incorporate a review of the Angus falls services.
- Address the variance in average length of stay in hospital following emergency admission between our localities through ECS.
- A review of the care home model in Angus is due to report to the IJB in September. Implement the recommendations of the care home review once approved by the IJB.

3.3 How we monitor progress

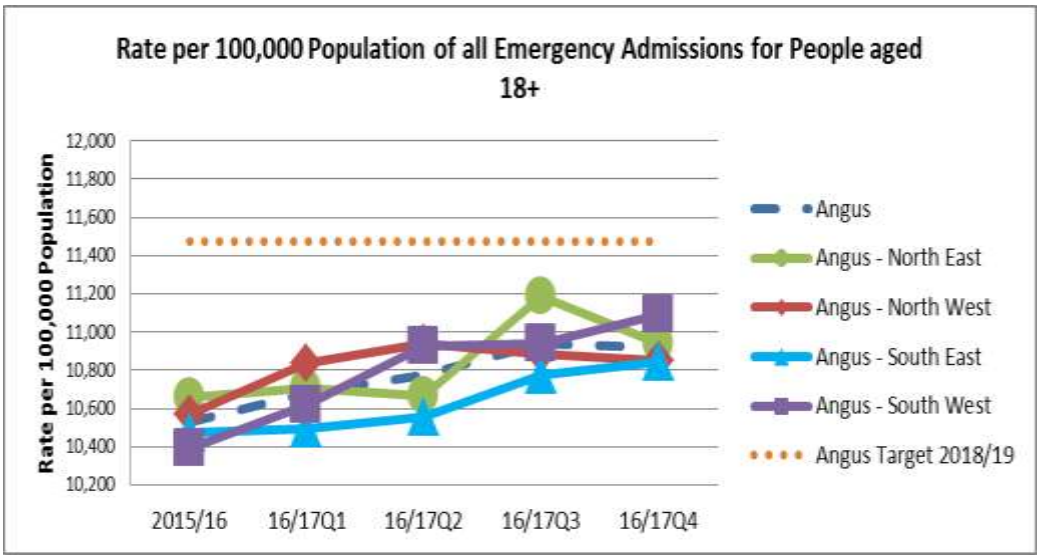
Progress is monitored through the following national and local performance measures:

Emergency admissions

3.3.1 Angus continues to perform well against the national picture and as at 2015/16 it is the 9th best performing partnership in Scotland.

3.3.2 Since 2015/16 all localities have seen an increase in emergency admission rates. There were 362 more admissions n 2016/17 than in 2015/16. In 2016/17, the South East has the lowest emergency admission rates and the South West has the highest emergency admission rates for people aged over 18 in Angus. The increase in the South West is driven by the increase in readmissions (see graph 20).

Graph 15: Management Information at Locality Level: Rate of Emergency Admissions for Adults



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

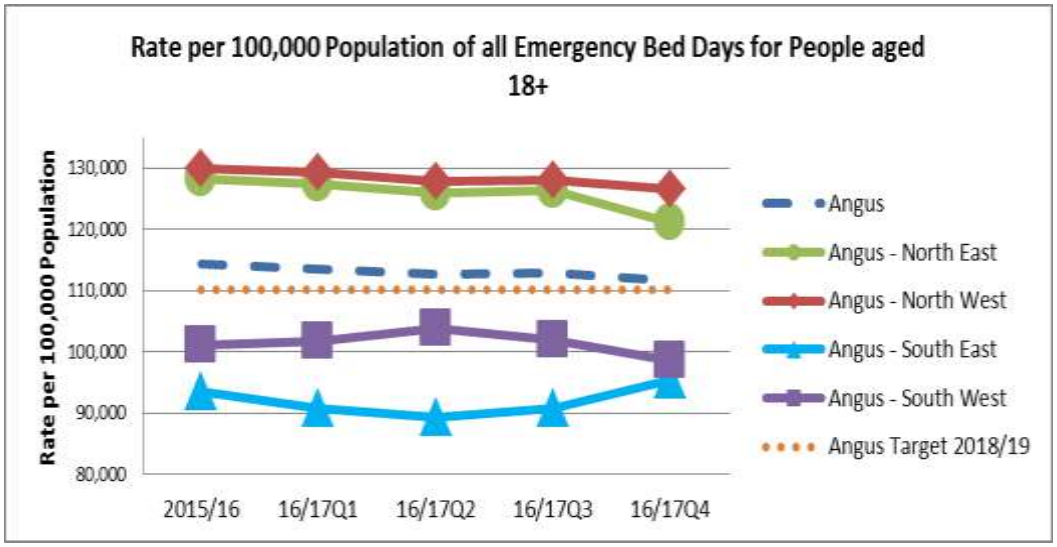
3.3.3 Although the rate of emergency admissions has increased, Angus continues to perform well against the national picture as admission rates are increasing across Scotland. Angus has continued to manage admission rates within the locally set target. This target had taken into account the national picture of increasing admissions and expected Angus admissions to increase in a similar way. Readmissions, which have increased in Angus, make a contribution to the overall picture of increasing admissions. It is anticipated that improvements in addressing readmission within our localities will lead to an improvement in overall admission rates.

Hospital Bed days used following an emergency admission

3.3.4 Angus had a higher emergency bed day rate (107,761) than the 2015/16 Scottish average at 106,531 per 100,000 population.

3.3.5 Although emergency admission rates have been increasing, emergency bed day rates in Angus have been steadily decreasing. The number of bed days used following an emergency admission in 2016/17 in Angus was 105,510 a decrease of 2.5% on the previous year. The lowest bed day rates are in the South East although there has been an increase in quarter 4 from improving South East performance earlier in the year.

Graph 16: Management Information at Locality Level: Rate of Emergency Bed Days for Adults



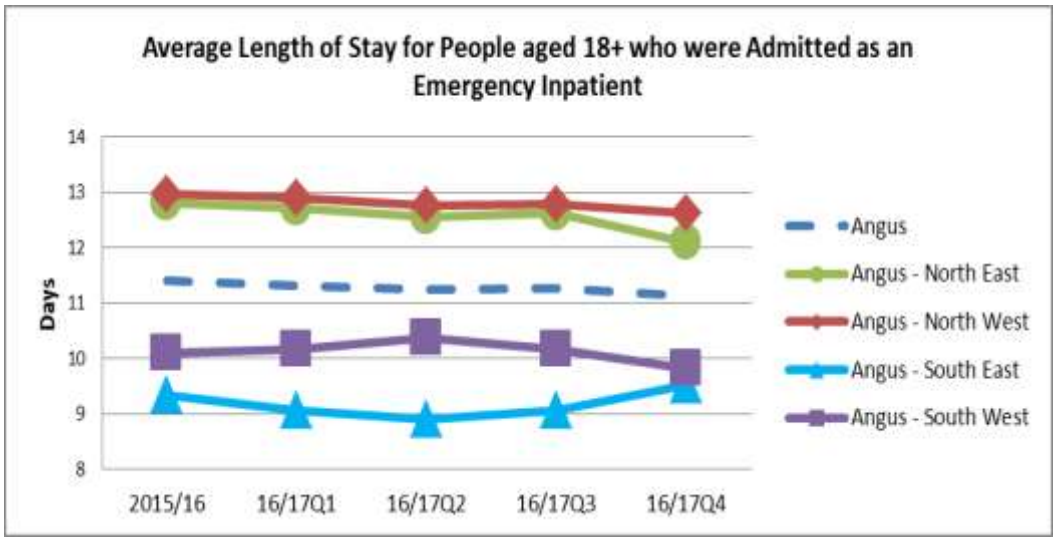
Source: NHS Tayside Business Unit (not official ISD statistics)

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

Length of hospital stay following an emergency admission

3.3.7 The overall emergency bed day rate in Angus has improved due to reductions in average length of stay following an emergency admission. Average length of stay improved in all of the 4 localities. There is room for further improvement as there is a difference of almost 3 days between the North West and the South East localities.

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



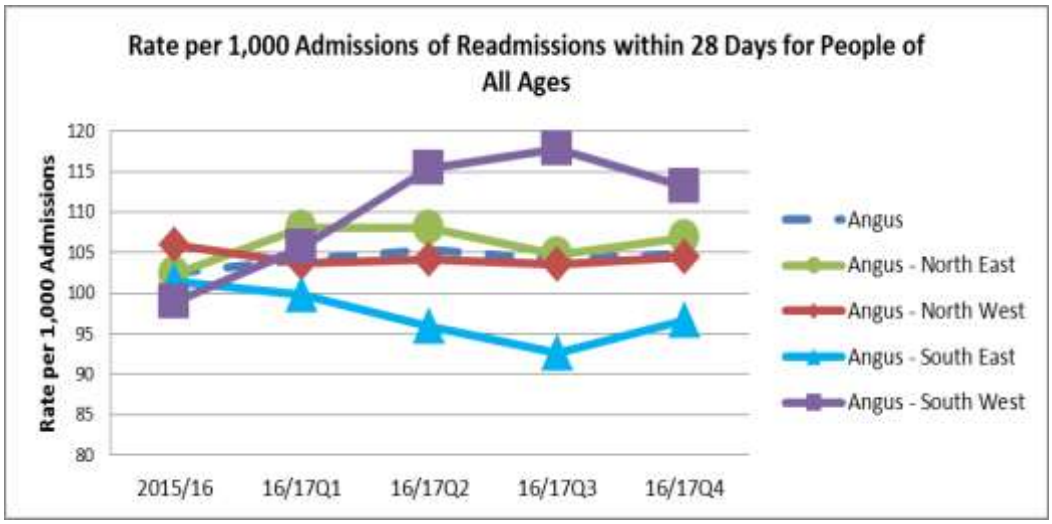
Source: ISD LIST management information (not official ISD statistics)

Readmissions to hospital

3.3.8 In 2015/16 the readmission rate for Angus was 104 per 1,000 admissions. This is above the Scottish readmission rate (96 readmissions per 1,000 admission) and ranked Angus as the 23rd performing partnership in Scotland.

3.3.9 Readmission rates in Angus in 2016/17 are higher than in 2015/16 at 107 readmissions per 1,000 admissions. The South West locality has seen the biggest increase in readmission rates between 2015/16 and 2016/17 but has begun to address this since the quarter 3 performance report. During 2016/17 the South East saw quarter on quarter improvements in readmission rates followed by an increase in quarter 4. A greater understanding of readmission data is required to understand how community responses might reduce readmissions to hospital.

Graph 18: Management Information at Locality Level: Emergency Readmission Rates within 28 days



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

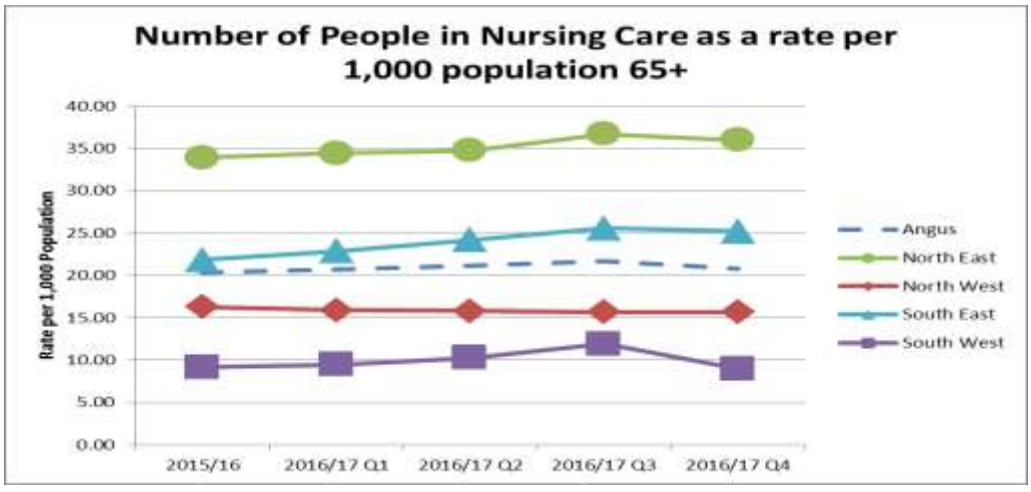
Residential and Nursing Care

3.3.10 The average age of a person placed in a care home in Angus is approximately 84.9 years, an increase from 84 years in 2015/16. The average length of stay has continued to decrease from 18 months in 2015/16 to 17.1 months in 2016/17. At any one time there are approximately 770 people placed in a care home. The total number of people in placements during 2016/17 was 1,985, an increase of 3.6% on 2015/16.

3.3.11 The North West has the lowest rate of total placements (residential and nursing combined) and utilises more care at home and respite. The South East locality makes high levels of placements by population rate. The North East make the most placements by population rate. The South West make the lowest number of placements. The South west was the only locality to reduce placements by rate in 2016/17. This equated to a 10% reduction in actual placements during the year. All other localites saw an increase in the number of placements in 2016/17.

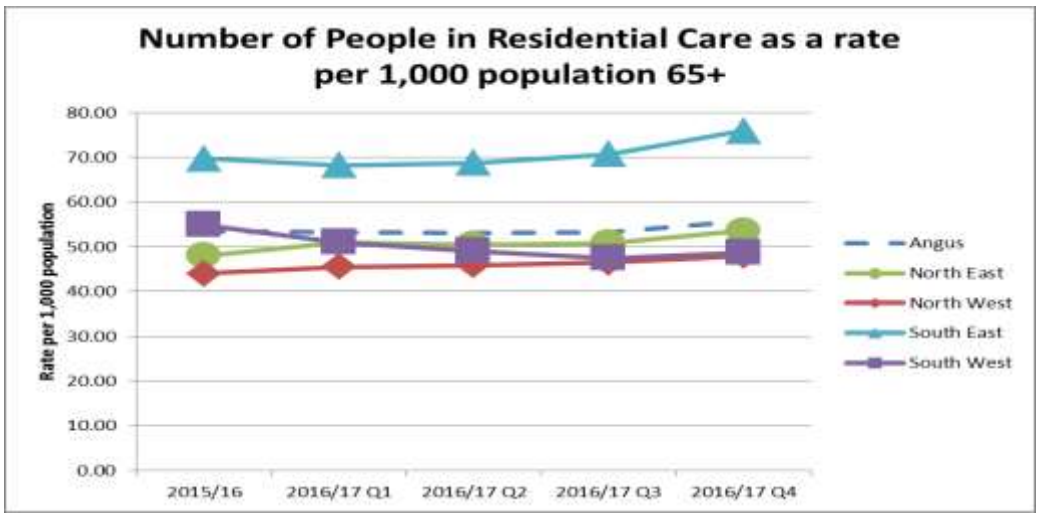
3.3.12 Patterns of care provision are inconsistent across Angus and the variation in the pattern of service uptake cannot be explained by variation in the proportion of over 85s in the population, the level of owner occupiers (who, anecdotally, are more reluctant to move into care) or older people living alone (who are more likely to be considered at risk and more likely to take up a care home placement). Commissioning of care home placements does relate more closely to the rate of bed provision within the locality.

Graph 19: Management Information at Locality Level: Nursing Care Placement Rate



Source: Care First (Angus Council)

Graph 20: Management Information at Locality Level: Residential Care Placement Rate



Source: Care First (Angus Council)

Priority 4: Improving integrated care pathways for priorities in care

Health and Social Care services are available to support all adults in need. There are some more complex needs that require additional support. This includes specialist needs such as mental health, learning disability and substance misuse. Services may wholly or in part be hosted by another Partnership. Angus Health & Social Care Partnership is working with other Partnerships and with Housing to develop responses to services in this area.

4.1 What we have achieved to date:

- Reviewed and implemented timely discharge processes including direct referral from discharge co-ordinators to early supported discharge and enablement teams.
- Provided additional resource for the discharge team at Ninewells.
- Provided access to social care IT systems for discharge staff working in Ninewells.
- A housing contribution statement has been agreed with Angus Council Housing services which sets out how specialist housing needs will be supported.
- Developed an accommodation overview and priorities for people with learning disabilities. Progressed three specific accommodation projects for people with learning disabilities.
- Increased the number of people with a power of attorney in place in Angus through our involvement in a campaign to improve uptake.
- An Angus Autism Strategy has been developed and approved. An implementation plan is being progressed.
- An older people's mental health strategy is being developed.
- The development of a Carers strategy is being progressed in line with the new Carers (Scotland) Act 2016. Commencement date for this new legislation is April 2018.
- A learning disability accommodation overview has been produced with three priorities agreed by the IJB.
- Progressed the delivery of new supported accommodation in Forfar for people with a learning disability.
- A strategy has been published by the Alcohol and Drugs Partnership and a delivery plan implemented.
- Worked with Perth and Kinross HSCP (host IJB) on issues facing in-patient adult mental health services.
- Successfully tested the delivery of mental health and wellbeing services within one GP practice.

4.2 What we plan to do next

- Work with Housing to ensure the availability of community based accommodation for people with mental ill health and learning disability.
- Replace The Gables Care Home with supported accommodation for the current residents.
- Conclude the review of hospital bed needs in Angus and implement the findings; this is due to report to the IJB later in 2017.
- Further develop discharge planning arrangements for adults with mental ill-health, learning disability, physical disability.
- Conclude the review of supported accommodation for older people and implement the findings.

- Undertake a review of supported accommodation for people with learning disabilities.
- Undertake a review of supported accommodation for people with adult mental health problems.

4.3 How we monitor progress

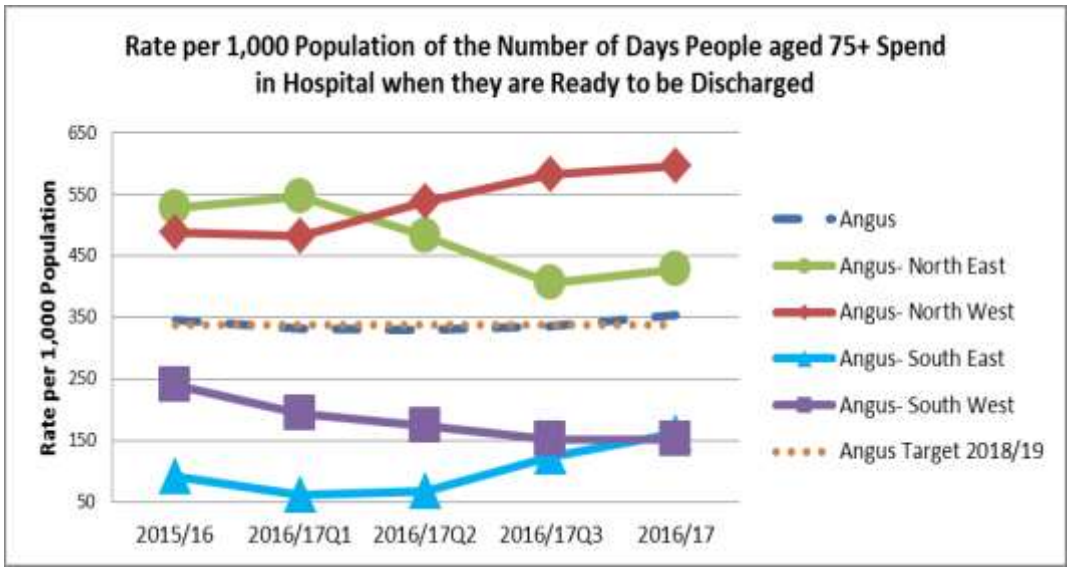
Angus Health & Social Care Partnership is working with housing, learning disability, adult mental health and other services to identify appropriate measures. We measure pathways in and out of secondary care through our work on timely discharge.

Timely discharge

4.3.1 As at 2015/16 the number of days people spend in hospital when they are ready to be discharged as a rate per 1,000 population, is 355 (down from 368) per 1,000 in Angus. This is below the 2015/16 Scottish rate of 915 per 1,000 population. In 2015/16 Angus was the 4th best performing partnership in Scotland.

4.3.2 The rate of all bed days lost to delayed discharges for people aged 75+ has increased from 4042 in 2015/16 to 4153 in 2016/17 (a 2.7% increase). There has been a continued decline in bed days lost to delayed discharge in South West. The average length of a delay has increased from 14.2 days in 2015/16 to 17 days in 2016/17. The total number of people delayed has decreased from 284 to 245. Delays relate to 4% of all bed days associated with emergency admissions. The variance in bed days lost to delayed discharges between the northern and southern localities suggests that there is still room for improvement in the north. Our plans aim to reduce bed days lost to delayed discharge by 4% by 2018 (166 days).

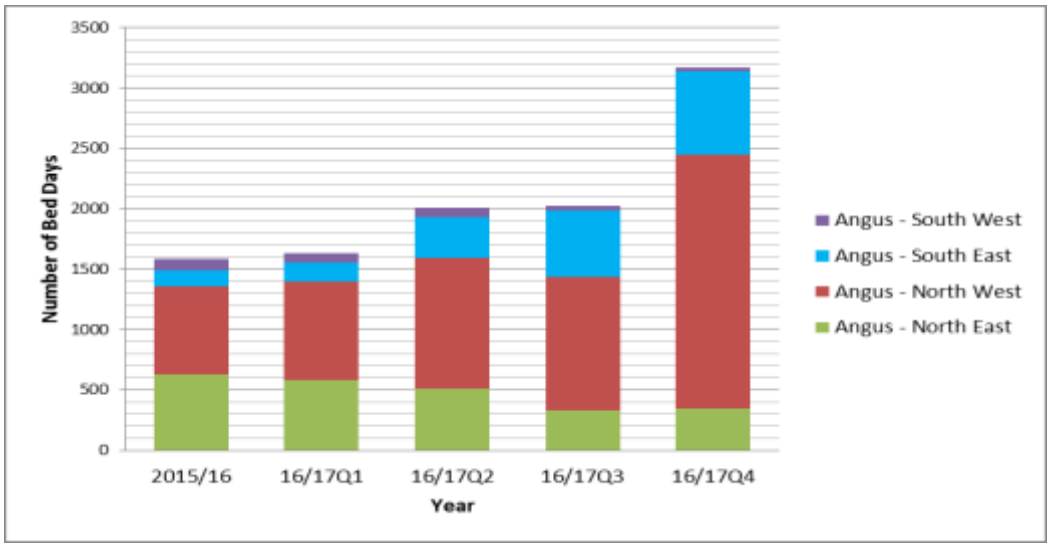
Graph 21: Management Information at Locality Level: Bed days lost to delays in discharge



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

4.3.3 The number of bed days lost to complex delayed discharge has doubled between 2015/16 and 2016/17. The main reason for delay is people awaiting legal process to be concluded for over 75s (guardianship). For under 75s, complex delays mostly relate to the provision of specialist accommodation to meet assessed needs.

Graph 22: Management Information at Locality Level: Bed days lost to complex delays in discharge



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

4.3.4 The roll out of ECS in North Angus and the continued development of Help to Live at Home is expected to have a reducing effect on patient delays in hospital. It is anticipated that these improvements being made in response to the strategic priorities will have a stabilising effect despite the increasing proportion of older people in Angus.

4.3.5 Campaigns to increase awareness and uptake of power of attorney are expected to have some effect on complex delays. The delivery of the learning disability accommodation priorities and work in mental health services with Housing is also expected to deliver improvements in complex delays. It is recognised that new build accommodation solutions take time.

Performance Area 1: Workforce

Angus Health & Social Care Partnership is working to improve the comparability of the workforce data and present information in a consistent way.

5.1 What we have achieved to date

The Angus Health and Social Care Partnership Staff Forum was established in June 2016 to ensure that the ethos of partnership working is embedded in practice. The forum's remit is to ensure the fair and consistent application of the employing authorities (NHS Tayside and Angus Council) staff governance standards within the Partnership. It addresses operational issues affecting staff and services and contributes to the development and implementation of strategy and policy.

In our Corporate Risk Register we have recorded that *'due to changing demographics affecting our staff and people who use our services there is a risk that Angus HSCP will be unable to develop and sustain its workforce to meet its objectives*,' We plan to mitigate this risk by:

1. Bringing together our health and social care staffing by creating opportunities to improve outcomes through increased efficiency and reduced duplication of effort.
2. Maximising our efficient recruitment and training opportunities to ensure our workforce can meet the services' strategic objectives.

Our Staffing Age Profile (Graph 23) illustrates this risk.

5.2 What we plan to do next

Performance reporting is already in place regarding workforce spend and sickness absence. We will develop an indicator measuring our vacancies and the length of time posts remain vacant.

We are developing a fully integrated workforce plan covering NHS Tayside, Angus Council, Third and Independent sector staff. This will include:

- joint training strategies,
- maximising modern apprenticeships,
- developing joint employer protocols which will permit flexible staffing arrangements to allow immediate staff shortage risks to be managed e.g. use of secondments, temporary contracts, etc.

iMatter, the Staff Experience Continuous Improvement Model will be rolled out across the majority of our services during the summer of 2017. This iMatter process begins with a staff questionnaire that gathers views on their experiences. These are aggregated and a team report is generated. The data in the report can then be used as the basis for the development work at team, service and organisational level, to enhance staff and patient / service user experience. It also offers an opportunity to understand where teams are currently (a baseline) in moving forward as new working arrangements become embedded in the Partnership.

5.3 How we monitor progress

Quantitative Data regarding staff sickness and vacancies will be complemented by qualitative feedback from the iMatter team action plans. These will be reviewed by the appropriate management groups. The progress of our improvement plans are dependent on having the right staff in the right place. Risks will be monitored and reported to the Strategic Planning Group.

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

Angus as a good place to work

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

Sickness Absence

The percentage of sickness absence amongst Angus NHS staff decreased by 0.55% between 2015/16 and 2016/17.

There has been a improvement in the percentage sickness absence of Angus Council staff working in Angus Health and Social Care Partnership between quarter 3 2016/17 and quarter 4 2016/17.

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
NHS staff	5.02	4.78
Angus Council staff	6.28	7.46

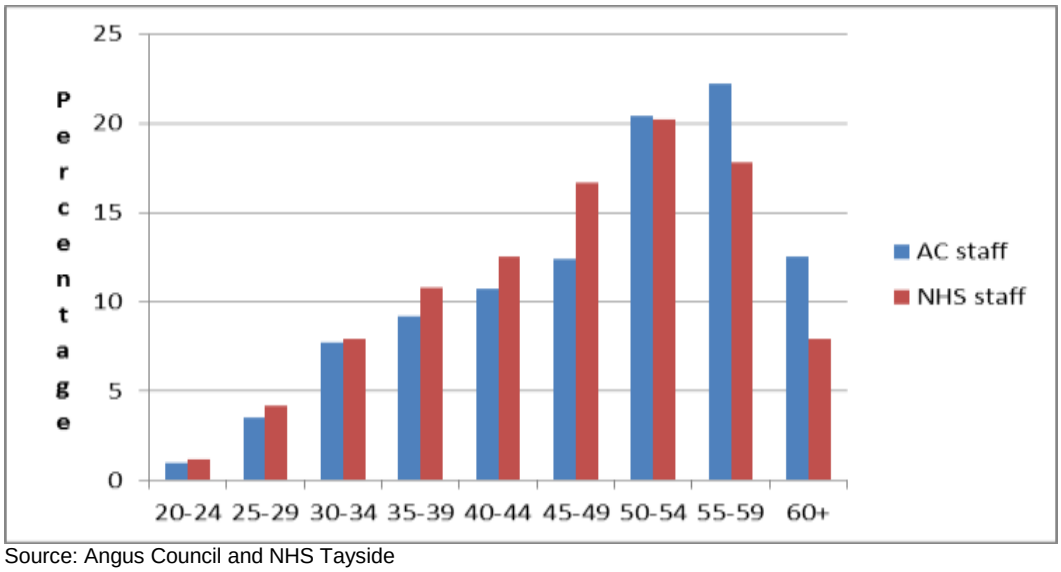
Source: Angus Council and NHST epayroll

We know that our staff are delivering services and care in an increasingly complex environment and that stress related illness is amongst the main causes of absence across Angus. The emerging workforce plan will ensure that appropriate support systems are in place to address sickness/absence.

Age profile

There are 833 NHS Tayside staff and 845 Angus Council staff working in AHSCP. The workforce is aging.

Graph 23 Management Information at Angus Level: Age profile of Angus Health and Social Care Workforce



Source: Angus Council and NHS Tayside

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

An adult care information governance group has been established in order to develop an internal information governance plan which complies with Angus Council policy. Data sharing agreements exist between Angus Council, Dundee City Council, Perth and Kinross Council and NHS Tayside. A SASPI data sharing agreement has also been put in place to support work between Angus Council, NHS Tayside and ISD. A review of data processing notices is underway to ensure that they continue to be compliant with how information is used.

There were 2 breaches in information governance in relation to adult care services. One involved a mis-addressed letter and the second a survey response. Remedial action was put in place to reduce the risk of further occurrence of similar breach.

Angus Council received 69 freedom of information act enquiries in relation to adult care services. The themes included:

- Uptake of self-directed support options
- A wider range of information in relation to home care services
- Charging and funding
- Procurement and contractual arrangements including contract values
- Occupational therapy, equipment provision and recycling
- Waiting lists and waiting times

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

6.2 Domain 2 - Professional Regulation and Workforce Development

Professional registration and revalidation

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

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

Support, Supervision and Appraisal

It has been identified that stress related illness is a significant cause of absence within Angus. Ensuring good uptake of effective, high quality appraisal that discusses performance

and identifies support and development opportunities for staff will ensure staff are better supported.

The R2 group has responsibility for professional governance and will be looking to develop adequate data on support, supervision and appraisal. There are also plans to seek staff feedback on appraisal with a view to ensuring that appraisal within Angus HSCP is of a high standard.

eKSF for health staff is managed as a rolling programme. A snapshot of performance against this rolling programme is not a reliable measure of the quality and effectiveness of the appraisal and support arrangements that are in place.

Information on the proportion of adult care staff that have had an appraisal within the last 12 months is no longer collected centrally. New systems for collecting this information are being developed within services.

Risks

Two risks in relation to staff availability are highlighted as red risks on the register. This includes the inability to maintain sufficient levels of band 6 and 7 nurses within community nursing and a lack of experienced staff within minor injury units. Both risks are being addressed through the workforce plan (Performance area 2 Workforce).

6.3 Domain 3 - Patient, Service User and Staff Safety

Adult Protection

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

Adverse events

Adverse events are reported routinely by health staff and are typically anything that raises a concern. Approaches to care that encourage rehabilitation and enablement carry a greater risk of falls as greater mobilisation is part of the rehabilitation. This likely accounts for the higher levels of falls which are category 3 (green event/ negligible impact) and all falls in designated rehab facilities. The available information does not include the number of falls attributable to or recorded against one individual. One person may account for multiple recorded falls. Given the number of individuals who pass through premises each year, the falls rate is low. All falls are investigated and any required action is taken.

6.4 Domain 4 - Patient, Service User and Staff Experience

The national core outcome indicators are detailed in Table 1 at the beginning of this report. Outcome indicators relate to people's perception of their experience in using services. Angus performs relatively well against the national picture. The latest national indicator information available is from 2015/16:

89% of adults supported at home agreed that they are supported to live as independently as possible

82% of Angus adults receiving any care or support rated it as excellent or good.

There is opportunity for improvement across all outcome indicators most notably in relation to:

- people's experience of care provided by GP practice
- carers feeling supported to continue with their caring role.

(Source: Biennial Health and Care Experience Survey 2015/16).

Service Feedback

All services undertake experience surveys with people who use those services. Feedback is generally positive but services recognise that there continues to be more work to do. A summary of feedback during 2016/17 is contained in appendix 3.

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 is 90% which is above the Scottish rate of 83%. 2016/17 data is not available at the time of writing. This ranks Angus as the 4th best performing partnership for this indicator. Care services include all registration categories: for example care home, day care, care at home.

Service inspections – Care Inspectorate

There are 76 registered social care services supporting adults in Angus. There have been 58 inspections in relation to care services provided within Angus in 2016/17.

There were 13 requirements made across all themes involving 6 homes

There were 123 recommendations across all themes involving 21 homes

Note: A **requirement** is a statement which sets out what a care service must do to improve outcomes for people who use services and must be linked to a breach in the Public Services Reform (Scotland) Act 2010 (the "Act"), its regulations, or orders made under the Act, or a condition of registration. Requirements are enforceable in law. Requirements are made where (a) there is evidence of poor outcomes for people using the service or (b) there is the potential for poor outcomes which would affect people's health, safety or welfare. A **recommendation** is a statement that sets out actions that a care service provider should take to improve or develop the quality of the service, but where failure to do so would not directly result in enforcement. Recommendations are based on the National Care Standards, SSSC codes of practice and recognised good practice. These must also be outcomes-based and if the provider meets the recommendation this would improve outcomes for people receiving the service.

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

Table 5 : Management Information – Themes of requirements and recommendations following inspections of care services in Angus.

Inspection Theme	Requirement themes	Recommendation themes
Care	medicines	care plans; medicines; skin management; activity; health monitoring; meal time experience
Staffing	recruitment and registration	recruitment; training; induction; supervision; registration
Management	audit	audit
Environment	N/A	signage; lighting; repairs

Source: Care Inspectorate data store

No enforcement action was taken by the Care Inspectorate in Angus during 2016/17.

Service Inspections – Healthcare Improvement Scotland (HIS)

An unannounced inspection of Stracathro Hospital in relation to older people in acute hospitals was undertaken on 21 - 22 February 2017.

Areas of Strength identified during the inspection

- All patients praised the care that they had received.
- DNACPR documentation was well completed.

- Good evidence of reassessments following transfer to Stracathro Hospital.
- Good mealtime management.

Areas for improvement identified during the inspection

- Documentation, such as care rounding sheets, fluid balance charts, food record charts and SSKIN bundles were not always accurately completed.

- The completion of person-centred care plans was variable. These should detail the interventions required to meet patients' identified care needs, but not all care plans reviewed did.

- There were some concerns around the completion of the assessment of capacity to consent and staff understanding of Adults with Incapacity documentation.

Complaints

In 2016/17, 53 complaints were received in respect of health services directed by the Angus Health and Social Care Partnership. The aim is to respond to 68% of complaints within 20 working days. In 2016/17 75% of complaints were responded to within the 20 working days.

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

6.6 Domain 6 - Promotion of Equality and Social Justice

The IJB approved a set of equality outcomes and mainstreaming report in May 2016. Indicators which show how services and outcomes vary between the most and least deprived communities in Angus are being developed. These are reported on separately.

Performance Area 3: Resources

One aim of our strategic plan is to evidence a shift in resources from health to social care provision and from institutional based care to community based services within our localities. We are working with Information Services Division (ISD) on the development of the Tableau health and social care dashboard. This is a system which matches health and social care data and generates information from spend on individuals to demonstrate the split between health and social care spend and between spend on institutional based care and community based services. We are working with ISD to improve the information we submit through their Source data collection system and working towards accessing the analysed data more quickly.

7.1 What we have achieved to date

- Introduced a new sheltered housing model.
- Developing community services including Enhance Community Support which support people to stay at home has resulted in less reliance on inpatient beds.
- Developing sustainable personal care through Help to Live at Home Programme
- Undertaken first phase of review on minor injury and illness services
- Delivered a series of operational, administrative and managerial efficiencies;
- The rate of use of care home beds has been reduced with commensurate improvements in the uptake and availability of care at home.

7.2 What we plan to do next

- Continue to move resources into the community through Enhanced Community Support as the roll out of our community based programmes become effective.
- Work with secondary care to better understand the higher costs in relation to emergency admissions and large hospital resources generally for Angus patients and to develop models of care which allow a shift in the balance of care with resource to the community.
- Further develop the Help to Live at Home Programme.
- Implement the changes to community nurse medicines administration.
- Progress the outcomes from the inpatient review.
- Further review minor injury and illness services.
- Seek to deliver a series of further operational, administrative and managerial efficiencies.
- We will work with Voluntary Action Angus to identify information on the contribution of the voluntary sector to our partnership.
- We will continue to work with the Source team at the Information Services Division (ISD) to improve the provision of social care information in order to develop measures relating to the balance of care between health and social care and the balance of care between community and institutional expenditure.
- Seek to develop locality reporting regarding resources.

7.3 How we monitor progress

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

Currently the availability of data within Tableau is dependent on our ability to upload our local data and on ISD's progress with the development of the dashboard. In respect of financial information the dashboard is currently providing information up to the year 14/15. We do not see this as relevant to the performance of the Partnership and wait for improved information in Tableau as the system is further developed.

Spend on hospital stays following emergency admission

7.3.1 Angus has one of the biggest percentages of total health and care spend on hospital stays where the patient was admitted as an emergency, at 26% against a Scottish average of 23%. This is not directly in the control of the IJB as most admissions are of an acute nature and are to Ninewells Hospital.

Appendix 1

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.	Premature mortality rate. Falls rate per 1,000 population in over 65s.
Priority 2 **Supporting Care needs at Home** **Priority 3** **Developing integrated and enhanced primary care and community responses** **Priority 4** **Improving Integrated care pathways for priorities in care**	**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.	**Priority 2** Percentage of adults with intensive needs receiving care at home. **Priority 3** Percentage of people with positive experience of care at their G.P. practice. Rate of emergency admissions for adults. Rate of emergency bed days for adults. Readmissions to hospital within 28 days of discharge. Proportion of last 6 months of life spent at home or in community setting. Number of days people spend in hospital when they are ready to be discharged. Percentage of people admitted from home to hospital during the year, who are discharged to a care home. Percentage of people who are discharged from hospital within 72 hours of being ready.

Angus Strategic Priorities and Performance Areas	National Wellbeing outcomes	National Core performance measures
Performance Area 1 **Clinical and Care Governance**	**7. People are Safe** People who use health and social care services are safe from harm.	Proportion of care services graded 'good' (4) or better in Care Inspectorate Inspections. Percentage of adults supported at home who agree that they are supported to live as independently as possible. Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided. Percentage of adults supported at home who agree that their health and care services seemed to be well co-ordinated. Percentage of adults receiving any care or support who rate it as excellent or good. Percentage of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life. Percentage of adults supported at home who agree they felt safe. Percentage of adults able to look after their health very well or quite well. Percentage of carers who feel supported to continue in their caring role.
Performance Area 2 **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.	Percentage of staff who say they would recommend their workplace as a good place to work.
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.	Percentage of total health and care spend on hospital stays where the patient was admitted in an emergency. Expenditure on end of life care

Appendix 2

ANGUS HEALTH AND SOCIAL CARE PARTNERSHIP

STRATEGIC DELIVERY PLAN

2017-2019

April 2017

INTRODUCTION

The Angus Health and Social Care Partnership sets out the vision for change and improvement in its strategic plan. The plan set out four strategic priorities through which change and improvement would be delivered.

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

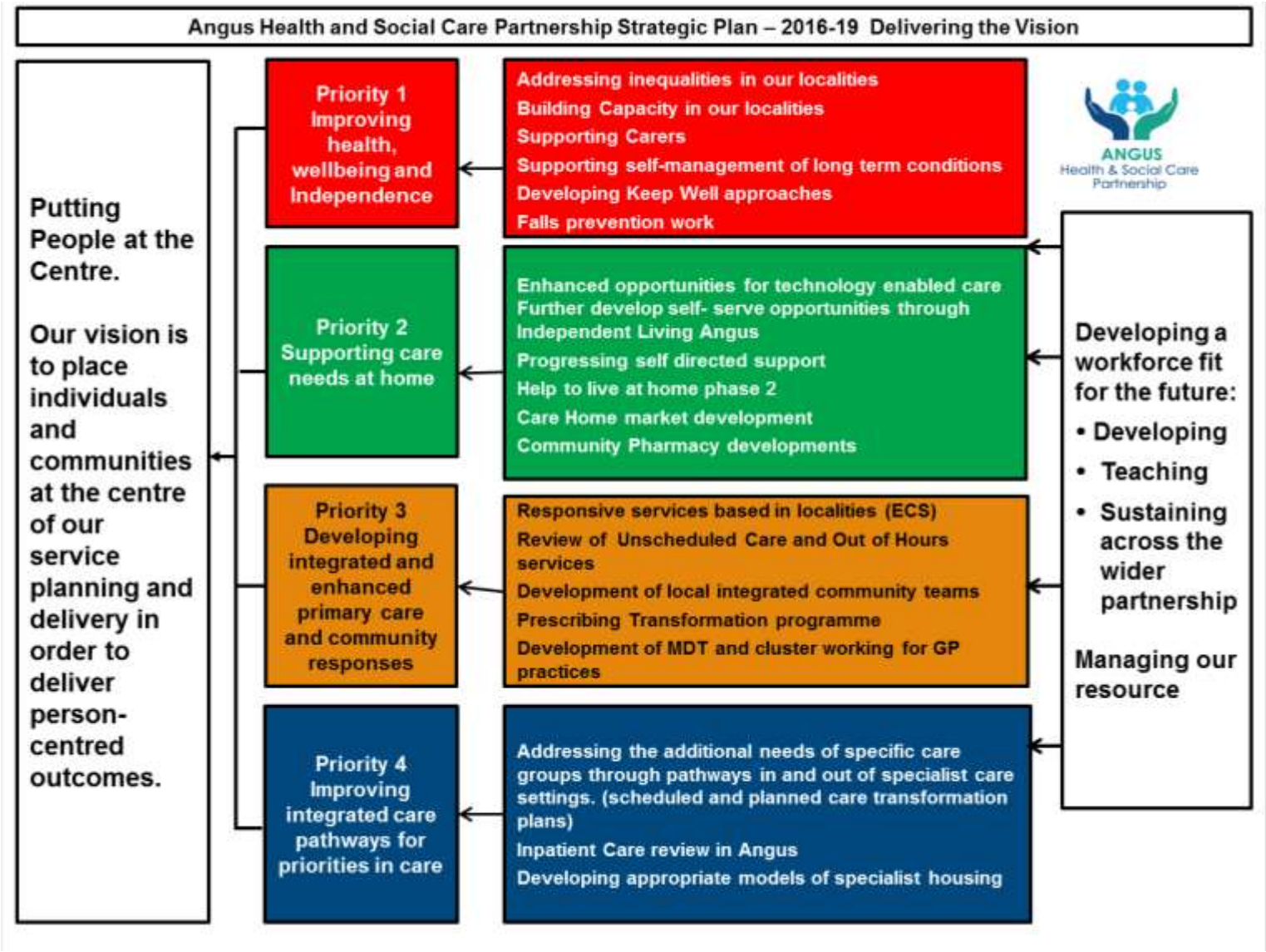
There is a growing demand for care provision. People are living longer with multiple and complex care needs that require more support from health and social care services. Local people have told us they want to access care closer to home, and which helps to maintain their independence and the support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

The strategic plan will be progressed by the delivery of a range of improvement activity across services. This will include integrating teams, delivering services differently and developing new types of service models. Managing this range of developmental and change work is challenging. During the first year of the Partnership we have learned more about how to progress change in a challenging financial and strategic environment. This delivery plan is an iterative document which aims to set out how we will continue to progress our vision over the next 2 years. The delivery plan (table 1) will be updated every 6 months to provide further detail, taking into account the outcome of reviews which are currently underway and the completion of other work. Progress on the achievement of the delivery plan will be reported biannually through a Strategic Progress and Performance report.

Each locality has developed a locality improvement plan which includes an action plan showing how Angus wide improvement projects are impacting on that locality. These plans also identify a number of locality specific tests of change and improvements within localities supported by the locality improvement groups. It is anticipated that some of these tests of change will identify further improvement opportunities that can be rolled out across Angus and be included in a future version of the delivery plan.

Key Improvement Delivery Areas



AHSCP Strategic Delivery Plan 2017-2019

Priority	Project	Outcome	Action	2017/18		2018/19	
				Q2	Q4	Q2	Q4
1	Supporting Carers	To ensure that Angus HSCP is fully prepared for implementation of the legislation on 1st April 2018. The Act furthers the rights of unpaid carers to ensure they are better supported and able to continue to care, if they wish to, and have a life alongside their caring role. To ensure that carers and their representative organisations are fully consulted in the development of the legislation. To create a benchmark of current provision and outcomes met in order to measure the impact of the new Act and track any increase in demand for services.	Identification of the scope and membership of workstreams	√			
			Collaboration and consultation with carers, their representative organisations and other stakeholders	√			
			Develop new Adult Carer Support Plan, Young Carers Statement and support plan	√			
			Local Eligibility Criteria for carers		√		
			Planning and delivery of changes to information systems, operational guidance,		√		
			Staff training		√		
			Publish public information		√		
	Technology Enabled care	Increase in number of people feel empowered to have greater choice and control to manage their own health, care and wellbeing through greater use of TEC. Staff feel more informed and confident to advise service users about TEC options.	Appoint Telehealth Project Manager to oversee implementation and evaluation of Tayside wide pilot of Florence (telehealth system)	√			
			Appoint Telecare Development Officer to increase awareness and uptake of telecare in Angus	√			
			Move from having TEC projects to developments at scale so that TEC shifts from being a desirable option to a core necessity.		√		√
	Falls prevention		Undertake a review of the falls pathway and identify further opportunity to improve falls prevention		√		

Priority	Project	Outcome	Action	2017/18		2018/19	
				Q2	Q4	Q2	Q4
2	Self-directed Support	Deliver personalisation and improve choice and control in relation to social care services for supported people	Develop a Performance Framework	√			
			Develop a Finance Reporting Framework	√			
			Undertake a self-evaluation in relation to SDS	√			
			Implement Phase 3 (2016-2018) National Action Plan		√		
			Implement Service Delivery 2016-2018 Project Plan		√		
			Implement Learning and Development Plan	√			
2	Review of care Home provision in Angus	Care home provision in Angus that is fit for the future need and demand	Agree preferred option from appraisal of local authority care homes	√			
			Agree future preferred option from appraisal of care home market shape	√			
			Publish market facilitation plan		√		
			Deliver intentions from market facilitation plan			√	√
2	Help to Live at Home	To ensure that sufficient personal care and housing support is available in each locality and that supported people have choice and control over their support arrangements	Deliver Phase 2 development of new 'enablement services' including developing criteria and processes for the new service	√			
			Confirm the proposed changes to the service with the Care Inspectorate	√			
			Deliver new contract to replace existing personal care and housing support framework		√		
			Fully implement Care Monitoring		√		
2	Medicines administration	To ensure effective resource management in supporting medicines administration at home	Implement option 3 of the review of medicines administration**.** Band 3 health care assistants undertaking medication administration duties instead of Band 5/6 trained nurses.		√		
3	Enhanced Community support	Improve multidisciplinary working around GP practice to support timely discharge and support people at home when needs increase	Implement ECS model in North East Locality	√	√		
			Implement ECS model in North West Locality		√	√	
3	Drug, alcohol and substance misuse services	Access to a single service, one pathway, one multidisciplinary team and ultimately a single budget. Reduced duplication,	Integrated teams: Alcohol and Drug services - Angus Council Drug, Alcohol and Blood Borne Virus Team and Tayside Substance Misuse Service (Angus) will merge.	√			

Priority	Project	Outcome	Action	2017/18		2018/19	
				Q2	Q4	Q2	Q4
		improved collaboration and integration of health and social care services					
3	Review of Care Management and District Nursing	To improve the effectiveness of care management and community nursing services. An improved understanding of how services are performing in a context of increasing complexity of care needs in the community & health and social care integration.	Produce a document for EMT outlining the learning from the review process and recommendations for further action		√		
3	Neighbourhood Care	Test approaches to integrated multi-service team in South Angus and at a later stage of potential for self - managing team	Project design revised in view of stakeholder feedback	√			
			Establish first pathfinder team in South West		√		
3	Prescribing	To ensure best value in the approach to Prescribing	Ongoing development, delivery and evaluation of Angus Prescribing Workplan.	√	√	√	√
			Enhanced outcome monitoring and reporting of current prescribing position and impact of programmes of activity within the Angus Prescribing Workplan	√	√	√	√
			Further develop our understanding regionally and locally of warranted variation	√			
			Ongoing development and prioritisation of additional initiatives to further reduce the overspend on FHS Prescribing	√			
			Enhanced horizon scanning to predict impact of changes to clinical pathways of care on prescribing locally as well as nationally.		√		
			Ongoing collaboration across the local community to maintain and develop ownership of the Angus Prescribing Workplan and promote ongoing locally identified tests of change related to prescribing.	√		√	

Priority	Project	Outcome	Action	2017/18		2018/19	
				Q2	Q4	Q2	Q4
3	Adult Mental Health Home Treatment Team	Focus More Attention Upstream: Promotion, Prevention and Effective Intervention, Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services (NHWO 4) People who use health and social care services are safe from harm (NHWO 7) Resources are used effectively and efficiently in the provision of health and social care services (NHWO 9)	Identify team manager who will then oversee recruitment of staff for the new team	√			
			Implementation of operational guidelines	√			
3	Identify improvement opportunities from first year of statistical and performance analysis	Delivery of the Angus Health and Social Care Partnership vision	Review reason for increases in readmission rates and agree a further improvement plan within ECS and services		√		
			Review what social care packages were in place for people who experienced readmission and consider opportunities for improvement in social care packages		√		
3	Minor injury and illness services	To ensure appropriate service to meet the needs of the Angus population	Complete review and agree future plan for service model to be delivered in Angus		√		
4	Effective Discharge Planning	Following an emergency people are supported to leave hospital in a timely manner (within 72 hours of being ready for discharge) . Carers are involved in the discharge planning process	Improve recording of delays in discharge	√			
			'Next steps to home' test of change to be delivered	√			
			Understand and address reasons for increasing readmission rates	√			
			Public information leaflet	√			
4	Review of Inpatient services	To ensure appropriate levels of inpatient beds to meet the needs of the Angus population	Complete review and agree plan for future service model	√			

Priority	Project	Outcome	Action	2017/18		2018/19	
				Q2	Q4	Q2	Q4
4	Delivering the Angus Autism strategy	To enable children, young people, and adults with Autism, and their families/carers, to receive the help they need.	Improving knowledge and understanding of autism by developing e-learning tool, other appropriate levels of staff training and promoting public awareness.		√		
			Improving support for children and families and adults by developing Social opportunities and activities for children, young people and adults with Autism to be further developed where possible in the local community. Autism friendly environments within mainstream and specialist services for adults to be developed. The number of Autism accredited specialist services for adults in Angus to be increased.		√		
			Improving learning opportunities for young adults. Information regarding suitable post school courses and links to agencies such as Skills Development Scotland to be made available to young people/adults with Autism. Links to be made with local businesses and colleges and universities with a view to promoting Autism awareness and necessary supports.		√		√
			Supporting adults with autism to live independently by Supported accommodation and mainstream tenancy availability to be increased for people with Autism.				√
4	Accommodation for people with learning disability	Adults with learning disability are supported to live independently.	Progress the replacement of the Gables Care Home				√
			Develop supported accommodation in South West locality				√
			Complete the redesign of Lilywynd in Forfar to support discharge from Strathmartine		√		
			Deliver replacement respite opportunities	√			
4	Palliative and end of life care	Adults feel supported at end of life	Develop an Angus palliative care strategy in conjunction with Lippen Care		√		

Appendix 3

Experience of services

1. What we have achieved to date

A&E and Inpatients

According to the most recent Inpatient Experience Survey 2016, the overall positive satisfaction was the greatest in relation to:

- How patients felt about the time waiting to be seen by a nurse or doctor in A&E (100%)
- In A&E patients had enough privacy when being examined or treated (100%)
- Patients were happy with the visiting hours (98%)
- The main ward or room patients stayed in was clean (97%)
- How patients felt about the time they waited to get to a ward (97%)

In-patients were, however, the least satisfied with the following aspect of their service:

- Patients knew which nurse was in charge of the ward (42%)
- Patients saw / received information on providing feedback / complaints about care received (45% positive response)
- Patients knew which nurse was in charge of their care (45%)
- Patients felt confident they could look after themselves after leaving hospital (52% positive response)
- Patients were not bothered by noise at night from other patients (52% positive response)

Between 2014 and 2016 Angus's inpatients' experience has improved in relation to the following:

- Patients saw / received information on providing feedback / complaints about care received (+12%)
- Prior to leaving hospital, patients felt confident that any help they needed had been arranged (+6%)
- Patients were involved in decisions about leaving hospital (+5%)
- Doctors discussed patients' condition and treatment with them in a way they could understand (+4%)
- If eligible, patients were happy with hospital transport arrangements for getting home (+4%)
- Nurses discussed patients' condition / treatment with them in a way they could understand (+3%)
- Staff took adequate care when carrying out physical procedures (+3%)
- Patients understood the possible side effects of their medicines (+3%)
- Patients had enough time with the people that matter to them (+2%)
- Doctors listened to patients if they had any questions or concerns (+2%)
- Staff took account of what matters to patients (+2%)
- How patients felt about the overall length of time they were in hospital (+2%)
- Staff treated patients with compassion and understanding (+1%)
- The hospital and ward's main ward or room patients stayed in was clean (+1%)
- The hospital and ward's bathrooms and toilets were clean (+1%)
- Patients felt people that matter to them were involved in decisions about their care / treatment (+1%)
- Nurses knew enough about patients' condition and treatment (+1%)

During the financial year 2016/17, there have been numerous improvements made to individual services provided across Angus with respect to patient/service user/carer and staff experience as well as promotion of equality and social justice, and ensuring equity in service provision.

Angus AHP Services

There has been a very positive status of seeking patient as well as carer experiences in Occupational Therapy (OT), Physiotherapy (PT) and Speech & Language Therapy (SLT) services, and of monitoring complaints/compliments and actioning and sharing complaints in OT, PT and SLT services in addition to a general promotion of evidence based practice, as evidenced by the status of data utilisation in service developments. The status of seeking staff experiences has all been well achieved in OT services.

Good performance has been evidenced with respect to seeking patient and carer experiences in SLT service as well as seeking staff experiences in PT and SLT services, and ensuring equity of service provision and targeting the greatest population needs in OT, PT and SLT services.

Older People and Physical Disability Service

There has been a very positive status of seeking patient and staff experiences as well as monitoring of complaints/compliments and sharing of the complaints findings in Assessment & Care Management (A&CM), OT, Glenloch and First Contact services. The same status has been evidenced in offering carers assessments and seeking carers views in these assessments in A&CM, OT and First Contact. All the sub-services also achieved standards in relation to ensuring equity of service provision across Angus. Early Supported Discharge/Prevention of Admission (ESD/POA) and Community Alarm services have achieved desired outcomes also in relation to ensuring equity of service provision across Angus. The Mainstream and SCO, Community Alarm and Accommodation services also had a well performing system in place for monitoring the demand per locality.

Learning Disability Services

There has been a very positive status of seeking service users and staff experiences as well as monitoring of complaints/compliments by Resource Centres, Care Management, Community Opportunities and The Gables services. The same status has been evidenced in relation to offering carers assessments by the Care Management Services. All services ensured equity of service provision across Angus and utilised data to inform service developments.

Accommodation and Home Care

There has been a very positive status of seeking regular service user feedback in Mainstream and SCO, ESD/POA, Community Alarm and Accommodation services as well as of carers in mainstream and SCO and Accommodation services. The same status has been evidenced for monitoring of complaints/compliments and actioning and sharing of complaints in Mainstream and SCO, ESD/POA, Community Alarm and Accommodation services.

The service performed well with further outcome/standard developments required with respect to seeking regular carer feedback in ESD/POA as well as ensuring equity of service provision across Angus by Mainstream and SCO, and Accommodation services. The same status has been observed with respect to monitoring of demand per locality by the ESD/POA service.

Angus Community Mental Health Services

The service achieved required outcomes/standard with respect to monitoring, actioning and sharing of complaints/compliments as well as lowering the number of delayed discharges.

The service performed well with further outcome/standard developments required with respect to seeking regular patient experiences.

Clinical Plan: Respiratory

There has been a very positive status of the seeking regular patient experiences as well as of monitoring, actioning and sharing of complaints/compliments. The service equally well utilised data to inform service developments as well as ensured that the greatest population needs are targeted (e.g. accessibility, inclusion).

The service performed well with further outcome/standard developments required with respect to seeking carer experiences.

2. What we plan to do next

Older People and Physical Disability

Further work is required to ensure that service user experiences are regularly sought in the First Contact services.

Accommodation and Home Care

Further work is required to ensure that regular service user feedback is sought by the Community Alarm service.

Angus Community Mental Health Services

Further work is required to ensure that regular carer experiences are sought by Angus Community Mental Health Services.