

# **Delivering the Angus Care Model**

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# Our Vision for Health and Social Care in Angus

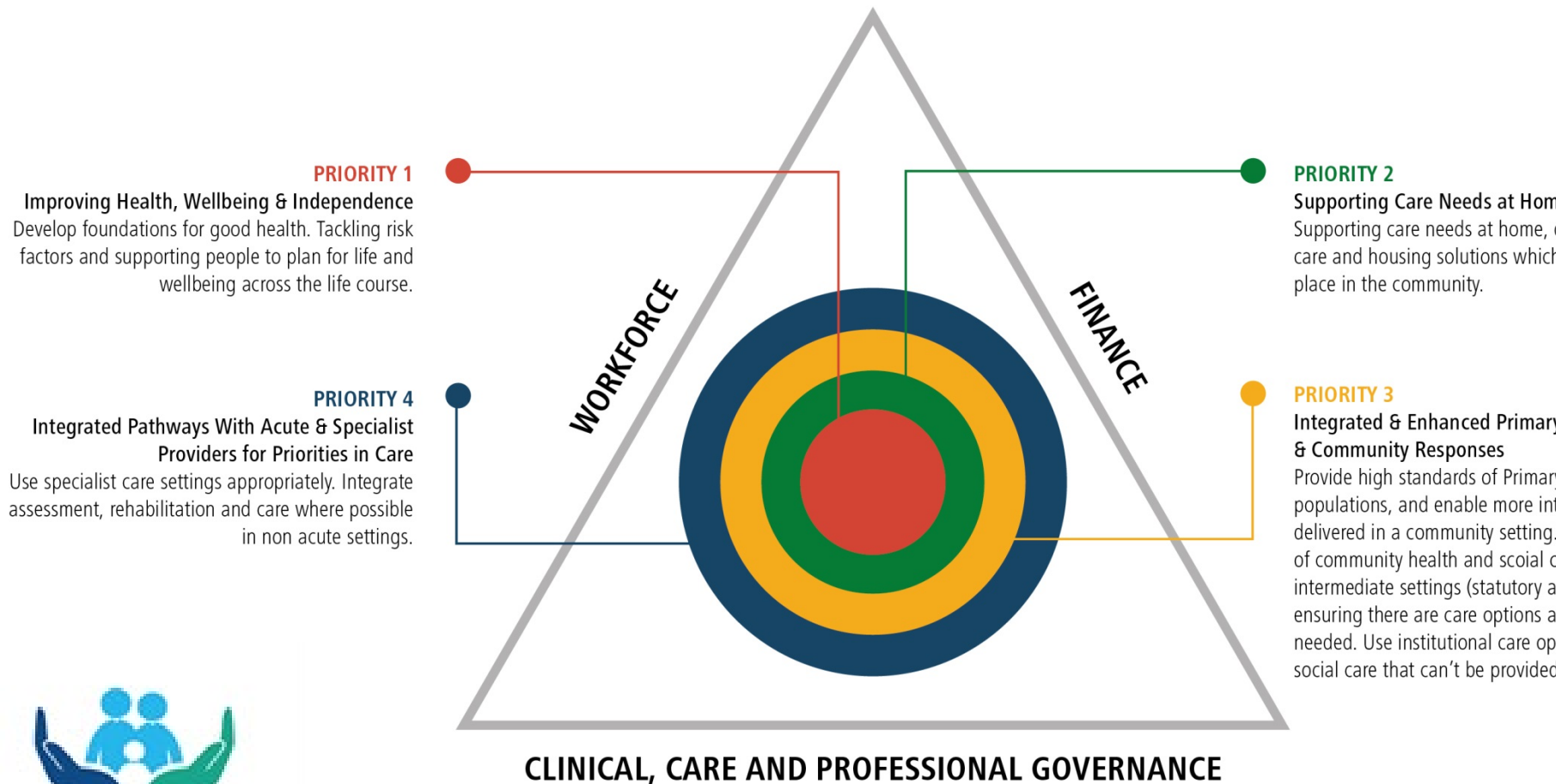
## People at the Centre

Our vision is to place individuals and communities at the centre of our service planning and delivery in order to deliver person-centred outcomes





# Angus HSCP Priorities and Performance Areas



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# The Case for Change

## Demographic change

### Increasing demand

- Population over the age of 75 years set to increase by 3% each year for 20 years
- Increase in chronic disease prevalence projected e.g. hypertension and T2 Diabetes prevalence growth by 47% and 65% by 2029

**2017**



Angus population

**116,520**

Over 65 years



**1 in 5**

Over 75 years (11,652 people)



**1 in 10**

Average life expectancy



**78.5**  
years



**81.6**  
years

**2037**



Angus population expected

**115,327**

Over 65 years



**1 in 3**

Over 75 years (20,930 people)



**1 in 5**

Life expectancy will continue to improve.  
We need to do more with less.





# The Case for Change

## Workforce challenge

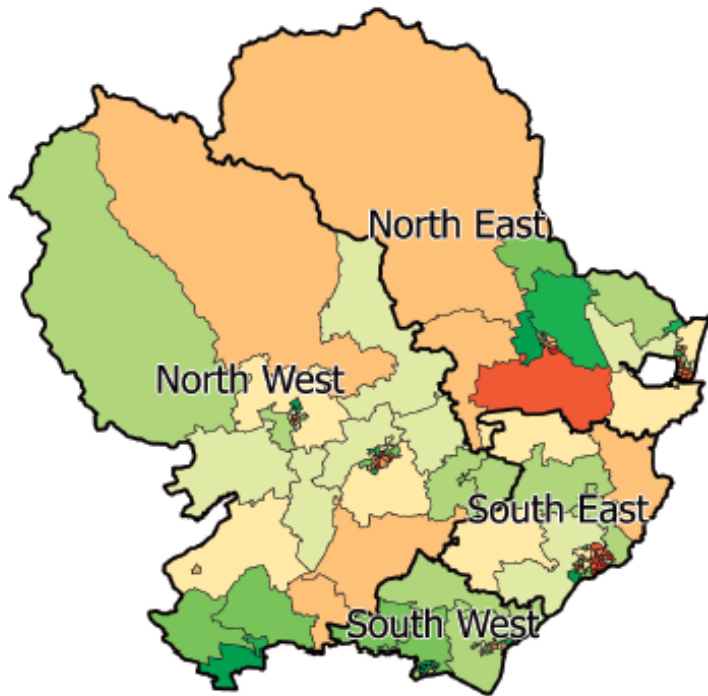
- 44% of our nurses in the Angus inpatient areas are aged over 50 years
- Struggling to recruit enough GPs
- Pharmacy vacancies are affecting our ability to achieve a reduction in prescribing costs
- Competition for the social care workforce

## Optimisation of estate

- A high number of hospital sites relative to the population (16k population per hospital in Tayside vs 25k in Scotland)
- High number of buildings both Council and NHS
- Minimum number of registered nurses per unit is 2 regardless of occupancy, although this number may vary according to the dependency of patient need.



# The Case for Change: Inequalities



The most deprived Quintile 1 (SIMD 2016)

**North East** : Brechin East (part)

**North West** : Forfar West (part)

**South East**: Arbroath Kirkton (part) ; Arbroath Harbour: Arbroath Warddykes; Arbroath Cliffrburn:

**South West**: none

Life expectancy for men and women is between 5.3 years and 3.3 years less than the Angus average.

Are 3 times more likely to be admitted to hospital for an alcohol related stay

30% more likely to be admitted to hospital in an emergency

More likely to experience an admission to general adult psychiatry

More likely to have a prescription for medication for anxiety/depression

Less likely to take up screening (e.g. bowel screening)



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# Our work-streams:

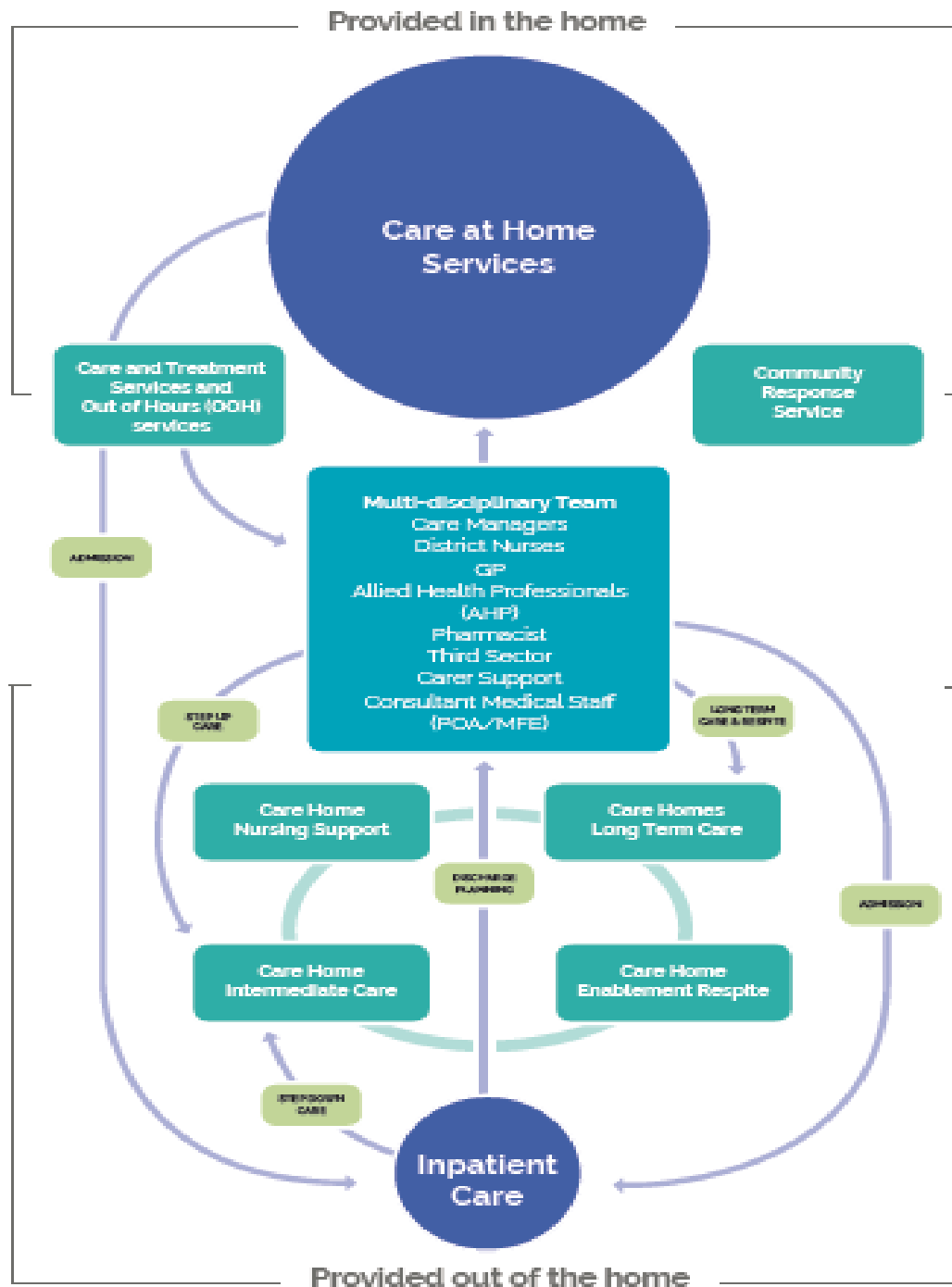


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- **Enhanced Community Support**
- **Inpatient Care Review**
- **Monifieth Integrated Care**
- **Falls review**
- **Help to Live at Home Programme ( includes Enablement and Response Team)**
- **Care Home Review implementation**
- **Review of Minor Injury and Illness Services and development of Community Care and Treatment Services**
- **Community Mental Health 7 day service**
- **ADP plan**
- **Carers plan**
- **Palliative and end of life care plan**
- **An Angus that Actively Cares**
- **Communication and Engagement**
- **Data and Performance, website and dashboards**
- **Prescribing**
- **Integration of Occupational Therapy Services**
- **Learning Disabilities**
- **Technology Enabled Care**
- **Implementation of the new GP contract**
- **Independent Living Angus**



# The Angus Care Model – built on a foundation of an Angus that actively cares





# An Angus that Actively Cares



This approach underpins the Angus Care Model.

We will work with our community planning partners to support the development of communities that are:

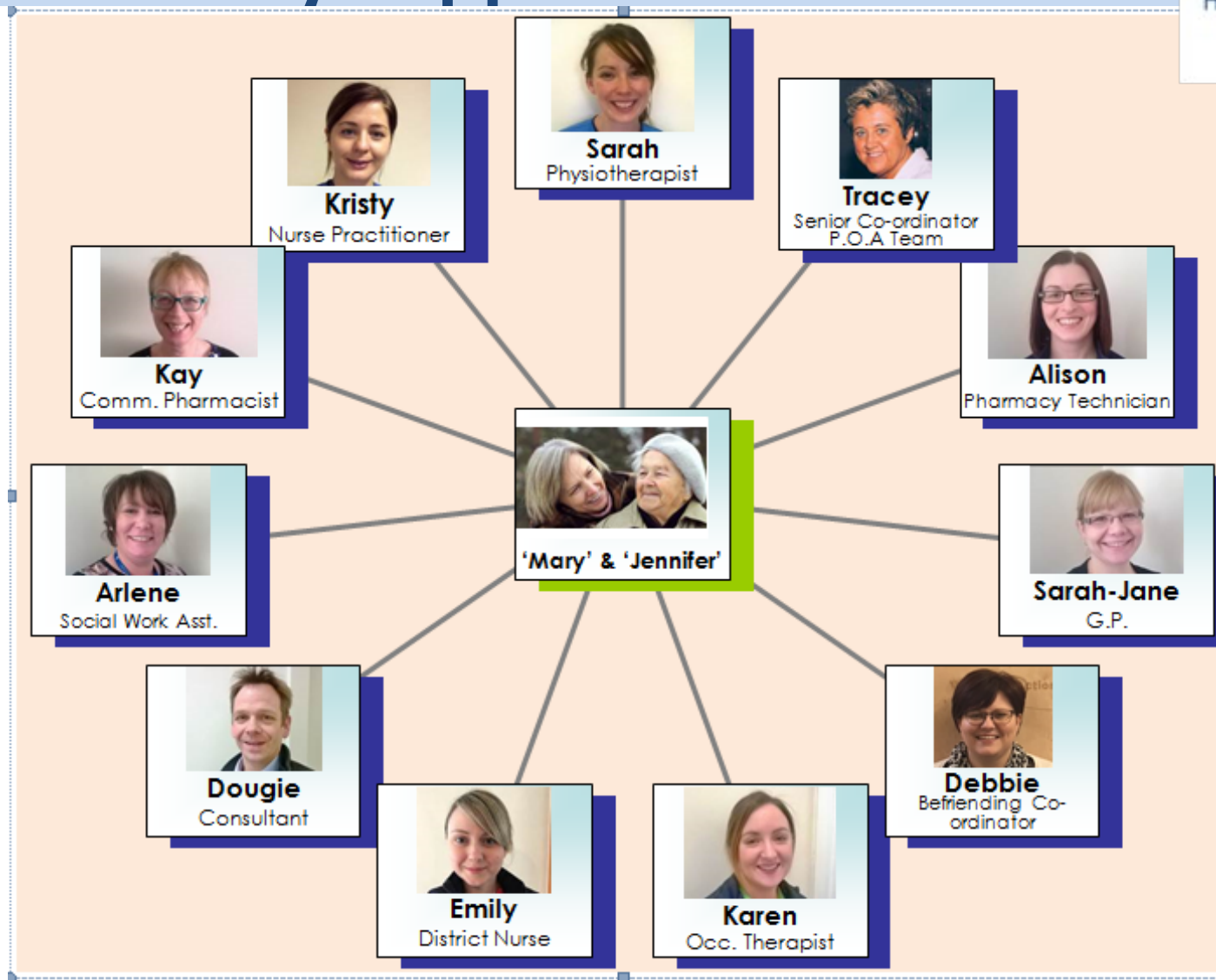
- Dementia friendly, Disability friendly, Suicide aware
- Working on promoting health and wellbeing including mental wellbeing, Supporting loneliness and isolation

Voluntary Action Angus are key to supporting development in this area and Angus HSCP will continue to fund their support for this work.

- 902 voluntary organisations
- Locality workers in GP surgeries ( signposting and social prescribing)
- Community co-investigators



# People at the Centre: Enhanced Community Support





# Testing change:

## Monifieth Integrated Care



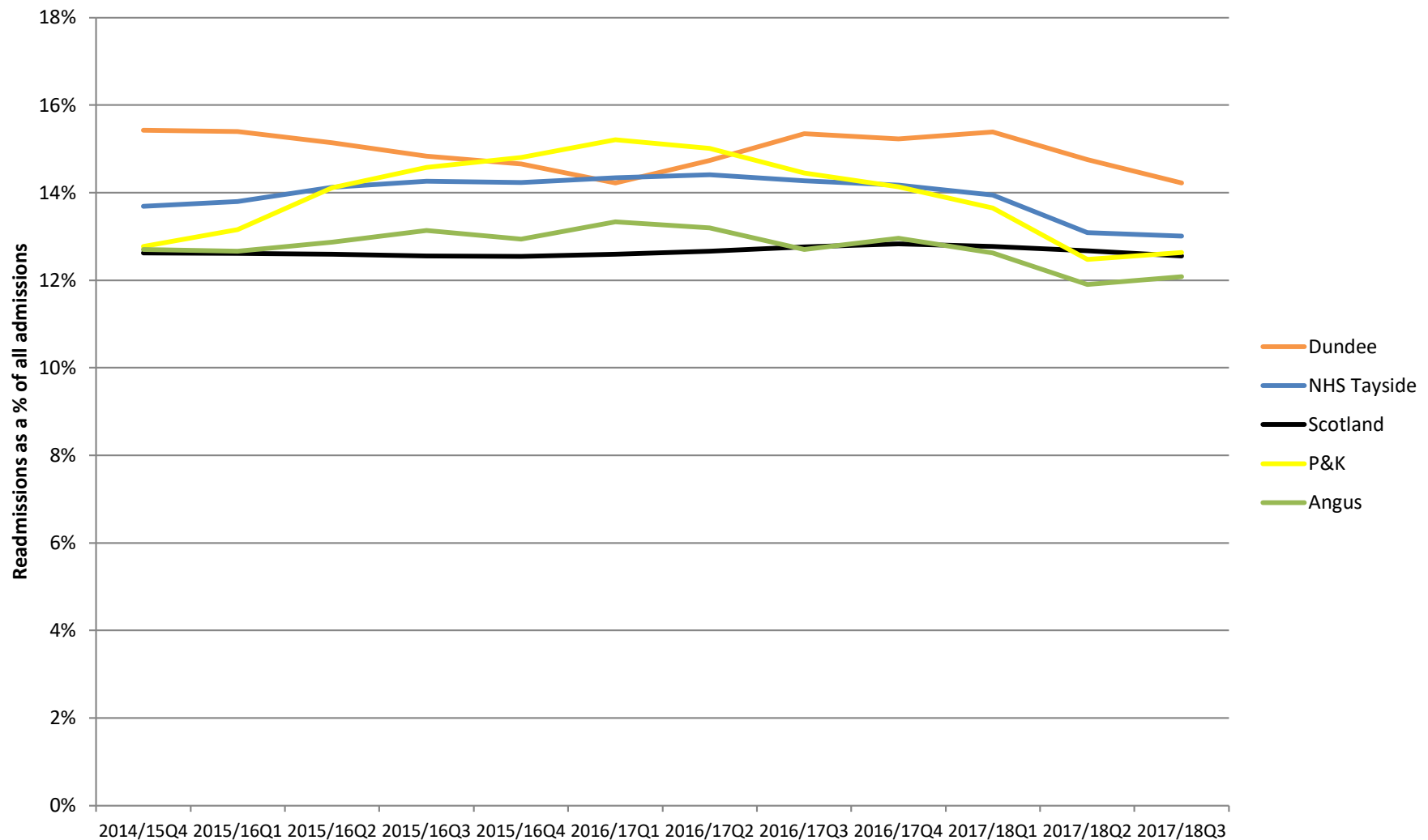
Builds on success of Enhanced Community Support improving integrated working. Vision-truly integrated service delivery; advanced empathy, cross-skilling, cultural change; shared problem-solving; reduced duplication of processes; strengthened communications and decision-making; more efficient use of resources; improved outcomes for people. It involves:

- Co-location of care management, home care, AHP, district nursing, third sector in GP practice in Monifieth
- Creation of a permanent multi-disciplinary response to service user/patient need
- A whole system approach to assessment, information-sharing and decision-making recognising the challenge of IT.
- In collaboration with third sector and independent sector providers
- Consistent with new GP contract
- Relationships will be crucial





# Readmissions within 28 days as a percentage of all admissions for 75+ age groups

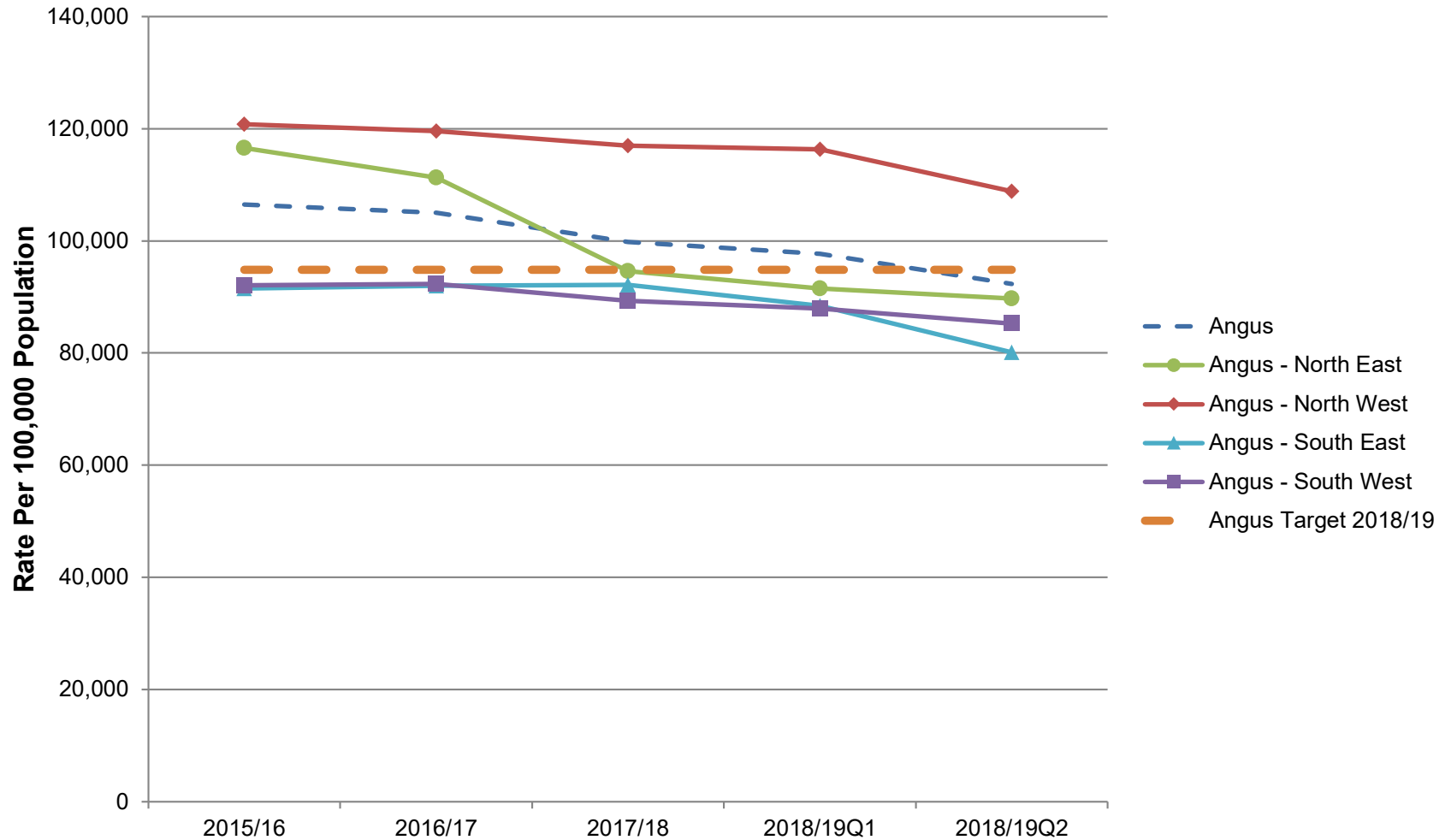






# Bed days reduced

Rate per 100,000 Population of all Emergency Bed Days for People aged 18+

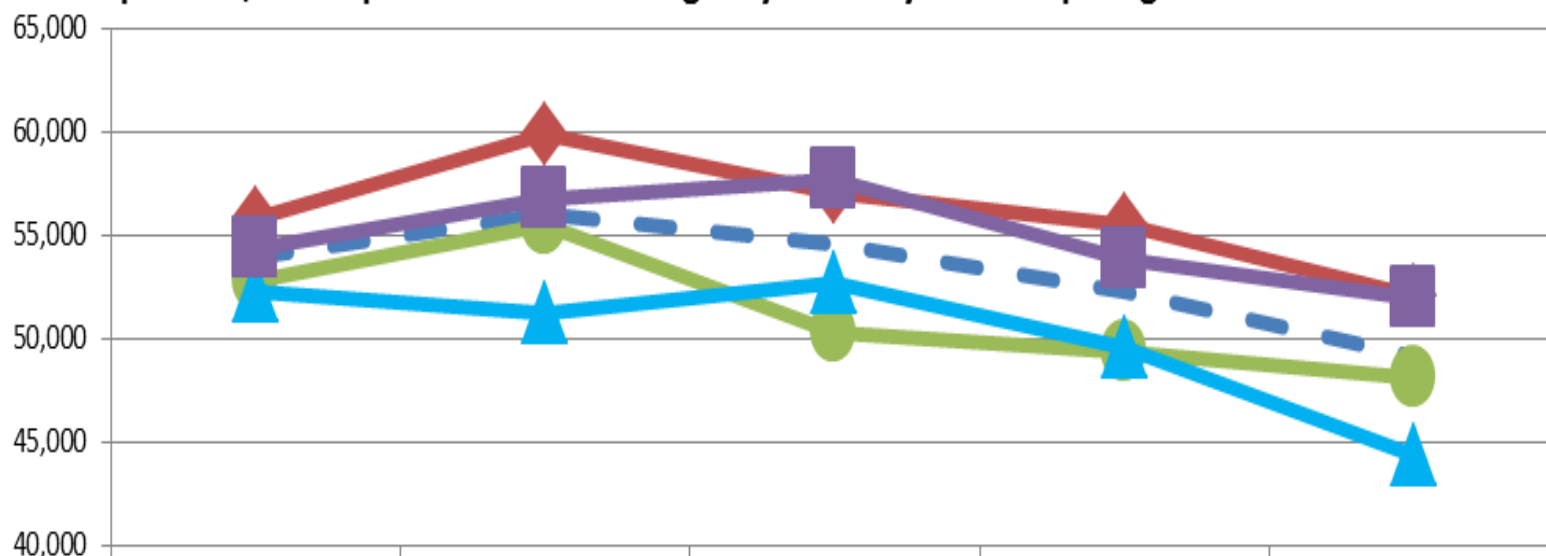




# Bed days- Ninewells Hospital

Rate per 100,000 Population of all Emergency Bed Days for People aged 18+

Rate per 100,000 Population



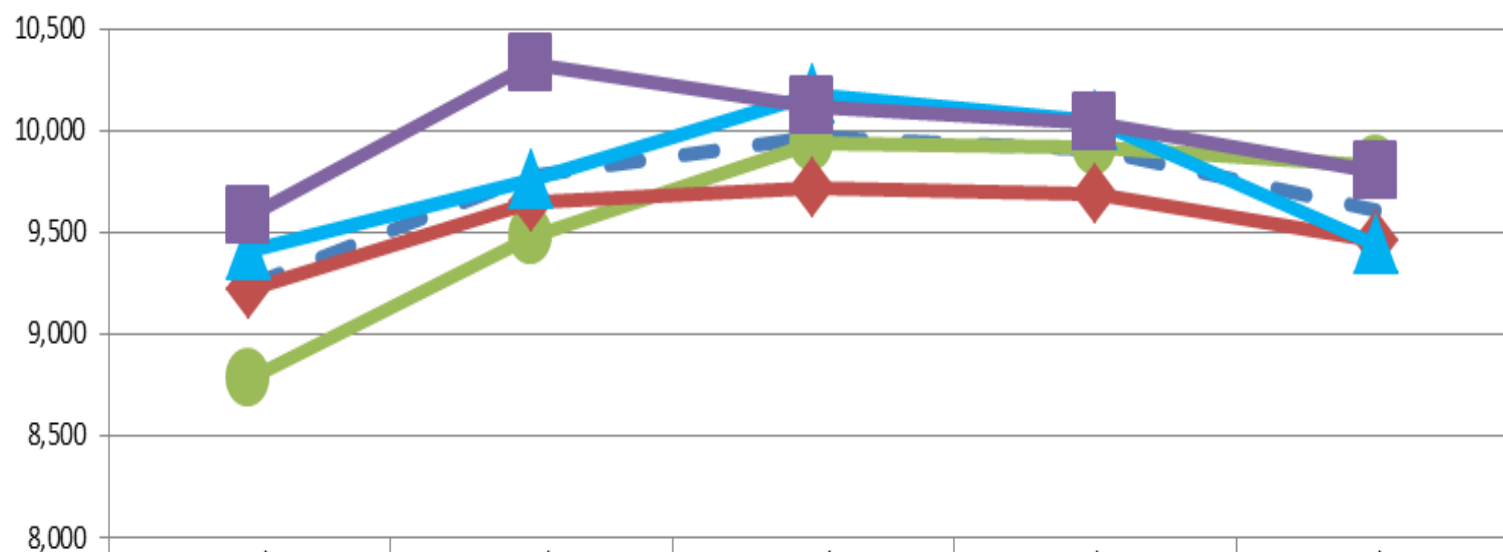
	2015/16	2016/17	2017/18	2018/19Q1	2018/19Q2
Angus	53,919	56,041	54,557	52,266	49,199
Angus - North East	52,846	55,465	50,260	49,364	48,086
Angus - North West	55,817	59,918	57,117	55,547	52,111
Angus - South East	52,242	51,196	52,708	49,554	44,319
Angus - South West	54,322	56,743	57,654	53,826	51,954



# Admissions to Ninewells

Rate per 100,000 Population of all Emergency Admissions for People aged 18+

Rate per 100,000 Population



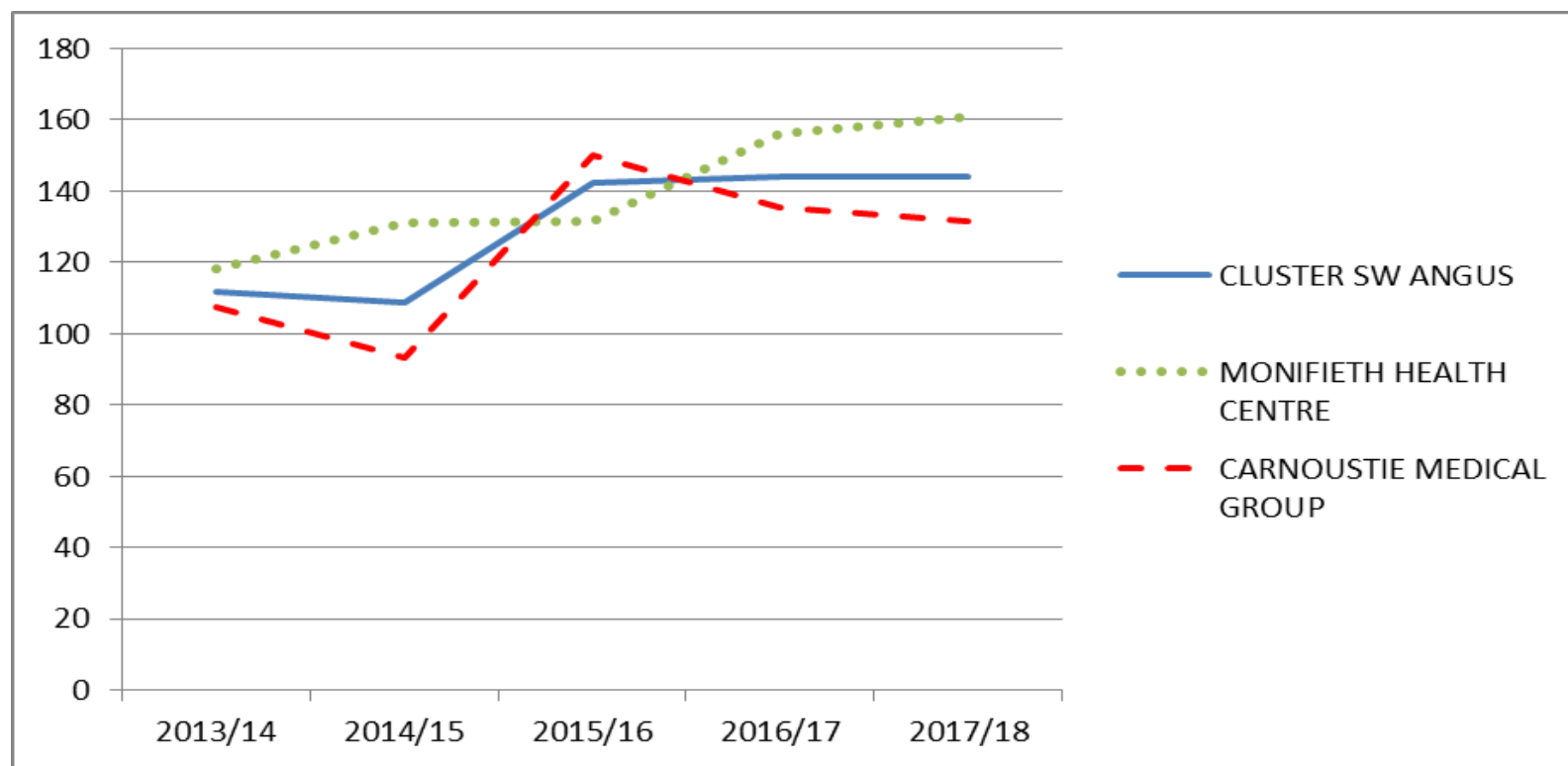
	2015/16	2016/17	2017/18	2018/19Q1	2018/19Q2
Angus	9,237	9,778	9,968	9,905	9,609
Angus - North East	8,778	9,474	9,942	9,919	9,826
Angus - North West	9,217	9,652	9,715	9,684	9,461
Angus - South East	9,405	9,754	10,174	10,052	9,437
Angus - South West	9,577	10,331	10,121	10,041	9,794





# Performance – Potentially preventable admissions

Admissions	2013/14	2014/15	2015/16	2016/17	2017/18
CLUSTER SW ANGUS	246	241	315	319	323
MONIFIETH HEALTH CENTRE	106	119	118	142	151
CARNOUSTIE MEDICAL GROUP	140	122	197	177	172





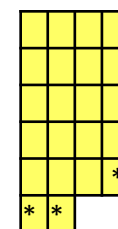
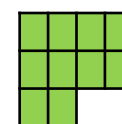
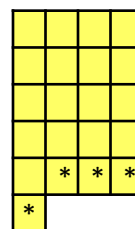
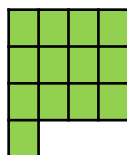
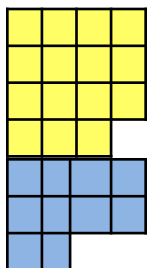


**What has this change in team working meant for our whole system?**



# Inpatient Care Review: Future State:

Site	Susan Carnegie Centre, Stracathro, By Brechin			Whitehills Health and Community Care Centre, Forfar			Arbroath Infirmary
Function	MFE and stroke	Functional admission and assessment	Organic admission and assessment	MFE (* including 4 beds suitable to meet non-complex palliative care needs		Organic admission and assessment	MFE (including 3 beds suitable to meet palliative needs)
Previous name of space	Mulberry Unit	Rowan Unit	Willow	Isla	Clova	Prosen	
Proposed number of beds	MFE 15 Stroke 10 Total 25	13	12	21		10	22



Description	Total Bed No.	Previous bed number	Difference
Stroke	10	10	No change
Psychiatry of Old Age	35	42	- 7
Medicine for the Elderly/GP/non complex palliative care	58	74	- 16
<b>TOTAL</b>	<b>103</b>	<b>126</b>	<b>- 23</b>

**No inpatient beds in Montrose or Brechin**

**Intermediate care beds**

South Localities: 6 beds in Arbroath

North East Locality: 3 beds in

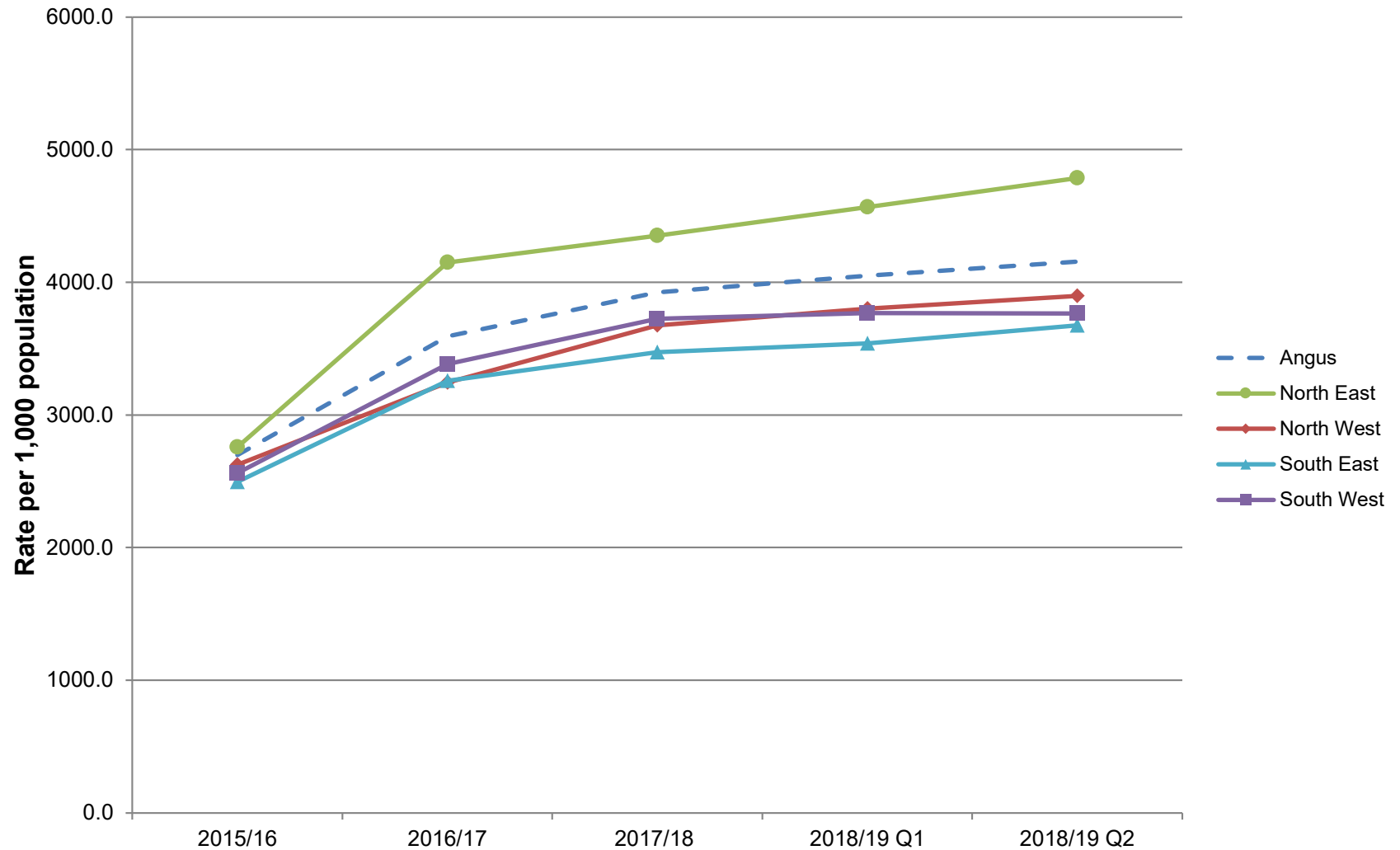
Montrose





# Personal care

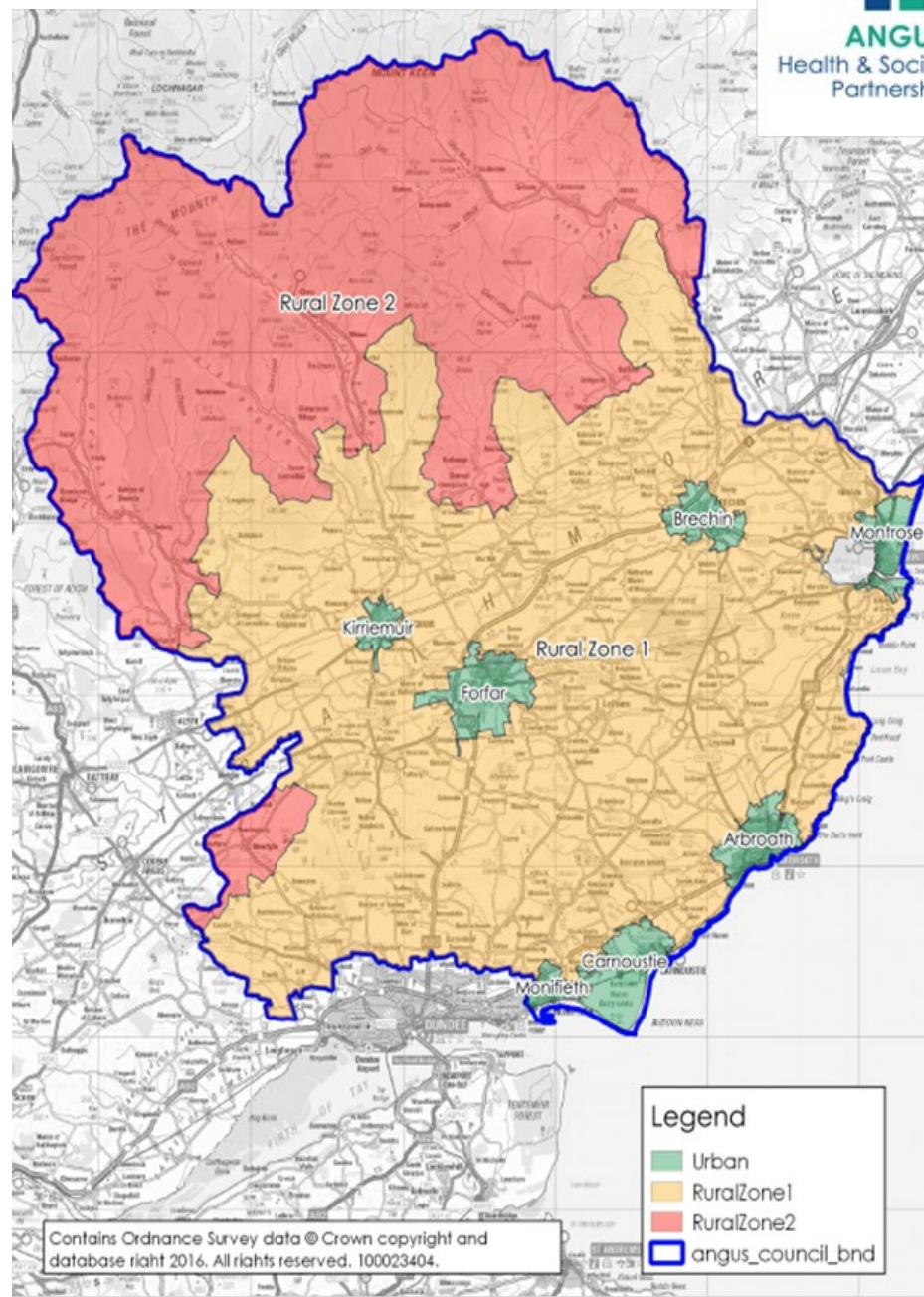
Total number of personal care hours planned as a rate per 1,000 adult population





## Changing how we contract for care at home services

- Quality led
- Fair cost of Care
- Sustainable model
- Locality providers
- Zoned rates
- Rural access







# Care Homes



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Change to internal provision to deliver:

- Best value
- Something that's different from the rest of the market
- Reductions in beds for older people

Change for the wider market:

- New model for the delivery of nursing being explored
- Support for training and development across Angus to work on quality
- Intermediate care
- Fair cost of care to be delivered through national care home contract cost of care calculator
- Challenge of over provision filled by neighbouring authorities



# Community Treatment and Care Services



Linking minor injury provision to primary care transformation

- Health and Wellbeing Nurses
- First contact physiotherapy
- New tests of change in
  - leg ulcer service , ear syringing service , spirometry service, ECG service , Urgent care paramedic

Refocus of other services to support locality model:

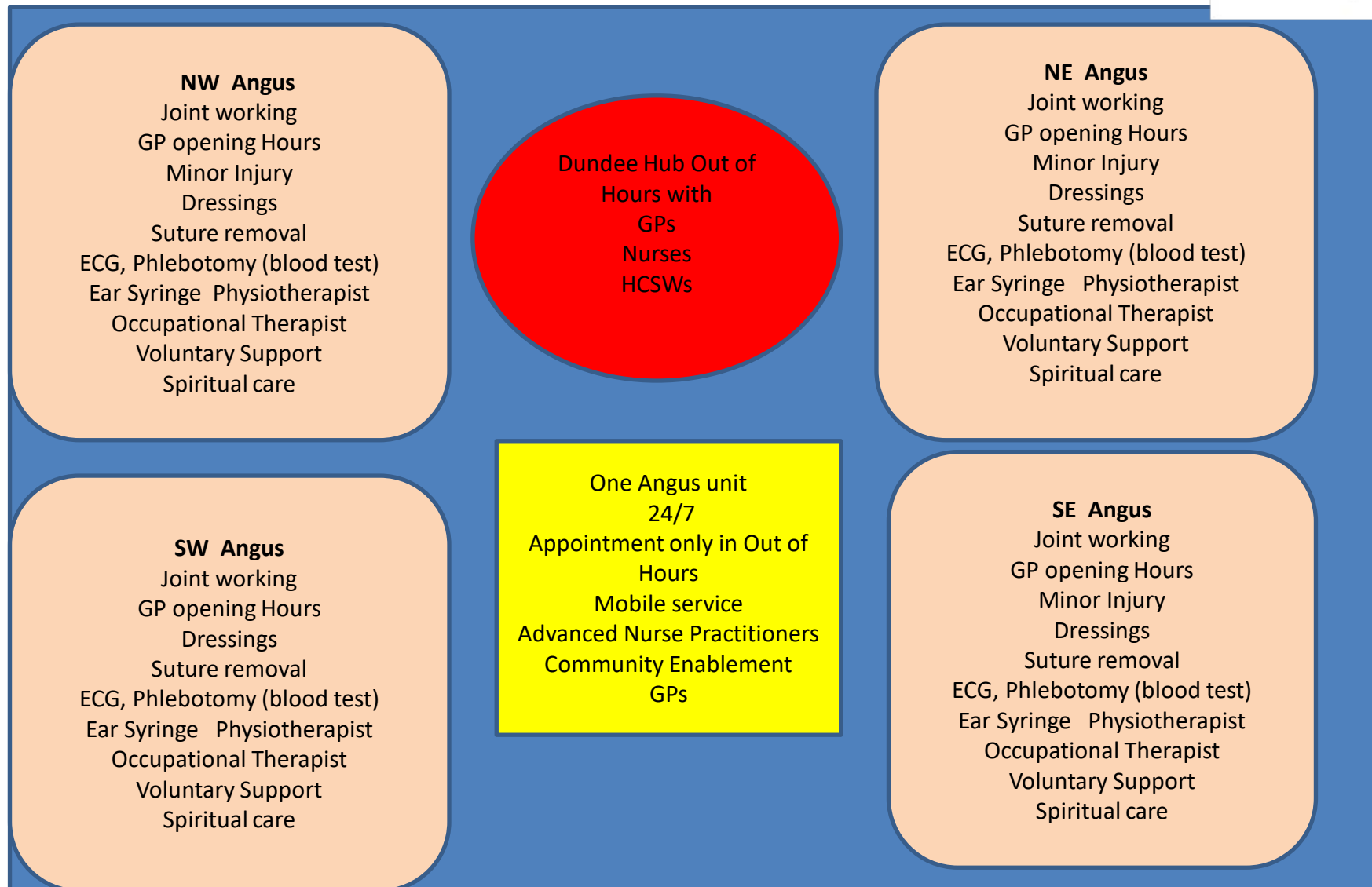
- Angus Integrated Drug and Alcohol Recovery Service
- Angus Council Drug and Alcohol Services
- Tayside Substance Misuse Services





# Community Treatment and Care Services

## Integrating GP practice and MIUs





# Realising the potential of technology



For self management

- Independent living Angus- Life curve
- Check TEC out
- Florence
- Attend anywhere

Self referral

- Independent Living Angus for community alarm and equipment

Still much more to do.....



# Communication and Engagement

- Continuing the conversation events
- Website design and development
- Facebook
- twitter





# Any questions?



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# For more information

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