ANGUS
Health & Social Care
Partnership

North East Locality Improvement Plan

2019-22

Published January 2020

Contents

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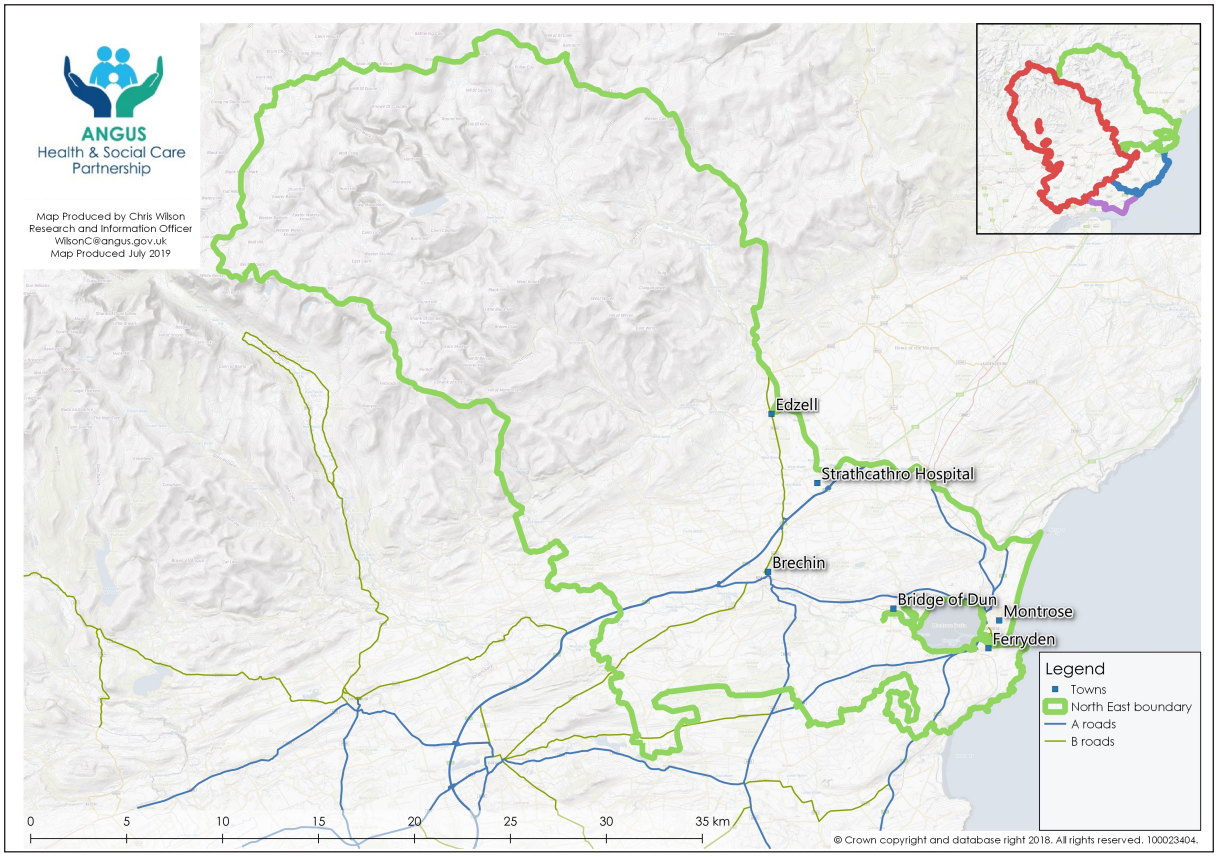
ANGUS
Health & Social Care
Partnership
Map Produced by Chris Wilson
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Map Produced July 2019
Edzell
Strathcathro Hospital
Brechin
Bridge of Dun
Montrose
Ferryden
Legend
Towns
North East boundary
A roads
B roads
0
5
10
15
20
25
30
35 km
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1. Introduction

About this plan

We are pleased to present the second North East Locality Improvement Plan. This plan is one of four locality plans for Angus Health and Social Care Partnership (AHSCP) and is shaped around the vision of the AHSCP as set out in the Strategic Commissioning Plan 2019-22.

This plan identifies the improvements that have been identified by the locality to enhance health and wellbeing outcomes in the North East Locality. Importantly, much of the plan is based on what people who live in the North East Locality and those currently involved in delivering health and social care in the area have said about how things could be better and what would make a difference. People have told us they want to live healthier, independent lives through: access to services, to information, to local support networks and by anticipating need before it arises.

This locality plan sets out the improvements that will be progressed in the North East Locality and will contribute to the delivery of the AHSCP's strategic priorities. This plan also considers how communities and individuals can help themselves and help each other to take control of their own health and wellbeing. This locality plan reflects the local priorities of the North East Locality. Angus wide priorities are detailed within the AHSCP Strategic Commissioning Plan 2019-22.

This is a live working document and will continue to evolve over the coming months.

Who is this plan for?

This plan is for everyone 16 years and over who lives and works in the North East Locality. It is for people who currently access health and social care services and for those who may require care and support in the future. It is also for people who are well and who wish to maintain or improve their current level of independence, health and wellbeing.

What is a locality?

The Public Bodies (Joint Working) (Scotland) Act 2014 puts in place the legislative framework to integrate health and social care services in Scotland. The Act requires each Integration Authority to establish at least two localities within its area.

Localities provide a way to influence local service planning, to inform the Integration Authority's strategic commissioning plan and to deliver the strategic priorities for Angus. It is important that localities are large enough to offer scope for service improvement but small enough to feel local and real for those people who live there.

In Angus there are four localities:

- North West: Forfar/Kirriemuir/SW Angus
- North East: Brechin/Edzell/Montrose
- South West: Monifieth/Carnoustie
- South East: Arbroath/Friockheim

Locality Improvement Group

A Locality Improvement Group (LIG) has been established in each of the four localities. The purpose of each LIG is to provide a strong, effective integrated partnership forum in order to improve provision, opportunity & health and wellbeing outcomes for all adults and young people in the locality, and support the delivery of the AHSCP Strategic Commissioning Plan 2019-22

The LIGs are the engine room of delivery and improvement at locality level to improve the health and wellbeing of the local population and reduce health inequalities. They should utilise the appropriate connections and partnerships in order to make the most of what is available in each local area.

Each LIG will develop and implement a Locality Improvement Plan, building on local knowledge and experience to ensure services are tailored to community needs and build on the considerable community assets that exist across each locality.

Where does this plan fit into the bigger picture?

This plan is aligned to both the wider strategic priorities outlined within the Angus Strategic Commissioning Plan 2019-22 and the Angus Joint Strategic Needs Assessment. It also reflects the strategic priorities within the Community Planning Local Outcome Improvement Plan.

The locality improvement plan should demonstrate consideration of the Angus 6 Rs for improvement and transformation:

The Angus 6 Rs for Improvement and Transformation in Health and Social Care are:

- Rebalance care, maximising support for people in their own homes.
- Reconfigure access to services delivering a workable geographic model of care outside the home.
- Realise a sustainable workforce delivering the right care in the right place.
- Respond to early warning signs and risks in the delivery of care.
- Resource care efficiently, making the best use of the resources available to us.
- Release the potential of technology.

Strengthening links between the Community Planning Locality Implementation Partnerships (LIPs) and the LIG is important to ensure people within communities are at the heart of decision making. Working better together will help us ensure people are supported to live a healthy, active and safe life.

As our progress continues to identify the priorities for the future, the North East locality improvement plan will help to inform the future strategic direction of the AHSCP.

Equality and Diversity

Equality and diversity will be central to improvement work in the North East Locality. The Public Sector Equality Duty sets out an obligation that due regard is given to the need to eliminate discrimination, harassment, victimisation and any other conduct prohibited under the Equality Act 2010, foster good relations between persons who share a “protected characteristic” and those who do not. Protected characteristics include age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race and ethnicity, religion and belief, sex/gender and sexual orientation. The Equality Duty also states that equality of opportunity should be advanced for people who share a protected characteristic by removing or minimising disadvantage, meeting the needs of particular groups that are different from the needs of others and encouraging participation in public life. An equality impact assessment on this plan will be completed.

The Angus Care model diagram on page 7 illustrates how health and social care is being delivered and how it will continue to evolve.

How will we know that we are making a difference?

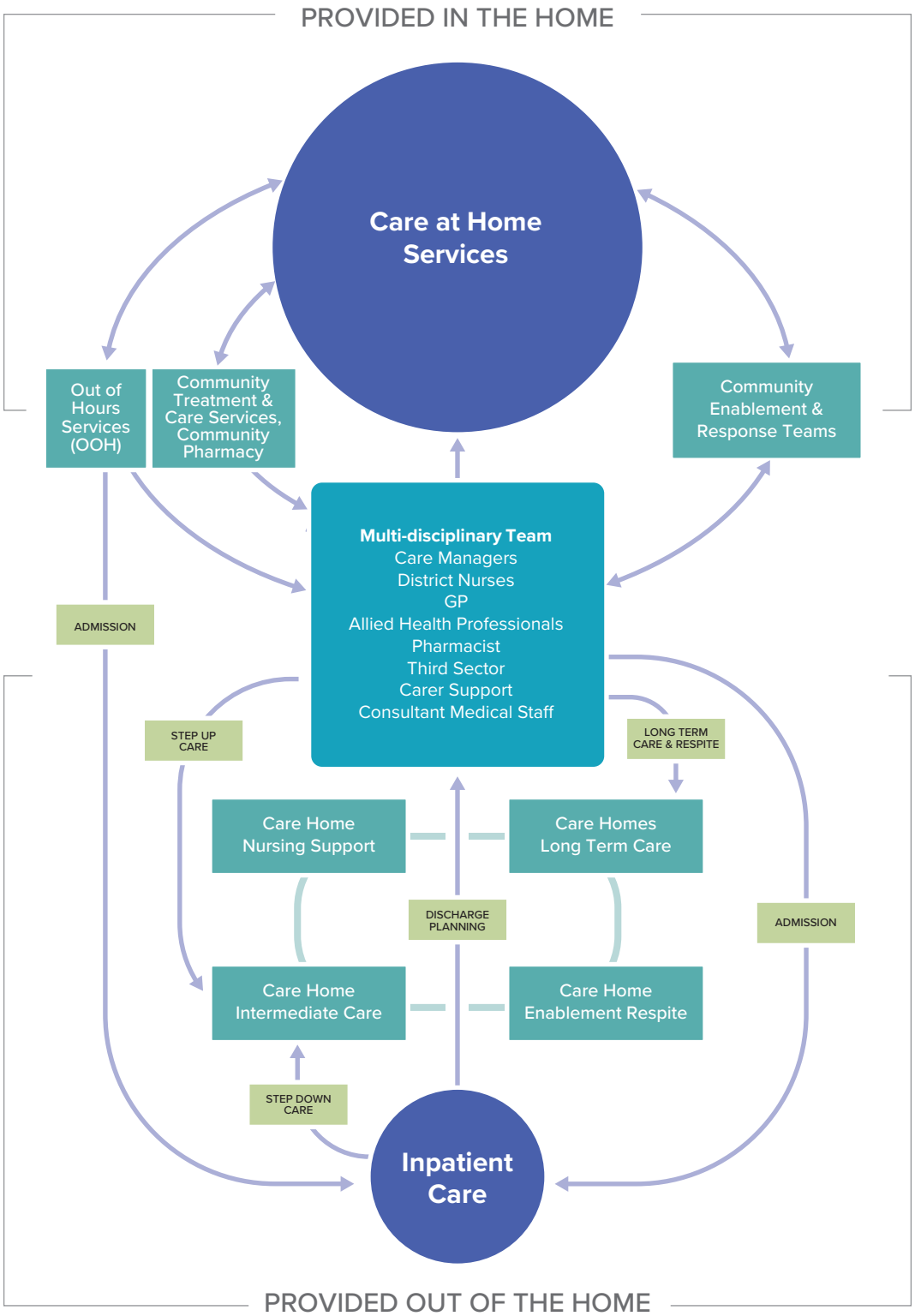
To help us monitor the progress of this plan and the wider Angus Strategic Plan, we will set out measures and improvement targets which will ensure a consistent approach across all four localities and the wider partnership.

The Partnership continues to make progress to extract meaningful qualitative and quantitative data at locality level. Over time, this information, together with feedback from service users, carers and staff, will allow us to see the impact that the improvements have made.

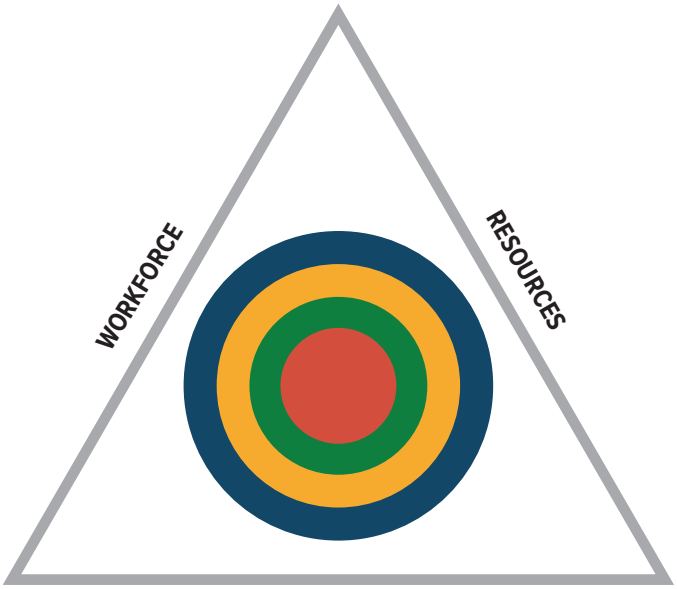
Regular updates will be reported to the AHSCP Strategic Planning Group (SPG).

ANGUS CARE MODEL

The Angus Care Model Built on a foundation of an Angus that actively cares



Angus HSCP priorities and performance areas



- **PRIORITY - Improving Health, Wellbeing & Independence**
  Develop foundations for good health. Tackle risk factors and support people to plan for life and wellbeing across the life course.

- **PRIORITY - Supporting Care Needs at Home**
  Support care needs at home, offering wider options for care and housing solutions which can sustain people's place in the community.

- **PRIORITY - Integrated & Enhanced Primary Care & Community Responses**
  Provide high standards of Primary Care for all practice populations, and enable more integrated responses to be delivered in a community setting. Make more effective use of community health and social care services in intermediate settings (statutory and non statutory), ensuring there are care options available 24/7 when needed. Use institutional care options only for health and social care that can't be provided at home.

- **PRIORITY - Integrated Pathways With Acute & Specialist Providers for Priorities in Care**
  Use specialist care settings appropriately. Integrate assessment, rehabilitation and care where possible in non acute settings. Consider whole pathways of care across all priorities.

WORKFORCE - Delivering a workforce fit for the future
RESOURCES - Delivering services with the funds available to us and in the right environments
CLINICAL, CARE AND PROFESSIONAL GOVERNANCE - Ensuring that services and environments are safe

2. Finance

The Partnership's financial planning environment will be challenging for the duration of this Locality Improvement Plan. This is consistent with the environment faced by the public sector generally and Angus Council and NHS Tayside specifically. Both organisations face significant financial challenges and require AHSCP to live within agreed devolved resources.

The Angus Integration Joint Board (IJB) has an ambitious Strategic Commissioning Plan for 2019-22 about what can be achieved within the resources available. You can find more details about resources and the financial planning environment within the Strategic Commissioning Plan 2019-22.

A key element of the locality planning approach is that control of resources be devolved to localities. The Angus Integration Joint Board (IJB) will continue to review the opportunity for devolving responsibility for the management of resources to localities as the organisation matures and management and governance arrangements evolve.

Currently, each LIG is responsible for a small budget to use to test how locality commissioning could develop within localities. This funding should be used to support projects or activities which will respond to local health and social care priorities within that locality and must directly support the delivery of one or more of the four strategic priorities listed within the AHSCP Strategic Commissioning Plan. Projects or activities should encourage collaborative approaches to improvement and deliver value for money.

3. Vision & values

The localities are supporting the partnership to deliver on its vision.

OUR VISION

Working together, developing communities that actively care, promoting wellbeing and creating the best possible health and social care across Angus

MAKING A **DIFFERENCE**

What we will do to make a difference

- Work with communities
- Focus on prevention and enablement
- Be realistic: provide safe and effective services in an increasingly challenging financial environment
- Be more creative, courageous and innovative
- Build for a future where digital technologies are more integrated in our work and used more widely by the population
- Deliver on our plans

What you can do to make a difference

- Take control of your own health and wellbeing
- Keep active whatever your stage in life
- Maintain a healthy weight
- Be informed about how to best address your health concerns
- Be mindful of the wellbeing of others in your community
- Get involved in your local community
- Join our conversations to help shape health and social care services for the future

Our Values

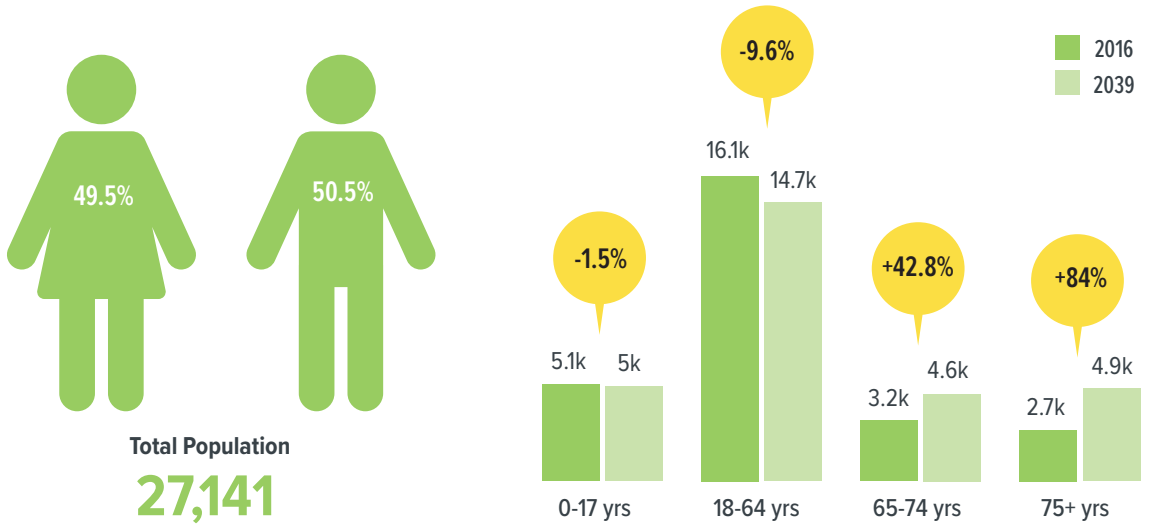
The work to achieve this vision is underpinned by our values:

- We believe in the potential and value of everyone in our community and will treat people with courtesy, compassion and respect for their beliefs
- We will work in partnership with our communities and respect each other as equal partners while creating our vision of an Angus that actively cares
- We believe everyone has the right to live a long and healthy life and to be supported to live at home when it is safe to do so
- We believe there should be inclusion, fairness and equity within and between our communities and will challenge the health inequalities that exist in Angus to achieve this
- We recognise the differences individuals can make for themselves and will encourage and support people to take control of their own health and wellbeing.

4. About the locality

The North East locality covers an area of 722 square kilometers and consists of the distinct areas of Montrose, Brechin and Edzell. As of 2017 it had a total population of 27,141 meaning the population density is 37 people per square kilometer. The number of adults (16+) living in the North East Locality is 21,524. With 21% of people aged 65+ it has the lowest proportion of those aged 65+ in Angus.

Population Summary - **North East Locality**



Estimates derived locally based on National Records Scotland mid 2017 estimates

It has been identified by the National Records of Scotland that the population of Montrose South has the poorest outcomes than the rest of Angus population in relation to:

- male life expectancy
- emergency hospitalisations
- alcohol-related hospitalisations
- drugs prescribed for anxiety/depression/ psychosis
- crime
- smoking in pregnancy

The population of Brechin East has significantly worse outcomes than the rest of Angus population in relation to:

- mental health prescribing
- crime rate
- bowel screening uptake

The population of Brechin West has significantly poorer outcomes than the rest of Angus population in relation to:

- crime

Life Expectancy

We know from the National Records of Scotland data 2014-2016 that the average life expectancy for males in Scotland is 78.5 and for women is 81.8.

The National Records for Scotland data 2011-2015 tells us that the average life expectancy for males in Angus is 78.6 and for females is 81.9.

Table 1 illustrates how the North East Locality compares to the national average life expectancy.

Table 1. Average life expectancy in the North East Locality

Intermediate Geography	Life Expectancy - Females (years) (2013)	Life Expectancy - Males (years) (2013)	Premature Mortality (All cause mortality among the 15-44 year olds) (2015) (per 100,000 population)
Brechin East	78.9	75.5	123.8
Brechin West	**83.2**	78	186.4
Hillside	**84.6**	**83.6**	**0**
Montrose North	81.3	78	101.2
Montrose South	80.4	**73.7**	215.3
Angus	**83.2**	**78**	89.5
Scotland	81.1	77.1	102.2

BOLD GREEN denotes statistically significantly better than Scotland outcome
denotes statistically significantly better than Angus outcome
BOLD RED denotes statistically significantly worse than Scotland outcome
denotes statistically significantly worse than Angus outcome

Source: National Records of Scotland

Deprivation

The Scottish Index of Multiple Deprivation (SIMD) is the Scottish Government's official tool for identifying those places in Scotland suffering from deprivation. It incorporates several different aspects of deprivation, combining them into a single index. The most recent version of the deprivation index, SIMD 2016, combines 38 indicators across 7 domains:

- income
- employment
- health
- education, skills and training
- housing
- geographic access
- crime

SIMD aims to provide a relative measure of deprivation. The overall index is a weighted sum of the seven domain scores.

Income Deprivation Indicator

- Percentage of people who receive certain benefits or tax credits and are therefore considered to be income deprived.

Employment Deprivation Indicator

- Percentage of working age people who receive certain benefits or tax credits and are therefore considered to be employment deprived.

Access Deprivation Indicator

- Percentage of people who live an above average travel time to a petrol station, a GP surgery, a post office, a primary school, a secondary school and a retail centre are therefore considered to be access deprived.

Table 2 illustrates the percentage of the North East Locality population who are classed as income deprived with both Angus and Scotland as a comparison.

Table 2 Deprivation status in North East Locality

% Income Deprivation*		
	2006	**2016**
NE	13.1	10.5
Angus	11.1	9.8
Scotland	13.8	12.2
% Employment Deprivation*		
NE	11.5	8.9
Angus	10	8.3
Scotland	12.7	10.5
% Access Deprivation*		
NE	17.5	16.12
Angus	25.4	23.85
Scotland	15	14.9

Source: Locality Health & Wellbeing Profiles provided by ScotPHO
*15% most deprived Source: Locality Health & Wellbeing Profiles provided by ScotPHO

The North East locality has the lowest access deprivation at 16.12%. The North East population has a second highest and above Angus income deprivation at 10.5% and a second highest and above Angus employment deprivation at 8.9%.

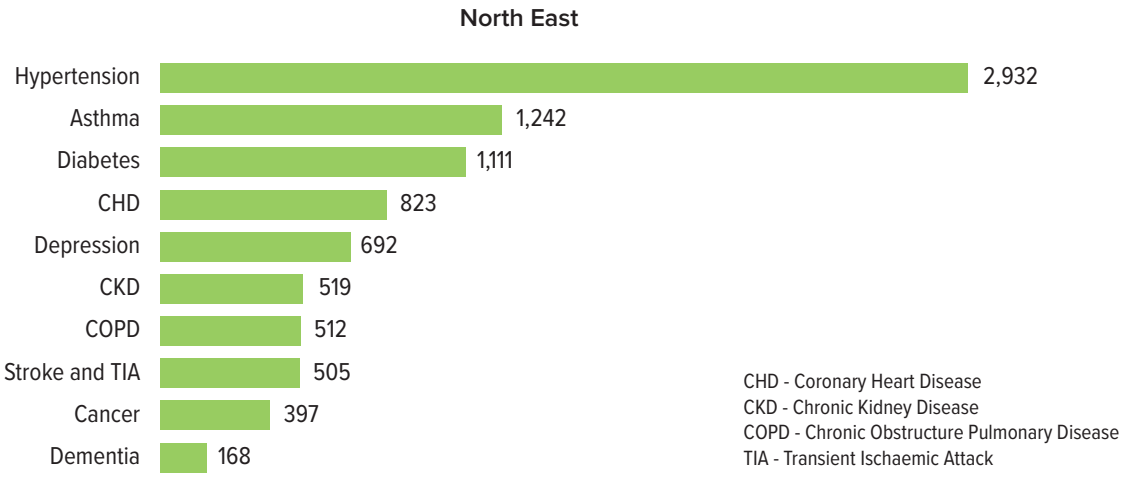
Based on the top 10 most deprived data zones in Angus, Montrose South and Brechin East are housing and employment deprived with Brechin East also considered income deprived.

The zones located in the North localities have the highest fuel poverty in Angus, thus are also at greater risk of winter deaths.

Long Term Conditions

Advances in health care mean that people are living longer than ever before. This is good news but also creates a challenge because as people get older the likelihood of having one or more long term conditions increases and this puts pressure on health and social care services.

Examples of long term conditions in the North East locality:



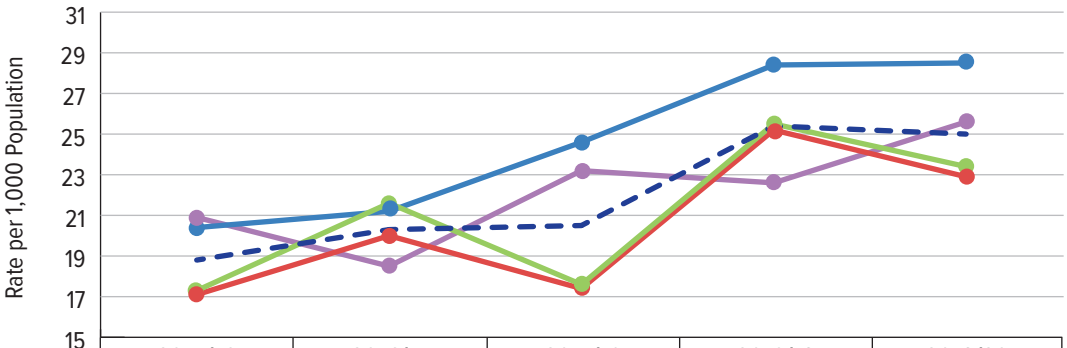
Source: GP cluster dashboard. Please note that this table contains information related to children and adults with long term conditions

Falls

Falls admission rates for people aged over 65 in Angus are increasing. In Scotland falls admission rates are falling. In Angus 45% of all fall admissions for people aged over 65 are people aged over 85 who account for 12% of the over 65 population. The percentage of people aged over 85 in our over 65 population is the same as Scotland as a whole.

AHSCP has had great success in looking after people at home rather than remaining unnecessarily in hospital, particularly around end of life care. It is important to recognise that as we manage people in their own homes for longer, we have a greater proportion of frailer people living in our communities. Unfortunately in frailer, older people, falls are not uncommon. Falls have many possible causes and often there are several reasons for why a person has fallen such as being on lots of medicines, having various medical conditions, eyesight problems and poor mobility. Our focus is how we prevent falls in the older population and encouraging good balance and mobility is the key to this. Falls have been identified as an area for further assessment and improvement in Angus, with a comprehensive falls action plan to be implemented. Table 3 details the falls rate for the North East locality.

Table 3. Rate per 1,000 population of Falls Admissions for People aged 65+



	2015/16	2016/17	2017/18	2018/19	2019/20
Angus	18.8	20.3	20.5	25.4	25.0
Angus - North East	17.3	21.6	17.6	25.5	23.4
Angus - North West	17.1	20.0	17.4	25.2	22.9
Angus - South East	20.4	21.2	24.6	28.4	28.5
Angus - South West	20.9	18.5	23.2	22.6	25.6

Source: ISD LIST Management Information (not official ISD statistics)

Carers

A proportion of people in the North East Locality look after someone because they can't manage on their own, due to illness, frailty, disability or other factors. People of all ages take on this unpaid role but for a number of reasons might not necessarily see themselves as a carer. Caring can be a hugely rewarding experience, but it can also lead to financial hardship and social isolation and impact on the carer's own health and wellbeing.

The Carers (Scotland) Act 2016 recognised the vital contribution that unpaid carers make to their families, communities, and the social care system in Scotland and introduced new rights for carers and people who are considering taking on the role. The legislation was introduced in April 2018 to ensure that carers are better and more consistently supported and can continue to care (if they are willing and able to) and have a life alongside their caring role.

Angus Health & Social Care Partnership is committed to ensuring that all carers are aware of the range of resources available to support and sustain them in their role. Its strategic outcomes for carers are that:

- Carers are identified
- Carers are supported and empowered to manage their caring role
- Carers are enabled to have a life outside of caring
- Carers are fully engaged in the planning and shaping of services
- Carers are free from disadvantage and discrimination related to their caring role
- Carers are recognised and valued as equal partners in care

At the time of the 2011 Census, 10,852 people in Angus identified themselves as a carer, including 263 who were under the age of 16. This amounted to about 9% of the Angus population and is likely to have understated the true picture. Carersweek.org estimated in 2019 that 1:6 people nationally is now an unpaid carer. This would be equivalent to over 19,000 people in Angus based on current population estimates. As the population ages and people are increasingly cared for in the community this is likely to continue to rise. Only a proportion of carers will ever need formal support but the Carers (Scotland) Act 2016 recognises that preventative support at an early stage can lessen the risk of carers coming to crisis.

AHSCP recognises that for carers each individual's journey is different and wants to ensure that carers and people considering a caring role, know where and how to access support. We will continue to work with Angus Carers Centre, NHS Tayside, Angus Council and other agencies in the North East Locality who provide support and services for carers. The North East LIG will work in partnership with carers and the organisations that represent them locally to meet our strategic outcomes.

Table 4 illustrates the number of carers in each locality who are actively supported by the AHSCP and/or Angus Carers Centre as of 01 June 2019. Other specialist services and organisations also provide vital support to carers across Angus.

Table 4. Carers supported in each locality

	*Carers supported by AHSCP Adult Services Teams	*Carers supported by Angus Carers Centre	
		Adult Carers	Young Carers** (under 16)
NE Locality	152	264	26
NW Locality	201	388	39
SE Locality	146	281	13
SW Locality	121	238	10

* A proportion of carers are supported by both Adult Services and Angus Carers Centre.
** Young carers could be caring for adults or for children.

Accommodation and Housing in the North East Locality

In 2017 56% of the North East locality population lived in owner occupied accommodation, 24% in social rented accommodation, 17% in private rented and 3% of accommodation was vacant. The average household income was estimated as £25,198 in 2018 which is the second lowest household income across the four localities.

Census data (2011) shows that the North East Locality has less people living in owner-occupied properties (62%) compared to the Angus average of 69%. Just over a fifth of the population (22%) live in social housing

which is higher than the Angus average. The reliance on social housing in the North East Angus outlines the importance of affordability and suggests that private sector options may be limited, whether due to under-supply or individual financial constraints.

The considerable increase in population of those aged over 65 plays a significant role in the increase in smaller sized households, as older people seek more manageable properties suited to their needs. Both the ageing population and changing dynamics of family structures will alter housing demand toward smaller household sizes. In 2017/18 34% of housing applications for people over the age of 55 identified a medical need.

Montrose South and Brechin East within the North East Locality are included within the 20% most deprived areas of Scotland. This means that people in these areas face restricted housing choice.

Applications for housing in the North East locality in 2018 are detailed below:

Under 55s, 22% (218) applications in 2018/19	**Over 55s, 21% (76) applications in 2018/19**
20% (18) had medical needs	31% (38) had medical needs
21% (37) of all applications resided in inadequate accommodation	20% (13) of all applicants resided in inadequate accommodation
• For over 55 applications, 19 needed sheltered accommodation • 20% (36) of the over 55 applicants would consider retirement housing • 23% (83) of all over 55 applicants across Angus would consider Amenity housing	

Advances in technology over recent years are enabling more people to continue living at home with safety and independence. By creating an environment that is, for example, safe and secure to reduce falls, disability, stress, fear or social isolation, technology has the potential to optimise quality of life and reduce the demand on health and social care services.

Anticipated Need for Supported Housing in the North East locality

Table A shows total specialist provision requirement for age, medical, disability and support reasons.
Table B shows specialist provision requirement for those under 65 with medical, disability or support reasons.

Table A

	NE locality (North Housing Market Area HMA)	**Angus**	**NE locality (North HMA) as a % of total for Angus**
Over 65	103	634	16%
Medical	71	467	15%
Disability	54	294	18%
Support	5	26	19%
Total (over 65) Specialist Need	233	1,424	15%

Table B

	NE locality (North Housing Market Area HMA)	**Angus**	**NE locality (North HMA) as a % of total for Angus**
Medical	42	295	14%
Disability	39	189	21%
Support	5	22	23%
Total (over 65) Specialist Need	86	506	17%

The ageing population in the North East locality means there is likely to be further strain on the waiting list as more people seek specialist housing. A proportion of need will be met from existing stock turnover or re-development, however these ongoing needs will be used to inform investment decisions. Through the Local Housing Strategy, Angus Council has committed to deliver 20% of new affordable housing to meet particular needs, with an anticipated delivery of 29 units in the North East locality over the period to 2023.

More housing information across Angus can be viewed in Angus Housing Market Profiles.

Snapshot of North East Locality

264
Adult Carers are supported by Angus Carers Centre

152
Carers are supported by care management teams

1 in every 40
people aged 65+ has been admitted to hospital as a result of a fall

1 in every 27
people receive personal care at home

5,202 hours
of personal care were delivered per 1,000 adults in 2018/19

1 in every 6
people over the age or 65 receives the Community Alarm Service

1 out of every 100
people aged 65+ receives community meals

The average length of hospital stay is **9 days**

1 in every 9
people is admitted to hospital for an emergency

3.5% of people in the NE Locality are depressed

Montrose South and Brechin East are amongst the **10%** most deprived areas in Angus

By 2039 it is estimated that there will be **2,200** more people aged 65+ living in the NE Locality

77.7 years **81.6 years**
Life expectancy is lower than the Angus average

15 in every 100
people have high blood pressure

6 in every 100
people have diabetes

Examples of Assets in the North East Locality

Asset	Total Number	Location
Health & Social Care		
GP Surgeries	5	Brechin x 1 Edzell x 1 Montrose x 3
Community Pharmacies	7	Brechin x 2 Edzell x 1 Montrose x 4
Opticians	5	Brechin x 2 Montrose x 3
Dental Surgeries	9	Brechin x 3 Montrose x 6
Hospitals	1	Stracathro Hospital • Medicine for the Elderly ward x1 • Stroke Rehabilitation ward x1 (Angus wide) • Psychiatry of Old Age dementia assessment unit x 1 (Angus wide) • Mental health admission and assessment unit (non dementia)
Independent Intermediate Care	3 beds	Fordmill Care Home, Montrose
Minor Injury and Illness Units (MIIU)	1	Links Health Centre, Montrose. NE Locality can also access MIIU in Arbroath and Forfar
Community Mental Health Team	1	Covers all NE Locality
Community Mental Health teams Older People	1	Covers all NE Locality
Mental Health and Wellbeing support workers	2	Covers all NE Locality
Dementia Liaison Team Post Diagnostic Dementia Support Team	1	Covers all of Angus – based in Susan Carnegie, Stracathro
Midwifery Clinics	1	Links Health Centre, Montrose
Allied Health Professionals (AHP) Includes general adult psychiatry, psychiatry of old age, learning disabilities, speech and language therapy and occupational therapy	1	Based in Stracathro Hospital and working across the NE Locality
Enablement and Response Team	1	Based in Panmure Street, Brechin
Learning Disabilities Team	1	Angus wide team
Physical Disability Team	1	Angus
AIDARs Team	1	North Localities
No of Care Homes There are no elderly medically infirm beds in the NE locality)	5 (194 beds)	The Glens, Edzell The Glade, Brechin Bearehill, Brechin Fordmill, Montrose Dorwood House, Montrose
Housing		
Supported Accommodation	2	Provost Johnston Road Montrose (20 flats) St Drostan's Court Brechin (14 cottages)

Asset	Total Number	Location
Community		
Chapel Bond	3 individual tenancies	Roger Drive, Montrose with Social Care staff supporting adults with mental health needs in their own homes
Community Centres/Village Halls	13	Crickety, Brechin YM Montrose Menmus Edzell cottage Borrowfield Logie & Pert Strathcathro Attic, Brechin Craigo Hillside Lethnot Tarfside Glenesk retreat
Day Centres (not in community centres/village halls)	2	The Adam Centre, Montrose The Dalhousie Centre, Brechin
Leisure Facilities	2	Brechin Community Campus Montrose Sports Centre
Libraries	2	Brechin and Montrose
Access Offices	2	Brechin and Montrose
Men's Shed	3	Brechin Montrose Edzell

5. Communication and engagement

Communication and engagement with those who live and work in each locality is essential to developing a good understanding of health and wellbeing in the area and what challenges and opportunities there are.

A number of different mechanisms are used to encourage local people, service users, the workforce and other stakeholders to come forward to express their views and experiences. This informs future priorities and influences the planning and design of services. Examples include:

- In 2017/2018 each locality held a series of Continuing the Conversation events where members of the public and other stakeholders were invited to contribute to transformation proposals and learn about a number of existing services across each locality.
- A Care Home Improvement Group exists in each locality which routinely meets to consider issues of concern and ideas for improvement.
- Each locality also has a GP Cluster Group at which all GP Practices in the locality are represented and where issues pertinent to primary care are discussed.
- The Angus Carers Voice network provides a forum for carers to contribute their views and ideas.
- Patient Participation Groups linked to the GP Practices in Brechin, Edzell and Montrose.
- North East Clinical Improvement Group.

It is important to continue to dedicate time and resources to meaningful engagement in each locality, building on the good work done so far.

AHSCP has developed a website where you can find out more www.angushscp.scot.

You can also follow us on facebook at www.facebook.com/ahscp.

Public Consultation

We would like to thank everyone who has expressed a view, shared an experience and come forward to help shape the creation of this Locality Plan.

We encourage feedback and comments on the locality plans. The information provided will be used to support the delivery of the current plans and to identify further improvements.

This is an evolving document so please continue to give us your views on this plan by completing the questions listed within Appendix 2, ***completing an online survey*** or by emailing your views to AngusHSCP.Tayside@nhs.net

6. What we've done so far

There have been a number of achievements which continue to benefit all four localities.

- Enhanced Community Support - a co-ordinated multidisciplinary team approach supporting people to remain in their own homes for as long as possible.
- Enablement and Response Team - bringing together Angus Health and Social Care personal care services and community alarm service.
- Angus Integrated Drug and Alcohol Service - integrated service bringing together the previous substance misuse services from health and local authority sectors in 2017.
- Implementation of support plans for adult carers.
- AHSCP website including news updates, locality data dashboard, Independent Living Angus, Know who to turn to.
- Development of the Locality Locator by Voluntary Action Angus.

An example of Enhanced Community Support

"Mum is a 90 year old lady with vascular dementia. Things have been very difficult over the last few weeks with paranoia and just her general health. She has bruising that she can't explain where she's got them from.

I made a call to the GP. Within a day I had District Nursing helping out with medication, assessing her for any need. The Occupational Therapist and Physiotherapist visited with equipment for her. I've had an Enablement Team who are helping with her showering, her meal preparation, helping her get to bed, and we've now got a Care Manager in place.

The difference to mum's life is unbelievable, and to myself. It is so much better for all of us".

Daughter of a service user

Specific Improvements made in the North East Locality

You said	We did
We need to improve educational opportunities for Care Home Staff.	LIG funded educational sessions for care home staff from NE homes. Staff from all care homes had educational sessions from Care Inspectorate, Tissue Viability, Audiology, Adult Protection, Pharmacy, falls service. Several changes to practice were actioned by homes – particularly around management of urinary tract infections, adult protection notifications. A national awareness campaign was initiated to support staff complete their registration requirements with SSSC. This work has highlighted the need for a more responsive way of providing education/learning opportunities for care home staff.
We need to improve the quality of discharge from Acute Hospitals to Care Homes.	The Care Home Improvement Group discussed the quality of discharge from Acute Hospitals, collected data around the issue and identified improvements. Participated in developing a discharge checklist for Angus Hospitals to use when discharging to care homes. Continue to look for improvements in discharge from acute settings.
We need to improve the improve the meal time experience for Care Home residents.	Audits were undertaken and changes have been made using the Plan, Do, Study, Act methodology. Improvements have led to a more relaxed mealtime with staff interacting at tables with residents. Residents are more settled and eating and drinking has improved. Plan to roll this approach to other care homes.
We need to do more to promote healthy lifestyles.	All Montrose GP Practices are Affiliated Park Run practices. As a result Nurses and GPs attend and promote the benefits of participating in a Park run to patients and more people are participating in the Montrose Park Run*.
You wanted activities for families in the holidays.	Working with a range of organisations Family Fun sessions were arranged for four weeks during Summer 2018 and two weeks in October 2018 where a range of games and activities took place with lunch available. This has continued in 2019 with the Brechin Community Pantry now involved in providing breakfasts and lunches.
You told us you wanted faster access to treatment from AIDARS in the North East Locality.	95% of people referred to AIDARS are seen within three weeks of referral.
We need to encourage people to take more exercise.	Edzell Village Improvement Society was awarded funding to install an outside gym at Edzell Muir.
We need further improve the Enhanced Community Support (ECS) approach in the North East Locality.	Brechin and Edzell were the first areas in the North East to introduce ECS. Montrose team participated in a Collaborative Leadership in Practice initiative to further build on their multidisciplinary team working and make it even more effective and sustainable. As a result, weekly multidisciplinary team meetings were initiated by all three practices. Work continues to further embed ECS in the North East locality.
We need to encourage people to take more exercise.	AHSCP have signed up to work with the Care Inspectorate on the Care About Physical Activity (CAPA) Programme which promotes physical activity across care settings. Day Care Providers in Brechin and Montrose have embraced CAPA and physical activity is now a daily part of an attendee's day care day.

* for more information or considering joining them visit www.parkrun.org.uk/montrose

7. Priorities for 2019-22

In addition to the Angus-wide priorities identified within the Strategic Commissioning Plan 2019-22, the North East Locality Improvement Group has identified the following priorities specific to the North East Locality:

- Improve access to information and health improvement opportunities
- Reduce the number of falls in the community
- Reduce social isolation by enhancing social prescribing opportunities
- Embed the Enhanced Community Support approach across the locality.

Appendix 1

North East Locality Improvement Group
Improvement Action Plan 2019-22

This improvement plan is about making decisions at a local level that will lead to improvements and deliver outcomes that are important to the local people of the North East locality. It's about empowering local communities, enabling professionals to do their best work and making best use of the resources in the locality by everyone working together. It focusses on recognising the assets which develop naturally in the community, looking at solutions based on local resources to meet the needs of the local population and tackling inequalities.

This Action Plan is a working document and will be used by the North East Locality Improvement Group to monitor progress against actions.

AHSCP Strategic Commissioning Plan 2019-22 has four strategic priority areas which this improvement plan will contribute to delivering;

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

Angus wide actions are identified in the strategic delivery plan in relation to the four strategic priority areas.

This improvement plan focusses on actions identified by the LIG to support locality led priorities identified by the LIG.

- **Rebalance** care, maximising support for people in their own homes
- **Reconfigure** access to services delivering a workable geographic model of care outside the home
- **Realise** a sustainable workforce delivering the right care in the right place
- **Respond** to early warning signs and risks in the delivery of care
- **Resource** care efficiently, making the best use of the resources available to us
- **Release** the potential of technology

This is an annual improvement plan that will be renewed every year. Therefore, within this 12 month period there may not be actions identified under each of the four strategic priority areas.

Timescale for completion/completed actions

N.B. People have been identified to progress individual actions

Improvement Action	Intended Outcome	Timescale	Link to National Outcome	Comments & progress
PRIORITY 1: Improving Health, Wellbeing and Independence				
Literacy/IT drop in classes. To deliver a combination of employability, literacy and basic IT provision to adults in Brechin for a 6 month pilot in Brechin Library. This initiative will support the delivery of one of the NE LIG priorities to reduce social isolation by enhancing social prescribing opportunities.	Adults improve their literacy and digital literacy skills for everyday life. Adults increase their confidence in everyday literacy, numeracy and ICT situations. Adults have skills and knowledge which can be transferred into accreditation Learners are able to feel better about themselves.	August 2019 - January 2020	1, 2	
Brechin Transport project	Publicise to groups working with elderly people about the off-line and telephone-based options for getting access to transport information, including distributing timetables and contact details of Traveline Conduct experiential learning research where elderly, those with disabilities and vulnerable adults explore with organisations their experience of local travel.	August 2019- March 2020	1. 2, 3	
Family Cooking: Brechin community campus & Maisondieu Primary School	Adults/children improve confidence in cooking basic meals with understanding of nutrition	August 2019- March 2020	1, 2	
Tackling Men's Health. Provide a relaxed and informal 'clinic' at Link Park Stadium where basic assessments can be undertaken e.g. height, weight, Body Mass Index and blood pressure. Advice on diet, physical activity and alcohol intake is available and men can also discuss other worries such as depression and anxiety.	Men will recognise and report health problems earlier . Onward referral to 'social prescribing' opportunities will be available e.g. walking football, Football Memories, Walk and Talk. Men may also be signposted to a proposed new service called TEAM-TALK.	August 2019 – March 2020	1, 2, 3, 5	
Providing falls prevention talks in the community	To provide information at an earlier stage in order to promote informative adjustments to lifestyle, and increase awareness of risks	Ongoing	1, 2	Building links with community partners. Difficult with engagement with those who have not yet fallen. Not seen as a priority within many of this group. Need to push this.

Improvement Action	Intended Outcome	Timescale	Link to National Outcome	Comments & progress
PRIORITY 1: Improving Health, Wellbeing and Independence continued...				
Providing better balance exercise classes.	To provide specific, targeted strength and balance exercises. To promote social inclusion.	12 week blocks - ongoing	1, 2	Measureable outcomes to evidence improvement.
Develop a social isolation and loneliness questionnaire for distribution across the NE locality.	Better understand the extent and impact of social isolation and loneliness in the NE locality which in inform identification of appropriate actions.	March 2020	1, 4, 5	
Submit application to the Scottish Partnership for Palliative Care Truacanta project.	Improve people's experiences of death, dying, loss and care and timelines.	December 2019	1, 3	We have got through the first round of the process and have been asked to submit a full application in partnership with Brechin Healthcare Group.
Patient Centred Diabetes Care. Pilot.	Shorten the pathway for patients attending Specialist Diabetes Clinic.	March 2020	1, 2, 3, 4	Patient invited to attend their practice for blood tests, review their results on Mydiabetesmyway, to allow for a more informed review by Consultant in clinic.
	Align Diabetes Care to the annual review in primary care.			Routine specialist clinic reviews will be replaced by rapid access to the specialist diabetic team.
	Explore & Develop Mydiabetesmyway as part of self management.			Focus group work in Diabetes Forum meetings Angus.

Improvement Action	Intended Outcome	Timescale	Link to National Outcome	Comments & progress
PRIORITY 2: Supporting care needs at Home				
Falls. Level 2 Multifactorial assessments continue to be carried out by the Angus Falls Service to those in NE Angus in a timely and appropriate manner.	To provide full multifactorial assessment of falls and signpost to relevant partners. Detailed plan provided to patient.	Ongoing	1, 2, 3, 4	Ongoing for those in the community in the NE and also carried out prior to attending MFE clinics in the NE.
Roll out of housing with care models at Provest Johnston Road (PJR) and St Drosden's Court (SDC) to enable the on site staff to provide personal care in addition to housing support and enhanced housing management.	This will allow residents in PJR and SDCt to choose the on-site staff as an option to provide personal care and housing support following a self-directed support assessment. The agreed future model at PJR and SDC will provide: • Personal care • Have sufficient staff to maintain a responsive service to meet tenant's needs • Support timely discharge from hospital • Prevent hospital admission where possible • Be more person-centred • Improve continuity and consistency for tenants • Reassure and support families and carers	March 2020	1, 2, 3, 4	
Ensure a clear pathway for people who are referred to the Enablement and Response Team (ERT).	People, carers and families understand what to expect from ERT and what to expect when ERT services end.	March 2020	1, 2, 3, 4, 6, 8	

Improvement Action	Intended Outcome	Timescale	Link to National Outcome	Comments & progress
PRIORITY 3: Developing integrated and enhanced Primary care and community responses				
Falls Service and Scottish Ambulance Service (SAS) have established pathway for those that do not require conveyancy to the Emergency Department (ED).	To reduce unnecessary hospital admissions as a result of a fall with no injury.	Established	1, 2, 3, 4	NE Angus has the highest rate of referring on to reduce conveyancy. Ongoing work with SAS and attendance from their rep at the Angus Falls group to look at improving referral rate. (low across Angus).
FIRST falls project – pathway developed and agreed with NHS 24 and community alarm service to respond to those who have fallen and are uninjured, who do not have telecare services.	To reduce unnecessary SAS response, and encourage increased uptake of telecare services for future prevention.	End of 2019	1, 2, 3, 4	To keep updated as project progresses.
Angus Falls Action Plan; input from Angus Falls Group, meetings quarterly to update and review. All activity reference to the 4 levels of the strategy.	To provide an integrated approach to Falls and falls prevention within Angus.	Ongoing	1, 2, 3, 4	Good representation from variety of stakeholders, profession specific rather than locality specific.
Review of Independent Intermediate Care (IIC) beds.	Inform bed model for NE Locality.	September 2019	2, 3, 4, 7, 9	
Improve the process behind the anticipatory care planning (ACP) conversations .	Further improve how we deliver person centred care. Share ACPs electronically with GP's on discharge from Ward 2 Stracathro. Hold ACP awareness sessions for all members of the Multidisciplinary Team.	February 2020	2, 3, 4, 8	ACPs shared electronically with GPs since 30 November 2019. ACP awareness session held.
Improve participation of residents in care homes. Three care homes, The Glade, Fordmill and Dorward House are developing resources around improving participation of residents within care homes.	All residents are able to particapate in home life to their full potential. Staff have resources which support them in their work.	October 2020	1, 3, 5	

Improvement Action	Intended Outcome	Timescale	Link to National Outcome	Comments & progress
PRIORITY 4: Improving Integrated care pathways for priorities in care				
Falls Pathways for referral into the Angus falls service established.			1, 2, 3, 4	
Draft falls pathway for District Nursing service including level 2 assessment in documentation at discussion level.	To encourage falls conversation using appropriate recording method and detailed plan for onward referral for those at risk of falls in the community/ECS.	2019	1, 2, 3, 4	
Falls: Enablement and Response Team carrying out Level 1 screenings within the locality.	To encourage appropriate referral to the Falls Service from frontline social care staff.		1, 2, 3, 4	Various methods tried and tested over the past year, now agreed that the Level 1 questions appropriate for this group of staff.
Falls: Emergency Department to Falls Service referrals now on Trakcare. Virtual clinic once weekly for Angus referrals for those who have presented to ED after a fall/ deemed to be at risk of falls.	To ensure full assessment of the fall in a timely, consented manner, and onward referral as appropriate across Tayside.	Established and monitored	1, 2, 3, 4	Ongoing need to educate ED staff to encourage more referrals, huge dip in numbers since changing to virtual clinic, although improvement in appropriateness of referral.

Appendix 2

Consultation on the North East Locality Improvement Plan

Thank you for reading the North East Locality Improvement Plan.

We would like to hear what you think about it and help us develop future plans. Please have your say in either of the following ways:

Fill in the response form below and post to:

Angus Health & Social Care Partnership, Locality Plan Response, Angus House, Orchardbank, Forfar, DD8 1WS
OR complete the survey online at www.surveymonkey.co.uk/r/XLFQZKX

Please add your comments to the following questions in the boxes below. If you are sending your answers by post please feel free to continue on a separate sheet of paper if there is not enough room, making it clear which question your comments relate to.

1. **Do you think we have missed anything important in the locality plan? If so, what?**

2. **How can we work better together to support people in the locality to manage their own health and wellbeing?**

3. **Any other comments**

This locality plan reflects the local priorities of the North East Locality. Angus wide priorities are detailed within the Angus Health and Social Care Partnership Strategic Commissioning Plan 2019-22. **THANK YOU**