ANGUS
Health & Social Care
Partnership

North West Locality Improvement Plan

2019-22

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Contents

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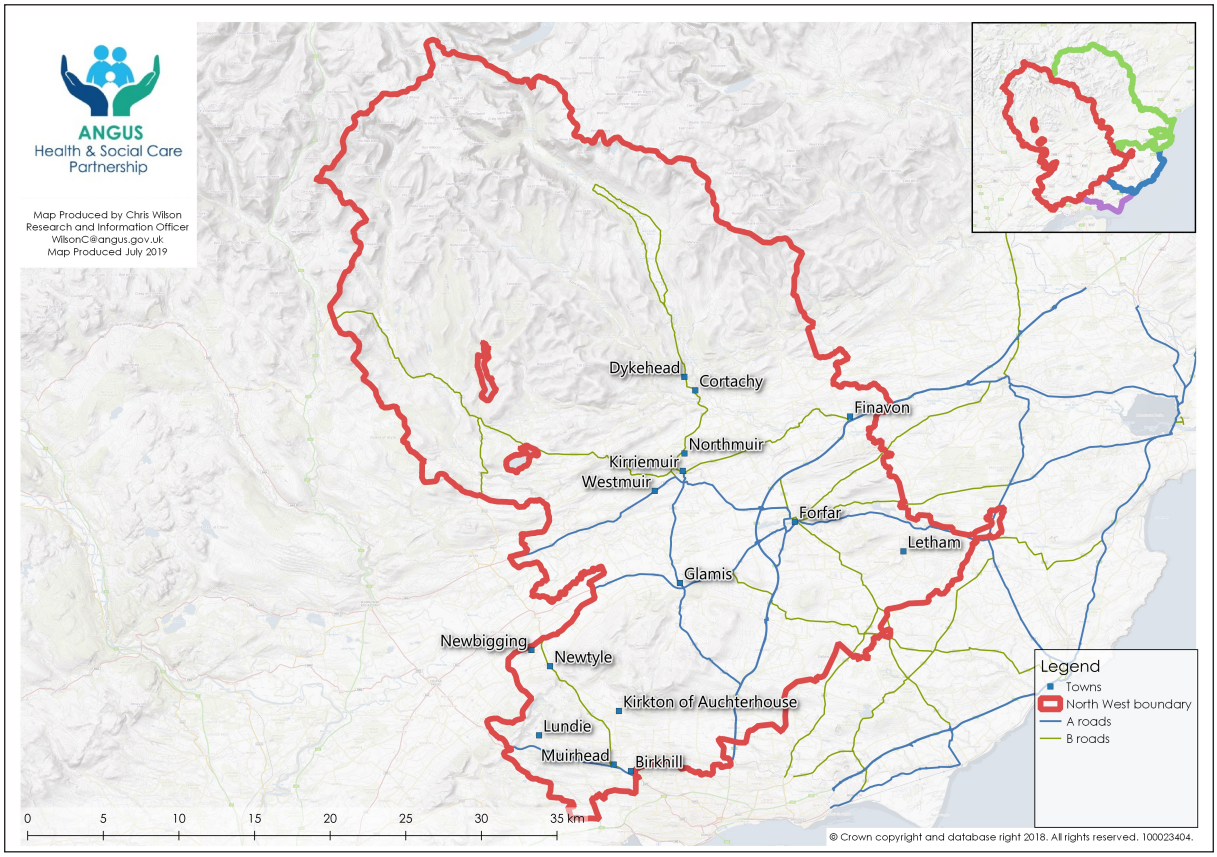
ANGUS
Health & Social Care
Partnership
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Map Produced July 2019
Dykehead
Cortachy
Finavon
Northmuir
Kirriemuir
Westmuir
Forfar
Letham
Glamis
Newbigging
Newtyle
Kirkton of Auchterhouse
Lundie
Muirhead
Birkhill
0
5
10
15
20
25
30
35 km
Legend
Towns
North West boundary
A roads
B roads
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1. Introduction

About this plan

We are pleased to present the second North West 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 sets out the improvements that have been identified by the locality to enhance health and wellbeing outcomes in the North West locality. Importantly, much of the plan is based on what people who live in the North West 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, information, local support networks and by anticipating need before it arises.

This locality plan sets out the improvements that will be progressed in the North West 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 West 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 live and work in the North West 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 West 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 West 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.

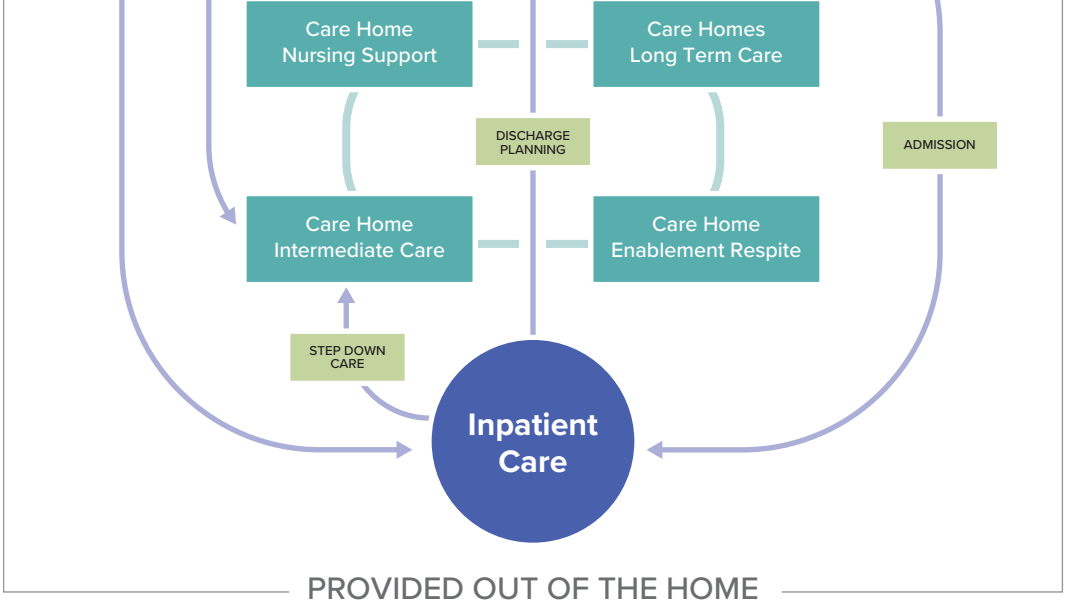
The Angus Care model diagram on page 7 illustrates how health and social care is being delivered and how it will continue to evolve.

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.

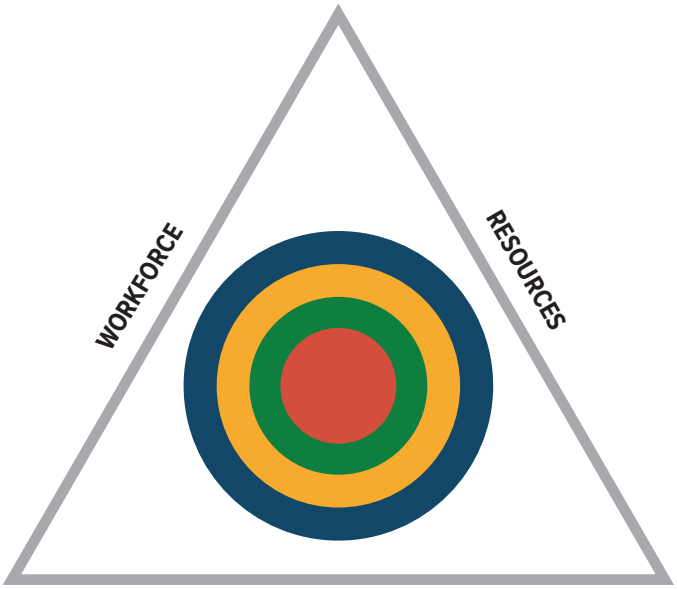
The Partnership continues to make progress to extract meaningful qualitative and quantitative data at locality level. Over time, this information, together with feedback from service users, carers and staff, will allow us to see the impact that the improvements have made.

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



PROVIDED OUT OF THE HOME

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

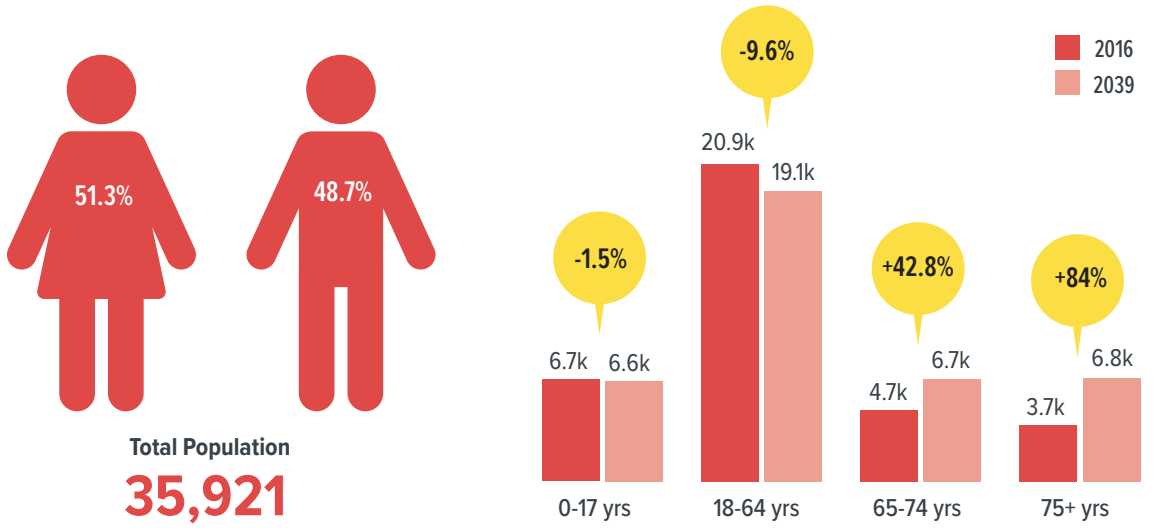
The work to achieve this vision is underpinned by our values:

- 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 West is the largest locality in Angus at 1,143 square kilometres which covers 52% of the entire Angus area. It is a predominantly rural area consisting of Forfar, Kirriemuir, Sidlaws, Birkhill and Muirhead. The North West also has the biggest population of the four localities. As of 2017, there were a total of 35,921 individuals living in the North West meaning it is the least densely populated area in Angus with only 31 people per square kilometre. With 23% of people aged 65+ it has the second highest proportion of those aged 65+ in Angus.

Population Summary - **North West 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 Forfar Central has significantly worse health 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 and bowel screening uptake

The population of Forfar West has significantly worse health outcomes than the rest of Angus population in relation to:

- mental health prescribing
- psychiatric hospitalisations

The North West population has the second greatest proportion of people aged over 65, (23%; up from 22.89% in 2016). The 65+ population has increased from 20.4% in 2013.

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 West 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)
Angus Glens	**84**	**82.6**	30.2
Forfar Central	82.7	75	150.2
Forfar East	**83.5**	79.3	83.4
Forfar West	79.3	77.6	103.1
Kirriemuir	79.8	**80.3**	53.5
Kirriemuir Landward	**83.5**	78.7	78.1
Letham & Glamis	**83.4**	80.4	0
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 West Locality population who are classed as income deprived with both Angus and Scotland as a comparison.

Table 2 Deprivation status in North West Locality

% Income Deprivation*		
	2006	**2016**
NW	9.4	9.04
Angus	11.1	9.8
Scotland	13.8	12.2
% Employment Deprivation*		
NW	8.5	7.8
Angus	10	8.3
Scotland	12.7	10.5
% Access Deprivation*		
NW	37	36.8
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 West locality has the highest rate of access deprivation at 36.8%, a 9.04% income deprivation rate and a 7.8% employment rate. The North West locality includes some of the 20% most deprived areas of Scotland (Forfar West and Forfar Central). It also includes some of the 20% least deprived areas of Angus (Forfar East and Kirriemuir).

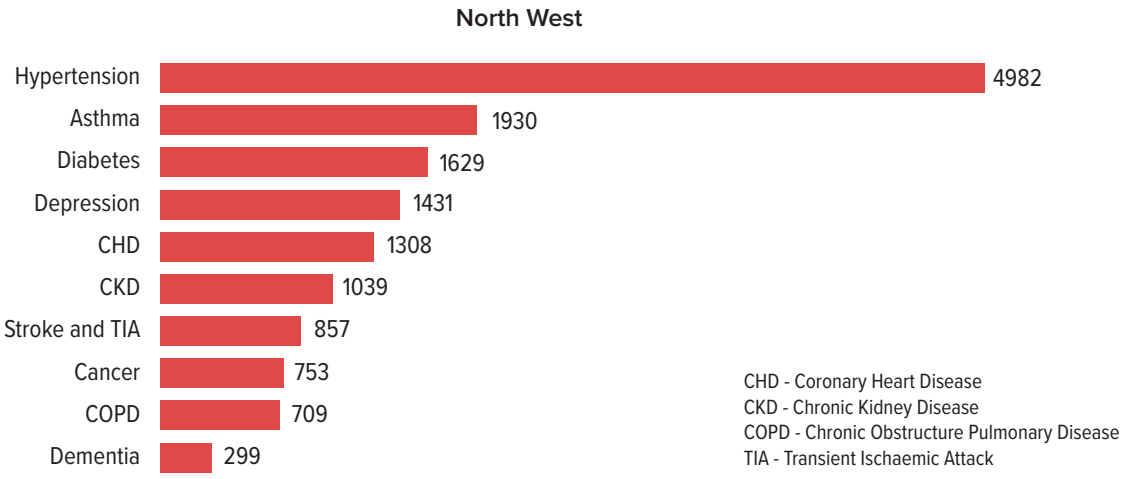
Academy Medical Centre supports the most people living in the most deprived areas of North West Angus (1,158 patients) and Lour Road Medical Group supports 647 living in those most deprived areas.

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 Wast locality:



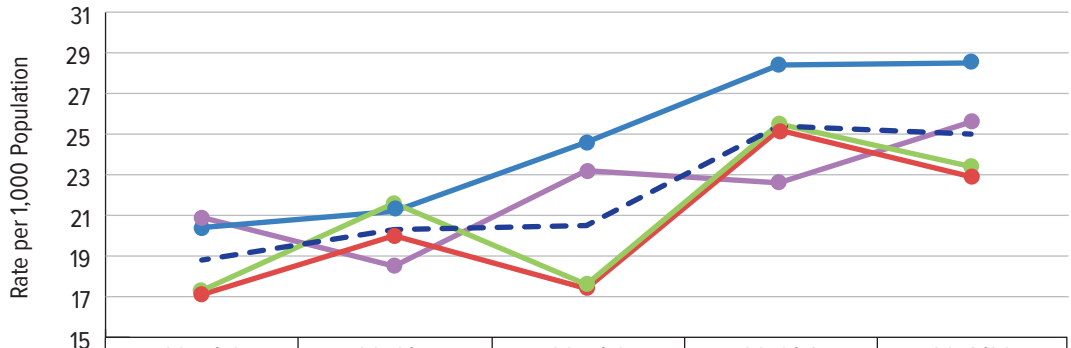
Source: GP cluster dashboard. Please note that this table contains information related to children and adults with long term conditions

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 West 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 West 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 for a number of reasons but 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, 582 people in Angus identified themselves as a carer, including 263 who are under the age of 16. This amounts to about 9.0% 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 West locality who provide support and services for carers. The North West locality improvement group 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 West Locality

In 2017 60% of the North West locality population lived in owner occupied accommodation, 21% in social rented accommodation, 15% in private rented accommodation and 4% of accommodation was vacant. The average household income was estimated as £28,519 in 2018. This is the 2nd highest household incomes across the 4 Angus localities.

Census data (2011) shows that the North West locality has less people living in owner-occupied properties (66%) compared to the Angus average of (69%). Just under a fifth of North West locality residents live in social housing, slightly above the Angus average.

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

Population growth identifies the continuing requirement for additional social sector supply, particularly for those aged over 65. This means the provision of housing suitable for older people is an immediate issue.

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 reshape housing demand toward smaller household sizes.

Forfar West and Forfar Central, within the North West locality are included within the 20% most deprived areas of Scotland. Residents in these areas face restricted housing choice other than the social sector.

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

Under 55s, 23% (227 applications in 2018/19	Over 55s, 26% (91) applications in 2018/19
24% (21) had medical needs	25% (32) had medical needs
26% (45) of all applicants resided in inadequate accommodation	18% (12) of all applicants resided in inadequate accommodation
• For over 55 applications, 19 needed sheltered accommodation • 25% (45) 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 West 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

	NW locality (West Housing Market Area HMA)	Angus	NW locality (West HMA) as a % of total for Angus
Over 65	201	637	32%
Medical	154	467	33%
Disability	88	294	30%
Support	7	26	27%
Total (over 65) Specialist Need	450	1424	32%

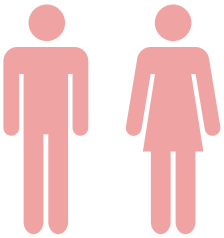
Table B

	NW locality (West Housing Market Area HMA)	Angus	NW locality (West HMA) as a % of total for Angus
Medical	102	295	35%
Disability	56	189	30%
Support	7	22	32%
Total (over 65) Specialist Need	165	506	33%

The ageing population in the North West 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 on-going needs will be used to inform investment decisions. Through the Local Housing Strategy, the Council has committed to deliver 20% of new affordable housing to meet particular needs, with an anticipated delivery of 36 units in the North West locality over the period to 2023. 36 units (29%) within the Council and Registered Social Landlord programme are to be provided for particular needs, surpassing the designated target (20%).

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

Snapshot of North West Locality



172
carers registerd at Angus Carers Centre

201
carers supported by care management teams

1st
locality in Scotland to have a dementia hub tackling isolation issues for people with dementia and their families

363 people
over 65 live in a care home and 131 in a nursing home

1 in every 40
people 65 and over have been admitted to hospital for a fall incident

1 in every 500
people is admitted to Accident & Emergency due to alcohol issues

1 in every 1000
people have been admitted to hospital due to a drug related issue

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

1 in every 7
people over 65 has a community alarm

1 in every 90
people 65 or over receive community meals

1 in every 20
people receive personal care at home

4661
hours personal care per 1000 adult population have been delivered in 2018/19

70,865
nights of long term care home placement for people 65 or over

11 days
is the average length of hospital stay

6.6% of the population have asthma – this is above the Angus average of 6.1% and is the highest rate in Angus

17.4% of the population have hypertension – this is above the **Angus average of 16.4%**

5.2% of the population suffer from depression. This is a much higher rate than any other locality in Angus

5.6% of the population has diabetes – this is the lowest rate in Angus and is shared with the North East locality

5%

of the NW population have been diagnosed with depression. **Highest rate of depression in Angus.**

Examples of Assets in the North West Locality

Asset	Total Number	Location
Health & Social Care		
GP Surgeries	6	Forfar x 3 Kirriemuir x 1 Muirhead x 1 Friockheim x 1
Community Pharmacies	7	Forfar x 3 Kirriemuir x 2 Muirhead x 1 Letham x 1
Opticians	4	Forfar
Dental Surgeries	4	Forfar x 2 Kirriemuir x 1 Letham x 1
Whitehills Health and Community Care Centre (WHCCC) (includes Medicine for the Elderly, Psychiatry of Old Age, Inpatient Unit, Strathmore Hospice).	1	Forfar
Minor Injury and Illness Units (MIIU)	1	WHCCC, Forfar
Community Mental Health Teams for Older People and Adults, outpatient clinics, nurse led clinics and psychology services	1	WHCCC, Forfar Muirhead
Mental Health Officers	1	WHCCC, Forfar (Angus wide)
Allied Health Professionals (AHP) Includes general adult psychiatry, psychiatry of old age, learning disabilities, speech and language therapy and occupational therapy	1	WHCCC, Forfar
Community Rehabilitation Team	1	WHCCC, Forfar
Outpatient clinics including midwifery, podiatry, physiotherapy and public dental service	1	WHCCC, Forfar
Substance Misuse Team	1	Forfar
Dementia Liaison Team	1	Covers all of Angus - based in Susan Carnegie Centre, Stracathro
Post Diagnostic Dementia Support Team	1	Covers all of Angus - based in Susan Carnegie Centre, Stracathro
Glenloch specialist day unit for adults with physical disabilities	1	WHCCC, Forfar
Older Peoples Care Management Team	1	Kirriemuir
Enablement and Response Team	1	Forfar
Learning Disabilities Team	1	Forfar
Physical Disabilities Team	1	Forfar
Angus Integrated Drug and Alcohol Recovery Service	1	North Localities
Community Meals service	1	Forfar
Lilybank Resource Centre for people with learning disabilities and/or autism	1	Forfar
Community opportunities team (adults with learning disability/autism)	1	Forfar
Homelessness Teams	1	Forfar

Asset	Total Number	Location
Health & Social Care continued...		
Access Offices	2	Forfar & Kirriemuir
Angus Council Chambers	1	Forfar
Angus Council Headquarters at Angus House	1	Forfar
Older People's Day Care Services	2	Forfar & Kirriemuir
Tayside Continence Advisory and Treatment Service for Angus locality based in Whitehills.	1	Whitehills, Forfar
Care Homes (older people)	9 (+1 LD unit)	Various locations across the NW locality
Residential Care Home Beds	96	Forfar & Kirriemuir
Elderly Mentally Ill (EMI)/Nursing Home beds	171	Forfar & Kirriemuir
Housing		
Older People Accommodation with housing management	1	Forfar
Supported Accommodation (learning disability)	3	Forfar
Sheltered Housing Developments	153	NW Locality
Retirement housing	62	NW Locality
Community		
Community Centres/Village Halls	19	Forfar (Montrose Road Centre) Forfar (Community Campus) Aberlemno Kirriemuir (Northmuir Hall) Padanaram Kingsmuir Letham Airlie Charleston Eassie Ruthven Glenisla Glen Prosen Kilry Kingoldrum Memus Reswallie Westmuir Birkhill Newtyle
Churches	61	North West locality
Leisure Facilities	2	Forfar & Kirriemuir
Libraries	3	Forfar, Kirriemuir & Newtyle
A library bus for rural areas	1	Angus wide
Access Offices	2	Forfar & Kirriemuir
Men's Shed schemes	2	Forfar & Kirriemuir
Care About Angus (Delivers essential home support services across Angus)	1	Forfar
Voluntary Action Angus	1	Forfar
Town Halls	2	Forfar & Kirriemuir
Fire Stations	2	Forfar & Kirriemuir
Glensview Community Flat	1	Forfar
Kirrie Connections	1	Kirriemuir

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.

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 at any time 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 West Locality

You said	We did
Certain referrals need a Multi-disciplinary Approach.	• Undertaken a test of change on Enhanced Community Support (ECS)Lite in preparation for implementing ECS in the North West locality in April 2019. • Placed a Mental Health nurse in Academy Medical Centre to achieve early access to treatment and quicker support. • Voluntary Action Angus have placed a worker in Academy Medical Centre as a social prescriber to take referrals where the benefit of non-medical support and intervention was identified. • Undertaken a test of change to support a holistic approach to chronic pain management in adults. • Academy Medical Centre employed 2 health psychologists to support people to come to terms with their conditions. • Enablement Response Team senior carers are now attending inpatient multidisciplinary team meeting at Whitehills Health and Community Care Centre to facilitate transfer of information between the inpatient units and Enablement Response Team.
You wanted more community supports available 7 days.	• Agreed that, starting in the North West locality, there will be a 7 day Community Mental Health home treatment service available.
We need to work more with community groups to promote health, wellbeing and inclusion, reduce isolation and make activities more accessible to all.	• Commenced a test of change via the Strathmore Rugby Club to introduce walking rugby, unified rugby and autism friendly rugby. • The Wellbean Café has opened in Forfar to support mental health, wellbeing and social isolation. This is led by the Alcohol and Drug Partnership.
We need to improve the patient journey for people living in the North West locality.	• Commenced a test of change for early diagnosis of dementia in non-complex cases where diagnosis can be undertaken by the G.P. enabling earlier access to post diagnostic support for people with dementia and their families. • To improve the patient journey we are ensuring the discharge from hospital is timely and the right people are involved at the right time. • Enablement Response Team senior carers are now attending inpatient multidisciplinary team meeting at Whitehills Health and Community Care Centre to facilitate transfer of information between the inpatient units and Enablement Response Team.
We need to improve communication with individuals, families and be more person centred.	• Implemented Treatment Escalation Plans within Isla Ward which has improved complex decision making and conversations with patients and carers to support people to make informed choices about their care and treatment. • Carried out a variety of patient journeys within Isla Ward and gathered patient feedback which has helped inform further improvements in communication with families, patients and between health and social care, discharge planning and anticipatory care planning. • Worked closely with Angus Carers and developed a carers 'clinic' within Isla/Clova wards to support carers and provide information to carers. • We have undertaken a process map of a patient journey from admission to discharge exploring Anticipatory Care Planning and developed an improvement plan. • The Medicine For the Elderly wards Isla and Clova have carried out extensive engagement with patients, relatives and health and social care staff in implementing 'Care of Older People in Hospital Standards' which continue to inform the improvement plan for Medicine For the Elderly.

You said	We did
We need to use technology to improve how we work.	• Undertaken a test of change to implement mobile data enabled technology to support Occupational therapists in a community role. This is now being tested more widely across other services. • Care Homes in the North West locality have commenced using Zoom technology for health and educational activities. • Developed a locality locator to allow access to community groups and supports. • The Letham health and wellbeing clinic now has a nurse led clinic for the residents of Letham and the surrounding area, which serves 7 GP practices.
We need to improve learning and development for care home staff in the North West locality.	• Set up a North West care home learning and development programme to improve person centred care, skills base and resilience in staff.
We needed ECS in the North West.	• Funded the Kirriemuir pilot and pushed for implementation of ECS in the North West that commenced on 01 April 2019. • We have carried out staff engagement sessions with nursing teams including development of processes, ways of working, nursing assessments, and training in recognition of deterioration.

7. Priorities for 2019-22

Strategic Priority 1 - Improving Health, Wellbeing and Independence

Health System Literacy - To have a clear process in place detailing what, how and when to access health and social care and independent/voluntary sector support in the North West locality using material and language suitable for all, building on the locality locator.

Strategic Priority 3 - Developing Integrated and Enhanced Primary Care and Community Responses

Prevention/Early Intervention - to have a comprehensive service to support patients and service users at risk of decline in physical/mental health, or social care situation through falls prevention, anticipatory care plans, enhanced community support, implementation of multi-disciplinary 6 week care home reviews, early diagnosis in dementia and multi-disciplinary team annual care home reviews.

Appendix 1

North West 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 West 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 West 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				
Health System Literacy – To have a clear process in place detailing what, how and when to access health and social care and independent/ voluntary sector support in the North West locality using material and language suitable for all, building on the locality locator.	People know what information and support is available within the North West locality and how and when to access it.	March 2020	1, 2, 3, 4, 5, 7, 9	
Test a system whereby volunteers (trained through VAA), can act as health and social care interpreters guiding patients through the system and handing over to the system which could be linked in with Social Prescribing strategy at low level. It will be tested initially with supporting people using the locality locator in Letham Hub and potential future sites will be scoped out.	Patients/service users increase their understanding of what the health and social care system consists off and what is happening for them resulting in a decrease in anxiety levels.	March 2020	1, 2, 3, 4, 7, 9	
All Hospital discharges, where there has been no input from social work or any services previously, should come through the Enablement and Response Team.	Ensure that people have the opportunity to realise their full potential and remain as independent as can be. Also, where long term support and care is identified as a need, to ensure the package is 'the right size' and not just a standard '4x per day' fits all approach.	November 2019	1, 2, 3, 9	
There is a need to create patient friendly language on Trak generated clinical appointment letters, testing with first contact physiotherapy in GP as letters from Trak are currently sent out as 'MSK' and patients don't know what this is. To explore feasibility of this being changed.	Patient appointment letters are worded in patient friendly language increasing patient understanding.	December 2019	1, 3, 4	

Improvement Action	Intended Outcome	Timescale	Link to National Outcome	Comments & progress
PRIORITY 1: Improving Health, Wellbeing and Independence continued...				
Explore a test of change with an infographic (a visual practice map) to help patients understand their health and what services and supports are available. This will also promote further team working for the patients. Further tests could connect up the 'building maps' to 'town maps' and could also be used in services such as Mental Health as this is a priority for service users. This could incorporate the locality locator.	Patient feedback - patients and staff are more aware of what goes on within a building, what services and supports are available and how the team works together for the patients.	August 2020	1, 2, 3, 4, 5, 7, 8, 9	
A Mental Health and Wellbeing peer worker will be in place in every practice in the North West locality.	People experience quick and easy access to local support for mental health and wellbeing when they need it. Resources will be used efficiently. Reduce prescribing for medication for depression.	December 2020	1, 7, 8, 9	
Strengthening Families Group 7 week programme to be delivered to build upon strengths within the family,	Reduce family related risk factors for adolescent problem behaviour and substance misuse.	August – October 2019	1, 2, 4, 6, 7	This could also link with Learn Laugh Play and community cafes.
Suicide prevention will be an identified priority with a specific focus on awareness raising with children and young people. In order to identify and support effective actions the North West Locality Group will support the work of the Angus Suicide Prevention Strategic Plan.	Children and young people become more aware of local help and support available for mental health and suicide prevention access this when needed.	September 2020	1, 2, 4, 5, 7, 9	
Support the establishment of 'Angus Creative Minds' – a social enterprise aimed at benefitting the health and wellbeing of anyone facing any health or social barrier to participating in creative activities, reduce the stigma of mental health and reduce isolation and loneliness.	Improved health and wellbeing through increased opportunities for public participation in art and creative expression in Angus, improved quality of life and reduction in health inequalities – measured via a mental wellbeing scale, feedback questinnaires, photos, videos, case studies, impact stories and data gathering.	March 2020	1, 4, 5	

Improvement Action	Intended Outcome	Timescale	Link to National Outcome	Comments & progress
PRIORITY 1: Improving Health, Wellbeing and Independence continued...				
Develop a loneliness questionnaire for distribution across the North West locality.	The extent of loneliness and the impact of this across the North West locality is established and informs future actions to reduce loneliness and isolation.	December 2019	1, 4, 5	
PRIORITY 2: Supporting care needs at Home				
Community nurses working in Letham undertaking nurse led clinics in partnership with Voluntary Action Angus supporting Pod measurements for long term condition review and supporting social needs.	Patient Feedback. Numbers of clinic attendances.	October 2020		Also, potential to extend to Anticipatory Care Plans
Develop a clear pathway for people coming to the Enablement and Response (ERT) Teams following hospital discharge, Prevention Of Admission or needs assessment, particularly for those who have been diagnosed with Dementia or other mental ill health or who have long term conditions. This could be quick and simplistic initially in practice. For example 'Ask me what the next steps are?' on name badges or folders.	Reduce confusion with people, carers and families and avoid frustration caused by being referred into a service when they do not know what to expect or what the pathway is when long term support is required. This should be the general ethos of all staff in the Enablement and Response Teams. This is what has happened... the next steps are... 1. What happens next section in folders. 2. Creating an ERT passport that will be passed on to the long term provider.	March 2020	1,2,3,4,6,8	
Undertake a mapping exercise to determine the future need for supported accommodation for older people in the NW locality and feed this into the Strategic Housing Investment plan.	Clear data is gathered to inform future supported housing projections and planning in the North West locality.	March 2020	2, 4, 5, 7, 9	
Explore the reasons for the low numbers of people in the North West locality who are being supported by the Angus Carers Centre and identify appropriate actions to address this.	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.	March 2020	2, 3, 4, 5, 6, 9	

Improvement Action	Intended Outcome	Timescale	Link to National Outcome	Comments & progress
PRIORITY 2: Supporting care needs at Home continued...				
Replace the Gables Care Home for adults with learning disability/autism with supported housing units.	A move away from an institutional environment towards more personalised models of supported housing is facilitated allowing individuals more opportunity to live independently within their local communities, to gain from greater choice and control over their support as well as maximising the financial resources available to them.	Sept 2020	1, 2, 3, 4, 5, 7, 9	
PRIORITY 3: Developing integrated and enhanced Primary care and community responses				
Prevention/Early Intervention – to have a comprehensive service to support patients and service users at risk of decline in physical/mental health, or social care situation through falls prevention, anticipatory care plans, enhanced community support, implementation of multi-disciplinary 6 week care home reviews, early diagnosis in dementia and multi-disciplinary team annual care home reviews.	People receive the support they need as early as possible and decline in individuals' physical/mental health is reduced or prevented. Percentage of medical anticipatory care plans that are complete at 2 months after care home admission. Reduction in % falls (via community alarm data rather than hospital admission falls data). % of annual multidisciplinary care home reviews. Increase the number of teams that are involved in Anticipatory Care Planning.	June 2020	1, 2, 3, 4, 5, 7, 9	There was the potential to do a multi agency and public event around Anticipatory care plans inclusing a 'Show and Tell@ in the new VAA premises but this looks more complex than first thought. Might be something for a future plan 2020/21.
Developing knowledge and competency of community nurses to support Enhanced Community Support and deteriorating patients in the community.	Reduce acute and community hospital admissions. Reduce readmissions.	December 2019	1, 3, 4, 7, 8, 9	
PRIORITY 4: Improving Integrated care pathways for priorities in care				
Develop integrated pathways between all mental health and substance services.	Early engagement for those people who present with co-existing conditions, supporting more positive long term outcomes. Reduce depression rates and impact on families and communities.	December 2020	1, 3, 4, 5, 7, 8, 9	North locality event on 11 Sept to identify and agree future pathways for joint working.

Appendix 2

Consultation on the North West Locality Improvement Plan

Thank you for reading the North West 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 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 West Locality. Angus wide priorities are detailed within the Angus Health and Social Care Partnership Strategic Commissioning Plan 2019-22. **THANK YOU**