ANGUS
Health & Social Care
Partnership

South East Locality Improvement Plan

2019-22

Published January 2020

Contents

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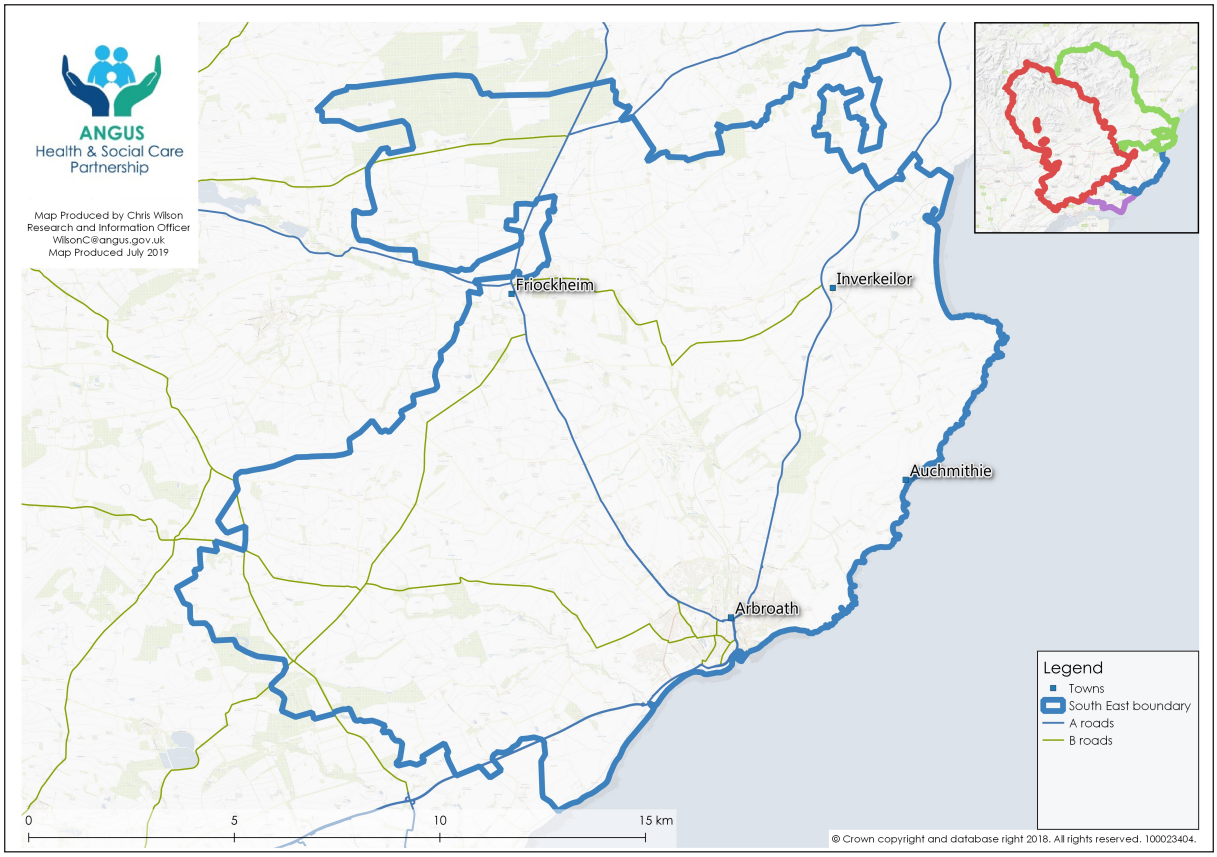
ANGUS
Health & Social Care
Partnership
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Map Produced July 2019
Friockheim
Inverkeilor
Auchmithie
Arbroath
Legend
Towns
South East boundary
A roads
B roads
0
5
10
15 km
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1. Introduction

About this plan

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

This locality plan sets out the improvements that will be progressed in the South 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 South 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 live and works in the South 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.

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 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 priorities, the South East locality improvement plan will help to inform the future strategic direction for AHSCP.

Equality and Diversity

Equality and diversity will be central to improvement work in the South 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; and 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?

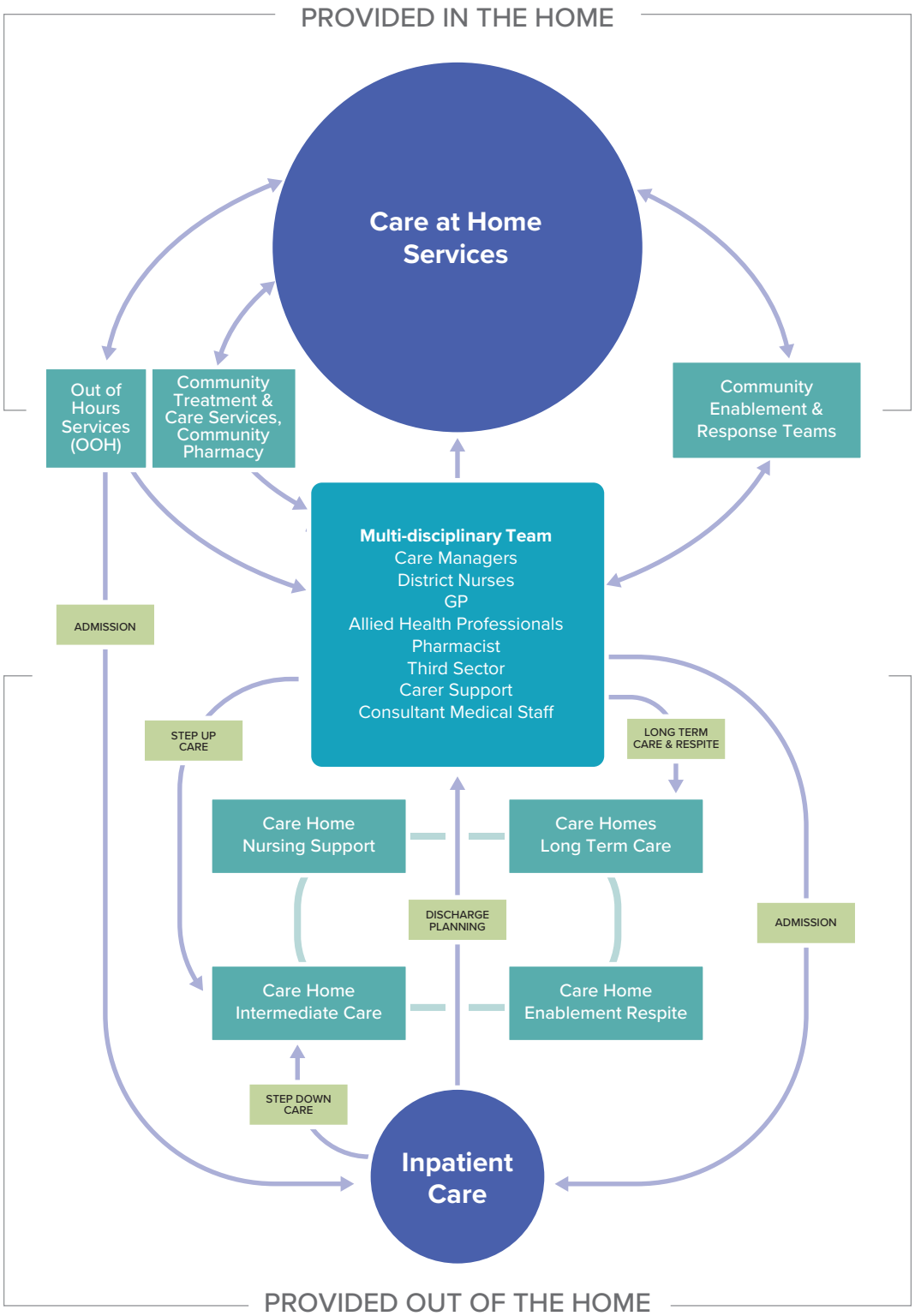
To help us monitor the progress of this plan and the wider Angus Strategic Plan, we will set out measures and improvement targets which will ensure a consistent approach across all four localities and the wider partnership.

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.

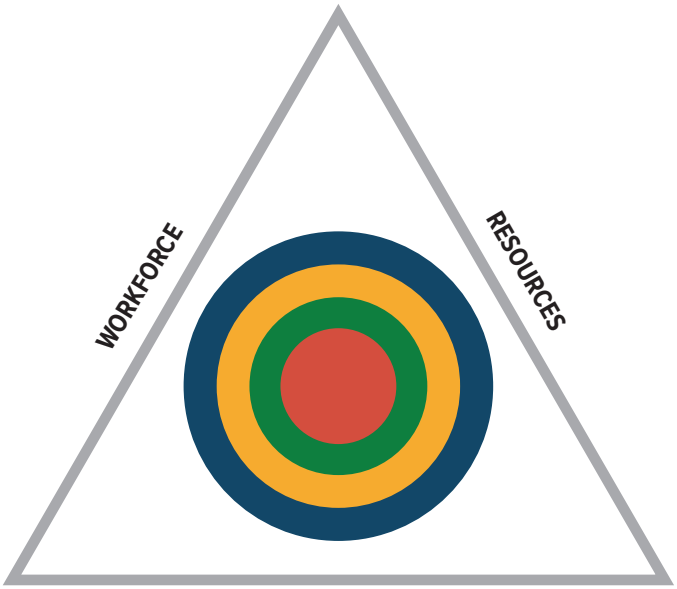
Regular updates will be reported to the AHSCP Strategic Planning Group (SPG).

ANGUS CARE MODEL

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



Angus HSCP priorities and performance areas



CLINICAL, CARE AND PROFESSIONAL GOVERNANCE

- **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

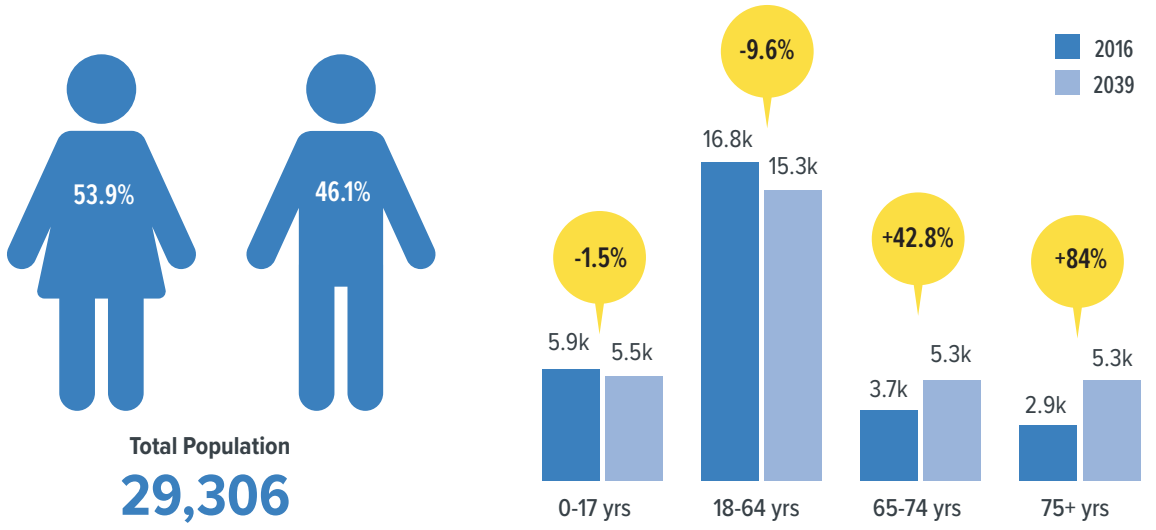
The work to achieve this vision is underpinned by our values:

- 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 South East locality covers an area of 209 square kilometres; it consists of the distinct areas of Arbroath, Friockheim, Auchmithie and Inverkeilor. The South East has a population of 29,306 people; it is the second most densely populated locality with density of 140 people per square kilometre. The South East population has the lowest proportion of older people aged 65+ years (22%) in Angus, up from 21.24% in 2016. It is projected that the 65+ population in the South East and other localities will experience a 20.8% increase by 2026 and a 42.8% increase by 2039.

Population Summary - **South 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 Arbroath Harbour has significantly poorer outcomes than the rest of the Angus population in relation to:

- male (71.3yrs) and female (76.9yrs) life expectancy
- deaths-all ages
- emergency hospitalisations
- psychiatric hospitalisations
- alcohol and drugs-related hospitalisations
- Chronic Obstructive Pulmonary Disease (COPD) hospitalisations

- drugs prescribed for anxiety/depression/psychosis
- bowel screening uptake

The population of Arbroath Warddykes has significantly worse outcomes than the rest of the Angus population in relation to:

- mental health prescribing
- crime rate
- smoking in pregnancy
- bowel screening uptake

The population of Arbroath Cliffburn has significantly worse outcomes than the rest of the Angus population in relation to:

- mental health prescribing for depression/anxiety/psychosis
- bowel screening uptake

The population of Arbroath Keptie has significantly worse outcomes than the rest of the Angus population in relation to:

- mental health prescribing
- male life expectancy

Only Arbroath Landward does not have any significantly worse outcomes than the rest of the Angus population.

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 South east locality compares to the national average.

Table 1. Average life expectancy in the South 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)
Arbroath Cliffburn	82.7	78.4	49.4
Arbroath Harbour	**76.9**	**71.3**	226.6
Arbroath Keptie	80	78.6	29.3
Arbroath Kirkton	**83.2**	75.5	69.2
Arbroath Landward	**85.5**	**82.5**	54.2
Arbroath Warddykes	80.6	75.5	134.6
Friockheim	82.1	**80.2**	103.5
Lunan	82.1	**80.4**	72.5
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.

The South East has the second lowest access deprivation at 18.16 yet the highest rate of income deprivation at 13.4%. This is above Angus and Scotland rates which increased from 12.5% in 2013 to 13.4% in 2016. The South East also has the highest rate of employment deprivation at 10.6% which is above Angus and Scotland rates.

GP practices located in the South East (and North West) localities have the greatest number of patients living in the 20% most deprived areas; Arbroath Medical Centre, West Practice of Springfield Medical Centre and Abbey Health Centre have the highest numbers. All four Angus GP practices which have patients living in the 15% most deprived datazone areas are located in the South East. South East Angus includes some of the 20% most deprived areas of Scotland; Arbroath Kirkton (part); Arbroath Harbour; Arbroath Warddykes; and Arbroath Cliffburn. The South East also includes some of the least deprived areas of Scotland: Arbroath Kirkton (part).

Table 2 illustrates the percentage of the South East locality population who are classed as income, employment or access deprived, with both Angus and Scotland as a comparison.

Table 2 Deprivation status in South East Locality

% Income Deprivation*		
	2006	**2016**
SE	15.5	13.4
Angus	11.1	9.8
Scotland	13.8	12.2
% Employment Deprivation*		
SE	13.5	10.6
Angus	10	8.3
Scotland	12.7	10.5
% Access Deprivation*		
SE	26.4	18.16
Angus	25.4	23.85
Scotland	15	14.9

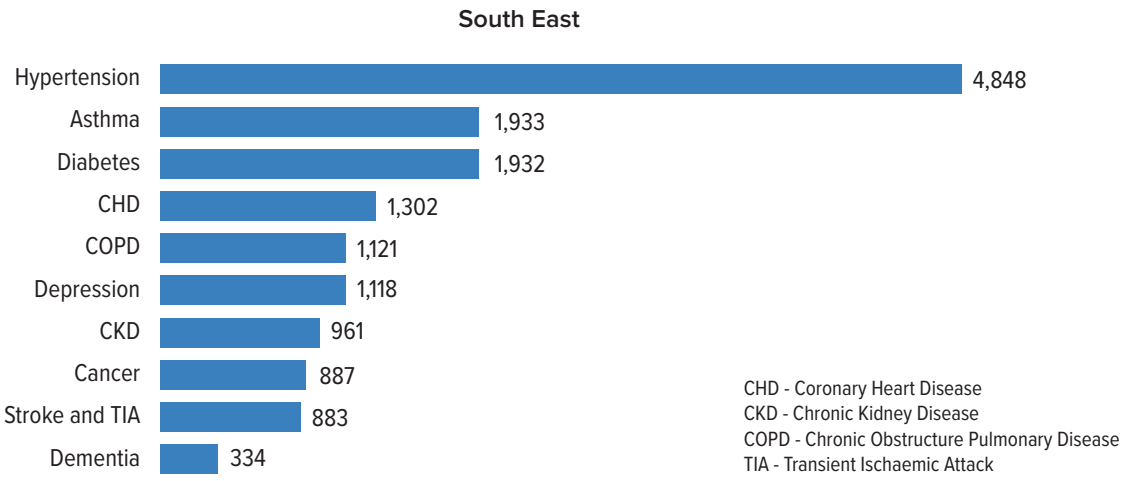
Source: Locality Health & Wellbeing Profiles provided by ScotPHO

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

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 South East locality:



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

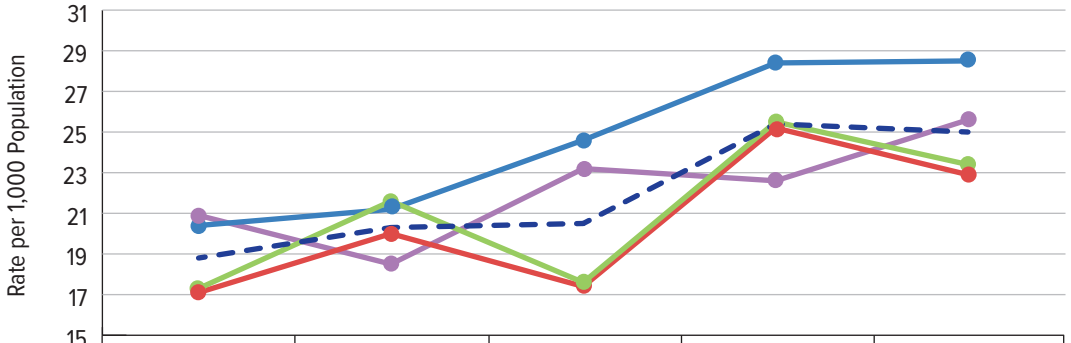
Falls

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 South 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 South 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 fulfilling life alongside their caring role.

AHSCP 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 in 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 South East Locality who provide support and services for carers. The South East Locality 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 South East Locality

In 2017 the population of the South East locality was 29,306. Around 24,000 people reside in Arbroath, with the remainder in rural areas and the surrounding villages such as Inverkeilor and Friockheim. 57% of the population lived in owner occupied accommodation, 28% in social rented accommodation, 12% in private rented accommodation and 3% of accommodation was vacant. The average household income was estimated as £24,670 in 2018, which is the lowest across the four Angus localities.

Census data (2011) shows that the South East locality has fewer people living in owner-occupied properties (61%) compared to the Angus average of 69%. Just over a quarter of South East locality residents live in social housing, which is the highest proportion of any of the Angus localities and compares to just under a fifth Angus-wide. The greater reliance on social housing in South 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.

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. As noted earlier, within the South East locality, four areas are included in the 20% most deprived areas of Scotland. This indicates that a large proportion of the local population face restricted housing choice other than in the social sector.

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

Under 55s, 10% (454) applications in 2018/19	Over 55s, 20% (116) applications in 2018/19
43% (38) had medical needs	32% (40) had medical needs
47% (81) of all applicants resided in inadequate accommodation	32% (57) of all applicants resided in inadequate accommodation
• For over 55 applications, 19 needed sheltered accommodation • 32% (57) 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 South 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

	SE locality (East Housing Market Area HMA)	Angus	SE locality (East HMA) as a % of total for Angus
Over 65	198	637	31%
Medical	183	467	39%
Disability	109	294	37%
Support	6	26	23%
Total (over 65) Specialist Need	496	1,424	35%

Table B

	SE locality (East Housing Market Area HMA)	Angus	SE locality (East HMA) as a % of total for Angus
Medical	116	295	39%
Disability	69	189	36%
Support	6	22	27%
Total (over 65) Specialist Need	191	506	38%

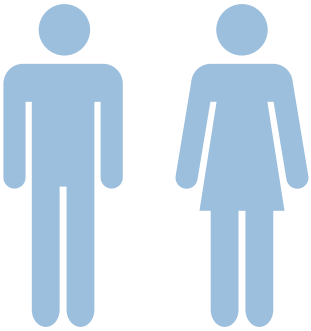
Anticipated need in the South East locality is the highest across the Angus Housing Market areas, yet stock levels are the lowest across Angus. The anticipated need-to-supply ratio does not take account of current usage and therefore suggests there will be an under provision of suitable stock in the locality.

The number of people in the South East locality aged over 65 is projected to increase by 2039 meaning there is likely to be additional specialist housing need, further straining supply, particularly for smaller households. 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 47 units in the South East locality over the period to 2023.

The current Strategic Housing Investment Plan (2018/19 to 22/23) specifies the delivery of 311 affordable units in the South East locality over a five year period.

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

Snapshot of South East Locality



294

adult and young carers are supported by Angus Carers Centre in the South East locality

146

adult carers are supported by AHSCP Adult Services Teams

Coronary Heart Disease rates are below the average for Angus

Diabetes is more prevalent than in any other Angus locality

1 in 35 people

in the South East locality have been admitted to hospital after a fall

In 2018 the South East locality had the highest rate of alcohol-related A & E attendance of the whole of Angus

1 in every 8

people over 65 has a community alarm

8 days

is the average length of hospital stays for adults during 2018/19

1 in every 20

people in the South East locality receives a personal care service at home

445 people

over 65 lived in a care home

129 people

over 65 lived in a nursing home

The percentage registered as having dementia in the South East locality **is above the average for Angus**

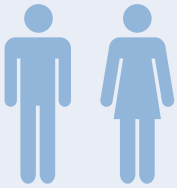
1 in every 1,118

people over 65 in the South East locality receive Community Meals

4,408 hours

of personal care per 1000 people have been delivered in the South East Locality in 2018/19

In the South East locality hypertension rates are **below the average for Angus**



Life expectancy in parts of the South East locality is lower than the Angus and the Scottish average

Examples of Assets in the South East Locality

Asset	Total Number	Location
Health & Social Care		
Health Centres	4	The Medical Centre, Arbroath Springfield Health Centre, Arbroath Abbey Health Centre, Arbroath Friockheim Health Centre
Community Pharmacies	6	Lloyds Pharmacy, Arbroath Davidsons Chemist, Arbroath Davidsons Chemist, Friockheim Boots, High St, Arbroath Well, High St, Arbroath Well, Fisheracre, Arbroath
Opticians	3	Specsavers, Arbroath Duncan & Todd, Arbroath Vision Right, Arbroath
Dental Surgeries	5	121 Dental Centre, Arbroath West Port Dental Practice, Arbroath Ian Robertson Dental Care, Brothock Bridge, Arbroath No. 80 Dental Practice, Arbroath K N Wallace, Arbroath
Hospitals	1	Arbroath Infirmary
Minor Injuries and Illness Unit	1	Arbroath Infirmary
Community Mental Health Teams Mental Health Officers Team	2	Adult and Over 65s teams are based at Gowanlea, Arbroath Covers all of Angus – based at Whitehills HCCC, Forfar
Dementia Liaison Team Post Diagnostic Dementia Support Team	1 1	Both cover all of Angus – based in Susan Carnegie Centre, Stracathro
Midwifery Clinics	1	Arbroath Infirmary
Allied Health Professionals: Occupational Therapy Physiotherapy Speech & Language Therapy Podiatry Nutrition and Dietetics		Community Rehab service based at Arbroath Infirmary Musculo-skeletal Outpatients, First Contact Physiotherapy and Community Rehab all based at Arbroath Infirmary Based at Abbey Health Centre Based at Abbey Health Centre Based at Abbey Health Centre
Older Peoples Care Management Team	1	Bruce House, Arbroath
Enablement and Response Team	1	Bruce House, Arbroath
Learning Disabilities Team	1	Bruce House, Arbroath
Physical Disabilities Team	1	Bruce House, Arbroath
AIDARs Team	1	Gowanlea, Arbroath
No. of Care Homes No. of Residential Beds Elderly Mentally Ill (EMI) beds Care Homes – Learning Disability	7 315 40	Tarriebank House, Marywell Kendale Hall, Arbroath Monkbarns, Arbroath Seaton Grove, Arbroath Antiquary House, Arbroath Cairnie Lodge, Arbroath Lunan Court, Arbroath St Vigeans, Arbroath
Housing		
Commissioned Supported Accommodation	2	Cliffview Court, Arbroath Doocot Park
Sheltered Housing Developments No. of flats No. with communal lounge	3 67 3	Adam Cargill Court Ponderlaw Lane Andy Stewart Court

Asset	Total Number	Location
Community		
Community Centres/Village Halls	3	Inverkeilor Church Hall High Street, Arbroath Auchmithie Hall
Day Centres	1	Lochlands Resource Centre, Arbroath
Leisure Facilities	2	Arbroath Sports Centre Saltire Sports Centre, Arbroath
Libraries	1	Hill Terrace, Arbroath
ACCESS Office	1	Kirk Square, Arbroath
Communities Team	1	Glenisla Drive, Arbroath
Angus Independent Advocacy	1	High St, Arbroath
Friockheim Community Hub	1	Eastgate, Friockheim
Angus Carers Centre	1	Grant Rd, Arbroath
Angus Young Carers	1	Grant Rd, Arbroath
Citizen's Advice Bureau	1	Millgate, Arbroath
Hope Organic Garden	1	Westway, Arbroath
Job Centre Plus	1	Chalmers St, Arbroath
Arbroath Learning Shop	1	Arbroath Library
Voluntary Action Angus	1	Guthrie Port, Arbroath
Alzheimer Scotland	1	High St, Arbroath
Hospitalfield	1	Hospitalfield Rd, Arbroath
Community Space	1	Glenisla Drive, Arbroath
Allotments	3	Brechin Rd, Arbroath Hillend Rd, Arbroath Ernest St, Arbroath
Men's Shed	1	Den's Road, Arbroath
Police Station	1	Gravesend, Arbroath
Fire Station	1	Ponderlaw St, Arbroath
Angus Foodbank	1	Craig O Loch Rd, Arbroath
Lighthouse Clothes Bank	1	Grant Rd, Arbroath
Furniture Recycling Project	1	Wardmill Rd, Arbroath
Havilah Project	1	Fisheracre, Arbroath
Churches & Places of Worship	16	St Vigean's Church, St Vigean's St Andrew's Parish Church, Arbroath St John's Methodist Church, Arbroath Church of St Mary the Virgin, Arbroath Old and Abbey Parish Church, Arbroath Arbroath Town Mission, Arbroath St Peter's Scottish Episcopal Church, Auchmithie Colliston Parish Church Salvation Army Citadel, Arbroath St Christopher's Church, RM Condor St Mary's Episcopal Church, Arbroath St Thomas of Canterbury Church, Dishlandtown St, Arbroath Arbroath Community Church, Arbroath West Kirk, Addison Place, Arbroath Friockheim & Kinnell Church Inverkeilor and Lunan Church

Asset	Total Number	Location
Community		
Primary Schools	12	Inverkeilor Primary School Colliston Primary School Friockheim Primary School Arbirlot Primary School Colliston Primary School Muirfield Primary School Timmergreens Primary School Ladyloan Primary School Hayshead Primary School St Thomas' Primary School Warddykes Primary School Inverbrothock Primary School
Secondary Schools	2	Arbroath High School Arbroath Academy
Further Education	1	Dundee & Angus College

5. Communication and engagement

Engagement and participation 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 South East Locality

You said	We did
We need to do more to support health and wellbeing and build capacity in the Arbroath community.	The Arbroath Healthy Living Project was launched as a test of change, with a pop-up community café in Strathairlie and a range of community-based activities. So far these have included exercise groups, healthy eating classes, welfare rights sessions, mental health support sessions and family learning activities. It also led to the development of the "Oot N Aboot" group focusing on outdoor learning activities.
We need to be more proactive in supporting individuals and their carers to plan for potential changes to a person's health and care circumstances.	We have recruited a temporary Nurse Practitioner to promote advance care planning for care home residents in the locality. This is a "thinking ahead" approach which needs professionals and services to work with individuals and their carers to look at what is most important to them if things change in the future. This information can then be recorded and shared in advance of a change in circumstances. The Nurse Practitioner will work closely with local care homes, to support and empower their staff to complete advance care plans with residents, during this test of change.
You told us you wanted faster access to treatment from AIDARS in the South Locality.	We reduced the time from an average of 54 days to 18 days.
You told us you wanted to have evening appointments with your key worker from AIDARS in the South Locality.	We set up an evening clinic on a Thursday evening to make the service more accessible.

7. Priorities for 2019-22

Priority 1: Improving Health, Wellbeing and Independence

- To address the high prevalence of type 2 diabetes in the South East locality
- To improve wellbeing in retirement for people in the South East Locality who are income deprived
- To Improve access to information which can enable people to take care of their own health and wellbeing
- To improve mental wellbeing in the South East locality
- To increase physical activity levels in the South East locality

Priority 2: Supporting care needs at Home

- To improve health and wellbeing for local unpaid carers

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

- To improve Anticipatory Care Planning for care home residents in the South East locality

Priority 4: Improving Integrated care pathways for priorities in care

Further details of how we plan to achieve our priorities are contained in the action plan appendix.

Appendix 1

South 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 South 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 South 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				
To address the high prevalence of type 2 diabetes in the South East Locality				
To identify local pathways for people who have type 2 diabetes or pre-diabetic symptoms and promote them.	Advice and support is consistent	Review progress by September 2020	1, 2 ,3, 5, 9	
To develop the capacity of key LIG partners to recognise the risk factors for diabetes and where to signpost for advice and support.	Advice and support is consistent			
To identify existing community initiatives which are connecting with people at risk of developing type 2 diabetes.	Improved access to information and education about healthy eating, lifestyle and exercise, particularly for people who are disenfranchised.			
To investigate if screening programmes and brief interventions can be targeted through existing community initiatives	Improved access to information and education about healthy eating, lifestyle and exercise, particularly for people who are disenfranchised.			
To identify ways to target young adults and encourage them to engage with their own health	Local adults are informed and aware of risk and protective factors from a young age			
To identify any gaps in support which the SE LIG can address	The risk factors for type 2 diabetes are reduced			
The impact of the improvement action will be monitored and evaluated via a project plan	We will know if the actions are making a difference			

Improvement Action	Intended Outcome	Timescale	Link to National Outcome	Comments & progress
PRIORITY 1: Improving Health, Wellbeing and Independence				
To improve wellbeing in retirement for people in the South East who are income-deprived				
To identify how this priority links with the Arbroath Plan and the work of the Locality Improvement Partnership.	Avoid duplication of effort and resources.	Review progress by September 2020	1, 2 ,3, 5, 9	
To link with agencies supporting local people who are income deprived, such as Citizens Advice Bureau and Welfare Rights.	Improve our understanding of the need, what is available and the barriers to accessing it. Avoid duplication of effort and resources.			
To link with other projects and activities targeting socially isolated older people such as Eat Well Age Well.	Improve our understanding of the need, what is available and the barriers to accessing it. Avoid duplication of effort and resources.			
To identify any gaps in support which the SE LIG can address.	The risk factors for long term health linked to poverty and inequality are lessened.			
The impact of the improvement action will be monitored and evaluated via a project plan.	We will know if the actions are making a difference.			
To improve access to information which can enable people to take care of their own health and wellbeing				
To identify how this priority links with the Arbroath Plan and the work of the Locality Improvement Partnership.	Avoid duplication of effort and resources.	Review progress by September 2020	1, 2, 9	
To identify existing community initiatives which are connecting with people who are disenfranchised and use these links to promote and support IT skills.	On line information which is already available is more accessible. People in the locality are empowered to take responsibility for their health.			
To identify the range of ways that information can be made available to maximize access.	Alternatives are considered for people who do not have access to on line information. People in the locality are empowered to take responsibility for their health.			

Improvement Action	Intended Outcome	Timescale	Link to National Outcome	Comments & progress
PRIORITY 1: Improving Health, Wellbeing and Independence				
To improve access to information which can enable people to take care of their own health and wellbeing				
To ensure that any information gathered is passed on to those in guidance roles.	Advice and support is consistent. Avoid duplication of effort and resources. People in the locality are empowered to take responsibility for their health.	Review progress by September 2020		
To work in partnership with the Social Prescribing Link Worker(s) to support the roll out and implementation of social prescribing in the area.	Advice and support is consistent. Avoid duplication of effort and resources.			
To ensure people are aware of wider supports available such as self-management groups for COPD and diabetes.	Advice and support is consistent. Avoid duplication of effort and resources. People in the locality are empowered to take responsibility for their health.			
The impact of the improvement action will be monitored and evaluated via a project plan.	We will know if the actions are making a difference.			
To improve mental wellbeing in the South East Locality				
To identify how this priority links with the Arbroath Plan and the work of the Locality Improvement Partnership.	Avoid duplication of effort and resources.	Review progress by March 2020	1, 2, 3, 4, 5, 6 & 9	
To link with the Principal Planning Officer - Mental Health & Wellbeing and other local partners.	Improve our understanding of the need, what is available and the barriers to accessing it. Avoid duplication of effor t and resources.			
Identify what is availaable locally to support mental wellbeing, particularly for carers, young people, and people whose lives are chaotic. Consider how these can be better promoted.	The risk factors for long term health linked to stress and depression are lessened.			
To identify any gaps in support which the SE LIG address.	The risk factors for long term health linked to stress and depression are lessened.			
The impact of the improvement action will be monitored and evaluated via a project plan.	We will know if the actions are making a difference.			

Improvement Action	Intended Outcome	Timescale	Link to National Outcome	Comments & progress
PRIORITY 1: Improving Health, Wellbeing and Independence				
To increase physical activity levels in the South East Locality				
To identify how this priority links with the Arbroath Plan and the work of the Locality Improvement Partnership.	Avoid duplication of effort and resources.	Review progress by September 2020	1, 4, 5, 6	
To develop links with Angus Alive and other local partners.	Improve our understanding of what is available locally and the barriers to accessing it, such as cost. Avoid duplication of effort and resources.			
Identify how what is available can be promoted locally and barriers can be reduced.	The risk factors for long term health linked to low physical activity levels are lessened.			
Identify gaps and opportunities for other activities especially for working age people and carers.	The risk factors for long term health linked to low physical activity levels are lessened.			
To identify any gaps in support which the SE LIG can address.	The risk factors for long term health linked to low physical activity levels and being an unpaid carer are lessened.			
The impact of the improvement action will be monitored and evaluated via a project plan.	We will know if the actions are making a difference.			
Priority 2: Supporting care needs at Home				
To improve health and wellbeing for local unpaid carers				
To identify how this priority links with the Arbroath Plan, the work of the Locality Improvement Partnership and Angus Carers Strategy.	Improve our understanding of carers' issues in this Locality and avoid duplication of effort and resources.	Review progress by September 2020	1, 4, 5, 6, 9	
Identify any actions needed in relation to: • Carer identification • Health checks for carers • Barriers to attending GP or accessing other support	Carers are identified at an early stage and supported to look after their own health and wellbeing.			
Identify what support is available locally for carers and how it can be promoted.	Carers and supported to look after their own health and wellbeing.			
To identify any gaps in support which the SE LIG can address.	The risk factors for long term health linked to being an unpaid carer are lessened.			
The impact of the improvement action will be monitored and evaluated via a project plan.	We will know if the actions are making a difference.			

Improvement Action	Intended Outcome	Timescale	Link to National Outcome	Comments & progress
Priority 3: Developing integrated and enhanced Primary care and community responses				
To improve Anticipatory Care Planning for care home residents in the South East locality				
As a test of change a nurse practitioner has been recruited to support care homes in the South East in the development and review of Anticipatory Care Plans. She has linked with other professionals, and is collecting and analysing data, including feedback from stakeholders.	The personal wishes of care home residents and their carers/ family members are appropriately recorded and shared in advance. The resident can then be confident that if their condition changes, their wishes will be taken into account.	Review progress by March 2020	2, 3, 4, 7, 8	
Evaluate the effectiveness of the test of change in partnership with TQIP (Tayside Quality Improvement Programme).	We will know if the test of change has made a difference.			
Consider further action following evaluation, for example the sharing of good practice within the Partnership.	Ensure any lessons are shared with other Locality Improvement Groups.			
Priority 4: Improving Integrated care pathways for priorities in care				

Appendix 2

Consultation on the South East Locality Improvement Plan

Thank you for reading the South 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 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**