APPENDIX

ANGUS HEALTH AND SOCIAL CARE PARTNERSHIP

ANNUAL PERFORMANCE REPORT

April 2022 to March 2023

Angus Health and Social Care Partnership

Introduction

Angus Integration Joint Board (IJB) set out the vision for change and improvement in their Strategic Commissioning Plan (SCP) 2019-22. The purpose of this Annual Performance Report (APR) is to show the progress Angus Health and Social Care Partnership (AHSCP) has made against the four priorities set out in the SCP and additional performance areas during 2022-2023. The data used within this report is the latest available at the time of reporting. The four priorities in the SCP aim to deliver the nine national health and wellbeing outcomes. Our performance in relation to the national health and wellbeing outcomes are set out in relation to our four strategic priorities and three performance areas (Figure 1). The relationship between our strategic priorities, the national outcomes and the national core indicators is set out in Table 2. Throughout this report, performance is shown by locality, where possible. This enables Locality Improvement Groups to focus on addressing variance in performance and support continuous improvement.

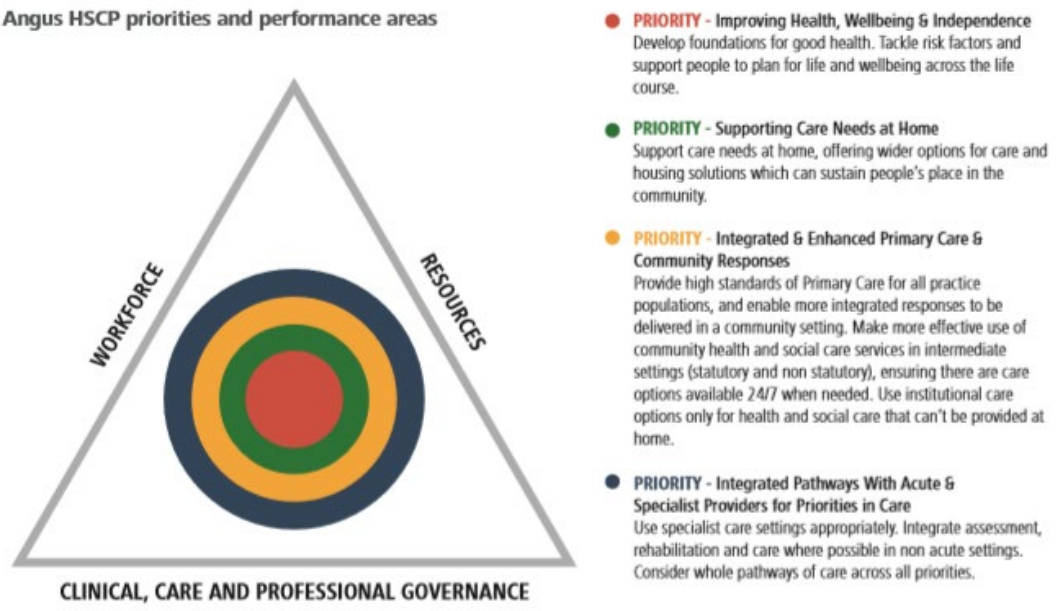
Availability of Data

The data used to compile this report is the latest available prior to the final publication. Data is sourced from Public Health Scotland, NHS Tayside and Angus Council. The majority of data has been collected for financial year 2022/23. It is recognised that some data is only available for the calendar year 2022. Tables/charts which do not have full year data are highlighted.

The Strategic Priorities

AHSCP is committed to placing individuals and communities at the centre of service planning and delivery in order to deliver person-centred outcomes. AHSCP is focused upon improving the long-term health of its population, providing timely health and social care interventions when needed and ensuring that such interventions give the best outcomes for our service users and unpaid carers. The SCP 2019-2022 made a commitment to shifting the balance of care from institution-based care to care at home; it called for health and social care to extend beyond the traditional setting of hospitals and care homes to reach more effectively into a person's own home and community. The SCP set out this ambition through four strategic priorities.

Figure 1



There is an increasing demand for care provision. People are living longer with multiple and complex care needs that require more support from health and social care services. Local people have told us they want to access care closer to home and in their community which helps maintain their independence.

Year on year we face a growing challenge with the requirement to manage the resources of the IJB in line with increased demand. Using the current resource framework as efficiently and effectively as possible is essential. The SCP identified a number of areas to the shift in the balance of care required.

Review of the Strategic Commissioning Plan

The IJB is required by law to review the SCP at least every three years. This has been delayed due to the COVID-19 pandemic. During 2022/23 engagement took place to review the SCP 2019 -2022. The SCP 2023-2026 will set the priorities to reduce inequalities and improve the health and wellbeing of the people of Angus.

Involvement and Engagement

AHSCP has continued to build on the communication and engagement that has already taken place to ensure that the views of people who use our services and wider stakeholders are constantly shaping the way services are delivered by the HSCP.

The AHSCP Communication and Engagement Plan was approved in October 2020 (IJB Report 69/20) and is due for review in 2023. The current objectives are defined in that plan are:

- Increase awareness, understanding and reputation of Angus HSCP
- Our workforce and people who access health and social care services, families, unpaid

Carers and the public are involved in shaping health and care proposals and plans.
- Empower people to improve their health and wellbeing.
- Make the most of digital information by enhancing our digital presence and increasing the number of people engaging with us through our digital platforms
- Prioritise communications and engagement to break down health inequalities.
- Improve the way we use feedback, including compliments and complaints

Since the formal establishment of the Angus IJB in 2016, the Partnership's communication and engagement activities continue to be supported by the NHS Tayside and Angus Council communication teams. AHSCP also works closely with Voluntary Action Angus the Independent Sector and the Healthcare Improvement Scotland-Community Engagement Team (HIS-CE).

Activities have included:

- Integration Matters, the Partnership's newsletter, continues to showcase a range of services across AHSCP.
- The Chief Officer continues to issue regular messages to staff and partnership organisations on a variety of topics. This includes recognition of the invaluable contribution made by our workforce and partners and also acknowledges the importance of staff wellbeing during these challenging times.
- The AHSCP Facebook, Twitter and Instagram platforms continue to provide regular updates on a wide range of topics. At the end of March 2023, the Partnership Facebook page had 3872 followers.
- AHSCP Website. We continue to work to improve the content on the website. Between 01 October 2021 and 30 September 2022 there were 13,553 visitors to the website. This is an 8% decrease compared to the same period for 2020/21. Work continues to increase the number of visitors to the website.
- The AHSCP intranet, launched in July 2021, continues to improve its content providing an integrated space for Partnership documents, news, resources, and multiagency collaboration. Further work is required to encourage more members of the workforce to access this resource.
- We continue to send out feedback questionnaires twice a year to people supported by enablement and response services, residents of AHSCP care homes and supported accommodation. Service users of community meals and community alarm are invited to provide feedback once a year which inform improvements.
- Media Relations. We undertake both proactive and reactive media management. We regularly welcome members of the media to IJB meetings, respond quickly to media enquiries when received and employ proactive media engagement as often as possible.
- AHSCP is committed to hearing people's and families' experiences and using that information to improve service provision. During 2022/23 AHSCP continued the pilot using Care Opinion, the UK's leading independent, non-profit feedback website which enables people to share their stories and suggest how their experiences could have been better. The service areas involved were:
    - Community Hospital inpatient (Medicine for the Elderly & Psychiatry of Old Age)
    - Community Physiotherapy Services
    - District Nursing Services
    - Minor Injury and Illness Units
    - Community Mental Health Services

- 36 stories were received during 2022/2023.

Examples of stories received:

> ***Care Opinion Stories***
>
> Minor Injury and Illness Service in Arbroath "Nurse did an amazing job of making me feel comfortable, with her caring and kind nature, very professional and explaining everything fully. I left Arbroath Infirmary, one very grateful patient with the treatment that I needed. Thank you."
>
> Isla Ward, Whitehills Health and Community Care Centre "My Dad received excellent care from all staff involved in his care. Everyone went above and beyond to make his stay comfortable including getting out to the garden so that he could spend precious time with his family during COVID restrictions."

- It is important that we encourage appropriate health promotion behaviour and we support local and national information and awareness campaigns on our social media platforms. For example; Dry January, Mental Health Day, Suicide Prevention Week etc. Together with other HSCPs in Scotland, AHSCP continues to contribute to the National Power of Attorney Day. As part of Falls Prevention Week, Partnership staff engaged with members of the public in local leisure centres, libraries to raise awareness of falls prevention.

Planned Engagement Activity for 2023/24

We will continue to work towards the actions detailed within the action plan. In addition, planned activity includes:

- Continue to develop the AHSCP User Voice Network to augment the voice of service users within all engagement activities.
- A refreshed Communication and Engagement Plan will be developed and shared in October 2023.

ANGUS PERFORMANCE SUMMARY

Some of what we have achieved in 2022/23

- We have reviewed the SCP 2019-22 to inform the new SCP for 2023 - 26.
- Collaboration between NHS and independent sector leads (ISL) in Tayside produced a Supporting Tayside Excellence Programme (STEP). The programme aims to promote a whole systems approach to improving health and care for residents of adult care homes in Tayside.
- Implementation, evaluation and roll out of the 7 Day Community Mental Health Service
- Roll out of the Mental Health and Wellbeing Enhanced Community Support Hub in the North West of Angus in February 2023.
- Implementation of Triangle of Care which is a partnership between professionals, the person being cared for, and their carers. It sets how they should work together to support recovery, promote safety and maintain wellbeing.
- Continued to support implementation of the Angus Carers Strategy, Improvement Plan and Carers (Scotland) Act 2016 through the work of the Angus Carers Strategic Partnership Group
- Continued promotion of Independent Living Angus (ILA) with the aim to encourage more people to access the site and promote use of the self-assessment tools.
- Some care homes and all of the day care providers in Angus 'signed up' to become part of the Paths for All programme. Some staff have undergone Walk Leader training to ensure the walks are as meaningful and beneficial as possible and to support evidence in regard to the positive effects and outcomes which these planned walks have for people.
- KOMP – Test of Change using very simple technology giving access to social contact and stimulation for those who cannot engage using normal social media platforms (maximising support for people in their own homes).
- Increase in the uptake of Telecare Equipment
- Eclipse – embed TEC assessment as part of the referral pathway to ensure access for all potential users – supporting more people in our communities and making best use of resources)
- A comprehensive and transparent learning and development framework has been established for care management. This includes an induction programme for all staff undertaking the function of care management, team manager induction and a broader spectrum of training and learning for individual services which delineates the respective cycles of refresher training
- In September 2022, Mental Welfare Commission publishes a report 'Ending the exclusion' which highlighted our Mental Health and Wellbeing ECS hub in Angus which did not reject any of the around 850 referrals.
- The IJB approved the Partnership's Workforce Plan 2022-2025 in June 2022 (Report IJB 36/22). The plan has subsequently been approved by the Scottish Government.
- New Equalities Mainstreaming Report and set of Equality Outcomes was approved by the IJB on 24 August 2022 published on partnership website

Table 1 – Relationship between Angus Strategic Priorities, the National Wellbeing Outcomes and the National Core Performance Indicators

Angus Strategic Priorities and Performance Areas	National Wellbeing outcomes	National Core Performance Indicators
Priority 1 **Improving health, wellbeing and independence**	**1. Healthier Living** People are able to look after and improve their own health and wellbeing and live in good health for longer. **5. Reduce Health Inequality** Health and social care services contribute to reducing health inequalities. **6. Carers are Supported** People who provide unpaid care are supported to look after their own health and wellbeing. This includes reducing any negative impact of their caring role on their own health and wellbeing.	**NI-11** **NI-16** **NI-1** **NI-8**
Priority 2 **Supporting Care needs at Home**	**2. Independent Living** People, including those with disabilities, long term conditions, or who are frail, are able to live as far as reasonably practicable, independently at home or in a homely setting in their community.	**NI-18** **NI-15**
Priority 3 **Developing integrated and enhanced primary care and community responses**	**3. Positive Experiences and Outcomes** People who use health and social care services have positive experiences of those services and have their dignity respected.	**NI-6** **NI-12** **NI-13** **NI-14** **NI-21 (data not available)** **NI-22 (data not available)**
Priority 4 **Improving Integrated care pathways for priorities in care**	**4. Quality of Life** Health and social care services are centred on helping to maintain or improve the quality of life of service users. Everyone should receive the same quality of service no matter where they live.	**NI-19**

Performance Area 1 **Managing our workforce**	**8. Engaged Workforce** People who work in health and social care services are supported to continuously improve the information, support, care and treatment they provide and feel engaged with the work they do.	**NI-10 (data not available)**
Performance Area 2 **Clinical and Care Governance**	**7. People are Safe** People who use health and social care services are safe from harm.	**NI-17** **NI-2** **NI-3** **NI-4** **NI-5** **NI-7** **NI-9**
Performance Area 3 **Managing our resources**	**9. Resources are used Efficiently and Effectively** To deliver Best Value and ensure scarce resources are used effectively and efficiently in the provision of health and social care services.	**NI-20** **NI-23 (data not available)**

Table 2 – Angus HSCP performance against national and local integration indicators

The National Indicators 1 to 9 are measured on a biennial basis. The next data collection is due 2023-24 financial year

	Indicator	Title	2019/20		2021/22		RAG Status
			Angus	Scotland	Angus	Scotland	
Outcome Indicators (Measured bi-annually)	NI-1	Percentage of adults able to look after their health very well or quite well	93.5%	92.9%	92.4%	90.9%	G
	NI-2*	Percentage of adults supported at home who agreed that they are supported to live as independently as possible	84.4%	80.8%	72.6%	78.8%	A
	NI-3*	Percentage of adults supported at home who agreed that they had a say in how their help, care, or support was provided	82.0%	75.4%	76.8%	70.6%	G
	NI-4*	Percentage of adults supported at home who agreed that their health and social care services seemed to be well co-ordinated	79.6%	73.5%	78.5%	66.4%	G
	NI-5*	Total % of adults receiving any care or support who rated it as excellent or good	85.3%	80.2%	79.5%	75.3%	G
	NI-6	Percentage of people with positive experience of the care provided by their GP practice	75.8%	78.7%	69.8%	66.5%	G
	NI-7*	Percentage of adults supported at home who agree that their services and support had an impact on improving or maintaining their quality of life	85.6%	80.0%	81.7%	78.1%	G
	NI-8	Total combined % carers who feel supported to continue in their caring role	34.9%	34.3%	29.5%	29.7%	A
	NI-9*	Percentage of adults supported at home who agreed they felt safe	89.5%	82.8%	84.9%	79.7%	G

** Figures for 2019/20 for indicators 2, 3, 4, 5, 7 and 9 are not directly comparable to figures in previous years due to changes in methodology*

	Indicator	Title	2021/22		2022/23		RAG Status
			Angus	Scotland	Angus	Scotland	
Data Indicators	NI-11	Premature mortality rate per 100,000 persons	419	466	Not available		G
	NI-12	Emergency admission rate (per 100,000 population)	10,833	11,618	11,300*	11,155*	G
	NI-13	Emergency bed day rate (per 100,000 population)	92,888	112,720	90,980*	113,134*	G
	NI-14	Readmission to hospital within 28 days (per 1,000 population)	114	107	115*	102*	A
	NI-15	Proportion of last 6 months of life spent at home or in a community setting	92.9%	89.8%	92.3%*	89.3%*	G
	NI-16	Falls rate per 1,000 population aged 65+	23.7	22.6	25.1*	22.2*	A
	NI-17	Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections	75.7%	75.8%	69.3%	75.2%	A
	NI-18	Percentage of adults with intensive care needs receiving care at home	60.8%	64.9%	61.6%	63.5%	G
	Ni-19	Number of days people aged 75+ spend in hospital when they are ready to be discharged (per 1,000 population)	221	748	222	919	G
	NI-20	Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency	22.9%	24.0%	Not available		G

** Figures for these indicators are using calendar year data rather than financial year.*

	Indicator	Title	2021/22		2022/23		RAG Status
			Angus	Scotland	Angus	Scotland	
Local Indicators	LI-24	Personal care hours rate per 1,000 18+	6,963		6,815		-
	LI-25	Care home nights rate per 1,000 65+	8,853		8,161		G

RAG scoring based on the following criteria

G	Angus is performing well against the Scottish average
A	Angus rate is similar to the Scottish average but there is room for improvement (<=5%)
R	Angus has greater room for improvement against the Scottish average

Table 3 – Ministerial Steering Group (MSG) Indicators

Each year HSCP performance is considered by the Ministerial Strategic Group, a joint group of MSPs and representatives from COSLA who are charged with considering the progress made through the integration of health and social care. These performance measures are published by Public Health Scotland who work with HSCPs to establish targets for improvement for these measures each year. The table below shows AHSCP performance against the MSG indicators for the last three reporting years, against locally set objectives. Angus has seen very significant achievements in reducing the average length of stay in hospital following an emergency admission which has led to significant reductions in bed day use. Angus has been less successful in relation to prevention of avoidable admissions.

Ministerial Steering Group (MSG) Indicators	Indicator	Title	Reporting Period		
			2020/21	2021/22	Jan – Dec 2022
	1a	Number of emergency admissions 18+	8,546	11,480	12,053*
	2a	Number of unscheduled hospital bed days; acute specialties 18+	55,490	65,005	68,181*
	2b	Number of unscheduled hospital bed days; mental health specialties 18+	24,551	27,200	22,393*
	3a	A&E attendances 18+	14,159	22,483	23,337*
	4	Delayed discharge bed days (all reasons)	5,409	6,595	7,359*
	5a	Percentage of last six months of life spent in the community (all ages)	92.9%	92.9%	Not available
	5b	Number of days during last six months of life spent in the community (all ages)	246,642	242,634	Not available
	6	Balance of care: Percentage of population 65+ living at home (supported and unsupported)	92.8%	92.9%	Not available

** Figures for these indicators use calendar data rather than financial year data. Latest data available Dec 2022.*

RAG scoring based on the following criteria

G	Angus is performing better than the previous year
A	Angus has improvement compared to the previous year but within 5%
R	Angus has much improvement compared to the previous year

Priority 1: Improving Health, Wellbeing and Independence

The aim of the AHSCP SCP 2019-22 has been to continue to progress approaches that support individuals to live longer and healthier lives. This includes having access to information and natural supports within communities. AHSCP's focus is on health improvement and disease prevention including addressing health inequalities; building capacity within our communities; supporting carers and supporting the self-management of long-term conditions. The health inequalities in Angus were identified in the Joint Strategic Needs Assessment. We are working with Public Health to determine appropriate measures which provide evidence in relation to health equity and the impact of services across Angus. This will include ensuring that data from primary providers is available in order to see performance in the most and least deprived areas of Angus against the Angus average performance. Addressing performance variation will go some way to begin to address health inequalities.

1.1 Highlights from 2022/23

- Continued to support implementation of the Angus Carers Strategy, Improvement Plan and Carers (Scotland) Act 2016 through the work of the Angus Carers Strategic Partnership Group.
- Continued promotion of Independent Living Angus (ILA) with the aim to encourage more people to access the site and promote use of the self-assessment tools.
- Some care homes and all of the day care providers in Angus 'signed up' to become part of the Paths for All programme. Some staff have undergone Walk Leader training to ensure the walks are as meaningful and beneficial as possible and to support evidence in regard to the positive effects and outcomes which these planned walks have for people.

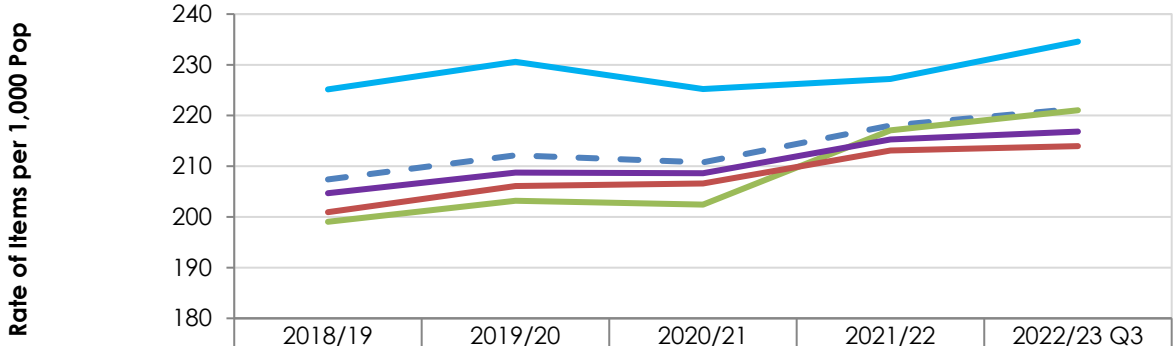
1.2 Making a Difference

1.2.1 We use proxy indicators that can help us understand the health and wellbeing of the population. Proxy Indicators include the use of medication for the management of depression and anxiety to help us understand mental health and wellbeing in our communities; and hypertension and diabetes to help us understand levels of people with healthy weights in our communities. Information is available at locality level.

Mental Health and Wellbeing

1.2.2 The SCP 2019-22 sets out an ambition to reduce the use of medications which support anxiety and depression as a proxy measure for other interventions that aim to improve the mental wellbeing of people in our communities. Graph 1 shows continued increase in prescribing for anxiety and depression which is likely related to increase in mental health problems because of COVID-19 with some interventions less accessible including face-to-face appointments with peer support.

Graph 1 Number of People Prescribed Items for Depression and Anxiety in Angus as a Crude Rate per 100,000 Population



	2018/19	2019/20	2020/21	2021/22	2022/23 Q3
Angus	207	212	211	218	221
North East	199	203	202	217	221
North West	201	206	207	213	214
South East	225	231	225	227	235
South West	205	209	209	215	217

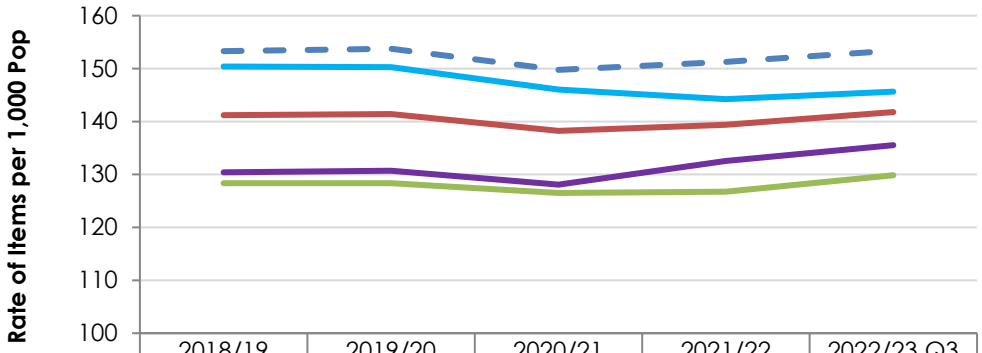
Source: PIS Dataset

1.2.3 Enhanced Community Support Services have delivered prescribing reviews by Pharmacists and Pharmacy Technicians, which has led to reductions in prescribing generally. The testing of Mental Health and Wellbeing Practitioners in GP practice has evaluated well with evidence to suggest that alternatives to prescribing can be delivered through this model.

Healthy Weight

1.2.4 Hypertension and Type 2 diabetes are closely associated to poor weight management. We are therefore using the prescribing of medication for the treatment of hypertension and diabetes as a means to consider the healthy weight of the population.

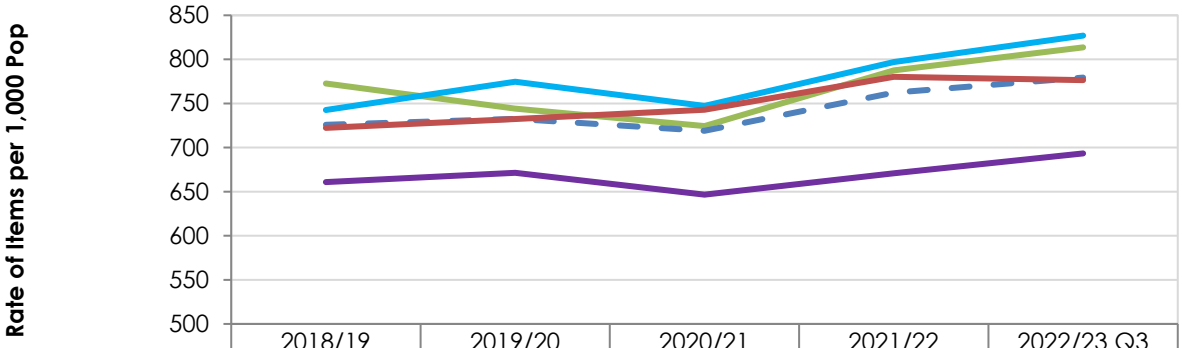
Graph 2 - Number of People Prescribed Items for Hypertension in Angus as a Crude Rate per 100,000 Population



	2018/19	2019/20	2020/21	2021/22	2022/23 Q3
Angus	141	141	138	139	142
North East	130	131	128	133	136
North West	153	154	150	151	153
South East	128	128	127	127	130
South West	150	150	146	144	146

Source: PIS Dataset

Graph 3 - Number of People that were Prescribed Items for Diabetes in Angus as a Crude Rate per 100,000 Population



	2018/19	2019/20	2020/21	2021/22	2022/23 Q3
North East	773	744	724	788	814
South East	743	775	747	797	827
Angus	726	733	719	762	779
North West	722	732	743	780	776
South West	661	671	647	671	693

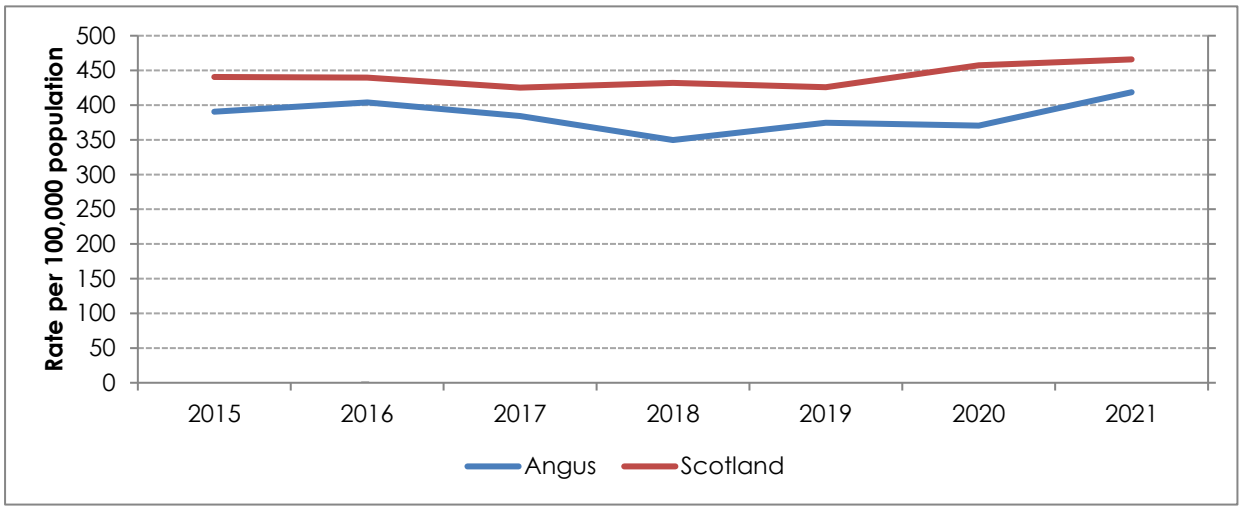
Source: PIS Dataset

1.2.5 The rate of hypertension and Type 2 diabetes has increased in Angus in 2022/23. The increases are small but support a need to identify new options for supporting healthy weight in the population.

Premature mortality

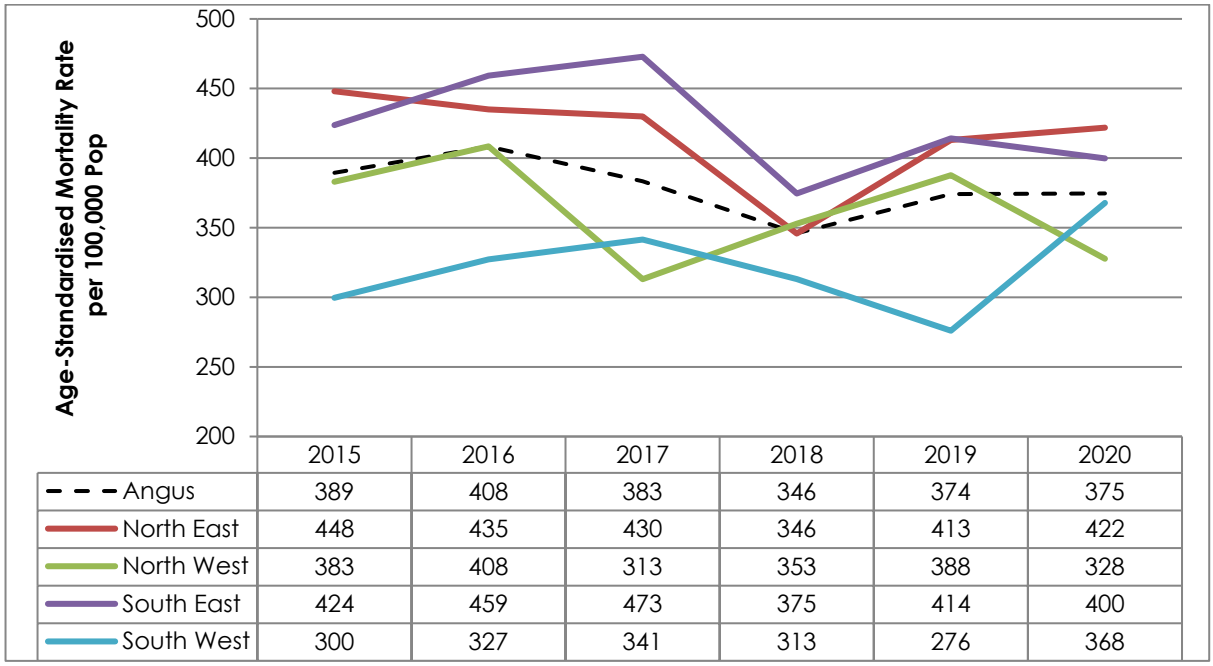
1.2.7 Premature mortality will vary from year to year, but our aim is to see a downward trend. Angus compares well to the Scottish average however there has been an increase in premature mortality in 2021. Data for 2022 onwards is not available. Understanding data from 2020 and 2021 is challenging due to the impact of COVID-19.

Graph 4 - Management Information: Premature Mortality Rate for People aged Under 75 per 100,000 Population (NI 11)



Source: Public Health Scotland

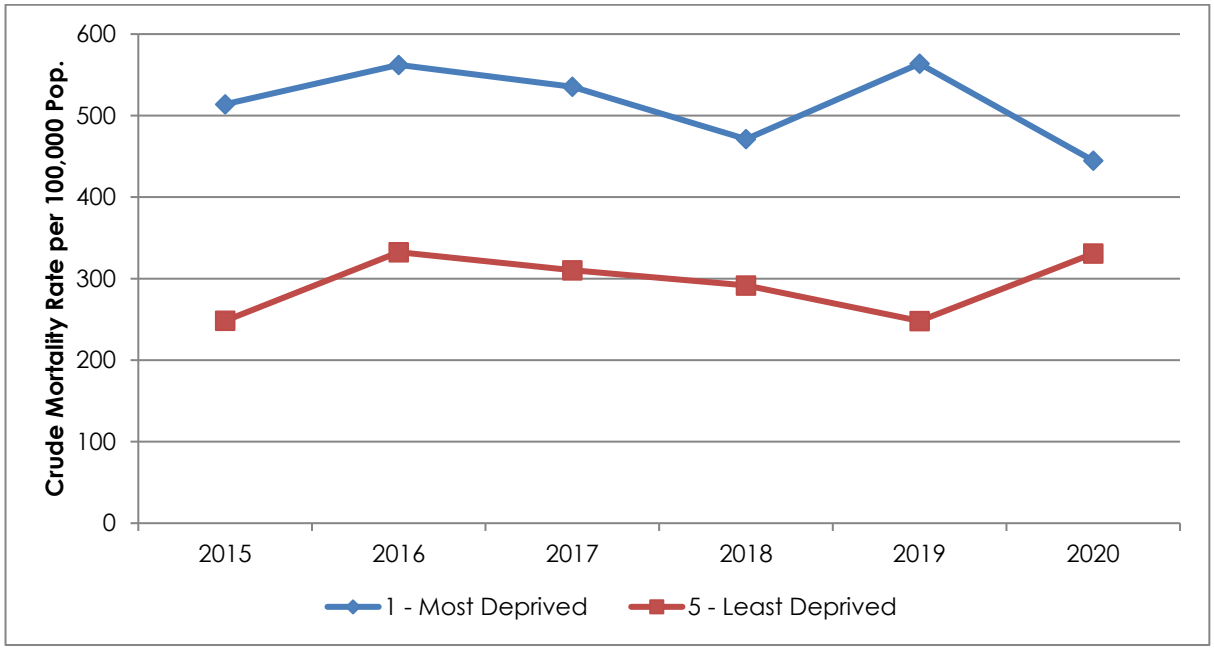
Graph 5: Management Information at Locality Level: Premature Mortality Rate for People aged Under 75 per 100,000 Population (NI 11)



	2015	2016	2017	2018	2019	2020
Angus	389	408	383	346	374	375
North East	448	435	430	346	413	422
North West	383	408	313	353	388	328
South East	424	459	473	375	414	400
South West	300	327	341	313	276	368

Source: Public Health Scotland

Graph 6: Management Information at Socio-economic Level: Premature Mortality Rate for People aged Under 75 per 100,000 Population



Source: ISD LIST (not official NRS statistics)

1.3 Prevention and Proactive Care Programme

1.3.1 In December 2022 the Prevention and Proactive Care Programme Group was established, which is a joint investment between Angus HSCP, Angus Council and ANGUSalive designed to achieve long term behaviour change in target areas identified to improve public health in Angus and contribute towards tackling health inequalities.

1.3.2 One of the initial actions agreed was to introduce Nature Prescribing, which is a guided conversation between a GP or other healthcare professional and their patient/client to encourage and support them to connect with the natural world to benefit their mental and physical wellbeing. Complementing other health interventions, this conversation is supported by a prescription leaflet and a seasonal calendar of mindful ideas and suggestions to enable people to explore ways of connecting to nature that are personal and meaningful to them.

The Third Sector and Volunteering

1.2.8 Angus continues to have high levels of volunteering. Voluntary Action Angus (VAA) are supporting the development of voluntary organisations and volunteering across Angus. VAA was formed in response to the Scottish Government's requirement to have a key local Third Sector Interface (TSI) in each local authority area.

1.2.9 VAA undertakes a crucial role in delivering on the aspirations of Health and Social Care Integration, locality working and prevention. Some of the areas in which we work together are:

- Enhancement and support work in the third sector
- Kirriemuir Friday Nite Project
- Volunteering
- Social Prescribing
- Befriending

1.2.10 The Social Prescribing Team have experienced significant growth since they established in September 2020. The aim of social prescribing is to work with people to assess their non-medical needs and assist them to access appropriate support and services within local communities. The service provides practitioners based in or aligned to an Angus GP surgery who work directly with people with social concerns rather than medical issues to help them navigate and engage with wider services. The service comprises a combination of supports to people, often from socioeconomically deprived communities, and assisting people who need support because of the complexity of their conditions or rurality. It should be noted that this is not a statutory function that sits with Angus Council under the Integration Scheme but that it contributes to the Angus Council Plan outcomes of improved physical, mental and emotional health, and wellbeing, and more opportunities for people to achieve success, and more generally to the statutory power to advance well-being of persons within our area.

The number of referrals across Angus in 2020 were 270. However, since the roll out, referrals have increased by 2,978. We expect further growth in the coming year. One of the main objectives of the service is to ensure people have access to an appointment within a maximum of 14 days. All appointments across each GP cluster have been accessed within the time frame.

Carers

1.2.11 AHSCP has continued to implement the strategy for unpaid carers which was published in February 2020. Although some improvement actions have been impacted by Covid-19 the vast majority have now been achieved, with this work project managed by Angus Carers Strategic Partnership Group. AHSCP will revise the carers strategy in 2023.

1.2.12 Implementation of the key requirements of the Carers (Scotland) Act 2016 has continued, with the audit of the adult carer support plan supporting a review of the Local Eligibility Criteria for Carers in Angus. There are a number of unpaid adult carers in Angus whose caring arrangements are stable and whose initial assessment by Adult Services predates the introduction of the adult carer support plan. They may have on-going support packages in place and have been periodically reviewed alongside the person they support, without their assessment being updated. An adult carer support plan must be provided if the carer requests one or a change in circumstances has a material impact on the caring situation. Adult Services practitioners completed 315 adult carer support plans in 2022/23 an increase on the 274 plans during 2021/22. Since 2016 2,489 adult carers have been assessed by Adult Services and 2,156 of them have been awarded a personal budget.

1.2.13 Grant funding for third sector organisations supporting adult and young carers in Angus predates the 2016 Act. The Angus Carers Centre (ACC) is our main strategic partner in delivering the Angus Carers Strategy and in particular supporting carers requiring relatively low-level/preventative support. Funding provided to Dundee Carers Centre (independent support for carers using SDS Option 1) and Change Mental Health (support for carers of people with mental health issues) continued during 2022/23. Funding was extended to Kirrie Connections in recognition of the support provided to the carers of people with dementia and to support the expansion of the meeting centres model across other Angus localities.

1.2.14 The ACC provides practical and emotional support for young and adult Carers. It helps Carers find their way through the health and care system, offers short breaks opportunities, wellbeing and financial supports. It runs support groups and activities across Angus to connect Carers with each other and build a sense of belonging. ACC also creates opportunities for Carers to shape local policy and practice. In 2022/23, ACC has supported 1,924 adult carers and 68 young carers.

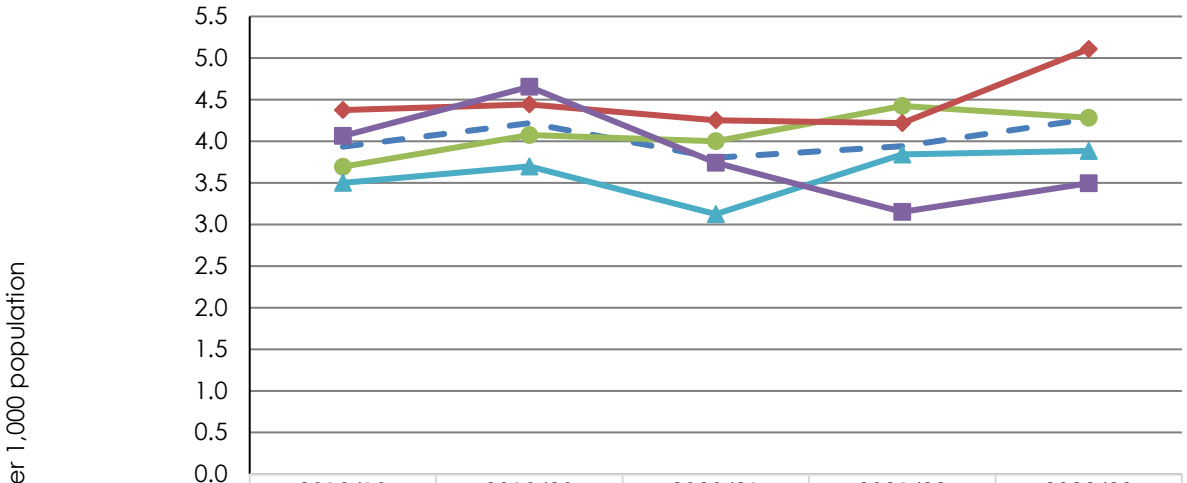
1.2.15 We estimate that across Adult Services, Children, Families and Justice (parent carers) and third sector partners, more than 2,500 unpaid carers were recognised and accessing support in Angus during 2022/23.

1.2.16 Across primary and secondary schools in Angus at the end of March 2022, there were 98 young carers (18% increase from 2021/22) recorded on SEEMis. All young carers identified are offered support and a Young Carer's Statement which sets out the personal needs and outcomes for each young person and the support required to meet their needs. Numbers remain low for young people taking up the offer of a Young Carer Statement relative to other local authorities.

1.2.17 The needs of young adult carers differ from older ones with some requiring active support relating to finances, housing, future planning etc rather than primarily guidance. 16 – 25-

year olds are regarded as the hardest to identify and engage and current service configuration is not meeting their needs.

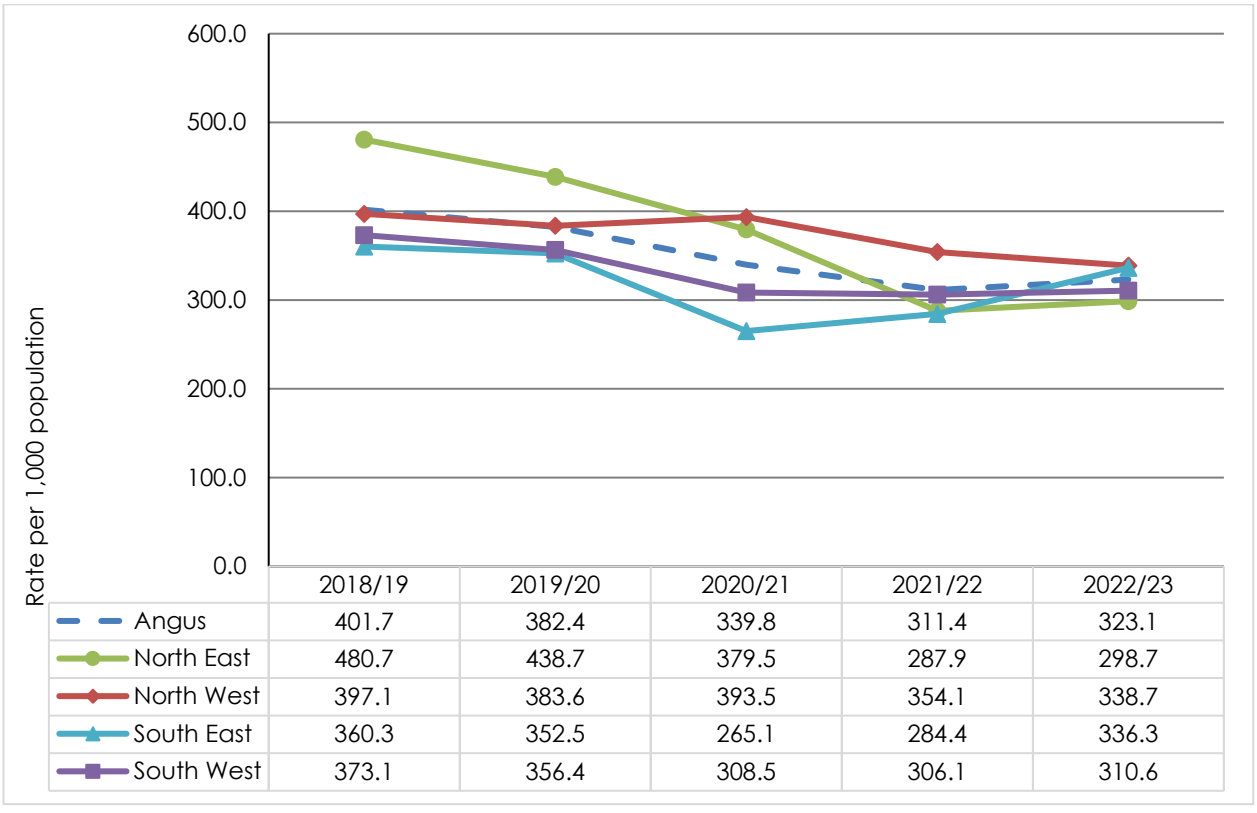
Graph 7 - Management Information at Locality Level: Rate of people using short breaks



	2018/19	2019/20	2020/21	2021/22	2022/23
Angus	3.9	4.2	3.8	3.9	4.3
North East	3.7	4.1	4.0	4.4	4.3
North West	4.4	4.4	4.3	4.2	5.1
South East	3.5	3.7	3.1	3.8	3.9
South West	4.1	4.7	3.7	3.2	3.5

Data Source: CareFirst (Angus Council)

Graph 8 - Management Information at Locality: Rate of short breaks (daytime hours)

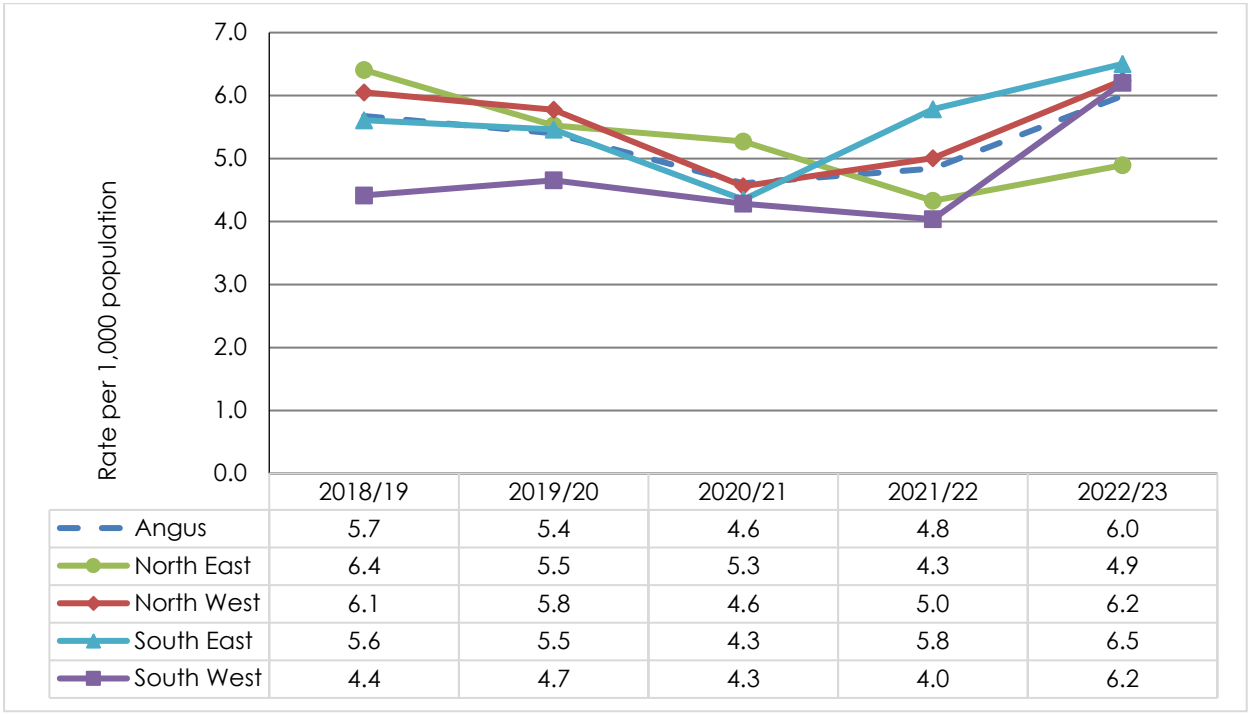


	2018/19	2019/20	2020/21	2021/22	2022/23
Angus	401.7	382.4	339.8	311.4	323.1
North East	480.7	438.7	379.5	287.9	298.7
North West	397.1	383.6	393.5	354.1	338.7
South East	360.3	352.5	265.1	284.4	336.3
South West	373.1	356.4	308.5	306.1	310.6

Data Source: CareFirst (Angus Council)

1.2.18 Day centres provide vital non-residential community building based care and support services for some of our most vulnerable residents. They provide the opportunity to meet others socially, to engage in activities, have refreshments or a meal. Day centres may also provide personal care and are a valued form of respite for people and their Carers.

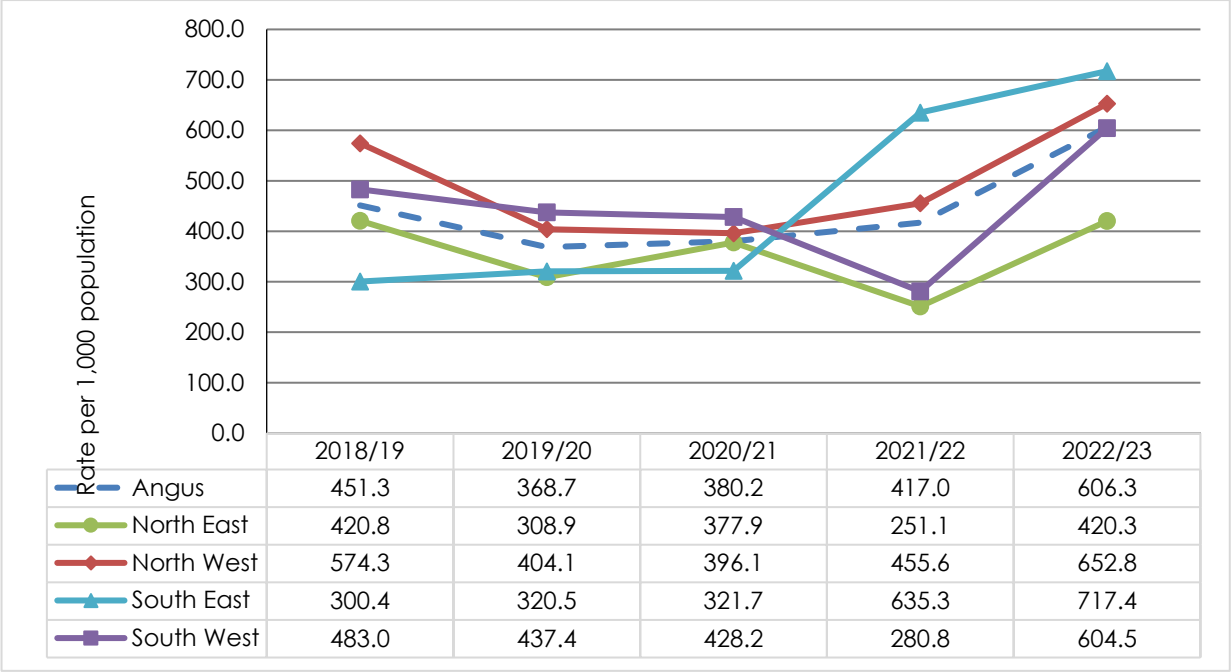
Graph 9 - Management Information at Locality Level: Rate of people using short breaks (nights)



	2018/19	2019/20	2020/21	2021/22	2022/23
Angus	5.7	5.4	4.6	4.8	6.0
North East	6.4	5.5	5.3	4.3	4.9
North West	6.1	5.8	4.6	5.0	6.2
South East	5.6	5.5	4.3	5.8	6.5
South West	4.4	4.7	4.3	4.0	6.2

Data Source: CareFirst (Angus Council)

Graph 10 - Management Information at Locality Level: Rate of short breaks nights



	2018/19	2019/20	2020/21	2021/22	2022/23
Angus	451.3	368.7	380.2	417.0	606.3
North East	420.8	308.9	377.9	251.1	420.3
North West	574.3	404.1	396.1	455.6	652.8
South East	300.4	320.5	321.7	635.3	717.4
South West	483.0	437.4	428.2	280.8	604.5

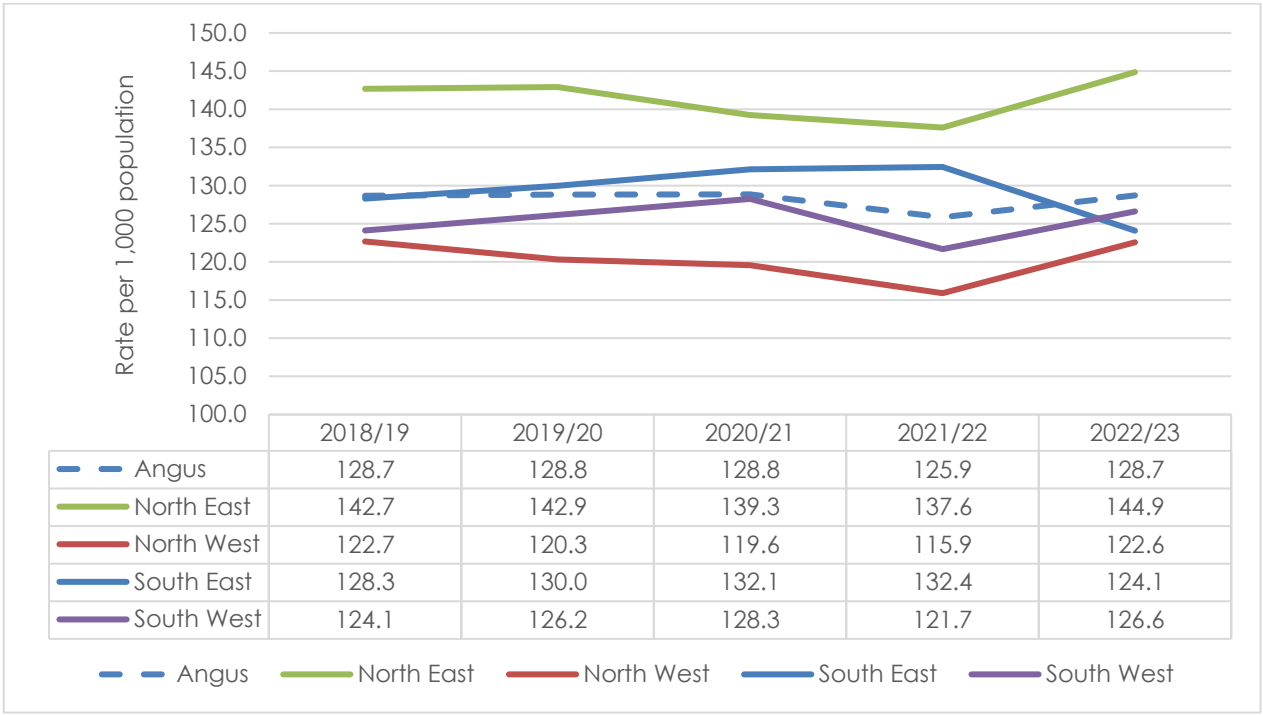
Data Source: CareFirst (Angus Council)

1.2.19 566 carers used a total of 57,232 respite nights in 2022/23. Since 2018/19 there has been an increase in both the number of carers receiving night time respite by 6% and nights increased by 34%. This suggests that services are supporting those with the greatest needs with more or longer periods of overnight respite. There has also been an increase in alternative use of carers support resources with individuals choosing short break holidays through direct payments which are not included in this measure.

Community Alarm

1.2.20 Although there are fluctuations in the use of community alarms, uptake has grown since 2018/19 by 14.5% (graph 11). There was some double counting of community alarm installations 2016/17 due to a service changeover in sheltered housing. Community Alarm supports around 3900 households.

Graph 11 - Management Information at Locality Level: Rate of community alarm use (65+) per 1,000 population



	2018/19	2019/20	2020/21	2021/22	2022/23
Angus	128.7	128.8	128.8	125.9	128.7
North East	142.7	142.9	139.3	137.6	144.9
North West	122.7	120.3	119.6	115.9	122.6
South East	128.3	130.0	132.1	132.4	124.1
South West	124.1	126.2	128.3	121.7	126.6

Data Source: CareFirst (Angus Council)

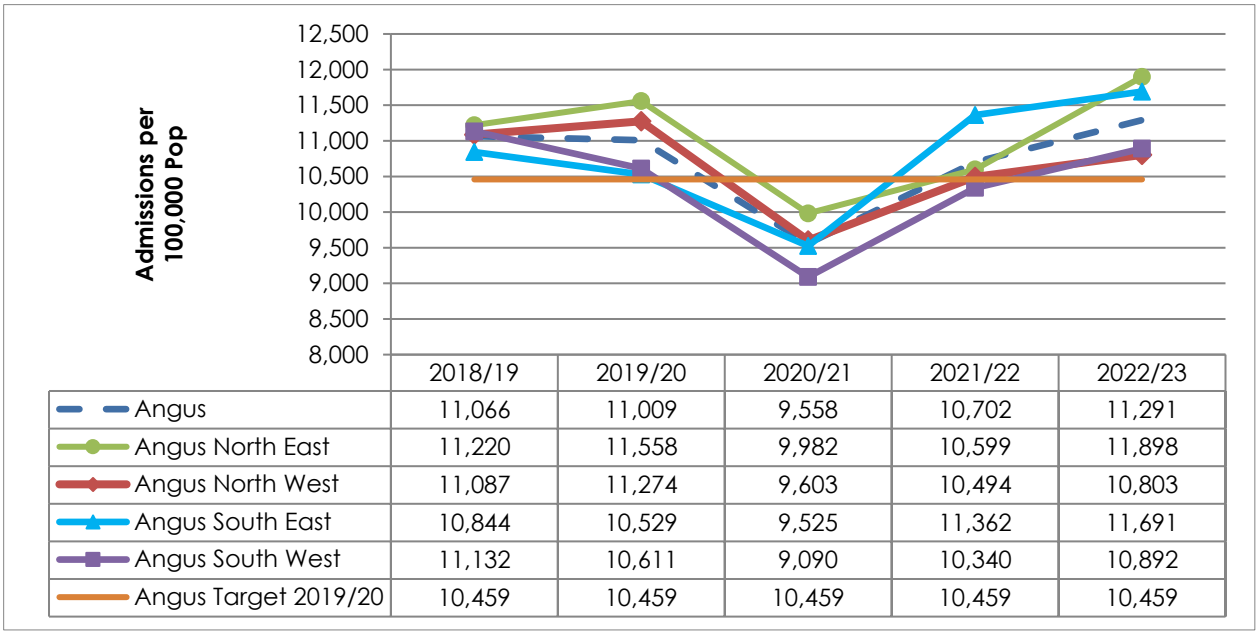
Enablement

1.2.21 Enablement services and community alarm teams have been merged into an Enablement Response Team (ERT). The aim of the team is to support people to be as independent as they can be and reduce reliance on services. The hours of planned care at home provision has risen from 8,550 hours of personal care per week in 2018/19 to c12,319 in 2022/23; this reflects the reduction in demand for residential care but the fact is that we have been able, through careful planning and matching, to meet increased demand.

Accident and Emergency

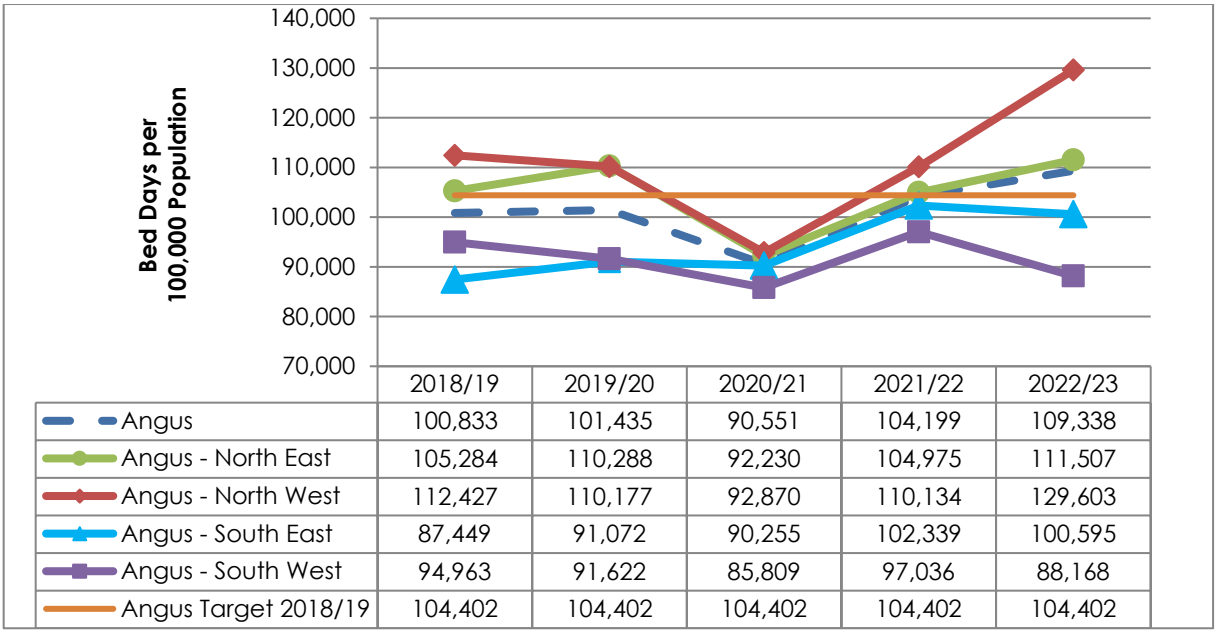
1.2.22 There were 11,291 unplanned emergency admissions in 2022/23, this was an increase of 9% on 2021/22 (see graph 12). This accounted for 109,338 hospital bed days, which is a decrease of 14% from 2021/22 (see graph 13). This information indicates that people are staying in hospital for less days.

Graph 12: Rate of emergency admissions per 100,000 population for people aged 18+



	2018/19	2019/20	2020/21	2021/22	2022/23
Angus	11,066	11,009	9,558	10,702	11,291
Angus North East	11,220	11,558	9,982	10,599	11,898
Angus North West	11,087	11,274	9,603	10,494	10,803
Angus South East	10,844	10,529	9,525	11,362	11,691
Angus South West	11,132	10,611	9,090	10,340	10,892
Angus Target 2019/20	10,459	10,459	10,459	10,459	10,459

Graph 13: Rate of emergency bed days per 100,000 population for people aged 18+



	2018/19	2019/20	2020/21	2021/22	2022/23
Angus	100,833	101,435	90,551	104,199	109,338
Angus - North East	105,284	110,288	92,230	104,975	111,507
Angus - North West	112,427	110,177	92,870	110,134	129,603
Angus - South East	87,449	91,072	90,255	102,339	100,595
Angus - South West	94,963	91,622	85,809	97,036	88,168
Angus Target 2018/19	104,402	104,402	104,402	104,402	104,402

1.2.23 Emergency admission rates vary across Angus. The highest emergency admission rate was in North East and the lowest rate was in North West.

1.2.24 Following an attendance at A&E the proportion of people who require to be admitted to an inpatient bed continues to increase with more than 75% of all attendances at A&E for a major issue resulting in an admission. We do not understand whether this is more appropriate use of A&E for major issues or there continue to be some admissions that could be preventable.

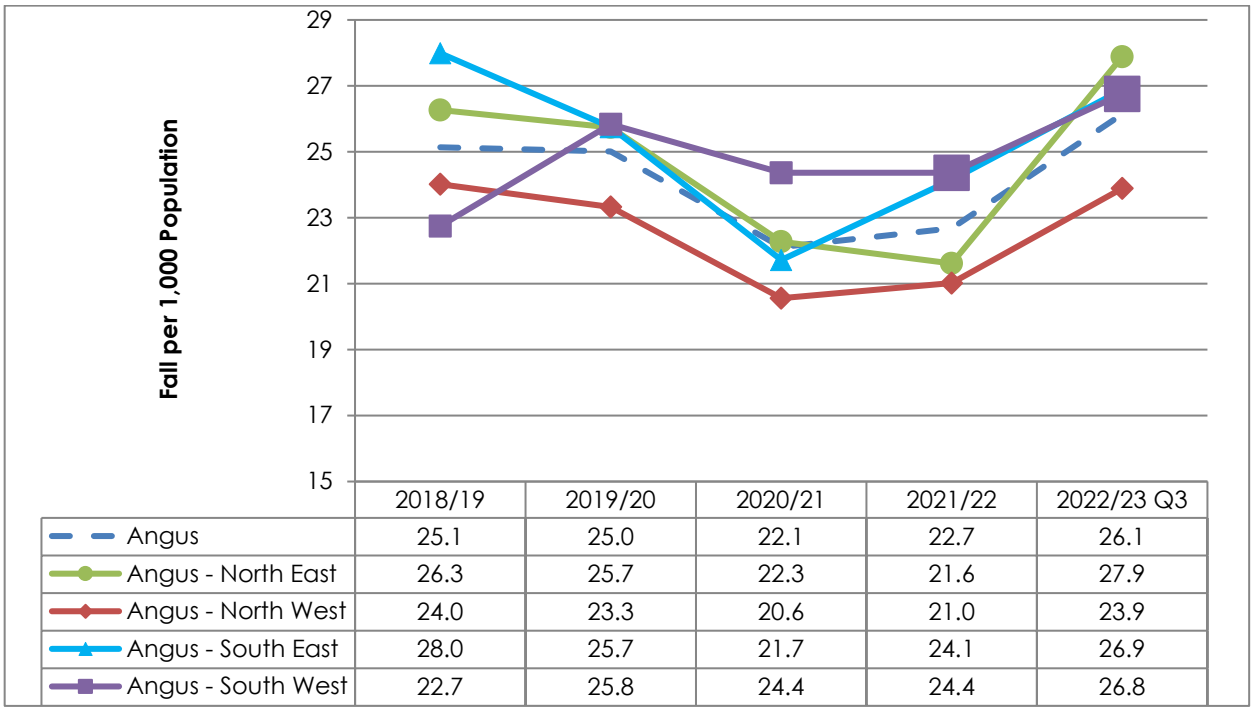
1.2.25 The stated aim of AHSCP submitted to the Ministerial Strategic Group is to continue to reduce all A&E attendances in line with the current projection.

Admissions following a fall

1.2.26 Admissions due to a fall represent 7% of all unplanned admissions. We have seen a slight increase in the number of people aged over 65 admitted to hospital following a fall. To the end of December 2022, we saw 715 people aged over 65 admitted following a fall an increase of 36 admissions on 20/21. During this same period there were 10,720 unplanned admissions for all adults (18+).

1.2.27 The falls pathways will be considered within the Angus urgent care programme of work. Falls prevention is the key focus of work for the prevention and proactive care workstream which is supported within the Getting it Right for Everyone Framework. There is particular focus being given to 'better balance' classes which have a strong evidence base.

Graph 14: Angus HSCP relative performance to Scotland. Rate of fall admissions per 1,000 population for people aged 65+ (NI 16)



	2018/19	2019/20	2020/21	2021/22	2022/23 Q3
Angus	25.1	25.0	22.1	22.7	26.1
Angus - North East	26.3	25.7	22.3	21.6	27.9
Angus - North West	24.0	23.3	20.6	21.0	23.9
Angus - South East	28.0	25.7	21.7	24.1	26.9
Angus - South West	22.7	25.8	24.4	24.4	26.8

Source: Public Health Scotland

1.2.28 During 2022/23 the rate of admissions following a fall for people aged over 65 in Angus was 26.1 per 1,000 population (graph 13). This is a slight increase on the 2018/19 data. The level of falls in our communities contribute to hospital admissions. They place ongoing pressure on services as individuals are more likely to need ongoing health and social care support on discharge. It should be noted, however, that admissions following a fall account for 7% of all admissions in an emergency and this proportion is increasing.

Priority 2: Supporting care needs at Home

The population of Angus is growing older and this will continue for the next 20 years. This change in demographics will place a further increase in demand on services. The focus of AHSCP is to support care needs at home by enhancing technology enabled care; further progress self-directed support; and deliver change in care at home services.

2.1 Highlights from 2022/23

- KOMP – Test of Change using very simple technology giving access to social contact and stimulation for those who cannot engage using normal social media platforms (maximising support for people in their own homes).
- Increase in the uptake of Telecare Equipment
- Eclipse – embed Technology Enabled Care (TEC) assessment as part of the referral pathway to ensure access for all potential users – supporting more people in our communities and making best use of resources)
- A comprehensive and transparent learning and development framework has been established for care management. This includes an induction programme for all staff undertaking the function of care management, team manager induction and a broader spectrum of training and learning for individual services which delineates the respective cycles of refresher training

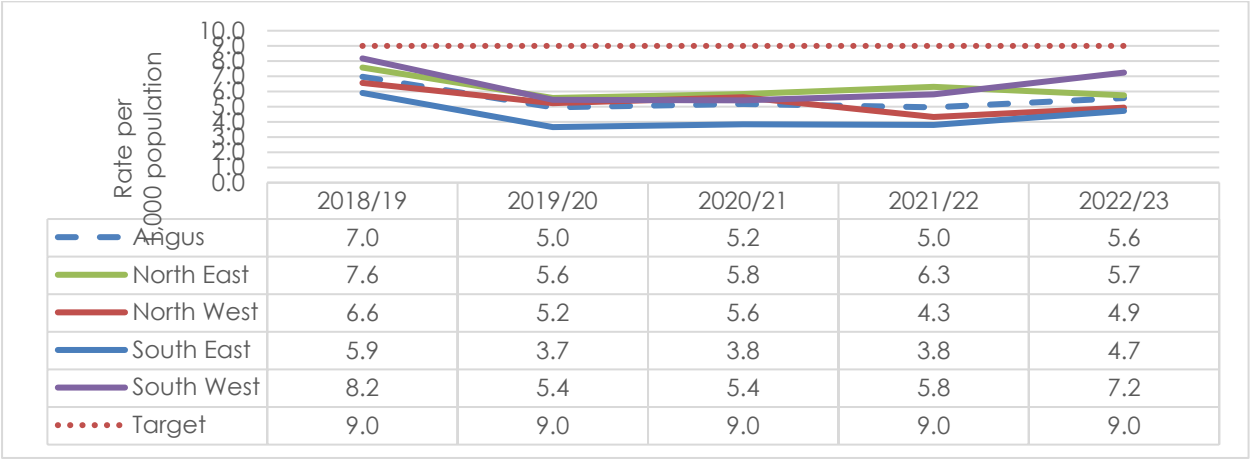
2.2 Making a Difference

Technology Enabled Care

2.2.1 We continue to progress technology enabled care solutions offering a range of peripheral equipment along with the community alarm. Currently more than 1500 peripheral telecare devices are in use across Angus. This is slowly increasing every year.

2.2.2 3,609 people used a community alarm during 2022/23, this is a 2% increase on the previous year and a 12% increase on 2015/16 baseline. Use of Telecare equipment offered in addition to community alarm has seen a slight increase from 13% of people in 2021/22 to 15% in 2022/23. It should be recognised that people are moving to digital alternatives that they can source themselves or recommended during our enablement period.

Graph 15 – Total number of people with Telecare Equipment as a rate per 1,000 population since 2018/19.



	2018/19	2019/20	2020/21	2021/22	2022/23
Angus	7.0	5.0	5.2	5.0	5.6
North East	7.6	5.6	5.8	6.3	5.7
North West	6.6	5.2	5.6	4.3	4.9
South East	5.9	3.7	3.8	3.8	4.7
South West	8.2	5.4	5.4	5.8	7.2
Target	9.0	9.0	9.0	9.0	9.0

Source: CareFirst, Angus Council

2.2.3 KOMP units are revolutionary, yet simple computers designed to alleviate loneliness and social isolation for those who would not manage to use a mobile phone or computer. The KOMP is a one button unit (the size of a small television) that is placed in the vulnerable person's home. It enables friends, family and designated professionals (such as GPs, District Nurses, Social Care and Day Care workers) to call the vulnerable person and carry out a 1:1 visual conversation via a mobile phone app which has a secure log in and registering procedure. The KOMP also has functions that enable displaying family photographs and text messages and provides a digital clock/day reminder facility when not in use to provide an aid to time/day orientation.

Alcohol and Drugs Services

2.2.4 Compared to 21/22, we have seen an increase of around 10% in relation to the measure for individuals accessing Alcohol and Drug services and treated within three weeks. The numbers of new waits for brand new treatments are relatively small compared to other disciplines, in the latest quarter (2022/23) 8 out of 130 waits missed the target.

Care Management

2.2.5 Access to long term social care support requires an assessment of need by Care Management Teams. People who require support choose what support or services would meet their needs and their personal outcomes, how and when those supports will be delivered/accessed and who will provide them. Self-directed support is the mechanism by which these choices are provided.

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

Table 4 - Self-Directed Support Uptake of Options

Indicator	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23
Option 1	6%	7%	7%	7%	9%	9%
Option 2	22%	23%	25%	23%	23%	21%
Option 3	67%	65%	61%	64%	63%	63%
Option 4	5%	6%	7%	6%	5%	7%

(Source: Eclipse, Angus Council)

2.2.6 3,815 people had a care plan in place (15% increase from 2021/22) which includes a self-directed support option. Since 2020, the number of people using option 3 has been fairly static. Like last year, we have seen an increase in the number of people choosing option 4 from 5 to 7% and a slight decline in the number of people choosing option 2 from 23 to 21%. The proportion of people using option 1 (direct payment) is broadly stable at 9% respectively.

2.2.7 The Care Management Improvement Programme is underpinned by the 6Rs for Improvement and Transformation in Health and Social Care. A slightly revised Project Initiation Document was approved back in 2021. The aims continued to include identifying opportunities to deliver improvements to services which would consistently achieve better outcomes and make more effective use of resources. There was also a clear commitment to facilitate incremental change alongside consideration of future service design.

Care at home including personal care

2.2.8 Whilst there is no target for personal care hours for all adults; there is a specific target for personal care for people aged over 65. This was agreed in IJB Report no 77/19 and subsequently revised in IJB report no 3/21. These reports focused on the impact of demographic change of services for older people, addressed the service cost base and also identified a number of approaches aimed at mitigating against continued growth. 456,065 hours of personal care were delivered to people aged over 65 in 2022/23, this was a decrease of -7% on the 2021/22 figures. Although a decrease, this has still exceeded the target for 2021/22 by 8%. The approaches aimed at mitigation against growth are still required to deliver in 2023/24. Work is ongoing to review current demand and further growth ending in 2023.

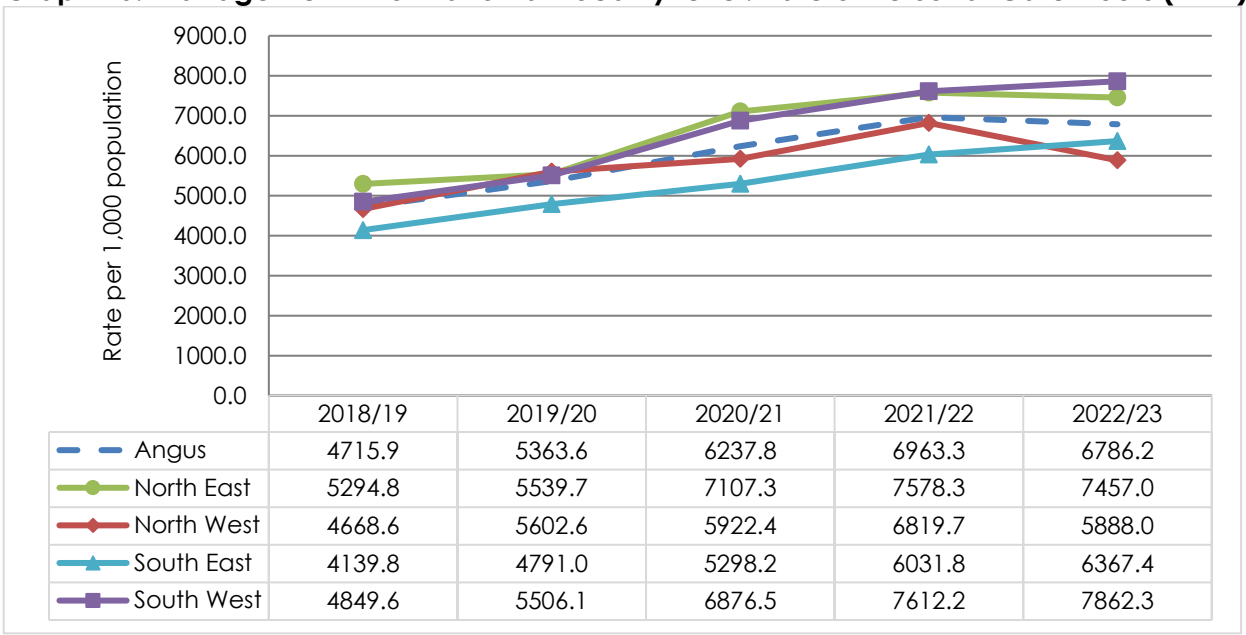
2.2.9 Overall, 640,525 hours of personal care were delivered in 2022/24 this was a slight decrease of 1% on 2021/22. 1895 people use personal care services in 2022/23. In

addition, 359,139 hours of care and support (non-personal home care) were delivered in 2021/22. This was an increase of 5% on 2022/23.

2.2.10 Demand and capacity issues continue in relation to personal care services. Independent providers of personal care have worked hard to address demand. For week commencing 28 March 2023 there were 375 people waiting for 1573 hours compared to 281 people and 1100 hours week commencing 04 April 2022. Various initiatives have been introduced to try reducing unmet need including, a recruitment campaign working with current providers to help increase their workforce/maintain existing service delivery. The increase in all personal care is largely driven by increased demand by people aged over 65. The actions previously agreed to mitigate against further increases in demand from people aged over 65 must be further developed to address the increase.

The graphs below show the changes in personal care hours planned from 2018/19.

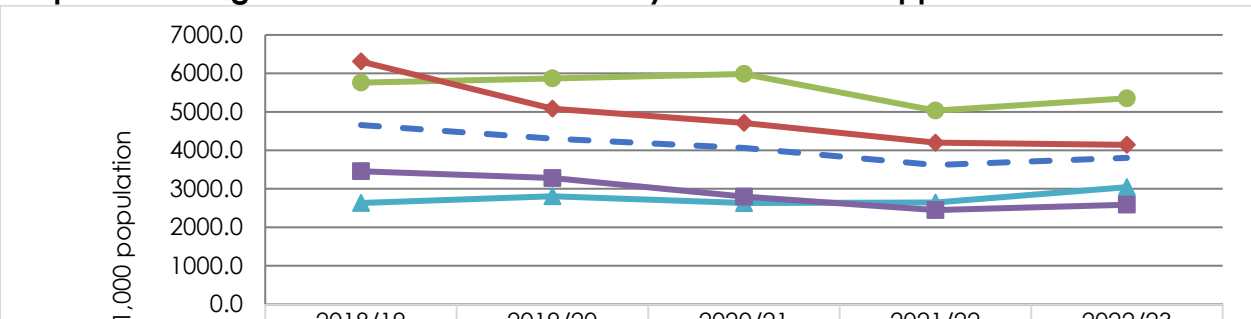
Graph 16: Management Information at Locality level: Rate of Personal Care Hours (LI 24)



	2018/19	2019/20	2020/21	2021/22	2022/23
Angus	4715.9	5363.6	6237.8	6963.3	6786.2
North East	5294.8	5539.7	7107.3	7578.3	7457.0
North West	4668.6	5602.6	5922.4	6819.7	5888.0
South East	4139.8	4791.0	5298.2	6031.8	6367.4
South West	4849.6	5506.1	6876.5	7612.2	7862.3

Source Care First (Angus Council)

Graph 17: Management Information at Locality level: Rate of Support and Care Hours



	2018/19	2019/20	2020/21	2021/22	2022/23
Angus	4657.6	4303.7	4064.9	3619.2	3804.4
North East	5761.9	5870.2	5985.2	5032.9	5352.2
NorthWest	6310.0	5084.1	4713.0	4198.2	4143.3
South East	2633.0	2807.0	2631.4	2642.5	3042.9
South West	3456.2	3280.3	2796.8	2447.6	2586.7

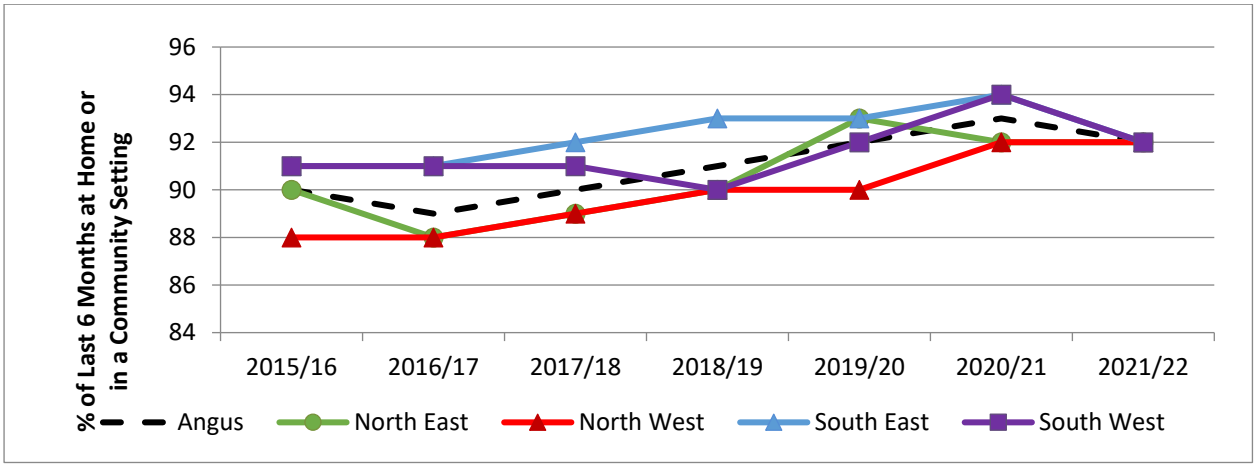
Source: Care First (Angus Council)

2.2.11 The average age of an individual receiving personal care continues to increase for older people this has improved from 81.3 years in 2015/16 to 82.5 years in 2022/23. Improving people's independence is an ambition set out in the HSCP SCP.

Last 6 months of life

2.2.15 Angus performs well in relation to end of life care. The percentage of time that people spend at home or in a community setting in the last 6 months of their life in 2022/23 in Angus was 92.3%. Angus performs better than the Scottish average, where 89.3% of the last 6 months of life is spent at home or in a homely setting in the community.

Graph 18: Management Information at Locality Level: Proportion of Last 6 Months spent at Home or in a Community Setting (NI 15)



Source: Public Health Scotland

2.2.16 We continue to develop our locality-based information on end of life care, to gain a greater understanding of place of death and the type of support that requires to be in place to continue to shift the balance from large hospital to community-based supports.

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

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

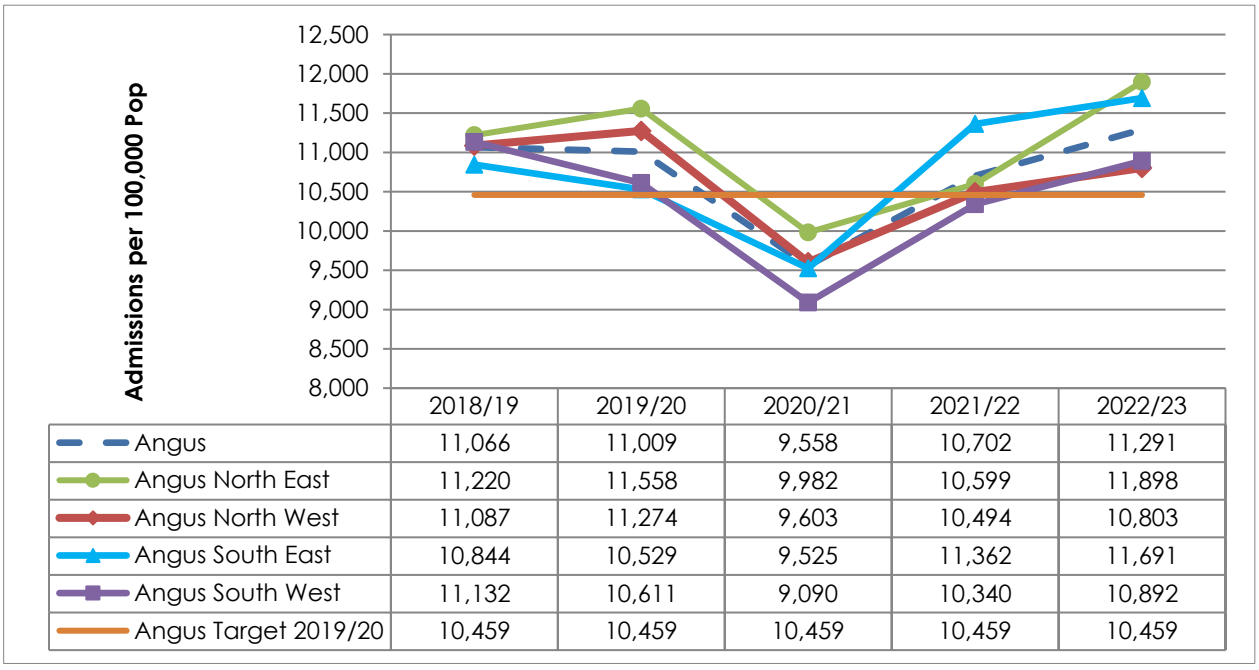
3.1 Highlights from 2022/23

- AHSCP now has Enhanced Community Support (ECS) model embedded throughout all four localities.
- Admissions accounted for 118,674 hospital bed days a decrease of 28% on 2020/21

3.2 *Emergency admissions*

3.2.1 There were 11,290 unplanned admissions in 2022/23, this was an increase of 9% on 2021/22. Admissions accounted for 118,674 hospital bed days a decrease of 28% on 2020/21

Graph 19: Angus HSCP relative performance to Scotland. Rate of emergency admissions per 100,000 population for people aged 18+



	2018/19	2019/20	2020/21	2021/22	2022/23
Angus	11,066	11,009	9,558	10,702	11,291
Angus North East	11,220	11,558	9,982	10,599	11,898
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Angus South East	10,844	10,529	9,525	11,362	11,691
Angus South West	11,132	10,611	9,090	10,340	10,892
Angus Target 2019/20	10,459	10,459	10,459	10,459	10,459

Source: Public Health Scotland

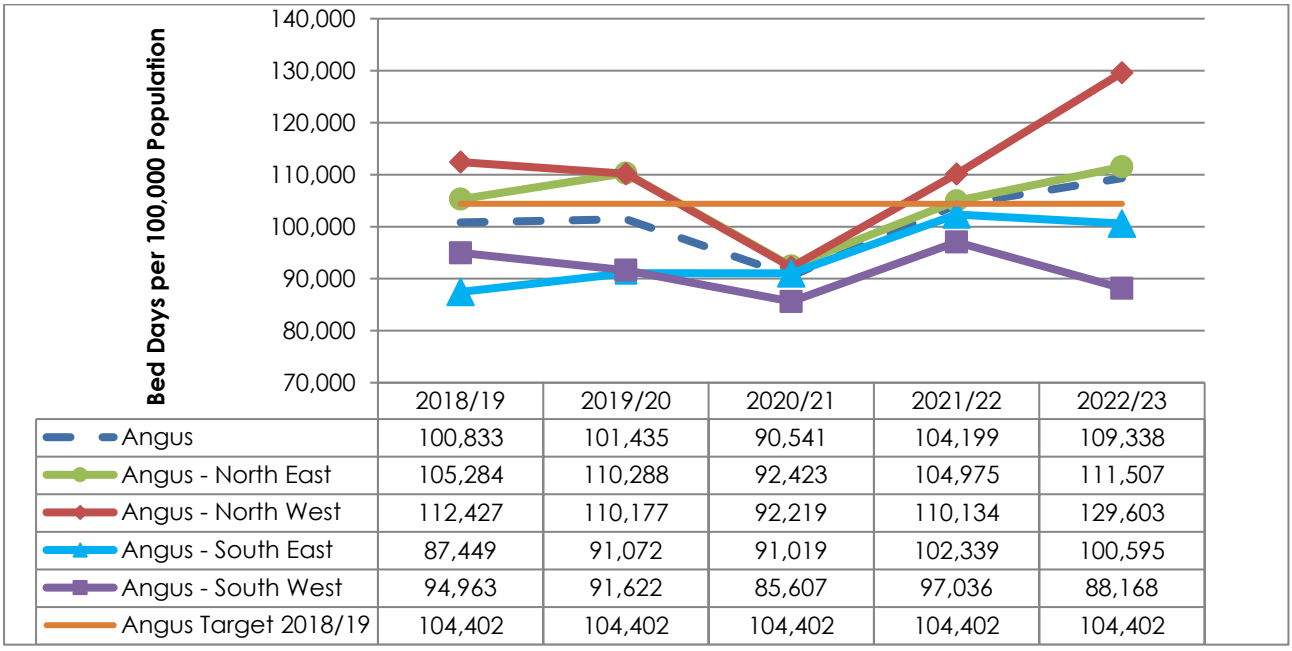
3.2.2 Emergency admission rates vary across Angus. The highest emergency admission rate was in North East and the lowest rate was in North West.

3.2.3 Following an attendance at A&E the proportion of people who require to be admitted to an inpatient bed continues to increase with more than 75% of all attendances at A&E for a major issue resulting in an admission. We do not understand whether this is more appropriate use of A&E for major issues or there continue to be some admissions that could be preventable.

Hospital Bed days used following an emergency admission.

3.2.4 The hospital bed day rate for all adults in Angus has seen a 8.5% increase in bed days since 2018/19.

Graph 20 - Management Information at Locality Level: Rate of Emergency Bed Days for Adults (NI 13)



	2018/19	2019/20	2020/21	2021/22	2022/23
Angus	100,833	101,435	90,541	104,199	109,338
Angus - North East	105,284	110,288	92,423	104,975	111,507
Angus - North West	112,427	110,177	92,219	110,134	129,603
Angus - South East	87,449	91,072	91,019	102,339	100,595
Angus - South West	94,963	91,622	85,607	97,036	88,168
Angus Target 2018/19	104,402	104,402	104,402	104,402	104,402

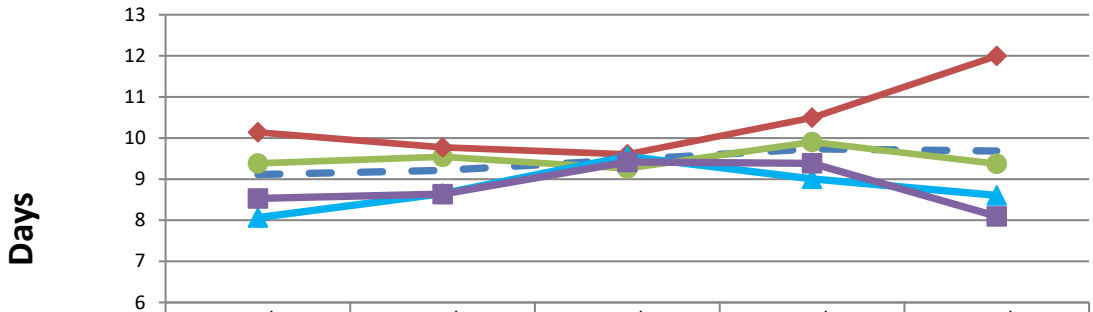
Source: NHS Tayside Business Unit

Length of hospital stay following an emergency admission

3.2.5 Improvements in bed days have up to this point been driven by improvements in average length however this was not continued in 2021/22 with a slight increase to 9.7 days from 9.5 in the previous year. It is expected that this is, in part, related to admissions for Covid-19. This has continued during 2022/23. There continues to be some room for continued improvement in this area when we consider the variation in performance in our localities from 9.7 days to 12.0 days and the performance of other partnerships.

3.2.6 Demand and capacity issues continue in relation to personal care services which will impact on the length of hospital stay.

Graph 21: Management Information at Locality Level: Average Length of Stay for Emergency Admissions for Adults



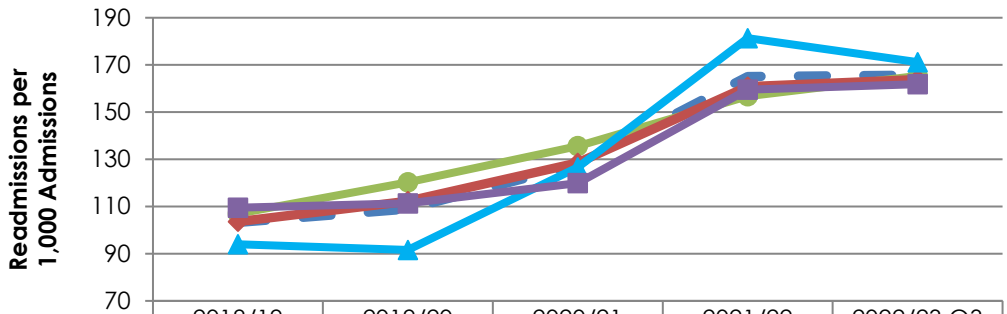
	2018/19	2019/20	2020/21	2021/22	2022/23
Angus	9.1	9.2	9.5	9.7	9.7
Angus - North East	9.4	9.5	9.3	9.9	9.4
Angus - North West	10.1	9.8	9.6	10.5	12.0
Angus - South East	8.1	8.6	9.6	9.0	8.6
Angus - South West	8.5	8.6	9.4	9.4	8.1

Source: Public Health Scotland LIST management information (not official ISD statistics)

3.3 Re-admissions to hospital

3.3.1 There has been a continued decrease in the performance in relation to emergency readmissions within 28 days of discharge (as a rate of all emergency admissions). However, we have seen a 30% decrease in this area between 2021/22 and 2022/23. This measure is a national indicator, but its definition is for both planned and unplanned admissions to hospital. Planned admissions in 2022/23 have increased with the continued backlog after the COVID-19 pandemic. Other factors which may be contributing to the increased rate of readmissions include increasing frailty in the community, management in the community rather than care homes.

Graph 22: Management Information at Locality Level: Emergency Re-admission Rates within 28 days (NI 14)



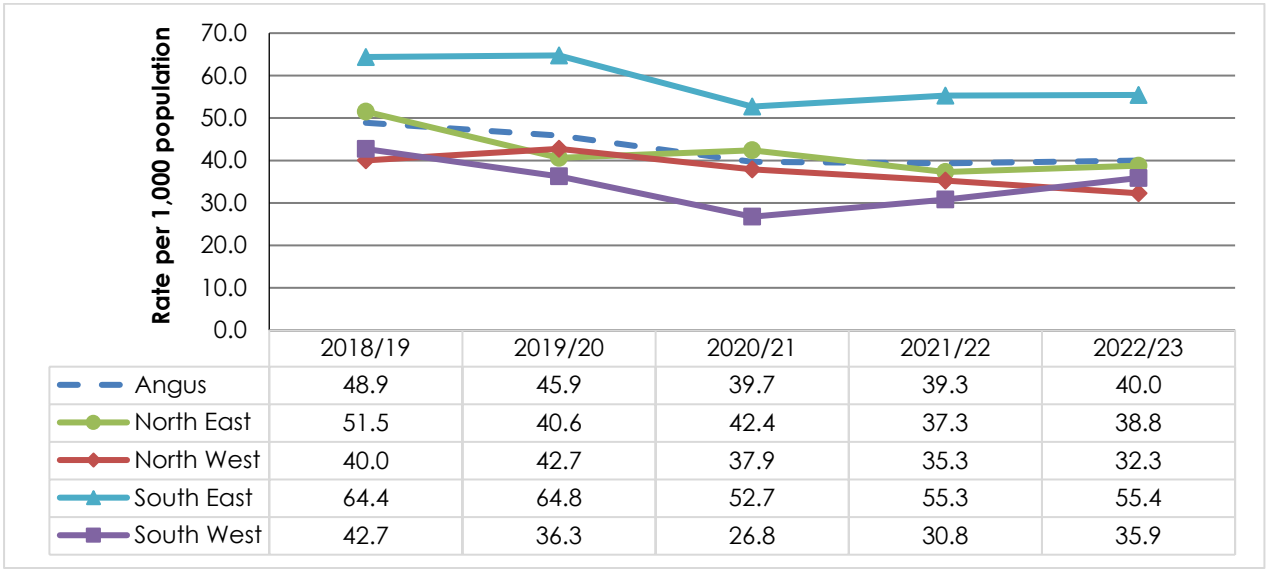
	2018/19	2019/20	2020/21	2021/22	2022/23 Q3
Angus	103	109	128	165	166
Angus - North East	107	120	136	157	165
Angus - North West	104	112	128	161	164
Angus - South East	94	92	127	181	171
Angus - South West	110	111	120	160	162

Source: Business Unit, NHS Tayside

3.4 Residential and Nursing Care

3.4.1 The number of adults placed in a care home at any one time in 2022/23 was 737. People tell us that they want to stay in their own homes for as long as possible, between 2018/19 and 2022/23 the number of people placed in a care home reduced by 16%. Older people live at home for longer and if moved to a care home remain in the care home for a shorter period.

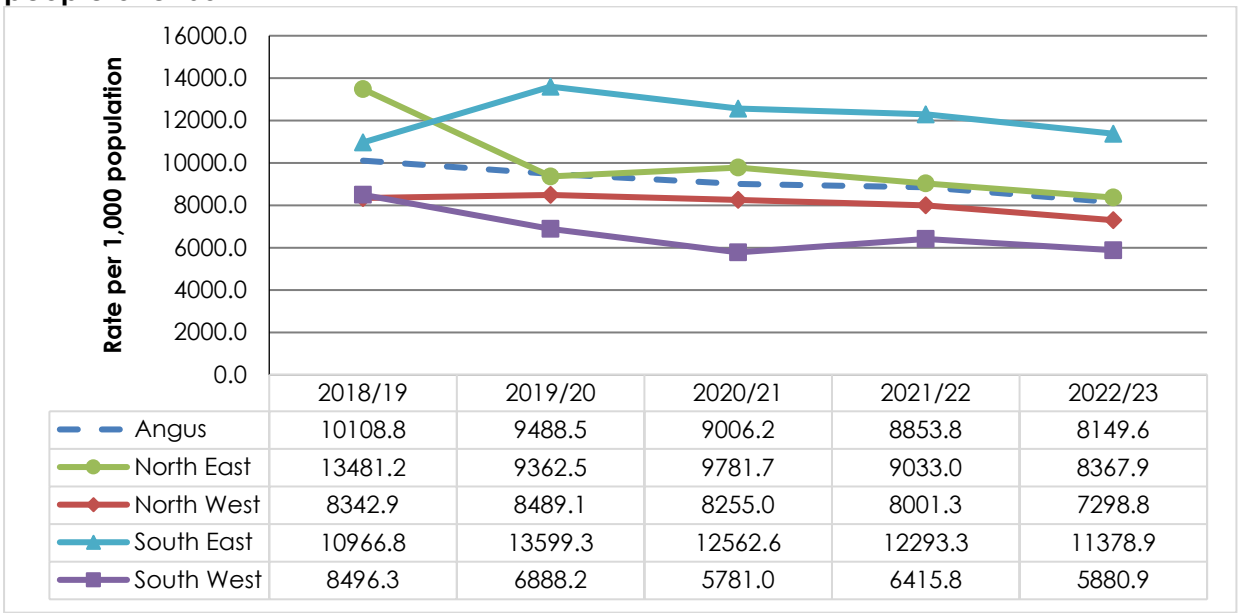
Graph 23: Management Information at Locality Level: Care Home Placement Rate per 1,000 people over 65



	2018/19	2019/20	2020/21	2021/22	2022/23
Angus	48.9	45.9	39.7	39.3	40.0
North East	51.5	40.6	42.4	37.3	38.8
North West	40.0	42.7	37.9	35.3	32.3
South East	64.4	64.8	52.7	55.3	55.4
South West	42.7	36.3	26.8	30.8	35.9

Source: Care First (Angus Council)

Graph 24: Management Information at Locality Level: Care Home Nights Rate per 1,000 people over 65



	2018/19	2019/20	2020/21	2021/22	2022/23
Angus	10108.8	9488.5	9006.2	8853.8	8149.6
North East	13481.2	9362.5	9781.7	9033.0	8367.9
North West	8342.9	8489.1	8255.0	8001.3	7298.8
South East	10966.8	13599.3	12562.6	12293.3	11378.9
South West	8496.3	6888.2	5781.0	6415.8	5880.9

Source: Care First (Angus Council)

3.4.2 Independent Sector Lead for Angus has been working alongside AHSCP and other agency staff to develop the Supporting Tayside Excellence Programme (STEP) which is a self-assessment tool to be completed by care homes to inform the oversight team of support required.

3.4.3 A test of change for an Advanced Nurse Practitioner (ANP) from the Medicine for the ELderly Service to be part of the 6 week care home review for all new residents of care homes within the North-West locality. The 6 week review is undertaken by the social work care manager and would not historically have included a health practitioner. The role of the ANP was to focus primarily on the three priority areas: all new residents had an anticipatory care plan (ACP), medication review and review of catheter care and ensure national catheter passport was in place where appropriate.

3.5 Urgent and Unscheduled Care

3.5.1 To help meet the ambition for urgent care across Tayside, the Angus Urgent and Unscheduled Care Improvement Programme was established in August 2022 and aims to optimise each stage in a person's urgent care journey, delivering physical and/or mental urgent health and care as close to home as appropriate, in a timely way, ensuring Angus's resources deliver the best possible health and care outcomes 24/7.

3.5.2 A Quality Improvement (QI) approach has been undertaken and the focus again has been on where improvements can be made: testing changes before rolling out improvements more widely, adopting a whole systems approach to urgent care planning to ensure improvement initiatives in one part of the urgent care system do not have unintended consequences elsewhere and continuously seeking patient feedback to understand what is working well, what is causing frustration and what factors are driving patient decision making when seeking urgent care.

Priority 4: Improving integrated care pathways for priorities in care

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

4.1 What we have achieved in 2021/22

- Implementation of Angus Discharge Team in September 2022 which links in with the Urgent and Unscheduled Care Collaborative delivering the Right Care in the Right place at the right time.
- Implementation, evaluation and roll out of the 7 Day Community Mental Health Service
- Roll out of the Mental Health and Wellbeing Enhanced Community Support Hub in the North West of Angus in February 2023.
- Implementation of Triangle of Care which is a partnership between professionals, the person being cared for, and their carers. It sets how they should work together to support recovery, promote safety and maintain wellbeing.

Making a difference

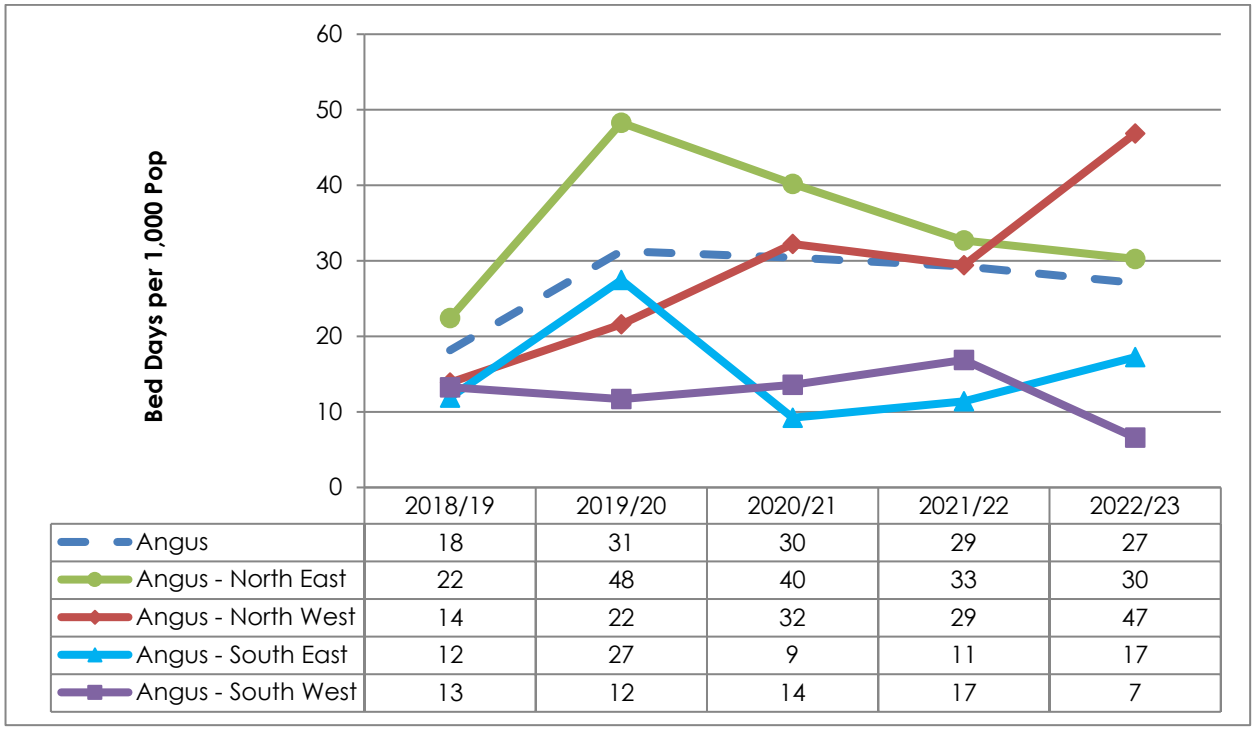
4.1.1 AHSCP is working with housing, learning disability, adult mental health and other services to identify appropriate measures. We measure pathways in and out of secondary care, in part through our work on admissions and re-admissions. These are all reported on in relation to Priority: Developing integrated and enhanced primary care and community responses (page 31).

4.1.2 AHSCP now has Enhanced Community Support (ECS) model embedded throughout all four localities. Monifieth Integrated Care has seen the amalgamation of the Care Management and District Nursing teams. Work is progressing to improve unscheduled care pathways with the Angus Urgent and Unscheduled Care Programme Steering Group taking forward a range of initiatives to improve the journey for people who have a physical and/or mental health need that does not require emergency care but cannot wait until a pre-planned care appointment.

4.1.3 Complex delays have increased mainly as a result of the lack of specialist care accommodation for people under 65. Guardianship applications also account for lengthy delays and although work has progressed to deal with the backlog of Guardianship applications, processing through the court system can delay people for longer than we would like.

4.1.4 Several initiatives are under way to improve the position regarding delays in discharge. A new social work discharge team created to be proactive and review all delayed patients both in acute and community hospital bed base plus we continue the role out of the planned date of discharge work.

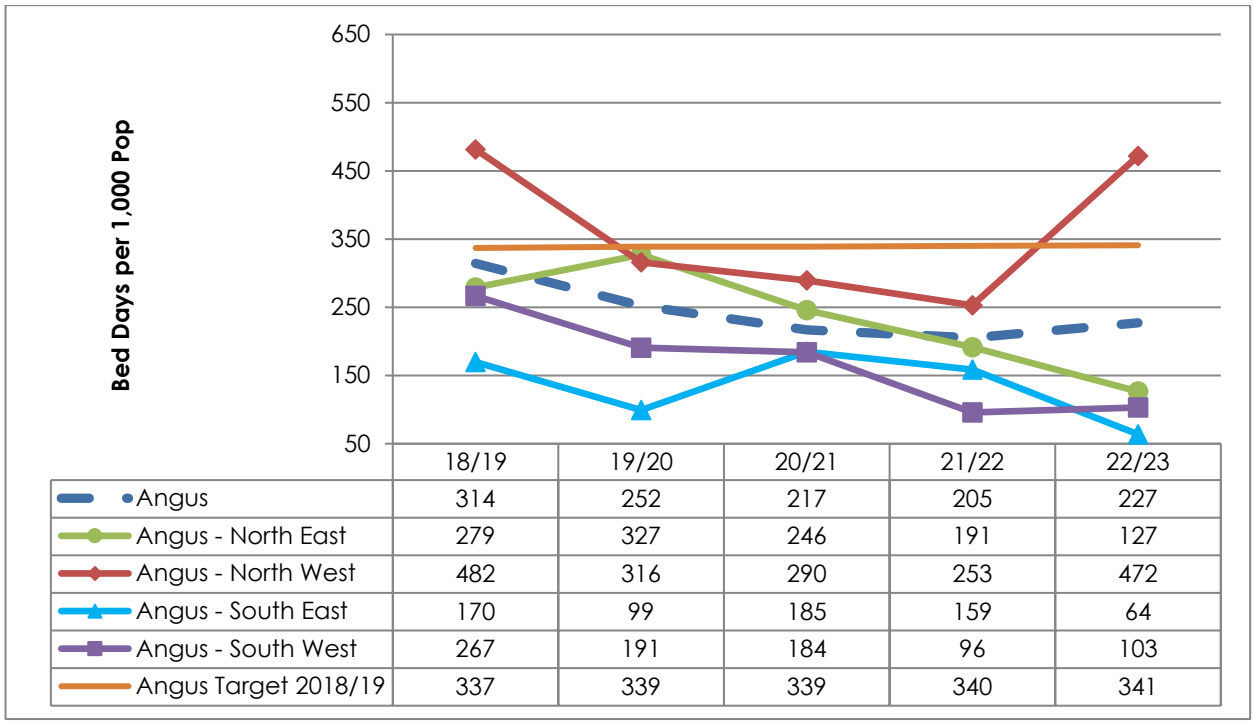
Graph 25 – Delayed Discharge Bed Day Rate per 1,000 Population for 18-74



	2018/19	2019/20	2020/21	2021/22	2022/23
Angus	18	31	30	29	27
Angus - North East	22	48	40	33	30
Angus - North West	14	22	32	29	47
Angus - South East	12	27	9	11	17
Angus - South West	13	12	14	17	7

Source – Public Health Scotland

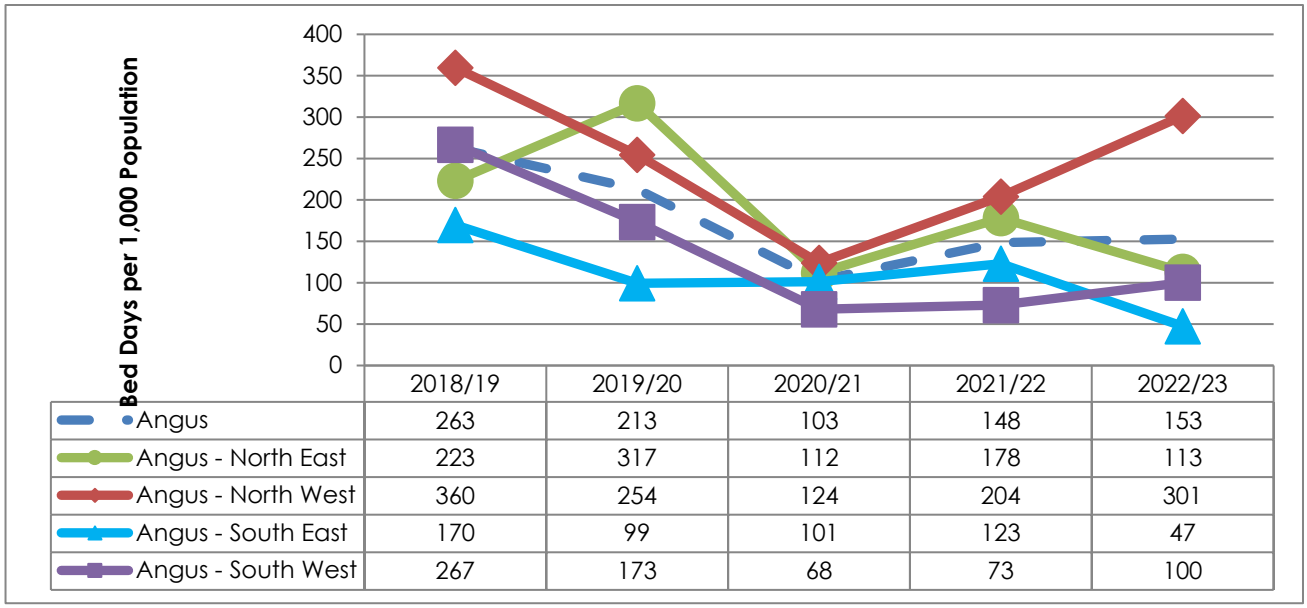
Graph 26 – Delayed Discharge Bed Day Rate per 1,000 Population for 75+



	18/19	19/20	20/21	21/22	22/23
Angus	314	252	217	205	227
Angus - North East	279	327	246	191	127
Angus - North West	482	316	290	253	472
Angus - South East	170	99	185	159	64
Angus - South West	267	191	184	96	103
Angus Target 2018/19	337	339	339	340	341

Source – Public Health Scotland

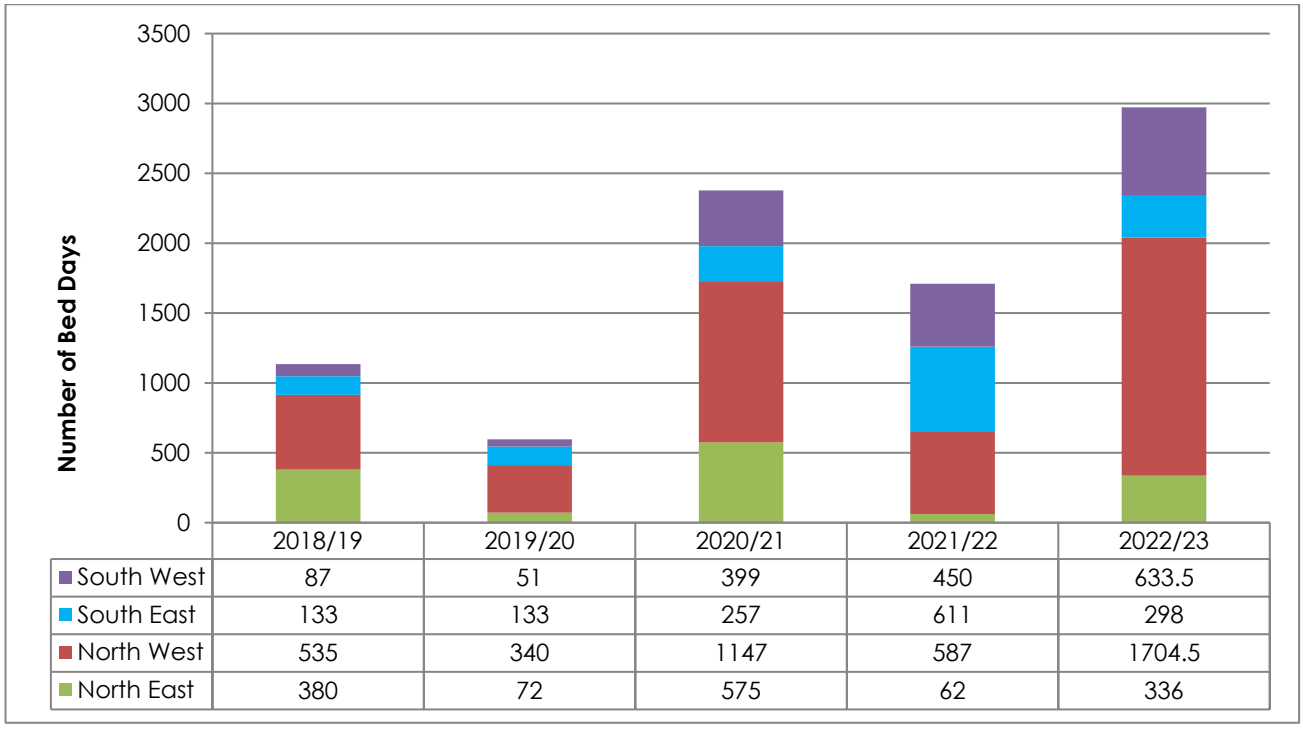
Graph 27 – Standard Delayed Discharge Bed Day Rate per 1,000 Population for 75+



	2018/19	2019/20	2020/21	2021/22	2022/23
Angus	263	213	103	148	153
Angus - North East	223	317	112	178	113
Angus - North West	360	254	124	204	301
Angus - South East	170	99	101	123	47
Angus - South West	267	173	68	73	100

Source – Public Health Scotland

Graph 28 – Delayed Discharge Bed Days for People with Complex Needs All Ages



	2018/19	2019/20	2020/21	2021/22	2022/23
South West	87	51	399	450	633.5
South East	133	133	257	611	298
North West	535	340	1147	587	1704.5
North East	380	72	575	62	336

4.2 *Angus Integrated Drug and Alcohol Recovery Service (AIDARS)*

4.2.1 Angus Integrated Drug and Alcohol Recovery Service (AIDARS) continues to support people and their families affected by substance misuse within their own communities. The collaborative approach with partners is embedded within a recovery orientated system of care (ROSC), which ensures a person's recovery sits at the centre of service delivery. AIDARS provides an open referral system and encourages those in need to

refer directly to the service. The teams also provide drop in contact within the Wellbeing Cafes in North localities in Angus, and through drop in contact with third sector services in Arbroath. The AIDARS service has been reorganised into Health and Social Work Teams (This replaces the former North and South teams). This does not affect the any referral route into service, nor does it affect the interventions that are available to service users. The reorganisation allows the teams to work more efficiently and safely in regard to systems and pathways of care.

4.2.3 Compared to 21/22, we have seen an increase of around 10% in relation to the measure for individuals accessing Alcohol and Drug services and treated within three weeks. The numbers of new waits for brand new treatments are relatively small compared to other disciplines, in the latest quarter (2022/23) 8 out of 130 waits missed the target.

4.2.5 The Scottish Government has developed Medically Assisted Treatment (MAT) Standards that all ADP areas in Scotland have to adopt and report their progress. The standards are in place to try and reduce the risk of overdose and death and improve the opportunities for recovery. There are national and local area supports from the MAT implementation team.

4.2.6 Each area has had to produce a current status in relation to how it is meeting the standards. The initial development plans have to address the requirements of Mat Standards 1-5 in the first phase of this 5-year project. AHSCP and the ADP are overseeing the plans.

4.2.7 Reducing the harm associated with substance use remains a priority for services, the multidisciplinary Near Fatal Overdose hub continues to provide assertive outreach and follow up to individuals affected, offering support to engage with services.

4.2.8 Following the successful test of change to align and integrate substance use and mental health services within a hub in Montrose, this model will be rolled out across all localities during 2023-24.

4.3 Mental Health and Wellbeing Enhanced Community Support (ECS) Hubs

4.3.1 Mental health and Wellbeing ECS hubs are at locality level, using community buildings which are co-located with a range of other services, to promote access to community assets, promote social prescribing, improve pathways of support, provide a compassionate response to distress, and remove demand for some lower level mental health and wellbeing intervention from GP Practices. This will provide a person-centred flexible service which will give people choice and the ability to access mental health and wellbeing support more easily in a GP practice or from a community building.

4.3.2 The Hub in the North East continues to work extremely well with referrals in Year 2 on par with Year 1 of around 1400 with no referral rejected. In the first month, the North West

Hub received 167 referrals with no referral rejected with the majority being seen by Peer, CMHT and Psychology.

4.3.3 An initial evaluation of the North West Hub with staff reported a positive impact on their practice with staff member commenting:

"It has been fantastic getting to know members of the multi-disciplinary teams and being able to share knowledge and expertise. It has been very beneficial for me as a practitioner, improving my knowledge and understanding in relation to mental health and the services available within the local area".

"It has enhanced the support for my peer workers, increased partnership working, enables a quicker response to patient care and shared learning and practice".

"Much better and more efficient communication between all involved, including new referrals and any further follow ups/joint working".

4.3.4 With patients commenting:

"The mental health peer worker I was allocated for very friendly and helpful".
"The referral definitely helped".
"Being able to talk to a professional really helped with my upsetting issues".
"The peer worker at made me feel really comfortable and supported".
"Very helpful and quick response".
"Was referred to peer support who helped me get support from psychology".

4.4 Mental Health Officer (MHO) Function

Mental Health Act

4.4.1 Statutory social work services provided under the Mental Health (Care & Treatment) (Scotland) Act 2003 and Adults with Incapacity (Scotland) Act 2000 are delivered by AHSCP.

4.4.2 As with last years' report, we continue to experience challenges recruiting and retaining Approved Medical Practitioners (AMP) (also known as Section 22 doctors) in Angus. There are no permanent AMPs in Angus and cover is being provided by one locum AMP for each locality.

Adults with Incapacity

4.4.3 This year, the number of Guardianship reports (new and renewal) requested under the Adults with Incapacity (Scotland) Act 2000 continued to increase with a total of 122 requests (an increase of 31 from last year).

4.4.4 After an internal audit, a full review of the guardianship process began to identify improvements to be implemented. Work is underway with an action plan being developed and a working group meeting monthly to review and update on progress.

4.4.5 Summary Stats from 01 April 2022 until 31 March 2023

Table 5 - Mental Health Care & Treatment Order (Scotland) Act 2003

Type	Numbers
Emergency Detention Certificates	37
Short Term Detention Certificates	89
CTO Applications	45
Social Circumstances Reports	79
Other reports regarding civil and forensic cases	85
No patients on a Compulsion Order	2
No patients on a Compulsion Order with Restriction	7

Table 6 – Adults with Incapacity (Scotland) Act 2000

Type	Local Authority	Private	Total
New Requests	27	48	75
Renewal Requests	17	30	47
Total requests received both Local Authority & Private			122

4.5 General Adult Psychiatry (GAP) Community Mental Health Service (CMHT)

4.5.1 The extended 7-day community mental health service was established in May 2021 in the North of Angus and following a successful pilot extended to include South Angus in September 2021. The service supports existing service users of the Community Mental Health Team (CMHT) who require an increased level of support for a limited period of time in addition to their existing care plan, or new service users who have been assessed and have a risk assessment and care plan in place which details the need for weekend support. The aim of the service is to offer person centred support in the local area to prevent crisis, manage risk, prevent a further deterioration, prevention of admission, early supported discharge from hospital and support service users who are on pass home from hospital when weekend support is identified within their discharge plan.

Care Opinion Feedback

I've been dealing with my anxiety for around 14 years now and was admitted to Carseview Centre in May 2021. My total stay was just over 10 weeks. It was the hardest thing I've ever done but was also the best.

The staff at Carseview get to know you on a personal level and have your best interests at heart. You can speak to any staff member at any time, day or night, and you know you'll have a sympathetic ear to listen. The courage, self-esteem and confidence I found whilst in Carseview is something I haven't felt for a long time and I can't thank the staff enough for everything they did for me.

I have since been working with my CPN at Whitehills, Forfar. The progress I have made with her is phenomenal and I know that I can be honest and open about absolutely anything. She listened attentively, we have a laugh which really puts me at ease and she is one of the most encouraging people I have ever met. My care here has been completely different to when I lived in England, and I wouldn't change it for the world. The system does work, you just have to be open to allowing it to work.

I have also been working with a Support Worker at Whitehills for the last 4 months or so. We get to go out for walks, or for coffee and talk, again about absolutely anything. I don't feel judged and I feel listened to 100%. I also get to share my news and achievements and to see how happy this also makes my support team really is so encouraging. I know they're behind me 100% and support me, and I can talk to them like friends. Putting me at ease is extremely difficult, but I have finally found the people who can do this and help me.

4.5.2 The 7-day community mental health service is now fully implemented with 200 referrals received between 01/04/22 to 31/03/23 with a 91% attendance rate.

4.5.3 Service Users who were referred to the 7-day community mental health service were sent a questionnaire asking 8 questions with the ability to add any additional comments and below are some of the comments received:

"Perfect. Just what needed at the time"

"Staff really flexible about time of appointment and support provided. I really felt listened to and felt the worker heard what I was saying. They also helped me plan ahead with next steps. I've been referred a couple of times and the service has been great both times"

"Worker was professional. Asked how I was feeling. Put me at ease"

"I felt really listened to as I was struggling to communicate what the issue was. Staff were really patient with me to make sure I was heard"

"Would have preferred to have been seen face to face. Would have felt more supported. All my CPN appointments are face to face"

Care Opinion Feedback

A year ago, pretty much everything wasn't working for me. There were more than one attempts to end my life. The constant wanting to leave everything behind was strong. I wanted to enjoy my life but I also didn't want life. My husband finally forced me to call my doctor and I was referred to a mental health nurse.

The first time I met her, I was scared. I hated every single cell in my body because I was ashamed of myself and now someone else is hearing me say stuff. woah that's horrible for me. She is this amazing person who made me feel comfortable. I'm not always comfortable around any medical professionals but she knew the person I am. To date, I still hate myself and I'm scared to face the world but the hate is a little less because of her.

4.6 Peer Support

4.6.1 Peer Support is now fully embedded across 15 GP surgeries in Angus with the Peer Workers part of both the Mental Health and Wellbeing Hubs in the North and this will be replicated as we roll out the Hubs in the South.

4.6.2 Between 01/07/22 to 31/3/23 Peer Support received 2464 referrals, 1380 in the North, delivered by Hillcrest Futures and 1084 in the South delivered by Penumbra.

4.6.3 Top 7 presenting issues consistent across both organisations. Some people identified more than one area of concern:

Mental Health (General) (720)

Low Mood (563)

Anxiety (603)

Bereavement (109)

Stress (172)

Relationship Issues (112)

Trauma (80)

4.6.4 **Outcome of referrals:** The majority of people were signposted to self-help activities (919) or community supports (661), followed by referral for specialist mental health support (257) or referral back to the GP (86).

4.6.5 The majority of people self-reported 'positive progress' of 'no change' as a result from being involved with the Peer Service through Hillcrest Futures and Penumbra. Hillcrest Futures SIPP trained 186 people, and Penumbra offered 18 wellbeing workshops which are open to Peer Service and Angus Nova referrals.

Case Study

A Service User was referred to their GP with extreme low mood, huge stress producing factors at work and broke down in GP appointment.

Areas of support identified during appointment:

- *Very low mood/motivation*
- *Huge anxiety when within workplace, extending to everyday life now*
- *Use of her own time – find an interest, something to look forward to*
- *Care of her physical health – lately has done nothing but "curl up in a blanket" often not even finding motivation to wash her hair – totally unlike her*
- *Support network – lives with supportive partner, worried about parents' reaction*
- *Job – feels this is the main contributor to her mood, hates the environment/people, feels hugely underappreciated, knows she can give much more*

Focussed Work:

- *Peer worker provided emotional support with open conversation, motivational interviewing to gain trust and share experiences.*
- *Provided some self-help tools and suggestions on how to break some unhelpful routines she was in*

Case Study (cont.)

Focussed Work:

- *Peer spoke of own experiences, things that had helped in similar situation.*
- *Provided some perspective on how it looked from an impartial point of view*
- *Offered some ideas to consider setting some near/long term goals*
- *Sent some resources to look at relating to mind set, mindfulness, meditation*
- *Encouraged Jennifer to think of her own time while signed off work, and what she could do with it, instead of doing nothing.*
- *Encouraged her to really consider if her job is worth the strain on her mental and physical health, were there other options for her?*

Outcome:

Service User made huge progress in a short space of time. They credit this to the first conversation they had with the peer worker and the realisation that they could change everything that wasn't working in their life if they wanted to. So they did. They said that they don't think they would have taken the plunge and quit their job had the initial conversation with the peer worker not highlighted to them just how much that was the main factor in their period of depression. They said they needed to believe in themselves again after having such a knock to their confidence, having the peer worker support encouraged them to remember what they were good at and begin from there in terms of rebuilding their life again.

Service User checked in with the peer worker via phone call after a couple of months in their new job, the upwards swing in their mood has continued and fully justified their switching jobs. They already feel so much more at home and works now in an environment that will allow them to thrive. Since seeing Service User, the service has had numerous people come through the referral system for peer support who have told us – "My friend encouraged me to come to this service after what it did for them" – which has further, hugely validated the service and efforts of the peer worker in supporting the Service User.

4.7 Angus Nova Project

4.7.1 Angus Nova Project provides flexible, person-centred and recovery-focused support. The primary aim of the service is to promote social inclusion through community integration and involvement. Individuals supported by the service are encouraged to access mainstream activities and increase their social network, which is achieved through careful planning of the individual's personal goals. Self-management and well-being tools are also offered.

4.7.2 A total of 283 referrals were received between 01/07/22 to 31/03/23.

4.7.3 Top 4 presenting issue reported by those accessing the service. Some people identified more than one area of concern:

Wellbeing management (88)

Anxiety (71)

Social inclusion (69)

Low confidence (65)

4.7.4 **Outcome of referrals:** The majority of people Moved Actively – person engaged in service, achieved planned outcomes and moved on (88 people) or Did not attend – person never engaged in service after being referred (85) followed by Disengaged – person engaged in service then stopped attending – reason not always known (73) or Service no longer meeting supported persons' needs – persons needs are no longer met by service remit (37).

4.7.5 Feedback from a small sample of people showed:

"Most people thought that support had a positive impact on their life 'very much' and 'quite a lot'"

"They were treated with kindness and dignity 'all or most of the time'"

"Staff did what they said they would do 'all or most of the time'"

"On a Scale of 1-10 rated the support they received between 8 and 10"

Case Study

What were things like when they started Nova?
Things were very bad. My anxiety was off the scale and I was very, very, low. I was battling many chronic physical conditions and was feeling that I was on a slippery slope to becoming dependent. I was unable to get in the shower for days and found interpersonal issues very difficult. I manage a horrific brain disease so the irritability and pain from this made it impossible to use the coping strategies I learned from my therapists over the years for my anxiety and depression. I was also trying to cope with a horrific situation in my life which I should never have found myself in. And in addition, unbeknown to me at the time I was coping with a horrific newly diagnosed autoimmune disease. I felt exhausted and done.

What helped?
I required someone to listen to my story and have an understanding/empathy re how I was feeling. Someone to listen to me and explore my issues with. Someone who helped me see the positive and how strong I was. To know that there was someone there who knew my story and followed it through being updated each time we spoke and I didn't have to repeat it over and over again.

Case Study (cont.)

That's the difficulty with Samaritans, you have to start afresh with every person you talk with. And for me there was so much ground to cover. My worker has always demonstrated great listening skills and I never felt judged by him, that there is gold in itself. Also knowing that he was always there was a massive thing. The service saw me through extremely bad times, the worst of my life. Even worse than the loss of my beautiful Dad. I added to some coping strategies with the WRAP app.

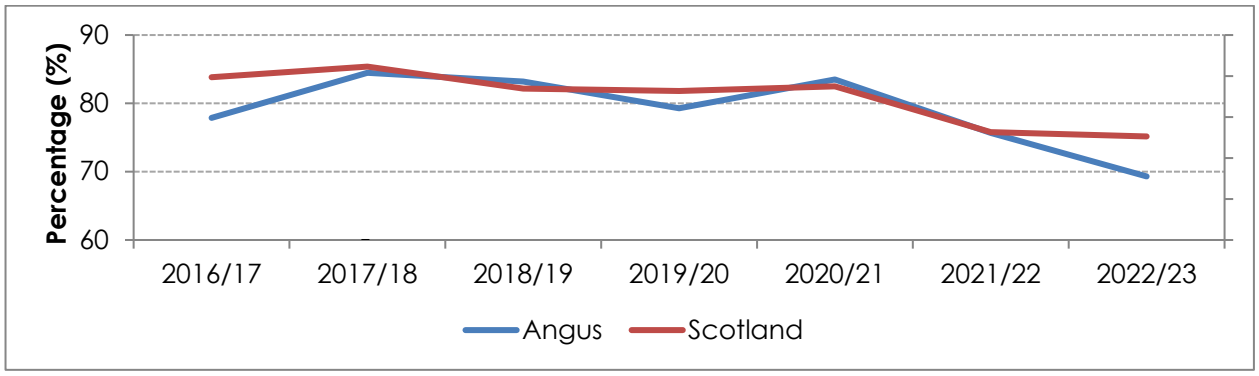
How were things when they moved on?

I generally felt much better physically and mentally by the end of my time with Penumbra. However horrific things are still droning on, I'm trying to cope with mounting neuro issues and have a massive amount to do physically and mentally for myself on a daily basis. I feel overwhelmed with it. But I am in a much better place. Thanks so much; Penumbra and my worker you are way up there on the list of people I hold in very high esteem. What a stellar job you do. Keep up the great work.

Inspection of Services

5.1 There are 73 registered providers of adult care services in Angus, this includes care homes, housing support services and support services providing care at home and day care. Services are subject to inspection and grading by the Care Inspectorate. The grading system operates by applying a grade between 1 and 6. The lowest grade in any area of the service is then given as the overall grade for that service.

Graph 29 - Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections (NI 17)



Source: Public Health Scotland

5.2 In Angus, 70% of services operate at grade 4 (Good) and above. In 2022-22, 18 care homes and 5 supported services were inspected. Following inspections in 2022-23, 15 providers had requirements which required action, and 20 providers had areas of improvement to address.

The requirements related to areas:

- Environmental improvement plan
- Quality assurance processes
- Infection prevention and control
- Provision for the health, welfare and safety of people using the service
- Medication administration
- Risk assessment and Support Planning

The areas for improvement were:

- Choice of range of social, creative, and learning activities
- Support at mealtimes
- Contingency planning

5.3 Providers including care homes are supported with improvement via various groups including Collaborative Care Home Support Team (CCHST). AHSCP also provided funding to Scottish Care to appoint an improvement officer to work with the independent care sector on quality improvement and change locally.

Adult Support and Protection Inspection

5.4 In 2022-23, Angus was subject to a multi-agency adult protection inspection. The inspection was led by the Care Inspectorate in collaboration with Healthcare Improvement Scotland and His Majesty's Inspectorate of Constabulary in Scotland with the purpose of seeking assurance that adults at risk of harm in Angus are supported and protected by the arrangements in place.

5.5 The Inspection Report highlights that Angus has clear strengths in ensuring adults at risk of harm are safe, protected and supported. It found the HSCP demonstrated a person-centred approach to adult support and protection which included the regular use of advocacy, promoting the voice of adults throughout all stages of key processes. The delivery of inquiries, investigations and case conferences themselves were assessed as highly effective. Core group meetings for adults at risk of harm which proceed to case conference were noted as reporting effective oversight of risk assessment and the management of concerns.

Clinical Care and Professional Governance (CCPG)

6.1 The IJB receives an annual assurance report about Clinical Care and Professional Governance (CCPG), this section merely presents a short summary of information from the assurance report.

6.2 The CCPG annual assurance report was presented to the IJB on 21 June 2023 about the 2022/23 activity. Link to report (https://www.angus.gov.uk/sites/default/files/2023-06/Report%20IJB%2038_23%20CCPG%20Annual%20Report.pdf)

6.3 The group met on twelve occasions during the period from 01 April 2022 to 31 March 2023 on the undernoted dates: -

CCPG Assurance Meetings

- 25 April 2022
- 13 June 2022
- 22 August 2022
- 24 October 2022
- 12 December 2022
- 6 February 2023

CCPG Risk Management Meetings

- 23 May 2022
- 18 July 2022
- 26 September 2022
- 14 November 2022
- 23 January 2023
- 27 March 2023

6.4 The role of the AHSCP CCPG Group is to provide assurance to the Angus Integration Joint Board (IJB), NHS Tayside Board (through the Care Governance Committee) and Angus Council, that there are effective and embedded systems for Clinical, Care and Professional Governance in all services within AHSCP.

6.5 All services provide ongoing assurance to the CCPG Group that there are robust processes in place for all six domains, and that there are ongoing efforts to further improve. This assurance includes both qualitative and quantitative information which is reported to the group on a regular basis throughout the year.

Resources

7.1 The IJB routinely considers reports on the Strategic Financial Plan, this section merely presents a short summary of some that information to best value.

7.2 A separate finance report was presented to the IJB on 21 June 2023 about the 2022/23 end of year financial position https://www.angus.gov.uk/sites/default/files/2023-06/Report%20IJB%2034_23%20Finance%20Report%202022_23.pdf

Best Value

7.2 The IJB has a duty of Best Value, by making arrangements to secure continuous improvements in performance, while maintaining an appropriate balance between quality and cost. In making those arrangements and securing that balance, the IJB has a duty to have regard to economy, efficiency, effectiveness, equal opportunities requirements and to contribute to the achievement of sustainable development.

7.3 Since late summer 2022 business as usual has resumed post COVID-19 with IJB continuing to progress service reviews and continuous improvement such as implementing the Primary Care Improvement Plan, supporting changes in Mental Health and approving the Mental Health and Learning Disability Services Improvement plan, progressing with the Learning and Physical Disabilities Priority Improvements, Adult Protection Improvement Work, Medicine for the Elderly Inpatient Bed Model and Supported Accommodation Review. This has been described in regular reports to the IJB.

7.4 The scale of the changes under consideration within Angus IJB are reflective of the scale of transformation required to meet the range of pressures the IJB faces - from financial, including inflationary pressures, to demographic and workforce pressures. This level of change, as demonstrated through reports (including Finance reports and Performance reports) submitted to the IJB, means that the majority of the IJB's resources and services continue to be subject to some form of service review and continuous improvement. The IJB does believe it can demonstrate that it is, at all times, seeking to secure best value from the resources available as part of our overall strategy as captured in both our SCP and Strategic Financial Plans.

7.5 Beyond accessing the corporate systems of both Angus Council and NHS Tayside as required (e.g. Procurement), the IJB's own governance systems includes regular financial, performance and risk reporting that is intended to allow the IJB to make judgements regarding the effective use of resources.

7.6 In terms of core Procurement, all the IJB's Procurement activity is managed through either NHS Tayside or Angus Council, and all Procurement consequently complies with all Procurement guidance applicable within these organisations.

Conclusion

Overall, this Annual Performance Report demonstrates that the AHSCP has continued to make progress against the ambitions set out in its SCP 2019-22. Some indicators have been impacted by COVID-19, particularly those related to hospital admissions. There are areas that require further work to be progressed to improve performance and work towards achieving the target or trajectory, in particular personal care provision and prescribing.

This report recognises a number of issues requiring to be addressed and progressed further including :-

- Admissions following a Falls – work is being reviewed by the Urgent and Unscheduled care work across Angus with the focus on prevention and proactive care.
- Substance Use – reducing the harm associated with substance use by offering support to individuals affected and offering support to engage with services.
- Supporting Care Needs at Home (Personal Care) – work is ongoing to review the impact of demographic change in services for older people and mitigate against continued growth.
- Unscheduled Care Programme – work is ongoing to improve the journey for people who have a physical and/or mental health need that does not require emergency care but cannot wait until a pre-planned care appointment

This work will be carried forward into the new SCP for 2023-26. This SCP will include a Strategic Delivery Plan detailing new/updated ambitions and revised indicators. These indicators will be reviewed, and target/trajectories set to ensure we can delivery on the new SCP.