ANGUS HEALTH AND SOCIAL CARE PARTNERSHIP

ANNUAL PERFORMANCE REPORT

April 2021 to March 2022

Angus Health and Social Care Partnership

Strategic Progress and Performance Report 2021/22

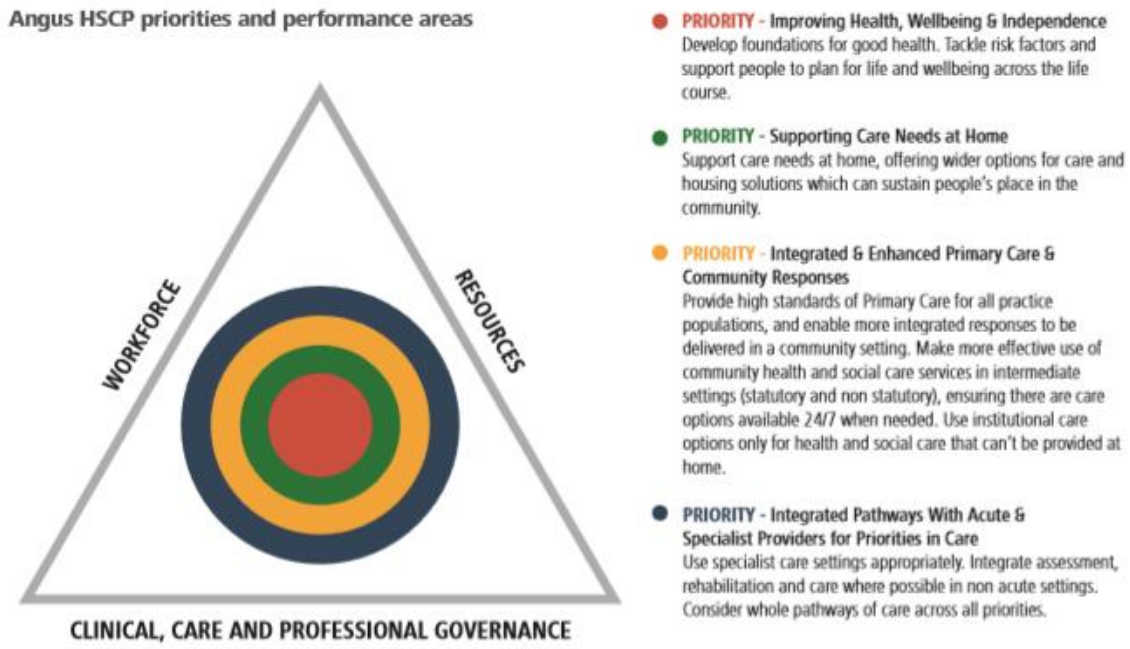
Introduction

The Angus Health and Social Care Partnership (AHSCP) set out the vision for change and improvement in its Strategic Commissioning Plan (SCP) 2019-22. The purpose of this Annual Performance Report (APR) is to show progress against the four priorities set out in the AHSCP Strategic Commissioning Plan and three further performance areas. The four priorities of our SCP aim to deliver the nine national health and wellbeing outcomes. Our performance in relation to the national outcomes will be 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 the report, performance is shown by locality, where possible. This allows locality improvement groups to focus on addressing variance in performance and continuous improvement.

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. The Partnership 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 their 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 a growing 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 care which helps to maintain their independence and the support of their own community.

Resource management is becoming more challenging because of increasing levels of demand. Year on year we face a growing 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 of efficiency, and the shift in the balance of care required.

Review of the Strategic Commissioning Plan

A review of the Strategic Plan is required by legislation, every three years. This does not necessarily mean there is a requirement to produce a new plan. In Angus, we have reviewed our strategic plan progress every year in our Annual Performance Report (APR).

The regulations governing the content of the APR require that we include any significant change to strategic direction that affects the strategic plan. For the 2020/21 APR, SPG agreed that the significant change would be to extend the current strategic plan by 12 months to March 2023, in line with Scottish Government permissions. (The reason for this was the reduced progress with some aspects of the plan due to the COVID-19 pandemic). This recommendation also required approval by the IJB, and this was granted. Progressing the development of a new strategic plan requires a revision of the strategic needs assessment; work on this is already underway. Once it is completed, the SPG will have to consider and make recommendations on priority actions for the next strategic plan. It may be that some or all of the existing 4 priorities remain valid but that the work to deliver on them changes. It is anticipated that:

- Public consultation on the content of the future plan will start in the New Year. This is likely to take the form of a more "blue sky" thinking approach so we can assess public expectations and aspirations for future service shape.
- An analysis of Scottish Government and other public policies will have to be undertaken to address national influences over local service design. It should also be possible to include learning from other IJBs.
- We gain an understanding of public aspirations, needs assessment and national policy intention to allow SPG to judge where future strategic direction lies.
- The financial opportunities and limitations to deliver this strategic direction will assist in the formation of the draft plan as we can only commit to deliver what is possible within the resources available.
- A formal consultation on any proposals will have to manage public expectations within the resources available.
- At various points we will be required to consult with NHS Tayside, Angus Council and other HSCP's
- A final plan must be approved by the IJB before 31 March 2023.

Involvement and Engagement

Communication and engagement is recognised as a priority area for the effective delivery of the Partnership's strategic plan. Not only does Angus HSCP seek to meet its legal duty to consult and engage with its population, but we aspire to keep people at the heart of everything we do. Furthermore, an efficient communications function is viewed as a key part of the Partnership's Remobilisation Plan following the COVID-19 pandemic.

The Angus HSCP Communication and Engagement Plan was refreshed and approved in October 2020 (IJB Report 69/20). The objectives as defined in that plan are to:

- 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

In March 2021, Scottish Government and COSLA published updated community engagement and participation guidance Planning with People. The guidance is designed to support NHS Boards, Integration Joint Boards and Local Authorities to deliver their existing statutory duties for engagement and public involvement. In recognising the good work that is taking place, the guidance is designed to complement and strengthen organisations' existing engagement strategies.

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. Angus HSCP also works closely with Voluntary Action Angus and Healthcare Improvement Scotland-Community Engagement Team (HIS-CE).

It is important to note that like our recent engagement and communication activities have been heavily influenced by the COVID-19 pandemic. Despite significant challenges, throughout 2021/22 we have continued to listen, engage and involve people which have ensured that their insights and experiences have influenced service change.

Information that is provided is used in the further improvement of those services. Activities have included:

- The Communication and Engagement Group continues to meet every 8 weeks to monitor progress of the actions within the Communication and Engagement Plan.
- Integration Matters, the Partnership's quarterly newsletter, continues to showcase a range of services across the partnership.
- 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 Chief Officer also issues messages to the public via Facebook, Twitter and the Angus HSCP website. Angus HSCP also joined Instagram in May 2021.
- The Angus HSCP Facebook page continues to provide regular updates on a wide range of topics, especially in relation to COVID-19.
- It is important that we continue to encourage appropriate health promotion behaviour and we have supported over 30 regional and national information and awareness campaigns on our social media platforms.
- Angus HSCP Website moved to a new server in August 2021, continues to improve its content providing a space for documents, news, resources and collaboration to the public.
- We continue to send out feedback questionnaires twice a year to people supported by enablement and response services, residents of Angus HSCP care homes and supported accommodation. Service users of community meals and community alarm are invited to provide feedback once a year which inform improvements.
- The Angus HSCP intranet launched in July 2021, continues to improve its content providing and integrated space for Partnership documents, news, resources, and multi-agency collaboration. Further work is required to encourage more members of the workforce to access this resource.
- Communication Guidance. It is a requirement of the Equality Act 2010 that information is provided in an accessible format to suit the needs of all people who may be accessing information. Guidance has been produced containing communication hints and tips for Partnership staff to improve the accessibility of communications, including advice as to how to produce documents in different languages and alternative formats such as Braille, Easy Read, Audio (CD) and British Sign Language.
- 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.
- Angus HSCP is a member of the Tayside Mental Health and Wellbeing Communication and Engagement Subgroup with supports the Listen, Learn, Change 4 action plan for mental health services in Tayside in response to the 'Trust and Respect' independent inquiry report. This includes and evaluation of:-
    - Enhanced Community Support for Community Mental Health Services in the North East Locality. The aim is to ensure that the person is directed to the most appropriate support quickly and efficiently. The feedback thus far has been extremely positive and is improving the patient pathway and joint working across services with all agencies working together to promote recovery, treatment and support opportunities.
    - Seven Day Working. The extended Community Mental Health Team commenced working 7 days on the 17th April 2021 within the North localities. Feedback indicates that this service is beneficial in supporting people to remain in their community, reducing admissions, and enabling earlier discharge from hospital. This has been further rolled out to the South localities from the end of September 2021.
- Care Opinion. Angus HSCP is committed to hearing people's and families' experiences and using that to improve. Care Opinion is 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. NHS Tayside have a licence to use and promote Care Opinion however any health or social care activity delegated to a Health and Social Care Partnership (HSCP) is not covered by the NHS Tayside licence.

- Angus HSCP has trialled Care Opinion for 12 months, utilizing NHS Tayside's licence. Work to promote Care Opinion in Angus commenced in April 2021. The areas (limited to health services in the first instance) included in the test if change are:
    - Community Hospitals
    - Community Physiotherapy
    - District Nursing
    - Minor Injury and Illness Units (MIIU).
- Up October 2021, AHSCP received 34 stories. The majority of responses are in relation to MIIU.

Planned Engagement Activity for 2022/23

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

- Angus HSCP is working with Police Scotland and colleagues from across Tayside to plan the Tayside launch of the Herbert Protocol. This is an information gathering tool to assist the police to find a person living with dementia, who has been reported missing, as quickly as possible.
- Explore the opportunity to create Angus HSCP User Voice Network to augment the voice of service users within all engagement activities. This would also complement the Angus Carer Voice Network.
- Engagement with unpaid carers about their experiences of using adult carer support plans.
- We will continue to progress engagement work to support the Living Life Well Mental Health and Wellbeing Implementation Plan for Angus. The Tayside Living Life Well strategy is a life course model and is a whole system approach to meeting the mental health and physical health needs of people with a mental health disorder. The Living Life Well strategy aims to improve the pathway for mental health and wellbeing both in Angus and across Tayside. Improvements are being developed through Tayside Listen Learn Change working groups and through local mental health and wellbeing networks. For example, in 2022 we will commence a review of the Angus 7-day Adult Community Mental Health Service which will include engagement with staff and users of the service.
- The main focus on communication and engagement in 2022/23 will be related to the refreshed Strategic Commissioning Plan and activities undertaken to implement the Plan.
- A refreshed Communication and Engagement Plan will be developed in 2023.

ANGUS PERFORMANCE SUMMARY

What we have achieved in 2021/22

- In December 2021, the teams who support the new Mental Health Hub based in the Links Health Centre in Montrose won the Community Mental Health Nursing category of the Mental Health Nursing Forum Scotland Awards. They were also joint winners of the Overall Winners Award.
- The Carers Emergency Card system has been extended to provide an additional card for the cared for person, so that if anything unforeseen happens to them when the carer isn't present, they can be contacted.
- Kirrie Connections have been commissioned to extend their Meeting Centre model to other Angus localities. The centres provide evidence-based support which includes a safe place where both people with dementia and their family carers can adjust to living with dementia, access creative and stimulating activities and get effective advice and peer support.
- A successful Enhanced Community Support (ECS) test of change in 4 medical practices in Angus, bringing together primary care, statutory and 3rd sector mental health and wellbeing and substance services, including psychological therapy with one referral route and no rejected referral.
- The second series of End of Life Skills for Everyone, a course designed to enable people to be more comfortable and confident supporting family and community members with issues they face during dying, death and bereavement was delivered in February 2022.
- The AHSCP has been complimented on the key supplier process – the process of applications to payment by providers. A range of support has been put in place to support care at home providers to support recruitment, retention and support rotas.
- The Learning and Physical Disability Improvement Plans have continued to progress, recognising the expansion of those services and changing governmental drivers. The Adult resource centres for people with a learning disability adapted to provide outreach support to individuals at home and in their communities, when national restrictions were in place. Video technology supported a large variety of group activities and helped to maintain connections amongst peers. Activity packs were created and delivered to individuals. Some of these adaptations have been retained due to being effective and successful for some families, although full face-to-face service has now resumed. The services were also successful in achieving the National Autism Certificate of Accreditation.
- Mental health services have developed an Angus Living Life Well (LLW) Improvement Plan which is aligned to the Tayside Living Life Well priority areas. The Plan supports the ambition within the Angus Strategic Commissioning Plan of "shifting the balance of care to support more people in our communities and support people to greater independence for longer". It supports all four of the strategic priorities within the Angus Health and Social Care Partnership Strategic Commissioning Plan, specifically promoting wellbeing approaches and improving integrated pathways.
- Development of a Dundee & Angus Stroke Pathway to deliver effective, high quality, specialist care within a community setting.

- Following the development of a draft governance framework for undertaking healthcare tasks in community settings, engagement with staff, staff side and Trade Unions is underway to inform a final framework.
- Penumbra - Penumbra Peer Service has expanded to all GP Practices in South Angus, providing mental health and wellbeing support to all patients aged 16 years and over. Peer Workers use their own lived experience and insight of mental health challenges to support others. This service operates with an open referral system with self-referrals encouraged.
- AHSCP now has Enhanced Community Support (ECS) model embedded throughout all four localities which is reflected in the performance of the above outcome measures.
- Independent Sector Lead for Angus has been working alongside partnership 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.
- A test of change with clinical staff being involved in the 6-week care home reviews. Clinical aspects of a resident's care addressed timely and an ACP and polypharmacy review completed.
- The Tayside Continence Advisory and Treatment Service (CATS) re-designed clinic builds across Tayside during COVID 19 Pandemic & re-mobilisation process & have now allowed for a designated education day to be planned into that build to ensure we were able to plan, deliver and evaluate bladder and bowel health promotion teaching dates.
- Telecare Charging Strategy – redefined to ensure equity in charging and allow opt in/out test of equipment with an aim to increase uptake of telecare supporting people to be independent for longer
- 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).
- 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
- 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.
- Continued to remobilise following COVID-19 pandemic

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

	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	2019/20		2021/22		RAG Status
			Angus	Scotland	Angus	Scotland	
Data Indicators	NI-11	Premature mortality rate per 100,000 persons	371	457	419	466	G
	NI-12	Emergency admission rate (per 100,000 population)	9,724	11,111	10,833	11,618	G
	NI-13	Emergency bed day rate (per 100,000 population)	83,263	102,961	92,888	112,720	G
	NI-14	Readmission to hospital within 28 days (per 1,000 population)	120	115	114	107	A
	NI-15	Proportion of last 6 months of life spent at home or in a community setting	92.9%	90.0%	92.9%	89.8%	G
	NI-16	Falls rate per 1,000 population aged 65+	23.4	21.7	23.7	22.6	A
	NI-17	Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections	83.5%	82.5%	75.7%	75.8%	A
	NI-18	Percentage of adults with intensive care needs receiving care at home	58.0%	62.9%	60.8%	64.9%	G
	Ni-19	Number of days people aged 75+ spend in hospital when they are ready to be discharged (per 1,000 population)	242	488	221	748	G
	NI-20	Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency	19.9%	21.2%	22.9%	24.0%	G

	Indicator	Title	2020/21		2021/22		RAG Status
			Angus	Scotland	Angus	Scotland	
Local Indicators	LI-24	Personal care hours rate per 1,000 18+	6,246		6,963		-
	LI-25	Care home nights rate per 1,000 65+	9,630		8,853		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 Angus HSCP 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 however Angus has been less successful in relation to prevention of admission. The 2020/21 figures are affected by the response to the COVID-19 pandemic and may not be a true reflection of the trend.

Ministerial Steering Group (MSG) Indicators	Indicator	Title	Reporting Period		
			2019/20	2020/21	2021/22
	1a	Number of emergency admissions 18+	10,186	8,546	11,480
	2a	Number of unscheduled hospital bed days; acute specialties 18+	65,907	55,490	65,005
	2b	Number of unscheduled hospital bed days; mental health specialties 18+	27,751	24,551	27,200
	3a	A&E attendances 18+	24,428	14,159	22,483
	4	Delayed discharge bed days (all reasons)	5,731	5,409	6,595
	5a	Percentage of last six months of life spent in the community (all ages)	91.8%	92.9%	92.9%
	5b	Number of days during last six months of life spent in the community (all ages)	218,840	246,642	242,634
	6	Balance of care: Percentage of population 65+ living at home (supported and unsupported)	93.1%	92.8%	92.9%

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: Improving Health, Wellbeing and Independence

The aim of the Angus Health and Social Care Partnership's Strategic Commissioning Plan 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. Angus HSCP'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 2021/22

- 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
- The Carers Emergency Card system has been extended to provide an additional card for the cared for person, so that if anything unforeseen happens to them when the carer isn't present, they can be contacted.
- Relaunch of Independent Living Angus (ILA) commenced in February 2022 with the aim to encourage more people to access the site and promote use of the self-assessment tools.
- Extension of mental health and wellbeing peer support service to young people over the age of 11 years old who attend secondary school.

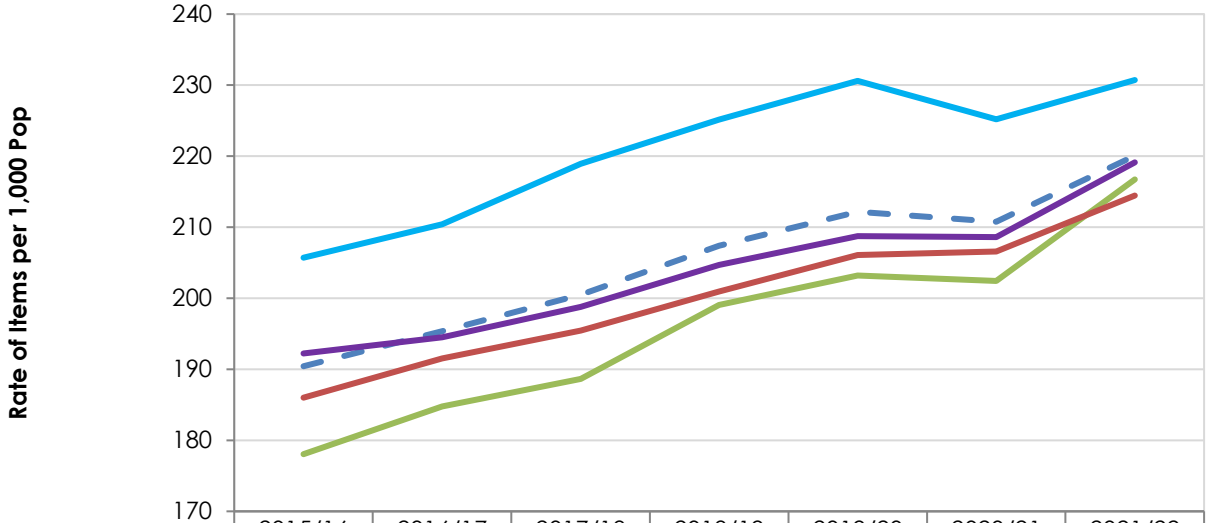
1.2 Making a Difference

1.2.1 We have identified 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 Wellbeing

1.2.2 The Strategic Commissioning Plan 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



	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
Angus	190	195	201	207	212	211	220
North East	178	185	189	199	203	202	217
North West	186	192	195	201	206	207	214
South East	206	210	219	225	231	225	231
South West	192	194	199	205	209	209	219

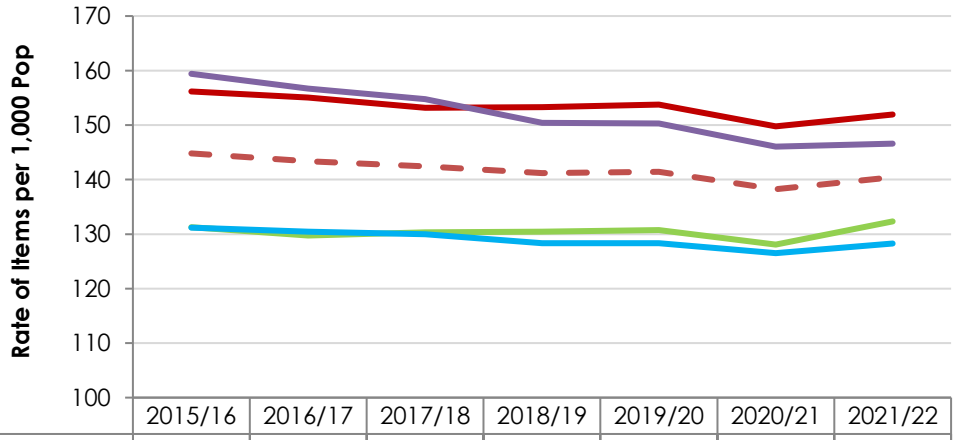
Source: PIS Dataset

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.

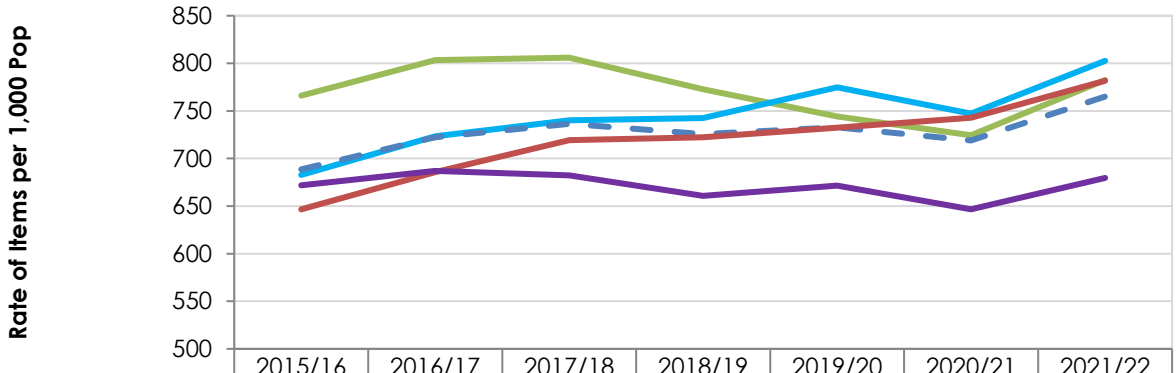
Graph 2 - Number of People Prescribed Items for Hypertension in Angus as a Crude Rate per 100,000 Population



	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
Angus	145	143	142	141	141	138	140
North East	131	130	130	130	131	128	132
North West	156	155	153	153	154	150	152
South East	131	130	130	128	128	127	128
South West	159	157	155	150	150	146	147

Source: PIS Dataset

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



	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
North East	766	803	806	773	744	724	783
South East	683	723	740	743	775	747	803
Angus	689	722	737	726	733	719	765
North West	647	686	719	722	732	743	782
South West	672	687	682	661	671	647	679

Source: PIS Dataset

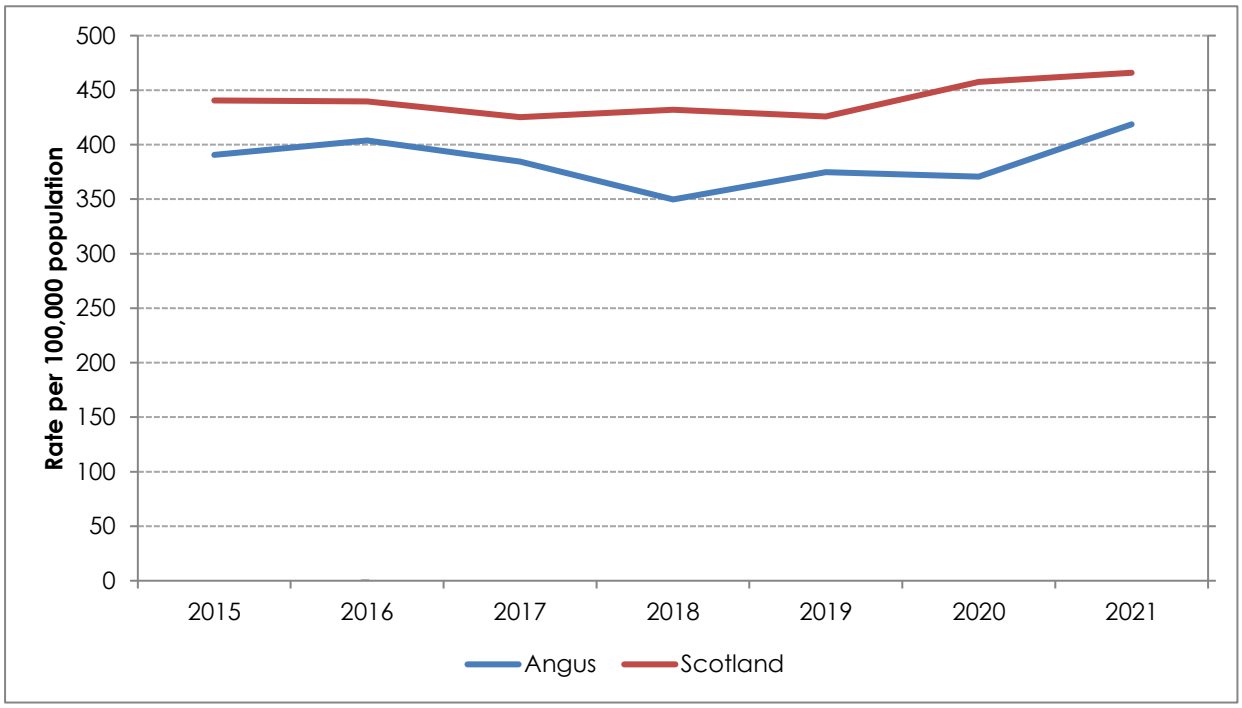
1.2.5 The rate of hypertension in Angus has been on the decrease, the decline is small but seen a slight increase in 2021/22. However, the rate of Type 2 diabetes is increasing in Angus. The increases are small but indicate a need to identify new options for supporting healthy weight in the population.

1.2.6 Developing prevention and early intervention services is a key strategic objective for AHSCP to ensure improved service provision and promoting of good self-care. AHSCP has entered into a partnership with Angus Council and Angus Alive to support the Angus populations health needs and wellbeing for all.

Premature mortality

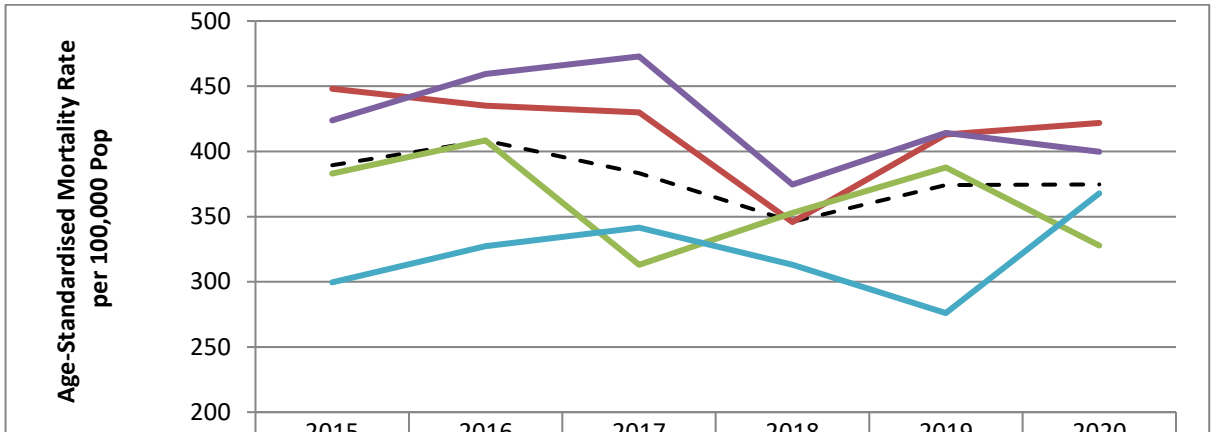
1.2.7 Premature mortality will vary from year to year, but our aim is to see a downward trend. Angus compares well to the Scottish average however there has been an increase in premature mortality in 2021. Understanding data from 2020 and 2021 is challenging due to the impact of COVID-19.

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



Source: Public Health Scotland

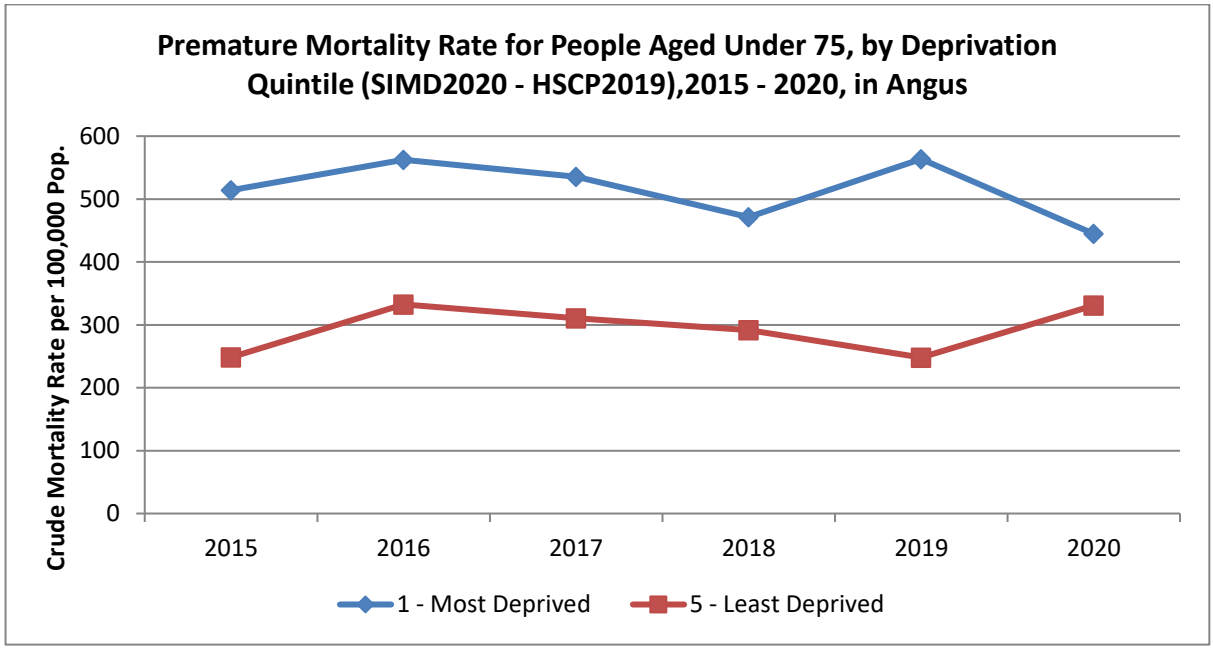
Graph 5: Management Information at Locality Level: Premature Mortality Rate for People aged Under 75 per 100,000 Population (NI 11)



	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)

Deaths relating to COVID-19

1.2.8 At 31 March 2022 there had been 1,806,056 confirmed cases of COVID-19 in Scotland; 127,648 of which were in Tayside and 33,830 of which were in Angus. There were 218 deaths of Angus residents where COVID-19 was mentioned on the death certificate. (https://www.nrscotland.gov.uk/covid19stats).

The Third Sector and Volunteering

1.2.9 Angus continues to have high levels of volunteering. Voluntary Action Angus (VAA) are supporting the development of voluntary organisations and volunteering across Angus. VAA has secured and distributed over £1.5million to a number of different Third Sector and especially grass root voluntary organisations. They have carried this role out so successfully that funders such as Lottery, Scottish Government and their local statutory partners are really keen on this becoming one of VAA's main roles. This is having a really positive impact on VAA and their work within the Angus HSCP.

1.2.10 Some of VAA's achievements this year are noted below:

- Kirrie Friday Nite Project – 390 Attendees since March 2022
- Locality Workers – 292 Local Events Attended
- Telephone Befriending Coordinator – 167 Volunteers supporting 245 Befriendees
- 3,248 Individuals Referred to Social Prescribers across Angus

1.2.11 The Social Prescribing Team have experienced significant growth since they've been established in September 2020. The number of referrals across Angus in 2020 were 270, taking into consideration this being a new service and the pandemic which had a huge impact on how this service was running. 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 cluster have been accessed within the time frame.

1.2.12 One of the main benefits of Social Prescribing within Voluntary Action Angus is the links they have as a Third Sector Interface and also with the locality workers. This allows the social prescribers an opportunity to have real time information of what's available in the local area for individuals to be referred onto. The data shows that most social prescribers have been able to refer onto either community groups or other Third Sector organisations which is a huge benefit to all involved. Although there are still some limitations to how they see referees at the moment it is comforting to know that the average initial appointments are still lasting up to 60 minutes which is allowing the social prescribers to get a full image of what the individual is dealing with at the time.

Carers

1.2.13 AHSCP has continued to progress implementation of its 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. Key achievements include an audit of the local adult carer support plan; the involvement of carers in co-producing and co-presenting training for newly qualified social workers; and the provision of training sessions on mental health awareness and suicide prevention for staff, volunteers and unpaid carers at Angus Carers Centre.

1.2.14 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. In line with statutory guidance, it has been agreed that if a practitioner assesses (in consultation with the carer and cared-for person) that this review process is proportionate to the situation, it can continue. 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. Much of care management contact with carers has continued to be via telephone and email to minimise risk and to support those who are shielding. Adult Services practitioners completed **274 adult carer support plans in 2021/ 22, a significant increase on the 174 plans during 2020/ 21**. In total **1,153** adult carers have been assessed by Adult Services and **1,015** of them have been awarded a personal budget.

1.2.15 Grant funding for third sector organisations supporting adult and young carers in Angus predates the 2016 Act. The funding of key partner Angus Carers Centre (ACC), Dundee Carers Centre (independent support for carers using SDS Option 1) and Support in Mind (support for carers of people with mental health issues) continued during 2021/ 22. 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.

1.2.16 ACC provide a range of information and independent advice to meet statutory duties in this area. They also provide emotional and practical support, access to short breaks, access to counselling services and peer connection opportunities including befriending and volunteering. The charity works in close partnership with the AHSCP ensuring effective routes of supports are developed and maintained to help unpaid carers sustain their caring role where they wish to and create opportunities to have a fulfilling life outside of caring.

1.2.17 In 2021/ 22, ACC supported **1, 331 adult carers** through individual and collective services. This was predominantly over the phone or online, with the team of staff and volunteers working from home and finding creative ways of supporting unpaid carers and their families, including a telephone befriending service. The charity also continued to disseminate personal protective equipment (PPE) to unpaid carers in Angus and identified if people required additional support. Although the number of unpaid carers supported was down on the previous year, the number of **referrals rose by 33% to 517**. ACC has seen significant changes this year including the departure of it's Chief Executive Officer and several staff members. This had some impact on service delivery, including a reduction in the capacity to deliver the same level of services.

1.2.18 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 2021/ 22.

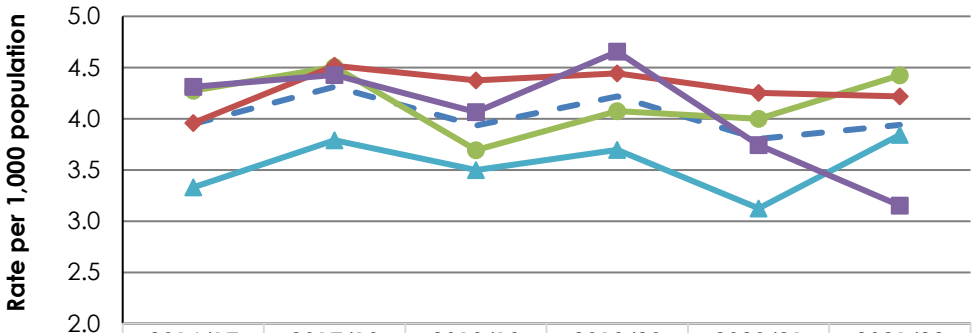
1.2.19 ACC's Young Carers Service has continued to provide support to young carers during 2021/ 22 and adapted services to ensure this was maintained during the pandemic in line with government guidance. Over the 12 month period **154 young carers** (aged 8 to 18) were supported, a slight increase on 151 in 2020/ 2. Schools lead in the identification of young carers and completion of Young Carer Statements. A Triangle Trust funded Education Development Worker was appointed within ACC in January 2022 to strengthen links between schools and Angus Young Carers Service and support carer awareness raising and early identification.

1.2.20 Across primary and secondary schools in Angus at the end of March 2022, there were 83 young carers 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. An audit of the Young Carer Statement is underway to identify and address the barriers to identification and provision of support to this important group. The offer of support remains open for all carers under 18 years, or over 18 if still at school.

1.2.21 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. A short life working group focusing on young carers in transition was established in October 2021 to identify gaps and emerging issues and propose actions and improvements as required.

1.2.22 The Angus Carers Centre is our main strategic partner in delivering the Angus Carers Strategy and in particular supporting carers requiring relatively low-level/preventative support.

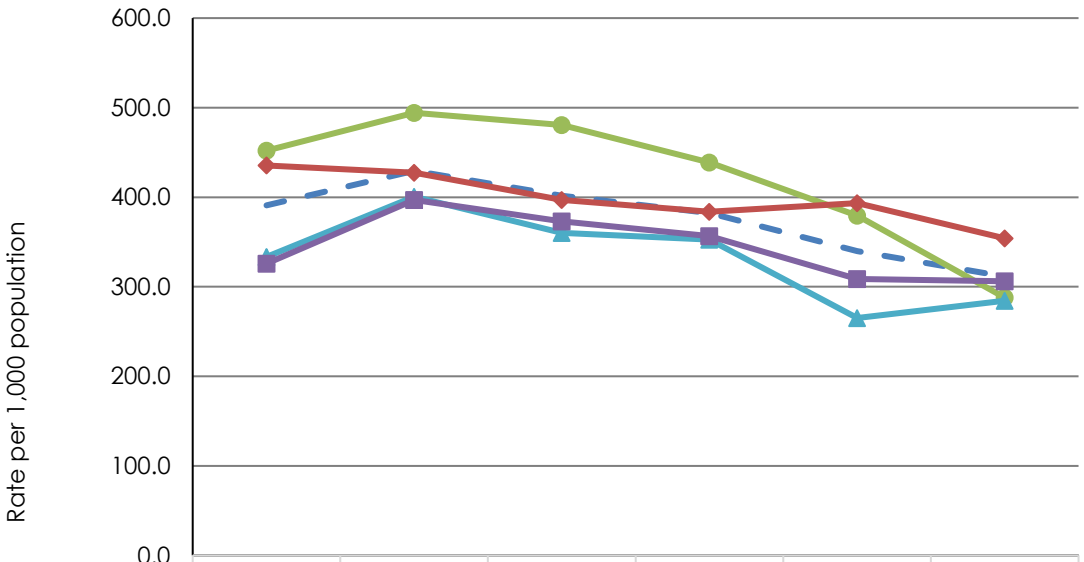
Graph 7 - Management Information at Locality Level: Rate of people using short breaks



	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
Angus	3.9	4.3	3.9	4.2	3.8	3.9
North East	4.3	4.5	3.7	4.1	4.0	4.4
North West	4.0	4.5	4.4	4.4	4.3	4.2
South East	3.3	3.8	3.5	3.7	3.1	3.8
South West	4.3	4.4	4.1	4.7	3.7	3.2

Data Source: CareFirst (Angus Council)

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

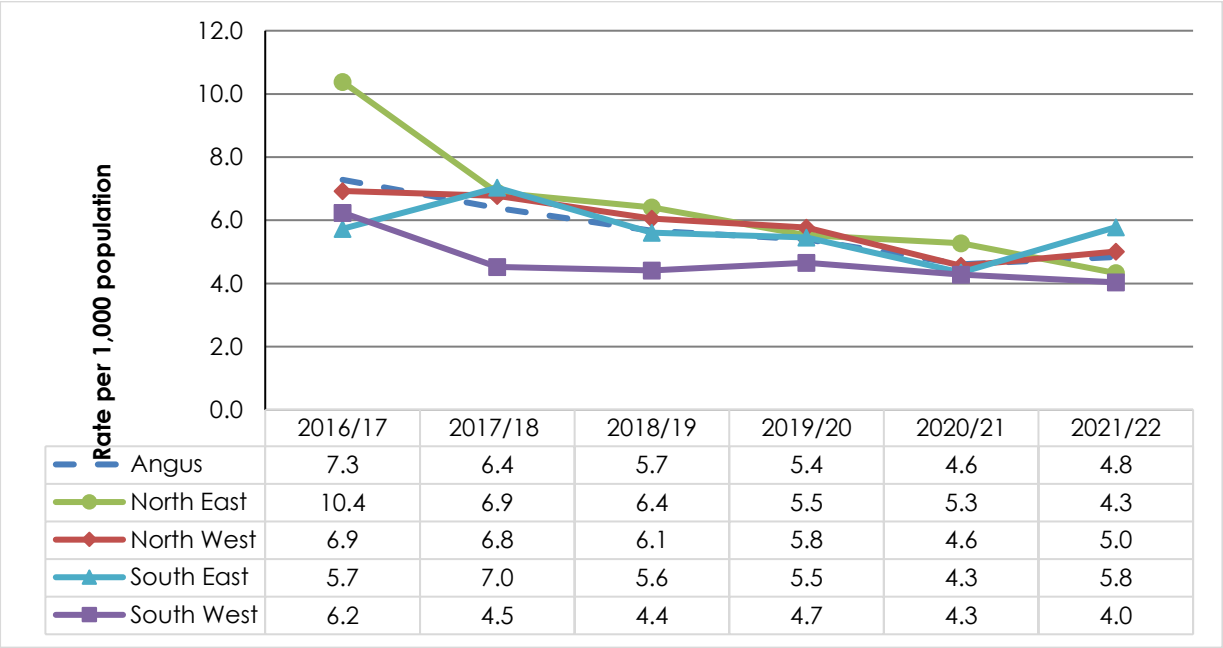


	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
Angus	390.8	429.4	401.7	382.4	339.8	311.4
North East	452.1	494.3	480.7	438.7	379.5	287.9
North West	435.4	427.3	397.1	383.6	393.5	354.1
South East	333.4	400.5	360.3	352.5	265.1	284.4
South West	325.7	396.9	373.1	356.4	308.5	306.1

Data Source: CareFirst (Angus Council)

1.2.23 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.

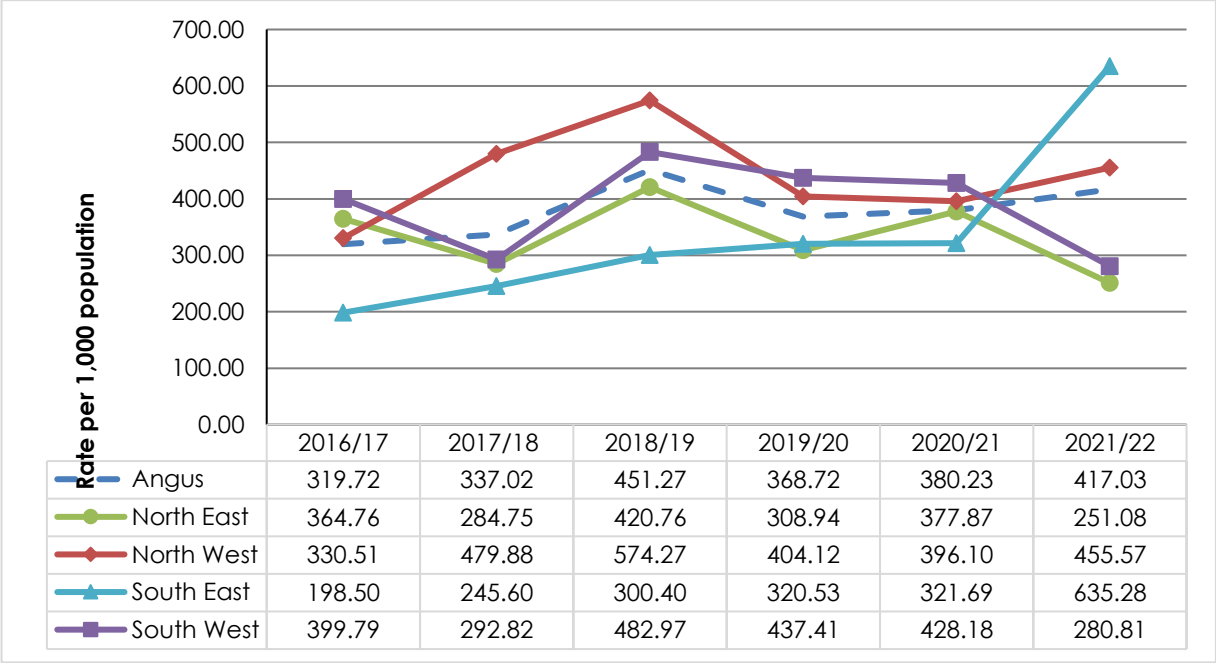
Graph 9 - Management Information at Locality Level: Rate of people using short breaks (nights)



	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
Angus	7.3	6.4	5.7	5.4	4.6	4.8
North East	10.4	6.9	6.4	5.5	5.3	4.3
North West	6.9	6.8	6.1	5.8	4.6	5.0
South East	5.7	7.0	5.6	5.5	4.3	5.8
South West	6.2	4.5	4.4	4.7	4.3	4.0

Data Source: CareFirst (Angus Council)

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



	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
Angus	319.72	337.02	451.27	368.72	380.23	417.03
North East	364.76	284.75	420.76	308.94	377.87	251.08
North West	330.51	479.88	574.27	404.12	396.10	455.57
South East	198.50	245.60	300.40	320.53	321.69	635.28
South West	399.79	292.82	482.97	437.41	428.18	280.81

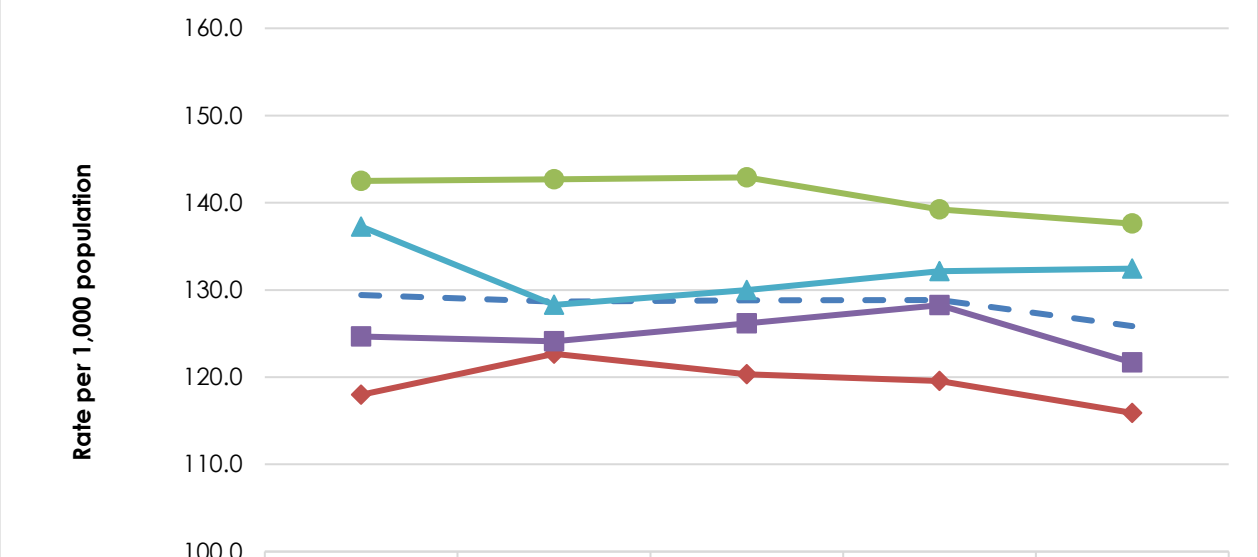
Data Source: CareFirst (Angus Council)

1.2.24 457 carers used a total of 39,368 respite nights in 2021/22. Since 2015/16 there has been a reduction in the number of carers receiving night time respite by 32% but an increase in nights by 43%. 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

1.2.25 Although there are fluctuations in the use of community alarms, uptake has grown since 2015/16 by 14.5% (graph 11 below). 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



	2017/18	2018/19	2019/20	2020/21	2021/22
Angus	129.4	128.7	128.8	128.8	125.9
North East	142.5	142.7	142.9	139.3	137.6
North West	118.0	122.7	120.3	119.6	115.9
South East	137.3	128.3	130.0	132.1	132.4
South West	124.7	124.1	126.2	128.3	121.7

Data Source: CareFirst (Angus Council)

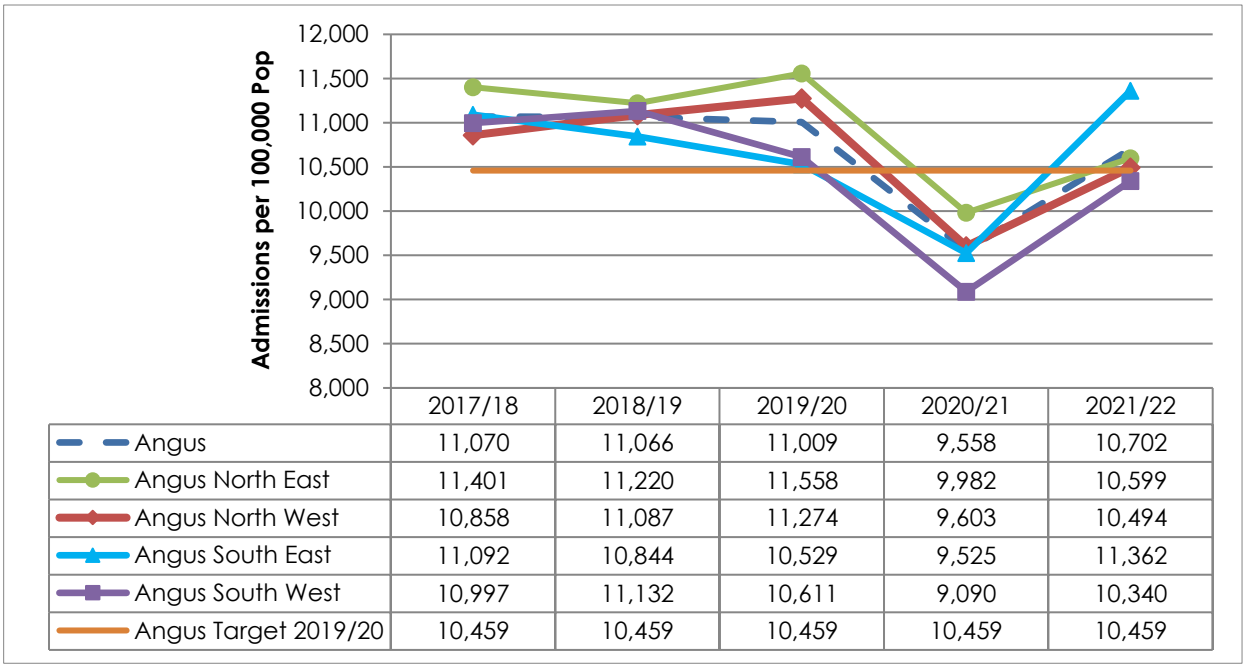
Enablement

1.2.26 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 10,300 hours of personal care per week to c10,800; 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

1.2.27 In 2020/21Angus seen a 12% reduction in the rate of attendance at A&E (including MIIU) compared to 2019/20. COVID-19 was also a contributor to the reduction of emergency admissions as more people were at home due to national lockdowns.

Graph 12: Angus HSCP relative performance to Scotland. Rate of emergency admissions per 100,000 population for people aged 18+



	2017/18	2018/19	2019/20	2020/21	2021/22
Angus	11,070	11,066	11,009	9,558	10,702
Angus North East	11,401	11,220	11,558	9,982	10,599
Angus North West	10,858	11,087	11,274	9,603	10,494
Angus South East	11,092	10,844	10,529	9,525	11,362
Angus South West	10,997	11,132	10,611	9,090	10,340
Angus Target 2019/20	10,459	10,459	10,459	10,459	10,459

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

1.2.29 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.

1.2.30 The stated aim of Angus HSCP 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

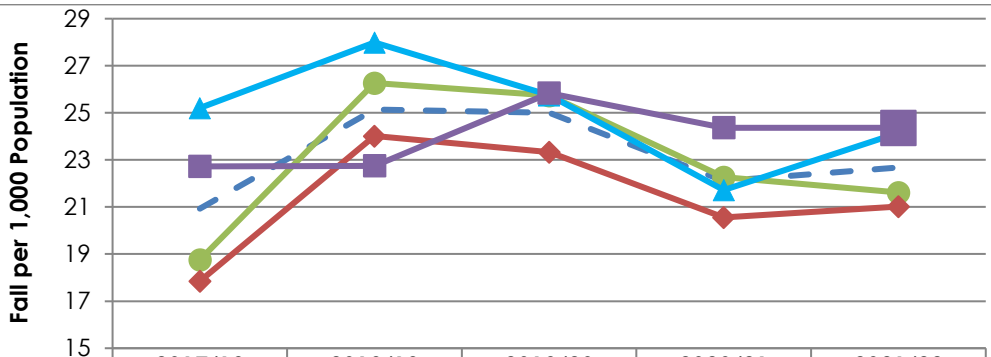
1.2.31 There were 636 admissions following a fall for people aged over 65 in Angus in 2021/22.

1.2.32 There has been a continued reduction in the number of people aged over 65 admitted to hospital following a fall and a reduction in referrals to the falls pathway. It is assumed this, in part, can be attributed to elderly people remaining indoors during winter period and shielding as a result of the COVID-19 pandemic. Parallel to this there has been:

- an increase in home safety advice by ERT, Fire & Rescue and care providers,
- better balance classes were reintroduced, and
- ERT are using the LifeCurve so providing exercise advice to improve mobility from independent living Angus

Admissions due to a fall represented 7% of all unplanned admissions.

Graph 13: Angus HSCP relative performance to Scotland. Rate of fall admissions per 1,000 population for people aged 65+ (NI 16)



	2017/18	2018/19	2019/20	2020/21	2021/22
Angus	20.9	25.1	25.0	22.1	22.7
Angus - North East	18.8	26.3	25.7	22.3	21.6
Angus - North West	17.8	24.0	23.3	20.6	21.0
Angus - South East	25.2	28.0	25.7	21.7	24.1
Angus - South West	22.7	22.7	25.8	24.4	24.4

Source: Public Health Scotland

1.2.33 During 2021/22 the rate of admissions following a fall for people aged over 65 in Angus was 22.7 per 1,000 population (graph 13). This is a 20% increase on the 2015/16 baseline 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.

1.2.34 The Angus population who are aged over 85 accounts for only 13% of the total population over 65 in Angus. In Angus however 48% of all admissions from a fall in older people relate to people aged over 85 years. This suggests that we need to have a greater focus on understanding the causes of falls and falls prevention in people aged over 85.

Priority: 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 Angus HSCP 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 2020/21

- The Tayside Continence Advisory and Treatment Service (CATS) re-designed clinic builds across Tayside during COVID 19 Pandemic & re-mobilisation process & have now allowed for a designated education day to be planned into that build to ensure we were able to plan, deliver and evaluate bladder and bowel health promotion teaching dates.
- Telecare Charging Strategy – redefined to ensure equity in charging and allow opt in/out test of equipment with an aim to increase uptake of telecare supporting people to be independent for longer
- 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).
- 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

2.2 Making a Difference

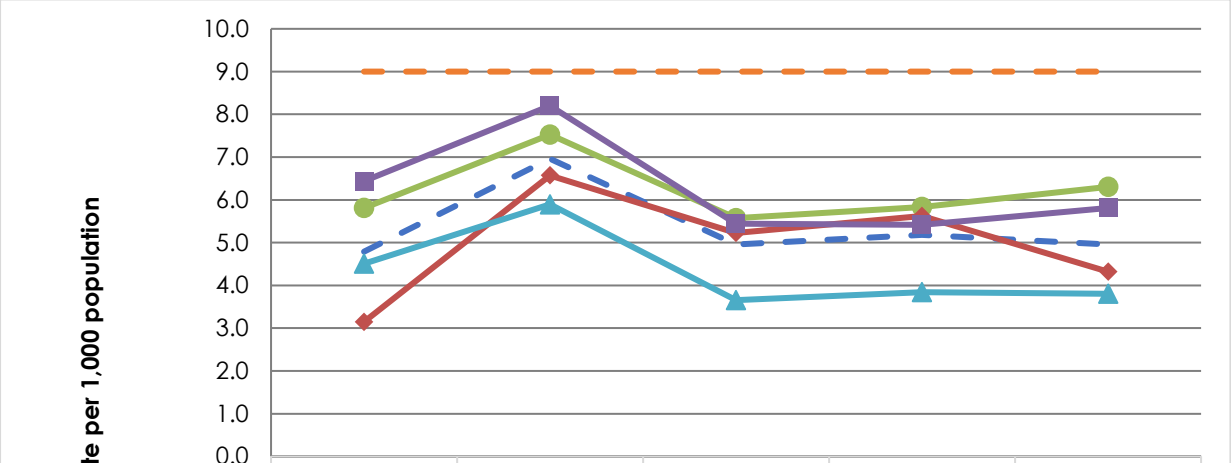
Technology Enabled Care

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 3,529 people used a community alarm during 2021/22, this is a 2% decrease on the previous year but still a 12% increase on 2015/16 baseline, the year prior to formation of the Integration Joint Board (IJB). Use of Telecare equipment offered in addition to community alarm has declined from a peak of 19% in 2018/19 to 13.3% of community alarm users in 2021/22 a 0.5% increase on 2019/20. Whilst it is recognised that people are moving to digital alternatives that they can source themselves, the decline in telecare

still follows the introduction of a charge of £1/week in addition to the charge for community alarm.

Graph 14 – Total number of people with Telecare Equipment as a rate per 1,000 population since 2016/17.



	2017/18	2018/19	2019/20	2020/21	2021/22
Angus	4.8	7.0	5.0	5.2	5.0
North East	5.8	7.5	5.6	5.8	6.3
North West	3.1	6.6	5.2	5.6	4.3
South East	4.5	5.9	3.7	3.8	3.8
South West	6.4	8.2	5.4	5.4	5.8
Target 2022	9	9	9	9	9

2.2.3 A test of change using 14 KOMP devices is currently taking place in Angus with results shared in Summer 2021. 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.

2.2.4 Florence (Flo) is a simple, text messaging, telehealth system that supports people with self-management of their long term health conditions. Flo communicates by text to and from patients' mobile phones. Flo has recently increased with new clinical areas testing protocols. For example the Angus Respiratory Team have developed a protocol to support people once they finished their usual Pulmonary Rehabilitation programme/classes. The Flo protocol itself provides reminder messages to help people maintain their self management behaviours

Alcohol and Drugs Services

2.2.5 There has been a reduction in performance against the measure for individuals accessing Alcohol and Drug services and treated within three weeks. With the combination of increase in alcohol referrals after lockdown, staffing issues within AIDARS and TCA (who provide support) due to COVID-19 over the reporting period, plus some team vacancies this impacted on the reduced performance.

2.2.6 Although the performance is lower, the numbers of new waits for brand new treatments are relatively small compared to other disciplines, in the latest quarter (2021/22 Q4) only 17 out of 108 waits missed the target. 10 were for alcohol treatment 5 for drug treatment and 2 for co-dependent clients.

Care Management

2.2.7 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	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
Option 1	8%	6%	7%	7%	7%	9%
Option 2	15%	22%	23%	25%	23%	23%
Option 3	73%	67%	65%	61%	64%	63%
Option 4	4%	5%	6%	7%	6%	5%

(Source: CareFirst, Angus Council)

2.2.8 3,815 people had a care plan in place (4% increase from 2020/21) which includes a self-directed support option. Until 2020, the number of people using option 3 had continued to decline whilst those choosing option 2 was increasing. However, from 2020 onwards, this trend has changed. Like last year, we have seen an increase in the number of people choosing option 3 from 60 to 63 percent and a slight decline in the number of people choosing option 2 from 24 to 23 percent. The proportion of people using option 4 (a

combination options) has also seen a slight decline from 7% to 5% and option 1 (direct payment) is broadly stable at 7 and 9 percent respectively.

2.2.9 The Care Management Improvement Programme is underpinned by the 6Rs for Improvement and Transformation in Health and Social Care. The Care Management Improvement work paused in 2020 due to the outbreak of Covid-19. A slightly revised Project Initiation Document was approved by the Improvement and Change Board in January 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

2.2.10 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. 488,497 hours of personal care were delivered to people aged over 65 in 2021/22, this was an increase of 13% on 2020/21. This has exceeded the target for 2021/22 by 8%. The approaches aimed at mitigation against growth are still required to deliver in 2022/23 in order for further growth to remain in target for the planning period ending in 2023.

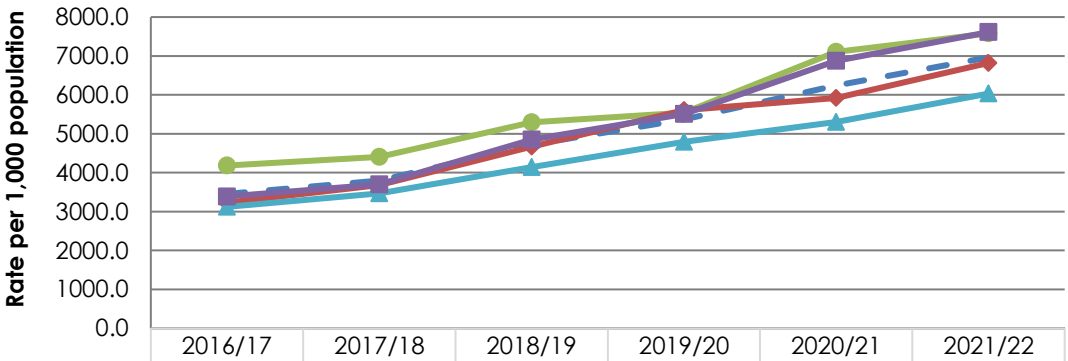
2.2.11 Overall, 657,331 hours of personal care were delivered in 2021/22 this was an increase of 12% in 2020/21 showing that most of the growth is attributable to older people services. 1854 people use personal care services in 2020/21. In addition, 341,649 hours of care and support (non-personal home care) were delivered in 2021/22. This was a reduction of 12% on 2020/21.

2.2.12 Independent providers of personal care have worked hard to address demand and it is possible that greater availability will continue to address a previously hidden demand. The increase in all personal care is largely driven by increased demand by people aged over 65. There is a shift towards the provision of personal care with people choosing to source more domestic support elsewhere. Personal care is provided free to everyone who needs it, domestic support is subject to a contribution policy.

2.2.13 Since the introduction of the Carers (Scotland) Act 2016 (the Act), and the implementation of new eligibility criteria for carers, both the number of carers being assessed, and the value of the support provided have increased. By 2019/20, there were 988 carers who had an assessment or adult support plan in place; 874 had either an adult care support plan or young carers statement in place. By 31 March 2022, 620 carers had been assessed as eligible for support and had a calculated budget. The purpose of the budget is in part to provide replacement care so that carers can achieve the outcomes agreed in their support plan. A proportion of the increase in care at home services will be associated with carers support plans and may be reducing the demand for emergency respite

The graphs below show the changes in personal care hours planned from 2016/17.

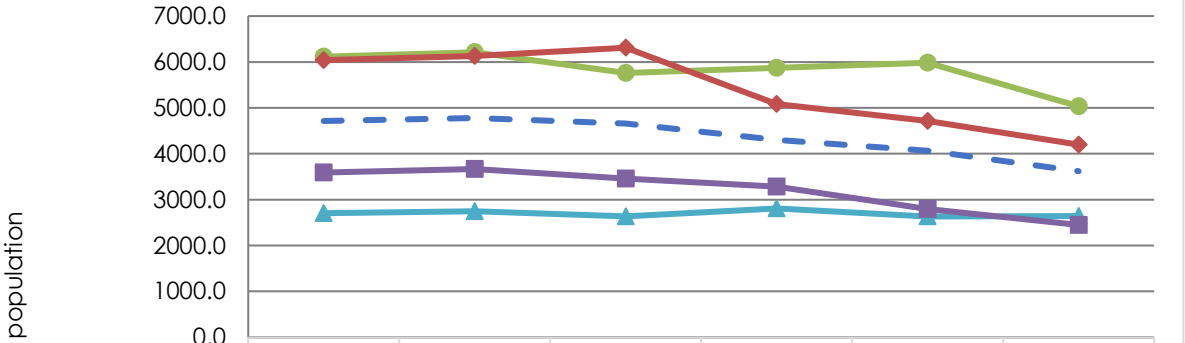
Graph 14: Management Information at Locality level: Rate of Personal Care Hours (LI 24)



	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
Angus	3454.1	3795.5	4715.9	5363.6	6237.8	6963.3
North East	4182.4	4401.1	5294.8	5539.7	7107.3	7578.3
North West	3228.9	3684.4	4668.6	5602.6	5922.4	6819.7
South East	3120.4	3468.5	4139.8	4791.0	5298.2	6031.8
South West	3386.0	3693.6	4849.6	5506.1	6876.5	7612.2

Source Care First (Angus Council)

Graph 15: Management Information at Locality level: Rate of Support and Care Hours



	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
Angus	4710.0	4777.6	4657.6	4303.7	4064.9	3619.2
North East	6117.7	6210.4	5761.9	5870.2	5985.2	5032.9
NorthWest	6042.0	6129.2	6310.0	5084.1	4713.0	4198.2
South East	2702.8	2746.0	2633.0	2807.0	2631.4	2642.5
South West	3590.3	3666.3	3456.2	3280.3	2796.8	2447.6

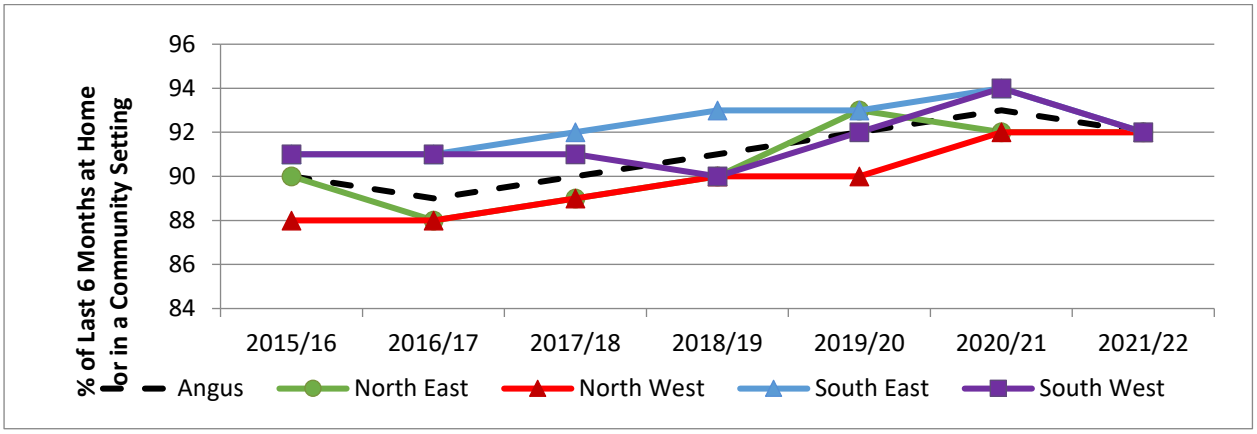
Source: Care First (Angus Council)

2.2.14 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 82.2 years in 2021/22. Improving peoples independence is an ambition set out in the HSCP Strategic Plan.

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 2020/21 in Angus was 93%. Angus performs better than the Scottish average, where 92% of the last 6 months of life is spent at home or in a homely setting in the community.

Graph 16: 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.

2.2.17 As part of the Palliative and End of Life improvement Plan, we have;

- Engaged with people who speak Polish as their first language to ascertain any unmet PEOLC needs, or support and information. (Priority – Supporting Care Needs a t Home)
- Launched a webpage for PEOLC information for the public on the AHSCP website (Support people to be as independent as possible)
- Gathered PEOLC feedback on Care Experience in Community Hospitals - Family Voices Diary & Health Improvement Scotland (HIS) Care Experience Improvement Model
- Started to gather care experience feedback on Family's perception of the care of their family member in the last days of life and the support they received.
- Delivered a Public Information Course on PEOLC
- Provided a range of PEOLC educational and development opportunities for the workforce

Priority: 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 What we have achieved in 2021/22

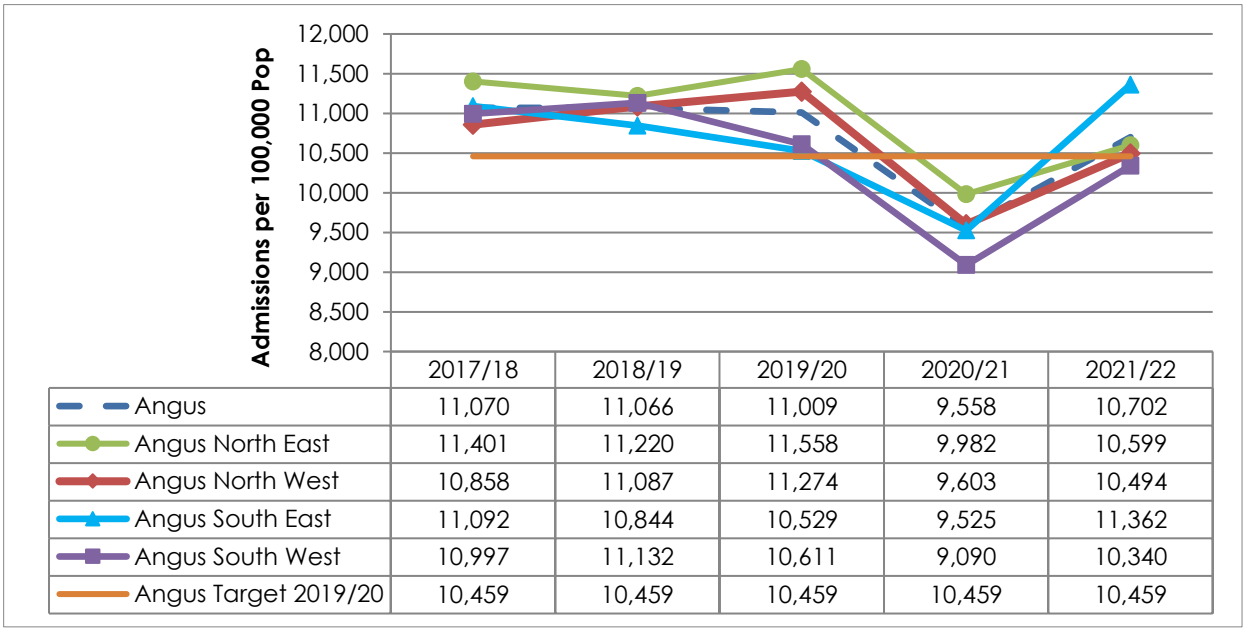
- Following the development of a draft governance framework for undertaking healthcare tasks in community settings, engagement with staff, staff side and Trade Unions is underway to inform a final framework.
- Penumbra - Penumbra Peer Service has expanded to all GP Practices in South Angus, providing mental health and wellbeing support to all patients aged 16 years and over. Peer Workers use their own lived experience and insight of mental health challenges to support others. This service operates with an open referral system with self-referrals encouraged.
- AHSCP now has Enhanced Community Support (ECS) model embedded throughout all four localities which is reflected in the performance of the above outcome measures.
- Independent Sector Lead for Angus has been working alongside partnership 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.
- A test of change with clinical staff being involved in the 6 week care home reviews. Clinical aspects of a resident's care addressed timely and an ACP and polypharmacy review completed.

3.2 Making a difference

Emergency admissions

3.2.1 In 2020/21Angus seen a 12% reduction in the rate of attendance at A&E (including MIIU) compared to 2019/20. COVID-19 was also a contributor to the reduction of emergency admissions as more people were at home due to national lockdowns.

Graph 17: Angus HSCP relative performance to Scotland. Rate of emergency admissions per 100,000 population for people aged 18+



	2017/18	2018/19	2019/20	2020/21	2021/22
Angus	11,070	11,066	11,009	9,558	10,702
Angus North East	11,401	11,220	11,558	9,982	10,599
Angus North West	10,858	11,087	11,274	9,603	10,494
Angus South East	11,092	10,844	10,529	9,525	11,362
Angus South West	10,997	11,132	10,611	9,090	10,340
Angus Target 2019/20	10,459	10,459	10,459	10,459	10,459

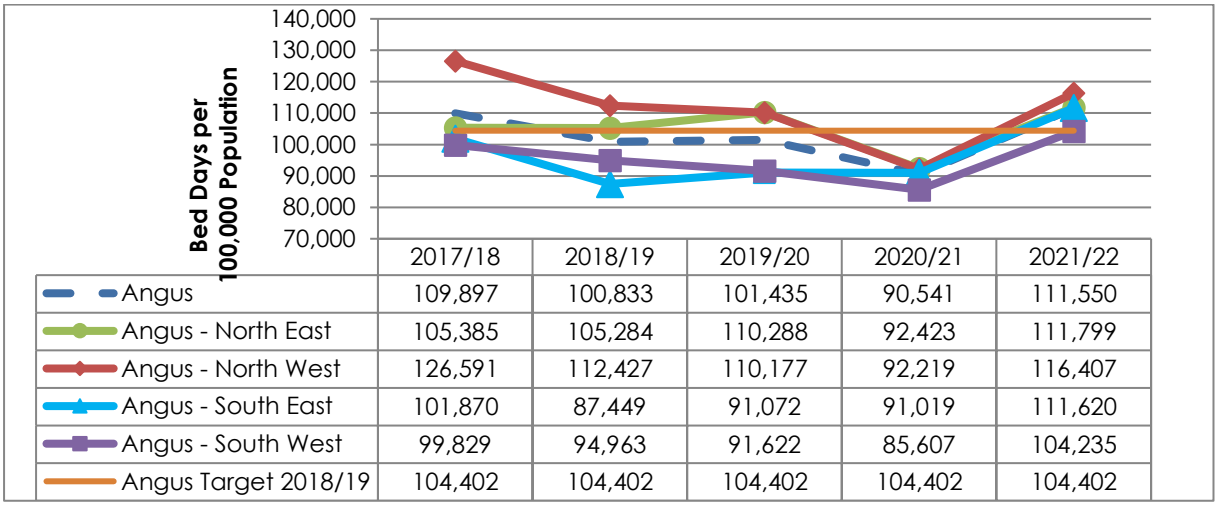
3.2.2 Emergency admission rates vary across Angus. The highest emergency admission rate was in South East and the lowest rate was in South West.

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 23% increase in bed days in 2021/22.

Graph 18 - Management Information at Locality Level: Rate of Emergency Bed Days for Adults (NI 13)



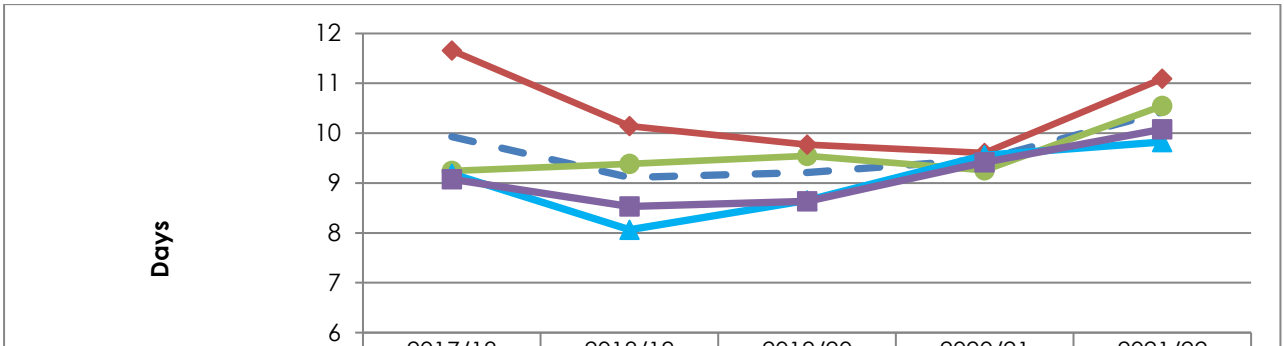
	2017/18	2018/19	2019/20	2020/21	2021/22
Angus	109,897	100,833	101,435	90,541	111,550
Angus - North East	105,385	105,284	110,288	92,423	111,799
Angus - North West	126,591	112,427	110,177	92,219	116,407
Angus - South East	101,870	87,449	91,072	91,019	111,620
Angus - South West	99,829	94,963	91,622	85,607	104,235
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 an increase to 10.4 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 2018/19. There continues to be some room for continued improvement in this area when we consider the variation in performance in our localities from 9.8 days to 11.1 days and the performance of other partnerships.

Graph 19: Management Information at Locality Level: Average Length of Stay for Emergency Admissions for Adults



	2017/18	2018/19	2019/20	2020/21	2021/22
Angus	9.9	9.1	9.2	9.5	10.4
Angus - North East	9.2	9.4	9.5	9.3	10.5
Angus - North West	11.7	10.1	9.8	9.6	11.1
Angus - South East	9.2	8.1	8.6	9.6	9.8
Angus - South West	9.1	8.5	8.6	9.4	10.1

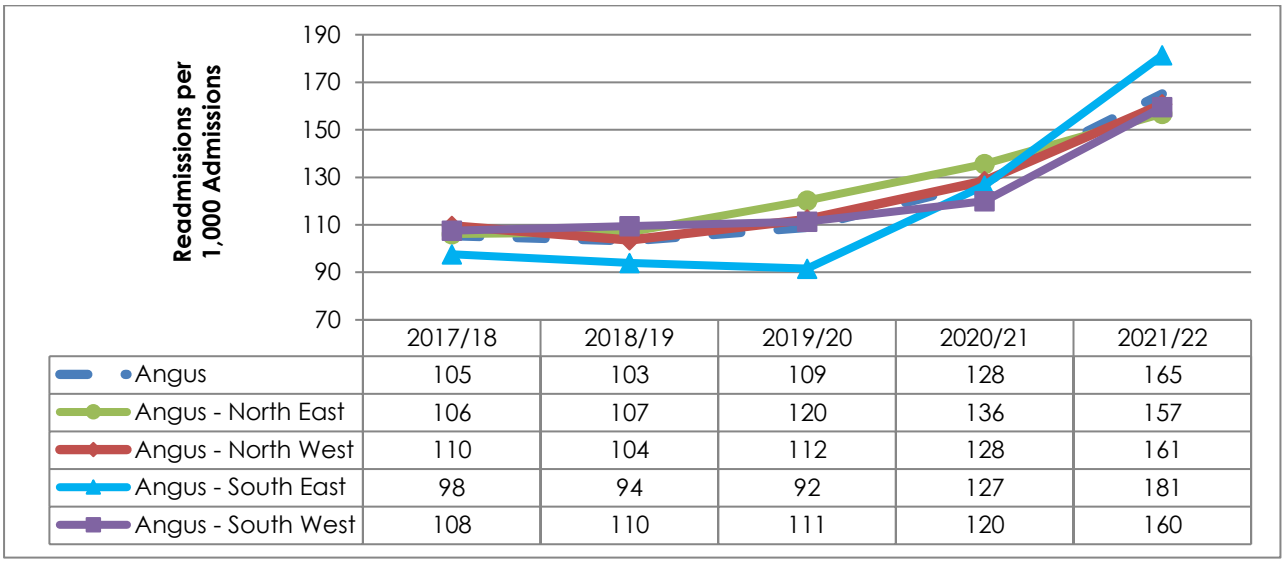
Source: Public Health Scotland LIST management information (not official ISD statistics)

Re-admissions to hospital

3.3.6 There has been a continued decrease in performance in relation to emergency readmissions within 28 days of discharge (as a rate of all emergency admissions). This measure is a national indicator, but its definition is for both planned and unplanned admissions to hospital. At this time, we have no specific data about the level of planned admissions.

3.3.7 Planned admissions in 2021/22 declined due to cancellation of procedures in preparation for the NHS response to COVID-19. This reduction will have had an impact on this indicator and the apparent increase in readmissions is likely attributable to this reduction in planned admissions. 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 and an increase in age in Angus of entry to care homes, along with the availability of emergency respite or other forms of care in the community at short notice.

Graph 21: Management Information at Locality Level: Emergency Re-admission Rates within 28 days (NI 14)



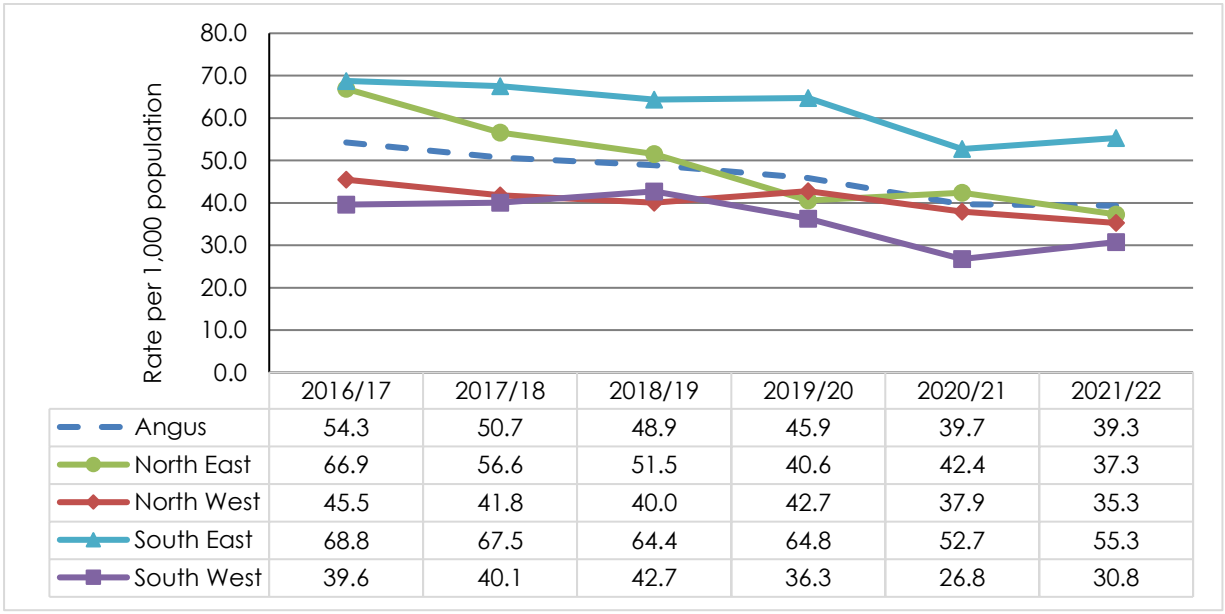
	2017/18	2018/19	2019/20	2020/21	2021/22
Angus	105	103	109	128	165
Angus - North East	106	107	120	136	157
Angus - North West	110	104	112	128	161
Angus - South East	98	94	92	127	181
Angus - South West	108	110	111	120	160

Source: Business Unit, NHS Tayside

Residential and Nursing Care

3.3.8 The number of adults placed in a care home at any one time in 2021/22 was 721. People tell us that they want to stay in their own homes for as long as possible, between 2015/16 and 2021/22 the number of people placed in a care home reduced by 14%. Older people live at home for longer and if moved to a care home remain in the care home for a shorter period.

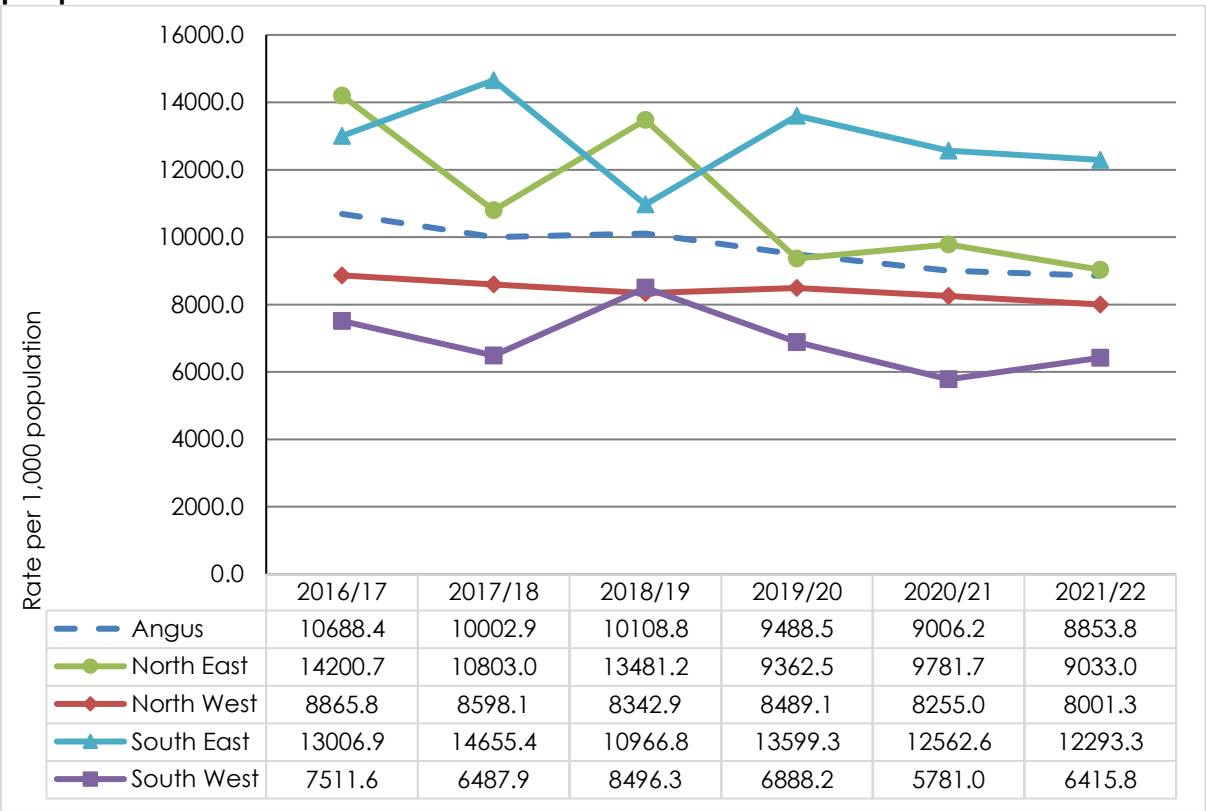
Graph 22: Management Information at Locality Level: Care Home Placement Rate per 1,000 people over 65



	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
Angus	54.3	50.7	48.9	45.9	39.7	39.3
North East	66.9	56.6	51.5	40.6	42.4	37.3
North West	45.5	41.8	40.0	42.7	37.9	35.3
South East	68.8	67.5	64.4	64.8	52.7	55.3
South West	39.6	40.1	42.7	36.3	26.8	30.8

Source: Care First (Angus Council)

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



	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
Angus	10688.4	10002.9	10108.8	9488.5	9006.2	8853.8
North East	14200.7	10803.0	13481.2	9362.5	9781.7	9033.0
North West	8865.8	8598.1	8342.9	8489.1	8255.0	8001.3
South East	13006.9	14655.4	10966.8	13599.3	12562.6	12293.3
South West	7511.6	6487.9	8496.3	6888.2	5781.0	6415.8

Source: Care First (Angus Council)

3.3.9 Independent Sector Lead for Angus has been working alongside partnership 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.

3.3.10 A test of change (TOC) for an Advanced Nurse Practitioner from the MfE 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.

3.3.11 The TOC was initially scheduled to run from July 2021 to the end of December 2021. The Covid-19 pandemic and other factors contributed to difficulties in accessing review dates and the TOC was subsequently extended to the end of March 2022. As a result of this test of change any clinical aspects of a resident's care were addressed timely and an ACP and polypharmacy review was completed.

Priority: 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. Angus Health & Social Care Partnership 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

- The Learning and Physical Disability Improvement Plans have continued to progress, recognising the expansion of those services and changing governmental drivers. The Adult resource centres for people with a learning disability adapted to provide outreach support to individuals at home and in their communities, when national restrictions were in place. Video technology supported a large variety of group activities and helped to maintain connections amongst peers. Activity packs were created and delivered to individuals. Some of these adaptations have been retained due to being effective and successful for some families, although full face-to-face service has now resumed. The services were also successful in achieving the National Autism Certificate of Accreditation.
- Mental health services have developed an Angus Living Life Well (LLW) Improvement Plan which is aligned to the Tayside Living Life Well priority areas. The Plan supports the ambition within the Angus Strategic Commissioning Plan of "shifting the balance of care to support more people in our communities and support people to greater independence for longer". It supports all four of the strategic priorities within the Angus Health and Social Care Partnership Strategic Commissioning Plan, specifically promoting wellbeing approaches and improving integrated pathways.
- Development of a Dundee & Angus Stroke Pathway to deliver effective, high quality, specialist care within a community setting.

Making a difference

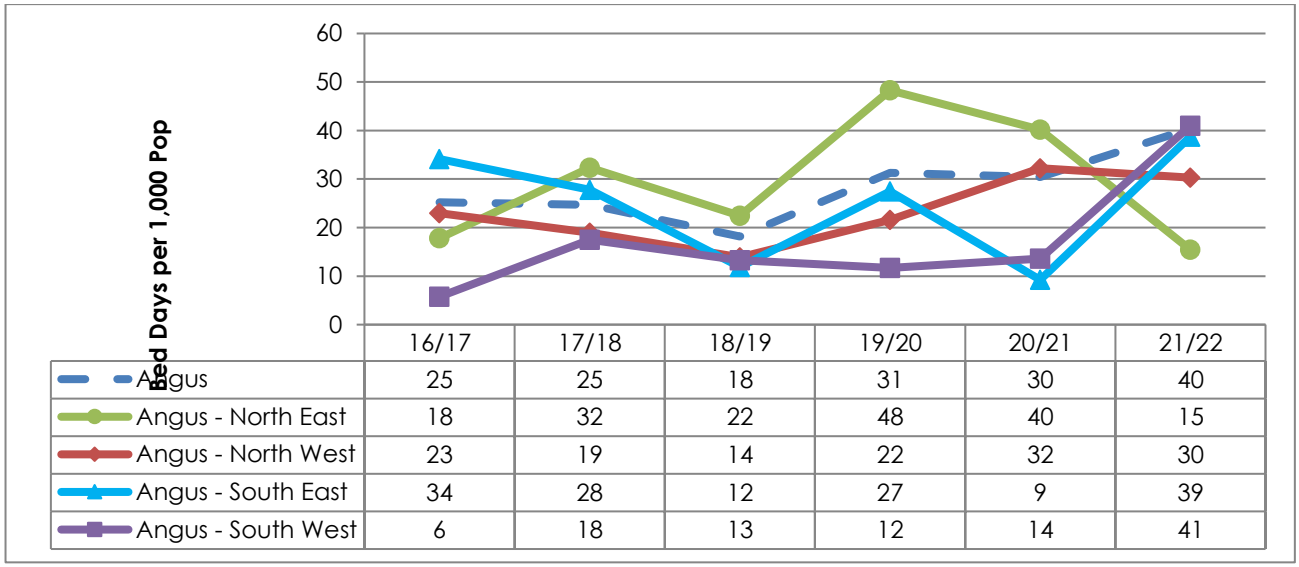
Angus Health & Social Care Partnership is working with housing, learning disability, adult mental health and other services to identify appropriate measures. We measure pathways in and out of secondary care, in part through our work on admissions and re-admissions. These are all reported on in relation to Priority: Developing integrated and enhanced primary care and community responses (page 34).

4.1.1 ECS model of care and the increased availability of personal care has also improved performance in relation to the timely discharge of older people. Proactive care around the individual allows the anticipation of needs and the prevention of hospital admission. Monifieth Integrated Care has seen the amalgamation of the Care Management and

District Nursing teams. This has been positively evaluated with plans to roll out in order to support other Angus localities.

4.1.2 Complex delays have increased mainly as a result of where guardianship applications have been slowed due to closure of the courts during the COVID 19 pandemic and although work has progressed to deal with the backlog of Guardianship applications, processing was slow. There are also some psychiatry of old age patients whose discharge is delayed due to the lack of availability of appropriate community accommodation and support solutions and work is ongoing with Angus Council Procurement Team with a view to commissioning an appropriate care home within Angus.

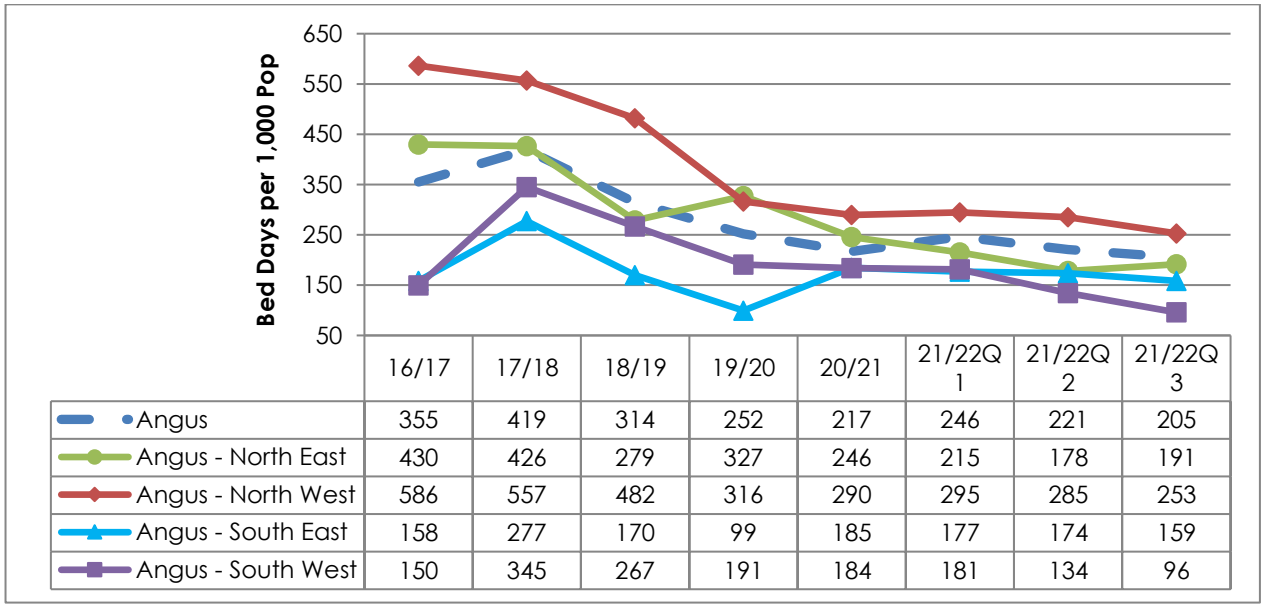
Graph 24 – Delayed Discharge Bed Day Rate per 1,000 Population for 18-74



	16/17	17/18	18/19	19/20	20/21	21/22
Angus	25	25	18	31	30	40
Angus - North East	18	32	22	48	40	15
Angus - North West	23	19	14	22	32	30
Angus - South East	34	28	12	27	9	39
Angus - South West	6	18	13	12	14	41

Source – Public Health Scotland

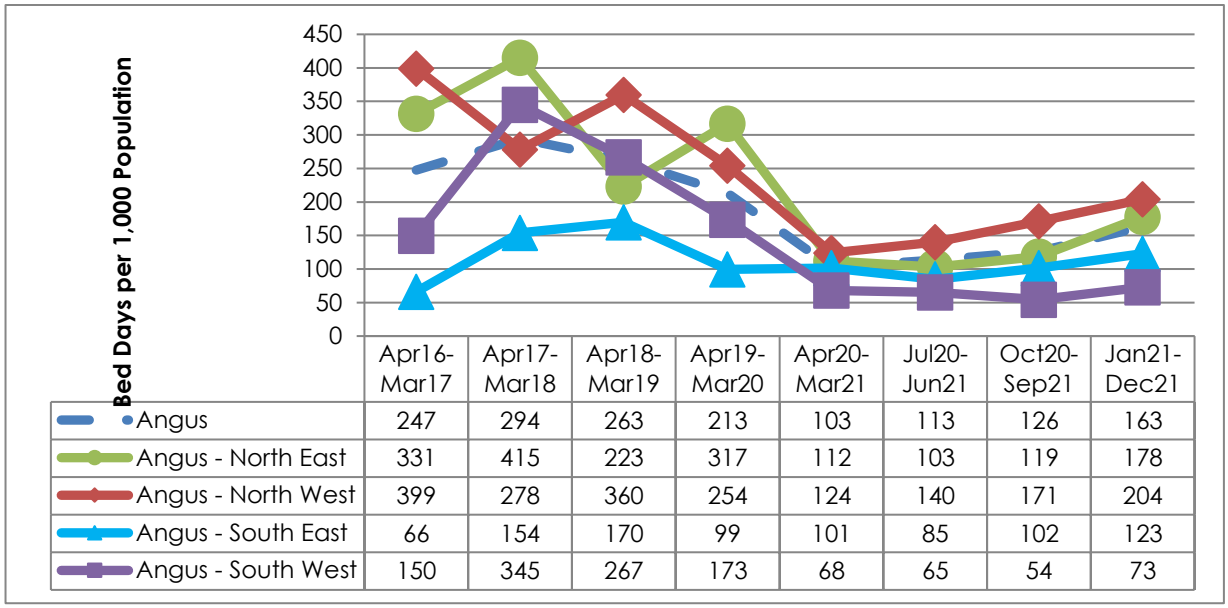
Graph 25 – Delayed Discharge Bed Day Rate per 1,000 Population for 75+



	16/17	17/18	18/19	19/20	20/21	21/22Q 1	21/22Q 2	21/22Q 3
Angus	355	419	314	252	217	246	221	205
Angus - North East	430	426	279	327	246	215	178	191
Angus - North West	586	557	482	316	290	295	285	253
Angus - South East	158	277	170	99	185	177	174	159
Angus - South West	150	345	267	191	184	181	134	96

Source – Public Health Scotland

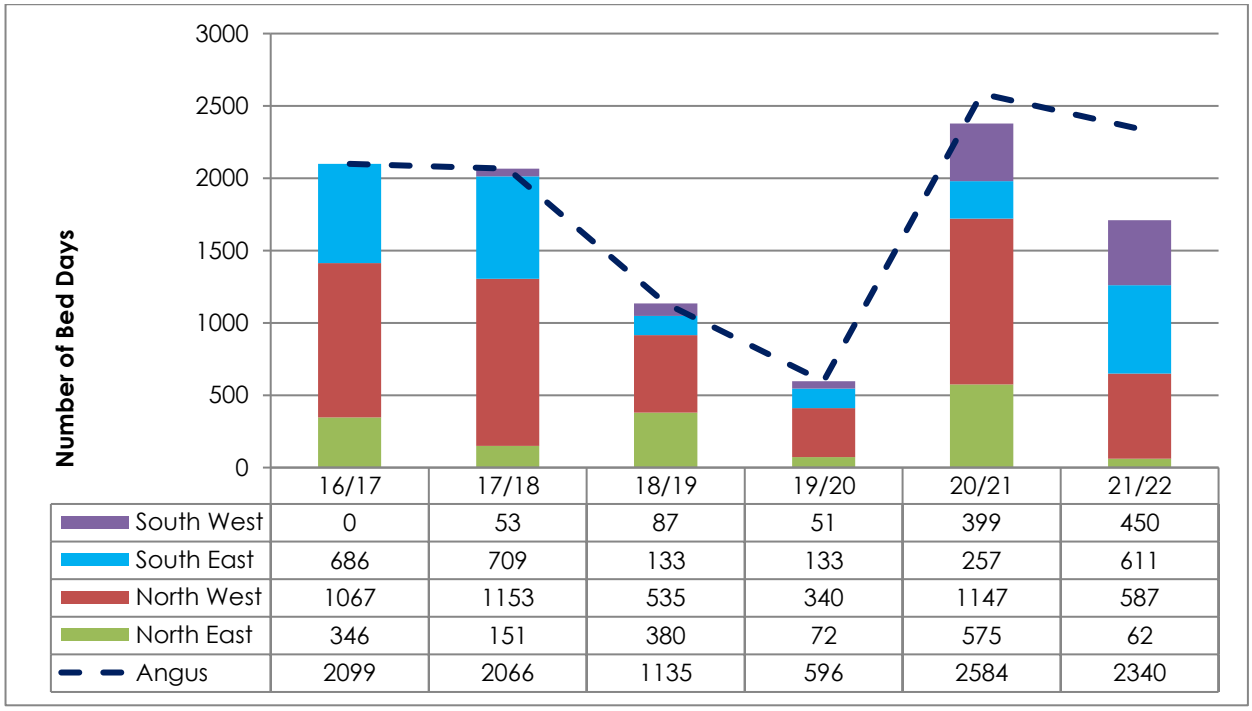
Graph 26 – Standard Delayed Discharge Bed Day Rate per 1,000 Population for 75+



	Apr16-Mar17	Apr17-Mar18	Apr18-Mar19	Apr19-Mar20	Apr20-Mar21	Jul20-Jun21	Oct20-Sep21	Jan21-Dec21
Angus	247	294	263	213	103	113	126	163
Angus - North East	331	415	223	317	112	103	119	178
Angus - North West	399	278	360	254	124	140	171	204
Angus - South East	66	154	170	99	101	85	102	123
Angus - South West	150	345	267	173	68	65	54	73

Source – Public Health Scotland

Graph 27 – Delayed Discharge Bed Days for People with Complex Needs All Ages



	16/17	17/18	18/19	19/20	20/21	21/22
South West	0	53	87	51	399	450
South East	686	709	133	133	257	611
North West	1067	1153	535	340	1147	587
North East	346	151	380	72	575	62
Angus	2099	2066	1135	596	2584	2340

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.

4.2.2 Over the past year, partners within the ROSC have continued to develop a number of initiatives to further support those in need and ensure supported people or their families see the right service at the right time, and in the right place. The weekly joint referral hub for substance services has been evaluated and reduced to once weekly with the continued benefit that supports early engagement and access to treatment.

4.2.3 The Angus services have not managed to achieve the HEAT standard of "90 percent of people engaged in treatment three weeks after receipt of referral". The service achieved 83.4% per cent of this standard during the last reported quarter. This reflects the performance of all services that report waiting times for Drug and Alcohol statistics. The reasons for the reduced performance level include sickness absence rates, vacant posts and increased demand through the complexity of referrals. There are plans for significant recruitment to take place and these are underway and the impact of having full staffing compliment will ensure a return to meeting the standard.

4.2.4 In partnership with Community Mental Health Team (CMHT) and Primary Care, AIDARS has also jointly developed referral hub within Links Medical Centre, Montrose, and this has been evaluated and developed into a model that will be replicated across Angus. This is part of several initiatives locally focused on aligned and integrated working between mental health and substance services. All suspected drug deaths in Angus are reviewed as part of the pan-Tayside Drugs Death Review Group led by Public Health. Learning is reviewed locally with AIDARS Business Governance Group and in partnership with Angus Alcohol and Drugs Partnership (ADP) and ROSC Partnership Group to identify themes and improvements. All suspected drugs deaths within Angus Services are also internally reviewed by AHSCP with multi-agency input. During the reporting period there were 16 suspected drug deaths in Angus. The reviews are taking place on time as the post Mortem and Toxicology reports are available on time now which means that learning and good practice can be shared.

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. Angus Health and Social Partnership and the ADP are overseeing the plans.

4.2.7 AIDARS works in partnership with NHS Tayside Harm Reduction Service and Scottish Ambulance Service to contact individuals who have recently experienced a near fatal overdose. This has been developed with other partners including Police Scotland on board that means that as many non-fatal overdoses that can be identified are dealt with. An assertive outreach approach is taken to each individual and contact is made directly by AIDARS staff to support engagement with the service. This is monitored through Angus ADP Strategy Group.After a series

4.3 Mental Health Officer (MHO) Function

Mental Health Act

4.3.1 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.

4.3.2 Unfortunately, there continued to be a shortage of Section 22 approved doctors and a limited number of locums available to fill the void. The number of locums used, and their turnover remains high and this is having a significant impact on the number of assessments the MHO Service has been able to undertake. Additionally, this shortfall has increased the reliance on General Practitioners being asked to undertake assessments for Emergency Detentions, which is of concern as not all have experience of the Mental Health (Care and Treatment)(Scotland) Act 2003, many of these detentions are being quickly revoked upon arrival to hospital, and many GP's are unaware of the requirement to seek consent from an MHO.

4.3.3 As with last year, the number of detentions and revocations correlate with the number of Section 22 Approved Doctors available, with the pattern of number of Doctors increasing highlighting a considerable shortage of beds. This has resulted in a number of individuals not being admitted to hospital. Also, like last year the use of the Mental Health Act and hospital admissions have regularly been delayed due to the shortage of beds.

4.3.4 Proportionately the largest increase in Mental Health Act work during this reporting period has occurred in the 14 to 18 years age bracket, with a substantial number being diagnosed with an eating disorder, personality disorder or emerging personality disorder.

Adults with Incapacity

4.3.5 With the reopening of the Courts and the Office of the Public Guardian operating at pre-pandemic levels the number of Welfare Guardianships has again increased, although during this reporting period at a more consistent level. The shortage of Section 22 approved Doctors able to provide medical reports required to accompany applications

does, however, continue to prove problematic in addition to an increasing number of General Practitioners stating they do not have the capacity to provide the second reports.

4.3.6 Over the last 12 months, the MHO Service again saw a considerable increase in attendance at adult support and protection and adults with incapacity case conferences, the latter being due to the significant increase in new applications and the significant number of renewals.

4.3.7 Summary Stats from 01 April 2021 until 31 March 2022

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

Type	Numbers
Emergency Detention Certificates	43
Short Term Detention Certificates	86
CTO Applications	43
Social Circumstances Reports	77
Other reports regarding civil and forensic cases	85
No patients on a Compulsion Order	2
No patients on a Compulsion Order With Restriction	7
No patients on Section 52M	0

Table 6 – Adults with Incapacity (Scotland) Act 2000

Type	Local Authority	Private	Total
New Requests	20	49	69
Renewal Requests	10	12	22
Total requests received both Local Authority & Private			91

Table 7 - Guardianships in operation

Type	Local Authority	Private	Total
Live Orders	126	275	401

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

4.4.1 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.

4.4.2 Referral data was collated using the weekend service database during the time period May 2021 to February 2022

- 151 referrals in total for 101 individuals, 91% from North (Forfar / Kirriemuir / Montrose / Brechin), 8% from South (Arbroath / Carnoustie / Monifieth)
- On average 3.4 people referred each weekend. During 2 weekends no-one was referred or seen. The highest number of people referred in a weekend was 9 (occurred once). The median value is 3 people, and the mode is 1 person (on 9 occasions) referred each weekend

4.4.3 Service Users who were referred to the 7-day 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"

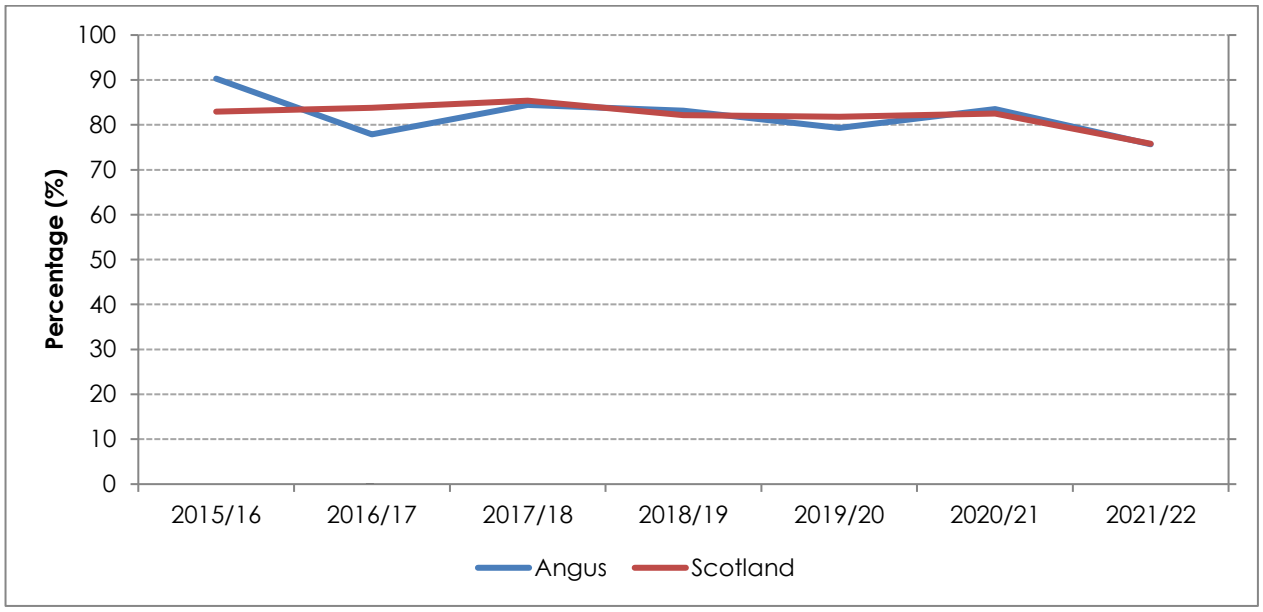
"I felt really listened to as I was struggling to communicate what the issue was. Staff were really patient with me to make sure I was heard"

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

Inspection of Services

5.1 There are 77 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 24 - Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections (NI 17)



Source: Public Health Scotland

5.2 In Angus, 76% of services operate at grade 4 (Good) and above. In 2021-22, 14 care homes and 3 supported services were inspected. Following inspections in 2021-22, 8 providers had requirements which required action, and 2 providers had areas of improvement to address.

The requirements related to areas:

- Environmental improvement plan
- Infection prevention and control

The areas for improvement were:

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

5.3 Providers are supported with improvement by AHSCP care management and district nursing. 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.

Clinical Care and Professional Governance (CCPG)

6.1 The IJB receives an annual assurance report about Clinical Care and Professional Governance, 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 22 June 2022 about the 2021/22 activity https://www.angus.gov.uk/sites/default/files/2022-06/Report%20IJB38_22%20CCPG%20Annual%20Assurance%20Report.pdf

6.3 From April 2021 the Clinical Care and Professional Governance Group met on a monthly basis with the focus alternating between service quality assurance; and strategic risk and adverse event management.

6.4 The group met on twelve occasions during the period from 01 April 2021 to 31 March 2022 on the undernoted dates:-

CCPG Assurance Meetings

- 19 April 2021
- 14 June 2021
- 16 August 2021
- 01 November 2021 (rearranged from 18 October 2021)
- 13 December 2021
- 28 February 2022

CCPG Risk Meetings

- 24 May 2021
- 12 July 2021
- 20 September 2021
- 15 November 2021
- 24 January 2022
- 21 March 2022

6.5 The group is responsible for monitoring and reviewing strategic risks held by Angus Health and Social Care Partnership.

6.6 All services have reviewed and updated Business Continuity Plans regularly over the past year. In addition to this development sessions have been held with Angus HSCP Executive Management and Senior Leadership Team in relation to the requirements of being a Category 1 Responder.

Resources

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

7.2 A separate finance report was presented to the IJB on 22 June 2022 about the 2021/22 end of year financial position https://www.angus.gov.uk/sites/default/files/2022-06/Report%20IJB35_22%20Finance%20Report%202021_22.pdf

Best Value

7.3 Prior to the COVID-19 pandemic, the IJB believed the scale of change being progressed through the IJB ensured that the vast majority of the IJB's resources and services were subject to some form of service review and continuous improvement. Consequently this, alongside the corporate systems accessed through Angus Council and NHS Tayside, assisted the IJB demonstrate that it was, at all times, seeking to secure best value from the resources available.

7.4 Despite the impact of COVID-19, the IJB has continued to progress issues such as implementing the Primary Care Improvement Plan, supporting changes in Mental Health, progressing the Learning and Physical Disabilities Priority Improvements and Adult Protection Improvement Work. While pace slowed during 2020/21, the scale of the changes under consideration within Angus IJB are reflective of the scale of change required to meet the range of pressures the IJB faces - from financial to demographic and workforce pressures and responding to the longer-term issues with regard to COVID-19 as reflected in the IJB's Remobilisation Plans.

7.5 The IJB was able to re-start most improvement work towards the end of 2020/21 and some of the changes seen during 2020/21 (including increased adoption of technology enabled care and shifts in the balance of care allowing us to support people to live in their communities longer than we may have expected) support delivery of the IJB's strategic objectives. 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 subject to some form of service review and continuous improvement.

7.6 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.

7.7 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.