AGENDA ITEM NO 11

REPORT NO IJB 7/25

ANGUS INTEGRATION JOINT BOARD

26 FEBRUARY 2025

STRATEGIC PLANNING UPDATE

REPORT BY JILLIAN GALLOWAY, CHIEF OFFICER

1. ABSTRACT

The purpose of this report is to provide Angus Integration Joint Board (IJB) with an update about progress to deliver the ambitions of the Angus IJB's Strategic Commissioning Plan 2023 – 2026. The report contains an update about each priority area and is supported by local indicator data and feedback from service users.

2. ALIGNMENT TO THE STRATEGIC PLAN

This report focuses on the IJB's Strategic Commissioning Plan (SCP) which is the primary strategic document for the IJB and relates to:

Priority 1: Prevention and Proactive Care
Priority 2: Care Closer to Home
Priority 3: Mental Health, Learning Disability and Substance Use Recovery.

3. RECOMMENDATIONS

It is recommended that the Integration Joint Board:

(i) Scrutinise and discuss and content of the report;

(ii) Endorse a reasonable level of assurance regards the progress made on the IJB's SCP during 2024; and

(iii) Request an update on work to progress the review of the current SCP in August 2025.

4. BACKGROUND

Section 29 of the Public Bodies (Joint Working) (Scotland) Act 2014 (the Act) requires the IJB to have a SCP. The SCP is a document which:

a) sets out the arrangements for the carrying out of the integration functions of the areas of the local authority over the period of the SCP,
b) sets out how those arrangements are intended to achieve, or contribute to achieving, the national health and wellbeing outcomes, and
c) includes other materials as the Integration Authority thinks fit.

In April 2023 the IJB approved the SCP for 2023 – 2026 (IJB 29/23) "Working Together to Improve Lives in Angus" describes the vision for integrated health and social care services and sets out the IJB's objectives to use resources in pursuit of achieving the national health and wellbeing outcomes and and local priorities.

The overarching vision of the plan is:

People in Angus receive the best services possible and enjoy physical and mental health to their full potential.

This vision is underpinned by the following values; that we are caring, compassionate, person-centred, honest and respectful. All the work being undertaken supports the joint commitment of ‘making a difference for you, with you’.

The Performance Report presented today (IJB 08/25), provides additional information regarding the progress to meet the national health and wellbeing outcomes.

5. CURRENT POSITION

Priority 1: Prevention and Proactive Care

Table 1 provides a summary of the status of the prevention and proactive care actions focused on preventing deterioration. Many actions are not due for completion in 2025/2026.

Table 1. Summary of the status of actions aligned to Prevention and Proactive Care.

Strategic Commitment	**No. of Actions**	**Status**				
		Blue (Complete)	**Green (On Track)**	**Amber (Concern meeting deadline)**	**Red (Requires Urgent Attention)**	**Paused/ cancelled**
Support people to look after their own health in a way which is manageable for them	12	3	9	0	0	0
Build stronger and more resilient communities	4	0	4	0	0	0
Act early to anticipate healthcare needs	3	0	3	0	0	0
Prescribing resources will be used effectively	5	0	5	0	0	0
TOTAL	24	3	21	0	0	0

Examples of work taking place include:

ANGUSalive BE ACTIVE...Live Well (BALW) Programme
Since the launch of the revised programme in April 2024, more than 700 referrals have been received, with the average number of referrals for BALW at approximately 75 per month. This is a significant increase on data from 1 Aug 2023 - 31 March 2024 which was 158. It is estimated that total referrals received by March 2025 will be approximately 900. Funding has been secured from the NHS Tayside Charitable Foundation and AHSCP to continue delivery of the BALW programme until March 2027.

Angus Falls Reduction and Safer Mobility Services
Following a very successful test of change in 2024, the Angus Falls Reduction and Safer Mobility Services have adopted two key improvements from the change as standard practice. As a result, people who have had a fall within the community, and are referred to

the service, will receive first contact within two working days. We are also committed to completing level two multi factorial falls assessments within fifteen working days within the person's home. To support these service developments a second Falls Assessor was recruited in January 2025.

We are also developing a new role within the service, with the introduction of a Wellbeing and Enablement Practitioner. This will assist the provision of both a reactive and proactive service, encouraging positive self-help actions that promote lifestyle changes encouraging increased activity, engagement with community services and developing confidence that may have been lost fallowing a fall. A 12-week better balance class is now delivered at three ANGUSalive leisure facilities (Montrose, Arbroath and Forfar).
Feedback from people who have completed the class has been very positive, with those who attended encouraged to follow-on provision with the ANGUSalive BALW programme.

Waiting Well
As part of the Scottish Government's Care and Wellbeing Portfolio, a Waiting Well work-stream has been developed, which aims to target and support people who are currently waiting for a required assessment or intervention. The work aims to prevent further deterioration in the health and wellbeing of people whilst they wait; supporting them to wait better, seeking stabilisation and in many cases, improvements in how people can self-manage and become more proactive in their own care, health and wellbeing. Passive waiting is associated with an increased risk of physical and mental deterioration, widening inequalities with patients from marginalised groups and those with co-morbidities being at disproportionately higher risk of poorer outcomes.

We are keen to improve the experience of those waiting for a hip or knee replacement and a pilot of a proactive programme is about to commence in four Angus GP Practices – Brechin, Kirriemuir, Monifieth and Ravenswood.

Optimising Medicines
Representatives from the Angus Prescribing Management Quality Assurance Group recently supported facilitation and participated in an Optimising Medicines Workshop hosted by the Improvement Academy within NHS Tayside. The 'Optimising Medicines' work stream is a key component of NHS Tayside's Delivery Plan. As part of this, 24 system leaders, including medics and pharmacists from both Primary and Secondary Care, gathered to discuss and workshop approaches. The aim of the workshop was to explore collaboration opportunities to optimise medication use for patients, further improving the quality of prescribing and positive patient outcomes.

The workshop findings highlight our shared commitment to improve patient safety, enhance quality of life, reduce adverse drug events, and minimise unnecessary medication. To achieve this, it is essential that we engage the wider system and work together to deliver on the actions identified during the workshop to make significant difference in providing integrated, patient-centred care across Tayside. As a next step, a project group will be established to help shape a project plan and drive this initiative forward and ensure regular communication of progress.

Pharmacogenomics
Angus is at the forefront of personalised medicine with the first implementation of a primary care pharmacogenomic testing pathway in Scotland. Four Angus GP Practices are currently participating in the pilot. This innovative approach uses individual patient's genetic information to guide prescribing of common medications. As part of this work, we plan to engage with communities to help us understand their awareness of the use of genetic information and to seek their guidance on how this development should be described to enable the greatest benefit to be obtained from this innovation.

Priority 2: Care Closer to Home
Table 2 provides a summary of the status of the actions relating to care closer to home.
Most actions are not due for completion until 2025/2026.

Table 2. Summary of the status of actions aligned to Care Closer to Home.

Strategic Commitment	**No. of Actions**	**Status**				
		Blue (Complete)	**Green (On Track)**	**Amber (Concern meeting deadline)**	**Red (Requires Urgent Attention)**	**Paused/ cancelled**
Provide care closer to home whenever possible	8	0	5	2	0	1
Work with partners to provide the right care in the right place at the right time	13	2	6	4	0	1
Reduce Homelessness	5	0	0	5	0	0
Support Carers to sustain their caring role and enable them to have a fulfilling life alongside caring	42	9	31	1	0	1
TOTAL	68	11	42	12	0	3

Examples of the work taking place include:

My Health, My Care, My Home Healthcare Framework
The Care Home Collaborative support team have been progressing working across the wider multi-agency teams regarding the delivery of the Scottish Government My Health, My Care, My Home Healthcare Framework which provides a series of recommendations that aim to transform the healthcare for people living in care homes. It is recognised that there are several areas which have been met or recommendations which are almost embedded across Angus for example improvements to access for urgent and emergency care. It is also recognised that there are areas requiring further development, for example supporting improvements within management and leadership across the private sector and improving preventative healthcare for care home residents and education to develop and support the workforce.

Discharge Planning
We continue to monitor our average length of stay against a local target of 28 days. We monitor all hospital discharges across Arbroath Infirmary (AI), Whitehills Health and Community Care Centre (WHCCC), Royal Victoria and Ninewells Hospital not just the delays. Senior Nurses from Angus and Dundee, District Nursing Services, Allied Health Professionals, Enablement and Response Team and Social Work meet every morning at 8.30 am to discuss hospitals discharges.

We have a 90% target for discharge without delay. From January to December 2024, 91% of discharges from ARI and 81% from WHCCC, experienced no delay. Work continues to ensure accurate recording of discharges. AI and WHCCC are the two top performing community hospitals for DWD in Tayside.

Over the past year we have carried out a test of change within WHCCC, where every person going home has a family/ carer meeting. This has improved the experience of the person going home and we are about to introduce this to AI.

There has been a realignment of work profiles to the service and this redesign will allow us to focus on prevention of admission and timely discharges with a real focus on HomeFirst

which should see an improvement in flow over the coming months with a real effort on prevention of admission.

Day Opportunities Framework
Work is ongoing to finalise the draft Day Opportunities Strategic Framework. Once complete, the draft Framework will be shared with key stakeholders, including the public, for a period of engagement to gather feedback on the future proposals for delivering Day Opportunities in Angus.

Medication Administration
The multidisciplinary/multiagency medication group, which was reinstated in May 2024, continues to progress actions focusing on ensuring people who require support to take their medication receive this from the most appropriate person, aimed to reduce duplication of visits.

Community Alarm Review
In June 2024 the AHSCP Executive Management Team agreed that there was a requirement to move to a cloud-based system because of the high risk to connection failure to the community alarm control centre and the proposed switch-off of the analogue phone network which is predicted by Ofcom to be completed by 2025. This decision was subsequently endorsed by Angus Council Committee in September 2024. As a result of this decision the community alarm control room service review has been stopped at this time.

Carers
Three additional actions have been completed since October 2024 when the IJB received the annual update on progress to implement the Angus Carers Strategy 2023- 2026 (IJB 54/24):

- Local Eligibility Criteria for Adult Carers has been reviewed and published on relevant platforms.

- Practitioners Forums were re-established in November 2024 with quarterly on-line sessions and a TEAMS channel for use out with these meetings. The meetings provide a forum that gives professionals opportunities to discuss issues around service delivery and Self-Directed Support frameworks for Carers with the aim to provide consistency of care.

- The Angus Support Pathway (previously SDS Toolkit) has been updated to reflect changing legislation, policies and procedures and includes in house guidance documents. Information about Self-Directed Support has been published and updated.

Launch of Angus Carers Academy
The Angus Carers Academy launched in February 2025 and aims to equip family members with the skills needed to care for loved ones who have dementia. The initiative, which is funded by NHS Tayside Charitable Foundation, has been developed in partnership with the University of West of Scotland and the Alzheimer Scotland Centre for Policy and Practice. The academy will initially provide a one-day programme designed to support carers to understand the effects of dementia, assist the development of practical care skills and demonstrate technology which can support people with dementia and their carers.
The programme will be delivered by a multidisciplinary team of healthcare, social work, academic and Alzheimer Scotland staff. It focuses on enhancing carers' abilities in key areas such as, the brain and how we store memories, sensory changes and communication, moving and mobility, technology that can be used at home.

Homelessness
In September 2024 the Scottish Government published Homelessness in Scotland: 2023-24. The report provides information about households assessed as homeless compared to all households, by local authority: 2023- 24. Angus sits within the lower quartile with less than 100 households per 10,000 assessed as homeless. Whilst the numbers of homeless applications have reduced there has been a significant increase in demand for an intervention from our Homeless Prevention & Solutions Team, particularly in prevention.

In 2024, 1257 contacts were made from the public looking for advice, assistance and an intervention. Only four out of the last twelve months saw numbers below one hundred, this workload is spread over five Case Managers.

The Homeless Prevention and Support Teams are working closely with Angus Council to attempt to reduce the length of time people are residing in temporary accommodation. It should be acknowledged however, that there is a deficit of suitable permanent accommodation across Angus; many applicants require one bed accommodation.
This situation can result in longer stays in temporary accommodation and an increase in people being placed in B&B accommodation for extended periods of time. These extended placements are placing a significant pressure on the HPST service and budgets, the Homeless Person Unsuitable Accommodation order states that the maximum number of days that local authorities can use unsuitable accommodation for any homeless person is seven days The majority of all unsuitable accommodation placements in Angus breach this order, to compound things further the increase use of B&B's and Hotels will see a potential spend of almost £250,000 in this financial year (24/25), the budget is £70,000.

Priority 3: Mental Health, Learning Disability and Substance Use Recovery

Table 3. Summary of the status of actions aligned to Mental Health, Learning Disability and Substance Use Recovery. Many actions are not due for completion until 2025/2026.

Strategic Commitment	No. of Actions	Status				
		Blue (Complete)	**Green (On Track)**	**Amber (Concern meeting deadline)**	**Red (Requires Urgent Attention)**	**Paused/ cancelled**
Deliver the ambitions of the Angus Living Life Well Improvement Plan, incorporating supporting people to recover or manage their condition	39	34	1	4	0	0
Provide consistent delivery of safe, accessible high-quality drug and alcohol treatment across Angus	3	0	3	0	0	0
TOTAL	39	34	1	4	0	0

Examples of the work taking place include:
Deliver the ambitions of the Angus Living Life Well Improvement Plan
- The LLW Plan which spanned June 2022 to December 2024 has now come to an end. This plan has been very successful in driving change. Of the 39 agreed actions, 34 have been completed, 1 is on track as per national timescales and 4 are not on track to meet deadlines. These actions will now sit with the identified Lead

Officer(s) and will be monitored through services' Clinical Care and Professional Governance meetings.

Supporting people to recover or manage their condition

- The Mental Health and Wellbeing Enhanced Community Support (ECS) Hubs are now operational across all four localities; to improve access to mental health and wellbeing support. The ECS hubs have the ethos of no wrong door and no rejected referral. There has been a significant increase in self-referrals for support.

- The Angus Community Wellbeing Centre has now been named "The Beacon". Work continues to be progressed by the Project Board and Project Teams. Hillcrest Futures have been formally awarded the Support Services Contract and are now part of the Project Board and the relevant Project Teams. The contract starts on 1st April 2025. The tender for the refurbishment work is now closed and currently being evaluated with the timeline of work commencing at the end of February, and opening end of May 2025.

  An animation for the public was produced and published at the end of December 2024, which can be accessed HERE and has had over 8,000 views

- Work continues the action plan and targeted roll out of the ARE YOU OK? campaign. The "ARE YOU OK?" website page is currently being updated to make it more user friendly.

Learning Disability and Physical Disability Improvement Plans

Several actions from the 2024-2025 LD and PD Improvement Plans are being progressed. These include addressing capacity issues within the service due to increased demographic growth and an increase in service users with complex care needs; this includes accommodation and Resource Centre provision and the Coming Home Implementation agenda. Until recently, certain actions have been progressed individually but concurrently; however, it is recognised a more holistic approach to identify potential solutions would be beneficial. This approach aims to ensure a cost effective and efficient future model of service delivery which maximises resources and continues to meet the needs of services users.

Substance Use Recovery

The Angus Alcohol and Drugs Partnership Annual Report 2023 – 2024 presented to the IJB today provides updates on the business and progression of national policy and priorities in relation to drugs and alcohol at a local level (IJB 01/25).

Services across the partnership continue to review their performance and service delivery aligned to national and local priorities. Waiting times for drug and alcohol treatment are consistently meeting the National waiting times targets, and Angus are performing well across the Medication Assisted treatment (MAT) Standards. Pathways are now well established for residential rehabilitation, and we continue to work closely with our partners across Mental Health and Primary Care to ensure that we firmly embed MAT standards 6.7.9 and 10 across Angus. Both developments form part of the HIS pathway groups for Residential Rehabilitation and the MHSU protocol development. Angus have implemented Buvidal administration and community pharmacist prescribing of Opiate Substitution Treatment in one community pharmacy which is progressing well. These additional services to the current Community Pharmacy Service Level Agreement have been implemented as tests of change will be fully evaluated over the next few months to assess viability for roll out across Angus and Tayside. The evaluation will include service user and service provider feedback.

Through our Recovery Orientated Systems of Care group, we are working to progress Action 2.4 of the ADP Delivery Plan: Pathways are developed to support those with specific needs. The group has prioritised women as data is showing an increase in risk amongst women in Angus. A scoping exercise has been undertaken and local data considered alongside this and an action plan under development.

Locally service have noticed an increase in referrals for people experiencing problems associated with alcohol use and a decline in opiate referrals, with increases in referrals from people using cocaine and ketamine. Working with partners across primary care,

community justice, third sector and mental health, we are assessing pathways and education to best meet the needs of these emerging populations.

Enablers

Workforce
In October 2024 approved the Annual Workforce Update Report October 2023 – September 2024 (IJB Report 67/24). The Workforce Steering Group oversee the four workstreams:

- Recruitment and Retention
- Workforce Data
- Staff Wellbeing and Development
- Safer Staffing

Financial Planning
Regular reports are provided to the IJB.

Collaborative Commissioning
AHSCP Third Party Providers Forum agreed that AHSCP should investigate the possibility of re-opening the Self-Directed Support Option 3 Care at Home Framework. This has been successful, with four new providers now added to the framework – all of whom have successfully undergone the tender evaluation and all who meet the required criteria as a provider for care at home. This will increase the capacity of Care at Home availability as the providers develop work across Angus.

A revised Market Facilitation Statement is currently being drafted. The revised Statement will include service specific sections with details of future commissioning requirements. There are plans to conduct development sessions with providers to share the updated Market Facilitation Statement and gain feedback on their appetite to support any future commissioning plans. The revised Market Facilitation Statement will be presented to Angus IJB in April 2025 for approval.

Communication and Engagement
Communication and engagement activities have been arranged in relation to a range of actions identified within the delivery plan and separate updates are provided within IJB reports. AHSCP will continue to involve our local communities in all ongoing service change and improvement activities.

Infrastructure, Data and Technology
The EmisWeb to Morse Electronic Patient Record System Implementation is currently taking place in planned phases, with the intension to complete by the end of September 2025.
All teams in Angus including community nursing and AHPs currently using EmisWeb will migrate over to Morse in either the second or third phase of the project. This will give staff greater flexibility to access electronic patient records in the community and non-health settings.

6. PROPOSALS

In line with our statutory duties, we must review the SCP every three years. In carrying out such a review we must:

- have regard to the Integration Principles and the national health and wellbeing outcomes; seek and have regard to the views of the Strategic Planning Group on:

    - the effectiveness of the arrangements for carrying out the integration functions and
    - whether the Integration Authority should prepare a replacement Strategic Plan.

It is proposed that there are three potential outcomes of a review:

- **Retain the existing SCP:** the main strategic direction of the plan remains relevant, and no updating of the document is required prior to the next relevant period.

- **Revise the existing SCP:** the main strategic direction remains relevant however some aspects on the current document need updated.
- **Replace the existing SCP:** the main strategic direction of the SCP is no longer relevant.

It is proposed that the IJB requests an update on work to progress the review of the SCP in August 2025.

7. FINANCIAL IMPLICATIONS

This report provides highlights the breadth of work currently happening locally. Generally, there has been limited progress with the elements of the Strategic Delivery Plan intended to support progression towards financial sustainability. This highlights the pressures the IJB and Service Managers face in delivering a broad range of quality services in line with our SCP while managing IJB and service financial challenges.

Many of the interventions within the Strategic Delivery Plan remain critical for the delivery of a balanced budget. It is essential that efforts are prioritised to progress agreed plans to support financial sustainability. Furthermore, without the implementation of planned interventions, it will become increasingly difficult to reinvest funding into service areas/strategic priorities.

A Strategic Financial Plan 2025/26 to 2027/28 is presented to the IJB today (Report IJB 06/25).

8. RISK MANAGEMENT

Risk Description	As a result of significant financial, workforce and capacity pressures, there is a risk that Angus Integration Joint Board (IJB) will fail to meet the ambitions outlined within the Strategic Commissioning Plan 2023 - 2026 and deliver on the priorities outlined in the SCP. This would result in a failure to improve the health and wellbeing outcomes of the population of Angus.
Risk Category	Quality (of care) /Clinical
Inherent Risk Level	Level Likelihood 5 Impact 5 = Risk Scoring 25 (very high-risk level).
Mitigating Actions	Ongoing dialogue/actions overseen by: • Strategic Planning Group – overseeing the delivery of the Strategic Commissioning Plan • Workforce Steering Group - identifying mitigating strategies and actions relating to workforce • Strategic Delivery Group and Performance Steering Group – overseeing the delivery of all priorities ensuring they are on target and make a positive impact on national indicators and local performance indicators.
Residual Risk Level	Likelihood 5 x Impact 4 = Risk Scoring 20 (very high-risk level)
Planned Risk Level	Likelihood 3 x Impact 4 = Risk Scoring 12 (Moderate level)
Approval recommendation	Given our developed understanding of the situation and in line with the IJB's risk appetite the risk is deemed to be high but manageable at the current time.

On 20 January 2025, Clinical Care and Professional Governance Group agreed that there is limited assurance with regard the mitigation in place to reduce the risks, in relation to closing the financial gap. Work continues to strengthen the mitigating actions.

9. PUBLIC HEALTH IMPLICATIONS

The nature of this report is to provide an update on various priorities of the SCP. Screening assessments will be conducted for each of the priority areas and full assessments will be completed if required.

10. CLIMATE SUSTAINABILITY IMPLICATIONS

The nature of this report is to provide an update on various priorities of the SCP. Screening assessments will be conducted for each of the priority areas and full assessments will be completed if required.

11. EQUALITY IMPACT ASSESSMENT, CHILDREN'S RIGHTS AND FAIRER SCOTLAND DUTY

The nature of this report is to provide an update on the progress to deliver the priorities of the SCP and as such it does not require an impact assessment to be completed. Screening assessments will be completed for each of the activities within a priority and full assessments will be progressed if required.

12. DIRECTIONS

The Integration Joint Board requires a mechanism to action its strategic commissioning plans and this is provided for in Section 26 to 28 of the Public Bodies (Joint Working) (Scotland) Act 2014. This mechanism takes the form of binding directions from Angus Integration Joint Board to one or both of Angus Council and NHS Tayside.

Direction Required to Angus Council, NHS Tayside or Both	**Direction to:**	
	No Direction Required	X
	Angus Council	
	NHS Tayside	
	Angus Council and NHS Tayside	

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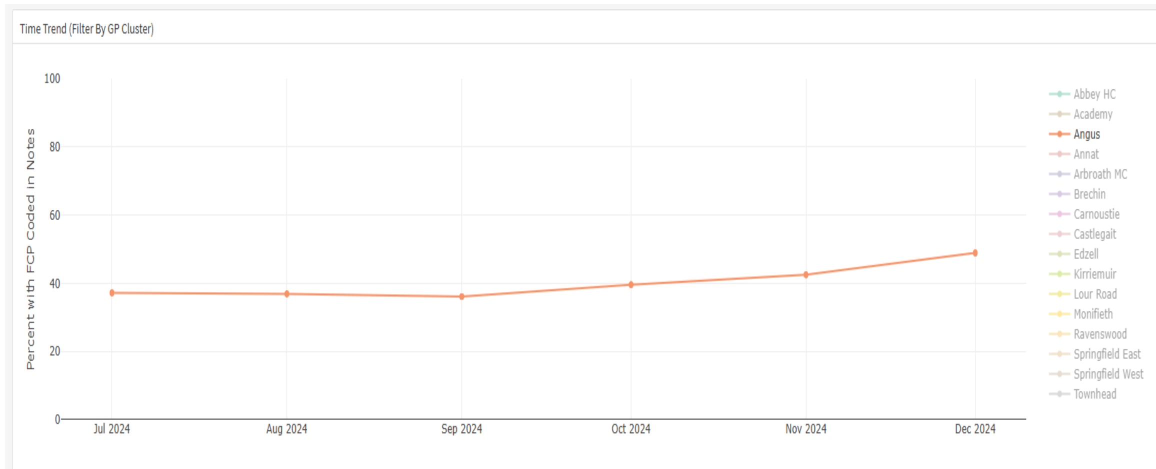
List of Appendices:
Appendix 1: Local data/indicators by priority area
Appendix 2: Examples of service user feedback by priority area.

Local data/indicators by priority **Appendix 1.**

Priority 1

Local Indicator	Results/Comments
% of patients coded as living in a care home with a future care plan coded in the last 56 weeks	Aim is for 95% of patients coded as living in a care home to have a future care plan coded in the last 56 weeks.

Graph 1. % of patients coded as living in a care home with a future care plan coded in the last 56 weeks

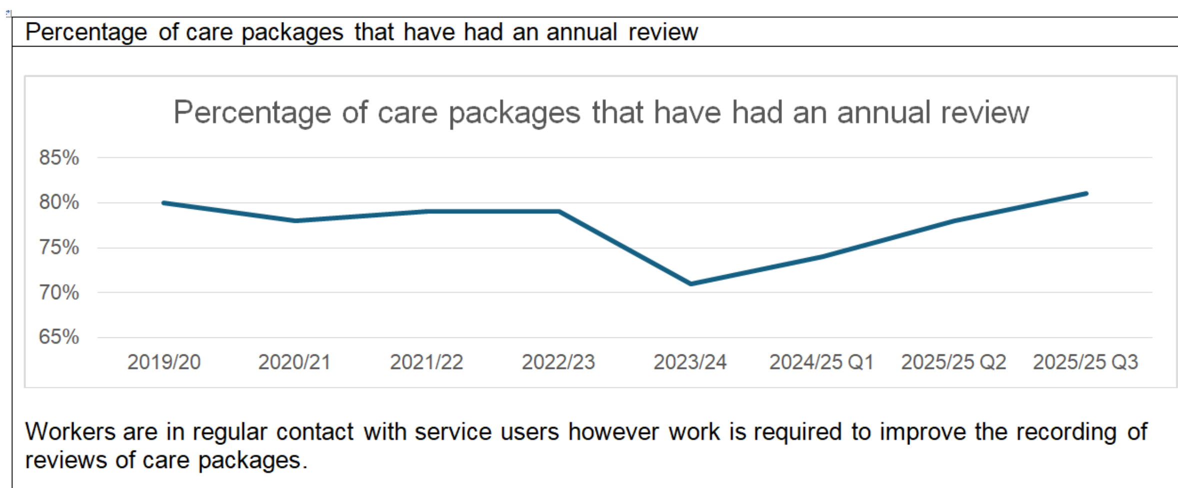


Local Indicator	Results/Comments
% increase in the number of people with a Power of Attorney (POA).	Number of POAs registered 2024/25: Q1 338 Q2 416 Q3 602 Q4 Awaiting data from the Office of the Public Guardian.
% increase in the number of people with a long-term condition who access the ANGUSalive 'Be Active – Live Well Programme.	Data collection commenced in March 2024, therefore it will not be possible to demonstrate a % increase until next year. Data from 1 January – 31 December 2024 is as follows: Total referrals – 842 (male: 329 / female: 510/ prefer not to say:3) SIMD breakdown: 1 – 73 2 – 225 3 – 231 4 – 220 5 – 86 (Unknown data – 7)

Local Indicator	Results/Comments
% of people aged over 75 on 10 or more medicines who have had a polypharmacy review in the past 56 weeks	Included in February 2025 prescribing report (IJB 11/25)
% of people living in a care home who have had a medication review carried out within 56 weeks	Included in February 2025 prescribing report (IJB 11/25)
% of generic prescribing comparison across two financial years i.e. what % of prescriptions issued in Angus are for a generic versus branded product?	A change to the data systems used has resulted in difficulties with accessing the relevant information. A solution is being investigated.

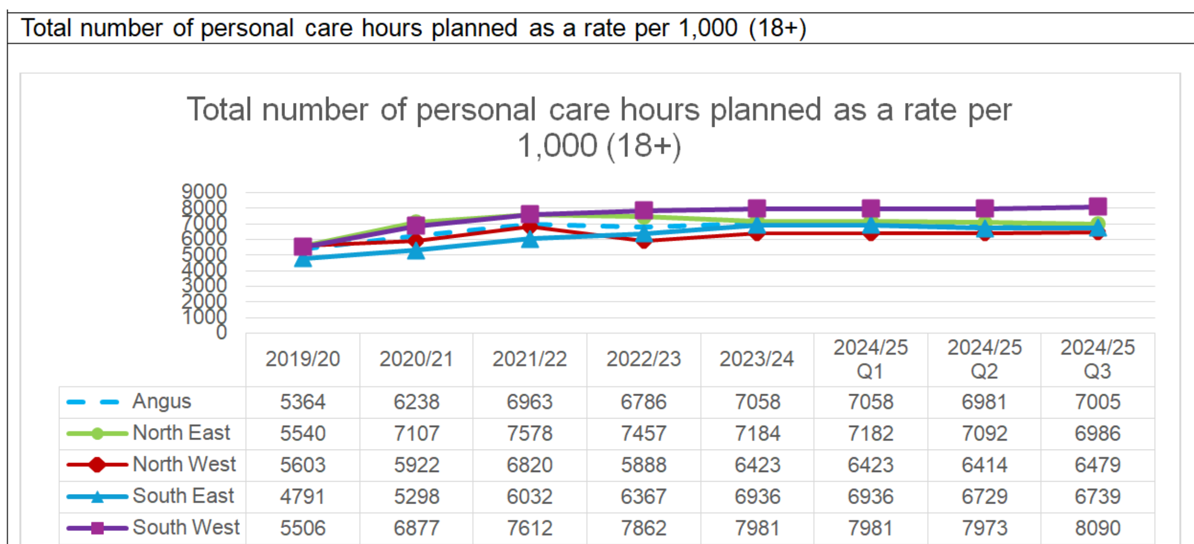
Priority 2

Percentage of care packages that have had an annual review



Workers are in regular contact with service users however work is required to improve the recording of reviews of care packages.

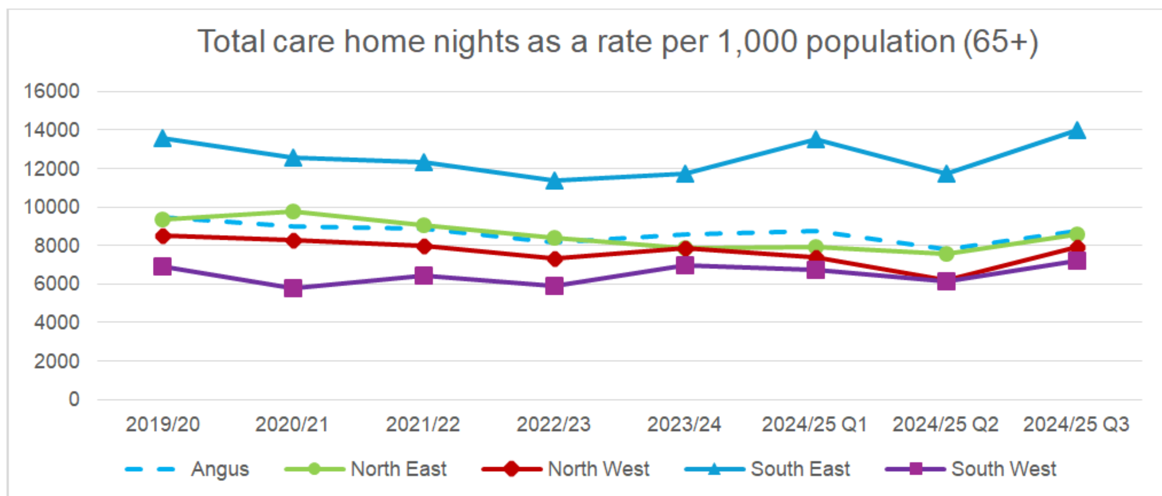
Total number of personal care hours planned as a rate per 1,000 (18+)



	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25 Q1	2024/25 Q2	2024/25 Q3
Angus	5364	6238	6963	6786	7058	7058	6981	7005
North East	5540	7107	7578	7457	7184	7182	7092	6986
North West	5603	5922	6820	5888	6423	6423	6414	6479
South East	4791	5298	6032	6367	6936	6936	6729	6739
South West	5506	6877	7612	7862	7981	7981	7973	8090

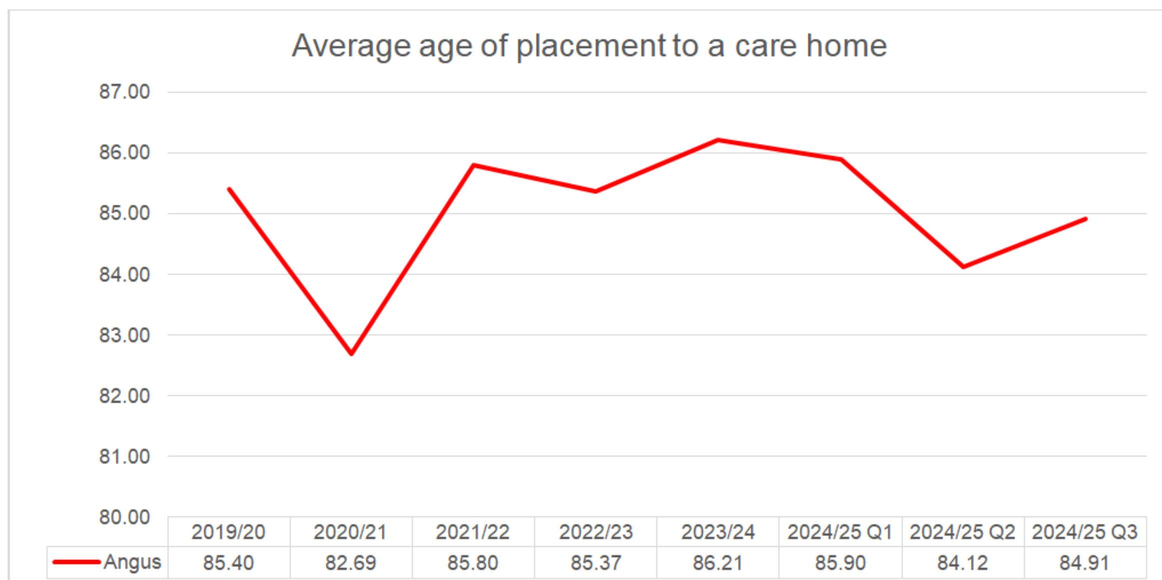
Personal Care hours rate per 1,000 18+ has increased from 5364 in 2019/20 to 7005 in 2024/25 Q3 (31% increase).

Total care home nights as a rate per 1,000 population (65+)

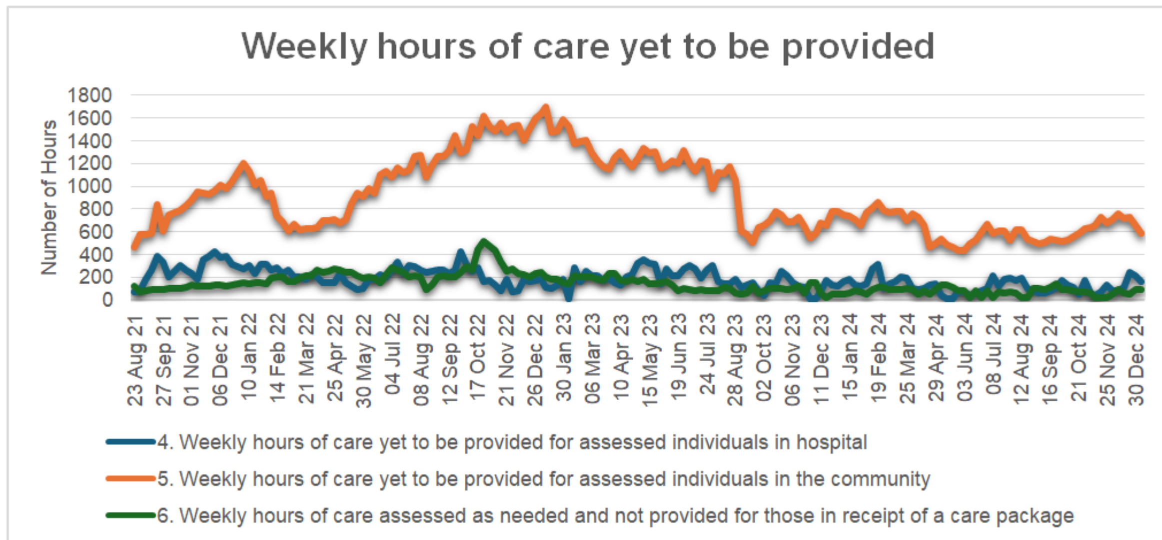


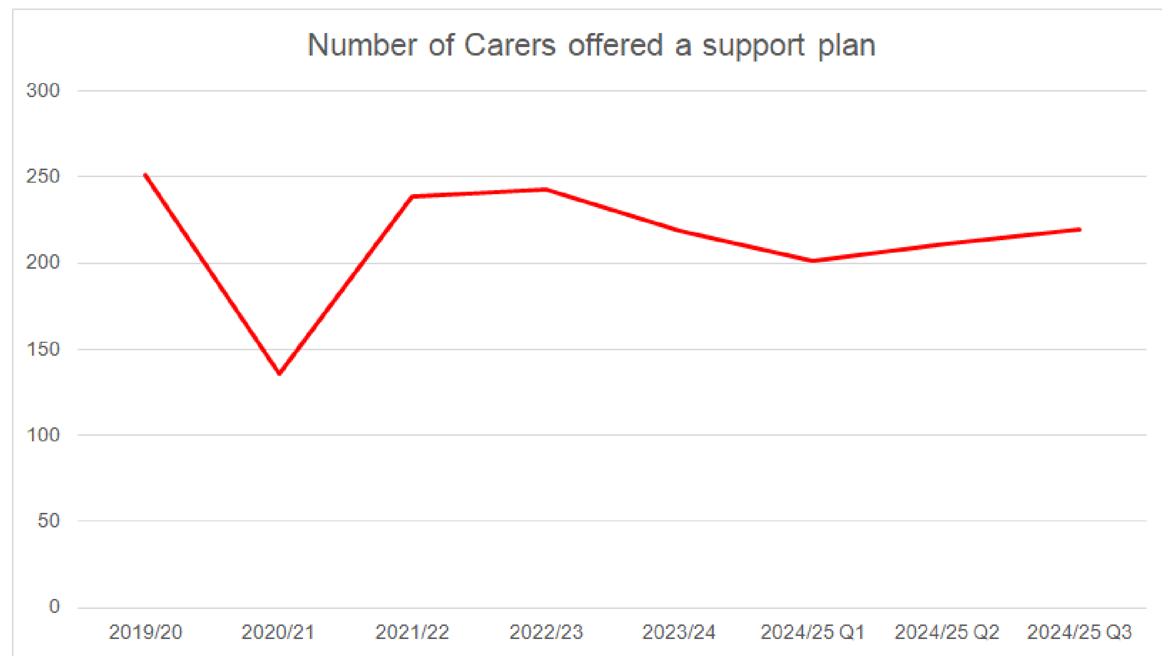
Care home nights rate per 1,000 65+ has decreased from 9487 in 2019/20 to 8771 in 2024/25 Q1 (8% decrease).

Average age of placement to a care home



The average age of placement to a care home decreased slightly from 85.40 in 2019/20 to 84.91 in 2023/24.

Number of hours of unmet need (including number of hours of care provided by Carers)

Number of hours of unmet need was 654 for Week commencing 23 August 2021 and is now 955 for week commencing 30 December 2025. The highest recorded unmet was 2291 hours for week commencing 22 October 2022.

Number of Carers offered a support plan

Number of carers offered a support plan has seen a slight increase in 2024/25 Q3. 2020/21 figures were impacted by COVID.

Priority 3

Mental Health

Mental health and Wellbeing Peers are making initial contact with the majority of people within 3 days.	42% of referrals to peer were self-referrals in 2024	Main reasons for referrals to peers were consistently Low Mood and Anxiety, followed by Stress and Relationships	The highest supported age ranges for peers were 40 to 49 years old in the North and 18 to 25 years old in the South
Over 10 thousand people’s needs have been triaged by the Mental Health and Wellbeing Enhanced Community Support hubs (ECS) since 2021.	Over two and a half thousand self-referrals to the ECS Hubs since 2021	24% of referrals to the ECS hub are self-referrals overall. This has reduced demand on GPs, improved access; with less delay and duplication.	452 people accessed the Are You OK? web page – when the campaign launched
1815 hits to Are You OK? Website in past 6 months	354 referrals for Distress Brief Intervention (DBI) Support in 2024	DBI Feedback: *“"It has been a lifesaving service. I don’t know what I would have done without that support. I found it hugely important for me to have someone to listen to me and someone to give me feedback. "*	35 Triangle of care actions achieved to raise awareness, improve communication and improve the experience of carers.
A leaflet and information pack has been developed, specifically for people identified as a carer of someone referred to CMHT.	Angus Carers Centre have delivered carer awareness session and supported CMHTs to improve early identification of carers.	88 people undertaken Suicide Intervention Skills Training (ASIST)	180 people undertook Suicide Intervention and Prevention Planning

Learning Disability

From April - December 2024, Learning Disability services across Angus received 100 positive stories from service users and family members.

Care Packages: in 2019 281 care packages were provided, this increased to 377 in 2024.

Examples of Service User Feedback **Appendix 2**

Priority 1. Prevention and Proactive Care

[Pulmonary rehab experience at Arbroath Saltire 2024. | Care Opinion]

I attended the classes for 6 weeks. They were given by 2 marvellous therapists / nurses - Evie and Deidre - lots of fun, always very professional. I was also rehabilitating from a long stay in hospital. This had resulted in loss of muscle mass and decreased confidence. The mix of exercise and lessons was great. The combination of exercises (upper / lower body strength) has inspired me to attend the local gym which I never thought I would do - had never lifted weights before. Cycling has also given me the confidence that I can get back on my road bike which I aim to do over the coming months. I'll keep practicing on gym bikes until then. I also look forward to swimming again. This six weeks of exercise has undoubtedly sped up my fitness and rehabilitation post hospital. The education sessions have been invaluable for helping me to better understand my condition and has provided useful information such as managing breathlessness, nutrition / healthy eating, travelling and local support groups.
I enjoyed attending each class and meeting the other participants, who were all lovely, and having wee chats over a cuppy and biscuits at the end of each session. Another thing that I didn't think I would enjoy doing!
Thank you so much

Feedback received from Better Balance Classes

- "My husband attended a better balance class in Montrose, normally a 12 week course, my husband attended for 2 blocks (24 weeks) what a difference it was amazing, and he left without having to use a zimmer, crutches or a stick"
- "Good Exercise, enjoyed it"
- "Helped my balance"
- "I appreciated the strengthening exercises and the interesting way they were presented"
- "Enjoyed all the exercises – can't think of anything I did not like"
- "Didn't know what to expect but enjoyed coming"

ANGUSalive Active Start participant feedback

"My family moved to Montrose two and a half years ago and I have been unable to walk down to the beach. Just before my last class I managed to walk down to the beach and back up. This is probably my biggest health achievement in over a decade. I believe I will be able to reduce my reliance on my wheelchair and open my social opportunities." (September 2024)

"I have a bit more energy, am now drinking bottle of water throughout the day and eating proper meals. Enjoyed the social aspects and the presentation of the classes. I have gained a lot more movement since I started and feel a lot stronger since I started. Looking forward to going to the next level." (October 2024)

"Since starting the classes, I've reduced my food intake and I'm eating a lot healthier. Made more of an effort to come to classes making friends through the classes and I'm taking care of myself more. I've lost weight and feel stronger mentally and physically since I started. I feel like I have more of a purpose in life now." (October 2024)

"I have noticed a difference in my health since starting the classes - I have been able to do more and be more active than I was before." (December 2024)

Priority 2. Care Closer to Home

[An outstanding service | Care Opinion]

My late Mum received the utmost personal and professional care from the Community Alarm Service in Arbroath, Angus. They were unfailing in their compassionate, patient and kind response, day and night when my Mum summoned assistance.
They also treated me, an anxious and emotional family member with respect and understanding.
I will never forget their attention to detail and the gentle handling and respectful care they gave my Mum. The Call handlers who listened and the Team members who attended to Mum provide an outstanding service.

All the staff were always very friendly and helpful | Care Opinion

Having been lucky enough to be given the use of the facilities at Arbroath Infirmary to help me to recover from a stroke. I would like to thank all the physio staff involved in planning my recovery. They couldn't do enough to ensure the best results possible for which I will be eternally grateful.
All the staff were always very friendly and helpful, it was always a pleasure to attend these sessions. Once again, thank you all (will miss you).

Minor Injury Unit Care Opinion

I had a fall on ice yesterday morning and injured my arm. Called 111 and had a quick response, was triaged by a nurse and spoke to a clinician. I had an appointment at my local minor injuries unit within two hours. Attended there and although there was no X ray facility on a Sunday my arm was placed in a splint and an appointment was made for an X ray this morning. I felt listened to and reassured that had I needed anything more urgently it would be available.
Seen this morning and X ray done.

Learning to manage a household. | Care Opinion

My two children and I became homeless due to very drastic circumstances and thanks to everyone's help, managed to find a place for us all to live.
It was a very anxious and stressful time for me personally and would of been a lot worse and most likely unmanageable, especially from an emotional standpoint, without all the support we got from social work, homeless prevention group (not exactly sure if this is what they are called, but was a lovely lady called Sarah).
I tried to mainly do most things myself as it's my first time trying to run a household without any other adults present, especially with having both of my children relying on me. It was amazing to have the support and backup there when and if needed, along with the words of encouragement.

Priority 3. Mental Health, Learning Disability and Substance Use Recovery

She makes me understand how to be happy again | Care Opinion

Anne-Marie from the Kirriemuir Community Mental Health Team has supported me for almost a year. She has worked with me on my autism and given me coping strategies, so I don't feel that I am struggling to cope. I am grateful to have her and wish others understood me like she does. I feel like she understands me and makes me feel happy and when I feel bad, she makes me understand how to be happy again.

Made me feel listened to and have encouraged openness | Care Opinion

My mental health took a decline a few times over the last couple of years and the CMHT have supported me through those times. They have made me feel listened to and have encouraged openness when it comes to talking about how I feel or what is going on for me, without judgement.

My experience of caring for a relative with a mental health condition | Care Opinion

The care and support my relative received from Gowanlea was excellent.
My relative was very unwell and it is down to Gowanlea (Cheryl and Julie) that she was finally admitted to Carseview for the treatment she desperately needed. Before she was admitted the duty worker was always just a call away if I needed them for my relative or if I was worried, and Cheryl was a great support.
Once my relative was in hospital (she was in Carseview for 6 months) I was offered support from Nicki as part of a scheme that helps the carers of people with mental health conditions. This consisted of weekly visits for 6 weeks. This was so helpful, and Nicki was great. My relative was sectioned and had ECT treatment and Nicki thoroughly explained everything surrounding the section and the procedure itself.
Once my relative was discharged, she was supported by Adrian who was also brilliant. He always ensured I was involved in my relatives ongoing care, and I know either of us would have been able to contact him if needed.
I am so thankful for Gowanlea, every member of staff we encountered are an asset to the team and I always felt fully supported and knew my relative was in the best hands.