ANGUS
Health & Social Care
Partnership

Strategic Commissioning Plan

2019-2022

Published March 2019


Internet

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1. Foreword

This is the Strategic Commissioning Plan 2019-22 for Angus Health and Social Care Partnership (Angus HSCP). The plan shows how the Angus HSCP will continue to integrate health and social care services and how we will encourage people to improve their health and wellbeing.

We believe that everyone has the right to live a long and healthy life and to be supported to live at home when it is safe to do so. We know that we cannot achieve this on our own. The biggest difference in health and social care in our communities will come from the things that we can do for ourselves by taking control of our own health and wellbeing. We know that Angus has great places to live and great communities. Together we can make a difference and be courageous by being open to doing things differently.

We know that the wider issues of poverty, housing and social isolation can have an impact on a person's health and wellbeing. The Angus HSCP will work through our Locality Improvement Groups and alongside Angus Community Planning Partnership to address these issues. This Strategic Commissioning Plan aligned to NHS Tayside's plans for Transforming Tayside, the Tayside Plan for Children, Young People and Families to deliver health and social care support for all our community.

Information to date, published in our annual report, suggests that we are already doing well. More than 90% of older people's care is delivered in our communities but there is still more to be done to achieve this for the whole adult population and for families. Hospital admission rates for people over 75 are declining as we support more people at home. Admission rates for people aged 50-74 are increasing as more people have long term conditions. We have already delivered good work in relation to self-management of long term conditions but as we learn more about reducing admissions for people aged 50-74 with Chronic Obstructive Pulmonary Disease (COPD), diabetes and asthma we can continue to improve services in our communities. This is an example of prevention that needs us to work together to do something different. By 2022 Angus HSCP aim to further improve health and social care.

This Strategic Commissioning Plan sets out the vision and future direction of, health and social care services in Angus and how those services are funded. It reflects the work that is already underway and looks at areas where we still need to improve. This plan is not a list of every action that Angus HSCP will take in the next three years. The detail of these smaller steps will be developed in conversation with the public and providers living and working in the four localities of Angus. Whilst we want to be ambitious with our plans we know that we need to be realistic about what can be achieved with the resources available to us. We believe this plans sets out that ambition and that realism.

We would like to thank all those who have contributed to the development of this Strategic Commissioning Plan in our conversations, in our groups, and on our website. This includes people who use health and social care services and people who may use services in the future. It also includes people who provide those services in the Angus Council, NHS Tayside and the third and independent sectors.

Lois Speed - Chairperson, Angus Integration Joint Board
Hugh Robertson - Vice Chairperson, Angus Integration Joint Board
Vicky Irons - Chief Officer, Angus Health and Social Care Partnership

2. Our Vision for Health & Social Care in Angus

OUR VISION

Working together, developing communities that actively care, promoting wellbeing and creating the best possible health and social care across Angus

MAKING A **DIFFERENCE**

What WE will do to make a difference

- Work with communities
- Focus on prevention and enablement
- Be realistic: provide safe and effective services in an increasingly challenging financial environment
- Be more creative, courageous and innovative
- Build for a future where digital technologies are more integrated in our work and used more widely by the population
- Deliver on our plans

What YOU can do to make a difference

- Take control of your own health and wellbeing
- Keep active whatever your stage in life
- Maintain a healthy weight
- Be informed about how to best address your health concerns
- Be mindful of the wellbeing of others in your community
- Get involved in your local community
- Join our conversations to help shape health and social care services for the future

3. Our Ambition

Progress on delivering integration is measured nationally through 23 national core indicators. These along with local measures are used in our annual report to show how Angus HSCP is delivering on the national outcomes for health and social care (see 9.2). To measure progress against this plan we believe that further measures are required to show that Angus HSCP is making a difference in three areas of ambition. The measures are:

1. Promote the wellbeing of the people of Angus by supporting approaches to prevention (see note below)

Where we are now in 2018	Where we want to be by 2022
Approximately 46 in 1,000 people received prescriptions for the treatment of diabetes. This has been increasing	Improve levels of healthy weight to see no further increase in rates of diabetes prescribing
Approximately 136 in 1,000 people received prescriptions for the treatment for hypertension. This has been decreased by 3% in the last 3 years	Improve levels of healthy weight to see a further 3% reduction in hypertension prescribing
Approximately 170 in 1,000 received a prescription for the treatment of anxiety and depression. This has increased by 5% in the last 3 years	Improve mental wellbeing to see no further increase in prescribing

2. Support people to be independent for as long as possible

Where we are now in 2018	Where we want to be by 2022
The average age that an older person was likely to require support with personal care at home is 82.91 years	Enable people to be independent and increase the average age that people access support with personal care by 6 months (83.41 years)
Approximately 41 in 1,000 people receive personal care at home support. This has been increasing	Support people to be independent reducing the number of people per 1,000 using personal care by 10%
Approximately 22 in 1,000 people aged over 65 were admitted to hospital following a fall. This type of admissions has been increasing	Support people to be independent, be mobile and active so there is no further growth in the rate of admissions due to falls in people over 65
82.7% of people with drug and alcohol concerns were seen within 3 weeks	90% people referred

3. Shift the balance of care from hospital to home, supporting more people in our communities

Where we are now in 2018	Where we want to be by 2022
Approximately 1 in 1,000 adults experienced an unplanned admission to hospital	We want to support people more effectively at home and reduce the rate of admissions by 10%
There were approximately 23 unplanned mental health hospital bed days used for every 1,000 adults	We want to support people more effectively at home and reduce the rate of unplanned mental health bed days by 10%
There are approximately 66 unplanned hospital bed days used for every 1,000 adults	We want o support people more effectively at home and reduce the rate of unplanned hospital bed days by 10%

Note: There are no reliable measures that help us directly understand the proportion of the population that have healthy weight, are active and experience positive mental wellbeing. To show our progress in achieving this ambition we will use measures that can be improved by health weight, active living and positive mental health. These measures are prescribing information for hypertension and diabetes and prescribing information for anxiety and depression. We recognise that these measures are not ideal but where these are declining that will act as an indicator of improvement in the health of the Angus population.

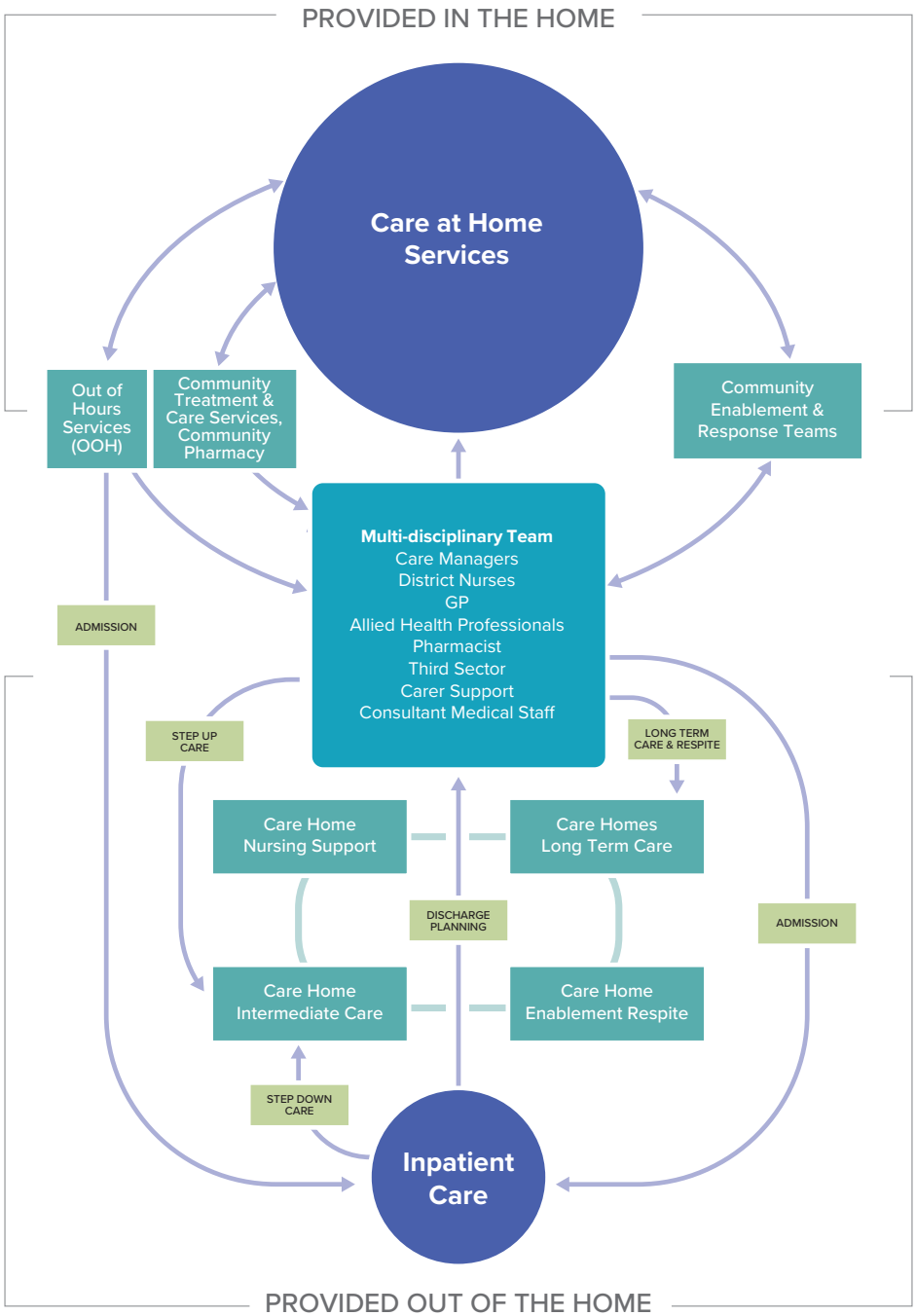
Our ambition will also continue on our journey with delivering the Angus Care Model, shifting the balance of care to support more people in our communities and support people to greater independence for longer.

Angus HSCP will continue to grow the Angus Care Model. This describes how multi-disciplinary teams in our communities work with different services to ensure that the right support and care can be provided to help people stay at home. We will take every opportunity to better integrate services at all levels of our partnership. We will think and do things differently to support people more effectively in their own homes and homely settings in our communities.

More information about the Angus Care Model can be found out on our website **www.angushscp.scot**

ANGUS CARE MODEL

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



4. Listening to our communities

As we develop the Angus Care Model, engaging with communities, people who use services, carers, staff, providers and the third and independent sectors is essential if we are to deliver change that is right for Angus. Engagement has been and will continue to be an ongoing activity. It serves to ensure that we understand our localities, and that we are progressing in the right direction, with consensus.

We host a range of groups and forums to deliver consensus on plans and the vision for the future. Involvement and engagement approaches include:

- Locality Improvement Groups
- Care Home Improvement Groups
- GP Clusters
- GP Clinical Partnership Forum
- Providers Forums
- Conversation events held in localities (drop in and talk to staff about services and potential developments)
- Questionnaires on our website, Facebook and Twitter feeds and paper copies available in a range of public accessible areas e.g. GP surgeries and libraries
- Face to face work in communities by Voluntary Action Angus and the Communities Team

In 2018 we asked stakeholders to tell us what we need to deliver through our strategic plan. This is what they told us:

We aim to show a greater commitment to prevention in this plan and ensure that our plans are realistic. We will continue to grow our approach to engagement within our localities. Locality Improvement Groups have a central role in ensuring that, as integration is progressed, communities are at the centre of change and improvement. This plan does not set out the detail of all the changes that might be made to services over the next three years. You have told us that you want to be more involved in service change. We will continue to develop information on our website and have more conversation events so that the people of Angus are involved and can influence change.

5. Localities

We will continue to build our locality improvement model including ensuring that there is greater integration with locality community planning arrangements and greater participation by communities.

Locality Improvement Groups (LIGs) are established in each locality. Each group includes a wide membership including front line staff, carers, members of the public, third sector organisations and independent providers of care and support working in the locality. Each LIG has access to information about their locality and uses that to consider how to address local issues. A Locality Improvement Action Plan is developed by the group and refreshed annually. This is a summary of their plans for 2019-20.

Angus Locality Map

North West

- Improve access to services
- Improve local approaches to Prevention/Early Intervention

North East

- Improve access to information and health improvement opportunities
- Reduce the number of falls in the community.
- Reduce social isolation by enhancing social prescribing opportunities
- Embed locality Enhanced Community Support approach

South West

- Address social isolation
- Continue to embed Level 1/2 Mental Health Support
- Clinical Effectiveness - support and development of the workforce
- Carer Wellbeing – to ensure we have the right and effective support for carers

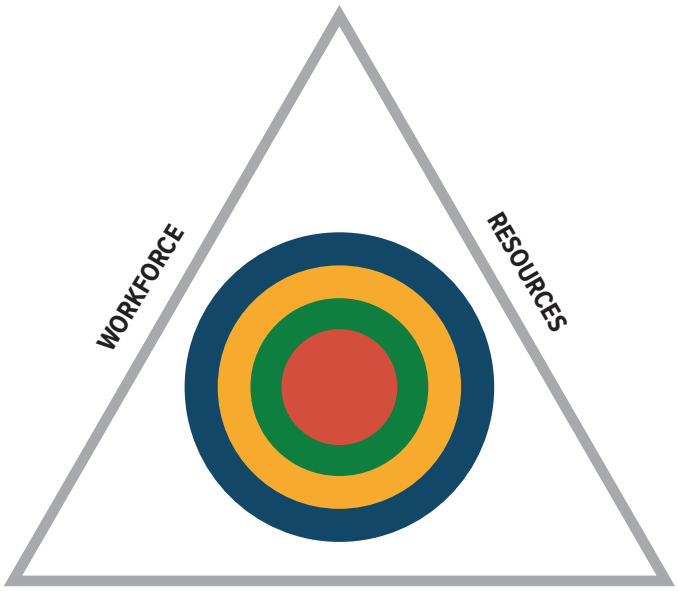
South East

- Deliver an Arbroath Healthy Living initiative
- Develop Anticipatory Care Plans

6. Delivering Our Vision, Achieving Our Ambition

We will deliver our vision through focusing service integration, improvement and transformation through four areas of work (strategic priorities). These areas of work are influenced by three performance areas that we also have to manage.

Angus HSCP priorities and performance areas



- **PRIORITY - Improving Health, Wellbeing & Independence**
  Develop foundations for good health. Tackle risk factors and support people to plan for life and wellbeing across the life course.
- **PRIORITY - Supporting Care Needs at Home**
  Support care needs at home, offering wider options for care and housing solutions which can sustain people's place in the community.
- **PRIORITY - Integrated & Enhanced Primary Care & Community Responses**
  Provide high standards of Primary Care for all practice populations, and enable more integrated responses to be delivered in a community setting. Make more effective use of community health and social care services in intermediate settings (statutory and non statutory), ensuring there are care options available 24/7 when needed. Use institutional care options only for health and social care that can't be provided at home.
- **PRIORITY - Integrated Pathways With Acute & Specialist Providers for Priorities in Care**
  Use specialist care settings appropriately. Integrate assessment, rehabilitation and care where possible in non acute settings. Consider whole pathways of care across all priorities.

WORKFORCE - Delivering a workforce fit for the future
RESOURCES - Delivering services with the funds available to us and in the right environments
CLINICAL, CARE AND PROFESSIONAL GOVERNANCE - Ensuring that services and environments are safe

These priorities and performance areas are designed to progress the national health and social care outcomes (see 9.2).

7. Our Plans

Each priority will be delivered through a number of projects. Each project will require an improvement plan which details all the small steps and timescales by when these will happen. An improvement plan will also show the approach to each of the Angus 6Rs for improvement and transformation.

The Angus 6Rs for Improvement and Transformation in Health and Social Care:

- **Rebalance** care, maximising support for people in their own homes.
- **Reconfigure** access to services delivering a workable geographic model of care outside the home.
- **Realise** a sustainable workforce delivering the right care in the right place.
- **Respond** to early warning signs and risks in the delivery of care.
- **Resource** care efficiently, making the best use of the resources available to us.
- **Release** the potential of technology.

The Angus 6Rs will ensure that we are able to match resources to our transformational and improvement activity and monitor progress though the mid-year and annual performance reports.

Projects will be required to set out measures, including improvement targets, to be achieved over the three years of the strategic commissioning plan.

Project improvement plans developed under each priority will be brought together into a delivery plan to demonstrate progress against this strategic plan. Improvement plans will be reported on in our annual report.

In the following pages we have set out for each strategic priority, examples of the plans that will be developed to make sure that we deliver on this Strategic Commissioning Plan.

Improving health, wellbeing and independence

Working together to create an Angus that actively cares

Communities are:

- Involved; making a difference
- Inclusive
- Compassionate
- Disability and dementia friendly
- Suicide aware
- Active
- Supporting loneliness and isolation

Deliver more housing solutions for the ageing population and those with other varying needs, ensuring housing models and related services meet the needs of our communities.

- Work with partners to increase the supply of affordable housing for people with particular needs
- Implement the Rapid Rehousing Transition Plan, preventing homelessness and ensuring that households achieve settled accommodation and necessary support needs
- Improve our equipment and adaptations service, ensuring we make best use of resources and deliver as needed

AHSCP will support the third sector by providing financial support for prevention, early intervention and the growth of communities that actively care. We will provide further support through Locality Improvement Groups to address community based issues.

Delivering for carers

Complete the implementation of the Carers (Scotland) Act 2016 by 2021 working towards:

- Carers are identified
- Carers are supported and empowered to manage their caring role
- Carers are enabled to have a life outside of caring
- Carers are fully engaged in the planning and shaping of services
- Carers are free from disadvantage or discrimination related to their caring role
- Carers are recognised and valued as equal partners in care

Promoting Health and Wellbeing; working on prevention

- Encouraging active living
- Promoting healthy weight
- Staying hydrated
- Avoiding smoking
- Reducing caffeine intake when affected by incontinence
- Following the Chief Medical Officers low-risk alcohol intake guidelines
- Building support online
- Promoting contact with pharmacy first

Supporting self-management of long term conditions

- Improving information on Independent Living Angus
- Growing technology for the future
- Diabetes prevention and early intervention
- Mental wellbeing
- Continence support
- Developing more support for chronic pain management
- Establish an anticipatory care plan for all those who need one

Supporting care needs at home

Promote independence by:

- Promoting wellbeing and independence through Enablement Response Teams
- Growing the potential of technology through community alarm and self-service digital platforms such as Independent Living Angus

Care management and community nursing:

- Delivering person centred care by the right person at the right time.
- Integrating working practice across teams.
- Enabling enhanced community support for people with the greatest needs.
- Co-ordinating care and treatment.

Palliative and end of life care ensures that care is:

- Compassionate and person centred
- Good information is available to support individuals and their carers
- Care is delivered as close to home as possible
- Both the workforce and families are informed and resilient
- Individuals and communities are involved in discussion on death, dying and bereavement

Learning disability services working to deliver:

- Increases in local supported accommodation
- Replacement of the Gables Care Home
- Longer term solution to residential respite care provision
- Minimal use of out of area placements
- Review overnight support

Review day care provision and ensure appropriate levels are available and that it offers best value

Help to live at home:

- focus support on those who need it
- extend free personal care provision to people aged under 65

Carers are recognised as equal partners in care

Protecting vulnerable adults; ensuring that the workforce is alert to the issues as increasingly vulnerable people are supported to live at home for longer. The Adult Protection Committee will continue to address knowledge, skills and understanding

Developing integrated and enhanced primary care and community responses

Improve primary care including:

- Developments in line with the 2018 GMS contract
- Deliver a general medical services premises plan.
- Improve access to community treatment and care services.
- Align pharmacy support.
- New models for urgent care services to be explored.
- Introduce additional professional services.
- Continue to build integrated working with the third sector.
- Grow technology for the future.

Embed Enhanced Community Support (ECS) model in all General Practices:

- Expand ECS to include all adult population.
- Develop potential for prevention of admission models.
- Build on the experience of Monifieth Integrated Care in other areas of Angus.

Older people, carers, professionals and local communities will be **informed about mental illness** that may affect older people.

Older people with mental illness and their carers will:

- know who they should speak to about a possible diagnosis and what to expect throughout that process and afterwards. After diagnosis, they will be given the information they need to access the appropriate support.
- feel assisted to plan for their future and will progress towards the level of independence that is right for them. They will feel safe, secure, supported and cared for. They will have an awareness of the range of options that are available to support them.
- be involved in planning for their own and/or their family member's future and will have confidence in professionals to provide appropriate support during transitions. Good communication and partnership working between professionals and families during transitions will take place.
- ensure care home models can effectively support people with advanced forms of dementia

Value your medicines, a best value approach to prescribing which will:

- Support a transformation of care pathways for diabetes.
- Implement of prescribing formulary and associated guidance.
- Focus on chronic pain pathways.
- Engage the public and provide information regarding medicines use and waste.
- Review of non medicines prescribing and the development of an agreed formulary.

Continence

Improve the pathway for continence services to deliver health improvement, self-management approaches and timely access to specialist support where required.

The Alcohol and Drug Partnership will continue to support people, their families and local communities to manage the challenges associated with drug and alcohol use.

Plans will ensure that people access support and treatment at the earliest opportunity including Alcohol Brief Interventions.

Improving integrated care pathways for priorities in care

A focus on whole pathway approach to:

	The Angus Care Model	Diabetes pathway	Mental Wellbeing Pathway
Priority Improving health, wellbeing and independence	Promote wellbeing and independence Deliver the enablement potential of the new Enablement Response Teams (ERT)	Working with communities to encourage and to normalise active living Promoting healthy weight	Working with communities to address loneliness and isolation Improve the physical health of people with mental health problems
Priority Supporting care needs at home	Focus personal care services on those who need support Delivering new models in local authority care homes Deliver sustainable nursing care in care homes Anticipatory care plans in place for care home residents and those who need them at home	Supporting access to weight management	Working with the third sector on accessible community based support Mental health and wellbeing practitioners working in every practice
Priority Developing integrated and enhanced primary care and community responses	Complete the roll out of Enhanced Community Support in all localities Providing a 24 hour model that delivers out of hours support appropriately	Timely access to specialists who will be able to see higher risk patients more frequently	Shift the balance of care from inpatient services to supportive community services Ensure timely discharge and reduce average length of stay in hospital
Priority Improving integrated care pathways for priorities in care	Continue to deliver a hospital bed model that supports people effectively and efficiently Maintain low levels of delays in timely discharge	Less morbidity from diabetes preventing the downstream social care costs associated with amputations and other high cost complications of diabetes	Develop a co-morbidity pathway or people with both substance misuse and mental health problems Work with Perth and Kinross HSCP to transform the interface pathway in and out of inpatient mental health services

Working with NHST and Tayside partnerships to deliver the Tayside Mental Health Alliance

Work with NHS Tayside to transform outpatient services. Better support for people and for our community based services

Deliver a more person centred approach to transition from child to adult services

Work jointly with Children and Families to deliver an approach to Adverse Childhood Experiences (ACEs)

8. Our resources

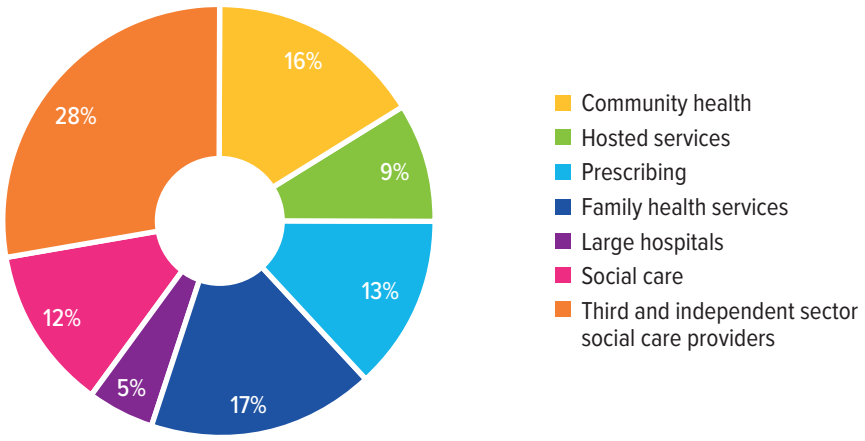
8.1 Finance

The Angus HSCP's financial planning environment will be challenging for the duration of this Strategic Commissioning Plan. This is consistent with the environment faced by public sector generally and Angus Council and NHS Tayside specifically. Both organisations face significant financial challenges and require Angus HSCP to live within agreed devolved resources. The final strategic financial plan for the period 2019-2022 for the Partnership will continue to be dependent on a number of factors including:

- The conclusion of annual budget negotiations with both Angus Council and NHS Tayside.
- Implications of the Scottish Government's annual budgets.
- The increased pressures the Angus HSCP has to absorb annually including inflationary, demographic, legal and service pressures.
- The scale and timing of change and interventions that the Angus HSCP plans to progress in response to the above pressures.

The chart below summarises the breakdown of the financial resources available to the Angus HSCP to plan and deliver health and social care services. This reflects the most current information regarding financial resources transfering from Angus Council and NHS Tayside to the Angus HSCP.

Angus HSCP Expenditure (2018/19)



In 2019/20 Angus HSCP's budget will be circa £170 million. The shape of Angus HSCP's future expenditure will be described in associated strategic financial plans. The Angus HSCP anticipates that most volume growth will happen within social care (particularly home care) and prescribing. National initiatives such as the General Medical Services (GMS) contract will also affect the shape of our resources.

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 Angus HSCP in line with

increased demand. Using current resources as efficiently and effectively as possible is essential. This strategic commissioning plan identifies a number of areas of improvement and the shift in the balance of care required. Angus HSCP's financial planning assumptions will continue to be developed during 2019/22 with regular "Strategic Financial Plan" reports shared with the IJB Board. Many of the changes that will be reflected in further detailed financial planning are described in the "Delivering our Vision" section of this plan. When brought together, these individual plans will contribute to Angus HSCP's overall strategic financial plan. Some of the financial planning includes:

Priority: Improving Health and Well Being

- Review the HSCP's overall funding to develop third sector capacity, independent sector capacity to increase support for prevention and early intervention.
- Review existing arrangements which support the self-management of long term conditions and consider how digital approaches can be included through the further development of Independent Living Angus platform.
- Work with local General Practices and Pharmacy Services to progress plans which ensure that local Prescribing resources are utilised effectively.
- Ensure we have a strategy that helps mitigate overall demand to allow us to focus available resources on those who need it most.
- Further develop Enablement response services to maximise support for promoting independence and promoting wellbeing approaches.

Priority: Supporting Care Needs at Home

- Consider the utilisation of HSCP funding, including Technology Funding, to further develop Technology Enabled Care.
- Further develop contracting frameworks with providers to ensure best value, to create effective contract mechanism and to support the sustainability of our providers.
- Undertake a review of Older People's day care provision to ensure best value and appropriate levels of service are available. Consider how this might be extended to ensure that adult resource centres continue to efficiently and affordably meet the needs of the population with learning disability and complex care needs.
- Community Equipment and Adaption Services – Continually review arrangements for service provision to ensure the provision of high quality sustainable Community Equipment and Adaption provision.
- Review the models of care for Care Home capacity provided in local authority care homes including reviewing support services.
- Modernise the approach to administration of medications in the community for those that require support.
- Deliver an evaluation of an Angus wide nursing model to support care homes in Angus
- Review models of care in supported accommodation.
- Review arrangements for supporting carers to meet the requirements of the Carers (Scotland) Act 2016.

Priority: Developing Integrated and Enhanced Primary and Community Responses

- Undertake a further review of local inpatient care to reflect planned changes in unplanned hospital bed use.
- Consider the development of a sustainable nursing workforce to support care homes.
- Consider how care home models might better support people with very high levels of need with dementia who currently require In patient care.
- Continue investment in locality and community support (including Enhanced Community Support and services provided through the third and independent sectors) to prevent increased demand for social care and health services thereby releasing resources to be re-invested.
- Conclude reviews of Minor Injury & Illness Units across Angus to ensure all services are delivered effectively and efficiently.

Priority: Improving Integrated Care Pathways for Priorities in Care

- Work to develop revenue and capital financial plans that reflect improved pathways of care for services that are delivered through community services, in patient services, care homes and supported accommodation including Adult Mental Health, Older People's Mental Health, Learning Disability and Autism Services and Substance Misuse services.
- Explore the resources available in the large hospital set aside that could be released from the reduction in Angus bed days used in Ninewells with a focus on the potential for different models which refocus staff towards community based models.

Other

- These issues will be taken forward in addition to the above and are expected to make a material impact within the IJB's strategic planning.
- Progress plans to respond to impending recruitment and retention issues.
- Work operationally and strategically to reduce levels of sickness absence.
- Review management structure and administration functions within Angus HSCP.
- Develop opportunities for collaborative working with neighbouring IJBs, Angus Council and NHS Tayside.
- Continue to review contribution and charging policies to best allow us to meet the cost of service provision.
- Work to introduce new legislation and other requirements (e.g. Free Personal Care for under 65s and the 2018 GMS contract) in an effective and efficient way as possible.
- Continue to develop plans with all locally hosted services to ensure efficient and effective services delivery within available resources, on behalf of all Tayside IJBs.

8.2 Workforce

Angus HSCP relies upon its employing authorities, Angus Council and NHS Tayside, for recruitment and retention. The policies of the employing organisations need to deliver a workforce that is:

- Sustainable
- Integrated
- Capable
- Effective in leadership and management
- Well informed
- Are valued for their contributions
- Treated fairly and consistently
- Supported to learn and develop
- Empowered
- Involved in decision making
- Working in a safe environment

We are able to predict with certainty that there will be an imbalance between our demand and supply of staff. This is partly due to the age profile of our workforce and shortages of key professionals. We cannot plan to increase the overall number of posts within the Council and NHS. The introduction of new models allows opportunities to ensure we have the right staff, in the right numbers, working in the right places at the right time, and we will work to streamline this in partnership with the Professional Leads including the Nursing and Allied Health Professionals Directorates and the Chief Social Work Officer.

Angus HSCP therefore will work with partners to deliver integrated workforce planning which will include:

- Profiling the workforce
- Re-designing jobs and services taking into account grading and terms and conditions
- Delivering a skills gap analysis and workforce development requirements
- Integrated workforce policies and practices
- Integrating approaches to proactive recruitment campaigns

Our approach will include identifying opportunities to give us better flexibility across roles within the Council, NHS, third and voluntary sector to support.

8.3 Property

Angus HSCP relies on its partners, NHS Tayside and Angus Council, to provide appropriate accommodation for staff with safe working environments and accommodation that is also appropriate and safe for the delivery of services. The Angus HSCP works with our partner agencies to ensure that accommodation needs are built into our improvement plans making the best use of the available accommodation resources. This includes, for example, the future use of the Susan Carnegie building at Stracathro Hospital and the development and delivery of a plan for the future of general medical services premises.

8.4 Information technology

Angus HSCP relies on its partners, NHS Tayside and Angus Council, to ensure that sufficient and appropriate information technology is available to support staff to deliver on the Partnership's ambitions. Angus HSCP recognise that digital technology and good data play a major role in improving services, enabling research and economic development and improving outcomes for the people of Angus. Angus HSCP will work with partners to deliver:

- A working environment which is agile, mobile and using the most appropriate technologies to support service delivery with shared access to agile environments and infrastructure in any property regardless of employing authority.
- An infrastructure which uses new and emerging technologies to support service redesign in a way which meets the changing digital environment.
- Digital technology which enables our services to be delivered with the capability to meet future needs, and designed in a way that customers choose to use them as a default, whilst still supporting those who are not yet capable of doing so.
- Better use of data and make data more accessible through online channels, increasing accessibility and transparency. This will require delivery of improvements in data quality.

9. The Case for Change

9.1 Understanding Angus

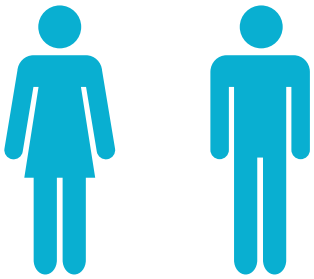
There is a growing demand for care provision. People are living longer with multiple and complex care needs that require more support from health and social care services. Local people have told us they want to access care closer to home, and care which helps to maintain their independence and the support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

Our strategic needs assessment and our current performance tell us that our future means addressing these challenges:

- Improving the health of the population
- Many more people who need support and care
- A smaller available workforce to deliver support and care
- Continued pressure on public finance
- Using more technology to improve efficiency and productivity

Our Population

Angus adult population 2017



Female **59,594** Male **56,686**

Age under 18	**21,907**
Age 18-64	**67,568**
Age 65-74	**14,852**
Age 75-84	**8,493**
Age 85+	**3,460**
All people	**116,280**

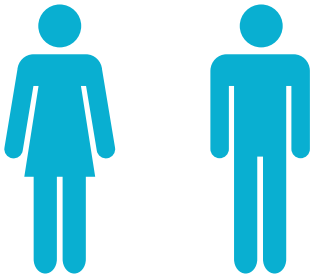
Since the publication of the last strategic commissioning plan the shape of the Angus population has changed. The population is getting older. The total population has remained fairly static in the last three years but the make up of the population has changed. The population aged:

- over 65 has increased by 11% (or by nearly 3,000 people)
- 65-74 has increased by 3% (or 445 people)
- over 85 years has increased by 39% (or 2,555 people)

Over the next three years the population of Angus is expected to grow slightly however the proportion of that population who are aged over 75 years is expected to grow by a further 20% (more than 1,000 more people over 75) to nearly 13,000 people.

During this time the working age population is expected to reduce by around 3% or by about 2,000 people.

Life Expectancy at birth (2017)



	Angus	Scotland
Male	**78.5**	**77.1**
Female	**81.8**	**81.1**

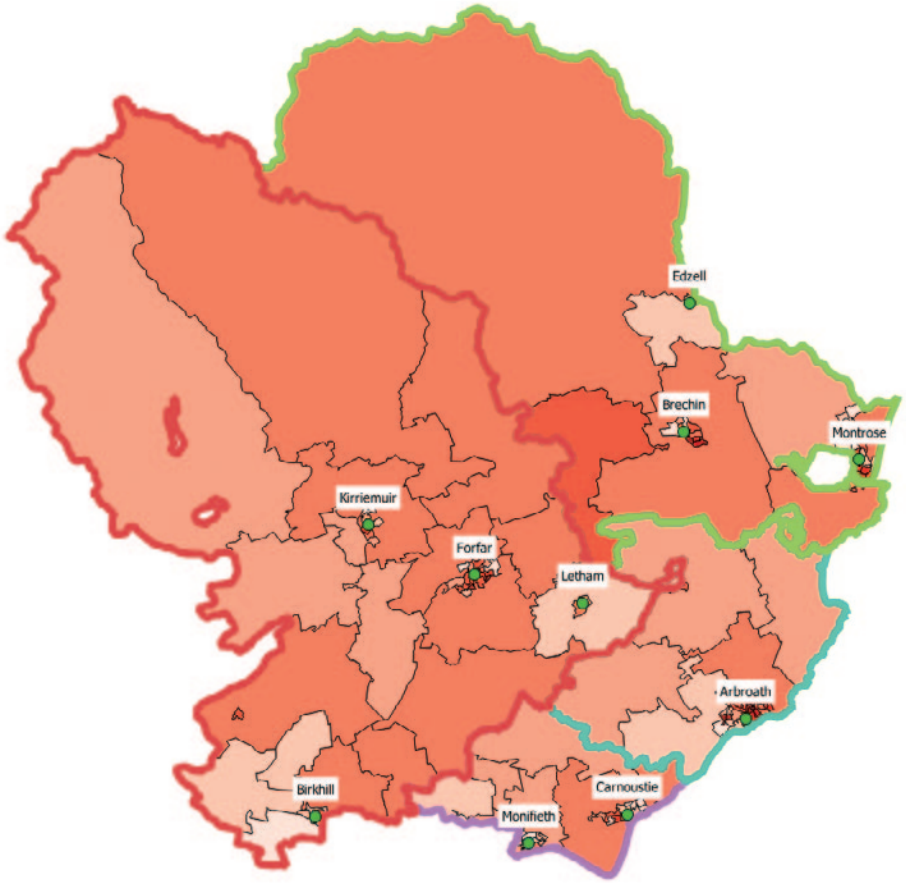
Life expectancy in Angus has not grown over the period of the last strategic plan. This is similar to the picture across Scotland.

There continues to be a real gap between life expectancy for those living in the most deprived areas of Angus where men can live approximately nine years less and women three years less than those living in the least deprived areas of Angus.

Deprivation in Angus

In the map below the deepest red shows the most deprived areas in Angus; the palest colour shows the least deprived areas of Angus.

Of Angus's 10% most deprived areas, two thirds are found in the South East Locality with the remainder in the North West and North East Localities.



Our Health

1/10
people has two or more long term conditions

1/5 people
smoke

1/40 people
has had a stroke or TIA

1/20 people are affected by depression

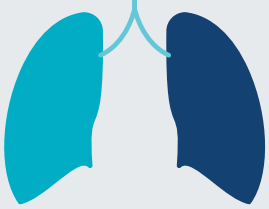
1/4 people
has high blood pressure

1/500 people
receiving palliative care

Around **3/5** adults are overweight and **1/4** are obese

1/14 people
has asthma

1/18 people
has diabetes



1/40 people
has chronic obstructive pulmonary disease

9.2 National Outcomes

The Scottish Government have set out nine national outcomes that are to be delivered through the integration of health and social care.

National Health and Wellbeing Outcomes

1	People are able to look after and improve their own health and wellbeing and live in good health for longer
2	People, including those with disabilities or long term conditions or who are frail are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community
3	People who use health and social care services have positive experiences of those services, and have their dignity respected
4	Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services
5	Health and social care services contribute to reducing health inequalities
6	People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and wellbeing
7	People using health and social care services are safe from harm
8	People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide
9	Resources are used effectively and efficiently in the provision of health and social care services

9.3. Scope of the Strategic Plan

The Angus Health and Social Care Partnership is responsible for planning and commissioning integrated services and overseeing their delivery. These services include:

- 16 GP practices
- 23 pharmacies
- Three community hospitals; Arbroath Infirmary, Whitehills Health and Community Care Centre and Stracathro Hospital. The Partnership currently provides 105 in-patient beds in Angus supporting medicine for the elderly, psychiatry of old age, palliative care, and stroke rehabilitation.
- Angus people also have access to emergency and acute services provided at Ninewells Hospital in Dundee.
- Care management teams co-ordinate packages of care throughout Angus for service users with a range of health, social, emotional or psychological problems.
- Integrated community learning disability teams, community mental health for older people teams and an Integrated Alcohol drugs and rehabilitation service (AIDARS).
- Homeless support services.
- District Nursing Teams who co-ordinate care and provide treatment.
- Allied Health Professionals providing access to a range of therapies.
- 31 care homes in Angus providing 1,030 beds supporting older people, people with dementia, adults with learning disabilities. Currently Angus HSCP commission around 740 beds at any one time including some intermediate care beds, beds for older people outwith Angus and some specialist learning disability places outwith Angus. In addition we commission residential respite.
- Approximately 7,000 hours of care at home support is commissioned every week alongside services such as supported accommodation, community meals, community alarm, enablement and prevention of admission services.
- Community organisations operate in Angus to support people in our communities.
- More than 6,000 volunteers contributing across Angus known to Voluntary Action Angus.
- 10,852 carers identified through the 2011 census.

Angus HSCP must have a strong relationship with secondary care in relation to unplanned hospital admissions. There are Tayside-wide hospital services at Ninewells Hospital, Strathmartine Centre , Roxburghe House and Murray Royal Hospital where a range of support for acute care, people with learning disability, adult psychiatry, specialist palliative care and drug and alcohol rehabilitation services are provided.

Some services are relatively small, are particularly specialist in nature or provide services across the whole of Tayside. This means that they are difficult to disaggregate to the three partnership areas in Tayside. In keeping with Scottish Government requirements, hosting arrangements have been established in relation to those services. This means that they are managed by one or other of the partnerships on behalf of all of the partnerships in Tayside.

Hosted Services

Angus	Dundee	Perth and Kinross
• Locality Pharmacy • Primary Care (excl. NHS Board administrative, contracting and professional advisory roles) • GP Out of Hours • Forensic Medical Services • Continence Service • Speech and Language Therapy	• Psychology • Sexual and Reproductive Health • Homeopathy • Specialist Palliative Care • Centre for brain injury rehabilitation • Eating Disorders • Dietetics • Medical Advisory Service • Tayside Health Arts Trust • Keep Well • Psychotherapy	• Learning Disability Inpatients • Substance Misuse Inpatient Services • General Dental • Community Dental Services • General Adult Psychiatry • Prisoner Healthcare • Podiatry

Hosted services will contribute to the delivery of the priorities for health and social care integration in Angus. Delivering transformation and improvement in hosted services means that Angus HSCP works closely with Dundee and Perth & Kinross Partnerships as well as NHS Tayside. We have shown through our priorities some of the work that we are progressing on hosted services. Hosted services are integrated with local service delivery arrangements but need a shared approach to improvement and transformation.

Angus HSCP has a strong relationship with, and is a key contributer to, the Angus Community Planning Partnership in order to deliver holistic support within our communities. Through this involvement Angus HSCP makes a contribution to supporting children and families so that the impact of the Angus HSCP's plan is felt by all ages.

10. More information

You can find out more information on the work of Angus Health and Social Care Partnership by reading papers considered by our Integration Joint Board. You can find these via our website **www.angushscp.scot**. This includes:

- Annual Performance Reports
- Reports to the Integration Joint Board (including finance reports)
- Plans from the Localities
- Joint Strategic Needs Assessment
- A Housing Contribution Statement
- A Market facilitation Statement
- A Workforce Plan
- An Involvement and Engagement Plan
- A Strategic Delivery Plan