Strategic Plan 2016 - 2019

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Foreward

Our strategic plan is built upon the importance of equal partnership, an approach to working across all sectors where genuine community engagement is at the heart of constructing new cultures of care. Our partnership includes NHS Tayside, Angus Council, the third and independent sector providers of health and social care services and the people who live and work in Angus.

Our aim has been to create a broader discussion-based approach where shared learning influences change. In this approach communities will, in time, effectively commission their own care. This aspiration for health and social care integration show our commitment to new ways of working and learning together where all contributions help shape the delivery of good outcomes for people who live in Angus.

This move towards a locality based, people-centred approach is gathering momentum across policy making nationally and is a central pillar of how we intend to reshape care.

This plan sets out the vision and future direction of health and social care services in Angus. It takes forward the approach of strategic commissioning recommended by the Scottish Government. It is not a list of actions outlining everything that Angus Health and Social Care Partnership are doing or plan to do over the coming years. The detail about how we make those steps will be developed through our four localities and Angus-wide engagement structures in collaboration with all partners in the public, independent and voluntary sectors, and in local communities, over the lifetime of the plan.

Glennis Middleton
Chairperson
Angus Integration Joint Board

Hugh Robertson
Vice Chairperson
Angus Integration Joint Board

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Chief Officer
Angus Health and Social Care Partnership

1 Introduction

The way that health and social care services are organised and managed changes from April 2016. We have been working together for some time to improve our partnership approach as we recognise that the population is changing and we cannot continue to deliver services and support in the same way. We want to make sure that our third and independent sector partners are part of this multi-agency approach. The legislation allows our partnership to grow even further to develop new services and improve outcomes for the people of Angus.

The case for change is set out in our Joint Strategic Needs assessment. We believe that the growing numbers of people in Angus who have complex care needs or are growing older will require better joined-up care, better anticipatory and preventative planning and a greater emphasis on community-based care. We know that people want to have care and support delivered to them in or as near to their own homes and communities as possible. We know that communities are a rich resource of innovation, support and intelligence about what is needed, what works and what role they can play in supporting community members. We already know from the success of projects we have tested out in recent years with funding from the Change Fund that through working in partnership with the third sector and with communities we can make a difference to people's quality of life. Community-based and third sector initiatives have demonstrated improved outcomes for a whole range of vulnerable and older people in our community.

From April 2016 Angus Council, NHS Tayside, the third and independent sectors are working together in a new Angus Health and Social Care Partnership (HSCP). The Angus HSCP has been established under the provisions of the Public Bodies (Joint Working) (Scotland) Act 2014. The partnership has been formed following the signing, by the parent bodies, of an Integration Scheme setting out the legal arrangements. The work of the partnership is overseen by the Integration Joint Board.

The intention of the legislation in bringing about the new arrangements is to provide:

- Better Services and Outcomes - to improve services and supports for patients, carers, service users and their families
- Better Integration - to provide seamless, joined-up quality health & social care for people in their homes or in a homely setting where it is safe to do so
- Improved Efficiencies - to ensure that resources are used effectively and efficiently to deliver services that meet the increasing number of people with longer term and often complex needs, many of whom are older.

Integration will allow us to think innovatively about how a growing population of people in need of support can be supported differently and how we can respond to peoples' expressed wishes to remain at home for longer. Our multi-agency approach will be delivered through working in four localities that make up Angus, delegating financial responsibility over time so more locally based decisions can be made on appropriate services. The partnership will also continue to work with NHS secondary care to reduce avoidable admissions to hospital, to reduce the need for emergency admissions to hospital, and to secure discharge from hospital at the earliest opportunity.

The vision for health and social care in Angus is one which is shared not just within the integrated organisation, but with our communities. Our vision and priorities have been tested through public engagement in a range of different ways, including at locality commissioning events held in September 2015. There has been significant support for our four identified priorities described later in this plan.

2 Our Vision for Health and Social Care in Angus

Putting People at the Centre

Our vision is to place individuals and communities at the centre of our service planning and delivery in order to deliver person-centred outcomes.

3 Why Change?

Bringing together our health and social care services creates opportunity to improve outcomes through integrated working in front line services, better communication, improved efficiency and reduced duplication of effort. Working effectively together will support people to remain at home, prevent unnecessary admissions to hospital or to care homes, and will ensure that people who have to go to hospital are discharged in a timely manner with the right supports in place. In delivering Integration the Scottish Government intends:

- To improve the quality and consistency of services for patients, carers, service users and their families;
- To provide seamless, integrated, quality health and social care services in order to care for people in their homes, or a homely setting, where it is safe to do so; and
- To ensure resources are used effectively and efficiently to deliver services that meet the needs of the increasing number of people with long term conditions and often complex needs, many of whom are older.

The Scottish Government has set out nine national outcomes for all integration partnerships to work towards.

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

There is also a wide range of national policy, supported in some instances by legislative underpinning, that drives the direction of health and social care service provision and development. Angus Health and Social Care Partnership is working within the framework of policy and legislation to progress towards achieving the national outcomes. Legislation and policy drivers all embrace common themes to be delivered strategically and operationally through service delivery. The themes are:

Integration, Partnership, Prevention, Outcomes, Choice, Control
Self-Management, Leadership

4 Strategic Commissioning

'Strategic commissioning is the term used for all the activities involved in assessing and forecasting needs, links investment to all agreed desired outcomes, considering options, planning the nature, range and quality of future services and working in partnership to put these policies into practice.'
Ref: Scottish Government Strategic Commissioning Guidance 2015

This plan is a working document for the workforce in our partnership. It includes the long term vision and resource requirements for the delivery of the plan. This plan is supported by a number of documents which describe how different aspects of the work will be progressed. These supporting documents are outlined in section 15.

This first Angus Strategic Plan aims to consolidate current single agency and joint service development and improvement plans, and to determine whether existing plans continue to progress towards the agreed vision for integration.

In delivering any change there are always risks to progressing improvement outcomes. To ensure that we manage any risks associated with the delivery of this plan a separate risk management plan has been developed.

An annual review and update will provide progress against the delivery and improvement plan as well as identified trends through key performance indicators.

5 Scope of the Strategic Plan

The Angus Health and Social Care Partnership will be responsible for planning and commissioning integrated services and overseeing their delivery. These services include: all adult social care such as assessment and care management, adult protection, care at home and care home services; adult primary and community health care services such as district nursing; elements of adult hospital care related to unplanned admissions; and hospital services for adults with learning disability, mental ill health, or who misuse substances. The Partnership must have a strong relationship with secondary care in relation to unplanned hospital admissions and will continue to work in partnership with the Community Planning Partnership in Angus.

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

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 will contribute to the delivery of the priorities for health and social care integration in Angus. Plans for hosted services need a Tayside wide approach and these plans will be provided separately.

6 A Snapshot of Angus

The total resource within the Angus Health and Social Care Partnership is approximately £150million. Health and social care expenditure per head of population in Angus is greater than the Scottish average. The voluntary sector in Angus is worth an estimated £50million.

There are a range of supports and services provided through:

- 16 GP practices.
- 23 pharmacies.
- Opticians in every town.
- Dental practices in every town.
- 4 community hospitals: Brechin Infirmary, Montrose Royal Infirmary, Arbroath Infirmary, Whitehills Health and Community Care Centre and Stracathro Hospital providing 200 beds supporting older people, hospice care, rehabilitation and adult psychiatry. Stracathro Hospital includes beds which are part of the delegated responsibility, and beds and out patient services that remain the responsibility of NHS Tayside
- 31 care homes in Angus providing 991 beds supporting older people, people with dementia, adults with learning disabilities. Currently we commission around 740 places including some specialist learning disability places outwith Angus.
- Approximately 3,700 hours of care at home support is delivered every week alongside services such as supported accommodation, community meals, community alarm, enablement and prevention of admission services.
- 902 community organisations operate in Angus to support people in our communities.
- 6,017 volunteers contributing across Angus
- Care management teams co-ordinate packages of care throughout Angus for service users with a range of health, social, emotional or psychological problems.

There are links to Tayside-wide hospital services at Ninewells Hospital, Strathmartine Centre and Murray Royal Hospital where a range of support for acute care, people with learning disability, adult psychiatry and drug and alcohol rehabilitation services are provided.

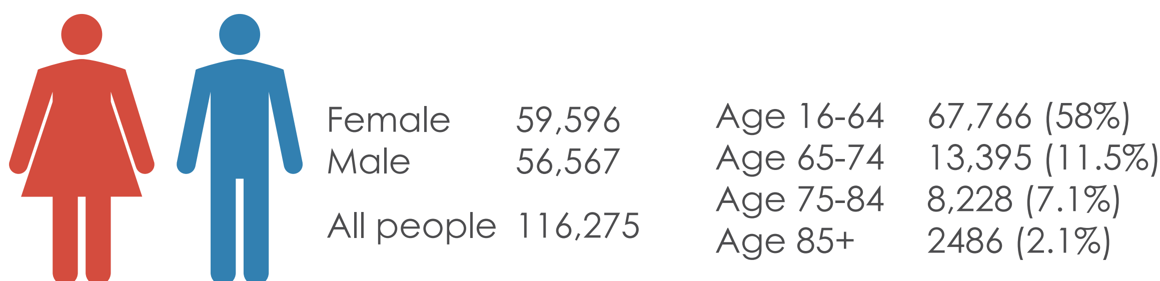
A market facilitation plan detailing our commissioning intentions in relation to care and support services will be available in September 2016

7 Understanding Angus

Understanding the population of Angus will help ensure that resources and services are delivered effectively, that they meet the needs of changing population and consider the impact of deprivation on our communities. A particular challenge for Angus is that the size of our population is now set to remain relatively static but the makeup of the population will see considerable change. The number of people aged over 65 is set to rise significantly as a percentage of the total population, whilst the number of people aged under 18 is reducing. Data in this plan is selected from the Joint Strategic needs Assessment. One in every 20 residents (4.9%) identified themselves in the last Census (2011) as non-British White. Our non-British White population has increased over the last decade, but most significantly in Polish communities. Nearly one in 5 residents (19.1%) identified themselves in the last census (2011) as having long term conditions or disabilities that limited activity. We understand that around one in every fourteen residents are Lesbian, Gay, Bisexual or Transgender (LGBT), although we have further progress to make in enabling service users and patients to routinely disclose equalities information.

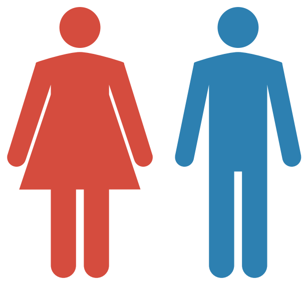
Our Population

Angus Adult Population 2015



The population of Angus is expected to remain static between 2013 and 2037. This will not be seen across all the age groups however, as the older age groups are expected to grow whilst the younger age groups will decline. The percentage of those over 65 will increase by 53% whilst the under 65 age group will decrease by 14%. The 75+ population will almost double in size from the smallest age group in 2013 to the second largest age group in 2037. As a percentage, the increase in the 75+ age group by 2037 is 89%. A different picture exists for the younger age groups, as by 2037, both the 0-15 and the 16-64 age groups will decrease by 9.4% and 8.1% respectively.

Life Expectancy



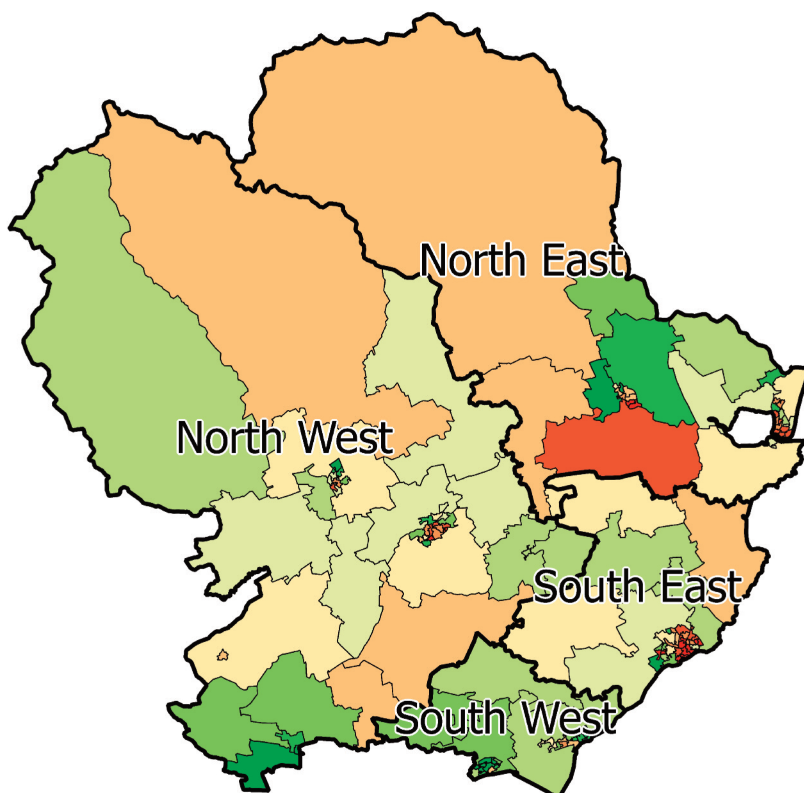
	Angus	Scotland
Male	78.3	76.6
Female	81.1	80.8

The life expectancy for females born in Angus between 2011 and 2013 is 81.6 years; this is higher than the Scottish average and it is an increase of 1 year and 9 months from those born in Angus between 2000 and 2002.

The life expectancy for males born in Angus between 2011 and 2013 is 78.5 years. This is also higher than the Scottish average and it is an increase of 3 years and 9 months on those born in Angus between 2000 and 2002.

Deprivation in Angus

In the map below the deepest red shows the most deprived areas in Angus; the deepest green shows the least deprived.



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.

More than half of Angus households of people over 60 years are considered to be in fuel poverty. This is higher than the Scottish average and all of Angus's neighboring authorities

Health Behaviours

	Angus	Scotland
Smoking prevalence	18.1%	20.2%
Alcohol related hospital stays	364.1	671.7
Drug related hospital stays	93	122

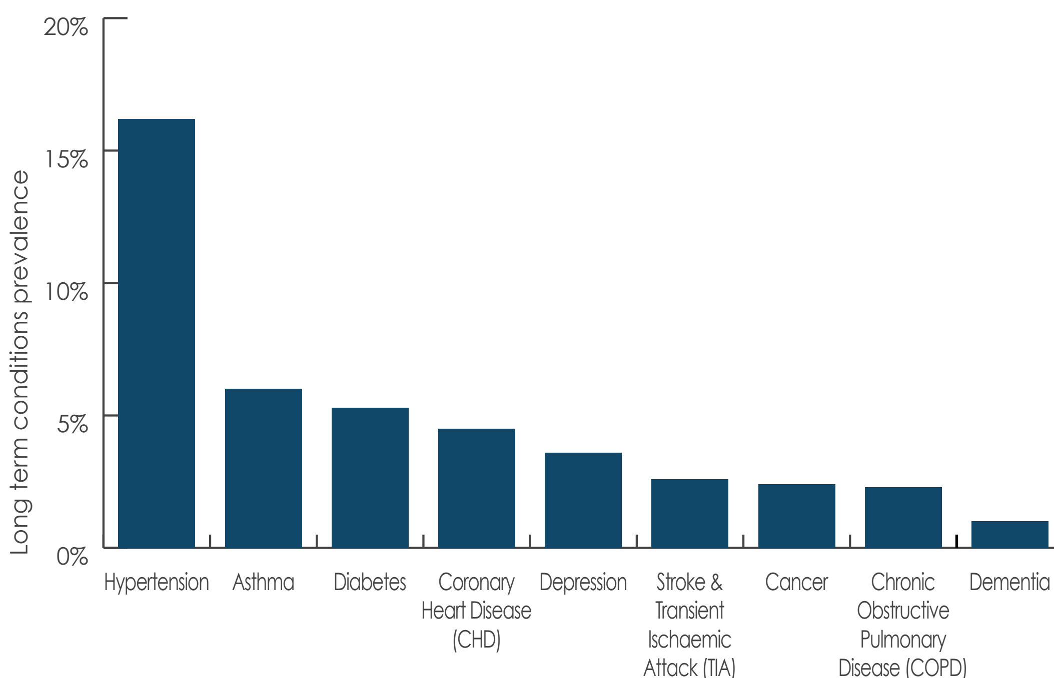
Data from Scotpho Health and Wellbeing profiles

Both Angus and Scotland as a whole have seen reductions in smoking prevalence and alcohol related hospital stays between 2013 and 2014 but drug related hospital stays have increased.

Long term conditions

Prevalence per 100 people in Angus from General Practice registers 2014/15

Note: depression figures relates to new diagnosis



The number of People with two or more long term conditions in Angus is estimated at17,761 or nearly 11% of the population.

Hospital admissions 2014/15

Unplanned admissions all adults	10,475
Bed days lost due to lack of timely discharge	6,991

We will work to establish strong working arrangements with equalities networks within and beyond Angus. This will include continuing to support the Community Planning Partnership's equalities work and in particular, to work with partners to support the Single Outcome Agreement, which sets out the planned improvements for local areas' thematic and place based priorities.

We aim to remove discrimination from all of our services to ensure that our services are provided in an equalities-sensitive way. We intend to contribute to reducing the health gap generated by discrimination, and to work in partnership to make Angus a fairer county.

Both the Health Board and the Council routinely publish Equalities progress reports which highlight the significant progress that is already being made. We will continue this journey to improve the health and care outcomes for equalities groups, recognising the additional challenges experienced by equalities groups living in poverty.

8 What we've learned

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 working in the right direction with consensus.

A variety of methods have been used to engage with communities: formal events, web based questionnaires, and informal pop up events in our town centres. We have employed a graphic artist at a number of events to capture discussions and have used the resulting artwork to capture the statements that are most important. One piece of artwork has been developed to portray our vision; it is the most repeated and the most voted for statement.

What our localities have asked us to address includes:

- Quality of service should be the same across Angus
- Equity of access to support and services
- Local services that are about what I need when I need them
- Quick and easy access to information in my local area-one point of contact
- Continuity of care/ same person providing my support
- Choice and control over when support and services will be provided and who will provide them
- Ability to stay in my own home, not go into a care home
- Support to remain independent
- Improve communication and information sharing between teams/support workers so you only have to tell one person
- A pop in service - could be volunteers
- Shorter waiting times
- If one person can do the job why have two people going in?
- Clear and user friendly communication and information is required to explain how Integration will make a difference
- Clarity required around locality boundaries
- The capability for information sharing/data collection to avoid duplication and improve communication and safety is a priority for many
- The locality model was supported, especially the idea of local resource hubs and one-stop shops.
- Many people identified the very close relationship with Self Directed Support
- Skills and capacity to deliver new models of care in the community were regularly explored

We will continue to grow our approach to engagement delivering through time co-production 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.

9 Delivering our Vision

We have identified four priorities for improvement for health and social care from what we have learned from public participation, from our needs assessment, from current performance and from the direction set by the national outcomes and other national policy drivers. There is both synergy and overlap between our priorities so we expect to work closely together to deliver progress. Alongside our improvement plans we must ensure that we achieve financial sustainability. Work is progressing to provide detail for each priority area and this will be identified in our delivery plan.

Priority 1:

Improving Health, Wellbeing and Independence

We aim to progress approaches that support individuals to live longer and healthier lives, and to have sufficient information and support to be active in the community. To progress this priority over the next three years we will have a focus on:

1.1 Health Improvement & Prevention of Disease Focusing on Addressing Health Inequalities in our Localities
1.2 Building capacity in our localities
1.3 Supporting carers.
1.4 Supporting self-management of long term conditions.

1.1 Health Improvement & Prevention of Disease Focusing on Addressing Health Inequalities in our Localities

The Director of Public Health publishes an annual report providing an updated profile of the Tayside population by locality as well as detailing progress across a range of public health issues such as obesity, health protection, substance use, oral health, sexual health and mental health and wellbeing. The report also sets out plans to address these issues within our communities.

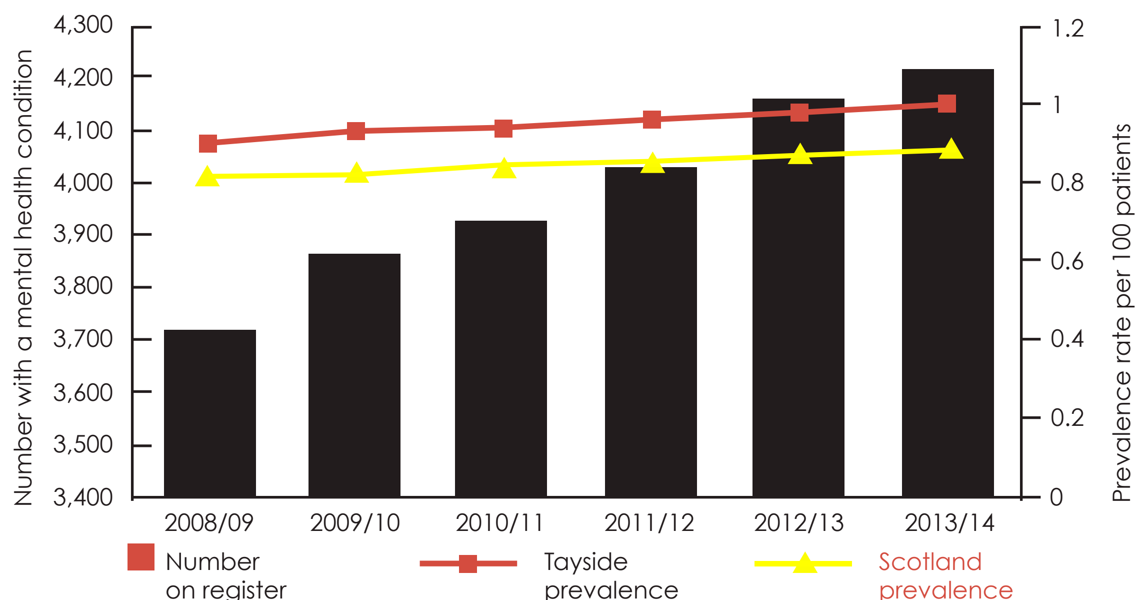
Where we are now

Indicators of health and wellbeing

GP registers tell us that in 2013/14:

- 14.31% of the Angus adult population was recorded as being obese. (Normal body mass index (BMI) is 20-25. Obesity is a body mass index of 30 or over.)
- The highest level of obesity recorded is in the North East at 16.08% of the population and the lowest level recorded in the South West at 10.7% of the population
- The prevalence of mental health conditions across Angus is increasing.
- There has been a 26% increase of prescriptions for antidepressants in the past five years whilst at the same time across Scotland as a whole there has been a 27% decrease.

Estimated prevalence of mental health conditions for those registered with Tayside practices 2008/09 – 2013/14



Ref: Angus JSNA

Deprivation
There is a direct relationship between population health and wellbeing and deprivation. The proportion of Angus residents that are classed as deprived is lower than that of Scotland. As at 2013, approximately 10% of Angus residents were classed as either income or employment deprived whereas Scotland has about 12-13% on average. The South East locality has the highest rate of income or employment deprivation with around 12.5% to 14% (as at 2013) classed as deprived.

Life Expectancy
The life expectancy for females born in Angus between 2011 and 2013 is 81.6 years; this is higher than the Scottish average of 80.97 and it is an increase of 1 year and 9 months from those born in Angus between 2000 and 2002. The life expectancy for males born in Angus between 2011 and 2013 is 78.5 years; like the females, this is also higher than the Scottish average of 76.88 and it is an increase of 3 years and 9 months on those born in Angus between 2000 and 2002.

Life expectancy split by age and deprivation shows that both male and female life expectancy has increased since 2001 for those born in the most deprived and the least deprived areas of Angus. For females, the life expectancy gap between the least deprived and the most deprived has decreased slightly from 3.6 years in 2001-2005 to 2.9 years in 2009-2013. For males, this gap has increased from 4.1 years in 2001-2005 to 5.5 years in 2009-2013. Men in the least deprived areas have increased life expectancy by 3.2 years whereas those in the most deprived have only increased life expectancy by 1.7 years.

Where we want to be
Increasing obesity rates and increasing mental health issues in our communities along with a widening gap in life expectancy between our least and most deprived communities tell us that, over the next three years, we must continue to support the efforts of public health aimed at addressing these issues. We will also develop an Angus approach in support of the efforts of public health to address issues relating to obesity, mental wellbeing and the inequalities faced by our most deprived communities. We also know that stronger communities make healthier lives. As part of the Community Planning Partnership we have been testing the use of participatory budgeting to improve and strengthen the community in East Brechin, one of the most deprived areas of Angus. This has already developed opportunities to engage with the community in a different way and to support the preferences of the community through investment decisions made locally on community based activity.

1.2 Building capacity in our localities.

Where we are now
During our engagement we learned about the importance of improving access to information. There were mixed views about what form an approach to improving access to information should take although the concept of single points of contact and the use of a 'hub' model in each of our localities was suggested by many. Such developments are a high priority for us going forward but require further exploration as the natural focus in each of our localities is different for different people. The local focus can include GP practices, libraries, Accessline and First Contact as well as online provision. As part of our approach to improving access to information we are progressing the development of ALISS (A Local Information System for Scotland) to facilitate accessible web-based information about health and social care services. Importantly it will also be the focus for how we ensure an accessible voluntary and independent sector.

Working with Voluntary Action Angus, we have identified 902 voluntary sector organisations active in our Angus Localities. About 35% of those organisations are currently included in ALISS. Volunteering in Angus continues to increase with, currently 6,017 volunteers active in Angus.

There is growing recognition of the scale of the problem of social isolation in Angus, matched by national recognition of the links between social isolation and:

- Risk of earlier death
- Depression
- Dementia
- Poor self-rated health

Ref: Campaign to End Loneliness, 2015

Statutory services alone cannot address social isolation, with some solutions lying within communities themselves. Social isolation is especially a concern for older and vulnerable people across Angus. Volunteering and voluntary organisations across Angus are committed to addressing social isolation through ensuring a broad range of community based activities are available and befriending services support those most affected.

Where we want to be
Harnessing the efforts of the voluntary sector will support people to become engaged in their communities and promote independence. We want to ensure that the number of organisations on ALISS is increased to 90% by April 2017.

Each Locality has a Locality Improvement Group. Membership of these groups is drawn from staff, the third and independent sector, users of services and the public who work and live in the locality. Locality plans are being developed by the locality groups. The plans build on the interaction between services, the voluntary and independent sectors and local communities. Locality plans will be produced by August 2016 and will be reviewed annually through the IJB's annual performance report.

1.3 Supporting Carers

Where we are now
'Carer' is a term used for family members or friends, who may or may not live with a person who needs support, but who give care and support which is unpaid.

In the 2011 census:

- 10,582 Angus people (9.1% population) identified themselves as carers;
- 7802 people (6.7% population) said that they delivered between 1 and 49 hours of care each week; and
- 504 people (2.4% population) over 50 hours of care each week.

In June 2015, 990 carers in Angus were receiving carer's allowance. This is generally paid by the DWP to people who provide more than 35 hours per week of unpaid care to one individual. Census information suggests that there is a high number of unidentified carers in Angus who are not accessing all the support that is available to them.

An increasing number of carers who are providing significant and regular care have accessed a carer's assessment following the introduction of self-directed support (SDS) in April 2014 - from 85 new assessments between April and October 2014 to 245 new assessments between April and October 2015. Carers are able to access a range of services delivered through Angus Carers Association and other voluntary sector organisations in Angus.

Recognising the health effects of caring, a collaborative programme between NHS Tayside and Angus Carers has been running in Angus since 2013, whereby health checks are offered through general practice to known carers. This health check covers physical and mental health and wellbeing and offers carer specific advice/support with 705 checks carried out to date. Significant physical symptoms have been noted in over 30% of carers. Carers also have greater flexibility in using the budget available to them from their SDS assessment to address their needs for respite and improve personal outcomes.

Where we want to be
We are working to improve the identification of carers with the support of GP practices and Angus Carers Centre. We will continue to work towards accurate registrations of carers at GP practices and work with practices to continue to

enable healthcare needs of carers to be considered and actively supported. We will continue to support access to an assessment for those who are supporting people with significant needs. We want to increase the number of carers who are accessing self-directed support by 20% year on year over the next 3 years.

1.4 Supporting Self-Management of long-term conditions.

Where we are now
Quality Outcomes Framework (QOF) data is collected by general practitioners and gives some indication of the prevalence of single - but not multiple - conditions.

The Scottish Government predict that 1 in 4 adults live with some form of disability and/or long term condition. The risk of long term conditions, and multiple long term conditions, increases with age with 2/3 people aged 65+ having at least one long term condition.

The prevalence of long term conditions changes, depending upon the demography of the population and advances in clinical care. The table below shows prevalence rates in Angus of some common conditions over the last five years:

Disease Register	2009/10 Raw Prevalence Rate (per 100 patients)	2014/15 Raw Prevalence Rate (per 100 patients)	Change in numbers on the disease register between 2009/10 and 2014/15
Atrial fibrillation	1.67	2.01	> 403
Asthma	5.61	5.96	> 481
Coronary Heart Disease	4.89	4.58	< 253
Chronic Obstructive Pulmonary Disease	1.89	2.32	> 511
Diabetes	4.32	5.41	> 1,273
Heart Failure	0.94	0.80	< 137
Hypertension	15.15	16.15	>1,361
Stroke/Transient Ischaemic	2.56	2.63	> 115

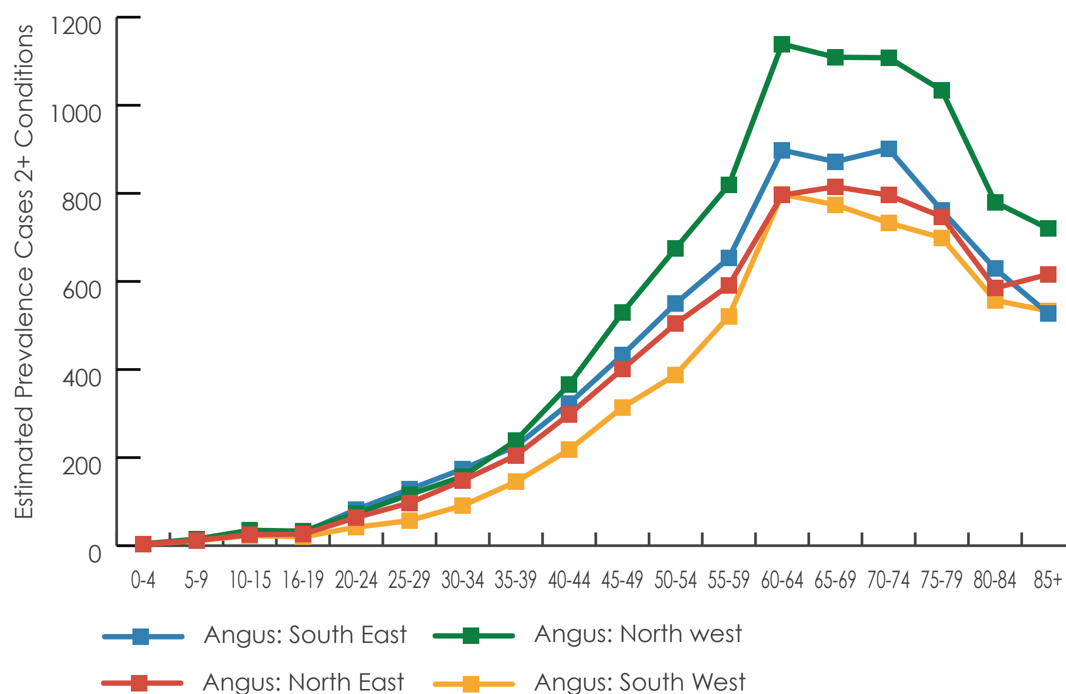
(Source, QoF, ISD)

Not all long term conditions have prevalence recorded consistently at practice level, amongst which are two of our most prevalent conditions - obesity and chronic pain (predicted prevalence of 18% of adult population, SIGN 136)

Long term conditions can impact significantly on someone's wellbeing and their use of health and social care services. People with long term conditions are twice as likely to be admitted to hospital and account for 60% of all bed days (Scottish Government).

Based on a recent Scottish cross-sectional study, prevalence estimates indicate that around 25% of the Angus population have two or more long term health conditions. The biggest variance can be seen in the 50-54 age-group between the South West and the two Eastern localities where the difference in prevalence rates is approximately 5%. Hospital admissions are more likely where an individual has multiple conditions.

Estimated prevalent cases of two or more long term conditions for Angus localities



Ref: Angus JSNA

Over many years Angus has adopted an approach to care which develops care pathways that support early identification and management of conditions, while maximising self-management. Following public nominations Angus was shortlisted for the Health & Social Care Alliance Self-Management Supporting Health Board of the Year and winners of the Scottish Health Awards Care for Long-term Illness Award in 2014. Examples of current good practice include:

- A Self-Management Network, consisting of long term conditions peer support groups and partner organisations meets bi-annually to continue to progress this collaborative model of care

- A range of disease specific peer support groups and health led educational forums exist in Angus to provide self-management support to those living with long term conditions.
- The long term conditions activity programmes running in Angus, led by Angus Cardiac Group, in collaboration with amongst others Angus Ahead, provide a range of activity options for people with long term conditions in every Angus locality.

Where we want to be

We recognise the need to support prevention of disease as a priority to reduce prevalence of long term conditions. We need to work to reduce the impact of long term conditions on health and wellbeing and the demand on health and social care services

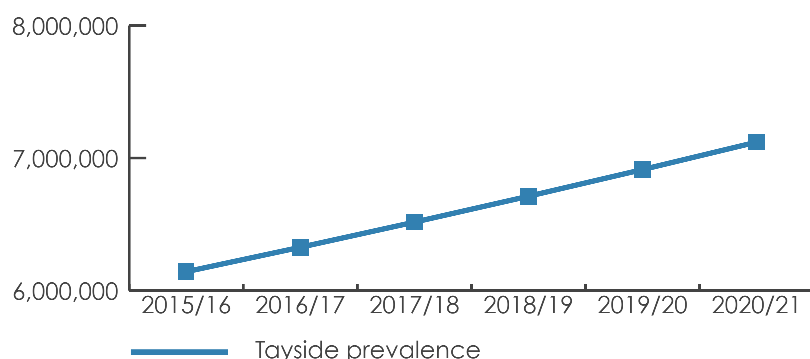
We need to maintain and continue to build upon our self-management capacity within Angus to enable those with long term conditions to live in good health for longer and improve their quality of life. We need to continue to deliver this activity in an equal way with those who use services.

Priority 2:

Supporting care needs at Home

The population of Angus has been changing. Our needs assessment tells us that this change will continue and that in the years to come we will continue to see a greater proportion of people aged over 65 in our population and a significant increase in those aged over 85. This has already placed and will inevitably place additional demands on social care and other services. Projecting a 3% increase in demand over the next three years we can see the impact on resource requirements in the graph below.

Projected care at home costs between 2015 and 2020 based on current model.



Ref: Angus Help to live at Home outline business case

In supporting care needs at home our overall objective is to shift the balance of care away from hospitals and care homes. We aim to enable people to stay at home safely and with appropriate support promoting greater independence, choice and control over their lives. Over the past several years we have supported individuals to greater independence through a range of interventions including the use of

enablement approaches on first referral to social care services and through the provision of intensive social care services at home. We continue to be committed to this approach.
To deliver this we will focus on:

2.1 Enhanced opportunities for technology enabled care
2.2 Further progressing self-directed support
2.3 Changes through the Help to Live at Home programme

2.1 Enhanced opportunities for technology enabled care (TEC)

Where we are now
The First Contact call centre has handled an increasing number of social care enquiries since its establishment. The centre now handles around 9,000 calls each year with approximately 60% dealt with by First Contact staff and requiring no onward referral for social care services.

Currently we support 2,982 people through technological means, via community alarm, falls monitors and other devices.

We expect technological solutions to impact on the way we deliver a range of services and supports from improving online self-assessment to self-management of long term conditions. We are already progressing the use of technology through video conferencing to support improvements in mobility by access to exercise classes.

Where we want to be
Improvements in technology enabled care will support independence and self-management. Over the next 3 years we aim to see a 10% increase year on year in the use of technology enabled care. We will use the Scottish Government's technology Enabled Care fund to support progress in this area.

Over the next three years technology will also support change in the efficiency and effectiveness of some services through, for example, the implementation of Panztel, a system which will improve scheduling of personal care staff through agile working, enabling staff to access systems in a variety of settings and through improvements in information sharing. Agile working improvements will be supported through technology alongside improvements in information sharing which will bring health and social care information closer together. Independent Living Angus, an online system to access professional advice and guidance, will go live in summer 2016.

2.2 Progressing self-directed support (SDS)

Where we are now
The Social Care (Self–directed Support) (Scotland) Act 2013 has been implemented since 1st April 2014 and is a key building block of public service reform. The Act makes provisions to ensure that individuals have greater choice and control over their care and support needs and shifts the focus of those arrangements from inputs to achieving improved outcomes. SDS is embedded in social care assessment and support planning practice which is delivered through Care Management and Assessment teams.

Social work services support approximately 1,500 people that require a comprehensive assessment. Prior to the implementation of SDS, 67 people accessed a direct payment (now option 1) whilst the remainder received services planned and organised by the local authority (now option 3). The introduction of option 2, where an individual directs their own care and support with the budget managed by the local authority, is seeing an increase in uptake with a range of providers coming into the market in Angus at the request of individuals. These providers are not on the provider framework, which supports provision through, option 3 where the local authority organise and directs the support. Option 3 is seeing a decrease in uptake as more people choose to have greater control over the services that come together in a support plan. Option 4 where people can have a mix of the other options in their support arrangements, has allowed people greater control and choice in some aspects of their support plan and an increasing number of people are choosing to organise their overall support plan with services using options 1, 2 and 3.

The implementation of SDS is a 10 year strategy and following implementation of the Act significant progress has been made in re-assessing existing users of social care services.

Number of people accessing SDS options following assessment (31 March 2016)

Option	0 - 17	18 - 64	65 - 74	75 - 84	85+	Total (By Option)
1 Direct Payment		22	3	4	8	37
2 Directing the available resource		74	23	19	19	135
3 Local Authority arranged	6	151	128	264	335	884
4 Mix of options 1, 2 and 3		22	6	6	6	40
Total (By Age Band)	6	269	160	293	368	1096

Ref: Angus Council social care data

We anticipate an increasing number of people taking up options 1, 2 and 4 over the next 3 years as staff and people with support needs become more confident in this approach. Although we have increased the number of providers of personal care across Angus, there are still issues in relation to the availability of personal care at peak times due in part to a range of recruitment and retention issues faced by providers. Whilst outcome based specifications are included in our contracting frameworks, we still purchase care and support in terms of inputs of periods of time.

Where we want to be
Over the next three years we will continue to improve awareness of SDS with the public, providers and staff across the health and social care system. All existing users of social care services will be re-assessed using the new arrangements by April 2017.

Embedding this new social work practice will require an ongoing approach to training and staff development that supports the asset based approach to assessment and the outcomes based approach to support planning that we wish to progress. A post implementation review which is supported by a project management approach to improvement will support further progress in this area.

We will work with providers to produce a market plan by August 2016 aimed at improving choice for individuals and addressing the various reasons for poor availability at times of peak demand.

2.3 Help to Live at Home programme

Where we are now

- Angus Council's Care at Home service provides mainly for older people. At the outset of the help to live at home programme, Angus Council was providing over 166,000 hours of care per annum. This equated to 96% of the demand by older people. Between the implementation of SDS and progress by the help to live at home programme, the balance of the market has already shifted with around 40% of care at home provided by the independent sector. Currently, approximately 200 hours of care per week cannot be delivered to service users through the care at home services, because of a lack of provider capacity to meet the demand across all sectors. This shortfall impacts on enablement services which then cannot move people to long term services following their period of assessment and enablement;
- The amount of personal care delivered in Angus has been increasing over the past 6 months from approximately 3,200 hours per week to 3,700 hours per week.
- The average care package per service user has been increasing over the last 3 years. The average care hours per service user increased from 4.4 hours per week in 2010/11 to 7.1 hours per week in 2013/14 for all types of Care at Home service;
- At the outset of the help to live at home programme, the Personal Care and Housing support hourly rate for Angus Council services was £41.01, based on actual costs and average contact time. The combined (all providers average) hourly rate was £35.01, mainly driven by the high in-house hourly rate. The cost of commissioned services from the external market was between approximately £13 and £22 per hour. Progress on reducing Angus Council costs has been made and the hourly rate is now some 20% less than at the beginning of the project. A further reduction in the hourly rate is expected by the end of April 2016.

Angus Council's care and support services have been awarded high grades for the quality of their services, staffing and management and leadership, as shown by the grading of "Very Good" by the Care Inspectorate. Angus Council

has also established a strict selection process for its external provision to ensure that commissioned services meet expected quality standards and provide the best value for service users. Analysis of a sample of the service's quality assessment for the existing main external providers highlights a constant rating above standards for these providers, including one provider achieving the highest possible grade from independent regulators. This particular provider delivers the highest service quality, but also charges one of the lowest prices to the Council (£13.95 an hour).

Where we want to be
Although the Council's in-house care and support services are of high-quality, the availability of services with comparable quality at a lower price than the Council, will have a considerable impact on the ability of the Council to retain its current in-house number of service users as people make different decisions about providers through self-directed support. In the long-term there will be questions about the sustainability of the in-house service. In future the role of Angus Council care at home services will therefore be much smaller, and will prioritise preventative work, crisis intervention and enablement services. This will involve the redesign of directly provided services based in localities and integrated with health services. Improving the design and delivery of Angus Council care at home services will aim to ensure that services are as effective as they can be, and that they work in harmony to support a shift in the balance of care.

The Help to Live at Home programme focuses on the development of effective and efficient care at home services. The first phase of the programme to be delivered by June 2016 will aim to maximise the efficiency of Angus Council care at home services and address capacity in the care at home system through working with independent sector providers.

In the next three years the Help to Live at Home programme aims to change the provider market in Angus from a position where Angus Council is the dominant provider to the independent sector delivering the majority of care at home services. The assessment of the independent sector care at home market indicates that there is potential to successfully expand. The need for services will be described in the market plan

Priority 3:

Developing integrated and enhanced primary care and community responses

Inpatient activity is described in two ways; admission rates, which allow comparison of performance between our localities in relation to the number of people admitted; and bed day rate which is impacted upon by reductions in admission, reductions in average length of stay and improvements in timely discharge.

The rate of emergency admission to hospital has been increasing in Angus.			
	2011/12	2012/13	2013/14
Number of admissions (all adults)	9,685	10,226	10,475
Crude rate per 100,000 population	8,334.8	8,799.6	9,011.5
Age standardised rate per 100,000 population	8,212.6	8,564.7	8,733.7

Ref: NHS Tayside

This increase in admission rates is due to the impact of the aging population and the greater complexity of individuals' health needs as more people have multiple long term conditions. People have told us that being looked after at home is very important and that they do not wish to be admitted to hospital unless really necessary. We have made some progress in relation to addressing admission rates in South Angus through tests of change involving an enhanced community support model aimed at older people.

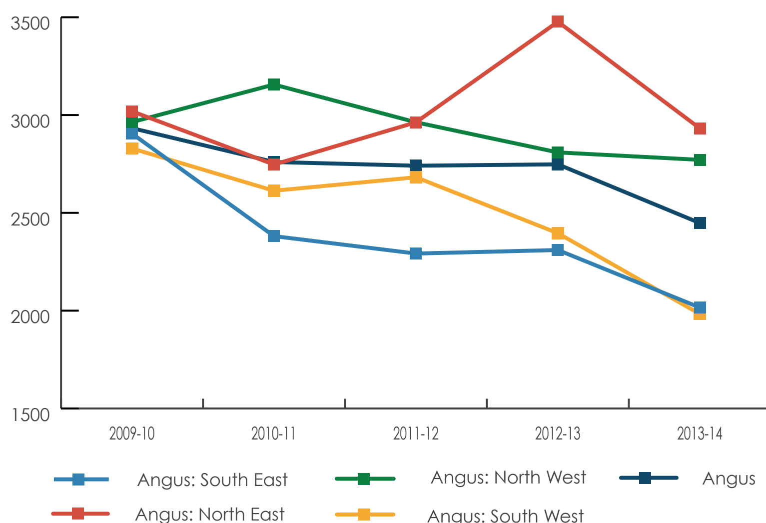
Emergency Admission Rate per 1,000 Population for Over 65s split by Localities in Angus

Ref: JSNA

We have made some progress in ensuring that once fit, people are discharged in a timely manner but we still have some way to go.

Bed days lost due to delays in timely discharge (all adults)					
Locality	**2010/11**	**2011/12**	**2012/13**	**2013/14**	**2014/15**
North East	1,504	2,127	3,246	2,817	2,313
North West	4,348	3,526	3,527	3,146	2,037
South East	3,010	1,989	2,597	1,530	1,446
South West	1,947	1,765	1,644	1,415	1,195
Angus Total	**10,809**	**9,407**	**11,014**	**8,908**	**6,991**

Emergency Bed Day Rate per 1,000 Population for 65+ split by Localities in Angus



Over the next three years we aim to deliver approaches that meet the aspirations of our communities, that is to be supported to stay at home when unwell and to only go to hospital when appropriate. When hospital admission is necessary, it is important to achieve a timely discharge with the right support available at home or in our localities. As we redesign our services and deliver them through integrated models we need to ensure that a skilled workforce is available at the time people need support and that we can offer a range of supports to ensure that people can live independently in their own homes for as long as they wish to do so. Taking this approach forward will reduce demand and need for hospital beds releasing resources to be re-invested in further services aimed at reducing emergency admissions.

To achieve our aim we require to deliver improvement with a focus on:

3.1 Responsive services based in localities

3.2 Working Towards 7 day services

3.1 Responsive Services based in localities

Where we are now

Social care and health teams do not always work effectively together. We know that services overlap and we know that teams sometimes work in isolation from each other. Information sharing is a challenge with health and social work information systems that cannot' talk' to each other. We have begun to develop an approach using multi-disciplinary working within and across teams. Multi-disciplinary working involves all partners in health and social care integration. So far:

- We have embedded effective discharge management by multi-disciplinary teams (MDT) into the discharge process. This benefits patients and their families and also optimises the management of hospital patient flow, which includes the use of hospital beds. In August 2015 a case file audit was undertaken which identified that 66% of patients were discharged from Angus community hospitals within 72 hours of being ready for discharge.

- We have been developing a model of responsive services around GP practices in South West Angus called 'enhanced community support' (ECS) model. This approach proactively assesses older people with frailty who are at risk of unplanned hospital admission and responds to an escalation of that person's health and social care needs. This has resulted in a reduction in avoidable hospital in-patient activity. This is a very promising development when there has been population growth amongst the over 65s during this period.

- Step-down or intermediate care for older people is provided in partnership with the independent sector. Intermediate care is short-term rehabilitation for people leaving hospital or to avoid admissions to hospital and is based in one locality. This is provided in a care home for up to 6 weeks; up to 6 people can be accommodated at any one time. Intermediate care is also being provided to Angus residents in our community hospitals and through early supported discharge and prevention of admission teams. We recognise however that the current model is limited in its availability within localities, may use hospital beds inappropriately and is not integrated across the different services in its approach.

- Anticipatory care plans are increasingly in place for individuals. They have a role in reducing hospital admissions and supporting end of life care. The key information summary is used to help ensure that patients' needs and choices are being met.

Where we want to be

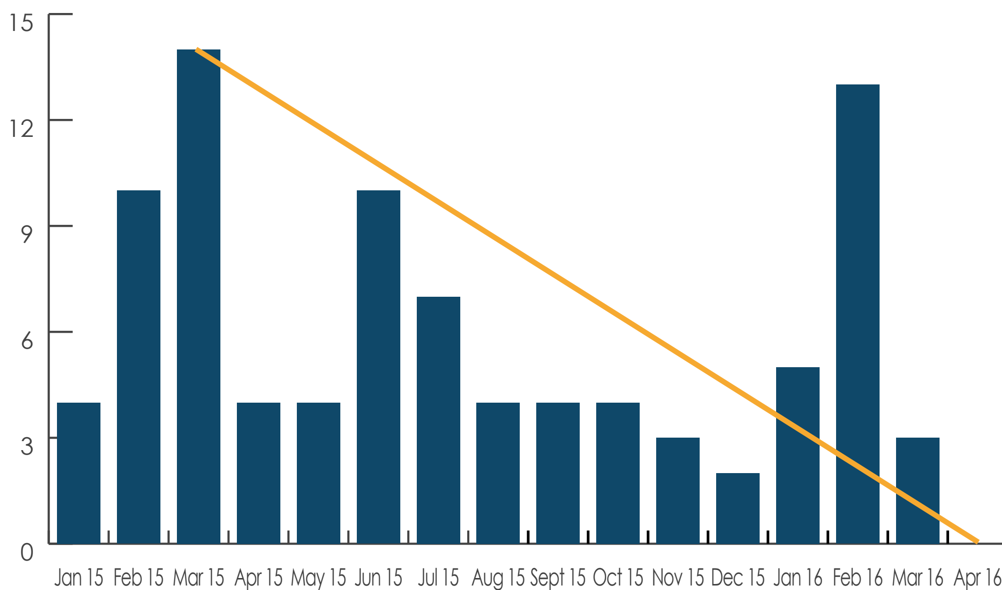
Following the implementation of ECS, the South West has the lowest admission rate for over 65s in Angus and the lowest bed day rate. The North East, where ECS has not yet been introduced has the highest emergency admission rate for over 65s and the highest bed day rate.

As a result of our success with the ECS model for older people in the South West locality (December 2013) and subsequently the South East locality (February 2015), we have reduced the number of medicine for the elderly beds by 12. We will extend this approach to all localities by April 2017. Investing in community services will reduce dependence on beds, releasing resource to re-invest in the further community models.

ECS has also contributed to reducing or delaying entry into long-term care home placement. There are early indications, however, that short term stays in care homes are increasing to support reduction in hospital bed days and unnecessary admissions. This means that we need to review our approach to step-down or intermediate care. In order to meet people's wishes to stay at home for as long as possible, we will conduct a pan Angus review of the intermediate care services and the admission and discharge pathway through intermediate care to ensure we develop access to effective short term rehabilitation support in our localities

By April 2016 we aim to have all Angus patients discharged within 72 hours of being assessed as ready for discharge.

Angus planned improvement for 72 hour discharge



In order to sustain effective and consistent discharge we will embed the planned date of discharge (PDD) approach. This will take the form of a consistent, daily focus on effective assessment and communications from the day of admission right through to discharge as defined in a multi-agency protocol. We will continue to explore and test how volunteers and local communities can play a greater role in supporting people to return home. Sustaining this approach will ensure that we reduce bed days lost to delayed discharge by 50% over the next year. We plan to roll out the ECS model across all Angus localities. This successful approach to supporting people at home for longer and at times of additional need will continue to reduce the need for medicine for the elderly beds in our localities and release further resources for reinvestment in integrated models of care.

3.2 Working towards 7 day services

Where we are now

In Angus our approach to 7 day services has been to ensure that out of hours services are consistently available. A range of professionals provide a variety of response services during out of hours (OOH). The hours that constitute OOH varies between services; for some services, OOH is after 5pm and before 9am; for other services it is after 8pm. Services any time on Saturday and Sunday are also considered to be OOH.

OOH services include:

- OOH medical cover is provided by NHS Tayside OOH service hosted in the Angus Health and Social Care Partnership.
- OOH social work cover is managed by Dundee Health and Social Care Partnership.
- The Primary Care Emergency Centre (PCEC) hosted by Angus Health and Social Care Partnership provides a 24 hour service where people are initially assessed by a Nurse Practitioner and, if appropriate, treated and discharged by the nurse, referred on to a specialist service or referred on to an OOH GP.
- The See and Treat service provides an emergency overnight service across Angus and responds to people requiring overnight palliative or symptom control.
- The Community Alarm Response Team, based in each locality, provides 24 hour emergency and unplanned personal care.
- NHS24 also provide 24 hour advice and support often signposting and referring to other local OOH services.
- Four Minor Injury & Illness Units (MIIU): Links Health Centre Montrose, and Whitehills Health & Community Care Centre, Forfar operate 7 days per week, Monday to Friday from 9am until 4.30pm and from 7.45am until 10pm on Saturdays, Sundays and public holidays; Brechin Infirmary operates 7 days per week between 9am and 4.30pm and Arbroath Infirmary open 24 hours, 7 days per week.

Where we want to be

People accessing services OOH are usually doing so when they are most vulnerable and often frightened. We need to ensure that the system is as seamless and uncomplicated to navigate as possible. We will conduct an in-depth review of our OOH provision and bring forward plans for improvement to ensure that services are integrated, sustainable, delivering faster, better and safer care, and providing the right treatment, at the right place, at the right time. This will include ensuring that an appropriate, effective and efficient response to need over 7 days is developed. We will explore opportunities to further develop technical capacity for call monitoring by community alarm services and how this can be integrated with telehealth and other OOH services.

Priority 4:

Improving Integrated care pathways for priorities in care

Health and social care services are available to and support all adults. There are, however, some more complex needs that require additional support; there are some overlaps between services that require particular attention to ensure that the right support is available. This includes specialist needs, such as mental health and learning disability; services such as inpatient services which are hosted by another integration partnership or by NHS Tayside; and specialist supported housing delivered through the Housing Strategy. Improving the integration of pathways to support these priorities in Angus has to focus on:

4.1 Addressing the additional requirements of people with specific needs,

4.2 Delivering a seamless pathway in and out of secondary care

4.3 Delivering appropriate models of specialist housing

4.1 Addressing the additional requirements of people with specific needs

Where we are now

Adult mental health services, older people's mental health services, learning disability and autism services and substance misuse services have been delivered through joint teams in Angus for many years. These joint community teams work with inpatient services and have developed pathways in and out of hospital that support individual needs. With the introduction of integration, community teams and inpatient services will be delivered by different parts of the health and social care system

National strategies such as 'Keys to Life', the 'Scottish Strategy for Autism', are impacting on the way that services are delivered operationally.

Each community planning partnership is required to have an Alcohol and Drugs partnership (ADP) to direct our strategic approach to alcohol and drugs difficulties in our communities.

Following on from successful initiatives, such as the "Link Up", Angus ADP has invested in the development of a "Whole Family Approach" to assessment and intervention. A Project Manager has been appointed on a twelve-month basis to oversee the implementation of a pilot in the Arbroath area. 2015 has seen the further development of this approach, in consultation with key stakeholders. The pilot, and any learning associated, will inform the implementation across all Angus localities over 2016-17.

The aim of the Whole Family Approach is to embed within the Recovery Orientated System of Care (ROSC) and beyond, the importance and necessity of a multi-dimensional and holistic assessment of an individual and their family/friends network. As noted above, a key element of this is the assessment of the needs of any children connected to the individual seeking support. In addition, the Whole Family Approach promotes the recognition of co-existing mental health and physical health issues for the individual and their significant others.

The emphasis on a person's extended social network is in recognition of the substantial evidence base illustrating the importance of developing a person's "social capital" and therefore, "recovery capital", and the pivotal role that their social and familial network plays in this (Best et al, 2010). Concurrently, the Whole Family Approach will promote the identification of Carers and, in line with the Carers (Scotland) Bill, ensure that Carers are offered support that is based upon a comprehensive, collaborative assessment of their particular circumstances

Where we want to be
All of these services will be impacted upon by the priorities set out in this strategic plan. The specialist nature of some of these services means that, whilst they have a role in localities, the teams will continue to provide pan-Angus services. Drug and alcohol services will continue to be developed in tandem with community planning partners through the Drug and Alcohol Delivery Plan.

4.2 Pathways in and out of Secondary Care

Where we are now
Managed Clinical Networks (MCNs) play a central role in enabling the development of structures and services to deliver evidence-based care, and we actively participate in MCNs within Tayside. A few examples of this are:

- Angus has a robust Chronic Obstructive Pulmonary Disease (COPD) pathway to aid accurate diagnosis and management. This includes a housebound service for people unable to attend a G.P. practice and a strong patient self-management network. (2.34% of the Angus registered population have a diagnosis of COPD.)

- An orthopaedic pathway has been introduced to ensure assessment of all older Angus patients admitted as an emergency to orthopaedics with an agreed plan for management and discharge.

- We have a surgical pathway providing support for assessment and management for older patients admitted as an emergency to surgery and which provides access to Early Supported Discharge. Current data for 2015 shows total bed days for older Angus patients in general surgery is reducing, with average surgical bed days per emergency admission dropping from 9.7 in 2013 to 8.5 in 2015.

- Monthly Pain Association Scotland Groups run in Arbroath and Forfar, Intensive Self-Management Programmes are delivered pan Angus by Pain Association Scotland and care models are being tested in Monifieth Health Centre in conjunction with the specialist pain service and involving community pharmacy.

- 5.41% of the registered population of Angus live with diabetes. A local enhanced service is in place to support the management of patients with Type 2 diabetes (not on insulin) within general practice. Local improvements are focussing on early detection, enablement, the empowerment of people to self-manage, and equality of access. The Tayside Diabetes Education Programme is delivered within each locality, in line with national strategy, and offered to all patients diagnosed with Type 2 diabetes within a month of diagnosis. Diabetes Forums run in 3 localities to enable ongoing access to information and peer support.

- Within Tayside we have an approved service model which promotes the delivery of evidence-based, safe care to patients requiring warfarin through a near patient testing service. Some 55 practitioners within Angus (practice nurses, community nurses, outpatient nurses and pharmacists) are trained in the service delivery and in 2014/15 provided care to 1,673 patients and 27,619 consultations. Pathways are supported by haematology and the laboratory services in Ninewells. A Multi-Agency Lead Clinicians Committee strategically oversees service developments and governance.

- Marie Curie provide an overnight nursing service, working in close partnership with community nursing teams.

Where we want to be
We will continue to participate in the development of managed clinical networks to support the effective management of patient pathways in and out of hospital based services. The first new development will be in relation to specialist palliative care. In future, Specialist Palliative Care services will be hosted within the Dundee partnership. A Managed Care Network is being developed. Dedicated Day Assessment and Treatment spaces will be developed in Arbroath Infirmary and Whitehills Health & Community Care Centre in partnership with Macmillan Cancer Relief.

4.3 Developing appropriate models of specialist housing

Where we are now
We have a range of supported housing arrangements in Angus for people with learning disability, people with autism and people with mental illness, enabling them to live in the community in safe and supportive environments. This includes approximately 72 tenancies. The supported accommodation model includes a level of core and cluster provision. This type of provision encourages individuals to greater independence through residing in mainstream tenancies whilst still being able to access the support available in core provision.

We recognise that there is a shortfall in the provision of supported accommodation for people with learning disability or with mental illness. There are people with learning disability and/or autism that live with family carers who are getting older and some people with learning disability who are placed in tenancies outwith Angus. We also have a small number of individuals who

remain in hospital due to the lack of an appropriate housing model to meet their needs. Currently, we are also dealing with an over-supply of some types of specialist housing for older people with voids in both sheltered and supported accommodation.

In August 2015 the Angus Housing Partnership was established to ensure good governance of the Angus Local Housing Strategy (LHS). The LHS 2012-17 has three strategic priorities, one of which is to provide special needs housing and housing support.

Where we want to be

Angus Council is currently developing the LHS 2017-22 which will take account of the revised Scottish Government guidance which strengthens the links between the LHS and the health and social care strategic plan. This will bring partners together to improve strategic planning in relation to specialist housing provision. The Housing, Health and Social Care Strategic Planning Group will inform decision making on the design and delivery of specialist provision housing and related services. The group is responsible for the development of a housing contribution statement identifying how housing and care services will work together to address the priorities set out in this plan.

The LHS 2017-22 will state what action is required within the life time of the LHS to support independent living and provide an assessment of the needs for specialist provision. Strategic planning arrangements between partners will be improved. The AHSCP provides the strategic direction on the priorities in relation to the housing requirements of people from specific care groups, balancing the needs of different groups and localities where necessary. This will ensure that housing opportunities can be delivered through prioritisation. Opportunities for re-provisioning and adapting existing properties will be considered to meet specialist need. New build developments or acquisitions will be delivered with an emphasis on flexible models which are fit for the future and can respond to the changing aspirations of our population. The Strategic Housing Investment Plan (SHIP) will be reviewed on a regular basis and will seek to provide a realistic delivery plan for all housing providers to meet the need for specialist provision.

The plans will ensure that appropriate models are developed to meet the needs of those currently in hospital and to give those who are placed outwith Angus an opportunity to return should they wish to. Over time, plans will ensure that there is a range of accommodation solutions in each locality. Timescales for housing developments will be set out in the LHS and SHIP.

10 Our Resources

The table below summarises the indicative 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 that will transfer from Angus Council and NHS Tayside to the new Angus HSCP.

Angus Integration Joint Board	**Annual Budget[5]**			
Estimate of Annual Resources	**Angus Council**	**NHST**	**NHST (Hosted on behalf of Angus)**	**Partnership**
	£k	**£k**	**£k**	**£k**
Older Peoples Services	29411	14400	0	43811
Mental Health	1362	2399	4661	8422
Learning Disabilities	10566	440	1739	12745
Physical Disabilities	2865	0	0	2865
Substance Misuse[4]	403	636	-31	1008
Community Services/Allied Health Professions	0	22726	4998	27724
Other Services	818	0	0	262
Planning/ Management	262	0	0	262
Family Health Services[1]	0	27130	0	27130
GP Prescribing	0	21021	0	21021
Other Resources[2]	613	884	0	1497
Less Funding from NHST (Partnership Funding)	-2463	0	0	-2463
Partnership Funding	0	8109	0	8109
Less Services Hosted in Angus on behalf of other IJBs [3]	0	-7491	0	-7491
Operational Management sub-total	43837	90254	11367	145458
Large Hospital Set Aside (In Patients)	0	11759	0	11759
Strategic Budget Grand Total	43837	102013	11367	157217

Notes

1. Includes General Medical Services (GP Funding), General Pharmaceutical
2. Includes Pay Awards and National Insurance adjustments
3. This all refers to 'Community Services/Allied Health Professions'
4. Hosted funding to be adjusted for other Scottish Government Funds
5. This information is Angus HSCP's Annual Financial Statement for 2016/17

The final financial framework for period 2016-2018 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 budget, including confirmation of short term and long term Scottish Government Partnership funding.
- The dynamic financial planning environment that both Angus Council and NHS Tayside are constrained by.
- Consideration of emerging developments and pressures.
- Transformational programmes Angus Council and NHS Tayside are progressing regarding 2016/17 and future years.
- The development of hosting arrangements for services devolved by NHS Tayside to Tayside IJBs (noting a number of services will be operationally managed by one IJB on behalf of all Tayside IJBs).

FINANCIAL PLANNING ENVIRONMENT

The Partnership's financial planning environment will be challenging, reflecting that of the public sector generally and Angus Council and NHS Tayside specifically. Both organisations face significant financial challenges and the budgets to be devolved to the Partnership in 2016/17 reflect the need to deliver significant efficiencies.

Efficiency initiatives totalling £2.466m (rising to £2.566m in 2017/18) associated with Angus Council resources devolved to the Partnership, have been developed and approved through Angus Council and are reflected in the budget settlement between Angus Council and Angus HSCP.

Efficiency savings targets for 2016/17 associated with NHS Tayside resources being devolved to the Partnership have been set at 5.5% as part of the budget settlement between NHS Tayside and Angus HSCP. This is as described in NHS Tayside's "Financial Framework 2016/17-2020/21". For IJB Services (excluding Prescribing) this equates to c£2.6m. Plans to deliver these saving are at an early stage of formulation.

In addition, Angus HSCP has a significant forecast variance (over £2.0m) between historic General Practice Prescribing costs and associated budgets for 2016/17(noting these budgets are after allowing for a 5.5% efficiency savings target). Prescribing will continue to be a major focus for Angus HSCP and a major factor in financial planning in 2016/17 and beyond.

Decisions regarding working towards savings targets and managing services within available resources will be taken forward through due planning and governance procedures.

As with 2016/17, future financial planning assumptions for both Angus Council and NHS Tayside will form part of the discussion regarding the resources available to Angus IJB in future years. Both Angus Council and NHS Tayside have published medium term financial plans that set out the scale of efficiencies they are required

to make for 2016/17 and estimates for future years. These are set out in the table below to provide context to the environment the Angus IJB will operate within. While there is a defined process for agreeing resources that will be devolved to Angus IJB from both partners, this process will be undertaken against the background of the constraint faced by both partners.

Partner	2017/18	2018/19
Angus Council[1]	5.4%	4.3%
NHS Tayside[2]	1.3%	1.2%

Notes
1.This information is an extract of Angus Council's Medium Term Financial Strategy (September 2015).
2.This information is derived from NHS Tayside Financial Framework – 2016/17 – 2020/21. These figures assume that all planned 2016/17 savings are delivered on a recurring basis, NHS Tayside's Financial Framework assumes 40% of 2016/17 savings are delivered on a recurring basis with consequent impact on future years.

FINANCIAL MANAGEMENT

As noted above, Angus Health and Social Care Partnership expects to operate in a difficult financial environment over the coming three years. This reinforces the need to maintain good quality financial management and to ensure the Partnership uses all available resources as effectively and efficiently as possible. To do that we will need to:-

- ensure we understand our current available financial resources, likely future financial resources and ongoing resources utilisation as best we can. To deliver this we will ensure that good financial planning and monitoring processes are in place;
- work with Angus Council and NHS Tayside to maintain and develop a good Finance support structure that adopts the best practices from both Angus Council and NHS Tayside Finance functions and which ensures that all financial reporting requirements are met;
- develop good, informed decision making processes and forums that include representation from across the Partnership including the third and independent sectors;
- work across the Partnership to ensure co-ordinated financial planning with Third and Independent Sectors;
- develop financial planning and monitoring processes that reflect the role of localities, the use of resources within localities and large hospital resources;
- develop financial planning and monitoring processes that reflect Scottish Government reporting requirements regarding funding such as Integrated Care Funding and Delayed Discharge funding; and
- make decisions that reflect the challenging financial environment in which we are operating.

FINANCIAL PLANNING

Angus HSCP's financial planning assumptions will continue to be developed during 2016/17. Many of the issues that will be reflected in further detailed financial planning are described in the "Delivering our Vision" section of this document. These, and other issues, will have local financial plans developed and progressed via the appropriate governance forums within Angus HSCP. When brought together, these individual plans will form Angus HSCP's overall financial plan.

Angus HSCP will invest Scottish Government funding received through Integrated Care Fund, Delayed Discharge and Integration Fund (Social Care) funding streams in line with the Strategic Plan.

Some of the financial planning issues reflecting the "Delivering Our Vision" section of this document are noted below.

Priority 1 – Improving Health and Well Being

- Consider the utilisation of Scottish Government funding to develop third sector capacity, independent sector capacity and to support carers.
- Consider the utilisation of Scottish Government funding to support the self-management of long term conditions.
- Work with local General Practices and Pharmacy Services to put in place plans which ensure that local Prescribing resources are utilised effectively.

Priority 2 – Supporting Care Needs at Home

- Consider the utilisation of Scottish Government funding, including Technology Funding, alongside existing local resources to develop Technology Enabled Care.
- Consider the utilisation of Scottish Government funding, alongside existing local resources, to further progress Self Direct Support.
- Implementation of the Help to Live at Home Programme to ensure Care at Home services are delivered effectively and efficiently in the long term. In doing so this will ensure that the Care at Home provider market is developed further thereby assisting with issues such as Delayed Discharge.
- Joint Equipment Store – Ensure the provision of high quality sustainable Community Equipment provision through the remodelling of existing resources.

Priority 3 – Developing Integrated and Enhanced Primary and Community Responses

- Consider the utilisation of Scottish Government funding, alongside existing local resources, to support initial investment in locality and community support (including Enhanced Community Support and services provided through the third and independent sectors). This will assist with resolving Delayed Discharge issues and generally reduce demand for hospital services and residential care thereby releasing resources to be re-invested.
- Review the provision of Out of Hours Services including Minor Injury & Illness Units across Angus to ensure all services are delivered effectively and efficiently.

Priority 4 – Improving Integrated Care Pathways for Priorities in Care

- Work to develop financial plans that reflect improved pathways of care for services that are delivered through community services, in patient services and supported accommodation including Adult Mental Health, Older People's Mental Health, Learning Disability and Autism Services and Substance Misuse services.

Workforce

- Note capacity issues within Community Nursing Services and review Medication Administration across Angus.
- Occupational Therapy – Ensuring services are provided efficiently through maximising the benefits of integrated working across Health and Social Work staff.
- Develop effective and efficient administrative support functions across the new Angus HSCP that reflect integrated working.
- Develop and implement a senior management structure for the new Angus HSCP that reflects integrated working.
- Work to develop financial plans that support workforce policies that deliver a sustainable workforce across all Partnership sectors (e.g. Social Work, Social Care, General Practice, Nursing, Third and Independent sectors) and protect the IJB from the service delivery and financial repercussions of staff shortages.
- Work in conjunction with Angus Council and NHS Tayside to ensure efficient use of Property assets (see Property Strategy section).

WORKING WITH PARTNERS

Angus HSCP will continue to work closely with NHS Tayside, Angus Council, the third and independent sectors and other Tayside HSCPs to ensure the effective and efficient use of resources across Angus and that Tayside delivers Health and Social Care outcomes.

NHS TAYSIDE

Angus HSCP will work in conjunction with NHS Tayside to derive savings from efficiency work streams initiated within NHS Tayside. There are 6 of these as follows:

- Workforce & Care Assurance
- Optimising Demand Management
- Optimising Our Care Environments
- Cost Effective Procurement
- Repatriating Services
- Property & Our Estate

ANGUS COUNCIL

Angus HSCP will work in conjunction with Angus Council to derive savings from the Transforming Angus programme. The main work streams within this programme are as follows:-

- Agile Working
- Help to Live at Home
- Estates Review
- Angus Digital
- Business Process review

WORKING WITH OTHER IJBS

Angus HSCP will work in conjunction with Dundee HSCP and Perth and Kinross HSCP to develop financial plans for services hosted by Angus IJB on behalf of other Tayside HSCPs. Angus HSCP will work with other HSCPs to facilitate the successful financial planning of services managed elsewhere on behalf of Angus HSCP including In Patient Services managed on behalf of Angus HSCP.

Property Strategy
Whilst the Angus HSCP is not responsible for any properties - these remain the responsibility of either NHS Tayside or Angus Council - decisions on property strategies will impact on our services. To support Angus HSCP, NHS Tayside and Angus Council are progressing a Property and Asset Strategy (PAS). The PAS has been developed in accordance with the guidance set out in the Scottish Government's Public Bodies (Joint Working) (Scotland) Act 2014. The aim of this IJB Property and Asset Strategy is to:

- Support the delivery of the IJB's Plan and strategy for the future delivery of adult healthcare services in Tayside.

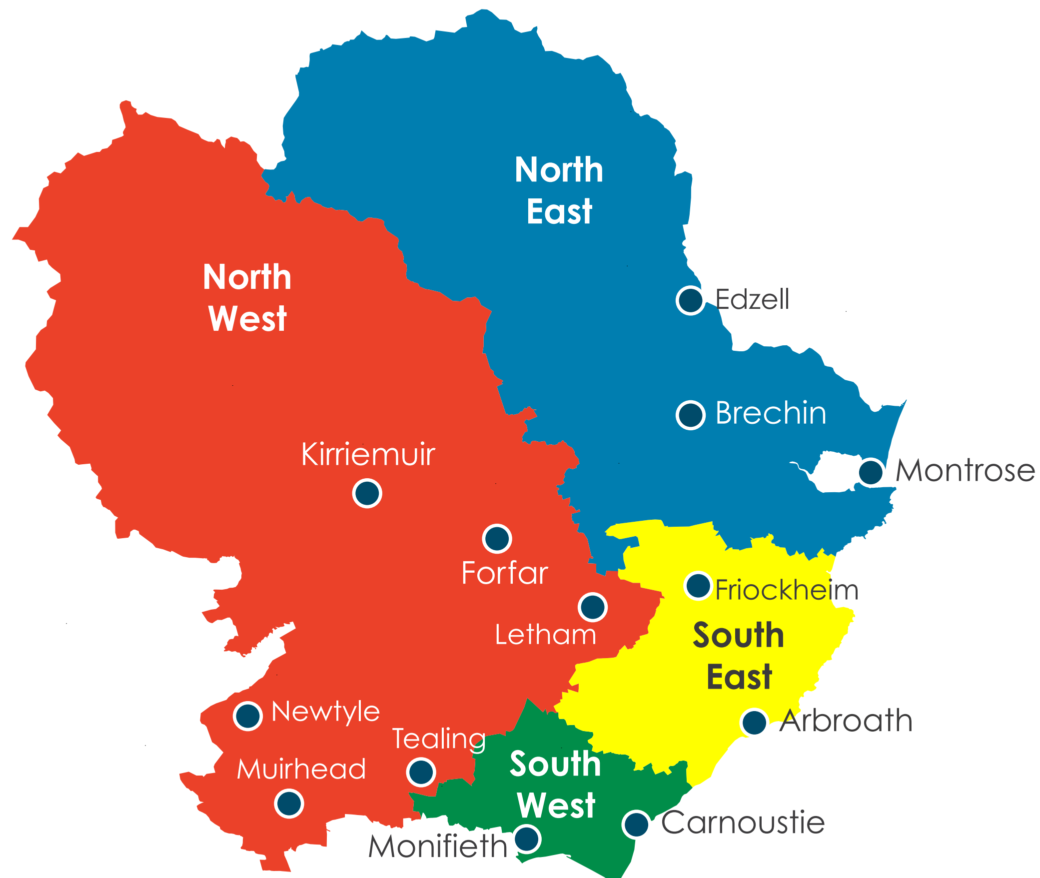
- Ensure that assets are used efficiently, coherently and strategically to support the future clinical and service needs of the population as agreed by the IJBs.

- Ensure that all assets are known and those that require funding are included within this Plan.

- Provide and maintain an appropriate number and quality of affordable assets which complement and support the provision of high quality services, which meet the population needs and that are sustainable over the long term.

11 Delivering our Locality Model

Working in localities allows us to deliver and develop services that are most relevant to the population. Angus will be organised in four localities.



Locality working will deliver:

- Local leadership
- Partnership between health, social care, third sector and independent sector providers and the community
- Greater opportunity for co-production and engagement
- A range of core services
- Relevant local services and support for local commissioning
- Local access to support

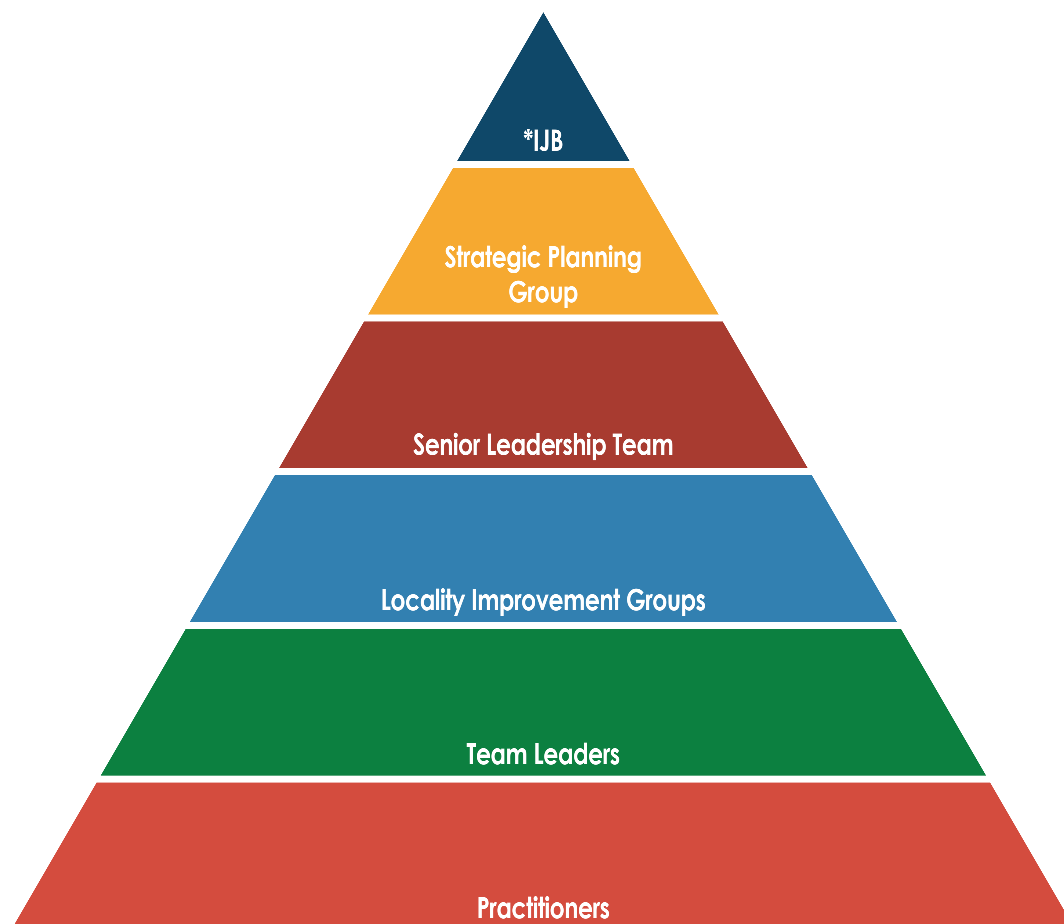
Each locality has its own plan which shows how the different needs in that locality are addressed.

12 Our Workforce

Angus Health and Social Care Partnership is committed to providing high quality integrated care to its patients and service users. Our workforce includes staff from NHS Tayside, Angus Council, the third and independent sectors, volunteers and unpaid carers. To maximise the benefits of our partnership, our workforce will be on a journey of change that will develop new ways of commissioning, managing and delivering services. A Workforce strategy provided separately details our approach to transformational change for our workforce.

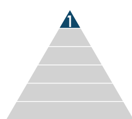
Many of us will choose to work longer, which will have implications for the opportunities and career pathways available to our younger workers. It is vital that we continue to commit to youth employment through, for example, modern apprenticeships, internships and work programmes. We are also faced with challenges in attracting applicants to a rural setting and we will work to demonstrate that Angus is an attractive place to live and work. Engaging with the workforce and developing their skills, knowledge, attitude and behaviours will enable us to be prepared for the changes and challenges of the future.

In the lead up to integration the development of our workforce has been focused on the delivery of an integration skills programme aimed at addressing culture change across our developing organisation.



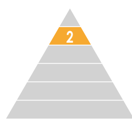
*IJB is Integration Joint Board

Angus Health & Social Care Partnership Integration Skills Programme (ISP) 2015-17 (Cross Sectoral)



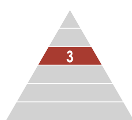
1

NES/SSSC Programme – Test against the Shadow Board
April – October (4/5 Sessions)
Action Learning Sets – Complex situations
Governance/performance
Induction pack for board members
Finance (CIPFA Programmes)
Strategic Issues



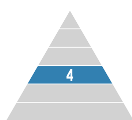
2

Strategic Commissioning programme from IPC
Tier 1 – Directors/Executives.1 day in March
Tier 2 – Technical strategic Planning Networks. 4 days, March – May
Local network learning. Develop specification tailored to Angus
ISD/data – What do we know?



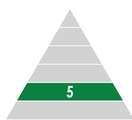
3

Who are they?
Have a specification session – 'What do they feel they need'?
Locality Manager job description proposal



4

To be formed
Relationships/roles
Who are they?
Potential/capacity building
Co-production and commissioning
HSCI team to develop a proposal for the Project Board. Inform ISP (lot of local application of the SMT and SPG ISP)



5

Generic items (see list below)
Interface Programme with the Locality Leadership Groups
Pathway Relationships – Action Learning Sets (ALS)

6

Information/engagement/communication
New roles/skills development
Data sharing/mobile working
Integrated care planning
ALS – How to deal with difficult situations
Practical skills – Mandatory training
Apprenticeship programmes
Learning passports
Self-directed support (SDS)

Generic

Leadership programmes
Coaching
Change Mangement
Improvement and service redesign
Co-production
Community capacity building
SDS/Personalisation
Personal outcomes
Engagement
General Induction

Staff wellbeing
Digital skills
Induction
Adult support and protection
E-learning training
SSSC Continuous learning framework
SSSC Step Into Leadership Website

Delivering integration of health and social care requires a transformational approach to the way we work in order to create one organisational culture focused on delivering good outcomes for the people of Angus. Our shared culture is based on an approach which includes shared values and service delivery principles recognised by the workforce of the partnership. As we move forward new roles to support integration will also emerge.

12.1 Shared Values

The Angus Health and Social Care Partnership has a set of core values which will underpin our culture and the way we work.

Individuality	People will be recognised and valued as individuals.
Co-production	An inclusive approach to the development of services and support will fully involve service users and carers.
Safety	People will be enabled to take risks that they understand.
Inclusion	People will be able to participate in and contribute to their community to the maximum of their potential.
Choice	People will be involved in making choices and have the necessary support to express choice.
Equity	There will be equality of access to services and support across all communities in Angus and all members of the community will have equal access to service provision.
Human Rights	There is a commitment to the promotion of Human Rights.
Accountability	People using services will be made aware of the accountability of the health and social care partnership to the public.
Transparency	Decision making that affects specific individuals and strategic decisions about services will be open and honest.
Quality	Services will be of good quality.
Respect	Everyone will be treated in a polite and courteous manner, with compassion, caring and kindness and with respect for their beliefs.
Responsibility	The health and social care partnership and the users of services have an equal responsibility to use services efficiently and effectively and to treat each other with respect.
Learning	The health and social care partnership will see events, good or bad, as an opportunity to learn and promote improvement in services and ways of working.
Best Value	The health and social care partnership will ensure that public resources are spent effectively and efficiently in the delivery of services and support.

12.2 Developing roles for integration

Where we are now
We have been progressing partnership working across health and social care for some time. We have a number of joint teams in place in adult mental health services, learning disability, older people's mental health services and substance misuse services. This has led to the development of shared roles in care provision and case management functions. Integration provides an opportunity to consider the roles, tasks and functions of staff in a different way with the emphasis on clarity of function for people who use services, reduced duplication and improved quality. This work is very much in its earliest phase.

Where we want to be
Over the next three years we want to develop more integrated roles for staff. This will include the development of a single management structure for all services and delegated to the Integration Joint Board; sharing administration roles; and, further progressing approaches to care and case management. This work is progressing, and a new senior management structure will be in place for April 2016 with our approach to locality management being developed over the following 12 months.

We are taking a transformational approach to change which will take three years to complete. We are learning from, for example, new ways of working for occupational therapists and from reviewing policies and practice in relation to the administration of medication

Occupational Therapy (OT). We have completed a test of change within the Brechin / Montrose locality which evidenced that OT staff across NHS and Social Work could change how they work, promoting greater continuity and reducing unnecessary duplication. Areas for change include:

- working within the revised response standards for referrals, providing consistency in performance in each of the localities
- agreeing the core functions of an OT role and support staff role as well as identifying the areas for a more specialist response
- developing one record system for use by all OT staff
- delivering consistency in the recruitment of staff and the training being undertaken by staff

Medication administration. Efficient and effective support for the administration of medication in our communities is essential. Anecdotal evidence suggests that a high proportion of hospital admissions include factors related to poor compliance with medication or other administration issues. Currently, a system supported by district nursing duplicates visits by social care staff. A 'test of change' in the north-west locality will look at how we can jointly increase our capacity and improve our performance, with a view to changing how we administer medication across Angus. Medication audits will be implemented to ensure quality and collate feedback from service users, staff and families. Once a successful model is developed the approach will be rolled out across Angus to everyone who receives a personal care service. This test of change will impact on all care providers from April 2016.

13 Our Quality and Performance

"Governance is a system through which Organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in care will flourish."
Ref: Scally and Donaldson, 1998.

We will have achieved our aims if:

- More people live longer in good health
- People are able to access support within their own communities
- More people are cared for at home
- More people are involved in the design and delivery of their own care.
- Carers feel supported

To effectively manage performance and the quality of services 'Getting it Right for Everyone - A Clinical, Care and Professional Governance Framework' has been agreed across Tayside to support clinical and care governance.

The framework has been developed to ensure that there are explicit and effective lines of accountability from care settings to each authority's IJB, the NHS Tayside Board and the three local authorities' Chief Executives and elected members. The proposed framework recognises that such accountability is essential to assure high standards of care and professionalism in the services provided by each Health and Social Care Partnership with the aim of achieving the best possible outcomes for service users in line with the National Outcomes Framework.

To support the framework a range of performance measures have been identified. These are designed to measure progress against the national outcomes and to monitor the quality of services.

Monitoring Progress

If we deliver on our priorities we believe we will deliver on the national outcomes. We will measure our progress through reporting on the following:

1. Percentage of adults able to look after their health very well or quite well.
2. Percentage of adults supported at home who agree that they are supported to live as independently as possible.
3. Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided.
4. Percentage of adults supported at home who agree that their health and care services seemed to be well co-ordinated.
5. Percentage of adults receiving any care or support who rate it as excellent or good
6. Percentage of people with positive experience of care at their GP practice.
7. Percentage of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life.
8. Percentage of carers who feel supported to continue in their caring role.
9. Percentage of adults supported at home who agree they felt safe.
10. Percentage of staff who say they would recommend their workplace as a good place to work.*

11. Premature mortality rate.
12. Rate of emergency admissions for adults.*
13. Rate of emergency bed days for adults.*
14. Readmissions to hospital within 28 days of discharge.*
15. Proportion of last 6 months of life spent at home or in community setting.
16. Falls rate per 1,000 population in over 65s.*
17. Proportion of care services graded ‘good’ (4) or better in Care Inspectorate Inspections.
18. Percentage of adults with intensive needs receiving care at home.
19. Number of days people spend in hospital when they are ready to be discharged.
20. Percentage of total health and care spend on hospital stays where the patient was admitted in an emergency.
21. Percentage of people admitted from home to hospital during the year, who are discharged to a care home.*
22. Percentage of people who are discharged from hospital within 72 hours of being ready.*
23. Expenditure on end of life care.*

Note: *indicates that data definitions have not yet been provided by the Scottish Government

A performance report showing progress against these national core indicators will be produced annually, with the first report providing a baseline for Angus HSCP being available in October 2016.

Regular monitoring of our progress towards our priorities and the national outcomes will be undertaken by the strategic planning group. This will allow a continual focus on improvement approaches that will continue to address the intentions of this strategic plan.

14 Supporting Information

A range of reports and working documents underpin how this strategy will be delivered and have been highlighted throughout this strategic commissioning plan.

These reports are:

1. **Joint Strategic needs assessment**

   The Joint Strategic Needs Assessment (JSNA) is the analysis of our communities. The purpose is to form the basis of intelligence-led strategic decision making within Angus in relation to Health and Social Care services. The JSNA measures such things as population distribution, life expectancy, disease prevalence and lifestyle factors. The JSNA informs any required reprioritisation of expenditure, service reconfiguration, commissioning and/or decommissioning of services. The JSNA will continue to grow and develop as our understanding and knowledge of our community grows.

2. **A mainstreaming and equality outcomes report**

   The Equalities Act (2010) requires public sector bodies to comply with general equalities duties. Integration Joint Boards have been added to the list of public sector organisations relevant to the Act and are therefore required to develop Equalities Outcomes by 30th April 2016 and report on these outcomes by 1st April 2018.

   This mainstreaming report sets out how Angus Health and Social Care Partnership is meeting its requirements under the Equality Act 2010 and the (Specific Duties) (Scotland) Regulations 2012.

   Under the Equality Act 2010, the Public Sector Equality duty, or ‘general equality duty’, requires public authorities in the exercise of their functions to have due regard to the need to:

   - Eliminate unlawful discrimination, harassment and victimisation and other conduct that is prohibited by the Equality Act 2010;
   - Advance equality of opportunity between people who share a relevant protected characteristic and those who do not; and
   - Foster good relations between people who share a protected characteristic and those who do not.

   The public sector equality duty covers the following protected characteristics: age, disability, gender, gender reassignment, pregnancy and maternity, race, religion or belief and sexual orientation. The public sector equality duty also covers marriage and civil partnerships, with regard to eliminating unlawful discrimination in employment.

3. **A policy evaluation**
   From time to time the Scottish Government sets out national policy and guidance in a range of reports. Many have an impact on the manner in which health and social care services are to be provided. The policy evaluation will be kept up to date as new policy and guidance is issued by the Scottish Government.

4. An evidence log of engagement activity maintained and held by the Chief Officer

A key principle of the commissioning process is that it should be equitable and transparent, and therefore open to influence from all stakeholders via a continuous dialogue with people who use services, their carers and providers. Engagement across our communities is therefore an ongoing activity which supports health and social care integration. Reports will be produced from engagement activity and published after each event. An evidence log of all activity will be maintained by the Chief Officer.

5. Locality plan for each locality

The Health and Social Care Integration Partnership is required to identify how it will carry out its functions in relation to each locality: this information must be set out separately for each locality, and cannot just be a generic statement that assumes that all localities will work in the same way as one another. Locality Improvement Groups have developed plans for their locality which show the relationship between the locality and the health and social care integration strategic plan, but which also set out specific priorities for each locality that will meet local needs and demands within the resources available.

6. Clinical and Care governance framework

The framework has been developed to ensure that there are explicit and effective lines of accountability from care settings to each authority's IJB, the NHS Tayside Board and the three local authorities' Chief Executives and elected members. The proposed framework recognises that such accountability is essential to assure high standards of care and professionalism in the services provided by each Integration Authority with the aim of achieving the best possible outcomes for service users in line with the National Outcomes Framework.

7. A performance management framework and report

The strategic plan articulates the direction of travel across the whole system of adult health and social care in improving outcomes. The delivery of the plan should result in the development of sustainable skills, systems and resources that progress the national outcomes and local priorities. The Strategic Planning Group and the Clinical and Care Governance Group have a role in ensuring that the ambitions of the Strategic Plan are delivered whilst assuring the quality of services. A performance framework will be developed to ensure the collection of data and, as a minimum, that an annual performance report is compiled for the Integration Joint Board, NHS Tayside and Angus Council, as well as being publicly available.

8. Workforce and organisational development strategy

The strategic plan articulates a vision for health and social care including a number of improvement activities. To deliver improvement, we must work with staff to create a new culture, new management arrangements for the partnership and develop a more integrated approach to working at every level. With this in mind, a shared approach to workforce development and a transformational approach to organisational development must be taken forward in a planned way.

9. **Annual Financial Statement**

The strategic plan and its associated priorities will have to be delivered within the finite resources available to the partnership. Angus HSCP is required to publish Annual Financial Statements, consistent with local Strategic Plans, describing the resources that will be allocated to delivering the Strategic Plan.

10. **A Market facilitation plan**

Market facilitation is the process by which commissioners seek to influence and shape the health and social care market to ensure that there is a diverse and suitable range of affordable provision to deliver good outcomes and to meet the needs of the population into the future.

11. **Plans for individual hosted services**

Each hosted service requires to develop an operational delivery plan which shows how the service will contribute to the aims and objectives of integration and how the service will be developed to meet the intentions of the strategic commissioning plan in each partnership area.

12. **The Housing Contribution Statement**

Housing Contribution Statements (HCS) were introduced in 2013 and provided an initial link between the strategic planning process in housing at a local level and that of health & social care. The HCS will now set out the role and contribution of the local housing sector in meeting the outcomes and priorities identified within the Strategic Commissioning Plan. It is the responsibility of the Health and Social Care Partnership to ensure that the HCS is in place as part of the Strategic Commissioning Plan.

These reports are all at various stages of development and will be made available as they are completed.

Glossary

Allied Health Professional (AHP)
This is a person registered as an Allied Health Professional with the Health Professions Council: they work in health care teams and include physiotherapists, dietitians, speech and language therapists, psychologists, occupational therapists, podiatrists, audiologists etc.

Anticipatory Care
This can take many forms and includes identifying a planned response to a change in an individual's health related to a pre-existing condition. It is expected to help reduce avoidable and unscheduled acute admissions for people with pre-existing conditions. The purpose of advanced/anticipatory care planning is to support the individual to have greater choice, and control of care preferences through communication across the support team, across agencies and across care settings.

Asset-Based Approach
Focusing on the skills and knowledge of individuals and the connections and resources within communities and organisations rather than concentrating on problems and deficits. The approach aims to empower individuals, support independence and enable them to rely less on public services.

Body Corporate Model
This is a model of integration where a Health Board and Local Authority both delegate the responsibility for planning and resourcing service provision for health and social care services to an Integration Joint Board, established as a separate entity. The body that acts as the Integration Authority for a particular area will be determined by reference to the model of integration used in that area.

Care Package
A term used to describe all the different types of care and support that an individual may receive. For example they may have support from a community alarm, have home care and have meals delivered. All these services together make up the care package.

Care Pathway
The route followed by a service user into, through and out of NHS and social care services

Change Fund
This was a short term fund as part of the reshaping care for older people initiative. It was designed to enable NHS boards and local authorities to refocus health and social care for older people towards prevention and early intervention. The fund ceased allocations in April 2015.

Community Capacity
This is used to describe activities, resources and support that strengthen the skills, abilities and confidence of people and community groups to take effective action and play leading roles in the development of their communities. It does this by focusing on the skills and knowledge of individuals and the connections and resources within communities and organisations rather than concentrating on problems and deficits. The approach aims to empower individuals, enabling them to rely less on public services.

Co-production
This is about combining our mutual strengths and capacities so that we can work with one another on an equal basis to achieve positive change.

Delayed Discharges
This term is used to describe a situation that can occur when a patient ready for discharge cannot leave hospital because the necessary care, support or accommodation is not available

Delegation
This is the process used to integrate functions, by giving responsibility for health and social care functions to the Angus Health and Social Care Partnership.

Efficiencies
This means reducing waste in services and making sure that best use is made of resources.

Enablement and Prevention of Admission
This is about giving people the opportunity and the confidence to relearn or regain some of the skills they may have lost as a result of poor health, disability, impairment or entry into hospital or residential care. As well as regaining skill, enablement and preventative services support service-users to gain new skills to help them maintain their independence.

Enhanced Community Support (ECS)
The Enhanced Community Support model involves a variety of professionals including GPs, district nurses, occupational therapists and physiotherapists, pharmacists, specialist hospital doctors, social work and voluntary sector colleagues working together as a single team to support individual patients. The team provides care and support in patients' own homes so that, where possible, hospital admission is avoided.

Equality and Diversity Impact Assessment (EQIA)
EQIA is a strategic process to be considered when planning a new, or redesigning an existing, policy, function or service.

Health inequalities
This is the gap which exists between the health of different population groups such as the affluent compared to poorer communities or people with different ethnic backgrounds.

Health and wellbeing outcomes
The nine national health and wellbeing outcomes provide a national framework for measuring the effect of integrated health and social care services on the health and wellbeing of individuals.

HEAT Targets
This is a performance management system sets out the targets and measures against which Health Boards are publicly monitored and evaluated. HEAT is an acronym for Health Improvement, Efficiency and Governance, Access and Treatment. These are the four areas being targeted.

Home Care or Care at Home
Help provided directly to you in your own home. Home carers are people who are employed to provide direct personal physical, emotional, social or health care and support to service users.

Independent Living
This means having the same freedom, choice, dignity and control as other citizens at home, at work and in the community. It does not necessarily mean living by your self or fending for yourself. It means rights to practical assistance and support to participate in society and live an ordinary life.

Independent Sector
This is a term used to encompass individuals, employers, and organisations who contribute to needs assessment, design, planning, commissioning and delivery of a broad spectrum of social care services, which are wholly or partially independent of the public sector. The independent social care sector in Scotland includes care homes, care at home, housing support and day care services.

Integrated Care
This is about improving services in relation to access, quality, user satisfaction and efficiency. The aim is to enable better coordinated, joined-up and more continuous care, resulting in improved patient experience while achieving greater efficiency and value from health and social care delivery systems.

Integration Authority/Integration Joint Board
This is the body that is responsible for planning integrated care. It will decide which integrated services will be provided, how they will be funded and what they should look like. It can direct the Health Board and Local Authority to deliver those services. An Integration Joint Board will oversee the integrated arrangements and future service delivery.

Integration Scheme
This is the agreement made between the Health Board and the Local Authority and approved by the Scottish Government. It sets out the make-up of the Integration Authority and how it will work.

Integration
This is the combination of processes, methods and tools that facilitate integrated care.

Integrated Resource Framework (IRF)
The IRF for Health and Social Care is a framework within which Health Boards and Local Authorities can better understand the patterns of care they provide, particularly to their shared populations of people and service-users.

Intermediate Care
This describes the services that support people to improve their independence and aim to provide a range of enabling, rehabilitative and treatment services in community and residential settings.

Locality Planning
This is intended to keep the focus of integration on improving care in local communities. It will draw on the knowledge and experience of users of services, carers, staff and the third and independent sectors and provide the route for leadership by local clinicians and professionals from across health and social care – and, particularly, GPs – in planning service provision. Every Partnership must have at least two localities within its boundaries for the purpose of locality planning. In Angus there are four.

Long-term Conditions
These are conditions that last a year or longer, impact on many aspects of a person's life, and may require ongoing care and support. Common long-term conditions include epilepsy, diabetes, some mental health problems, heart disease, chronic pain, arthritis, inflammatory bowel disease, asthma and chronic obstructive pulmonary disease (COPD).

Managed Clinical Network / Managed Care Network (MCNs)
These are linked groups of health professionals and organisations working in a co-ordinated manner to ensure equitable provision of high quality, clinically effective services. A clinical network is usually focussed on a condition for example cardiac, stroke or diabetes. A care network focuses on care groups such as older people.

Market Facilitation
This is a key aspect of the strategic commissioning cycle. Authorities will undertake a range of activities to promote the successful development of services to meet the needs of the local population effectively. These activities should include the development of an accurate picture of local need and markets, published as a Market Facilitation Plan.

Multi-disciplinary Team (MDT)
This is a team made up of professionals from across health, social care and third sector who work together to address the needs of their patients/service users/clients in order to improve the delivery of care and reduce fragmentation/duplication.

Participatory Budgeting
Participatory budgeting directly involves local people in making decisions about the public money being spent in their community.

Personal Outcomes
Personal outcomes are about the impact or end result of services, support or activity on a person's life. The focus is on the individual as a person with strengths and preferences who may already have a network of support and resources, which could include family and friends. This approach reinforces the idea that the individual is best placed to know what their needs are and how those needs could then be met. It means that people can make their own decisions about what they require and what information and support they need to enable them to do so.

Person-centred
This is an approach to working with people which respects and values the uniqueness of the individual and puts the individual's needs and aspiration firmly at the centre of the process.

Primary Care
This is health care provided in the community. The main primary care services are provided by GP practices, dental practices, community pharmacies and high street optometrists as well as community nurses and allied health professionals.

Secondary Care
This is medical care provided by a specialist or facility. Referral would be made by a primary care physician that requires more specialised knowledge, skill, or equipment.

Self-directed Support (SDS)
This is the term used to describe the way in which people are assessed and helped to decide what support they may need. It also gives the service-user as much or as little control as they want to arrange some or all of their own support. This is instead of receiving services directly from Local Authority social work or equivalent. The SDS process allows people more flexibility, choice and control over their own care so that they can live more independent lives with the right support.

Self-management
This is when people with health and social care needs are encouraged to stay well, learn about their condition and their care and support needs, and remain in control of their own health.

Strategic Needs Assessments (SNA)
SNAs analyse the health and care needs of populations to inform and guide commissioning of health, wellbeing and social care services within Local Authority areas. The main goal of a SNA is to accurately assess the health and care needs of a local population in order to improve the physical and mental health and wellbeing of individuals and communities. The SNA will underpin the Strategic Plan.

Strategic Commissioning
The term used to describe all activities involved in:

- assessing and forecasting need,
- linking investment to agreed desired outcomes
- planning the nature, range and quality of future services
- working in partnership to put these in place

This is the process that informs the Angus Partnership's strategic plan

Strategic Plan
The Strategic Plan is at the heart of integration and is intended to be the means by which services are redesigned in an integrated way to improve the quality and coherence of care for people using them. Each Partnership must put in place a Strategic Plan (Strategic Commissioning Plan) for functions and budgets under its control. These plans will be co-produced through a strategic planning group whose members will include representatives of non-statutory partners, service users and service user representatives.

Supported Living
Supported living is an alternative to residential care or living with family members that enables adults with disabilities to live in their own home, with the help they need to be independent. It allows people to choose where they want to live, who they want to live with and how they want to be supported.

Technology Enabled Care/Telehealth care
Telecare and telehealth is technology that can be used to help service users live safely and independently in their own home. This can range from simple alarms, devices and sensors in the home through to more complex technologies such as monitor daily activity and detect falls etc.

Third Sector
This is a term used to describe the range of organisations that are neither public sector nor private sector. It includes voluntary and community organisations (both registered charities and other organisations such as associations, self-help groups and community groups), social enterprises, mutual and co-operative organisations.

Transformational Planning/ Leadership/ Change/ Approach
As opposed to the management of services, change, approach and so on these terms are used to describe the ability and need to inspire, motivate and engage across, in this case, a broad range of individuals and communities. These skills are seen as being particularly important at a time of significant change.

2020 Vision
Healthcare Quality Strategy for Scotland is the approach and shared focus for all work to realise the 2020 Vision. It aims to deliver the highest quality healthcare to the people of Scotland to ensure that the NHS, Local Authorities and the Third Sector work together, and with patients, carers and the public, towards a shared goal of world- leading healthcare.

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