Angus Health and Social Care Partnership

Draft Strategic Plan 2016-2019

V4 IJB
January 2016

Note : the final version will be formatted and designed by print and design services.

FOREWORD

Our strategic plan is built upon on 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 aim has been and will continue to go beyond consulting with communities to create a broader discussion based approach where learning affects change. As detailed in our plan, many of the key aspirations of 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.

Glennis Middleton **Chairperson** **Angus Integration Joint Board**	**Hugh Robertson** **Vice Chairperson** **Angus Integration Joint Board**	**Vicky Irons** **Chief Officer** **Angus Health and Social Care Partnership**

1. Introduction

Angus Council and NHS Tayside are working together in a new Angus Health and Social Care Partnership. The Angus Health and Social Care Partnership 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 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.

We need 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. Health and social care services are being brought together on a multi–agency basis to address these challenges. Very often this will be delivered through working in the four localities that make up Angus. The partnership will also work with acute services to reduce avoidable admissions to hospital, 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 a wider partnership that exists within our communities. This partnership includes people who live and work in Angus, staff and providers of services and support, the independent sector, and the third sector, including voluntary organisations and volunteers. 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 the four identified priorities for health and social care integration in Angus. (See below).

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.

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, to prevent unnecessary admissions to hospital or to care homes and 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

A summary of policy drivers is maintained and available on the website.

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.'

The commissioning plan will be a working document for the staff of Angus Council and NHS Tayside working on behalf of the Integration Authority. It will include the long term vision and the year on year fully costed delivery and improvement plan for the achievement of the vision. An annual review and update will provide progress against the delivery and improvement plan as well as identified trends through key performance indicators.

This first Angus Strategic Plan aims to consolidate current single agency and joint service development and improvement plans, and to review 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.

5. Scope of the Strategic Plan

The Angus Health and Social Care Integration Partnership will be responsible for planning and commissioning integrated services and overseeing their delivery. These services include all adult social care, adult primary and community health care services; 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 wider Community Planning Partners in Angus. This includes charities, voluntary and independent sectors and community groups so that, as well as delivering flexible, locally based services, we can work in partnership with our communities.

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 Angus. In keeping with Scottish Government requirements, hosting arrangements have been established in relation to those services. This means that they are managed by one or other of the partnerships on behalf of all of the partnerships in Tayside.

Hosted Services

Angus	Dundee	Perth and Kinross
Pharmacy Primary Care GP out of hours Forensic medicine Continence service	Learning disability inpatients Psychology Sexual and reproductive health	Substance Misuse inpatient services General Dental/ Community Dental services

Speech and language therapy	Homeopathy Specialist palliative care Centre for brain injury rehabilitation Eating disorders Dietetics Medical advisory service Tayside Health Arts Trust Keep Well Psychotherapy	General Adult Psychiatry Prisoner Healthcare Podiatry

Hosted services will contribute to the delivery of the priorities for health and social care integration in Angus. Delivery plans for hosted services will be made available separately by 31 March 2015.

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
- 7 community hospitals providing 200 beds supporting, older people, hospice care, rehabilitation and adult psychiatry.
- 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 2000 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.
- 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 and Murray Royal 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 will be provided separately by 31 March 2015.

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 as people get older. The number of people aged over 65 is set to rise significantly as a percentage of the total population.

Angus population 2015

All people 116,275

Age 16-64	67,766
Age 65-74	13,395
Age 75-84	8,228
Age 85+	2486

Female 59,596 Male 56,567

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%. Figure 6 shows that the 75+ will almost double in size and go from the smallest age group in 2013 to the second biggest age group in 2037. As a percentage, as shown in table 7, the increase in the 75+ age group is 89%. This paints a different picture to 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.

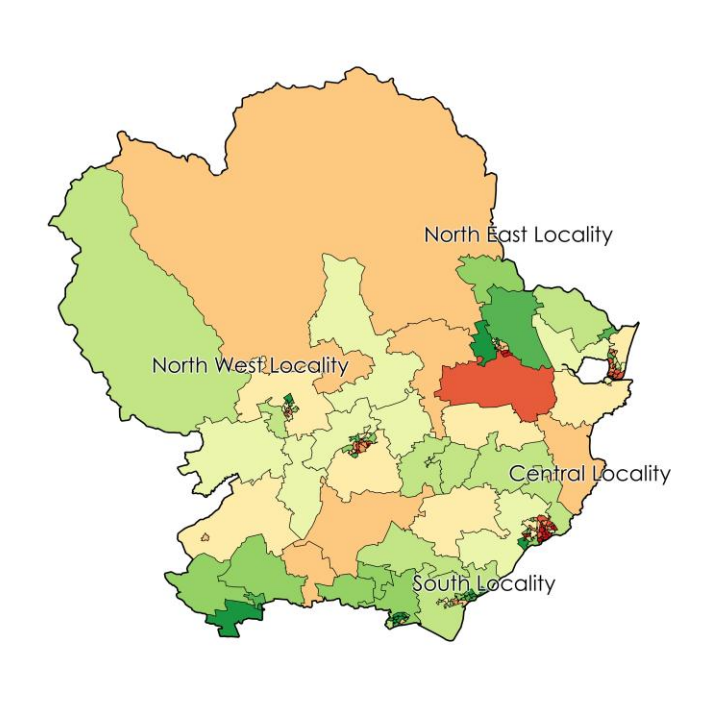
Life Expectancy

	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.

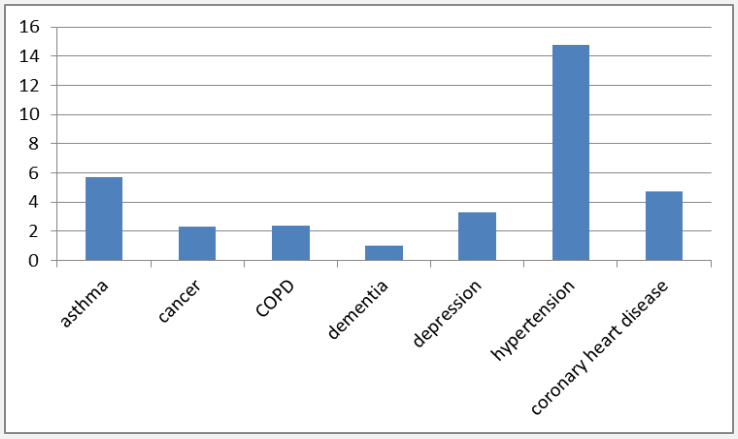
More than half of Angus households of people over 60 years are considered to be in fuel poverty. This is higher than the Scottish average and all of Angus's neighboring authorities

Health Behaviours

	Angus	Scotland
Smoking prevalence	21.4%	23.0%
Alcohol related hospital stays	381.4	704.8
Drug related hospital stays	83	116.6

Long term conditions

Prevalence per 100 people in Angus



The number of People with two or more long term conditions in Angus is 17,761 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	6991

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.

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 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; 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 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.

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.

A joint strategic needs assessment is available.

A mainstreaming and equalities outcomes report will be made available by 30 April 2015.

8. Our resources

The table below summarises the indicative budget available to the Partnership to plan and deliver health and social care services. This reflects provisional estimates of resources that will transfer from Angus Council and NHS Tayside to the new Angus Health and Social Care Partnership.

Angus Integration Joint Board Provisional Estimate of Resources	Angus Council	NHST	Partnership
	Annual Budget	Annual Budget	Annual Budget
	£K	£K	£K
Older Peoples Services	29,724	18,483	48,207
Mental Health	1,375	3,096	4,471
Learning Disability	9,491	787	10,278
Physical Disabilities	2,801	0	2,801
Substance Misuse	424	598	1,022
Community Services / Allied Health Professions	0	3,188	3,188
Other Services	813	515	1,328
Planning / Management Support	1,518	951	2,469
General Medical Services	0	15,972	15,972
GP Prescribing	0	21,048	21,048
General Pharmaceutical Services	0	3,391	3,391
General Dental Services	0	5,906	5,906
General Ophthalmic Services	0	2,037	2,037
Operational Management Sub-total	46,146	75,972	122,119
Large Hospital Services (Set Aside)	0	22,455	22,455
Strategic Budget Grand Total	46,146	98,427	144,574
Notes:-			

The above excludes hosted services as the Angus share of hosted services is still to be clarified.

The above budgets include a limited element of one-off funding for 2015/16

A number of hosted services will be delivered for the whole of Tayside by one of the three Tayside Health and Social Care Partnerships. Arrangements for the funding of these services are still under discussion.

The final financial framework for the Partnership will be dependent on a number of factors including:-

- The outcome of negotiations with both Angus Council and NHS Tayside during budget setting discussions,
- The issues that have been reflected in the Due Diligence process undertaken in advance of formal Integration. That process is intended to identify and quantify financial risks for the Partnership.
- The financial planning environment that both Angus Council and NHS Tayside are governed by.

The Angus Health and Social Care Partnership expects to operate in a difficult financial environment over the coming three years. This reinforces the need to review models of service delivery across Health and Social care and to ensure that we use all available resources as effectively and efficiently as possible. To do that we will need to:-

- Ensure we understand our resources and resource utilisation as best we can.
- Review and remodel service delivery where this is required.
- Develop effective, informed decision making processes and forums.
- Make decisions that reflect the financial environment in which we are operating.

The Partnership is continuing to work towards developing a financial plan which reflects the overall strategic plan and which is deliverable within agreed resources.

Property Strategy

The Property and Asset Strategy(PAS) is available separately. It 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

9. What we've learned

Engaging with communities, people who use services, carers, staff, providers and the third sector 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 used 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

A comprehensive engagement activity log is maintained and held by the Chief Officer. Reports from specific engagement work can be found on our website.

10. 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, 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 delivered 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, 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:

Health Improvement and prevention of disease and addressing health inequalities in our communities.

1.1 Working with the third sector to build capacity within Localities.

1.2 Supporting carers.

1.3 Supporting self-management of long term conditions.

There is some overlap between these focus areas that further drive our plans to deliver on this priority.

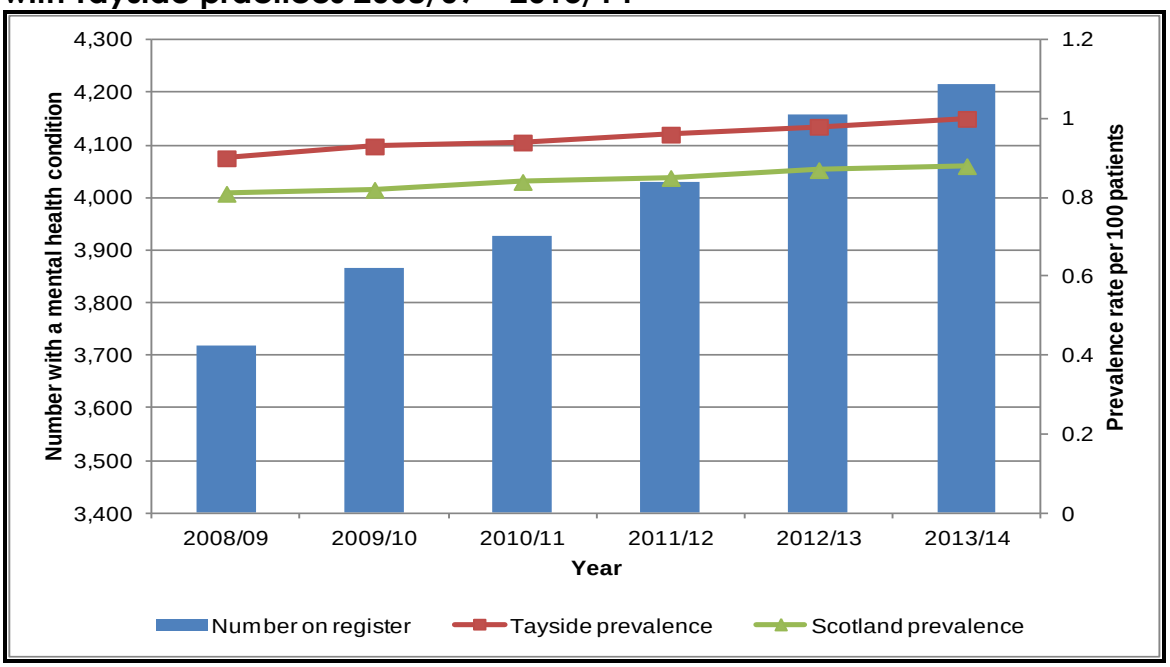
1.1 Health Improvement & Prevention of Disease Focusing on Addressing Health Inequalities in our Localities

The Director of Public Health publishes an annual report detailing progress across a range of public health issues such as obesity and mental health and wellbeing. The report also sets out plans to address these issues within our communities.

Indicators of health and wellbeing

Angus from GP registers tells us that in 2013/14, 14.31% of the Angus population was considered to be obese. The highest level of obesity is in the North East at 16.08% of the population and the lowest level 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 whole there has been a 27% decrease. There has been an improvement in dementia diagnosis.

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



Deprivation

There is a relationship between population health and wellbeing and deprivation. The proportion of Angus residents that are classed as deprived is below that of Scotland (see tables 5 and 6). 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 males and females life expectancy has increased since 2001 for those born in the highest deprivation and the least deprivation. 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. However, for males, this gap has actually increased from 4.1 years in 2001-2005 to 5.5 years in 2009-2013; this is largely because males 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.

Life expectancy for males born in Angus split by levels of deprivation (most deprived 15% and least deprived 85%)

Years Born In	Angus - Least Deprived	Angus – All	Angus – Most Deprived
2001-2005	76.0	75.4	71.9
2009-2013	79.2	78.3	73.6

Source: National Records of Scotland

Life expectancy for females born in Angus split by levels of deprivation (most deprived 15% and least deprived 85%)

Years Born In	Angus - Least Deprived	Angus – All	Angus – Most Deprived
2001-2005	80.2	79.7	76.7
2009-2013	81.6	81.2	78.7

This information on health and wellbeing, deprivation and life expectancy tells us that over the next three years we must continue to support the efforts of public health but also develop plans to address issues relating to obesity, mental wellbeing and the inequalities faced by our most deprived communities.

1.2 Building capacity in our localities.

One of the key messages from our engagement activities has been about improving access to information. This could be through the development of single points of contact and the use of a 'hub' model in each of our localities. 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 ALLISS (A Local Information System for Scotland) to facilitate

accessible web-based information on health and social care services. Importantly it will also be the focus of 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. Volunteering in Angus (*we need to get figures from VAA*) continues to increase. Harnessing the efforts of the voluntary sector will support people to become engaged in their communities and promote independence.

Each Locality has a Locality Improvement Group. Membership of these groups is drawn from staff, users of services and the wider public who work and live in the locality. Locality plans have been developed by the locality groups. The plans build on the interaction between services, the voluntary and independent sectors and local communities.

1.3 Supporting Carers.

In the 2011 census some 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 September 2015, in 8 of the 16 General Practices only 956 carers were registered as carers. In June 2015, 990 Angus carers were receiving carer's allowance. This suggests that there continues to be a high level of unidentified carers in Angus. We are working with Angus Carers Association to further the identification of carers.

An increasing number of carers providing significant and regular care have accessed a carers assessment following the introduction of self-directed support (SDS) from 85 assessment in 2012 to 245 assessments between April and October 2015. Carers are able to access a range of services delivered through Angus Carers and other voluntary sector organisations in Angus. 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.

We will continue to work towards accurate registrations of carers at GP practices supporting access to a SDS assessment for those who are supporting people with significant needs.

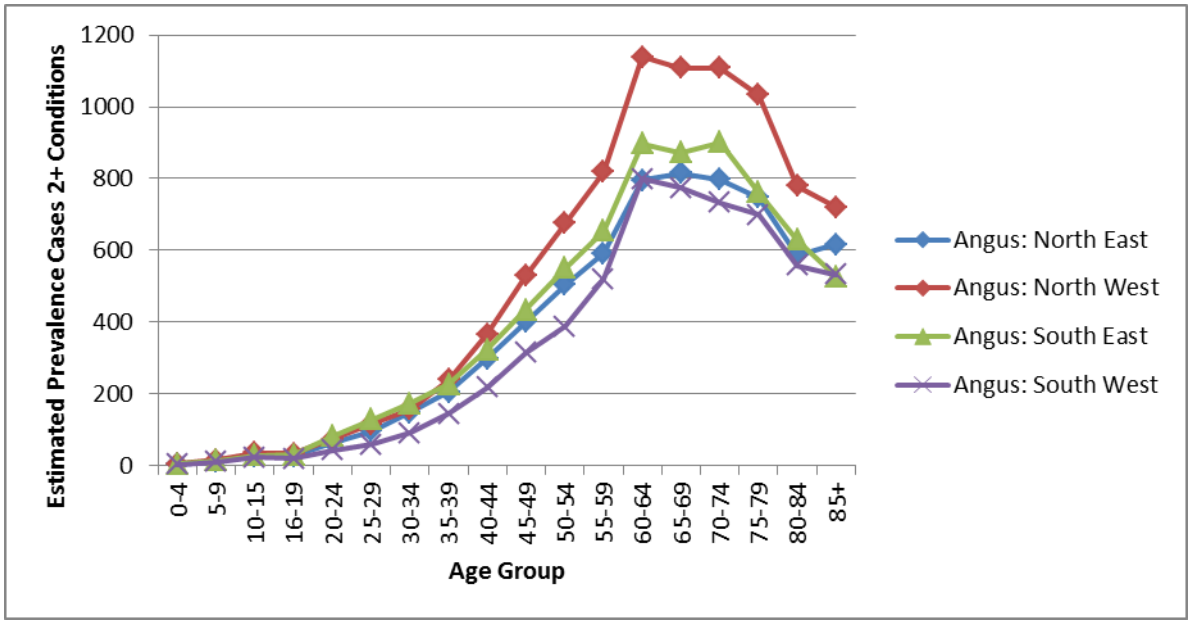
1.4 Supporting Self-Management of long-term conditions.

Quality Outcomes Framework (QOF) data is collected by general practitioners and gives some indication of the prevalence of single - but not multiple - conditions. QOF data shows little change in prevalence of long term conditions over the past 5 years. We know that long term

conditions such as heart disease, diabetes and chronic obstructive pulmonary disease (COPD) play a significant role in hospital admissions.

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



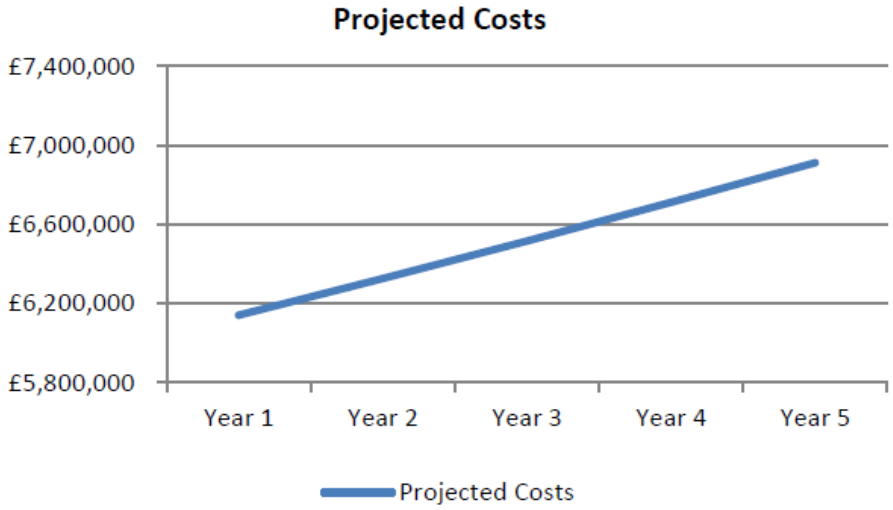
Improving information, advice and support to self-manage long term conditions is key to supporting individuals to stay well. We have good examples of local voluntary activity that support self-management of long term conditions such as active peer support groups for COPD (Chronic Obstructive Pulmonary Disease) and other disease groups These groups include singing (THAT programme), chair based exercise and yoga. Introducing video conferencing in leisure centres will promote wider access to physical activity supported by volunteering.

Priority 2: Supporting care needs at Home

Our needs assessment tells us that the population of Angus is aging, that in the years to come we will see a greater proportion of people aged over 65 in our population and a significant increase in those aged over 85. This will inevitably place additional demands on social care and other services. If we project a 3%

increase in demand over the next three years we can see the impact on the resource requirements in the graph below.

Projected care at home costs based on current model.



In supporting care needs at home our overall objective is to shift the balance of care away from hospitals and institutions and towards more homely settings. We aim to enable people to stay at home safely and with appropriate support promoting greater independence, choice and control over their life. Over the past several years we have supported individuals to greater independence through the use of enablement approaches on first referral to social care services. 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 Help to live at home
2.4 Supporting the administration of medication
2.5 Improvements in occupational therapy, equipment and adaptation support

2.1 Enhanced opportunities for technology enable care (TEC)

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. Improvements in technology enabled care will support independence and self-management.

We expect technological solutions to impact in 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.

Over the next 3 years we aim to see a 10% increase year on year in the use of technology enabled care.

2.2 Progressing self-directed support (SDS)

The Social Care (Self–directed Support) (Scotland) Act 2013 has been implemented since 1st April 20014 and is a key building block of public service reform. The Act makes provisions relating to ensuring individuals have greater choice and control over their care and support needs and shifts the focus of those arrangements from inputs to achieving. SDS is embedded in social care assessment and support planning practice. Practitioners are gaining confidence in this new approach but continue to need support to and have identified training needs to be addressed.

Social care 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). The introduction of option 2 where an individual directs their own care and support with the budget managed by the local authority and option 4 where people have a mix of other options in their support arrangements has allowed people greater control and choice.

Number of people accessing SDS options following assessment (October 2015)

Age	SDS Option				
	1	**2**	**3**	**4**	**Total**
18-64	11	50	85	7	153
65-74	1	11	60	4	76
75-84	1	9	148	4	162
85+	2	18	185	5	210
Total	15	88	478	20	601

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.

Over the next three year we will continue to improve awareness of SDS with the public, providers and staff across the health and social care system. Using the development of the market facilitation plan as a means of continuing the dialogue with providers about the importance of an outcome based approach and how traditional models of service will

need to change to support the choices individuals will make about their support needs. Embedding practice will require an ongoing approach to training and staff development that supports an asset based approach to assessment and outcomes based approach to support planning. A post implementation review will support further progress in this area.

2.3 Help to live at home programme

Angus Council's Care at Home service for older people is increasingly under pressure. At present, the Council is providing over 166,000 hours of care per annum. This equates to 96% of current demand. It is apparent that current demand pressures are forecast to increase:

- Currently, approximately 135 hours of care per week cannot be delivered to service users through the Care at Home service, because of a lack of in-house and external supplier capacity to meet the demand;
- Over a 12 week period (from December 2014 to March 2015), the Council commissioned approximately 3,360 hours of Care at Home to 636 services users who are over 65 years old;
- The average care package per service user has been increasing over the last 3 years. This is believed to be due to a growing complexity of service user needs, which has resulted in the average care hours per service user increasing 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;
- In terms of Angus Council provided services, the current Personal Care and Housing support hourly rate is at £41.01, based on actual costs and average contact time. The current combined hourly rate is £35.01, mainly driven by the high in-house hourly rate.

Despite a historical reduction in overall service user numbers, the changing demographics of Angus, coupled with increasingly complex needs, means that forecast growth in demand for Care at Home services is expected to be 3% per annum. To meet the current level of supply (96% of demand), the Council is using its specialist 'Enablement' service to provide standard Care at Home support. This is reducing the capacity of the Enablement service to focus on its core purpose, namely supporting new service users to regain their independence and rely less on Council services. Consequently, the ability of the Council to mitigate future service demand pressures is being reduced.

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). Therefore, 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, could have a considerable impact on the ability of the Council to retain its current in-house number of service users, and in the long-term the relevance of the in-house service.

The help to live at home programme will focus on the development of effective and efficient care at home services. The first phase of the programme will aim to maximise the efficiency of Angus Council care at home services and address wider capacity through working with independent sector providers. 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 facilitation plan.

In future the role of Angus Council care at home services will be much smaller, and will focus on preventative work, assessment, crisis intervention and enablement services. This will involve the redesign of directly provided services based in localities and integrated with health services. Opportunities to improve the design and use 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 implementation of electronic systems for scheduling services and monitoring service delivery for Angus Council services will deliver greater efficiency from April 2016.

2.4 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.

2.5 Occupational Therapy (OT)

In Angus, OT staff across NHS and Social Work already work closely together to provide an efficient and effective OT service. 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 we work allowing for greater continuity in worker and reduce unnecessary duplication. Areas for change include:

- working within the revised response standards for referrals providing consistency in our 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 used by all OT staff;
- delivering consistency in the recruitment of staff and the training being undertaken by staff.

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

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. Furthermore when admitted to hospital, 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 them 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.

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

3.1 Providing responsive services based around GP practices that reduce unnecessary admissions to hospital
3.2 Delivering appropriate intermediate (step up/step down) care at times of need
3.3 Delivering responsive and integrated out of hours services
3.4 Effective hospital discharge management.

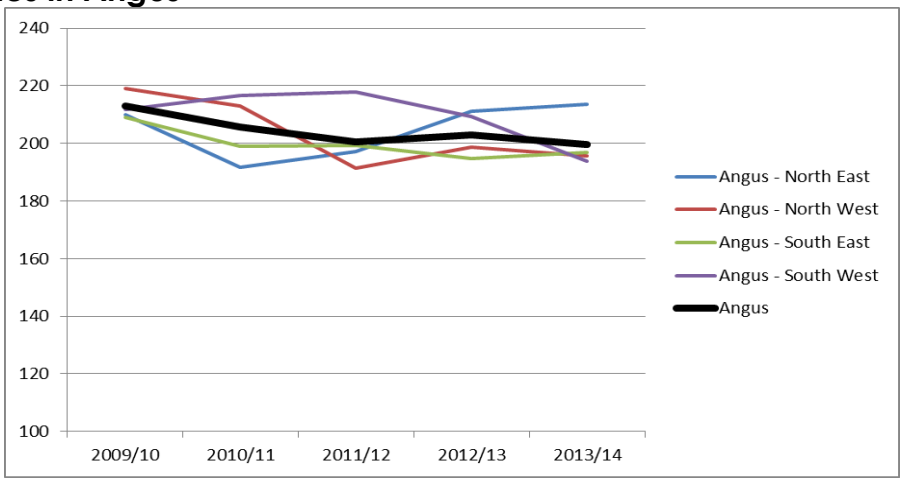
3.1 Responsive Services based around GP practices

We have been developing a model of responsive services around GP practices in South West Angus called enhanced community support (ECS) model.

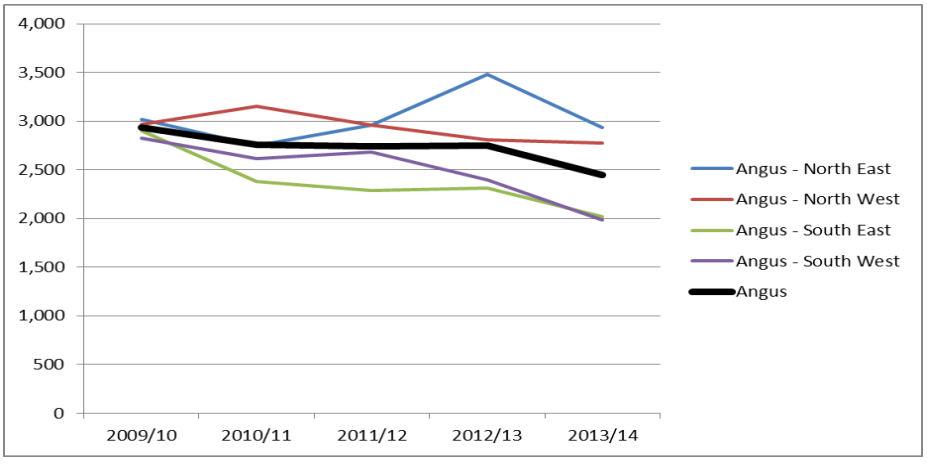
This approach proactively assesses older people with frailty who are at risk of unplanned hospital admission and responds to an escalation of that person's health and social care needs. This approach has resulted in a reduction in avoidable hospital in-patient activity. This is very promising where there has been population growth amongst the over 65's during this period. Inpatient activity is described in two ways, admission rates which allows us to compare performance between our localities in relation to the number of people admitted, and bed day rate which is impacted by reductions in admission, reductions in average length of stay and improvements in timely discharge.

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 has the highest emergency admission rate for over 65s and the highest bed day rate.

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



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



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

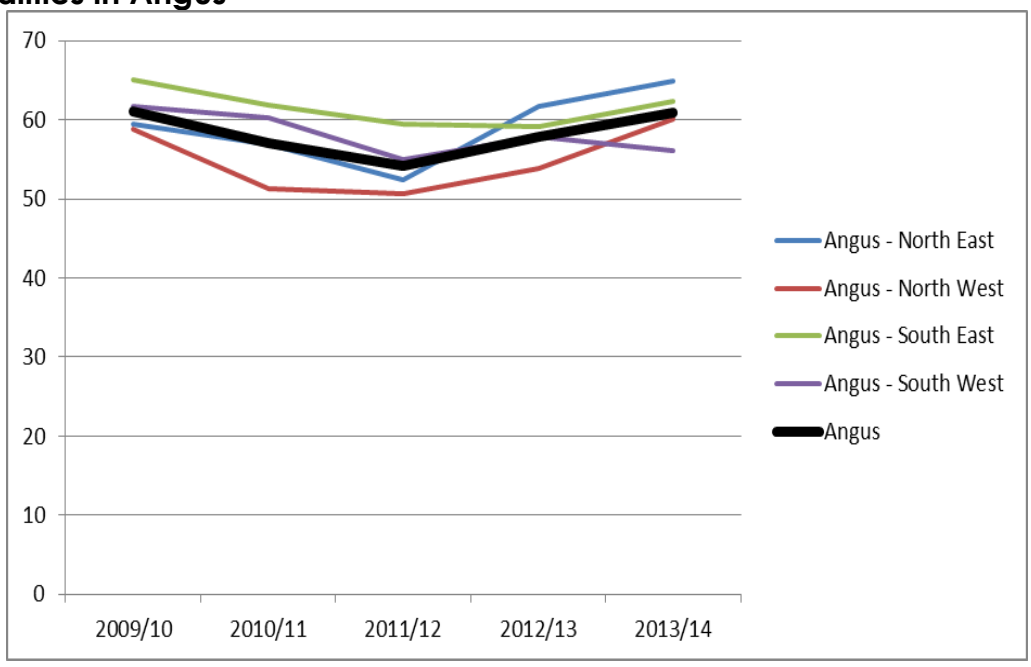
(February 2015), we have reduced the number of medicine for the elderly beds by 12. Investing in community services will reduce dependence on beds, releasing resource for re-invest in the further community models. ECS has also contributed to reducing or delaying entry into permanent care home placement.

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.

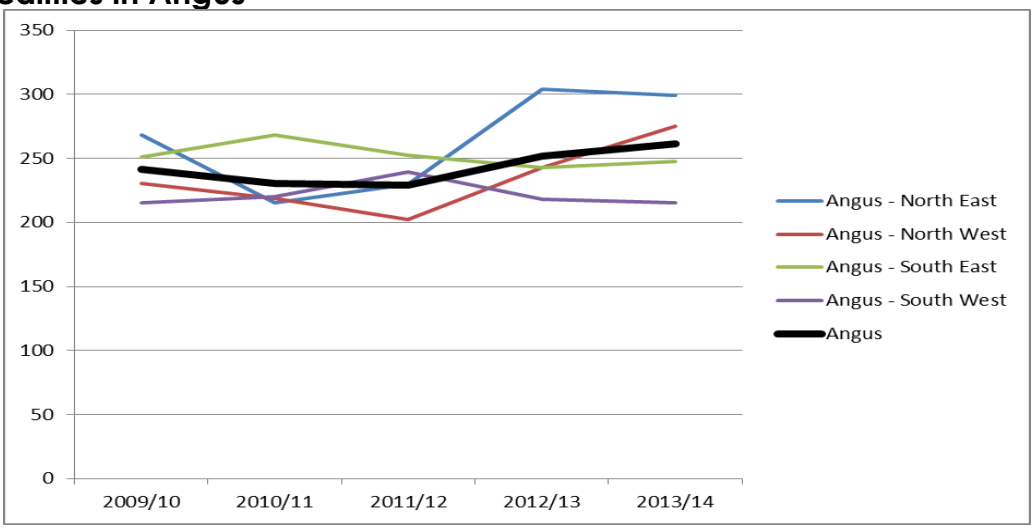
Still to include rate of admissions anticipated in 3 years.

We need to investigate the reasons for the increasing admission rates and bed use in the under 65's. The South West has the lowest emergency admission rate in Angus and the lowest bed use in relation to under 65's with a reducing trend. We believe this may be an additional benefit of the ECS model introduced first in this locality. The North East has the highest emergency admission rate for under 65s in Angus and the highest bed use with an increasing trend. As ECS is implemented across Angus we need to consider how it can also impact on under 65's.

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



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



3.2 Delivering appropriate Intermediate Care

In partnership with the independent sector we provide intermediate care for older people. Intermediate care is short-term rehabilitation for people leaving hospital or to avoid admissions to hospital. 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 be provided to Angus residents in our community hospitals and through our early supported discharge and prevention of admission teams. 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

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 services and the admission and discharge pathway through intermediate care to ensure we develop access to effective short term rehabilitation support in our localities.

3.3 Delivering effective and integrated Out of Hours Services

A range of professionals provide a variety of response services during out of hours (OOH). The hours that constitute OOH varies between services; the range of variance in the OOH definition across services is before 0900 and after 1700 Monday – Friday and after 2000 to 0800 hours

OOH services include:

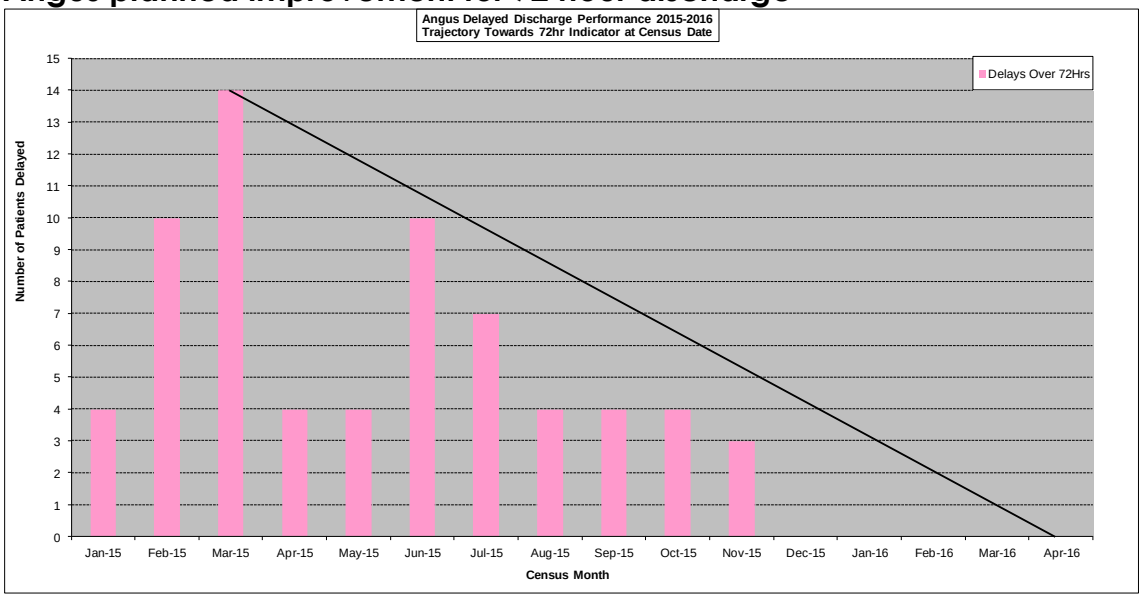
- OOH medical cover is provided by NHS Tayside OOH service hosted in the Angus Health and Social Care Partnership.
- OOH social work cover is managed by Dundee City Health and Social Care Partnership.
- The Primary Care Emergency Centre (PCEC) hosted by Angus Health and Social Care Partnership provides 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 in response to Scottish Ambulance Service calls and respond to people requiring overnight palliative or symptom control.
- The Community Alarm Response Team, based in each locality, provides 24 hour emergency and unplanned personal
- NHS24 also provide 24 hour advice and support often signposting and referring to other local OOH services.

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 services are integrated, sustainable, delivering faster, better and safer care providing the right treatment, at the right place, at the right time. As part of this we will explore our available technical capacity to increase our call-monitoring capacity through community alarm services, and consider how we might expand the service to include telehealth and/or increase the customer numbers as required.

3.4 Effective hospital discharge management

We have embedded effective MDT discharge management into the discharge process which not only benefits patients and their families, but also optimises management of hospital patient flow. In August 2015 66% of patients are discharged from our community hospitals within 72 hours of being ready for discharge. ***Need other data***

Angus planned improvement for 72 hour discharge



By April 2016 we aim to have all Angus patients discharged within 72 hours of being assessed as ready for discharge. As a result we will reduce the number of lost bed days by **XX**.

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. We will continue to explore and test how volunteers and local communities can play a greater role in supporting people to return home.

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 needs that require additional support and some overlaps in services that require particular attention to ensure the right support is available. This includes specialist needs such as mental health and learning disability and services such as inpatient services which are hosted by another integration partnership or by NHS Tayside and specialist housing delivered through the Housing Strategy. Improving the integration of pathways to support these priorities in Angus has a focus on:

- Addressing the additional needs of people specific needs,
- Delivering a seamless pathway in and out of secondary care
- Delivering appropriate models of specialist housing

4.1 Adult Mental Health

Almost 1 in 100 patients registered with Angus practices are recorded to have a mental health problem. People with mental health difficulties tend to die ten years younger than the average population. Mental Health services work closely with health improvement to tackle smoking and alcohol misuse and commission services that ensure people have access to work, education and training. We measure the numbers of inpatients who would like to be more physically active, waiting times from referral to first outpatient appointment, the time it takes from referral to starting treatment, the numbers of people commencing psychological therapies, and we are auditing records to ensure that they are based on recovery principles.

"An Integrated Approach to Mental Health: Bringing Health and Social Care Models Together." We want to ensure that people are able to access the support that they need when they need it by improving care pathways especially given that community mental health services and in-patient services within adult mental health are going to be managed by different regions of Tayside after full integration. We will also focus on young people's mental health and wellbeing and we need to ensure that local services respond better to depression, anxiety and stress. Address the unmet supported accommodation needs. Identify budget sources for future accommodation care and support needs

4.2 Learning Disability (LD)

The life expectancy of people with a learning disability is approximately 20 years less than that of the population as a whole. 16.9% of the LD population in Angus have autism which is 3% higher than the national average. 76 adults with a learning disability (14%)in Angus live in the 20% most deprived areas. Only 33 adults with a learning disability in Angus (6%) live in the least deprived areas. 38.5% of Angus people with a learning disability and/or autism live with family carers this is higher than the national average (34.8%). Too many people with LD in Angus are living in care homes – 18% (national average is 8.6%). We also know we are below the national average in relation to supporting people with LD to live in supported housing (national average 18.7% - Angus 13.5%) or mainstream housing (national average 66.2% - Angus 60%).

Work is progressing to implement the four strategic outcomes of the national learning disability strategy Keys to Life (KTL). In Angus, consultation has established the local priorities as human rights, health and independent living. We are working with NHS Tayside and the other Integration Partnerships on delivering an improvement programme on health inequalities, complex needs, care pathways, practice development & workforce. Specifically we will:

- address specialist accommodation needs through the housing strategy. There are a small group of individuals in hospital and living in residential

care due to the under supply of supported accommodation. We are also aware of the pressure that this places on some, particularly older, family carers. We are also aware that current care home provision for people with learning disability does not meet the latest standards in terms of the quality of the environment. We want to address the unmet accommodation needs specifically in relation to supported housing provision and care home replacement.

- improve the range of respite provision available. The implementation of SDS has seen a decreased demand for residential based respite and increase in demand for flexible outcome based opportunities both in the community and at home. We want to ensure that residential based respite continues to be available for those who need it.
- address hate crime by engaging Angus in the national 'I Am Me' and 'Keep Safe' initiatives. Although we know that Angus is affected by hate crime, we need to consolidate information from Police Scotland and from adult protection to establish a baseline to ensure that we address the isu appropriately.

4.3 Older People's Mental Health

Historically improvement work in older people's mental health has tended to focus on dementia – in response to the strong national drivers. There is a new focus on functional mental health issues that affect older people, for example depression/anxiety, bipolar disorder and schizophrenia. This has been influenced by emerging issues such as low rates of diagnosis of depression in older people and transition from adult services to older people's services for those with chronic and enduring mental health issues.

Work continues to progress regarding the implementation of the national dementia standards. There have been 323 people over the past 2 years who have received post diagnostic dementia support in Angus. Alzheimer Scotland report that approximately 90,000 people have dementia in Scotland at 2015. Around 3,200 of these people will be under the age of 65. In Angus the breakdown is: Under 65: 71 – Over 65: 2,259, giving a total of 2,329 people. We know that from April 2013-2015 in Tayside there have been 1,383 people newly diagnosed with dementia, 384 of these people live in Angus.

Have an Older People's Mental Health Improvement Plan agreed and a work group model to progress key issues emerging such Dementia Standards, Promoting Excellence Framework, Functional Standards, Transitions and Service Redesign. We want to complete our investigations of a model of enhanced community support and develop future services based on the outcome of these. Data is currently being collected and analysed to ensure our new planned provision meets the changing needs of our older people with mental health population in Angus. It is likely this model will see further integration across a few services – social work, mental health, medicine for the elderly, voluntary services to provide enhanced levels of assessment, care and treatment for older people in care homes. We need to improve our

partnership working with voluntary, private and wider statutory colleagues. We will work in partnership with all partners to provide the best outcomes for older people in Angus and develop our use of volunteers and third sector in a flexible way.

4.4 Special Needs Housing

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 and work is ongoing to implement the actions associated with this outcome.

Angus Council is currently developing the LHS 2017-22 which will take account of the revised Guidance which strengthens the links between the LHS and the Strategic Plan. It is recognised that there is a requirement to bring partners together to improve strategic planning in relation to specialist 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 housing contributions statement for the strategic plan is currently being developed.

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 IJB will provide the strategic direction on the priorities in relation to the housing needs of people with particular needs, balancing the needs of different groups and localities where necessary. This will ensure that housing opportunities can be delivered in the areas of most need. 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 needs and 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 needs for specialist provision.

4.5 Pathways in and out of Secondary Care

Managed Clinical Networks (MCNs) play a central role in enabling development of structures and services to deliver evidence based care, and we actively participate in MCN's 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 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 a supported plan for management and discharge agreed.

- We have a surgical pathway providing support for assessment and management for older patients admitted as an emergency to surgery and to provide 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.

- In Angus, 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.

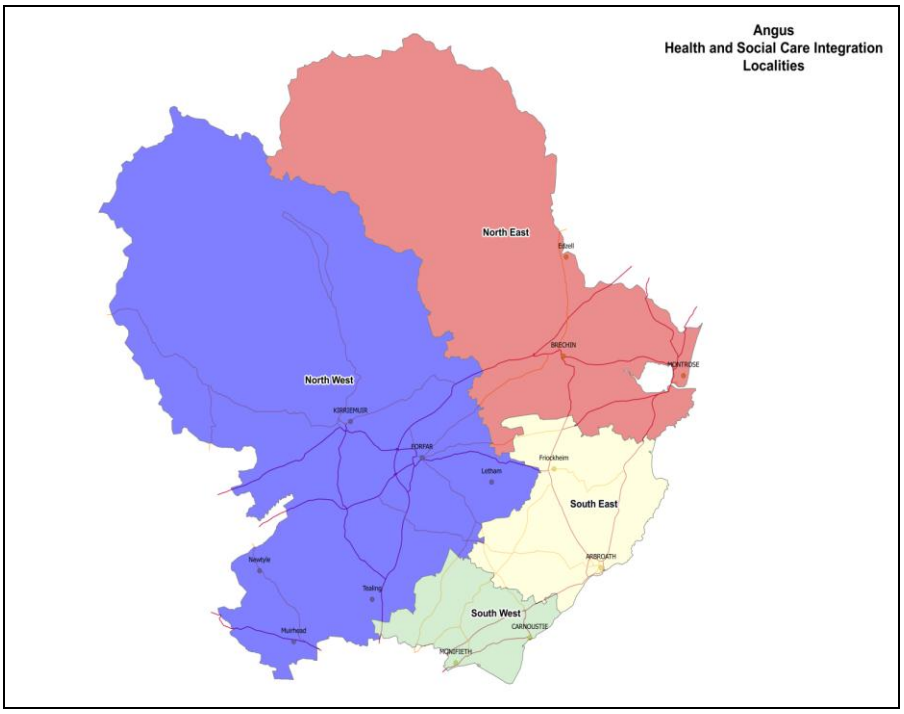
- 5.41% Angus registered population live with diabetes. A Local enhanced service is in place to support management of patients with Type 2 diabetes (not on insulin) within general practice. Local improvements are focussing on early detection, enablement and empowerment of people to self-manage and equality of access. 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 runs in 3 localities to enable ongoing access to information and peer support.

- Within Tayside we have an approved service model which allows 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 and a Multi-Agency Lead Clinicians Committee strategically oversees service developments and governance.

- 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.

11. Delivering our locality model

Working in localities allows us to deliver and develop services that are most relevant to the population. Angus lends itself to four localities.



Locality working will deliver:

- Local leadership
- Partnership between health, social care, third sector and independent sector provide
- A range of core services
- Relevant local services and support local commissioning
- Local access to support

Each locality has its own development plan which shows how the different needs in that locality are addressed. Locality plans are available on our website.

12. Our Workforce

Delivering integration of health and social care requires a transformational approach to the way we work to create one organisational culture focused on delivering good outcomes for the people of Angus.

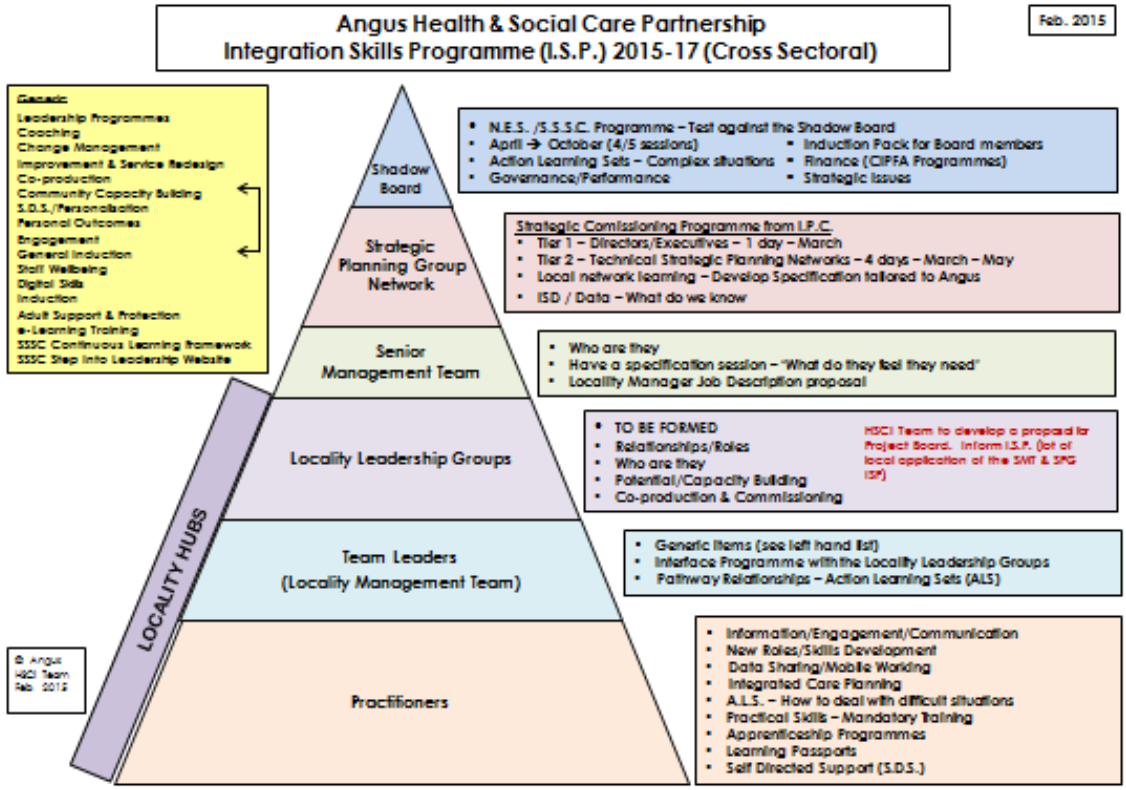
Shared Values

The Angus Health and Social Care Partnership has a set of core values which will underpin 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 affect 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.

To date organisational development has been focused on the delivery of an integration skills programme aimed at addressing culture change across our developing organisation.



Note: diagram to be redeveloped

This integration skills programme is delivering our approach to organisational change.

We know that there are workforce challenges going forward. This includes: a predominately older workforce in some areas. We are facing a future where the working population is reducing at a time when demands for services will be increasing.

These real challenges are explored and addressed in a Workforce strategy provided separately.

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." ***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. A full copy of this document is available.

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 authority's 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 and the Board of NHS Tayside 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 set 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 our priorities will be produced annually, with the first report being available in October 2015.

14. Support Arrangements

A range of support arrangements are to be put in place by Angus Council and NHS Tayside to ensure that the IJB can function effectively. Very often these supports are providing by centralised/corporate-wide services within the respective organisations and in many instances will continue as previously. These support arrangements were not detailed in the Integration Scheme but a clear understanding is required as to how such support can be provided in an integrated environment and the level of support from each parent body that is sustainable. Support arrangements include arrangements for:

- Committee support for the IJB, the Strategic Planning Group and any other sub groups established under the IJB
- Communications support both internally and externally from specialist staff
- Arrangements for investigating and managing complaints
- Property and facilities management arrangements
- Information technology support including agile working and support for essential business systems and new ways of working
- Procurement and contract management
- Equality legislation duties and diversity
- Strategic planning
- Performance management
- HR, workforce planning and organisational development
- Infection control, central decontamination and laundry
- Emergency planning and critical incident support

An agreement around the support arrangements will be available by 31 March 2016.

15. 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

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 an on-going 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 set out plans for their locality which show the relationship between the locality and the health and social care integration strategic plan but also set out specific priorities for that locality that 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 and the Board of NHS Tayside 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 ensure that as a minimum an annual performance report is compiled and distributed to 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 and a number of improvement activities. To deliver this we must work with staff to create a new culture, new management arrangements for the partnership and shift focus in the work of some staff. 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. A financial plan

The strategic plan and its associated priorities will have to be delivered within the finite resources available to the partnership. The financial plan will provide a summary of the overall resources relating to integration as well as the key priorities to be delivered within the lifetime of the 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 appropriate range of affordable provision to deliver good outcomes for people and meet the needs of the population into the future.

11. An operational delivery plan

This plan will provide the detailed action plan that all staff will work towards to ensure that we can deliver our strategic plan. It details the actions and timescales that we will require to meet to deliver on our improvement plans.

12. A description of the arrangements with NHS Tayside and Angus Council for ongoing support.

Section 4.13 of the Angus Integration Scheme identifies the responsibility of NHS Tayside and Angus Council to provide the Integration Joint Board (IJB) with support services that will allow the IJB to carry out its functions and requirements. Although not exhaustive the Integration Scheme identified the following areas of support for which the terms and arrangements were to be agreed:

- Human resources
- Finance
- Business support
- Administrative support
- Performance management
- Strategic planning support
- Communications
- Improvement academy
- Clinical, care and risk management
- Change and innovation
- Information governance
- Occupational health service
- Procurement
- Property
- Spiritual care
- Training and development
- Complaints

13. A Risk management plan

Implementing the strategic plan comes with a number of risks. An approach to risk management has been agreed and a report on risk will be developed.

14. 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.

15. 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 on our website.