Item 6 Appendix 1

ANGUS HEALTH AND SOCIAL CARE PARTNERSHIP

Development of the Strategic Commissioning Plan 2019-2022

November 2018

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INTRODUCTION

The purpose of this report is to show the progress to date made by the Strategic Planning Group on the development of the Strategic Commissioning Plan for 2019-22. A Strategic Commissioning Plan must show how progress will be made against the national outcomes described for health and social care by the Scottish Government. Our approach will continue to be to deliver the national outcomes through 4 priority areas of improvement. The relationship between the national outcomes and our local priority areas are described in Appendix 2.

1 Strategic Needs Assessment

The Joint Strategic Needs Assessment (JSNA) is currently being updated. It is anticipated that a final version will be available for publication along with the new Strategic Commissioning Plan. As part of our approach to developing knowledge led services a data dashboard has been published on the Angus Health & Social Care Partnership website. The information displayed on the dashboard in relation to needs will grow as our needs assessment is completed.

So far our needs assessment work confirms that over the past three years Angus has already begun to experience demographic change:

- People aged 0 to 15 years decreased by 1.6%
- People aged 16 to 64 years decreased by 1.2%. Within this age group the population is also getting older; population aged 30 to 49 years decreased by 3.7% and population aged 50 to 64 increased by 0.8%)
- People aged over 65 years increased by 6.1%

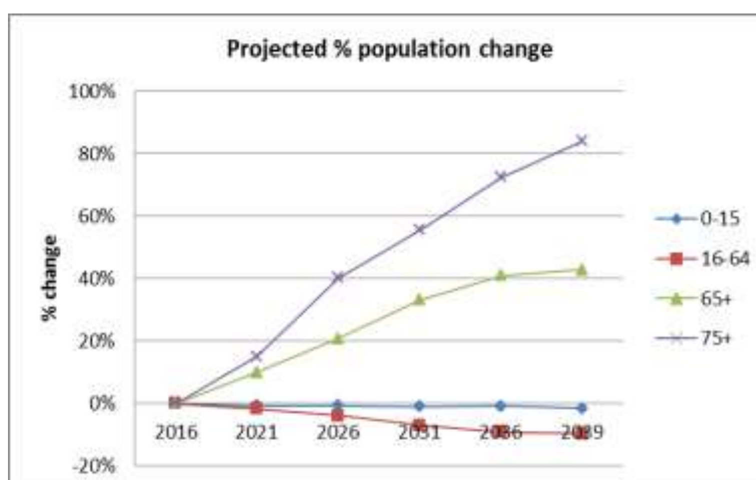
Population projections suggest that this trend will continue.

Table 1 Age distribution of Angus population in 2016 and 2037

	0-15	16-29	30-49	50-64	65-74	75+	Total
Mid-2016 Population	19,445	17,429	27,959	25,200	14,726	11,761	**116,520**
Projected Population in 2039	19,154	15,748	26,650	21,424	16,178	21,645	**120,799**

Source: National Records Scotland

Graph 1 Projected percentage population change in Angus between mid-2016 and 2039, by age



Source: National Records of Scotland

Demographic change suggests that demand for support from health and social care services is likely to continue to grow at the same time as the available working age population is in decline. Whilst retirement age is increasing to 68 this does not necessarily increase the available workforce for health and social care due to the capacity to undertake direct caring tasks.

Conclusion: The Strategic Commissioning Plan 2019-2022 will be concerned with approaches to delivering different types of support that in part mitigate against increasing demand, both the long term demand identified above and the short term demand arising during the period of the plan. This demand includes further increases in the population aged over 75 than has been experienced during the past 3 years.

Table 2 Older people population growth in Angus 2016-2022

<table>
<tr><th></th><th colspan="4">2016-2019 Strategic Plan</th><th colspan="4">2019-2022 Strategic Plan</th><th rowspan="2">Overall population growth from baseline year (2016)</th></tr>
<tr><th>Age Group</th><th>2016/17</th><th>2017/18</th><th>2018/19</th><th>Growth 2016-18/19</th><th>2019/20</th><th>2020/21</th><th>2021/22</th><th>Growth 18/19-21/22</th></tr>
<tr><td>65-74</td><td>15,746</td><td>15,949</td><td>16,242</td><td>3.1%</td><td>16,384</td><td>16,452</td><td>16,583</td><td>2.1%</td><td>5.3%</td></tr>
<tr><td>75-79</td><td>4860</td><td>4986</td><td>5088</td><td>4.6%</td><td>5310</td><td>5420</td><td>5591</td><td>9.8%</td><td>15%</td></tr>
<tr><td>80-84</td><td>3539</td><td>3652</td><td>3805</td><td>7.5%</td><td>3852</td><td>3946</td><td>3988</td><td>4.8%</td><td>12.7%</td></tr>
<tr><td>85+</td><td>3362</td><td>3522</td><td>3584</td><td>6.6%</td><td>3707</td><td>3833</td><td>3965</td><td>10.6%</td><td>17.9%</td></tr>
</table>

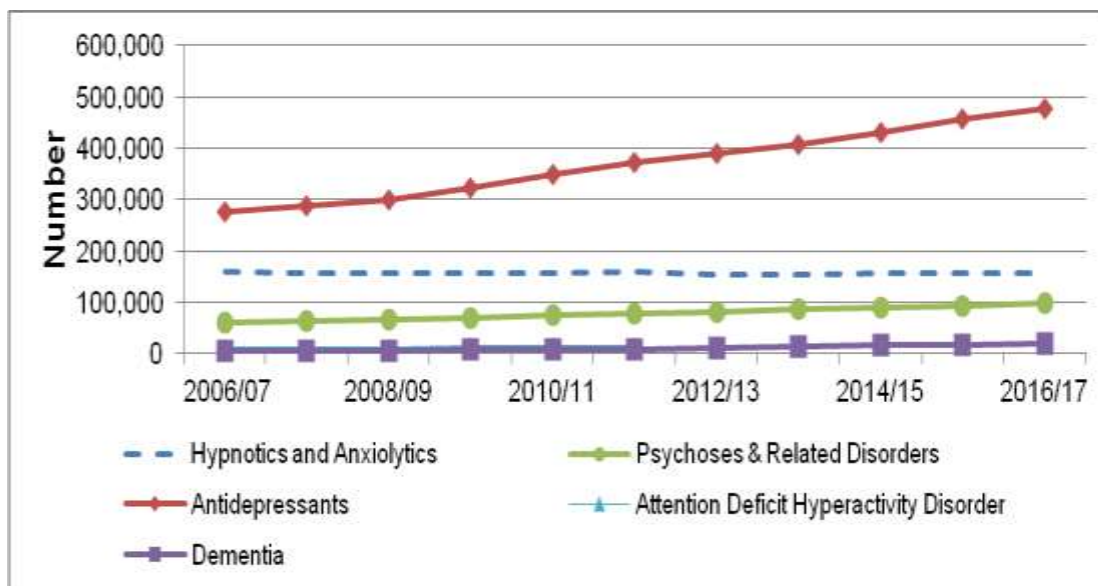
Source: National Records Scotland

The JSNA assessment also tells us that:

- The South East includes areas that are within the 10% most deprived populations of Scotland (part of Arbroath Harbour and part of Arbroath Warddykes).
- In Angus, income deprivation is higher than employment deprivation in all localities which indicates that Angus is affected by in-work poverty.
- Angus population is almost twice as access-deprived as the Scottish population as a whole. The North West locality has the highest rate of access deprivation at 36.8%.
- It is projected that between 2016 and 2037 there will be a 4% increase in the number of households, with a consistent increases across each of the Housing Management Areas.
- Since 2006 the average household size in Angus has decreased 3.5% from 2.23 to 2.16.
- There is a projected increase in smaller households with an increase in 'single adult' and 'single adult with children' households.
- The demand for minor housing adaptations has been growing significantly over the past few years.
- Hypertension is the most common long term condition in Angus according to the Quality Outcomes Framework with a prevalence rate of 16.4%, followed by Asthma (6.1%), Diabetes (5.7%) and Cardiovascular Disease (4.5%) and Depression (3.9%). South West and North West have the highest prevalence of hypertension and asthma whilst South West and South East have the highest prevalence of diabetes.
- Diabetes and Heart Disease are the two most common long term conditions that people in Angus are admitted to hospital for as an emergency admission.
- Atrial Fibrillation and Dementia were the two most common long term conditions that, as a rate of the prevalent population, people in Angus were admitted to hospital for as an emergency admission.

- As a rate of the prevalent population, people with Dementia occupy the most number of emergency beds.
- Prescribing of medications for mental health is increasing, particularly in relation to antidepressant medication.

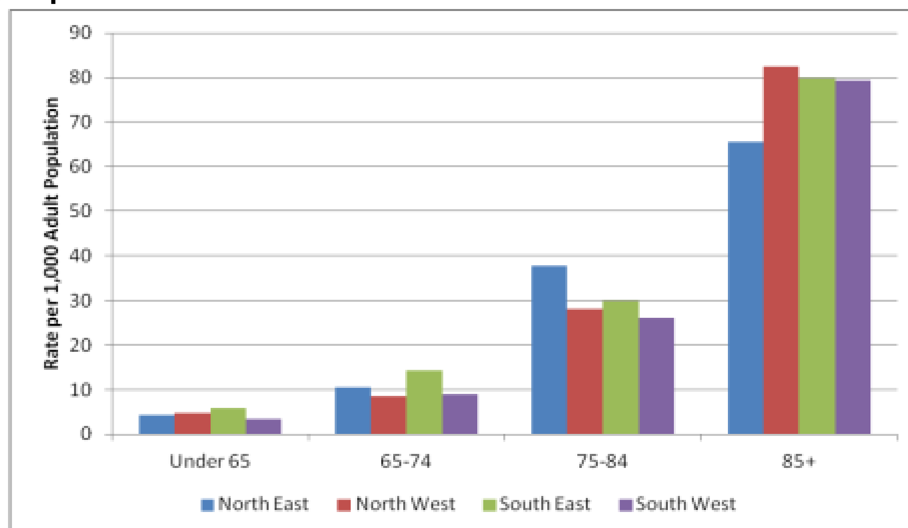
Graph 2 Medicines for mental health (No of dispensed items), Tayside, 2006/07 - 2016/17



Source: Medicine for Mental Health 2016/17, ISD Scotland

Information also shows the relative risk of unscheduled hospital admission in the population. Whilst the greatest risk lies with the over 85s we also know from performance information that admission rates are increasing in the population under 65 at a time when we have made progress in arresting the increase in admissions of those over 75.

Graph 3 Number of people at high risk (50%+) of a hospital emergency admission in the next 365 days from 1st October 2017 as a rate per 1,000 population split by locality and age-groups



Source: Scottish Patients at Risk of Readmissions and Admissions as at 1st October 2017 (ISD)

Conclusion: The JSNA confirms that we must shift focus to a more preventative and enabling model of support provision to promote wellbeing that will begin to reduce demand and promote better outcomes for the population.

2 Involvement and Engagement

We continue to be committed to engagement with stakeholders in our services. We host a range of groups and forums which aim to deliver consensus on plans and the vision for the future. Involvement and engagement approaches include:

- Locality Improvement Groups
- Care Home Improvement Groups
- GP clusters
- GP clinical partnership groups
- Providers Forums

In addition to the above we have developed a 'Continuing the Conversation' approach in each locality to create greater 'public facing' opportunity for discussion on the narrative of change.

'Continuing the Conversation' events have been held in each of our four localities on four occasions in the last 12 months. These have provided members of the public with the opportunity to speak to members of staff directly about issues affecting, and plans for, various services. The events provided examples of the work that is contributing to the delivery of the strategic plan and started conversations on new areas of improvement that will be included in the new strategic plan. For example, current care pathways and why changes need to be made. Members of the public had an opportunity to challenge the thinking behind the need for change, give their opinion on services, and comment on ideas for change; helping to shape how services will be organised and operate in the future.

The majority of people who attended the events told us that they had been given sufficient opportunity to comment and offer their opinion and had found the events helpful. Attendees have told us that they felt encouraged, interested, hopeful and reassured about what they had seen and heard.

As part of our conversation events we asked the public to give three words that they would use to describe the ambition that the Partnership should have for its new strategic commissioning plan using an online tool which creates a visual display of the words used. Words repeated most often appear larger in the visual display. The public have told us that our ambition for the new Strategic Commissioning Plan 2019-2022 should be:

home subjective personal harmonious sustainable manageable motivation self-management co-production understandable shared-decision-making flexible seamless safe realistic medicine meaningful progressive proactivity proactive local support holistic stretching person centred patient centred co operation forward-thinking quality care community centred reliable empathetic inspire asset-based co location co-location ambitious realistic listened to conversations relationships strong brave efficient informed risk taking compassionate digital community prevention commitment collaboration conversation technology partnership courageous creative meaningful relationships support tailored supportive unrealistic after care challenge positive experiences interconnected caring united responsive imorovement collaborative innovative achievable carer-considered enable refreshing inclusive professional accessible technology bold challenge status quo together wellbeing prevent equitable virtual empowerment unlikely hopeful

During our conversation events we have also asked the public to help with the delivery of future plans. There was support from all events to include in our new strategic plan what that might mean including:

The Public can help to make a difference:

- By getting involved
- By taking care of your own health and wellbeing
- By being more informed about how to best address your health concerns, know who to turn to
- By being mindful of the wellbeing of others in your community
- By joining our conversations on the shape of service for the future

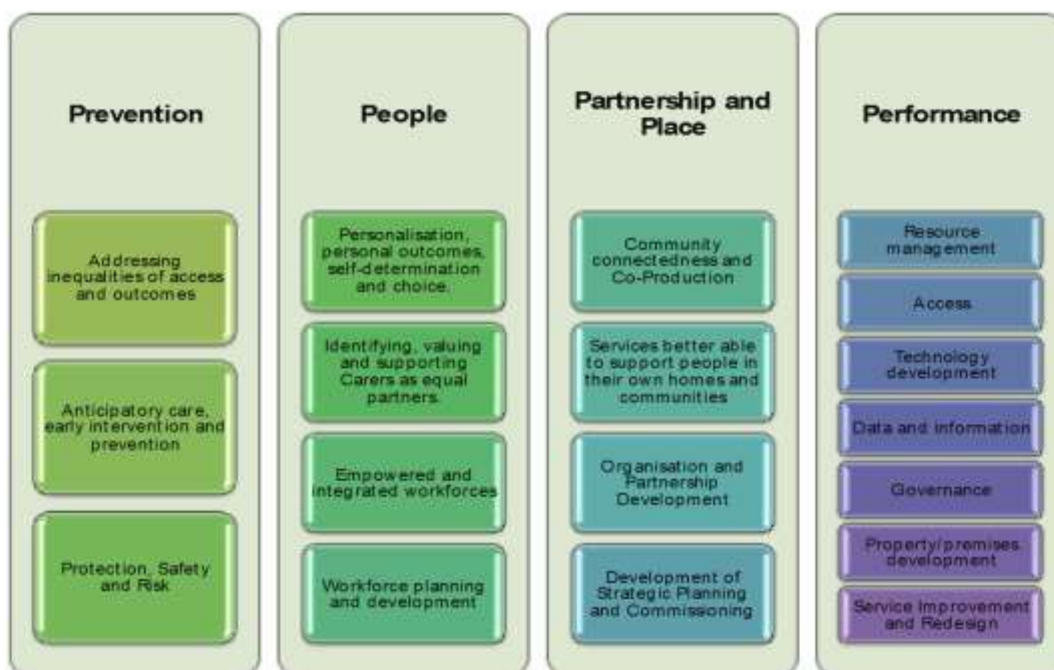
Angus Health and Social care Partnership will work to make a difference by:

- Working with communities
- Focusing on prevention
- Being realistic: providing safe and effective services in an increasingly challenging financial environment
- Being more creative, courageous and innovative
- Building for a future where digital technologies are more integrated in our work and used more widely by the population

Next Steps: There will be a formal online consultation in the New Year focused on the draft strategic commissioning plan once a draft has been approved by the Strategic Planning Group.

3 Impact of national policy development and other drivers

We continually review Scottish Government policy development and new legislation as well as other publications. An analysis has been completed showing how the common themes of national policy development revert back to the constructs of The Christie Commission Report (Commission on the Future Delivery of Public Services, June 2011). These themes include:



Further detail can be found in Appendix 1.

4 Growing our vision for the future

A range of developments have been delivered since the publication of the Strategic Commissioning Plan 2016-19. These developments have been designed to:

- deliver personalised approaches to services summarised by the Angus Care Model;
- engage the public in the design of services through the development of conversation events, survey monkey questionnaires and the development of a digital presence for the Partnership;
- promote public information about services and performance.

Recognising the progress that has been made in delivering integration and on involving people both in the design of services at a strategic and individuals level, the Strategic Planning Group continues to work on the development of a new vision. Our new vision needs to address the public's views on the Partnerships future ambition addressing prevention (promoting wellbeing), becoming more digital, being creative, involving communities whilst continuing to be personal centred. The Strategic Planning Group believe this is about doing things differently and making a difference for people yet recognises that a shift to prevention can only realistically be delivered by working with communities. The Strategic Planning Group recognises the view that our new Strategic Commissioning Plan has to be realistic about what can be achieved. Although further work is required on the wording and visual, our drafting so far suggests the following vision:

Angus Health and Social Care Partnership

Our vision is to work with communities, developing communities that actively care, promoting wellbeing and creating the best possible health and social care across Angus

5 Developing the delivery plan

Our delivery plan for the Strategic Commissioning Plan 2016-19 has begun to realise our aspiration that an integrated package of assessment, enablement, treatment, rehabilitation and support in the community, along with help for carers, can better serve the needs of Angus people and help deliver more effective deployment of the resources available to the Angus HSCP. This approach requires people to be central to decisions about their own needs, outcomes and support. We believe we have made progress in delivering the vision for integration. We must now refocus our vision on what we can deliver for the future. A future focused on working with communities, progressing more preventative models of care, supporting self-management and reducing demand on services.

Our performance so far suggests we are already doing well, with more than 90% of older people's care being delivered in the community, but there is still more to do for the whole adult population. We know that whilst hospital admission rates for people over 75 are reducing, admission rates for people aged 50-75 are increasing. We have already delivered good work in relation to self-management but we are beginning to understand more about opportunities for improvement around potentially preventable admissions relating to people aged 50-74 with COPD, diabetes and asthma.

Optimising resources and joining up health and social work services is critical to realising the ambitions of health and social care integration. We continue to take every opportunity to better integrate services at all levels of our partnership. We plan to think differently and do things differently to support people more effectively in their own homes, making a difference in the outcomes for people in our communities. As we continue to progress with change, our focus must be to deliver improvements in care which are realistic yet creative. The Strategic Commissioning Plan 2019-22 will be delivered through a number of Improvement or Transformational plans which will require to demonstrate an approach which delivers the Angus 6 Rs. The strategic planning group believe these are essential to making a difference:

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

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

We will continue to deliver our vision through four strategic priorities underpinned by effective management of three performance areas.

Angus HSCP Priorities and Performance Areas

Our Strategic Delivery and Improvement programme for 2019-2022 continues to develop. Our delivery plan will recognise the need to deliver improvement around two care pathways which draw upon activity in all four priority areas. These are:

- Diabetes
- Mental wellbeing

Table 3 sets out a summary of the current draft view of expected activity. Additional improvement and transformation areas may emerge in the coming weeks and those currently identified will be refined or may be removed. Each area of activity will require an improvement plan that demonstrates consideration of the 6 Rs and sets out measures including improvement targets to be achieved over the 3 years of the strategic commissioning plan. These will ensure that we are able to match resources to our transformational and improvement activity and monitor progress though the mid-year and annual performance reports.

We will establish new measures and targets in our Strategic Commissioning Plan for each improvement area in order to measure progress in the delivery of the plan. These measures and targets will be set out in our strategic commissioning plan

Table 3 Draft Strategic Delivery and Improvement Plan

<table>
<tr><td rowspan="4">Our vision is to work with communities that actively care, promoting wellbeing and creating the best possible health and social care across Angus

Angus HSCP making a difference</td><td>Priority
Improving health, wellbeing and independence</td><td>1. An Angus that actively cares (including addressing loneliness)
2. Public health and wellbeing
3. Diabetes prevention and early intervention
4. Mental wellbeing approaches
5. Carers strategy
6. Self-management including diabetes, mental wellbeing and continence
7. Falls prevention and improvement
8. Housing Contribution Statement</td><td rowspan="4">Delivering our workforce plan

Facilitating the third and independent sector care provision</td></tr>
<tr><td>Priority
Supporting care needs at home</td><td>9. Personal care demand management (including Enablement, community alarm and community meals)
10. Free personal care for people under 65
11. Day care
12. Delivering the care home review in local authority facilities and peripatetic nursing model
13. Growing technology for the future
14. Learning disability
15. Palliative and end of life care
16. Protecting vulnerable adults</td></tr>
<tr><td>Priority
Developing integrated and enhanced primary care and community responses</td><td>17. Complete the delivery of the Angus Care Model including addressing the needs of the under 65 population
18. Primary care improvement plan and general medical services premises plan
19. ‘Value your medicines’ best value approach to prescribing
20. Improve response to mental health
21. Drug and alcohol services</td></tr>
<tr><td>Priority
Improving integrated care pathways for priorities in care</td><td>22. Working with NHST on the transformation programme and the North region
23. Working with NHS Tayside work in transforming outpatients, inpatient flow
24. Working with children’s services to improve Transition from child to adult services
25. Working with Perth and Kinross HSCP to transform interface pathway in and out of inpatient services for people with mental illness, shifting the balance of care (resources)
26. Improving whole system pathways around diabetes management and co-morbidity in younger adults</td></tr>
</table>

Development Notes on Table 1

The notes provided below show progress to date in scoping out some of the ambitious programmes established in our delivery plan. These will be updated as work progresses on our delivery plan.

Improving Health, Wellbeing and Independence

1. An Angus that actively cares.

This approach underpins the Angus care model. We will work with our community planning partners to support the development of communities that are:

- Dementia friendly
- Disability friendly
- Suicide aware
- Working on promoting health and wellbeing including mental wellbeing
- Supporting loneliness and isolation

Voluntary Action Angus is a key organisation in supporting development in this areas and Angus HSCP will continue to fund their support for this work.

2. Public health and wellbeing

We will review the existing support through the Partnership for health improvement. We need to ensure that our resources are supporting improvement in the health of our communities and are better targeted at those affected by inequalities. We will develop an improvement plan that aims to ensure that our approach to health and wellbeing focused on delivering:

- improvements in mental and emotional wellbeing,
- increasing activity levels
- improving mobility in older people
- reducing obesity.

We will continue to work with our communities through the Locality Improvement Groups (LIGs). The mental health and wellbeing pilots are positive examples of where LIGS have commissioned services to support people with psychological or emotional distress and not solely relying on higher tariff statutory services. In the coming years we will have a greater focus on how we promote wellbeing, creating the right strategic conditions for good mental health and wellbeing, with a focus on early interventions through all age groups.

We expect that we will be required to publish an annual performance report which will set out how we are improving nationally agreed health and wellbeing outcomes.

Examples of current and future initiatives include:

- Prevention and advice targeting the whole population
- Promoting resilience and self-management
- Mental health and wellbeing in primary care.
- Actively tackling stigma and promoting a positive mental health message

Delivering this level of change will require working in a shared way with the community planning partnership. A more joined up approach between the CPPs and the LIGs is being developed.

3. Diabetes prevention and early intervention

Early intervention and prevention of diabetes requires an approach to managing obesity. We are working with NHST and the other Health and Social Care Partnerships in Tayside to develop a collaborative approach to the care pathway. This work is at a very early stage.

4. Mental wellbeing approaches

There is growing evidence that positive mental health and wellbeing at a population level can reduce health inequalities and improve wider outcomes in relation to physical health, social cohesion and economic productivity. There are a number of strategic drivers which influence the future of integrated mental health services and which include the involvement of third, independent and statutory sectors. These involve services which have not traditionally been considered to be part of the mental health system.

There are a number of Government strategies, including The Scottish Mental Health Strategy and the National Suicide Prevention Action Plan, which commit to having mental health issues 'tackled earlier and where possible in the community'. This is reinforced in our local engagement with the public which provides a clear message that we should increase our investment in preventative, easily accessible services as well as improving services designed to meet an individual's acute mental health problems.

5. Carers Strategy

The Angus Carers Strategy will be developed through the Carers Planning & Development Group and be published as part of the Strategic Commissioning Plan. It will ensure implementation of the Act, address broader issues facing local carers, and progress the Angus HSCP's approach to supporting this agenda.

6. Self-management, including diabetes and continence

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. We recognise the need to support prevention of disease as a priority to reduce the 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.

This work is consistent with our plans for health improvement across our communities. The focus of work around self-management of long term conditions will include:

- aligning community cardiology with the community
- developing more support for chronic pain management
- building the Independent Living Angus platform to provide support and links for self-assessment and referral when appropriate

Chronic pain affects approximately 20% of the population and costs us dearly in terms of prescribing, service demand and wider economic costs. Based on outcomes to date from the North West locality test of change and the wide experience gathered over recent years, during which we have been building self-management options, we believe that a primary

care pain service, similar to our respiratory service in approach, would significantly support localities to better manage pain in a holistic way. This requires further exploration.

7. Falls prevention

Following a review of the falls pathway, an improvement plan is currently being developed

8. Housing First

An individual's housing situation can limit their ability to be independent. We are working with housing providers on the development of an updated housing contribution statement where there will be a focus on supporting individuals to be in homes that can best meet their needs.

Angus HSCP is committed to repatriating people with complex needs who have been placed outwith Angus, where this is practicable. This particularly affects a group of adults with learning disability. This includes the development of supported accommodation for people with learning disabilities in South Angus.

9. Personal care demand management (including Enablement, community alarm and community meals)

This area of work will include approaches to:

- *Self-assessment for occupational therapy equipment through Independent Living Angus*

The introduction of Independent Living Angus to provide advice on maintaining and improving independence by using an approach called "life curve"

- *Changes to eligibility criteria in assessment and care management.*

Approved by the IJB in June 2018, its implementation requires to be embedded within services through a new operational instruction and the introduction of a high cost care package resource panel.

- *Activities of the Enablement Response Team.*

A review of our approach to enablement and the activities of the ERT is underway.

10. Free personal care for people under 65

The extension of Free Personal Care to people aged under 65 is to be introduced from April 2019.

11. Day care

Report no. 45/18 addresses some of the issues. A review of day care provision across Angus is underway.

12. Delivering the residential and nursing care home review

The work is being progressed and a report will be brought before the IJB in February 2019.

13. Growing technology for the future

We are developing a digital improvement plan which will deliver improvements in the availability and the accessibility of telehealth solutions. Currently developments include:

- ‘Flo’, a text mentoring system supporting the management of long term conditions. There is potential to grow the use of this system across a range of services;
- ‘Attend Anywhere’, a secure video conferencing system that allows remote contact between patients and clinicians aimed at reducing missed appointments and unnecessary journeys;
- Independent Living Angus, an assessment and self-management system currently delivering access to some equipment without the need to see an occupational therapist. This system has potential to grow to support self-assessment and self-management across many long term conditions.

The digital improvement plan will also address workforce productivity issues, focusing on systems development and then systems integration to improve the sharing of relevant information between members of the multi-disciplinary team.

As we progress a digital approach, it will be essential that staff have access to the systems and equipment necessary but also to any training required. We will work with community planning partners to promote learning about digital systems amongst the public.

15. Learning disability

Plans are developed to:

- return people placed outwith Angus to nearer home
- deliver the replacement for the Gables
- address supported accommodation need in South West Locality
- complete rehabilitation of patients from Strathmartine Centre, Dundee
- revise arrangements for college support
- introduce TEC to overnight support
- review respite arrangements

16. Palliative and end of life care

An improvement plan is currently being developed.

Developing integrated and enhanced primary care and community responses

17. Primary care improvement plan and general medical services premises plan

On approval of the implementation plan, a more detailed performance tracker will be developed and maintained over the next 3 years to enable local monitoring of progress and performance.

The proposed NHS Tayside Primary Care Improvement Plan, outlining in detail the key milestones over the 3 year period.

In summary Angus improvements against the agreed priority areas are proposed as follows:-

Priority Area	Summary
Vaccinations	National Vaccination Transformation Programme - led regionally by public health with representation from each HSCP. NHS Tayside introduced a Children's Immunisation Service in 2016. Plans for 2018/19: Expand remit of Children's Immunisation teams to cover all children's vaccinations Begin shift of adult immunisations away from general practice eg vaccinations in pregnancy Expand community pharmacy administration of vaccinations for residents in care homes.
Pharmacotherapy services	Planning being led regionally by the Director of Pharmacy with representation from each HSCP. The first phase of Primary Care Transformation Monies supported increases in pharmacy WTE input pan Tayside - this will continue over coming years to deliver the range of pharmacotherapy support outlined in the contract- but national workforce challenges well recognised. Plans for 2018/19: Test of change in 2018/19 will scope workload resulting from level one service and estimate resource requirements for roll out between 2019-2021. An additional 5 wte pharmacist posts will be advertised in 2018/19 to continue to increase the pharmacy support available to practices.
Community Care & Treatment Services	Regional planning and development of the enablers required to support this development - fit for purpose IT particularly is critical. Local ownership of modelling of services within each HSP in light of geographical and demographic variances. Plans for 2018/19: Baseline data collection to support modelling Stabilisation of minor injury services within each cluster as per agreed Angus Care Model Development of leg ulcer service model with implementation in one cluster Development and implementation of ear syringing service within each cluster Testing of a cluster level spirometry service in North West Angus Council Testing of a cluster level ECG service in South East Angus Testing of IT within a virtual Community Treatment and Care Service in South West Angus (which will inform regional planning)
Urgent Care Services	Regional planning and development of the enablers required to support this development- fit for purpose IT particularly is critical. Local ownership of modelling of services within each HSP in light of geographical and demographic variances. Plans for 2018/19: Test within one cluster of a cluster based specialist paramedic supporting enhanced community support and provision of urgent in-hours care.

Priority Area	Summary
Additional professional services	**First Point of Contact Physiotherapy:** Regional planning led by Director of Allied Health Professions with representation from each HSCP. Plans for 2018/19: Different models being tested in each HSCP which will be reviewed to agree principles for future service delivery from 2019 onwards. Within Angus practice funded tests within 3 practices will continue in 2018/19. **Mental Health & Wellbeing:** Local planning with regional collaboration. Being developed in conjunction with mental health services with planning for utilisation of resources allocated separately to support Action 15 of the mental health strategy. Plans for 2018/19: Develop a sustainable model for Mental Health & Wellbeing Nurse deployment across Angus to build on existing successful models. Maintain Angus wide access to 'Do You Need to Talk' and increase appointment capacity within each cluster.
Community links workers(known locally as social prescribers)	Being developed within each HSCP with sharing of learning. Within Angus social prescribing roles within practices by Voluntary Action Angus, with short-term financial contributions via Primary Care Transformation. Plans for 2018/19: Maintain current levels and models of service provision in 2018/19 Stakeholder event planned for August 2018 to agree future modelling, in context of wider social prescribing within localities, with phased roll out of agreed model from 2019. Social prescribing to be accessible to all practices by 2021.

All of the above is dependent upon the recruitment and retention of workforce, and the accessibility of suitable premises.

18. Drug and alcohol services

The Alcohol and Drugs Partnership will deliver an improvement plan for future years.

19. Complete the delivery of the Angus Care Model including addressing the needs of the under 65 population

Complete roll out of Enhanced Community Support (ECS) and ensure its application to all ages. A new improvement and delivery plan for ECS is currently being completed.

Further reviews of care management and district nursing are required in light of the Monifieth Integrated Care pilot.

Complete the delivery of the Angus Care Model across all localities. Grow the model to include under 65s.

Extend Review of In-Patient Services. In January 2018 plans to implement the Angus Care Model (In-Patients), the planned ward configuration resulted in wards with varying nurse staffing ratios, largely dependent on the bed numbers in those wards. Noting both workforce and financial constraints, it is expected that a move towards more efficient nurse staffing ratios through reconfiguration could contain staffing costs.

Angus Care Model – Psychiatry of Old Age (POA) - The January 2018 plans resulted in 3 remaining POA wards. Further review of this could be undertaken to explore in-patient bed capacity and to potentially increase POA use of Care Home beds or other community resources.

Angus Care Model – Care Home Review - In House Care Provision – While this was initially part of the overall Care Home Review within the Angus Care Model, it is now proposed to treat this as a discrete work stream.

Angus Care Model – Care Home Review - Nursing Services - While this was initially part of the overall Care Home Review within the Angus Care Model, it is now proposed to treat this as a discrete work stream.

Angus Care Model – Care Home Review - Support Services - While this was initially part of the overall Care Home Review within the Angus Care Model, it is now proposed to treat this as a discrete 'Support Services' work stream. Support services review will include the development of an improvement plan around services including catering, laundry and cleaning in care homes, community meals and community laundry services.

19. 'Value your medicines' best value approach to prescribing

Practices have been invited to identify and progress prescribing efficiency programmes. All actions will be completed and audit data submitted by 31 January 2019 to facilitate financial planning and planning for 2019/20 based on the findings. Practices have been invited to provide a summary of their prescribing initiatives planned by 1 July, after which time the Angus Prescribing Action Plan (Appendix 3) will be updated and resubmitted to the Integration Joint Board.

Over the coming month a scoping exercise is also to be completed within each Angus practice to review in detail all high value, non-formulary prescribing to ensure due governance and review where clinically appropriate. It is anticipated that most of this prescribing will not have been initiated in primary care.

In addition to the above, locally agreed actions we will continue to implement regional priorities as agreed through the Prescribing Management Group. These include:

- Supporting a transformation of care pathways for diabetes, with an increased emphasis on supporting lifestyle changes such as weight management and increased activity and a much more personalised approach to diabetes management.
- The development and implementation of a mental health prescribing formulary and associated guidance.
- A continued focus on chronic pain pathways of care in line with agreed national standards.

- A system-wide approach to review and prescribing management around medicines of low clinical value.
- Increased levels of public engagement and education regarding medicines use and medicines waste.
- Implementation of the pharmacotherapy aspects of the 2018 GMS Contract to enhance and standardise support to practices to manage prescribing safely.
- Development of an appliances group which will support review of non-medicines prescribed items, such as baby milk, gluten free foods, stoma products.
- Conclusion of roll out of programmes of work initiated in 2017/18 as outlined above will contribute significantly to delivery on the proposed financial framework outlined below.

Prescribing plans will be developed in parallel to the IJB's overall plans. For now opening commitments and interventions are only reflected at a high level and are consistent with previously documented intentions to reduce the Angus variation from national weighted average costs per patient (including increasing funding to support Prescribing).

Improving integrated care pathways for priorities in care

Work in this area will be developed in conjunction with NHS Tayside plans;

20. Working with NHST on the transformation programme and the North region
21. Working with NHS Tayside work in transforming outpatients, inpatient flow

22. Working with children's services to improve Transition from child to adult services

Some progress has been made with children's services in scoping out this piece of work.

23. Working with Perth and Kinross HSCP to transform the interface pathway in and out of inpatient services for people with mental illness, shifting the balance of care (resources)
24. Improving whole system pathways around diabetes management and co-morbidity in younger adults

Appendix 1

Developing the Angus Health and Social Care Partnership Strategic Commissioning Plan for 2019-2022

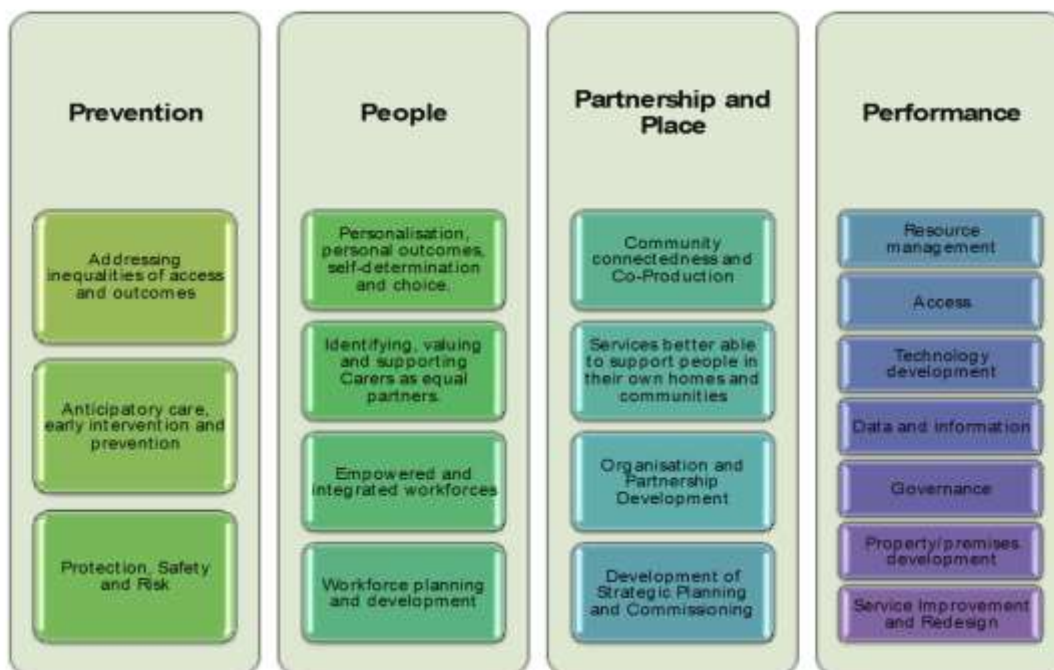
Policy Drivers

This paper is a review of the national outcomes and other policy drivers that impact on the provision of health and social care and how these will be enacted. It has been undertaken to inform the development of the Angus Health and Social Care Strategic Plan.

There is 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 the national outcomes. Legislation and policy drivers all embrace common themes to be delivered strategically and operationally through service delivery.

The analysis of Scottish Government priorities, strategies and legislation (Appendix A) demonstrated a consistency of strategic direction with the four pillars of the **Christie Commission** (Commission on the Future Delivery of Public services in Scotland)

The themes are:



It is recommended that the themes from national drivers are used as follows:

Prevention – matched into Priority 1

People – matched across all priorities and performance areas and specifically addressed in the workforce plan

Partnership and Place - used to support communication and engagement in the development and delivery of the plan

Performance – addressed through the support arrangements from Angus Council and NHS Tayside and within our own framework arrangements to ensure that an appropriate framework within which improvement happens

Appendix 2

The Policy Drivers include:

All by Scottish Government unless otherwise stated:

A route map to the 2020 Vision for Health and Social care
A Fairer Healthier Scotland: 2017 – 2022. A Strategic Framework for Action
A healthier future: Scotland's diet and healthy weight delivery plan July 2018
A More Active Scotland: Scotland's Physical Activity Delivery Plan July 2018
Achieving Excellence in Pharmaceutical Care: A Strategy for Scotland 2017
Adult Support and Protection (Scotland) Act 2007
Adults with Incapacity (Scotland) Act 2000
Age Home and Community: A Strategy for Housing for Older People 2012- 2022
Beating Cancer: Ambition and Action 2016
Beating Cancer: Ambition and Action, Scottish Government March 2016
Carers (Scotland) Act 2016
Carers Charter 2018
Changing Scotland's Relationship with Alcohol: A Framework for Action
Chief Medical Officer for Scotland, January 2016. **Realistic Medicine, the Chief Medical Officer's Annual Report 2014-15** The Scottish Government.
Children and Young People's (Scotland) Act 2014
Community Empowerment (Scotland) Act 2015
Community Eyecare Services Review
Community Justice (Scotland) Act 2016
Convention of Scottish Local Authorities (COSLA) **and the Scottish Government Public Health Priorities for Scotland.** June 2018
Creating a Healthier Scotland. What Matters to You
Draft Fuel Poverty Strategy 2018
Equally Safe - A Delivery Plan for Scotland's Strategy to Prevent Violence Against Women and Girls November 2017.
Everyone Matters 2013
Framework for Local Partnerships on Alcohol and Drugs
Getting it Right for Every Child
Health and Social Care Delivery Plan (HSCDP)
Healthcare Quality Strategy for NHS Scotland 2010
Homelessness and Rough Sleeping Action Group: final recommendations report June 2018
Homes Fit for the 21st Century.
Housing (Scotland) Act 2010
Housing (Scotland) Act 2014
Joint Housing Delivery Plan for Scotland
Keys to Life: Improving quality of life for people with Learning Disabilities 2013
Mental Health (Scotland) Act 2015
Mental Health Strategy for Scotland 2017-2027 - a 10 year vision March 2017
National Clinical Strategy (NCS)
National Health and Social Care Workforce Plan - Part 1 June 2017
National Health and Social Care Workforce Plan Part 2 Dec 2017
National Health and Social Care Workforce Plan: Part 3 2018

National Performance Framework (NPF) June 2018
National Strategy for Community Justice.
New GP Contract
NHS Education for Scotland (NES) and the Scottish Social Services Council (SSSC)
Promoting Excellence: A framework for all health and social services staff working with people with dementia, their families and carers 2011.
Oral Health Improvement Plan 2018
Primary Care Outcomes Framework
Private Housing (Tenancies) (Scotland) Act 2016
Progressing children's rights in Scotland: an action plan 2018 to 2021
Public Bodies (Joint Working) Act
Public Health (Scotland) Act 2008
Realising Scotland's full potential in a digital world
Realistic Medicine
Reshaping Care for Older People – A Programme for Change 2011- 2021
Review of Out of Hours primary care services February 2017
Review of Public Health in Scotland
Saving Lives. Giving Life Back
Scotland's National Dementia Strategy 2017-20
Scotland's National Dementia Strategy 2017-2020
Scotland’s Digital Health & Care Strategy 2018; Enabling, Connecting and Empowering
Scottish Strategy for Autism March 2018.
See Hear – A Strategic Framework for People with a Sensory Impairment in Scotland
Social Care (Self-directed Support) (Scotland) Act 2013
Social Services in Scotland: a shared vision and strategy 2015-2020
Strategic Framework for Action on Palliative and End of Life Care 2016
Substance misuse services: delivery of psychological interventions June 2018
The Best Start: A Five-Year Forward Plan for Maternity and Neonatal Care in Scotland 2017
The five-year strategic priorities for Scotland May 2016
UK Government Equality Act 2010
UK Government Welfare Reform Act 2012
Health and Care (Scotland) Staffing Bill
Free Personal care for under 65s
Gaun Yersel! The Self-Management Strategy for Long Term Conditions in Scotland 2008
Health and Social Care Standards My support, my life Jun 2017 Scottish Government
Trees that bend in the wind: Exploring the experiences of front line support workers delivering palliative and end of life care Feb 2017 Scottish Care
Nursing 2030 Vision: Promoting Confident, Competent And Collaborative Nursing For Scotland’s Future

Appendix 3

Table 2 - Relationship between Angus Strategic Priorities, the National Wellbeing Outcomes and the National Core Performance Indicators

<table>
<tr><th>Angus Strategic Priorities and Performance Areas</th><th>National Wellbeing outcomes</th><th>National Core performance measures</th></tr>
<tr><td>Priority 1
Improving health, wellbeing and independence</td><td>1. Healthier Living. People are able to look after and improve their own health and wellbeing and live in good health for longer.
5. Reduce Health Inequality. Health and social care services contribute to reducing health inequalities.
6. Carers are Supported. People who provide unpaid care are supported to look after their own health and wellbeing. This includes reducing any negative impact of their caring role on their own health and wellbeing.</td><td>NI-11 Premature mortality rate.
NI-16 Falls rate per 1,000 population in over 65s.
NI-1 Percentage of adults able to look after their health very well or quite well.
NI-8 Percentage of carers who feel supported to continue in their caring role.</td></tr>
<tr><td>Priority 2
Supporting Care Needs at Home</td><td rowspan="2">2. Independent Living.   People, including those with disabilities, long term conditions, or who are frail, are able to live as far as reasonably practicable, independently at home or in a homely setting in their community.
3. Positive Experiences and Outcomes. People who use health and social care services have positive experiences of those services and have their dignity</td><td>NI-18 Percentage of adults with intensive needs receiving care at home.
NI-15 Proportion of last 6 months of life spent at home or in community setting.</td></tr>
<tr><td>Priority 3
Developing integrated and enhanced primary care and community</td><td>NI-6 Percentage of people with positive experience of care at their G.P. practice.
NI-12 Rate of emergency admissions for adults.
NI-13 Rate of emergency bed days for adults.
NI-14 Readmissions to hospital within 28 days of discharge.
NI-21 Percentage of people admitted from home to hospital</td></tr>
</table>

Angus Strategic Priorities and Performance Areas	National Wellbeing outcomes	National Core performance measures
responses	respected. 4. Quality of Life. Health and social care services are centred on helping to maintain or improve the quality of life of service users. Everyone should receive the same quality of service no matter where they live.	during the year, who are discharged to a care home (data not available) NI-22 Percentage of people who are discharged from hospital within 72 hours of being ready. (data not available)
Priority 4 Improving Integrated care pathways for priorities in care		NI-19 Number of days people spend in hospital when they are ready to be discharged.
Performance Area 1 Managing our workforce	8. Engaged Workforce. People who work in health and social care services are supported to continuously improve the information, support, care and treatment they provide and feel engaged with the work they do.	NI-10 Percentage of staff who say they would recommend their workplace as a good place to work.(data not available)
Performance Area 2 Clinical and Care Governance	7. People are Safe. People who use health and social care services are safe from harm.	NI-17 Proportion of care services graded 'good' (4) or better in Care Inspectorate Inspections. NI-2 Percentage of adults supported at home who agree that they are supported to live as independently as possible. NI-3 Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided. NI-4 Percentage of adults supported at home who agree that

Angus Strategic Priorities and Performance Areas	National Wellbeing outcomes	National Core performance measures
		their health and care services seemed to be well co-ordinated. NI-5 Percentage of adults receiving any care or support who rate it as excellent or good. NI-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. NI-9 Percentage of adults supported at home who agree they felt safe.
Performance Area 3 **Managing our resources**	9. Resources are used Efficiently and Effectively. To deliver Best Value and ensure scarce resources are used effectively and efficiently in the provision of health and social care services.	NI-20 Percentage of total health and care spend on hospital stays where the patient was admitted in an emergency. NI- 23 Expenditure on end of life care(data not available)