Strategic Commissioning Plan

2023 – 2026

Working together to improve lives in Angus

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Foreword

Cllr Julie Bell, Chair Angus Integration Joint Board

It is my pleasure to introduce to you the third Strategic Commissioning Plan (Plan) on behalf of Angus Integration Joint Board (IJB). As a Board, we are committed to the work that we and our partners – across public, Third Sector and Independent Providers - do to improve the health and wellbeing of the people we serve. We all want Angus residents to live in communities that care and have long, healthy and happy lives with the greatest possible independence.

The Plan outlines how we will:

- Support a shift from reactive services to preventative actions that can increase life expectancy and reduce health inequalities.
- Support more people to remain independent or regain the independence they want and value.
- Work with partners to provide a more joined-up health and social care system.
- Reduce demand and focus resources on those who need them.
- Continue to use public resources effectively.

Angus is a great place to live and work and generally our population is healthy. However, outcomes are not as good for some of us as they could be. The reality is that demand for services is increasing and health inequalities are widening. A key feature of this Plan is our ambition to work with our partners and you - the people of Angus - to continue to narrow the gap between those of us with the best and worst health and wellbeing. The Plan

also focuses on the 'quadruple aim' of improving the experience for service users, improving the experience for staff, better health outcomes and lower the cost of care.

It is important that we are honest from the outset. We recognise that the landscape in which we have developed this Plan is markedly different compared to our previous Plans. The joint impact of the COVID-19 pandemic and the ongoing cost-of-living crisis has been substantial. We know that, as poverty deepens, health worsens. This means that the resource challenges that we face, both in terms of finances and workforce, are bigger than they have ever been.

The greatest improvement in people's health and wellbeing will be as a result of what we do for ourselves. I welcome the increased emphasis we have placed on prevention and proactive care. This is critical to protecting health and wellbeing and to ensure health and social care services have the capacity to deliver the best possible care. I am very supportive of our joint commitments with the intention to make a difference for the people of Angus, with the people of Angus.

The COVID-19 pandemic had a significant impact on our communities and our health and social care system. People who provided support to the most vulnerable worked tirelessly to deliver services during very challenging conditions. We continue to see countless examples of people going above and beyond to provide care. I would like to thank our staff, our communities and especially unpaid carers (Carers) for your support, dedication and commitment.

I would also like to thank everyone who has given us feedback and contributed to the development of this Plan. The information that follows gives a broad sense of our purpose and direction for the next three years, with both the aspiration of where we want to get to and the reality of the current landscape.

I ask that people continue their conversations with us, understand why changes need to happen and help us make the best decisions for our local

communities. I look forward to sharing our journey ahead with you – together we can make sure that everyone is able to live and age well in Angus.

Our Plan on a Page

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

Our Values - We are caring, compassionate, person-centred, honest and respectful.

Our Mission - Working together, being courageous and innovative, always aiming to provide safe, effective high-quality health and social care.

HSCP Strategic Ambitions

Support people to be independent for as long as possible | Ensure services are sustainable and proportionate to need | Provide Integrated and Co-ordinated Care

HSCP Strategic Priorities / **Commitments in support of Strategic Priorities**

Prevention and Proactive Care	Care Closer to Home	Mental Health and Wellbeing & Substance Use Recovery	Equity of Access and Public Protection
• Support people to look after their own health in a way which is manageable for them • Build stronger and more resilient communities • Act early to anticipate healthcare needs • Prescribing resources will be used effectively	• Provide care closer to home whenever possible • Work with partners to provide the right care in the right place at the right time • Support carers to sustain their caring role and enable them to have a fulfilling life alongside caring	• Deliver the ambitions of the Angus Living Life Well Improvement Plan • Support people to recover or manage their condition • Provide consistent delivery of safe, accessible, high quality drug and alcohol treatment across Angus	• Remove barriers to accessing services and address inequalities • Reduce homelessness • Keep vulnerable people safe

HSCP Strategic Enablers / **Commitments in support of Strategic Enablers**

Workforce	Financial Planning	Collaborative Commissioning	Communication and Engagement	Infrastructure, Data and Technology
• Improve recruitment and retention • Develop workforce dataset • Support the health and wellbeing of our workforce • Promote learning and development	• Deliver financial sustainability • Continually seek to achieve best value and cost effectiveness in our service delivery	• Co-design solutions with the third and independent sectors focusing on social care market stability • Improve Primary Care by working with General Practice and wider multi-disciplinary teams	• Building relationships with our communities. • Honest and transparent dialogue with our communities, partners and workforce • Promote shared decision making	• People have access to appropriate facilities • Accurate and robust data to inform transformation and improvement • Maximise the potential of digital solutions

How we will deliver the changes

HSCP Delivery Plan prioritised and informed by best evidence	Angus Community Planning Partnership, Angus Council and NHS Tayside Plans	Lead Services Improvement Plans

Our **Strategic Ambitions** describe what we want to achieve over the next three years.

Our **Strategic Priorities** describe the areas we will focus on over the next three years to achieve our vision and meet the nine national health and social care outcomes.

Our **Strategic Enablers** are the things we need to have in place to support us to achieve our priorities.

Our **Strategic Commitments** are the key, high level actions /activities /developments that we will do.

Our **Strategic Delivery Plan** provides the detail of how we will deliver these priorities.

Our **Annual Performance Report** publicly reports on our progress each year.

Introduction

Gail Smith, Chief Officer, Angus Health and Social Care Partnership

The Angus Health and Social Care Partnership (HSCP) provides support in a variety of ways, often when people are at a vulnerable time in their lives and have the highest level of need. This can include people with a disability or a long-term illness, frail older people and Carers.

The Plan confirms the Angus IJB's commitment to support and improve people's health and wellbeing. It also describes the vision and key priorities for the next three years. In particular, we want to support people to keep well by being more focused on what we can all do to prevent ill health and offer earlier proactive support. The challenges to maintain and improve the health and wellbeing of our communities are great but the benefits, that I believe are within our grasp, are greater still.

Local achievements in our response to the COVID-19 pandemic, where we worked collaboratively to accelerate planned innovations to identify new ways of working was unprecedented. Angus 'actively cares'. This was clear to see in the response from citizens, family, friends, Carers, neighbours, volunteers and our workforce.

We are committed to making optimal use of the resources we have. Setting the strategic objectives in this uncertain time has been challenging and I appreciate that the Angus IJB will have difficult decisions to make in the years ahead. Whilst we continue to transform services, we remain committed to reducing the duplication, variation and inefficiencies that exist in our systems whilst remaining focused on delivering value-based health and care. We will

do this through shared decision-making with people who use our services to ensure we support the outcomes that matter to people.

Looking forward, I am confident that we can build a healthier and brighter future. We need to work together to turn this plan into a reality and further improve the health and wellbeing of the population of Angus.

Background

What is a Strategic Commissioning Plan and why do we need one for Angus?

As required by the Public Bodies (Joint Working) (Scotland) Act 2014 (referred to as The Act), Angus IJB assumed responsibility for the strategic direction of health and social care services delegated to it from Angus Council and NHS Tayside. Every IJB is required to produce a Plan that sets out how the nine National Health and Wellbeing Outcomes will be delivered locally (Appendix 1). The nine outcomes are embedded in the Framework for Community Health and Social Care Integrated Services (Appendix 2). This Framework aims to improve the pace and scale of integration agreed by the Ministerial Strategic Group for Health and Community Care and supports the ambition for the redesign and improvement of services with a strong focus on prevention, quality and sustainability. It describes what 'good' looks like in terms of the provision of effective, integrated community-based assessment, treatment, care and support and has at its heart, an inclusive and collaborative approach.

Due to factors that have impacted on the health and social care sector in the last 16 months, Angus IJB decided to extend the 2019-2022 plan for a further year. Whilst this has resulted in a delay to some of the ambitions within our previous plan, it has also meant we have achieved others faster than expected.

Implementing the Plan

Angus IJB (Strategic)	• Formal public body. • Responsible for development and review of the strategy for health and social care functions that have been delegated by NHS Tayside and Angus Council. • Take into consideration and act upon national developments in policy and practice. • Issues Directions to NHS Tayside and Angus Council as to how the delegated functions will be carried out. • Ensure stakeholder engagement.
Angus HSCP (Operational)	• Takes forward the operational implementation of the Plan. • Provide assurance to the IJB, NHS Tayside and Angus Council on progress against the Plan.

Angus Integration Joint Board

Following the Scottish Government (SG) legislation (Public Bodies, (Joint Working) (Scotland) Act 2014) to integrate health and social care services, Angus Council and NHS Tayside have integrated the planning and delivery of all community health and social care services for adults and older people. Angus IJB is a separate legal entity and has the responsibility to direct the work of the delegated services. The IJB includes members of Angus Council and NHS Tayside (voting members) as well as those representing the interests of the Third Sector and Independent Providers, Carers, staff and service users. The IJB is responsible for allocating the integrated revenue budget for health and social care so that the objectives set out in its Plan can be met.

Angus Health and Social Care Partnership

Angus HSCP, formed in 2016, delivers services for Angus Council and NHS Tayside. This means that we have a single system for planning and delivering local health and social care. The Angus HSCP Chief Officer is responsible for the management of planning and operational delivery on behalf of Angus HSCP.

What services and functions are integrated in Angus?

Examples of the services and functions delegated from Angus Council and NHS Tayside to Angus IJB, along with their budget, are detailed in Table 1. below. These services are planned and delivered by Angus HSCP and a range of partners and providers. A full list of the functions delegated to the IJB can be found within the Angus Integration Scheme.

Table 1. Examples of services and functions delegated to Angus IJB.

Adult Social Care Services	**Community Health Services**
Adult and Young unpaid carer support services	Community based Allied Health Professionals for example: Occupational Therapy Physiotherapy
Adult Support and Protection	Community Hospital Inpatient Services
Reablement, adaptations and telecare	Community Pharmacists
Drug and Alcohol Services	District Nursing Services
Care and support for adults with physical and learning disabilities	Minor Injury and Illness Services
Care at home services	Palliative Care
Community mental health services	Angus Primary Care
Social care services provided to adults and older people	Services to promote public health and improvement
Respite provision	Community Learning Disability Services

HSCP Lead Partner Service areas in Tayside

Angus HSCP is one of three HSCPs in the Tayside area (others being Dundee HSCP and Perth & Kinross HSCP). To ensure consistency and for economy of scale, some health services are organised Tayside-wide, with a nominated HSCP Partner leading the service on behalf of its own and the other two HSCPs.

Delivering transformation and improvement in Lead Partner service areas means that Angus HSCP works closely with Dundee and Perth & Kinross Partnerships as well as NHS Tayside. Table 2 provides examples of the Lead partner service areas.

Table 2 Lead partner services.

Angus	**Dundee**	**Perth and Kinross**
Locality Pharmacy Primary Care (excluding NHS Board administrative, contracting and professional advisory roles)	Psychology	Learning Disability and Mental Health Inpatients
GP Out of Hours	Sexual Reproductive Health	Substance Use Inpatients
Forensic Medical and Custody Healthcare Services	Specialist Palliative Care	General Dental
Continence Service	Centre for brain injury rehabilitation	Community Dental Services
Speech and Language Therapy	Eating Disorders	Podiatry Services
	Dietetics	Prison Healthcare
	Medical Advisory	

	Service	
	Tayside Health Arts Trust	
	Keep Well	
	Psychotherapy	

Some of the areas delegated to the IJB also provide services to children, for example Primary Care, Minor Injury and Illness Services, Carers, Continence Services and Angus Council delegated Occupational Therapy Services.

Strategic Planning Group

As required by The Act, Angus IJB has established a Strategic Planning Group (SPG) to support the strategic planning process. The SPG monitors the delivery of the strategic priorities. It also assesses new policies and strategies and provides a strategic perspective on these to the IJB.

Our approach to service delivery

By following the Integration Planning and Delivery Principles we work to ensure our services are:

Joined up and easy for people to access.

We have longstanding examples of integrated service delivery within our mental health teams and Angus Integrated Drug and Alcohol Recovery Services (AIDARS).

We continue to develop a new model for integrated working around General Practices. This has brought together health and social care staff in a shared base within General Practices to improve multi-disciplinary working with the aim of improving outcomes for individuals.

Takes account of the particular needs of different service users and respects the rights and dignity of service users.

We have developed and are implementing our Equalities Mainstreaming Report 2022 - 2024 whilst also complying with the Public Sector Equality Duty in line with the Equality Act 2010 and the Equality Act (Specific Duties) (Scotland) Regulations 2012.

Our Equality Outcomes:

- We will make all services accessible to meet the needs of people with a protected characteristic(s) to allow them to be as independent as possible.
- People with Protected Characteristic(s) and equality groups are able to make informed choices so they can have control over their own life.
- People with Protected Characteristic(s) will be involved in their own care to allow them access to services that meet their physical, cultural, religious and equality needs.
- Angus HSCP will promote an equality driven culture within the organisation.

We recognise that there is a widening gap in inequalities. The World Health Organisation (WHO) describes health inequalities as 'avoidable inequalities in health between groups of people'. Working with partner organisations, Angus

HSCP has a key role to play in addressing inequality, in particular the health inequalities that contribute to deaths every year in Angus. This can be as a result of poverty, social or educational status combined with discrimination based on age, disability, race, or any other protected characteristic and this can impact on an individual's health and wellbeing. We also acknowledge that the wider the gap, the poorer the outcomes are for everyone.

We are also committed to developing a human-rights based approach. We will continue to take practical steps to put human rights principles at the centre of our daily practice and policies.

Protects and improves the safety of service-users.

Adult protection is everyone's business. In 2023 a joint inspection of multi-agency arrangements for adult support and protection was carried out in Angus, led by the Care Inspectorate. The focus of the joint inspection was the contribution of Social Work, Police Scotland, Health and other agencies to keep adults at risk of harm safe, and how they work collaboratively to do this. Inspectors concluded that the partnership's key processes for adult support and protection were very effective and demonstrated major strengths supporting positive experiences and outcomes for adults at risk of harm. They concluded that the partnership's strategic leadership for adult support and protection was effective with some areas for improvement. There were clear strengths supporting positive experiences and outcomes for adults at risk of harm, which collectively outweighed the areas for improvement.

Improves the quality of the service.

The Angus HSCP Clinical, Care and Professional Governance Group (CCPG) oversees the quality and safety of care provided by our services. This includes those contracted by Angus HSCP which enables assurance to be provided to Angus IJB, NHS Tayside and Angus Council.

From April 2020 the CCPG has adopted a new quality framework to support our continuous improvement approach. This has been developed in line with

the Scottish Government's Health and Social Care Standards which set out what people should expect when using health, social care or social work services in Scotland (Appendix 3). They seek to provide better outcomes for everyone and to ensure that individuals are treated with respect and dignity and that the basic human rights we are all entitled to are upheld. This ensures our focus remains on what matters most to people.

Over the last six years we have evidenced how a consistent approach to integrated working has improved the quality of care provided across Angus. This will continue to be monitored to ensure the standards of integrated care delivery are high across the spectrum of services across Angus.

Planned and led locally.

In Angus, local health and social care services are delivered across our four localities. This fulfils the legislative requirement to work at locality level, and supports us in shaping services to be more responsive to the different characteristics and needs of our distinct Angus Communities.

Angus Locality Map

Our four localities are:

North West: Forfar and Kirriemuir areas

North East: Brechin, Montrose and Edzell areas

South West: Monifieth and Carnoustie areas

South East: Arbroath and Friockheim areas

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

- Locality Improvement Groups (LIG) are well established in each locality and ensure our services are planned and led locally. LIGs are locally accountable forums that can inform and influence how local services are designed and delivered to meet the needs of the local community. Each LIG includes a wide membership including members of the public, front line staff, Third Sector organisations and Independent Providers of care and support in the locality.

Anticipating people's needs and be more proactive to prevent them from arising.

Collaborating with Community Planning Partners, Public Health Scotland and other stakeholders, we will work together to achieve long term behaviour in target areas identified to improve population health in Angus and contribute towards tackling health inequalities.

Makes the best use of the available facilities, people and other resources.

This plan has identified strategic enablers which underpin the successful delivery of the plan whilst achieving best value.

Working in Partnership

With Organisations

Angus HSCP is committed to collaborative working and has a strong track record of delivering with our partners to develop whole-system solutions. This is a result of considerable work that has been undertaken since the inception of Angus HSCP, building relationships and trust with, for example, Angus Council, NHS Tayside, Angus Community Planning Partnership, Tayside Alcohol and Drug Partnership (ADP), ANGUSalive, Scottish Ambulance Service and the Third Sector and Independent Provider organisations.

Our quick and flexible response to address people's needs during the COVID-19 pandemic provided strong evidence of the effective way we all work together. For example, the Care Home and Care at Home Operational Group was created at the beginning of the pandemic which have strengthened and enhanced professional clinical and care oversight of care homes and care at home services. Over the next three years we want to further strengthen our integrated partnership working with partners.

Voluntary Action Angus (VAA) is the Third Sector Interface and provides a single point of access for support and advice for the Third sector within Angus. The Third sector includes charities, social enterprises and voluntary groups which deliver essential services which help improve people's wellbeing and plays a vital role in supporting communities at a local level. Our work with Independent Providers is reinforced through the funding of a dedicated Scottish Care Independent Lead post and a Senior Planning Officer Post (Strategic Partner Relations).

Developing and maintaining positive relationships with our partners and communities is crucial to the successful delivery of this Plan. Our Market Facilitation Document help us and our partners to take a strategic approach to understanding and meeting local need for Angus health and social care services. It also recognises the role that our partners have in actively contributing towards economic growth in the Angus area whilst also creating employment opportunities for service user in Angus.

There are forums that are involved in planning services. In addition to the LIGs mentioned earlier, the Providers Network ensures that Third Sector and Independent Providers who deliver care commissioned by Angus HSCP are involved in service planning. Staff working in Angus HSCP are regularly provided with the opportunity to influence the way services are delivered.

Primary Care is often the first point of contact when accessing health and social care services in Angus. This includes contact with community-based services provided by general practitioners (GPs), district and community nurses, dentists, dental nurses, optometrists, dispensing opticians, pharmacists and pharmacy technicians, allied health professionals such as physiotherapists and occupational therapists and pharmacists. The Angus Primary Care Improvement Plan (PCIP) provides the framework to transform primary care services so we can better meet changing needs and demands.

We have a well-established Clinical Partnership Group which advises on all clinical aspects of service improvement. These and other approaches will continue to be developed to ensure service planning and delivery is led by people who live and work in Angus.

With the people of Angus

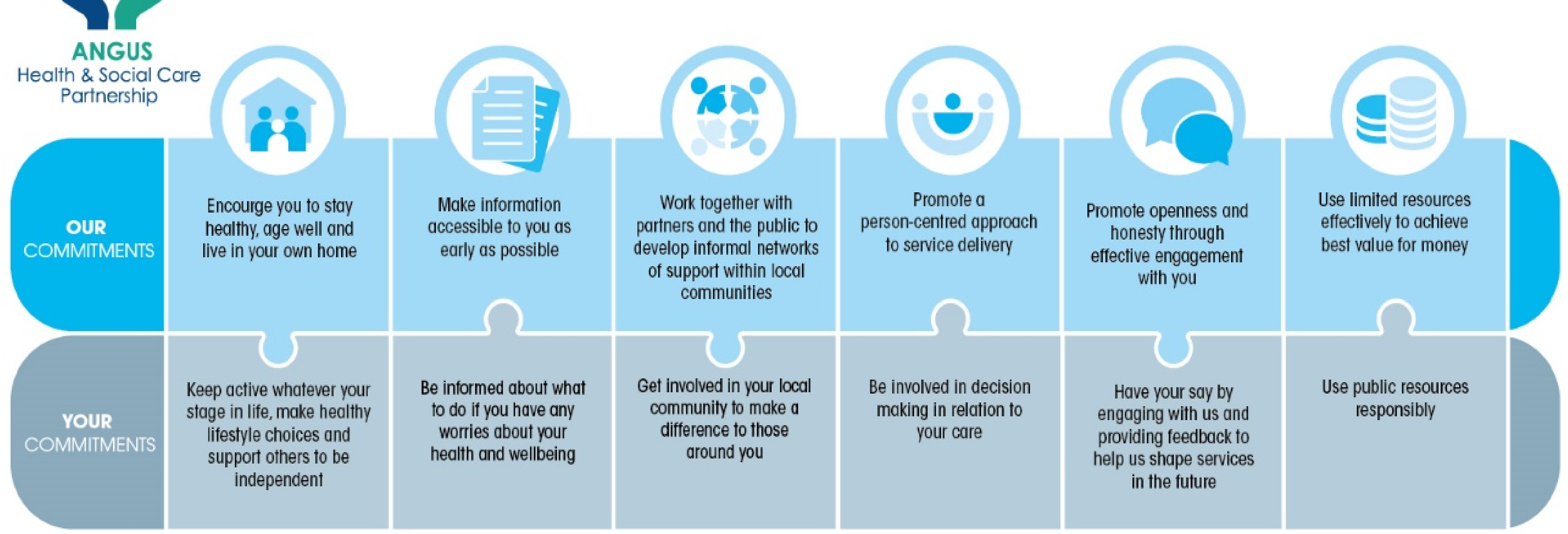
The Public Bodies (Joint Working) (Scotland) Act 2014 places a legal requirement upon the IJB to involve people in the design and delivery of care services and this was strengthened with the introduction of the Community Empowerment (Scotland) Act 2015. Listening to the views of people who use services and actively involving them throughout the process of planning care delivery, is a key improvement recommendation of the recent Independent Review of Adult Social Care in Scotland.

Participation is also a key element of a Human Rights based approach, which requires that people are supported to be active citizens and that they are involved in decisions that affect their lives. The joint SG and the Consortium of Scottish Local Authority (COSLA) Planning with People Guidance supports our approach to engaging with our communities to enable people to have their

say to ensure the improvements we make and the services we provide reflect what matters most to our communities and stakeholders.

Angus HSCP is committed to hearing people's experiences and using that information to improve service provision. We want to build on the relationships with the people of Angus who use our services now or may do so in the future and will further develop our Service User Voice Network. It is only by working together that we can make a difference to outcomes for all our residents. With the support from people who live in Angus we have developed a series of joint commitments which reflect the notion of two parties (public and the community) contributing to a common goal to make a difference.

Joint Commitments - making a difference for you, with you



During the lifetime of this Plan, we will review and refresh our Communication and Engagement Plan 2020-2023 and will continue to provide regular opportunities for stakeholders, people who use services and communities to continue the conversation with us as we make the changes that are required to implement our strategic priorities.

In 2021 we undertook a test of Care Opinion which provides people the opportunity to give feedback about services they receive. Plans are underway to roll this out across all our delegated service areas.

Examples of Care Opinion Feedback:

A report, setting out our activities and findings from engagement activity linked to the development of this Plan is available.

Strategic Context

The national strategic and policy context in relation to health and social care continues to evolve with developments being driven by economic, social and technological changes and advances. This Plan, our local improvement plans and policies are guided by national legislation, frameworks and guidance.

The Public Health Scotland three-year plan: 2022-25 has a clear focus on preventing disease, prolong healthy life and promote health and wellbeing. This Plan support these priorities with the aim to see an Angus where everybody thrives.

The Scottish Government's Housing to 2040 Strategy sets out a vision for housing in Scotland to 2040 and a route map to get there. It aims to deliver the ambition for everyone to have a safe, good quality and affordable home that meets their needs in the place they want to be. At time of writing Angus Council are refreshing the Angus Local Housing Strategy (LHS) 2023-28 which will set out the strategic priorities to meet housing need and demand in Angus. The LHS covers a wide range of housing issues including housing supply and affordability, house conditions, homelessness, specialist needs and placemaking.[1]

The inclusion of a Housing Contribution Statement in our Plan is designed to ensure that the role and contribution of the housing sector is given a strong profile in contributing to the shared priorities and outcomes for health and wellbeing.

The Scottish Government Digital Health and Care Strategy recognises the health and wellbeing of the people of Scotland can, and should, be enhanced and transformed using digital technology. Like other organisations across Scotland Angus HSCP have used digital technologies to work

[1] (Placemaking means creating places and focuses on transforming public spaces to strengthen the connections between people and these places).

differently, both to respond to COVID-19 and to sustain essential health and care services, at great speed and under incredible pressure.

The Independent Review of Adult Social Care in Scotland (the Feeley Report), proposed the creation of a National Care Service (NCS) and the National Care Services (Scotland) Bill was laid before parliament in June 2022. Much of the detail of this proposal remains to be developed.

Appendix 4 provides a summary of National policies, legislation, regulations and guidance that this Plan is aligned to.

We have also taken account of plans and strategies from other services across Tayside and Angus (Appendix 5).

Services within Angus HSCP have developed their own improvement plans to deliver on the strategic priorities and these are listed in Appendix 6.

Review of the last four years

Our previous Plan covered the three-year period from April 2019- March 2022. Responding to the challenges of the COVID-19 pandemic has meant that we have been diverted from some of our planned work and as explained earlier the Plan had been extended for another year. However, as a result of the pandemic we have been able to accelerate some activities and introduce new ways of working that have improved our service delivery and efficiency. In line with our statutory obligations, we publish an Annual Performance Report and biannual performance reports which provide a retrospective look at the performance in the previous year aligned to the national health and wellbeing outcomes. We report our performance using data indicators that are common across Scotland. Previous reports for 2019/20 and 2021/2022 can be found here.

Some of the key initiatives we have implemented and achieved include:

Learning from COVID-19 which has empowered staff to make rapid change, has shaped the development of this plan by embedding the urgency, flexibility and creativity that was so readily embraced during the pandemic

to help us tackle the inequality and disadvantage that was exposed by the pandemic.

In particular we saw this in relation to the accelerated adoption of **new technology** for example, Near Me, an online consulting tool, and Remote Patient Monitoring where people send updates via text about their blood pressure or weight to their clinician. Video technology also supported a large variety of group activities within our adult resource centres and helped to maintain connections amongst peers and staff members. Staff continue to use Microsoft Teams which has increased the efficiency of meetings.

The pandemic also helped to raise awareness of the vital work that social care and Carers play in supporting people to live independently in their own homes. The public's perception of care homes has also changed, which has accelerated what was already a clear direction of travel to **shift the balance of care** with people exercising a preference towards care at home. This led to the IJB decision in Autumn 2021 to reduce its commissioning of Angus HSCP care home beds by approximately 40 placements, including a reduction of up to 20 internal beds. This has enabled us to re-direct and invest those resources into our care at home service where demand is greatest and into preventative work.

Use of real time data to support an understanding of how the health and social care system in Angus contributes to the Tayside-wide situation. This helps to plan services and makes sure an action in one area does not have an unintended negative impact in another.

Our **Enhanced Community Support** model of care and the increased availability of personal care have improved performance in relation to the timely hospital discharge of older people. Proactive care around the individual allows the anticipation of needs and the prevention of hospital admission. Monifieth Integrated Care has seen the amalgamation of the Care Management and District Nursing teams. This has been positively evaluated and we are in the process of rolling this out across Angus.

In June 2019 we published our first adult **Palliative and End of Life Care (PEOLC)** improvement plan which describes how we aim to improve palliative and end of life care and support. End of Life Skills for Everyone courses have been delivered which are designed to enable people to be more comfortable and confident supporting family and community members with issues they face during dying, death and bereavement.

A **Complex and Co-existing Conditions Panel** was created in 2019. The panel has created a strong, effective integrated and collaborative partnership forum that has improved the provision, opportunity and health and wellbeing outcomes for adults with complex and co-existing conditions in Angus.

Since July 2020 **Health and Wellbeing Peer Support workers,** available to people 11 years and over, and **Social Prescribers** have been based in all GP Practices across Angus. This has increased the amount of mental health and wellbeing peer support that is delivered across every GP Practice in Angus.

A new **Carer's Emergency Plan** for Carers has been introduced. The **Carers Emergency Card** system has been extended to provide an additional card for the cared for person, so that if anything unforeseen happens to them when the carer is not present, they can be contacted.

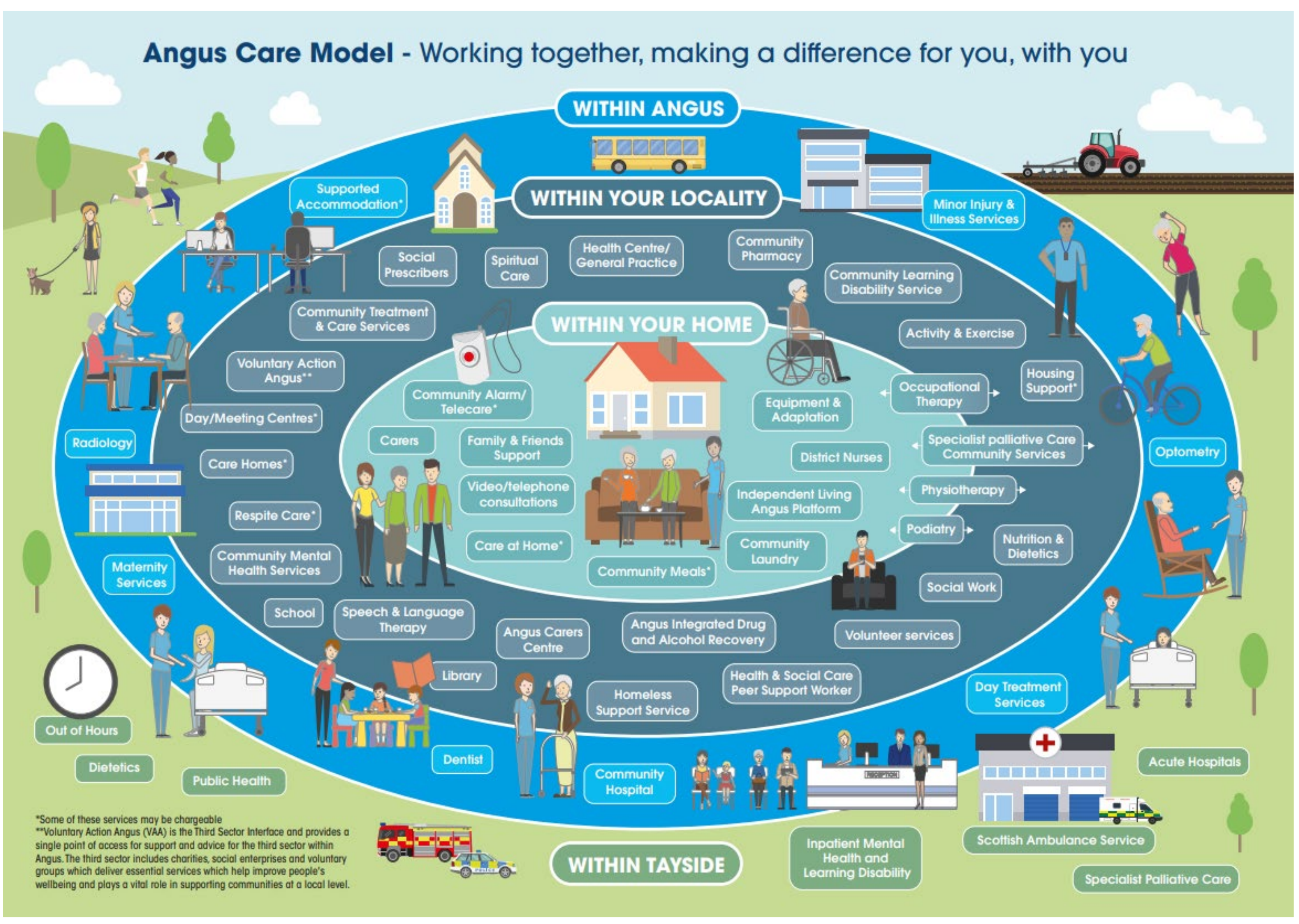
Community Mental Health services have developed the **Angus Living Life Well Improvement Plan** which is aligned to the Tayside Living Life Well priority areas. A new **Mental Health Hub** based in the Links Health Centre in Montrose, provides a wide range of multi-agency services for patients, including access to the community mental health team, drug and alcohol services, psychology, Third sector peer support and social prescribing. This approach is being rolled out across Angus.

Learning and Physical Disability Improvement Plans have continued to progress albeit at a slower pace than expected. Staff, service users and families all contributed to a comprehensive review of overnight support. The review has resulted in the replacement of identified sleepovers/waking nights with alternative ways of providing overnight support, achieving less intrusive, more person centred and enabling support for the individual.

Kirrie Connections have been commissioned to support the development of the Meeting Centre model to other Angus localities. The centres provide evidence-based support which includes a safe place where both people with dementia and their family Carers can adjust to living with dementia, access creative and stimulating activities and get effective advice and peer support.

We continue to develop the **Angus Care Model** to shift the balance of care from the traditional setting of hospitals to supporting people to live in a homely setting for as long as possible. The Angus Care Model has people at its heart, ensuring that services are fit for the future. The following illustration demonstrates the range of services available within the home, locality, Angus-wide and across Tayside.

The Angus Care Model



Our Vision, Mission and Values

Through engagement with the public and staff we revised our vision and clarified our values. Collectively these redefine our purpose as we continue to focus on making difference to health and wellbeing outcomes across Angus.

Our Vision

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

Our Mission

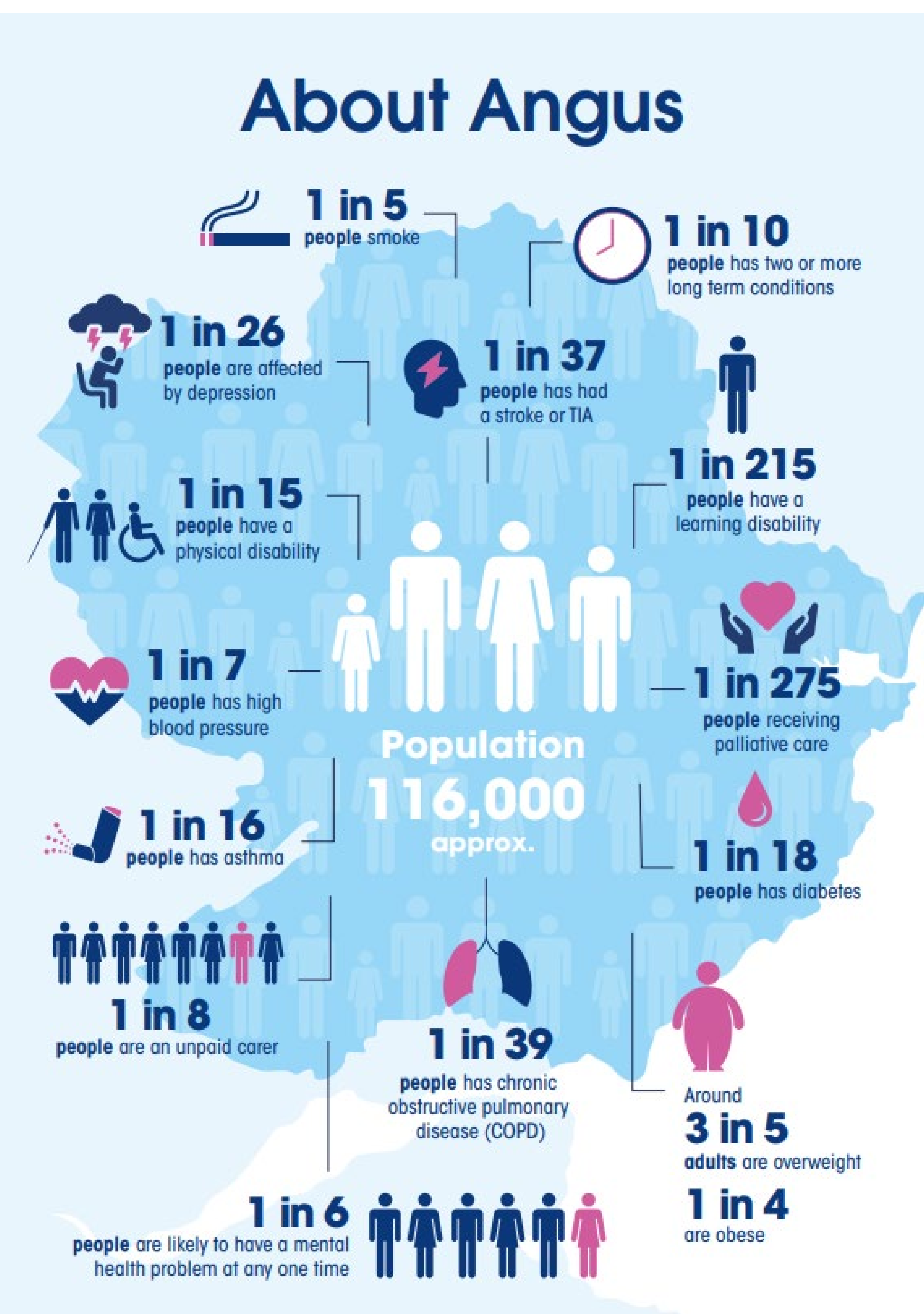
Working together, being courageous and innovative; always aiming to provide safe, effective and high-quality health and social care.

Our Values

Caring, compassionate, person-centred, honest and respectful.

The Case for Change

An understanding of the communities and people who live in Angus is vital as we plan the provision of health and social care services. We have used a range of population data as well as our own local intelligence. From the data, it is clear that Angus faces challenges of inequality demographic change. We are determined to target our services at these challenges using the resources we have at our disposal. Further details to support planning can be found in the Joint Needs Assessment Data and Housing Contribution Statement.


About Angus
1 in 5
people smoke
1 in 10
people has two or more long term conditions
1 in 26
people are affected by depression
1 in 37
people has had a stroke or TIA
1 in 215
people have a learning disability
1 in 15
people have a physical disability
1 in 7
people has high blood pressure
1 in 275
people receiving palliative care
Population
116,000
approx.
1 in 16
people has asthma
1 in 18
people has diabetes
1 in 8
people are an unpaid carer
1 in 39
people has chronic obstructive pulmonary disease (COPD)
Around
3 in 5
adults are overweight
1 in 4
are obese
1 in 6
people are likely to have a mental health problem at any one time

Our Population (Source National Records Scotland)

	Age Under 18	**21,172**
	Age 18 - 64	**66,484**
	Age 65-74	**15,410**
	Age 75-84	**9,433**
	Age 85+	**3,621**
Female **59,571** Male **56,549**	**All people**	**116,120**

For the ten-year period 2018 – 2028, the population of Angus is expected to slightly decrease. However, we expect there will be fewer people aged 65 and under which reduces the number of working aged adults. We also expect the number of people aged 75 years and over will increase by 30%. This has implications for service provision as evidence indicates that the older people become, they tend to have more long-term health problems.

Life Expectancy at birth (2021) (Source National Records Scotland)

	Angus	Scotland
Male	78	76
Female	82	81

Life expectancy in Angus has not grown over the period of the last strategic plan. This is similar to the picture across Scotland. People in Angus have a higher life expectancy than Scotland, however, there continues to be a real gap between life expectancy for those living in the most deprived areas of Angus where men can live approximately nine years less and women three years less than those living in the least deprived areas of Angus.

The proportion of life spent in good health varies, with men experiencing 81% of their life in good health (2% higher than the Scottish average) compared to women who spend 74% of their life in good health (2% less than the Scottish average).

Physical Disabilities

The 2011 census data suggests that there are approximately 7,489 Angus residents living with a physical disability. According to the Scottish Health Survey 2021, between 2011 and 2021, the percentage of women who were disabled increased from 30% to 39%. Over the same period the percentage of men who were disabled increased from 26% to 30%.

Learning Disabilities

The latest data in relation to the number of adults with Learning Disabilities and/or on the autism spectrum known to local authorities in Scotland* is 23,584 or 5.2 people per 1,000. Angus currently sits below the national average with 5.0/1,000 population. In February 2023, 512 people were supported by the Angus Learning Disabilities team.

*Scottish Consortium for Learning Disabilities Learning Disability Statistics Scotland 2019, published on 17 December 2019.

Carers

Carers are a vital part of the health and social care system in Angus and make a huge contribution to the people they care for and to communities throughout Angus. It is so important that we continue to support Carers to maintain their caring role.

Data from the 2011 census tells us that there were 10,582 Carers in Angus which equates to one in ten of the population. The Scottish Health Survey (November 2022) indicates that 13% or one in eight of Angus residents identify as a Carer, compared to the national average of 15%. 60% of the Carers

living in Angus are aged 65 years and over and 3% are aged under 16 years of age. Approximately 2,200 Carers are registered with Angus Carers Centre.

Mental Health

Mental health and physical health are often thought of as separate entities, but the two go hand in hand. Poor physical health can lead to an increased risk of developing mental health problems. Similarly, poor mental health can negatively impact on physical health, leading to an increased risk of some conditions.

Approximately one in four people experience a mental health problem at some point in their lifetime and approximately one in six (15,825) adults are likely to have a mental health problem at any one time in Angus (Scottish Health Survey). (No increase since 2017).

In 2021, one in six 5–16 year olds were estimated to have a probable mental health problem. (This has increased from one in nine in 2017).

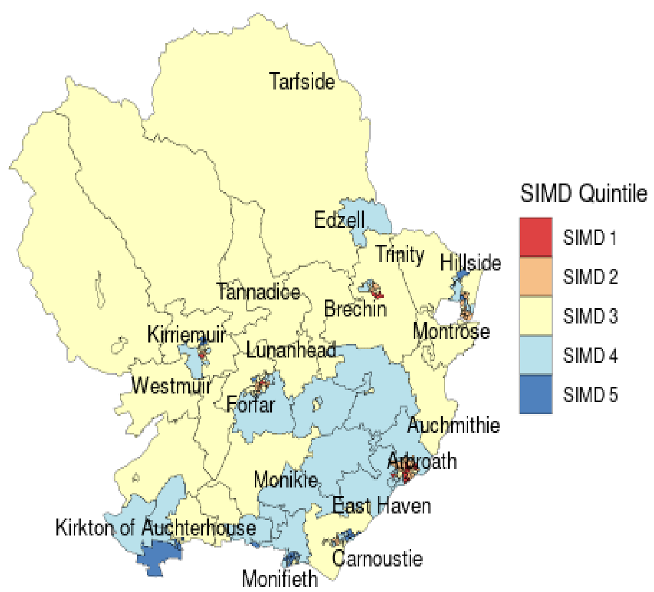
Mental health problems are not equally distributed across the population. Socially disadvantaged people have an increased risk of developing mental health issues to the extent that adults living in the most deprived areas are twice as likely to have common mental health problems as those in the least deprived areas (22% versus 11%).

Deprivation

The Scottish Index of Multiple Deprivation (SIMD), the official tool for finding the most deprived areas in Scotland, measures deprivation by dividing the Scottish population into fifths (Quintiles) according to the levels of deprivation in relation to access, crime, education, employment, health, housing and income.

Of the 2021 population in Angus, 7.7% live in the most deprived Quintile (SIMD 1) and 12% live in the least deprived Quintile (SIMD 5).

Map of Data Zones within Angus coloured by SIMD quintiles.



Source: Scottish Government, Public Health Scotland

When we compare data from 2016 with that from 2021, the percentage of people living in the most deprived Quintile has increased by 0.4% and the percentage of people living in the least deprived Quintile has decreased by 6.1%.

It is widely accepted that deprivation is linked to poorer health outcomes. The COVID-19 pandemic is likely to have had a disproportionately detrimental financial and social consequences impact on people living in more deprived areas. It is more important than ever to work with our partners to address the economic, environmental and social factors with form the structural determinants of inequalities.

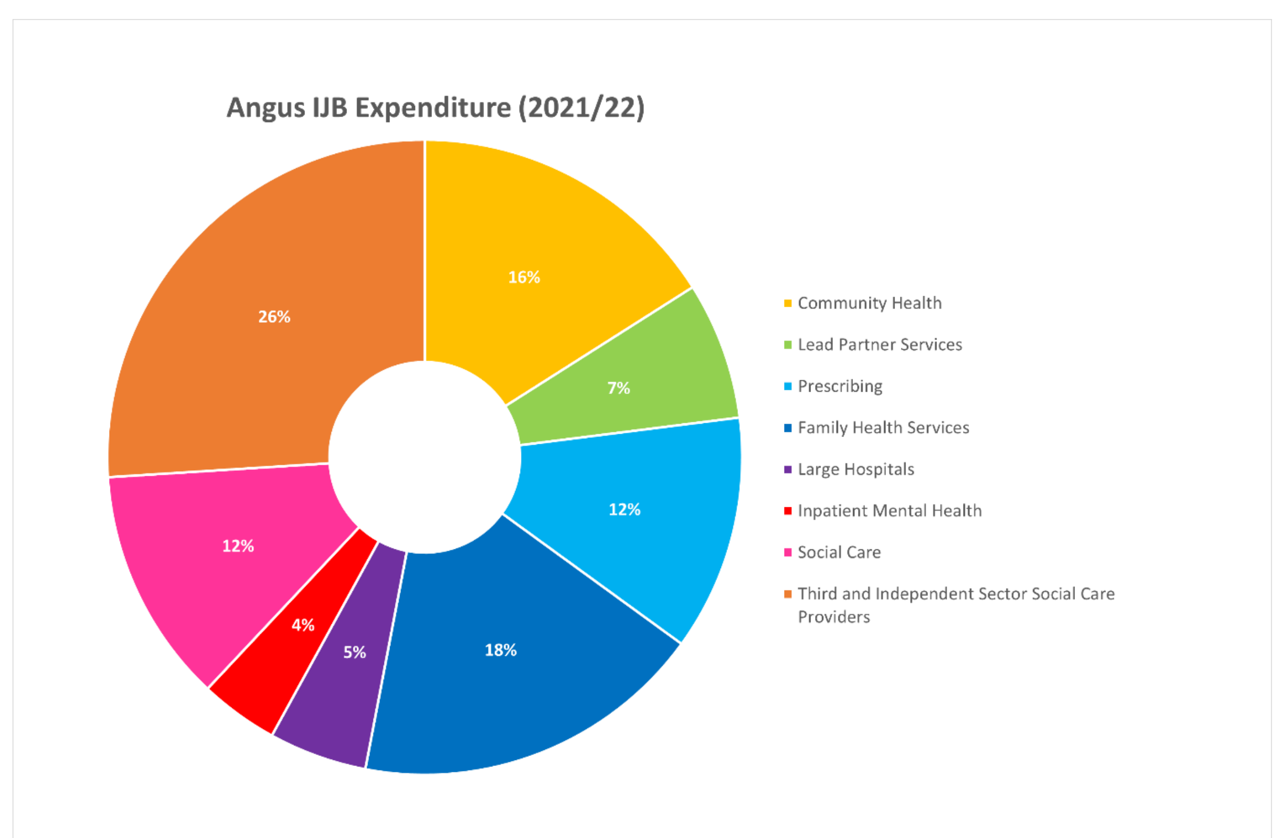
Financial Resources

Angus IJB's financial planning environment will be increasingly challenging for the duration of this Plan. This is consistent with the environment faced by the public sector generally and within Angus Council and NHS Tayside specifically. Both organisations face significant financial challenges and require Angus IJB to live within agreed devolved resources.

Angus IJB's Strategic Financial Plan (SFP) is intended to be consistent with, and a financial representation of, the IJB's Plan. Angus IJB has a responsibility to make strategic decisions that, alongside operational management, ensure that services can be delivered sustainably.

The final SFP for the period 2023-2026 for the Partnership will continue to be dependent on several factors including:

- The funding available to Angus IJB through Angus Council, NHS Tayside and the Scottish Government.
- Angus IJB has to absorb, manage, or contain inflationary, demographic, legal and service pressures annually.
- The scale and timing of change and interventions that the Angus IJB plans to progress in response to the above pressures.



In 2022/23 Angus IJB's budget will be circa £220 million. The shape of Angus IJB's future expenditure will be described in associated and future strategic financial plans. While Angus IJB previously anticipated that most volume or demographic growth would happen within social care (particularly home care) and prescribing, for the duration of this Plan it is more likely that financial and workforce pressures will mean demands have to be mitigated, where possible, rather than an assumption of the IJB being able to continue to meet increased demands.

National factors and initiatives such as the inflationary environment, the National Care Service and issues such as the further development of General Medical Services (GMS) contract will also affect the shape of our resources.

Angus IJB will also retain a Strategic Planning Reserve specifically intended to support the implementation of this Plan over the duration of the plan. The fund will be overseen by Angus IJB's SPG and will support interventions to facilitate the planning and delivery of this plan.

As resource management becomes increasingly challenging, using current resources as efficiently and effectively as possible is essential. The SDP identifies a number of areas of improvement and change and these will be further developed and inform the overall SFP. Angus IJB's financial planning assumptions will continue to be developed during 2023-26. We will continue to explore all opportunities and further develop the SDP to ensure we can deliver services within available resources.

Our Strategic Ambitions & Priorities for 2023-2026

The information outlined in the Strategic Needs Assessment, performance reports and the legislative and policy context highlight the need to do things differently. As a result, we have identified three **Strategic Ambitions**:

- Support people to be independent for as long as possible.
- Ensure services are sustainable and proportionate to need.
- Provide integrated and co-ordinated care.

We have identified the following **Strategic Priorities** to support these ambitions:

Priority 1. Prevention and proactive care.
Priority 2. Care closer to home.
Priority 3. Mental health and wellbeing & substance use recovery.
Priority 4. Equity of access and public protection.

We have identified a variety of high-level commitments to support the delivery of the priorities. Appendix 7 details the SDP the actions we will undertake over the next three years and how we will measure success. We have also identified five **Strategic Enablers** to help support the delivery of our Plan. These are:

- Workforce.
- Financial planning.
- Collaborative Commissioning.
- Communication and Engagement.
- Infrastructure, Data and Technology.

Priority 1: Prevention and proactive care

We want to tackle the various conditions that cause ill health and help people to age well and add healthy years to life.

Support people to look after their own health in a way which is manageable for them

We recognise that more needs to be done to improve the health and wellbeing of people in Angus at a scale and pace to realise our ambitions. The biggest difference will come from the things that people can do for themselves by taking control, whenever possible, of their own health and wellbeing. We want people to be able to:

- take responsibility for their own health and wellbeing, accessing services in a timely manner, keeping healthy, active and safe, including managing emerging and existing conditions.
- choose the right health care when they need it. This may be through self-care at home, visiting their local pharmacist or their General Practice.

We will maximise opportunities for integrated working across all teams to promote independence and wellbeing approaches. By working together, people will be able to take control of their lives, manage their conditions, and live with a sense of independence. An example of how this will be realised is a joint investment between Angus HSCP, Angus Council, ANGUSalive designed to achieve long term behaviour change in target areas identified to improve public health in Angus and contribute towards tackling health inequalities.

Build stronger and more resilient communities

We want to ensure that people have access to appropriate levels of information, advice and support to maintain their health, wellbeing and independence with the aim to see a reduction in the number of people engaging with services at a time of crisis.

Preventing and dealing with problems at an early stage prevents issues from becoming much more serious and difficult to address. This is why we will promote the adoption of self-care and self-management approaches.

Act early to anticipate healthcare needs

Everyone's heath is influenced by a range of factors for example childhood experiences, education, housing, income, employment, health, social support and the communities we live in. We will work with our partners and our communities to influence the positive change needed to address the deep-rooted inequalities, which impact on the health and wellbeing of people living in some parts of Angus.

Local prescribing resources will be used effectively

Angus HSCP continues to work in partnership with clinical leaders to deliver the vision for quality prescribing as set out in the Tayside Prescribing Strategy. In Angus we will facilitate best practice, with safe, high quality prescribing choices; enable shared decision making with an informed, empowered patient; nurture innovation and enable change and ensure governance, systems and processes support quality prescribing. This approach will ensure the ongoing financial challenges in relation prescribing are addressed through a refreshed focus on prevention, best value, waste minimisation and reduction in unwarranted variation.

Where do we want to be by 2026?

- People are better informed about what they can do to help themselves maintain and improve their health and wellbeing.
- Increased availability of evidence-based exercise programmes to support people to maintain and improve their health and wellbeing.
- Reduce the variation in the way medicines are prescribed, undertaking medication reviews and increasing awareness and availability of evidence-based alternatives to a prescription.
- People in Angus are more aware of how they can reduce their risk of falling.

- Increased use of anticipatory care planning so people are more informed regarding support, care and treatment available for their mental and physical health, which supports making choices about planning for the future.

Priority 2: Care Closer to Home

Provide care closer to home whenever possible

People tell us that they would like to live independently in their own homes and in their community for as long as possible.

We know that there are people waiting to be assessed and there are people who have been assessed and are waiting to receive a care package. This is not acceptable. We need to do everything we can to make sure people who are assessed as requiring services receive the support they require. To do this, we need to work together with families, friends and communities to make sure we direct our finite resources to those who need us most. Actions have been identified and aimed to support people to stay at home, avoid unnecessary admissions to hospital and support timely discharge from hospital.

We will continue to develop our Angus Care Model which is shifting the balance of care from the traditional setting of hospitals to supporting people to live at home or in a homely setting for as long as possible. This will mean that no one will be in hospital unless they need to be, and no one is in hospital longer than they need to be.

We will work to ensure care home and care at home provision is sustainable and the quality of care is measurable so that people will have access to sufficient supply of quality services.

Palliative and end of life care (PEOLC) and support is everybody's business. Though we have become good at prolonging life, we still cannot prevent death. There are, however, many ways we can improve people's experience of death, dying and bereavement. Working with and through the Tayside

PEOLC Managed Clinical Network we will continue to work to ensure we can provide the best palliative and end of life care and support we can.

Work with partners to provide the right care in the right place at the right time

We will review all community services to ensure they are fit for purpose and sustainable for the future. This will ensure services meet the needs of the local community and will be realistic and adaptable.

There are currently improvement plans in place for the Learning and Physical Disability and Adult Mental Health Services which contain actions to address this priority area. These will continue to be progressed over the next three years.

We acknowledge the recommendations within the Scottish Government Coming Home Implementation Report (2022) aimed to support people with complex needs and learning disabilities in their local communities. It will be necessary to balance this requirement with our available resources and statutory duties.

Angus HSCP is heavily reliant on services commissioned externally from the Independent Providers and Third Sector and we are committed to working with our partners to ensure the stability and sustainability of these service providers. We will work with all our partners to enhance the whole-system use of assets to better support the delivery of care and boost local resources through better linked-up, partnership working with Third Sector and Independent Providers.

Support Carers to sustain their caring role and enable them to have a fulfilling life alongside caring

Carers have a vital role in the delivery of health and social care. Carers tell us that they experience challenges accessing support and we know that the COVID-19 pandemic impacted on them significantly. Through the development and implementation of the Angus Carers Strategy, 2023-2026, developed in partnership with Carers, we will support Carers in their caring role and help them to have a fulfilling life outside their caring role.

Where do we want to be by 2026?

- Reduce the number of hospital admissions, length of stay in hospital, occupied bed days and delayed discharges.
- Have an equitable and sustainable model of care home and care at home provision which best meets people's needs and available within their locality.
- Reduce variation in community care provided across Angus localities including access to care provided at home rather than in hospital.
- Reduce hospital attendances and admissions, length of stay, occupied bed days and delayed discharges.
- Multidisciplinary Teams are available in primary, community and social care settings in each locality so people are seen closer to home whenever possible and appropriate to do so.
- Continue to work with Third and Independent partners to be responsive to the changing needs of Angus service users.
- Increase the number of Carers who feel supported to continue in their caring role.

Priority 3: Mental Health and Wellbeing and Substance Use Recovery

Deliver the ambitions of the Angus Living Life Well Improvement Plan

We want to work together to reduce stigma and discrimination often surrounding mental health, putting it on an equal par with physical health.

In June 2022, Angus IJB approved the Angus Living Life Well Plan (LLW) which identified the following themes:

- Good Mental Health for All - Helping people to know what to do to keep themselves mentally well.
- Primary and Community Mental Health - Getting help from GP practices and local community support networks quickly so that people can get back to feeling well.
- Specialist Adult Mental Health – Improvements in access and delivery of specialist mental health services for adults.

- Older People's Mental Health – focus on improvements for specialist mental health services for people over the age of 65 years.
- Leadership and Culture.

The actions within the Angus LLW Implementation Plan support the delivery of the priorities identified in the Tayside Living Life Well Strategy. This plan will be reviewed in line with Tayside Mental Health and Learning Disability Services Improvement Plan which has been prepared in response to six recommendations set out in the final report of the Independent Oversight and Assurance Group into Tayside Mental Health Services published in January 2023.

Support people to recover or manage their condition

The number of people with mental health and wellbeing needs including substance use, has increased particularly as a consequence of the pandemic. It is important that we provide access to prevention and self-management in local communities as well as access to specific resources for people with complex needs.

We will continue to play an active role in the Angus Alcohol and Drug Partnership (ADP) which is the strategic, multiagency group tasked by the Scottish Government to reduce harm caused by alcohol and drug use. One of the priorities of the Angus ADP Strategic Delivery Plan 2020-2023 focuses on a recovery approach which reduces harms and prevents alcohol and drugs deaths with the outcome that recovery is visible and celebrated across Angus. When people need services, they are easy to access "the right service at the right time" and are good quality, providing compassionate responses that are trauma informed and person and family centred. Another priority is focused on embedding a whole family/whole system approach across Angus services.

Deliver Medication Assisted Treatment Standards for people using drugs and alcohol

In 2021, the Scottish Government published the Medication Assisted Treatment (MAT) national standards. These are evidence-based standards to enable the consistent delivery of safe, accessible, high-quality drug treatment across Scotland. These are relevant to people and families accessing or in need of services, and health and social care staff responsible for delivery of recovery-oriented systems of care.

Where do we want to be by 2026?

- Reduced waiting times with access to the right support at the right time in the right place. This will include implementation of community mental health and substance use hubs in all four Angus localities to provide co-located GPs, mental health, substance services and wellbeing services. The hubs will provide one referral route for mental health and wellbeing and substance services with no wrong door and no rejected referral, so people are supported by specialist multidisciplinary teams providing support in communities rather than in hospitals and reduced timescales for prescribing.
- Consistent delivery of safe, accessible, high-quality drug and alcohol treatment across Angus via implementation of the Medication Assisted Treatment (MAT) national standards
- Increased awareness of suicide prevention.
- All those with a diagnosis of dementia will have access to post-diagnostic dementia support for the first year of diagnosis.
- All those who have shared care plans in place with Primary Care for the treatment of mental health will have their treatment reviewed in line with the shared care plan.

Priority 4: Equity of access and public protection

Remove barriers to accessing services and address inequalities

GPs have a unique role in identifying the non-medical causes of disease. Despite increasing workload and issues with recruitment and retention, General Medical Services (GMS) provided by GPs and their multidisciplinary colleagues provide a vital frontline service. The 2018 GMS contract and associated Memorandum of Understanding, aims to create a sustainable model of general practice through the development of an enhanced multidisciplinary team working in and around general practice, enabling GPs to have more capacity to fulfil their role as Expert Medical Generalists. We want to modernise and transform Primary Care services to ensure sustainability.

We know that improvements are required for people who have a physical and/or mental health need that does not require emergency care but cannot wait until a pre-planned care appointment; this is referred to as urgent and unscheduled care.

Reducing homelessness

A person's home has a crucial role in improving the health and wellbeing of people in Angus. It is vital that there is adequate provision of appropriate housing and housing related support for those who need it. The Housing Contribution Statement sets out the role and contribution of the local housing sector in meeting the outcomes and priorities of this Plan.

The proportion of people applying as homeless has steadily decreased over the past five years. Proposed changes to Homelessness Prevention legislation aim to ensure homelessness is prevented at an earlier stage. Angus HSCP has worked with Housing partners on actions identified within the Angus Rapid Rehousing Transition Plan, including the development and implementation of Housing First and undertaking a strategic homelessness support needs assessment to help inform the future delivery of support and supported housing for homeless households with complex support needs.

Keep vulnerable people safe

We continue to develop and enhance arrangements to ensure the most vulnerable within our communities are protected and kept safe.

We want to continue to improve our ability to promote and protect people's human rights, including social and economic rights and meet our duties under human rights law, through our services and support. We will continue to contribute to the work of Protecting People Angus, the collective term for the multi-agency committees, partnerships and networks in Angus that work together to develop the shared agenda, ensure collaboration and coordination, make best use of available resources and consider a whole family approach to care, wellbeing and protection.

Where do we want to be by 2026?

- We will deliver physical and/or mental urgent health and care needs as close to home as appropriate, in a timely way, ensuring our resources deliver the best possible health and care outcomes 24/7.
- Improved access to housing support for people at risk of homelessness.
- Increase the number of staff who have completed the Angus core Roles and Responsibilities in adult protection training and expand our number of council officers.

Strategic Enablers

Our 'Strategic Enablers are areas of activity which apply across all of the services provided and activity undertaken by Angus HSCP. The enablers inform this Plan and are the foundations which ensure that we are equipped to deliver on our priorities.

Workforce

Angus HSCP comprises a total of around 4,900 Social Work (Angus Council) and Health (NHS Tayside) staff. In addition, there are a number of people who are engaged in health and social care in the Independent Sector for example Primary Care, care home and care at home providers and the Third sector.

Carers in Angus also play a vital role within the Angus HSCP as part of its broader workforce. Most recent estimates suggest that there are approximately 16,800 adult Carers (18+) in Angus.

The Angus HSCP **Workforce Plan 2022-2025** includes a Workforce Implementation Action Plan, sets out how we aim to make sure we have a workforce which is fit for purpose and is enabled to deliver to meet the current and future needs of those who rely upon our services. The plan also details what we will do to anticipate future workforce needs, based on legislative requirements, changes in demographics, the impact of ongoing change implementation and in particular a shift towards the provision of more community-based health and care services.

Financial Planning

Angus HSCP is committed to targeting its resources to support our long-term conditions. Details of the financial planning environment are detailed in Section related to Financial Resources.

Collaborative Commissioning

The Market Facilitation Statement sets out how we intend to build on current practice and maximise opportunities for collaborative commissioning with the aim of improving services, outcomes, processes and efficiency. We have moved a long way from the traditional commissioner/provider role to one of a more joined up, integrated approach and we plan to build on this during the lifetime of this Plan. As an example, we will:

- Further develop contracting frameworks with providers to ensure best value, to create an effective contracting mechanism and support the sustainability of our providers

Communication and Engagement

Sustainable change requires effective communication and involvement with the people who live and work in Angus so we can find out what matters to them. Our approach to communication and engagement has been outlined

in the earlier section regarding 'Working in Partnership – with the people of Angus'.

The duty to involve people in the design and delivery of care services was strengthened with the introduction of the Community Empowerment (Scotland) Act 2015. Participation is also a key element of a Human Rights based approach, which requires that people be supported to be active citizens and that they are involved in decisions that affect their lives.

We will continue to strengthen our relationships with our partners, workforce and people who use services and continue to ensure our services are person-centred, informed by robust data and are evidence based.

During the lifetime of this Plan, we will review and refresh our Communication and Engagement Plan and will continue to provide regular opportunities for stakeholders, people who use services and communities to engage with us as we make the changes that are required to implement our strategic priorities.

Infrastructure, Data and Technology

Infrastructure: It is essential that the property and assets we use for the delivery of health and social care are fit for purpose and driven and shaped by the needs and demands of services. Consideration also needs to be given to transport for service users, their families and Carers to access services as easily as possible.

Data: The Performance Steering Group brings together representatives of Angus HSCP services, NHS Tayside and Angus Council to provide assurance that systems and procedures are in place to monitor, manage and improve overall performance and best value is achieved from resources.

Technology: The COVID-19 pandemic has shown us that the health and wellbeing of the people can be enhanced and transformed through the use of digital technology. In 2022 Angus HSCP formed the Angus Digital Partnership Group bringing together representatives of Angus HSCP services,

NHS Tayside and Angus Council to support and develop digital projects which link with and/or impact on the business of the Health and Social Care Partnership. These projects will be developed in line with both Angus Council and NHS Tayside Digital Strategies and include:

- Continue to explore opportunities to utilise technology to support people to manage their own health and wellbeing and remain living independently. This includes the switch from analogue to digital care at home services by 2025. Further develop contracting frameworks with providers to ensure best value, to create effective contract mechanism and to support the sustainability of our providers, including embedding single-handed care.
- Deliver a working environment which is agile, mobile and using the most appropriate technologies to support service delivery with shared access to agile environments and infrastructure in any property regardless of employing authority. This will include exploring the implementation of an electronic patient record to support staff with the demands of their roles.
- Improved use of data, manage data more accessible through online channels, increasing accessibility and transparency. This will require delivery of improvement in data quality.

How we will know we have made a difference

The SDP (Appendix 7) provides details of the programmes of work and projects to be undertaken in relation to each priority, the timescale within which it will be delivered and the strategic measures. It is important to recognise that at April 2023, this Plan, and the associated SDP and SFP does not yet demonstrate that it is affordable over its 3-year duration. The SDP is a working document which will be reviewed, and progress monitored via the SPG and the IJB. Specific actions may be added, updated or amended in response to emerging needs to deliver within our financial framework.

We will continue to collect qualitative data which provides evidence of people's experience of using health and social care services in Angus. We will also continue our conversation with the people of Angus to ensure people are involved in shaping health and social care services in Angus.

Actions in the SDP will seek to improve our performance on all the indicators in our Annual Performance Report indicators but particularly those which show a declining trend.

We will continue to report our progress via our Annual Performance Reports and biannual performance reports. Actions detailed within the Strategic Delivery Plan (SDP) (Appendix 7) seek to improve our performance on these indicators but particularly those which show a declining trend. As we refine the SDP, we will make sure we deliver services within the resources available to us.

Each of the four localities in Angus will play a crucial role in delivering the Plan via their Locality Improvement Plan.

Appendix 1

National Health and Wellbeing Outcomes

The national health and wellbeing outcomes apply across all integrated health and social care services, ensuring that Health Boards, Local Authorities and Integration Authorities are clear about their shared priorities by bringing together responsibility and accountability for their delivery. They provide a strategic framework for the planning and delivery of health and social care services. Our priorities, commitments and the actions within the Strategic Delivery Plan (SDP) (Appendix 7) are aligned to delivering the national outcomes. The nine outcomes are:

Outcome 1	People are able to look after and improve their own health and wellbeing and live in good health for longer.
Outcome 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.
Outcome 3	People who use health and social care have positive experiences of those services and have their dignity respected.
Outcome 4	Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.
Outcome 5	Health and social care services contribute to reducing inequalities.
Outcome 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 in their own health and wellbeing.
Outcome 7	People who use health and social care services are safe from harm.

Outcome 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.
Outcome 9	Resources are used effectively and efficiently in the provision of health and social care services.

Appendix 2 Framework for Community Health and Social Care Integrated Services

A Framework for Community Health and Social Care Integrated Services

Principles of Integration

National Health and Wellbeing Outcomes

People look after & improve own health	Carers supported to look after own health	People live independently at home	Positive experience of care	Reduced health inequalities	Staff supported & engaged in their work	People benefit from improved quality of life	People are safe from harm	Resources are used effectively

Sharing good practice to integrate care and improve outcomes

Characteristics of Effective Integrated Care

People are supported to self-manage	People set their own goals and priorities	People are safe & have equality of opportunity	Professionals know roles and responsibilities	Integrated MDTs aligned to GP Practices	GPs support those with most complex needs	Focus on care and support at home	People can easily access help & support	Targeted care & support to meet changing needs	Focus on early intervention & prevention

Promoting healthy, independent living, supporting people to:	Improving outcomes by working more effectively to deliver:	Making services more accessible and responsive by developing:
Adopt an assets based approach	Fully integrated community teams	First Point of Contact
Manage their own conditions	Teams aligned to General Practice	Anticipatory Care Planning
Connect with their communities	Seamless working with acute care	Reablement within all services
Live independently at home or homely setting	Enhanced Care in Care Homes and Supported Accommodation	Short-term, targeted interventions to meet more complex needs

Building services on a foundation of CARE

Come together with individuals and those who care for them to assess their needs	Adopt a Care Co-ordination approach to offer a consistent, single point of contact	Respond positively and proactively to an individual's needs as they change	Empower and encourage individuals to express choice and take control

Enablers for Organisational Development

- Collaborative Leadership
- Shared Accountability
- Clarity of Vision
- Well Developed Relationships
- Culture and Values
- Strong Team Ethos
- Clinical and Care Governance

Enablers for Strategic Planning and Service Delivery

- Aligned Strategic, Financial, Operational, Workforce and Primary Care Improvement Plans
- Fit for Purpose Premises and Agile Working
- Information Sharing Arrangements
- Robust Management Information
- Well Developed Lead Professional Role

Appendix 3 Scottish Government Health and Social Care Standards

1. I experience high quality care and support that is right for me.
2. I am fully involved in all decisions about my care and support.
3. I have confidence in the people who support and care for me.
4. I have confidence in the organisation providing my care and support.
5. I experience a high-quality environment if the organisation provides the premises.

Appendix 4 National policy, legislation, regulations and guidance

- Advocacy Strategy- refreshed in 2018
- Carers (Scotland) Act 2016
- NHS Recovery Plan 2021-2026
- Enabling Connecting and Empowering: Care in the Digital Age – Scotland's Digital Health and Care Strategy 2021
- National Mental Health Strategy 2017 - 2027
- Mental Health – Scotland's Transition and Recovery Plan (October 2020)
- National Workforce Strategy for Health and Social Care (2022)
- Recovery and Redesign: An Action Plan for Cancer Services (December 2020)
- National Cancer Strategy Refresh (April 2022)
- A National Clinical Strategy for Scotland (2016)
- General Medical Services Contract in Scotland (2018)
- Public Health Scotland Strategic Plan 2022 – 2025
- Protecting Scotland-Renewing Scotland 2020
- Coming Home Report
- My health, my care, my home
- Delivering Value Based Health & Care
- Care in the Digital Age: Delivery Plan 2022-2023
- Planning with People Guidance
- Public Health Strategy Refresh (2022)
- NHS Scotland Recovery Plan
- Greater access, better insight, improved outcomes: a strategy for data-driven care in the digital age.

Appendix 5 Angus and Tayside-wide Plans and Strategies

- Angus Communities Plan
- Angus Housing Strategy (currently under review)
- Angus NHS Tayside Digital Strategy 2021 -2026
- NHS Tayside Annual Delivery Plan
- Tayside Prescribing Strategy
- Tayside Mental Health and Learning Disabilities Improvement Plan
- Angus Rapid Rehousing Transition Plan
- Angus Alcohol and Drug Partnership Strategic

Appendix 6 Angus HSCP Improvement Plans

- Living Life Well – A Lifelong Approach to Mental Health in Tayside (2021)
- Angus HSCP Workforce Plan 2022 – 2025
- Angus Carers Strategy 2019 – 2023 (currently under review)
- Angus HSCP Communication and Engagement Plan (2020 – 2023)
- Learning Disability Improvement Plan
- Physical Disability Improvement Plan
- Angus HSCP Advocacy Plan 2022-2025
- ADP Improvement Plan
- Angus HSCP Remobilisation Plan
- Primary Care Improvement Plan
- Angus Living Life Well Plan

Appendix 7 Strategic Delivery Plan and Measures

Priority 1 Prevention and Proactive Care

Strategic Measures to include:

- NI 1 - % of adults able to look after their health very well or quite well.
- NI 7 - % of adults supported at home who agree that their services and support had an impact on improving or maintaining their quality of life.
- NI 11- Premature mortality rate per 100,000 persons.
- NI 16 - Falls rate per 1,000 population aged 65+.
- All older people being discharged from hospital to a long-term care setting should have an Anticipatory Care Plan developed prior to their discharge.
- National Therapeutic Indicators.

What we will do	**Year 1 23/24**	**Year 2 24/25**	**Year 3 25/26**
Promote ways to keep people healthy			
Work with partners to enable and support individuals and communities to take ownership of their health and wellbeing e.g. improving the quality and access to information and activities that promote a healthy lifestyle.	✓	✓	✓
Explore and introduce evidence-based alternatives to a medicines first approach e.g. Nature Prescriptions.	✓	✓	✓
Explore and improve the provision of condition specific exercise classes provided across Angus e.g. falls prevention, stroke rehabilitation and pulmonary rehabilitation.	✓	✓	✓
Together with NHS Tayside, explore opportunities to help people look after themselves while they are on a waiting list for treatment.	✓	✓	✓

Continue to review and support the self-management of long-term conditions and promote digital solutions.	✓	✓	✓
Provide targeted support for quality improvements in prescribing.	✓	✓	✓
Build stronger and more resilient communities			
Promote the range of private sector services available in community.	✓	✓	✓
Increase community involvement through existing networks and look to build new ones.	✓	✓	✓
Refresh and deliver Locality Improvement Plans and report on progress.	✓	✓	✓
Act early to anticipate need			
Increased focus on planning for the future so potential issues will be identified before they become a crisis.	✓		
Promotion of digital solutions to support independence e.g. Independent Living Angus Platform and LifeCurve.	✓	✓	✓
Ensure young people who require services as adults receive the support to meet their needs.	✓		

Priority 2: Care Closer to Home

Strategic Measures to include:

- NI 2 - % of adults supported at home who agree that they are supported to live as independently as possible.
- NI 3 - % of adults supported at home who agreed that they had a say in how their help, care or support was provided.
- NI 4 - % of adults supported at home who agreed that their health and social care services seemed to be well co-ordinated.
- NI 5 – Total % of adults receiving any care or support who rated it as excellent or good.
- NI 8 – Total combined % of Carers who feel supported to continue in their caring role

- NI 12 - Emergency admission rate per 1000,000 population
- NI 13 - Emergency bed day rate per 100,000 population
- NI 14 - Readmission to hospital within 28 days per 1,000 population
- NI 15 - Proportion of last 6 months of life spent at home or in a community setting
- NI 18 - % of adults with intensive care needs receiving care at home
- NI 19 – Number of days people aged 75+ spend in hospital when they are ready to be discharged, per 1,000 population
- NI 20 - % of health and care resource spent on hospital stays where the patient was admitted in an emergency

What we will do	**Year 1 23/24**	**Year 2 24/25**	**Year 3 25/26**
Provide care closer to home whenever possible			
Explore delivery options to meet unmet need in care at home provision.	✓		
Continue to build the community stroke rehabilitation pathway.	✓	✓	
Develop a property plan to ensure that care is provided in the most appropriate location.	✓		
Implement Healthcare Framework - My Health, My Care, My Home.	✓	✓	✓
Revise care provision models to allow a greater proportion of delivery of healthcare tasks by social care staff in community settings.		✓	
Explore and improve the delivery of health and social care closer to home preventing the need for admission to hospital and focus on early discharge.	✓		
Commissioning of reliable, sustainable service provision that meets required quality standards and provides the choice to meet their individual needs.	✓	✓	✓
Refresh the Angus Palliative and End of Life Care Plan 2019	✓		

– 2023.			
Introduce an Electronic patient record for community nursing and Allied Health Professionals to enable community staff to have mobile access to person’s clinical information.	✓	✓	
Continue to work with partners to provide the right care in the right place at the right time			
Continue to develop and implement the Angus Primary Care Improvement Plan and the Angus Primary Care Premises Strategy.	✓	✓	✓
Continue to develop and implement the physical and learning disability improvement plans and develop an older people’s services improvement plan.	✓	✓	✓
Explore how we can ensure that people access the right type of care and support regardless of which care home they live in.	✓		
Identify local opportunities which will contribute to the development and implementation of the Tayside Primary Care Strategy.	✓	✓	✓
Undertake a strategic review of the GP Out of Hours service to ensure the sustainability and provision of accessible services.	✓	✓	✓
Complete the review of day care provision.	✓		
Review the delivery model for community meals.		✓	
Review the delivery model for community alarm.	✓		
Review how people are supported to take their medications in the community so that people receive support from the most appropriate person.	✓		
Ensure people’s homes meet their needs especially in relation to equipment, adaptations and use of telecare.	✓	✓	✓
Develop a framework for decision-making and eligibility criteria for complex care packages.	✓		

Support Carers to sustain their caring role and enable them to have a fulfilling life alongside caring			
Refresh the Angus Carers Strategy with a focus on the priority areas of visibility, empowerment, life-balance, influencing and equity.	✓	✓	✓
Improved access to support for Carers and hard to reach groups	✓	✓	✓

Priority 3 Mental Health & Wellbeing and Substance Use Recovery

Strategic Measures in relation to Mental Health and Wellbeing are in the process of being finalised. Once approved they will be added here.

- MAT Standards

What we will do	Year 1 23/24	Year 2 24/25	Year 3 25/26
Deliver the ambitions of the Angus Living Life Well Improvement Plan			
Continue to develop specialist mental health multi-disciplinary teams providing mental health care in communities rather than in hospitals, developing new roles for staff and pathways of care in the community.	✓	✓	✓
Improve access to high quality suicide prevention training.	✓		
Support people to recover or manage their condition			
Improve social support, prevention and self-management opportunities for people with mental distress.	✓		
Provide consistent delivery of safe, accessible, high quality drug and alcohol treatment across Angus			
Continue to develop multi-disciplinary teams providing substance use services in communities. Developing new roles for staff and integrated pathways of care to holistically meet care and treatment needs in a timely manner.	✓	✓	

Further develop pathways of care to ensure people at high risk of drug and alcohol related harm are identified early and offered support.	✓		
Work with Healthcare Improvement Scotland and local partners to develop and deliver pathways of care that ensure people with co-occurring mental health difficulties can receive mental health care.	✓		

Priority 4 Equity of access to high quality health and social care

What we will do	Year 1 23/24	Year 2 24/25	Year 3 25/26
Remove barriers to accessing services			
Revise the Angus Equalities Mainstreaming Report (AEMR) prior to the 2024 deadline and deliver on the outcomes identified within the AEMR.	✓		
	✓	✓	
Ensure staff understand the levels of inequality in Angus to enable improved decision making that makes a positive contribution to reducing health inequalities.	✓	✓	✓
Work with Community Planning partners to mitigate against the impact of inequalities across our communities to ensure an integrated approach to reducing inequalities.	✓	✓	✓
Progress actions to improve access to advocacy services as outlined in the AHSCP Advocacy Plan 2022-2025 so all adults, Carers and care experienced children and young people will have timely access to advocacy services allowing them to have their voices heard and interests protected in relation to their care.	✓		
Work with Angus Council to expand housing options so more people can live independently in their own homes.			

Reduce homelessness			
Develop new models of support for people at risk of homelessness with the aim to reduce the number of people who are registered as homeless.	✓	✓	✓
Continue to implement the national Ending Homelessness Together strategy and Angus Rapid Rehousing Transition Plan in collaboration with housing partners and other stakeholders.	✓	✓	✓
Continue with the implementation of the homelessness service review, embedding a person centred, trauma informed response to preventing and addressing homelessness.	✓	✓	✓
Keep vulnerable people safe			
Progress quality assurance and improvement work in protection across all services to protect individuals who may be at risk of harm.	✓	✓	✓