**Appendix 1**

ANGUS Health & Social Care Partnership

# Strategic Delivery Plan

## Version 5 February 2024

| Status Description | | Total |
|---|---|---|
| | Blue (Complete) | 1 |
| | Green (On track) | 35 |
| | Amber (Some concerns with meeting deadlines) | 6 |
| | Red (Requires urgent action) | 0 |
| | Activity commencing in 2024/25 | 1 |
| | | **43** |

## Priority 1: Prevention and Proactive Care

| **What we will do** | | Year 1 23/24 | Year 2 24/25 | Year 3 25/26 | Status |
|---|---|---|---|---|---|
| **Promote ways to keep people healthy** | | | | | |
| 1.1 | Work with partners to enable and support individuals and communities to take ownership of their health and wellbeing, this includes whilst awaiting treatment e.g. improving the quality and access to information and activities that promote a healthy lifestyle, increase community involvement through existing networks and look to build new ones. | ✓ | ✓ | ✓ | |
| 1.2 | Explore and introduce evidence-based alternatives to a medicines first approach e.g. Nature Prescriptions, self-management of long-term conditions (condition specific exercise classes including digital solutions). | ✓ | ✓ | ✓ | |
| 1.3 | Provide targeted support for quality improvements in prescribing. | ✓ | ✓ | ✓ | |
| **Build stronger and more resilient communities** | | | | | |

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| 1.4 | Refresh and deliver Locality Improvement Plans and report on progress. | ✓ | ✓ | ✓ | |
| **Act early to anticipate need** | | | | | |
| 1.5 | Increased focus on 'planning for the future' so potential issues will be identified before they become a crisis. | ✓ | ✓ | ✓ | |
| 1.6 | Identification and promotion of telecare solutions to support independence at home. | ✓ | ✓ | ✓ | |
| 1.7 | Ensure young people who require services as adults receive the support to meet their needs. | ✓ | ✓ (Revised) | | |

**Priority 2: Care Closer to Home**

| **What we will do** | | Year 1 23/24 | Year 2 24/25 | Year 3 25/26 | Status |
|---|---|---|---|---|---|
| **Provide care closer to home whenever possible** | | | | | |
| 2.1 | Continue to build the community stroke rehabilitation pathway. | ✓ | ✓ | | |
| 2.2 | Develop a property plan to ensure that care is provided in the most appropriate location. | ✓ | ✓ (Revised) | ✓ | |
| 2.3 | Plan and Implement Healthcare Framework - My Health, My Care, My Home. | ✓ | ✓ | ✓ | |
| 2.4 | Revise care provision models to allow a greater proportion of delivery of healthcare tasks by social care staff in community settings. | ✓ | ✓ | | |
| 2.5 | Improve the delivery of health and social care to reduce unnecessary admissions to hospital and improve the hospital discharge pathway. | ✓ | ✓ | ✓ | |
| 2.6 | Commissioning of reliable, sustainable service provision that meets required quality standards and provides the choice to meet people's needs. | ✓ | ✓ | ✓ | |
| 2.7 | Review and identify improvements for the Angus Palliative and End of Life Care Plan 2019 – 2023. | ✓ | ✓ (Revised) | ✓ | |
| 2.8 | Introduce an Electronic Patient Record (EPR) for community nursing and Allied Health Professionals to enable community staff to have mobile access to a person's clinical information. | ✓ | ✓ | ✓ | |

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| **Continue to work with partners to provide the right care in the right place at the right time** | | | | | |
| 2.9 | Continue to develop and implement the Angus Primary Care Improvement Plan | ✓ | ✓ | ✓ | |
| 2.10 | Implement the Angus Primary Care Premises Strategy | ✓ | ✓ | ✓ | Action paused |
| 2.11 | Continue to develop and implement the physical and learning disability improvement plans | ✓ | ✓ | ✓ | |
| 2.12 | Develop and implement an older people's services improvement plan (including Care Management, Psychiatry of Old Age, Medicine for the Elderly, Accommodation & Home Care, Self-Directed Support) to ensure people access the right care at the right time. | ✓ | ✓ | ✓ | |
| 2.13 | Identify local opportunities which will arise from the development of the Tayside Primary Care Strategy. | ✓ | ✓ | ✓ | |
| 2.14 | Undertake a strategic review of the GP Out of Hours service to ensure the sustainability and provision of accessible services. | ✓ | ✓ | ✓ | |
| 2.15 | Complete the review of day care provision. | ✓ | | | |
| 2.16 | Review the delivery model for community meals. | | ✓ | | |
| 2.17 | Review the delivery model for community alarm. | ✓ | | | |
| 2.18 | Ensure people who require support to take their medication receive this from the most appropriate person, reducing duplication of visits. | ✓ | ✓ | | |
| 2.19 | Ensure people's homes meet their needs especially in relation to equipment and adaptations. | ✓ | ✓ | ✓ | |
| 2.20 | 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:** | | | | | |
| 2.21 | Refresh and implement the actions within the Angus Carers Strategy with a focus on the priority areas of visibility, empowerment, life-balance, influencing and equity. | ✓ | ✓ | ✓ | |

**Priority 3: Mental Health & Wellbeing and Substance Use Recovery**

| **What we will do** | Year 1 23/24 | Year 2 24/25 | Year 3 25/26 | Status |
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| **Deliver the ambitions of the Angus Living Life Well Improvement Plan** | | | | | |
| 3.1 | Deliver actions in the mental health and wellbeing Living Life Well Plan to improve leadership and culture, and quality of care in Specialist Adult Mental Health and Older People's Mental Health Services. | ✓ | ✓ | ✓ | |
| **Support people to recover or manage their condition.** | | | | | |
| 3.2 | Deliver actions in the mental health and wellbeing Living Life Well Plan to deliver good mental health for all, and improve Primary and Community Mental Health, including suicide prevention. | ✓ | ✓ | ✓ | |
| **Provide consistent delivery of safe, accessible, high-quality drug and alcohol treatment across Angus** | | | | | |
| 3.3 | 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. | ✓ | ✓ | | |
| 3.4 | Further develop pathways of care to ensure people at high risk of drug and alcohol related harm are identified early and offered support. MAT Standards. | ✓ | ✓ | | |
| 3.5 | 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. MAT Standards. | ✓ | ✓ | | |

**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 | Status |
|---|---|---|---|---|---|
| **Remove barriers to accessing services** | | | | | |
| 4.1 | Revise the Angus Equalities Mainstreaming Report (AEMR) prior to the 2024 deadline and deliver on the outcomes identified within the AEMR. | ✓ | ✓ (Revised) | | |
| 4.2 | Improve urgent, unscheduled and planned care pathways so that people access the right care at the right time in the right place. | ✓ | ✓ | ✓ | |
| 4.3 | Ensure staff understand the levels of inequality in Angus to enable improved decision making that makes a positive contribution to reducing health inequalities. | ✓ | ✓ | ✓ | |
| 4.4 | Work with Community Planning partners to mitigate against the impact of inequalities across our communities to ensure an integrated approach to reducing inequalities. | ✓ | ✓ | ✓ | |

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| 4.5 | Progress actions to improve access to advocacy services as outlined in the Angus Advocacy Strategic Framework 2023-202. | ✓ | ✓ | ✓ | |
| 4.6 | Work with Angus Council to expand housing options so more people can live independently in their own homes. | ✓ | ✓ | ✓ | |
| **Reduce homelessness** | | | | | |
| 4.7 | 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. | ✓ | ✓ | ✓ | |
| 4.8 | Continue to implement the national Ending Homelessness Together Strategy and Angus Rapid Rehousing Transition Plan in collaboration with housing partners and other stakeholders. | ✓ | ✓ | ✓ | |
| 4.9 | Continue with the implementation of the supported accommodation service review, embedding a person centred, trauma informed response to preventing and addressing homelessness. | ✓ | ✓ | ✓ | |
| **Keep vulnerable people safe** | | | | | |
| 4.10 | Progress quality assurance and improvement work in protection across all services to protect individuals who may be at risk of harm. | ✓ | ✓ | ✓ | |