



ANGUS
Health & Social Care
Partnership

**DRAFT STRATEGIC COMMISSIONING PLAN
2019-2022**

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FOREWORD

Thank you for taking the time to read this draft strategic commissioning plan. We hope you will contribute to our consultation after reading it. We aim to give you an insight into how the Angus Health and Social Care Partnership will continue to build the Angus Care Model. This plan shows how we will work to integrate services and how we will work differently to improve health and promote wellbeing. We believe that everyone has the right to live a long and healthy life and to be supported to live at home when it is safe to do so. By 2022 we want to progress towards that belief. We know that we can't achieve this on our own. We know that Angus has great places to live and great communities; together we can make a difference. Together, we can be courageous by being open to doing things differently. We need you to help by taking control and responsibility for your own health and wellbeing.

We know that wider issues of poverty, housing, loneliness and social isolation can have an impact on a person's health and wellbeing. The Angus Health and Social Care Partnership is committed to working through our Locality Improvement Groups and the Angus Community Planning Partnership to contribute to addressing these issues.

Information to date, published in our annual report, suggests we are already doing well, with more than 90% of older people's care being delivered in the community, but there is still more to do for the whole adult population. Our data tells us that while hospital admission rates for people over 75 are declining, admission rates for people aged 50-75 are increasing. We have already delivered good work in relation to self-management but we are beginning to understand more about opportunities for improvement around potentially preventable admissions for people aged 50-74 with Chronic Obstructive Pulmonary Disease (COPD), diabetes and asthma. The importance of delivering prevention in partnership with communities cannot be underestimated.

This strategic commissioning plan is built upon the importance of equal partnership with people and communities, with providers and the users of services. It sets out the vision and future direction for health and social care services in Angus and how those arrangements will be funded. It is not a list of every action that the Angus Health and Social Care Partnership will deliver over the coming years; the detail about how we make those smaller steps will continue to be developed through our four localities and our Angus-wide engagement structures in collaboration with all partners in the public, independent and voluntary sectors, and in local communities, over the lifetime of the plan. Whilst we are aiming to be ambitious with our plans we also recognise the need to be realistic about what can be achieved within the resources available to us. We hope this plan sets out this ambition and the realism.

We would encourage you to let us know what you think of our plans by completing our questionnaire; perhaps identifying more ways we could improve whilst continuing to be realistic about our available resources.

Lois Speed
Chairperson
Angus Integration Joint
Board

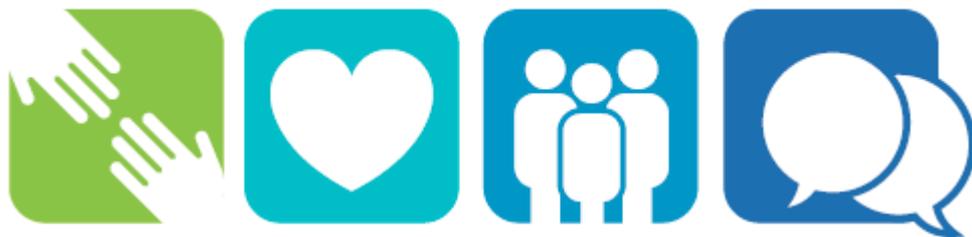
Hugh Robertson
Vice Chairperson
Angus Integration Joint
Board

Vicky Irons
Chief Officer
Angus Health and
Social Care Partnership

1. Our Vision for Health and Social Care in Angus

OUR VISION

Working together, developing communities that actively care, promoting wellbeing and creating the best possible health and social care across Angus



MAKING A DIFFERENCE

What we will do to make a difference

- Work with communities
- Focus on prevention
- Be realistic: provide safe and effective services in an increasingly challenging financial environment
- Be more creative, courageous and innovative
- Build for a future where digital technologies are more integrated in our work and used more widely by the population
- Deliver on our plans

What you can do to make a difference

- Take control of your own health and wellbeing
- Keep active whatever your stage in life
- Maintain a healthy weight
- Be informed about how to best address your health concerns
- Be mindful of the wellbeing of others in your community
- Get involved in your local community
- Join our conversations on the shape of health and social care services for the future

2. Our Ambition

Progress on delivering integration is measured nationally through 23 national core indicators. These along with other measures are reported on in our [annual report](#). To measure progress against this plan we believe that further measures are required to show that Angus Health and Social Care Partnership (HSCP) is making a difference in 3 areas of ambition. These are:

1. Promote the wellbeing of the people of Angus by supporting approaches to prevention.	
Where we are now	Where we want to be by 2022
Prescribing of medication for type 2 diabetes	Reduce rate of growth to zero
Prescribing of medication for hypertension	Reduce rate of growth to zero
Prescribing of medication for depression and anxiety	Reduce rate of growth to zero
Prescribing of medication for pain management	Reduce rate of growth to zero

2. Support people to be independent for as long as possible	
Where we are now	Where we want to be by 2022
The average age that an older person is likely to require support with personal care	Increase by 6 months
Number of older people in every 1,000 using personal care services.	Reduce by 10%
Admissions due to falls in 2017/18	Reduce rate of growth to zero
Following an assessment, people with drug and alcohol concerns have a support and treatment plan in place within 3 weeks	80% people referred

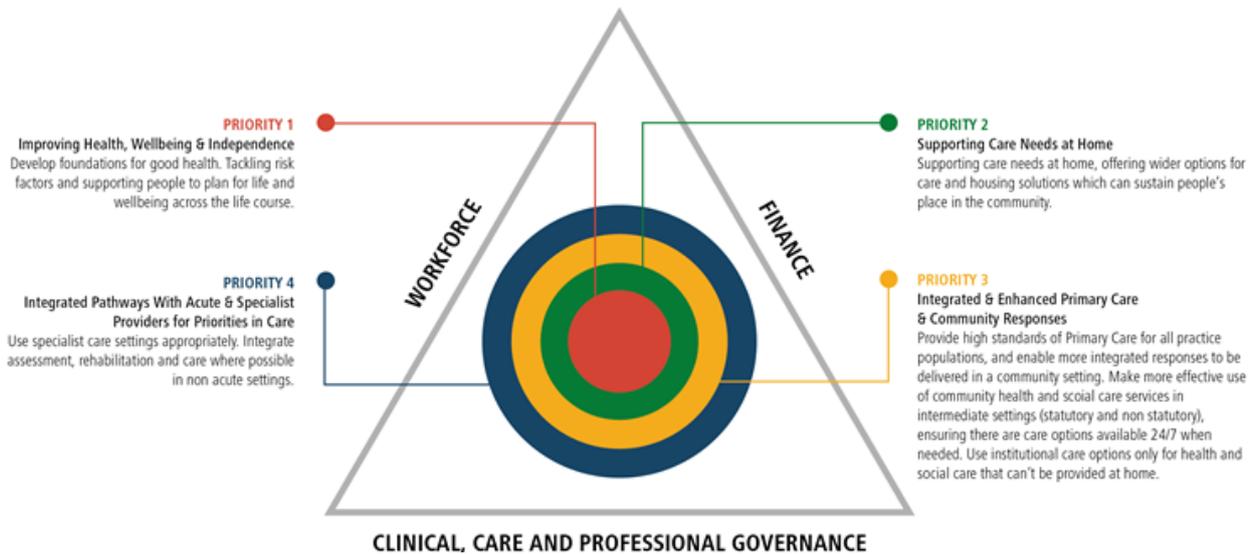
3. Shift the balance of care from hospital to home, supporting more people in our communities.	
Where we are now	Where we want to be by 2022
Unplanned hospital admissions	Reduce by 10%
Unplanned hospital bed days in adult mental health services	Reduce by 10%
Unplanned hospital bed days used for all adults	Reduce by 10%
People admitted in an emergency return to hospital within 28 days after being discharged	Reduce by 10%

The baseline for these measures will be established in our 2018/19 annual report.

4. Delivering Our Vision, Achieving Our Ambition

We will deliver our vision for the Angus Care Model through focusing service integration, improvement and transformation on four strategic priorities, underpinned by the effective management of three performance areas.

Angus HSCP Priorities and Performance Areas



5. Our Plans

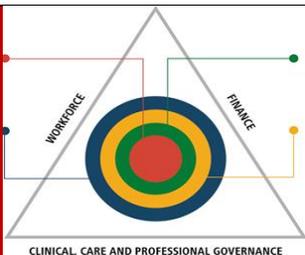
Each priority will be delivered through a number of projects, and each project will require an improvement plan that demonstrates consideration of the Angus 6 Rs for improvement and transformation. Projects will be required to set out measures, including improvement targets, to be achieved over the 3 years of the strategic commissioning plan.

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

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

The 6Rs will ensure that we are able to match resources to our transformational and improvement activity and monitor progress through the mid-year and annual performance reports.

Project improvement plans developed under each priority will be brought together into a delivery plan to demonstrate progress against this strategic plan. The following provides a summary of these plans.



Improving health, wellbeing and independence

Is

Working together to create an Angus that actively cares.

Communities are:

- Involved; making a difference
- Inclusive
- Compassionate
- Disability and dementia friendly
- Suicide aware
- Active
- Supporting loneliness and isolation

Deliver more housing solutions for the ageing population and those with other varying needs, ensuring housing models and related services meet the needs of our communities.

- Work with partners to increase the supply of affordable housing for people with particular needs
- Implement the Rapid Rehousing Transition Plan, aiming to prevent homelessness and ensure that households achieve settled accommodation and necessary support needs
- Work with partners to improve our adaptations service, ensuring we make best use of resources and deliver as needed

AHSCP will support the third sector by providing financial support for prevention, early intervention and the growth of communities that actively care. We will provide further support through Locality Improvement Groups to address community based issues.

Delivering for carers:

Complete the implementation of the Carers (Scotland) Act 2016 by 2021 by working towards:

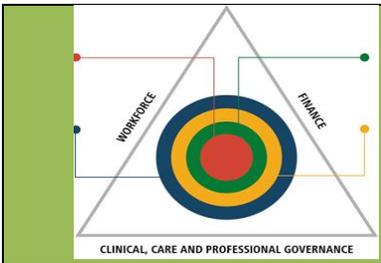
- Carers are identified
- Carers are supported and empowered to manage their caring role
- Carers are enabled to have a life outside of caring
- Carers are fully engaged in the planning and shaping of services
- Carers are free from disadvantage or discrimination related to their caring role
- Carers are recognised and valued as equal partners in care

Promoting Health and Wellbeing; working on prevention

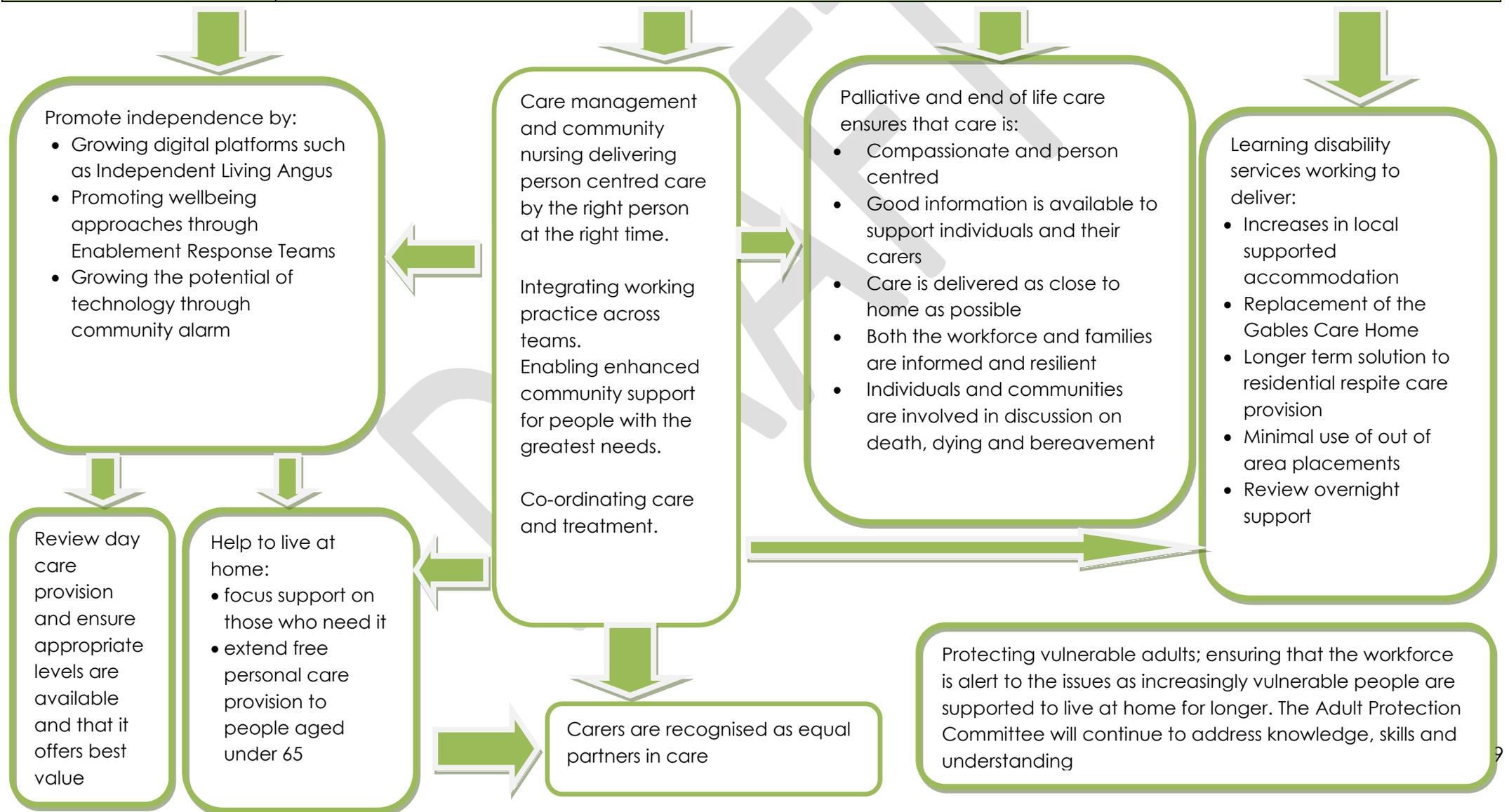
- Encouraging active living
- Promoting healthy weight
- Drinking water
- Reducing caffeine intake when affected by incontinence
- Following sensible alcohol intake guidelines
- Building support online
- Promoting contact with pharmacy first

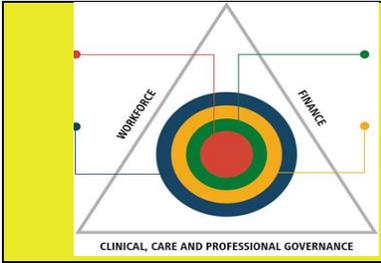
Supporting self-management of long term conditions:

- Improving information on Independent Living Angus
- Growing technology for the future
- Diabetes prevention and early intervention
- Mental wellbeing
- Continence support
- Developing more support for chronic pain management



Supporting care needs at home





Developing integrated and enhanced primary care and community responses

Improving primary care including developments in line with the 2018 GMS contract:

- Delivering a general medical services premises plan
- Improving access to community treatment and care services
- Aligning pharmacotherapy support
- New models for urgent care services to be explored
- Introducing additional professional services
- Continue to build integrated working with the third sector
- Growing technology for the future

Embed Enhanced Community Support model in all practices

Expand to include all adult population

Develop potential for prevention of admission models using e frailty index

Build on the experience of Monifieth Integrated Care in other areas of Angus

Older people, carers, professionals and local communities will be informed about mental illness that may affect older people.

Older people with mental illness and their carers will:

- know who they should speak to about a possible diagnosis and what to expect throughout that process and afterwards. After diagnosis, they will be given the information they need to access the appropriate support.
- feel assisted to plan for their future and will progress towards the level of independence that is right for them. They will feel safe, secure, supported and cared for. They will have an awareness of the range of options that are available to support them
- be involved in planning for their own and/or their family member's future and will have confidence in professionals to provide appropriate support during transitions. Good communication and partnership working between professionals and families during transitions will take place

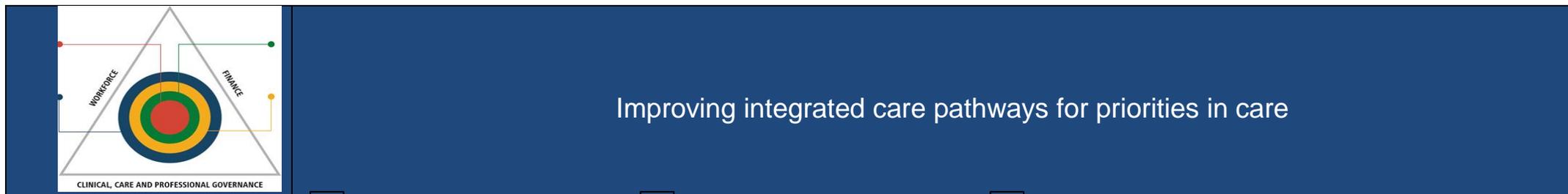
Continence
 Improve the pathway for continence services to deliver health improvement, self-management approaches and timely access to specialist support where required

Value your medicines, a best value approach to prescribing:

- Supporting a transformation of care pathways for diabetes
- Implementation of prescribing formulary and associated guidance
- A focus on chronic pain pathways
- Engaging the public and providing information regarding medicines use and waste
- Review of non medicines prescribing and the development of an agreed formulary

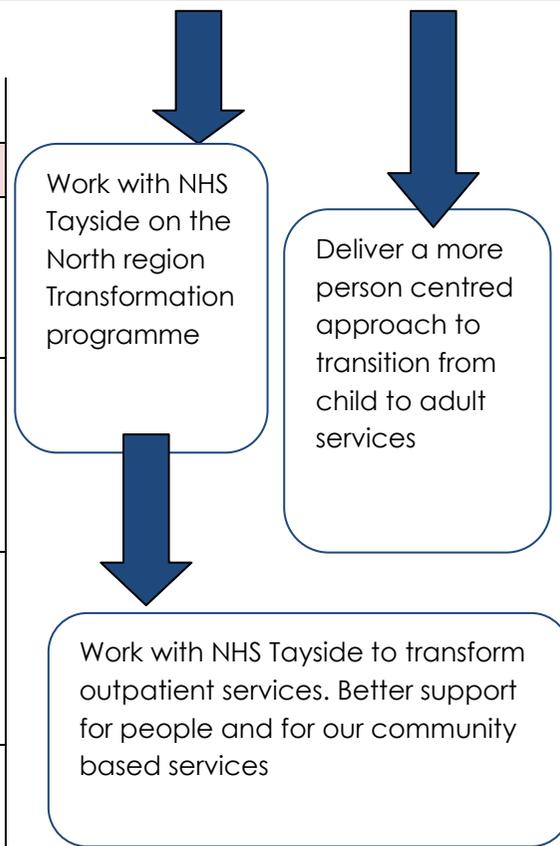
The Alcohol and Drug Partnership will continue to support people, their families and local communities to manage the challenges associated with drug and alcohol use.

Plans will ensure that people access support and treatment at the earliest opportunity



A focus on whole pathway approaches to:

	The Angus Care Model	Diabetes pathway	Mental Wellbeing Pathway
Priority Improving health, wellbeing and independence	Promote the use of life curve to support independence Deliver the enablement potential of new Enablement and Response service	Working with communities to encourage and to normalise active living Promoting healthy weight	Working with communities to address loneliness and isolation Improve the physical health of people with mental health problems
Priority Supporting care needs at home	Focus personal care services on those who need support Delivering new models in local authority care homes Deliver sustainable nursing care in care homes	Supporting access to weight management	Working with the third sector on accessible community based support Mental health and wellbeing practitioners working in every practice
Priority Developing integrated and enhanced primary care and community responses	Complete the roll out of Enhanced Community Support in all localities Providing a 24 hour model that delivers out of hours support appropriately	Timely access to specialists who will be able to see higher risk patients more frequently	Shift the balance of care from inpatient services to supportive community services Ensure timely discharge and reduce average length of stay in hospital
Priority Improving integrated care pathways for priorities in care	Continue to deliver a hospital bed model that supports people effectively Maintain low levels of delays in timely discharge	Less morbidity from diabetes preventing the downstream social care costs associated with amputations and other high cost complications of diabetes	Develop a co-morbidity pathway or people with both substance misuse and mental health problems Work with Perth and Kinross HSCP to transform the interface pathway in and out of inpatient mental health services



6. Our resources

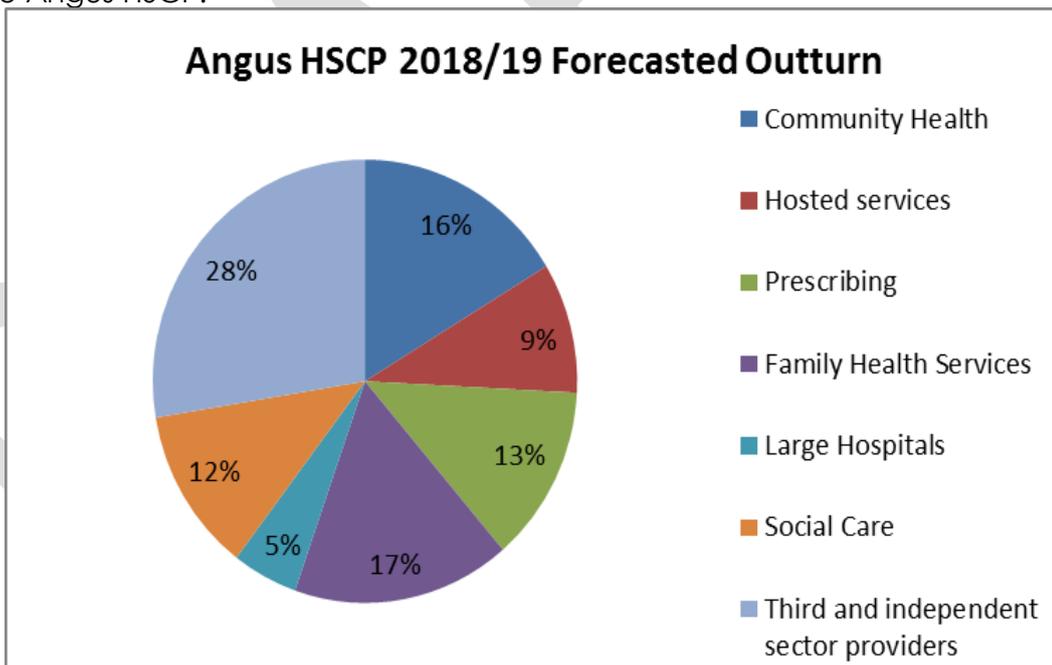
6.1 Finance

The Partnership's financial planning environment will be challenging for the duration of this Strategic Commissioning Plan. This is consistent with the environment faced by the public sector generally and Angus Council and NHS Tayside specifically. Both organisations face significant financial challenges and require Angus HSCP to live within agreed devolved resources. The final strategic financial plan for the period 2019-2022 for the Partnership will continue to be dependent on a number of factors including:

- The conclusion of annual budget negotiations with both Angus Council and NHS Tayside.
- Implications of the Scottish Government's annual budgets.
- The increased pressures the HSCP has to absorb annually including inflationary, demographic, legal and service pressures.
- The scale and timing of change and interventions that the HSCP plans to progress in response to the above pressures.

The charts below summarise the indicative financial resources available to the Angus HSCP to plan and deliver health and social care services. This reflects the most current information regarding financial resources that will transfer from Angus Council and NHS Tayside to the Angus HSCP.

**Angus
HSCP
Spend
Profile**



**2021/22
expected
spend
profile**

The IJB's future spend profile will be described in associated strategic financial plans. The IJB anticipates that most volume growth will happen within social care (particularly home care and prescribing).

National initiatives such as the General Medical services (GMS) contract will also shift spend profiles

Resource management is becoming more challenging because of increasing levels of demand. Year on year we face a growing requirement to manage the resources of the IJB in line with increased demand. Using the current resource framework as efficiently and effectively as possible is essential. The strategic plan identifies a number of areas of efficiency, and the shift in the balance of care required. Angus HSCP's financial planning assumptions will continue to be developed during 2019/22 with regular "Strategic Financial Plan" reports shared with the IJB Board. Many of the issues that will be reflected in further detailed financial planning are described in the "Delivering our Vision" section of this plan. These, and other issues, will have detailed financial plans developed and progressed via the appropriate governance forums within Angus HSCP. When brought together, these individual plans will contribute to Angus HSCP's overall strategic financial plan. Some of the financial planning issues include:

Priority: Improving Health and Well Being

- Review the HSCP's overall funding to develop third sector capacity, independent sector capacity to progress support for prevention and early intervention.
- Review existing arrangements which support the self-management of long term conditions and consider how digital approaches can be included through the further development of Independent Living Angus platform.
- Work with local General Practices and Pharmacy Services to progress plans which ensure that local Prescribing resources are utilised effectively.
- Ensure we have a strategy that helps mitigate overall demand to allow us to focus available resources on those who need it most.
- Further develop Enablement response services to maximise support for promoting independence and promoting wellbeing approaches.

Priority: Supporting Care Needs at Home

- Consider the utilisation of HSCP funding, including Technology Funding, to further develop Technology Enabled Care.
- Further develop contracting frameworks with providers to ensure best value, to create effective contract mechanism and to support the sustainability of our providers.
- Undertake a review of Older People's day care provision to ensure best value and appropriate levels of service are available. Consider how this might be extended to ensure that adult resource centres continue to efficiently and affordably meet the needs of the population with learning disability and complex care needs.
- Joint Equipment Store – Continually review arrangements for service provision to ensure the provision of high quality sustainable Community Equipment provision.
- Review the models of care for Care Home capacity provided in local authority care homes including reviewing support services.
- Modernise the approach to administration of medications in the community for those that require support.
- Review models of care in supported accommodation.
- Review arrangements for supporting carers to meet the requirements of the Carers (Scotland) Act 2016.

Priority: Developing Integrated and Enhanced Primary and Community Responses

- Undertake a further review of local inpatient care to reflect planned changes in unplanned hospital bed use.
- Consider the development of a sustainable nursing workforce to support care homes.

- Consider how care home models might better support people with very high levels of need with dementia who currently require In patient care.
- Continue investment in locality and community support (including Enhanced Community Support and services provided through the third and independent sectors) to prevent increased demand for social care and health services thereby releasing resources to be re-invested.
- Conclude reviews of Minor Injury & Illness Units across Angus to ensure all services are delivered effectively and efficiently.

Priority: Improving Integrated Care Pathways for Priorities in Care

- Work to develop revenue and capital financial plans that reflect improved pathways of care for services that are delivered through community services, in patient services, care homes and supported accommodation including Adult Mental Health, Older People's Mental Health, Learning Disability and Autism Services and Substance Misuse services.
- Explore the resources available in the large hospital set aside released from the reduction in Angus bed days used in Ninewells with a focus on the potential for different models which refocus staff towards community based models.

Other

These issues will be taken forward in addition to the above and are expected to make a material impact within the IJB's strategic planning.

- Progress plans to respond to impending recruitment and retention issues.
- Work operationally and strategically to reduce levels of sickness absence.
- Review management structure and administration functions within Angus HSCP.
- Develop opportunities for collaborative working with neighbouring IJBs, Angus Council and NHS Tayside.
- Continue to review contribution and charging policies to best allow us to meet the cost of service provision.
- Work to introduce new legislation and other requirements (e.g. Free Personal Care for under 65s and the 2018 GMS contract) in an effective and efficient way as possible.
- Continue to develop plans with all locally hosted services to ensure efficient and effective services delivery within available resources, on behalf of all Tayside IJBs.

6.2 Workforce

Angus HSCP relies upon its employing authorities, Angus Council and NHS Tayside, for recruitment and retention. The policies of the employing organisations need to deliver a workforce that is:

- Sustainable
- Integrated
- Capable
- Effective in leadership and management
- Well informed
- Treated fairly and consistently
- Empowered
- Involved in decision making
- Work in a safe environment

We are able to predict with certainty that there will be an imbalance between our demand and supply of staff. This is almost entirely due to the age profile of our workforce and shortages of key professionals. We cannot plan to increase the overall number of posts within the Council and NHS. The introduction of new models allows opportunities to ensure we have the right staff, in the right numbers, working in the right places at the right time, and we will work to streamline this in partnership with the Professional Leads including the Nursing and Allied Health Professionals Directorates and the Chief Social Work Officer.

Angus HSCP therefore needs partners to deliver integrated workforce planning which will include:

- Profiling workforce,
- Re-designing jobs and services taking into account grading and terms and conditions,
- A skills gap analysis and
- Workforce development requirements,
- Integrated workforce policies and practices.
- An integrated approach to proactive recruitment campaigns

There is a need to identify opportunities to give us better flexibility across the roles within the Council, NHS, third and voluntary sector to support.

6.3 Property

Angus HSCP relies on its partners, NHS Tayside and Angus Council, to provide appropriate accommodation for staff with safe working environments and accommodation that is also appropriate and safe for the delivery of services.

6.4 Information technology

Angus HSCP relies on its partners, NHS Tayside and Angus Council, to ensure that sufficient and appropriate information technology is available to support staff to deliver on the Partnership's ambitions. Angus HSCP recognise that digital technology and good data play a major role in improving services, enabling research and economic development and improve outcomes for the people of Angus. Angus HSCP will work with partners to 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.
- An infrastructure which uses new and emerging technologies to support service redesign in a way which meets the changing digital environment.
- Digital technology which enables our services to be delivered with the capability to meet future needs, and designed in a way that customers choose to use them as a default, whilst still supporting those who are not yet capable of doing so.
- Better use of data and make data more accessible through online channels, increasing accessibility and transparency.

7. The Case for Change

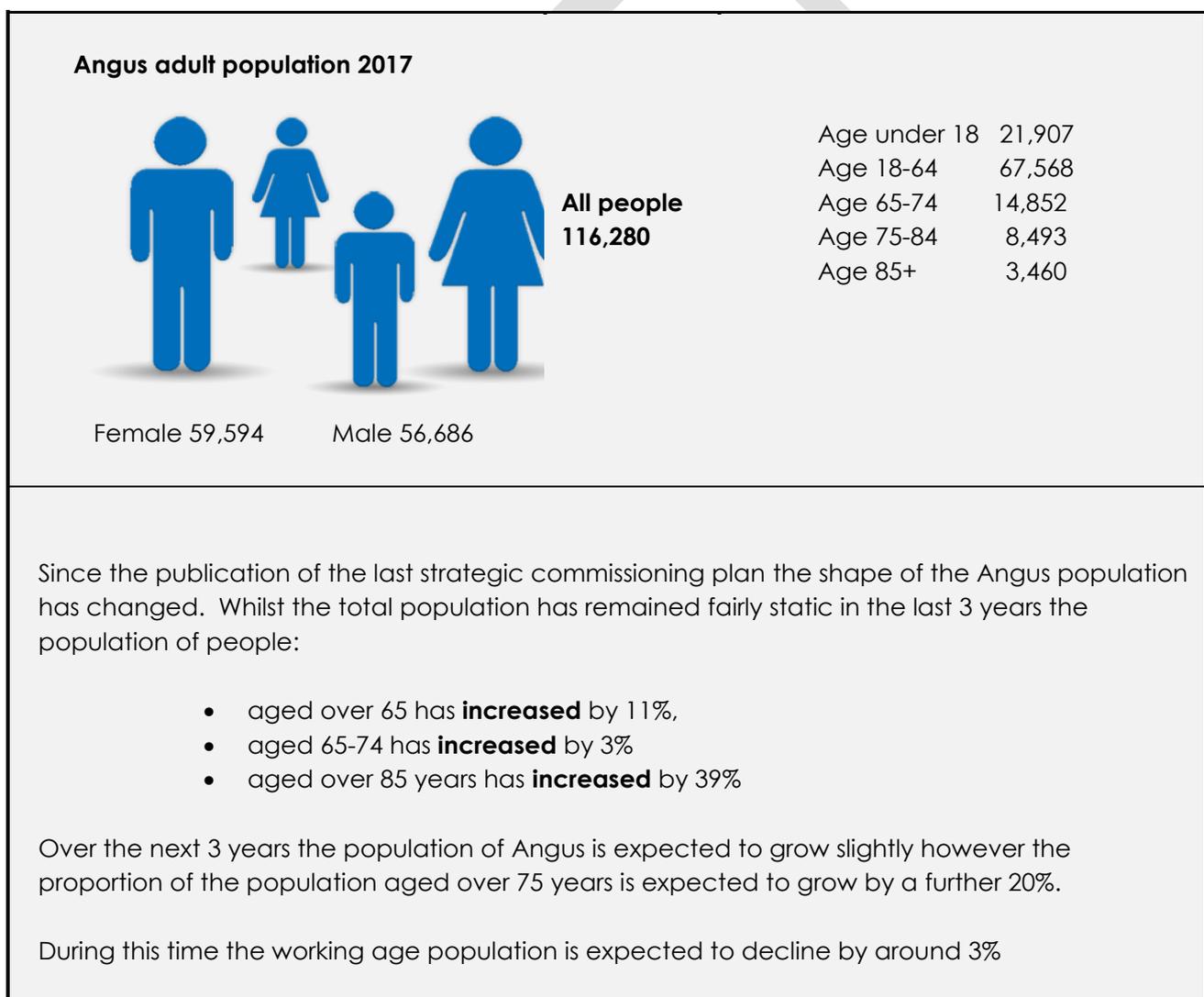
7.1 Understanding Angus

There is a growing demand for care provision. People are living longer with multiple and complex care needs that require more support from health and social care services. Local people have told us they want to access care closer to home, and care which helps to maintain their independence and the support of their own community.

Our strategic needs assessment and our current performance tell us that our future means addressing these challenges:

- Improving the health of the population;
- Many more people who need support and care;
- A smaller available workforce to deliver support and care;
- Continued pressure on public finance;
- Using more technology to improve efficiency and productivity.

Our Population



Life Expectancy at birth (2017)

	Angus	Scotland
Male	78.5	77.1
Female	81.8	81.1



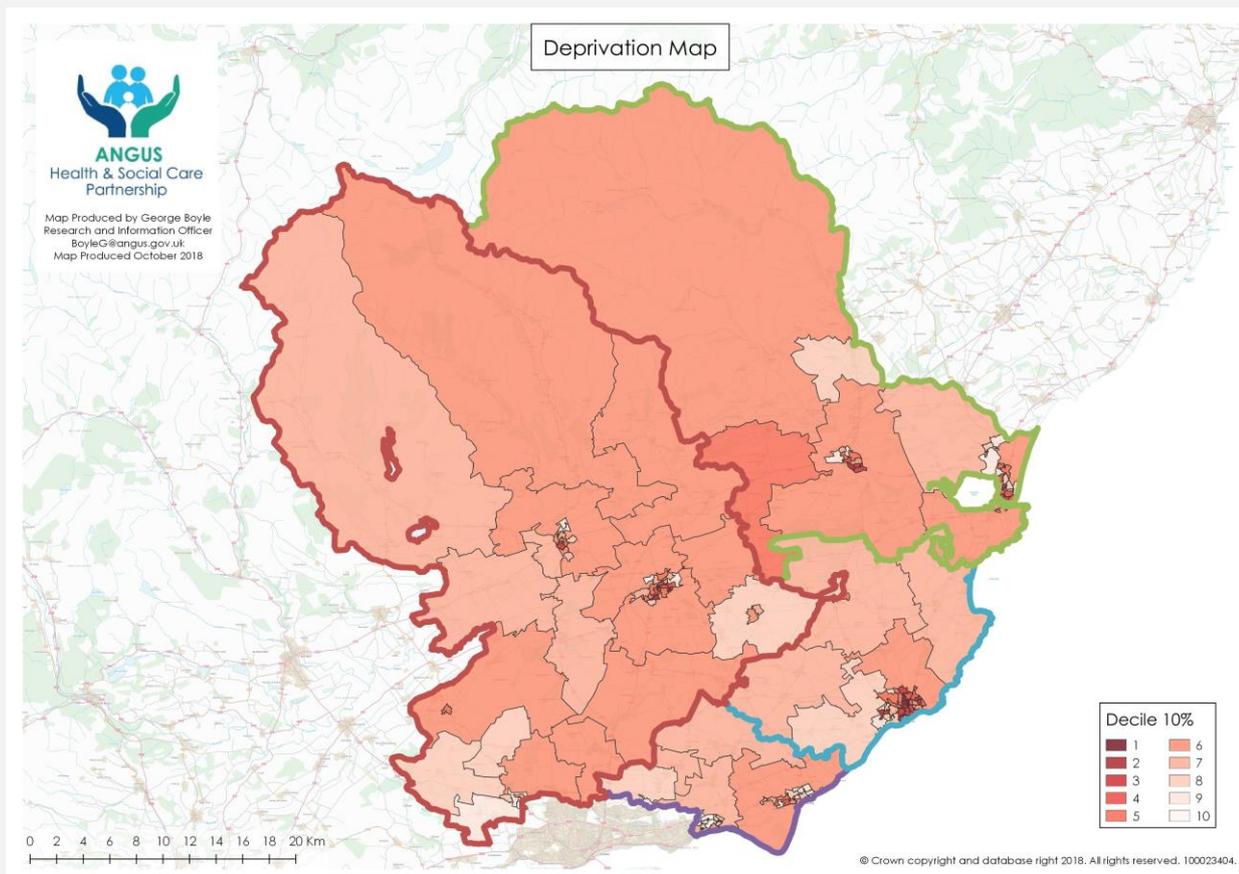
Life expectancy in Angus has not grown over the period of the last strategic plan. This is similar to the picture across Scotland.

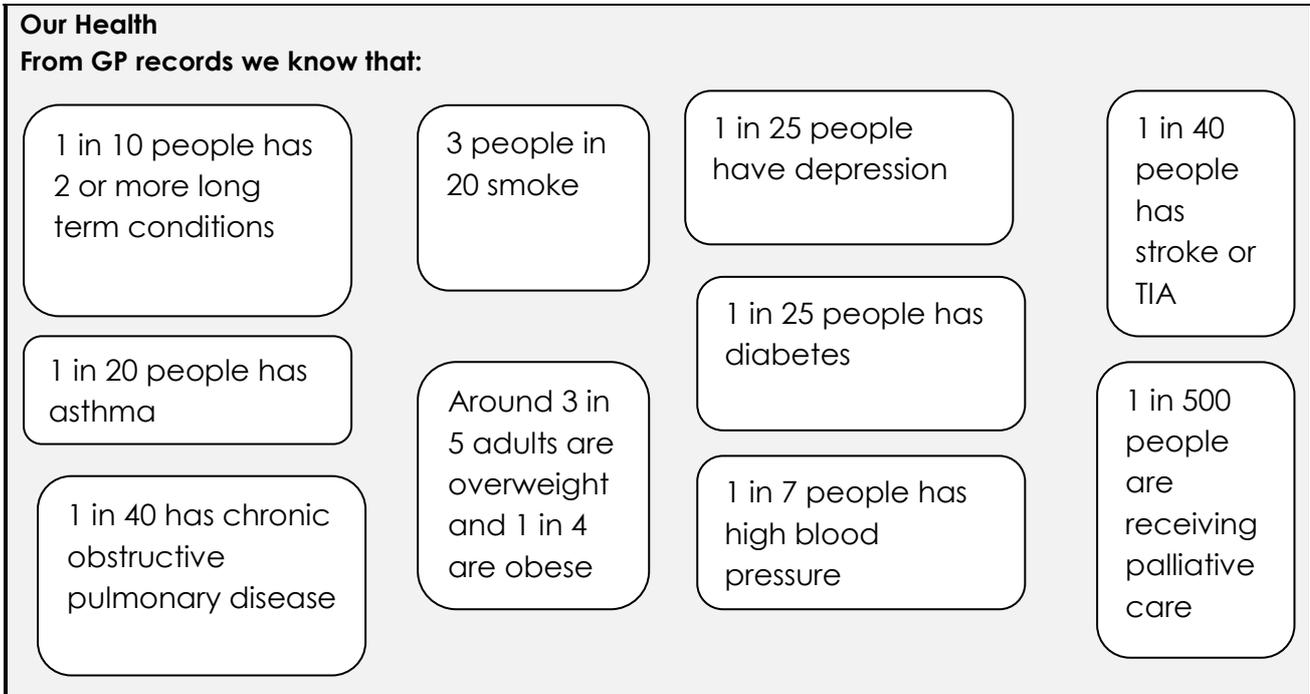
There continues to be a real gap between life expectancy for those living in the most deprived areas of Angus where men can live approximately 9 years less and women 3 years less than those living in the least deprived areas of Angus.

Deprivation in Angus

In the map below the deepest red shows the most deprived areas in Angus; the palest colour shows the least deprived areas of Angus.

Of Angus's 20% most deprived areas, two thirds are found in the South East Locality with the remainder in the North West and North East Localities.





7.2 National Outcomes

Our vision sets out to progress the nine national outcomes:

National Health and Wellbeing Outcomes

1	People are able to look after and improve their own health and wellbeing and live in good health for longer
2	People, including those with disabilities or long term conditions or who are frail are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community
3	People who use health and social care services have positive experiences of those services, and have their dignity respected
4	Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services
5	Health and social care services contribute to reducing health inequalities
6	People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and wellbeing
7	People using health and social care services are safe from harm
8	People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide
9	Resources are used effectively and efficiently in the provision of health and social care services

7.3. Scope of the Strategic Plan

The Angus Health and Social Care Partnership is responsible for planning and commissioning integrated services and overseeing their delivery. These services include:

- 16 GP practices.
- 23 pharmacies.
- 3 community hospitals; Arbroath Infirmary, Whitehills Health and Community Care Centre and Stracathro Hospital. The Partnership currently provides 105 in-patient beds in Angus supporting medicine for the elderly, psychiatry of old age, palliative care, and stroke rehabilitation.
- Angus people also have access to emergency and acute services provided at Ninewells Hospital in Dundee.
- Care management teams co-ordinate packages of care throughout Angus for service users with a range of health, social, emotional or psychological problems.
- Integrated community learning disability teams, community mental health for older people teams and an Integrated Alcohol drugs and rehabilitation service(AIDARS).
- Homeless support services.
- District Nursing Teams who co-ordinate care and provide treatment.
- Allied Health Professionals providing access to a range of therapies.
- 31 care homes in Angus providing 991 beds supporting older people, people with dementia, adults with learning disabilities. Currently we commission around 740 beds at any one time including some intermediate care beds, beds for older people outwith Angus and some specialist learning disability places outwith Angus. In addition we commission residential respite.
- Approximately 7,000 hours of care at home support is commissioned every week alongside services such as supported accommodation, community meals, community alarm, enablement and prevention of admission services.
- Community organisations operate in Angus to support people in our communities.
- 6,017 volunteers contributing across Angus.
- 10,852 carers.

The Partnership must have a strong relationship with secondary care in relation to unplanned hospital admissions. There are links to Tayside-wide hospital services at Ninewells Hospital, Strathmartine Centre and Murray Royal Hospital where a range of support for acute care, people with learning disability, adult psychiatry and drug and alcohol rehabilitation services are provided.

Some services are relatively small, are particularly specialist in nature or provide services across the whole of Tayside. This means that they are difficult to disaggregate to the three partnership areas in Tayside. In keeping with Scottish Government requirements, hosting arrangements have been established in relation to those services. This means that they are managed by one or other of the partnerships on behalf of all of the partnerships in Tayside.

Hosted Services

Angus	Dundee	Perth and Kinross
<ul style="list-style-type: none"> • Locality Pharmacy • Primary Care (excl. NHS Board administrative, contracting and professional advisory roles) • GP out of hours • Forensic Medical Services • Continence service • Speech and language therapy 	<ul style="list-style-type: none"> • Psychology • Sexual and reproductive health • Homeopathy • Specialist palliative care • Centre for brain injury rehabilitation • Eating disorders • Dietetics • Medical advisory service • Tayside Health Arts Trust • Keep Well • Psychotherapy 	<ul style="list-style-type: none"> • Learning disability inpatients • Substance Misuse inpatient services • General Dental/Community Dental services • General Adult Psychiatry • Prisoner Healthcare • Podiatry

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

8. More Information

You can find out more information on the work of Angus Health and Social Care Partnership by reading papers considered by our Integration Joint Board. You can find these via [our website](#). This includes:

- Annual Performance Reports
- Reports to the Integration Joint Board (including finance reports)
- Plans from the Localities
- Joint Strategic Needs Assessment

We continue to develop additional information which will become available on the website as the final version of this Strategic Commissioning Plan is approved by the IJB. This will include:

- an updated version of the Strategic Needs Assessment
- a new Housing Contribution Statement
- a Workforce Plan
- a Communication, Participation and Engagement
- a Strategic Delivery Plan which shows the activity that will deliver on our plans

9. Get involved, complete our survey.

You can tell us what you think of our plans for the next 3 years by completing our survey. You can find the survey at <http://www.angushscp.scot/category/consultations/>

The survey will close on 28 February 2019