ANGUS
Health & Social Care
Partnership

Angus Integration Joint Board

Strategic Framework
2026 - 2036



Working together to improve lives in Angus


Beacon
The Beacon



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Foreword

STEVEN WHYTE
Chair, Angus Integration Joint Board

As Chair of Angus Integration Joint Board, I am pleased to present this Strategic Framework for 2026 – 2036, which sets out a clear vision for the future of adult health and social care across communities in Angus, with the needs of the people who live in our communities firmly at its centre.

Angus Integration Joint Board (AIJB) is committed to providing safe, high-quality, and sustainable health and social care across our local communities. Care that is designed to last and is delivered by a workforce empowered to make a difference.

It is important that we are honest from the outset and acknowledge the increasingly complex and challenging context in which this Strategic Framework has been developed. Unprecedented financial pressures across public services, combined with the ongoing cost-of-living crisis and workforce shortages, have created significant challenges which are unlikely to ease. At the same time, it is vital that we plan for a future in which more people will be living with frailty than ever before.

Current forecasts indicate a financial gap of at least £13.6m, alongside other risks that are not yet quantifiable. We can no longer assume that significant additional funding will be available each year, and without changes to the way we operate, the financial gap will continue to grow. As a result, it is becoming increasingly difficult to sustain the current range and level of service provision.

Doing more of the same is not an option. We need to re-think how services are delivered and move from reacting to short-term pressures to transforming services for long-term affordability. Time is against us, and we must move at pace. This Strategic Framework sets out the bold decisions that will be required to be made if we are to respond to the changing needs of our population and the realities facing our health and care system. This will include options to reduce or discontinue certain services.

While the priorities outlined in our previous Strategic Plan remain relevant, we have undertaken a review to ensure this Strategic Framework is up to date, effective, and focused on delivering tangible improvements for local communities. We are committed to providing high-quality, sustainable health and social care services that respond to the evolving needs of our population. Central to this approach is a strong place-based focus, recognising that health outcomes are shaped by the communities in which people live. By tailoring services to local needs and building on community assets, we will sharpen our focus on preventing illness before it occurs, delivering more care in community settings, as close to home as possible, and transforming service delivery through digital innovation.

This will support staff to do their jobs more effectively, enable people to live independently and manage their own care, and ensure they remain connected to the right support when they need it.

We will do everything we can to ensure we provide the best possible services. However, the biggest improvements in people's health and wellbeing will come from the actions they take themselves. That is why we need the people of Angus to work with us and do what they can to maintain and improve their own health and wellbeing. I fully support our shared commitment to making a difference for the people of Angus, with the people of Angus.

Our dedicated workforce remains our greatest asset. I know how hard they work, and their professionalism, expertise, and commitment are integral to the successful delivery of this Strategic Framework and to ensuring the continued provision of high-quality, safe, and compassionate care for the people of Angus. Equally, I recognise and value the vital role of unpaid carers, whose unwavering support and commitment are essential to the people they care for and to the success of our health and social care system.

I would like to thank everyone who has provided feedback and contributed to the development of this Strategic Framework. Your input has been invaluable in shaping our shared aspirations while grounding them in the realities of the current landscape. I encourage your continued engagement and participation to ensure this plan remains responsive, informed, and grounded in the needs of our communities.

This Strategic Framework is for everyone who lives and works in Angus. The path ahead will be challenging, but I believe that together, we will build a healthier, more connected, and sustainable future for adult health and social care in Angus which will improve life expectancy and narrow health inequalities. I hope we can all take ownership of this Strategic Framework and use it to guide our decision-making in the years ahead.

ANGUS STRATEGIC FRAMEWORK 2026 – 2036 *Plan on a Page*

ANGUS
Health & Social Care Partnership

OUR VISION

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

OUR APPROACH

- Prevention and early intervention
- Care provided as close to home as possible
- Integrated and coordinated care
- Person-centred support
- Community engagement and empowerment
- Sustainable and effective use of resources

WHAT WE WANT TO ACHIEVE

Improving Health and Wellbeing

- Improved physical and mental wellbeing
- Reduced health inequalities
- Greater independence and self-management
- Stronger community resilience

Improving People's Experience

- Better access to information and support
- Improved coordination across services
- More joined-up care and support
- Increased confidence and choice

Supporting Sustainable Services

- Effective use of resources
- Sustainable workforce and services
- Increased use of digital solutions
- Reduced reliance on reactive models of care

Workforce & Partnership Working

- Skilled and supported workforce
- Strong partnership working
- Meaningful community engagement
- Collaborative commissioning and planning

OUR STRATEGIC PRIORITIES

1 Prevention and Proactive Care

- Future Care Planning and Early Support
- Proactive and Coordinated Care
- Personalised Care and Support
- Communities, Prevention and Reducing Inequalities
- Understanding Need and Improving Services
- Supporting Sustainable Services

2 Care Closer to Home

- Future Care Planning and Early Support
- Community-Based Alternatives to Hospital
- Integrated Teams
- Access and Navigation
- Discharge and Recovery at Home
- Supporting Sustainable Services

ENABLERS

- Workforce
- Financial Planning
- Digital
- Data and Insight
- Collaborative Commissioning
- Communication and Engagement

HOW WE WILL MEASURE SUCCESS

- People feel informed, supported and able to make choices.
- More people live independently and remain connected to their communities.
- Improved experience of coordinated and person-centred care.
- Improved outcomes for people with complex needs.
- More carers feel supported in their caring role.
- Staff feel valued, supported and equipped to deliver high-quality services.
- Services remain financially sustainable.

HOW WE WILL WORK

- Work in partnership with people and communities.
- Focus on prevention, early intervention and wellbeing.
- Deliver joined-up and person-centred care.
- Use data and insight to inform decisions.
- Learn, improve and innovate.
- Make best use of local assets and community strengths.

WHO WE WORK WITH

- Individuals, families and carers.
- Communities and local groups.
- Third and independent sector partners.
- Housing and community planning partners.
- Primary care and wider health services.
- Social work and social care services.
- Schools, education and early years services.
- Employers, universities and local businesses.

OUR VALUES

- Caring
- Compassionate
- Person-Centred
- Honest
- Respectful

OUR COMMITMENT

By working together with our communities, partners and staff, we will deliver prevention-focused, person-centred, sustainable health and social care services that improve outcomes and support people to live well, independently and connected to their communities.

Introduction

This Strategic Framework sets out our shared vision for health and social care in Angus and how we will work together with local people, communities, and partners to improve outcomes, reduce inequalities, and build sustainable services for the future.

It provides the long-term direction for health and social care services in Angus between 2026 and 2036 and is supported by two strategic priorities: Prevention and Proactive Care and Care Closer to Home.

This Framework covers the period 2026–2036 and will be reviewed every three years.

About Angus Integration Joint Board

The Public Bodies (Joint Working) (Scotland) Act 2014 (the Act) requires local councils and health boards to integrate the planning of services and functions delivered to adults and older people. As a result of this legislation the Angus Integration Joint Board (AIJB) was established, and it is the formal legal body that makes the decisions about how health and social care services are delivered in Angus. The Integration Scheme is the formal agreement between Angus Council and NHS Tayside and sets out how health and social care services are delegated, planned, and funded between the IJB and its partner organisations. The membership of AIJB is partly defined in the legislation and details of the current Angus IJB membership is available on our website.

The IJB's purpose is to plan services that support better health and wellbeing outcomes in our communities and is responsible for an integrated budget received from Angus Council and NHS Tayside. AIJB is responsible for ensuring resources are used effectively and sustainably to meet the needs of local people, however, this is becoming increasingly challenging to achieve because of rising demand and costs for services rising faster than the budget, we have available to spend. The priorities described in this Framework will guide how we allocate the money we receive.

The Scottish Government (SG) measures our performance through our work to deliver the nine National Health and Wellbeing Outcomes (Appendix 1). The Act sets out the Integration Planning and Delivery Principles (Appendix 2) which describe "how" integrated care should be planned and delivered and require services to be person-centred, safe and effective, focused on prevention, and delivered in a way that upholds dignity, reduces inequalities and makes best use of resources. They emphasise joined up working across health, social care, and community partners, ensuring that planning and delivery reflect local needs and support carers. These principles provide the legal and ethical foundation for all IJB decision-making and underpin the priorities set out in this Strategic Framework.

About Angus Health and Social Care Partnership

Angus Health and Social Care Partnership (AHSCP) is the organisation formed by mutual agreement between Angus Council and NHS Tayside to manage and deliver a range

of delegated services on behalf of AIJB. Working with third and independent sector partners we have a single system for planning and delivering local health and social care. The AIJB's Chief Officer is responsible for the management of planning and operational delivery on behalf of AHSCP.

Our Services and functions

The services and functions covered by this Strategic Framework that are planned and delivered by AHSCP, and a range of partners and providers include:

- Adult Social Care
- Care at Home
- Community Treatment and Care
- Learning and Physical Disability
- Primary and Urgent Care
- Adult Support and Protection
- Care Homes
- Day Services
- Minor Injury and Illness
- Support for Carers
- Aids and Adaptations
- Community Hospitals
- District Nursing
- Palliative Care
- Psychiatry of Old Age
- Allied Health Professionals
- Community Mental Health
- Substance Use
- Pharmacy
- Telecare

Some of the areas delegated to AIJB also provide services to children, for example Primary Care, Minor Injury and Illness Services, Carers, Continence Services and Angus Council delegated Occupational Therapy Services. Subject to the enactment of the Children (Care, Care Experience and Services Planning) (Scotland) Bill, introduced to the Scottish Parliament in June 2025, AIJB will review its responsibilities in relation to care-experienced children.

IJB Lead Partner Services

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

Delivering transformation and improvement in Lead Partner service areas means that AIJB works closely with Dundee and Perth & Kinross IJBs as well as NHS Tayside. The table below provides examples of the Lead partner service areas.

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

Why have we developed this Strategic Framework?

The Act requires each IJB in Scotland must prepare a Strategic Plan that is reviewed every three years to make sure it is relevant to the needs of the area and the people who live there. AIJB agreed that the strategic direction of the Strategic Commissioning Plan 2023 - 2026 remains relevant, however some aspects require to be revised to ensure alignment with new national policy, shifting needs, emerging challenges, and new opportunities.

The document has been renamed the Strategic Framework to better reflect its purpose in setting the overall framework within which the IJB will operate. It will be supported by separate Strategic Plans aligned to the two key priorities, Priority 1 – Prevention and Proactive Care and Priority 2 – Care Closer to Home.

The statutory requirement to undertake a formal review of the Strategic Framework every three years is fully recognised. This will ensure that the Strategic Framework remains current, evidence-based, and responsive to emerging priorities, risks, and opportunities.

How the Framework Will Be Delivered

This Strategic Framework sets the overall direction for health and social care in Angus over the next ten years.

Delivery will be supported through two strategic priority plans:

Priority 1 – Prevention and Proactive Care

Supporting people to stay well, maintain independence and access support earlier through prevention, early intervention, Future Care Planning, and community-based approaches.

Priority 2 – Care Closer to Home

Supporting more people to receive care and support in their own homes and communities through integrated teams, community-based alternatives to hospital admission and recovery at home.

Together these plans will help improve outcomes, reduce inequalities, and support the long-term sustainability of health and social care services in Angus.

The detailed delivery arrangements for each priority are set out within the separate Strategic Plans.

Strategic Planning Group

As required by the Act, AIJB has established a Strategic Planning Group (SPG) to support the strategic planning process. The SPG monitors delivery of the Strategic Framework and provides oversight of progress against the two strategic priorities.

Our Vision, Values and Ambitions

Following engagement with the public and staff our vision and values remain unchanged. Collectively these define our purpose as we continue to focus on making a difference to health and wellbeing outcomes across Angus.



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.

We have identified the following ambitions for integrated care in Angus:

- Support people to be independent for as long as possible.
- Reduce health inequalities.
- Keep people safe and reduce the risk of harm.
- Ensure resources are used effectively, services are sustainable and aligned with the needs of the community.
- Provide care that is joined up and coordinated across services.
- Use digital technologies to enhance access, care delivery and teamwork for improved outcomes.

Our primary focus must continue to be on achieving the outcomes that matter to people. This Strategic Framework is underpinned by the principles of Realistic Medicine, ensuring that care is personalised, evidence-based, and focused on what matters most to people, supporting shared decision-making. We will take a Value-Based Health and Care approach, prioritising interventions that deliver the greatest outcomes relative to resources.

It is vital that we recognise and respond to the many challenges facing public services, including the pressures of financial constraints and workforce shortages, while navigating

the increasing complexity of delivering sustainable health and social care services. The ongoing cost of living crisis continues to place significant pressure on families, with the greatest impact felt by people living in areas of deprivation. Of particular concern is the decline in life expectancy in Angus, which presents a challenge for the whole community. Working alongside our partners, integrated health and social care has a crucial role to play in addressing these issues and driving meaningful change.

Working together with our partners we will continue to build on the work that has already taken place in Angus to improve health and wellbeing outcomes, sustaining and extending areas of progress whilst acknowledging and addressing the evident challenges that exist.

How was this Strategic Framework developed?

The Public Bodies (Joint Working) (Scotland) Act 2014 sets out requirements for the development of strategic plans to ensure that stakeholders are fully engaged in the preparation, publication, and review of the Strategic Plan. A significant amount of engagement was undertaken to develop the Strategic Plan for 2023-26 and this remains highly relevant. Since 2023 we have engaged with the public about a range of improvements. The feedback that we have received has reiterated that people would like care to be delivered as locally as possible, by the right person and at the right time. Our recent engagement, detailed within the Statement of Engagement has informed this Strategic Framework.

We also considered the following:

Person-Centred and Integrated Care

We will ensure care is designed around the individual, emphasising shared decision-making and co-ordinated pathways across health, social care, and community supports. This aligns with the Service Renewal Framework's focus on personalisation and integration to improve outcomes and experiences.

Addressing Inequalities and Promoting Population Health

Guided by the Population Health Framework, we commit to tackling health inequalities by focusing resources and interventions on the most deprived and vulnerable groups. This includes upstream prevention, early intervention, and cross-sector collaboration to address social determinants of health such as housing, education, and employment.

Innovation and Digital Transformation

Building on the Service Renewal Framework's emphasis on innovation, we will expand digital health solutions, including remote monitoring, telehealth, and data analytics, to improve access, efficiency, and quality of care, particularly in underserved communities.

Workforce Renewal and Support

Recognising workforce pressures, we will invest in sustainable workforce planning, development, and wellbeing initiatives to ensure a resilient and skilled workforce capable of delivering renewed services aligned with both frameworks.

Financial Sustainability and Strategic Investment

We will apply robust financial planning to support sustainable service renewal, ensuring resources are allocated effectively to support population health priorities and innovative care models.

Resilience and Future-Proofing Services

Through evidence-based planning and service design, we aim to build resilient health and social care systems able to respond dynamically to demographic changes, public health challenges, and economic uncertainties.

Review of the last three years

As part of 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 can be found here.

The following examples illustrate the progress made against the ambitions of the previous Strategic Commissioning Plan and provide a foundation for future improvement. Progress since 2023 has been possible through strong partnership working with staff, third-sector organisations, independent providers and listening to the people who live and work in Angus:

- The Angus Nature Prescribing Calendar, launched in September 2023 in collaboration with ANGUSalive, NHS Tayside, and RSPB Scotland. It offers seasonal, nature-based activities to boost mental and physical health and acts as a "green prescription" for residents, featuring accessible, local activities.
- Publication of the Angus Carers Strategy 2023 – 2026. In October 2025 the IJB provided substantial assurance on the progress that had been made to implement the actions within this strategy. The report included information about the launch of the Angus Carers Academy which delivers training every month for people caring for people with dementia.
- Publication of the new Joint Angus Advocacy Strategic Framework 2023 - 2026 which outlines the provision of independent advocacy across Angus and progress has been made in increasing awareness and delivery of all independent advocacy services and advocacy support available.
- In 2023/24, Learning Disability Day Services maintained their Autism Advanced Accreditation Specialist Award for each of the three Resource Centres in Angus.
- Mental Health and Wellbeing Enhanced Community Support Hubs (ECS) are now available in all four localities which support people aged 16 and over who need support for mental health, wellbeing, self-harm, or substance use. A team of professionals, including nurses, social workers, psychologists, peer support workers, and community link workers, reviews each referral to connect you with the right services quickly and efficiently.
- There has been a sustained improvement in our hospital discharge processes, and we have achieved a 43% improvement in our delayed discharge performance between October 2024 – October 2025. As a result, Angus is one of the best performing health and social care partnerships in Scotland. In October 2025 the number of hospital delays per 100,000 population was 18 compared to 43 across Scotland.
- A new Living Well With Dementia website and interactive app was launched in 2024 to support people in Angus living with dementia and their carers. This was developed by the Angus Post Diagnostic Dementia Service with Healthcare Improvement Scotland.

The platform offers health and wellbeing resources, along with a diary app to help users stay independent and keep carers informed.

- During Mental Health Awareness Week in May 2024, the IJB and partners launched the "Are You OK?" campaign to encourage conversations about mental health and promote access to support.
- Launch of Self Directed Support (SDS) public website pages in December 2024 to support raising awareness of how to access SDS in Angus.
- Publication of the Angus Carers Information Pack in 2024. The pack was produced for Carers with Carers and contains information that Carers and professionals told us would be useful to have all in one place.
- Opening of The Beacon, a new Community Wellbeing Centre for mental health support in Angus, officially opened in Kirk Square, Arbroath, on June 30, 2025. Managed by Hillcrest Futures, it provides a safe space for individuals aged 16+ experiencing emotional distress, open 7 days a week from 12 noon to 12 midnight.
- A major focus during 2025 has been on embedding a "What Matters to You?" approach, ensuring that services are shaped by what matters most to individuals, their families and carers.
- Prevention and Proactive Care work in Angus has gained national recognition, featuring at the NHS Scotland National Conference, in the Chief Medical Officer's Annual Report 2024–25, and at national leadership forums, supporting wider learning and sharing of local practice.
- Minor Injury Services and pathways have been developed to ensure timely access to appropriate care for people with minor injuries.
- We have improved our Facebook reach by 21% since 2023/2024 and launched 21 podcasts.
- The number of stories received via Care Opinion, an independent online feedback tool, continues to increase and over 90% of the stories are positive.

Health and Social Care Policy

When deciding on our priorities we have considered national policies. These are the things that the Scottish Government asks IJBs, and other organisations who deliver health and social care, to do.

National Strategic Context: A new future for health and social care

The IJB operates within a wider health and care system shaped by SG and this Strategic Framework is aligned with both national and regional objectives. Since the publication of our previous Strategic Plan, the Scottish Government have published documents that will influence the future direction of health and social care in Scotland outlining priorities for service delivery, workforce planning, and system reform. This Strategic Framework aligns fully with the Scottish Government's vision and focuses on creating a healthier, more equitable future for our communities. It prioritises renewal, transformation, and resilience across all areas of service delivery, taking a holistic approach that supports the whole person, their family, and the wider community.

The NHS Scotland Operational Improvement Plan commits to reducing waiting times and improving timely access to care. It also seeks to shift care from hospitals into the community, harness digital technology, and emphasise prevention to deliver more person-centred, efficient health and social care across Scotland.

Health and Social Care Service Renewal Framework 2025 - 2035 (SRF) sets out a 10-year plan to improve health and social care in Scotland. It prioritises prevention, community-based care, and person-centred services, shifting more care into community and primary care settings, reducing reliance on hospitals, and improving access through digital and local services. The SRF aims to make services more sustainable, equitable and efficient over the next decade, while giving people greater choice and control over their care and supporting the workforce to deliver integrated, modern health and social care. In doing so, it also fosters innovation and resilience across the system.

Scotland's Population Health Framework 2025 - 2035 (PHF) sets out a 10-year, whole-system strategy to improve health and wellbeing across Scotland by tackling the social, economic, and environmental determinants of health. It shifts the focus from treating illness to preventing it, strengthens community and economic conditions, and supports healthy living and equitable access to care. Its core aim is to increase overall life expectancy while closing the life-expectancy gap between the most deprived 20 per cent of communities and the national average by 2035. The PHF promotes preventative, community-led approaches that reduce inequalities and improve wellbeing across all life stages.

Scotland's Public Services Reform Strategy – Delivering for Scotland sets out a bold, system-wide plan to transform Scottish public services by focusing on prevention, joined-up delivery, and greater efficiency, aiming to make services more integrated, responsive, and sustainable rather than simply cutting provision. It commits to removing duplication, embedding data and digital tools, strengthening collaboration across public bodies and

communities, and reshaping leadership, accountability, and culture to improve outcomes for people across Scotland.

Scottish Government continue to implement the priorities of the Care Reform (Scotland) Act 2025 and await further details from the SG and will update our plans and direct care accordingly.

In November 2025 the SG instructed NHS boards to organise themselves into two new regional groupings, Scotland East, and Scotland West, to strengthen collaboration and improve strategic planning. With the aim to reduce duplication, improve resource use and support system-wide reform across Scotland's health system, importance of an integrated workforce is emphasised in addition to service planning across the new regions to support more efficient and sustainable delivery of care. AIJB is committed to supporting NHS Tayside as these changes are implemented.

Local Context

AIJB will continue to work with Angus Council, NHS Tayside, ANGUSalive, third sector and community partners to ensure alignment between strategic commissioning intentions, maximising opportunities for collaborative planning, locality engagement and shared outcomes. AIJB will support and encourage opportunities for collaboration with local businesses, universities, and wider partners to share expertise, innovation, and learning, helping to address complex health and social care challenges.

Angus Council and Angus Community Planning Partnership

This Strategic Framework is fully aligned with the Angus Council Plan 2024–29 and the Angus Community Plan 2022 - 2030. Together, these plans set a shared direction for improving the wellbeing of people in Angus, tackling inequalities, and delivering sustainable, community-based care. We are key partners contributing to the vision that 'Angus is a great place to live, work and visit'. Our work supports the 'Caring for our People' priority by aiming to reduce inequalities across all communities, create more opportunities for people to live well and achieve their personal goals, and improve physical, mental health and wellbeing.

The Angus Community Learning and Development Plan 2024–2027 contributes to improved health and wellbeing outcomes through community empowerment, adult and family learning, youth work, digital inclusion and volunteering, particularly for people and communities experiencing disadvantage. These approaches support self-management, resilience, and social connection, and complement integrated health and social care services by addressing wider social determinants of health.

NHS Tayside

Through NHS Tayside's (NHST) strategic programme 'Tayside Together', we contribute to the achievement of NHST's corporate objectives. There is a shared ambition to transform health and care services through inclusive engagement with communities and partners.

We will continue to contribute to NHS Tayside's Annual Delivery Plan and will be a core partner in strategic planning through the new Strategic Oversight Board. We also sit as key

members of NHS Tayside's Integration Programme Board, supporting oversight of Urgent and Unscheduled Care, Planned Care, and Cancer Care.

Recognising the decline in women's health, we will continue to contribute to NHS Tayside Women's Health Plan Strategic Oversight Group.

AHSCP is a member of the Angus Sport and Physical Activity Steering Group, which is driving forward delivery of the Angus Sport and Physical Activity Framework. The Framework is aligned with the SG's Active Scotland Outcomes and directly supports the strategic priorities of the Angus Community Plan, contributing to the shared vision of Angus as a place where an active life is accessible to all. Physical activity is a cornerstone of prevention, supporting physical health, mental wellbeing, and social connection, while helping to reduce health inequalities and future demand on services. Working in partnership, we will continue to ensure opportunities to be active are inclusive, accessible, and embedded in everyday life.

AIJB recognises the strategic importance of supporting refugees and people seeking asylum as integral members of Angus communities. The Angus New Scots Refugee Integration Strategy 2025–29 sets out a framework for delivering coordinated support, ranging from accommodation and resettlement to engagement with local services, underpinned by partnership working, empowerment and inclusive practice. In alignment with this strategy and the national New Scots framework, we will ensure health and social care planning and delivery are culturally responsive, trauma-informed, and fully integrated with broader efforts to promote wellbeing, equity, and social inclusion.

While a wide range of national policies and strategies inform the direction of health and social care in Scotland, this Strategic Framework focuses on those which most directly shape service delivery in Angus. In particular, the Health and Social Care Service Renewal Framework, Scotland's Public Service Reform Strategy and the Population Health Framework provide the primary policy context for our strategic priorities of prevention and proactive care and care closer to home. Other national policies are considered as enabling or contextual frameworks, supporting alignment across public services rather than determining local priorities.

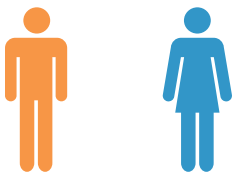
A more expensive list of national policy and local drivers that inform and direct our work can be found in Appendix 3 and Appendix 4.

About Angus: The Case for Change

Information about the health and social needs of the people who live in Angus, people who provide unpaid care and the health and social care workforce has been used to make decisions about what the strategic priorities should be.

You can find out more about the needs of people in Angus, including unpaid carers in the full Strategic Needs Assessment and Housing Contribution Statement. The evidence highlights significant challenges relating to inequality and demographic change across Angus. In response, we are committed to targeting our resources and designing services that address these challenges, reduce inequalities, and improve outcomes for our population.

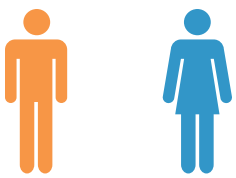
Our Population (Source National Records Scotland (estimated population mid 2024))



Male	Female		
55,530	59,280	20,491	**Age under 18**
		64,609	**Age 18-64**
		15,075	**Age 65-74**
		10,910	**Age 75 -84**
		3,725	**Age 85+**
		114,810	**All people**

Over the next four years, the population of Angus is projected to rise to 115,206, before declining slightly to 114,942 by 2035. During this period, the working-age population (18–64 years) is expected to decrease by 5% to 61,489. In contrast, the number of residents aged 75 and over is projected to increase by 21%, reaching 18,275 by 2035. This represents an additional 3,640 people aged 75+ living in Angus in 2035. 25% of the Angus population lives in rural areas and 2% in remote rural areas with access issues.

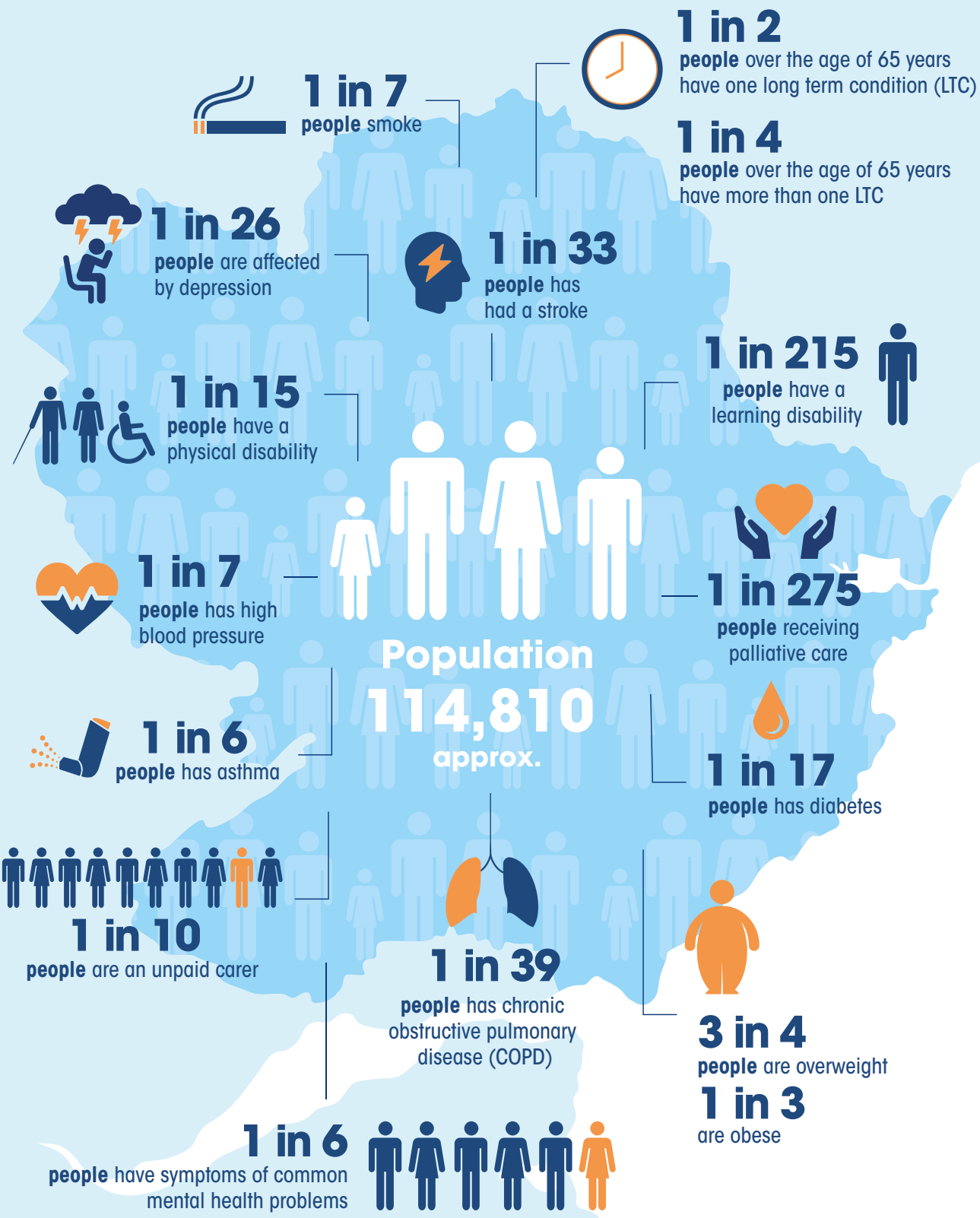
Life Expectancy at Birth (Source National Records of Scotland 2021-2023)



	Angus	Scotland
Female	81.2	80.8
Male	78.2	76.8

Of note is the decline in life expectancy for females in Angus, reflecting a trend seen across Scotland. While overall life expectancy in Angus remains higher than the Scottish average, significant inequalities persist. There continues to be a substantial gap in life expectancy between residents living in the most deprived and least deprived areas of Angus, with men in the most deprived areas living approximately 8 years less, and women approximately 5 years less, than their counterparts in the least deprived areas.

About Angus



Source: 2021-2024, Scottish Health Survey and 2019-2023 ScotPHO Online Profiles Tool

Healthy life expectancy remains an important measure of population health, reflecting not only how long people live, but how many of those years are spent in good health. The proportion of life spent in good health varies by gender. Men in Angus spend around 80% of their lives in good health, which is 3% higher than the Scottish average, while women spend approximately 78% of their lives in good health, 4% higher than the Scottish average.

Disabilities

The most recent population data from Scotland's Census 2022 indicates an increase in the proportion of people reporting a long-term health condition or disability that limits day-to-day activities. Nationally, 21.4% of the population reported a long-term condition or disability in 2022, compared with 18.7% in 2011. The most recent census data reports that 11,149 (9.8%) Angus residents are living with a physical disability and 5,554 (4.9%) Angus residents with one or more learning disability. According to the Scottish Health Survey 2024, between 2021 and 2024, the percentage of women who were disabled increased from 39% to 41%. Over the same period the percentage of men who were disabled increased from 30% to 35%.

Unpaid Carers

Data from the 2022 Census indicates that there are 13,196 carers in Angus (people aged three and over), representing an increase of 22% since the 2011 Census. Carers now account for approximately 11% of the population of Angus. The estimated nominal value of unpaid care provided in Angus is £332.9million, highlighting the substantial economic and social contribution made by carers (Valuing Carers 2022: Scotland report).

Deprivation



The Scottish Index of Multiple Deprivation (SIMD), the official tool for finding the most 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 2022 population of Angus, 8% live in the most deprived Quintile (SIMD1) and 12% live in the least deprived Quintile (SIMD 5).

Map of Data zones within Angus coloured by SIMD Quintiles:

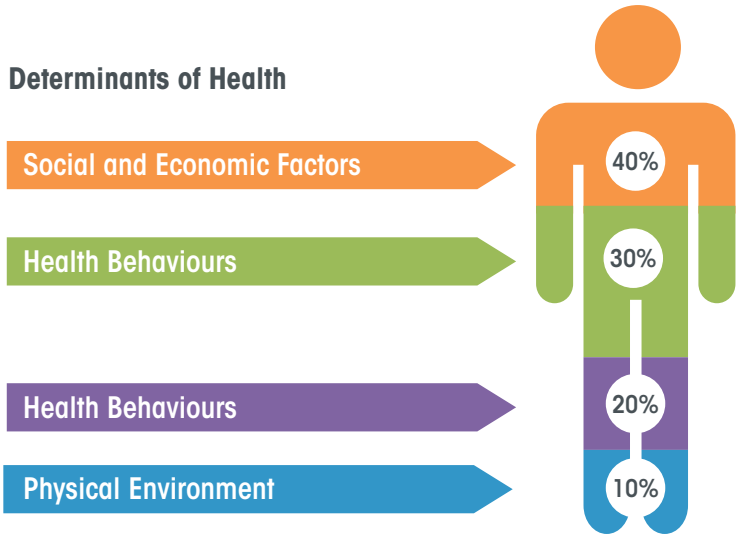
- Q5 (Least Deprived)
- Q4
- Q3
- Q2
- Q1 (Most Deprived)

Poverty in Angus is a significant issue, as it is across Scotland, with various areas experiencing diverse levels of deprivation. The distribution of poverty across Angus is not uniformly spread but concentrated in specific areas. The highest concentration of child poverty is found in the Arbroath East and Lunan ward, where 28% of children are living in poverty. More affluent areas of Angus often have lower overall poverty rates, but pockets of deprivation exist. As described in Angus's Child Poverty Local Action Plan 2023-25 (Updated March 2024) there are many reasons why drivers for poverty across Angus which are multifaceted and interconnected.

Differences in housing, income, and local environments help explain why some people in Angus experience better or worse outcomes compared to others. These unfair differences are known as health inequalities. To help address them, we will continue to work with our Community Planning Partners, we will tackle these wider determinants of health to create the conditions that enable healthier behaviours, support mental and physical wellbeing, and reduce inequalities. By progressing our work on prevention and proactive care, and focusing on evidence-based activities, for example, Nature Prescribing, pulmonary rehabilitation, falls prevention and collaborating closely with our partners in ANGUSalive who provide a wide-range of exercise programmes, we aim support healthier behaviours and improve overall health and wellbeing outcomes.

This approach will bring us closer to achieving equity in health and wellbeing for everyone, at every stage of life.

The Scottish Burden of Disease Study (2025) forecasts that the overall burden of disease in Scotland is set to increase by 21% over the next 20 years, with cancers, cardiovascular disease and neurological conditions together accounting for around two thirds of this rise. This trend highlights the urgent need to strengthen prevention, early intervention, and proactive care to improve long-term health outcomes and reduce future pressure on health and care services. Of particular concern is the deterioration in women's health and the widening of health inequalities across population groups

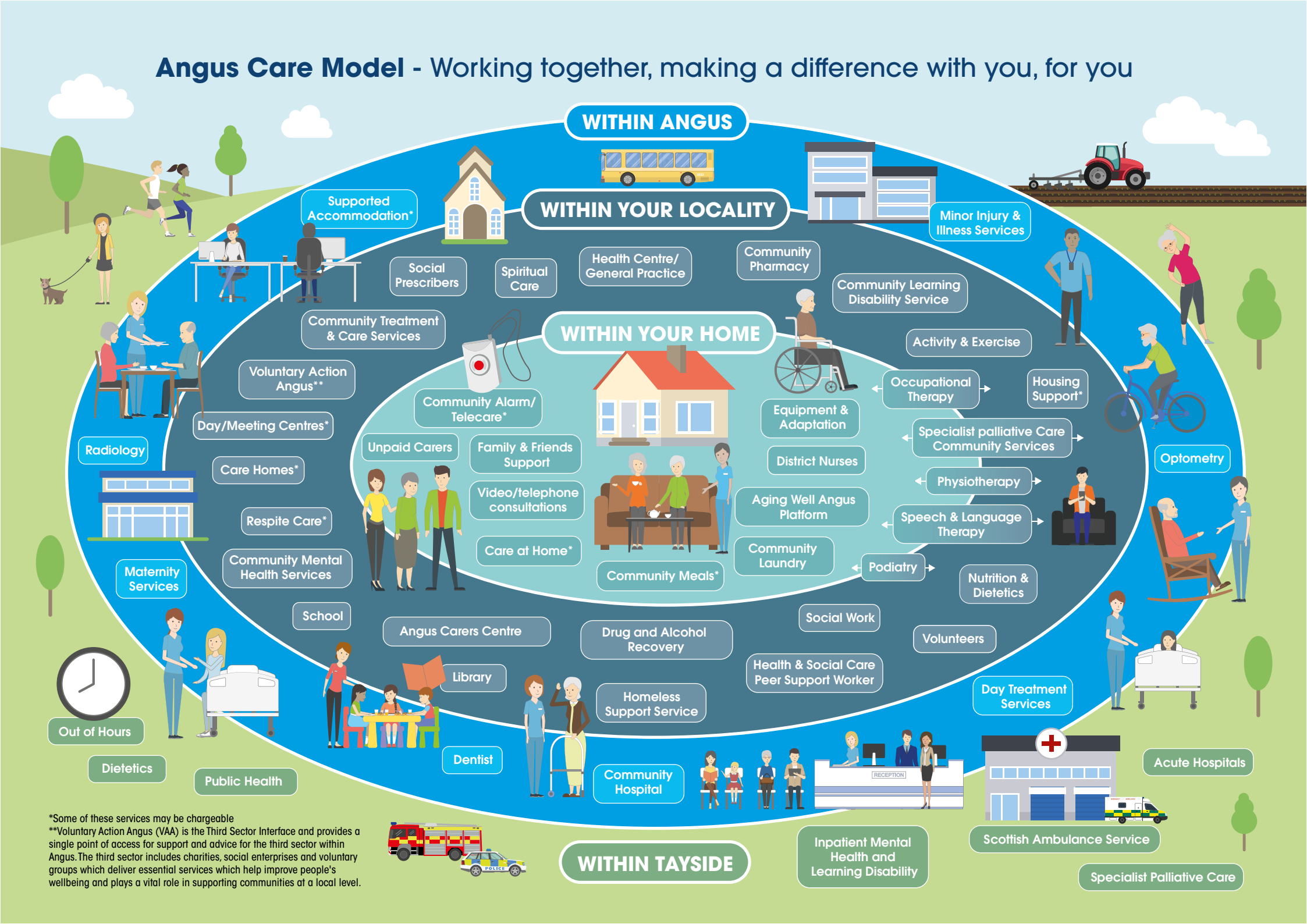


Angus Care Model

The Angus Care Model sets out how we will work together, with our communities, to enable the conditions for good lives, prevent poor health and ensure support is available before crises occur and to provide the best services possible. We are continuing to build a model of care that emphasises the contributions of people and communities, in addition to the support provided by health and care services.

The illustration below demonstrates the range of services available within the home, locality, Angus-wide and across Tayside.

Angus Care Model - Working together, making a difference with you, for you



*Some of these services may be chargeable
**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 Approach to Service Delivery

By following the Integration Planning and Delivery Principles we work to ensure everything we do is person-centred, outcomes-focused, collaboratively delivered, transparent in governance, and aligned with national policy, enabling sustainable services that improve health and social care outcomes for people and communities across Angus. Examples of this approach include:

Joined up and easy for people to access

In 2024, we asked people to share their experiences of accessing our services, and the feedback we received was positive.

We continue to build on our integrated service delivery across our Mental Health teams, Learning Disabilities and Substance Use Services. The Mental Health and Wellbeing Hubs provide a single point of access for anyone aged 16 and over in Angus who needs support with mental health, substance use, or wellbeing, coordinating referrals to the most appropriate services.

AIJB is committed to well-planned, person-centred transitions from children to adult services that support continuity of care and positive outcomes for young people, recognising transition as a process requiring early and proportionate planning in line with Getting it Right for Every Child (GIRFEC) and Getting it Right for Everyone (GIRFE). This rights-based approach reflects the United Nations Convention on the Rights of the Child (UNCRC) (Incorporation) (Scotland) Act 2024, the Promise, the National Transitions to Adulthood Strategy, ARC Scotland principles and relevant legislation, and ensures young people are meaningfully involved in decisions about their care, supported to exercise choice and control, and listened to throughout. The publication of the first National Transitions to Adulthood Strategy for Young Disabled People, in 2025, has provides an opportunity to refresh current practice and ensure that work already underway is aligned with the new strategy. Integrated, multi-agency pathways across health, social care, education, housing and the third sector will be promoted, with a focus on equity and inclusion, particularly for care-experienced and disabled young people and those with additional support needs, with progress monitored through Social Work Governance, feedback from young people and families, and continuous improvement activity.

Taking account of the needs of different service users and respects the rights and dignity of service users

Equality remains at the heart of everything we do, including how we consider protected characteristics in the planning and commissioning of health and social care services. It is vital that our health and social care services reflect the demographics of Angus. This Strategic Framework recognises that the main challenges to improving health in Angus are due to an ageing population, more people living with frailty, persistent health inequalities, the continuing shift in the pattern of disease towards long term conditions and growing numbers of people with multiple conditions and complex needs. AIJB is committed to

further development of a preventative and proactive care approach to tackle social inequalities and improve wellbeing in our communities.

We have developed a new set of Equality Outcomes 2025-2029 and the Angus Equalities Mainstreaming Report 2025 – 2027 which details our compliance with the Public Sector Equality Duty in line with the Equality Act 2010 and the Equality Act (Specific Duties) (Scotland) Regulations 2012.

Our current Equality Outcomes (2025-2029) are:

- Angus Health and Social Care Partnership will continue to work towards all services being accessible, inclusive, and responsive to meet the needs of people with a protected characteristic(s).
- Angus Health and Social Care Partnership will continue to promote an equality driven and inclusive culture within the organisation and actively challenge any forms of discrimination.
- Angus Health and Social Care Partnership will actively involve people, communities, and staff —including those with lived experience— in shaping services to reflect the diverse needs of the Angus population, while empowering individuals to make informed choices and to maintain control over their own lives.
- Angus Health and Social Care Partnership will proactively enhance our collection, analysis, and application of equalities data in order to inform equitable decision-making and reduce health inequalities.

We recognise that there is a widening gap in inequalities. For example, healthy life expectancy for women in Angus is declining, with women now spending around three fewer years in good health in 2021/23 compared to 2002/04. This trend highlights the growing impact of long-term conditions, mental health challenges, and social inequalities on women's health and underlines the urgent need for a stronger focus on prevention, early intervention, and targeted support. We want to reverse negative trends and ensure all women can live longer, healthier lives.

Health inequalities are avoidable and driven by social, economic, and structural factors, and reducing them is essential to improving population health and fairness. We must focus on prevention across the life course, remove barriers to access and quality of services, strengthen the use of data and accountability, and work in partnership with communities to co-design solutions, build trust, and address discrimination.

We are committed to further developing our human rights approach. We will continue to take practical steps to put human rights at the centre of our daily practice and policies. In addition, we continue to support the delivery of the equality agenda with our employing organisations to ensure equalities is mainstreamed across our staff groups.

Protecting and improving 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. Building on this strong position, AHSCP was chosen as a pilot area to undertake a Supported Self Evaluation of Adult Support and Protection (ASP) alongside the Care Inspectorate during 2025. The focus was on early intervention, and AHSCP chose its Early Screening Group (ESG) as the area for self-evaluation. The evaluation concluded in Autumn 2025 and the ESG was evaluated across 10 Quality Indicator Questions as either Good or Very Good for each indicator. In 2026, AHSCP is driving forward work with Police Scotland, the Office of the Public Guardian, and the Sheriff Court to consider new joint ways of investigating financial and sexual harm in Angus. This work highlights the commitment of all agencies to support and protect adults in Angus and how AHSCP continues on an improvement journey in ASP.

Improving the quality of the service

AHSCP's Clinical, Care and Professional Governance Group (CCPG) provides assurance to the AIJB's Chief Officer, Angus Council, and NHS Tayside that health and care services across Angus are safe, high-quality, and centred on the needs of individuals. Using a quality management system approach, the group focuses on continuous improvement through learning and collaboration. We will continue to regularly monitor and review standards, ensuring that services meet both local and national health and social care standards, demonstrating the benefits of integrated working to enhance care quality.

Planned and led locally

In Angus, health and social care services are delivered across four localities. This fulfils the legislative requirement to work at locality level and supports the planning and delivery of services that reflect the different needs, characteristics, and priorities of communities across Angus.

We are committed to ensuring that everyone can access the care they need, based on the needs of their community. While it is not always possible or clinically appropriate to provide every service in every town, we will plan services, so they are delivered where they are most needed and ensure safe, timely access for all.

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

During the lifetime of this Strategic Framework, we will undertake a review of our locality structure to ensure it best supports service delivery, population needs, and efficient use of resources.

We will strengthen our place-based approach to planning and delivering health and social care, recognising that people's needs, experiences, and outcomes are shaped by where they live. By working collaboratively with local community organisations and businesses we will build on community strengths, reduce inequalities, and design services that are responsive, integrated, and sustainable. This approach will empower people to recognise local strengths and connect with their communities, supporting prevention, improving access to care, and enabling people to live healthier and more independent lives. Community and voluntary organisations play a vital role in this approach by providing locally responsive support, strengthening community networks, and helping people access services and opportunities that promote wellbeing and independence.

Early Identification, Future Care Planning and Proactive Support

Identifying needs earlier and providing proactive support is essential to improving outcomes and reducing the risk of harm. Working with Community Planning Partners, Public Health Scotland, and other stakeholders, we will focus on prevention, early identification, and timely intervention, using data, insight and partnership working to target support where it is most needed. We will continue to design services around people's whole lives and empower individuals and communities to improve health and wellbeing, build resilience and deliver better long-term outcomes.

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

We will prepare a Property Strategy which will identify opportunities to maximise the value of available facilities, people, and resources by aligning them to population needs,

reducing duplication, and improving coordination across services. Through our Workforce Strategy we will optimise workforce skills, using assets more flexibly, strengthening partnerships, and applying data and continuous improvement approaches to ensure resources are deployed efficiently, equitably, and where they deliver the greatest impact.

Working Together

This Strategic Framework is rooted in system-wide collaboration. Its success will depend on building and sustaining our strong, trusted partnerships with Angus Council, NHS Tayside, ANGUSalive, Third and Independent Sector partners, unpaid carers, and people who use services.

The aim of integrated health and social care is to ensure that everyone in Angus has access to joined-up care and support. We take pride in the strong collaborative relationships we have built with our partners, for example Angus Council, NHS Tayside, Angus Community Planning Partnership, Angus Alcohol and Drug Partnership, ANGUSalive, Protecting People Angus, Scottish Ambulance Service and the Third and Independent Sector organisations, and recognise the importance of continuing to work together with a shared purpose to make a real difference to the people of Angus. By working in this way, we will avoid duplication, make better use of resources, share expertise, and deliver more coordinated and effective support that meets people's needs.

The Scottish Government Service Renewal Framework emphasises the importance of collaborative planning to break down organisational silos and ensure that decisions are driven by the needs of local populations rather than administrative boundaries. Through collective leadership, we will continue to plan and deliver services together, enabling people to live well and remain independent for longer.

We will build on the progress already made with our partners to ensure that, collectively, our offers reach and support more people. Where possible, we will co-develop plans across the whole system, using mechanisms such as our Market Facilitation Plan to drive alignment and meaningful change.

This approach is already underway in key areas, including workforce planning, and we will continue to identify further opportunities to collaborate and develop shared solutions.

This Strategic Framework identifies clear opportunities to strengthen partnership working and unlock the full potential of our shared facilities, skilled workforce, and voluntary and community sector assets. By doing so, we will deliver improved outcomes for people and communities while making the best use of the resources available to us.

Examples of working together include:

The Third Sector	The Independent Sector
Voluntary Action Angus 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 play a vital role in support communities at a local level. There are at least 1,382 voluntary sector groups and organisations in Angus. Angus Health and Social Care Partnership will continue to work in partnership with Voluntary Action Angus, the Third Sector Interface for Angus, to support engagement with community and voluntary organisations and to strengthen collaboration in delivering preventative and community-based support.	The independent sector is a key partner and contributes significantly to service delivery across a range of settings, including care at home, care homes, community services, and specialist provision. The sector brings flexibility, capacity, and innovation to the system, supporting responsiveness to local needs and enabling AHSCP to meet statutory duties and strategic priorities. Independent sector partners also play an important role in workforce development, quality improvement, and market sustainability. 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). These posts support effective engagement with the independent sector, strengthens collaboration, informs commissioning and service planning, and supports the delivery of safe, sustainable, and outcome-focused services.

We will continue to work in partnership with unpaid carers, recognising them as equal partners in care and valuing the vital role they play in supporting people to live well at home and in their communities. By listening to carers' voices, involving them in planning and decision-making, and working closely with carer organisations and community partners, we will ensure carers are supported, informed, and enabled to sustain their caring role without detriment to their own health and wellbeing.

Angus Community Planning Partnership (CPP) brings together public sector organisations, community groups, voluntary organisations, and other local partners to plan, deliver and monitor services and activities that improve outcomes for people living in Angus. The CPP provides strategic leadership for community planning, applying Scottish Government principles to support collaborative working and the delivery of responsive, high-quality public services tailored to local needs.

The Angus Alcohol and Drug Partnership (ADP) is a multi-agency partnership that leads and coordinates the local response to alcohol and drug-related harms in Angus. Working with statutory, third sector and community partners, it plans and oversees prevention, treatment, harm reduction and recovery services informed by local need and evidence. The ADP Strategy 2023–26 places a strong emphasis on partnership working, evidence-based action and the meaningful involvement of people with lived experience, while tackling stigma and promoting recovery.

We have a well-established **Clinical Partnership Group** which advises on all clinical aspects of service improvement. This ensures early clinical input, shared ownership, and appropriate clinical governance oversight of service change.

The **Prescribing Quality Management and Assurance Group** provides multidisciplinary oversight and assurance of prescribing quality, safety, and value across primary care. It supports the implementation of national and local prescribing guidance, oversees medicines optimisation activity, and provides clinical governance around high-risk or high-cost prescribing, contributing to both quality improvement and financial sustainability.

Housing and Reducing Homelessness

Access to safe, secure, and appropriate housing, including timely adaptations and housing-related support, enables independence, supports prevention, and facilitates timely hospital discharge. Housing to 2040, published in 2021, is the SG's long-term national housing strategy and sets out a 20-year vision for housing in Scotland, aims to ensure that everyone in Scotland has access to a safe, warm, affordable, and good-quality home, and that housing plays a stronger role in improving health, wellbeing, and equality. The Housing Contribution Statement sets out how we will work with all our Partners but particularly Angus Council to ensure people live in safe and quality housing within their community.

Homelessness remains a significant issue with direct impacts on health, wellbeing, and demand for health and social care services. We recognise housing as a critical social determinant of health and will work with our partners to address the root causes of homelessness, prevent homelessness where possible, and respond quickly when it does occur. The Housing (Scotland) Act 2025 places duties on public bodies to act early to prevent homelessness and to promote decent, stable housing. In line with these duties, the IJB will work collaboratively with partners, including local authorities and housing providers, to align care and support services with statutory homelessness prevention and tenancy sustainment responsibilities.

Children's Services

In June 2025 legislative proposals to improve the experiences of children and young people in Scotland's care system were published in a Bill introduced to Parliament. The Children (Care, Care Experience and Services Planning) (Scotland) Bill proposes extending the aftercare support currently available for 16-to-26-year-olds who were in care on their 16th birthday to those who had left care before that point, including providing help with accommodation, education, employment, and wellbeing. If passed by Parliament, the legislation would also secure for people with care experience a right to access lifelong advocacy services, ensuring their voices are better heard throughout their care journey. AIJB and AHSCP will work closely with Angus Council as legislative proposals are implemented.

Climate Change

Tackling climate change and progressing towards Net Zero is a national priority and Scotland has some of the most ambitious climate change legislation in world and has a national ambition to become Net Zero by 2045. IJBs are subject to the climate change

duties set out in the Climate Change (Scotland) Act 2009, which require public bodies to act in ways that contribute to emissions reduction, climate adaptation, and overall sustainability.

While AIJB does not directly own or manage buildings or vehicle fleets, it has a critical role in ensuring that its strategic planning, commissioning, and investment decisions support national climate targets. This includes strengthening the resilience of vulnerable populations, promoting sustainable and preventative models of care, and reducing the environmental impact of health and social care services.

AIJB plays an important role in supporting Angus Council and NHS Tayside to fulfil their statutory climate change duties, supporting low-carbon models of care. We also meet statutory requirements for annual reporting on climate performance. Our work is aligned to the Angus Council Transition to Net Zero Action Plan (2022–2030) which sets out actions to ensure the SG's interim target of a 75% reduction in emissions by 2030 is on track towards achieving Net Zero by 2045. NHS Tayside has established a Climate Change and Sustainability Board which oversees seven workstreams focused on reducing emissions across clinical care, travel and transport, property and energy, procurement, waste management, greenspace and biodiversity, and the delivery of the Board's Anchor ambitions.

What matters most to people and communities?

The Public Bodies (Joint Working) (Scotland) Act 2014 places a legal requirement on the IJB to involve people in the design and delivery of care services. This duty was strengthened by the Community Empowerment (Scotland) Act 2015. Participation is also a key principle of a human rights–based approach, which recognises people as active citizens and supports their involvement in decisions that affect their lives.

The Planning with People Guidance underpins our approach to engaging with communities, enabling people to have their say and ensuring that the improvements we make and the services we provide reflect what matters most to our communities and stakeholders. We are committed to listening to people's experiences and using this feedback to improve service delivery.

We want to continue building strong relationships with the people of Angus who use our services now, or may do so in the future, and to further develop our Network. By working together, we can make a meaningful difference to outcomes for all residents. This includes supporting people to achieve what matters most to them, while also understanding what is working well and where improvements can be made.

Through our engagement to deliver this Strategic Framework, and feedback we have received over recent years we know that what matters most to people is receiving health and social care that is compassionate, timely, and responsive to their individual needs. People want to feel listened to, respected, and involved in decisions about their care, with support that enables care to be provided as close to home as possible. Being supported to live independently for as long as possible, with clear communication and well-coordinated services is also very important to people.

We know that people have concerns about access to public transport. As we continue to develop more community-based services, it is essential that there are good local transport links to support people to travel sustainably. We will work with the Community Planning Partnership to explore opportunities to improve transport provision.

With the support of people living in Angus, we have further developed a series of joint commitments that set out how we can work together towards our shared goal of making a positive difference.

ANGUS
Health & Social Care
Partnership

Joint Commitments - making a difference for you, with you



Our Priorities and Enablers

In previous plans, we prioritised specific groups of people, including those with mental health needs, learning disabilities, and those in substance use recovery. In developing this Strategic Framework, we have reviewed our previous priorities, analysed national and local drivers for change and key challenges, and listened carefully to feedback from stakeholders and communities. As a result, we have identified two strategic priorities, supported by six strategic enablers, to deliver our vision.

The two strategic priorities within this Framework are closely connected.

- **Prevention and Proactive Care** focuses on helping people stay well, maintain independence and access support earlier.
- **Care Closer to Home** focuses on ensuring people can receive the right care and support, in the right place, at the right time, as close to home as possible.

Together, these priorities support a shift towards prevention, early intervention, coordinated care and sustainable services that improve outcomes for the people and communities of Angus.

We have identified a range of key factors, called enablers, which will support and drive the successful implementation of this Strategic Framework. Our enablers are:

- Workforce
- Financial Planning
- Digital
- Data
- Collaborative Commissioning
- Communication and Engagement

These strategic priorities and enablers form the framework for change. The actions required to achieve this change must be specific, measurable, achievable, realistic, and deliverable within the set timescales. Separate Strategic Plans will be developed for each priority which will provide more detailed insight into the specific areas the IJB will focus on as we work toward achieving our priorities.

Prevention and Proactive Care

Why is this a strategic priority?

The number of people living with frailty is rising, increasing pressure on health and social care services. Reducing demand on these already stretched services through early prevention and timely support is essential. This approach underpins the Scottish Government's Service Renewal Framework and Population Health Framework. Health and social care must work together to support people earlier, helping them stay well for longer. Social care plays a key role by identifying emerging needs, coordinating person-centered support, and preventing crises that could lead to hospital or residential care. This integrated approach improves outcomes, optimises system capacity, and eases overall demand. Achieving it requires sustained investment in proactive, preventive care, ensuring timely support and minimising the need for more intensive interventions.

We will not allow challenges in parts of our health and care system to distract us from the urgent need to build our already successful programme of prevention and proactive care. Over the lifetime of this Strategic Framework, we will work with partners to further transform health and social care services to be more proactive, person-centred and sustainable, shifting from reactive care to proactive prevention, from siloed interventions to cross-sector collaboration. By embedding prevention and early intervention across services, we will help people stay well for longer, add healthy years to life, reduce inequalities, and ease pressure on acute and emergency care.

Third Sector organisations play an important role in supporting prevention and early intervention through community-based services, volunteering, peer support and social connection initiatives. Working in partnership with Voluntary Action Angus and local organisations will continue to support community resilience and help people remain independent for longer.

Support people to when needed. Through early advice, accessible services, and action on the wider determinants of health, we aim to build resilient communities and improve outcomes across the life course.

Health literacy is a fundamental aspect of healthcare, it enables individuals to understand risk factors, navigate health systems, and make informed decisions about screening, lifestyle changes, and early intervention. When people have the knowledge and confidence to act on health information, they are more likely to engage in preventive behaviours, adhere to care plans, and seek support before conditions become acute or costly. We will work with partners to further improve health literacy by strengthening clear communication, co-designing appropriate resources with communities, and embed health education across care pathways and local settings.

We will continue to promote Ageing Well Angus, our local online self-help and support resource, as a key enabler of healthy ageing, independence and self-management for people in Angus and VAA's Angus Community Connector.

AHSCP will continue to promote opportunities that strengthen social connections and support independent living. We will explore and test innovative approaches, such as using the creative arts, and in 2026 we will be collaborating with Luminate (Scotland's creative ageing organisation) and Scottish Ballet to bring these ideas to life.

We will continue to promote the use of Pharmacy First Scotland is a service for people living in Scotland, registered with a Scottish GP Practice, residents in a care home and care settings, people who are experiencing homelessness, and the traveller community. The service provides access to advice and treatment quickly without needing a GP appointment, reducing waiting times for common conditions.

Build stronger and more resilient communities

Resilient communities are places where people are supported to live well, stay connected and use local strengths and assets rather than relying solely on formal services.

We have some powerful examples of how communities in Angus have supported each other when faced with unexpected challenges. It is important that we are prepared for the impact of climate change such as heatwaves, cold snaps, floods and severe snow which are likely to become increasingly common. Building community resilience is an Angus-wide responsibility and does not sit entirely with the IJB, however, we have a responsibility to play our part.

Act early to identify healthcare needs

Future Care Planning (previously referred to as anticipatory care planning) is a core, person-led element of our strategic planning approach, supporting people to identify what matters to them and agree informed actions should their circumstances deteriorate. It enables timely, proportionate decision-making across health and care settings, improves shared decision-making, and supports care to be delivered in the right place. People of all ages, particularly those living in care homes, will be supported to have meaningful, person-centred conversations with their health and social care teams.

We will expand the reach and quality of Future Care Planning by embedding supported conversations at key points of care, strengthening workforce capability and digital sharing, improving public awareness, and promoting discussion of welfare Power of Attorney, aligned with Scotland's care home framework's focus on prevention and earlier identification of need.

Use local prescribing resources effectively.

Prescribing is an area which AHSCP, and Scotland as a whole, has experienced a sustained growth in demand and rising costs for prescription medications. These pressures are further compounded by medication shortages and an increasing number of people living with multiple conditions who require several medicines. In Angus, this challenge is intensified by a growing older population.

Angus's ageing population means more people are living with long-term health conditions that require medication, leading to a growing number of prescriptions. Wasted medication costs in Angus is around £1.2m each year and we will continue to raise awareness of how to reduce medicines waste.

AHSCP is leading the way in personalised medicine with Scotland's first primary care **pharmacogenomic** testing pathway. This innovative approach uses an individual's genetic information to guide the prescribing of common medications, helping us understand why some treatments work well for some people but cause side effects or are less effective for others. By using this insight, healthcare professionals can choose the safest and most effective medicine for each person.

Where do we want to be by 2036?

- Improved health and wellbeing outcomes.
- More people supported to live independently in their own homes.
- Reduction in the levels of unmet need in the community.
- People tell us they feel supported to take control of their own health and wellbeing with appropriate access to information and tools that enable healthy lifestyles and informed choices.
- Avoidable hospital admissions are reduced, and when people do require inpatient care, they experience timely, efficient discharge with the right support in place to continue their recovery at home or in the community.
- Reduction in the variation in the way medicines are prescribed and increase in the number of people offered an evidence-based alternative to a medicine.
- Continued reduction in the number of people falling.
- Increase in the use of future care planning so people feel more informed about the support, care and treatment available for the mental and physical health, which support making choices about planning for the future, for example, increase in the number of people with a Power of Attorney.
- Our workforce is confident, skilled, and supported to deliver proactive, prevention-focused care, ensuring every interaction with people contributes to better health and wellbeing outcomes.

Care Closer to Home

Why is this a strategic priority?

People tell us that they would like to live independently in their own homes and in their community for as long as possible. Moving care closer to home means enabling people with specific care needs to receive safe, effective, and person-centred support in their own homes or local communities wherever possible. This approach promotes independence, improves outcomes and experience, and reduces reliance on hospital or institutional care. Additionally, from the individual's perspective, receiving care closer to home often means remaining connected to family, friends and local community supports. This is important not only for health outcomes but also for personal wellbeing and the experience of care. Technology and digital health tools will play in important part in supporting this shift.

Delivering care closer to home requires strong community services, integrated working across health, social care and third sector partners, and effective use of local assets and digital solutions to ensure timely, coordinated, and sustainable care.

Community and voluntary organisations play an important role in supporting care closer to home by providing a wide range of preventative and community-based services, including social connection initiatives, wellbeing activities, peer support and volunteering opportunities. Working in partnership with Voluntary Action Angus and local organisations will help strengthen community capacity and enable more people to remain independent within their own communities.

We know that 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 community pharmacies. AHSCP is leading on the development of the Tayside Primary Care Foundational Strategy 2026 – 2028 which sets out a collective and forward-looking ambition for strengthening Primary Care across Tayside. The Strategy provides a clear and coordinated plan for stabilising the primary care system during a period of significant pressure, while preparing for the wider transformation required to meet the needs of our population over the next decade.

We will:

Provide care closer to home whenever possible

We will continue to develop the Angus Care Model to ensure an effective and sustainable health and care system, shifting the focus from hospital-based care to primary and community services.

We will make sure services are available where they are needed most and delivered by skilled professionals using the best available resources. This includes exploring new ways

to provide care so people can access support more flexibly, even if it is not always in a traditional setting.

AHSCP will contribute to the NHS Tayside whole-system programme to reform outpatient services which aims to address the challenges of an ageing population, increasing number of patients living with a long-term condition, workforce pressures and rising demand. This new programme, developed with input from staff, patients, and staff side colleagues, will adopt a Tayside Together approach that is led by clinicians and supported by managers, bringing staff and patients together to design and deliver innovative improvements.

We will continue to support the delivery of the Primary Care Improvement Plan, working collaboratively with GP practices and NHS Tayside.

We will continue to develop and expand multidisciplinary teams, improve access pathways, and enhance community-based services. These developments are integral to achieving our priorities of prevention and proactive care, supporting people closer to home, and shifting the balance of care toward community settings.

While we are not responsible for Accident and Emergency services, we are responsible for a range of services that people may require unexpectedly. This is known as unscheduled care and includes services such as GP out-of-hours and community pharmacy. We continue to work in a whole-system way with Angus Council and NHS Tayside and local providers to develop new ways of working that ensure people are not admitted to hospital unless clinically necessary, and that, where admission is required, people are not in hospital for longer than needed. Through this partnership approach, we aim to reduce avoidable emergency admissions by shifting the balance of care towards prevention and community-based services.

Palliative and end of life care and support is everybody's business. Though we have become good at prolonging life, we still cannot prevent death. There are, however, many ways in which we can improve people's experience of death, dying and bereavement. We will continue to contribute to the development of a Tayside Palliative Care Strategy which is being progressed as part of the Tayside Together Corporate Priority for Palliative Care, aimed at ensuring we can provide the best palliative and end of life care and support that we can.

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

It is vital that we plan appropriately. In some areas, the demand for certain services is very low. This means it is not always possible, or safe, to provide everything everywhere. For example, keeping a service open in a location with very little demand, can lead to staff shortages, long waits, or lower quality of care. Our goal is to make sure everyone gets the right care, at the right time, in the right place, even if that sometimes means travelling a little further for more specialised services.

Working with partners across NHS Tayside and Angus Council, the whole-system **Mental Health and Learning Disabilities Change Programme** focuses on ensuring high-quality care and treatment through effective, equitable models of support for people in our communities with complex mental health needs and learning disabilities.

We will continue to develop **Home First**, a new working model that streamlines communication and enhances care coordination through a unified referral pathway. This approach supports hospital admission prevention and frailty-at-home initiatives, aligning with the SG's vision for optimising access as part of its urgent and unscheduled care strategy. By wrapping care around people in their homes, hospital becomes the alternative rather than the default, helping to reduce admissions, support early discharge, and minimise length of stay. To support this, we have established a Single Point of Contact (SPOC) providing direct access to community teams. The multidisciplinary team works closely with GPs and partners to prevent unnecessary hospital admissions, while offering Social Care Assessors alternatives to emergency respite through enhanced home-based care. A dedicated Home Care Matching Unit within the SPOC will coordinate home care service requests, working with providers and using a newly developed system called Care Locator to match people with appropriate care packages based on assessed need and availability.

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

We recognise the vital contribution unpaid carers make to the sustainability of the health and social care system in Angus. Carers play a crucial role in supporting people to stay well and remain at home, and this Strategic Framework commits to supporting carers to sustain their caring role while leading fulfilling lives alongside caring. This commitment applies to carers of all ages, including young carers. We will continue to work with partners to improve access to carer support services, strengthen the quality and consistency of support, and enhance access to clear, timely information.

The Carers (Scotland) Act 2016 places specific duties on public bodies, including the requirement to produce a Carers' Strategy. In 2026 we will review our Angus Carers Strategy 2023 - 2026 to ensure it remains fit for purpose, continues to meet statutory requirements under the Carers (Scotland) Act 2016 and the Care Reform (Scotland) Act, and provides the right support to enable carers to continue caring for as long as they are able and willing to do so.

Where do we want to be by 2036?

- Most of the care and support for people with complex or long-term needs is delivered close to home, in local communities, or digitally where appropriate, reducing reliance on hospital or institutional care.
- Individuals, families, and carers are supported to manage their care at home where possible, with access to information, resources, and guidance to promote independence and wellbeing.
- Hospital admissions and lengths of stay are minimised through proactive community care, with care homes, community clinics, and home-based services able to manage complex needs safely.
- People tell us that they experience coordinated care that is personalised to their needs, with health, social care, and third and independent sector partners working together across settings.

- Digital solutions are used effectively to provide high-quality care close to home, improving efficiency, experience, and sustainability.
- More carers feel supported in their caring role.

Enablers

Workforce

Our workforce is our greatest asset and is fundamental to the delivery of the priorities set out in this Strategic Framework. While the IJB does not directly employ staff, health and social care services are delivered by a diverse workforce employed by Angus Council and NHS Tayside, alongside partners in the Third and Independent Sectors. We also recognise unpaid carers and volunteers as a vital and valued part of the wider health and social care workforce, whose contribution is essential to achieving improved outcomes for people and communities.

The Angus IJB Workforce Plan 2025–2029 sets out how the AHSCP will develop, support and sustain its workforce in response to growing demand, demographic change and national reform. Building on progress from our previous Workforce Plan, it focuses on improving recruitment and retention, strengthening leadership and wellbeing, making better use of workforce data and digital solutions, and planning proactively for future skills and capacity needs. The Workforce Plan aligns with local and national priorities to ensure a skilled, resilient, and adaptable workforce with the capacity and capability to deliver safe, effective, compassionate, and person-centred care, supporting the needs and wellbeing of the population now and over the next ten years.

Collaborative Commissioning

The Collaborative Commissioning enabler reinforces the IJB's commitment to delivering joined-up, sustainable services that meet the needs of local populations. By working across health, social care, housing, and third and independent sector partners, commissioning decisions are informed by shared evidence, outcomes, and community insight.

Our 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 further build on this during the lifetime of this Strategic Framework. 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.

Financial Planning

Financial Planning underpins the IJB's ability to deliver sustainable, person-centred services. By embedding whole-system financial planning and transparent governance, the IJB ensures that resources are aligned to strategic priorities and invested where they achieve the greatest impact, in prevention, early intervention, and community-based support. Further information is provided in the financial resources section.

Data

Efficient and effective use of data enables the IJB to plan and deliver services based on robust evidence, shared intelligence, and a comprehensive understanding of population needs. Strengthening data sharing, integration, and analytical capability across partners will allow the IJB to anticipate demand, identify emerging trends, target resources more effectively.

Digital

As part of our commitment to transformational health and social care, we recognise digital innovation as a core strategic enabler for delivering integrated, person-centred, efficient, and equitable services. While digital will expand how services are designed and delivered, offering new opportunities for prevention, integration and improved access, alternative routes will continue to be available. We are committed to supporting people to become digitally enabled where they wish, ensuring innovation is inclusive and that no one is excluded from accessing care.

This approach aligns with the Scottish Government's Digital Strategy and Digital Strategy and Sustainable Digital Public Services Delivery Plan 2025-2028, which emphasise shared digital solutions, data-driven decision-making and collaborative digital leadership to improve public service outcomes and reduce duplication across the public sector. Using this national policy context, we will advance interoperable digital systems, strengthen workforce capability in digital, data and technology, and support preventative and personalised care pathways that are easier for citizens to access and navigate.

By embedding digital transformation across all strategic priorities and areas of service delivery, from partnership working and inclusive engagement to remote monitoring and shared data systems, we will make better use of resources and ensure people can access the right care, at the right time and in the right way, regardless of geography or circumstance, supporting a robust, resilient, and digitally enabled health and social care system.

Communication and Engagement

Engaging and listening to communities, staff and partners has been central to determining the IJB's priorities. Patient, service user and carer engagement and involvement is a continuous process to ensure views from all sectors of the community are captured and shared to influence decisions made. By creating consistent and inclusive channels for dialogue with communities, staff, and partners, the IJB promotes transparency and supports continuous improvement in service design and delivery, driven by the voices of the people we serve, strengthening trust and accountability across the whole system. We will continue to expand and diversify the range of podcasts and animations which help people better understand services and how to access them.

In 2025, we introduced a new way for people to provide feedback on proposed service changes through the use of Engage. This safe and accessible platform allows people to share their ideas on issues, projects, and activities.

We continue to welcome feedback through Care Opinion which gives people the opportunity to share their experiences and help improve the services they receive. During

the lifetime of this Strategic Framework, we will review and refresh our Communication and Engagement Strategic Framework 2023 – 2026 and will continue to provide regular opportunities for stakeholders including staff, 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.

Financial Resources

AIJB is operating in a significantly challenging financial planning environment and is expected to face further financial pressures throughout the duration of this Strategic Framework. Like all other IJBs, AIJB must operate within the resources allocated to it by its partner organisations, as funded by the SG. The IJB must strategically manage inflationary, demographic, legal and service-related pressures within its financial framework.

The latest AIJB Strategic Financial Plan suggested unsustainable financial shortfalls of at least c£19.3m by 2028/29, if no further planned saving are successfully delivered. Ongoing pressures in the wider system mean that, unless steps are taken, this shortfall is likely to increase every year.

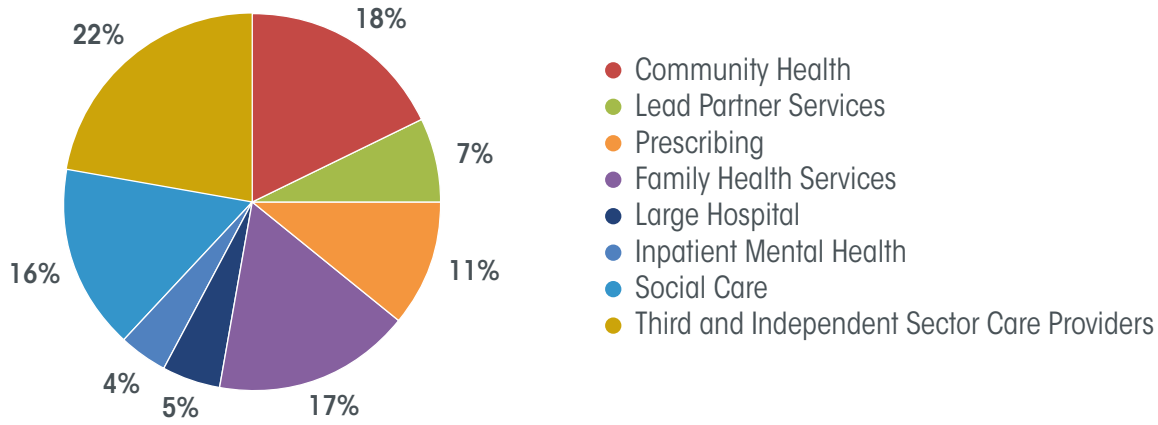
The way funds are allocated to the services that AHSCP deliver, is based on this Strategic Framework. We need to be mindful that we may not have the resources in the future to deliver services as we do now, without offsetting actions being taken. Despite these challenges we remain committed to improving outcomes for everyone in Angus.

The IJB has a duty to deliver value for money by ensuring strong governance and effective management of resources, with a continuous focus on improvement to achieve the best possible outcomes for the public. We know that achieving Best Value will only be possible through effective collaboration with our partner organisations including Third and Independent Sector organisations. To help us do this we continually monitor our performance against the following Best Value characteristics:

- Vision and leadership
- Governance and accountability
- Effective use of resources
- Partnerships and collaborative working
- Working with communities
- Sustainability
- Fairness and equality

For the financial year 2024/25 the IJB expenditure is presented as a percentage breakdown across the following service areas.

Angus IJB Expenditure (2024/25)



In 2025/26, the IJB's budget is circa £250 million, with the allocation of this funding outlined in the current and future strategic financial plans.

The IJB faces increasing demand, demographic growth alongside rising costs including inflation. Financial and workforce challenges are expected to further impact on service delivery, meaning the IJB may not be able to fully meet rising demand within available resources. National Factors and initiatives, such as the Care Reform (Scotland) Act 2025 and growth in complex care packages will also impact on our resources.

AIJB expects to retain a Strategic Planning Reserve, specifically designated to support the implementation of this Plan during its first three years. The fund will be overseen by IJB's Strategic Planning Group and will be used to support interventions to facilitate the planning and delivery of this Strategic Framework.

As the management of our resources becomes increasingly challenging, it is essential that funds are used as efficiently and effectively as possible. This Strategic Framework identifies a number of areas of improvement, and these will be further developed and inform the overall Strategic Financial Plan. The IJB financial planning assumptions will continue to be developed throughout the duration of the Plan. We know that continuing with existing approaches will not be sufficient to meet current and future challenges. We need to take bold steps to respond effectively to changing needs and we must be prepared to adapt our ways of working. Some of the financial planning initiatives includes:

Priority 1: Prevention and Proactive Care

- Increase the focus on proactive and person-centred care, ensuring that Future Care Planning becomes a routine part of care delivery and support people to have meaningful conversations about what matters to them.

- Improve the use of data, intelligence, and digital methods to allow the targeting of prevention more effectively, understand needs better and allow more robust planning around our people and communities.
- Ensure that prescribing is safe, effective, and sustainable with a focus on reducing variation and waste and championing innovation to make sure that people gain the most from their prescribed medicines.
- Support practical implementation of pharmacogenomics in Primary Care.
- Expand community-based early intervention pathways, for example in respiratory health, frailty, falls prevention and mental wellbeing, to reduce avoidable hospital admissions and long-term care costs.
- Continue to develop the role of Allied Health Professionals supporting the population to maintain independence.
- Integrate prevention and proactive approaches within all commissioned services so that every contact supports wellbeing, independence, and reduced reliance on reactive care.
- Explore how we can continue to build upon The Beacon, our Community Wellbeing Centre.
- Further develop the Neurodevelopmental Pathway prioritise early, proportionate support and reducing reliance on medication.

Priority 2: Care Closer to Home

- Continue to implement HomeFirst, with a multidisciplinary team approach aiming to prevent hospital admissions and support individuals to be cared for at home.
- Continue to review and adapt provision of Care at Home.
- Continue to improve Adult with Incapacity processes to ensure effective pathways of care.
- Continue to support carers to live well and continue their caring responsibilities, reviewing arrangements to ensure we meet the requirements of the Carers (Scotland) Act 2016 and Care Reform (Scotland) Act 2025.
- Review of local Medicine for the Elderly inpatient beds.
- Revisit options around the future model for service provision for internal Care Homes beds.
- Review arrangements to ensure we meet the requirements of the Carers (Scotland) Act 2016 and Care Reform (Scotland) Act 2025.
- Review the best mix of home visits and clinic-based care to meet growing demand in all service areas.
- Revisit options around the future model for service provision for General Practice services directly managed by NHS Tayside (2C Practices).
- Review implementation of eligibility criteria for social care support.
- Continue with the implementation of the Tayside GP Out of Hours Strategic Framework 2026-2036.

- Explore opportunities to optimise the Community Alarm Service.
- Explore opportunities to enhance the use of telecare to enable people to live independently at home.
- Implement the Model of Care for General Adult Mental Health Services.
- Explore the development of a new Supported Accommodation model within the Learning Disability service to address accommodation shortages.
- Develop plans for capital works within Learning Disability Resource Centres to maximise building capacity.
- Review of delivery models within internal Supported Accommodation.

How will we know we have made a difference?

We will use robust data and stakeholder engagement to monitor progress, ensuring continuous improvement aligned with national frameworks. Separate Strategic Delivery Plans will be developed to provide more detailed insight into the specific areas the IJB will focus on as we work toward achieving our priorities. Progress will be monitored through our performance in relation to the national health and wellbeing performance indicators and local indicators. We will continue to report our progress via our Annual Performance Report and biannual performance reports.

As a result of implementing this Strategic Framework:

- People will feel informed, supported, and able to take control of their health and wellbeing.
- More people feel supported to live independently, feel connected to their community and are confident about accessing local support networks.
- Services are person-centred and joined up, resulting in improved outcomes.
- People receive the right medicines at the right time with minimal waste.
- More unpaid carers feel supported in their caring role and lead a fulfilling life alongside caring.
- Staff feel valued, supported, and equipped to deliver high quality innovative services, with reduced absence and improved retention.
- We plan and deliver services within a sustainable financial framework, reducing the needs for reactive budget decisions.

The table below illustrates the difference we want to make:

2026: Current ways of working	2035: Future ways of working
• Most services react to illness meaning care and support starts once people are unwell. • Majority of care is provided in hospitals and clinics. • Some people use health apps and video appointments but not everyone has access or confidence in them. • Data tends to be retrospective. • Staff spend a lot of time on paperwork leaving less time for direct care.	• The aim is to stop people getting ill in the first place, identifying risks early and hep people stay healthy. • More care is provided in homes and communities. • Technology is easier to use and more part of everyday life. • Data is real time and there is more predictive analysis. • Technology is used to support routine tasks so staff can focus on direct care.

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.

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
Integration Planning Principles

(a) that the main purpose of services which are provided in pursuance of integration functions is to improve the wellbeing of service-users,

(b) that, in so far as consistent with the main purpose, those services should be provided in a way which, so far as possible:

(i) is integrated from the point of view of service-users,

(ii) takes account of the particular needs of different service-users,

(iii) takes account of the particular needs of service-users in different parts of the area in which the service is being provided,

(iv) takes account of the particular characteristics and circumstances of different service-users,

(v) respects the rights of service-users,

(vi) takes account of the dignity of service-users,

(vii) takes account of the participation by service-users in the community in which service-users live,

(viii) protects and improves the safety of service-users,

(ix) improves the quality of the service,

(x) is planned and led locally in a way which is engaged with the community (including in particular service-users, those who look after service-users and those who are involved in the provision of health or social care),

(xi) best anticipates needs and prevents them arising, and

(xii) makes the best use of the available facilities, people and other resources.

APPENDIX 3
National Policy and Drivers

- A Fairer Scotland for Disabled People: Delivery Plan (2016) and Duty (2018)
- A National Clinical Strategy for Scotland (2016)
- A Scotland Where Everybody Thrives: Public Health Scotland's Strategic Plan 2022–25
- Achieving Excellence in Pharmaceutical Care; a strategy for Scotland (2017)
- Article 19 of the UN Convention on the Rights of Persons with Disabilities (2008)
- Best Value: revised statutory guidance (2020)
- Care in the Digital Age: Delivery Plan 2022 – 2023
- Care Reform (Scotland) Act 2025
- Carers (Scotland) Act 2016
- Charter of Rights for People Affected by Substance Abuse (2024)
- Climate Change (Emissions Reduction Targets) Scotland Act - Health Impact Assessments (2024)
- Coming Home Implementation: report from the Working Group on Complex Care and Delayed Discharge (2022)
- Coming Home Report: Complex care needs and out of area placements (2018)
- Community Mental Health and Wellbeing Supports and Services Framework (2021)
- Creating Hope Together – Scotland's Suicide Prevention Strategy 2022
- Delivering Value Based Health & Care: Vision for Scotland
- Dementia in Scotland: Everyone's Story Delivery Plan 2024-26
- Diabetes Improvement Plan (2014)
- Enabling Connecting and Empowering: Care in the Digital Age – Scotland's Digital Health and Care Strategy 2021
- Equality Act (2010)
- Equipment and Adaptations: Guidance on Provision
- Fair Work Action Plan (2021)
- Fairer Scotland Duty: guidance for public bodies (2021)
- General Medical Services Contract in (2018)
- Getting it Right for Every Child Policy Statement (2022)
- Getting it Right for Everyone (Scotland) (2024)
- GP Contract and Memorandum of Understanding (2018)
- Greater access, better insight, improved outcomes: a strategy for data-driven care in the digital age

- Health & Care (Staffing) (Scotland) Act Implementation (2024)
- Health and Social Care Standards: My support, my life
- Health Improvement Scotland - Ageing and Frailty Standards of Care (2024)
- Housing to 2040 (2021)
- Human Rights Act 1998
- Independent Review of Adult Social Care in Scotland (2021)
- Learning/Intellectual disability and autism transformation plan (2021)
- Medication Assisted Treatment (MAT) standards (2021)
- Mental Health – Scotland's Transition and Recovery Plan (October 2020).
- Mental Welfare Commission: Hospital is not a Home
- My Health, My Care, My Home.
- National Cancer Strategy Refresh (April 2022).
- National Carers Strategy (2022)
- National Drug Mission Plan (2022 – 2026)
- National Health and Wellbeing Outcomes Framework (2015)
- National Health Service (Scotland) Act (1978)
- National Mental Health Strategy 2017 – 2027
- National Performance Framework: Proposed National Outcomes
- National public protection statute and guidance
- National Strategy for Dementia in Scotland 2023
- National Transitions to Adulthood Strategy for Young Disabled People
- National Workforce Strategy for Health and Social Care (2022).
- NHS Recovery Plan 2021 – 2026.
- NHS Scotland Operational Improvement Plan (2025)
- NHS Scotland Recovery Plan
- Palliative Care Strategy: Palliative Care Matters for All. (2024)
- Planning with People Guidance
- Primary Care Improvement Plan (2018)
- Principles for Planning and Delivery of Integrated Health & Social Care (2015)
- Protecting Scotland-Renewing Scotland 2020
- Public Bodies (Joint Working) (Scotland) Act (2014)
- Public Health Scotland 10 year Strategy to 2035: Together we can create a Scotland that thrives
- Public Health Strategy Refresh (2022)
- Public Services Reform (Scotland) Act (2010)

- Realising Realistic Medicine (2017)
- Realistic Medicine – Doing the Right thing – Chief Medical Officer Annual Report 2022 – 2023
- Recovery and Redesign: An Action Plan for Cancer Services (December 2020)
- Rehabilitation and Recovery: a person-centred approach (2022)
- Rights, Respect and Recovery: Alcohol and Drug Treatment Strategy (2018)
- Scottish AHP Public Health Strategic Framework 2022 – 2027
- Scottish Government Equality, Opportunity, Community - Our Programme for Government 2023
- Scottish Government: Framework for Community Health and Social Care Integrated Services (Nov 2019)
- See Hear – A strategic framework for meeting the needs on people with a sensory impairment in Scotland (2014)
- Social Care (Self-directed Support) (Scotland) Act 2013
- The Consumer Scotland Act (2020) - Consumer Scotland guide - Consumer Duty
- The Right for Advocacy. Carers (Scotland) Act 2016
- UN Convention on Rights of a Child (UNCRC) (2022)
- UNCRC (Incorporation) (Scotland) Act 2024

APPENDIX 4
Local Strategic Documents

- Angus Carers Strategy 2023 - 2026
- Angus Alcohol and Drugs Partnership (AADP) Strategy 2023-2026
- Communication and Engagement Strategic Framework 2023 – 2026
- General Practice Premises Strategy (2023-2026)
- Joint Angus Advocacy Strategic Framework 2023 - 2026
- The Angus Community Partnership Plan 2022 - 2030

ANGUS
Health & Social Care Partnership

PLAN ON A PAGE – PRIORITY 1
PREVENTION AND PROACTIVE CARE

Improving Outcomes, Reducing Inequalities, Sustaining the System

OUR VISION

Supporting people in Angus to live healthier, more independent lives for longer through prevention, early support, community wellbeing and proactive care.

OUR APPROACH

We will focus on preventing ill health, supporting wellbeing and intervening early to help people live well for longer.

- Focus on prevention, early support and wellbeing
- Strengthen future care planning and proactive support
- Reduce crisis and support people to manage their health and wellbeing
- Work with communities to tackle the wider causes of ill health
- Target support to those at greatest risk of poor outcomes

WHAT WE WANT TO ACHIEVE

IMPROVING HEALTH AND WELLBEING

- Improved health and wellbeing outcomes.
- Increased independence and wellbeing.
- Improved mental wellbeing.
- Earlier identification of need and risk.

IMPROVING PEOPLE'S EXPERIENCE

- Earlier support and intervention.
- Better coordination across services.
- More people supported through alternatives to hospital admission.
- Improved access to advice, information and self-management support.

WORKFORCE AND PARTNERSHIP WORKING

- A skilled and supported workforce.
- Strong partnership working across services and communities.
- Increased community capacity and resilience

SUPPORTING SUSTAINABLE SERVICES

- Better use of resources.
- More prevention and early intervention.
- Greater use of community-based support.
- Reduced reliance on reactive care.

HOW WE WILL MEASURE SUCCESS

- Improved health and wellbeing outcomes
- Progress towards reducing inequalities in access and outcomes
- Increased independence and wellbeing
- More people supported through alternatives to hospital admission
- Improved experience of care and support
- Greater use of community-based support
- Improved sustainability and effective use of resources

OUR PRIORITY AREAS

1 FUTURE CARE PLANNING AND EARLY SUPPORT

Helping people plan ahead and providing early support at the right time to improve outcomes and prevent future need.

2 PROACTIVE AND COORDINATED CARE

Working together across services to deliver joined-up, proactive care that supports people to stay well and independent.

3 PERSONALISED CARE AND SUPPORT

Providing personalised support that is right for each individual and helps them live the life that matters to them.

4 COMMUNITIES, PREVENTION AND REDUCING INEQUALITIES

Building stronger, healthier communities and tackling the wider causes of ill health to reduce inequalities in access and outcomes.

5 UNDERSTANDING NEED AND IMPROVING SERVICES

Using data, insight and feedback to understand need, identify gaps and continuously improve our services.

6 SUPPORTING SUSTAINABLE SERVICES

Ensuring our resources and interventions are people and communities with the greatest need and poorest outcomes.

HOW WE WILL WORK

- Work in partnership with people and communities
- Focus on prevention, early support and wellbeing
- Tackle the wider causes of ill health and inequality
- Provide joined-up, person-centred support
- Make best use of local assets and community strengths
- Use data and insight to inform our decisions
- Listen, learn and improve continuously
- Work together to achieve the best outcomes

WHO WE WILL WORK WITH

- Individuals, families and carers
- Communities and local groups
- Third and independent sector
- Housing and community planning partners
- Primary care and wider health services
- Social work and social care services
- Schools, education and early learning
- Employers and local businesses

OUR COMMITMENT

By working together with our communities, partners and staff, we will support people to access the right care, in the right place, at the right time, helping more people to live independently at home and in their communities whilst supporting sustainable services for the future.

OUR SHARED AMBITION | Better lives, stronger communities, sustainable services

Angus Health & Social Care Partnership

Priority 1

Prevention and Proactive Care - Strategic Plan

'Improving outcomes, reducing inequalities, sustaining the system'

Our Approach

Prevention and Proactive Care is central to Angus Integration Joint Board's (AIJB) vision for the future of health and social care in Angus.

It is about helping people stay well for longer, supporting independence, improving wellbeing, and ensuring people receive the right support at the right time, as close to home as possible.

This approach recognises that improving health and wellbeing is not only about responding when people become unwell. It is about working earlier, alongside individuals, families, carers, communities, and partners, to prevent ill health where possible, reduce inequalities and support people to live healthy, connected, and independent lives.

The need for this approach has never been greater.

People are living longer, and more people are living with frailty, long-term conditions, and complex needs. At the same time, there are increasing pressures across health and social care services, alongside significant workforce and financial challenges.

If we continue to deliver services in the same way, services will become increasingly difficult to sustain. Prevention and Proactive Care therefore represents a continued shift of investment towards earlier intervention and preventative models of care.

This means:

- Identifying opportunities to intervene earlier to support health and wellbeing.
- Providing support before situations reach crisis point.
- Supporting people to manage their health and wellbeing.
- Strengthening community-based and preventative support.
- Improving coordination between services.
- Implementation of best evidence
- Targeting support towards people and communities experiencing the greatest inequalities.

This approach aligns with the wider ambitions set out within the Strategic Framework 2026–2036 and national priorities focused on prevention, reducing inequalities, community-based care and improving population health.

Clinical, Care and Professional leadership across health, social work and social care services will continue to play a key role in ensuring care and support are safe, effective, person-centred, trauma-informed, and rights-based.

Most importantly, this approach recognises that improving health and wellbeing cannot be achieved by health and social care services alone. Communities, carers, families, and individuals themselves all play an important role in supporting health, wellbeing, resilience, and independence.

Prevention and Proactive Care therefore represents a shared commitment to working together to improve outcomes, reduce inequalities and support sustainable health and social care services for the future.

What We Want to Achieve

By 2029, Prevention and Proactive Care will support measurable improvements in population health outcomes, reduced inequalities and a more sustainable and resilient health and social care system.

Improving Health and Wellbeing

We will see improved health and wellbeing outcomes across Angus, particularly for people and communities experiencing the greatest inequalities. This will include:

- Increased healthy life expectancy.
- Reduced inequalities between communities.
- Improved management of long-term conditions.
- Reduced incidence and impact of preventable illness.
- Improved mental health and wellbeing.
- Greater independence and ability to live well at home.
- Increased access to community-based and preventative support.

Improving People's Experience of Care and Support

We will reduce avoidable demand on high-intensity services and improve whole-system resilience. This will include:

- More people supported through alternatives to hospital admission.
- Reduced crisis presentations and unplanned care.
- Improved continuity and coordination of care.
- Improved discharge processes and reduced delays.
- Reduced reliance on reactive and high-cost models of care.
- Improved Future Care Planning.

Workforce and Partnership Working

We will strengthen workforce capability and establish sustainable models of integrated delivery aligned to Prevention and Proactive Care. This will include:

- Increased workforce capability in prevention, Future Care Planning, and realistic care.
- Strong multidisciplinary working across health, social work, and social care.
- Improved staff experience through more coordinated and planned approaches to care.
- Enhanced professional leadership across community-based models.
- Greater integration with third sector and community partners.

Supporting Sustainable Services

We will improve value, sustainability, and effective use of resources. This will include:

- Increased investment in prevention and early intervention.
- Reduced reliance on high-cost reactive services.
- Improved productivity and value-based care.
- Better targeting of resources using population need and evidence.
- Improved alignment between commissioning, investment, and outcomes.

By the end of the three-year period, Prevention and Proactive Care will be increasingly embedded across services, supporting improved outcomes, better experiences, and more sustainable delivery.

Priority Areas

These priority areas provide a framework for improving outcomes, reducing inequalities, and supporting sustainable health and social care services across Angus.

Together, they support a shift towards earlier intervention, better coordination of care and support, stronger community-based approaches and improved use of information and evidence to support decision-making.

Progress will be monitored through the Prevention and Proactive Care Dashboard, Balanced Scorecard, Annual Delivery Plan, and associated performance reporting arrangements. Measures will focus on outcomes, experience, inequalities, workforce, and sustainability.

Priority 1: Future Care Planning and Early Support

This priority focuses on identifying need earlier and providing support on a timely basis.

We will strengthen approaches to identifying individuals and communities who may benefit from earlier support and intervention.

This will include:

- Strengthen long-term condition management working with the integrated workstream of the planned care board.
- Strengthen respiratory services through earlier identification, improved assessment, and increased access to evidence-based support.
- Embed access to evidence-based community, leisure, and rehabilitation programmes.
- Continued development of integrated mental health and learning disability services with a 'no wrong door' culture.
- Embed a make every contact count approach across all services.
- Improved coordination of support for people with more complex needs.

This approach will support early intervention to increase healthy life expectancy and the amount of time spend in good health, also improving independence and quality of life.

Priority 2: Proactive and Coordinated Care

This priority focuses on providing more proactive, coordinated, and planned care and support.

Prevention and Proactive Care works alongside Care Closer to Home to support people to remain independent, connected to their communities and receive care in the most appropriate setting.

We will continue to scale Future Care Planning approaches, ensuring that individuals, families, and professionals are involved in decisions about current and future care and support.

This will include:

- Ensure investment in care which supports Care Closer to Home priorities through use of data and promotion of evidence-based care.
- Strengthen community-based prevention and recovery approaches.
- Develop and embed a focus on unmet need of service users and carers.
- Refresh the model of multi-disciplinary working within General Practice.
- Embed a Future Care Planning approach within communities.
- Supporting people to remain independent and connected within their communities through addressing inequalities and stigma.

This approach will improve continuity, strengthen coordination across services and support more person-centred care.

Priority 3: Personalised Care and Support

This priority focuses on ensuring care and support are centred around what matters most to people.

Care and support will be person-centred, trauma-informed, rights-based and focused on improving outcomes and experience.

This will include:

- Embedding shared decision-making and "What Matters to You?" conversations.
- Supporting informed choice and control.
- Strengthening medicines optimisation and polypharmacy review.
- Reducing low-value and unnecessary interventions.
- Supporting realistic medicine and stewardship approaches.
- Promoting relationship-based approaches to care and support.
- Implement the Values Based Health and Care Framework

This approach supports improved outcomes, reduced harm, and better use of resources.

Priority 4: Communities, Prevention and Reducing Inequalities

This priority recognises that improving health and wellbeing is not only the responsibility of health and social care services.

We will strengthen community-based prevention, address the wider determinants of health and support people to live well within their own communities.

This will include:

- Develop a model of social prescribing for Angus.
- Strengthening partnership working with third sector and community organisations.
- Supporting community resilience and peer support.
- Supporting communities experiencing the greatest inequalities with targeted interventions.

We will continue to strive to work with communities to achieve the best possible outcomes, recognising the importance of enabling partnership working.

Priority 5: Understanding Need and Improving Services

This priority focuses on improving understanding of population need, inequalities and opportunities for improvement.

We will strengthen the use of data, local intelligence, and evidence to support planning, improvement, and better targeting of resources.

This will include:

- Strengthening the Prevention and Proactive Care Dashboard and the quality management system approach.
- Improved use of population health intelligence to support planning and decision-making.
- Using benchmarking to identify opportunities for improvement.
- Strengthening understanding of unmet need.
- Supporting evidence-based commissioning and resource allocation.

- Improving data quality and consistency.
- Using data and intelligence to identify opportunities for service redesign and improvement.
- Evaluating impact and outcomes to inform future investment decisions.

This approach will help ensure services are responsive to local need, inequalities are better understood, and resources are used where they have the greatest impact.

Priority 6: Supporting Sustainable Services

Supporting Prevention and Proactive Care requires strong foundations across services and partners.

This includes:

- Workforce planning and capability development.
- Supporting workforce wellbeing, recruitment, and retention.
- Developing workforce models that support integrated and sustainable care.
- Strong clinical, care and professional leadership.
- Digital and data infrastructure.
- Financial sustainability and investment alignment.
- Strategic commissioning.
- Quality improvement and continuous learning.
- Partnership working across health, social care, housing, and communities.

Together, these enablers will support Prevention and Proactive Care to become embedded, scalable, and sustainable across Angus.

How This Work Will Be Led

The delivery of Prevention and Proactive Care requires strong professional leadership, partnership working and clear governance arrangements across health, social work, social care, and community partners.

These arrangements are intended to support joined-up planning, shared accountability and coordinated delivery across services and partners.

Strategic Oversight

Angus Integration Joint Board (AIJB) and Strategic Planning Group (SPG)

The AIJB retains overall accountability for delivery of Prevention and Proactive Care.

The Strategic Planning Group will provide strategic oversight of delivery and alignment with:

- The Strategic Framework.
- Population needs and the Strategic Needs Assessment.

- Financial planning and commissioning.
- Risk management and assurance.
- National and local priorities.

This level of governance will focus on outcomes, sustainability, and strategic improvement.

Prevention and Proactive Care Steering Group

This group will oversee delivery of the Prevention and Proactive Care Annual Delivery Plan, monitor progress against agreed outcomes and measures, and support coordination across services and partners.

Angus Executive Management Team (EMT)

The EMT will provide executive operational leadership and organisational oversight.

This will include:

- Translating strategic priorities into operational delivery.
- Supporting organisational alignment.
- Addressing workforce, operational and delivery risks.
- Maintaining oversight of performance and improvement.
- Supporting whole-system collaboration.

Clinical, Care and Professional Governance (CCPG)

Robust Clinical, Care and Professional Governance arrangements will underpin all Prevention and Proactive Care pathways. This will support an integrated approach to governance and assurance across health, social work, and social care services, ensuring care delivered within community and proactive models remains safe, effective, and person-centred.

This includes:

- Clear professional accountability for clinical and care decision-making and oversight.
- Clear escalation routes for deteriorating patients and individuals across community and acute interfaces.
- Strong multidisciplinary leadership, including agreed prescribing responsibilities and clinical leadership within multidisciplinary team models.
- Systems for quality assurance, safety monitoring, learning and continuous improvement.
- Oversight of professional practice, prescribing and care management.
- Assurance that care is safe, effective, person-centred and rights-based.
- Alignment with Clinical Governance and Social Work and Social Care Governance Frameworks.

This approach will help ensure care remains equitable, coordinated, safe and sustainable across Angus.

Supporting Delivery

Operational delivery will be supported through integrated programme and operational arrangements.

Integrated Management Team (IMT)

The Integrated Management Team will support operational implementation and day-to-day delivery.

The IMT will:

- Lead implementation of agreed pathways and models of care.
- Support consistent delivery across services and localities.
- Provide operational oversight and escalation.
- Support multidisciplinary and integrated working.
- Ensure operational delivery remains aligned to strategic intent.

Integration Across the System and Communities

These arrangements are designed to operate as a coordinated system with:

- Shared objectives and outcomes.
- Agreed priorities.
- Coordinated planning and delivery.
- Clear understanding of system interdependencies.
- Alignment across urgent care, planned care, primary care, community health, social work, and social care.

This approach recognises that improving population health and reducing inequalities cannot be achieved by health and social care services alone.

Success will depend on strong partnership working with:

- Communities.
- Third and independent sector partners.
- Unpaid carers.
- Housing and community planning partners.
- Local organisations and community groups.
- Individuals and families themselves.

This will include:

- Co-designing prevention and wellbeing approaches with communities.
- Strengthening community resilience and peer support.
- Supporting self-management and informed decision-making.
- Expanding community-led prevention approaches.

- Ensuring lived experience informs planning and delivery.
- Building stronger place-based approaches across Angus.

This reflects the wider ambitions of the Strategic Framework to work with communities to improve health, wellbeing, and independence.

Governance and Accountability

Clear decision-making and accountability arrangements will be essential to successful delivery.

This includes:

- Clearly defined roles and responsibilities.
- Transparent escalation and governance arrangements.
- Defined authority for pathway redesign and resource allocation.
- Strong clinical, care, professional and managerial leadership.
- Alignment between operational delivery and strategic priorities.
- Clear oversight of risk, quality, and performance.

These arrangements will support joined-up leadership, shared accountability and coordinated delivery across partners.

Conclusion

Prevention and Proactive Care is central to improving the health and wellbeing of people and communities across Angus.

It supports a shift towards earlier intervention, better coordination of care and support, stronger community-based services and greater focus on prevention and wellbeing.

Through this approach, Angus Integration Joint Board and its partners aim to:

- Improve health and wellbeing outcomes.
- Progress towards reducing inequalities in access and outcomes.
- Support people to remain independent for longer.
- Improve people's experience of care and support.
- Support more people at home and within their communities through alternatives to hospital admission.
- Ensure services remain sustainable for the future.

Delivery will focus on strengthening the foundations required to support longer-term change. This includes strengthening Future Care Planning, enhancing community

prevention and wellbeing approaches, improving coordination across services, and using data and insight more effectively to identify need earlier and support informed decision-making.

Over time, this work will help create a more joined-up, person-centred and sustainable health and social care system, built around what matters most to the people and communities of Angus.

ANGUS
Health & Social Care Partnership

PLAN ON A PAGE – PRIORITY 2
Care Closer to Home

Improving Outcomes, Reducing Inequalities, Sustaining the System

OUR VISION

Care Closer to Home means providing the right care, in the right place, at the right time, helping more people to remain independent and supported within their own homes and communities wherever possible.

Our Approach

Care Closer to Home is about improving how care is delivered across Angus.

- Earlier intervention and future care planning
- Reduced reliance on hospital-based care
- More coordinated care across services and teams
- Greater independence and recovery at home
- Stronger community-based support
- Better experiences for individuals, families and carers

What We Want to Achieve

Improving Health and Wellbeing

- More people living independently for longer.
- Reduced inequalities and better support for people with long-term conditions.
- Improved health and wellbeing outcomes.
- Earlier identification of need and risk.

Improving People's Experience

- More people supported to remain at home and in their communities.
- Better access to the right support at the right time.
- More coordinated and person-centred care.
- Improved experience for individuals, families and carers.

Workforce and Partnership Working

- Strong multidisciplinary and integrated team working.
- Better staff experience and support.
- Stronger partnership working across services and communities.
- Increased community capacity and resilience.

Supporting Sustainable Services

- Reduced reliance on hospital-based care.
- Better coordination across health and social care services.
- Better use of resources and capacity.
- Greater investment in prevention, early support and community-based care.

How We Will Measure Success

- More people supported for alternatives to hospital admission
- More people supported at home and in the community
- Reduced delayed discharge
- Improved experience of care and support
- Better outcomes for people with frailty and long-term conditions
- Sustainable use of resources

Our Priority Areas

1 Future Care Planning and Early Support

Supporting people earlier through future care planning, early identification and proactive support to improve outcomes and reduce crisis.

2 Community-based Alternatives to Hospital

Expanding safe and effective alternatives to hospital care, including Hospital at Home, urgent community response and step-up/step-down care.

3 Integrated Teams

Delivering coordinated, person-centred care through integrated teams across health, social work, and community services.

4 Access and Navigation

Making it easier for people to access the right support, at the right time, through clearer routes and better coordination.

5 Discharge and Recovery at Home

Supporting people to leave hospital when ready and continue recovery at home with the right support in place.

6 Supporting Sustainable Services

Building the foundations we need across workforce, leadership, digital, data, partnerships and continuous improvement.

How We Will Work

- Work in partnership with people and communities
- Focus on prevention, early support and wellbeing
- Tackle the wider causes of ill health and inequality
- Provide joined-up, person-centred support
- Make best use of local assets and community strengths
- Use data and insight to inform our decisions
- Listen, learn and improve continuously
- Work together to achieve the best outcomes

Who We Will Work With

- Individuals, families and carers
- Communities and local groups
- Third and independent sector
- Housing and community planning partners
- Primary care and wider health services
- Social work and social care services
- Schools, education and early learning
- Employers and local businesses

Our Commitment

By working together with our communities, partners and staff, we will support people to access the right care, in the right place, at the right time, helping more people to live independently at home and in their communities whilst supporting sustainable services for the future.

OUR SHARED AMBITION | Better lives, stronger communities, sustainable services

Angus Health & Social Care Partnership

Priority 2

Care Closer to Home - Strategic Plan

'Improving outcomes, reducing inequalities, sustaining the system'

Our Approach

Care Closer to Home is central to Angus Integration Joint Board's (AIJB) vision for the future of health and social care in Angus.

It is about ensuring people can receive safe, effective, and person-centred care and support within their own homes and communities wherever possible.

This approach recognises that many people achieve better outcomes when care is provided earlier, closer to home and in a more coordinated way across health, social work, social care, and community services.

Care Closer to Home supports a shift towards:

- Earlier intervention and prevention.
- Reduced reliance on hospital-based care where appropriate.
- Alternatives to hospital admissions.
- More coordinated care across services and professional groups.
- Greater independence and recovery at home.
- Improved access to community-based support.
- Better experiences for individuals, families, and carers.
- Increased range of services available in patient's communities.

This approach responds to increasing demand across health and social care services, an ageing population, growing complexity of need, workforce pressures and the need to ensure services remain sustainable for the future.

It also recognises the importance of delivering care and support that reflects the needs of local communities across Angus, including challenges associated with rurality, travel time, transport, and access to services.

Care Closer to Home is not a standalone programme. It is a whole-system approach to improving how care and support are planned, coordinated, and delivered across Angus.

Clinical, Care and Professional leadership across health, social work and social care services will continue to play a key role in ensuring care remains safe, effective, person-centred, and consistently assured.

Most importantly, Care Closer to Home is about improving outcomes and experiences for people and communities across Angus by ensuring care is delivered in the right place, at the right time, by the right people.

What We Want to Achieve

By 2029, Care Closer to Home will support a measurable shift in the balance of care across Angus, helping more people to receive care and support within their own homes and communities wherever appropriate.

Improving Health and Wellbeing

We want people across Angus to experience improved health, wellbeing, and independence.

This includes:

- Supporting more people to live independently at home for longer.
- Reducing inequalities in access, experience, and outcomes.
- Improving support for people living with frailty and long-term conditions.
- Supporting earlier intervention and recovery.
- Improving continuity and coordination of care and support.

Improving People's Experience of Care and Support

We want people to experience care and support that is coordinated, timely and centred around what matters most to them.

This includes:

- More people supported through alternatives to hospital admission.
- Reduced delays in discharge from hospital.
- Improved access to community-based support.
- Better coordination across services and professional groups.
- Increased use of Future Care Planning.
- Greater involvement of individuals and carers in decisions about care and support.

Workforce and Partnership Working

We want to support a sustainable workforce and strengthen multiagency working across services and communities.

This includes:

- Strong multidisciplinary working across health, social work, and social care.
- Greater integration across community services.
- Strengthening advanced practice and community-based roles.

- Improved staff experience through coordinated and integrated models of care.
- Stronger partnership working with primary care, housing, third sector and community partners.

Supporting Sustainable Services

We want to ensure services remain sustainable and responsive to population need.

This includes:

- Reducing reliance on high-cost reactive hospital care.
- Supporting more care within community settings.
- Better coordination across health and social care services.
- Making best use of available resources.
- Aligning investment towards prevention, early intervention, and community-based support.
- Delivering Best Value through effective and sustainable use of public resources.

By the end of the three-year period, Angus will continue to move towards a more coordinated, community-based, and person-centred model of care, with hospital care used purposefully and appropriately when required.

Priority Areas

These priority areas provide a framework for improving outcomes, reducing inequalities, and supporting sustainable health and social care services across Angus.

Together, they support a shift towards earlier intervention, better coordination of care and support, stronger community-based approaches and improved use of information and evidence to support decision-making.

Progress will be monitored through the Dashboard, Balanced Scorecard, Annual Delivery Plan and associated performance reporting arrangements.

Priority 1: Future Care Planning and Early Support

This priority focuses on identifying need earlier and supporting people before situations deteriorate or reach crisis point.

This will include:

- Ensuring people's wishes are supported at times when they require support to live at home or in a homely setting.
- Earlier identification of people who may benefit from additional support and improved transitions across adult services.
- Coordinated support for frailty and long-term conditions.

- Implementing falls pathways which support more people to remain in their communities.
- Increased multidisciplinary working across community services.
- Coordinated support for people with more complex needs.
- Further development of the minor injury and other unscheduled care pathways with a population health approach to unscheduled care planning

This approach will support improved outcomes, greater independence and more people being supported through alternatives to hospital admission.

Priority 2: Community-Based Alternatives to Hospital

This priority focuses on strengthening safe and effective alternatives to hospital care within community settings.

This will include:

- Expanding Hospital at Home approaches.
- Strengthening urgent community response services.
- Improving access to step-up and step-down care.
- • Developing community-based pathways that support alternatives to hospital admission and timely discharge.
- • Improving coordination across urgent and unscheduled care pathways.
- • Supporting carers in their role.
- • Implement the Tayside Palliative Care SFutitrategy.

This approach will support more people to receive care in the most appropriate setting whilst reducing pressure on acute services.

Priority 3: Integrated Teams

This priority focuses on delivering coordinated care through integrated, locality-based multidisciplinary teams.

This will include:

- Bringing together health, social work, social care, and community services.
- Strengthening integrated working across professional groups.
- Supporting coordinated care for people with complex needs.
- Developing clear lead professional arrangements.
- Improving continuity of care across pathways and services.
- Ensuring person-centred approaches particularly where people are living with multiple conditions, both mental and physical.

This approach will support more joined-up and person-centred care within local communities.

Priority 4: Access and Navigation

This priority focuses on improving how people access care and support across services.

This will include:

- Simplifying referral and access routes.
- Improving coordination across urgent, planned and community care.
- Strengthening navigation and triage arrangements.
- Improving access to digital and community-based support where appropriate.
- Reducing duplication and delays across pathways.
- Promoting a 'no wrong door' culture

This approach will help people access the right support, at the right time, from the right service.

Priority 5: Discharge and Recovery at Home

This priority focuses on supporting people to leave hospital as soon as they are clinically ready and continue their recovery within community settings wherever possible.

This will include:

- Strengthening Discharge Without Delay approaches.
- Expanding Discharge to Assess models.
- Improving coordination between hospital and community services.
- Strengthening enhanced Care at Home and reablement support.
- Supporting recovery and independence at home.

This approach will improve flow across the system while supporting better experiences and outcomes for individuals and carers.

Priority 6: Supporting Sustainable Services

Supporting Care Closer to Home requires strong foundations across services and partners.

This includes:

- Workforce planning and capability development.
- Supporting workforce wellbeing, recruitment, and retention.
- Developing workforce models that support integrated and sustainable care.
- Strong clinical, care and professional leadership.
- Digital and data infrastructure.
- Integrated commissioning and financial planning.
- Continuous improvement and learning.
- Supporting community capacity and resilience through stronger partnership working with communities and the third sector.

Together, these enablers will support sustainable and scalable community-based models of care across Angus.

How This Work Will Be Led

The delivery of Care Closer to Home requires strong leadership, partnership working and clear governance arrangements across health, social work, social care, and community partners.

These arrangements are intended to support joined-up planning, shared accountability and coordinated delivery across services and partners.

Strategic Oversight

Angus Integration Joint Board (AIJB) and Strategic Planning Group (SPG)

The AIJB retains overall accountability for delivery of Care Closer to Home.

The Strategic Planning Group will provide strategic oversight of delivery and alignment with:

- The Strategic Framework.
- Population needs and the Strategic Needs Assessment.
- Financial planning and commissioning.
- Risk management and assurance.
- National and local priorities.

This level of governance will focus on outcomes, sustainability, and strategic improvement.

Care Closer to Home Steering Group

This group will oversee delivery of the Care Closer to Home Annual Delivery Plan, monitor progress against agreed outcomes and measures, and support coordination across services and partners.

Angus Executive Management Team (EMT)

The EMT will provide executive operational leadership and organisational oversight.

This will include:

- Translating strategic priorities into operational delivery.
- Supporting organisational alignment.
- Addressing workforce, financial, operational and delivery risks.
- Maintaining oversight of performance and improvement.
- Supporting whole-system collaboration.

Clinical, Care and Professional Governance (CCPG)

Robust Clinical, Care and Professional Governance arrangements will underpin all Care Closer to Home pathways.

This will support an integrated approach to governance and assurance across health, social work, and social care services.

This includes:

- Clear professional accountability for clinical and care decision-making and oversight.
- Defined escalation and risk management arrangements, including escalation routes across community and acute interfaces.
- Strong multidisciplinary leadership and agreed clinical responsibilities within integrated models of care.
- Systems for quality assurance, safety monitoring, learning and continuous improvement.
- Oversight of professional practice, prescribing and care management.
- Assurance that care is safe, effective, person-centred and rights-based.
- Alignment with Clinical Governance and Social Work and Social Care Governance Frameworks.

This approach will help ensure care remains equitable, coordinated, safe and sustainable across Angus.

Supporting Delivery

Operational delivery will be supported through integrated programme and operational arrangements.

Integrated Management Team (IMT)

The Integrated Management Team will support operational implementation and day-to-day delivery.

The IMT will:

- Lead implementation of agreed pathways and models of care.
- Support consistent delivery across services and localities.
- Provide operational oversight and escalation.
- Support multidisciplinary and integrated working.
- Ensure operational delivery remains aligned to strategic intent.

Integration Across the System and Communities

These arrangements are designed to operate as a coordinated system with:

- Shared objectives and outcomes.
- Agreed priorities.

- Coordinated planning and delivery.
- Clear understanding of system interdependencies.
- Alignment across urgent care, planned care, primary care, community health, social work, and social care.

This approach recognises that improving population health and reducing inequalities cannot be achieved by health and social care services alone.

Success will depend on strong partnership working with:

- Communities.
- Third and independent sector partners.
- Unpaid carers.
- Housing and community planning partners.
- Local organisations and community groups.
- Individuals and families themselves.

This will include:

- Strengthening community resilience and local support.
- Supporting recovery and independence at home.
- Improving coordination across services and partners.
- Ensuring lived experience informs service planning and delivery.
- Building stronger place-based approaches across Angus.

Governance and Accountability

Clear decision-making and accountability arrangements will be essential to successful delivery.

This includes:

- Clearly defined roles and responsibilities.
- Transparent escalation and governance arrangements.
- Clear leadership across strategic and operational delivery.
- Alignment between operational delivery and strategic priorities.
- Oversight of quality, performance, and risk.
- Shared accountability across services and partners.

These arrangements will support coordinated leadership and sustainable delivery across the system.

Conclusion

Care Closer to Home is central to the future delivery of health and social care services across Angus.

It supports a shift towards earlier intervention, stronger community-based support, improved coordination across services and reduced reliance on hospital-based care where appropriate.

Through this approach, Angus Integration Joint Board and its partners aim to:

- Improve health and wellbeing outcomes.
- Progress towards reducing inequalities in access and outcomes.
- Support people to remain independent for longer.
- Improve people's experience of care and support.
- Increase the number of people supported through alternatives to hospital admission and reduce delays in discharge.
- Ensure services remain sustainable for the future.

Delivery will focus on strengthening the foundations required to support longer-term change, including Future Care Planning, integrated team approaches, discharge and flow improvement, urgent community response and strengthened community-based alternatives to hospital care.

Over time, this work will help create a more joined-up, person-centred and sustainable health and social care system, built around the needs of the people and communities of Angus.

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