IMPLEMENTATION PLAN				
Strategic Objective	**Outcome**	**Sub-Actions**	**Milestone/Target**	**Timeline**
To assess need and plan care by focusing on personal outcomes, assets and relationships	People have timeous access to community care assessments to ensure that their needs are addressed	1.0 Balance and risk assess those awaiting assessment at home or in the hospital to ensure best use of care at home capacity	Care at Home/Residential service embedded into weekly capacity planning	March 2026
		1.1 Unmet need monitored with triaging of referrals in place to risk assess and prioritise. Recruitment for vacancies and fixed term absences on-going. Workforce re-directed to address acute pressures. Transparent sharing of waiting lists to enable immediate release of resource.	*Capacity for step-up/step-down service confirmed and included in admission avoidance/ discharge to assess processes*	*June 2026*
	People with long-term conditions and disabilities exercise choice and control over the management of their health and well-being	2.0 Capacity to deliver Post Diagnostic Support for people with Dementia is increased through commissioning of services across 3rd sector providers where financial resources allow	Commissioning/contract in place	March 2026
		2.1 Post diagnostic commissioned services continue based on existing grant allocation. Recruitment for Lead Nurse Dementia and Frailty complete and will provide leadership for reviewing Dementia strategy and associated commissioning matters.	*Dementia Strategy refreshed and implementation plan incorporated into the Strategic Commission Plan*	*October 2026*
		3.0 Anticipatory Care Plan templates developed and rolled-out to support people across residential care estate, focusing initially on Goathill complex	ACP in place for all Care Home residents	March 2026
		3.1 Respect documentation in place in care homes.	*Complete.*	*N/A*
	Unpaid carers are supported to continue in their role	4.0 Carers Plans are co-produced with all carers who could benefit from support to identify how best their needs can be met	Increase the number of plans by 2% each quarter	March 2026
		4.1 Data shows an increase of from 47 plans to 83 from years 2024 to 2025. Number offered, undertaken, reviewed and the	*Complete. Operational issue*	

		standard of plans is included in file audit scheduling for 2026/27.		
To increase and diversify support at home, focusing on maximising people's independence	People with additional support needs live safely and independently at home, and are socially connected	5.0 Reablement service is aligned with admission avoidance services to maximise the capacity to collaborate and enhance community based care.	Planning for service integration undertaken alongside Hospital at Home expansion	March 2026
		5.1 Consideration of step-up/step-down capacity as detailed earlier to be actioned. Reablement staff can work across all settings and is included in the core care at home job descriptions in addition to the START service.	*Duplicate action*	*N/A*
		6.0 Digital opportunities around remote home monitoring support safety in the home	Exploration and mapping of digital innovation undertaken	March 2026
		6.1 The Integration Joint Board services work to deliver the digital strategies associated with the parent bodies. An umbrella strategy/plan to be produced to provide an overview of priority areas for development. Systems development is led through the parent bodies and this will include collaborating as required on the national app. Telecare services are leading on the implementation of analogue to digital for all service users and working with national partners to seek opportunities for service innovation.	*Strategy/Plan in place for digital developments across the delegated services. Accreditation criteria has been met.*	*December 2026*
Strategic Objective	Outcome	Sub-Actions	Milestone/Target	Timeline
To reduce the length of stay in hospital by supporting effective discharge planning	People are supported to return home as soon as appropriate, without their needs escalating	7.0 Best practice is used from across Scotland (through CRAG) to ensure that our patient flow processes are as smooth and efficient as possible	Secure support from Targeted Support Team at SG	March 2026
		7.1 Support in place and fortnightly meetings with SG leads. Learning from CRAG shared with service leads. Chief Officers forum utilised for wider sharing of best practice and leadership actions relating to service pressures.	*In place and operational.*	*On-going*

		8.0 Engage in renewed national Discharge with Delay (DWD) Collaborative	Embed DwD principles into weekly discharge planning	March 2026
		8.1 Leads identified and will be engaged in DWD from March 2026.	*Refreshed DWD Action Plan approved by ICMT*	*June 2026*
		9.0 A home-first model to be developed to ensure people are supported back to the environment in which they are most comfortable	Discharges are planned to support Home First principles	March 2026
		9.1 Will be addressed through 1.1 and 8.1	*Duplicate action*	*N/A*
	People with mental illness do not stay in hospital for longer than their mental health recovery requires	10.0 The Acute Psychiatric unit operates on the basis of a short-stay model, where people are discharged home as soon as possible	Criteria based discharge protocols operationalised in line with CMHT SOPs	March 2026
		10.1 Discharge planning for the ward follows the principles of best practice and is subject to the same governance as medical wards. Any further improvement activity will be led by audit and scrutiny findings.	*Closed. Operational issues. DWD improvements will apply to all wards.*	*N/A*
To reduce the number of hospital admissions	Hospital admissions are prevented by developing new services and pathways to deliver more complex care in the community	11.0 Ensure Acute Assessment Unit is fully utilised to prevent avoidable admissions	Quarterly audit of AAU activity	March 2026
		Enhance H@H service to deliver increased capacity in line with the Urgent and Unscheduled Care Plan	Monitor and review H@H capacity across 4 service lines against delivery plan	March 2026
		Frailty assessments are routinely undertaken at front door and to promote early intervention	HIS Frailty Collaborative drives improvement	March 2026
		11.1 Frailty at the Front Door national investment is being fully utilised to conclude recruitment to enable the expansion of services to be implemented. The service developments will provide new resources for facility assessments, expansion of hospital at home and support Emergency Department activity. Centre for Sustainable Delivery (CSfD) evaluation of progress is	*Specified criteria met; services operational.*	*June 2026*

		positive. DWD and this improvement agenda to be linked for a holistic approach to flow improvement activity.		
		12.0 'Call before you convey' is developed with partners (including SAS) to ensure that we provide optimal care and support to frail older people	Quarterly Audit of admissions to highlight performance and missed opportunity	March 2026
		12.1 Service operational. Audit activity to be confirmed.	*Operational activity*	*N/A*
Strategic Objective	**Outcome**	**Sub-Actions**	**Milestone/Target**	**Timeline**
To optimise our residential estate in favour of Extra Care Housing, Intermediate Care and Respite Care	People are supported in high quality environments which are co-located with other services	13.0 Departmental input into the Barra and Vatersay Campus Project continues to include housing with extra care as detailed in the previous business care with the existing home asset management actions undertaken across all homes	Project proposals refined and approved; Residential Care Estate Improvement and Maintenance Plan	March 2026 (Barra and Vatersay Hub Project timeframe tbc)
		13.1 Project Team and Project Board in place. Next steps confirmed by Scottish Government and focus is on development of the Business Case.	*Revised Business Case*	*To be agreed at Project Board*
	People experience high quality residential care and are supported to be as independent as possible	14.0 Service investment to date is maximised through the implementation of the service improvement plans and the introduction of a step up/step down service	IMPACT Project findings and workforce plans	March 2026
		14.1 Regulator feedback is included in service improvement plans for all registered services. Senior service managers have oversight of sharing of good practice, requirements and recommendations. World café event scheduled and participation will identify any additional opportunities through the IMPACT project focused on the prevention of frailty. Note previous action re Step-Up/Step-Down	*Outcome of the workstreams will feed into future service/strategic planning.*	*N/A*
To utilise the GP contract and other	People are supported by fully integrated teams capable of delivering complex care at	15.0 Daily huddles between GPs, ANPs, Community Nurses, Care & Support supervisors and OTs are developed to ensure a coordinated response to patient need	Review through Primary Care Improvement Plan	March 2026

levers to deliver a system of primary care that supports complex care at home, self-management and prevention	home or in community settings	*15.1 The viability of a standardised approach to daily huddles to be considered further at a senior operational level and progressed as appropriate through GP Sub and OSDT in the first instance. Regulated services have communication and referral processes in place.*	*MDT engagement processes mapped for targeted services as appropriate.*	October 2026
		16.0 Community Nursing capacity is aligned to General Practice requirements through the delivery of CTAC services locally	CTAC service optimised-audit completed	March 2026
	People are able to access a wider primary care team without always having to first consult with their GP	Vaccination and Community Treatment is transferred from GP Practices to NHS WI	All new capacity in place	March 2026
		GPs prescribing practice is supported by increasing primary care pharmacy capacity and risk share approach undertaken to optimise prescribing spend	Targeted intervention supported by PCP team delivered	March 2026
		GPs are supported to develop as Expert Medical Generalists, providing clinical direction to locality teams	Pathfinder projects established with GP practices through Cluster Programme	March 2026
		16.1 Such actions are predominantly addressed through the Primary Care Improvement Board. PCIB resources are fully deployed and in the event of unplanned underspends, prioritisation of resources for specific activities is agreed by PCIB.	*The refreshed Strategic Plan will include reference to the PCIB responsibilities and priorities.*	*June 2026*
	People have greater choice about how they are supported at end of life	17.0 Delivery of 7-day palliative care service	Audit end of life choice/destination	March 2026
		17.1 No bespoke activity undertaken on this action. To be considered further in relation to data sets and future strategic intentions.	*Included in options for future Strategic Plan priorities.*	*June 2026*
Strategic Objective	**Outcome**	**Sub-Actions**	**Milestone/Target**	**Timeline**
To capitalise on the redesign of mental	People experience improved mental health	18.0 People are given improved access to psychological therapies, including through new remote delivery models	Capacity mapped to meet SG targets	March 2026

health services and Scottish Government support to deliver enhanced community based support, with a focus on recovery and prevention		*18.1 Psychological therapy service provision includes Near Me consultations. Performance activity under review in relation to national targets.*		*June 2026*
		19.0 Community Mental Health teams are strengthened and skill mix considered to ensure support can be provided to people who are experiencing mental illness	Scoping exercise commissioned	March 2026
		19.1 Mental Health Service and Workforce Plan to be developed to address strategic and service priorities, detailing matters such as skills mix.	*Plans approved*	*October 2026*
		20.0 A new clinical partnership is developed with a mainland NHS Board to ensure effective specialist care and reduced OOA placements over time	Initial agreement developed in partnership and supported by SG	March 2026
		20.1 Positive discussions with potential partner Board to facilitate a SLA for specialist placements with further engagement scheduled in the next 2 months. Refreshed Strategic Plan will address current service and future opportunities for development.		*April 2026*
	People who are supported by mental health, justice and homelessness services experience improved support and service coordination	21.0Development of clear pathways and multi-professional support for people with complex and chaotic lives	Monitor Complex case reviews to ensure a true multi-professional approach is delivered	March 2026
		21.1 Care Programme Approach in place to enable MDT co-ordination to support patients/service users. Mental Welfare Commission engagement integral to service improvement planning. Routine audit processes to be established.	*Operational matter*	*N/A*
		22.0 Operational reform delivers on the strategic requirements of Alcohol & Drugs Partnership and Community Justice Partnership	Outcome agreements in place	March 2026
		22.1 Future revision of the Strategic Plan can reference the role of the other strategic partnership groups and their responsibilities to provide a holistic view of strategic planning activity.	Clarification is provided in the future Strategic Plan on the relationship with other Strategic	

			Groups and delegated services.	
Strategic Objective	**Outcome**	**Sub-Actions**	**Milestone/Target**	**Timeline**
To ensure that multi-agency arrangements deliver effective public protection and facilitate the sharing of information and intelligence	Vulnerable adults and children are protected through effective inter-agency liaison	23.0 Adult and child protection capacity and systems are continually reviewed and refreshed	Annual reviews are undertaken. Report to Chief Officer Group	March 2026
		23.1 The Adult Support and Protection improvement plan is implemented with the two subgroups delivering on learning and development and audit and quality assurance. Schedule file audit has been completed with the Adult Protection Committee retaining oversight and reporting to the Chief Officer Group.	*Quarterly performance updates to APC then COG*	*N/A*
Strategic Objective	**Outcome**	**Sub-Actions**	**Milestone/Target**	**Timeline**
To deliver oral health improvement plan and OIP locally as advised by SG	Oral Health Improvement Programme is implemented	24.0 A delivery plan and workforce plan is developed to support improvement in key oral health improvement initiatives (e.g. Childsmile, Caring for Smiles)	Plan developed and in place	March 2026
		Revised workforce plan aligned to service delivery is secured	Plan developed and in place	March 2026
	People have improved equity of access to the Public Dental Service	Digital solutions are explored through the Digital Health and Care Leaders Forum	DLP – Local plan	March 2026
		24.1 as the implementation of the organisational change process continues, key appointments have been made to support the oral health improvement activity in the service	*Updated Plans approved through*	*October 2026*

		supporting child smile and priority groups. Service and workforce planning is underway to address immediate service requirements and longer-term opportunities to support service capacity and resilience. Digital opportunities will be considered as part of the service planning exercise.	*established governance processes.*	