

Aberdeenshire

Health and Social Care  
Partnership

Strategic Plan

2016 – 2019

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*An accessible version is available at <https://www.aberdeenshire.gov.uk/social/healthsocialcareintegration.asp> This document is also available in large print and other formats and languages on request. Please call Alison Davidson on 01467 628265.*

# Introduction

On behalf of the Aberdeenshire Health and Social Care Partnership, we are delighted to share this strategic plan with you. The purpose of the plan is to describe how the Aberdeenshire Health and Social Care Partnership intends to improve the health and wellbeing of adults in Aberdeenshire through the design and delivery of integrated health and social care services.

The plan explains what the challenges and opportunities are for health and social care services. We believe wholeheartedly that by working together – NHS Grampian, Aberdeenshire Council Social Work, Third Sector organisations, private providers of health and social care, and, not least, the residents of Aberdeenshire – we can all enjoy better health and wellbeing.

The principles that underpin this plan are, for all of us, about looking after our health, planning ahead to meet our health and social support needs as we get older, and making informed choices about how we use our local services. We are fortunate in Aberdeenshire in having diverse and vibrant communities that make a valued contribution to health and wellbeing alongside public, private and voluntary services.

We recognise that to achieve all we believe is possible, the way services are organised and provided will have to change. We will explain these changes in a set of commissioning plans that will be available during spring 2016. This is a three year plan, but we will review our progress at the end of the first year and report back to you.

Our vision for better health and social care services is ambitious, but by working together we are confident that we can achieve all that we have set out in the pages of this document. The community consultation events that took place during 2015 have contributed very greatly to the plan. We hope they will be just the start of a dialogue that will continue for the life of this Partnership.

Raymond Bisset,  
Chair of the Integrated Joint Board, Aberdeenshire Health and Social Care Partnership

Councillor Anne Allan,  
Vice Chair of the Integrated Joint Board, Aberdeenshire Health and Social Care Partnership

## Vision

***“Building on a person’s abilities, we will deliver high quality person centred care to enhance their independence and wellbeing in their own communities.”***

# Our Philosophy and Principles

## Philosophy

Care and treatment should be designed round the needs of the person.

People are entitled to expect the best possible advice, care and support from our staff, in a timely way and in the right place. Health and social care should be provided by a single team.

Every individual is able to contribute to their own health and wellbeing, make their views known, and participate positively in their own care.

A person's family, their social network and their close community all have a part to play to achieve healthy lifestyles and to support those who need help to continue to live in their own homes.

## How we will work

Every individual is treated with dignity and respect at all times.

Health and social care staff will promote and maintain a person's independence as much as possible, with the starting point being an assessment of what they are able to do for themselves. This principle includes a single assessment of risk to the person, to themselves, from others and to others and includes appropriate positive risk taking by the individual.

Nothing is concluded or decided about a person's care or support without the individual's involvement and agreement and that of their significant others, unless considerations of capacity or risk intervene.

All discussions and decisions about treatment, support, and risk are made collaboratively and consensually by the team of appropriate practitioners, respecting differences. Accountability for decisions is held collectively by the team.

A 'one team' approach is fostered where we trust each team member to deliver on their unique contributions and respective obligations confident that the combined effect of all team members will deliver the best outcomes for people.

With the person's agreement, information is shared freely by professionals within the team/ partnership and without restrictions that could inhibit their best interests.

Health and care practitioners will provide the right support for the person at the right time and in the right place, making the best use of all available resources.

## The Scottish Context

The Christie Commission on the Future Delivery of Public Services (2011) recommended radical changes to the way public services are designed and delivered if they are to be sustainable and capable of meeting the needs and expectations of individuals and communities. Our strategic plan recognises and reflects the principles set out in the Christie report, especially:

- Effective services that are designed with and for people and communities
- Making full use of all available resources from the public, private and third sectors, individuals, groups and communities
- Working closely with individuals and communities to understand their needs, maximise their talents and resources, support self-reliance, and build resilience
- Delivering integrated health and social care services
- Prioritising preventative measures to reduce demand and lessen inequalities that persist over generations
- Improving the oversight and accountability of public services

## Health and Social Care Integration

The Scottish Government has agreed a piece of legislation called The Public Bodies (Joint Working) (Scotland) Act 2014. The legislation requires each Health Board and Local Authority to publish an integration scheme. The scheme sets out how they will work together to improve the health and wellbeing of people who use health and social care services, particularly those whose needs are complex and involve support from health and social care at the same time. Aberdeenshire's integration scheme can be found at

<http://committees.aberdeenshire.gov.uk/FunctionsPage.aspx?dsid=81013&action=GetFileFromDB>

The Scottish Government has launched a 'national conversation' about the future of health and social care in Scotland. In Aberdeenshire, through our events and consultations, we are already taking part in that conversation. We will learn from and contribute to debates that will shape national and local policy and services.

People who use health and social care services can expect to be listened to, to be involved in deciding upon the care they receive and to be an active participant in how it is delivered. This will result in a better experience of using health and social care services, enabling them to enjoy better health and wellbeing within their homes and communities.

## The Housing Contribution

Good quality, affordable housing is essential to good health. Aberdeenshire Council Housing Service and Registered Social Landlords have identified four themes for which they will take the lead. These are ensuring an adequate supply of houses of different tenures and sizes; developing effective and fair processes for housing adaptations and aids; encouraging meaningful involvement of tenants in service planning and delivery; and making the best use of all available sources of funding.

Further details can be found in the Housing Contribution Statement that accompanies this document.

# Aberdeenshire

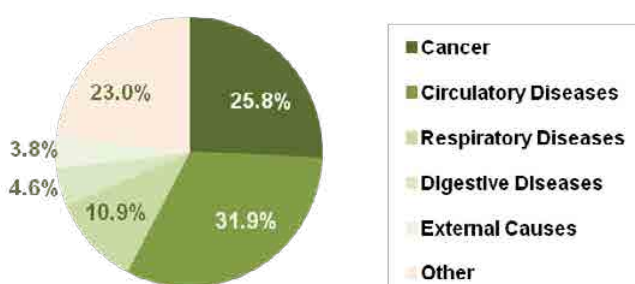
The 2014 population for Aberdeenshire is 260,500; an increase of 1.1 per cent from 2013. The population of Aberdeenshire accounts for 4.9 per cent of the total population of Scotland (National Records of Scotland). The traditional industries of farming, forestry, fishing and tourism are important, but in the last 40 years the oil and gas industries have contributed greatly to the population increase and the high rate of economic growth. Unemployment, measured by the claimant rate, was 0.8% in 2014, much less than the Scottish average of 2.9%. It can be an expensive place to live, with the average house price in Aberdeenshire in 2014 being £226,919 compared with the Scotland average of £163,563 (Registers of Scotland).

Aberdeenshire has low levels of deprivation compared with the rest of Scotland. By this we mean, for our population, educational attainment, employment, income, health and housing are better than elsewhere, with lower levels of crime and good access to services in most areas. However, for individuals, deprivation is often experienced quite simply as a lack of opportunity to make choices about how and where they want to live.

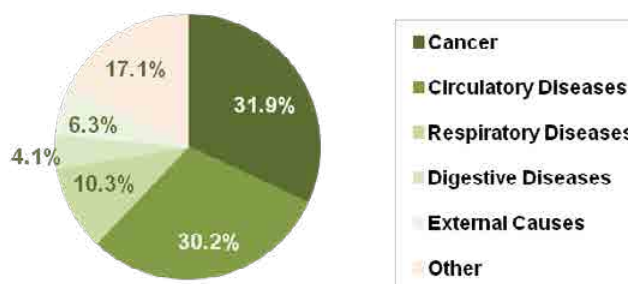
Aberdeenshire has a better health profile than most areas of Scotland, in terms of life expectancy, mental health and common physical health problems such as respiratory or heart disease. On the vast majority of health and wellbeing indicators, for example prescriptions for anxiety and depression, the uptake of adult health screening programmes and the number of adults claiming disability welfare benefits, Aberdeenshire rates very positively. However, a high number of people smoke, obesity is a concern as it is across Scotland, and deaths and injuries from road traffic accidents here are unacceptably high. There is very considerable potential to influence culture, attitudes and health related behaviours in order to improve wellbeing and reduce the need and demand for health and social care services and the number of premature preventable deaths.

## Cause of death in Aberdeenshire (2013)

### Female

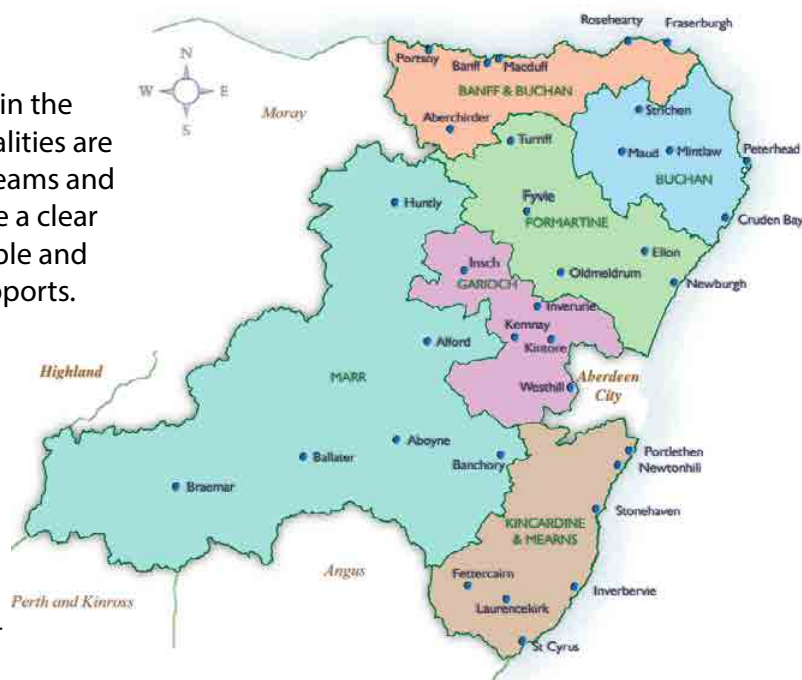


### Male



# Our Localities

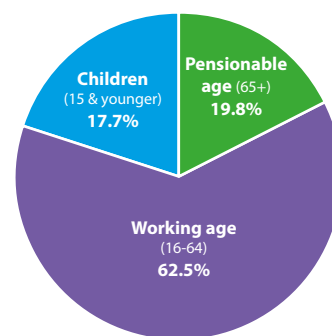
A locality is described as a small area within the Integration Authority borders. Our six localities are organised so that health and social care teams and the people in the area they serve can have a clear influence on the resources that are available and the development of new services and supports. Localities are defined by geography, the people that live and work in the area, the characteristics of the population and to some extent by existing services such as the location of community hospitals, health centres and social work offices. We recognise that within our localities there is considerable variation in the make-up of the population. We will set up 20 multi-disciplinary locality teams that will work closely with services from all sectors to offer care and treatment that best meets those particular needs.



## Banff and Buchan – Population 35,500

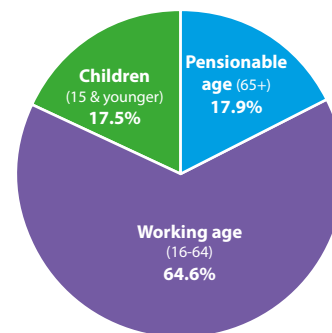
The economy of Banff and Buchan is mainly based on the traditional industries of fishing and agriculture. The area is largely rural, with fewer employment and service connections to the city of Aberdeen than other parts of Aberdeenshire. Hospital services are provided at Chalmers Hospital, Banff and Fraserburgh Hospital. Parts of Fraserburgh have significantly lower life expectancy for both males and females and increased mortality rates although as a whole people living in the area have a life expectancy that is higher than the Scottish average.

Rates of emergency admission to hospital remain high. There are pockets of deprivation associated with difficulties in accessing public services. The area also continues to face deep-seated issues due to problematic use of alcohol and other drugs that directly and indirectly threaten the wellbeing and economic prospects of the area. Community Planning partners, however, are committed to supporting and building confident, skilled, influential and active communities and have carried out a programme of local engagement events, conversations and focus groups in order to encourage a debate about boosting community capacity. One of the ways in which this can be achieved is through encouraging people, particularly older people, to volunteer. This benefits both the volunteer and the community alike. Service developments include improving community transport to offer better access to hospital and health appointments for rural areas.



## Buchan – Population 39,400

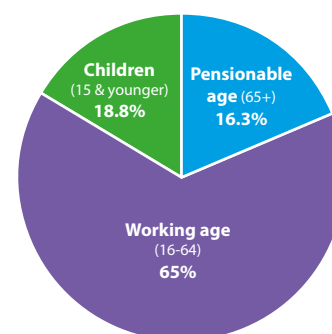
The area has a contrasting mix of farms, villages and industrial areas. Peterhead is the largest town in Aberdeenshire, the principal white fish landing port in Europe, and a major oil industry service centre. Despite this affluence, there is considerable demand for affordable housing. There are relatively deprived areas where rates of most cancers and heart disease are higher. Although across Buchan the life expectancy of the majority of communities is above the Scottish average, parts of Peterhead have significantly lower life expectancy for both men and women and increased mortality rates. People over 65 years in Buchan are more likely to experience emergency hospital admissions than the general population and have higher rates of admissions for this age group than elsewhere in Aberdeenshire. However, the rate of emergency admissions for this age group is reducing yearly.



For younger people, there are health concerns associated with alcohol and drug misuse. For the older generation, priorities include combating fuel poverty and finding ways to employ enough carers to provide personal care. However, considerable work to improve mental and physical health is happening. There are successful initiatives such as the Buchan Feeling Good Festival and community activity and training to raise awareness of good mental health for all, and there is encouraging evidence that more people are keeping physically active. Peterhead Community Hospital and Ugie Hospital provide a range of inpatient and outpatient services to the local population.

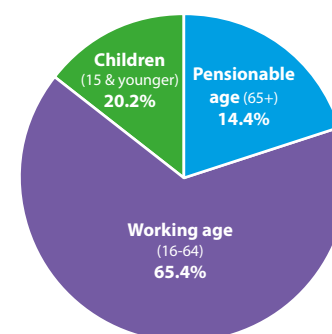
## Formartine – Population 39,400

This is an area of rapid population growth, particularly in the main towns in the Aberdeen commuter belt, and with very low levels of deprivation. The population is ageing, and therefore there has been work to promote healthy and active lifestyles for older people. Across Formartine, the life expectancy of the all communities is better than the Scottish average, as is the mortality rate for deaths for all ages. People aged over 65 years in Formartine are more likely to experience emergency hospital admissions than the general population but have the lowest rate per 100,000 population than all other areas of Aberdeenshire. There are low levels of crime and substance misuse. There are, however, concerns about the effect of welfare reforms on individuals and communities. Other priorities include increasing the housing choices with care for older people, supporting people who are at risk of being homeless, reducing obesity, and improving options for demand-responsive transport. The area is served by Turriff Community Hospital.



## Garioch – Population 50,500

The area experienced rapid population growth in recent years and the population is expected to grow further by nearly 12% over the next decade, which is the fastest projected growth rate in Aberdeenshire. The life expectancy of people living in Garioch is above the Scottish average. Inverurie and Insch Hospitals provide inpatient and outpatient services. Asthma, which is one of the most prevalent health conditions in Aberdeenshire, is particularly a concern in Garioch. Garioch's age profile has a higher representation of younger age groups than Aberdeenshire generally and an increasing proportion of older people. Unemployment levels are low and Garioch is seen as thriving and prosperous. As an indicator of affluence, the percentage of the over 60 years population in receipt of pension credit is the lowest of all the six local

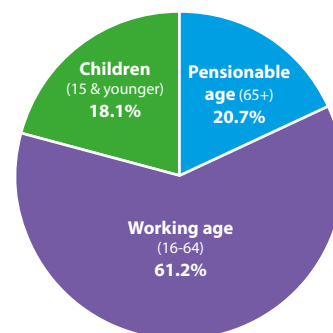




authority areas. Greater social inclusion, which has a significant impact on people’s health and life expectancy, is a priority for this area. Service providers from all sectors are responding to the needs of older people and people with learning disabilities by offering more choice and control in how they access services, and by supporting unpaid carers and family members to look after their own health.

### Marr – Population 37,000

Much of the area is sparsely populated, with 21% of the population being over 65 years. Across Marr, the life expectancy in all communities is better than the Scottish average, as are mortality rates. There are three community hospitals, Jubilee Hospital in Huntly, Glen o’ Dee in Banchory, and Aboyne Hospital. The rural nature of the area and the increasing age profile of the population will provide unique challenges for health and social care services in the future. However, the increasing numbers of retired people could have a very positive impact on volunteering, which is one of Marr’s priorities. Many communities are active, engaged and successfully developing and running a wide range of projects and services. One challenge in the future will be to maintain this level of activity, and effectively support community leaders to continue to use their skills and influence. Local initiatives to improve the health and fitness of all ages is seen as vital. There is good evidence to suggest that Marr has a significantly lower prevalence of problem drug and underage alcohol use compared to elsewhere in Aberdeenshire. However, emergency hospital admission rates per 100,000 are higher in Marr for all ages compared to elsewhere in Aberdeenshire. Other concerns in the Marr area include dispersed rural deprivation and isolation where access issues, lack of public transport, high dependency on cars and fuel poverty particularly affect the older population.

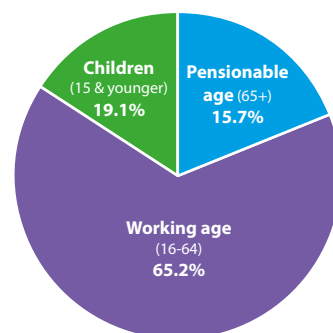


### Kincardine and Mearns – Population 42,000

The area reflects the Aberdeenshire age profile, with, overall, an ageing population and a decreasing number of children. Within this there are some rapidly developing commuter-belt communities with much higher numbers of young families than in more rural areas. Each requires a different approach to community inclusion. Across Kincardine & Mearns, the life expectancy is better than the Scottish average, as are the rates of mortality for all ages. Data from community pharmacists suggest that the area has the lowest prevalence of potential harmful drug use across all of Aberdeenshire. The percentage of the over 60 years population in receipt of pension credit is consistently below the Aberdeenshire average.

The area is served by Kincardine Community Hospital in Stonehaven.

Issues relating to social inclusion have been specifically highlighted for those towns that have rapidly expanded and where the lack of any central focus or community facilities is becoming apparent. However, across the area, more residents are being encouraged to take part in social, leisure and support activities that promote positive health and wellbeing, and helping older people to plan better for their future needs is a priority.



# The Views of Aberdeenshire Communities: Community Engagement

We know that many people want to have their say in decisions that affect their community. However, we recognise that not everyone feels they have enough information and understanding about health and social care, how it is organised and provided, and the priorities and challenges that we face in Aberdeenshire. This plan is one of the ways in which we can stimulate an open dialogue with communities and individuals, leading to a greater transparency about the choices that, as a partnership, we have to make.

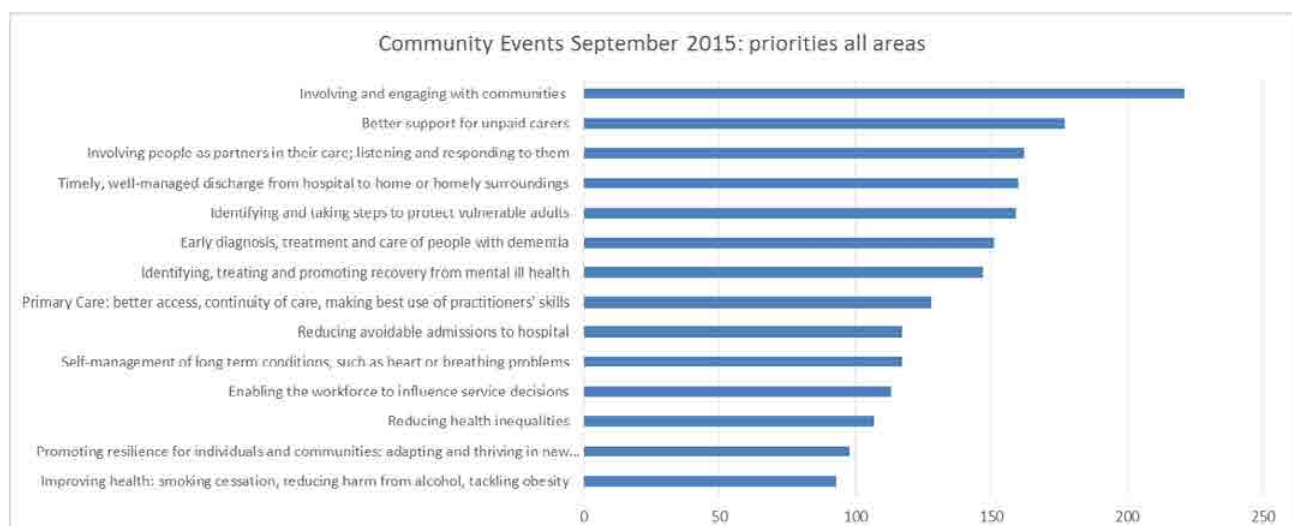
In March 2015 residents were asked what individuals and communities could do to improve their health and wellbeing and to consider what resources were available in their area to support this. Attendees shared their experiences of health and social care, and outlined what they believed should be the main components of high quality services. Their responses along with national and local information have informed the first iteration of the strategic plan.

A further twelve community events were organised in September 2015 to consult on the content of the draft strategic plan. Two events were arranged in each of the six administrative areas. A total of 251 people attended.

Some of the people who attended were there to represent local organisations or groups, or had a current or previous interest from working in health and social care services. Others had a specific concern about the care of a relative or friend. However, all those who attended had a wealth of knowledge and experience that brought richness and lived experience to the discussions.

Most attendees were in the 40 – 70 year age group, with an even gender split. People with disabilities were not well represented, though unpaid carers were. At each meeting there was a representative from Grampian Opportunities (GO) whose remit it was to facilitate the contribution of anyone who required it. In addition, GO carried out separate consultation meetings with groups that might not find the community events accessible. GO consulted with more than 200 people, asking what was working well regarding health and social care services, what could be better, and generating ideas about improvement.

Members of the Aberdeenshire Youth Council provided their views at a consultation event, helping to ensure that young people, for whom the long term strategic aims will have a very real impact, were included.



An online survey available between late August and early November 2015 attracted 39 responses, 84% of which were from people in the age range 17 – 64years.

The views of employees from health, social care and the Third Sector were sought via a series of six participatory events. A total of 295 people attended.

A summary from the engagement and consultation activities is as follows:

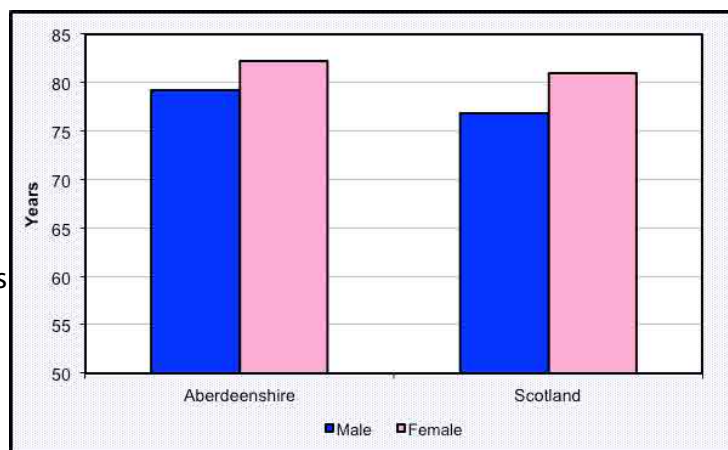
- Clear support for the proposed strategic priorities
- Comments about omissions tend to be about areas of services not devolved to the partnership
- Clear support for a 'top three' of involving and engaging with communities, better support for carers, and involving people as partners in their care; listening and responding to them
- Employees largely agreed with the community views although they also highlighted the need for effective treatment and care
- Respondents with a particular disability or health problem offered informed views about their circumstances and consistently highlighted the importance of a patient/professional relationship based on mutual respect, listening to the person and involving them in treatment plans
- Young people who were consulted strongly supported the need for greater equality in health outcomes and identifying, treating and promoting recovery from mental ill-health
- Comments were made about poor experiences in the transitions between child and adult services and acute to community services
- Acceptance that everyone should take more responsibility for their health
- Agreement that people should plan ahead to meet their needs in old age
- Understanding that professionals with additional training can take on other tasks, e.g. to reduce the demand for GPs
- Generally positive views that the proposed changes will offer a better experience of using services and better outcomes

## Why must health and social care change in Aberdeenshire?

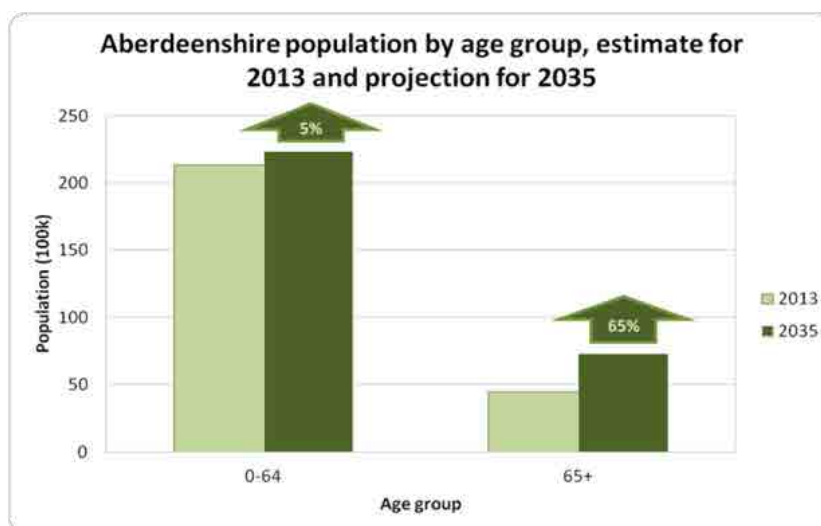
Our population is ageing, as it is across the whole of Scotland. This is one of the great success stories of better health care and treatment. By the year 2035, the number of people aged over 65 will have increased by 65%. Many older people are living long, healthy lives and are fit and active well into old age. Life expectancy in Aberdeenshire is better than the rest of Scotland.

## Life expectancy at birth in Aberdeenshire and Scotland, 2011-2013<sup>1</sup>

However, increasing age can often be accompanied by increasing disability due to health conditions such as stroke or dementia, and simply the frailty that comes with the aging process. Older people and people with disabilities who experience these kinds of health problems need high levels of health care as well as personal and practical help if they are to continue to



live in their own homes or in homely surroundings in their community. Adults of all ages who need access to urgent hospital treatment should be confident that they will be treated and discharged home without delay. These are some of our challenges for the next 20 years.<sup>2</sup>



Health and social care services in Aberdeenshire are not currently resourced, organised and provided in ways that are likely to be equal to these challenges. The rate of emergency admissions to hospital has not decreased in recent years, despite many initiatives. The number of people who cannot be discharged from hospital when they are clinically ready to do so, often because the care they require at home is not available, remains unacceptably high. Emergency admissions to hospital cost us dearly in financial terms and in the distress and anxiety felt by the person and their family. Some people take longer than expected to return to full health or never regain their previous abilities. Health and social care services can be difficult for people to navigate, so that sometimes they do not get the help they need when they need it. Recruiting staff is not easy; in some areas there are problems in employing enough home carers or health assistants, or GPs. The imperative for change is visible to us all.

Budgets for public services have been reducing in recent years, a trend that is likely to continue. If we maintain the current organisation and delivery of health and social care services, we would require an additional £110 million every year – money that we know is not available to us. However, the costs of services – things like hospital-based treatment, specialised equipment and medication – are increasing. Public expectations of the treatment that should be available are also increasing. In order to provide the high quality care that people with health conditions or frailty have a right to expect,

<sup>1</sup> National Records of Scotland

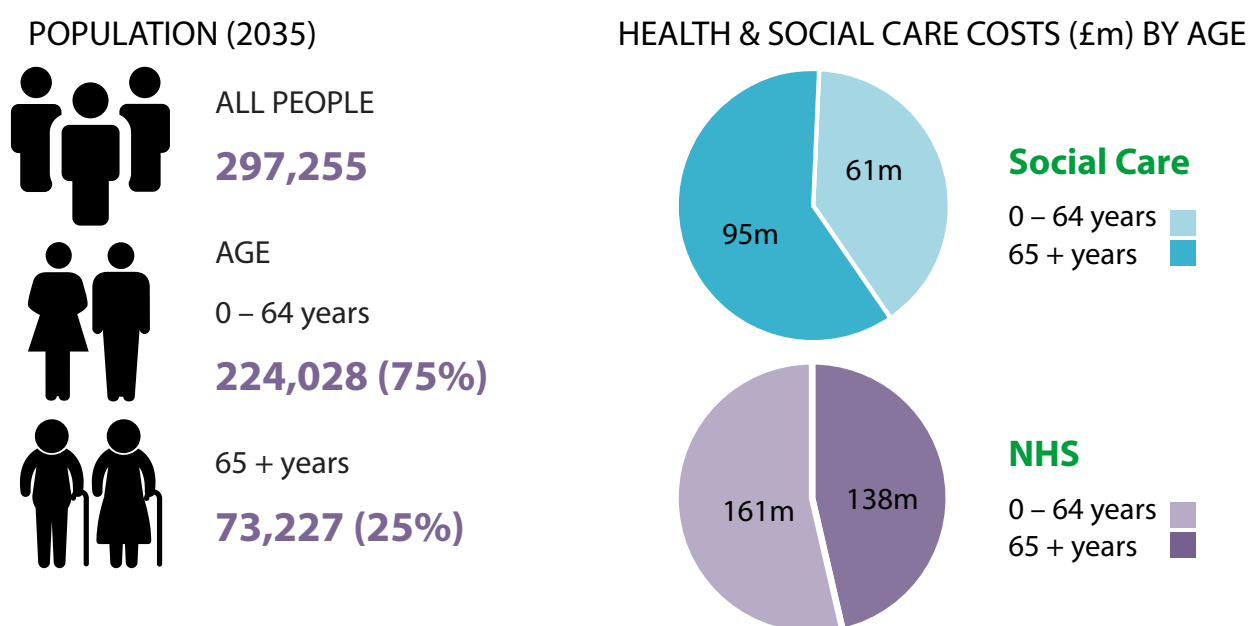
<sup>2</sup> Aberdeenshire health Profile 2015

we need to seek sustainable solutions. Some of this builds on work we have already started, but some demands that we take a different approach.

We want to continue to encourage people to take a greater level of personal responsibility for their health, by making the best choices about not smoking, not drinking alcohol to the detriment of their health, eating a healthy diet and taking regular exercise. These public health messages, if successfully communicated and acted on, are the vital foundation for better health for all.

Personal responsibility should also, where possible, extend to planning ahead to meet care and support needs. Although many health problems are unpredictable and necessitate an immediate response, some requirements, such as suitable accommodation, are more certain. Individuals with long term conditions can be assisted to become experts in managing their care, with fewer crises and better outcomes.

## Projected population and hypothetical service costs – Aberdeenshire 2035



The picture above shows that a large increase in the number of older people is likely to lead to very considerable additional costs – costs that cannot currently be afforded. Encouraging people to develop lifelong health-promoting habits will reduce the demand for health and care services and at the same time will enable more people to have a good quality of life.

Organisations that have service planning responsibilities should act locally, fostering resilient, safe and inclusive communities with strong social networks. Many Third Sector organisations are responsible for small-scale projects that can have a positive impact on everyone's health<sup>3</sup> and quality of life, but are particularly important for older people and people with disabilities.

Directing services from a local point of view has other benefits. Services are more accessible and are better known and owned by the people that use them, including unpaid carers. We describe further in this plan our proposals to organise integrated teams of professionals, including GPs, district nurses, social workers, care managers and a wide range of therapists.

The Aberdeenshire Health and Social Care Partnership extends beyond community-based provision and includes some hospital services. Better planning, better continuity of treatment and care and better person-centred care across the board will ensure that acute hospital care is available when needed. Our aim is to have a single integrated system to plan and deliver health and social care.

<sup>3</sup> Improving the Public's Health, King's Fund 2013

# Strategic Priorities

We recognise that the changes we need to make will require a different relationship between individuals, the communities of Aberdeenshire and organisations that provide health and social care advice and support. These changes will take time, but they are essential if we are to achieve our vision that care will be based on people’s abilities, not disabilities, it will be high quality, person-centred and locally-based, and it will support the person to be as independent as possible.

Theme	Priority	Historical situation	Mid term	Longer term	Contributes to National Outcomes
<b>Partners in health and social care</b>	Involving and engaging with communities	Information and decisions about service development are made largely by services, with occasional opportunities for community involvement	Community leaders are aware of the important matters that face health and social care services. Locally responsive service development is the norm	Local people say they can influence health and social care planning. They actively participate in the creation and improvement of services.	All
	Improving the way unpaid carers are recognised and supported	A small proportion of carers are known and receive support and can plan ahead with confidence	Carers, including young carers, have access to personalised assessment and support plans	Individuals providing unpaid care and those thinking about it for the future are effectively supported	1,2,3,4,6,9
	Involving people as partners in their care; listening and responding to them	Passive recipient of treatment, care and services	Consistent recognition of each individual as a partner in planning their care and treatment	Support and treatment plans are based on people’s abilities and personal outcomes, with an effective balance of formal health and social care services, Third Sector and community assets	1,2,3,4,7,9

Theme	Priority	Historical situation	Mid term	Longer term	Contributes to National Outcomes
<b>Partners in health and social care con't</b>	Self-management of long term conditions such as heart or breathing problems	A lack of foresight, often reactive, vulnerable to crises, with insufficient planning to meet housing needs	People can access the information, advice and technology they require to help them access suitable housing and manage their health condition	People are consciously in control of their health condition and helped to manage it well	1,2,4,5,9
	Empowering the workforce to influence service decisions	Employees contribute to service development occasionally; local knowledge and experience is an underutilised resource	Employees in public and Third Sector services contribute to service development	Employees contribute to service development as an fundamental part of their role in an integrated locality team	3,4,5,8,9
<b>The best of health and care for everyone</b>	Reducing health inequalities	There is an unacceptable gap between health outcomes for people in the most deprived areas and those for people in the most affluent areas	Health and social work intelligence underpins decisions aimed at reducing health inequalities	Health and social care outcomes for people are improving in areas with the highest levels of deprivation	1,2,3,4,5,9
	Improving health; smoking cessation, reducing harm from alcohol, tackling obesity	Aberdeenshire residents have good health relative to the rest of Scotland but there is considerable scope for improvement	More people make healthy choices, change their health – related behaviour and seek help to make these changes	Fewer people have the most common preventable health conditions	1,3,4,5,9

Theme	Priority	Historical situation	Mid term	Longer term	Contributes to National Outcomes
<b>Effective treatment and care</b>	Primary Care: better access, continuity of care, making best use of practitioners' skills	Many health services are centralised and hospital-based. People often wait to see a GP when access to another practitioner could be a better use of resources and would offer a high quality but more accessible service	There is increased capacity to offer local diagnosis and treatment, with strong local leadership and consistently effective community engagement	People know the formal and informal services and supports that are available and use them appropriately	1, 2, 5, 8, 9
	Early diagnosis, treatment and care of people with dementia	The strategic intentions to improve outcomes for people with dementia is set out in the Aberdeenshire Dementia Strategy 2015-2018	Local support is increasing, through professional intervention and developments such as dementia friendly communities	People with dementia and their carers feel included and can participate in the life of their community	1, 2, 3, 4, 6, 7, 9
	Reducing avoidable admissions to hospital	Many acute hospital services are coping with rising levels of unplanned need and demand	People work with health and social care practitioners to anticipate and plan their care needs	Community-orientated specialised, planned treatment	1, 2, 7, 9
	Timely well-managed discharge from hospital to home or homely surroundings	Some people, particularly very dependent older people, have not been able to go home when medically fit because care is not available	Service demand and capacity is known, processes and procedures are agreed and followed and inter-agency working is effective	Suitable accommodation and care at home is available when people are ready to leave hospital	1, 2, 3, 6, 7, 9



Theme	Priority	Historical situation	Mid term	Longer term	Contributes to National Outcomes
<b>Effective treatment and care con't</b>	Identifying, treating and promoting recovery from mental ill health	Mental illness retains a stigma in some areas that make it difficult for people to seek help at an early stage	There is a smooth transition between services for people with ongoing needs and easy access to community resources as part of their recovery plan	People understand what affects their mental health and wellbeing and take steps to improve it	1, 2, 3, 4, 5, 6, 7, 9
	Identifying and taking steps to protect vulnerable adults	Awareness of adult support and protection procedures and how to identify an adult at risk of harm has been limited to professionals who work with people	Service providers and Aberdeenshire residents recognise their role and responsibility to help protect vulnerable people and uphold their human rights	People who are unable to protect themselves are kept safe in their homes, when they use our services and in their community	1, 2, 4, 7, 8

# Health and Social Care Services

## Public health

Public health includes health improvement, improving health services and health protection. Our success in these areas of work will go a long way to help reduce the demand for intervention, by which we mean assessment, treatment, care and support, from formal services. The work covers all ages, from promoting physical activity for children, to Keep Well checks, Health Walks and seated exercise programmes for adults. Volunteers support some initiatives along with professional guidance.

## Clinical services

We intend to deliver care as close to people's homes as possible, building services around natural communities. This includes diagnostic and treatment services which can be appropriately delivered within local community settings. Services include, for instance, ultrasound scanning, dermatology, orthopaedics, cardiac assessment, minor surgery, diabetes, endoscopy and hospital based x-ray facilities.

## Social Work Services

Social work services include a wide range of assessment, care and support planning activities. Individuals have access to practical help such as care at home, residential and nursing care, Occupational Therapy, day services and assistance with employability through a range of Local Authority, Third sector and private providers. Social Work teams are currently aligned to one or more GP practices. Many already have effective practice links through multidisciplinary team meetings in general practice and in community hospitals, and this will be extended to all areas. Our plan will take account of advances in new technology and will make the most efficient and sustainable use of our skilled workforce.

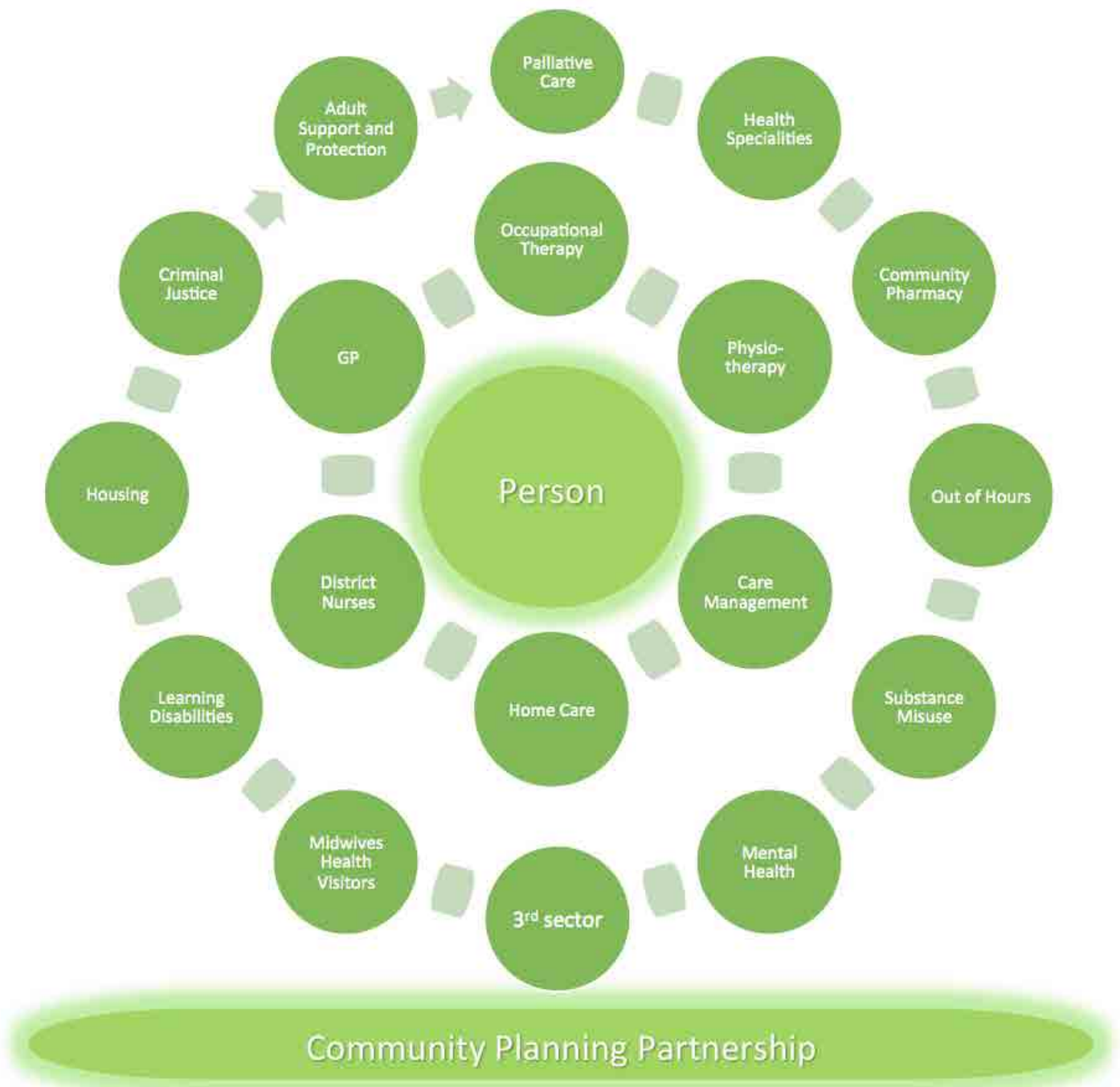
## Integrated locality teams

We are designing integrated teams that will consist of a core team with associated specialties in an extended team, illustrated in the diagram below. The precise make-up of the teams will depend on the requirements of the local population. Teams will follow General Practice catchment areas with specialties covering several areas.

## Hosted Services

Some health services are provided on a Grampian-wide basis. These cannot be planned and delivered by each partnership separately but require a different approach called 'hosting'. One partnership will take the lead responsibility on behalf of the other two for planning, or for planning and service delivery. Decisions about hosting will require to be made for hospital-based acute services, GMED out of hours service, hospital-based mental health and learning disability services, and community health services that had previously been hosted.

## An extended team will be aligned to more than one core team



# Outcomes

## **Outcome 1: People are able to look after and improve their own health and live in good health for longer**

This is a fundamental aspiration for everyone, regardless of their health status, whether they have a number of health conditions or whether they have no health concerns. Everyone has the potential to improve their health and sustain that improvement, with the right basic conditions that include good housing, a safe neighbourhood, access to education and training, an adequate income and access to reliable advice to improve their health and wellbeing.

- Good health advice and health promotion at an early age will be essential to achieve our goal of better health for everyone.
- People expect to make their own decisions about important matters in their lives, and should have that same expectation for their health and social care needs, with advice, guidance and advocacy as required.
- We want to help develop safe supportive communities that are empowered to take decisions about health and social services and play their part in making them effective.

Health-related behaviour is shaped early on in life, by parents, peers, school, the wider community, the media and role models. One of our challenges is to help young people to make good choices about their diet, exercise, not smoking or misusing alcohol or other substances. More people should understand what works for them with regard to improving their mental health, including reducing and managing stress. Everyone working in the health and care sector or education should be informed about the latest advice and should look for opportunities to spread this advice in their daily work.

For this public health information to make a difference to the health of individuals, they need to be willing to accept personal responsibility for the health and social care choices they make and be motivated and well-informed so that they can participate in decisions that affect them.

Communities across Aberdeenshire vary in the extent to which they are self-supporting and inclusive. A commuter town where many people are away from home during the working day is very different to a relatively remote village with a small population, though both often have very able and willing community leaders. One of our challenges is to ensure that we encourage community interest in health and wellbeing across all areas but narrow the gap between those communities that have community leadership and volunteers, and places where people need help to develop these skills. There should be enough enthusiastic people who are motivated, feel they have influence and can effect change; the tasks of community engagement cannot be left to a few.

Aberdeenshire Council has had a strategic aim to move towards the role of enabler as well as provider for many years. We want to continue in this direction, encouraging active participation and personal responsibility and, similarly, NHS Grampian expects all staff to take every opportunity to promote and improve the health of residents.

Support and protection for vulnerable adults remains one of our highest priorities. Staff working in services such as day services for adults with disabilities that are moving towards a community integration model have a responsibility to identify and assess risk, as do home carers supporting older people. Communities that take responsibility and know who to contact with concerns will be valuable partners.



## Making Aberdeenshire More Active

This initiative aims to raise awareness about why physical inactivity remains a challenge in Aberdeenshire, especially for those people who are more vulnerable, and to develop ideas and actions to support people from all ages and stages in life to be more active.

**The conversation café in Maud Resource Centre** is organised monthly and is run by volunteers and staff members from statutory and voluntary organisations. Meetings involve cups of tea, coffee and cakes, and lively conversation. At some

conversation cafes there are taster sessions, e.g. making cards or jewellery or exercise classes using the Maud Centre gym. People have made connections with others in their community, helping to reduce the experience of isolation.



**MACBI**, a company limited by guarantee and with charitable status, was set up by local people in the Central Buchan area with the aim of improving community leisure facilities in Mintlaw and Central Buchan. The centre has a multi-purpose hall that is two badminton court size with temporary staging

that can be assembled for events ie: Fitness room; Soft play area; Meeting rooms /Lounge/ viewing area; Café; Reception/foyer; Changing rooms. It offers yoga, aerobics, martial arts, badminton, keep fit, dance, drama, singing and music making, youth groups, mums and toddlers, interest groups. Centre users range from individuals to community groups, organisations and businesses.



## **Outcome 2:** People including those with disabilities or long term conditions or who are frail are able to live independently at home or in a homely setting in their community

We have much to celebrate about the health of people in Aberdeenshire. People are living longer, many health conditions are being diagnosed and treated at an earlier stage, and the range of treatments and therapies is getting wider. However, one consequence of this is that more people are living with a number of health conditions. On a daily basis they are managing the complexities of appointments with different professionals in different locations, often taking a number of different medications, and coping with uncertainty and anxiety about what the future holds for them. We want to learn from their experiences and help them to take greater control over their health and social care. Self-help and self-care should be 'the way we do things around here'<sup>4</sup>

- Accommodation for people with physical disabilities or older people who are frail is a prerequisite, with adaptations planned well ahead or that can be arranged without delay
- People with long term conditions should be informed and empowered to manage their care, as far as they are able. Unplanned admissions to hospital should be reduced to a minimum, with effective, detailed anticipatory care plans in place for those who would benefit and rehabilitation and reablement the default approach
- Adequate levels of care and support of different types – care at home, care homes and very sheltered housing – must be available in locations where we have anticipated there is need and demand.

Good quality, well-heated accessible housing is a basic necessity for all residents. The current supply of housing is not adequate, with high numbers of people on housing waiting lists and levels of rent above many people's means. There is a steady demand for funding for major adaptations such as showers, ramps and automatic door opening mechanisms. We are working towards a system for allocating and installing adaptations that will be simpler and quicker to navigate. By making clear advice and information available we expect that home owners and tenants themselves will anticipate and take responsibility for their future housing needs.

Unplanned admissions to hospital cause distress and anxiety to individuals and their families and are a very great cost to health and social care. Good anticipatory planning is a priority and should help to keep such admissions to a minimum. Treatment plans should be detailed, written with full involvement of the person and any carers, and to be fully effective, they should be available to staff working out of hours.

In Aberdeenshire it continues to be difficult to recruit and retain staff to work in the care services across all sectors, whether this is care at home, in care homes or in very sheltered housing. Recruiting sufficient community nursing staff and GPs can also be a challenge. More needs to be done to improve capacity if we are to be successful not only in preventing some admissions to hospital but, even more so, enabling people to leave hospital as soon as they are medically ready. Integrated community teams will help us to share information about supply and demand and there will be opportunities to explore how staff roles could be redesigned to make best use of skills and time.

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4 Self-management – lived experience , Alliance

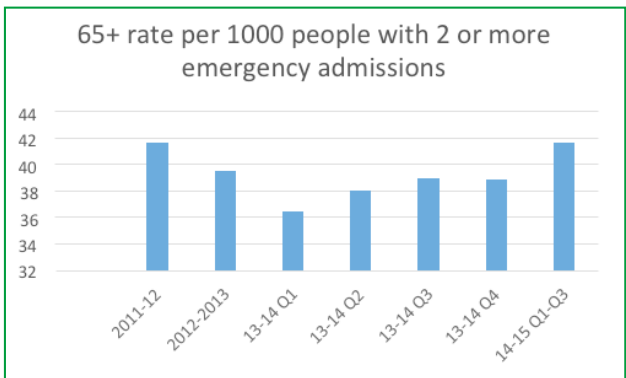
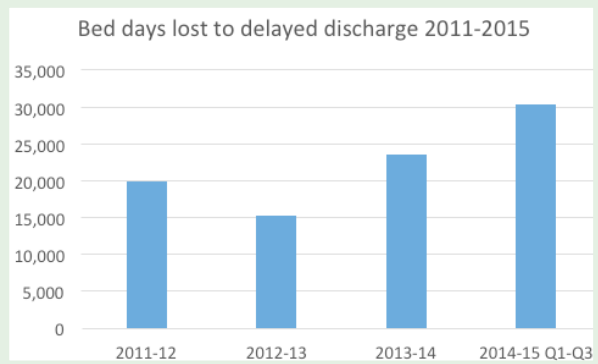
People who have respiratory problems and who live in areas of relatively high deprivation are more likely to be admitted to hospital in an emergency than people from more affluent areas.

There were an estimated 4,105 people in Aberdeenshire with dementia in 2014. It is a condition which is increasing, mostly affecting people over the age of 65, and current projections estimate that the number of people with dementia will double in the next 25 years.

Locally-based **Third Sector mental health services** work with people to support improvements in both mental health and physical health – diet, exercise and social activities. People are encouraged to join mental health support groups where they gain confidence and develop social skills, and then

move onto mainstream community activities. Group work includes teaching resilience and self-management. This complements the work of psychiatrists, community psychiatric nurses, psychologists, occupational therapists and support workers.

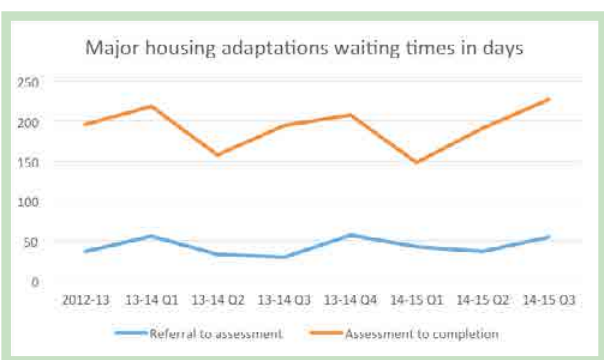
We have created a **Priority Discharge Team** whose role is to enable people to leave hospital when they are medically fit thus avoiding a delayed discharge. This team is working across health and social care, involving ward staff, occupational therapists from the joint health and social work team, care managers and a team of carers who are working to an enablement plan with these individuals.



**Keep Well** is an anticipatory care programme to assist in reducing health inequalities. It provides 'holistic health checks' and onward signposting/referral for those at risk of preventable serious ill health. Now in its fifth year of delivery in Aberdeenshire, the Keep Well Programme continues to be delivered in GP practices and some community pharmacies. Targeted Keep Well checks in Aberdeenshire are also delivered in substance misuse and in other partner agencies. In 2014, this expanded to employability services and carers' services with a planned introduction in criminal justice. For 2014/2015, almost 400 health checks were completed in Aberdeenshire.

- Reduction in ill-health
- Increase in health improvement
- Reduction in health inequalities

The chart shows that the rate of multiple emergency admissions to hospital for people over 65 years had been decreasing but now seems to be on the increase again.



It takes on average 43 days from referral to assessment and between six to seven months for the adaptation to be finished. There is considerable variation in time because of the wide range of adaptations that are made. (2012 – 2015)

## **Outcome 3: People who use health and social care services have positive experiences of those services and have their dignity respected**

We asked people across Aberdeenshire what 'high quality care' meant to them<sup>5</sup>. They described care that was safe, reliable, effective, and provided within an acceptable timescale. Care that is well-coordinated and takes account of personal wishes and preferences is important, as is being treated in a way that reinforces the person's feelings of self-worth. We will ensure our staff are skilled, well-trained and demonstrate the core values of dignity and respect in their everyday practice.

- Information and advice should be readily available to assist people to exercise the level of choice that they want and are able to make.
- Continuity of care and care-givers should be as consistent as possible across the whole system of health and social care.
- Services should take account of individual needs in their particular situation and make every effort to reduce the stigma that some people experience.

It is important that people feel they have been treated as an individual and with courtesy and respect. They do not want to have to explain their circumstances to each worker every time they come for an appointment. Good inter-professional communication is essential; the lack of integrated IT systems does not relieve professionals from their responsibilities to know which other workers are involved in someone's care, and speaking to them. Our systems should move towards records that keep information separate only when necessary and that professionals can get access to the information when required. This is especially the case when dealing with someone in an emergency or out of hours, when access to up to date information can be a matter of patient safety and the safety of others.

Each and every episode of care and treatment should leave the person feeling that they have been listened to and that their personal circumstances have been taken into account. They should have an opportunity to explain what they would like to achieve from any treatment or care. It is only by having this dialogue that professionals can work with them, using their combined knowledge and abilities to achieve a successful outcome. Staff working with people who have a severe and profound learning disability or advanced dementia require specialist skills. Self-directed support principles should underpin our work, offering people the level of informed decision-making that suits them best.

People value the personal contact and the relationship they build up with named staff. However, efficient ways of providing support at home, such as telecare, give good value in terms of staff time, maintain independence and help to keep people safe. Telehealth and telephone appointments are some of the routes we can use to monitor and review someone's health.

Caring for people at the end of their lives is a hallmark of a high quality service and system, but too often people do not get the integrated, well-managed care they and their families need. Our aim is to ensure that where people want to die at home they should be able to do so in peace and comfort and with dignity. We will improve communication between hospital and the community, and continue our recruitment drives for home carers.

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5 Aberdeenshire Community Engagement Report May 2015



**We are proud of the quality of care** provided in our care homes and very sheltered housing. Our newest care homes, in Stonehaven and one planned on the same 'care village' model for Inverurie, provide new opportunities for the local community to be invited into the home and for residents to be involved in the life of the area in which they live. In our open door policy, we are balancing our duty to protect vulnerable people in our care with their human rights.



*Of the 773 people who were using self-directed support, 508 were over the age of 65 years. 86% of people had chosen to have the local authority to manage their care (June 2015)*

*We would want to ensure that in future more people are empowered to take a greater degree of control themselves.*

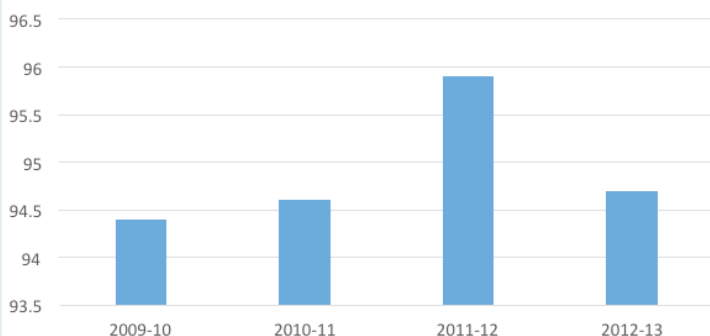
*We need to do more to further embed stakeholder engagement in the organisation right through to frontline staff.*

*We need to make it easier for people to share their experiences, ideas and opinions and to be genuinely engaged in decision-making at all levels.*

*We need consistently to learn and act as a result of what people tell us.*

NHS Grampian Stakeholder Engagement Framework

% of time in the last 6 months of life spent at home or in a community setting



We have very good quality end of life services and aim to support individuals at the end of their lives to die in the place of their choosing.

## **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

Quality of life is a very personal matter. But there are some very basic concepts that all those providing services should bear in mind: reducing isolation and helping to maintain social networks, reduction in pain or discomfort, having a choice in where and how you are looked after, and feeling in control of the services and supports that are available.

- People with long term conditions should be helped to manage their health and social care needs in a way that suits their circumstances, and early identification is one of our aims.
- A system that is better integrated across the current division between acute hospital and community care will help people using services, carers and families and employees. Services that are locally designed and delivered should increase the sense of ownership and responsibility by public and staff.

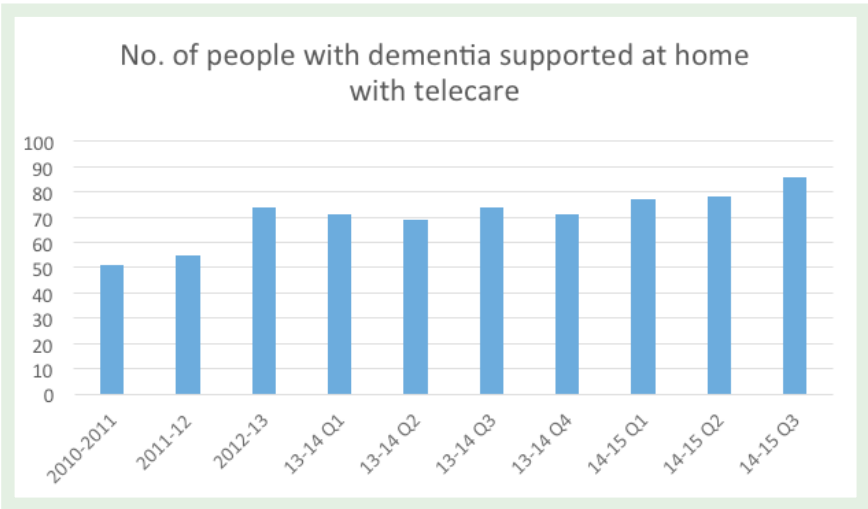
Many of the people who make most use of health and social care services have long term medical conditions such as diabetes, respiratory disorders or who cope with the effects of having had a stroke. They often have a good understanding of their condition and want to work collaboratively with clinicians and therapists. Across our integrated system we would want to have an acknowledgement of this and a culture of mutual respect.

Some long term conditions have a predictable pathway and for these it is helpful to explain and educate people so that they can plan their daily life comfortably and avoid crises that sometimes require urgent admission to hospital. This is work that acute sector colleagues and community teams could do together. Health promotion and social support should be part of the whole package of care and treatment to optimise health and functioning.

Allied to this is the intention to improve patient education, having this in accessible formats, to help people to manage their condition confidently and well. This should mean that they can live well with a condition that does not prevent them from being part of their community. Suitable housing with planned adaptations if necessary are an essential element if this is to be successful.

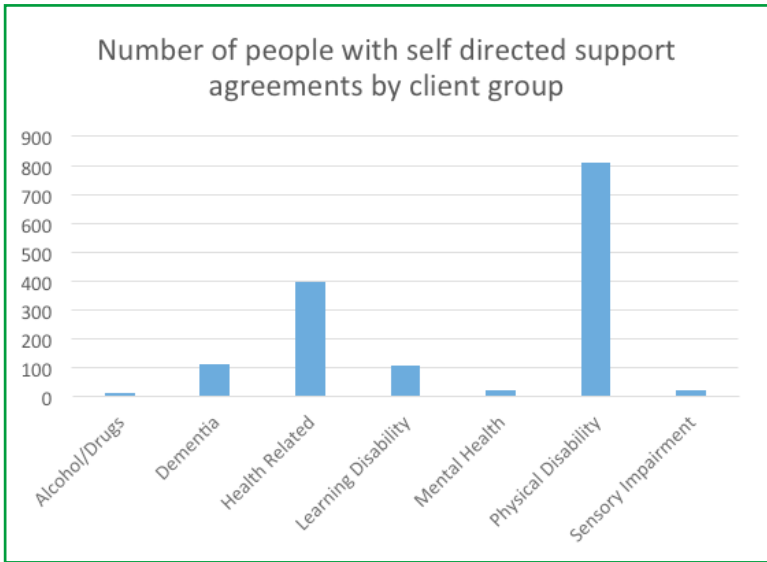
New technology can help people with dementia to keep their independence, it can give families and carers peace of mind and can reduce reliance on scarce care at home services.

Our strategic direction, which is to bring diagnostics and screening nearer to where people live, is working well and will continue. This is more convenient and less stressful for individuals and their families. Involving local people in the planning should help to put the right services in accessible locations.



**A robotic pharmacy kiosk** has been installed in a shop in Inverallochy. The kiosk, which is linked to a pharmacy in Fraserburgh enables people to talk to a pharmacist remotely and have their prescriptions dispensed. People can order medicine and collect their prescription next day. The new service is designed to improve access to residents who may not have easy access to a pharmacy.

We are using technology to help people to understand their diagnosis and treatment. During a consultation a patient may miss information; the explanation of the diagnosis may involve quite technical medical information and language, the diagnosis may be a shock and the patient may be stressed and unable to take it in. No Delays allows the GP or the specialist to prescribe a digital postcard by email to the patient. This is a personalised package of short videos that explains their condition in detail and informs them about local services.



## **Outcome 5: Health and social care services contribute to reducing health inequalities**

Health inequalities are non-random and unfair differences in health outcomes. Income, education, employment and access to services all contribute to health inequalities. Although life expectancy in Aberdeenshire has increased, there is still a strong association between where people live and their health<sup>6</sup>. People who are supported in early childhood to develop resilience to life's ups and downs and who have access to good education and stable jobs are more likely to have good health outcomes – but the gap between those who have these advantages and those who do not have them is increasing. It is the shared responsibility and business of all organisations that provide services to the public to work together to close the health inequality gap.

- The community planning partnership has an overarching role and interest in reducing health inequalities. As a health and social care partnership, we should help and encourage colleagues to assess the health impact of decisions to ensure that these are positive where possible, and any negative impact is mitigated.
- Communities that we know have higher levels of deprivation need our support most, to help build motivation and optimism, especially amongst young people. Working with community planning partners, we can help young people to develop the skills and knowledge to transform health and wellbeing in their localities.

We are designing local health and social care teams based on natural communities and clusters of services. These teams will have the great advantage of a good local presence and local knowledge and will be well-placed to tailor their services to the local population needs. However, more disadvantaged areas need health and social work services that are very accessible. Our support in these areas should be persistent and responsive, helping to identify local needs and wants, and partnering people who are interested in starting up support groups and learning opportunities. We recognise that all of this requires secure long term resourcing.

There are challenges in providing Primary Care in some parts of Aberdeenshire, but nowhere are the skills and experience of these staff more needed than in areas of deprivation. The same applies to any service where improving mental health is one of its main objectives.

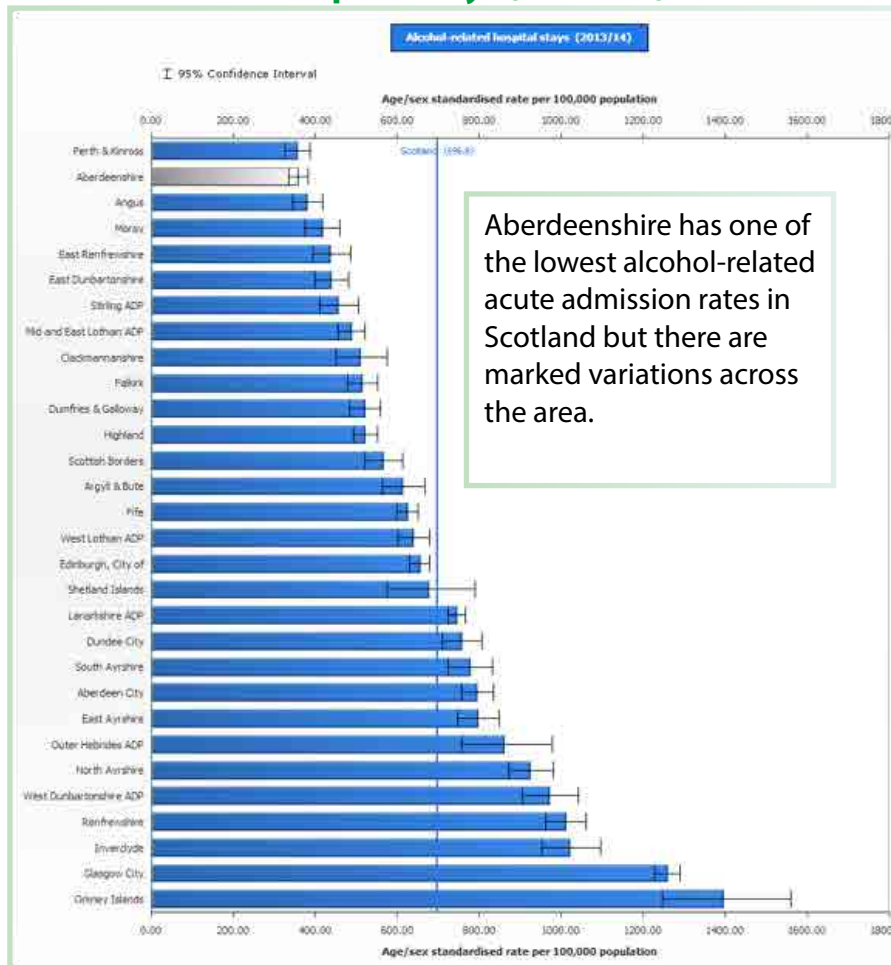
Across Aberdeenshire, residents should expect to get a high quality service, with easy access to self-help information and health and social care. However, there is no one size fits all; some communities will find it easier, and will wish, to do more with less formal support. The way we measure and report the success of the partnership should concentrate on outcomes rather than the volume of services provided.

Health inequalities persist unfairly over generations. Along with colleagues in Education and Children's services, we want to continue to work with children and young people, from preschool age to young families, to inspire and motivate them to achieve their full potential. Young people who have been looked after have, as a group, poorer health outcomes than other young people. We will continue to work in partnership to improve their life chances – safe, healthy, active, nurtured, achieving, respected, responsible and included.

The focus for the Criminal Justice Service has been to recognise the specific health and social support needs, for example of women offenders. The current plan for Criminal Justice highlights the benefits of community sentences as opposed to custody where appropriate; the need to support offenders (and their families) to reduce the likelihood of their reoffending, to break the generational cycle of offending, as well as to punish; and that offenders are members of their communities, and communities can play a role in supporting individuals to achieve a crime-free life.


6 Director of Public Health Report 2013-2014

## Alcohol-related hospital stays (2013/14)<sup>7</sup>



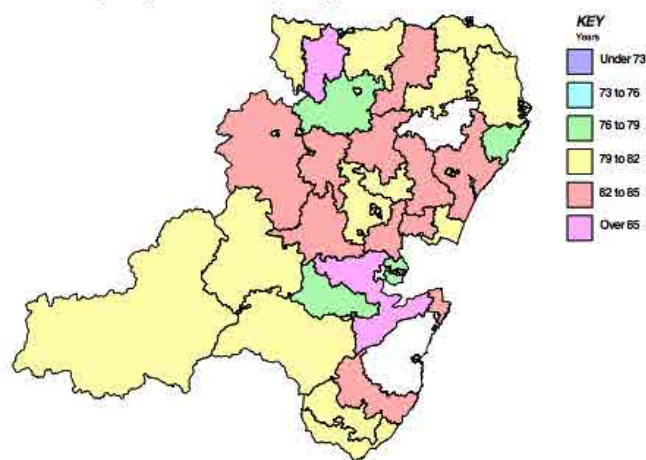
Aberdeenshire has one of the lowest alcohol-related acute admission rates in Scotland but there are marked variations across the area.

**The Garioch Community Kitchen** developed and commissioned a purpose built community kitchen facility in the Wyness Hall, Inverurie. The project aims to encourage practical cookery skills within local communities, raise awareness of healthy eating messages and deliver training through its brand name 'Confidence to Cook'. It offers a variety of courses, including practical cooking, Nutrition and Food Hygiene courses and Training for Trainers courses for members of the Community and support workers. The training kitchen welcomes all ages and groups of people, from all over Grampian, whatever their skill level.

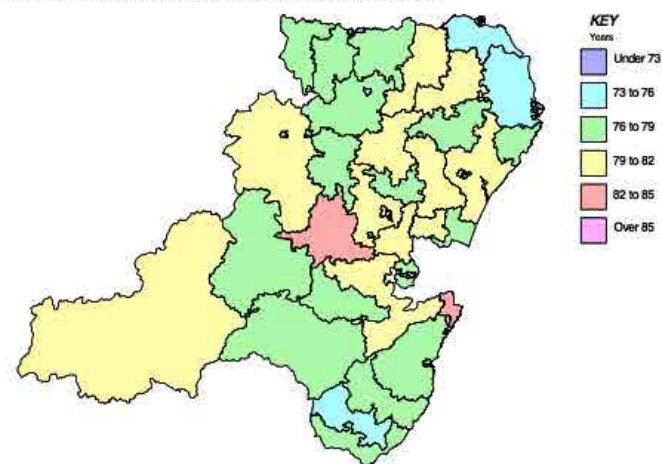


Life expectancy has not risen equally for all people in Aberdeenshire –people living in more affluent areas are likely to live longer.

Female Life Expectancy in Aberdeenshire (2005-09) by Intermediate Zone



Male Life Expectancy in Aberdeenshire (2005-09) by Intermediate Zone



## **Outcome 6:** People who provide unpaid care are supported to look after their own health, including to reduce any negative impact of their caring role on their own health

Unpaid carers are vital to the sustainability of health and care services. The health of carers is as important as the health of those for whom they provide care. In a similar way, their support needs are unique and the help they get to continue in their caring role should be personalised.

- Many people take on a caring role for friends and families for periods of time ranging from a few days or weeks to a lifelong commitment. We need to identify unpaid carers quickly and reliably so that we can support them with information and advice.
- Carers need access to information and advice about the needs of the person they are caring for and for their own health and wellbeing.
- If we are to recognise carers as equal partners, their health must be our priority.

There are a number of systems currently that we use to identify and record carers, including GP registers, social work records and from services commissioned from Voluntary Services Aberdeen. However, these do not individually or collectively give us a reliable picture of who our carers are and where they are so that we can target assessment and support.

Not all carers wish to be formally identified with their caring role, seeing this as a natural family responsibility. Nevertheless, we do want to recognise them as equal partners in care and have this partnership acknowledged, respected and included in professional planning and professional culture across the entire integrated health and care system.

Carers should not have poorer health, social life or life opportunities because of their caring role. The population of carers changes constantly, with new carers taking on this role and these tasks every day. The work to provide information and advice needs to be continually refreshed, seeking new routes and methods of communication including the peer support that is so highly valued.

Although carers' support services are commissioned from the Third Sector, health and social care staff across all disciplines and all sectors have a responsibility to recognise carers and direct them to sources of information.

Some carers tell us that stress, worry and the physical strain of caring can affect their health. Access to regular, planned short breaks is essential, with resources used in a creative and personalised way. Not all breaks need to be extensive or complicated; the informal help that local groups offer by being inclusive and welcoming is very important.

The mental and physical health needs of carers should be better recognised and prioritised, and should have a place in many of the plans for improvements in community care and acute health services. Although the role of carer is not a protected characteristic as such, we should consider the impact of decisions we make with respect to integrated service delivery on the availability and capacity of unpaid carers.

## Support for carers to undertake an SVQ

There are currently 18 carers going through the SVQ qualification with one to one support from Aberdeenshire Council. Some carers want to do the course for their own development and others want to get back into employment or are employed part-time at the moment and would like to move into a job in the care sector.

Aberdeenshire Council has become only the second local authority in Scotland to be awarded the Scottish Government's **Carer Positive Kitemark**.

The Carer Positive Engaged award is for employers in Scotland who have a working environment where staff who are also unpaid carers are valued and supported. This might be through flexible working policies or with simple practical measures which can make a big difference to carers.

*"We will develop plans to help address rural carer issues in Aberdeenshire and create more effective links to ensure the views of all carers are taken into account in forming links between housing, social care and health policies and services. We will increase the accessibility of services for the cared for person, offer on-line support, arrange short breaks, offer carer training, maximise carer health and income, improve transport, expand telehealth care solutions, offer telephone support and develop community networks"*

Aberdeenshire carers' strategic outcome group

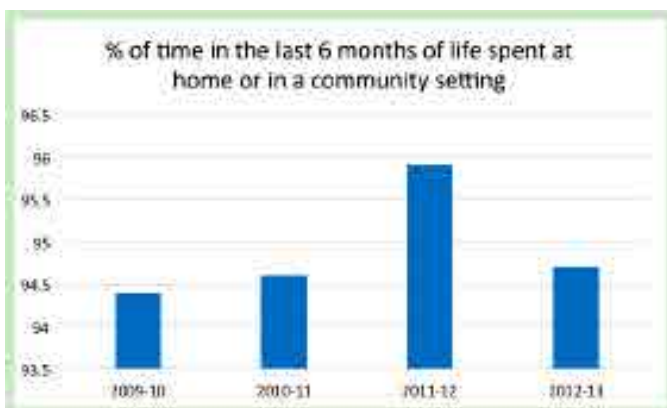
*"52% of carers thought that they had enough of a say in the services that were arranged for the person they look after"*

Health & Care Experience Survey 2013-14:  
Aberdeenshire



*"Unpaid carers can receive a budget to pay for a relaxing break. Mary, a carer for her two sons, used her Creative Break funding to have some fun. Mary really enjoys singing as part of a local choir and benefits from the time away from her caring role."*

VSA Carers' Support



## **Outcome 7: People who use health and social care services are safe from harm**

People who use health and social care services have a right to expect that services will be organised and managed in a way that will keep them safe in their homes and communities. We should aim to reduce to zero all avoidable harm, and act swiftly on the best available evidence to reduce the chances of someone being harmed to a minimum. We must have a consistent knowledge of our duty to support and protect adults at risk of harm<sup>8</sup> across all service providers and use people's experiences as a shared learning tool<sup>9</sup>.

- Employees, volunteers, families and unpaid carers all share a professional and personal responsibility to help identify people who might be at risk of harm, and to report their concerns. Early identification of vulnerable people can help to develop a safety network or circle of family, friends, neighbours and professionals.
- Employees must have ready access to sound professional guidance and advice.
- Strong resilient communities are best prepared to help create a culture where avoidable harm is minimised but people of all ages who have disabilities are not prevented from taking the sort of risks that others would accept for themselves.

Our strategic direction is, very broadly, to provide treatment and care in people's communities or in their own home. For people who are at increased risk, for example of falls, or of causing injury to themselves or others, any risks need to be identified and plans put in place to keep these risks to a minimum.

We have worked hard to come to a common understanding of risk and enablement in different situations, but we will continue to rely on the individual and professional responsibility of employees and individuals to detect and take action where needed. The assurance that comes with excellent standards of training for all staff has to apply across all sectors. In addition, new management structures will ensure that all staff have a named professional contact and personal plans to assure their professional competence.

We want the new Health and Social Care Partnership to be a learning organisation. We are designing procedures that will safeguard people who use services, and that will ensure we detect and learn from any adverse incidents that might occur.

In consultation<sup>10</sup>, people told us that individuals should take more personal responsibility for their own health and wellbeing. This includes keeping themselves and others safe – being a good neighbour. Communities that demonstrate concern, individually and collectively for vulnerable people, including children, will be the foundation for safer environments. As the trend for vulnerable older people to be cared for at home continues, so communities will have to take these sorts of needs into account when they are being consulted about locality developments generally, such as housing developments, schools and leisure facilities.

This plan talks about localities and communities, generally, in the geographical sense. But we know that there is a great deal of knowledge and experience within 'communities of interest', by which we mean, for example, support groups for parents/people with autism, or expert patient groups for conditions such as diabetes. Our clinical and care governance framework<sup>11</sup> directs us to use these resources in the monitoring and improvement of the safety and quality of services.

8 Adult Support and Protection(Scotland) Act 2007

9 NHS Grampian Policy for the Management and Learning from Adverse Events and Feedback

10 Aberdeenshire Community Engagement Report May 2015

11 Health and Social Care Integration Clinical and Care Governance Framework

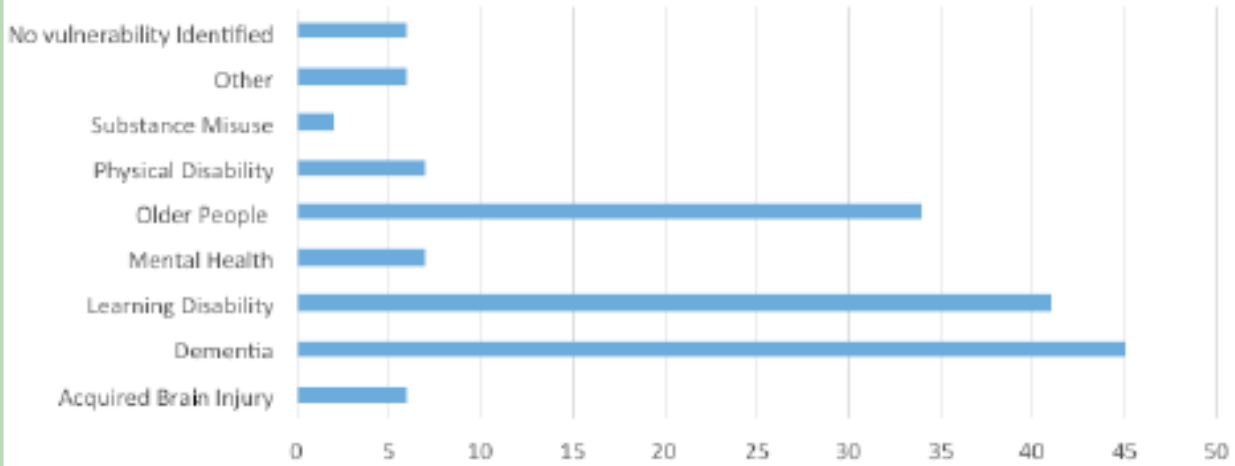


Two service users who share a tenancy have progressed to having time on their own in their home without staff for short periods of time. They have community alarms in place for added safety and are encouraged to wear these when staff leave. They also have their own phones for when they are out on their own and are aware of how to use these to contact key individuals involved in their support should they need to do this.

98%  
of people said they  
had enough information  
about how and when to take  
their medicines

Health and care experience survey  
2013-2014: Aberdeenshire

### Adult support and protection referrals Oct 2014 - March 2015



## Supporting and Protecting Adults from Harm

Advice on who to contact if you have concerns about the wellbeing of an adult at risk

[www.aberdeenshire.gov.uk/care/help/protection/adult-support-protection.asp](http://www.aberdeenshire.gov.uk/care/help/protection/adult-support-protection.asp)



## **Outcome 8: People who work in health and care services feel engaged with the work they do and are supported to improve**

Creating a formal health and social care partnership will not in itself solve all of the difficulties we face in delivering better health and social care<sup>12</sup>. But we do know that some features of partnerships, such as co-location of staff, are effective because they offer people a single point of contact, improving access and communication. Our multidisciplinary teams work to a holistic care model, focussing on the person's quality of life, not only on the treatment of disease. Moving towards services planned and delivered in this way often improves the working environment for staff, with associated benefits for morale and job retention. In a nutshell, it is not structural change that makes good partnerships, it is people.

- Our workforce is clear about the direction of travel and knows how to contribute to this direction in planning services and in their daily work providing treatment and care.
- Managers are supportive, consistent and fair, providing excellent role models for the asset-based, trusting and trustworthy relationships we have with people who use services.
- High quality modern facilities and support services create safe environments for employees and the people for whom we provide services.

The Health and Social Care Partnership has a history of effective joint working. We recognise that integration of health and social care brings with it many changes, but we are clear that much of what we plan to do builds on existing good intentions and good practice. By enabling an approach where employees are very much involved in designing new teams and services, we expect to keep levels of morale and job satisfaction high. We will underpin our empowering approach with strong leadership, developing the knowledge and skills of the integrated joint board members especially around the critical decision-making that will be required over the lifetime of this plan. In particular, the engagement and consultation activities that we have begun will continue as a regular dialogue with communities. Managing public expectations consistently and well will be invaluable in supporting employees and giving them confidence in their decisions.

During 2014-2015 we have continued our plans to co-locate staff with the aim of improving communication and working relationships. It is clear that we should make much faster progress to improve ICT, with shared access to records and email. The current disconnect between assessment documents held in the acute hospital, community hospital, GP, Primary Care and social work is not helpful for team building. Equally, we need to do more to improve the trust and understanding between staff in all different sectors. Their different perspectives should be a strength, not a barrier to person-centred care and treatment.

As well as providing high quality resources and equipment, teams should have access to up to date information about the quality of services, information that includes, in real time, feedback from people using services, their carers and families. We should develop indicators of quality that we can use to understand unhelpful variation and drive improvement, and account for this performance to residents.

We have been innovative and forward-looking in setting up Locality Reference Groups, where health and social work colleagues have taken the lead in deciding what localities should look like. The results have been based on geography, an understanding of the variety of need and demand across Aberdeenshire, knowledge of our current resources, and the best bits of our shared history of cooperative working. We believe the Locality Reference Groups are best placed to design the new core teams and the satellite groups of specialties.

<sup>12</sup> Petch,A, An evidence base for the delivery of adult services 2011

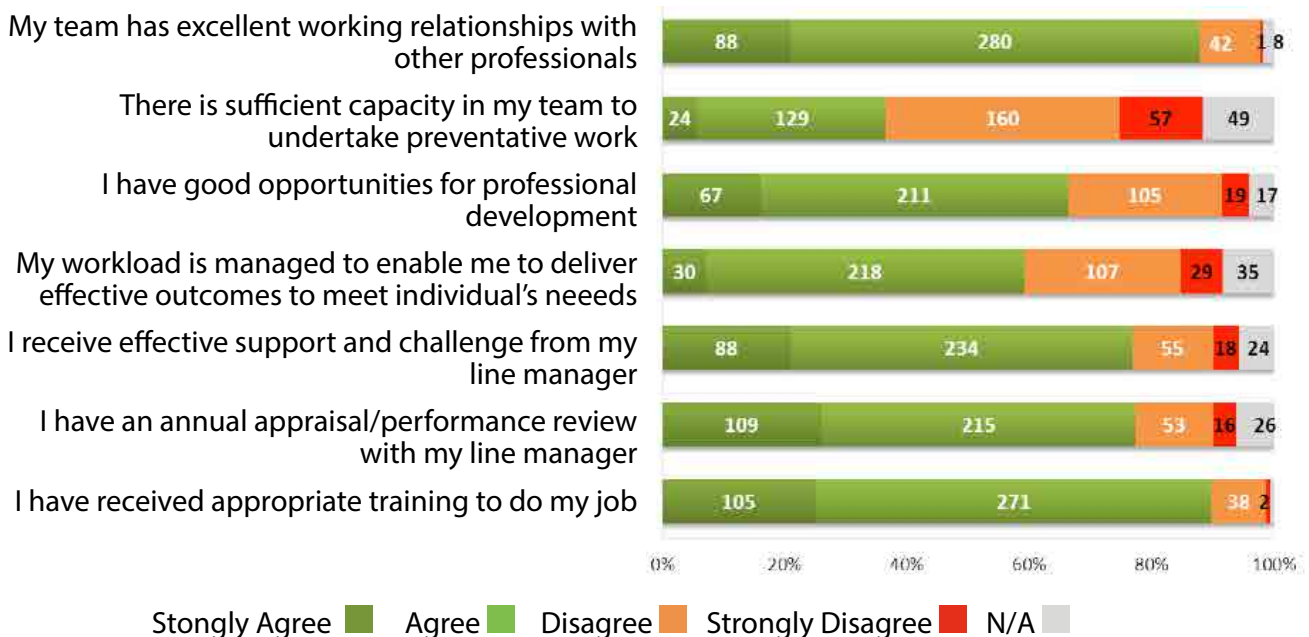


*“Speaking as an Occupational Therapist, joint location has thus far been helpful - I am able to pop through to my social work occupational therapy colleagues to find out about progress with aids and equipment for individuals. This is a bonus after working pretty much on my own previously. I have done joint training with a social work OT for carers about involving residents in activities at a nearby care home. As I choose to sit in the main office with the care managers/social workers there is more communication about people, and I have a better understanding of the care manager’s role and they of mine. An interesting observation is that since co- location our monthly joint clinical meeting has become much shorter in duration – information is not being saved up but communicated more frequently”*

Occupational therapist, Portlethen

*“42% of Health and Social Care respondents agree/strongly agree that their services recognise and consult diverse local communities about levels, range, quality and effectiveness of services. 53% of Health and Social Care respondents agree/strongly agree that there is strong positive engagement between the partners and local community and voluntary groups.”*

Aberdeenshire Staff Survey, Care Inspectorate 2012



## Outcome 9: Effective resource use

This outcome underpins our ability as individuals, communities and organisations to achieve our vision. We recognise that our decisions about where and how we allocate resources should be based on the best available evidence. Increasingly we want to direct more of our resources towards prevention and be in a position where we work with individuals and communities to influence health-related behaviour.

By 'resources' we do not mean only the staff and budgets of health and social care organisations. We know we will be on the right path when people seeking treatment or care recognise their contribution – their assets – as integral to the design and resourcing of successful care. Equally, for those staff assessing and planning support, their role will be to help identify what those contributions might be, rather than looking for traditional service-led answers. Self-directed support will be the norm.

- The overall aim is 'right service, right place, right time'.
- The partnership has a strategic role and responsibility to consider all the available resources – the person, their family and community, the Third Sector, private businesses and formal services in planning and delivering services.
- It is important to identify the appropriate roles for each sector, e.g. as a direct provider of care and treatment, in an advisory capacity, offering informal ad hoc support, and a combination of all of these that suits the individual, giving them choice and control.

For people who are likely to need health care and treatment or social support, this means taking personal responsibility, with help if required, to plan and contribute to the design of their future care.

The partnership aims to design and deliver services with the full active participation of local people. This might mean community leadership either seeking or contributing time or volunteers or it may mean the local authority identifying and releasing resources – venues, facilitation or other help in kind, or funds to start up and sustain services.

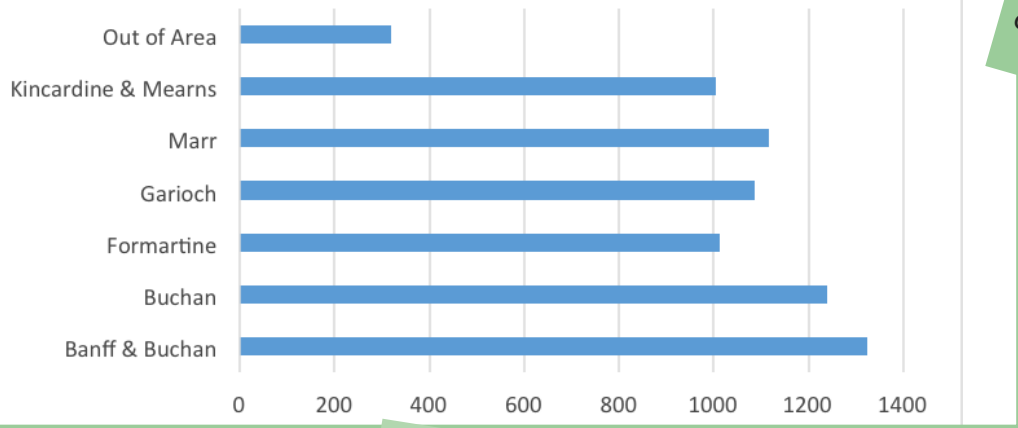
We will continue to expand the range of health screening, diagnostics and treatment that is available in health centres or community hospitals. These include, for example, endoscopy, chronic care management or orthopaedics. The role of community hospitals is vital and will be enhanced in line with the high value that residents place on them.

The role of hospitals - Aberdeen Royal Infirmary and Dr Gray's Hospital in Elgin – in providing treatment to people who are acutely ill will continue to be essential. Integration between health and social care offers us greater opportunities, initially in better co-ordinated care and health outcomes for people after treatment. In the longer term, our collective leadership could have a positive impact on the health of the population through our mutual interest in preventing ill health.

Community health and social care teams will be designed and will develop in response to local circumstances and need, with an effective balance between equality and equity of access to services. If we can achieve this balance we will be moving in the right direction towards improving the health of the local population in general as well those with particular health needs.

We expect that this better use of resources will be pivotal in reducing health inequalities, an aim that runs through this entire strategic plan. However, community representatives will also make an important contribution to decisions that affect their area. We will improve the information and guidance that we offer them so that we can have confidence in informed, evidence-based decisions.

### Caseloads - Adults and Older People September 2015

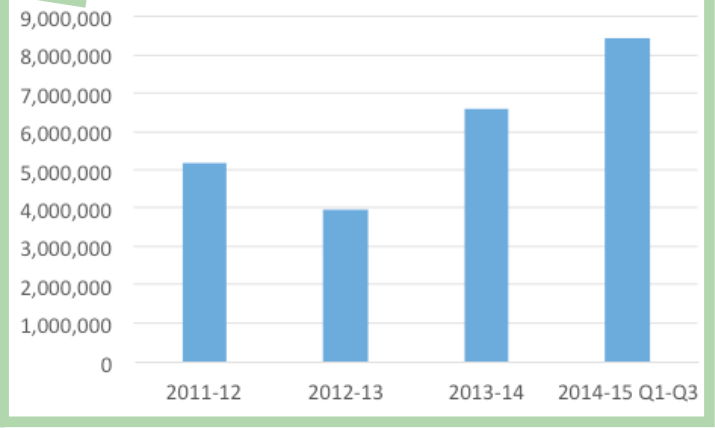


North Aberdeenshire tends to have the highest caseloads

Numbers exclude Criminal Justice Social Work

The cost of keeping people in hospital when they are clinically ready to leave is increasing

### Cost per capita of bed days lost to delayed discharge 2011-2015 (Q3)

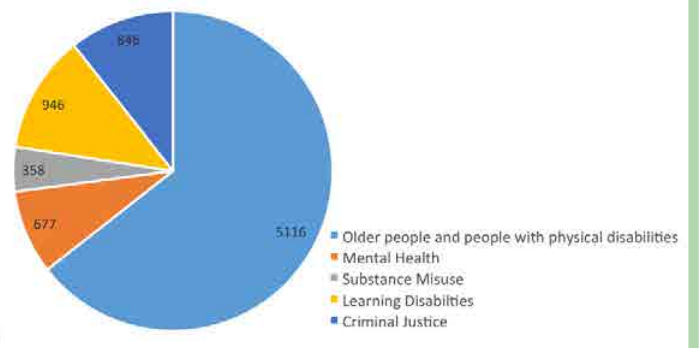


***“Building on existing links with local communities, integrated health, social care teams and third sector organisations, Community Hospitals will become resource centres, supporting people to fulfil their desire to stay at home longer, receive diagnosis and treatment closer to home, receive inpatient care in their local community and when specialist care is required, facilitate the earliest possible return to their community”***

Community Hospital Strategy June 2015

We intend to maximise the use of community hospitals

### Social work caseloads: adults and older people September 2015



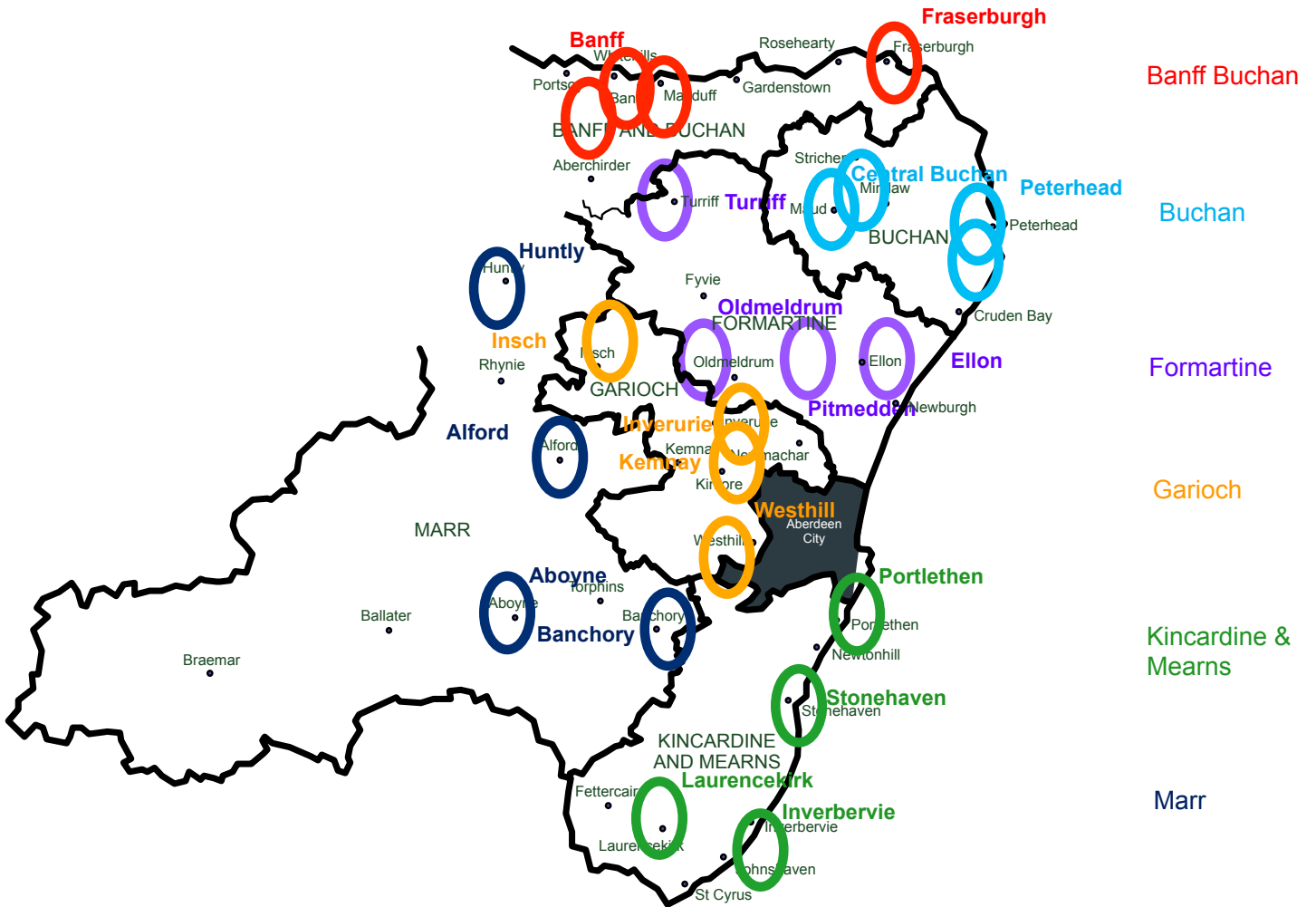
## Performance

Health and social care partners have well-established systems to monitor, manage and report performance. We will develop and refine these systems to create a comprehensive suite of performance indicators for the partnership. National and local data will help us to demonstrate the impact of our strategy over time and to compare our performance with the best in Scotland.

# Appendices

## Appendix 1

### The proposed location of integrated health and social care teams (July 2015)



# Appendix 2

## Current organisation of health and social work services<sup>13</sup>.

Council Services	Health Services
Social work services for adults and older people	District nursing services
Services and support for adults with physical disabilities and learning disabilities	Alcohol and drug addictions services
Mental health services	Services provided by allied health professionals in an outpatient department, clinic, or outwith a hospital
Drug and alcohol services	The public dental service
Adult protection and domestic abuse	General dental services
Carers support services	Primary medical services provided under a general medical services contract
Community care assessment teams	General ophthalmic services
Support services	Pharmaceutical services
Care homes	Out of hours primary medical services
Adult placement services	Community-based geriatric medicine;
Health improvement	Community palliative care services
Aspects of housing support, including aids and adaptations	Community learning disability services
Day services	Community mental health services
Local area co-ordination	Continence services provided outwith a hospital
Respite provision	Community kidney dialysis services
Occupational therapy	Health promotion
Re-ablement services, equipment and telecare	
Criminal Justice	

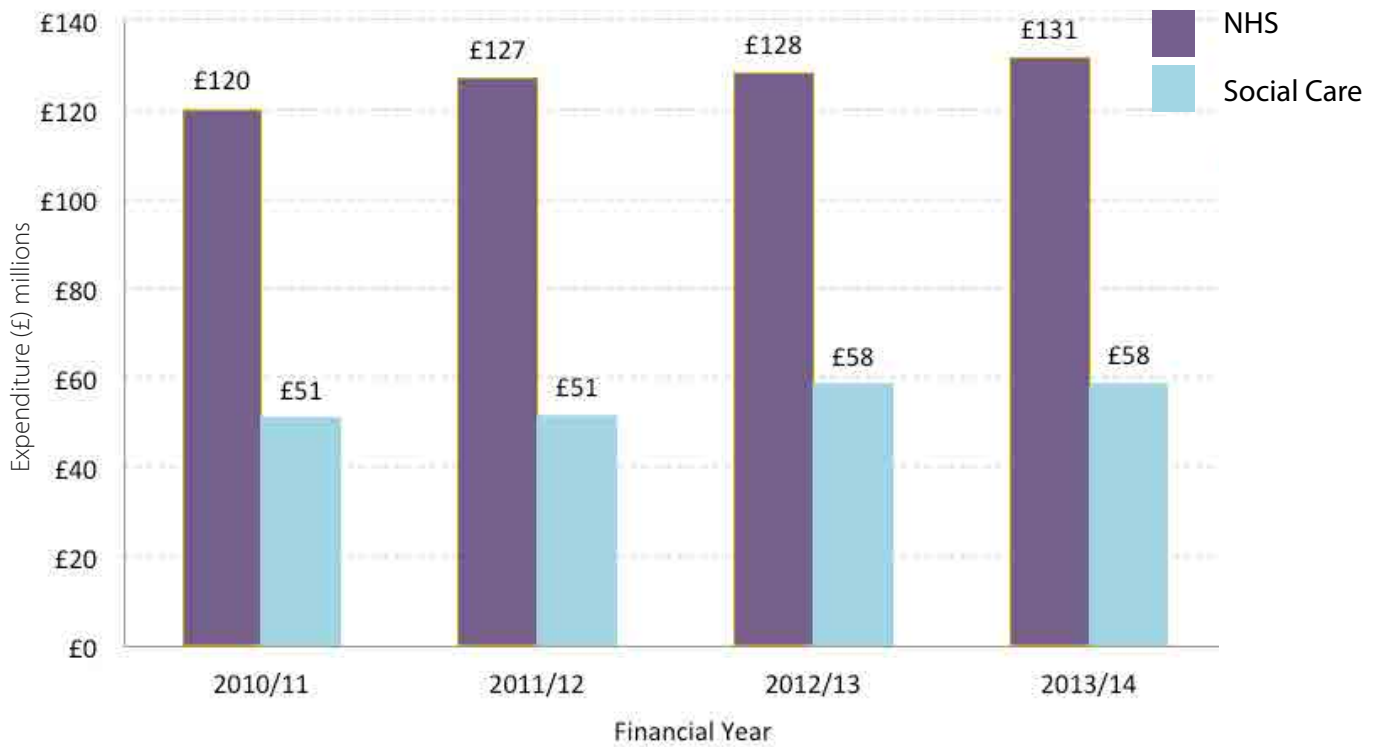
Some hospital-based services will also be included in the partnership:

- Accident and emergency services
- General medicine; geriatric medicine; rehabilitation medicine; respiratory medicine; psychiatry of learning disability
- Palliative care services
- Inpatient hospital services provided by GPs
- Alcohol and drugs addiction services
- Mental health services except secure forensic mental health services

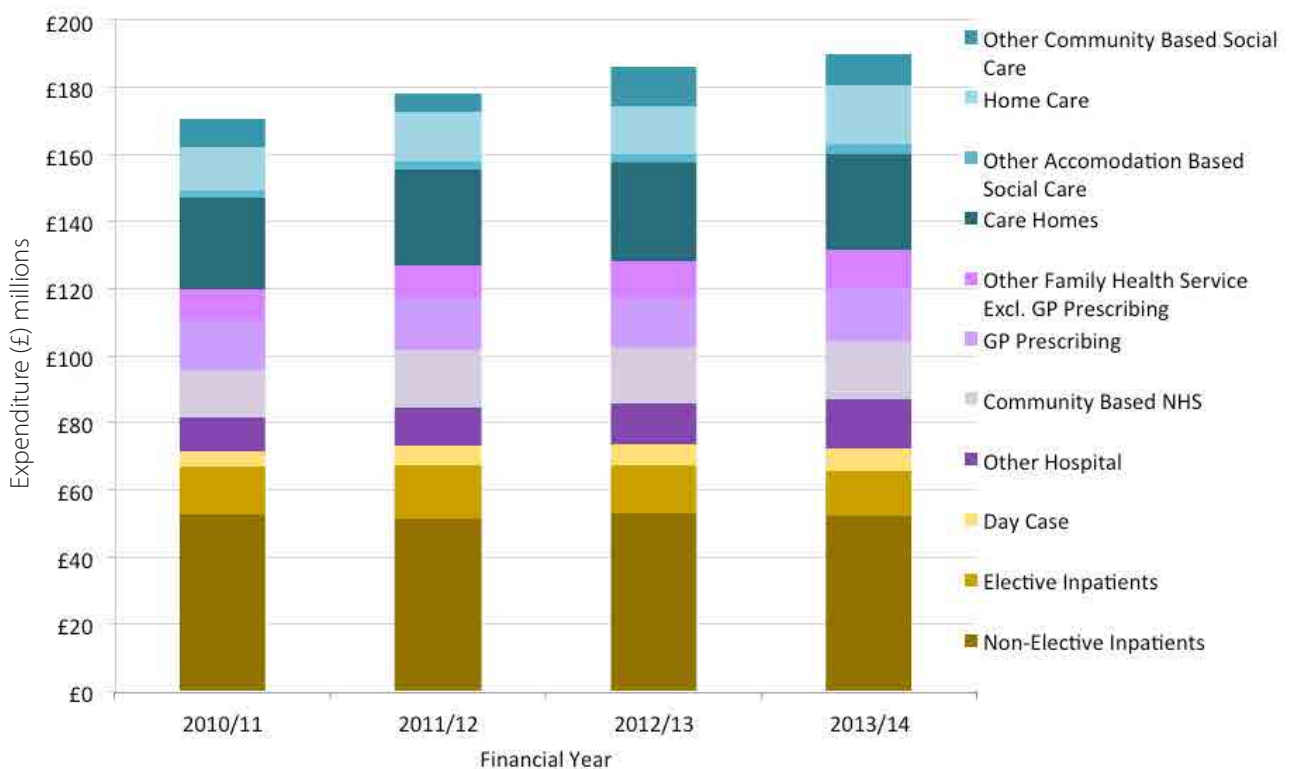
13 ISD July 2015

# Appendix 3

## NHS Grampian and Aberdeenshire Social care spending on services for people aged 65+years Aberdeenshire<sup>14</sup>



## Allocation of budget for services for people aged 65+years<sup>15</sup>.



14 Integrated resource framework 2015

15 Integrated resource framework 2015



# Appendix 4

## Aberdeenshire Health and Social Care Partnership Annual Budget (Sept 2015)

	Partner	Annual	Whole Time Equivalent
		Budget	Staff
Shadow IJB Core	NHSG	£42.2m	967
Shadow IJB Hosted	NHSG	£5m	76
Primary Care	NHSG	£36m	0
Prescribing	NHSG	£41.8m	0
Community Mental Health	NHSG	£6.6m	122
Criminal Justice	Council	Grant Income *	72
Adult Services – Learning Disabilities	Council	£37.5m	261
Adult Services – Mental Health	Council	£4.9m	49
Adult Services – Substance Misuse	Council	£1.8m	23
Older People - Care Management	Council	£36.3m	73
Older People - Other Services	Council	£30.9m	1,036
<b>TOTAL</b>			
		<b>£243.1m</b>	<b>2,679</b>

\*Income is capped at £3m





