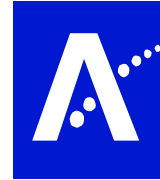


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July 2010

Aberdeenshire
COUNCIL



ABERDEENSHIRE HEALTH & COMMUNITY CARE
STRATEGIC PARTNERSHIP

Strategy
2009 – 2014

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1 **Introduction**

The Aberdeenshire Health and Community Care Strategic Partnership consists of senior managers from Aberdeenshire Council and NHS Grampian. The aim of the group is to work together to improve health and community care services for the people of Aberdeenshire. There is a continued drive to achieve an increasing level of integrated working across the Partnership which will open up opportunities for greater efficiencies, improved quality and performance. This document sets out the priorities and strategic direction for community care services for the next 5 years and the action plans set out how this is to be achieved.

2 **Background**

There has been an excellent joint working relationship between Aberdeenshire Council and NHS Grampian for many years and the Aberdeenshire Health and Community Care Strategic Partnership will continue to build on this.

In 2008 a 'Kaizen Blitz' performance improvement event was held to streamline the strategic planning process. At that point in time there were many strategies and plans in existence but it was identified that improvements could be achieved by rationalising this number. Changes were agreed with the intended outcome of improving timescales, action plans, monitoring systems and service user involvement in the process.

The 50 plus strategies have been reduced to four:

- An Integrated Children's Strategy
- A Health & Social Care Strategy
- A Local Housing Strategy
- A Criminal Justice Strategy

Each strategy has SMART outcome statements and an outcome focused monitoring and evaluation framework.

The Health & Community Care Strategic Partnership is responsible for the Health & Social Care Strategy and will review and evaluate progress.

The Aberdeenshire Housing and Social Work Committee approved these changes at a meeting held on 10th April 2008.

3 **Aberdeenshire Profile**

Aberdeenshire is the fourth largest local authority area in Scotland covering 2,500sq miles and by population it is Scotland's sixth largest, serving over 239,000 people. The area was recently rated as having the best quality of rural life in Scotland in a survey which rated levels of crime, life expectancy, earning power and school results.

Over the last 35 years the population of Aberdeenshire has increased by more than 50% to 239,000, boosted most recently by an estimated 3,000 migrants from Eastern Europe. Aberdeenshire's population represents 4.6% of Scotland's total. Major towns are:

- [Peterhead](#) (17,560),
- [Fraserburgh](#) (12,450)
- [Inverurie](#) (11,060)
- [Stonehaven](#) (10,610)
- [Westhill](#) (10,390) and
- [Ellon](#) (9,710).

The total population of Aberdeenshire is predicted to remain relatively stable over the next 22 years, however the number of households is forecast to increase by more than 20,000. There will be a significant increase in the number of people living alone.

Aberdeenshire faces significant pressures around demographic projections for the future. In five years time (by 2014), the 65yr+ population is projected to increase to 40% of the total population, the highest in Scotland. In twenty five years time the projected rise in people aged over 75 yrs old is 234%, well above the Scottish equivalent of 81%. It is also projected that there will continue to be increasing requirements for services for those with disabilities; the number of people with a learning disability is expected to rise by 1% each year.

In order to meet these expected increases in service user need and demand we need to plan now how quality services can continue to be delivered. This document sets out how the main partners will work together to ensure the community care needs of the people of Aberdeenshire will be met for the next five years and beyond.

4 Vision

Aberdeenshire Council's Vision is:

Serving Aberdeenshire from mountain to sea – the very best of Scotland

The best area

Helping to create and sustain the best quality of life for all through...

- happy, healthy and confident people
- safe, friendly and lively communities
- an enterprising and adaptable economy
- our special environment and diverse culture

The best council

Aiming to provide excellent services for all by...

- involving, responding and enabling
- finding new and more efficient ways of doing things
- providing elected leadership for our area
- working with our partners in the North East and beyond
- always looking to the future

NHS Grampian Vision is:

To improve the health of the population of Grampian and reduce inequalities in health by providing high quality services for patients and to help people choose the best ways to look after their health.

Our Joint Vision is:

NHS Grampian, Aberdeenshire Council and people resident in Aberdeenshire planning and working together to achieve health and well being for all

We will achieve this by:

- Working together
- Involving and consulting
- Reviewing and monitoring outcomes
- Continually improving services

5 Principles and Priorities

A common set of values and principles set out below influence all aspects of community care planning and service provision. These principles are shared by all partners.

- **Respect for the Individual**
We will endorse the rights of individuals to live as valued and equal members of their local communities and treat individuals with dignity and respect.
- **Equal Opportunities**
We will promote equal opportunities and not discriminate on the basis of; age, race, gender, sexuality, disability, beliefs or status.
- **Safeguarding Rights**
We will ensure that the rights of the individual are safeguarded and that independent advocacy services and effective complaints procedures support this.
- **Choice**
We will provide accessible information to inform and offer choice to individuals.
- **Quality**
We will provide services that are of a high standard – flexible, responsive, accessible, and innovative – and use quality assurance methods and staff training to continuously improve standards.
- **Equity**
We will allocate resources equitably and fairly in accordance with assessed need and local circumstances.
- **Service User and Carers Involvement and Participation**
We will involve service users, carers and local communities in the design of services, communicate clearly and support personalisation of services.
- **Service Delivery**
We will deliver quality services to people within their communities and in their existing accommodation where possible - with due regard to the safety of the individual and community.

The Aberdeenshire Health and Community Care Partnership have identified the following as priorities for Community Care Services in Aberdeenshire:

- Identifying adults eligible for support, assessing their needs consistently and reviewing care packages to ensure continued appropriateness and effectiveness
- Planning, commissioning/purchasing and monitoring appropriate and effective care packages which respect dignity and enable individuals to live safely within the community
- Supporting informal carers who provide regular and substantial care enabling them to continue to care for as long as they/the cared for person wish and where appropriate maximising their capacity to take up/remain in or return to employment
- Implementing and promoting measures to support and protect adults at risk of harm through the Adult Support and Protection Act
- Enabling, where possible, those individuals assessed as requiring social care support who are of working age to have their capacity to take up, remain in or return to employment maximised
- Working in partnership to avoid unnecessary hospital admission and delayed/inappropriate discharge
- Promoting participation and involvement of service users and carers in service planning and evaluation
- Improving health and reducing health inequalities
- Involving patients, public, staff and partners towards mutuality
- Delivering safe, effective and timely care in the right place
- Developing the workforce and empowering staff
- Improving efficiency, productivity and sustainability - getting the best from our resources

6 Performance Monitoring and Review Processes

Each strategic outcome group consists of representatives from NHS Grampian, Aberdeenshire Council, Third Sector (voluntary organisations) and Service Users and Carers directly or through reference groups. They agree what will be measured and monitored and used as indicators of the quality of services being provided.

The Strategic Outcome groups review progress made on action plans on an annual basis and this is reported to the Health and Community Care Strategic Partnership and in turn to the Community Health Partnership Committee and the Housing and Social Work Committee (as shown in the diagram on page 11)

Statutory community care performance indicators are reported to the Scottish Government on an annual basis and published.

At an internal local level, all partners, including service users and carers, are involved in reviewing, commenting on and providing suggestions for change and improvement in the quality of services provided through:

- Customer feedback procedures e.g. Have Your Say, Patient Focus Public Involvement Groups (PFPI)
- Service User and Carers and public involvement events e.g. 'Ageing Well' and 'With Inclusion in Mind'
- Individual service provision reviews
- Self assessment processes

At an external national level there are a number of agencies who are responsible for inspecting the quality of services, report publicly on findings and have legal powers to ensure improvements are made where any shortcomings are identified. These include:

- The Care Commission
- Social Work Inspection Agency
- Audit Scotland
- Quality Improvement Scotland (QIS)

7 Organisation and Governance

The Health and Community Care Strategic Partnership meets four times a year. Membership is a balance of senior managers from Aberdeenshire Council and NHS Grampian.

This group is responsible for ensuring that priorities and plans are agreed for providing services for people who require community care services in Aberdeenshire. These plans are called strategic outcome statements and they are reviewed every year. Strategic outcome statements for each care group are set out in sections 8 – 15 of this document.

Strategic outcome statements are developed by Strategic Outcome Groups (SOGs). These consist of staff from health and social work, the third / voluntary sector and service users and their carers. These groups discuss and agree jointly what services are needed and how they will be provided. Service users and carers are involved in a number of ways including; directly as members of strategic outcome groups, through public events, through small group and one to one discussions and through feedback about what service users and customers think about the quality of the services they receive.

The Health and Community Care Strategic Partnership is accountable to the Aberdeenshire Community Health Partnership Committee, the Aberdeenshire Council Social Work Committee and to the Aberdeenshire Community Planning Partnership.

The Health and Community Care Strategic Partnership is focussed on delivering the outcomes specified in the Single Outcome Agreement and is connected into Community Planning through having representatives on both groups and agreed communication channels.

The following diagrams show:

1. Overarching joint strategic planning governance and reporting structure
2. Strategic Outcome Group structures for Community Care
3. Strategic Outcome groups and cross cutting areas structure

Diagram 1
Overarching
joint structure

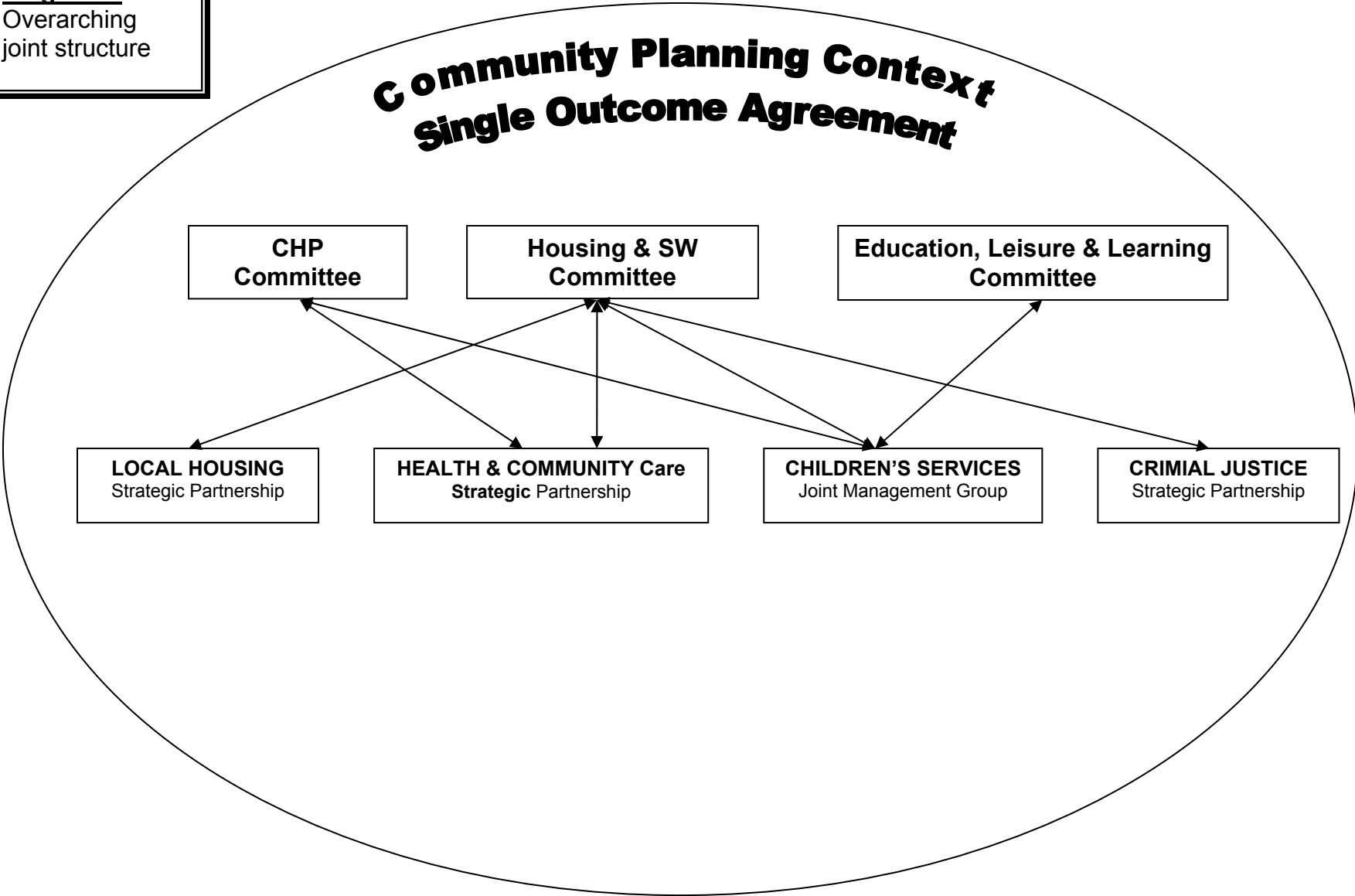


Diagram 2
SOG structure

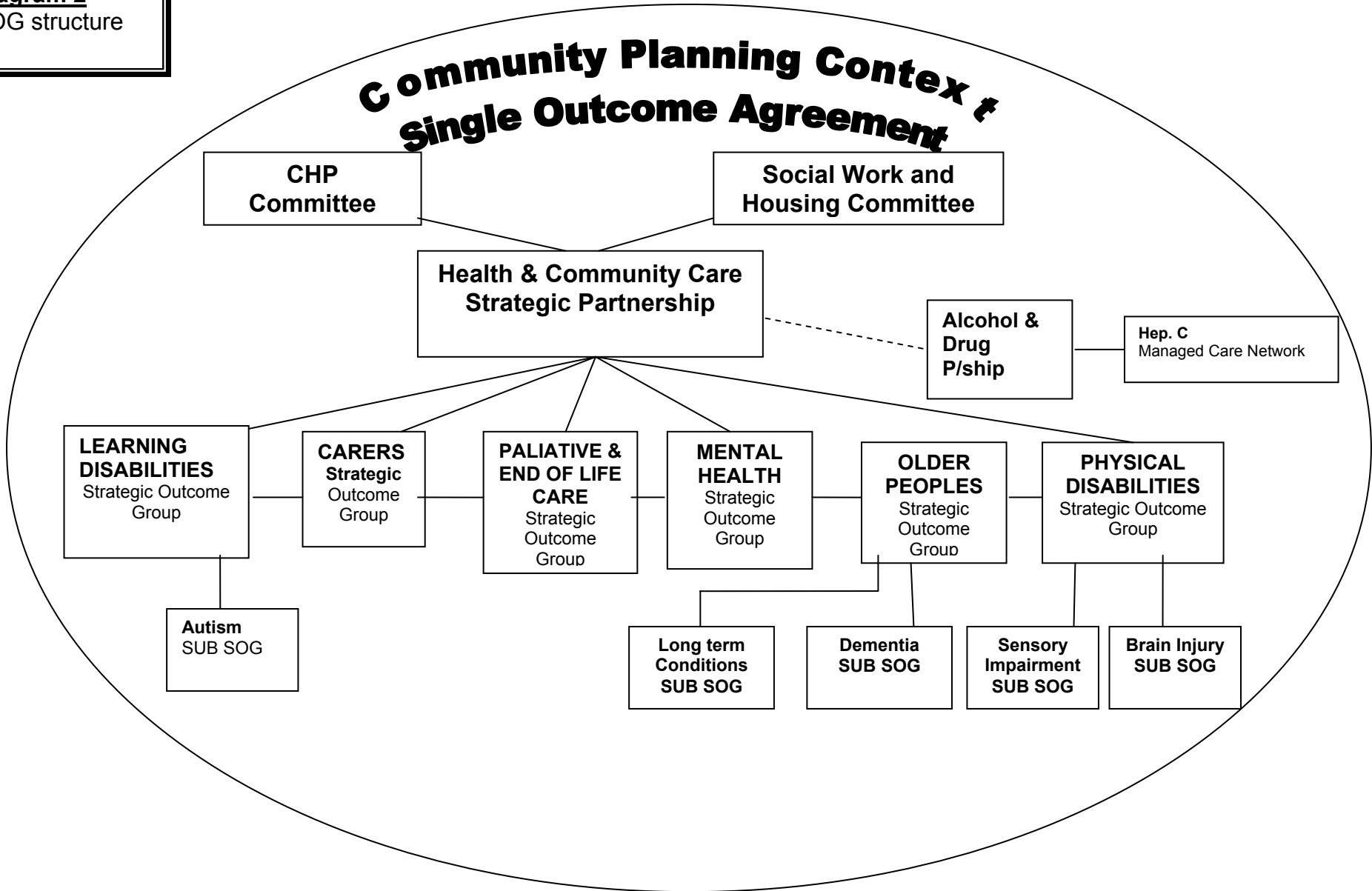


Diagram 3
Cross Cutting
Issues

There are a number of important areas of work which have an impact on and are relevant to the work of **all** the Strategic Outcome Groups as shown on diagram 3.

	OLDER PEOPLE DEMENTIA LONG TERM CONDITIONS	MENTAL HEALTH	LEARNING DISABILITIES AUTISM	PALLIATIVE END OF LIFE	CARERS	PHYSICAL AND SENSORY DISABILITY BRAIN INJURY	DRUGS & ALCOHOL (ADP)	
Health Improvement/Equality								
Single Shared Assessment & Data Sharing								
Joint Commissioning								
Telecare/Assistive Technology								
Adult Support & Protection								
User/Carer Involvement								

8 Older People

Theme
Strategy
Sub Theme
Vision for older people

- Health and Well-Being
Health and Social Care
Older People
- Living a full life with opportunities to plan and prepare for the future
 - To stay as healthy as possible
 - To be as active as possible
 - To have choice and control over how to live their life
 - To stay in their own home
 - To feel safe and involved in their communities

Strategic Outcome

In helping older people achieve this vision, the role of OPSOG is to enable older people who have been identified as requiring health and community care services to:

- Sustain and improve their health and wellbeing
- Manage their long-term condition
- Cope with disability
- Enable them to live as independently as possible

(Local Outcome 6.4)

How do we want to achieve this

- Ensure personal outcome focused assessment, treatment and care planning
- Enable self management
- Good information, easily accessed, with advice and assistance as required
- Pro-active engagement with people identified as at risk of admission to hospital or care home, to reduce unscheduled contacts, prevent admission and support discharge
- Gold standard palliative and end-of-life care
- Provide effective rehabilitation and re-enablement services
- Ensure an integrated and flexible, multi agency response based on good practice to individuals and their carers

Lead Officer
Strategic Outcome Group

Patricia Maclachlan / Sandy Dustan
Older People Strategic Outcomes Group

Policy Context

Wider Strategy Context and research

- Aberdeenshire Change and Innovation Plan
- Aberdeenshire Older People's Housing Strategy/Action Plan
- Aberdeenshire Care Homes Review Implementation Plan
- Aberdeenshire Workforce Plan
- Aberdeenshire Carers Strategy
- Delayed Discharge Action Plan
- Outcomes from Ageing Well conference – Westhill 3rd Oct
- Outcomes from Shifting The Balance of Care conference – Pittodrie 30th Oct.

Policy Drivers & National Work streams

- Better Outcomes For Older People
- All Our Futures - Planning for a Scotland with an Ageing Population
- National Housing Strategies for Older People
- Shifting The Balance of Care – 8 Improvement Areas (48 High impact changes)
- National Telecare Development Programme
- Long-Term Conditions Collaborative
- Anticipatory Care Planning
- Dementia – Scottish Government National Priority
- Home Care Re-Ablement
- Personalisation
- Self-Management of Long-Term Conditions
- Self-Directed Care
- National Benchmarking Project – Balanced Scorecard
- Framework for Adult Rehabilitation in Scotland
- Carers Information Strategy

8.1 Dementia

Theme	Health and Well-Being
Strategy	Health and Social Care
Sub Theme	Dementia
Vision	
Strategic Outcomes	People with dementia, and their families and carers are able to live as fully, as actively and as independently as possible, through having access to the care, support, and information that they need.
How we want to achieve this	<ul style="list-style-type: none">• People with dementia and families and carers receive early diagnosis, assessment, and intervention.• People with dementia receive the most effective treatments for their condition, and support for distressing or challenging behaviours.• People with dementia, their families and carers have easy access to good quality information and advice post-diagnosis.• People with dementia, their families and carers have access to a wide range of flexible and reliable services, responsive to individual needs, preferences and family circumstances.• People with dementia, their families and carers are able to take an active role in the development and provision of local services.• Improving public and professional awareness of dementia.• Promotion of health and lifestyle choices that support the prevention of, or delay the onset of, dementia.• Improvement in the quality of care in hospitals and care homes.• Ensuring the needs of people with dementia are addressed in palliative/end of life care strategies.• Ensuring the needs of families and carers of people with dementia are addressed in carers' strategies.
Priorities are set within action plan	
Lead Officers	Patricia MacLachlan / Ali Walker
Strategic Outcome Group	Older People

Strategic Outcome Sub-Group

Dementia

Reference Documents

Living Well With Dementia: A National Dementia Strategy (England & Wales)
The National Dialogue on Dementia: National Strategy Consultation Paper (Scotland)
The Dementia Manifesto (Alzheimer Scotland, 2007)
'Meeting Our Needs' (Alzheimer Scotland, 2008)
Better Health, Better Care
Mental Health Delivery Plan

9 Carers

Theme	Health and Well-Being
Strategy	Health and Community Care 2009-2014
Sub Theme	Carers
Vision for carers	<ul style="list-style-type: none">• To stay as healthy as they can• To be recognised for their vital role• To be supported in their caring role• To have choice and control over how they live their life <p>The Carers Strategic Outcomes group is currently revising the Aberdeenshire Carers Charter to be more specific as to what carers have a right to expect from the Council</p> <p>The National Carers Strategy will be published in 2010 and this will highlight what the vision will be for all carers in Scotland</p>
Strategic Outcomes	<p>In helping carers to achieve this vision, the role of the Carers Strategic Outcomes group is to</p> <ul style="list-style-type: none">• Identify the priorities for carers to enable them to continue in their caring role• Enable them to sustain and improve their health• Ensure that there is recognition of carers and that they are supported by a wide range of services• Encourage participation of carers in strategic planning and development of services
How we want to achieve this Priorities are set within action plan	<ul style="list-style-type: none">• Carers are enabled to identify themselves as carers and are recognised by the appropriate organisations and services• Carers are aware of their rights including that of assessment• Carers are supported in their caring role• Carers have knowledge and practical skills to continue in their caring role• Carers are involved as key partners in the planning and provision of care services• Carers feel they are well supported by available resources
Lead Officer	Patricia Maclachlan

10 Physical Disabilities

Theme	Health and Well-Being
Strategy	Health and Community Care Strategy 2009-2014
Sub Theme	Physical Disability
Vision for carers	A fully inclusive community that provides co-ordinated, quality, timely and efficient services and support systems for people with physical and sensory disabilities and acquired brain injury, in a way that is shaped by service user and carer needs
Strategic Outcomes	<p>In helping disabled people to achieve this vision, the role of the Physical Disability Strategic Outcomes group is to enable disabled people who have been identified as requiring health and community care services to</p> <ul style="list-style-type: none">• Sustain and improve their health• Manage their long-term condition• Cope with disability• Enable them to live as independently as possible
How we want to achieve this Priorities are set within the action plan	<ul style="list-style-type: none">• Opportunities for disabled people to self care and maximise well being are promoted and consistently available• Disabled people have greater control and choice in planning their care• Disabled people have access to effective rehabilitation and enablement services when they need them• Disabled people have access to a range of health and care supports that meet their needs• Disabled people have access to a range of ordinary lifestyle choices including social and recreational activities based on individual interest and personal choice and employment options that encourage the development of individual skills and build on personal strengths
Lead Officer	Patricia Maclachlan / Iain Ramsay

11 Learning Disabilities

The development of this strategic group has been undertaken in the final phase of this strategy development and consequently the planning group are at an earlier stage in the process. The joint working group are actively working on how the best outcomes can be effectively achieved. Research involving service users has been commissioned in Aberdeenshire and this will contribute to the development of the action plan. The strategic outcomes and priority actions will be updated on this page as progress is achieved.

Theme Health and Well-Being

Strategy Health and Social Care

Sub Theme People with learning disabilities

Vision for people with learning disabilities

Strategic Outcomes

- Young people and adults with learning disability in Aberdeenshire reach their full potential.
- People with learning disability have improved health and emotional wellbeing.
- People with learning disability have access to care, support and housing that addresses their specific needs.
- People with learning disability have an improved quality of life.
- People with learning disability are meaningfully engaged in the planning and development of their specific services and are supported to influence public services.
- Parents and unpaid carers feel supported to continue in their caring role and have appropriate involvement in the provision of services.
- People with learning disability have greater self esteem and confidence as a result of the services they receive.

How we want to achieve this

Priorities are set within the action plan

Lead Officers Susan Carr/ Chris Booth

Strategic Outcome Group Learning Disabilities

12 Palliative and End of Life Care

Theme	Health and Well-Being
Strategy	Health and Social Care
Sub Theme	Palliative and end-of-life care
Vision for palliative and End-of-life care	To have services in place which will embed a cohesive and equitable approach to the delivery of palliative and end of life care for patients and families living with and dying from any advanced, progressive or incurable condition across all care settings in Aberdeenshire.
Strategic Outcome	In helping to achieve this vision, the role of the Palliative and end-of-life SOG is to plan and develop services to enable people who have been identified as requiring palliative and/or end-of-life care to receive services and support to their individual needs, delivered equitably irrespective of age or diagnosis and delivered in a location of their choosing.
How do we want to achieve this	<ul style="list-style-type: none">• By implementing the national strategy 'Living & Dying Well' across Aberdeenshire focussing on the 8 key actions for Primary and Community Care• By ensuring that all people across Aberdeenshire receive care and services appropriate to their individual palliative care and end of life needs, delivered on an equitable basis, across the age span, irrespective of cause, in a location of their choosing• By having systems in place to learn from experience of delivering services to people who require palliative and/or end of life care who live in Aberdeenshire and to share learning• By ensuring all relevant partners work together for the best possible delivery of services and/or support to people in Aberdeenshire with palliative care and/or end of life care needs, linking across other Strategic Outcome Groups where appropriate
Lead Officer	Fiona Francey
Strategic Outcome Group	Palliative and end-of-life care Strategic Outcomes Group

13 Mental Health

Theme	Health and Well-Being
Strategy	Health and Community Care
Sub Theme	Mental Health
Vision for people with Mental Health Issues	<ul style="list-style-type: none">• Reduce the impact of mental illness• Improve mental well-being• Improve quality of life• Improve resilience• Reduce suicide• Reduce inequalities• Improve healthy life expectancy• Have choice and control over how to live their life• To stay in their own home• Feel safe and involved in their communities
Strategic Outcomes	<p>In helping people achieve this vision, the role of the Mental Health Strategic Outcome Group is to enable people who have been identified as requiring mental health and associated community care services to:</p> <ul style="list-style-type: none">• Sustain and improve their mental health• Sustain and improve their physical health• Recover as far as possible from their long-term condition• Share their lived experience with others• Cope with disability• Live as independently as possible• Experience increased respect and inclusion• Live in more supportive environments• Have increased social connectedness, relationships and trust• Have maximised employment, financial security, learning and development skills• Live in mentally healthy and inclusive communities

How we want to achieve this
Priorities are set within the action plan

- Assessment for and Review of services will focus upon improving outcomes for people.
- Individuals will have access to effective rehabilitation and enablement services when they need them.
- Opportunities for people to recover and maximise wellbeing will be widely promoted and made consistently available.
- Services will promote people's recovery, resilience and independence.
- Services will aim to support improved family and community connections.
- Service provision will aim to support better health status and healthier behaviours.
- The role of our Community Planning Partners in achieving improved well-being, mentally healthy and inclusive communities will be supported.
- National strategies for Inclusion, Stigma and Choose Life will be taken forward at local level.
- By supporting and promoting Peer-led initiatives.
- Self-Evaluation and Continuous Improvement will be promoted across services.

Lead Officers

Chris Booth / Kevin Dawson

Strategic Outcome Group

Mental Health Strategic Outcomes Group

14 Substance Misuse / Alcohol and Drugs Partnership

Theme	Health and Well-Being
Strategy	Health and Community Care
Sub Theme	Alcohol and Drugs
Vision for community health and care alcohol or other drug services	<p>The majority of care, treatment and support will be provided within the community and referral to specialist secondary care services will occur only where necessary. All community services will promote safer consumption patterns and equip people to avoid harm.</p>
Strategic Outcomes	<ul style="list-style-type: none">• Harm caused by the misuse of alcohol and other drugs is reduced• Children get the help they need when they need it• People who require health and community care services are enabled to sustain and improve their health, manage their long-term condition, cope with disability and to live as independently as possible.• We will have moved from a model of managing symptoms to a more ambitious vision of hope, recovery and community engagement in strengthening recovery capital.• Access to treatment and support will be improved through the use of a broader range of mainstream services
How we want to achieve this	<p>In addition to the Alcohol and Drugs Service Delivery Subcommittee/ SOG's range of wider goals contained within the ADP work plan, the Health and Community Care Strategic Partnership will look to the SOG to ensure provision of adequate community services to:</p> <ul style="list-style-type: none">• Strengthen recovery capital and promote recovery• Improve accessibility by reducing waiting times for assessment and treatment• Streamline referral pathways to reduce duplication and increase effectiveness of intervention• Increase the number of clients sustaining their recovery through involvement in peer or mutual aid support groups or fellowships• Provide preventative advice, screening and brief intervention where indicated• Ensure only complex and demanding cases are referred to specialist secondary care substance misuse services• Ensure all services adhere to 'Getting it Right for Every Child' principles
Lead Officers	Chris Booth / Mike Ogg / Bill Harrison
Strategic Outcome Group	Alcohol and Drugs Service Delivery Subcommittee/ SOG