



Aberdeenshire
Health & Social Care
Partnership

Aberdeenshire Health and Social Care Partnership

Annual Report 2017 – 2018

June 2018



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Foreword

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

Aberdeenshire Health and Social Care Partnership Vision

On behalf of the Aberdeenshire Integration Joint Board we are very pleased to present the Aberdeenshire Health and Social Care Partnership Annual Report for 2017-18.

The last year has seen both significant areas of progress and considerable challenges for Aberdeenshire. We have sought to present these in a balanced and informative way, recognising that the HSCP is still a young organisation and continuing to learn and evolve.

We describe the progress we have made in delivering against our 10 strategic priorities, including selected case studies to provide more detail as to what this has meant for both users of our service and staff.

We recognise and thank all staff working within the HSCP for the significant contribution they make on a day to day basis in helping us progress towards the delivery of cohesive, integrated and person-centred care for the people of Aberdeenshire. The process of integration presents many challenges, and there is much work still to be done. However the stories and examples of improvement and good practice provided throughout this report evidence the considerable progress already made by our local teams.

Finally, we wish to acknowledge the contribution of the people of Aberdeenshire to helping us learn and improve as an organisation. Our recent review of our Minor Injury Units represented the most significant piece of public engagement undertaken by us to date, indeed the scale of public involvement was unprecedented. We know this is reflective of local communities' high regard for their local health and care services. We are committed to continuing to listen and respond to the views of the people of Aberdeenshire as we move forward with our transformational change programme to ensure we provide safe, effective, responsive and sustainable local services for the future.

Feedback on the Annual Report is welcomed and can be provided via: integration@aberdeenshire.gov.uk



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Executive Summary

This annual report describes the key areas of progress and performance of Aberdeenshire Health and Social Care Partnership (HSCP) over 2017-18 in planning and delivering the range of health and social care services that we are responsible for.

The report is structured around our ten strategic priorities:

- i. Meaningful engagement with all stakeholders to optimize effective planning and use of resources
- ii. Empowering the workforce
- iii. Developing the support mechanisms that enable people to have improved health and wellbeing
- iv. Ensuring quality through safe, effective and sustainable service provision
- v. Reducing inequalities to provide equitable outcomes for our communities
- vi. Involving people as partners with early identification, management and appropriate support to promote recovery and achieve their potential
- vii. Public protection
- viii. Prevention and early intervention to promote healthy lifestyles and resilient communities
- ix. Development of services that are fit for the future
- x. The most appropriate and effective use of acute and community resources.

Our strategic priorities are closely aligned with the nine National Health and Wellbeing Outcomes set by the Scottish Government. These provide the framework for how we can improve the quality and experience of services for individuals, families and carers, and what difference we can achieve through delivering integrated health and social care services.

A key highlight in 2017-18 has been the continued evolution of our **locality organisational structures and integrated health and social care teams** to deliver joined-up, person-centred care to our communities. Our locality teams have also developed their own locality plans involving wide stakeholder engagement resulting in the identification of agreed local priorities to be taken forward.

Major projects have commenced or continued with the aim of ensuring we have safe, high quality, effective and sustainable services for the future. This included a **review of our Minor Injury Units** across Aberdeenshire, involving extensive public engagement.

In addition the **Virtual Community Ward model has continued to be implemented locally**, bringing together multidisciplinary health and social care teams who provide care for people who need regular or urgent attention, with the aim of improving their outcomes and experience. Data routinely collated suggests a significant number of people have avoided unnecessary admission to hospital as a result of this approach.

We have developed **Local Carer Strategies for both adult and young carers** outlining what we will do over the next few years to best support carers in Aberdeenshire.

We describe our performance against both the national core integration indicators for HSCPs and our own local suite of performance indicators. **Aberdeenshire continues to perform exceptionally well** when compared nationally.

Our changing demography, in particular a growing population of older people with more complex health and social care needs, remains one of our major challenges. We have also continued to experience workforce recruitment and retention challenges across a variety of professions.

We acknowledge that 2017-18 was a very challenging year in terms of financial performance but describe the proactive approach we are taking to address this over the next 5 years through our Medium Term Financial Strategy.

We know that continuing to deliver services in the same way will not be sustainable nor meet the needs of our communities in the future. This report describes the four programme plans developed in 2017-18 which will drive forward the operational service change required to deliver models of care fit for the future: Reshaping Care; Enabling Health and Wellbeing; Facilitating Shared Ownership and Engagement; and Safe, Effective and Sustainable.

The report illustrates the continuing commitment and progress of the HSCP in delivering its strategic vision for the population of Aberdeenshire, and the intended outcomes for the people who receive our services, their families and carers.

Introduction

Aberdeenshire Health and Social Care Partnership (HSCP) formally came into existence in 2016 following publication of the Public Bodies (Joint Working) (Scotland) Act 2014. We are responsible for the integrated planning and delivery of a range of health and social care services for adults and older people.

The work of the HSCP is governed by our Integration Joint Board (IJB). Further information regarding the Aberdeenshire IJB is provided later in this report.

- xi. All Integration Joint Boards are required to publish an annual report. This annual report documents our performance over our second year of operation. Throughout this report, performance information for our first two full years of operation – 2016-17 and 2017-18 – has been provided, to report on progress through our formative years. Our first annual report for 2016-2017 can also be referred to.¹

Organisational Overview

Through a partnership agreement between Aberdeenshire Council and NHS Grampian, known as [The Integration Scheme](#), locally agreed operational arrangements for the delivery of integrated services were set out.

In addition to the broad range of integrated adult health and social care services that Aberdeenshire HSCP is responsible for, the HSCP has also retained responsibility for children's health services, and works closely with multi-agency partners in the planning and delivery of these services to improve outcomes for children and young people. In relation to GIRFEC, (Getting It Right For Every Child,) the importance and vulnerability around transition periods is recognised. Various workstreams are delivering improved pathways to ensure better transition across services, but we recognise there are challenges to be addressed.

Aberdeenshire also 'hosts' the planning and management of a number of services on behalf of all 3 Health and Social Care Partnerships in Grampian (Aberdeen City, Aberdeenshire, and Moray), including Marie Curie nursing services, HMP Grampian health services, the Forensic Medical Examiner service, and Diabetes/Retinal Screening.

Aberdeenshire HSCP covers a workforce of just over 4,000 people and a total revenue budget of £303 million (in 2017-18).

Aims of the Annual Report

The purpose of the annual report is to provide an open account of our performance in relation to planning and carrying out the health and social care services that we are responsible for.

In this report for 2017-18 we have also set out to:

- Describe the key areas of work and achievements for Aberdeenshire Health and Social Care Partnership (HSCP) from April 2017 to March 2018.
- Acknowledge the various challenges we have faced in the last year, what we have learned, and how we have responded to these challenges.
- Describe the progress of the HSCP in delivering our strategic priorities, and the work we must still undertake.
- Explain what this has meant for individuals, carers and families at the heart of our local communities.

We have structured the 2017-18 annual report around our ten strategic priorities, which are explained in more detail below.

The report also seeks to demonstrate our commitment to 'Best Value', a formal duty placed on all public sector organisations to ensure 'good governance and effective management of resources, with a focus on improvement, to deliver the best possible outcomes for the public'.² Best Value is defined through 9 fundamental characteristics:

- Commitment and leadership
- Sound governance at a strategic and operational level
- Accountability
- Sound management of resources
- Responsiveness and consultation
- Use of review and options appraisal
- A contribution to sustainable development
- Equal Opportunities arrangements
- Joint working.

In describing our progress and performance during 2017-18 throughout this report we also aim to reflect how we have demonstrated these characteristics.

Policy and Strategic Context

Aberdeenshire HSCP set out its objectives and priorities for the future delivery of integrated health and social care services through its Strategic Plan 2016-2019,³ underpinned by the following core 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.

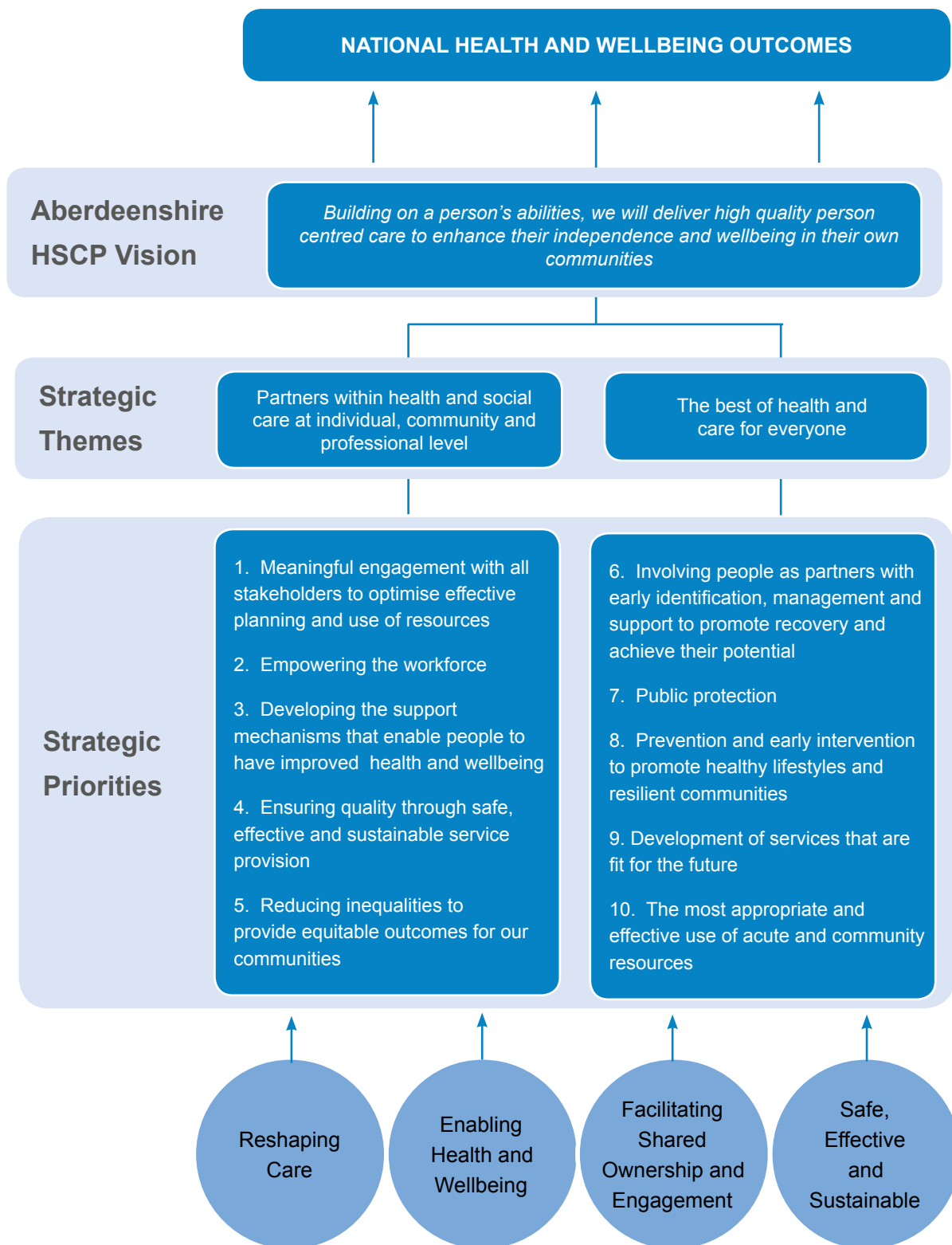
Our Strategic Plan described some of the challenges facing us as we embarked on the process of integration. Throughout 2017-18 these have remained unchanged, including:

- **Our changing demography** – By the year 2035, it is forecast that the population of people aged over 65 in Aberdeenshire will have increased by 65%. Whilst a great success story, it also means that people will be living longer with potentially more complex health or care needs.
- **Increasing financial constraints within the public sector** – The increase in demand on health and social care services will place an increasingly unsustainable pressure on resources and current models of service delivery. Put in context, we expect a year on year increase in costs of at least 1.7%, or around £5 million per annum.
- **Workforce pressures** – Our recruitment challenges in Aberdeenshire mirror many of those being reported nationally, for example there have been well documented challenges in the GP workforce across Scotland. But we also see similar challenges in nursing, home care, and a variety of other health and social care professions.

We know that continuing to deliver services in the same way will not be sustainable nor meet the needs of our communities in the future. Through integration however, we are committed to planning and delivering health and social care services in a more effective, efficient, and person-centred way, particularly for those individuals with complex needs who require both health and social care input at the same time.

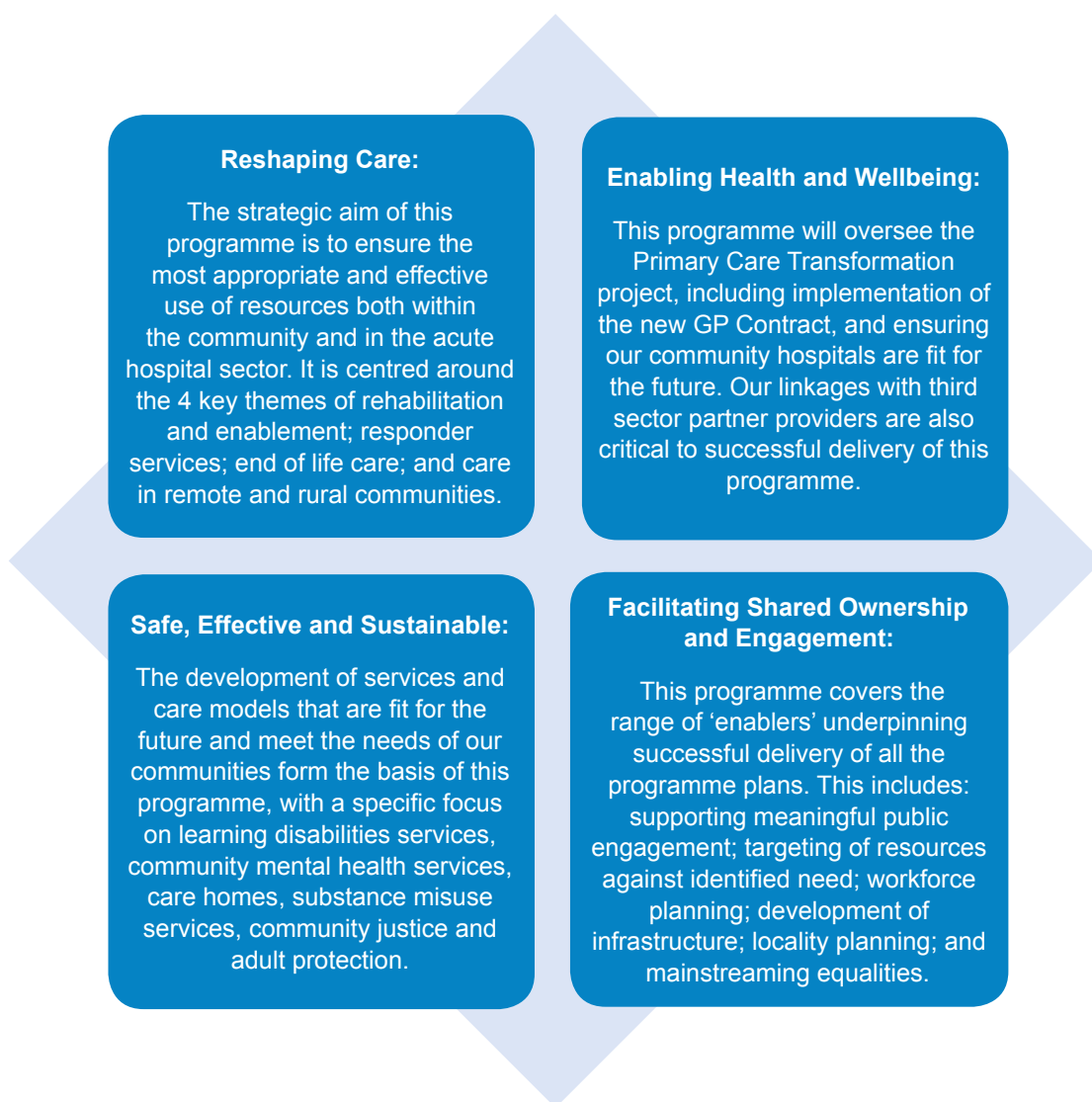
Our strategic approach is guided by the nine National Health and Wellbeing Outcomes set by the Scottish Government which provide a framework of shared priorities for all integrated health and social care services to work to (see Appendix 1). These centre on how we can improve the quality and experience of services for individuals, families and carers, and what difference we can achieve through delivering integrated health and social care services.⁴

The following diagram attempts to set out the relationship between the national outcomes and our own strategic priorities and vision.



In the last year we have produced our new Commissioning Plan (Implementation and Change Plan) 2017 – 2019.⁵ This document sets out our intentions in terms of service planning and priorities to deliver the Strategic Plan within available resource. In this updated Commissioning Plan, we have streamlined our strategic themes and priorities to ensure they remain locally relevant whilst continuing to support the delivery of the National Health and Wellbeing outcomes.

In addition, the HSCP has developed four programme plans which will drive forward the operational service change required to deliver models of care fit for the future, in line with our Strategic Plan and within identified resource. Each of the Programme Plans has a particular focus but encompasses a range of diverse and inter-dependent projects, as described below.

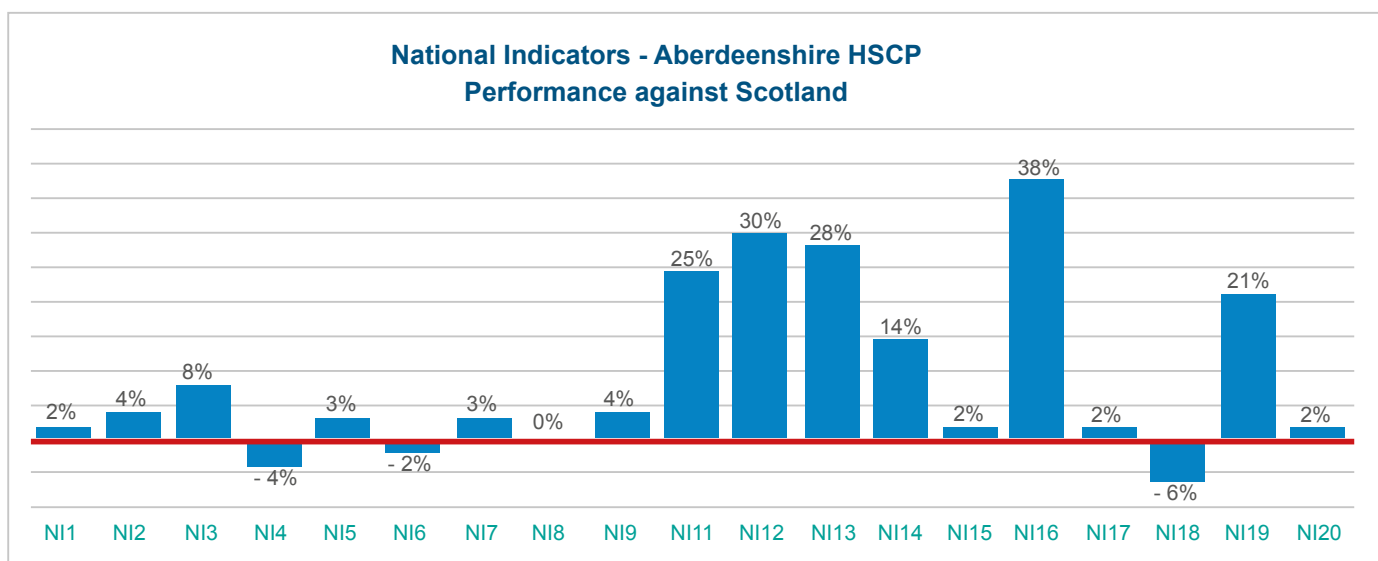


The four programme plans will be crucial to ensuring we can deliver against our strategic priorities and within available budgets. We are aware of the huge challenges facing us and consequently during 2017-18 we developed a Medium Term Financial Strategy to help us take a more planned and pragmatic approach to our financial planning over the next five years within a complex and changing environment. Further detail on our financial performance over the last year is provided later in this report.

Performance Measurement

Since Aberdeenshire HSCP was formed, our performance against a suite of both nationally and locally agreed indicators has been reported every quarter to the IJB. The performance reports are also presented to the Aberdeenshire Area Committees and Communities Committee on an alternate quarterly basis.

There are 23 national indicators for Health and Social Care Partnerships, 19 of which presently have data available for reporting from ISD (Information Services Division). As illustrated below, during 2017-18 Aberdeenshire has maintained a very high level of performance against most national indicators when compared across Scotland.



The red line shows the Scotland position and the bars show for each indicator the percentage Aberdeenshire HSCP's performance differs from Scotland's performance for the current reporting period. Positive bars show where we are performing better than Scotland and negative bars show where our performance is worse than Scotland. For the current reporting period **Aberdeenshire HSCP performed better than Scotland for 15 of the 19 national indicators.**

Whilst providing assurance as to how we are performing, we are aware that continued delivery of this level of performance will become increasingly more difficult due to the projected increase in our population of older people and other challenges previously described. Appendix 2 provides the full set of indicators and annual performance for 2017-18, and many of these are considered in more detail throughout this report.

In addition, we have 40 local performance indicators which further help us measure and understand how we are performing in key areas across health and social care (see Appendix 3 for a summary of our 2017-18 performance). Our local indicators have been given challenging targets to meet. Where our performance against any targets falls outside target tolerances these are identified and improvement actions agreed.

During 2017-18, we commenced a review of our performance measurement framework to ensure it remains fit for purpose. This will support the IJB in decision-making, governance and scrutiny, and will inform local service planning and delivery. Our key aim is to understand and demonstrate what outcomes we are achieving for the people of Aberdeenshire, in line with the National Health and Wellbeing Outcomes.

Performance management is intrinsically linked with risk management and the management of risk is one of the IJB's key responsibilities. The key risks to Aberdeenshire HSCP are provided in our risk register, including detail of risk owners (lead manager with responsibility for each risk), potential impact of the risk and control measures in place to manage this risk. The risk register is reviewed on a regular basis.

Performance against Priorities

This report details our key areas of work, achievements and challenges against each of our 10 strategic priorities, as summarised below.

Meaningful engagement with all stakeholders to optimise effective planning and use of resources	<ul style="list-style-type: none">• Locality Planning, Minor Injuries Unit Review, Participatory Budgeting
Empowering the workforce	<ul style="list-style-type: none">• Locality team development, Workforce plan, iMatter
Developing the support mechanisms that enable people to have improved health and wellbeing	<ul style="list-style-type: none">• Implementation of Carers (Scotland) Act, Development of Carers Strategies for adults and young people
Ensuring quality through safe, effective and sustainable service provision	<ul style="list-style-type: none">• Mental Health Services, Suicide prevention, Quality Improvement projects
Reducing inequalities to provide equitable outcomes for our communities	<ul style="list-style-type: none">• Mainstreaming equalities, Ethnic minority involvement and consultation
Involving people as partners with early identification, management and appropriate support to promote recovery and achieve their potential	<ul style="list-style-type: none">• Primary Care Transformation, Dementia Strategy
Public Protection	<ul style="list-style-type: none">• Multi Agency Public Protection Arrangements, Community Justice, Adult Support and Protection, Inspection of services
Prevention and early intervention to promote healthy lifestyles and resilient communities	<ul style="list-style-type: none">• Children and young people's health, Making Every Opportunity Count, Alcohol Brief Interventions, Health Inequalities
Development of services that are fit for the future	<ul style="list-style-type: none">• Learning Disability Services, Inclusive day services, Community detoxification and rehabilitative pathway, Older people's accommodation
The most appropriate and effective use of acute and community resources	<ul style="list-style-type: none">• Joint Equipment Service, Technology Enabled Care, Virtual Community Ward, Rehabilitation and Enablement, Responder service, Mainstream homecare

Theme 1: Partners within health and social care at individual, community and professional level

Priority 1: Meaningful engagement with all stakeholders to optimise effective planning and use of resources

In our last annual report, we explained how our strategic plan set out the aim of bringing about transformational change which would be driven by a different approach to how we engage with the people in our communities. The aim is to empower and support people in Aberdeenshire to maintain their health and wellbeing, and to involve them in decisions at every stage of their health and care.

Building on the previous commissioning plan, our new Commissioning Plan (Implementation and Change Plan 2017-19) continues to focus on enabling a shift towards services being identified and commissioned locally, to build long-lasting relationships with communities. Over 2017-18, a number of key pieces of public engagement work have been carried out across Aberdeenshire, which will continue to inform our work during 2018-19 and beyond.

Locality Planning

Aberdeenshire HSCP's approach has been to encourage local decision making within natural communities in relation to planning, service management and operational delivery.



Previously, we reported that we had established locality planning groups within each of the six local authority areas: Banff & Buchan, Buchan; Garioch, Formartine, Kincardine & Mearns, and Marr. The groups are made up of a range of stakeholders, including health and social care staff, third sector representatives, staff from housing services, community planning, patients, and carers. The core purpose of the groups was to ensure wide representation and involvement in the process of developing Aberdeenshire HSCP's first set of locality plans for 2018-21, which were produced during 2017-18.

Continuous stakeholder engagement was central to the development of the locality plans. Members of each locality planning group had a responsibility to involve their internal and external networks in reviewing the proposed areas of focus for each plan and in providing comments and feedback as the plans were developed.

Each plan includes several priority themes and a programme of work to improve health and social care outcomes in the locality, based on local evidence and need. Each area across North, Central, and South Aberdeenshire developed a local, 'grass roots', approach to involving people living and working in the locality in the development of the priority themes and action plans.

Between August and December 2017, a wide range of stakeholder engagement activities took place to inform the development of the plans. This included, amongst others:

- Stakeholder workshops
- Round table discussions
- Sharing outputs from workshops and discussions with wider external and internal networks for feedback and comments
- Public surveys

Draft versions of the plans were shared widely as part of a stakeholder consultation for five weeks in February and March 2018. The consultation was promoted widely through social media, HSCP and third sector organisation staff members, community groups, and networks. Location Managers and other staff from Aberdeenshire HSCP also presented the plans at events across Aberdeenshire, including area committees, community councils and area forums. Feedback from these consultation events was used to inform the final plans.

Moving forward into 2018-19, stakeholder and partners in each locality, led by the location manager, will be involved in the implementation of the actions within their plans. They will also be involved with forward planning for the development of the next versions of the locality plans. Ongoing engagement with communities and the groups and organisations supporting local communities will continue to be a defining feature of locality planning as the plans are implemented, to ensure that we involve people in decision making about health and social care services.

In addition, the priority themes identified in the Locality Plans because of the stakeholder engagement activity during 2017-18 will be used to inform the new Aberdeenshire HSCP Strategic Plan for 2019-22.

A breakdown of the financial allocation for our localities during 2017-18 can be viewed in the Financial Performance section below.

Reviewing Aberdeenshire's Minor Injury Units



As explained above, we are committed to planning and delivering health and social care services in a more effective, efficient and person-centred way. Part of that commitment means ensuring that people can access the right treatment at the right time in the right place. In line with this aim, during March 2018 we carried out our most extensive piece of public engagement to date, to review the Minor Injury Units (MIUs) across Aberdeenshire.

The purpose of the MIU review was to seek assurance regarding the current MIU provision across the nine units in Aberdeenshire, taking

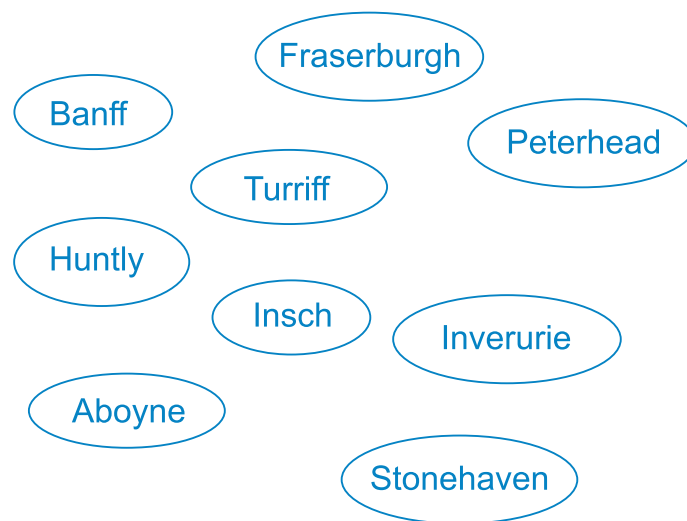
into consideration location, demand and activity, practitioner competency and ongoing sustainability.

The engagement process was informed by the Scottish Health Council Participation Toolkit, which provided guidance on how to structure engagement events so that we reach the broadest audience and enable those who may not normally participate to share their views.

The review covered several areas, including:

- Number of people who attend the units and why
- Patient experiences and outcomes
- Views of both the communities and staff
- Staffing of the units
- Alternative settings for treatment
- If MIUs provide the best available service

In total, nine public engagement events took place across Aberdeenshire, an online public survey was published and publicised via social media, and a staff survey was also circulated to ensure that staff could share their views.



The review was supported by NHS Grampian, Aberdeenshire Council and other partners, and the public response to the engagement programme was the biggest that NHS Grampian has ever had. In total, 1,047 people attended the events and there were 4,369 responses to the online survey.

Looking ahead into 2018/19, the IJB will continue to consider recommendations developed in response to the MIU review. These will be developed into an implementation plan, overseen by a Project Board.

Participatory budgeting

Supporting individuals and communities to take greater responsibility for their own health and wellbeing, and to have more influence in how services are delivered, has been a priority for Aberdeenshire HSCP since it was formed in 2016.

As part of our approach to enabling local people to have greater influence, participatory budgeting (PB) was introduced in Aberdeenshire in 2016. The aim of this was to:

- Increase community participation in decision making processes about HSCP funding;
- Make spending decisions that reflect the community's needs and priorities; and
- Stimulate positive action for health and wellbeing in communities experiencing deprivation / health inequalities and build community capacity / social capital.

In 2017-18 over 3,000 people voted in six PB activities to determine the allocation of a total funding allocation of £326,000 for small grants.

Empowering and enabling communities: Your Voice Your Choice

The Aberdeenshire Health and Social Care Partnership awarded £30,000 to be allocated in Kincardine & Mearns through a participatory budgeting method called Your Voice Your Choice. This is a project involving local people in the South Mearns Coastal Strip where residents had to decide which projects were needed to improve health, wellbeing and community links in their area, and to be involved in their delivery.

23 applications went forward to the voting stage and groups ranged from a local primary school pupil council to the organisers of a local fish festival. The 'Big Event' was held at Bervie Primary School on Saturday 24th June 2017. Following all presentations, votes were cast and then winners were announced. There were six successful projects, five received full funding and one partial funding.

One of the successful applicants was Kincardine & Deeside Befriending. Their project was about befriending in the South Mearns Coastal Strip, with the aim of reducing loneliness and isolation for five older people living in the area. K & D Befriending is a local registered charity which aims to reduce social isolation and loneliness in older people by matching them on a one-to-one basis with a volunteer befriender. A regular visit from a befriender can provide companionship, practical and emotional support, and generally improve physical and mental wellbeing; in many cases, a carer also benefits from the welcome respite provided.

Brigitte said: "I just explained to voters what befrienders do for their befriendees and the difference that is making to older people who feel lonely and isolated. The credit for winning the funding has to go to our volunteer befrienders for doing such a fantastic job."

Priority 2: Empowering the Workforce

Our intention is to develop and maximise our workforce to ensure that it is sustainable and has the right skill mix to meet the challenges of the future, including an ageing population.

During 2017-18, location managers across North, Central, and South Aberdeenshire were focussed upon establishing their teams and processes for moving forward with integrated working. Within each area, local management teams include location managers, district nurses, health visitors, care management, home care, clinical leads, GPs, allied health professionals such as occupational therapists, and the third sector. In addition to leading on operational matters within their locality, location managers are involved with Aberdeenshire Council-led Community Planning groups and Area Committees.

There were some changes in our team of partnership and location managers during 2017-18, but the senior and operational management teams are now well established and working effectively to support local planning and service delivery. Work is ongoing to align and devolve budgets to our Health and Social Care teams and when complete will enable local teams to use their budgets more creatively and in the most effective way to meet local need.

A significant programme of work has continued during 2017-18 to create bases for integrated teams in both Council and NHS buildings. Looking ahead to 2018-19, The Workspace – Office Space Strategy will provide further opportunities for co-location at all levels of the partnership, recognising the opportunities this provides for enhanced communication, decision making and shared accountability.

We do not yet have shared Information Communication Technology (ICT) Services, however improvements in ICT infrastructure to provide access to both NHS and Aberdeenshire Council networks at many of our sites, are enabling teams to work smarter and use their time effectively. It is anticipated that there will be an opportunity to consider a shared record keeping system for the Health and Social Care Teams in 2018-19 as existing contracts come to an end.

Two specific pieces of work that were progressed during 2017-18 to support development of the workforce were the Workforce Plan and iMatter staff engagement process.

iMatter

In 2017, we invited our teams to participate in the iMatter Staff Engagement process. In total, 2,461 people completed a survey with questions covering staff governance, experience as an individual, experience of team and direct line manager and experience of the organisation and the system. A response rate of 65% was achieved, which is considered very positive for a survey of this type.

Team reports were provided following completion of the survey, using a red, amber, green scale to provide at a glance information about each dimension. The full results are included at Appendix 4, which shows the percentage of respondents who either agreed or strongly agreed with each of the question statements. There were very few red or amber ratings overall and staff rated their experience of working for the Partnership at 7.25 (on a 1= very poor to 10= very good scale). Key results from the iMatter survey included:

- 71% of staff feel appropriately trained and developed;
- 80% feel confident that performance is managed well within their teams; and
- 81% of staff would be happy for a friend or relative to access services within the Aberdeenshire Health and Social Care Partnership.

Team managers then came together with their teams to share the report and to reflect on experiences at work. They agreed action plans for improvement and to date, 205 out of 247 teams have created and added these plans to the iMatter story board. This demonstrates the strong commitment from staff and managers throughout the Partnership to the iMatter process.

Using iMatter means that teams can work collectively to make improvements that really matter to them. We will maintain our focus on improving staff experience at work by repeating the iMatter cycle in 2018.

iMatter – A Team's Experience

Team Manager

'My team chose to complete the iMatter survey as smaller locality teams as this is how we work in practice and I was pleased that most team members completed the survey.

I held a workshop with each team to reflect on the iMatter results and explore these in more depth. The conversation could be a little uncomfortable at times, but the team had the opportunity to speak openly and directly about what was working well for them and what could be better.

We concluded the workshops by developing an action plan for improvement, and we regularly reviewed our progress against the action plan at team meetings.

The iMatter process allowed team members to be heard. I feel my teams are better connected – to each other, to me and to the organisation - because of the process. '

Team Member

'The iMatter staff survey gave each member of the team the opportunity to feedback on their experience at work. Going through the questions gave me an opportunity to think about my immediate team and the wider service in more detail.

I feel the workshop was the most essential part of the process. It was an opportunity to reflect on positives and to build from there as well as discuss what wasn't going so well. The team developed an action plan together rather than having one imposed upon us and I feel we have ownership of the plan and collective responsibility for it.

Working through the action plan has gelled the team together and there have been benefits beyond what was originally intended. The actions taken have reduced isolation, caseload management has improved and time delays have been reduced to name just a few.

A small incremental change in how we work has had a transformational effect on our team and has also improved service delivery'.

The Workforce Plan

The 2018 Workforce Plan sets development of the workforce within the context of the Health and Social Care Partnership Strategic Plan and the Commissioning (Implementation and Change) Plan 2017-19. Its purpose is to ensure that we have the correct size of workforce with the right skill mix to support the ongoing redesign of services across Aberdeenshire that can be delivered and sustained within the available budget. The plan defines the current workforce and that which will be required in the future to achieve the Partnership's vision. It covers all staff employed by NHS Grampian and Aberdeenshire Council working within the integrated framework.

The Workforce Plan aims to integrate:

- Individual, team, location and area **objectives** with the HSCP strategic themes, work programmes, local strategic priorities and Locality Plans; and
- Individual personal **development plans**, team development plans, locality plans and the overarching Partnership Strategic Plan.

An action plan is incorporated into the Workforce Plan, the overall success of which will be measured against achievement of the outcomes above. The action plan identifies our current key challenges and risks in relation to the workforce along with the specific actions that will be taken to address and mitigate these. It includes a learning and development plan which identifies priorities for training and other development activities and outlines responsibility and accountability for implementing the plan.

Identifying training and development needs

There has been an increase in referrals to Adult Care Management, both for adults who have been formally diagnosed with autism and those who suspect themselves to be on the autistic spectrum but have been unable to obtain a formal diagnosis. These cases can present complex issues for staff, adults with autism and their families/carers, and given the breadth of the spectrum and individual responses to terminology, staff and services need to be sensitive to differences in how individuals and their families or carers wish to view themselves and how they wish to describe their autism.

A number of staff across the Aberdeenshire HSCP identified the need for more training and awareness in supporting people with autism. In response, an 'Autism Informed' course was commissioned and has been running since September 2017. To date, 71 staff have completed the training and the feedback from evaluation forms has been extremely positive.

Support and guidance has also been provided to teams across the HSCP in process improvement and effective team working. The aim is to support and enable a culture of continuous improvement throughout the organisation, recognising the benefits this can bring in ensuring the effectiveness and efficiency of what we do whilst maintaining high quality of services.

Integrated working through single point of referral

Patients and service users in Peterhead and Cruden now benefit from improved person-centred access to Health and Social Care services following a review of the referral process in the area.

The team identified the need for a streamlined system that allowed “Mrs Smith” to access services without having to contact individual professionals. This led to the development of a single point of entry which enabled the patient, their families or associated professionals to refer into the core team either by email or telephone. The referral is then screened by a joint Health and Social Care line-managed liaison person who contacts the appropriate individuals. The assessment process is simplified by the one-off referral which ensures that service users only have to give their details once and that professionals are provided with the necessary background information to start offering relevant support.

Location Manager, Lorna Watt, explains: “The project encapsulates many disciplines: GP, Occupational Therapy, Physio, Community Nurses, Community Hospitals, Care Management, Homecare. The original aim was to create a single point of contact for patients/service users, but we have discovered many more benefits, such as bringing the core team together in a much more cohesive way.

“The new system has helped the flow of communication between professionals and the patient/service user, it has reduced duplication and increased signposting to relevant services including Third Sector, for example Quarriers, Alzheimer’s Scotland, Financial matters and Housing.

“One of the key developments is that the wider community can use this referral process. Since its introduction the ‘Core Team’ has expanded to include services such as mental health, learning disability and substance misuse. Because a wider range of services are sharing information and identifying needs at an earlier stage, the patient/service user is provided with more appropriate support at every stage of their journey, tailored to their decision-making and needs. The patient/service is seeing the right person at the right time and feedback indicates that our users are more aware of what is happening to them during the referral process and enjoying more effective communication between them and the Health and Social Care staff.”

The success of this approach has led to interest from other partnership organisations wishing to be involved. There is also ongoing dialogue with the Acute Sector around how this model can be utilised and built on.

Priority 3: Developing the support mechanisms that enable people to have improved health and wellbeing

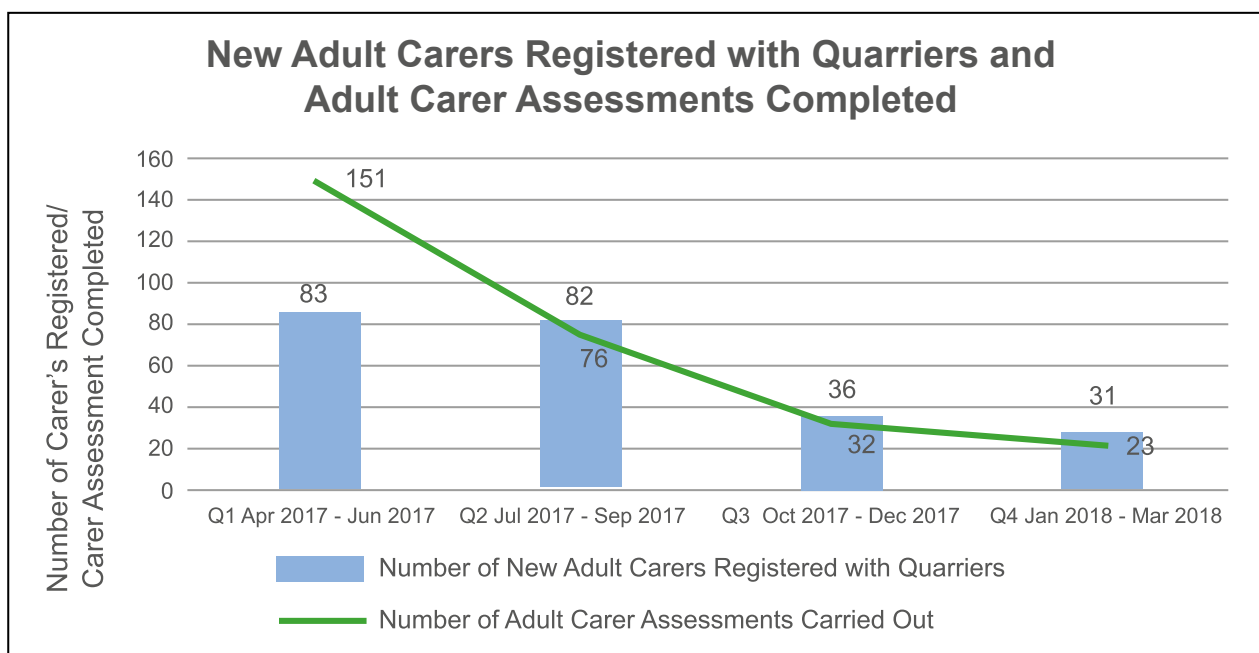
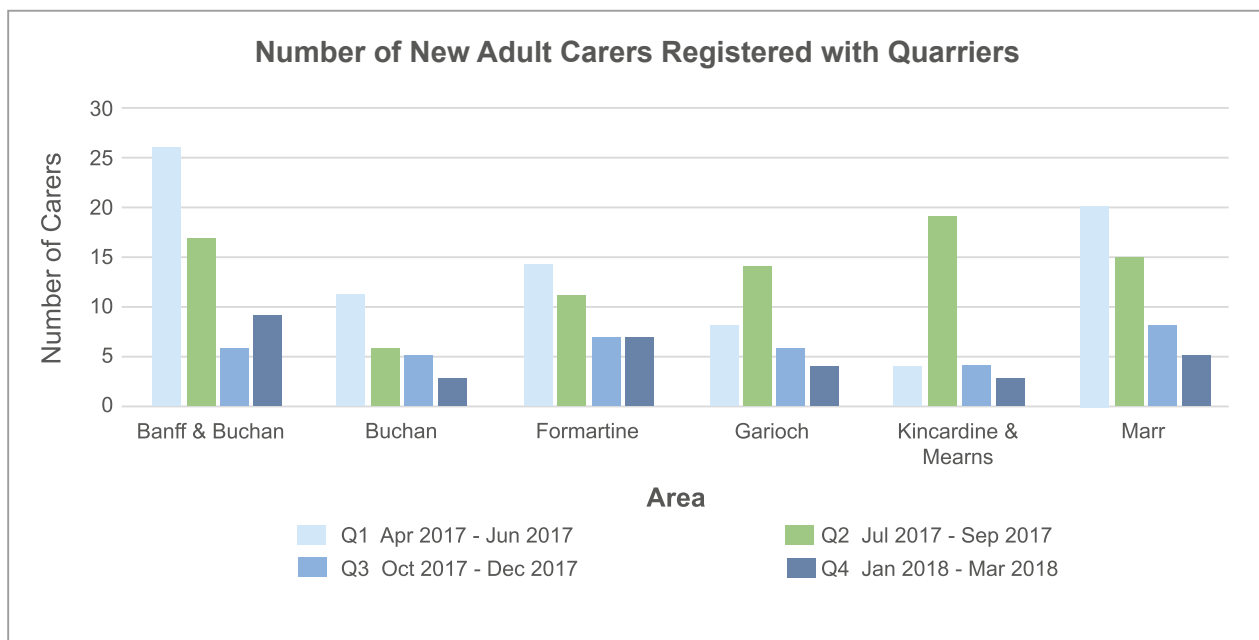
Engaging and working with unpaid carers continued to be a priority during 2017-18. During this year, our main area of focus was on preparing for introduction of the Carers (Scotland) Act 2016. This new legislation came into force on 1st April 2018 and brings new duties and responsibilities for the Health and Social Care Partnerships. The intention is to support carers in a flexible, person-centred way with an emphasis on supporting carers on a preventative basis.

With this new legislation, carers are recognised and valued more than ever before. Many carers are well-supported but some are not. Caring responsibilities can affect some carers’ physical and mental health with many carers having long-term health conditions. Some carers are looking after people with complex needs and many carers are aging. The imperative is to better support carers on a more consistent basis so that they can continue to care, if they so wish, in good health and to have a life alongside caring.

The HSCP commissions a carers support service from [Quarriers](#),⁶ which provides support to young and adult carers. In addition to this service, other organisations also provide support to carers; for example, the organisation Promoting A More Inclusive Society (PAMIS), provides a specialist service for families of people with profound and multiple disabilities.

Looking ahead to 2018-19, from 1 April 2018, carers will be offered an Adult Carer Support Plan (ACSP) or Young Carer Statement (YCS), which for this reporting period will be described as a carer's assessment. This assessment determines what information, training and assistance will enable the carer to continue in their caring role.

The graphs below show the number of carers registered with Quarriers across Aberdeenshire and the number of assessments that have been carried out by Quarriers during 2017/18.



The number of carer assessments was higher at the start of Quarter 1, due to Quarriers working through a backlog of referrals since starting the service. The reason for this being that data was not transferred from the previous commissioned carer support service and so they had to start from the beginning. The number of carer assessments then gradually decreased over the year as Quarriers caught up with their referrals.

Community Mental Health Teams

Community Mental Health services are provided by our multi-disciplinary Community Mental Health Teams (CMHT) which include mental health nursing, social workers, psychiatry, psychology, local area coordinators (who provide a link to community resources) and occupational therapy. They provide holistic and recovery focussed interventions in the community on an individual and group basis. Each GP Practice has an allocated CMHT to support good communication and continuity of care. The majority of CMHT staff are co-located in the same building regardless of their professional discipline.

Primary Care Psychological Service

The Primary Care Psychological Service has been further enhanced in recent months with the introduction of Primary Care Psychological Therapists to deliver a range of therapies for people with mild to moderate mental health problems. 2 posts have been recruited to cover North and South Aberdeenshire, with a further 2 posts being recruited for Marr and North. This service is complemented by 4 WTE (Whole Time Equivalent) Primary Care Mental Health Workers, who work across Aberdeenshire.

Direct Access Community Supports

In our last report we highlighted work undertaken to commission a more inclusive and sustainable model of community support for people with mental health problems with an increased focus on recovery, achievement of personal outcomes, and equitable access. SAMH are currently commissioned to provide a range of recovery focused community services, branded [My Life Dynamic](#).⁷ My Life Dynamic comprises six elements which people can access based on their individual needs and what would be most helpful to them in building self-resilience and achieving their recovery goals. These are Supporting Wellness through Employment and Learning (SWEL), The Listening Project, AyeConnect, Know-where-to-go, Cultivate, and hearME. A dedicated website provides further information on what is available and how to make contact.

The most recent contract monitoring report indicates that 236 people currently access these services across Aberdeenshire with 15-20 new referrals being received each week. The 'hearME' initiative has proved particularly useful in engaging people with lived experience of mental illness in influencing service objectives and developments.

A pilot [1st Response](#)⁸ service is currently provided by Penumbra and allows immediate and direct access to people feeling overwhelmed or in crisis. There is no application form and no waiting list. The service supported 100 service users during the first seven months of 2017.

Public Health

Conversation Cafes have been established across Aberdeenshire, with venues in Banff, Ellon, Fraserburgh, Inch, Inverurie, Huntly, Maud, Peterhead, Stonehaven, and Turriff. Originally initiated via Community Mental Health Teams and Public Health, they are now supported via community routes. The aim is to promote and sustain recovery and reduce stigma through peer support and community integration by engaging the broader community.

Autism

During 2017-2018, 17 AHSCP staff were trained by the National Autistic Society to implement the 'Understanding Autism' Course. Online training resources are currently being developed and near completion. This work is overseen by an Autism Training Steering Group, which meets 4 times a year.

An 'Autism Friendly Aberdeenshire' community project was undertaken in 2017 by National Autistic Society. 2 organisations, Garioch Leisure Centre and The Museum of Scottish Lighthouses, achieved an 'Autism Friendly' award, with a further 3 organisations in the process of progressing the award.

Next Steps

Looking ahead to 2018 – 2019, the key areas of focus for the Mental Health Strategic Outcomes Group are:

- Development of an Aberdeenshire Mental Health and Wellbeing Strategy for adults.
- Development of an integrated care pathway for young people transitioning from Child Adolescent Mental Health Service.
- Development of an action plan to determine future priorities for Autistic Adults, aligned to the current Aberdeenshire Autism Strategy 2014-2024.
- Review of supported accommodation placements available to residents of Aberdeenshire.

Suicide Prevention

The Local Suicide Prevention Action Plan is coordinated by the Choose Life Steering Group. During 2017-18 suicide prevention material was widely distributed and numerous events, forums, meetings, conferences, media interviews, training inputs, and presentations.

The prevent suicide app and supporting website continue to grow and have been promoted at every opportunity since the launch in March 2016 and have now been used by more than 30,000 people.

Facebook has been used extremely effectively again this year and a Google campaign continues to show a high number of internet searches on words and phrases associated with suicide.

Members of the Steering Group attended the Scottish Health Awards 2017 in Edinburgh hosted by Scottish Government and the Daily Record newspaper where we won the Innovation and Care for Mental Health Awards for the app, Facebook, and Google digital campaign.

In September many people were reached through numerous stands and publicity events held during Suicide Prevention Week. Activity was launched on Sunday 3 September with a live Facebook interactive panel session. Many messages were received, and total engagement amounted to 196 posts. We reached almost 8000 people and the number of followers for our Facebook page increased by more than 100 as a direct result of this event and we now have more than 1700 followers.

Local Suicide Statistics

Although a significant amount of positive work has been undertaken, there was a 10% increase in suicides across Aberdeenshire in 2017 following a 16% decrease seen the previous year. This emphasises the importance of continuing our work through the Local Suicide Prevention Action Plan to try to effect a consistent positive change on suicide rates.

On 3 August 2017, national suicide data was released for 2016. NHS Grampian area recorded the largest decrease in Scotland, with a 21% reduction compared with 2015.

The Aberdeen City and Aberdeenshire Choose Life Steering Group and sub groups will continue to be the focal point of local suicide prevention activity and membership of these groups will be constantly reviewed. A themed approach focussing on issues such as relationships, debt, addiction, and bullying is being taken in 2018 with extensive use of social media to maximise year-long impact and reduce stigma.

Physiotherapy Quality Improvement Projects

Last year our physiotherapy team undertook a project to evaluate the use of telephone consultations for those accessing the musculoskeletal (MSK) pathway. The pilot involved four members of staff and was carried out over a three-month period, during which time 137 people were offered telephone consultation. Of those, nine people did not answer at their specified time and 42 needed a face to face appointment. 86 people were given the option to opt back in should they subsequently require an appointment. Of the 86, only 16 people opted back in and 70 people were discharged with no further treatment. This represents just over 50% of the pilot group.

The team involved identified that training would be required to enable staff to be confident in telephone consultation. We worked in collaboration with the Robert Gordon University (RGU) to review the literature and undertake research with the patients and staff who were involved in the pilot to identify what makes a good telephone consultation, with the aim of producing a training package for staff. This is currently being written up by RGU.

A further development during 2017-2018 has been a test of change in one GP Practice to establish physiotherapy as first contact for people requesting an appointment with their GP. Kemnay GP Practice applied for funding to enable patients to be directed, following screening by reception staff at the time of contact, to a physiotherapist for telephone consultation. Ongoing evaluation suggests that this is working very successfully and has proved popular with patients who now have immediate access to a physiotherapist for assessment and advice. If follow up is required, this can be booked at the time. To date 221 people have been directed to the physiotherapist first; only 58% required a face to face appointment and 26% were discharged following telephone advice.

Theme 2: The best of health and care for everyone

Priority 5: Reducing inequalities to provide equitable outcomes for our communities

Mainstreaming equalities means ensuring that equality, diversity and inclusion are integrated into both strategic development and day-to-day operational delivery of services. In Scotland, there is a specific duty for institutions to mainstream equality across their functions. Mainstreaming is an effective way to ensure that we are considering equalities matters in relation to the work of the whole HSCP.

Over the last year, we have been mainstreaming equalities matters in the way we go about our business across the following areas:

- Leadership and accountability;
- Decision making, resource allocation and measuring performance;
- Policy and strategic planning;
- Service delivery;
- Supporting the workforce; and
- Engaging with people.

Our ambition is to provide high quality person-centred care. This requires people to be able to access, use and navigate local services. Ease of access to health and social care services can vary depending on communication needs, physical access needs, complexity of health problems and frailty, access to transport, understanding of how systems work and the impact of discrimination.

Building on existing good practice in NHS Grampian and Aberdeenshire Council a range of support has been put in place to provide opportunities to provide equitable access. This includes:

- Availability of trained interpreters for face-to-face interpreting services;
- Availability of 'language line' telephone interpretation services;
- Key health and social care information available in translation;
- On request published material translated into other language / other formats;
- Front line services have access to induction loops (portable or fixed) to help people with hearing difficulties;
- Information on sources of help /support for people experiencing domestic abuse available;
- Inclusion of a statement on AHSCP publications explaining how members of the public can request the document in another format or language; and
- The public can request the document in another format or language.

In April 2018, we published our two year [equalities mainstreaming progress report](#),⁹ as required by the Public Sector Equality Duty, set out by The Equality Act 2010. This set out the progress we have made between 2016-18 in relation to mainstreaming equalities across the HSCP and towards the equalities outcomes that were set in 2016. The report also detailed the next steps which we will take forward over the next two years.

Ethnic minority involvement and consultation

Feedback from engagement events which took place in 2017 has provided insight about the experiences of ethnic minorities using a range of health and social care services in north Aberdeenshire.

The Grampian Regional Equality Group was commissioned by NHS Grampian to manage and facilitate a number of involvement and consultation events, including two events in Fraserburgh during November 2017.

These events have been taking place on an annual basis since 2008. They have yielded a great deal of useful health care related information and are a very effective way of identifying areas where further improvement is needed.

The two events in Fraserburgh involved around sixty participants, who defined their origin as Polish, Russian, Lithuanian, Latvian, Brazilian, Scottish and British. Participants completed questionnaires and took part in group discussions about experiences and accessibility of a range of services, including GP services, community services, dental services, pharmacy services, and alcohol and substance misuse.

A report from the events was shared within the HSCP in June 2018. Findings and output will be reviewed and recommendations for all areas of Aberdeenshire will be developed, as part of the Partnership's mainstreaming equalities work programme.

Dental care for Syrian new Scots

Since April 2016 Aberdeenshire Public Dental Services have been offering routine dental care to a group of Syrian New Scots who had been resettled in areas across Aberdeenshire.

The dental team worked very hard to ensure that this group were welcomed into the service and received high quality dental care, whilst having to negotiate difficult issues around the obvious language barrier, patient contact problems and a large amount of oral and dental disease which in some cases had been causing long term pain and infection. The dental team has forged close links with the individual council support workers and this aids greatly with patients' access to the service. Several information sheets were translated, for example an Arabic appointment card system which proved to be very useful. Input from interpreting services at appointments has been helpful in helping to build positive relationships between this group of patients and the dental team.

There have been significant improvements in oral health amongst this patient group, with treatment and full preventive measures.

Priority 6: Involving people as partners with early identification, management and appropriate support to promote recovery and achieve their potential

Primary Care Transformation

Primary care is often described as being the 'first point of contact' for people when they require health care advice or treatment. It covers the broad range of services provided in the community including General Practitioners (GPs), pharmacists, dentists, optometrists, community nursing, (for example, district nurses and health visitors), and allied health professionals such as physiotherapists and occupational therapists.

A strong and thriving general practice is critical to sustaining high quality universal healthcare and we are proud of the quality of care and locally accessible services provided by our primary care teams across Aberdeenshire.

We nonetheless have not been immune from many of the challenges facing primary care nationally, particularly in terms of recruitment and retention of GPs. This has perhaps been most keenly felt in some of our smaller, more rural GP practices. During 2017-18 this has required us to look at putting in place various supportive measures to maintain effective local primary care services within communities where the recruitment of GPs has been especially difficult.

We are, for example, seeing the development of other practitioners with enhanced skills such as nurses, allied health professionals and pharmacists, who can take on more of the care within GP practices which traditionally may have been seen as exclusively part of the GP's role. The pharmacy service has been developing a model using both pharmacists and pharmacist technicians, supported by dedicated funding, to ensure availability across each area. This model will continue to be developed through the new contract for General Practice in Scotland.

In November 2017, the Scottish Government published the draft 2018 General Medical Services (or GP) Contract in Scotland. In January 2018, this contract was accepted by General Practitioners across Scotland.

Within Aberdeenshire we are now planning for implementation of this contract over the next three years. It is hoped that the new contract will bring a number of benefits for patients through:

- Maintaining and improving access;
- Introducing a wider range of health and social care professionals to support GPs as Expert Medical Generalists (EMGs);
- Enabling more time with the GP for patients when it is really needed; and
- Providing more information and support for patients.

This will continue building on our existing approach to maximising the contribution of other members of the primary care multi-disciplinary team to providing effective, sustainable and high quality care to patients. In delivery of our Primary Care Improvement Plan, a core aim for us is also to maintain services as close to patients' homes as possible.

Ensuring effective engagement and involvement of patients and our communities will be particularly crucial as we implement the new GP contract locally. The Health & Care Experience Survey (previously the GP and Local NHS Services Patient Experience Survey) has been run by the Scottish Government every two years since 2009. [The data used for national outcome indicators 1-9 is taken from the Health & Experience Survey, see Appendix 2.]

The survey was sent to a random sample of those registered with a GP in Scotland in October 2017 for completion between November 2017 and January 2018.

The survey asks about people's experiences of:

- Accessing and using their GP practice and Out of Hours services;
- Aspects of care and support provided by local authorities and other organisations; and
- Caring responsibilities and related support.

Of the 16,677 Aberdeenshire residents invited to participate, 5221 responded; a response rate of 31%. Results are broadly comparable with Scotland as a whole, however Aberdeenshire respondents were more likely to report that they have a say in how their help, care, or support is provided, and that they were able to look after their own health.

A key indicator where our performance declined slightly was the percentage of people with a positive experience of care provided by their GP Practice, moving from 83% in 2015-16 to 81% in 2017-18 (lower than the Scottish average of 83%). This strengthens our commitment to realising the full opportunities and benefits presented by the new GP contract in terms of outcomes for patients.

Aberdeenshire Dementia Strategy

In 2017 the Scottish Government launched a new National Dementia Strategy. In response an Aberdeenshire Strategy and Action Plan is being developed. One of the main aims of the National Strategy is to extend Post Diagnostic support for the duration of the person's dementia journey. At present we have 3 link workers, employed by Alzheimer Scotland, linked to Community Mental Health Teams in North, Central, and South Aberdeenshire. This is a valued service to those who receive it.

Presently, we monitor the percentage of new dementia diagnoses who receive one-year post-diagnostic support as a local indicator within our performance framework. The data for this indicator is provided by ISD. It is available only as a percentage and for the 12-month financial year period. Aberdeenshire achieved 89.5% for 2016/17, this compares to the Scotland figure of 86.2%. Data for patients with a diagnosis of dementia in 2017/18 is not yet available as complete data is not collected until 12 months after diagnosis.

The figures reported on for post-diagnosis support are based on the data recorded by the three Link Workers.

As noted, they are integrated within the local Community Mental Health Teams through which a range of post-diagnostic support is provided by all members of the multi-disciplinary team, including Community Psychiatric Nurses, Occupational Therapy, and Social Work colleagues. Evaluation is underway of how Post Diagnostic Support could be extended beyond the guaranteed first year of support and to ensure that everyone diagnosed has access to this vital support.

The Aberdeenshire Dementia action plan also aims to improve Dementia services and awareness across all areas of the person's life. This includes ensuring that practitioners from all settings are trained to a high standard using the Promoting Excellence Framework. From April to December 2017, 102 staff took part in the Best Practice for Dementia Course.

Over the last three years, Aberdeenshire Council has funded Dementia Friendly Aberdeenshire to embed awareness of Dementia in local communities. The work completed includes awareness raising training with Shops, Museums, sports centres, medical practices, and many more as well as a series of 'Boogie in the Bar' events. This includes a 'Boogie in the Library' at Mearns Academy which is beginning to forge some positive links between younger and older people in that area. This project is funded until April 2019 and the next phase for them is accumulating learning to be shared beyond the scope of the project.

Priority 7: Public Protection

Multi Agency Public Protection Arrangements (MAPPA)

On 31 March 2016, the MAPPA arrangements that had existed since 2007 were extended to include Other High Risk of Serious Harm Offenders (OROSHO) also referred to as Category 3 MAPPA Offenders. These new criteria have been applied to a small number of High Risk (and generally high-profile offenders) across the Aberdeenshire area during the past 2 years, with the outcome that these clients have been managed on a more robust and formalised multi-agency basis than would have existed previously. The referral and management process and local practice is in line with national guidance and is a valued addition to the public protection toolkit.

During late 2017, and following considerable consultation, the Scottish Government published Minimum Practice Standards for MAPPA Level 1 clients, this being the level at which by far the majority of Registered sex offenders are managed in the community. The Grampian area MAPPA Management Group (GMOG) arranged a workshop event through which the Responsible Authorities across Grampian – with Criminal Justice Social Work, Children & Families Social Work, Housing, Health, and Police Scotland representation – considered the Standards and how they might be applied and met across the area.

A protocol was subsequently developed and agreed that, whilst reflecting long-standing practice across the area, will enhance the recording and thereby defensibility of the multi-agency efforts in managing those Registered sex offenders managed at MAPPA level 1. The protocol has recently been adopted and will be reviewed to ensure that it is proportionate and adds value.

Whilst MAPPA operates to National Legislation and Guidance, an ethos of continuous improvement exists across all agencies and Services involved with a view to ensuring that best practice is followed and that the efforts of all concerned is defensible, proportionate and directed at enhancing public protection, particularly with regards to young persons and the vulnerable in our communities.

A revised [MAPPA awareness package](#)¹⁰ has been developed within Aberdeenshire and is now widely available.

Domestic Abuse

The Aberdeenshire Gender Based Abuse Partnership is multi agency and the Health and Social Care Partnership is represented by key adult services staff. The group sits within one of the thematic priorities of Aberdeenshire's Community Safety Partnership. It continues to work to ensure the ambitions of the Equally Safe Strategy are rooted in practical delivery that makes a difference to the lives of women, girls, and young people in Aberdeenshire. Dedicated Domestic abuse workers are integrated into Children's Services and offer support and intervention to women and children who have been affected by domestic abuse. The interface between statutory services and third sector organisations is crucial to the continued positive development of work in this area.

Community Justice

Aberdeenshire Health and Social Care Partnership is represented on the Aberdeenshire Community Justice Partnership and last year we told you that we had developed an action plan for 2017-2018, setting out the priorities and the actions that statutory and other partners would take collectively to prevent and reduce reoffending to improve outcomes for community justice. The Community Justice Partnership meets quarterly and is responsible for delivering these outcomes.

During 2017-18 we established a new Community Justice 'Theme Forum' to facilitate effective communication between community justice partners and Third Sector Groups operating in the Aberdeenshire area with an interest in improving local community justice outcomes. The Forum is led by Aberdeenshire Voluntary Action and met three times during the year, providing input to the Community Justice Outcomes Improvement Plan and the Aberdeenshire Community Payback Order Unpaid Work Service.

Links with the Youth Services Strategic Group have been enhanced this year, in support of its activities to 'Advance the Whole System Approach to Youth Justice within Aberdeenshire' and associated aims within the Children's Services Plan for 2017-20.

Over the past year we have worked with the Aberdeenshire Employability Partnership to improve access to employability services for people at all stages within the justice system. An Employability Officer works jointly with a Criminal Justice Social Worker to deliver this service and the project has now been running for 6 months. An employability group has also been established and meets weekly with a programme led by participants. Relevant guests have been invited from e.g. housing, welfare benefits, etc. We have also set up a running group.

A joint early intervention, diversion and prevention initiative between Criminal Justice Social Work, Community Substance Misuse Service, and Police Scotland was piloted during 2017-18, focusing on risk periods for over indulgence such as pay day weekends and seasonal events. The team attended Meldrum Sports, Banchory Show, Aboyne Games, and Tarland Show to identify and support those at risk of becoming a victim or potential perpetrator due to excessive alcohol or illicit drug taking. We have now rolled-out this approach to the monthly pay day weekend in Fraserburgh, Peterhead and Inverurie.

Operation Hotspur, which is a joint initiative with Police Scotland and Community Substance Misuse Service, runs in North Aberdeenshire and offers referral for follow up support where substance misuse is identified as a factor during contact with the police.

The Community Justice Resource Centre in Peterhead now offers a full programme of services and activities, including a Women's Drop in and Women's Group, Harm Reduction Clinics, and Caledonian Group. A rolling 8-week programme, covering benefits and budgeting advice, healthy living and healthy diet, physical activity, job skills and employability, community safety, and consequential thinking, has recently commenced at the centre. We plan to redesign Inverurie Resource Centre to ensure that it is fit for future service provision and once complete, we will replicate the programme there as well as providing a base for the Integrated Community Substance Misuse Service.

We now have a Worker from the Community Substance Misuse Service based at HMP Grampian two days per week, so that someone who already has support from this service in the community can continue to access this while they are in custody and vice versa. This helps to ensure equitable access to substance misuse services both in custody and in community.

We have also developed a dedicated Social Work post to support both those who present a high risk of harm and a high risk of reoffending, including areas of health, housing and employability. The post holder has a small caseload of male clients aged 25 years and over who are open to the Criminal Justice Social Work Service. Work is ongoing with the Scottish Prison Service to look at how we can continue to work with people who have been open to the service during any periods of remand or new sentences to improve through-care and lessen the impact of custody.

In the coming year we aim to increase our capacity to support practitioners in working with people involved in the justice system who have mental health issues through provision of a dedicated Criminal Justice Mental Health Practitioner. The practitioner will carry out preventative work to address underlying lower-level mental health issues.

Adult Support and Protection

Adult protection is everyone's responsibility and we are working hard to support and encourage staff to work together to identify when people may be at risk. Where harm is a risk factor, a multi-disciplinary approach involving relevant staff as well as the person's family and/or carers can ensure the best outcome for the person and support them to remain safe in the future.

The cornerstones of Adult Support and Protection in Aberdeenshire are the Adult Protection Network (APN) operated by the Council and the North East Concern Hub (NECH), operated by Police Scotland. The expertise and skill fostered through these ensures a responsive, consistent and robust approach to Adult Support and Protection concerns.

The Adult Protection Network is a central point of contact for advice and guidance, referral and investigations and in the past year has received 160 referrals under Adult Support and Protection legislation. This team has facilitated consistent application of the three-point test and the merging of Adult Support and Protection with other protective legislation and practice. The Adult Protection Network duty system is operated by a social work senior practitioner.

In 2017 the Adult Protection Network advice and guidance process was developed as part of the referral pathway. This service enables staff, relatives and members of the public to discuss individual cases with an experienced practitioner and to apply the principles of the Act to take the most appropriate actions to benefit the adult. Over 100 people have accessed this service each month.

In 2016, the Chief Executives of the three local authorities; NHS Grampian, and the NE Police Scotland Divisional Commander, commissioned the Good Governance Institute to review all public protection arrangements. The final report on Public Protection in North East Scotland: A Joint Governance Framework was produced in April 2017 and considered the future governance of public protection in the North East of Scotland. It explored how these new challenges could be met between statutory agencies, other partners, communities and the public, in a joint governance approach. In line with the recommendation, an Aberdeenshire Public Protection Chief Officers Group was formed. This group has representation from the HSCP and the Independent Chair of the Adult Protection Committee also attends.

In order to develop our practice and ensure better outcomes for adults at risk we are committed to the practice of formal case reviews. A tiered structure of case reviews has been developed and the Operational Practice Group acts as a subgroup to recommend actions to the Adult Protection Committee. The process for case reviews is followed to enable us to learn from situations where it is believed an adult has not been kept safe and four cases have been considered to date. Of these, two proceeded to formal review with recommendations made upon conclusion to the relevant organisations.

The Adult Support and Protection Partnership has taken an innovative approach to prevention and early detection of harm by introducing a training programme for service users, 'Keeping Yourself Safe from Harm'. The programme raises awareness of Adult Support and Protection to adults potentially at risk of harm with the aim of empowering them to protect themselves.

In November 2017 a Joint Thematic Inspection of Adult Support and Protection in Aberdeenshire was carried out, led by the Care Inspectorate with support from Her Majesty's Inspectorate of Constabulary and Health Improvement Scotland. The Inspection involved submission of a position statement and supporting evidence, pre-inspection file analysis (50 adults), on-site file reading of social work and police information (50 adults), and 12 scrutiny sessions.

The IJB has provided significant scrutiny and input into the improvement plan for HMP and YOI Grampian, with significant positive results. Verbal feedback indicated that adults were safe and there were no significant concerns identified. The full inspection report is awaited and will be considered at the Adult Protection Committee following publication. Recommendations from the report will be included in the Adult Protection Committee 2018-20 Action Plan.

Inspection of Services – Care Inspectorate

The Care Inspectorate undertakes inspections of regulated care services on an unannounced basis for all care service types. Inspections take place at any time of the day or night and these inspections provide members of the public with reassurance that the services are delivering quality care and support in appropriate accommodation for the people that require this. The Care Inspectorate uses a six-point grading scale to assess the quality of registered services:

6 – Excellent	5 – Very Good
4 – Good	3 – Adequate
2 – Weak	1 – Unsatisfactory

Services are assessed by four quality themes:

Quality of Care and Support	Quality of Environment
Quality of Staffing	Quality of Management and Leadership

Overall, the services which are operated by Aberdeenshire HSCP are achieving a high standard. Where we procure accommodation with care from private and third sector providers, these are quality controlled through the commissioning and contracts team.

Table: Care Inspectorate Average Grades

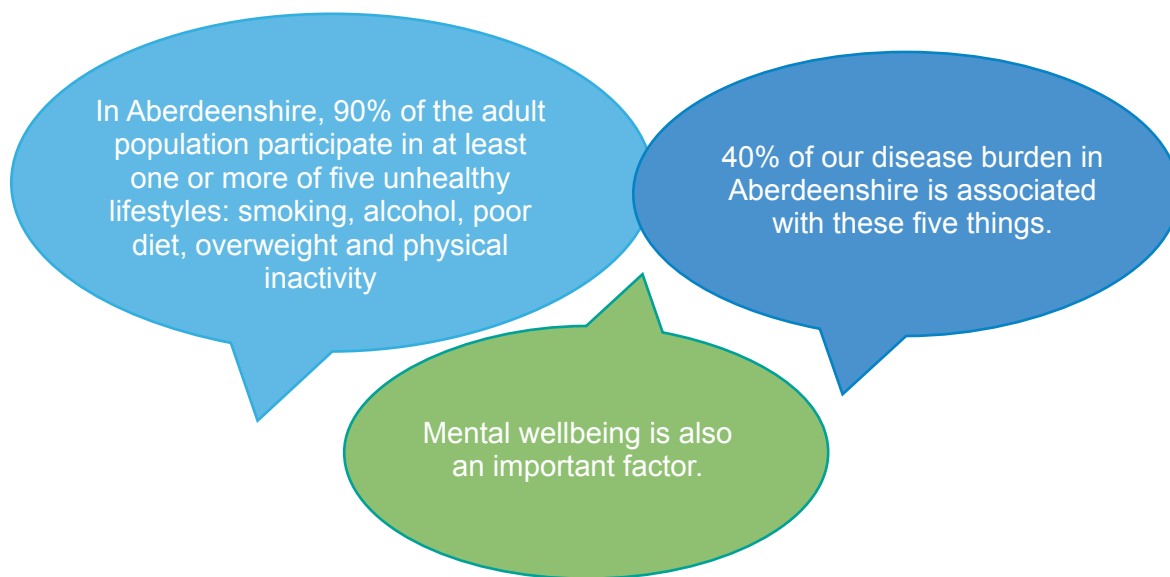
Reporting Year		Quality of Care & Support	Quality of Environment	Quality of Staffing	Quality of Management & Leadership
2016/17	Average Grades	4.7	4.9	4.8	4.4
2017/18		4.6	4.5	4.6	4.2

The above grades apply to our own care services and do not include services which are commissioned from the private or voluntary sector.

If a service does not achieve the expected grades, improvement action plans are put in place and staff will work directly with the Care Inspectorate to ensure issues are addressed quickly and professionally. Full details of all inspections of Aberdeenshire services can be found on the Care Inspectorate website: www.careinspectorate.com

Priority 8: Prevention and early intervention to promote healthy lifestyles and resilient communities

Aberdeenshire is generally characterised by lower levels of deprivation and a better health profile when compared nationally. However, we recognise that whilst Aberdeenshire has good health compared to most other parts of Scotland, this should not be our benchmark. Scotland's overall health is poor when considered in the UK and European context. There is a need to further improve health in Aberdeenshire and reduce avoidable poor health, long term conditions and diseases.



A key element of the Aberdeenshire HSCP's core vision is about enhancing a person's independence and wellbeing in their own community. Below are some examples of the range of healthy lifestyle interventions that were implemented in 2017/18 to support individuals and communities to take positive steps to improve their health and wellbeing.

Children and young people's health

A population approach from pre-birth to later life is needed to improve health and wellbeing in Aberdeenshire. Early interventions to improve children and young people's health are an important part of this. Health Visitors play a key role in the early identification of need, and support to families. In 2017 the Universal Health Visiting Pathway has been rolled out in an incremental way, with more universal home visits undertaken, and increased use of the Pathway materials and guidance.

The UNICEF Baby Friendly Initiative has been further embedded, with 25 Health Visitor team staff completing training and audits of staff, mothers, and NHS premises undertaken to ensure consistent and high-quality advice on infant feeding is provided. In Aberdeenshire the exclusive breastfeeding rate at 6-8 weeks in 2016-17 was 33.5%¹. In 2017 a specialist service for women with complex breastfeeding problems was introduced offering 1:1 support to Health Visitors and breastfeeding women.

Working with parents, Health visitors, Home Start and Community Learning & Development staff, the Public Health team have developed a practical weaning toolkit to support parents. This colourful resource is now available to early years practitioners and families. It includes: a visual flip chart presentation, detailed background information for early years practitioners, fun games/activities to support learning, and a planner for parents demonstrating textures at the various weaning stages.

Upper Marr Health Visiting Service

A parent and toddler group in a remote and rural part of Upper Marr has been enabled to continue because of the involvement of a Trainee Health Visitor. The group was well attended and provided social and peer contact for parents and children under five within the community, but the cost of running the sessions had become prohibitive and the group was at risk of closure.

The Trainee Health Visitor raised the issue for discussion at the Early Year Forum Meeting, specifically to look at income streams that would enable the group to continue. The Early Years Forum includes partner agencies from statutory services and third sector, including Home Start which has a national agreement for reduced rental of public premises to support group activities for children under five years.

As a result of this intervention and with the support of Home Start, the group was able to continue to fund the hire of their premises at a reduced rate. In addition, three of the parents have become Home Start volunteers, which has raised the profile of this service within a small rural community with minimal resources. Further social activities are being planned for school holiday periods for families in this rural location with minimal public transport links.

¹ Latest available figure at time of publication

Childsmile has been instrumental in improving oral health outcomes for Aberdeenshire's children.

Across Aberdeenshire during 2017-18, daily supervised tooth brushing took place with:

- 5,330 nursery aged children in 117 preschool nurseries
- 14 playgroups
- 2,147 primary aged children

The Childsmile teams also worked with 87 nurseries and primaries in the 20% most deprived areas of Aberdeenshire, and in rural and remote areas, to apply fluoride varnish to 4237 children.

In 2017 a fixed term joint funded post with Education & Children's Services, supported Aberdeenshire schools to adopt a whole school approach to health and wellbeing, with a specific focus on child healthy weight, healthy eating and active living. Initiatives taken forward included adoption of the Daily Mile, the Food For Life programme and Grow Well Choices - a locally developed resource for Early Years establishments and Primary Schools, to support children to adopt healthy lifestyles and a healthy weight. The latest available data shows that 77% of Aberdeenshire children in Primary 1 had a healthy weight.

Health walks

To increase physical activity levels a network of Health Walks led by qualified volunteer Walk Leaders has been developed, partly funded by Paths For All. The walks are low level and ideal for anyone recovering from an injury or illness or just wanting to become more active. Walks are available in the communities of: Banff, Macduff; Banchory; Balmedie; Fraserburgh; Gardenstown; Inch; Inverurie; Kemnay; Kintore; Laurencekirk; Peterhead; Pitmedden; Portlethen; Stonehaven; St. Cyrus and Westhill.

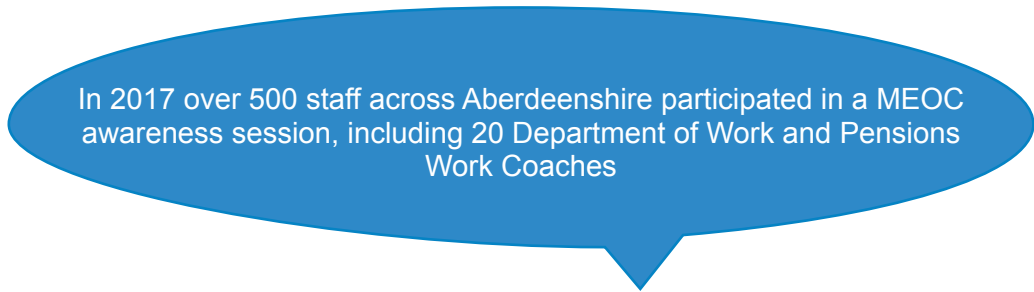
Across Aberdeenshire this has included the following activities.



Links have been developed between health walk groups, Care homes, Move More MacMillan programme and Aberdeenshire Council Leisure Services.

Making Every Opportunity Count

Making Every Opportunity Count (MEOC) is a brief intervention used to engage with individuals (patient, clients relatives and/or carers), routinely and consistently on issues affecting their health and wellbeing. A commitment was made by the HSCP to roll out MEOC training to support all HSCP staff to encourage self-care and management.



More focussed support was provided to services working with people experiencing disadvantage to embed MEOC into everyday practice. For example, Victim Support reported that using MEOC routinely has helped provide 'a more rounded service' with MEOC conversations covering a range of issues including housing, finances and access to health services. MEOC conversations are now undertaken and being recorded, with signposting to support for a range of issues e.g. smoking cessation, financial concerns and unpaid care. This approach is now being explored with Health and Social Care Teams teams, for example the Diabetes and Heart Failure Team and North Aberdeenshire Physiotherapy Team, to mainstream health and wellbeing conversations.

Aberdeenshire Wellbeing Festival

The second Aberdeenshire Wellbeing Festival was held in May 2017, to promote mental wellbeing, reduce stigma and promote recovery across Aberdeenshire. A wide range of community activities were available with 66 events in the South programme, 48 in Central and 48 in the North. Many of the events were provided locally by organisations such as Aberdeen Football Trust, Scottish Association for Mental Health (SAMH) and the Grampian Fire Service.



The Facebook campaign to promote the festival reached 58,878 people, with 52,616 video views. 375 participants and 30 event holders completed evaluation forms. All event holders (100%) said they would support another Wellbeing Festival. Participants reported on the aspects that they enjoyed and that improved their wellbeing; having fun (15%), networking (10%) and feeling calm (10%) were the most common things identified.

Alcohol Brief Interventions

Alcohol Brief Interventions (ABIs) provide effective and evidenced-based early intervention for those individuals over the age of 16 who are drinking at hazardous and harmful levels to moderate their level of drinking and thereby reducing their risk of developing more serious alcohol-related problems.

Currently we measure our performance against this target in terms of the number of ABIs recorded within primary care alone (Local Indicator L18 – see Appendix 3). This shows a decline in numbers reported between 2016-17 and 2017-18, from 1,112 to 962. However, this does not represent the totality of settings in which ABIs are delivered as illustrated below in our overall performance recorded for the calendar year 2017.

Pressures within primary care and competing priorities are cited as reasons for the decline in the number of ABIs delivered, and this is also being seen nationally.

As illustrated above, in 2017/18, a further 1704 ABIs were delivered in what are termed wider settings, by the substance misuse services, criminal justice service, Her Majesty's Prison (HMP) Grampian health service and in police custody. These are important settings for addressing the inequalities associated with alcohol. Compared to 2016/17, the number of ABIs delivered in wider settings by Aberdeenshire HSCP has increased by 144%.

Additional improvement actions have also been put in place within primary care and wider settings, including supporting antenatal care providers to raise the issue of alcohol through training and follow up support, and to work with MIU staff to increase their confidence in raising the issue of alcohol, ABI delivery and signposting to support services.

Health inequalities

The smoking rates among children in care are still persistently high, illustrating the continuing health inequality among vulnerable groups. In 2017 a study of attitudes and behaviours of Looked After Children and their carers towards tobacco smoking and electronic cigarettes was undertaken in partnership with Children's Services Social Work. More children living in residential care smoked and used e-cigarettes compared to those living in foster care settings. Very few of the children who smoked said they would consider using NHS stop smoking services. Carers highlighted the need for specialised tobacco and electronic cigarette training that incorporates the wider emotional and behavioural issues that can affect Looked After children. ASH Scotland has now been commissioned to develop and test specialised training, this will be rolled out in 2018.

In 2017 Aberdeenshire HSCP jointly led the commissioning of The Poverty Alliance and Glasgow Caledonian University to undertake research to inform the development of an Aberdeenshire Child Poverty Action Plan, on behalf of the Community Planning Partnership.

The study researched the nature and impact of poverty and deprivation across Aberdeenshire and gathered families lived experience. It also identified actions for Aberdeenshire Community Planning Partnership partners to tackle child poverty and enhance the coping strategies and resilience of people experiencing/at risk of poverty. It found that one in six children in Aberdeenshire is living in poverty (12.6%) with the rate in three wards higher than the average for Scotland as a whole, and close to the Scottish average for child poverty. The findings are now informing the Child Poverty Action Plan for Aberdeenshire to comply with Community Empowerment (Scotland) Act and Child Poverty (Scotland) Act requirements.

Priority 9: Development of services that are fit for the future

Learning Disability Market Position Statement

Last year we told you about the successful development of extra care housing at St James' Court, Inverurie. An evaluation of this development has provided us with insights which will inform our approach to the provision of extra care housing for those with learning disability in future.

We intend to reduce the number of people with learning disabilities inappropriately placed or placed out of area because of the lack of availability of suitable local accommodation. An increase in the provision of extra care housing will be required to support this objective. We are in the process of developing a Market Position Statement which makes our strategic intentions clear to potential third and independent sector partners. We hope that when published this will stimulate future development of extra care housing. We will work with our housing colleagues to ensure the Market Position Statement reaches potential developers.

Inclusive Day Services – Enabling Aberdeenshire (IDEA) project

In our last annual report, we told you about the transformation of adult day services across Aberdeenshire, through a project called IDEA – Inclusive Day Services Enabling Aberdeenshire. In the Inverurie area this has resulted in a community-based service called Inverurie Days being developed. This project has enabled people to be more involved in their communities and for the service to move from a buildings-based model to one which facilitates equal participation in more meaningful activities in the community.



It included the development of a fully accessible changing place with the aim of improving access to the community for those with profound and multiple disability. This project also made it possible to close a building which was no longer fit for purpose and was increasingly costly to maintain and for those who still required a building base for some of the time, to move into much improved facilities in Port Road. Use of the innovative Pitscurry Project was also increased.

The Pitscurry Project provides craft and work activities including gardening, horticulture, wood kindling, wood work, arts, crafts and pottery for up to 25 adults with learning disabilities each day. The gardens produce soft fruit and vegetables which supply the on-site training café. The Buzzard Café provides up to six people the opportunity to work both in the kitchen and serving meals to members of the public each day with support from two staff members.



An evaluation of the IDEA project was undertaken one year in, taking account of the views of service users, family carers, day service staff and Health and Social Care professionals. This highlighted that we have been particularly successful in enabling those with low to moderate learning disabilities without multiple and complex physical disability to access community activities and to feel more integrated with the community.

However, it has been more difficult to achieve these outcomes for those with profound and multiple disability, those who present behaviour which challenges and those with severe autism.

The changing place is well used by those who

attend Inverurie DAYS but has not been accessed this year by other members of the Community yet. The IDEA approach is now mainstreamed and being applied across all other adult day services sites across Aberdeenshire.

Community detoxification and rehabilitative pathway

Health and Social Care Integration in Aberdeenshire has brought together the two statutory services which deliver assessment, treatment and intervention to people and their families who are affected by problematic drug and alcohol use.

Alcohol and Drug Detoxification is now offered as a community model as opposed to the residential and out of authority detoxification and rehabilitation provision. Community detoxification is delivered jointly by community substance misuse mental health nurses and community substance misuse social workers and support workers. The practice is a working model in North Aberdeenshire where use of both “home detox” and community hospitals is established. In South and Central Aberdeenshire, the clinical lead nurse for alcohol has delivered training and support to health and social care staff. Working links are also being established with relevant Location Managers and community hospitals. The model is now ready to be rolled out.

Clearer links have also been established around pathways out of Aberdeen Royal Infirmary and the acute sector where people have required detoxification as part of primary care. The period of such a short detox is most effectively enhanced through the continuation of the detoxification process through community support, intervention and treatment.

Older People's Accommodation

The availability and provision of varied accommodation with care and support for older people in Aberdeenshire is an ongoing consideration for the Partnership. A significant amount of work has been and continues to be undertaken around reviewing our existing provision, to identify what is needed to ensure there are fit-for-purpose services to meet the long-term needs of our communities.

The outcome of this work to date is that two care homes which were no longer fit for purpose - St Drostans, Old Deer and Rose Innes, Aberchirder – have now closed and two new build in-house care homes have opened in Stonehaven and Inverurie. A third, North Aberdeenshire Care and Support Village in Peterhead, is at the planning stage. We have also started looking at sheltered housing, very sheltered housing and care home capacity to help us ensure there is sufficient capacity in the right places enabling people to continue to live in their own communities as their needs change.

During 2017-18, we have been working in partnership with our Housing colleagues and will continue to do so to ensure that there is an appropriate balance of safe, affordable and equitable provision of accommodation with support for older people in Aberdeenshire.

Using social media to deliver services

The Kincardine and Mearns Health Visitor team have been using social media to communicate with clients.

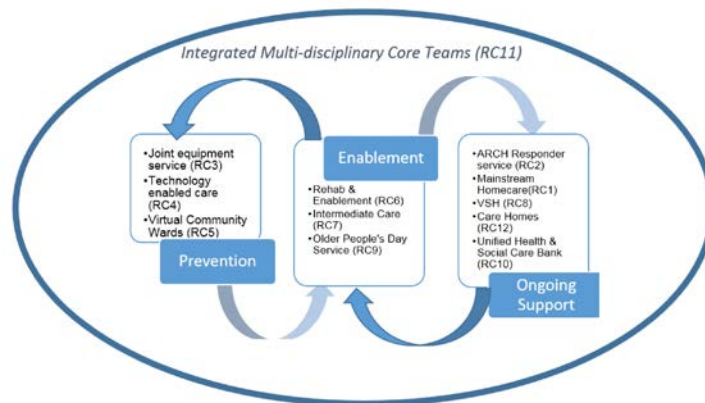
“We have started a Facebook page for the Kincardine and Mearns Health Visiting Team to allow us to keep in touch with the community we serve. One area that I have found the page particularly useful for was in setting up an online baby book club with the aim of promoting use of the Bookbug bags and encouraging parents to read to their children. The page also regularly shares play tips, safety tips, healthy weights, immunisations, speech and language development, events, clinics and wellbeing for both children and carers.

“I personally am excited about how the Health Visiting role is going to evolve and the ways in which we can improve therapeutic relationships and enhance delivery of evidence-based practice to reach a greater proportion of our communities and effect change in the future health of our clients.”

Priority 10: The most appropriate and effective use of acute and community resources

Through our Reshaping Care programme, Aberdeenshire HSCP is implementing a range of challenging service redesign projects to ensure our services are effective and sustainable. These projects centre around the 4 main themes of: rehabilitation and enablement; responder services; end of life care; and care in remote and rural communities.

Although care at home is broadly thought of as “homecare”, the reshaping care programme looks beyond this to consider how all resources are coordinated to support the person at home or as close to home as possible. The diagram below describes the potential interaction between different resources in relation to prevention, enablement and ongoing support.



Aberdeenshire Joint Equipment Service

The Joint Equipment Service (JES) plays a crucial role in supporting people at home by providing an integrated and responsive community equipment service. Located in Inverurie, the service has grown exponentially since opening in 2010 and now provides a range of OT, nursing and physiotherapy equipment as well as community alarms, telecare, housing adaptations and bariatric equipment.

The Service employs a range of staff performing a variety of functions including arranging delivery, installation, training (supported by occupational therapists) and return collections, and a full maintenance and repair service for equipment provided. The number of deliveries made over the 7 years of operation and value of orders provided has more than doubled. As an example, around 40 community profiling beds are installed in residents' homes each month alone.

During 2017-18 the service has been working towards taking on the delivery, servicing, decontamination and maintenance of children's equipment, which will facilitate more effective and efficient provision of equipment across Health, Community and Education settings. A range of specialist equipment has also been incorporated including communication aids.

As an illustration of the volume of work undertaken by the service, in 2017/18 approximately 1,800 items were delivered each month. Approximately 150 people per month were enabled to return home to Aberdeenshire soon after undergoing hip replacement at ARI, Dr Gray's, and Woodend through provision of adaptive equipment.

Technology Enabled Care

During 2017-18 we have also progressed several projects in technology enabled care, including:

Home and Mobile Health Monitoring (HMHM): National funding has been secured to support and encourage GP practices in Grampian to free up practice appointments and practice staff time using HMHM for blood pressure monitoring. This initiative is being led by Aberdeenshire HSCP.

Video Consultation: National and NHS Grampian funding has been committed to support and encourage primary care and community-based services in Grampian to spread the use of video consultations direct from people's homes and mobile devices to allow greater and more convenient access to both routine care and more specialist support. Primary care and Allied Health Professionals (AHPs), along with support for models of care including the Virtual Community Wards, are amongst those services that the opportunity for greater use of video consulting has been identified. Access to, and use of, Attend Anywhere, the nationally procured video consulting platform, is currently available to services, alongside provision of basic equipment (webcams, speakers, microphones, and screens/monitors) which has been procured in Grampian using the national Digital Primary Care Development Fund.

Virtual Community Ward

In last year's annual report, we provided an overview of the Virtual Community Ward (VCW) model, which began operation in the Spring of 2016. The VCW works by bringing together multidisciplinary health and social care teams who provide care for patients who need regular or urgent attention, with the aim of avoiding unnecessary hospital admissions. The VCW is very effective at identifying individuals who need health and social care services at an earlier stage, which can significantly improve patient outcomes and experience.

Every quarter, the VCW team provide a report on the actual VCW discharge outcome as well as what the presumed outcome might have been if the VCW were not in operation. While the presumed outcomes are arguably speculative, they are based on the views of experienced clinicians. Based on their opinions, the results suggest that a significant number of patients have avoided admission to hospital because of the VCWs.

The table below shows the number of VCWs in operation over the last two years, the number of patients who have been admitted, and the number of hospital admissions we believe have been avoided.

Year	Number of VCWs	Number of admissions to VCWs	Number of hospital admissions avoided
2016-17	26	1,674	627
2017-18	27 (84% of Aberdeenshire practices)	1,619	592

Based on these figures, some 1,219 hospital admissions may have been avoided over 2016-17 and 2017-18, which can be broken down into 411 acute and 808 community hospital admissions over the two reporting years.

There has, as yet, been no formal evaluation of patient satisfaction and experience with the VCW model. In part this is because many may not be aware that their care is being organised behind the scenes in a different way and a way to compare services provided with, and without, VCW input needs to be identified. However, anecdotal evidence, where patients are aware of the VCW structure and have heard of its success, shows that in some areas patients are actively asking for admission to the VCW model as a preferred pathway.

During summer 2017, VCW teams were asked to provide feedback on their experiences of the VCW. VCW team responses were overwhelming positive in relation to the role and benefits that the introduction of the VCW model had made to their local services and patient outcomes.

The primary benefit was **better and more effective communication** between the core team of health and social care staff, which in turn led to:

- Better use of resources, better targeting and prioritisation of resources and patients.
- Quicker access to interventions.
- Improved care pathways (better organisation of care, more integrated/seamless patient pathways, with less disruption).
- More holistic / person centred care.
- Reduction in hospital admissions.
- Better overall staff experience.

Based on the responses submitted by VCW teams, several recommended action areas have been identified as a starting point for further refinement of the VCW model and towards the development of a sustainable model for the future. This includes improving information and awareness of local third sector services and facilitating dialogue with VCW teams, and ensuring there is clarity around the remit, access route and processes associated with responder teams.

Rehabilitation and Enablement

We are committed to delivering health and social care services with the principles of rehabilitation and enablement at their core. Our intention is that everyone who requests care at home will have a period of enablement first so that they can regain their skills and confidence and remain as active and independent as possible. Last year we told you that over 500 home care staff had been trained to provide support in an enabling way. Over the past two years, training has also been offered to all members of our core Health and Social Care Teams and Community Hospital staff.

There are areas of good practice for rehabilitation and enablement, but uptake has broadly been slow across Aberdeenshire. Feedback from practitioners has given us some insight into the reasons for this and we recognise that further work is required to support teams to embed rehabilitation and enablement as routine practice. This will be taken forward during 2018-19 in line with the development of multidisciplinary teams. We will also develop e-learning materials for inclusion in the induction programme for new starts and as an ongoing reference for all staff.

Success will be measured by the outcomes achieved by people who participate in rehabilitation and enablement, an improvement in their Community Indicator of Relative Need score and a reduction in the amount of care required.

Intermediate Care refers to intensive support being provided in a more supportive environment (usually a Care Home) and is a key component of rehabilitation and enablement for those who have a higher level of need which cannot be met immediately at home. We have introduced two intermediate care beds in Burnside Care Home, Laurencekirk. Despite strong commitment from the provider, staff turnover in the health and social care team has had an impact on our ability to make most effective use of these beds in 2017. We also introduced an additional two beds at Bennachie Care Home, Inverurie, but staff shortage has again impacted. With demand increasing, we aim to expand the provision of intermediate care across Aberdeenshire and will apply what we have learned from our two early implementation sites when doing so.

Ugie Hospital Peterhead review

We are currently undertaking a review of the provision of services on the Ugie Hospital site with a view to ensuring that our buildings are used most effectively and efficiently to deliver in-patient services in a high-quality environment that is fit for purpose.

Over the last year we established a short life working group to produce an options appraisal for alternative patient pathways at Ugie Hospital and six options are currently under consideration. A public consultation exercise and community engagement event were held in Peterhead with the approach informed by the National

Standards for Community Engagement.¹¹ A questionnaire was developed and published on the Health and Social Care Partnership Facebook page and provided in paper format at local healthcare premises. The questionnaire was also available for completion at the engagement event. 577 responses were received, and these are currently being analysed. 159 people attended the engagement event. Results of the questionnaire will be used to inform the next stage of the report.

Responders Service (ARCH)

In our last report we told you about the development of the Aberdeenshire Responder Care at Home (ARCH) service. This service is now fully established across Aberdeenshire providing a response primarily for emergency and immediate need but also facilitating planned care for our virtual community wards, priority discharges and enablement. In February 2018 responders were called out over 400 times, with the majority of calls relating to personal care needs and resulting in people being supported to remain at home. This illustrates the level of demand and success of this service.

Mainstream Homecare

A model of in-house home care service delivery, based on the four pillars of enablement, rapid response, end of life care and remote rural areas, was approved by the Integration Joint Board in November 2016. We intend to purposefully reduce the level of long-term homecare provided by our internal service but there have been some challenges in achieving this operationally and we recognise that teams require support to make this happen.

Early implementer sites have been identified – Peterhead and Central Buchan, and Garioch. The teams in these areas have developed plans to redress the balance of care in line with the four pillars model and to move towards external providers having the main role in providing longer term Self-Directed Support care packages under Options 2 and 3. Work is in the early stages but will be taken forward over the coming year.

Performance in ensuring appropriate and effective use of acute and community resources

The Ministerial Strategic Group for Health and Community Care (MSG) agreed a set of 6 indicators to be used by all Integration Authorities (HSCPs) from 2017-18 to help measure performance under integration across Scotland. Our performance against these indicators helps us understand how we are progressing towards ensuring the most appropriate and effective use of resources particularly in relation to our Reshaping care Programme. In general terms, our performance in 2017-18 against key performance targets has compared favourably and above national averages. Moving forward we are however aware that this will become increasingly more challenging because of the significant projected increase in our population of older people.

Two indicators focus on the number of emergency admissions into Acute (hospital) specialties and number of unscheduled hospital bed days. It is desirable to see a reduction in emergency admissions and unscheduled hospital bed days over time as this will generally evidence a more proactive and planned approach to people's care, supported by anticipatory care planning and close partnership working across services, which is helping to keep people at home and prevent unnecessary admission.

The most recent reportable full year data available from ISD is for 2016-17, which shows a 1% reduction in emergency admissions compared with the previous year. Provisional data for 2017-18 indicates a similar declining trend.

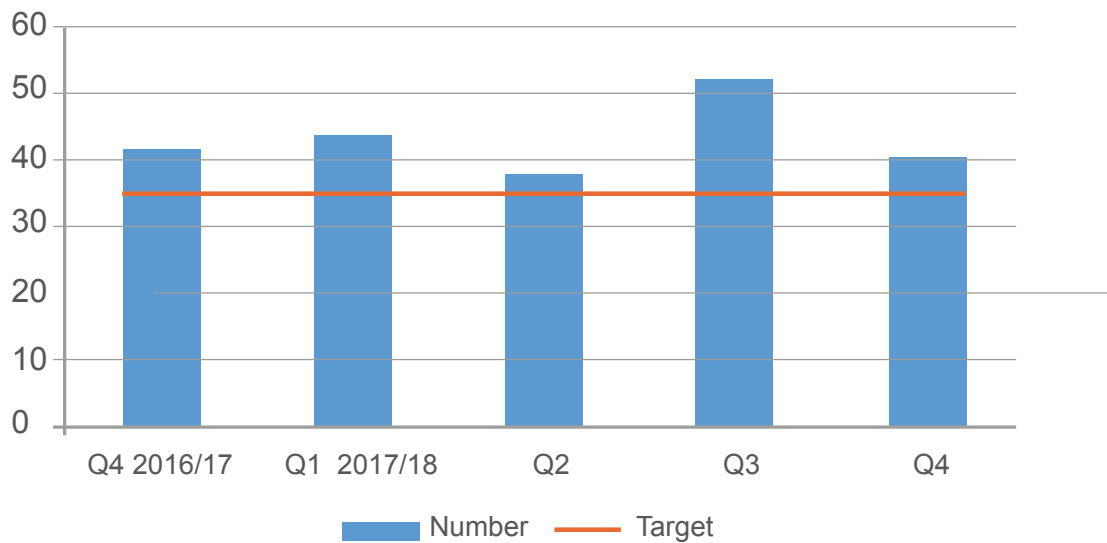
The number of unscheduled hospital bed days for Acute Specialties (excluding Geriatric Long Stay and Mental Health) saw an increase of 2% between 2015-16 and 2017-18 (rising from 149,809 to 153,454). For 2017/18, the latest available data shows 142,408 unscheduled bed days, which is a **decrease** of 7.2%.

Our performance is also measured against the number of delayed discharge bed days. This indicator is important because it tells us about the number of days that patients in hospital, having been assessed as medically fit to be discharged, have experienced delay because the required care, support or resources are not available.

Our performance against the national target of number of Delayed Discharge bed days again based on most recent data available from ISD shows a significant 36% reduction in the number of bed days occupied by delayed discharges between 2015-16 (28,293) and 2016-17 (18,176). Provisional data for 2017-18 suggests the positive downward trend is continuing, with a figure of 16,334 Delayed Discharge bed days, a reduction of

10% on the previous year.

Delayed Discharges



We also monitor our performance against a locally set indicator (Local Indicator 11, see Appendix 3) which provides a census snapshot of the number of delayed discharges. In comparing our performance against this target between quarter 4 of 2016-17 and quarter 4 of 2017-18, we can see a slight downward trend from 42 to 40 albeit this has fluctuated during the year.

This reflects seasonal variations as the number of delayed discharges will generally be higher during the winter months as activity and pressures on the system increase. There are further complexities for example these figures will include several people with complex requirements, such as incapacity which requires legal intervention, or people with mental health illness who require very specialised supported accommodation.

The overall trend for people waiting for a care home place or home care continues to decrease. The overall lengths of delay are reducing having halved since 2014. Reducing delayed discharges remains a significant priority for Aberdeenshire HSCP and managed carefully to ensure it remains person-centred and does not promote poor outcomes.

The national core integration indicators also include performance against the percentage of last 6 months of life spent in the community. This indicator helps assess progress against the national action plan for end of life (palliative) care, rather than being a specific measure of compliance with an individual's preferred place of care.

Aberdeenshire's performance in 2017-18 was 90.1%² which represented an improvement from 2016-17 (89.3%). This also means that Aberdeenshire has continued to remain just above the Scottish average (88.6% in 2017-18) and indeed has been above the Scottish average for the last 8 years.

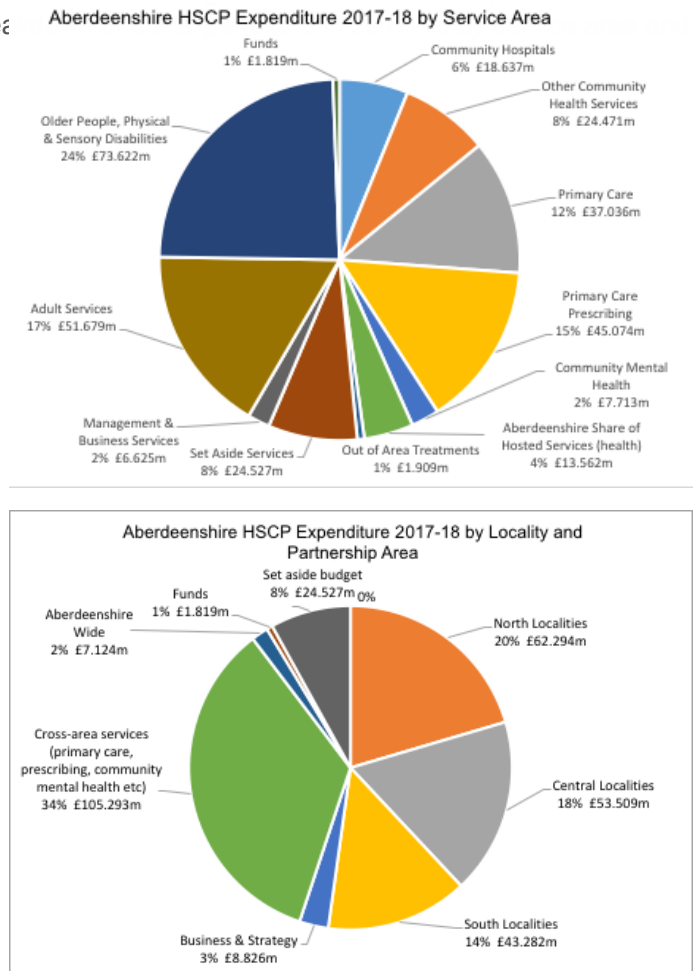
² ISD data for 2017/18 are provisional and may be revised in future.

Financial Performance

We have described earlier the significant challenges impacting on our ability to deliver safe, affordable and effective services within existing resources, and at the current scope and standard. There is a significant task facing us in responding to the forecast demographic changes against a backdrop of increasing public sector funding constraints. This is a task that we are determined to meet through integrated partnership working as well as prioritised resource management. To put in context, our current planning assumptions are to expect a year on year increase in costs of at least 1.7% or around £5 million per annum.

During 2017/18 we continued to see significant pressures on particular areas of budget, including home care services, prescribing and community hospital services. A range of actions were implemented to monitor and mitigate these specific areas of financial pressure. Whilst we were able to effect positive changes on our expenditure in many areas, the financial position remained extremely challenging resulting in a year-end position of £3.483 million over budget. This is a significant amount of money but, to put in context, this also represents 1.1% of a £303 million revenue budget.

The complex range of services and funding which the HSCP is responsible for is illustrated in the following two diagrams providing a bre



NB: "Set aside budget" refers to funding from NHS Grampian primarily in respect of acute hospital services. NHS Grampian continue to manage these costs whilst the IJB has a strategic role over the level of demand placed on them.

Within our last Annual Report we set out our aim to establish a medium-term financial strategy to ensure a strategic approach to our financial planning within a complex and changing environment over the next five years. This strategy has now been developed, constructed around our 4 programme plans, and agreed by the IJB. This will enable us to take a proactive and longer-term approach to our financial planning, to ensure we

can continue to meet the needs of our communities in the provision of high quality, safe and affordable local services within identified resources, whilst achieving the transformational change required in the future delivery of health and social care services.

Audit and Governance

As previously described the Aberdeenshire Integration Joint Board (IJB) was established in 2016 under The Public Bodies (Joint Working) (Scotland) Act 2014 and has responsibility for the strategic planning and delivery of adult health and social care services within Aberdeenshire.

Members of the IJB for the period 1 April 2017 to 31 March 2018 were as follows:

Members

Name	Organisation
Cllr Anne Stirling (Chair from 18/05/17 until 31/03/18) ³ (Vice Chair from 01/04/18)	Aberdeenshire Council
Dr Lynda Lynch (Vice Chair until 31/03/18) (Chair from 01/04/18)	NHS Grampian
Cllr Anne Allan	Aberdeenshire Council
Amy Anderson	NHS Grampian
Cllr Raymond Christie (until 18 May 2017)	Aberdeenshire Council
Sharon Duncan	NHS Grampian
Cllr Alison Grant (until 18 May 2017)	Aberdeenshire Council
Alan Gray	NHS Grampian
Cllr Bill Howatson	Aberdeenshire Council
Cllr Denis Robertson (from 18 May 2017)	Aberdeenshire Council
Cllr Ann Ross (from 18 May 2017)	Aberdeenshire Council
Eric Sinclair	NHS Grampian
Name	Position
Adam Coldwells	Chief Officer
Alan Wood	Chief Finance Officer
Robert Driscoll	Chief Social Work Officer
Dr Chris Allan	General Medical Practitioner
Eunice Chisholm	Nurse Practitioner Representative
Mr Paul Bachoo (until 14 March 2018)	Medical Practitioner – Secondary Care Adviser
Dr Malcolm Metcalfe (from 14 March 2018)	Medical Practitioner – Secondary Care Adviser
Name	Position
Inez Kirk	Trade Union Representative
Martin McKay	Trade Union Representative
David Hekelaar	Third Sector Representative
Sue Kinsey	Third Sector Representative
Denise Cromar (from 30 Aug 2017 until 25 Oct 2017)	User Representative
Elizabeth Fairley (from 20 December 2017)	Carer Representative

³In line with the Integration Scheme Cllr Anne Stirling stepped down as Chair of the IJB on 31/03/18 and was replaced by Dr Lynda Lynch.

The IJB has a responsibility to ensure that its business is conducted in accordance with the law and proper standards, that public money is safeguarded and properly accounted for and used economically, efficiently and effectively. The IJB has continued to meet monthly during 2017-18 including receiving regular reports on the HSCP's financial position. Meetings are held in public and meeting papers are made publicly available online in advance.

Internal governance arrangements have continued to support the IJB in fulfilling its governance and scrutiny responsibilities.

Audit Committee

IJB scrutiny is delegated to Audit Committee, which is a joint committee with representation from Aberdeenshire Councillors and NHS Board members.

The purpose of the Committee is to assist the IJB to deliver its responsibilities for the conduct of public business, and the stewardship of funds under its control. In particular, the Committee will seek to provide assurance to the IJB that appropriate systems of internal control are in place to ensure that: business is conducted in accordance with the law and proper standards; public money is safeguarded and properly accounted for; Financial Statements are prepared timeously and give a true and fair view of the financial position of the IJB for the period in question; and reasonable steps are taken to prevent and detect fraud and other irregularities.

An area of focus for the Committee during 2017-18 was the Post Integration Review, which reported against how the HSCP was meeting the requirement of Scottish Government Integration Financial Assurance Guidance.

This provided assurance over whether integration objectives were in line to be achieved, including evaluation of actual risk and financial performance against pre-integration assumptions, performance on relevant integration milestones, lessons learned and whether the partnership was on course to deliver the long-term benefits. Assurance was obtained over each of these areas.

A number of improvements to governance and reporting arrangements were agreed, including the development of Locality budgets for 2017/18. The Committee has been updated on progress with these actions.

Clinical and Social Work Governance Committee

The Aberdeenshire Clinical and Adult Social Work Governance Committee was established via the IJB in July 2017 as a mechanism to provide assurance on the systems for delivery of safe, effective, person-centred Adult Health and Social Care in Aberdeenshire. It is chaired by Councillor Ann Ross who is a voting member of the IJB, and has been chaired by Eric Sinclair as interim chair, following Cllr Stirling becoming Chair of IJB. A Governance Group also meets in advance of the Committee which considers Operational Governance reports from each location and determines any issues which require to be escalated to the Committee.

The Committee meets quarterly and are updated via an assurance plan which provides an overview of both internal and external audits, inspections and consultations as well as exception reporting on relevant local governance issues.

Most recently the group have been considering a thematic overview of complaints and compliments and how best to ensure learning is gathered through this to inform practice in locations across Aberdeenshire.

Grampian and North of Scotland Context

The Chief Officer of the HSCP is accountable to the IJB for the management of integrated services. At a Grampian level, the Chief Officer meets on a weekly basis with the Chief Officers of Aberdeen City and Moray HSCPs, and has regular performance reviews with the Chief Executives of NHS Grampian and Aberdeenshire Council.

In line with the regional work of the NHS, the Chief Officers of the HSCPs meet regularly to identify appropriate opportunities for joint working on a North of Scotland basis.

Appendices

Appendix 1: National Health and Wellbeing Outcomes

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

Outcome 2: People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community

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

Outcome 4: Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services

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

Outcome 6: People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and well-being

Outcome 7: People using health and social care services are safe from harm

Outcome 8: People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide

Outcome 9: Resources are used effectively and efficiently in the provision of health and social care services

Source:

Scottish Government (2015) National Health and Wellbeing Outcomes – A framework for improving the planning and delivery of integrated health and social care services. <http://www.gov.scot/Resource/0047/00470219.pdf>

Appendix 2: Aberdeenshire Core Suite of National Integration Indicators – Annual Performance

Data Source: ISD
Last updated: July 2018


Data for the Core Suite of Integration Indicators, NI - 1 to NI - 23 are populated from national data sources and data is issued nationally. Indicators 1 to 10 are outcome indicators based on survey feedback and are updated bi-annually. Data for National Indicators 11 to 23 are derived from organisational/system data and are updated quarterly. Data for indicators 10, 21, 22 and 23 are not yet available.


	Indicator	Title	Aberdeenshire		Scotland	RAG
			Previous score 2015/16	Current score 2017/18	Current score 2017/18	
Outcome indicators	NI - 1	Percentage of adults able to look after their health very well or quite well	96% (3979)	95% (4821)	93%	A
	NI - 2	Percentage of adults supported at home who agreed that they are supported to live as independently as possible	84% (213)	85% (151)	81%	G
	NI - 3	Percentage of adults supported at home who agreed that they had a say in how their help, care, or support was provided	79% (203)	84% (150)	76%	G
	NI - 4	Percentage of adults supported at home who agreed that their health and social care services seemed to be well co-ordinated	75% (203)	70% (126)	74%	A
	NI - 5	Total % of adults receiving any care or support who rated it as excellent or good	81% (222)	83% (160)	80%	G
	NI - 6	Percentage of people with positive experience of the care provided by their GP practice	83% (3227)	81% (3531)	83%	A
	NI - 7	Percentage of adults supported at home who agree that their services and support had an impact on improving or maintaining their quality of life	85% (216)	83% (148)	80%	A
	NI - 8	Total combined % carers who feel supported to continue in their caring role	40% (185)	37% (225)	37%	A
	NI - 9	Percentage of adults supported at home who agreed they felt safe	82% (206)	87% (152)	83%	G
	NI - 10	Percentage of staff who say they would recommend their workplace as a good place to work	NA	NA	NA	


	Indicator	Title	Aberdeenshire		Scotland	RAG
			Previous score	Current score	Current Score	
Data indicators	NI - 11	Premature mortality rate per 100,000 persons (<i>European age-standardised mortality rate per 100,000 for people aged under 75</i>)	349 ²⁰¹⁵	331 ²⁰¹⁶	440	G
	NI - 12	Emergency admission rate (per 100,000 population)	8,441 ^{2016/17}	8,395 ^{2017/18}	11,959	G
	NI - 13	Emergency bed day rate (per 100,000 population)	90,234 ^{2016/17}	82,753 ^{2017/18}	115,518	G
	NI - 14	Readmission to hospital within 28 days (per 1,000 population)	79 ^{2016/17}	83 ^{2017/18}	98	A
	NI - 15	Proportion of last 6 months of life spent at home or in a community setting	89% ^{2016/17}	90% ^{2017/18}	88%	G
	NI - 16	Falls rate per 1,000 population aged 65+	16 ^{2016/17}	13 ^{2017/18}	22	G
	NI - 17	Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections	90% ^{2016/17}	87% ^{2017/18}	85%	A
	NI - 18	Percentage of adults with intensive care needs receiving care at home	53% ^{2015/16}	55% ^{2016/17}	61%	A
	NI - 19	Number of days people aged 75+ spend in hospital when they are ready to be discharged (per 1,000 population)	677 ^{2016/17}	609 ^{2017/18}	772	G
	NI - 20	Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency	22% ^{2016/17}	21% ^{2017/18}	23%	G
	NI - 21	Percentage of people admitted to hospital from home during the year, who are discharged to a care home	NA	NA	NA	
	NI - 22	Percentage of people who are discharged from hospital within 72 hours of being ready	NA	NA	NA	
	NI - 23	Expenditure on end of life care, cost in last 6 months per death	NA	NA	NA	

RAG scoring based on the following criteria


If current Aberdeenshire position is better than current Scotland position


 and Aberdeenshire value has improved or stayed the same then "Green"


 and Aberdeenshire value has worsened by 5% or less of previous Aberdeenshire value then "Amber"

 and Aberdeenshire value has worsened by more than 5% of previous Aberdeenshire value then "Red"

If current Aberdeenshire position is worse than current Scotland position

 and Aberdeenshire value has improved or stayed the same then "Amber"

 and Aberdeenshire value has worsened by 5% or less of previous Aberdeenshire value then "Amber"

 and Aberdeenshire value has worsened by more than 5% of previous Aberdeenshire value then "Red"

Appendix 3: Aberdeenshire HSCP Local Indicators – Annual Performance Summary

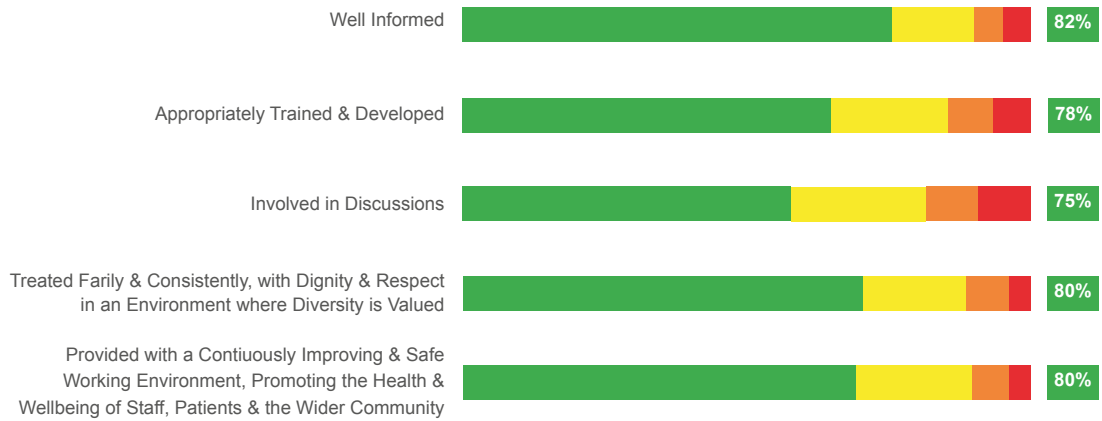
ID.	Indicator Description	2016/17	2017/18	RAG Rating
L01	Percentage of Adult Protection Cases screened within 24 hours of notification	78%	84%	R
L02	Percentage of Adult Protection enquiries that proceed to Investigation	22%	36%	G
L03	Rapid response service, Home Care Responders Referrals (median minutes between referral and visit)	16	21	
L04	Percentage of all clients on SDS pathway	83.5%	92%	G
L05	OT Assessments completed within timescales	89%	88%	R
L06	Number of people receiving community alarm and/or telecare	3336	3342	G
L07	Rate of emergency occupied bed days for over 65s per 1000 population, average over 12 months	2393	2334	G
L08	Emergency Admissions rate per 1000 population for over 65s, average over 12 months	195	189	G
L09	Number of people over 65 years admitted as an emergency in the previous 12 months per 1000 population, average over 12 months	127	125	G
L10	Number of Bed Days Occupied by Delayed Discharges (inc code 9) per 1000 18+ population	88	79	G
L11	Number of delayed discharges inc code 9 (Census snapshot, 12 monthly average for annual figure)	47	43	G
L12	A&E Attendance rates per 1000 population (All Ages)	88	87	G
L13	A&E Percentage of people seen within 4 hours, within community hospitals	99.6%	99.7%	G
L14	Percentage of new dementia diagnoses who receive 1-year diagnostic support	89.5%	not yet available	
L15	Smoking cessation in 40% most deprived after 12 weeks	431	not yet available	
L16	Percentage of clients receiving alcohol treatment within 3 weeks of referral	90%	88%	A
L17	Percentage of clients receiving drug treatment within 3 weeks of referral	90%	84%	R
L18	Number of Alcohol Brief Interventions being delivered	1112	962	R
L19A	Number of complaints received and % responded to within 20 working days - NHS	56%	53.6%	A
L19B	Number of complaints received and % responded to within 20 working days - Council	86.5%	93.8%	G
L20	NHS Sickness Absence % of Hours Lost, quarterly average over 12 months	4.7%	5.0%	A
L21	Council Sickness Absence (% of Calendar Days Lost)	5.2%	5.1%	A

Notes:

Indicators L22 – L40 are based on the results of our local bi-annual survey of service users and carers. This was not repeated in 2017-18 and therefore these indicators have been omitted to prevent inconsistency in presentation of data.

Appendix 4: Aberdeenshire HSCP iMatter Results

Staff governance standards



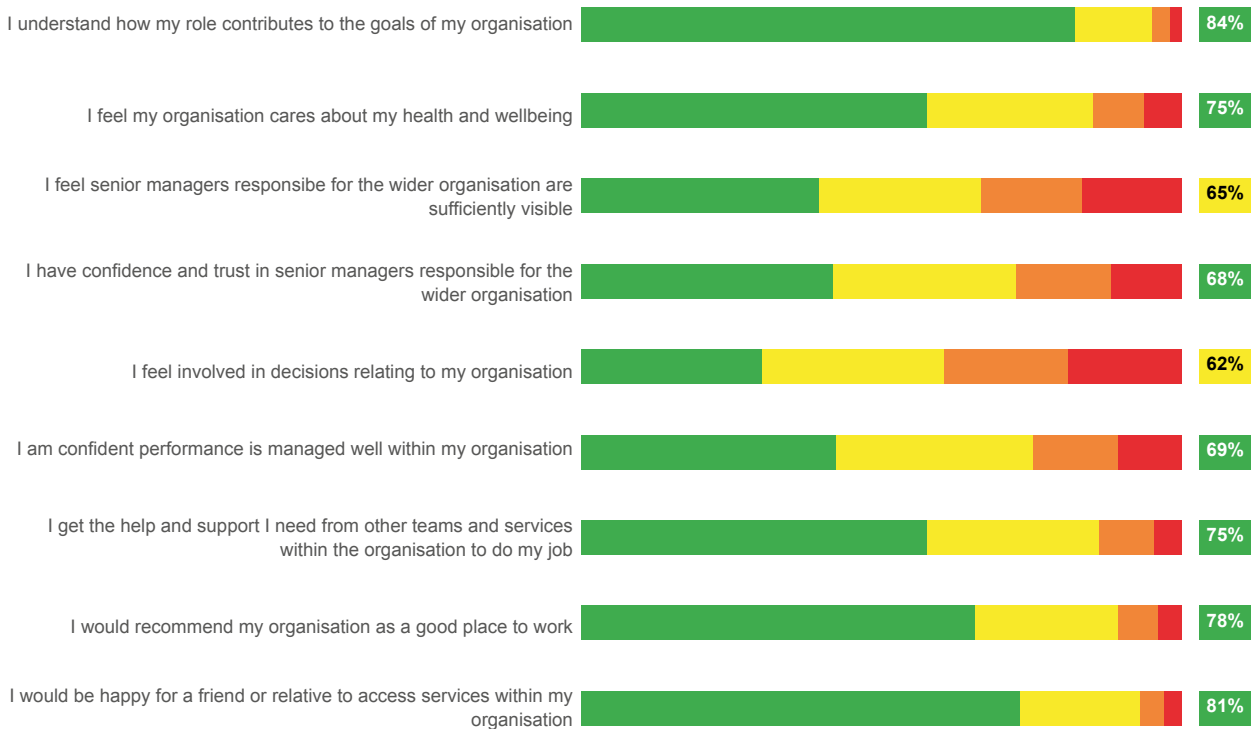
Experience as an individual



My team/my direct line manager



My Organisation References



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