Aberdeenshire Health and Social Care Partnership Strategic Plan 2020 to 2025

Contents

Please contact Aberdeenshire Health and Social Care Partnership if you require:

- this document in another format (including easy read),
- a telephone translation service, or
- if you would like to make a comment on any aspect of this plan

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Foreword

The Aberdeenshire Health and Social Care Partnership and the Integration Joint Board's (IJB) Strategic Plan for 2020 to 2025 focuses on improving outcomes for people through the design and delivery of an integrated health and social care service. Over the past three years, the Health and Social Care Partnership has made significant progress in transforming the way integrated services are delivered and has developed a strong foundation from which to manage future challenges.

This plan outlines the vision of the Health and Social Care Partnership and the key priorities we will focus on for the next five years. We recognise that demand for health and social care continues to change with people living longer, and needs becoming more complex. This coupled with growing financial pressures allows an opportunity to be innovative in the way we support people in local communities to stay healthy and continue to provide an effective and sustainable health and social care service.

The development of the plan involved listening to people who live in our communities, our partners and the dedicated and skilled staff who work in health and social care across all sectors. It is increasingly important to create new conversations and ways of working to ensure we align our priorities to those which will ensure we provide the information, guidance, support and care the people of Aberdeenshire need. By working together, we will continue to involve people in shaping the care and support that is right for them, providing choice and control and empowering people to lead healthy lives.

A framework to deliver transformational change supports this plan and our commissioning plan details how we allocate our resources and link our priorities to a performance framework allowing us to monitor our progress and effectively manage our services. To continue to move towards models of care based on the needs of the person, our ambition is to shift care and the associated resources away from residential and hospital-based care towards a greater focus on prevention, self-management and community-based care. With an increased community focus we hope to address key challenges such as reducing health inequalities.

We are looking forward to working with staff, partners and our communities to deliver a shared vison and ambition.

Councillor Anne Stirling
Chair Aberdeenshire IJB

Rhona Atkinson
Vice Chair Aberdeenshire IJB

Angie Wood
Interim Chief Officer Aberdeenshire HSCP

View our short animation video to tell the story of our plan and what it means to you and your community.

Executive Summary (Plan on a page)

Why do we need a Strategic Plan?
Over the next 5 years there will be many changes in the way we deliver and you use, community based Health and Social Care Services. The Aberdeenshire Health and Social Care Partnership (AHSCP) and our governance board, the Integration Joint Board (IJB) will use the Strategic Plan to make decisions which are based on the 5 Strategic Priorities which you have helped us to shape.
By using the plan to guide our decisions we will invest more of our resources, (Time, Money People, Effort, Buildings) in some areas and will reduce our investment in others to ensure we meet the needs of our communities and our strategic priorities.

What do our Strategic Priorities mean for you?
Prevention and Early Intervention

- We will support people to live healthy lifestyles
- We will support people to self-manage long term conditions
- We will work to help people avoid preventable conditions

Reshaping Care

- We will support people to remain in a homely environment
- We will ensure that people can access the right support when they need it
- We will support people to live healthy and independent lives

Engagement

- We will be clear and transparent in our decision making
- We will listen to and be responsive to what individuals and our communities say
- We will be open, honest and transparent when communicating with individuals and our communities and continue to engage with our staff

Tackling Inequalities and Public Protection

- We will work to keep vulnerable people safe
- We will work to make sure that everybody is able to access the service or treatment that they might need
- We will work to remove barriers to accessing services
- We will work with partners to ensure that Aberdeenshire is a safe and happy place to live for everyone

Effective Use of Resources

- We will work to ensure that we have the right amount of staff with the right skills
- We will focus our resources where they are most needed
- We will manage our reducing budget against increasing need

How will we know if it is working?
There are 9 National Health and Wellbeing Outcomes that every Health and Social Care Partnership is measured against which means that we can measure our performance in some areas, nationally. We will publish an annual report, to show you how we are doing and where we think
we can improve.
We will engage, directly, with communities across Aberdeenshire to see how YOU feel we are doing!

Introduction

Aberdeenshire Health and Social Care Partnership was established in April 2016 following Scottish Government legislation to integrate health and social care services. The work of the Partnership is governed by the Integration Joint Board (IJB) which is comprised of members from both Aberdeenshire Council and NHS Grampian, as well as those representing the interests of the Third Sector, staff, service users and carers.

The first Strategic Plan 2016 to 2019 set out to improve the health and wellbeing of adults in Aberdeenshire through the design and delivery of an integrated health and social care service. In 2018 the Partnership produced five Locality Plans which were developed in consultation with local communities. The Locality Plans provide a framework for how the Partnership intends to improve health and wellbeing at a local level whilst contributing to the achievement of the overall strategic priorities.

This second plan reflects on the progress the Partnership has made and sets out the strategic direction for the next five years and the key priorities it will focus on. Our vision remains unchanged, and our refreshed strategic priorities continue to reflect and support delivery of the National Health and Wellbeing Outcomes. In addition to this strategic plan our commissioning plan provides the detail of the financial and operational activities involved in delivering the priorities, and provides clarity on the measures against which we will monitor performance to ensure we are meeting our outcomes. The annually reviewed commissioning plan outlines our commissioning intentions over the next five years and will be key in how we organise and use our resources over the coming years. As part of the framework to support the delivery of our priorities we will continue to develop local strategies and delivery plans which provide specific direction for our services and link directly to the Partnerships vision.

Our 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

It is predicted we will see significant change in the make up of our population, with an increase in people living longer with multiple conditions and complex needs who require health and social care services. This rise in demand will increase pressure on financial resources rendering current models of service delivery unsustainable. We have shaped this plan to move in a strategic direction that is responsive and flexible to the future changes.

Working together

When making difficult decisions we commit to using robust data, taking into account the experiences of people and communities, and include our learning from the programmes and initiatives that have already been implemented.
The plan celebrates the diverse and vibrant communities in Aberdeenshire that make a valued contribution to health and wellbeing alongside public, private and voluntary services. By working with partners and people in our communities we aim to achieve effective and lasting transformation of sustainable health and social care services. Working with a range of stakeholders we need to look at the most effective ways in which services can be structured, planned and delivered to better support people.

Our commitment

We will:

- Design care and treatment round the assessed needs of the person
- Provide the best possible advice, care and support in a timely way and in the right place, irrespective of people's circumstances
- Work closely with individuals and communities to understand their needs, maximise their talents and resources, support self-reliance, and build resilience

Aberdeenshire resident's commitment

We will:

- Take responsibility for living as healthy a life as we can
- Contribute to our own health and wellbeing, make our views known, and participate positively in our own care
- Help to create a thriving, resilient community and use community resources to help us stay healthy and active

About us

Integration of health and social care

The way in which health and social care services are planned and delivered across Scotland has significantly changed through integration. The IJB is responsible for the integrated planning and delivery of adult health and social care services. In addition, it is key to delivery of Aberdeenshire's Children's Services Plan and it retains responsibility for some aspects of children's health services (health visiting and school nursing), transitions planning, and services provided to adults who are parents/carers.

Aberdeenshire Health and Social Care Partnership is one of three in the Grampian area. The others are Aberdeen City and Moray. The Aberdeenshire Partnership hosts the management of some health services which are Grampian wide, including; health care services within Her Majesty's Prison (HMP) and Youth Offender Institute (YOI) Grampian, forensic custody health care, and Marie Curie nursing services. A full list of the health and social care services and delegated function is set out in the Integration Scheme including, but not restricted to:

Adult Social Care Services

- Social care services for adult care home provision
- Home care services
- Community mental health services
- Care and support for adults with physical and learning disabilities
- Carer support service
- Adult support and protection
- Alcohol and other drug services

- Community based Allied Health Professions
    - Occupational Therapy
    - Physiotherapy
    - Podiatry
    - Speech and Language
    - Dietician
- Aids and adaptations for homes
- Supported accommodation
- Health improvement services
- Telecare
- Criminal Justice

Community Health Services

- Primary care services
- General Practices (GPs)
- Community pharmacists
- Optometry services
- Dental services
- Community hospitals
- Minor injury units
- Public health services
- Health visitors
- School nurses
- Vaccination programme
- Pharmacotherapy services
- Community link workers

We recognise the Third Sector's important role in providing a diverse range of preventative and specialist services. Aberdeenshire Voluntary Action (AVA) provides the Third Sector Interface (TSI) which is the main conduit between the Third Sector and the Partnership. The Third Sector brings great value through its flexibility, innovation and the active engagement with communities and individuals in the design and delivery of services.

Performance to date

Through the delivery of health and social care services in line with the first strategic plan, and the later development of our Locality Plans the Partnership has made significant progress in delivering against the nine National Health and Wellbeing Outcomes. The list below highlights key areas where we have made improvements and progress by working with partners to achieve better outcomes for people.

List of the progress supporting the delivery of the National Health and Wellbeing Outcomes

National Health and Wellbeing Outcome 1 People are able to look after and improve their own health and wellbeing and live in good health for longer.
Examples of areas of progress = Implementation of successful healthy lifestyle interventions as part of the Health Improvement Delivery Plan.

Supports national indicators 1, 11 and 12, and local indicators 1, 2, 3 and 4.
National Health and Wellbeing 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.
Examples of areas of progress = Virtual Community Ward resulting in many hospital admissions being avoided. Roll out of training to support Rehabilitation and Enablement.
Supports national indicators 2, 13, 16 and 18, and local indicators 7, 8 and 9.

National Health and Wellbeing Outcome 3 People who use health and social care services have positive experiences of those services, and have their dignity respected.
Examples of areas of progress = Inspection of 6 care homes under the new Quality Framework were measured as achieving a high standard.
Supports national indicators 3, 4, 5, 6 and 17.

National Health and Wellbeing 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
Examples of areas of progress = Improvements to Dementia post-diagnostic support. Improved performance for Alcohol Brief Interventions.
Supports national indicator 7.

National Health and Wellbeing Outcome 5 Health and social care services contribute to reducing health inequalities
Examples of areas of progress = Link workers within Primary Care settings in areas with the highest level of deprivation.
Supports national indicator 11, and local indicators 5 and 6.

National Health and Wellbeing 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 wellbeing
Examples of areas of progress = Carers offered Adult Carer Support Plans or Young Carer Statements as part of the implementation of the Carers (Scotland) Act.
Supports national indicator 8.

National Health and Wellbeing Outcome 7 People using health and social care services are safe from harm
Examples of areas of progress = Implementation of the Adult Protection Committees action plan.
Supports national indicator 9, and local indicator 5.
National Health and Wellbeing 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
Examples of areas of progress = Positive and consistent results from iMatter, staff engagement process which enables views to be gathered from staff about their experience working for the Partnership.
Supports national indicator 10.

National Health and Wellbeing Outcome 9 Resources are used effectively and efficiently in the provision of health and social care services
Examples of areas of progress = Technology Enabled Care via Video Consultation, and Home and Mobile Health Monitoring. Primary Care Improvement Plan, developing of new models of care within the primary care teams.

Supports national indicators 4, 14, 15, 19, 20, 21 and 23.

See appendix 1 for local indicator descriptions and follow the link for national indicator descriptions.

The Partnership continually assess progress and measure performance in line with the National Performance Framework. Annual Reports are published providing an open account of how well we have performed, and details on progress we have made, in relation to planning and delivering health and social care services.

Health and wellbeing of our population

The population of Aberdeenshire is projected to grow over the next 20 years. The largest increase will be in those of pensionable age (42.5%) with more than half of this group aged over 75. This compares with a small increase in people of working age (2.7%).

Graphic explanation
Aberdeenshire's population is estimated to increase from 270,181 in 2020, to 295,021 by 2040. The increase in working age people of 2.7% equates to a rise from 173,737 in 2020, to 178,405 in 2040, and the increase in pensionable age people of 42.5% equates to a rise from 45,450 in 2020, to 64767 in 2040.
Data source is NRS 2018 Mid year population estimates.

Population studies show that in the future people will live longer. The good news for Aberdeenshire is that average life expectancy for both men and women is higher than that of Scotland and Grampian and this is coupled with an increase in 'healthy' life expectancy.

Graphic explanation
The Life Expectancy in Aberdeenshire for men and women is higher than the Grampian and Scotland average.
Life Expectancy in Aberdeenshire for men is 79.2 years and women 82.4 years.
Life Expectancy in Grampian for men is 78.1 years and women 81.8 years.
Life Expectancy in Scotland for men is 77.1 years and women 81.1 years.
Data source is Scotpho Male and Female Life Expectancy figures (3 year aggregate 2014 to 2016).

However, this improvement has not been experienced by all sections of society, resulting in growing health inequalities. This growth in inequality has resulted in a slowdown in mortality improvements and for the first time in decades we have seen a stall of average life expectancy since 2014 with depravation and increasing alcohol and other drug related deaths playing an important part.

Graphic explanation
Average males and females life expectancies across different areas of deprivation.

- The average life expectancy for a male in Aberdeenshire is 79.2 years, in areas of higher deprivation ie Peterhead Harbour it is 71.6 years, and areas of lower deprivation ie Banchory West it is 83.6 years.
- The average life expectancy for a female in Aberdeenshire is 82.4 years, in areas of higher deprivation ie Fraserburgh Harbour and Broadsea it is 78.0 years, and areas of lower deprivation ie Banchory East it is 90.6 years.

Data source is Scotpho Male and Female Life Expectancy figures (3 year aggregate 2014 to 2016).

As a result in the predicted changes in life expectance we expect to see a rise in the number of people living with Dementia. This rise will result in increased demand for housing support, housing adaptations in addition to specialist dementia care and post diagnostic support. We also anticipate an increase in the number of people living alone, or in a household where all persons are aged 65 or older.

Another change we forecast is an increase in the prevalence of long-term health conditions which is known to increase with age. Whilst some factors contributing to ill health are responsive to intervention, we expect to have more people living in Aberdeenshire who need increased levels of care.

Within the Aberdeenshire population we are seeing growing numbers of people of all ages with long term conditions such as diabetes, COPD (Chronic Obstructive Pulmonary Disease), heart disease and anxiety.

Graphic explanation
Disease/Condition prevalence in Primary Care data from October 2019. This shows the rate per 100 GP practice population and displays data from the lowest to highest rate.

Chronic Obstructive Pulmonary Disease (COPD) = 1.8
Stroke - Transient ischemic attack (ITA) = 2
Cancer = 2.5
Chronic Kidney disease = 3.3
Heart disease = 3.8
Diabetes = 4.9
Depression = 5.8
Asthma = 6.3
High blood pressure = 14
Data source is ISD Primary Care Information Dashboard for Disease Prevalence October 2019.

Increasingly, people are living with more than one long term condition and their care can be more complex. Those in the most deprived areas of Aberdeenshire are more likely to live with multiple long-term conditions than those in the least deprived. These health inequalities are evident in the variation in average life expectancy across Aberdeenshire communities.

National frameworks and guidance are in place which supports the Partnership in reducing inequalities. The introduction of the Fairer Scotland Duty by Scottish Government aims to ensure Partnerships are as effective as they can be in tackling socio-economic disadvantage and reducing inequalities. This requires targeting resources to reflect the needs of areas with historically high levels of deprivation and poorer health outcomes. Additionally the Partnership will ensure its work is in line with Scotland's National Action Plan for Human Rights, supporting the vision that 'everyone is able to live with human dignity'.

In light of these predicted changes in our population we will see increasing demand for services and increasing pressure on limited resources. These challenges must be managed in a way which enables us to continue to improve services and outcomes for the people who use are service.

We need to make better use of our workforce and the resources we have by working more effectively together. If we do not change, we will not be able to continue to deliver the high quality services the people of Aberdeenshire expect.

National context for this strategic plan

Nationally the strategic and policy context in relation to health and social care continues to evolve with developments being driven by economic, social and technological changes and advances. National legislation, frameworks and strategies are developed and exist to provide guidance for Partnerships.

At a local level our strategies, action plans and policies are guided by these national developments and guidance.

National Policy and Legislation

- Community Care and Health (Scotland) Care Act 2022
- Social Work (Scotland) Act 1968
- Welfare Reform Act 2012
- Social Care (self-directed support) (Scotland) Act 2013
- Public Bodies (Joint Working) (Scotland) Act 2014
- Children and Young People (Scotland) Act 2014
- Community Empowerment (Scotland) Act 2015
- Carers (Scotland) Act 2016
- The 2018 General Medical Services Contract in Scotland

Good Practice Guidance and Frameworks

- The Parliament and End of Life Strategic Framework for Action
- Realising Realistic Medicine
- National Primary Care Vision
- A Fairer Healthier Scotland: A Framework for Action
- Health and Social Care Standards
- Getting it Right for Every Child (GIRFEC)

National Strategies

- A National Clinical Strategy for Scotland
- Social Services in Scotland: A shared vision and strategy
- Health and Social Care Delivery Plan
- Making Care Better - A strategy for supporting better care in Scotland
- A Public Health Strategy for Scotland
- Rights, respect and recovery: alcohol and drug treatment strategy

Local Plans and Strategies

- Grampian Clinical Strategy
- Local Outcomes Improvement Plan
- Local Community Plans
- Children’s Services Strategy
- Local Housing Strategies
- Rapid Housing Transition Plans
- Primary Care Improvement Plan
- HSCP Locality Plans

- HSCP Learning Disability Strategy
- HSCP Mental Health Strategy
- HSCP Adult Carers Strategy
- HSCP Dementia Strategy
- Aberdeenshire Autism Strategy

Some future demands will not always be visible at a given point, and implementation of new legislation and duties for the Partnership may have cost implications which are unforeseen. The Partnership will continue to transform services and make difficult decisions when needed, whilst focusing on providing the best outcomes for the people in our communities.

Working Together

The Health and Social Care Partnership must take account of plans and strategies from other services within Aberdeenshire. Partnership working is of utmost importance to make the best use of our local resources for the benefit of people living and working in our communities.

The Partnership works closely with NHS Grampian, Aberdeenshire Council and the third sector to align priorities and identify opportunities for partnership working. We work with and alongside partners such as; Aberdeenshire Alcohol and Drug Partnership (ADP), Fire and Rescue, Live Life Aberdeenshire, Community Planning Partnership and the Scottish Ambulance Service.

Local Plans and Strategies we support

- Grampian Clinical Strategy
- Local Outcomes Improvement Plan
- Local Community Plans
- Children's Services Plan
- Local Housing Strategies
- Rapid Housing Transition Plans
- Aberdeenshire Young Carers Strategy
- Alcohol and Drugs Strategy Aberdeenshire
- Community Justice Outcomes Improvement Plan
- Grampian Respiratory Strategy
- Culture, sport and physical activity strategies

All Public Bodies, including Health and Social Care Partnerships, are required by the Scottish Government to reduce greenhouse gas emissions, adapt to a changing climate and promote sustainable development.

This responsibility sits primarily with Aberdeenshire Council and NHS Grampian and the Partnership adheres to the policies of these two organisations. The Partnership has agreed to their share of the carbon reduction target by; reducing business miles, flexible working policies, reducing waste, improving planning of staff journeys, and promoting a behavioural change to staff regarding energy efficiency.

Health and social care standards

The new health and social care standards were published by the Scottish Government in June 2017. They seek to provide better outcomes for everyone and to ensure that individuals are treated with respect and dignity and that the basic human rights we are all entitled to are upheld. The new standards are relevant across all health and social care provision. The new standards are:

1. I experience high quality care and support that is right for me.
2. I am fully involved in all decisions about my care and support.
3. I have confidence in the people who support and care for me.
4. I have confidence in the organisation providing my care and support.
5. I experience a high quality environment if the organisation provides the premises.

The Care Inspectorate and Health Improvement Scotland will inspect against the new standards and will expect Partnerships to evidence they are providing a personalised service to support the unique needs and wishes of each individual service user. The introduction of Self-Directed Support encouraged care to be provided in a way which is focused on meeting outcomes and this approach is supported by the new standards.

Strategic context

The Partnerships strategic focus is to deliver more integrated care organised around the individual needs of people. Aberdeenshire covers a wide geographical area characterised by diverse localities and in response to this we have developed Locality Plans which, at a local level, identify what is important to individuals and communities and shape the services in their area based on those needs.

Graphic explanation

We have used the following to develop our understanding of health and social care needs in Aberdeenshire.

- Analysis of national and local data and statistics
- Priorities identified in Locality Plans
- Consultation and engagement with people who use services
- Views from partners across health and social care
- Knowledge and experience of staff working within the community

Using this information, coupled with the priorities identified in our Locality Plans and linking in with the national outcomes, we have identified five strategic priorities:

- Prevention and Early Intervention
- Reshaping Care
- Engagement
- Effective use of Resources
- Tackling Inequalities and Public Protection

To deliver these priorities the Partnership has four Programme Boards which will drive forward the strategic and operational service change required to deliver models of care fit for the future.

Each of the Programme Boards has a particular focus and encompasses a range of diverse and inter-dependent changes. The Programme Boards are:

- Enabling Health and Wellbeing
- Reshaping Care
- Safe, Effective, Sustainable
- Engagement

The four Programme Boards provide a strategic focus linking service design and delivery to our strategic priorities and the priorities identified within our local service development plans and strategies.

The diagram on the next page represents this relationship between the programme boards and the priorities and also identifies the important links with other plans and strategies including our Medium Term Finance Strategy, Workforce Development Plan and Engagement and Participation Strategy.

In developing this plan and delivering on our Strategic Priorities the Partnership reaffirms its commitment to and seeks to demonstrate evidence of 'Best Value'. This is 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'.

Graphic explanation

The flow chart displays the relationship between the nine National Health and Wellbeing Outcomes, the Partnership's vision, the strategic priorities, the Medium Term financial plan, the Programme Boards and also identifies the important links with other plans and strategies which all contribute to delivering positive outcomes for the people of Aberdeenshire.

- Plans and strategies listed include:
- Learning Disability
- Mental Health
- Dementia
- Older People
- Autism and ADHD
- Carers
- Physical Disability
- Palliative and End of Life Care
- Discharge
- Primary Care Improvement
- Community Hospitals
- Engagement and Participation
- Workforce
- Commissioning
- Localities

Our strategic priorities

Our strategic priorities have been developed in response to the wealth of information available to us regarding what is important to our communities, how our demography is expected to change over time and how Aberdeenshire is currently performing in relation to health and social care indicators.

The information below gives an example of some of the rationale behind the identification of these priorities.

Prevention and Early Intervention

- 27% of adults in Aberdeenshire have a life limiting long-term condition (2013 to 2016)
- 41% of people in Aberdeenshire are overweight or obese (2013 to 2016)
- The average life expectancy in Aberdeenshire is up to 5.8 years less in males in deprived areas, and up to 3.9 years less in females in deprived areas (2012 to 2016)
- 3 in 10 men and 4 in 10 women in Aberdeenshire do not meet the recommended daily activity levels (2014 to 2017)

Reshaping Care

- Expected 42% increase in pensionable aged people by 2040
- 8% of total population are aged over 75 years (2018)

Engagement

- 64% of people involved in the development of the Strategic plan would like to be involved in shaping and making decisions about services (2019)
- 46% of the health and social care workforce are aged over 50 years old (2018)

Tackling Inequalities and Public Protection

- 14% of children in Aberdeenshire live in poverty after housing costs (2018)
- 224 adult protection referrals in Aberdeenshire (2018 to 2019)

Effective Use of Resources

- The Partnership provides building based services including; community hospitals, GP practices, care homes, sheltered and very sheltered housing complexes, day centres and learning disability residential accommodation (2019)
- 2018/2019 budget for the partnership is £320.7m

Through our engagement and consultation we found out ‘what was important to you’ and have listed some examples below against each priority.

Prevention and Early Intervention

- People are empowered to self-manage and self-care
- More support for carers
- It can be a struggle to get a GP appointment

Reshaping Care

- Roll out of digital health options to support remote and rural locations
- Multi-disciplinary teams working together to provide person centred care

Engagement

- People need to know what is available in their local community
- Care staff should be respected and valued
- The role of the Partnership is not understood

Tackling Inequalities and Public Protection

- Transport can be a barrier to accessing services, particularly for people living in rural locations

Effective Use of Resources

- We need to focus resources to support people before their needs escalate
- We need to ensure there are enough resources for all whilst ensuring those most in need are supported

Prevention and Early Intervention

Given the significant and rising costs associated with ill-health and the delivery of health and social care services, there is both a public and economic benefit in improving health in Aberdeenshire.

One way to achieve this is placing a strong emphasis on prevention and early intervention. Communities and the local environment play an important role in promoting good health and providing opportunities to be active, to be involved and to connect with others.

By working towards achieving better outcomes for people, the Partnership will focus on prevention and early intervention through its local 'condition specific' strategies and plans, and in line with national plans, examples include:

- The Primary Care Improvement Plan (PCIP) – this provides a framework through which we will address the operational challenges linked to the demands on GP's and support new models of care fit for the future.

- Aberdeenshire's Health Improvement Delivery Plan (HIDP) – focuses on seven priorities which will improve the health of the population, reduce health inequalities and move service provision towards prevention and early intervention.

Where we are now

- 40% of our disease burden in Scotland is associated with 5 key health and lifestyle behaviours: smoking, alcohol, diet, weight and low physical activity
- 93% of adults confirmed they are able to look after their health very well or quite well (2018)
- 15% of affordable new build homes will be suitable for people with 'particular need' each year
- 924 care packages in Aberdeenshire were active for people living with Dementia who were eligible for support services 2018

You told us

- Be good to see promotion and help for people of all ages to access fitness programmes.
- People need to be better educated in order to make the right choices about their own health.
- We need to be able to access support and services before something becomes more serious.
- Greater and easier access to GP's and general health care is important.

What outcomes will we achieve

Through the redesign of how we deliver primary care we will seek to ensure that people get the right advice and support to maintain their independence and minimise the occasions when they need to engage with services. We want to avoid, where possible, people waiting until a point of crisis in their life before they seek support. Our strengthened focus on prevention and early intervention will promote good, positive physical and mental health and wellbeing for all people across all ages and client groups.

How will we achieve these outcomes?

The list below identifies the key areas of work which will help us to achieve the outcomes for Prevention and Early Intervention.

Enabler 1 = Primary Care provision

Area of activity
The Primary Care Improvement Plan (PCIP) will shape how we deliver the new 2018 GMS contract. It aims to improve services for patients by ensuring that the workload for GPs and other professionals is manageable and delivering high quality care.
Focus is on 6 priority areas:

- Vaccination Transformation Programme
- Pharmacotherapy Services
- Community Treatment and Care Services
- Urgent Care
- Additional Professional Roles
- Community Link Workers

Outcome
People who need to see their GP will be able to do so with minimal delay. For those people where it is more appropriate for them to be supported by another professional, they will be able to go directly to that person without needing a referral from a GP. This will help people to get the right support quicker and makes the best use of the different skills mix of a multi-disciplinary team.

Enabler 2 = Health Improvements

Area of activity
The ambition of the Health Improvement Delivery Plan (HIDP) is that local people are able to look after and improve their own health and wellbeing and live in good health for longer, it will achieve this by delivering seven priorities:

- ensuring every child has a good start in life
- encouraging healthy weight, diet and activity
- reducing smoking
- encouraging low risk alcohol consumption
- improving mental health and wellbeing
- minimising the impact of poverty and inequality
- making health improvement everyone's business

Outcome
People will be able to access support to maintain and improve their health and wellbeing enabling them to avoid unnecessary admissions to hospital.

Enabler 3 = Dementia whole system approach

Area of activity
A Dementia Strategy will be developed through engagement with people living with Dementia, carers, commissioned services and relevant staff. This will consider how and where support is delivered to best meet need.

Outcome
People will have access to appropriate support at all stages of their dementia journey. Care will be person-centred and designed with input from family carers.

Enabler 4 = Independent Living

Area of activity
Work to meet both the National Housing Outcomes and the Local Housing Strategy Priorities focus on the development of homes that meet people's needs and support independent living. Through a range of supported accommodation options to the availability of home adaptations those with a particular need will have the right to the practical assistance and support required to participate in society and to live an ordinary life.

Outcome
People with an identified particular need will have access to appropriate affordable housing and support to allow them to sustain and improve their health to live as independently as possible.

Reshaping care

Reshaping care is about how we deliver services in a way which contributes to the delivery of the Scottish Government's "Reshaping Care for Older People; A Programme for Change" which sets the direction in developing support for older people which is fit for the future. Both national and local strategies recognise the population of Aberdeenshire is increasing. As it does so, and as life expectancy increases for people with a range of health and social care needs, the demand on services is also increasing. At the same time, there is a clear message that people want personalised support delivered in their own homes, rather than in institutional settings. Reshaping care is about how we balance this increasing demand for services whilst continuing to provide person centred care which promotes independence and enables people to remain connected to their local community.

Where we are now

- 5,128 people in Aberdeenshire supported by the responder service enabling them to stay at home (2018 to 2019)
- 907 new users of telecare in Aberdeenshire (2018 to 2019)
- 421 hospital admissions across Aberdeenshire avoided due to the operation of the Virtual Community Ward (2018 to 2019)
- 9.8% average percentage of referrals in Aberdeenshire going down the rehabilitation and enablement pathway (2018 to 2019)

You told us

- Need appropriate planning and care in place for people to be discharged from hospital.
- We need access to the right service, at the right time, in the environment we have chosen.
- Getting care can feel like a fight. Those who shout the loudest get what they need.
- I would welcome being able to have a consultation online or a phone call instead of having to go and see the doctor.

What outcomes will we achieve

We have made great progress to date and over the life of this next strategic plan the Partnership will continue to explore how we deliver services in a way which supports people to be as independent as possible whilst remaining either at home or in a homely setting for as long as possible. We understand the unique challenges of an ageing population and recognise the importance of the way we need to adapt and change how we deliver services now in order to make them sustainable for the future.

How will we achieve these outcomes?

The list below identifies the key areas of work which will help us to achieve the outcomes of reshaping care.

Enabler 1 = Mainstream Homecare

Area of activity
We will focus the internal home care service on 4 key themes:

1. Enablement – 6 week intensive intervention
2. Rapid Response - providing a 24 hour responder service for planned and unplanned need
3. Complex cases, end of life and palliative care
4. Hard to reach, remote and rural areas

Outcome
People will be able to access the support they need when they need it to enable them to stay at home or avoid unnecessary admissions to hospital.

Enabler 2 = Technology enabled care

Area of activity
We are in the process of implementing a number of digital initiatives:

- Home and Mobile Health Monitoring (HMHM)
- Video Consulting
- Telecare

Outcome
People will be able to access specialist support and advice without the need to travel, making health and social care services more accessible to all. People will be supported by the HMHM to take control of existing health conditions through improved monitoring which may reduce the need for primary and secondary care interventions.

Enabler 3 = Virtual Community Ward (VCW)

Area of activity
The VCW continues to make use of multidisciplinary teams to work together to make the best use of local resources to support people to remain at home. The model is currently in place in 28 of Aberdeenshire's 35 GP practices.

Outcome
Where appropriate, people will be supported to remain in their own home rather than having to be admitted to hospital.

Enabler 4 = Rehabilitation and enablement

Area of activity
The objective is for all new referrals to care management to be directed first through the rehabilitation and enablement pathway. The rehabilitation and enablement pathway will support people to recover and regain their abilities following a period of illness, injury or increase in frailty.

Outcome
People will be supported to regain their skills and abilities following an episode of ill health enabling them to stay at home longer with increased independence and less requirement for care at home support.

Enabler 5 = Homely setting

Area of activity
Aberdeenshire offers a number of accommodation options for people who have particular housing needs because of a long-term condition or frailty. Work is in progress to evaluate our current model of support with the aim of achieving the most efficient model, with the appropriate mix of options, for our population. This work will be carried out in partnership with Aberdeenshire Council's Housing Service and the Third Sector.

Outcome
People will be able to access accommodation with support which is flexible and tailored to meet their needs. They will be able to stay in their community where appropriate if they choose and continue to access activities and maintain social relationships.

In addition to these programmes of work, a number of additional projects have been established which aim to:

- prevent delayed discharge
- improve integrated working for our multidisciplinary core teams
- develop management systems to support integrated working
- extend the application of a "risk assessed care" approach to moving and handling support

These projects will further enhance our ability to provide the right service at the right time to prevent admission, facilitate discharge and ensure equitable access to care when it is needed.

Engagement

Sustainable change requires effective communication and involvement with the people who live and work in Aberdeenshire. By engaging and listening to communities, staff and partners we can find out what matters to them and work together to design and deliver services. When services are shaped by listening to and involving people in the process it has been found to result in improved outcomes.

Our engagement is guided by legislation from the Scottish Government which supports the way public services involve and engage with communities, this includes: Community Empowerment (Scotland) Act 2015, Young Persons (Scotland) Act 2014 and those responsibilities as identified in the Public Bodies (Joint Working) (Scotland) Act 2014.

Where we are now

- The Partnership has a legal responsibility to involve people in the future delivery of services
- 84% of Aberdeenshire staff reported that they understood how their role contributes to the goals of the organisation (2018)
- 3,710 completed 'Public View Questionnaires' as part of the initial Aberdeenshire Minor Injury Unit review (2018)
- 270+ people in Aberdeenshire participate in public events providing their views on mental health services (2018)

You told us

- People need to be more informed about the function and structure of the partnership.
- Engagement via social media and online platforms has improved over the last 3 years.
- Happy to engage but would like feedback about what is happening and what is not, and why.
- Actually listen to us, the users, and act on what we say.

What outcomes will we achieve

Through delivering this priority the Partnership will strengthen its relationships with the service users and the wider community to actively involve people in all aspects of health and social care service planning and delivery as well as decisions about their own health and care. We will:

- Build on existing, long-standing relationships, partnerships and local networks, as well as inspiring new participation.
- Develop ongoing and sustained dialogue with key stakeholders.
- Learn from practice and develop and refine our approaches.

This way of working encourages real partnerships which mean listening to what people say they need and what would make a difference.

How will we achieve these outcomes?

The list below identifies the key areas of work which will help us to achieve the outcomes under our engagement priority.

Enabler 1 = Improvements to Participation and Engagement

Area of activity
Work began with partners on the development of a Participation and Engagement strategy in 2019. The engagement activities carried out for the Partnership's strategic plan provided valuable information which will inform the strategy. The strategy will be published in 2020 and

provide a clear and consistent framework for how the Partnership involves people in the design and delivery of services.

Outcome
People who access our services, our staff, local communities and partners will all have opportunities to influence decision-making, service planning, and delivery at all levels.

Enabler 2 = Workforce planning

Area of activity
A robust workforce planning cycle based on national guidance and utilising 'six steps' workforce planning tool is in place. Using the tool establishes a systematic approach, ensures closer integration between all staff providing care, and identifies education and training requirements. The plan will consider not just the health and social care partnership but be extended to consider the Third Sector.

Outcome
Staff will be fully trained and respected and will have opportunities to influence decisions. People will benefit from an improved service delivered by a competent workforce.

Enabler 3 = Support Third Sector organisations to increase community capacity

Area of activity
The Third Sector is a valued and equal partner within the Partnership, and this relationship can be further strengthened and joint resources maximised to ensure we provide the services and support people want and need. Improvements required:

- Raise awareness of the range of Third Sector organisations, the services they can provide and how these services can be accessed by the public.
- Develop a long term and sustainable method of communication and engagement with the Third Sector linking with locality planning.
- Develop consistent and appropriate representation from Third Sector in strategic planning and commissioning.

Outcome
People will benefit from a range of support options available in their area which provide the level of support they require and take advantage of the knowledge, skills and experience of the third sector.

Enabler 4 = Locality Planning

Area of activity
The Plans place a strong emphasis on empowering local communities in identifying and driving forward local priorities based on local need. The plans were developed with the involvement of partners and stakeholders and inform local service delivery and decision-making.

Outcome
Communities will be empowered and have opportunities to shape local services to meet local priorities.

Effective use of Resources

As we plan for our future, we need to make difficult decisions about where to invest and where to reduce or withdraw spending whilst always focusing on person centred care. We need to understand how we can manage the resources we have and what we will need in the future to meet the increasing demand for health and social care services.

To maximise our resources it is vital we work closely with partners in the third sector. The services and opportunities they provide are key to increasing the capacity of the health and social care support needed. Additionally, the irreplaceable number of unpaid carers in Aberdeenshire who provide care and support for close family members, relatives and neighbours are essential. We will continue to involve unpaid carers in our decision-making process and support their health and wellbeing to allow them to continue in their caring role.

Where we are now

- 1 in 4 people in Scotland will experience a mental health problem at some point in their life (2019)
- 6% increase predicted in the number of people in Aberdeenshire with a learning disability in the next 10 years
- £139bn saved across the UK through unpaid carers (2015)
- £5,693,118 Aberdeenshire Partnership's annual spend on mental health out of area placements (2018 to 2019)

You told us

- Money needs to be spent on service delivery.
- We need more effective coping strategies such as carer support and respite.
- Need increased investment in mental health services.
- Focusing on prevention now will make savings in the long term.

What outcomes will we achieve

Effective use of resources will ultimately ensure that we use the resources we have in the right way to ensure people receive the support they need at the right time and in the right place to meet their individual needs. With ever reducing budgets and increased demand for services we need to make some difficult decisions about our priorities and ensure that we can continue to care for the most vulnerable people in our society.

How will we achieve these outcomes?

The list below identifies the key areas of work which will help us to achieve the outcomes of effective use of resources.

Enabler 1 = Investment in mental health support

Area of activity
Through Action 15 (National Mental Health Strategy Action 15) the Scottish Government is providing additional funding to increase the number of mental health workers across Scotland. In Aberdeenshire this will include:

- Increased opportunities to engage with staff who can provide low level and preventative mental health support
- Professional support available for people out of hours and in times of crisis
- Improved availability of peer support

Outcome
People will find it easier to access support to maintain and improve their mental health and wellbeing when they need it. This will include preventative support and support for people in crisis.

Enabler 2 = Supported accommodation review

Area of activity
We are reviewing our accommodation with support for people with learning disabilities and other additional needs. This includes looking at capacity to analyse supply against demand and the models of care that are offered within these premises.

Outcome
People will be able to access accommodation locally which meets their needs and enables them to retain their independence, access activities and retain social connections.

Enabler 3 = Support for unpaid carers

Area of activity
Unpaid carers have a hugely important role in our society. The care they provide can help people to remain at home and reduce their need for health and social care services. All carers are offered an Adult Carer Support Plan or a Young Carers Statement. These assessments identify the impact of someone's caring role. This may then identify areas where support for the carer would help that person to continue in their caring role.

Outcome
Unpaid carers will receive the support they need to look after their own health and wellbeing and receive the training they need to be confident in their caring role. This will enable people to continue in their caring role and can help families to stay together.

Enabler 4 = Changes to daycare provision

Area of activity
The IDEA project looked at providing day services in a different way for people with learning disabilities and other additional support needs. The focus was to make use of community resources and identifying opportunities for people to be part of and contribute to their local communities rather than use of traditional building based day care services.
IDEA has been working well in Central Aberdeenshire and over the next five years this will be rolled out in North and South Aberdeenshire.

Outcome
Through the IDEA project people will have increased opportunities to get involved in their local community and access activities and employment which develops their skills and interests and helps to maintain social relationships.

Tackling Inequalities and Public Protection

Health inequality is when a person's ability to live a longer, healthier life is limited by circumstances largely beyond their control. People from minority communities or with protected characteristics (including religion, belief, race or disability) in particular may experience health inequalities due to their inability to access services.

There is a commitment from the Partnership to ensure everyone in Aberdeenshire is safe and protected from harm. Public Protection includes but is not limited to:

- Protecting vulnerable adults from abuse or neglect
- Response to domestic violence
- Community Justice
- Support for children at risk of harm

Where we are now

- 1,270 referrals to Aberdeenshire's housing support service from people unintentionally homeless or at risk of homelessness (2016 to 2017)
- £16,654 spent at HMP Grampian on agency intimate/personal care workers (2018 to 2019)
- 224 adult Protection referrals across Aberdeenshire (2017 to 2019)
- 3 x higher death rates in Aberdeenshire than in the UK of people in contact with the criminal justice system (2019)

You told us

- People have pre-conceived ideas towards prisoners.
- People want to feel reassured that they are living in a safe community.
- Low availability of housing for people being released from prison.
- Health, social care, police, fire and ambulance need to work together to ensure vulnerable people receive fast care from the correct person.

What outcomes will we achieve

Ensuring the people of Aberdeenshire are protected and have equitable access to health and social care services and housing support will have a number of benefits:

- People feel safe in their communities
- Reduction in avoidable health conditions
- Reduction in offending and re-offending
- Reduction in homelessness

How will we achieve these outcomes?

The list below identifies the key areas of work which will help us to achieve the outcomes for Tackling Inequalities and Public Protection.

Enabler 1 = Protecting adults and ensuring equality for people with mental health problems

Area of activity
A review of the Mental Health (Care and Treatment) (Scotland) Act 2003 will improve the rights and protections of people with a mental health problem and remove barriers to those caring for their health and welfare.

Outcome
People with mental health problems will have their social, economic and cultural rights respected and will not be detained unnecessarily.

Enabler 2 = Improving access to social care provision at HMP Grampian

Area of activity
The Partnership is exploring a test of change to extend the integrated health and social care team to include provision of holistic support to prisoners who are held at HMP Grampian. The team will more accurately assess prisoner need and be able to meet the needs of prisoners at pre-admission stage, during the completion of their custodial sentence and post sentence/release into the community.

Outcome
The prison population will have the same access to health and social care services as people living in the community. People will benefit from continuity of care on their release from prison.

Enabler 3 = Delivering equitable health and social care provision for people in the criminal justice system

Area of activity
The Partnership needs to reduce the health inequalities of people in contact with the criminal justice system through:

- Improving access to health and social care services
- Reducing stigma
- Supporting self-management

Outcome
People in the criminal justice system will not suffer from prejudice when accessing health and social care services and will have the same access to high quality support as everyone else.

Enabler 4 = Support for people at risk of becoming homeless

Area of activity
In line with the Local Housing Strategy and the Rapid Rehousing Transition Plans Aberdeenshire is part of a consortium which builds on the support offered by the Housing First Scheme. There is a commitment to provide 120 Housing First tenancies within Aberdeen City and Aberdeenshire by March 2021. These homes will benefit people who are unintentionally homeless – many of whom are disadvantaged due to a mental health problem or drug or alcohol dependency. This is a joint approach with Aberdeen City, Aberdeen Cyrenians, Aberdeen Foyer and Turning Point Scotland and therefore there is the added benefit of encouraging partnership working and information sharing.

Outcome
People at risk of becoming homeless will get the support they need to find and manage a tenancy. People will be linked into other services which can provide support in other areas which are effecting their ability to manage their housing needs.

Measuring Performance

We measure our performance on a regular basis to help us understand where we are doing well and where we need to improve. This is one way in which we regularly monitor and review our services and is an essential part of continuous improvement. Measuring performance helps us to effectively manage our services to ensure that we are providing the people of Aberdeenshire with high quality health and social care.

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.

National Performance Indicators

The Scottish Government set 23 performance indicators that measure progress towards the nine national health and wellbeing outcomes for adults. In addition, the Ministerial Group for Health and Community Care (MSG) developed a set of six indicators to monitor the effectiveness of health and social care integration. They are:

- Unplanned admissions
- Unplanned bed days
- A and E attendances
- Delayed discharges
- End of life care
- Balance of care

Local performance indicators

Our local performance indicators (see appendix 2) help us measure and understand how we are performing in key areas across health and social care. 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.

Our reporting cycle ensures that we regularly report our performance to a range of internal and external stakeholders. It includes:

- Regular performance reporting at meetings of the Chief Executives of NHS Grampian and Aberdeenshire Council with our Chief Officer.
- Quarterly reporting to our Senior Management Team and Integrated Joint Board.
- Annual Performance Reporting for the Scottish Government.
- Performance monitoring at the appropriate programme board for our four programmes of work.

Linking Performance to Priorities

Our Strategic Plan is one of a suite of documents which guides the direction of the Partnership and gives us clarity on the measures against which we monitor performance. Supporting our Strategic Plan is our Commissioning Plan, Workforce Plan and Medium-Term Financial Strategy.

The list below details the purpose of each of the plans:

- Strategic Plan = What we want to achieve
- Commissioning Plan = The detail of how we change service provision and what resources we need in order to deliver our priorities.
- Workforce plan = How our workforce will be shaped by the specific actions identified in the strategic and commissioning plan.
- Medium Term Financial Strategy = How we manage the financial resources we need to deliver the priorities as set out in our strategic plan.

From these plans the content of our programme boards identifies how we will manage these resources and change operational delivery in order to achieve our priorities. The programme plans identify specific performance measures for each project which will help to monitor progress and identify how each project contributes to the overall delivery of our strategic priorities.

Our commissioning plan is an important link between the priorities identified in the strategic plan and the tasks and performance measures identified in the programme plans. We review our commissioning plan on an annual basis in order to ensure we are making sufficient progress through delivery of the projects managed through the programme boards.

The Partnership's Financial Plan

The Partnership set out its objectives and priorities for the future delivery of integrated health and social care services through the first strategic plan, commissioning plan and this second strategic plan. A key driver is to respond to our changing demography. By 2035, it is forecast that the number of people aged over 65 will have increased by 65%. The resulting increase in demand on health and social care services is well known, placing 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 £5million per annum.

The financial plan is set out within a Medium Term Financial Strategy (MTFS) which in turn is a coherent and integral part of the Partnership's strategic plan. This is deliberate so that the financial resources are not seen as separate to the plans and outcomes of the Partnership, but are recognised as resources to be considered, prioritised and deployed to enable the delivery of the strategic plan.

At a strategic level, the five year planning horizon within the MTFS supports the expected twenty year view which shows year on year increases as mentioned above and is depicted in the graph.

Graphic explanation:
Financial scenarios from 2019 to 2034 assume no 'new pressures' this would cover any changes for example in legislation which might affect eligibility for services which would impact on service budgets. This graph demonstrates how the partnership's budget might change in the future. The blue line shows the anticipated budget required for the partnership in order to meet future demand for services and the increase in operating costs due to inflation. The orange line for 'flat

cash' assumes the Partnership receive no increase in budget and would anticipate a shortfall of £75m by 2034. The yellow line shows the budget increase the partnership expects to receive which still demonstrates a shortfall of £37.5m by 2034. The grey line considers if the Partnership was to see a reduction in budget which could lead to a shortfall of £90m by 2034.

Whilst the financial expectation of the Partnership is not to receive an extra £5 million per year of funding, it is equally unrealistic to expect £5 million to be removed from the budget each year without a significant impact on service delivery. Therefore, the integration of health and social care services across Aberdeenshire with NHS Grampian and Aberdeenshire Council as partners is critical as this partnership is strong, mature and respectful of the demographic circumstances being faced and being forecast.

The Partnership is changing and is playing its part in mitigating rising costs within a rising population with the Virtual Community Ward, Community Hospitals and the use of technology being three real examples of this change in practice.

The 2019-20 budget agreed by the IJB at its meeting on 20 March 2019 is funded by contributions from Aberdeenshire Council of £111.683 million and NHS Grampian £180.449 million. Within this funding there is £2.097 million for transformational activity. On top of this there is £28.524 million for the set aside budget.

The set aside budget is an amount of money allocated to all Partnerships to meet the cost of unscheduled care or emergency admissions to large hospitals. Most of this budget relates to services provided to Aberdeenshire residents at either Aberdeen Royal Infirmary or Royal Cornhill Hospital. The Integration Joint Board has responsibility for reducing spend on unscheduled care through delivery of our strategic priorities. Operational management for unscheduled care remains with NHS Grampian.

The IJB also receives funding during the year for a range of Scottish Government priorities. Significant allocations are for schemes like the Primary Care Improvement Fund (which supports implementation of the new national contract for GPs) and Action 15 Mental Health funding (which will increase the number of community based mental health workers). Both of these schemes are crucial in developing ways in which services are being redesigned and improved to meet demographic and workforce challenges.
An indication of how resources are committed is shown below:

The IJB also receives funding during the year for a range of Scottish Government priorities. Significant allocations are for schemes like the Primary Care Improvement Fund (which supports implementation of the new national contract for GPs) and Action 15 Mental Health funding (which will increase the number of community based mental health workers). Both of these schemes are crucial in developing ways in which services are being redesigned and improved to meet demographic and workforce challenges.

Graphic explanation: This indicates of how resources are committed for the 2019 to 2020 budget:

- Community Care and Health Services = 58%
- Primary Care (including prescribing) = 26%
- Set Aside = 8%
- Mental Health Services = 5%
- Management and Support = 3%
- Change Programme = 1%

Medium Term Financial Strategy

The Medium Term Financial Strategy aims to set out a forecast position for the lifetime of this strategy and beyond to inform and enable the process of prioritising resource and delivering sustainable financial balance. The MTFS will continue to be refined over the life of the Strategic Plan to reflect updated Commissioning Plans and the aspiration to shift care and the associated resources away from residential and hospital based care towards a greater focus on prevention, self-management and community based care.

The approach will be driven by four operational themes:

1. Self-management – helping people to take responsibility for, and have control over their own health and wellbeing
2. Realistic medicine – enabling more personalised, shared decision making with people about their care and treatment, reducing potential harm and waste and focusing on the real value of any healthcare intervention
3. Enablement – supporting people to regain and maintain independence, thereby improving their confidence and helping them to achieve to the maximum of their abilities
4. Technology and digital innovation – supporting people to live more independently through new and different approaches to the use of digital technology

Graphic explanation:
The graphic display is of the four operational themes mentioned in a circle around an inner circle containing ‘Individuals, families, communities’

The MTFS contributes to the context for this different environment and what needs to happen to support and enable individuals, communities, staff and partners to move forwards. The MTFS supports the need for change; allows the people of Aberdeenshire to understand what services they will have access to and, as a result of this, what services they will require less of. This will evidence how, in a sustainable way, the partnership will continue to deliver high quality, appropriate care within the resources available.

Commissioning

To support this plan and provide the detail of how we will deliver on our priorities we will publish a Commissioning Plan and refresh this at regular intervals over the course of this strategic plan. This will set out the how the Partnership considers the current and future needs of our population, and links investment to our priorities. The commissioning plan considers the options available to the Partnership and plans the nature, range and quality of future services required and works alongside the strategic plan to put these in place.

In order to develop the plan, we will work with people who use services, carers, providers and communities to think innovatively about what services are needed for the future, how they should be provided and who they should be provided by. This may mean a shift in resources to disinvestment in current provision to reinvest in other areas.

Appendices

Appendix 1 - Public involvement in the development of the plan

Introduction

The Public Bodies (Joint Working) (Scotland) Act 2014 sets particular requirements for the preparation of a strategic plan for health and social care, stating 'stakeholders must be fully engaged in the preparation, publication and review of the strategic plan'. The AHSCP have a long tradition of engaging with the people in our communities, and this plan has been informed using the feedback from initial engagement activities and further consultation on the draft plan with our partners, staff and the people who live in our communities.

Method

The Strategic Planning Group developed a programme of engagement with a range of activities and approaches to enable as many people as possible to be easily involved and share their views. An online platform was developed providing short videos explaining our key priority areas and online surveys to capture people's views. In addition to this resource packs were available online to enable existing community groups to run workshops and have open discussions about what was important to them, some groups carried out sessions themselves and many others were facilitated by Partnership and AVA staff.

The information from the engagement was analysed and themed and used in the development of the draft strategic plan. A six week consultation phase was then carried out to gain views and comments on the draft plan as a whole. The feedback from the consultation informed the final strategic plan.

The approach and evaluation of the engagement and consultation was informed by Visioning Outcomes in Community Engagement (VOiCE), the National Standards for Community Engagement, and the Scottish Health Councils Participation Toolkit.

Involvement

Engagement:

- The online platform hosting the engagement information was visited 2,422 times by 1,707 different individuals. Social Media reach = 33,309.
- 598 online surveys were fully completed.
- 437 people (across 41 groups) participated in the engagement workshops, and an additional 183 people received face to face presentations on the opportunities to be involved in the engagement.
- 3,879 comments were analysed from workshop exercises and online open ended survey questions.

Consultation:

- The online platform hosting the consultation information was visited 1,689 times by 1,216 different individuals. Social Media reach = 11,711.
- 178 online surveys were fully completed, 171 by individuals and 9 by groups/organisations.

- 130 comments were analysed from open ended questions.

Reports on the engagement and consultation phases can be found on Aberdeenshire Councils consultation database.

Appendix 2 - Performance Indicators

Aberdeenshire HSCP Local Indicators

LO1 Percentage of clients receiving alcohol treatment within 3 weeks of referral
LO2 Percentage of clients receiving drug treatment within 3 weeks of referral
LO3 Smoking cessation in 40% most deprived areas after 12 weeks
LO4 Number of Alcohol Brief Interventions being delivered
LO5 Number of adult protection referrals
LO6 Percentage of unpaid work orders instructed within seven days
LO7 Rate of emergency occupied bed days per 1,000 population over 65s
LO8 Emergency Admission rate per 1,000 population over 65s
LO9 Number of people over 65 years admitted as an emergency in the previous 12 months per 1,000 population
LO10 Number of bed days occupied by delayed discharges per year
LO11 Number of delayed discharges
LO12 Emergency Department attendance rates per year per 1,000 population
LO13 Percentage of people seen within 4 hours within community hospital Minor Injury Units

Local and National Indicators against the five priorities

Prevention and Early Intervention
Local Indicators = LO1, LO2, LO3 and LO4
National Indicators = NI-1, NI-8, N1-11 and NI-12

Reshaping Care
Local Indicators = LO7, LO8 and LO9
National Indicators = NI-2, NI-3, NI-12, NI-13, NI-14, NI-15, NI-16, NI-18,NI-19, NI-20, NI-21, N1-22 and NI-23

Engagement
National Indicators = NI-3, NI-4, NI-5, NI-6, NI-10, NI-14, NI-15, NI-17, NI-19, NI-22 and NI-23

Effective Use of Resources
Local Indicators = LO10, LO11, LO12 and LO13
National Indicators = NI-4, NI-7,NI-12, NI-13, NI-14, NI-15, NI-16, NI-19, NI-20, NI-22 and NI-23

Tackling Inequalities and Public Protection
Local Indicators = LO5 and LO6
National Indicators = NI-9, NI-11, NI-12, NI-13, NI-15, NI-16 and NI-20

Appendix 2 - Data Sources

National Records of Scotland – Statistics and Data
Source for:
Diagram - Mid-year 2016 Population prediction

Scottish Public Health Observatory Profiles (ScotPHO)
Source for:
Diagram - Male and Female Life Expectancy (3 year aggregate 2014 – 2016)
Diagram - Average Male and Female Life Expectancy across different areas of Aberdeenshire (3 year aggregate 2014 – 2016)
Information Service Division (ISD)
Source for:
Diagram - Information on Long Term conditions for Disease Prevalence – October 2019 (Primary Care Information Dashboard)

Our Strategic Priorities

Priority = **Prevention and Early Intervention**
Fact = Long-term conditions (2013 to 2016)
Source = Scottish Public Health Observatory Profiles (ScotPHO)

Fact = Overweight and obese figures
Fact = Men and women in Aberdeenshire not meeting daily recommended activity level
Source = Scottish health survey results for local areas 2014 to 2017

Fact = Average Life Expectancy (5 year aggregate 2012 to 2016)
Source = National Records of Scotland – Statistics and Data

Priority = **Reshaping Care**
Fact = Expected increase in pensionable age
Source = NHS Grampian Health Intelligence

Fact = Population aged over 75 years (2018 Mid-year population estimate)
Source = National Records of Scotland – Statistics and Data

Priority = **Engagement**
Fact = Workforce aged over 50 years
Source = Aberdeenshire Health and Social Care Partnership workforce plan (2018)

Fact = % of people who would like to be involved in shaping and making decisions about services (2019)
Source = AHSCP Strategic Plan Development – Engagement Survey (2019)

Priority = **Tackling Inequalities and Public Protection**
Fact = % of children living in poverty after housing costs (2018)
Source = Child poverty local action report Aberdeenshire (June 2019)

Fact = Referrals to adult protection
Source = Carefirst – Care Management System

Priority = **Effective Use of Resources**
Fact = Partnership provisions
Source = AHSCP Annual Report

Fact = Partnership budget (2019/2020)
Source = Medium Term Financial Strategy

Where we are now

Priority = **Prevention and Early Intervention**
Fact = % of our disease burden
Source = Aberdeenshire's Health Improvement Delivery Plan 2018 to 2019

Fact = % of adults who are able to look after their health
Source = Information Service Division (ISD)

Fact = % of affordable new homes built for 'particular need'
Source = Aberdeenshire Local Housing Strategy 2018 to 2023

Fact = Referrals to Aberdeenshire housing support service
Source = Carefirst – Care Management System

Priority = **Reshaping Care**
Fact = People supported by the responder service
Fact = Users of telecare
Fact = Admissions to the virtual community ward
Source = Integration Joint Board Paper 'Update on reshaping Care Programme Board' (19th June 2019)

Fact = Clients on rehab and enablement pathway
Source = Carefirst – Care Management System

Priority = **Engagement**
Fact = % staff understanding how their role contributes to organisation goals
Source = imatter – Staff satisfaction survey (2018)

Fact = Legal responsibility
Source = The Public Bodies (Joint Working) (Scotland) Act 2014

Fact = Number of 'Public View Questionnaires' completed
Source = Review of Minor Injury Unit Provision (2018)

Fact = Number of people participating in public events on mental health services
Source = Adult Mental Health and Wellbeing Strategy 2019 – 2024 Consultation Report

Priority = **Effective Use of Resources**
Fact = People experiencing a mental health problem
Source = Scottish Government – Our Mental Health Strategy (2016)

Fact = Increase in number of people with a learning disability in Aberdeenshire
Source = Aberdeenshire Health and Social Care Partnership Learning Disability Market Position Statement (draft)

Fact = Cost saved by unpaid care (2015)
Source = Carers UK Facts and Figures

Fact = Annual spend on mental health out of area placements
Source = Aberdeenshire Health and Social Care Partnership Commissioning Team

Priority = **Tackling Inequalities and Public Protection**

Fact = Referrals to Aberdeenshire housing support service
Source = Aberdeenshire Local Housing Strategy 2018 to 2023

Fact = HMP Grampian spend 2017 to 2018
Source = Scottish Prison Service

Fact = Referrals to adult protection
Source = Carefirst – Care Management System

Fact = Death rate in Aberdeenshire in the criminal justice system
Source = Changing the Record (Annual Report 2017/18)