Aberdeenshire Health & Social Care Partnership

Appendix 1

Aberdeenshire Health and Social Care Partnership

Strategic Delivery Plan

2020 – 2022

Aberdeenshire Council

NHS Grampian

1 Introduction

This Strategic Delivery Plan should be read alongside the Health and Social Care Partnership's Strategic Plan which was agreed by the Integration Joint Board (IJB) in December 2019.

The purpose of this plan is to set out the transformational pieces of work and key projects which will be a priority for delivery during the first year of this current Strategic Plan. This plan was already in development prior to the outbreak of the COVID-19 pandemic, however, responding to COVID-19 has meant that some of the work which was being identified in that original plan has moved at pace. The adoption of new digital technologies, building new partnerships, supporting self-management and supporting the workforce have in particular been key to the partnership's response. Other areas of transformation may however be more challenging during the pandemic, uncertainty within the social care market being an example. In developing this plan we have been conscious of prioritising areas of change and transformation that are most likely to be deliverable.

Despite the pandemic we are clear that our ambitions and the priorities that were identified in the strategic plan have not changed. What has changed is our starting position.

The five agreed strategic priorities remain:

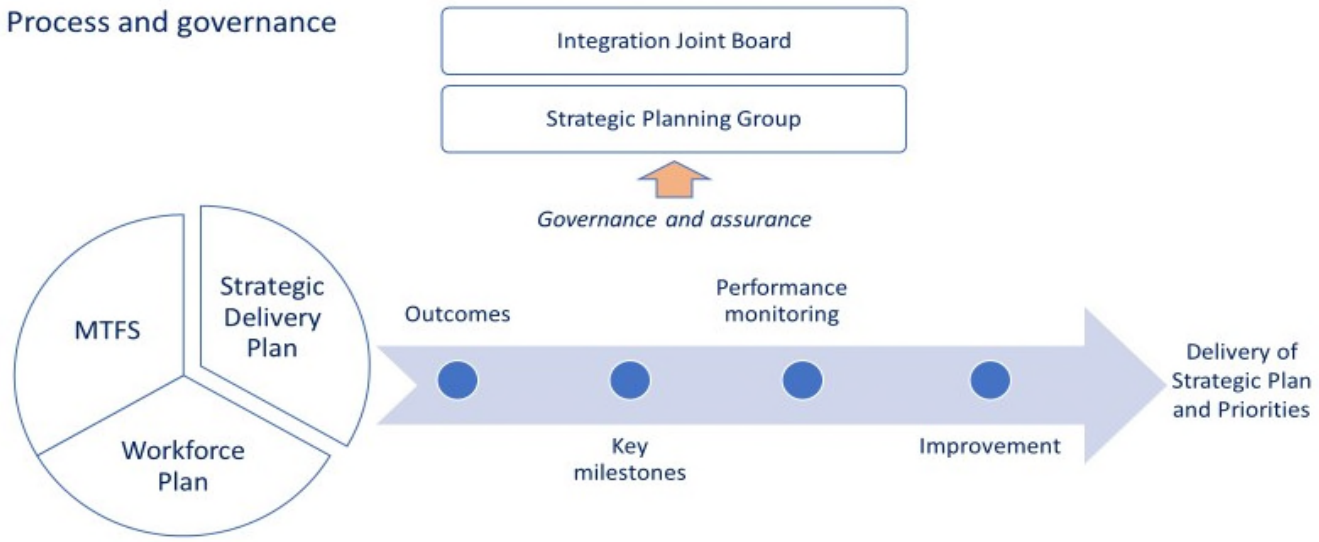
Prevention and Early Intervention
Reshaping Care
Engagement
Effective use of Resources
Tackling Inequalities and Public Protection

The following pages set out how the partnership plans to take forward these priorities over the next 18 – 24 months. We will take this opportunity to capitalise on the learning resulting from Covid-19 and transform delivery models to provide services that are COVID-19 secure, agile, responsive and sustainable.

2 Implementation and Governance

The plan will be supported by a performance framework, with responsibility for oversight of performance held by the Strategic Planning Group reporting to the Integration Joint Board. This will provide assurance as to progress against each of the key areas of transformation and in turn towards delivery of our strategic priorities.

The performance reporting framework will set out the outcomes to be achieved against each project, the key milestones for delivery, and the performance indicators that will provide assurance that the required changes and improvements are taking place. The Strategic Delivery Plan will be closely aligned with the HSCP's Medium Term Finance Strategy (MTFS) and Workforce Plan, as the three main levers through which we will deliver the HSCP's Strategic Plan. Reflecting the ongoing fluid and changing landscape presented by COVID-19, the Strategic Delivery Plan will be a 'live' document which may be subject to further revision to respond to any new or emerging challenges or opportunities.



3 Strategic Delivery Plan

The next few pages highlight the key themes which will drive the delivery of our strategic priorities. Our priorities around Prevention and Early Intervention and Reshaping Care are key to the way in which we will transform services for the future. In line with our MTFS, Effective Use of Resources will ensure services are sustainable and can be delivered within the resources available to us. Engagement, Tackling Inequalities and Public Protection are at the heart of all these projects. We will continue to involve people in making decisions about their care and listen to communities as we develop services, taking into consideration local needs and working alongside partners including those in the third and independent sector. Any changes to service delivery will consider the impact on people with protected characteristics and we will take every opportunity to address health inequalities.

Plan on a Page

Digital First **Maximise the use of technology**	• Work with partners to address digital inequality in our communities, ensuring that addressing digital access becomes an integrated part of our assessments
	• Maximise use of smart technology in homes and homely settings to promote independence.
	• Total Triage will be maintained and developed through use of E-consult etc.
	• Support the further roll out of technology to support the management of long-term conditions
	• Support reduction in rural health inequalities through access to digital technology making services more accessible
	• Support our integrated teams with shared systems that improve real time information
	• Embed flexible working, reduce travel and define our future building bases estate needs
Partnerships **Develop existing partnerships and build new ones**	• Capitalise on opportunities to work strategically with partners in Housing and Education
	• Maximise opportunities to work together with Live Life Aberdeenshire and others to promote improved physical and mental health.
	• Joint working with housing partners to ensure access to accommodation that promotes independence
	• Alongside Partners in the CPP address the LOIP Community Justice and ADP Priorities
	• Enable communities to support community capacity building and resilience
Operation Home First **Develop community services**	• Develop a new community-based Frailty Pathway
	• In partnership with the Acute sector we will implement 'Hospital at Home' pilots, moving more secondary care supports into our communities
	• Enhance community-based specialist dementia care
	• Transformation of Hosted Mental Health services in line with agreed Grampian Strategy.
Reshaping Care **Person centred and sustainable services for the future**	• Support Pharmacy First – supporting people to access quick, local advice and treatment from the pharmacist.
	• Primary Care Improvement Plan
	• Move the balance from unscheduled to scheduled care
	• Complete a future needs analysis on Care Home / Homely Setting provision and plan, with all partners, both for the future estate required and sustainable models of care provision.
	• Utilise the 'Action 15' funding to increase the mental health workforce to give enhanced access to mental health support across Primary Care, Police Custody and HMP Grampian.
	• We will work with partners and providers to enhance 'commissioning for outcomes'
	• Work with all partners to reduce the need for out of area placements (both inpatient and social care)

Digital First – Maximise the use of technology

Context:	Key areas of work:
Prior to Covid-19 the partnership was exploring the use of Attend Anywhere and Near Me in order to enable people to access support through digital means. The restrictions placed on us through Covid-19 meant that this work has been progressed at pace to help us to maintain social distancing, keep vulnerable people safe and prevent the spread of infection. This progress is something we want to capitalise on and we will explore opportunities to continue to grow the use of digital technology. Integration has seen health and social care teams come together in order to put the person at the centre and build personalised services around the individual. Currently patient information is held on a variety of systems and this can mean people needing to repeat information and a duplication in form filling. Alongside the importance of sharing client information staff need to be able to meet virtually and access shared information. All of the above work will link with the NHS Grampian and Aberdeenshire Council digital strategies.	• Supporting 'Near me' and other digital platforms to be the default, where appropriate, across primary and secondary care. • Maximise use of smart technology in homes and homely settings to promote independence ie Florence and ALEXA pilot • Maintain Total Triage through use of E-consult etc. • Continue to work with partners and communities to address loneliness, learning lessons from creative 'Virtual Visiting' during the initial phase of COVID-19 'lockdown'. • Work with partners to address digital inequality in our communities, ensuring that addressing digital access becomes an integrated part of our assessments. • Alongside the Scottish Government Digital Health and Care Directorate, expand access to cCBT (computerised Cognitive Behavioural Therapy) • Support reduction in rural health inequalities through access to digital technology making services more accessible • Ensure access to information and shared systems for staff, improving communication and information sharing.
Individual outcomes (If we get this right people will say …)	**System outcomes:**
• I find it easy to access information on health and social care services. • I have a better understanding of my condition and how I can help manage it. • I know who to turn to. • I can link to my healthcare professional from home without the need to travel. • I only had to tell my 'story' once. • I am more independent.	• Improved triage will ensure people see the right professional first, reducing the number of interactions each individual requires to access support. • Increased support for self-management will support people to manage their own conditions with less input from professionals. • Smart technology will allow more people to increase or maintain their independence. • Working with partners to improve digital connectivity is likely to positively impact on Health Inequalities. • Digital technology is likely to make it easier to deploy staff resource to hard to recruit areas. • Improved communication and live time information sharing between professionals. • Improved sign posting to the correct information and support. • Increased ability for staff to access and share information. • Ability for staff to work from home where required.

Partnerships - Develop existing partnerships and build new ones

Context:	Key areas of work:
There is a wealth of resources within our local communities and in the third sector and we recognise the importance of valuing and supporting that contribution. As Aberdeenshire dealt with the Covid-19 pandemic we saw a surge in community resilience as communities pulled together and we want to build on this. Communities have a key role particularly around prevention and supporting people to integrate into supportive communities. The HSCP recognises the importance of working alongside the third sector and Aberdeenshire Voluntary Action (AVA) in order to realise that potential. This work links to the Aberdeenshire Health Improvement Delivery Plan and other workstreams supporting and promoting self-management.	• Strengthening community resilience by: supporting access and opportunities to participate in healthy living opportunities; working alongside community groups to support their community to live well and mitigate the impacts of poverty. • Building on strong partnership working with the wider community through the Local Resilience Groups and contributing to the development and implementation of Community Planning Locality Plans to address inequalities. • Building on our Covid19 partnership with Live Life Aberdeenshire, maximising opportunities to work together to promote improved physical and mental health.
Individual outcomes:	**System outcomes:**
• I am aware of and can access support and information within my community to meet my needs. • I have the knowledge and confidence to take responsibility for my own health and wellbeing. • I feel safe, involved and included within my community.	• Meaningful and sustainable relationships in place with third sector partners. • Robust evaluation of funded projects. • Third sector partners feel fully involved and integrated in service planning and decision making. • Strong and sustainable relationships by connecting third sector and statutory services. • All partners recognise the added value of third sector knowledge, skills and experience. • The third sector is enabled to better influence and inform service design, commissioning and delivery.

Operation Home First – Develop community services

Context:	Key areas of work:
Within the context of our response to Covid-19, we have benefitted from the strong relationships with Aberdeenshire Council and NHS Grampian. This enabled a swift, cohesive response, ensuring that our residents and staff have the protections and supports they need to stay safe. Operation Home First is the next phase in the health and social care response to COVID-19 across Grampian, involving all three HSCPs and the Acute Sector and harnessing the strong collaborative working and "whole systems" approach which was adopted across all sectors during the response phase. Operation Home First describes the framework within which we can create the right environment for keeping people at home safely, reducing hospital admissions where an alternative intervention is possible, and making sure that people who do need care in hospital do not stay in hospital longer than they need to. A key focus within Aberdeenshire will be directing support towards prevention and an increased community focus to improve outcomes for older people. This will be based on a principle of 'home first' for all care, ensuring the system remains flexible and agile to respond to any surges in demand, and considering the whole person, their circumstances and supports.	• Continue to encourage people to plan ahead with Anticipatory Care Plans, and make information more accessible - Know who to turn to, NHS inform, NHS Scottish Services Directory, enhancing our own online presence. • In partnership with the Acute Sector implement 'Hospital at Home' pilots, moving more secondary care supports into our communities. • Redesign of Frailty Pathway in conjunction with Acute Sector and City HSCP. • Build on the success of our Virtual Community Wards, by potentially expanding this into a "Hospital at Home" model with additional interventions and pathways for an identified patient group, to allow clinical assessment and specialist treatment at home, where safe to do so. • Analyse patient journeys where we have successfully promoted early discharges from hospital directly to home (or a homely setting) and aim to capture the right conditions in order to embed this into our everyday working; identifying the resource needed to do so.
Individual outcomes:	**System outcomes:**
• I am happy with my quality of life. • I feel involved in decisions relating to my care, and that my individual needs and circumstances are taken into account in the planning of my care. • Support and services are available to me close to home. • I have the information I need to make decisions about my care and support. • The people who care for me feel supported in their role.	• People are supported in a way which meets their personal outcomes. • More people are supported to remain safely at home ("home" being where a person normally lives or would choose to live and may include a care home). • Reduction in unnecessary hospital attendances or admissions. • Safe, supported and earlier discharge of people back home after essential specialist care.